BOARD MEETING

Date: Wednesday 15 July 2020

Time: 1:00pm

Venue: Te Waiora Room, HBDHB Administration Building
Corner Omahu road and McLeod Street, Hastings

Members: Shayne Walker (Chair)
Hayley Anderson
Ana Apatu
Kevin Atkinson
David Davidson
Evan Davies
Peter Dunkerley
Joanne Edwards
Charlie Lambert
Anna Lorck
Heather Skipworth

Apologies: Nil.

In Attendance: Craig Climo, Interim Chief Executive Officer
Executive Leadership Team members
Robin Whyman and Jules Arthur, Co-Chairs Hawke's Bay Clinical Council
Rachel Ritchie, Chair Hawke's Bay Health Consumer Council
Members of the public and media

Minute Taker: Kathy Shanaghan, EA to CEO

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	Karakia	1.00
2.	Welcome and Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting – 17 June 2020	
5.	Matters Arising - Review of Actions	
6.	Board Workplan	

7.	Chair's Report (verbal)	
8.	Chief Executive Officer's Report	1.15
9.	Financial Performance Report – Carriann Hall, Executive Director Financial Services	1.20
10.	Planning & Funding Monthly Report – Emma Foster, Acting Executive Director Planning & Funding	1.25
11.	Health Services (DHB Provider Arm) Monthly Report – Chris Ash, Chief Operating Officer	1.30
12.	Board Health & Safety Champion's Update	1.35
	Section 2: Governance / Committee Reports	
13.	Māori Relationship Board Report – Chair, Ana Aptau	1.40
14.	Hawke's Bay Health Consumer Council Report – Chair, Rachel Ritchie	1.45
	Section 3: For Information / Discussion	
15.	Health Hawke's Bay Update – Wayne Woolrich, Health Hawke's Bay CEO (presentation)	1.50
16.	General Practice and Community Pharmacy During COVID19 - Wayne Woolrich, Health Hawke's Bay CEO	2.00
17.	Ageing Well in Hawke's Bay - Emma Foster, Acting Executive Director Planning & Funding	2.10
18.	Executive Clinical Leaders – Workforce (joint presentation) - Karyn Bousfield, Acting Chief Nursing & Midwifery Officer/Andy Phillips, Chief Allied Health Professions Officer/Robin Whyman, Chief Medical & Dental Officer	2.20
19.	COVID-19 Recovery Planning – Anne Speden, Executive Director Digital Enablement (presentation)	2.30
	Section 4: For Decision	
20.	Two Tier Treaty Partnership Governance Structure - Patrick Le Geyt, Acting Executive Director Health Improvement & Equity	2.40
21.	**Section 5: Recommendation to Exclude the Public** Under Clause 33, New Zealand Public Health & Disability Act 2000	

Public Excluded Agenda

Item	Section 6: Routine	Time
22.	Minutes of Previous Meeting – 17 June 2020 (public excluded)	2.55
23.	Matters Arising – Review of Actions (public excluded)	-
24.	Board Approval of Actions Exceeding Limits Delegated by CEO (public excluded)	-
25.	Chair's Report - verbal (public excluded)	3.00
	Section 7: Governance / Committee Reports	
26.	Hawke's Bay Clinical Council Report (public excluded) – Co-Chairs, Jules Arthur and Robin Whyman	3.05
27.	Hawke's Bay Health Consumer Council Report (public excluded) – Chair, Rachel Ritchie	3.10
	Section 8: For Information / Decision	
28.	Skin Lesions Pathway in Primary Care (public excluded) – Emma Foster, Acting Executive Director Planning & Funding	3.15
29.	Finance Risk and Audit Committee (public excluded) - Chair, Evan Davies - Summary of Meeting 15 July 220 (verbal) - Minutes 17 June 2020	3.25
	Meeting concludes	**3.35**

The next HBDHB Board Meeting will be held on
Wednesday 19 August 2020

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

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

	✔	✘
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore people, doesn't look up, rolls their eyes
Respectful	Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity	Lacks respect or discriminates against people Lacks privacy, gossips, talks behind other people's backs
Kind	Shows kindness, empathy and compassion for others Enhances peoples mana	Is rude, aggressive, shouts, snaps, intimidates, bullies Is abrupt, belittling, or creates stress and anxiety
Helpful	Attentive to people's needs, will go the extra mile Reliable, keeps their promises; advocates for others	Unhelpful, begrudging, lazy, 'not my job' attitude Doesn't keep promises, unresponsive

ĀKINA IMPROVEMENT

*Continuous **improvement** in everything we do*

	✔	✘
Positive	Has a positive attitude, optimistic, happy Encourages and enables others; looks for solutions	Grumpy, moaning, moody, has a negative attitude Complains but doesn't act to change things
Learning	Always learning and developing themselves or others Seeks out training and development; 'growth mindset'	Not interested in learning or development; apathy "Fixed mindset, 'that's just how I am', OK with just OK
Innovating	Always looking for better ways to do things Is curious and courageous, embracing change	Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
Appreciative	Shares and celebrates success and achievements Says 'thank you', recognises people's contributions	Nit picks, criticises, undermines or passes blame Makes people feel undervalued or inadequate

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

	✔	✘
Listens	Listens to people, hears and values their views Takes time to answer questions and to clarify	'Tells', dictates to others and dismisses their views Judgmental, assumes, ignores people's views
Communicates	Explains clearly in ways people can understand Shares information, is open, honest and transparent	Uses language / jargon people don't understand Leaves people in the dark
Involves	Involves colleagues, partners, patients and whanau Trusts people; helps people play an active part	Excludes people, withholds info, micromanages Makes people feel excluded or isolated
Connects	Pro-actively joins up services, teams, communities Builds understanding and teamwork	Promotes or maintains silo-working 'Us and them' attitude, shows favouritism

TAUWHIRO CARE

*Delivering high quality **care** to patients and consumers*

	✔	✘
Professional	Calm, patient, reassuring, makes people feel safe Has high standards, takes responsibility, is accountable	Rushes, 'too busy', looks / sounds unprofessional Unrealistic expectations, takes on too much
Safe	Consistently follows agreed safe practice Knows the safest care is supporting people to stay well	Inconsistent practice, slow to follow latest evidence Not thinking about health of our whole community
Efficient	Makes best use of resources and time Respects the value of other people's time, prompt	Not interested in effective user of resources Keeps people waiting unnecessarily, often late
Speaks up	Seeks out, welcomes and give feedback to others Speaks up whenever they have a concern	Rejects feedback from others, give a 'telling off' 'Walks past' safety concerns or poor behaviour

Board "Interest Register" - as at 7 July 2020

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Shayne Walker	Active	Dr Rachel Walker	Wife - is a contractor to HBDHB	Potential conflict. Will abstain from decisions related to perceived conflict.	CEO	08.01.20
Kevin Atkinson	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	26.10.17
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Māori Party	Candidate for Ikaroa-Rāwhiti Seat	Will manage HBDHB governance information in confidence	The Chair	18.03.20
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Whariki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	The Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Anna Lorck	Active	Attn! Martketing & PR	Owner & Director (Marketing & Comms, publishing).	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	09.12.19
			Communications Contractor/Advisor to multiple businesses.	Will provide a list of health related contracts to Chair and CEO. Will disclose if any conflict is related to agenda items. Will manage HBDHB governance information in confidence.	The Chair	06.04.20
	Active	Labour Party	Labour Party candidate for Tukutuki electorate	Will manage HBDHB governance information in confidence	The Chair	18.03.20
	Active	Mother	Mother is an employee of the DHB at Central Hawke's Bay Health Centre	Will advise of any perceived or real conflict prior to discussion	The Chair	04.02.20
Hayley Anderson	Active	Hawke's Bay District Health Board	Employed as Interim GM Population Health	Potential conflict. Will advise of any conflict of interest.	The Chair	7/07/2020
		Cranford Hospice Trust	Health Consultant - contracted with provider	Will advise of any conflict of interest. If in doubt, will discuss with HBDHB Chair	The Chair	09.12.19
David Davidson	Active	2020 End of Life Choice Act Referendum Society		Will abstain from all decisions related to end of life choice.	The Chair	28.03.20
	Active	Weem Charitable Trust	Provides support services to Cancer sufferers eg Cranford & Cancer Society	Will advise of any perceived or real conflict prior to discussion	The Chair	09.12.19
Joanne Edwards	Active	KiwiGarden Ltd	Director/CEO	Potential conflict. Will abstain from all discussions/decisions that may have some direct relevance to this interest.	The Chair	08.01.20
Charlie Lambert	Active	Hawke's Bay Regional Council	Council Member	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	06.04.20
Evan Davies	Active	Chair, Capital Investment Committee	DHB Capital Prioritisation	Potential conflict.	The Chair	7/01/2020
	Active	Crown Infrastructure Partners Covid Recovery Infrastructure Programme	Sector Expert Representative - Health	Potential conflict. Will not take part in any decisions that may have some relevance to this interest and will absence himself from discussions if asked by the Chair.	The Chair	22/04/2020

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 17 JUNE 2020, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.30pm

PUBLIC

Present: Shayne Walker (Chair)
Evan Davies
Hayley Anderson
Ana Apatu (via Zoom)
Kevin Atkinson
David Davidson
Peter Dunkerley
Joanne Edwards
Charlie Lambert
Anna Lorck
Heather Skipworth

In Attendance: Craig Climo, Interim Chief Executive Officer
Members of the Executive Leadership Team
Keriana Brooking, Incoming Chief Executive Officer
Rachel Ritchie, Chair Hawke's Bay Health Consumer Council
Jules Arthur, Co-Chair Hawke's Bay Clinical Council (via Zoom)
Members of the Public and Media (via livestream)
Kathy Shanaghan, Executive Assistant to CEO

1. The Chair opened the meeting with a mihimihi and welcomed everyone to the meeting including the community across Hawke's Bay who were viewing the meeting via Facebook livestream.

2. APOLOGIES
There were no apologies.

3. INTEREST REGISTER
The Chair advised he was no longer an employee of the Bank of New Zealand and asked that this be removed from the Conflicts of Interests Register.

No Board member advised of any interests in the items on the agenda.

4. CONFIRMATION OF PREVIOUS MINUTES
The minutes of the Board meeting held on 20 May 2020 were confirmed as a correct record of the meeting.

Moved: Joanne Edwards
Seconded: Peter Dunkerley
Carried

5. MATTERS ARISING FROM PREVIOUS MINUTES
Status updates for all actions were noted together with the following comments:

- Item # 1: Opportunity for Pasifika Health Leadership Group (PHLG) to meet with Deputy Director-General (DDG) Māori Health. Members were advised that the DDG had agreed to come back to Hawke's Bay District Health Board (HBDHB) to give another presentation to which the PHLG would be invited. Board members asked to be invited to that presentation. **Action**

- Item # 8: Health Improvement & Equity Quarterly Report. Clarification was provided that the action is that future reports include the number required to meet **all** targets. **Action**

6. BOARD WORK PLAN

The Board work plan was noted. It was noted that a number of reports on the workplan were going straight to FRAC and Board without passing through the Māori Relationship Board, Clinical Council or Consumer Council. Management was asked to review the workplan and identify any reports that should go through those committees. **Action**

7. CHAIR'S REPORT (VERBAL)

- The Chair welcomed incoming CEO Keriana Brooking to the meeting and said he looked forward to her commencing in the role on 10 August 2020.
- Expressions of Interest will be sought from across the community for a governance role to sit at the Board table to learn about the health system and governance generally. That person would have non-voting rights.
- It was agreed to reinstate the Board induction which was put on hold due to COVID-19. The induction would also include facilities tours for members. **Action**

- The Chair advised of the following retirements, with a letter being sent conveying the Board's best wishes and thanks for their extended years of devoted service.

Name	Role	Service	Years of Service	Retired
Mary Silo	Administration Coordinator	Operations Directorate	24	29-May-20
Kathleen Kavanagh	Staff Midwife	Communities Women & Children	15	12-Apr-20
Christine Hickton	Assistant Laboratory Manager	Operations Directorate	22	11-Jun-20

The Chair thanked the above staff for their dedication and years of service to the DHB and the community, and wished them all the best in their next journey.

8. CHIEF EXECUTIVE OFFICER'S REPORT

This report was taken as read.

RECOMMENDATION

That the HBDHB Board:

1. **Note** the contents of this report.

Adopted

9. FINANCIAL PERFORMANCE REPORT

This report was taken as read, noting this had been discussed in the Finance Risk and Audit Committee (FRAC) meeting earlier in the day.

RECOMMENDATION

That the HBDHB Board:

1. **Note** the contents of this report.

Adopted

10. HEALTH SERVICES (DHB PROVIDER ARM) REPORT

This report was taken as read. There was a brief discussion around the recovery prioritisation process.

The Acting Chief Operating Officer advised that Hawke's Bay Hospital continued to be full. He also advised that Paediatrics, Assessment Treatment & Rehabilitation and Ward A1 would be moving back to their home wards the week beginning 22 June.

RECOMMENDATION

That the HBDHB Board:

1. **Note** the contents of this report.

Adopted

11. PLANNING & FUNDING REPORT

Emma Foster, Acting Executive Director of Planning & Funding (ED P&F), took this report as read, however highlighted the work being undertaken around recovery planning.

Board member comments included:

- Ngātahi Project: Due to COVID-19, four of the Mental Health and three Trauma Informed Practice learning circles had to be cancelled. Heather Skipworth asked how the DHB would ensure those people would receive that training before they graduated. The ED P&F undertook to follow that up and provide a response. **Action**
- It would be interesting to know the uptake of immunisations undertaken in pharmacies. ED P&F to follow up. **Action**
- In response to a question around the timeframe for community workers in Wairoa, the ED P&F said she expected these to be implemented in the new financial year.

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

Adopted

12. BOARD HEALTH & SAFETY CHAMPION UPDATE

Peter Dunkerley advised he attended the May Safety and Wellbeing Committee meeting by zoom which was attended by about 30 people. He said he would now contact the Safety & Wellbeing Manager to organise some site visits.

REPORT FROM COMMITTEE CHAIRS

13. MĀORI RELATIONSHIP BOARD (MRB)

MRB Chair, Ana Apatu, spoke to this report which provided a summary of the discussion from the MRB meeting held on 3 June 2020. She referred to the Pūhoro presentation and the request to establish a fully integrated service embedded across the Hawke's Bay region to uplift Māori achievement and engagement in STEM1 related pathways. MRB noted there was currently no budget to fund this programme and therefore agreed to put a recommendation to the Board to consider a new investment proposal to implement Pūhoro Phase 1 in Hawke's Bay. The total budget required was $150k per annum for 100 students.

Kevin Atkinson supported this type of initiative but suggested that we might consider we establish a fund where anyone could apply for funding.

Board members were supportive of the concept and acknowledged the challenge in getting Māori to work in health. Upon confirmation from management that this was within the guidelines for funding, Board members agreed the first preference would be to fund this collectively from within budget or through reprioritisation. If there was a need for new investment, then management would need to work up a business case. **Action**

RESOLUTION

That the HBDHB Board:

1. **Note** the contents of this report.
2. **Note** the actions requested.
3. **Endorse** that management consider a new investment proposal to implement Pūhoro Phase 1 in Hawke's Bay (total budget of $150k per annum) subject to confirmation that this is within the guidelines for funding.

MOVED: Evan Davies
SECONDED: Anna Lorck

Carried

14. CONSUMER COUNCIL REPORT

This report was taken as read. Consumer Council Chair, Rachel Ritchie, provided a brief overview of the meeting, highlighting a recommendation that the terms of three Council members be extended from 30 June 2020 to 30 September 2020, to coincide with the expiry of the Chair's term.

The CEO was not supportive of ongoing extensions and instead believed the membership should be reviewed. Some Board members thought it was a reasonable request given COVID-19.

The ED Planning & Funding advised that a paper regarding the membership of the Consumer Council was being developed for consideration by the CEOs of HBDHB and Health Hawke's Bay, which included the process for replacement of members, including the Chair. A recommendation would then come to the Board for endorsement.

RECOMMENDATION

That the HBDHB Board:

1. **Note** the contents of this report.

Adopted

15. PASIFIKA HEALTH LEADERSHIP GROUP (PHLG)

The Chair welcomed PHLG Chair, Traci Tuimaseve, to the meeting and thanked him for his leadership particularly during COVID-19. Traci acknowledged Caren Rangi for chairing the meeting on 25 May 2020 and provided an overview of the discussion from that meeting, highlighting the four key learnings from the COVID-19 response.

Mr Tuimaseve advised that Board members would be receiving an invitation to attend an introduction to the Hawke's Bay Pasifika Intersector Leaders Group to be held on Tuesday 30 June 2020 at 6pm at the Cook Islands Community Centre in Flaxmere.

Board members acknowledged the work being undertaken to improve the health for Pasifika, especially around dental health of young children.

RECOMMENDATION

That the HBDHB Board:

1. **Note** the contents of this report.

Adopted

FOR DECISION

16. WORKING DRAFT – HBDHB 2020/21 ANNUAL PLAN

In addition to receiving the 2020/21 Annual Plan, Board members received a presentation which also included aspects of the Corporate Performance Report Quarter Three. The presentation covered the following areas:

- Strategic priorities
- Development process
- Planning for equity
- Current state
  - Cost allocation
  - Performance – First 1000 days
  - Long term conditions
  - Mental health and addictions
  - Performance – Frail and older people
  - Responsive health system
- Future state
- The delivery of the Annual Plan
- What can we do better in 2020/21?

Comments noted during discussion included:

- The Annual Plan had a specific focus on achieving equity in health and wellness for Māori and Pacific populations
- 153 of the actions were equitable outcome actions (EOA)
- 58% were locally based
- Health Improvement & Equity were working on how to embed Treaty Based Governance into the Annual Plan

Board members acknowledged the tremendous work undertaken, however expressed some anxiety around achieving the outcomes due to directives from central government which would consume a significant amount of the DHB's budget. The ED Planning & Funding advised there were some specific actions in the Annual Plan which could be progressed quickly which would see those actions moving from red into green.

Further comments from Board members included:

- It would be good to progress any quick wins as soon as possible
- The language in the Annual Plan needs to be consistent and focused on whānau centred care
- It would be useful to understand what would change for consumers at the end of 12 months
- It would be useful for the performance measures to be benchmarked against other DHBs

It was agreed that if Board members had any comments to make on the Annual Plan, that these be sent direct to the ED Planning & Funding. **Action**

RESOLUTION

That the HBDHB Board:

1. **Note** the contents of this report.
2. **Review and provisionally approve** noting the outstanding actions.
3. **Agree** final approval of the plan to be given by the HBDHB Chair.

MOVED: Anna Lorck
SECONDED: Hayley Anderson

Carried

17. CORPORATE PERFORMANCE REPORT QUARTER THREE

This report was taken as read, noting that some of the aspects were covered within the Annual Plan presentation.

RECOMMENDATION

That the HBDHB Board:

1. **Note** the contents of this report.

Adopted

GENERAL BUSINESS

There being no further discussion, the Chair accepted a motion to move into Public Excluded.

18. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

1. Confirmation of previous minutes 20 May 2020 - Public Excluded
2. Matters Arising (Public Excluded)
3. Board Approval of Actions exceeding limits delegated by CEO (Public Excluded)
4. Chair's Report (Public Excluded)
5. Health Services (DHB Provider Arm) Monthly Report (Public Excluded)
6. Hawke's Bay Clinical Council Report (Public Excluded)
7. Recovery Plan (Public Excluded)
8. Finance Risk and Audit Committee (Public Excluded)
   - Minutes 20 May 2020
   - Minutes 17 June 2020

MOVED: Shayne Walker
SECONDED: Peter Dunkerley

Carried

The public section of the Board meeting concluded at 3.10pm.

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

5

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	17/6/20	**Health Improvement & Equity Quarterly Report** Future reports to include the number required to meet all targets	Acting ED Health Improvement & Equity		Future quarterly reports will include actual numbers as well as percentages. Action closed.
2	17/6/20	**Deputy Director General Māori Health John Whaanga Presentation** Invitation to include Board members and Pasifika Health Leadership Group	Acting ED Health Improvement & Equity		MoH Māori Health Directorate will be presenting on WAI2575 and if relevant to PHLG they can attend.
3	17/6/20	**Reinstate Board Induction** To include facilities tour	ED Financial Services	August	Two dates provided to Board members. Date to be confirmed.
4	17/6/20	**Ngātahi Project** Advise how the DHB will ensure those people whose learning circles were cancelled will receive the training	Acting ED Planning & Funding		Update included in Planning & Funding Report for July Board meeting
5	17/6/20	**Uptake of Immunisations in Pharmacies** Provide numbers to Board members	Acting ED Planning & Funding		Update included in Planning & Funding Report for July Board meeting
6	17/6/20	**New Investment to Implement Pūhoro Phase 1 in Hawke's Bay (total budget of $150k per annum)** Management to consider the request from MRB to implement Pūhoro Phase 1 following confirmation that this is within the guidelines for funding	Acting ED Health Improvement & Equity		The HIE and P&F Directorates will develop a business case within Quarter 1.
7	17/6/20	**2020/21 Annual Plan** Board members to send feedback direct to Emma Foster, Acting ED Planning & Funding	Board members	As soon as possible	Completed. Action closed.

BOARD as at 9 July 2020	Email	Destination Month	EMT Member	Lead/Author	EMT Meeting Date	PHLG Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
PHO Quarterly Report - PRESENTATION FOR INFORMATION		Jul-20	Wayne Woolrich								15-Jul-20
General Practice and Community Pharmacy During COVID19		Jul-20	Wayne Woolrich								15-Jul-20
Skin Lesions Pathway in Primary Care		Jul-20	Emma Foster	Penny Rongotoa			1-Jul-20	1-Jul-20	2-Jul-20		15-Jul-20
Executive Clinical Leaders - Workforce (Joint Presentation)		Jul-20	Robin Whyman/ Andy Phillips/ Karyn Bousfield								15-Jul-20
COVID19 Recovery Planning (Presenation)		Jul-20	Anne Speden								15-Jul-20
Ageing Well in Hawke's Bay		Jul-20	Emma Foster	Suzanne Parkinson			5-Aug-20	5-Aug-20	6-Aug-20		15-Jul-20
Audit New Zealand Management Letter		Jul-20	Carriann Hall							15-Jul-20	
Internal Audit Plan		Jul-20	Carriann Hall	Jared McGillicuddy						15-Jul-20	
Collective Insurance Renewal 2020/2021		Jul-20	Carriann Hall							15-Jul-20	
Two Tier Treaty Partnership Governance Structure		Jul-20	Patrick Le Geyt								15-Jul-20
Purchase of Mobile Dental Units for Hawke's Bay Oral Health Model of Care		Aug-20	Emma Foster							19-Aug-20	
He Ngakau Aotea - First 1000 Days		Aug-20	Patrick Le Geyt								19-Aug-20
Cardiology Services Business Case		Aug-20	Chris Ash	Paula Balchin			5-Aug-20	5-Aug-20	6-Aug-20	19-Aug-20	19-Aug-20
HB Health Awards - preparation for judging **2019**-2020		Aug-20	Anna Kirk					1-Jul-20	2-Jul-20		19-Aug-20
Communications Quarterly Report to Board - PRESENATION FOR INFORMATION		Aug-20	Anna Kirk								19-Aug-20
Alcohol Harm Reduction Strategy (6 monthly update) - moved to August 2020		Aug-20	Patrick Le Geyt	Rachel Eyre	4-Aug-20		5-Aug-20	5-Aug-20	6-Aug-20		19-Aug-20
HIE & Pop Health Quarterly report to board		Aug-20	Patrick Le Geyt								19-Aug-20
Corporate Performance Dashboard (quarterly)		Aug-20	Chris Ash				5-Aug-20	5-Aug-20	6-Aug-20		19-Aug-20
Te Ara Whakawaiora - Adult Health (Access Local Indicator/Cardiovascular National Indicator/Smoking National Indicator		Aug-20	Emma Foster/ Patrick Le Geyt				5-Aug-20	5-Aug-20	6-Aug-20		19-Aug-20
Integrating the Equity Lens within Clinical Processes		Aug-20	Patrick Le Geyt							19-Aug-20	
IAR RMO Rostering Review		Aug-20	Carriann Hall	Jared McGillicuddy						19-Aug-20	
IAR Primary/Secondary Data Sharing and Utilisation Review		Aug-20	Carriann Hall	Jared McGillicuddy						19-Aug-20	
People Safety and Wellbeing Quarterly Report (FRAC) (Feb, May, **Aug**, Nov)		Aug-20	Carriann Hall	Tracey Paterson						19-Aug-20	
Patient Safety and Quality Quarterly Report (FRAC) (Feb, May, **Aug**, Nov)		Aug-20	Robin Whyman	Susan Barnes				5-Aug-20		19-Aug-20	
Integrating the Equity Lens within Clinical Processes		Aug-20								19-Aug-20	
MAP initiative evaluation summary		Aug-20	Patrick LeGeyt				5-Aug-20				
BASIC Trust		Aug-20	Carriann Hall							19-Aug-20	
Te Ara Whakawaiora - Workforce Representation (Culturally Competent Workforce Local Indicator/Did not Attend Local Indicator)		Sep-20	Carriann Hall Tracey Patterson Chris Ash				2-Sep-20	2-Sep-20	3-Sep-20		16-Sep-20
PHO Quarterly report to Board - PRESENTATION ONLY		Sep-20	Wayne Woolrich								16-Sep-20
Matariki update to Consumer council written report		Sep-20	Patrick Le Geyt	Shari Tidswell					3-Sep-20		
Wairoa Community Health report to MRB only (quarterly Nov 19/March 20/June 20/**Sept 20**		Sep-20	Emma Foster	Emma Foster			2-Sep-20				
Shareholders Representatives for Allied Laundry, TAS and NZ Health Partnerships		Oct-20	Carriann Hall								21-Oct-20
Communications Quarterly Report to Board		Oct-20	Anna Kirk								21-Oct-20
Service Improvement Quarterly Report		Oct-20	Anne Speden								21-Oct-20
Te Ara Whakawaiora - Mental Health (Mental Health and AOD National and Local Indicators		Oct-20	Chris Ash	David Warrington			7-Oct-20	7-Oct-20	8-Oct-20		21-Oct-20
Wairoa System Dashboard (quarterly)		Oct-20	Emma Foster				7-Oct-20				21-Oct-20
Chief Medical & Dental Officer report to Board		Oct-20	Robin Whyman								21-Oct-20
Chief Nursing & Midwifery Officer report to board		Oct-20	Chris Mckenna								21-Oct-20
Chief Allied Health Professions Officer report to board		Oct-20	Andy Phillips								21-Oct-20
Comms report to Board		Oct-20	Anna Kirk								21-Oct-20
Audit NZ - Interim Audit Report for y/e June 2020 (timing TBC)		Oct-20	Carriann Hall		13-Oct-20					21-Oct-20	
Audit New Zealand - Interim Audit Report for year ended June 2020		Oct-20	Carriann Hall							21-Oct-20	
Corporate Performance Dashboard (quarterly)		Nov-20	Emma Foster								18-Nov-20
Te Ara whakawaiora - Health of Kaumatua (New)		Nov-20	TBD				4-Nov-20	4-Nov-20	5-Nov-20		18-Nov-20
Model of Care for the Elderly		Nov-20	Emma Foster				4-Nov-20	4-Nov-20	5-Nov-20		18-Nov-20
HIE & Pop Health Quarterly report to board		Nov-20	Patrick Le Geyt								18-Nov-20
People Safety and Wellbeing Quarterly Report (FRAC) (Feb, May, Aug, **Nov**)		Nov-20	Carriann Hall	Tracey Paterson						18-Nov-20	
Patient Safety and Quality Quarterly Report (FRAC) (Feb, May, Aug, **Nov**)		Nov-20	Robin Whyman	Susan Barnes				4-Nov-20		18-Nov-20	
Access Picking and Choice (Outpatient)		Nov-20	Chris Ash							18-Nov-20	
PHO Quarterly report to Board - PRESENTATION ONLY		Dec-20	Wayne Woolrich								16-Dec-20
Surgical Service Expansion Project update (6 months)		Dec-20	Carriann Hall							16-Dec-20	

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report - Public**
	For the attention of: **HBDHB Board**
Document Owner:	Craig Climo, Interim Chief Executive Officer
Month as at	9 July 2020
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

1. **Receives and notes** the contents of this report.

