



HAWKE'S BAY
District Health Board

REVITALISING THE HEALTH SECTOR IN HAWKE'S BAY



MARCH 2010

EXECUTIVE SUMMARY	3
<i>Introduction.....</i>	3
<i>Key Areas for Focus.....</i>	3
REVITALISING THE HEALTH SECTOR IN HAWKE’S BAY	4
<i>Key Problems to be Addressed.....</i>	4
<i>Key Premises.....</i>	4
<i>Governance Arrangements - Existing Governance Structure</i>	5
<i>Governance Arrangements - Refining the Existing Governance Structure.....</i>	5
<i>Governance Arrangements - Establishment of a Clinical Council</i>	6
<i>Governance Arrangements - Proposed new Governance Structure.....</i>	8
<i>Executive Management Team - Current EMT.....</i>	9
<i>Executive Management Team - Proposed EMT structure.....</i>	9
<i>Provision of Primary Care Services.....</i>	10
<i>Background.....</i>	10
<i>Key Considerations</i>	10
<i>Summary</i>	11
ORGANISATION DEVELOPMENT	12
<i>Background.....</i>	12
<i>The Way Forward</i>	12
<i>The Programme.....</i>	13
SERVICE AND FINANCIAL IMPROVEMENT	16
<i>Background - National Economy</i>	16
<i>Current Position.....</i>	16
<i>Trends</i>	17
<i>Historical Process for Allocation of Resources</i>	18
<i>Service and Financial Improvement Programme</i>	18
<i>Goal</i>	18
<i>Milestones / Timeframes</i>	19
<i>Health Sector Productivity Projects.....</i>	20
<i>Hospital and Community Service Productivity Projects.....</i>	21
<i>Corporate Productivity Projects</i>	22
<i>Workforce Related Projects</i>	22
<i>Approach / Key Principles</i>	23
<i>Programme Structure.....</i>	24
<i>Roles and Responsibilities.....</i>	24
<i>Programme Budget</i>	24
<i>Quality Requirements.....</i>	25
<i>Risk Management.....</i>	25
<i>Reporting.....</i>	25
<i>Assumptions</i>	26
<i>Communications.....</i>	26
<i>Summary</i>	26
APPENDIX – THE CLINICAL COUNCIL.....	27

EXECUTIVE SUMMARY

Introduction

The Hawke's Bay health sector has been through some relatively troubled times in recent years. It is moving forward, but in order to make more effective progress, it is time to review the way it is structured and organised in order to ensure it is more effective in improving health and health care and that its services are clinically and financially viable.

Hawke's Bay serves a population of 155,000 and travel times to a major centre are significant (four hours to Wellington by road). In international terms, it is a small population to sustain comprehensive services. In order to do this, it must be efficient and all of its constituent parts need to be pulling in the same direction whether they are primary or secondary care, medical or nursing, health or social care, clinical or managerial. The DHB also needs to work effectively with its colleagues in the Central Region in order to sustain and improve services. If we do not ensure that local effort is properly managed and coordinated then we will see some local services become more difficult to sustain. One of the symptoms of the local dysfunctional arrangements is the poor financial position of the DHB and one of the key indicators of recovery will be an improvement in the local financial position alongside a demonstrable improvement in relation to key service indicators.

Key Areas for Focus

In order to improve the local situation we have identified actions that need to be taken to address:

- Structure through measures that will impact upon the DHB Governance, the DHB Corporate, the Hospital and the PHOs
- Culture and Capability through an Organisational Development Programme
- Sustainability through a Service and Financial Improvement Programme

Each of these elements is interrelated - putting in place the right structure should support the right culture which should enable better financial control and service improvement. The key elements of each of these areas are presented to the Board as work in progress. Where appropriate, implementation has commenced, where further work or consultation is necessary then this is underway and is identified in the document.

“...putting in place the right structure should support the right culture which should enable better financial control and service improvement.”

REVITALISING THE HEALTH SECTOR IN HAWKE'S BAY

Key Problems to be Addressed

A number of issues have been identified, they echo and build upon the assessment done by PricewaterhouseCoopers in 2008/9:

1. Intelligence is fragmented so decision-making is not well supported.
2. Performance management is not focussed and therefore poorly done.
3. The Executive Management Team ("EMT") is too large and roles and responsibilities are confused.
4. Clinicians are poorly engaged within the DHB.
5. The DHB is too hospital-centric.
6. That satisfactory action is taken to address the inequalities in health in Hawke's Bay, particularly relating to the Maori population.
7. The funder-provider split is unhelpful in fostering a collaborative ethos.
8. There is a misalignment of responsibility for spending resources with accountability for their expenditure.
9. Primary health care oversight is fragmented and the Minister's direction is clearly to reduce the numbers of PHOs.
10. The DHB has allowed itself to become too removed from engagement with General Practice.

Key Premises - any reorganisation should:

1. Align accountability with responsibility.
2. Foster cooperation and collaboration over competition.
3. Enhance quality and efficiency.
4. Ensure that clinicians are involved at each level of the decision-making process.

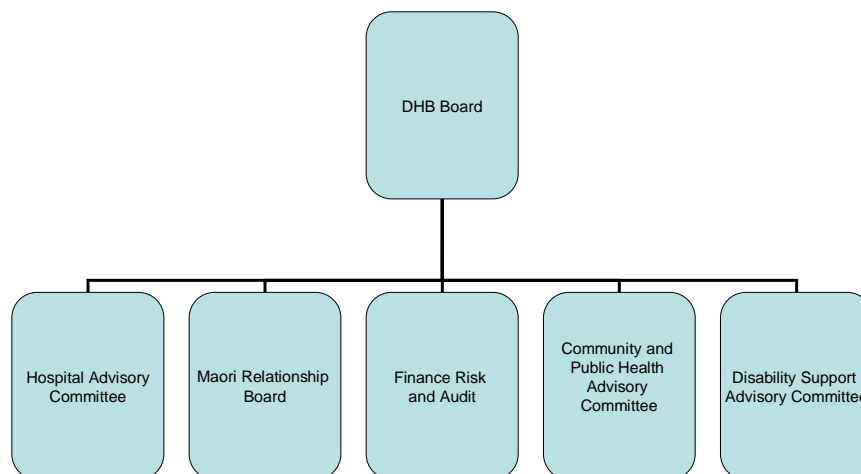
In order to do this the governance and structural arrangements need to be realigned to ensure that:

- Clinical advice is firmly embedded;
- Clinical accountability is supported structurally;
- There are governance and structural arrangements that clearly focus on secondary and primary care as well as those which must span both;
- Managerial roles and responsibilities are clarified; and
- Purchaser/provider separation is clearly secondary to functional delivery.

