BOARD MEETING

Date: Tuesday 25 February 2020

Time: 1:30pm

Venue: Te Waiora Room, DHB 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:

In Attendance:
Craig Climo, Interim Chief Executive Officer
Ken Foote, Company Secretary
Executive Leadership Team members
Robin Whyman and Jules Arthur, Co-Chairs of Clinical Council
Rachel Ritchie, Chair HB 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.	Welcome and Apologies	1:30
2.	Interests Register	
3.	Minutes of Previous Meeting 18 December 2019	
4.	Matters Arising - Review of Actions	
5.	Board Workplan	
6.	Chair's Report (verbal)	

7.	Chief Executive Officer's Report	
8.	Financial Performance Report - Carriann Hall, ED Financial Services	1.45
9.	Planning & Funding Report to Board - Chris Ash, ED Planning & Funding	1.55
10.	Provider Services Report to Board - John Burns, ED Provider Services	2.05
11.	Health Improvement & Equity Directorate Quarterly Report – Patrick Le Geyt, Acting ED Health Improvement & Equity	2.15
12.	Board Health & Safety Champion's Update (verbal) - Board Safety Champion	2.25
	Section 2: Governance / Committee Reports	
13.	Māori Relationship Board Report - Chair, Ana Apatu	2:30
14.	Hawke's Bay Clinical Council Report - Co-Chairs, Julie Arthur & Dr Robin Whyman	2:35
15.	Hawke's Bay Health Consumer Council Report - Chair, Rachel Ritchie	2:40
16.	Pasifika Health Leadership Group report	2.45
	Section 3: For Decision	
17.	Governance Appointments and Meeting Schedule for 2020 - Appendix 3	2.50
	Section 4: For Information and Discussion	
18.	Corporate Performance Report Quarter Two	3.05
19.	Te Ara Whakawaiora Mental Health	3.15
20.	**Section 5: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000	

Public Excluded Agenda

Item	Section 6: Routine	Time (pm)
21.	Minutes of Previous Meeting 18 December 2019 (public excluded)	3.25
22.	Matters Arising (public excluded) – Review of Actions	-
23.	Board Approval of Actions exceeding limits delegated by CEO	-
24.	Chair's Update (verbal)	-
25.	Chief Executive Officer's Report (public excluded)	3.35
26.	Hawke's Bay Clinical Council (public excluded) Co-Chairs, Julie Arthur & Dr Robin Whyman	3.45
27.	Chief Medical Officer Update (verbal) – Robin Whyman	3.50
28.	Planning & Funding Report to Board (public excluded) – Chris Ash	3.55
	Section 7: For Information/Decision	
29.	Finance Risk and Audit Committee – Interim Chair, Peter Dunkerley	4.00
	Meeting concludes	

The next HBDHB Board Meeting will be held on
Wednesday 18 March 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 18 February 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	Bank of New Zealand	Employer. BNZ provides banking services to HBDHB.	Potential conflict. Will abstain from all decisions related to financial banking services.		08.01.20
	Active	Dr Rachel Walker	Wife - is a contractor to HBDHB	Potential conflict. Will abstain from decisions related to perceived conflict.	Company Secretary	08.01.20
Kevin Atkinson	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	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 of FRAC	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	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	PCDP 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	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
	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	4.02.20
Hayley Anderson						
David Davidson	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.	Company Secretary	08.01.20
Charlie Lambert						
Evan Davies	Active	Chair, Capital Investment Committee	DHB Capital Prioritisation	Potential conflict.		7/01/2020

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 18 DECEMBER 2019, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.30pm

PUBLIC

Present:	Shayne Walker (Chair) Hayley Anderson Ana Apatu Kevin Atkinson Peter Dunkerley Joanne Edwards Charlie Lambert Anna Lorck Heather Skipworth
Apology	David Davidson Evan Davies
In Attendance:	Craig Climo (Interim Chief Executive Officer) Ken Foote (Company Secretary) Members of the Executive Management Team Robin Whyman and Jules Arthur (Co-Chairs, Hawke's Bay Clinical Council) Rachel Ritchie, Chair (Hawke's Bay Health Consumer Council) Kathy Shanaghan (EA to CEO) Members of the public and media

The Chair welcomed new and returning Board members to the meeting and thanked the Maori Health team for the Powhiri earlier in the day. He also paid tribute to Kevin Atkinson for his chairmanship of the Board over the past 19 years and presented him with a taonga in appreciation of all the work he had undertaken over those years.