OVERVIEW OF THIS MONTH'S AGENDA

Financial report will be a late item
The Executive Director of Financial Services financial report may not be available until Monday. This is due to this Board meeting being on the earliest possible date of a month – members were aware of this issue - and the month is also year-end, as well as accounting for COVID-19.

Late papers
This segues into late papers. After comment at the last Board meeting we looked at the incidence this calendar year. There were a couple of one-offs that were particular to the circumstance such as EDX (the Emergency Department extension for COVID-19), but what has recurred is late papers from the committees. The Executive has been asked to ensure they are in the agenda on time or held to the next Board meeting.

Other non-standing agenda items
There are two matters for decision:

1. **Skin lesion**
    a. This is based on moving to targeted funding and therefore is likely to be a service change and is subject to Ministerial approval. The paper is in the public excluded section of this agenda. It is open to the Board to move it to public.

2. **Māori and DHB governance**
    a. A proposal to put in place two groups, with one being a governance counter-part to the Board and the other an expert advisory group to inform the governance group. The Māori Relationship Board (MRB) would be disestablished.
    b. The concept has been discussed with MRB.
    c. The challenge for the Board will be in how "joint" decision making would work. The paper points to arrangements elsewhere in New Zealand.

There are four presentation type papers:

1. PHO change journey and new strategy report to the Board plus a snapshot of PHO activity. A paper on the impact of level 4 on general practice is also included. The PHO Chief Executive, Wayne Woolrich, will attend for this item. The PHO Chair is not available for this meeting.

2. A workforce paper jointly from the professional leads for medical, nursing, and allied health. They selected workforce and it will be inked to the annual plan.

3. Service Improvement. The Service Improvement work has for three months been focused on "Recovery" and this month will be third "Recovery" presentation, and last as currently planned.

4. Health of Older Persons is in the agenda to further introduce this big part of the sector to members in advance of what may be significant decisions sought later this calendar year.

Four presentations would normally not be doable in a single Board meeting but we propose to deal with them, not in a presentation style, but as papers that will be taken as read and for which the presenters will be available to ask questions. The four have accumulated due to being held over during peak COVID-19 activity. All but one is what we started to schedule from late last calendar year as quarterly (or less frequent) reports to the Board from executives who do not have standing monthly reports.

FINANCIAL PERFORMANCE

The raw result came to hand at the time of finalising this paper for publication. In outline it is:

- The interim result for the 2019/20 year, excluding abnormal items, is $30M, as forecast, compared to a planned $12.9M deficit. With abnormals included, such as COVID-19 net costs and Holidays Act, the result is a $43.3M deficit.
- The June month result was $2.9M unfavourable excluding abnormals. It was $10.4M including abnormals $2.3M of the $2.9M variance was in the provider-arm.

ANNUAL PLAN 2020/21

Firstly, a correction to advice I provided the Board on the back of the Government's budget announcement of a $980M funding increase for each of the next four years starting 1 July 2020. I had advised that it was incremental year-on-year. Whereas the $980M is for this current year and will be maintained i.e. not taken away in the subsequent three years, which makes more sense than my interpretation.

The timeframe and process from here for plan approval is:

- 10 July the Ministry will feedback to DHBs including advice re escalation of issues
- 17 July DHBs are to send any changes back to the Ministry
- 24 July the Ministry will respond
- 31 July Board sign-off
- 7 August plans will go to the Minister

The Board agreed at the June meeting that the Chair approve minor changes to the plan. Any significant changes will be referred to the Board with a decision process to meet the timeframe above.

The Ministry had advised that draft plans tended to be weak in areas of sustainability, and linking changes in resourcing to service changes and outcomes. This Board's management sees a plan that naturally has parts that are more or less well developed than others. Approving the plan is a step in an ongoing planning process, and we will continue to work on the case for as yet uncommitted expenditure. We will bring these to the Board, for example the $2.4M for Board priorities from the Board's March hui. Our plan also translates into about 67 FTE additional staff, which we are working through to identify the benefit or deliverable from each position.

MINISTERIAL APPROVAL/FUNDING FOR CAPITAL INVESTMENT

As has been publicised, we now have approval for:

1. Dental bus replacement – 4 x $0.4M = $1.6M from the $300M infrastructure fund announced pre-Christmas by the Government. The Ministry has asked us for opportunities to fund a further $10M from this fund on which we are in discussion with them.
2. The Surgical Expansion and Radiology major capital cases, which each being over $10M required Ministerial approval. Funding has also been approved on the basis we understood it would.

COVID-19

Andy Philips, our Chief Allied Health Professions Officer, has added the COVD-19 response to his other executive duties and I am comforted having Andy in the role. The desirability for having a lead executive became evident after the emergency response structure was wound right down.

It continues to be that there are no known cases of COVID-19 in Hawke's Bay, as it is for NZ.

The COVID-19 activity/response continues, mostly in the swabbing/testing space where the community criteria remains subject to change. Hawke's Bay Hospital is using a definition that allows it to return to normal, noting that normal differentiates patients with influenza like illness. This has been timely to allow for the usual impact of seasonal illness and to lift elective services to normal levels and beyond. The hospital has been under extreme bed pressure on some days over the last week or so.

Members may wonder where Hawke's Bay is placed in terms of being a location for managed isolation facilities. I am advised that Hawke's Bay is logistically not as good as other locations in New Zealand. This includes transporting to and from Hawke's Bay and the type of accommodation required, including a preference for at least 150 beds in any one facility.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report June 2020** For the attention of: **HBDHB Board**
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Reviewed by	Carriann Hall, Executive Director Financial Services
Month/Year	July, 2020
Purpose	For Information

RECOMMENDATION:

That the HBDHB Board:

Note the contents of this report

Resolve that the Chair of the Board and Chair of FRAC are delegated to sign the Joint Statement of Representation to the DHB's appointed auditor and the Director General of Health, in relation to the information provided to the Ministry of Health for the Government's financial statements.

Refer Appendix 12

Resolve that the Chair of the Board request a Letter of Comfort from the Joint Ministers of Health and Finance to support the going concern attestation in the 2019/20 Annual Report. To be submitted before the 17th August deadline.

Refer Appendix 12

Resolve that the Board approve the representation to the Minister of Health that Q4 cost increases between the 2018/19 and 2019/20 financial years, have only been approved where unavoidable (refer Section 14)

Refer Appendix 13

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

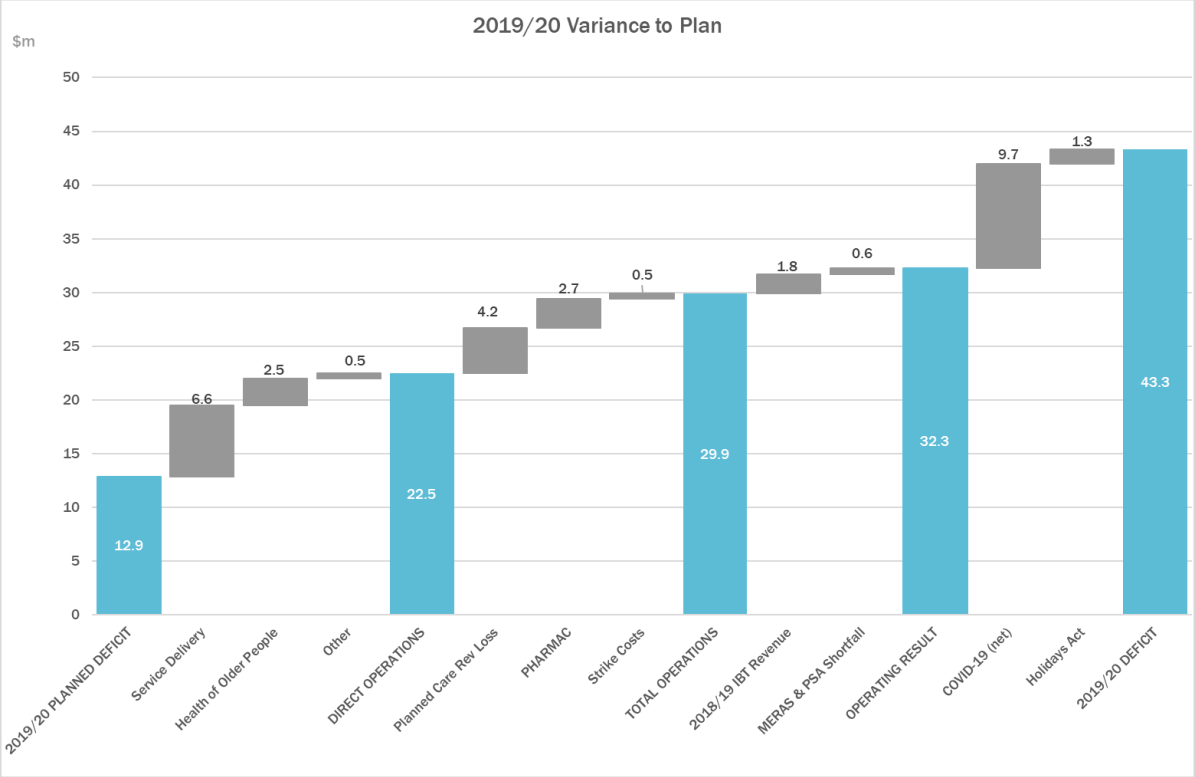
Financial Performance

The interim result for 2019/20, for all costs including the impact of COVID-19, is $43.3m deficit, which is $30.4m adverse to plan. Of this $13.8m relates to exceptional expenditure (the majority being COVID-19) giving an Operating Result of $32.3m against a forecast of $30m:

The variance to the planned $12.9m deficit is analysed in the chart over page and shows:

- $22.5m deficit on normal business operations, the costs that are directly managed. The majority are likely to have an ongoing impact into future years and have been included in the 2020/21 plan
- $7.4m deficit as a result of indirect impacts on operations with unplanned overspends in PHARMAC, strike costs and the Planned Care revenue clawback. All but the strike costs are likely to have an ongoing impact and have been factored into the 2020/21 plan

- $2.3m deficit related to MoH revenue, detailed further in this paper, the majority being a 2019/20 impact only



The Operating Result is $2.3m worse than forecast, attributed to two factors:

1. Release of 2018/19 revenue accrual related to In Between Travel of $1.8m, due to accruals for revenue that had already been received via funding envelope. This had been followed up with MoH in year, but misunderstanding around the funding streams meant the revenue was double counted in 2018/19
2. Shortfall on MERAS & PSA settlement $0.6m. The delta between MoH settlement and actual cost has been an ongoing discussion in year and we have low expectation that the difference will be provided

The result for June is $10.4m unfavourable to plan comprising:

	$m
• COVID-19 net costs	4.4
• Holidays Act provision for 2019/20	1.3
• In Between Travel – MoH income	1.8
• Normal operations	2.9

Whilst there was an expectation (and forecast) of higher costs in June due to winter activity and the push to deliver Planned Care activity, impacting surgical services and clinical equipment, underlying data around ordinary hours worked shows high staffing levels currently. The activity rebound related to COVID-19 may be a factor in this, but this is an area of high focus going into the new financial year.

It should be noted that this is an interim result as we finalise the result with MoH. We do expect some movement in COVID-19 costs as MoH finalise their advice and Holidays Act, which will be informed by the EY sample review due early August.

$'000	June Actual	June Budget	June Variance		Full Year Actual	Full Year Budget	Full Year Variance		Refer Appendix
Operating Revenue	48,836	51,196	(2,360)	-4.6%	604,803	612,702	(7,899)	-1.3%	1
Less:									
Providing Health Services	27,990	25,562	(2,428)	-9.5%	309,613	300,167	(9,446)	-3.1%	2
Funding Other Providers	23,237	22,140	(1,097)	-5.0%	270,097	264,850	(5,247)	-2.0%	3
Corporate Services	5,071	5,137	65	1.3%	60,799	60,637	(162)	-0.3%	4
Reserves	145	(107)	(252)	-234.8%	(2,092)	(52)	2,039	3895.3%	5
Operating Result	**(7,607)**	**(1,535)**	(6,073)	-395.7%	**(33,615)**	**(12,900)**	(20,715)	-160.6%	
Plus:									
Emergency Response (COVID-19)	(4,378)	-	(4,378)	0.0%	(9,672)	-	(9,672)	0.0%	
	(11,985)	**(1,535)**	(10,450)	-680.9%	**(43,286)**	**(12,900)**	(30,386)	-235.6%	

Key Drivers

The detail of the variances are covered in the appendices to the report. The main areas driving adverse variances for the year are:

- Income (Appendix 1)

  Loss of Planned Care revenue of $4.2m for the year based on pre COVID-19 forecast volumes, reduced estimates of wash-ups for PHO performance, pay equity/in-between travel. The COVID-19 lock-down from late March to May also impacted revenue that is highly sensitive to activity levels such as ACC activity.

- Providing Health Services (Appendix 2)

  Underlying drivers are higher than budgeted patient demand, which increases staffing and locum costs, volumes of certain high value low volume clinical supplies, flight and security costs. To keep transparency for analysis purposes, the impact of cancelled leave is transferred to COVID through the 'Reserves' line (hence the favourable YTD variance). This shows that Providing Health Services has been impacted by low leave levels resulting from the COVID-19 response.

- Funding Other Providers (Appendix 3)

  Faster than expected take-up of new pharmaceuticals and changes to a higher cost/mix of care in Health of Older People have been the main underlying issues all year.

- Emergency Response (COVID-19)

  Gross expenditure is $14.9m in year, netted off by $5.2m revenue to give a net result of $9.7m expense YTD. The main drivers in month are the transfer of staffing impacts which can be attributed to COVID-19, costs of recovery / backlog and testing costs.

  Testing costs to date are $3.3m against revenue received of $2.6m and we expect to have further discussions with MoH the cost of delivering the testing volumes required.

Other Performance Measures

	June				Full Year				Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance		
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	
Capital spend	3,448	1,757	1,691	96.2%	15,521	21,695	(6,174)	-28.5%	10
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	
Employees	2,752	2,668	(84)	-3.2%	2,531	2,506	(25)	-1.0%	2 & 4
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	
Case weighted discharges	2,927	2,425	501	20.7%	30,094	29,239	854	2.9%	2

- Capital spend (Appendix 12)

  Slippage in our strategic projects resulted in an underspend in the early part of the year and actions to substitute with other capital projects in the closing months of the year have been impacted by COVID-19 either through delayed deliveries or difficulties getting contractors on site. Capital spend efforts were retasked to COVID-19 related projects from late March, and most of the locally funded budget was spent by year end.

- Cash (Appendices 11 & 13)

  The cash low point for the month was $15.8m overdrawn on 3 June immediately prior to receipt of MoH income, and reflects the receipt of $20m of deficit funding in the second half of April. Deficit support is by equity injection and does not impact the operating result. A position of net expenditure on COVID-19 is impacting our cash profile.

- Employees (Appendices 2 & 4)

  Unfavourable due to the impact of patient watches and activity in the wards earlier in the year, then to cancellation of leave and staffing levels relating to the possible escalation of COVID-19 from late March.

- Activity (Appendix 2 and 7)

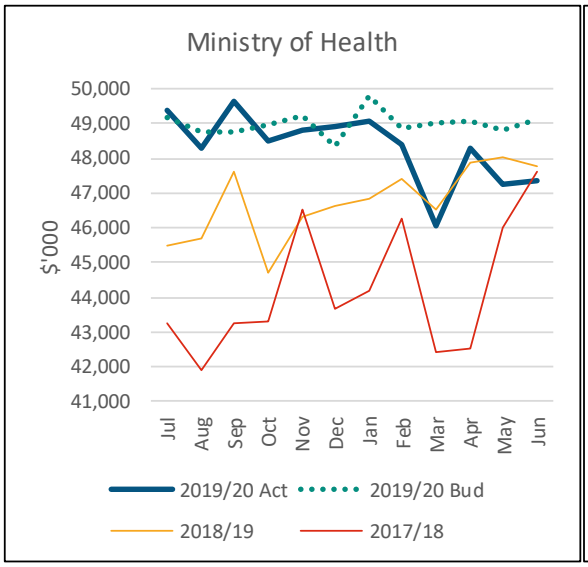
  Prior to March case weight discharges (CWDs) were close to plan, as high maternity and acute volumes offset low elective surgery numbers. COVID-19 impacted CWDs in April, partly recovering in May, and substantially recovering in June.

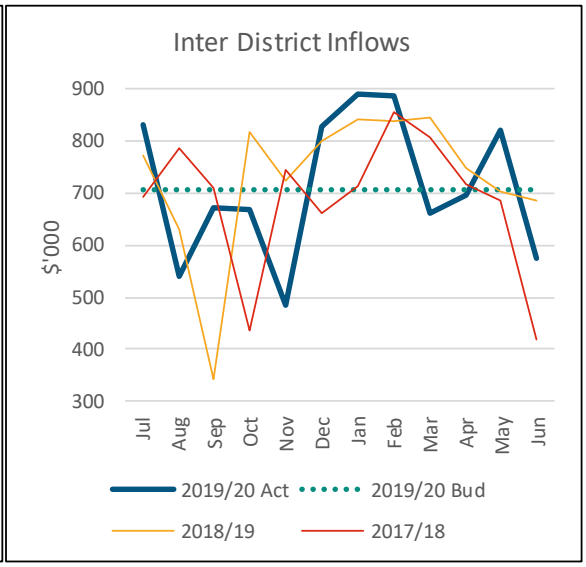
  On Planned Care significant effort has been made to meet 85% of planned activity in June and early data indicates this was achieved. This has meant we have not had to take further revenue loss into the financial position.

APPENDICES

1. OPERATING REVENUE

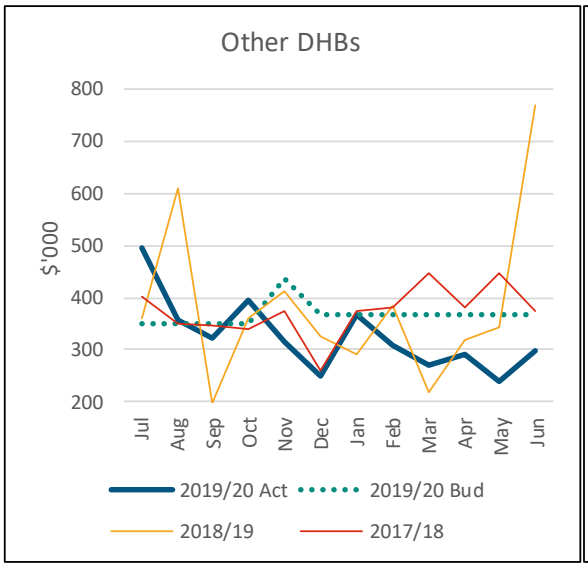
Excludes revenue for COVID-19	*June*				*Full Year*			
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*	
Ministry of Health	47,380	49,119	(1,739)	-3.5%	580,055	587,949	(7,894)	-1.3%
Inter District Flows	576	707	(131)	-18.5%	8,558	8,489	68	0.8%
Other District Health Boards	298	368	(69)	-18.9%	3,911	4,395	(484)	-11.0%
Financing	36	7	29	418.1%	150	84	66	78.2%
ACC	523	468	55	11.7%	5,112	4,976	137	2.7%
Other Government	25	44	(19)	-42.3%	479	520	(41)	-7.8%
Abnormals	-	-	-	0.0%	6	-	6	0.0%
Patient and Consumer Sourced	104	104	1	0.6%	1,424	1,244	179	14.4%
Other Income	(108)	379	(487)	-128.5%	5,108	5,046	63	1.2%
	48,836	**51,196**	(2,360)	**-4.6%**	**604,803**	**612,702**	(7,899)	**-1.3%**

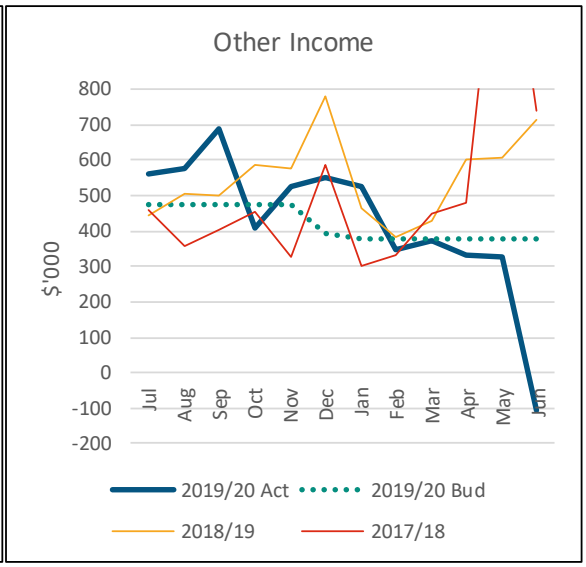




Ministry of Health ($7.9m adverse year to date)
Loss of planned care (elective surgery) revenue, partly offset by capital charge funding relating to the revaluation of land and buildings at the end of 2018/19, and additional funding for social work services were the main factors up to February. MoH advice that they will not allow the offset of a shortfall in planned elective surgery against higher volumes in other areas, was recognised in March.

Inter District Inflows ($0.4m adverse YTD)
Close to budget for the year, inter district flows are inherently volatile, and subject to a wash-up that adds add some risk to the DHB result.



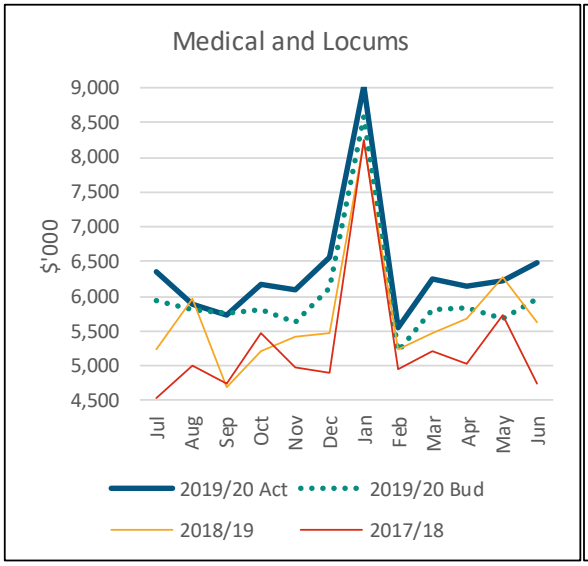


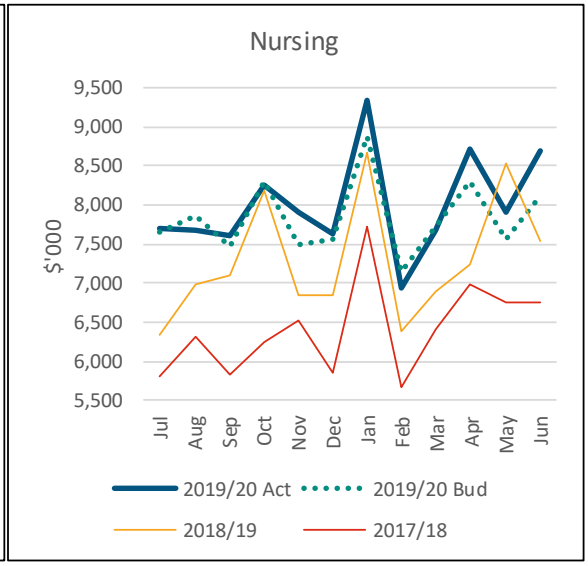
Other District Health Boards ($0.5m adverse YTD)
A fall off in revenue from Tairawhiti DHB (cancer drugs) and Mid Central DHB (oncology services) is part of a long term trend, and in the last few months was impacted by the COVID-19 travel restrictions.