Governance Arrangements - Existing Governance Structure

The existing Governance Structure is set out in Figure 1.

Figure 1
The Existing Governance Structure



“There may be some merit in merging both DSAC and CPHAC in order to address clinical involvement in the governance of the DHB and for the structure not to become unwieldy.”

Governance Arrangements - Refining the Existing Governance Structure

Whilst much of the governance structure is prescribed by legislation and/or nationally, there are few active clinicians who have formal membership of this arrangement.

There may be some merit in merging both DSAC and CPHAC in order to address clinical involvement in the governance of the DHB and for the structure not to become unwieldy. However, sections 34 and 35 of the New Zealand Public Health and Disability Act 2000 (“the NZPHDA”) requires the establishment of each of these committees, and sets out their functions, how members are to be appointed to the committees, the processes to be followed at meetings and so on, in Schedule 4 of the NZPHDA. There is no provision in the NZPHDA for the merger and/or disestablishment of these committees.

Whilst the legal advice received is that it is not open to the Board to merge DSAC and CPHAC and to replace these committees with one new committee, it is open to the Board to appoint the same members to DSAC as to CPHAC. It is also open to have both DSAC and CPHAC to meet at the same time, on the same date. However, each committee will remain responsible for meeting each of their functions, and for following the processes set out in Schedule 4 (for example, notifying the public of meetings etc).

A closer working arrangement of this nature would allow these two committees to function in a way which would effectively mirror the responsibilities of HAC for non-hospital and community oriented services.

Governance Arrangements - Establishment of a Clinical Council

To significantly improve services and address financial control, there must be greater engagement of local clinicians. 'In Good Hands', which was produced by a Ministerial working group, defines clinical governance as:

'the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.' (Sally, Donaldson 1998 adapted)

The principles identified are:

- Quality and safety will be the goal of every clinical and administrative initiative;
- The most effective use of resources occurs when clinical leadership is embedded at every level of the system;
- Clinical decisions at the closest point of contact will be encouraged;
- Clinical review of administrative decisions will be enabled;
- Clinical governance will build on successful initiatives; and
- Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

This seems to be a good starting point for ensuring that clinicians are brought together across primary and secondary care to provide an oversight of clinical governance for the district.

The report goes on to describe how clinical governance must cover the whole patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services; through being involved with EMT and at all levels in the organisation sharing in decision making, responsibility and accountability.

It is proposed that, in order to implement good clinical governance in Hawke's Bay, a new body called the Clinical Council be established. The Council's purpose would be to provide clinical advice to the DHB on key proposed service changes and to provide oversight of clinical quality and patient safety locally. In addition, it would seek to break down boundaries across primary and secondary care to ensure that services are organised around the needs of people.

The Council will be responsible for advising the local health sector on the redesign of the local clinical governance framework, across the hospital and primary care, to take account of a range of factors including:

1. Clinician involvement at all levels of the organisation.
2. Devolvement of decision making and responsibility to the most appropriate clinical unit or team.
3. The development of clinical leadership at all levels.
4. More systematic use of information about clinical outcomes.

"The Council's purpose would be to provide clinical advice to the DHB on key proposed service changes and to provide oversight of clinical quality and patient safety locally."

5. Ensuring that information from different sources is brought together so that a fuller picture about professionals' practice is properly considered.
6. Ensuring local organisations adopt best practice in investigating critical incidents and acting on concerns.

It is proposed that the Council be chaired by a Chief Medical Officer (whose role may need to be redefined as set out in further detail under the heading "Executive Management Team" below), and that its membership be comprised of 13 multi-disciplinary clinicians as identified and appointed by the CEO. Such membership could be comprised of:

CMO Primary Care
CMO Hospital
DON Primary Care
DON Hospital
Clinical Director x 3
GP Advisers x 3
1 other clinician (neither medical nor nursing) hospital
1 other clinician (neither medical nor nursing) primary care
1 clinician with a population health perspective

The CEO would also be a member of the Council.

All positions will be appointed to and will have clear requirements placed upon them within a job description. The posts will be remunerated.

Each CMO position will be for three sessions per week and the other positions will carry an expectation that they spend one session per week on this work which will be remunerated.

The Council will provide a regular report to the HBDHB Board on clinical outcomes and patient safety – **this will be given equal prominence to the reporting of financial information**. The proposed terms of reference of the Clinical Council are set out in the appendix.

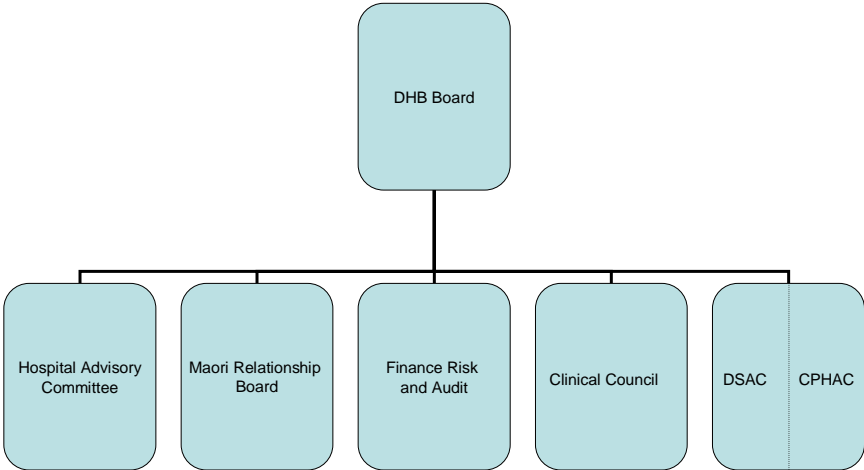
“All positions will be appointed to and will have clear requirements placed upon them within a job description.”