Board members and Executive Leadership Team (ELT) were then invited to introduce themselves.

2. INTEREST REGISTER
The interest register was currently being updated with the new member's interests. Heather Skipworth declared an interest with the Mobility Action Programme (item # Provider Services Report).

3. CONFIRMATION OF PREVIOUS MINUTES
The minutes of the Board meeting held on 27 November 2019, were confirmed as a correct record of the meeting.

Moved: **Peter Dunkerley**
Seconded: **Ana Apatu**
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES
Item 1: **Person & Whanau Centred Care.** Moved to April 2020 work plan. Complete
Item 2: **TAW Adult Health – Smoke free.** The Executive Director of Health Improvement & Equity (HIE) said there was inconclusive data relating to child smoking uptake with vaping (*update was provided after meeting*). Complete.

Item 3: **MRB Recommendation from Te Ara Whakawaiora re ASH rates and whanau wellness)**. Board members advised that they want to see some actions to address the inequalities and requested an update report to come back to MRB and Board (date to be confirmed). **ACTION**

Item 4: **Community Pharmacists – responsibility of Pharmacists to promote Subsidy Scheme to their customers.** While this was a national scheme, the Executive Director (ED) Planning & Funding agreed that something more could be done locally and therefore would link in with the community pharmacists. Di Vicary, Planning & Commissioning Manager Pharmacy, would also be attending the Consumer Council meeting for their input into the communications around this. **ACTION**

5. BOARD WORK PLAN

The Board Work Plan was noted. The Chair provided the following feedback from the 'board only' session earlier in the day:

- Workshop on 27 January confirmed for Planning and Induction, although it was acknowledged that the induction may not be covered in just one day
- Management to come back with more detailed plans around how we can achieve our goals, namely equity, prioritisation and financial sustainability **ACTION**

6. CHAIR'S REPORT

- The Chair acknowledged Board members and said he was inspired and invigorated from the conversations from their first meeting earlier in the day and the challenges in achieving better health outcomes for the community.

- The Chair advised that the Minister of Health had approved and signed HBDHB's Annual Plan for 2019/20 and congratulated the previous Board.

- The Chair advised 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
Gloria Morgan	Clinical Nurse Specialist	Medical Directorate	13	29-Nov-19
Judith Thompson	Registered Nurse	Medical Directorate	23	20-Dec-19
Querida Rewi	Registered Nurse	Older Persons, Allied & NASC HB	16	15-Nov-19
Alison Wall	Receptionist	Medical Directorate	24	8-Nov-19
Irene Cudd	Medical Typist	Operations Directorate	16	20-Dec-19

7. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO noted his report as read.

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report
Adopted

8. FINANCIAL PERFORMANCE REPORT

The Executive Director of Financial Services presented the Financial Report for November 2019, which showed the result for the month of November was $2.27m unfavourable to plan, taking the year-to-date (YTD) result to $3.86m unfavourable. Comments were made on the following:

- Annual leave and whether back-fill is factored into the budgets
- MECA settlements. Concerns were noted around the Ministry's funding for additional costs which was less than originally conveyed to the DHB and which had led to an increased forecast deficit. The CEO acknowledged the need to ensure that commitments were absolutely binding and noted that the DHB would never have committed to the plan if it had known what the exact funding was
- A member said they would like an understanding about capital projects, e.g. radiology including timeframes and budget **ACTION**

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report
Adopted

9. PLANNING & FUNDING REPORT TO BOARD

The ED Planning & Funding provided an overview of this report highlighting the following:

- The whānau voices hui in Tuai on 16 December 2019
- HBDHB had been successful in its Request for Proposal (RFP) for Integrated Primary Mental Health and Addiction Services which would see over $5m in investment into Hawke's Bay over two years. Rachel Ritchie, Consumer Council Chair, highlighted the need for consumers to be involved in the co-design of that service. **ACTION**
- The Board Chair advised that Board members were keen to engage with communities and asked to be informed of those dates when known. **ACTION**

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report
Adopted

10. PROVIDER SERVICES REPORT TO BOARD

The Acting Executive Director of Provider Services provided an overview of this report.