Other income ($0.5m adverse in June)
This classification usually benefits from unplanned revenue across a wide range of services, and that was the case until February from when the COVID response reduced both food and general revenue. A forecast provision for transfer of special funds was recognised in June and further information will be provided to the August FRAC.

2. PROVIDING HEALTH SERVICES

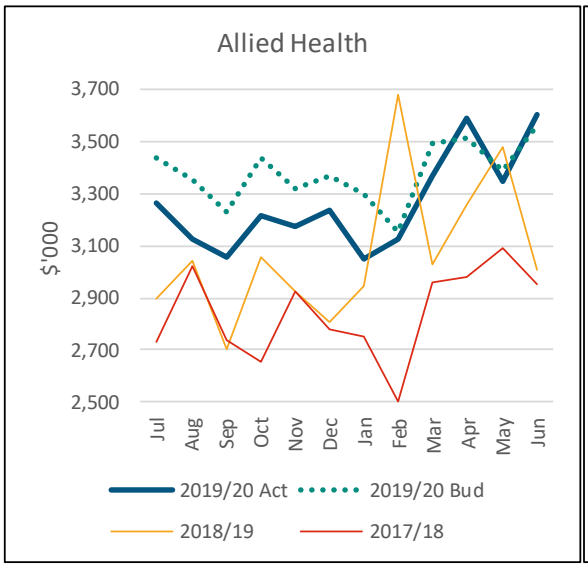
	June				Full Year			
	Actual	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*	
Expenditure by type $'000								
Medical personnel and locums	6,495	5,951	(544)	-9.1%	76,483	72,128	(4,355)	-6.0%
Nursing personnel	8,697	8,109	(588)	-7.2%	96,077	94,074	(2,003)	-2.1%
Allied health personnel	3,602	3,566	(36)	-1.0%	39,165	40,566	1,401	3.5%
Other personnel	2,277	2,291	15	0.6%	26,380	25,954	(426)	-1.6%
Outsourced services	908	736	(171)	-23.3%	9,943	9,569	(375)	-3.9%
Clinical supplies	4,401	3,457	(944)	-27.3%	43,707	40,494	(3,213)	-7.9%
Infrastructure and non clinical	1,612	1,452	(160)	-11.0%	17,858	17,383	(475)	-2.7%
	27,990	**25,562**	(2,428)	-9.5%	**309,613**	**300,167**	(9,446)	-3.1%
Expenditure by directorate $'000								
Medical	8,159	7,275	(884)	-12.2%	88,867	84,807	(4,061)	-4.8%
Surgical	6,347	5,692	(655)	-11.5%	70,030	68,809	(1,221)	-1.8%
Community, Women and Children	4,158	4,233	75	1.8%	49,662	49,950	288	0.6%
Mental Health and Addiction	2,054	1,881	(174)	-9.2%	23,323	21,966	(1,357)	-6.2%
Older Persons, NASC HB, and Allied H	1,566	1,515	(51)	-3.4%	17,439	17,790	350	2.0%
Operations	4,614	3,883	(731)	-18.8%	47,594	45,189	(2,406)	-5.3%
Other	1,092	1,084	(8)	-0.7%	12,698	11,657	(1,040)	-8.9%
	27,990	**25,562**	(2,428)	-9.5%	**309,613**	**300,167**	(9,446)	-3.1%
Full Time Equivalents								
Medical personnel	405.2	399.5	(6)	-1.4%	376	375	(1)	-0.3%
Nursing personnel	1,168.8	1,080.3	(89)	-8.2%	1,060	1,022	(38)	-3.7%
Allied health personnel	530.6	531.0	0	0.1%	480	495	15	3.0%
Support personnel	103.6	123.2	20	15.9%	124	115	(9)	-8.0%
Management and administration	309.4	299.5	(10)	-3.3%	280	279	(1)	-0.2%
	2,517.7	**2,433.6**	(84)	-3.5%	**2,320**	**2,286**	(34)	-1.5%
Case Weighted Discharges								
Acute	2,199	1,736	463	26.7%	22,147	19,957	2,190	11.0%
Elective	438	490	(51)	-10.5%	5,534	6,850	(1,316)	-19.2%
Maternity	268	161	107	66.5%	2,076	2,000	76	3.8%
IDF Inflows	22	38	(17)	-43.7%	337	432	(96)	-22.1%
	2,927	**2,425**	501	20.7%	**30,094**	**29,239**	854	2.9%

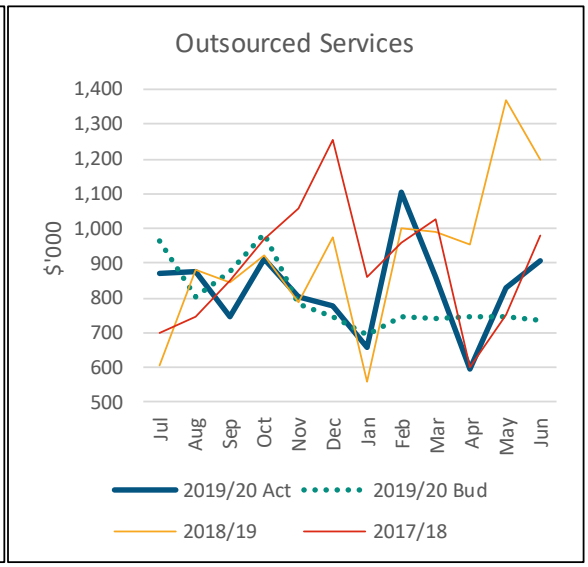




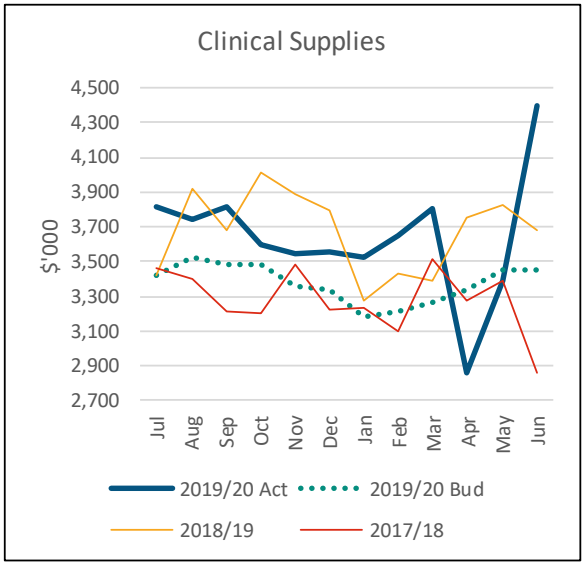
Medical personnel and locums ($4.4m adverse for the year)
Vacancies were more than offset by locum vacancy and leave cover, and additional sessions to cope with volume. In March and April cancellation of leave in case of pandemic escalation and additional shifts to support the establishment of a COVID hospital, should it be required, increased the adverse result. In May and June COVID-19 recovery and push to deliver Planned Care activity maintained costs at the higher level.

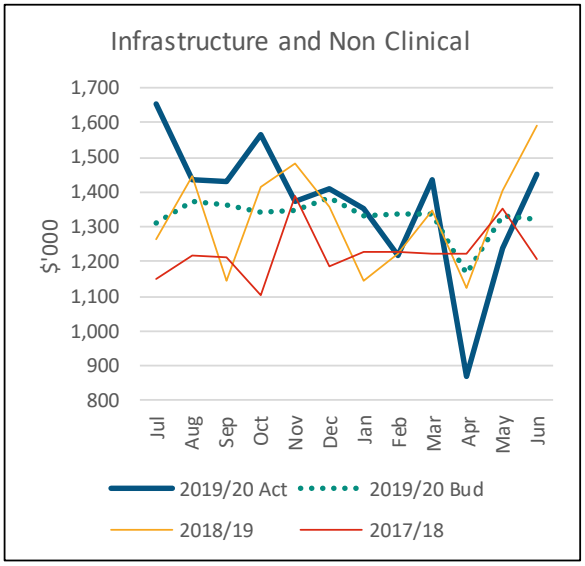
Nursing personnel ($2.0m adverse for the year)
Unfavourable nursing personnel costs from high casual and on-call allowances and overtime payments relating to patient volume. Cancelled leave, additional shifts to support our COVID preparations/response, and COVID-19 recovery/rebound increased costs over the last few months.





Allied health personnel ($1.4m favourable for the year)
Favourable allied health personnel expenditure from vacancies in social workers, technicians, psychologists, occupational therapists, laboratory technicians, cultural workers, and pharmacists, early in the year. Cancelled leave, additional shifts and COVID-19 recovery have increased costs up to budget between March and June.



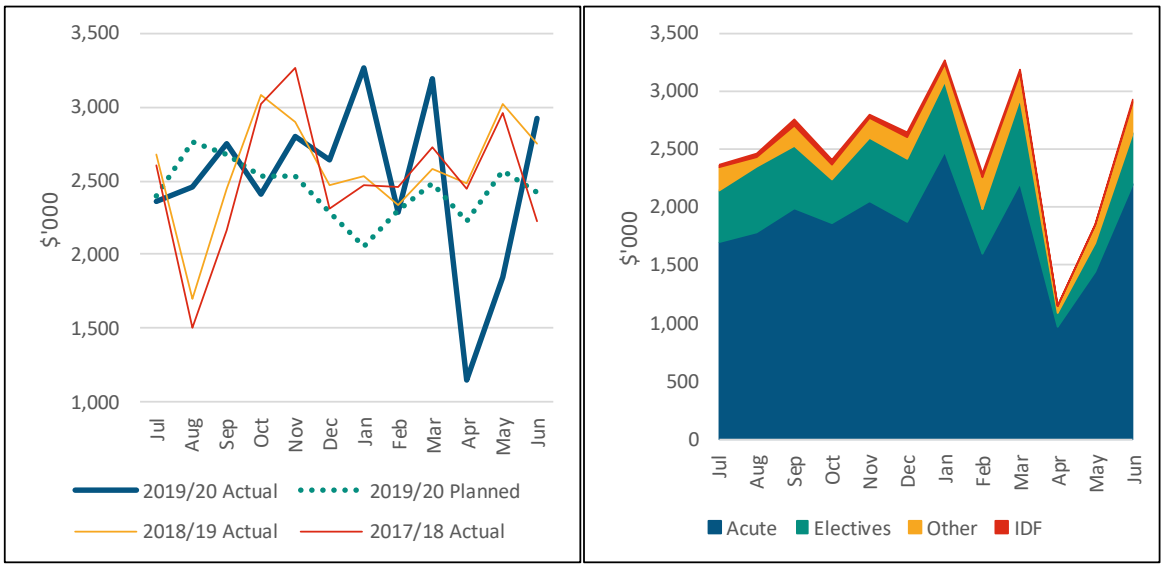


Clinical supplies ($3.2m adverse for the year)
Unfavourable clinical supplies included efficiencies not achieved, adverse blood product (mainly Intragam) costs, patient transport costs, and implants and prostheses, partly offset by pharmaceutical reimbursements. Lockdown reduced costs in April as patient numbers fell significantly, partially recovering in May as patient numbers began building up.

June patient transport was affected by a busy month and unexpected backdated flight cost increases. Implants and pharmaceuticals were also up on May due to the push on Planned Care activity.

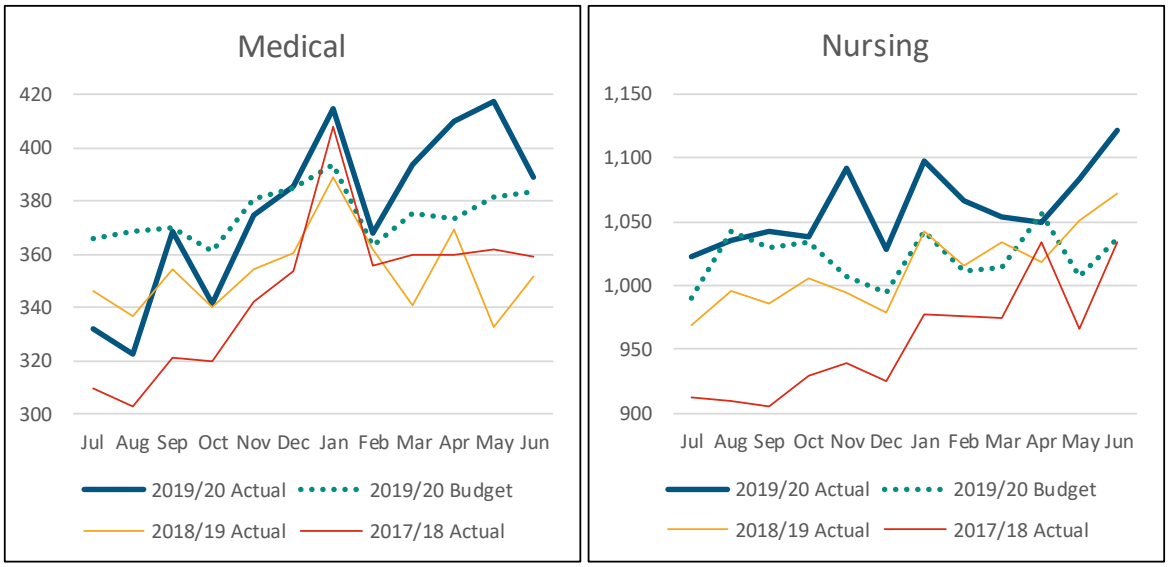
Infrastructure and Non-Clinical supplies ($0.5m adverse for the year)
Security (patient watches), food and laundry services, and timing of Maori workforce scholarships contributed to the result to May. High feasibility costs to support capital projects, and additional information technology costs increased costs above budget in June.

Case Weighted Discharges (CWDs)



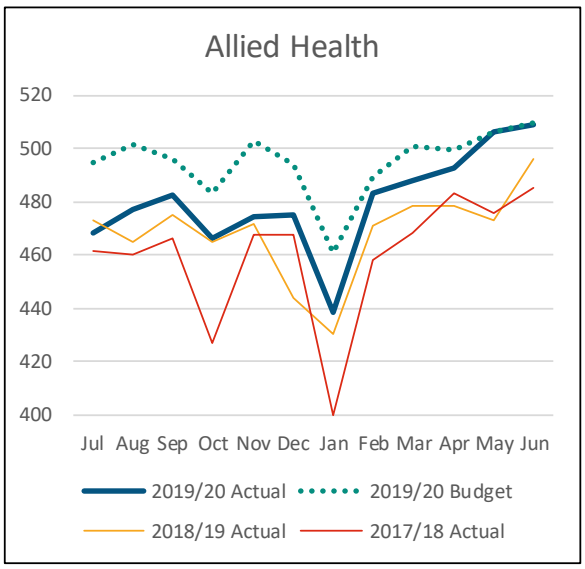
Overall CWDs are 2.9% above plan. Acute patient volumes partly offset by low elective surgery pushed CWDs to 7.4% ahead of plan at the end of February. However the impacts of lockdown in preparation for a possible COVID-19 influx impacted on CWDs levels in April and May. COVID-19 recovery increased CWDs above plan in June.

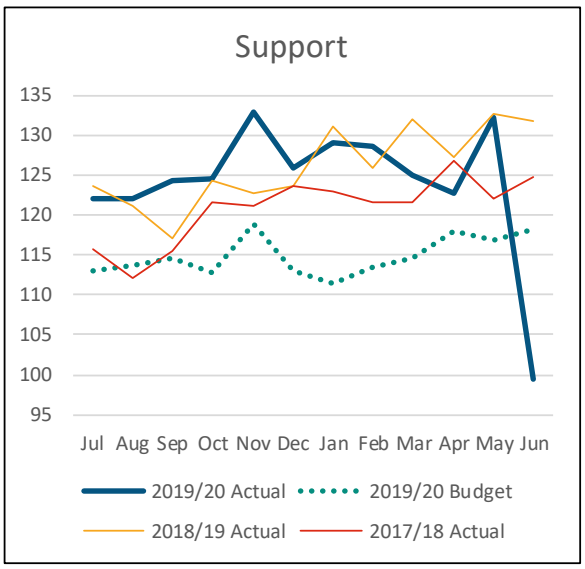
Full Time Equivalents (FTE)



Medical personnel (-1 FTE / -0.3% adverse)
Vacancies in the early part of the year have been offset by the COVID-19 response – cancelled leave in case of escalation and higher staffing levels to support our COVID preparations/response, and COVID-19 recovery in May. In June FTEs reduced to be closer to budget, as some additional positions were removed, restrictions on taking annual leave were lifted, and some positions became vacant.

Nursing personnel (-38 FTE / -3.7 adverse)
Reflects the impact of patient watches and higher than planned levels of activity mainly in the wards earlier in the year. Lower staffing in surgical wards and early supported discharge in March/April, was mostly offset by higher staffing in emergency, mental health and the medical wards reflecting the COVID-19 response. The move back to business as usual (COVID-19 Recovery) from May increased staffing in the surgical wards to support Planned Care activity, while staffing in the other areas remained high due to continuing emergency response and high patient demand.



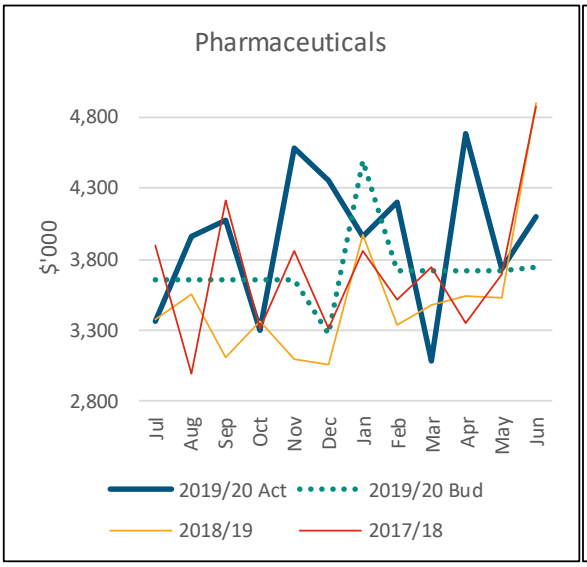


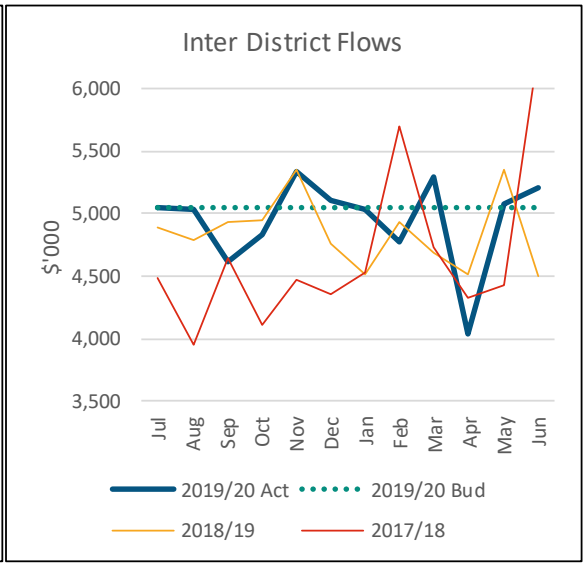
Allied health personnel (15 FTE / 3.0% favourable)
Ongoing vacancies in allied health personnel, including social workers, psychologists, laboratory and pharmacy technicians, and occupational therapists. FTEs are closer to budget in May and June as positions for early supported discharge have been filled. These positions were budgeted in nursing, so obscure the continuing issue with vacancies.

Support personnel (-9 FTE / -8.0% unfavourable)
Efficiencies expected from the reorganisation of the orderlies service were offset by pressure on support personnel including security (patient watches), kitchen staff, and orderlies. Security costs relating to the CBACs has been transferred from Providing Health Services to Covid-19 costs in June.

3. FUNDING OTHER PROVIDERS

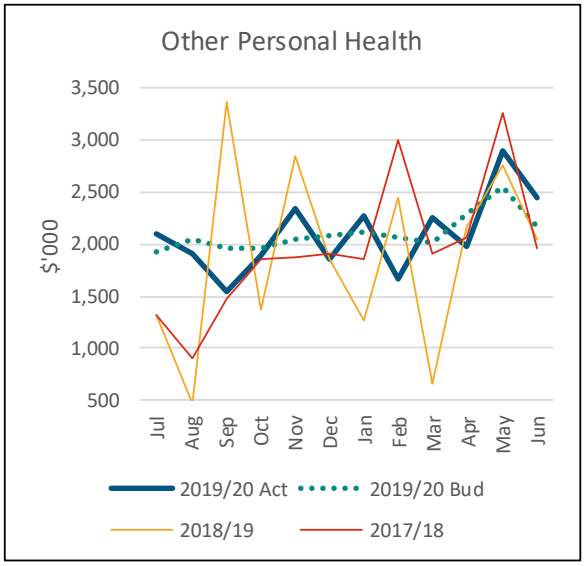
$'000	June Actual	June Budget	June Variance		Full Year Actual	Full Year Budget	Full Year Variance	
Payments to Other Providers								
Pharmaceuticals	4,107	3,742	(364)	-9.7%	47,434	44,716	(2,718)	-6.1%
Primary Health Organisations	4,021	3,591	(430)	-12.0%	43,704	43,681	(23)	-0.1%
Inter District Flows	5,208	5,043	(166)	-3.3%	59,410	60,513	1,103	1.8%
Other Personal Health	2,284	2,173	(112)	-5.2%	26,383	25,223	(1,160)	-4.6%
Mental Health	1,043	1,089	46	4.2%	13,551	13,007	(544)	-4.2%
Health of Older People	6,242	6,161	(81)	-1.3%	75,694	73,609	(2,085)	-2.8%
Other Funding Payments	331	341	10	2.9%	3,921	4,102	181	4.4%
	23,237	22,140	(1,097)	-5.0%	**270,097**	**264,850**	(5,247)	-2.0%
Payments by Portfolio								
Strategic Services								
Secondary Care	4,752	4,641	(110)	-2.4%	54,834	55,686	852	1.5%
Primary Care	9,704	8,724	(980)	-11.2%	107,856	104,254	(3,602)	-3.5%
Mental Health	1,375	1,418	43	3.1%	17,584	16,956	(628)	-3.7%
Health of Older People	6,804	6,722	(82)	-1.2%	82,334	80,319	(2,015)	-2.5%
Maori Health	465	505	39	7.8%	5,967	6,087	120	2.0%
Population Health	137	130	(8)	-5.9%	1,523	1,549	26	1.7%
	23,237	22,140	(1,097)	-5.0%	**270,097**	**264,850**	(5,247)	-2.0%

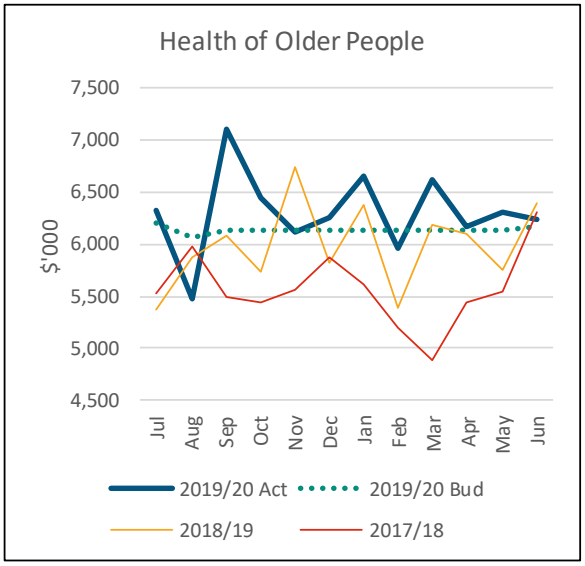




Pharmaceuticals ($2.7m adverse for the year)
The graph shows the huge volatility in the pharmaceutical position we have experienced during the year, partly driven by the financial model and partly due to underlying unfavourable pharmaceutical spend as a result of faster than expected take up of new pharmaceuticals and over-representation of HBDHB in some classes of pharmaceuticals, notably Pharmaceutical Cancer Treatments. High pharmaceutical claims in April reflects changes in prescribing due to the lock down, followed by a return to a more normal level from May.

Inter District Flows ($1.1m favourable for the year)
As per MoH guidance we have outturned the year at our position at February, which was $1.1m favourable.





Other Personal Health ($1.2m adverse for the year)
Unfavourable other personal health costs, mainly relates to an increase in the contribution to National Haemophilia Management Group incurred in April.

Health of Older People ($2.1m adverse for the year)
Unfavourable Health of Older People spend resulting from changes in mix of care to higher cost packages, pay equity and In-Between-Travel costs.