Governance Arrangements - Proposed new Governance Structure

The proposed new Governance Structure is set out below in Figure 2

“The Council will provide a regular report to the board on clinical outcomes and patient safety – this will be given equal prominence to the reporting of financial information.”

Figure 2
The Proposed Governance Structure



Executive Management Team - Current EMT

The EMT currently comprises 11 people as follows:

- Chief Executive
- Chief Operating Officer
- Chief Financial Officer
- General Manager HR
- Chief Information Officer
- General Manager Planning, Funding and Performance
- Director, Maori Health
- Chief Medical Adviser
- Associate Director of Nursing (Hospital)
- Associate Director of Nursing (Primary Care)
- Communications Manager

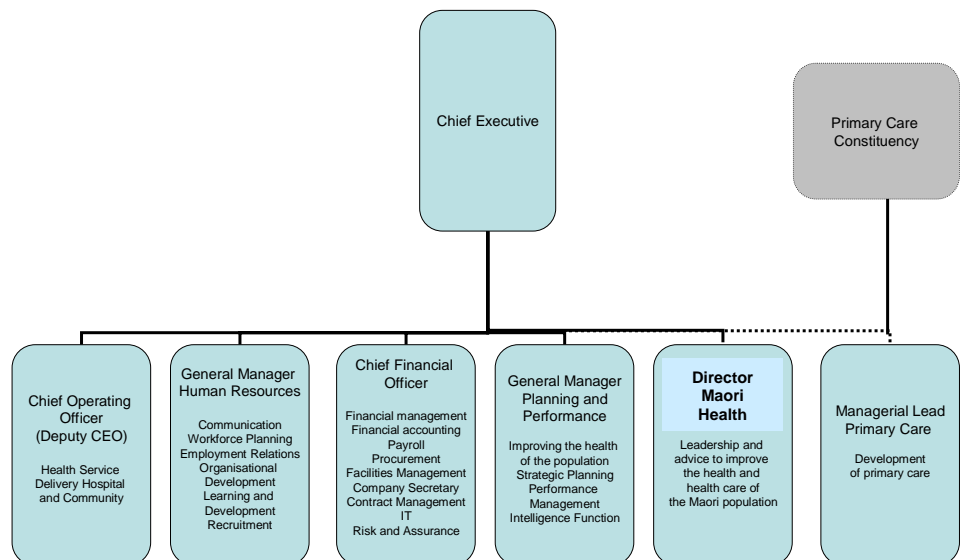
In addition, the internal Risk and Assurance Manager is accountable to the CEO, although not part of the EMT.

Executive Management Team - Proposed EMT structure

It is suggested that this group is too large for effective day-to-day running of the DHB and responsibilities are confused. In order to simplify the structure, clarify the responsibilities and to ensure that there is both a primary and secondary care balance to the team, the revised structure in figure 3 is proposed.

“...this group is too large for effective day-to-day running of the DHB and responsibilities are confused.”

Figure 3
The Revised Management Team



The proposal to restructure CEO Direct Reports is subject of consultation and the new structure put in place during April. The CMOs and DONs will attend for a monthly extended strategic EMT meeting and will be free to attend any other EMT meeting.

Provision of Primary Care Services

Background

In Hawke's Bay, there are currently three PHOs - Hawke's Bay PHO, Wairoa PHO and Tu Meke First Choice PHO.

Whilst there is evidence of collective working from the PHOs, it is clear from the central direction of travel, and to ensure that there is the right level of support and scrutiny within primary care, that the way in which primary care services are currently funded within Hawke's Bay should be reviewed.

The DHB is currently considering the way in which primary care services are funded by the DHB, and what changes can be made to ensure horizontal integration across primary and secondary/tertiary services, resulting in more efficient, effective delivery of health services.

There are a number of options open to the DHB in terms of the funding of primary care services, which will be consulted on as and when these have been further explored. These will include the status quo, two PHOs, a single PHO and the development of a Primary Care Directorate within the DHB.

Key Considerations

The key considerations when exploring possible options include:

- Achieving a closer working relationship with local primary care providers in order to develop local primary care;
- Ensuring that there is clear accountability to the DHB and full participation in the sector's management and leadership processes;
- Ensuring community participation in governance is genuine; giving communities a meaningful voice; and ensuring that locally communities are appropriately responded to;
- Seeking the views of providers and practitioners and having sufficient processes in place to ensure that decisions take account of the range of views;
- Reporting and disclosure requirements allow the DHB and the public to fully understand the use of public funds and the quality and effectiveness of services in order to evaluate the results;
- Enabling service development through the development of appropriate service providers;
- Ensuring that management overheads are minimised to ensure that there is maximum investment in patient services.

“...changes can be made to ensure horizontal integration across primary and secondary / tertiary services, resulting in more efficient, effective delivery of health services.”

“... further organisational development will need to be undertaken to underpin the structural change and tight project management to ensure effective service and financial recovery.”

Summary

The reorganisation of Governance, Executive Management and PHO services attempts to address a set of issues that afflict the Hawke's Bay health system and are amenable, at least in part, to improvement through structural change.

We have drawn on a review undertaken by PricewaterhouseCoopers of the management arrangements within the DHB and proposed wider systemic changes to address what are in reality wider problems.

If the proposals are adopted in Hawke's Bay, governance across primary and secondary care will be simplified, clinicians from primary and secondary care will be involved together at all levels of decision-making, the “line of sight” from proposal through to delivery and outcome will be clarified and the opportunities for clinical integration will be significantly improved.

Structural change is, however, only part of the solution and further organisational development will need to be undertaken to underpin the structural change and tight project management to ensure effective service and financial recovery.

ORGANISATION DEVELOPMENT

Background

Structural changes as outlined in the previous section need to be supported by having the necessary organisational culture and capability in place.