Comments from Board members included:

- EmergencyQ App. It would be useful to include emergency dentists (not waiting times but phone numbers and where they are located) or details of the ones that are open **ACTION**
- Requested a lens on primary care spend (this could be included as part of the workshop) **ACTION**
- Further information was requested in respect to the comment about the 'increasing trend of social issues such as lack of whānau support….with the hospital increasingly seen as refuge of last resort'. The Acting ED Provider Services advised that issues such as health literacy and cost were factors while some people were very socially isolated. **ACTION**

The ED Planning & Funding complimented the mental health team in reducing the number of mental health patients in seclusion.

11. BOARD HEALTH & SAFETY CHAMPION UPDATE

For the benefit of new members, Heather Skipworth provided an outline of the Board Health & Safety Champion's role. This was a rotating role for six months, with two Board members as Champions at any one time. Each member would do a stint in the role over the next three years.

This then led to a discussion around staff surveys including the frequency. Board members were informed that a large survey was undertaken every 2-3years, with the next one due to be undertaken in November 2020. Small Pulse surveys were then undertaken every two months, with the next one in February 2020. The 'Big Listen' was undertaken in September 2017. This provided staff and consumers to have their say about their experience of working in the sector or being cared for in the sector – through surveys and/or attending a specific listening session.

Board members were keen to understand the sense of the DHB workforce and looked forward to the next survey. There was a lot of information available from the last Pulse survey which could be made available to them if they wished.

It was suggested that the CEO's KPIs include something around this. **ACTION**

REPORT FROM COMMITTEE CHAIRS

12. MĀORI RELATIONSHIP BOARD (MRB)

Ana Apatu provided an overview of the report from the MRB meeting on 11 December 2019, highlighting in particular the discussion around Violence Intervention Programme (VIP) and Family Harm. In response, the ED Health Improvement & Equity advised that the DHB receives $140k per annum for its part of the VIP and there was a team of six people working in the screening process. The DHB was looking to develop a whole-of-agency iwi partnered approach to family violence and advised that a report would be provided to MRB in February providing a more consolidated update in terms of this work.

13. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair Jules Arthur spoke to the report from the Council's meeting held on 11 December 2019. Discussion included:

- Information Services update
- Verbal reports provided by members on the Te Pitau Alliance Governance Group and Consumer Experience Committee

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report
Adopted

14. HAWKE'S BAY HEALTH CONSUMER COUNCIL

The Chair of Consumer Council provided an overview of the matters discussed at the Consumer Council meeting on 12 December 2019 highlighting the following:

- Implementation Plan for 10 year strategy 'Whānau Ora, Hāpori Ora'. Consumer Council requested clarity on progress to date, the planning process and timing for the development of the implementation plan; the 20/21 Annual Plan and assurance that Consumer Council would participate meaningfully in both.

The CEO advised that just this week the Executive Leadership Team (ELT) considered a long list of priorities for 20/21 and a lot of work was being done around costs and inter-dependencies. That information would be provided to the Board for discussion at their meeting on 27 January. The Board agreed to invite Clinical and Consumer Council Chairs to the meeting on the 27th.

- Disability Plan. Consumer Council requested that this be brought to the attention of ELT, the implementation plan acknowledged and actively integrated in planning and delivery, and the Executive Director role accountable for the delivery of the Plan is confirmed to Council.

  The ED Health Improvement & Equity (HIE) advised that the issue with implementation was that resourcing needed to come from the Ministry as they fund the activities directly. However, when the DHB challenged the Ministry about their funding of resources, their response was that the DHB was already funded for that work. The ED HIE said he would bring an update to Consumer Council at their next meeting. **ACTION**

  Board members expressed concern regarding the issues around resourcing and asked for this to be included on the agenda for 27 January. **ACTION**

15. PASIFIKA HEALTH LEADERSHIP GROUP

The ED Health Improvement & Equity presented the report from the Pasifika Health Leadership Group meeting on 2 December 2019. The meeting focused on development of a work plan for 2020 of which four key areas were identified:

1. Engaged Pacific communities.
2. Enhancing DHB and health services understanding of Pacific people.
3. Promoting the value of the Pacific health workforce.
4. Targeted initiatives to positively improve Pacific health outcomes.