4. CORPORATE SERVICES

$'000	June Actual	June Budget	June Variance		Full Year Actual	Full Year Budget	Full Year Variance	
Operating Expenditure								
Personnel	1,749	1,783	33	1.9%	19,806	20,752	946	4.6%
Outsourced services	107	76	(30)	-39.7%	1,690	916	(774)	-84.5%
Clinical supplies	55	56	1	2.4%	624	668	44	6.5%
Infrastructure and non clinical	1,584	1,377	(207)	-15.1%	16,757	16,474	(283)	-1.7%
	3,495	3,292	(203)	-6.2%	38,876	38,809	(67)	-0.2%
Capital servicing								
Depreciation and amortisation	1,210	1,229	19	1.6%	13,576	14,465	890	6.2%
Financing	37	3	(34)	-1236.1%	244	17	(227)	
Capital charge	329	612	283	46.2%	8,103	7,346	(757)	-10.3%
	1,576	1,844	268	14.6%	21,923	21,828	(94)	-0.4%
	5,071	**5,137**	65	1.3%	**60,799**	**60,637**	(162)	-0.3%
Full Time Equivalents								
Medical personnel	1.3	0.3	(1)	-326.8%	1	0	(0)	-120.2%
Nursing personnel	19.2	17.7	(1)	-8.1%	16	17	1	3.7%
Allied health personnel	-	0.4	0	100.0%	0	0	0	98.3%
Support personnel	33.3	32.0	(1)	-4.0%	30	30	0	0.4%
Management and administration	180.6	183.6	3	1.7%	164	172	8	4.6%
	234.3	**234.1**	(0)	-0.1%	**211**	**220**	9	4.0%

Personnel is mainly executive staff vacancies partly offset by contracted executives in outsourced services.

Infrastructure includes data network costs relating to the new telephone system and outsourced and deferred maintenance costs relating to facilities. Lower maintenance and feasibility costs during COVID were followed by high costs in June reflecting a level of catch-up.

Depreciation and amortisation reflects the extension of building lives projected in the 30 June 2019 revaluation of land and buildings and slower than planned capital expenditure. Financing is bank overdraft interest, and reflects the cash position year to date and the effect of the $20m cash injection in April.

Capital charge is adverse due to the equity funding and property revaluations at the end of the last financial year. The impact from property revaluations is offset in revenue by MoH funding.

5. RESERVES

$'000	June Actual	June Budget	June Variance		Full Year Actual	Full Year Budget	Full Year Variance	
Expenditure								
Contingency	-	82	82	100.0%	-	1,003	1,003	100.0%
Other	145	(190)	(335)	-176.3%	(2,092)	(1,056)	1,036	98.1%
	145	**(107)**	(252)	234.8%	**(2,092)**	**(52)**	**2,039**	

The contingency budget reduces when use of reserves is approved. These have been largely allocated against specific initiatives expected to drive improvements in patient outcome and access. The YTD favourable variance shows the release of contingency into the result.

The "Other" category includes prior year adjustments and loss on disposal of clinical equipment. In May and June it has been used to transfer the increase in leave costs over the lockdown period to Emergency Response (COVID-19) expenditure.

6. FINANCIAL POSITION

30 June 2019		*30 June 2020*			
	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2019*
	Equity				
188,048	Crown equity and reserves	208,983	174,339	34,644	20,935
(44,407)	Accumulated deficit	(87,693)	(29,271)	(58,422)	(43,286)
143,641		121,290	145,068	(23,778)	(22,351)
	Represented by:				
	Current Assets				
759	Bank	1,198	840	358	439
1,881	Bank deposits > 90 days	1,449	1,855	(406)	(432)
29,342	Prepayments and receivables	20,903	26,488	(5,585)	(8,439)
4,023	Inventory	4,626	3,933	693	603
-	Investment in NZHP	-	2,638	(2,638)	-
36,005		28,176	35,754	(7,578)	(7,830)
	Non Current Assets				
190,552	Property, plant and equipment	190,156	188,324	1,833	(396)
13,790	Intangible assets	15,978	3,412	12,566	2,188
1,189	Investments	1,120	9,002	(7,881)	(69)
205,532		207,254	200,737	6,517	1,723
241,537	**Total Assets**	**235,430**	**236,491**	**(1,061)**	**(6,107)**
	Liabilities				
	Current Liabilities				
10,208	Bank overdraft	14,430	1,828	(12,602)	(4,223)
31,318	Payables	36,224	47,228	11,004	(4,906)
53,370	Employee entitlements	60,485	39,576	(20,909)	(7,115)
94,895		111,139	88,633	(22,507)	(16,244)
	Non Current Liabilities				
3,001	Employee entitlements	3,001	2,790	(211)	-
3,001		3,001	2,790	(211)	-
97,896	**Total Liabilities**	**114,140**	**91,423**	**(22,718)**	**(16,244)**
143,641	**Net Assets**	**121,290**	**145,068**	**(23,778)**	**(22,351)**

Crown equity and reserves variance from budget includes:

- changes in the 2018/19 result subsequent to the preparation of the 2019/20 budget including land and building revaluations, the equity injection for cash flow purposes and Holidays Act remediation provisioning
- budgeted capital funding for 2019/20 phased to be received at the mid-point of the year due to uncertainty over timing
- the April 2020 deficit funding, and
- the year to date result.

The current assets variance reflects differences between estimated and actual receipt of wash-up funding such as Planned Care (elective) surgery, the write-off of the investment in New Zealand Health Partnerships (NZHP) at the end of last year, partly offset by additional inventory relating to PPE relating to COVID-19.

Higher than budgeted non-current assets results from the revaluation of land and buildings at 30 June 2019, partly offset by later than planned capital expenditure.

The movement in current liabilities mainly reflects Holidays Act remediation provisioning, and the impact of the operating result on the overdraft, partly offset by the $30m of deficit funding between June 2019 and April 2020.

7. EMPLOYEE ENTITLEMENTS

30 June 2019		*30 June 2020*			
	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2019*
7,755	Salaries & wages accrued	8,709	9,483	774	(954)
1,027	ACC levy provisions	1,058	1,174	115	(31)
5,530	Continuing medical education	6,492	5,656	(836)	(962)
37,303	Accrued leave	41,950	21,255	(20,695)	(4,646)
4,755	Long service leave & retirement grat.	5,277	4,798	(479)	(522)
56,371	**Total Employee Entitlements**	63,486	42,366	(21,120)	(7,115)

Accrued leave includes provisioning of $14.3m for the remediation of Holidays Act non-compliance, in accordance with the memorandum of understanding with health sector employee representatives and the Ministry of Business, Innovation and Employment (MBIE).

8. PLANNED CARE

MoH data on Planned Care delivery is provided in the table below. This shows total Planned Care discharge performance, which is the term MoH uses for the sum of Inpatient Surgical Discharges, Minor Procedures and Non Surgical Interventions.

Due to MoH timing this is only to May and is heavily impacted by COVID-19.

The material shortfall on case weight has had a significant impact on revenue as recognised in March. As a result of the actions taken in June to ensure activity exceeded 85% of plan, we do not expect to take further revenue loss.

2019/20 Year to Date Contracted Volume Summary

	Base YTD Planned Volume	Additional YTD Planned Volume	Total YTD Planned Volume	Actual Delivery	YTD Delivery %	2019/20 Total Planned Volume
Inpatient Caseweight Delivery	7,143.5	2,560.1	9,703.6	7,924.6	81.7%	10,490.0
Inpatient Surgical Discharges	4,911	1,830	6,741	5,428	80.5%	7,298
Minor Procedures	1,708	599	2,307	3,900	169.1%	2,481
Non Surgical interventions	0	35	35	0	0.0%	38

Figures are DHB of Domicile and include publicly funded, Elective and Arranged Surgical Discharges reported to NMDS, and selected Minor Procedure Purchase Units reported to NMDS and NNPAC

NMDS Refresh Date: 6/07/2020 **NNPAC Refresh Date:** 6/07/2020
Data up to: May 2020 **Report Run Date:** 6/07/2020

9. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by NZHP under a sweep arrangement facilitated by BNZ. The DHB provides forecast cash flow information to NZHP to allow it to invest the funds at the most advantageous rates and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due. The cash balance at the end of June was a $13.7m overdraft (May $10.3m).

The cash low point for each month is generally incurred immediately prior to receipt of MoH funding on the 4th of the month. June's low point was $15.8m overdraft on 3 June. July's low point is projected to be the $18.6m overdrawn on 2 July and shortfall on COVID-19 costs will be a significant driver of this. Our statutory overdraft limit is currently $32m reflected the approved 2019/20 Annual Plan.

The main cash risks are net expenditure on COVID-19 and the remediation of the Holidays Act, which the MoH are aware of.

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

No material transactions occurred during the month. No transactions met the criteria that would trigger the requirement to arrange foreign exchange rate cover.

10. CAPITAL EXPENDITURE

While COVID-19 refocused effort from locally funded projects, most of the remaining planned expenditure was committed in advance, and delivered in June. COVID-19 asset purchases that will only be used for the emergency response have been treated as operating costs in the separate Covid report.

See table on the next page.

	Full Year		
	Actual	*Budget*	*Variance*
	$'000	*$'000*	*$'000*
Source of Funds			
Operating Sources			
Depreciation	13,576	14,465	890
Equity requirement	(20,332)	7,230	(15,023)
	(6,756)	21,695	(14,134)
Other Sources			
Special Funds and Clinical Trials	131	-	(131)
Funded Programmes	853	-	(853)
Equity Injection approved	21,293	-	21,293
	22,277	-	20,308
Total funds sourced	**15,521**	**21,695**	**6,174**
Application of Funds:			
Block Allocations			
Facilities	3,045	3,362	317
Information Services	3,241	3,320	78
Clinical Equipment	3,892	4,360	468
	10,179	11,041	862
Local Strategic			
Replacement Generators	228	500	272
Endoscopy Building	(3)	-	3
Travel Plan	(5)	-	5
Radiology Extension	380	2,550	2,170
High Voltage Electrical Supply	691	700	9
Seismic AAU Stage 2 and 3	1,297	2,069	772
Seismic Surgical Theatre HA37	188	1,500	1,312
Seismic Radiology HA27	80	200	120
Surgical Expansion	394	1,202	808
Matching Capacity to Demand	120	962	842
	3,370	9,683	6,313
Other			
Special Funds and Clinical Trials	131	-	(131)
Funded Programmes	853	-	(853)
Other	(113)	-	113
	871	-	(871)
Regional Strategic			
Regional Digital Health Services (formerly RHIP)	1,101	971	(130)
	1,101	971	(130)
Capital Spend	**15,521**	**21,695**	**6,174**

11. ROLLING CASH FLOW

	Jun-20			Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
	Actual	**Forecast**	**Variance**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Cash Inflows															
Devolved MOH revenue	57,730	59,580	1,850	57,450	54,537	61,437	55,037	53,537	109,874	-	53,537	56,537	53,537	53,537	56,637
Other revenue	6,905	4,190	-2,715	6,600	4,190	4,680	4,390	4,080	4,040	3,750	4,250	4,550	4,200	4,350	4,100
Total cash inflow	64,635	63,770	-865	64,051	58,727	66,117	59,427	57,617	113,914	3,750	57,787	61,087	57,737	57,887	60,737
Cash Outflows															
Payroll	13,157	12,000	1,157	16,241	12,400	11,950	12,390	12,400	14,730	12,400	12,400	16,200	12,450	12,400	14,700
Taxes	8,548	8,700	-152	8,466	8,700	8,600	9,200	8,800	5,600	8,800	8,800	8,800	8,800	8,800	8,800
Sector Services	26,736	26,665	71	27,177	26,600	26,200	27,400	28,050	26,145	15,350	26,755	27,050	18,700	24,200	20,393
Other expenditure	19,533	19,414	119	13,684	11,870	11,902	11,458	11,904	16,890	12,939	12,998	13,046	13,038	11,967	17,067
Total cash outflow	67,974	66,779	1,195	65,568	59,570	58,652	60,448	61,154	63,365	49,489	60,954	65,096	52,988	57,367	60,960
Total cash movement	-3,339	-3,009	330	-1,517	-843	7,465	-1,021	-3,537	50,549	-45,739	-3,167	-4,009	4,749	520	-223
Add: opening cash	-10,338	-10,334	-	-13,677	-15,194	-16,037	-8,571	-9,592	-13,129	37,420	-8,319	-11,486	-15,495	-10,746	-10,226
Closing cash	-13,677	-13,343	330	-15,194	-16,037	-8,571	-9,592	-13,129	37,420	-8,319	-11,486	-15,495	-10,746	-10,226	-10,449
Maximum cash overdraft (in month)	-15,825	-16,993	1,168	-15,190	-16,033	-20,336	-9,588	-13,125	-18,057	-8,316	-14,997	-17,614	-10,742	-11,002	-14,094

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12. JOINT STATEMENT OF REPRESENTATION AND LETTER OF COMFORT

JOINT STATEMENT OF REPRESENTATION

DHBs are required to submit audited financial information to the Ministry of Health for consolidation into the Crown Financial Statements. The information is in the form of detailed financial templates and is part of the usual year end process required by Treasury.

A Joint Statement of Representation signed by the Chair, one other board member, the Chief Executive and the Chief Financial Officer is required to accompany the submission. A draft copy of the statement is attached, and is complete except for the consolidated net result and the consolidated total Crown equity figures, that are yet to be finalised, and any material events subsequent to balance date that may be identified, including the review of the Holidays Act provision.

As the due date is 10th August, the Board is asked to delegate to the Chair of the Board and the Chair of FRAC, the authority to sign the statement on its behalf.

LETTER OF COMFORT

The Board will be required to attest that HBDHB is a going concern in the 2019/20 financial statements. Given the deficits in recent years, the planned deficit for 2020/21 and ongoing pressure on cash, the Board are advised to request a Letter of Comfort from the Joint Ministers of Finance and Health to support their attestation.

The Joint Ministers anticipate requests will be received from the Board Chair before the 17th August and the Board is asked to request on their behalf.

Joint Statement of Representation

10 August 2020

Kelly Rushton
Director
Audit New Zealand
PO Box 99
WELLINGTON

Dr Ashley Bloomfield
Director-General of Health
Ministry of Health
PO Box 5013
WELLINGTON

Dear Kelly and Ashley

Letter of Representation for the year ended 30 June 2020 – template provided to the Ministry of Health for the Government's Financial Statements

This representation letter is given to you in connection with your responsibility to provide audit clearance to the auditors of the Government's financial statements as to whether the financial information included in the DHB financial templates and attached schedules (the schedules) provided to the Ministry of Health fairly reflects the financial position of Hawke's Bay District Health Board as at 30 June 2020 and of the results of its operations and cash flows for the year then ended.

The Board and management of Hawke's Bay District Health Board confirm, to the best of our knowledge and belief, the following representations:

1 We accept responsibility for the preparation of the financial information included in the schedules provided to the Ministry of Health and the judgements made in the process of producing that template.

2 We accept responsibility for establishing and maintaining, and have established and maintained, a system of internal control procedures that provide reasonable assurance as to the integrity and reliability of the financial information in the schedules. We confirm that the system of internal control has operated adequately throughout the period.

3 We confirm that the following key financial information is fairly and appropriately reflected in the schedules:

- Opening equity balance agrees to the closing balance of 2019;
- Income in Advance;
- Accruals for expenditure on community provided services (e.g. community pharmaceuticals);
- PHARMAC rebate accrual;
- Movements in Holidays Act provision;
- Accrual for Inter-district flows;
- The carrying value of land and buildings does not materially differ from fair value; and

- Revenue and expenses with other Crown owned entities (e.g., Air New Zealand, New Zealand Post, energy companies).

In addition we verify that:

a. Consolidated Net Result for the financial year ending 30 June 2020 is a $43.3 million deficit.

b. Consolidated total Crown Equity as at 30 June 2020 is $121.3 million.

c. The schedules contain information that accurately reflects our financial activities and cashflows during the period 1 July 2019 to 30 June 2020. Where the date of the information supplied differs from 30 June 2020, there were no significant movements in our net equity position up to 30 June 2020 that would affect the financial statements of the Government.

d. The amounts recorded in the schedules are complete.

e. We are satisfied that all guarantees, indemnities, securities and other contingent liabilities or assets that remain outstanding at 30 June 2020 have been included in the Contingencies Template.

f. We are satisfied that all contractual commitments have been disclosed accurately in the schedule on the Statement of Commitments.

g. The schedules have been prepared in accordance with the accounting policies of the Crown and Generally Accepted Accounting Practice (Public Benefit Entity Accounting Standards), as applicable for the year ending 30 June 2020.

h. Transactions and balances with entities within the Crown reporting entity greater than $10 million have been confirmed with the other entity.

i. We confirm we used Treasury's central table of risk-free discount rates and CPI assumptions for valuations to comply with *PBE IFRS 4 Insurance Contracts* and *PBE IPSAS 39 Employee Benefits.*

j. There have been no material events subsequent to 30 June 2020 that should be reported in the financial statements.

k. We agree to notify Treasury, the Ministry of Health and the appointed Auditor immediately of any material amendments to the schedules, or subsequent events that should be reported in the financial statements, identified after this Statement of Representation is signed but prior to the finalisation of the financial statements of the Government on 30 September 2020.

l. There are no other matters that you should be aware of in the preparation of the financial statements of the Government for the year ended 30 June 2020.

These representations are made at your request, and to supplement information obtained by you from the records of Hawke's Bay District Health Board and to confirm information given to you orally.

Yours sincerely

Carriann Hall
Chief Financial Officer
10 August 2020

Evan Davies
Board Member
10 August 2020

Keriana Brooking
Chief Executive Officer
10 August 2020

Shayne Walker
Chairperson
10 August 2020

13. CASH SUPPORT CONDITIONS

Financial delegations

The Minister of Health expects the Board to assure itself that any increases to HBDHB's cost base are only approved where unavoidable. To that end he expects the Board will limit its delegations of financial authorities to ensure that potential increases to the major elements of the DHB's cost base are approved directly by the Chief Executive. This expectation is in respect of:

- Recruitment to new positions;
- Increases in contracts for community providers; and
- Approval of capital expenditure plans.

The delegations have had minor amendments to accommodate these expectations.

Approval of capital expenditure plans are reserved to the Board.

Quarterly Report to the Minister of Health

The Minister also expects the Board to provide him, on a quarterly basis, with representation that cost increases have only been approved where unavoidable. The representation is to be accompanied by supporting reports which include the detail of, and explanation for, any increases in expenditure from the corresponding quarter of the previous year, including:

- Full Time equivalents (FTE), personnel and outsourced personnel expenditure;
- Total provider arm expenditure;
- Expenditure on community provider contracts; and
- Actual capital expenditure.

No feedback has been received in relation to the representations and supporting reports sent to the Minister for the first three quarters.

Because the report is a comparison between quarters in different financial years, it will have differences that arise from year-to-date adjustments and changes in accounting practice that are unrelated to financial performance. The main differences relate to COVID-19 and the provisioning for Holidays Act remediation where the 2018/19 amount relates to ten years and the 2019/20 amount is for one year.

The June 2020 representation and supporting report which compares Quarter 4 ended June 2019 to Quarter 4 ended June 2020 is below.

Quarterly Report to the Minister of Health

Quarter Ended 30 June 2020

Description	*This Year*	*Last Year*	*Variance*	*Var %*
FTEs	2,713	2,531	-182	-7.2%
	$'millions	*$'millions*	*$'millions*	*%*
Personnel Costs	67.8	74.5	6.7	8.9%
Outsourced Personnel	2.1	2.2	0.1	6.8%
Provider Arm Expenditure	106.4	108.8	2.3	2.1%
Expenditure on Community Provider Contracts	69.9	63.6	-6.3	-9.9%
Actual Capital Expenditure	5.9	5.9	0.0	-0.7%

FTEs (182 increase)

Includes:	FTE
• impact of the COVID-19 response and recovery on staffing numbers during the quarter;	210
• increase in medical personnel driven by cancellation of leave for COVID-19 preparedness;	12
• reduction in nursing (8), allied health (11), support (16) and management and administration (5) as resources were moved to support the COVID-19 response and recovery;	(40)

Personnel Costs ($6.7m decrease)

Includes:	$'m
• provisions for Holidays Act remediation of $13m in 2018/19 and a further $1.3m in 2019/20;	(12.0)
• impact of the COVID-19 response and recovery on personnel costs	5.3

Outsourced Personnel ($0.1m decrease)

Includes:	$'m
• reduction in vacancy and leave cover during COVID-19;	(0.4)
• impact of the COVID-19 response and recovery on outsourced costs	0.2
• interim executive positions	0.1

Provider Arm Expenditure ($2.3m decrease)

Includes:

• provisions for Holidays Act remediation of $13m in 2018/19 and a further $1.3m in 2019/20;	(12.0)

• impact of the COVID-19 response and recovery	13.9
• Reduction in outsourced costs, clinical supplies and infrastructure and non-clinical as resources were moved to support the COVID-19 response and recovery;	(4.2)

Expenditure on Community Provider Contracts ($6.3m increase)

Includes:	$'m
• increases in community pharmaceutical costs	0.7
• increases in inter-district out flows costs	0.7
• increases in residential care and home support	0.5
• increases in capitated primary practice payments	0.9
• increases in public health costs	0.2
• COVID-19 related costs	3.3

Actual Capital Expenditure (no change)

Expenditure is below plan this year as a number of projects could not progress until equity funding for the radiology extension was confirmed. Expenditure was similarly below plan last year due to procurement lead times for some of the clinical equipment and plant assets purchased in that quarter.

The Board and management of Hawke's Bay District Health Board confirm, to the best of our knowledge and belief, that cost increases between Quarter 4 of the 2018/19 and Quarter 4 2019/20 financial year, have only been approved where unavoidable.

HAWKE'S BAY District Health Board Whakawāteatia	**PLANNING & FUNDING MONTHLY REPORT**
	For the attention of: **HBDHB Board**
Document Owner:	Emma Foster, Executive Director of Planning & Funding (Acting)
Document Author:	Emma Foster, Executive Director of Planning & Funding (Acting)
Month:	July 2020 - PUBLIC
Consideration:	For Noting
RECOMMENDATION **That the HBDHB Board** 1. Note the contents of the report	

Development and Innovation

Annual Plan 2020/2021

Since the last Board meeting we have received and incorporated feedback from Board members and aligned the system recovery plan. Yet to be incorporated are Regional Services Plan actions and financial summary information. Ministry of Health feedback is due on the 10 July, at which point we will be making final adjustments and be ready for formal sign off by the Board 31 July at the latest.

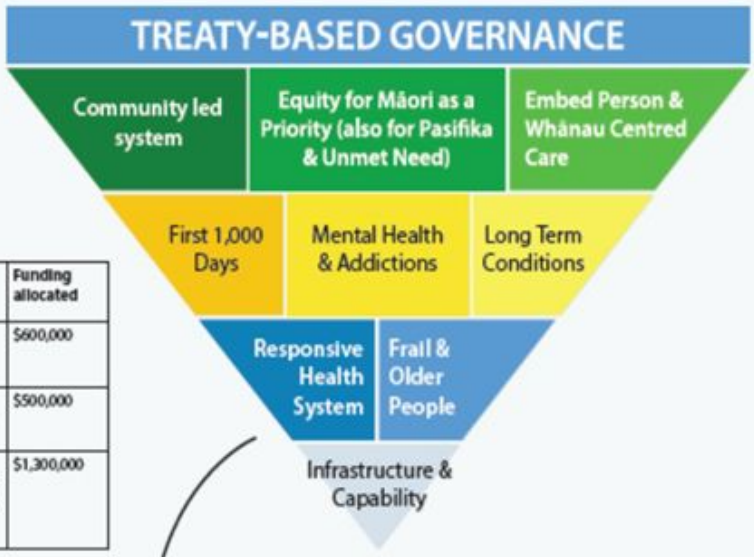
HBDHB System Priorities Performance programme 2020/21

A framework has been developed to provide a structured approach to system performance, both governance and providers using system priorities as the structure. The intention of this framework is to have transparency for Governance and Management. See below.

HBDHB System Priorities Performance 2020/21

HBDHB System Priorities

New investment to support system change



System priority	Action	Funding allocated
1st 1000 days	He Ngakau Aotea and Alliance actions	$600,000
Long term conditions	Clinical Pharmacy Facilitators, CVD response.	$500,000
Responsive Health System	Sexual health strategy, Localities Wairoa, Localities Napier, Outpatients, Health Pathways	$1,300,000

Board focus workshops

We will run workshops to provide more in-depth analysis and focus on each System priority.