The health sector in Hawke's Bay has run deficits for nine out of the last 10 years. For the National Health Targets the DHB sits mid to lower table for four out of the six targets. This indicates that the DHB has not been able to consistently manage to deliver balanced budgets, nor has it been able to focus improvements in patient care on a level with other DHBs. This needs to change. We must deliver on our financial targets and health targets as part of our drive to deliver high standards of patient care and where patient safety and quality of care are paramount and delivered in a sustainable way.

The culture needed across the health sector must be one of continuously looking at the way we do things and asking how we can improve. Hawke's Bay needs to make a success of the Service and Financial Improvement Programme, the deficit needs to be removed and the service and financial improvements made under the programme captured, sustained and improved upon.

Additionally, the DHB can support capability building across the whole Hawke's Bay health sector.

The Way Forward

We need a culture where patient safety and quality of care are paramount. We need a professional clinical and management culture where staff are highly motivated and supported to solve problems and identify opportunities for improving productivity and quality of care.

To do this we need:

- Both clinical and managerial leadership
- Staff who are engaged in delivering the goals of the organisation
- Improvements that can be sustained
- Clarity of accountability which is properly aligned with responsibility
- A good understanding of problem solving and quality improvement methodologies
- Best practice in recruitment to ensure that we:
 - get the best candidates
 - new recruits are clear what is expected of them
 - are appropriately reviewing all vacancies
- Good appraisal systems
- Staff with the necessary capabilities to deliver their objectives
- Consistent and frequent communication across the sector to ensure that all staff understand the goals of the organisation and its progress in delivering those goals
- Highly engaged and productive staff who are fairly remunerated
- Unions who are engaged with the delivery of key health sector goals

“The culture needed across the health sector must be one of continuously looking at the way we do things and asking how we can improve.”

“...that we have the necessary capability to deliver on the service and financial improvement programme and to deliver quality improvements which improve patient safety and quality.”

- An approach to learning and development that ensures that investment in staff is fully aligned with the goals of the local health sector and fully addresses key capability gaps such as:
 - continuous quality improvement
 - project management
 - clinical leadership
 - performance management
 - financial management

To ensure sector-wide transformation, a specific organisation development programme has been commissioned.

The Programme

Develop management and leadership capability. Strong foundations of management basics and better management capability are needed to move the transformation programme forward. The health sector needs high calibre clinical leaders. These are leaders who can make a contribution to the strategic direction of the local service, improved patient safety and quality and able to make high quality decisions and interact with colleagues and staff in a way which supports the achievement of Hawke’s Bay DHB’s health and financial targets. To achieve this we will:

- Develop a clinical leadership programme for our clinical leaders with high potential in the sector
- Review and implement a new set of local competencies and review our current managers against competencies and develop plans to bridge gaps
- Implement new competencies in position profiles and recruit to those
- Continue with our Basic Leadership programme with a focus on management basics including performance management, quality and process improvement and problem solving
- Continue with our existing management development offerings
- Reinstate regular financial management training and introduce project management training
- Institute a new revised Advanced Leadership programme focusing on our 20 staff with high managerial potential

Develop organisational capability. We need to have the organisational capability to deliver on the health and financial targets. Part of this is ensuring that we have the necessary capability to deliver on the service and financial improvement programme and to deliver quality improvements which improve patient safety and quality. To achieve this we will:

- Increase the utilisation of on-line learning across the organisation to increase the effectiveness and reduce the costs of Learning and Development
- Centralise the design, development and delivery of all learning to ensure it is optimally organised and delivered in a consistent and cost effective way
- Assess and bridge the gap in our project management capability
- Introduce new training and development modules e.g. problem solving for staff
- Develop a sector-wide Learning and Development Strategy prioritising the capabilities we need to develop.

“...unions will have to be engaged strategically and operationally...”

Improve the consistency and efficiency of recruitment. Our recruitment processes need to be best practice and consistent across the organisation to ensure we identify the roles we need to recruit and get the highest quality applicants applying for our roles at the lowest cost. We also need to ensure that our workforce is representative of the

public we serve. With Maori being only 10% of the DHB staffing but 25% of HBDHB's population, we have some distance to go. To achieve this we will:

- Centralise recruitment
- Ensure best practice recruitment practices are in place and operating consistently across the DHB, and offer support to the sector as a whole
- Increase the recruitment of Maori through targeted promotion of health service careers to Maori and identifying and removing barriers to the recruitment and development of Maori
- Ensure the local health service has an attractive employment brand.

Increase staff engagement and retention. Highly engaged staff are more productive and will deliver a better service for patients. Highly engaged staff are well inducted, clearly understand what they do links to the organisation's goals and are consistently supported and encouraged to achieve their objectives through good management. To achieve this we will:

- Ensure there is a consistent performance appraisal and development review process across the DHB ensuring that high performance is recognised and poor performance managed
- Conduct a staff engagement survey and implement improvement plans that arise out of that
- Develop aged workforce staffing strategy
- Review and implement new induction processes aligned to and supporting the achievement of our financial and health targets.

Improve effectiveness of communications. Managers, staff and the Hawke's Bay public need to be able to get timely and accurate information to enable them to make quality decisions and engage in the local transformation programme. To achieve this we will:

- Ensure every project and change initiative has a quality communications plan developed to support it
- Redesign HBDHB's website

Increase workforce efficiency. We need to improve how staff are deployed and supported within the organisation. To achieve this we will:

- Systematically reduce annual leave accumulations above two years and then one year's accumulation
- Implement optimal rostering solutions across Health Services
- Support staff in delivering service improvements

Enhance the competitiveness and appropriateness of remuneration systems. Our remuneration systems need to be able to attract high quality applicants, support retention of staff and be financially affordable and sustainable. To achieve this we will:

- Develop a Hawke's Bay DHB remuneration strategy
- Develop a new remuneration system for staff on IEAs

“Responsibility and accountability need to be properly aligned for all staff and, above all else, staff need to be enabled to achieve their full potential so that the care they provide for patients can be truly excellent.”