Board members were invited to attend the fundraising concert for Samoa at Flaxmere Park on Friday 20 December commencing at 6pm.

RECOMMENDATION
That the HBDHB Board:
Note the contents of this report **Adopted**

FOR DECISION

16. "NEW' BOARD GOVERNANCE ISSUES

This report was taken as read. There was discussion regarding focusing the 27 January meeting more on planning and looking at a date in the week of 13 January for Board induction. **ACTION**

GENERAL BUSINESS

There were no items of general business.

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

17. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

18. Confirmation of previous minutes 27 November 2019 - Public Excluded
19. Matters Arising (Public Excluded)
20. Board Approval of Actions exceeding limits delegated by CEO
21. Chair's Update
22. Chief Executive Officer's Report (Public Excluded)
23. Hawke's Bay Clinical Council Report (Public Excluded)
24. Chief Medical Officer Verbal Report
25. Planning & Funding Report (Public Excluded)
26. CEO Recruitment
27. Finance Risk and Audit Committee

Moved: **Kevin Atkinson**
Seconded: **Ana Apatu**

Carried

The public section of the Board meeting closed at 3.15pm.

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	27/11/19	**MRB Recommendation** October MRB report to Board contained recommendation from Te Ara Whakawaiora, which was not addressed. This endorsement of next steps to be brought back through to Board in December	Patrick Le Geyt	December 2019	Report will be provided to MRB and Board in March 2020 outlining actions being taken to address inequities for Maori.
2	27/11/19	**Community Pharmacists (raised by Chair Consumer Council)** Responsibility of pharmacists to promote Subsidy Scheme to their customers. Executive Director of Planning & Funding will take this back to the Community Pharmacists for feedback on promotion of this communication to patients	Chris Ash	December 2019	Planning & Commissioning Manager met with Consumer Council on 13 February to deliver an update on activity undertaken to raise awareness. Members provided additional suggestions to expand the reach, which will be acted upon. Action closed.
3	18/12/19	**Board Workplan** Management to provide more detailed plans around achievement of goals, namely equity, prioritisation and financial sustainability	Chris Ash	February 2020	Addressed in the Planning session. Action closed.
4	18/12/19	**Capital Projects** Board requested a report on capital projects, e.g. Radiology including timeframes and budget	Carriann Hall	February 2020	A Capital Plan report will be provided to the February FRAC meeting which will include capital projects.
5	18/12/19	**Primary Mental Health and Addiction Services** Consumers to be involved in co-design of this service Board members also wish to engage with consumers and to be informed of the dates when known	Chris Ash	February 2020	Direct conversations between Consumer Council Chair and CEO Health Hawke's Bay to ensure this is addressed when implementation

Action	Date Entered	Action to be Taken	By Whom	Month	Status
					commences. Action closed.
6	18/12/19	**Emergency Q App** Suggested including emergency dentists phone numbers and addresses	Anne Speden	February 2020	Verbal update to be provided at February meeting.
8	18/12/19	**Increasing Trend of Social Issues** Further information to be provided	John Burns	February 2020	See attached update.
9	18/12/19	**Disability Plan Implementation (Consumer Council request)** Update to be provided to Consumer Council on how this is being implemented and reflected in planning activities An update on resourcing issues to be included on the agenda for 27 January	Bernard Te Paa Chris Ash	February 2020	Chair of Consumer Counci working with new executive lead for Clinical Council to assess. Addressed in Planning session. Action closed.

HAWKE'S BAY District Health Board Whakawāteatia	Provider Services Monthly Report
	For the attention of: HBDHB Board
Document Owner	John Burns, Executive Director of Provider Services
Month/Year	February 2020
Reviewed By	
Purpose	Response to the Board on social issues
Previous Consideration/Discussions	Provider Services Monthly Report to the HBDHB Board, December 2019

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. Note the contents of this response.

EXECUTIVE SUMMARY

At the December 2019 Board meeting the topic of the increasing trend of social issues such as lack of whānau support with the hospital increasing seen as a refuge of last resort was discussed. Arising out of this discussion was a request by the Board for further information to support this reported issue.