August	1st 1000 days (including dental)	
October	Long term conditions (including pharmacy)	
November	Frail and Older People	
February	Mental Health and Addiction	

Each focus workshop will use the Health Equity process as below:

1. **Identify health equity issues**
   a) health status (utilising Te Ara Whakawaiora, plus other relevant population health information)
   b) whānau voice (what have we heard is important to whānau?)
2. **Co-design solutions**
   a) What has been done? What needs to be done?
3. **Put solutions in place**
   a) What needs to be repurposed, what does current investment need to be focussed on, is there a potential for future investment.
   b) Procurement
4. **Monitor progress and measure effectiveness**

Annual Plan Governance Accountability dashboards

Quarterly reports

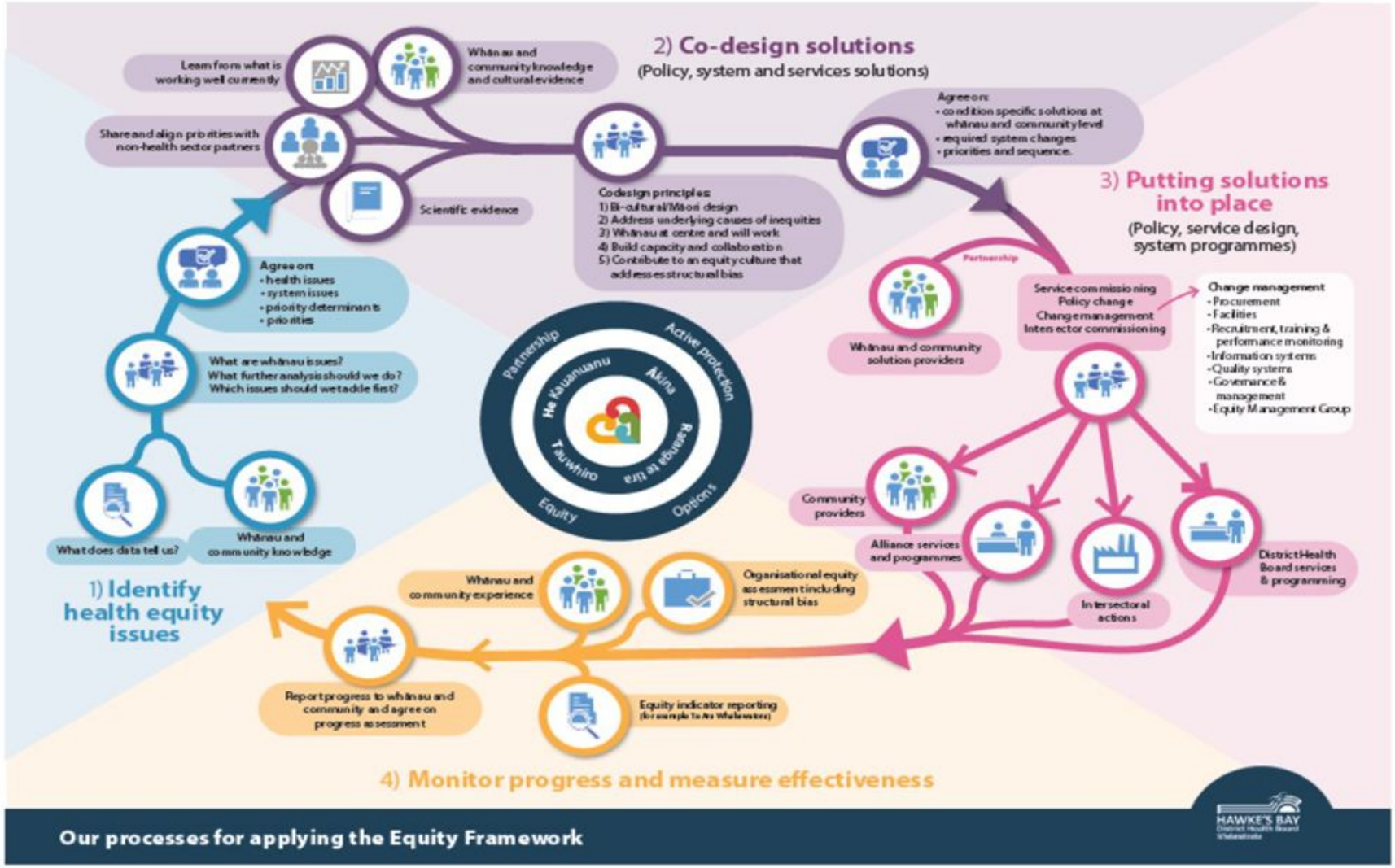
We will report via a dashboard quarterly reporting on the progress of the System Priorities 20/21.

- Hawke's Bay District Health Board, incl Patient Quality and Safety
- Māori Relationship Board
- Clinical Council
- Consumer Council
- FRAC (including capital, risks, and audits)

System Performance Monitoring

We will monitor our performance to ensure that our whānau and community get what they need.

- Provider Arm (monthly)
- Health HB (monthly)
- Wairoa (quarterly)
- plus other localities as we understand what is important to them.


1) Identify health equity issues
Learn from what is working well currently
Whānau and community knowledge and cultural evidence
Share and align priorities with non-health sector partners
Scientific evidence
What does data tell us?
Whānau and community knowledge
What are whānau issues?
What further analysis should we do?
Which issues should we tackle first?
Agree on:
• health issues
• system issues
• priority determinants
• priorities
2) Co-design solutions
(Policy, system and services solutions)
Codesign principles:
1) Bi-cultural/Māori design
2) Address underlying causes of inequities
3) Whānau at centre and will work
4) Build capacity and collaboration
5) Contribute to an equity culture that addresses structural bias
Agree on:
• condition specific solutions at whānau and community level
• required system changes
• priorities and sequence.
Partnership
Whānau and community solution providers
3) Putting solutions into place
(Policy, service design, system programmes)
Service commissioning
Policy change
Change management
Inter sector commissioning
Change management
• Procurement
• Facilities
• Recruitment, training & performance monitoring
• Information systems
• Quality systems
• Governance & management
• Equity Management Group
Community providers
Alliance services and programmes
Intersectoral actions
District Health Board services & programming
Partnership
Active protection
Options
Equity
Tauwhiro
Whānau and community experience
Organisational equity assessment including structural bias
Report progress to whānau and community and agree on progress assessment
Equity indicator reporting
4) Monitor progress and measure effectiveness
Our processes for applying the Equity Framework
HAWKE'S BAY

Exceptions

Growing well
Oral health – Work is underway co-led between Māori Health and Planning & Funding in relation to community oral health services. This work will provide recommendations to inform future decisions in relation to service delivery and accountability measures. This will be linked into the First 1000 days mahi underway as one of our health system priorities.

Living Well
Mental Health & Addiction – The Ministry of Health has confirmed additional funding to support the development of a Hawke's Bay specific crisis response. The funding is to initially support the establishment and then ongoing funding to support capacity and capability where whānau present with a crisis. The development of this model is through staged engagement with DHB-NGO-Consumer focus groups.

Additional funding has been secured to increase Springhill capacity and the service reopened to referrals from the middle of June. This service is open to central region DHBs and also extends to Bay of Plenty and Taranaki through individual agreements.

Long Term Conditions - Heart disease is the highest cause of avoidable death for Māori. Māori have the highest prevalence of risk factors associated with heart disease compared to the general population and subsequently the highest morbidity, readmission and mortality statistics.

This is across all cardiovascular disorders, but especially heart failure. Māori have rates of readmission for heart failure of 30percent within 30 days.

Under our 2020/21 Annual Plan activities, we will be incorporating heart failure patients into an already successful pulmonary rehabilitation service, as these two cohorts experience the same symptoms and improve with similar rehabilitation. The service will be renamed appropriately and the extension to the service will cover both Wairoa and CHB as well as Hastings and Napier. This expansion will be monitored closely for improved outcomes, especially for Māori and will make up the part of the governance accountability reporting and provider system reporting.

Ageing Well
See separate paper

Matters arising from June Board Minutes of Meeting
Ngātahi Project - The project team will be handing the responsibility to complete wānanga over to the operational team, so that it can be picked up again and not lost. Some of the practitioners that would have attended the wānanga, cancelled under covid, were included in the final one on 16 June. Others will be given spaces in upcoming wānanga.

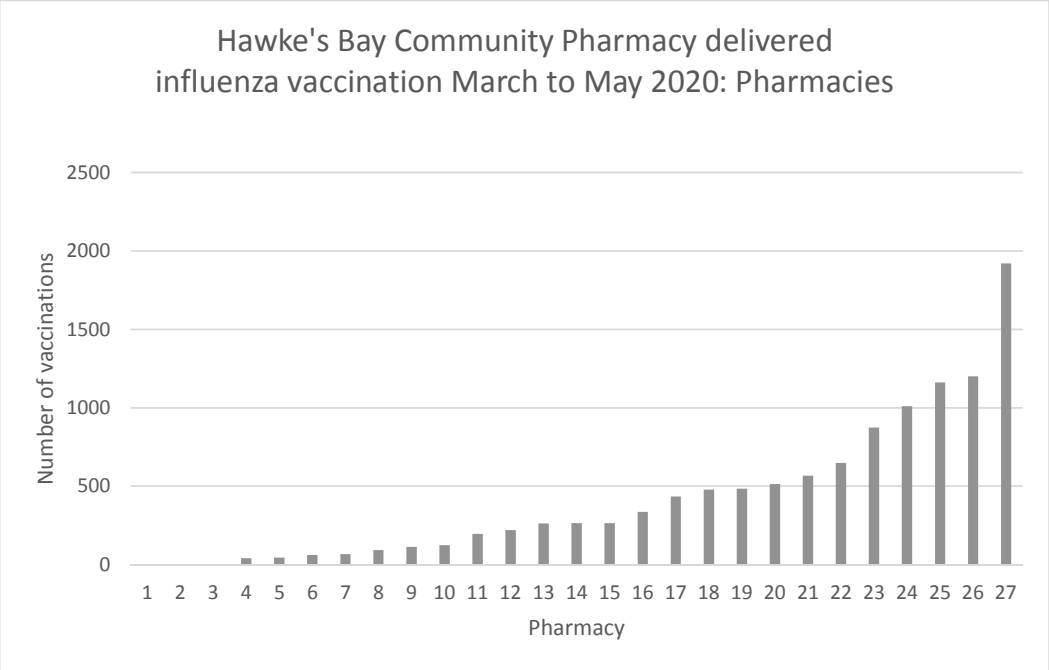
Update of Immunisations in Pharmacies
HBDHB Board has requested information about community pharmacy vaccinations, particularly understanding which patients are utilising this service. As a matter of interest below is the the current influenza immunisation coverage over the past 4 years:

6 months to:	Target	Total	Maori	Pacific	Other
Sep-16	70%	60.4%	59.8%	57.4%	60.9%
Sep-17	70%	59.1%	56.3%	51.5%	60.0%
Sep-18	70%	58.1%	53.0%	51.7%	59.4%
Sep-19	75%	59.8%	52.8%	45.6%	61.4%

Pharmacies providing influenza vaccinations

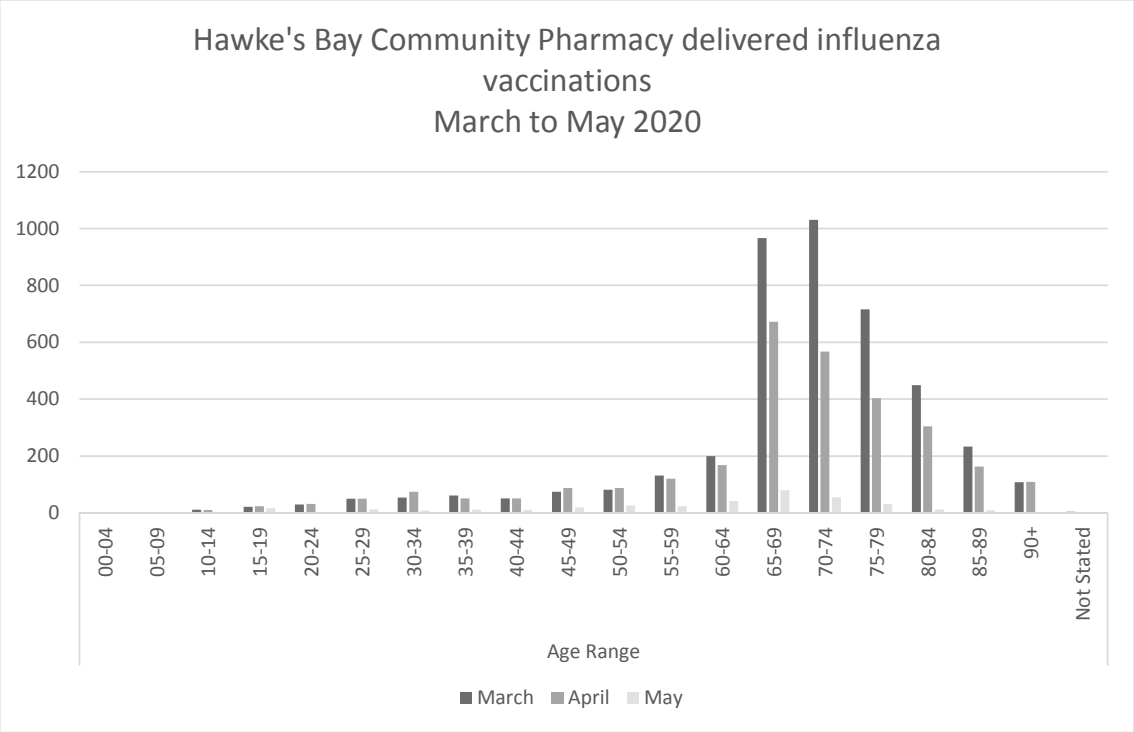
Hawke's Bay DHB has 40 community pharmacies; all but one have a contract to provide influenza vaccinations. Data shows that between 1 January and 25 June 2020

- 27 pharmacies loaded information into Immunisation register
    - Geographic spread: Wairoa, Napier, Hastings, Central Hawke's Bay
    - Four pharmacies have delivered over 1,000 vaccinations

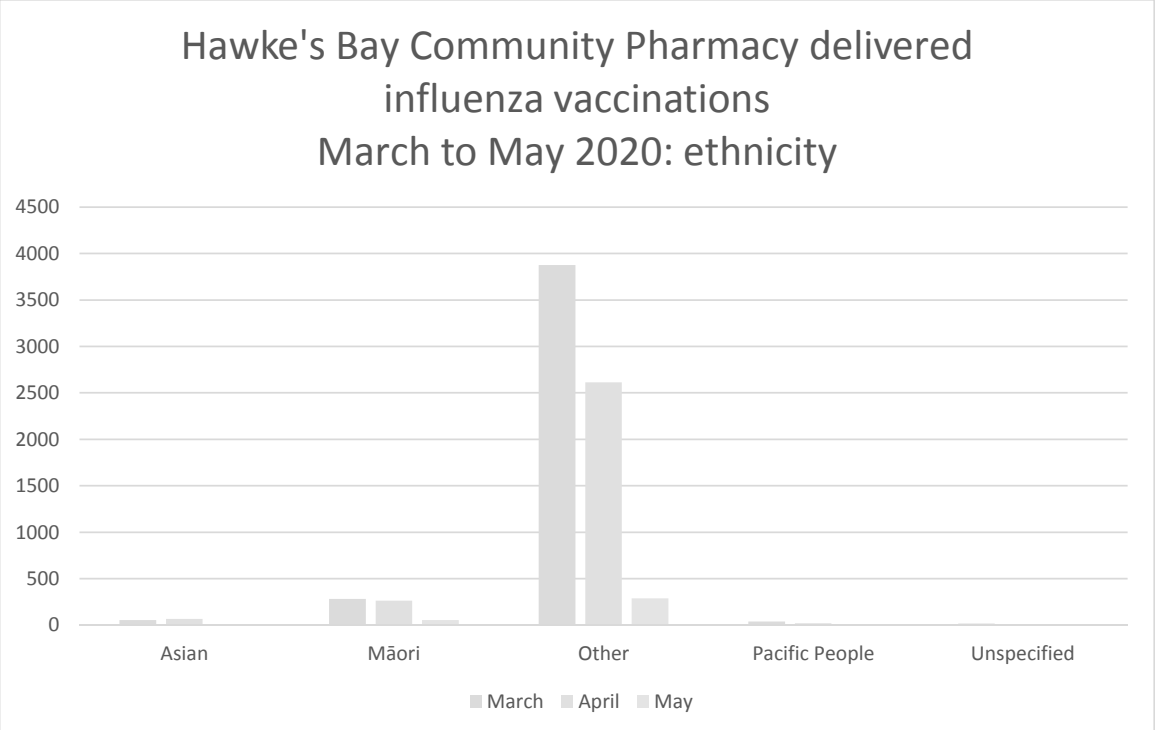


Population Demographics

Age: Majority of consumers are aged 65 - 80 years of age. Prior to 2020 pharmacy could only provide influenza vaccination to 65 years and older; younger age groups have only been allowed this year.



Ethnicity: Majority of consumers are of 'Other' ethnicity; 601 Māori consumers, and 68 Pacific, received their influenza vaccination via community pharmacy between March and May 2020.



HAWKE'S BAY District Health Board Whakawāteatia	**Health Services (DHB Provider Arm) Monthly Report**
	For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Chief Operating Officer
Month/Year	July 2020
Reviewed By	Craig Climo, Interim Chief Executive
Purpose	Update HBDHB Board on Health Services Performance
Previous Consideration/Discussions	Health Services Leadership Team

RECOMMENDATION:

That the HBDHB Board:

1. Note the content of the June 2020 report

Executive Summary

- Demand and activity have largely recovered post the COVID-19 heightened alert, although challenges remain for both recovery and 'deferred demand'.
- The DHB achieved 99.3% of its Ministry of Health surgical discharges target for June, although performance is not sustainable in the short- to medium-term without extra external capacity. Good progress is being made on increased outsourcing.
- Progress has been made in the recovery plan for Gastroenterology, including recruitment of key clinical staff and immediate-term solutions to boost endoscopy capacity.
- The Ngā Rau Rākau Acute Mental Health Unit continues to experience a high level of delayed patients with complex, but non-acute needs. Intensive work is taking place with Planning & Funding to create bespoke solutions for these clients.
- Increased emergency demand on the hospital and delayed transfers of care (due to both internal and external factors) have resulted in a high level of inpatient bed occupancy.

Activity – June 2020

Demand and activity recovered to pre-COVID levels in June, across all major categories of DHB work.

Outpatient First Specialist Assessment (FSA) Referrals – Potential 'Deferred Demand'

- The last two weeks of June saw an average of 871 referrals received per week, compared to an average of 751 referrals per week during February 2020 (a 16% increase). This change since moving to Level One of the national COVID Alert Framework is potentially important and is therefore being closely monitored.

- During the eight weeks spent at Levels Four and Three, a total of 2,774 referrals were received. At the February rate, 6,008 referrals would have been received over this time period. If 'missing' demand of over 3,000 referrals is fed into the DHB system over the coming weeks it will place considerable extra demand and capacity pressure on the system during the spring.

Recovery – Surgical Outsourcing Update

Recovery within surgical specialties is significantly dependent on external capacity in the short- to medium-term. Once on-site and Inter-District Flow (IDF) discharges are accounted for, HBDHB will require up to 25% of its total elective surgical discharges to come from other sources if it is to meet Ministry of Health delivery targets. Some agreements, for example for off-site ophthalmology work, are already in place and working well.

Good progress has been made in negotiations with local private providers. This includes advanced work on a proposal to increase the number of outsourced major joints by over 65% in 2020/21, and discussions with a number of providers (including our main private surgical partner, Royston Hospital) around increased volumes across multiple specialties over a multi-year period.

Gastroenterology Recovery

The DHB has made strong progress during June in addressing long-standing issues facing the Gastroenterology Service. In the coming months this will enable reduction of the wait list backlog, improvements in key access standards, and ultimately recommencement of the National Bowel Screening Programme. Progress in recent weeks includes:

- Two gastroenterologists accepted full-time roles. Subject to meeting NZ Medical Council and Immigration requirements, they will start in November 2020 and January 2021. An offer for the remaining vacant position is in progress. In the interim, the service is being supported by HBDHB General Surgeons and a range of short-term locums.
- The purpose-built Ruakopito endoscopy unit has been reverted to its intended function, with two procedure rooms working full scope. Additional endoscopy lists are being performed on-site, including weekend activity.
- The DHB is negotiating a contract with Royston Hospital to perform at least two endoscopy lists per week off site.
- Remote support arrangements have been confirmed with other DHBs for patients admitted under General Surgery with Inflammatory Bowel Disease (IBD) conditions.

Long-Stay Patients in Ngā Rau Rākau (NRR, Acute Mental Health Unit)

The NRR Acute Mental Health Unit currently has around fifteen high and complex need clients who require placement or who were homeless at the time of their admission – a number of these with extended lengths of stay. These patients do not have acute mental health needs, and the situation has impacted demand and capacity within the NRR service.

Work is ongoing with Planning & Funding to develop creative and sustainable plans to facilitate the transfer of these clients to more appropriate care settings. Early results have been promising, including the discharge last week of a high and complex need client to the Wai o Rua residential facility, run by Te Taiwhenua o Heretaunga (TToH).

The ongoing work includes:

- Building a case, in partnership, to potentially discharge four long-stay clients to a non-governmental organisation (NGO) facility with DHB support.
- Collaboration with Health of Older Peoples Directorate to discuss referrals to Age Related Residential Care (ARRC) for two long-stay clients.

Panui

New Mental Health Crisis Role Approved

A three-year funding package has been approved by the Ministry of Health for a Nurse Educator role, based in the Emergency Department or other locations where people present in mental health crisis. The role is intended to build the professional development, capability and confidence of front-line clinical and non-clinical staff who interact with people in mental health need, and their whānau or support, at a clearly challenging or distressing point in their lives.

Key Quality Measures & Statement of Performance Expectations (SPE)

Ministry of Health Planned Care (Surgical Discharges) Target

The DHB hit 99.3% of its elective surgical discharge target for June – the figure may rise slightly as additional IDFs are registered. This achievement - which comfortably exceeded the Ministry of Health minimum standard of 85% June outturn to qualify for the full Planned Care income (March-June) – reflected enormous work and dedication from surgical specialties and our theatre team.

Outsourcing formed a relatively small component of total delivery (12.5%), with on-site discharges significantly elevated on prior months. Increased out-sourcing is essential to hitting this target sustainably during 2020/21.

ED6

Performance against the standard, for patients to be seen, admitted, or treated and discharged from ED within 6 hours fell by 2.6% in June, to 80.2%. This contributes to a full-year result of 79.1%.

Pressure on the hospital bed base has been significant in-month. During week commencing 15th June, a final series of ward moves restored the hospital to its pre-COVID bed configuration, enabling:

- Establishment of the additional ward beds on A2
- Services such as Paediatrics and the AT&R Rehabilitation ward returning to their purpose-built environments
- Reinstatement of 10 beds hospital overflow capacity (unfunded flex)

The impact of these changes has been significantly reducing the number of patients in 'outlier' wards from last year (i.e. medical patients in surgical beds, and vice versa). However, emergency demand and acuity has remained significant. This, coupled with a higher level of patient dependency and some barriers to timely discharge, has placed significant strain on hospital occupancy. This results in bed availability being the most common cause of ED target breaches.

Elective Services Performance Indicators (ESPI)

- ESPI 2 performance (Outpatient Referrals Waiting Longer than 4 Months) has seen only marginal improvement in June, with 44.2% of referrals now overdue (down from 44.4%). Of these referrals, ~50% have been waiting longer than 6 months.
- ESPI 5 performance (Waits for Surgery Longer than 4 Months) has deteriorated in June, with 43.6% of patients now overdue. This movement is largely due to a 6.8% reduction in the total size of the waiting list (112 fewer patients waiting in total), which in turn is partly on account of the DHB hitting 99.3% of its elective surgical discharge target in-month.

Other key measures

- Faster Cancer Treatment – 86% in month (six out of seven patients) were treated within the 62-day standard. This is against a national target of 90%.
- Patient Seclusion – The recent increases in seclusion hours were repeated in June. The total of 417 hours involved seven consumers, five of whom were Māori. As with the May result, one client accounted for almost 50% of the total hours.

Financial Performance

At the time of writing, the month-end financial result for June was not available. An analysis of the position will be addressed in the report of the Executive Director of Financial Services to the Finance, Risk & Audit Committee (FRAC).

HAWKE'S BAY District Health Board Whakawāteatia	**BOARD HEALTH & SAFETY**
	For the attention of: **HBDHB Board**
Document Owner	Hayley Anderson
Month/Year	July 2020
Reviewed By	Peter Dunkerley
Purpose	For Information
Previous Consideration/Discussions	

RECOMMENDATION:

That the HBDHB Board:

1. **Notes** the content of this report.

EXECUTIVE SUMMARY / INTRODUCTION

The Board Health & Safety representatives have taken the opportunity to attend the last two organisational Health & Safety meetings. The meetings are noted to have good coverage across the District Health Board, being representative of different occupational groups and facilitation ensures that there is genuine staff engagement. There has been one representative of Executive in attendance. There are areas of Health & Safety the Board will need to ensure closer monitoring and these include Safe365 performance and the development of Health & Safety indicators.

KEY POINTS

An update was given by the team responsible for fit testing of N95 masks. One staff member has been qualified to fit test in house depleting the need to engage with contractors.

The DHB has self-assessed against the ACC Health & Safety best practice scorecard and achieved 39%. Approaches to increase this rating will be shared with ELT and then Board.

The Health & Safety team are working to bring improved data to Board to ensure we have line of sight to key indicators, Lead (ensuring future safety performance and continuous improvement) v Lag (safety incidents/accidents that have occurred).

It is pleasing to see positive staff enhancing initiatives in place, for example, the sick leave bank, where staff with excessive amounts of leave gift into a bank that those requiring sick leave apply to. The staff influenza vaccination programme was reported to be at 78.3%, the highest uptake to date.

Both Board representatives are planning a walkabout in the next fortnight.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**
	For the attention of: **HBDHB Board**
Document Owner:	Ana Apatu (MRB Chair)
Month:	July 2020
Consideration:	For Information
Reccomendation **That HBDHB Board:** **Note** the content of this report	

13

MRB met on 1 July 2020. An overview of issues discussed and recommendations at the meeting are provided below.

REVIEW OF CHILD UPLIFTS IN HBDHB HOSPITAL
A discussion was carried over from the MRB June 2020 meeting about an update of the HBDHB Board recommendations in June 2019 related to the internal review of Maternity Services Uplift Case. Specifically, in June 2019, the Board recommended:

1. **Support** that the HBDHB must strive to ensure that no uplifts occur on our premises and that a letter be sent from the Chair of HBDHB and Chair of MRB addressed to the Minster of Health stating HBDHB resolution and recommending this issue be elevated nationally.,

2. **Support** that processes are put in place that ensure the HBDHB works with Oranga Tamariki to **implement** the above on all HBDHB premises,

3. Notes **the requirement from the CEO to conduct a standard internal incident review and debrief, as with any other significant incident of this nature.**

4. Notes that there should be no conditions restricting the Māori midwives' ability to work with their patients.

MRB were particularly concerned whether Recommendation 3 had ever been completed.