- Influence MECA bargaining strategy development to help best achieve our remuneration objectives

Improve union engagement. Because of the significant period of change that we are going through, unions will have to be engaged strategically and operationally to ensure that union delegates and organisers engage in the focus on our financial and health targets. To achieve this we will:

- Shift the focus of the Bi-partite meetings and all union relationship meetings to strategic issues and engagement on the financial and health targets
- Engage proactively with unions in all restructuring initiatives

Improve HRIS utilisation and reporting for management analysis. Managers need to have good quality HR and financial data to make decisions on. To achieve this we will:

- Implement HRIS project including implementation of on-line leave approvals
- Provide high quality and reliable HR and financial reports to managers and hold them to account for variances and actions to remedy variances

The Cost

Further work is to be undertaken to clarify the full cost of the programme, but it is expected that most will be undertaken in-house and all will be contained within existing resources already earmarked for management and professional development.

Summary

This section has provided an outline of a programme of work to develop the right culture and improve many of our processes in Hawke’s Bay. If we are to deliver continuously improving services for the population of Hawke’s Bay, we require a number of things to be in place:

- A workforce across the sector that is engaged, equipped, supported and motivated
- The health sector in Hawke’s Bay needs to be seen as an attractive place to work
- Responsibility and accountability need to be properly aligned for all staff and, above all else, staff need to be enabled to achieve their full potential so that the care they provide for patients can be truly excellent.

SERVICE AND FINANCIAL IMPROVEMENT

Background - National Economy

Over recent years the health sector has received \$750m of new funding annually. DHBs receive between 60-70% of this directly, however with the global recession the Government has made it very clear that health cannot continue to sustain this level of growth and needs to be much more efficient and effective with the money allocated. DHBs are getting to grips with this situation, some better than others. For 2010 the proposed increase is \$350m.

The message is clear - Hawke's Bay DHB needs to live within its funding and all our stakeholders need to understand this. We need to target our resources better and improve our productivity in order to get better value for the money we are allocated.

The National Health Board is yet to be operational, but it is clear from the correspondence we have seen that they rightly have a key focus on financial sustainability and productivity. With a more active direction from government, this means national and regional collaboration will become the norm and, in some cases, further mergers or rationalisation of DHB staffing will occur.

Current Position

Hawke's Bay DHB has developed a service and financial improvement plan which sees a \$3.5m deficit next year and break even in 2011/12.

In 2009/10 our planned deficit is \$4.9m and year to date we are favourable by \$1.5m. The \$4.9m target, however, is going to be difficult to achieve as much of the favourable variance relates to timing, and provider arm costs which are significantly higher than budget. In addition, ACC revenue is forecast to drop significantly and negotiations on major awards are due in the early part of 2010.

The challenges we face are similar to those of other DHBs, and include:

- Clinical engagement/leadership
- Pay inflation as a consequence of MECA settlements above affordability
- High acute growth, challenging the ability to deliver elective and emergency department targets
- A need to significantly improve productivity in line with national and international best practice

“We need to target our resources better and improve our productivity in order to get better value for the money we are allocated.”

“The Minister’s objective is clear – we must live within the funds received and we must get back to break even.”

Trends

Hawke’s Bay DHB has been over many years a poor financial performer, having delivered an operational deficit every year since 2001 with one exception in 2004/5. This has been at a time of record periods of growth in health service funding.

The following table sets out the DHB’s position over the last decade.

	Projection		2008/09	2007/08	2006/07	2005/06	2004/05	2003/04	2002/03	2001/02
	2010/11	2009/10								
Revenue \$ms	443.9	429.0	408.0	382.6	363.2	323.1	296.9	259.9	194.8	182.8
Net Result \$ms (surplus / (deficit))	(3.5)	(4.9)	(6.0)	(6.7)	9.2	(3.9)	6.4	0.2	(6.5)	(8.7)
Abnormal					12.1		1.9	0.7	(0.2)	1.1
Operational result surplus / (deficit)	(3.5)	(4.9)	(6.0)	(6.7)	(2.9)	(3.9)	4.5	(0.5)	(6.3)	(9.8)
% of income	-0.8%	-1.1%	-1.5%	-1.8%	-0.8%	-1.2%	1.5%	-0.2%	-3.2%	-5.4%
Break out of Surplus / (deficit) (\$ms)										
Funding health Services (Funder arm)				3.5	2.3	3.0	5.0	1.5	0.2	-
Governance & funding admin				0.3	0.1	(0.4)	(0.6)	(0.1)	(0.6)	(1.1)
Providing Health Services (including Corporate)				(10.5)	(5.3)	(6.5)	0.1	(1.9)	(5.9)	(8.7)
Operational result surplus / (deficit)	-	-	-	(6.7)	(2.9)	(3.9)	4.5	(0.5)	(6.3)	(9.8)
	3.5	4.9	6	0	0	0	0	0	0	0
DHB commenced 1st January 2001										
PBFF introduced (\$20m short received \$3.26m extra)										***
PBFF introduced (\$20m short received \$2m extra)										***
Full funding under PBFF (additional \$20m)							*** \$12.1m	*** \$5.1m		
Patient transport growth high compared to FFT				***	***	***	***	***		
impact of extra FTE's Health Services						***	***	***		
MECCA settlements above FFT (\$4m)			***	***			***	***		
Major capital developments							Risk PAC	AAU		
							CT scanner			
Services devolved							HOP Oct	DSS > 65		

The Hawke’s Bay health sector faces the same challenges as many other DHBs and all have been expected to develop strategies to remain in balance, or close to balance. The Minister’s objective is clear – we must live within the funds received and we must get back to break even.

Historical Process for Allocation of Resources

DHBs were set up from 1 January 2001. With the introduction of the Population Based Funding Formula (PBFF), Hawke's Bay was underfunded by approximately \$20m. This money was received over the 2002-05 period which coincides with the significant increase in FTEs in the provider arm. Effectively the new funds were invested in the provider arm boosting staff numbers, particularly in doctors and nurses.

Total	FTE growth using the "FTE accrued" definition								2010 Growth since		
	2003 FTEs Actual	2004 FTEs Actual	2005 FTEs Actual	2006 FTEs Actual	2007 FTEs Actual	2008 FTE's Actual	2009 FTE's Actual	2010 FTE's Budget	2003	2007	2008
Medical	157	152	184	209	215	234	249	243	55.0%	12.8%	3.7%
Nursing	694	719	738	775	792	789	838	800	15.2%	0.9%	1.3%
Allied Health	313	311	324	331	349	387	390	400	28.0%	14.8%	3.5%
Support Mgmt & Admin	142	133	129	132	133	128	148	146	2.7%	10.4%	14.4%
Total FTE's	1,649	1,674	1,762	1,832	1,891	1,941	2,037	1,989	20.7%	5.2%	2.5%

This growth has not been in response to a coherent strategic plan. It has been disconnected from delivery and the focus has been primarily operational and demand driven.

Service and Financial Improvement Programme

We need to ensure that we operate differently in the future and that our resources are better managed and prioritised. In order to meet Government expectations and address local needs, we are therefore committed to make significant performance improvements that will result in elimination of the deficit through a programme that focuses on four key areas:

- Health sector productivity improvements
- Hospital and community service productivity projects
- Corporate services productivity
- Workforce

Goal

Our goal is to implement a change in structure and process that results in the elimination of our financial deficit and generates surpluses by 30 June 2011 whilst improving performance. We are currently running a recurrent (structural) deficit of \$7.9m.

We need to address this problem in a sustainable way, building in some additional savings to mitigate additional potential risks that are likely to occur in-year.

We are currently only able to deliver a result of \$4.9m (2009-10 planned end of year outturn) through non-recurrent (unsustainable)

“We need to ensure that we operate differently in the future and that our resources are better managed and prioritised.”

savings. The intention of the programme is to support the achievement of the following result:

Year	Current (Deficit) Surplus Projection	Programme (Deficit) Surplus Projection
2009/10	(\$4.921m)	(\$4.921m)
2010/11	(\$3.5m)	\$0
2011/12	\$0	\$0

In order to deliver this position it is estimated that a savings programme will be required as follows:

Year	Recurrent	Non - recurrent
2010/11	\$ 5m	\$ 5m
2011/12	\$ 5m	\$ 2m

This should deliver recurrent balance and address any potential risk. Future funding from Government will continue to be at lower levels for the foreseeable future. It would be wise, therefore, to view the level of cost improvement delivered in 2011/12 of around 2% to be the norm for future years to enable investment in services.

Milestones / Timeframes

- February 2010
 - Establish programme framework and resource
 - Initiate planned projects

- March 2010 – June 2012
 - Monitor and report savings
 - Manage risks and issues
 - Recognise planned efficiencies in the budget
 - Coordinate interdependencies
 - Communicate progress
 - Mobilise additional projects as identified
 - Bed-in all processes and confirm ongoing operational responsibilities as projects close. Confirm budget adjustments.

- May 2012 – June 2012
 - Facilitate programme closure and organisational stocktake of benefits resulting from the programme

“... funding from Government will continue to be at lower levels for the foreseeable future.”

Health Sector Productivity Projects

Project Name	Description
Acute services in primary care	Review models of acute primary care provision in Hastings and Napier to ensure such services are provided at the right time, in the appropriate location, by the appropriate health care provider.
Napier Health Centre services	Explore opportunities for increasing services provided from NHC and an Integrated Family Health Centre concept that will enhance access and responsiveness of health services for Napier residents.
Integrated ambulatory services by specialty	Outpatient follow ups – reduce, return to primary care where appropriate Review limited value procedures Identify scope for delivery of outreach services that are more integrated with primary care Review IDF criteria e.g. cardiac Admissions avoidance programme, e.g. management of cellulitis
Diagnostic investigations by private sector	Review payment for diagnostic investigations by private sector
Electronic integrated information systems	Information Systems development to enable health sector productivity gains and alignment with regional and national infrastructure
Contract Performance Management	Ensure effective contracting for outcomes and hold to account. Contract reviews to remove duplication and enhance value
IDF Claim Review	Review IDFs to ensure that claims are correct and to ensure that bills from / to other DHBs are all appropriately claimed
IDF Case Management	Case management of high cost cases
New / Proposed Developments	Review new / proposed developments with a view to stopping, scaling back or rescheduling
Prescribing advice for primary care	Build on previous initiatives to further reduce the overall cost of supplying community pharmaceuticals without compromising the clinical value or quality of such services to patients.
PHO surpluses	Ensuring that surpluses are used to support existing programmes and health priorities
Service configuration of primary care	Undertake consultation process to rationalise / optimise PHO and primary care service configurations.

Hospital and Community Service Productivity Projects

Project Name	Description
Theatre productivity	Increase theatre utilisation and reduce costs.
Ward productivity	Ensure that wards are delivering a safe, quality patient experience with effective and efficient discharge planning processes
Skill-mix review	Implement the most cost effective skill mix taking into account RMO; nurse, therapists and other care providers.
Nurse Rostering Review	Work with Clinical Nurse Managers to utilise Trendcare to set a roster pattern that provides safe clinical care that optimises costs
Hospital After Hours Services	Improve hospital services at night to implement ideal service coverage 24/7
Hospital throughput and infrastructure	Review the hospital infrastructure in terms of bed availability to manage acute, elective and ATR contracts and to identify improvements for more efficient and effective infrastructure utilisation
CHB Services	Identify and analyse options for health service delivery at Central Hawke's Bay Health Centre.
IDFs and ACC follow-ups	Ensure accurate capture and coding
Lab optimisation	Reduce unnecessary diagnostic requests
Radiology optimisation	Reduce unnecessary diagnostic requests
Loan of equipment	Improve the recall of loan equipment and identify opportunities for improved procurement
Patient and supporter transport	Optimise and review patient/supporter transport arrangements.
Patient billing	Establish billing and payment mechanisms, including eftpos terminals, that are supported by the appropriate reliable systems
Theatre procurement	Centralise theatre supplies procurement and standardise inventory

Corporate Productivity Projects

Project Name	Description
Estate management	Review use of existing estate to rationalise and sell off redundant property
Staff hospitality and travel costs	Review expenditure on hospitality and travel
Centralise inventory management	Centralise inventory management
More efficient procurement	Increase capability and efficiency and effectiveness of procurement
Journal subscriptions	Realign subscriptions of journals to CME budget
FMIS system productivity	Implement process changes to fully maximise FMIS system use.
Journal Subscriptions	Funding of journal subscriptions review