MRB were particularly interested in the First 1000 Days continuum and how Maternity Services are placed to deliver culturally responsive care than focusing on one historical incident.

MRB were pleased that an improvement action plan to improve cultural responsiveness will be jointly developed between Maternity Services, Health Improvement & Equity and Planning & Funding directorates.

HEALTH HAWKE'S BAY PHO MĀORI RESPONSE PLAN - KA HIKITIA

Wayne Woolrich, Henry Heke and Fiona Thomson presented Health Hawke's Bay change programme Ka Hikitika.

The PHO Board Chair, Na Raihania acknowledged all the contributors to the Ka Hikitika programme, which commenced prior to his chairmanship and how the PHO Board own every single word and unashamedly support the focus on Māori. He commended the team on the work and acknowledged former PHO chair Bayden Barber for his passion, leadership and support; Patrick Le Geyt for his strategic input and operational investment, as well as Emma Foster and Chris Ash for their support and innovative thinking operationally and contractually to enable this to move forward.

MRB were pleased to see the 4 key outcomes within the Framework, included:

1. Providers are well-equipped to serve Māori
2. Services are accessible where and when Māori need them
3. Care provided to Māori is of high quality
4. Resources are available for Māori to manage their health and wellbeing

MRB members acknowledged that 'Māori are treated with aroha and respect' had been included in the Framework, as that had been the leading cause of whānau and consumer dissatisfaction with the health system.

MRB were pleased that key features of the Nuka System of Care, Clinical Services Plan and Whānau Ora Hapori Ora Strategy were evident in the Framework.

HAWKE'S BAY District Health Board Whakawāteatia	**Hawke's Bay Health Consumer Council**
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie (Chair)
Month/Year:	July 2020
Consideration:	For Information

RECOMMENDATION:
That the HBDHB Board:

1. **Note** the contents of the report.

Consumer Council met on 2 July 2020. An overview of the matters discussed follows.

We welcomed Dr Andy Phillips as our new executive lead.

Council work is getting back on track after the COVID interruption. Consumer engagement is now continuing with a number of steering and service review groups. For example Telehealth focus group (working with the PHO) and the CIMS review process have all been progressing following the COVID experience. Consumers continue to provide input across the Partnership Advisory Group (MH&A), the Disability Working Group, Pharmacy Services Advisory Group amongst others. A number of these groups reported back to Council after being on hold for a period of time. Consumer Council members are currently providing input into 10 committees and advisory groups. The growth in the number of review and steering groups with consumer input gives Council assurance that consumer input is expanding and normalising across the organisation; albeit slowly.

A communications framework for Council was agreed. This sets out fundamental components such as website content, internal communication documents - induction and recruitment materials. Consumer Council is committed to ensuring that there is clarity around our role and the way we work.

HEALTH HAWKE'S BAY

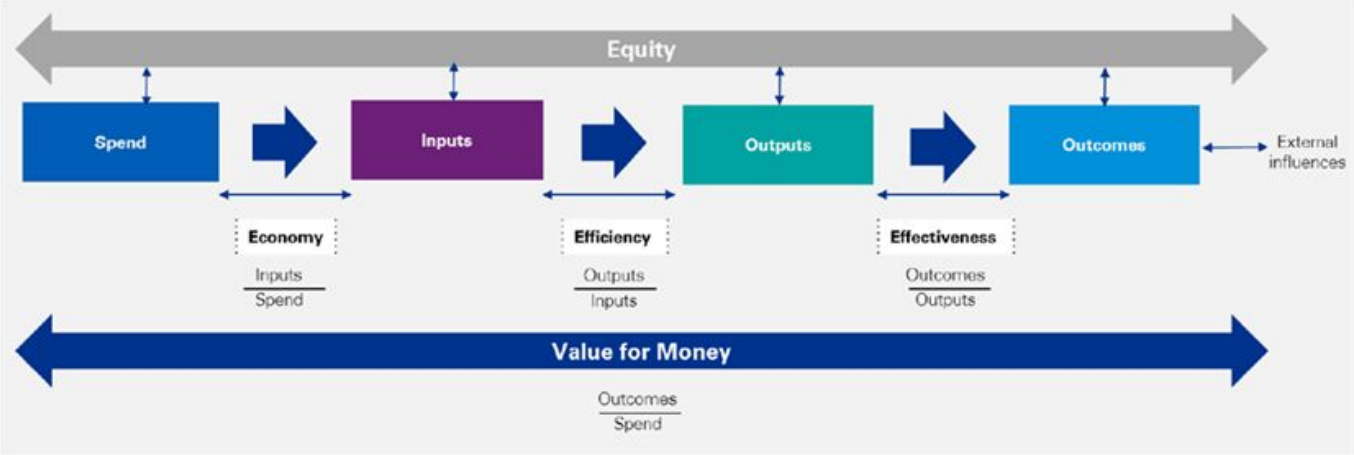
Update

Hawke's Bay District Health Board

July 2020

2019-2020 Journey

- ***Independent Value for Money review of investments from PHO Flexible Funding (~$6m)***
  - Services to Improve Access (SIA)
  - Care Plus
  - Health Promotion
  - Management Services



2019-2020 Journey

- ***KPMG Recommendations from review:***
  - Re-define the core business of the PHO and agree most appropriate and effective model to deliver in its vision
  - Establish best practice programme and investment logic
  - Re-purpose administrative contract management to deliver value-added contracting
  - Review current suite of FFP investments and identify which to "continue, amend or discontinue" investment in
- Resulted in the launch of a programme of work called **Ka Hikitia,**

2019-2020 Journey

Case for Change

- Our Māori population experience the poorest health outcomes of any population group
- Our current primary health care framework is not enabling us to meet our Treaty commitments to Māori
- Not all of our current investments are providing support to the right people, at the right time, in the right place
- Our current operating model doesn't make best use of the resources and expertise we have at our disposal
- Funding is limited and we need to ensure every investment is delivering maximum impact

HEALTH HAWKE'S BAY
Te Oranga Hawke's Bay

Ka Hikitia

- Stakeholder Partnership
  - Cross Sector Working Group made up of 17 partners
  - Whānau group
  - General Practice Leadership Teams
- Focus:
  - What is the vision and purpose of Health Hawke's Bay?
  - What are we ultimately aiming to achieve?
  - What is our core business (operating model) – what activities should we undertake, and which are not within our scope?
  - Who are our customers and which group(s) are we here to serve?
  - Where we have discretionary funding, which priority group(s) should this be targeted to?

Ka Hikitia

- A commitment to deliver change and equity for our population by:
  - Being Māori health equity champions. We will ensure we achieve equity for Māori and other disadvantaged populations, and ***put our commitment to Te Tiriti o Waitangi at the forefront of every conversation we have***
  - Addressing institutional racism in our health system. We will leverage data on equity of access, quality of care received and health outcomes to ask difficult questions of ourselves, the organisations we work in, and our partners across the health system to call out and address bias
  - Modelling the behavioural change we want to see across the system. We will act as advocates of change and demonstrate the behaviours we want to see in others

Our New Strategy

- Through Ka Hikitia we have developed a new three-year Strategy

Our Vision:

Whānau ora, Hapori ora

Family wellbeing, Community wellbeing

Key principles:

- Acknowledgement and explicit recognition of our commitment to Te Tiriti o Waitangi
- A commitment to tautoko the delivery of equitable (or better) health and wellbeing outcomes for Māori as a priority population
- A focus on wellbeing as a broader concept than health care
- Consideration of the outcomes our community as a whole is seeking to achieve: a "life lived well"
- A commitment to a shared aspirational vision, built on the expectation that we will achieve what we set out to

Outcomes Framework

Our purpose: To support our provider network to achieve equitable health outcomes with Māori

Our purpose: To support our provider network to achieve equitable health outcomes with Māori

Whānau ora, Hapori ora

Family wellbeing, Community wellbeing

Our purpose

To support our provider network to achieve equitable health outcomes for Māori.

The key outcomes we will achieve for Māori in Hawke's Bay are:

Providers are well-equipped to serve Māori

Health HB will support providers in ensuring:

- Māori are equal partners in service co-design
- Tikanga Māori is embedded in daily practice
- Integrated Care Team (ICT) partnerships with Kaupapa Māori services are established
- The workforce is supported to develop and maintain wellbeing

Health HB will support providers by providing:

- Service investment which is aligned with achieving equitable health outcomes for Māori as a priority
- Health intelligence which underpins continuous improvement in services
- The opportunity and flexibility to innovate
- A Treaty partnership governance framework

Services are accessible where and when Māori need them

Health HB will support providers in ensuring:

- Māori have access to quality primary care services
- Māori can choose a service that is right for them
- Care is provided and co-ordinated in the community wherever possible
- Support and advocacy for Māori to access the care that is right for them

Care provided to Māori is of high quality

Health HB will support providers in ensuring:

- Māori receive quality clinical care appropriate to their need
- Māori are supported within the service (culturally and clinically)
- Māori are treated with aroha and respect
- Māori are asked to give feedback which is used to inform service design and delivery
- Māori are free from discrimination
- Māori see the same care team wherever possible

Resources are available for Māori to manage their health and wellbeing

Health HB will support providers in ensuring:

- Māori receive support to make informed health choices
- Māori have access to appropriate preventative services
- Māori have access to knowledge and tools that support them to actively manage their health and wellbeing

HEALTH HAWKE'S BAY
Te Oranga Hawke's Bay

Next Steps

- Align Annual Plan, Quality Plan and Annual Work Plans with the new strategic direction
- Shift resource allocation in line with new Strategy
- Pilot new contracting framework with 3 practices with high Māori populations (July 2020)
- Progressively rollout new contracting framework across the general practice network 2020_21

2020/21 Annual Plan

	2019/20				Annual Plan 2020/21				2021/22			
HHB Outcomes	Q1	Q2	Q3	Q4	**Q1**	**Q2**	**Q3**	**Q4**	Q1	Q2	Q3	Q4
Providers are well-equipped to serve Māori	Equity Framework			Finalise Equity Framework and embed in organisation	**Service Design Framework**				All HHB contracts are reviewed using the HHB Service Design methodology			
	Develop a consumer engagement framework, with Maori, for use in service redesign		Work with HBDHB to widen the scope of the consumer engagement framework to whole sector		**Consumer Engagement Framework**				Widen scope and embed into all general practices			
			Develop the Cultural Competency Framework for HHB and provider use		**Cultural Responsiveness Programme**				Widen scope and embed into all general practices			
	Deliver a General Practice Symposium for contiunuing education for general practice in Hawke's Bay				**Develop Cultural training programme**				Further embed cultural training for primary care staff in Hawke's Bay			
	Implement successful data analysis and visualisation programme following Q4 2019/20 RFP process Integrate data sharing with Health Care Home and new Flexible Funding Framework				**Shared Data across Primary and Secondary**				All outcome and coontributory measures are available to all practices			
			Develop a digital capability strategy		**Digital Capability Plan**				Implement & review three year Digital Capability Plan			
					Governance Review							
Services are accessible where and when Māori need them					**Integrated Mental Health Service (Te Tumu Waiora) in General Practice**							
					Review & Redesign the Primary Mental Health Service							
	Implement Health Care Home in tranche 1 practices				**Health Care Home Tranche 2**				Implement all domains of Health Care Home in all willing Health Hawke's Bay practices to meet national accreditation standards			
				Roll out Telehealth in practices as required	**Telehealth**							
					Review of Coordinated Primary Options							
	Approve recommendations and develop a new Flexible Funding Framework for HHB				**Priority Patient Partnership agreements**				Extend Priority Patient Partnership agreement			
Care provided to Māori is of high quality					**Collect whanau experience data**	**Report whanau experience data**						
					Clinical pathways							
					Shared Incident Management System							
			Develop a HHB Quality framework		**Quality Dashboard**				Practice Quality Plan completed by practices covering 80% of Māori population			
Resources are available for Māori to manage their health and wellbeing					**Increase CVDRA by using outreach models**							
					Best practice systems for care planning							

HEALTH HAWKE'S BAY
Te Oranga Hawke's Bay

165,204
PATIENTS ENROLLED WITH HEALTH HAWKE'S BAY

94.4% Total Pop (96% N.A)

91.2% Māori Pop (88% N.A)

704,825
NURSE & GP CONSULTS

21 PRACTICES
27 SITES

166 GPs
205 RNs
8 NPs
22 CPs

1620 TREATMENTS THROUGH
COORDINATED PRIMARY OPTIONS ACUTE CARE PATHWAYS

HEALTH HAWKE'S BAY
Te Oranga Hawke's Bay
2019/20

293 WHĀNAU ENROLLED IN
WHANAU WELLNESS
2020 - THAT'S 1105 PEOPLE

COORDINATION
M 8.2 NM 8.6
National Average
M 8.2 NM 8.6

PARTNERSHIP
M 7.5 NM 7.5
National Average
M 7.5 NM 7.6

PHYSICAL EMOTIONAL NEEDS
M 7.2 NM 7.3
National Average
M 7.5 NM 7.6

COMMUNICATION
M 8.2 NM 8.4
National Average
M 8.4 NM 8.4

PATIENT EXPERIENCE SURVEY

AVERAGE GP/NURSE CONSULTS PER PATIENT PER YEAR BY:

NZ EUROPEAN	MĀORI	PACIFIKA	OTHER	ASIAN
4.7	4.4	4.3	3.7	3.4

4 SITES HAVE GONE LIVE WITH HEALTH CARE HOME
6 ARE INITIATING IMPLEMENTATION

25.6% ARE REGISTERED WITH PATIENT PORTAL

In 2019 we had 369 participants in the Kia Ora Programme (74% Māori)

39,319 PATIENTS ARE ENROLLED IN VERY LOW COST ACCESS PRACTICES

AS A PERCENTAGE OF ENROLMENTS THAT'S...

Wairoa	Hastings	Napier	CHB
100%	33%	7%	0%

15

HAWKE'S BAY District Health Board Whakawāteatia	**General Practice and Community Pharmacy during COVID19**
	For the attention of: **HBDHB Board**
Document Owner	Health Hawke's Bay
Month/Year	July 2020
Reviewed By	N/A
Purpose	For information
Previous Consideration/Discussions	N/A
RECOMMENDATION: **That the HBDHB Board:**	

Purpose

To provide information to the DHB Board on Hawke's Bay General Practice and Community Pharmacy activity during COVID-19 Level 4.

Key Points

General Practice - the call to action

In the early evening of Saturday 21 March 2020 the Royal NZ College of General Practitioners issued a statement to GP members urging them to move to a "virtual" service model effective 8am Monday 23 March. At this time the only Health Hawke's Bay (Health HB) practices using virtual consultation modalities were the Tranche 1 general practices implementing the Health Care Home model of care.

At that time the Health HB clinical staff were heavily involved in the establishment and staffing of CBACs and the facilitation of the practices' rapid change to a virtual environment (and all that entailed) was picked up by Health HB management and support staff.

Information

On the 23 March the Prime Minister announced the country would move into Level 4 Lockdown on the 25 March. Health HB was able to support general practice (and community pharmacy) in the following areas:

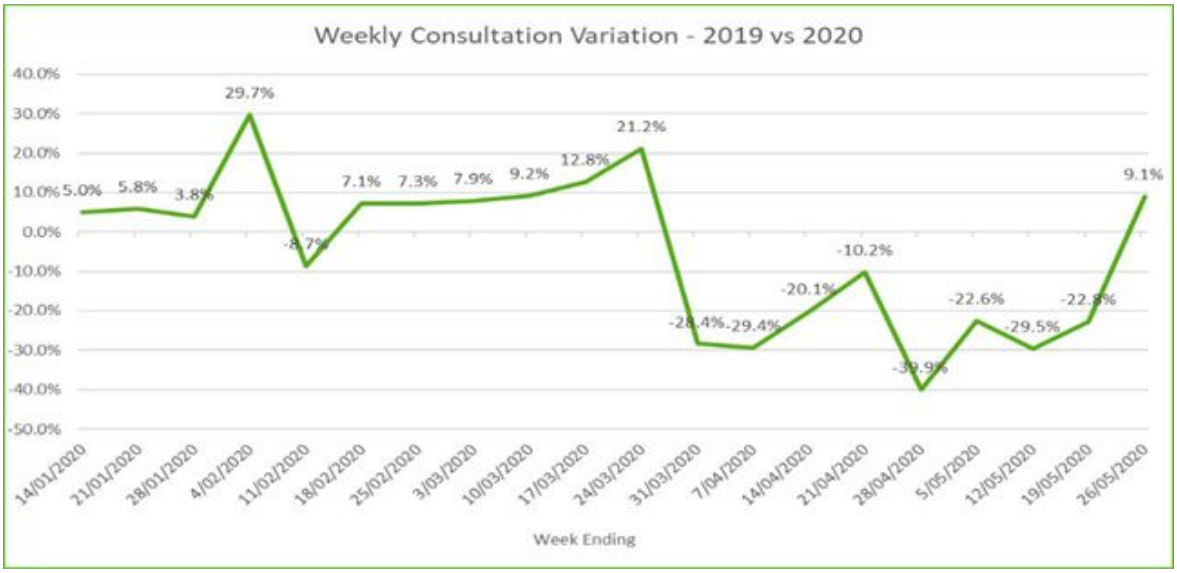
- Procurement of additional practice phone lines
- Procurement of tablets with video capability
- Procurement of surgical scrubs (we had these made locality as supply was limited)
- Dissemination of Health Care Home Collaborate telehealth resources (e.g. clinical triage video consultation guidelines)
- Procurement of secure video consultation software
- Identification of COVID-vulnerable patients (using NHS / BMA material)
- PPE collection and delivery
- Procurement of medicines delivery service for vulnerable patients (HB Combined Taxis)

Impact on general practice consultations

General practice funding is a mix of crown patient subsidy (universal capitation formula) and a patient co-payment. The ratio of these two funding streams ranges from 50% patient subsidy and 50% co-payment in non-high needs practices to 85% patient subsidy and 15% patient co-payment in high needs practices.

The patient co-payment component is strongly linked to a 15 minute in-person consultation with a GP (or nurse). Level 4 lockdown resulted in a sharp drop in consultation numbers (see graph below) and the consultation held during this period where predominantly telephone or video consultations. In-person consultations were limited to only those that needed physical examination.

The drop in consultation numbers and the change of consultation modality to virtual meant practices had limited ability to recover patient co-payments and their overall revenue drop range was 30-50%.



Ironically those practices worst affected are those with non-high needs patients as they rely heavily on patient co-payment revenue.

About half of Health HB practices applied for the COVID-19 Wage Subsidy. Eligibility for the subsidy was based on reduced revenue but did not take into account increased practice costs.

During Level 4 general practice received two government payments – one for costs associated with COVID preparation (Perspex screens, infection control, virtual consultation platform, security etc.) and one to compensate for loss of co-payments. There was an expectation of a third government payment in compensation for loss of co-payment revenue which didn't eventuate. Health HB was able to cobble together a similar dollar amount from various contracts and under-spends and make a payment to general practice which maintained practice viability during this time but resulted in many practice being ineligible for the COVID-19 Wage Subsidy.

The vulnerability of the general practice funding model was highlighted during Level 4 (and 3) which has reinforced our position that the funding model for primary care requires a significant re-think. The role of general practice going forward is likely to be more focused on proactive (and outreach) long term condition management by Integrated Care Teams and because this model is "service" initiated rather than patient initiated our ability to charge and recover a patient co-payment is

limited.

How did this effect vulnerable populations?

In any public health emergency situation we are always concerned about the wellbeing of our vulnerable populations. We were pleasantly surprised to see Māori and Pasifika consultation rates did not drop as much as the non-Māori/Pasifika population. This was validated in a practice survey during Level 4 where practices reported good engagement and one practice commented Māori and Pasifika were among their best adopters of virtual consultation modalities.

Some barriers have been identified (locally and nationally) that we are looking into:

- 0800 lines for phone and video consultations ("data usage" is an issue)
- Ultra-Fast Broadband coverage – more attention needs to be given the rural / remote areas
- More extensive use of video technologies for those facing the tyranny of distance or lack of transport / mobility (and those wanting to access care in more appropriate settings e.g. Marae)

General Practice concerns (from survey conducted during Level 4)

- Ongoing practice financial viability with a service model which is increasingly proactive and telehealth enabled and a funding model that is geared to 15 minute in-person (GP) consultations
- A wave of unmet need at the end of Level 3 (hasn't yet eventuated as practices have focused on managing vulnerable patients via telephone during Level 4 and 3)
- Having to re-assess patients for FSA / manage patients delayed in the FSA process
- Triaging / managing respiratory illness over the winter season in a COVID environment (staying safe)

Community Pharmacy

Building relationships during COVID

The increasing concern over the rapid spread of COVID19 in early March saw the beginning of journey

that over a 12-week period would see significant changes to the way primary healthcare services were delivered to consumers.

A surge in demand from consumers to access health services was impacting the primary healthcare system and leading to consumers stockpiling medicines. A guidance statement from the Pharmacy Guild NZ was released to primary care, requesting prescribers not issue prescriptions in advance to avoid potential medicine supply and safety concerns from the increasing demand. In contrast to this guidance statement, Health Hawke's Bay clinical leadership identified it would be appropriate for consumers vulnerable to complications associated with COVID19 to have a supply of medicine early to enable social distancing and self-isolation.

Health Hawke's Bay and a local community pharmacy representative meet to develop combined messaging to primary care on medicine supply and develop strategies to enable consumers vulnerable to complications associated with COVID19, to self-isolate. The following strategies were communicated to the primary care sector through Health Hawke's Bay and Hawke's Bay District Health Board:

1. All prescriptions are to be transmitted to the pharmacy by electronic methods
2. Identify on prescriptions if the medicine was urgent or non-urgent
3. Where possible deliver medicines to consumers vulnerable to complications associated with COVID19
4. Increase utilisation of NZ e-Prescription Service (NZePS) to generate prescriptions.
5. Transmission of e-prescriptions using e-mail, moving away from faxing of prescriptions.

The aim of the first two strategies was to reduce the risk of COVID transmission through paper prescriptions and improve workflow for pharmacists during high demand. The second strategy was also utilised to ensure consumers were able to access medicines prior to self-isolating, thereby eliminating access concerns during Level 4 restrictions. Where possible, consumers identified as vulnerable were contacted by general practice and prescriptions arranged ahead of time, to reduce acute demand on practices and pharmacies if a consumer were to run out of medicines.

Medicines delivery to vulnerable patients

Delivery of medicine was viewed by Health Hawke's Bay and Community Pharmacy as an effective strategy to enable vulnerable consumers to self-isolate. Prior to COVID19 restrictions, medicine deliveries were not a funded service or a requirement of the Integrated Community Pharmacy Services Agreement (ICPSA). Health Hawke's Bay facilitated a funded delivery service utilising Hawke's Bay Combines Taxis throughout the 7-week period of COVID19 restriction levels 4 to 2. The service was utilised for consumers vulnerable to complications associated with COVID19 living in Hastings and Napier. The service was well received by pharmacists and consumers, with approximately 5,000 medicine deliveries being completed during the 7-week period.

Feedback from pharmacists identified the service as an essential part of the COVID response, particularly as many pharmacies were unable to use existing delivery services during COVID due to resource constraints. Many felt without the Taxi based medicine delivery service, access to medicines would have been reduced, potentially exacerbating concerns over equity of access to medicines.

The move to prescriptions

Strategies 4 and 5 were adopted in response to the guidance from the Royal New Zealand College of General Practitioners (March 21, 2020) for general practice to rapidly reduce face to face consultations and adopt telehealth for patient consultations. General Practice responded positively, with rapid adoption of telehealth, supported by Health HB. Several General Practices split the practices into teams in an attempt to maintain service continuity if a staff member became infected with COVID19.

A solution was needed to assist doctors to be able to work remotely, including prescribing of medicines. To enable this the Ministry of Health (MOH) issued a notice that e-prescriptions generated using NZePS would be signature exempt, thereby allowing prescribers to generate prescriptions and send directly to pharmacies without a wet ink signature.

Health HB supported general practices to adopt NZePS, increasing the number of practices from 5 to 19 over 4 weeks. In addition to supporting practices to adopt NZePS, a coordinated approach was taken to collate and distribute prescription e-mail addresses for pharmacies to enable e-mailing of prescriptions. The combination of supporting practices to adopt NZePS and enabling specific pharmacy prescription e-mail addresses has increased the use of e-prescription to greater than 50% for most pharmacies.

Over the next 12 months the aim will be to have all prescriptions generated using NZePS, allowing an opportunity to analyse prescribing data compared to dispensing data in order to identify gaps in equity in access to medicine. To enable this, further facilitation is needed between practices and pharmacies to embed and sustain change.

Identifying Vulnerable Patients

As part of the response to COVID19, Health Hawke's Bay sought to identify consumers vulnerable to complications associated with COVID19. The aim was to prepare a dashboard for practices to provide support to vulnerable consumers. The British Medical Association and National Health Service, Vulnerable Patients – The Role of General Practice during COVID19 document was used as a basis for data analysis and categorisation. Patients categorised as being very high risk are to be receive further support from practices.

Several barriers to data collection have been identified, particularly variation inter and intra-practice in coding of medical conditions. Totara Health and TTOH patient datasets have been reviewed using the BMA/NHS criteria, identifying 5-7% of the population meeting the criteria of being at very high risk of COVID19 complications. Using this as a baseline, remaining practices have been requested to supply medical condition codes to support the development of dashboards for individual practices. Analysis of practice medical condition codes has been prioritised, and a programme for supporting identified vulnerable consumers is being developed.