Workforce Related Projects

Project Name	Description
Request for recruitment	Review all proposed recruitments with a view to maximising the redeployment of staff
Centralise all recruitment	Centralise the support functions for recruitment whilst retaining manager accountability for individual recruitment processes. Realise opportunities for saving and improve recruitment process speed and quality. Deliver ongoing savings to the organisation
Centralise learning and development	Reduce duplication and ensure consistency and lower cost of delivery.
Annual leave liability	Plan to reduce existing accruals by ensuring that all leave is taken
Rural staffing solutions	Investigate cost effective staffing options to support sustainable, quality coverage – Wairoa, Waipukurau and the Chatham Islands
Staffing to budgets	Review and realign actual staff levels to budgeted levels
Corporate staffing review	Review and reduction of FTE to align with DHB requirements

Savings Assumptions and Timing

- Savings will not be fully quantified until projects are able to complete the relevant analysis. This analysis will be completed by April 2010 in most cases.

- 2010-11 budget will include the efficiencies to be realised through these projects as well as those efficiencies that can be realised through “good management”. . Performance to budget will be used to monitor project success.
- Projects will identify changes in practice targets through which project delivery will be monitored.
- Estimates of savings by project give an indication of the potential recovery opportunity from this programme as follows:
- Service improvements will be made through increased productivity and quality patient care

Category	Savings Estimate Recurrant (R)	Savings Estimate Non Recurrant (N)	Timing
Health Sector Productivity	\$1M - \$1.7M		Commence July 2010 – fully in place by June 2011
Hospital and Community Services Productivity	\$3.6M - \$4.1M		Commence July 2010 – fully in place by June 2011
Corporate Productivity		\$250k	Feb 2011 onwards
	\$100k		Commencing Aug 2010
		\$800k - \$1.4M ¹	Commencing July 2011 – February 2013
Workforce	\$1.5M	\$1.0M	Commence July 2010
TOTAL	\$6.2M - \$7.4M	\$1.25M²	

Approach / Key Principles

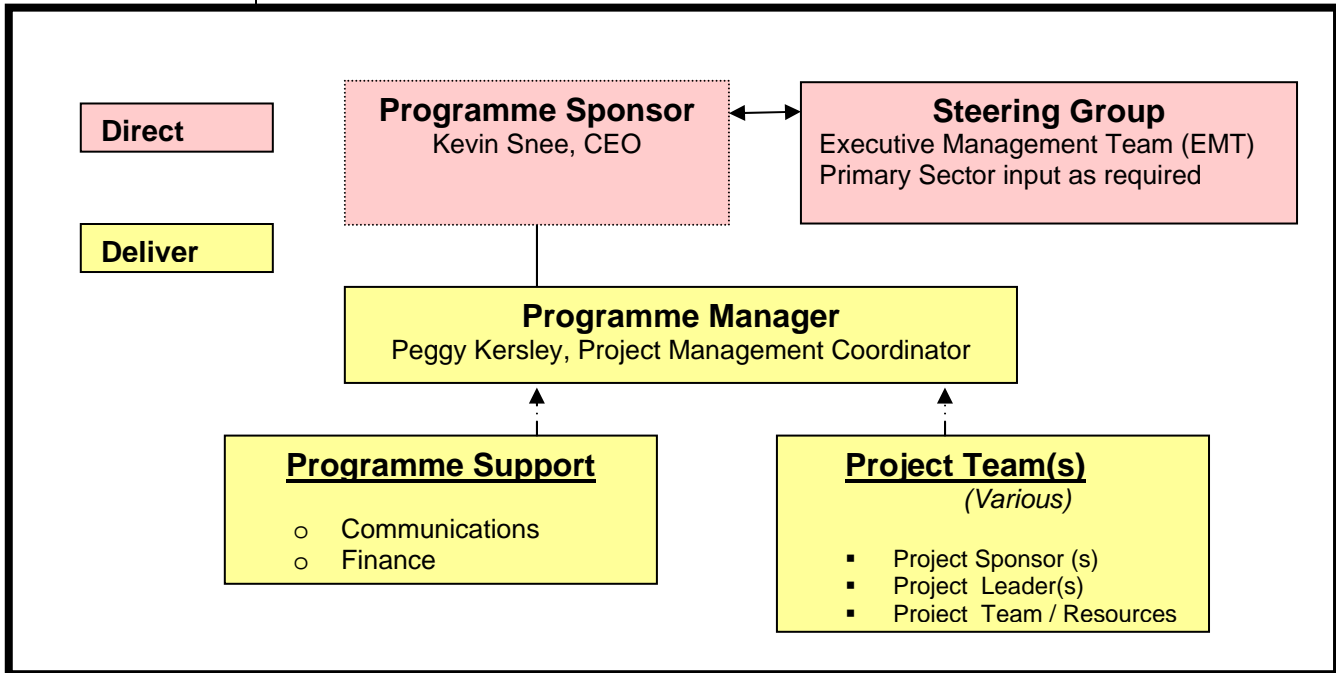
1. Projects will undertake robust information analysis to confirm that the full costs of implementation are identified before implementation is approved. Analysis will include: identification of all flow on impacts to patients, services, resourcing and financial impacts.
2. Independent Review / Peer Review / Benchmarking will be used to validate assumptions and to promote achievable performance targets.
3. Decision makers will ensure that there is a positive and measureable financial benefit to the health sector overall through the implementation of each option and that quality of service delivery is not compromised.
4. The programme will reinforce rather than cut across EMT accountabilities by recognising that each EMT member has signed

¹ This savings is from Estate and not included in total savings. It relates to capital savings which may need to be offset by operational expenditure for lease buy back.

² (excluding estate project related savings)

up to their budget and it is their responsibility to realise the savings inherent in those budgets.

5. The programme will seek cross sector participation and leadership for initiatives that cut across EMT accountabilities in order to facilitate agreement on innovative options for service delivery that will return savings across the sector.
6. Project interdependencies will be identified and managed.