Where to next?

- There is a strong desire to embed the changes we have made during COVID (not slip back to the old way of working) – Health HB facilitation around this will be key
- Build on the high level of collaboration between general practice and community pharmacy demonstrated during COVID19
- Enhance our focus on consumer engagement and feedback and use this drive service improvement

- Utilise the flexibility we have developed within our service models as a platform for our hard to reach population
- Re-orientate the Health HB operating model around supporting our provider network (and partners) to achieve equitable outcomes for Māori (as per our Ka Hikitia programme of work)

HAWKE'S BAY District Health Board Whakawāteatia	**Ageing Well in Hawke's Bay**
	For the attention of: **HBDHB Board**
Document Owner/Authors	Owner: Emma Foster, Executive Director Planning & Funding (Acting) Author: Suzanne Parkinson, Portfolio Manager
Month/Year	July 2020
Reviewed By	Lisa Jones, Portfolio Manager
Purpose	Monthly update to HBDHB Board
Previous Consideration/Discussions	Not applicable

Recommendation

It is recommended that the HBDHB Board:

1. **Note** the contents of the report.

Executive Summary/Introduction

The purpose of this paper is to provide the Board with overview of the New Zealand Healthy Ageing Strategy and Hawke's Bay older persons population. This will support developing strategy and health system approaches in relation to Ageing Well in Hawke's Bay.

Ageing Well in Hawke's Bay

This is the first in a series of updates in preparation for a discussion with the Board, at the November 2020 meeting, on Ageing Well in Hawke's Bay. The Planning & Funding Directorate (P&F) will be providing the following updates:

- July – overview of NZ Healthy Ageing Strategy and Hawke's Bay older persons population
- August – known significant risks for ageing well in Hawke's Bay
- September – key stakeholder voice on ageing well in Hawke's Bay
- October – highlight what is occurring elsewhere in ageing well
- November – recommendations for health system approach to ageing well in Hawke's Bay.

During this five-month time period, P&F will be taking the Board on a journey that will provide information and evidence that supports future design and system approaches which will impact on cost drivers and health outcomes for our frail and older people. In addition, we are interested in any areas of focus the Board would like us to consider.

Ageing well acknowledges that people at various ages require support to maintain independence, right through to end of life care. Health and wellbeing services for ageing well focus on need, rather than age, with the understanding that individuals' genetics, upbringing and adult lifestyle impacts on their individual needs at different times. Ageing well balances the need to focus on individuals' life expectancy, and maximising quality of life.

While the data shown below is based on age, this is in absence of frailty assessment and an integrated collection set, meaning that an unsophisticated measure of age groups could be used as a proxy of frailty, being 65-74 as pre-frail, 75-84 as frail and 85+ as high/complex frailty in their last thousand days.

Using frailty assessment scales, assists planning and monitoring functions to transfer focus from age to frailty. Morris et al. (2016) view frailty as "a relative state of weakness, with an expected gradual increase in the likelihood of future loss." They indicate a "frailty scale had to incorporate items that covered a wide range of systems, including measures of cognition, functional performance, health status, social status and clinical problems", endorsing the consideration of interRAI Home Care Frailty Scale as a robust option.

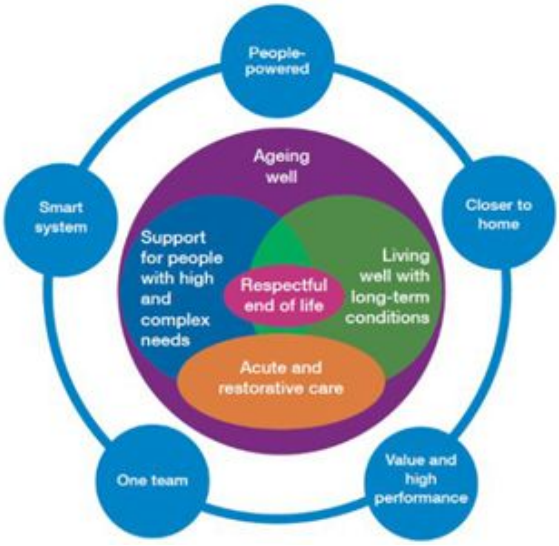
New Zealand's Healthy Ageing Strategy
In December 2016, the Associate Minister of Health, released the New Zealand Healthy Ageing Strategy and detailed action plan. This sets the strategic direction for those delivering health and wellbeing services to older people for the next 10 years.

> *Healthy ageing does not refer to the absence of disease or physical or mental ill health; it is the process of developing and maintaining the functional ability that enables wellbeing in older age, and reflects the ongoing interaction between an individual and the environments we inhabit.*

Vision Statement
Older people live well, age well and have a respectful end of life in age-friendly communities.

Outcomes needed to achieve this vision
- Prioritise healthy ageing and resilience into and throughout people's older years.
- Enable high-quality acute and restorative care, for effective rehabilitation, recovery and restoration after acute events.
- Ensure older people can live well with long-term conditions.
- Better support for older people with high and complex needs to ensure they are able to receive the care that most appropriately meets their needs.
- Provide respectful end-of-life care that caters to personal, cultural and spiritual needs.
- Implement in a way that is people-powered, provides services closer to home, delivers value and high performance, and works as one team in a smart system.

Strategic Framework for Healthy Ageing



Source: Ministry of Health (MoH)

DHB's involvement in 2019-22 priority actions developed from the NZ healthy ageing strategy

DHB lead

- Expand provision of health literacy and health promotion including for Māori, Pasifika and vulnerable groups.
- Implement the National Framework for Home and Community Support (HCS), improve resource allocation in HCS using case-mix methodology, agree a national service specification for HCS services.
- Use digital technology to improve self-management and alleviate social isolation.
- Promote use of the allied health workforce in primary care and aged care to improve restoration outcomes.
- Develop systems to improve identification of socially isolated, vulnerable older people.

DHB co-lead

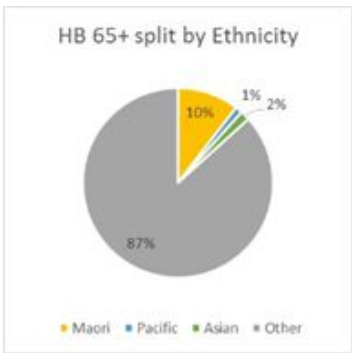
- Provide strength and balance programmes to older people at risk of falls – co-lead with ACC.
- Enhance hospital avoidance and early supported discharge services by improving integration across primary care and older persons' services – co-lead with ACC.
- Use data to identify older people at risk of falls and fractures – co-lead with ACC.
- Implement improved dementia care in line with the NZ Framework for Dementia Care and sector priorities – co-lead with MoH.
- Develop frailty pathways and identify and treat frailty in the community – co-lead with PHO.
- Better integrate primary care and aged care services – co-lead with DHB shared services.

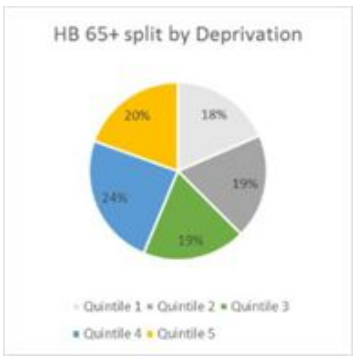
DHB key partner

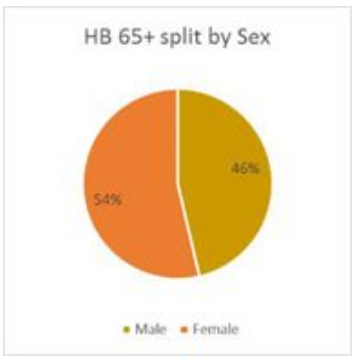
- Co-ordinate assistance to socially isolated and vulnerable people – led by MSD.
- Recruit and retain more Māori and Pasifika in the aged care workforce – led by MoH.
- Support the implementation of Te Ara Whakapiri: principles and guidance for the last days of life – led by MoH

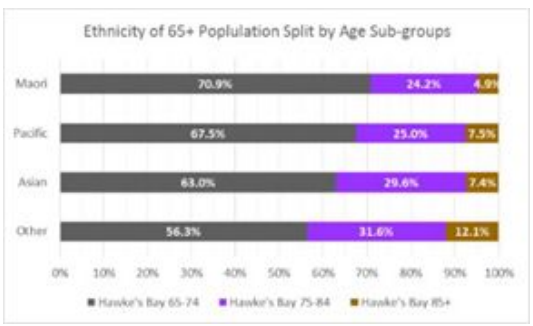
Current Older Persons Population in Hawke's Bay

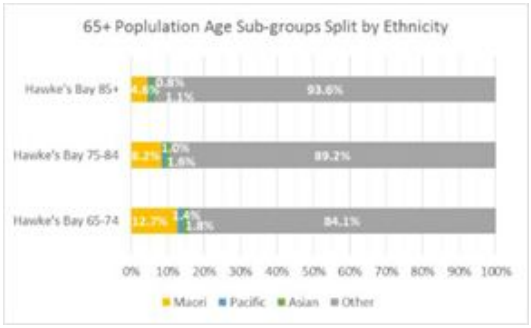
19.0% of Hawke's Bay population is currently aged 65 years and over (in 2019/20 that is approximately 33,230 residents), compared to New Zealand at 15.8%.

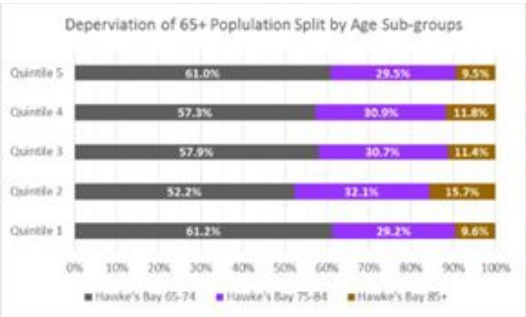


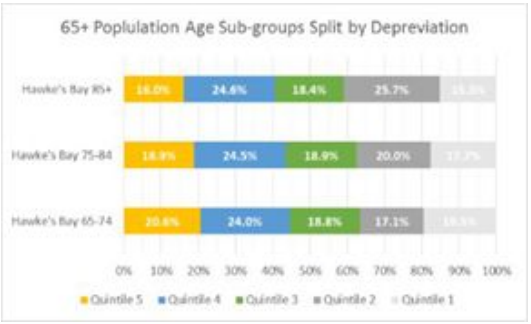












Current Older Persons Service Demand in Hawke's Bay

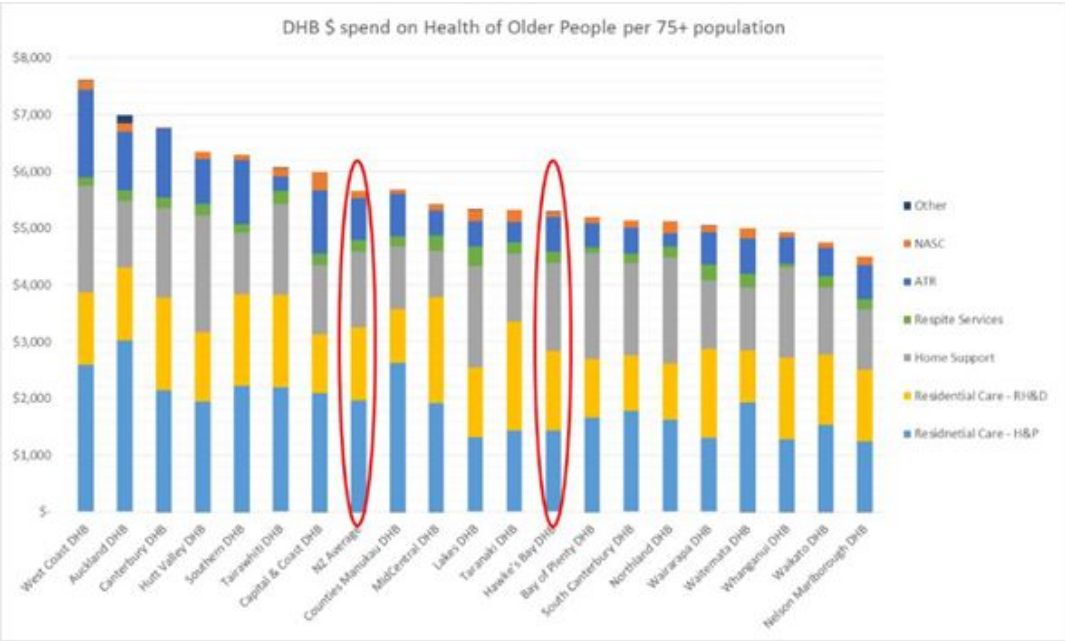
Demand trends on some key services, adjusted for population growth.

Population 65 years and over	27,580	28,690	29,880	31,000	32,110
Per 1,000 capita 65 years and over	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
PHO enrolled nurse consultations	3,813	4,105	4,337	4,851	5,330
PHO enrolled GP consultations	1,599	1,663	1,776	1,910	2,089
Hawke's Bay Hospital ED presentations	424	422	411	416	408
Hawke's Bay Hospital discharges	476	454	432	435	447
Hawke's Bay Hospital inpatient bed nights	1,887	1,749	1,656	1,647	1,606
Short-term aged residential bed nights	193	223	265	304	315
Permanent subsidy residential care nights	14,209	13,524	12,991	12,239	12,192
New entries to permanent ARC	18.6	17.4	17.3	16.8	18.0
Discharged from hospital to permanent ARC	4.1	4.2	3.8	4.3	5.5

Comparative benchmarking of DHB spending in Health of Older People

This indicative information received from the Ministry of Health shows the comparison of 2019 actual HBDHB spend per head of population over 75 years, with other DHBs and the New Zealand average. The below graph breaks this into different categories of service.

Inter DHB comparison is challenging due various factors such as, strategic direction, older persons percentage of the population, hospitalisation rates, level of residential care investment, ethnicity, rurality, Inter District Flows, varying residential care rates and proportion of client contributions.



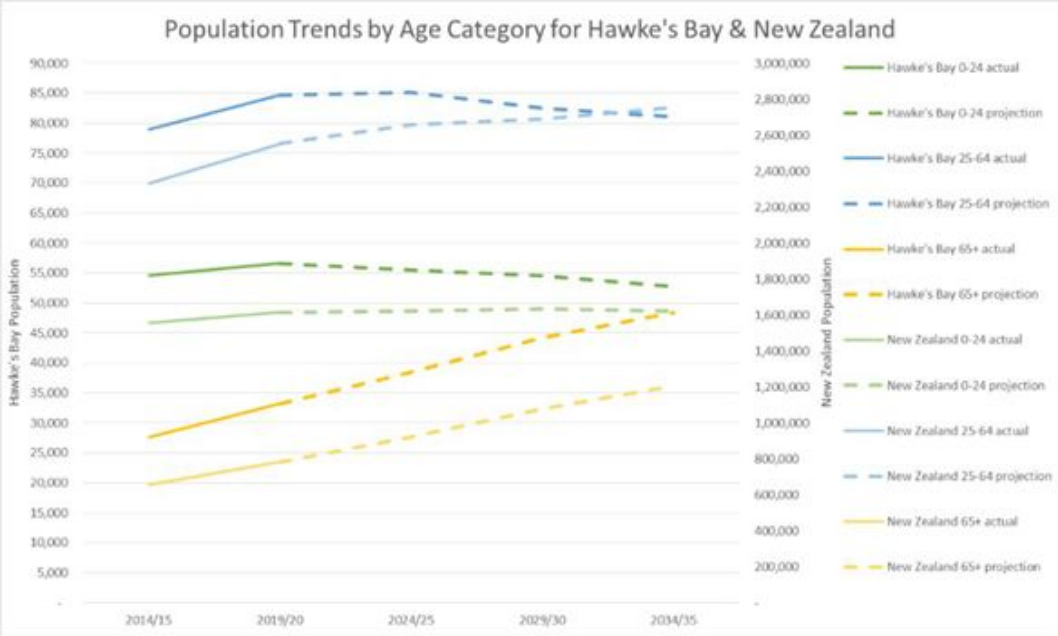
HBDHB spend in comparison with NZ average is:

- below for total spend per person of population 75 and over
- below on residential care at hospital and psychogeriatric (H&P) level of care
- slightly above on residential care at rest home and dementia (RH&D) level of care
- above on home community support services
- below on Assessment Treatment & Rehabilitation (ATR)

The purpose of this paper is to provide you with this information, but not to draw conclusions based on financial information alone. Please note that we currently have not received any break down of the population based on ethnicity or geographical information.

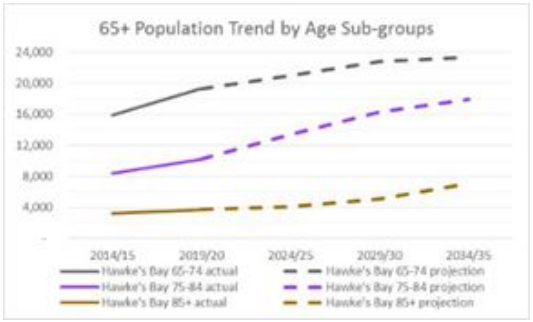
Population Projections for Older Persons

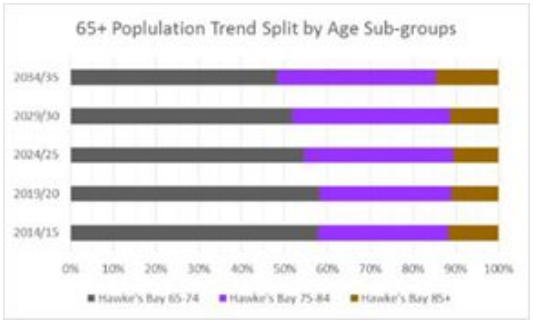
Hawke's Bay's population is growing slower than the New Zealand average, in both the total population, and the 65 years and over population. However, Hawke's Bay has a higher proportion of its population aged 65 and over, and this will continue to grow. Below population trends shows the stagnation of the 0-24 years and 25-64 years age categories, while 65+ years grow. In 15 years Hawke's Bay expects to have nearly as many over 65 residents as it does 24 and under residents.

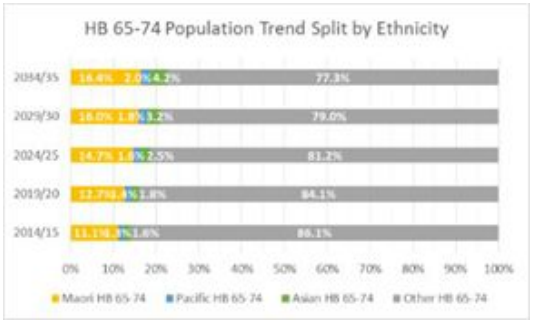


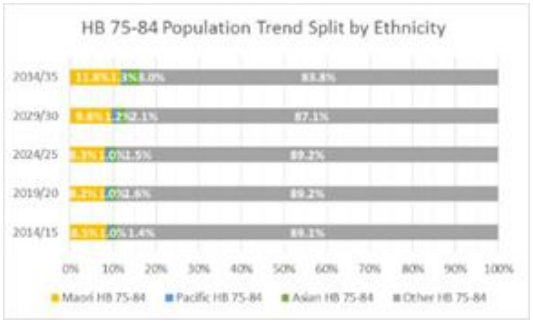
In 15 years, current projections indicate 26.5% of Hawke's Bay population will be aged 65 years and over (approximately 48,360 residents), compared to New Zealand at 21.6%. During this time both New Zealand and Hawke's Bay older person population is becoming more ethnically diverse.

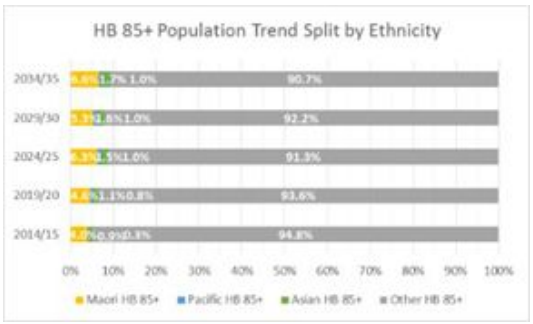
Population projections for the next 5 years & 15 years	**5 years 2024/25**		**15 years 2034/35**	
Comparison between Hawke's Bay & New Zealand	**HB**	**NZ**	**HB**	**NZ**
Growth in total population	2.6%	5.0%	4.4%	12.8%
Growth in 65 years and over population	15.8%	17.5%	45.5%	53.9%
65+ proportion of total population	21.5%	17.7%	26.5%	21.6%
Māori Pacific or Asian proportion of 65+ population	14.9%	19.5%	18.3%	25.1%

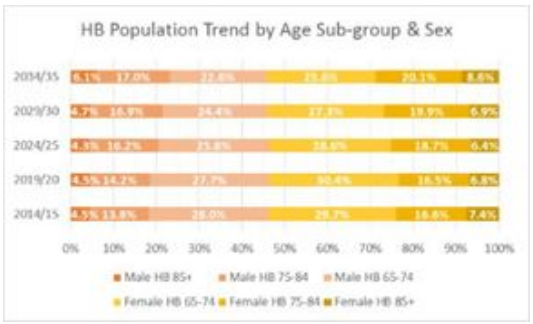












Future Service Demands for Older Persons in Hawke's Bay

On the assumption that our population has no change in complexity, and using the 2018/19 per capita rates, the projection of future demands on some key services under status quo are:

		Actual	Status Quo Projection	
		2018/19	2024/25	2034/35
Population 65 years and over		32,110	38,490	48,360
PHO enrolled GP consultations	Total	171,139	205,143	257,748
	Average per day	469	562	706
	DHB Cost p.a.	$11,034,602	$13,227,089	$16,618,914
ED presentations	Total	13,101	15,704	19,731
	Average per day	36	43	54
	DHB Cost p.a.	$4,270,926	$5,119,504	$6,432,306
Inpatient bed nights	Total	51,581	61,830	77,685
	Average per day	141	169	213
	DHB Cost p.a.	$81,919,397	$98,196,551	$123,376.986
Permanent subsidy residential care nights	Total	391,487	469,272	589,608
	Average per day	1,073	1,286	1,615
	DHB Cost p.a.	$45,130,621	$54,097,676	$67,970,010

Cost is based on 2018/19 estimated average unit rate, future projections do not factor in inflation.

This service growth is not sustainable, and highlights the importance of an innovative collaborative system-wide approach to ageing well in Hawke's Bay. The next update will focus in more detail on significant risks, and how Hawke's Bay compares with other similar DHBs.

References

Associate Minister of Health. (2016). *Healthy Ageing Strategy.* Wellington: Ministry of Health.

Morris, J. N., Howard, E. P., & Steel, K. R. (2016). Development of the interRAI home care frailty scale. *BMC Geriatrics*, 16:188.

Executive Clinical Leaders - Workforce

Presenters Karyn Bousfield, Acting Chief Nursing and Midwifery Officer,
Andy Phillips, Chief Allied Health Professions Officer
Robin Whyman, Chief Medical and Dental Officer

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

- Annual Plan 2020 2021
  - Ensuring workforce planning supports innovative models of care is a key factor in supporting improved system sustainability.
  - Strategic focus is improving access and inter-professional practice
  - Future proofing our workforce

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Māori Workforce Action

HAWKE'S BAY District Health Board Whakawāteatia

- We will create a strong Māori workforce pipeline that support Māori workforce growth within DHB
  - Whāinga tahi: build the capability and capacity of our Māori workforce
  - Whāinga rua: increase Māori representation in our workforce to reflect population
  - Whāinga toru: improve the cultural capability of the workforce
  - Whāinga whā: increase Māori leadership visibility at all levels within the HBDHB workforce

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

18

Workforce - Medical

HAWKE'S BAY District Health Board Whakawāteatia

- Annual Plan 2020 2021
  - Complete Gastroenterologist recruitment to increase Colonoscopy capacity. (EOA Māori, Pacific)
  - System outcome - We have health equity for Māori and other groups
  - Govt priority outcome - Support healthier, safer and more connected communities

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Workforce - Medical

	People	FTE
SMO	160	135
RMO Registrars	109	103
RMO House Officers	66	62
Total	335	300

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Workforce - Medical

- Achievements
  - Fewer vacancies and recent recruitment in challenging specialities (Radiology, Psychiatry, Geriatricians)
  - Hard to recruit vacancies remain (Gastroenterology, Cardiology, ENT, OMF, Ortho geriatrician)
  - Achieved MCNZ accreditation of prevocational training until 2023
- Challenges
  - 2 union RMO environment - from 1 union
  - Ongoing trust and confidence

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Workforce - Nursing

- Largest workforce, broadest scope of practice.
- Nurse Practitioners, Registered Nurses, Enrolled Nurses.
- We will develop nursing models that maximise our scopes of practice. This will enable improved capacity and capability within the nursing workforce to meet population needs within our community.
    - Increase our Registered Nurse Prescribers
    - Develop and deliver a Hawke's Bay Community Nurse Prescribing pathway.

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Workforce - Midwifery

- Midwifery challenges - survey consumers in relation to current provision of maternity services to influence and shape a new rural primary maternity model of care

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Allied Health

HAWKE'S BAY District Health Board
Whakawāteatia

Role

Apply expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialties. Deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions.

Diverse

Allied Health Professionals encompass over 50 professional groups working in a wide variety of services delivering treatments and assessments and utilising technology to provide diagnostic measurement, testing and treatment.

Contribution

The AHP workforce is the second largest after nursing with 620 staff. AHPs are 20% of DHB staff.