“The Programme Manager will be the direct interface to the project teams to ensure the monitoring of project performance, management of interdependencies and to facilitate issues resolution.”

Roles and Responsibilities

- The CEO is responsible for overall delivery and will report monthly to the Board on progress.
- EMT will comprise the Steering Committee and will fortnightly consider the progress report, identify and resolve issues.
- Primary sector representation is anticipated to be required at a strategic level. The structure for this is yet to be identified.
- Programme Support resources will work directly with the CEO as required, and together as a team with the Programme Manager, to support the programme.
- The Programme Manager will be the direct interface to the project teams and the CEO and EMT to ensure the monitoring of project performance, management of interdependencies and to facilitate issues resolution.

Programme Budget

The projects are anticipated to be delivered within existing operational resource (with exceptions). Where additional resource is needed, budgets for specific projects will be approved as part of individual project Terms of Reference sign off process. This budget will be held by the CEO who will approve any expenditure.

“The Service and Financial Improvement Programme is dependent on the effective delivery of the organisational development programme and structural changes to realise the goal.”

It is noted that external resource will be procured on the principal of utilising internal talent and capacity in the first instance. It is recognised that independent review and benchmarking expertise will be a requirement for some projects.

Quality Requirements

Programme delivery will be consistent with the following:

- Operational Budget Variance tolerance of + / - 1%
- Recognition of critical timelines related to the financial year
- Lean methodology will be utilised
- PMI (Project Management Institute) / Hawke’s Bay DHB Programme Management Standards

Risk Management

Preliminary Risks	Likelihood Hi/Med/Low	Impact Hi/Med/Low	Mitigation Strategy
Timelines / Duration of projects / tendency to extend analysis and planning	Med	High	Terms of Reference will set clear timelines for completion of analysis and mobilisation of agreed implementation plans
Proposals for savings fall short of requirements	Med	High	Utilise external advice and benchmarking expertise to inform projects of best practice targets /
Projects aren't established quickly enough to achieve budget	High	High	Early sign off of TOR / project monitoring
Previous organisational history with reviews and budget recovery negatively impacts enthusiasm	Med	High	Maintain leadership through EMT and CEO to set expectations for delivery
Barriers to consultation with primary and secondary clinicians impacts re-organised service delivery across the continuum	High	High	Identified primary sector input into steering group and projects as required
Organisational resources that have the capacity to drive the programme are restricted by operational demands	High	High	Ensure clarification of ideal resource and negotiate release from operational duties as appropriate early in the planning

Reporting

Report Required	Timing	Responsibility
Update to Steering Group – progress, barriers and issues	Fortnightly	Programme Manager
Update to the Board – progress against plan and savings realisation	Monthly	Programme Manager
Project progress reports to Project Sponsors and Programme Manager	Monthly and as required	Work stream Leaders

*“The Service and
Financial
Improvement
Programme
provides a
controlled process
for restoring
Hawke’s Bay DHB
financial
performance to
budget...”*

Assumptions

1. Government priorities and service expectations are known.
2. Hawke’s Bay DHB geographical boundaries will not change in the short to medium term.
3. The employment terms and conditions of most DHB staff will continue to be determined nationally rather than at a local level.
4. Break-even financial results in an environment of “finite resources and infinite demand” are only achievable by rethinking service delivery across the primary/secondary continuum and achieving efficiencies across the whole sector.
5. Primary and secondary sectors will commit resource to redesign new models of service delivery.
6. There will be no major capital building projects within the current DAP period (2009/10 – 2011/12). The DHB will continue to constrain capital spend within the depreciation funding.

Communications

The Service and Financial Improvement Programme communication strategy will support stakeholder communications and engagement that is appropriate and timely.

Summary

The Service and Financial Improvement Programme provides a controlled process for restoring Hawke’s Bay DHB financial performance to budget during the 2010/11 financial year and forward into 2011/12. It includes internal projects as well as sector-wide projects. The Service and Financial Improvement Programme is dependent on the effective delivery of the organisational development programme and structural changes to realise the goal.

APPENDIX – THE CLINICAL COUNCIL



HAWKE'S BAY
District Health Board

TERMS OF REFERENCE Hawke's Bay Clinical Council

Purpose	The Clinical Council provides clinical advice to Hawke's Bay DHB on key service changes and provides oversight of clinical quality and patient safety locally. It seeks to break down boundaries across primary and secondary care to ensure that services are organised around the needs of people.
Functions	<p>The functions of the Clinical Council are to give the board advice on issues that span both primary and secondary care in relation to:</p> <ol style="list-style-type: none"> 1. The clinical implications of proposed service changes 2. Measures that will address patient safety and improve clinical quality 3. Measures that will use resources more effectively <p>The aims of Clinical Council's advice must be to ensure that:</p> <ol style="list-style-type: none"> 1. Effective clinical risk management processes are in place 2. Effective clinical accountability at an individual, team and service level is in place 3. Service changes are introduced across primary and secondary care to address both clinical and cost effectiveness 4. Education, training and research is properly overseen
Level of Authority	The committee has the authority to give advice, and make recommendations, to the Board.
Membership	<p>Members of the Clinical Council will be appointed for a 2 year term and may be re-appointed.</p> <p>CMO Primary Care CMO Hospital DON Primary Care DON Hospital Clinical Director x 3 GP Advisers x 3 1 other clinician (neither medical nor nursing) hospital 1 other clinician (neither medical nor nursing) primary care 1 clinician with a population health perspective Chief Executive</p>
Chairperson	The committee will be co-chaired by the CMO (Hospital) and CMO (Primary Care).
Quorum	A quorum will be 7.
Meetings	<p>Meetings will be held monthly, or more frequently at the request of the chair.</p> <p>Workshops will be held from time to time.</p> <p>Matters may be dealt with between meetings through discussion with the chair and other relevant members of the committee.</p> <p>The Standing Orders adopted by the Board apply to committee meetings.</p>
Reporting	The committee will report through the CEO to the board.
Minutes	Minutes will be circulated to all members of the Committee and the Board, within one week of the meeting taking place.