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE


Allied Health - A Diverse, Agile & Creative Workforce
THEY MUST BE DEMOLISHING THE OLD PHYSICS LAB.
PHARMACY
Dogs can't operate an MRI Machine
But... Catscan
DENTAL HYGIENIST RETIREMENTS:
25 YEARS OF CLEANING PEOPLE'S TEETH AND ALL I GET IS SOME LOUSY PLAQUE?!
Okay, you win. You're a coffee table trapped in the body of a man.

Workforce - Allied Health Innovative Models

HAWKE'S BAY District Health Board Whakawāteatia

- We will develop allied health models that maximise our scopes of practice. This will enable improved capacity and capability within the allied health workforce to meet population needs within our community
  - Enhanced Recovery After Surgery Service
  - Implement Allied Health Governance Framework
  - Implement Allied Health CCDM to ensure we have right people in the right place at the right time
  - Embed Telehealth into routine practise using Relationship Centred Practise
  - Introduce an integrated service for respiratory patients in partnership with nursing

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

18

Workforce - Allied Health Advanced Practice

HAWKE'S BAY District Health Board Whakawāteatia

- We will develop advanced practice roles for Allied Health to deliver autonomous practice including :
  - Developing Psychologists into Responsible Clinician roles
  - Developing Radiographer Reporting
  - Musculoskeletal Physiotherapist
  - Increase Pharmacist Prescribers

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Workforce - Allied Health Sustainability

HAWKE'S BAY District Health Board Whakawāteatia

- We will address workforce sustainability in:
  - Age profile of oral therapists
  - Recruitment and retention of Psychologists, Cardiac Echosonographers and MRTs,
  - Training of Anaesthetic Technicians and Sterile Services Staff

18

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Workforce

- Model of care changes are evolutionary and rely on trust and confidence
- Legislative changes enable scope expansion
  - Endoscopy Nurse, RN & Allied prescribing, sick notes
- Changes occur with high functioning teams
  - Leadership, strong culture, vision, trust, capability, plan
- Traditional models of training do influence achieving change
  - We require innovation to work with traditional standards

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Recovery Planning

HAWKE'S BAY District Health Board
Whakawāteatia

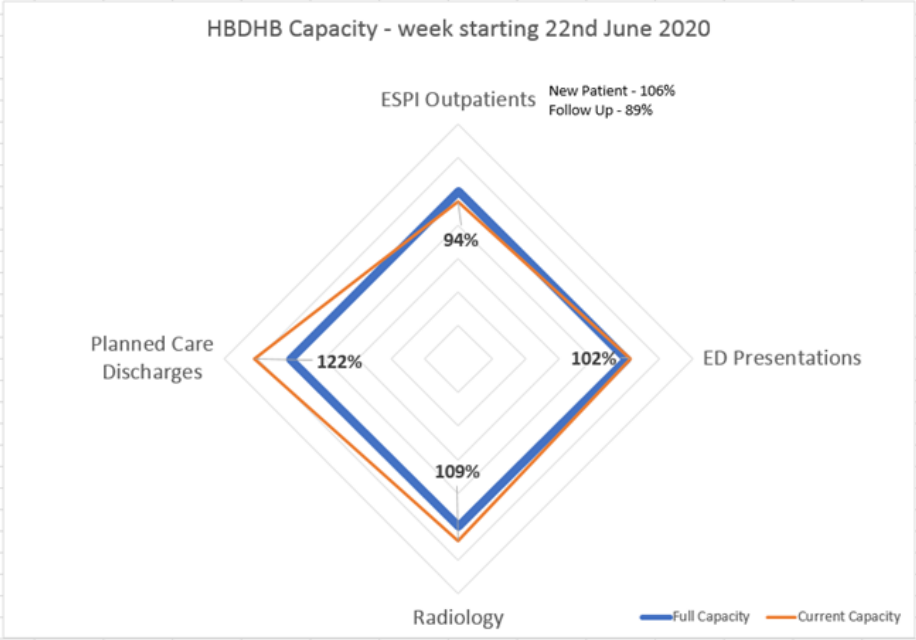
'Respond, Recover, Redesign'

Board Meeting
15 July 2020

Recovery Plan - *Key Objectives - Update*

'Immediate Focus – now to July 2020'

- ✓ Stand up core hospital services – rapid, clinically led, agile methodology
- ✓ Integrated plan with stream lined decision making
- ✓ Open to innovation and new ways of working
- ✓ A key focus balancing demand and capacity

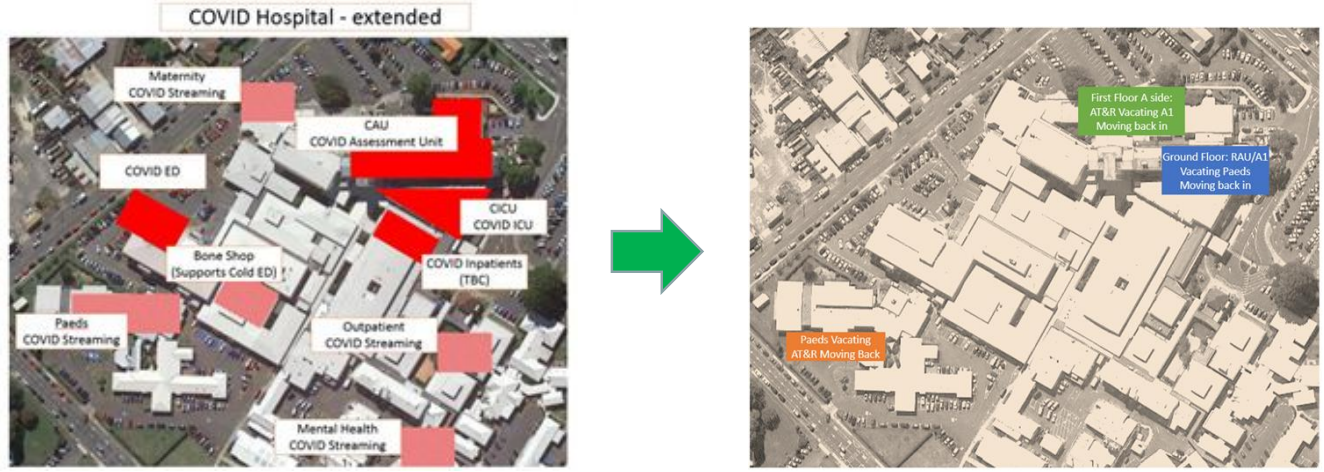


Tactical and Strategic initiatives across Equity, Community, Primary Care are being focused on in parallel

Recovery - *Key Deliverables*

- **Hospital Reconfiguration** – ***'7 Years in 7 Days'***

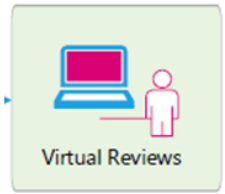
  - ✓ Redesign – including Bone Shop, 23 Hour Stay, General Surgery Villa 1, Allied Health
  - ✓ Capacity and Flex, Medical and Surgical - Overflow Capacity for Peak Times
  - ✓ Clinical Teams, Facilities, Digital Enablement – **huge effort from everyone!**



Recovery - *Key Deliverables*

- ## New Ways of Working

  - ✓ Flex to Demand - Ear, Nose and Throat
  - ✓ Community Based - Ophthalmology
  - ✓ Utilising GP's with Special Interests, Breast Pathways
  - ✓ Closer to Community - TOPs
  - ✓ Reconnecting Patients with Primary Care
  - ✓ New Models of Care - Virtual Clinics



- ## Enabling Teams – COVID

  Remote Working Including:

  - ✓ Clinical Coders – Digital Scanning - *Now Available for Wider Clinical Teams*
  - ✓ Medical Typist - Specialist Audio
  - ✓ Radiologist - Digital Imaging
  - ✓ Mobile Dictation/Transcription Services

Recovery - *Key Deliverables*

- **Mobile/Desktop Broadcast**
  - ✓ Emergency Broadcast Application – *In House Development*
  - ✓ Important And Urgent Notifications
  - ✓ All Desktops/Laptops Enabled - *Remote and Mobile Users - Phase 2*

- **Roseanne Retirement Home**
  - ✓ Community Partnerships – *Rotary and ARC*
  - ✓ Enabling Whanau to Connect via Virtual Visitor
  - ✓ Simple, Portable and Proven Solution

Recovery – *In Progress*

- **Waitlist Prioritisation** ***Enabled by Outpatient Referral Clean up***

  - ✓ Standardised Metrics Targeting Five Specialties Initially – ENT, Dermatology, Ophthalmology, Cardiac and Dental
  - ✓ Utlising Equity Insights
  - ✓ Insights will Drive Service Improvements
  - ✓ Prioritising Patients Based on Clinical Need – *Enhanced Acuity Application*

- **Health Round Table Insights**

  - ✓ Key Targeted Service Improvement Initiatives

SPECIALTY		Cardiothoracic		
PRODUCTION, M1-6 2019/20				
First Outpatients			605	1210
Follow-Up Outpatients			880	1760
Elective Procedures			47	94 FYE
Caseweight Discharges			276	552 FYE
Caseweights per Procedure			5.9	
WAITING LIST				
#		End Feb 20	End May 20	% Change
ESPI 2		175	152	-13.1%
ESPI 5		19	27	42.1%
REMOVAL RATE (Declined Rate) 6 Months to February 2020				
%		ALL	ONSITE ONLY	
		To End Feb 20	To End Feb 20	May-20
ESPI 2		8.21%		
ESPI 5				
ETHNICITY ANALYSIS ,M1-6 2019/20				
%		Māori	Pasifika	Other
ESPI 2 Received		18.57%	2.83%	78.60%
ESPI 2 Overdue		28.21%	0	71.79%
ESPI 2 Declined		18.40%	2.08%	79.51%
ESPI 2 Listed %		19.11%	3.05%	77.85%
ESPI 5 Triage	Urgent			
	Semi			
	Routine			
ESPI 5 Overdue				

Cardiothoracic | Ophthalmology | Dental | Dermatology

In Summary – 'new ways of working'

'Respond, Recover and Re-design'

- ✓ **Recovery** - *now to July 2020, activity delivered and in progress*
- ✓ **Re-Design** - *On-going focus*
  Enabling measurable initiatives that improve health outcomes
- ✓ **Ongoing** – *transition into Service Improvement as 'business as usual'*

HAWKE'S BAY District Health Board Whakawāteatia	**TWO TIER TREATY PARTNERSHIP GOVERNANCE STRUCTURE**
	For the attention of: **HBDHB Board**
Document Owner	Patrick Le Geyt (Acting Executive Director, Health Improvement & Equity)
Month/Year	July 2020
Reviewed by	N/A
Purpose	For Decision
Previous Consideration/Discussions	N/A

RECOMMENDATION:

That the HBDHB Board

Note:

1. The contents of this report.

Approve:

2. The Chair and executive management meet with key stakeholders to advance negotiations for a two tier Māori governance structure.

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EXECUTIVE SUMMARY / INTRODUCTION

Incorporating the principles of the Treaty of Waitangi (*Te Tiriti o Waitangi*) into health legislation, policy and operational frameworks, as well as developing governance structures that reflect partnership with Māori, are seen as an urgent priority by the New Zealand Government (WAI2575, NZ Health & Disability System Review Report). Government agencies are expected to form closer partnerships with Post Settlement Group Entities (PSGES) and iwi authorities.[1] These developments create significant challenges about current DHB governance arrangements with iwi.

This paper proposes, and seeks approval, to advance negotiations towards a new governance structure that is consistent with WAI 2575, the NZ Health and Disability System Review Report and the post settlement environment. It proposes a two-tier Treaty partnership governance structure that enables a direct governance to governance function, between iwi and settlement groups and HBDHB board, and an expert Māori advisory function at operational level. These governance arrangements provide a significant step to ensuring Hawkes Bay District Health Board (HBDHB) is 'Treaty compliant'.

[1] Ngāti Kahungunu Iwi Inc.; Heretaunga Tamatea Settlement Trust (Hastings and CHB); Tātau Tātau o Te Wairoa Trust (Wairoa); Ngāti Pahauwera Development Trust (South Wairoa); Maungaharuru-Tangitū Trust (North Napier); Te Kōpere o te iwi o Ngāti Hineuru (North West Napier); Mana Ahuriri Trust (Napier); Ahuriri District Health Trust (Napier); Nga Taiwhenua o Ngāti Kahungunu Iwi

BACKGROUND

The Treaty of Waitangi, signed in 1840, is New Zealand's founding document and forms the basis for partnerships and relationships between Māori and the Crown (NZ Government). It is based on the fundamental exchange of kāwanatanga, the right of the Crown to govern and make laws for the country, in exchange for the right of Māori to exercise tino rangatiratanga over their land, resources, and people.

New Zealand has a rich history of Māori (and some non-Māori) political agitation, lobbying and reconciliation efforts with, and against, the NZ Government concerning breaches of the Treaty of Waitangi. In 1975, The Treaty of Waitangi Act was passed to establish the Waitangi Tribunal and other mechanisms for hearing, researching, and settling grievances. The tribunal has a mandate to investigate alleged breaches of the Treaty of Waitangi.

In HBDHB region, the Crown (NZ Government) and Māori have made significant progress towards settling all historical Treaty of Waitangi land claims and both parties are turning their attention to post–settlement matters and co-governance arrangements. In accordance with Deeds of Settlement, Ministers of relevant Crown bodies are encouraging their agencies to build ongoing relationships with claimant governance entities – Post Settlement Governance Entities (PSGE). PSGEs are the new hapū/iwi organisational structures government agencies need to work with, including Ngāti Kahungunu Iwi Inc.

TREATY AND HEALTH

The relevance of the Treaty to health is well-established. This relationship is also established in law through the New Zealand Public Health and Disability Act (NZPHD Act) 2000, which requires the health sector to work towards eliminating entrenched health inequities between Māori and other New Zealanders. It expects the sector to engage with Treaty principles of partnership, protection and participation that were developed by the Royal Commission on Social Policy 1988.

The NZPHD Act establishes the statutory requirements of District Health Boards, including accountabilities to Māori, by recognising and respecting the principles of the Treaty (partnership, protection, participation), and with a view to:

1. providing for mechanisms to enable Māori to contribute to decision-making;
2. enabling Māori to participate in the delivery of health and disability services; and
3. reducing health disparities by improving health outcomes for Māori.

WAI 2575 KAUPAPA INQUIRY STAGE ONE REPORT

The Waitangi Tribunal 2575 Kaupapa Inquiry Stage One Report (2019) - Hauora – enquired into grievances and claims by Māori related to the NZ health system legislation, policy, strategies and structures. It concluded the Crown had breached the Treaty in a number of ways but, in relationship to Māori partnerships and decision-making, it specifically reported that:

- The Treaty clause in the NZPHD Act is a reductionist effort and fails to afford Māori control of health decision-making in relation to design and delivery
- DHB governance arrangements do not reflect Treaty partnerships

NZ HEALTH AND DISABILITY SYSTEM REVIEW 2020

The NZ Health and Disability System Review 2020 also states the failure of the health and disability system to address its Treaty commitments. It also identified specific areas of urgent concern and changes that are critical in relationship to Treaty partnerships by:

- incorporating te Tiriti o Waitangi principles across the system and updating legislation accordingly
- reflecting te Tiriti partnership in governance structures

CURRENT DHB AND IWI RELATIONSHIPS

Currently, the NZPHD Act does not require District Health Boards (DHBs) to have formal relationships with Māori groups representing local iwi[2]. DHBs, however, have mostly established 'Māori/iwi relationship boards'. These advisory boards constitute an attempt by DHBs at interpreting and delivering to sections 22 and 23 of the NZPHD Act, i.e. 'providing for mechanisms to enable Māori to contribute to decision-making'. However, whilst most arrangements reference the Treaty and acknowledge Māori health inequities; most are advisory in nature, with limited decision-making functions related to planning and engagement with Māori communities.

HBDHB treaty partnership with iwi is currently through a Memorandum of Understanding (MOU) with Ngāti Kahungunu Iwi Inc. (NKII). The partnership relationship is primarily managed and maintained on behalf of NKII, through the NKII designated representatives, of the Māori Relationship Board (MRB) and, on behalf of HBDHB, through the HBDHB Board members appointed to the MRB. The MRB has the authority to provide tangible advice and make recommendations to the HBDHB Board. The MRB serves as advisory committee for HBDHB. However, the oversight and decision-making power of the MRB is often not robust enough to give effect to the Treaty principle of partnership adequately.

The Waitangi Tribunal (WAI 2575) found that, in regards to DHBs relationships with Māori, "DHBs do not work consistently to afford Māori Treaty-compliant control of decision-making in relation to health care design and delivery. In particular, the lack of specific provision for Māori relationship boards and the variable effectiveness and oversight powers of those boards are not Treaty-consistent." The Tribunal concluded that: "these failures by the Crown constitute breaches of the Treaty duty of good faith and the principle of partnership."

THE PRINCIPLE OF PARTNERSHIP

The principle of partnership is of particular importance when assessing the nature and implementation of government health policy with Māori. Partnership is a much stronger concept than participation. Partnership under the Treaty, underpinned by recognition of tino rangatiratanga, means at least joint decision-making between Crown and Māori agencies and groups, not mere 'contributions to' or 'participation in' decision-making. This is a crucial distinction.

The Waitangi Tribunal found the principle of partnership recognises that Māori have the right as a Treaty partner to choose how they organise themselves, and how or through what organisations they express their tino rangatiratanga. This means the Crown needs to be willing to work through the structures Māori prefer in the circumstance, whether through iwi, hapū, and whānau or any other organisation.

EXAMPLES OF ADVANCED PARTNERSHIPS BOARDS

In response to WAI 2575 and the Health & Disability System Review Report, MOH are currently developing guidance and principles on effective Māori Crown partnerships and arrangements (building on the Northern and Midlands regional Iwi partnership arrangements):

- Build an effective Iwi - DHB partnership model for the future
- Review, with a view to co-design, current partnership arrangements across all levels of the health and disability sector
- Based on Te Tiriti o Waitangi, including partnership principles
- Is evidence based
- Iwi/ Maori make decisions including commissioning
- Fits with the partnership direction set in the Health and Disability System Review

[2] Likely to change as a result of WAI2575 and Simpson Report both recommending treaty compliance changes to NZPHD Act

Recent developments in the northern and midland regions were cited in the majority *Alternate View* of Māori commissioning in the Health & Disability System Review Report (p175):

- Northern Iwi-DHB Partnership Board: 50:50 governance arrangement between Te Kahu O Tāonui (Te Tai Tokerau Iwi Chairs Forum) and Auckland, Waitematā and Northland DHB Chairs. Delegated authority to determine Māori health equity priorities and outcomes; lead, advise and guide Te Tiriti O Waitangi compliance, and oversee resource allocation and investment for Māori wellbeing for the region.
- Te Manawa Taki Regional Equity Collaboration: 50:50 governance arrangement (MOU) between the Midland DHB Chairs with their Iwi equivalents to develop a Regional Equity Plan to drive regional services planning and delivery.

The most advanced treaty partnership board is the 'Northern Iwi – DHB Partnership Board'. The Partnership Board replaces existing northern DHBs' Māori health advisory committees and iwi relationship arrangements and will focus on issues that require in-depth discussion, decision making and high-level direction setting from a Māori perspective. They have a shared understanding of jointly identified priorities and a collective work plan that equitably allocates resources to drive actions and strengthen Māori provider, workforce and service development in the region.

The Minister of Health gave approval for the delegation of district health board functions, duties and powers (under section 39 (5) of the NZPHD Act 2000) related to Māori Health to the Northern Iwi-DHB Partnership Board, which operates under a principles-based relationship model that gives effect to the Treaty. Delegations include:

- Determining Māori health outcomes and equity priorities across the three DHB areas
- The provision of Māori health leadership, advice and guidance across all DHB funded and provided services, activities and workforce to meet their Te Tiriti and statutory obligations to Māori
- Oversight of DHB resource allocation and investments for the purpose of achieving Māori health outcomes and advancing Māori wellbeing in the rohe
- Engagement of experts and advisors to carry out the work and complete specific tasks on behalf of the Partnership Board

These advanced examples of Treaty partnerships need to be considered in the development of Treaty compliant governance arrangements in Hawke's Bay and HBDHB.

IWI TREATY PARTNERSHIPS WITH HBDHB – A NEW GOVERNANCE TIER

There is a need for a new governance tier for PSGE and Iwi, in partnership with Crown agencies (i.e. HBDHB). A new governance tier is where priority setting and joint decision-making around Māori health priorities can be negotiated and set by respective organisational governance representatives. Relationships and trust will be essential for the success of any negotiated agreement and the governance partnership will require relationship building, good planning and information as well as reviewing and evaluating progress.

PSGE and Iwi Authority leaders would form a new governance group and would meet six monthly with HBDHB Board. The meetings would coincide with HBDHB planning and review schedule to ensure effective input into strategic and annual plan priority setting and annual reviews of progress made against negotiated priorities[3].

[3] This process will also follow the HBDHB Equity Framework – Equity Cycle, which starts with identifying the health priority areas (population health intelligence), obtaining consumer experience, health expert advice, evidence based best practice to inform service improvement, redesign and procurement options and evaluating the results

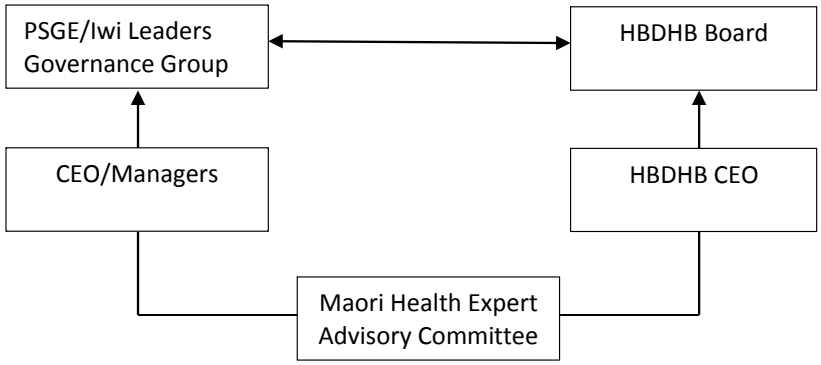
The first scheduled meeting would be in December each year where Māori health priorities would be established and high level focus areas and plans to address Māori health priorities negotiated. The health priorities setting meeting would be informed by a suite of population health intelligence (data trends and consumer experience) developed by the Māori Health Expert Advisory Committee.

The second scheduled meeting would occur in June each year. The purpose of this meeting would be to review the previous year's performance and progress against the priority focus areas. This meeting would be informed by performance matrix developed by the Māori Health Expert Advisory Committee in partnership with HBDHB and HHB PHO business intelligence teams.

MĀORI HEALTH EXPERT ADVISORY COMMITTEE – A NEW OPERATIONAL TIER

The Māori Health Expert Advisory Committee (MHEAC) would be an operational focused group comprising health experts from within and outside HBDHB and its functions would replace the Māori Relationship Board. The role of MHEAC is to provide advice to the respective CEOs and management on how to best address the health focus priority areas. Moreover, MHEAC will also provide a planning and monitoring function, in partnership with DHB associated functions, of actions and progress against the health focus priority areas. MHEAC would be resourced by HBDHB. HBDHB Māori Health and the Health Improvement and Equity Directorate would provide administrative support as well as a number of health expert committee members, i.e. General Manager Māori Health, Nursing Director, Programme Manager, Public Health Medicine Specialist etc. Appropriate terms of reference would be developed.

Treaty Partnership Governance Structure



RISK ASSESSMENT

There is the potential risk that PSGEs will either not want to, or do not have the current capacity to, become involved in the governance arrangement. The HBDHB Board Chair and associated executive leadership would need to meet with respective PSGE and Iwi Authority board chairs and discuss the merits of the new structure to gain buy-in and go through structure, processes and commitments required.

There is also a potential risk that Ngāti Kahungunu Iwi Inc. (NKII) and MRB do not wish to transition to the new governance structure from the current MOU and MRB arrangement. In 2017, NKII had initiated discussions about moving towards an iwi governance board relationship with various government agencies (*Te Toi Ora*), which was very similar in nature to the proposed structure in this paper. Similarly HBDHB Board Chair and associated executive leadership would need to meet with NKII chair and MRB chair to discuss the merits of the new structure to gain buy-in.

HBDHB Board may also not wish to change to a new governance structure from the current MOU and MRB arrangement. This paper, WAI 2575, the Health & Disability System Review Report, and MOH pending policy guidance provide a clear direction towards improved relationships model that gives effect to the Treaty.

NEXT STEPS

A communications and transition plan will need to be developed that includes socialising the two tier Treaty Partnership Structure with HBDHB Board.

The DHB Chair and executive management will meet its treaty partner Ngāti Kahungunu Iwi Inc. and PSGE groups to discuss the concepts, benefits and process of the two-tier Treaty partnership governance structure.

HBDHB should aim to establish the two-tier groups by October 2020, ready to meet in December 2020.

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 33, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

22. Confirmation of previous minutes 17 June 2020 (Public Excluded)
23. Matters Arising – Review of Actions (Public Excluded)
24. Board Approval of Actions Exceeding Limits Delegated by CEO (Public Excluded)
25. Chair's Report (Public Excluded)
26. Hawke's Bay Clinical Council Report (Public Excluded)
27. Hawke's Bay Health Consumer Council Report (Public Excluded)
28. Skin Lesions Pathway in Primary Care (Public Excluded)
29. Finance Risk and Audit Committee (Public Excluded)
    - Summary of Meeting 15 July 2020 – verbal (Public Excluded)
    - Minutes 17 June 2020 (Public Excluded)

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).