Action

To assess the significance of the issue I requested that "spot audits" be conducted.

The two specialties mainly affected with difficulties in discharging patients are Medicine and Mental Health and Addictions.

A committee reviews all long stay patients accommodated within the hospital, i.e. those whose length of stay is greater than 10 days, twice weekly. It is at these reviews that the committee is faced with the issues of difficulty in discharge.

Mental Health and Addictions have their own review process. They review all long stay complex patients on a fortnightly basis in conjunction with Needs Assessment Service Coordination and the Planning and Funding Directorate

Mental Health and Addictions

The results of the audit for Mental Health and Addictions revealed that there were nine inpatients who the Acute Mental Health Inpatient Services team believed no longer required inpatient care but they were unable to find appropriate accommodation options in the community, whether these be with non-government organisations, aged related residential care, whānau or general accommodation.

The combined bed days, in excess of the expected accommodation, is estimated at 1,500 days per annum. These bed days convert to increasing bed availability by approximately four beds per day if patients could be placed in appropriate external accommodation.

The number of patients not requiring inpatient services was considered to be a fair ongoing representation and therefore it was decided no further audits were necessary.

Hospital

The assessment of patients not requiring hospital accommodation is a moving number and the reasons can also very from day to day. There are, however, regular stories arising from the reviews that involve whānau not co-operating in assisting with the discharge of patients to residential care or to alternative accommodation, including to their home. Whānau quite understandably have difficulty in having to select a residential care home for their elderly whānau member or have difficulty caring for them at home. This decision making can be complex when there are whānau dynamics, which is not uncommon.

One of the recurrent comments from senior medical staff during my review last year was the considerable time now consumed through the need to have discussions with whānau members about the treatment and care options relating to the ongoing care of a whānau member. This can be very stressful to the clinician especially where there is discontent amongst whānau members. This aspect is not necessarily stopping patients from being discharged but it is consuming considerable clinical consultant time and impacting on scarce resources.

To gain a balanced view of the hospital situation “spot audits” were undertaken on three separate days. The first audit was conducted in January 2020 and it showed there were 12 patients waiting for a residential home beds and one waiting for a palliative care bed.

The above results appeared to be on the high side so a further audit was conducted in the first week of February 2020. The results showed two patients waiting as no whānau member could be contacted, and two patients waiting to be placed in aged related residential care.

Given the significant variance between the two audits a further audit was conducted in the second week of February 2020. This showed two patients who were palliative but had not been referred to hospice accommodation, two patients waiting Assessment, Treatment and Rehabilitation accommodation, which is provided internally by the hospital and three patients waiting to be placed in aged residential care.

It has been commented that the most difficult patients to accommodate are psycho-geriatric patients, stages three to five. These patients generally have severe behavioural problems and there is only one residential care facility available in Hawke’s Bay that provides this level of care.

Conclusion

The results show that while at times the hospital does have patients who no longer require inpatient services, the numbers can fluctuate but based on the two audits taken in February 2020, it could be concluded that the number is not excessive given the complexity of the hospital and the external options that are available.

This is not to say that staff do not have difficulties in placing patients while dealing with whānau dynamics. The relatively low number is probably testament that staff are working effectively to have patients discharged.

We are further investigating whether aged residential care beds and their support services reduce over the summer period, which would impact on our ability to return patients there at this time.

In the case of Mental Health and Addictions there is a problem in finding appropriate accommodation for patients no longer requiring inpatient services. This issue requires further discussion between Mental Health and Addictions, external providers and the Planning and Funding Directorate.

BOARD as at 18 February 2020	EMT Member	BOARD Meeting date
Finance Report (Dec)	Carriann Hall	25-Feb-20
Te Ara Whakawaiora - Mental Health (National & Local indicators)	John Burns	25-Feb-20
Primary Care Directorate Monthly Report	Chris Ash	25-Feb-20
Provider Services Monthly Report - Executive Summary	John Burns	25-Feb-20
HIE & Pop Health Quarterly report to board	Patrick Le Geyt	25-Feb-20
Governance Appointments and Meeting Schedule for 2020	Ken Foote	25-Feb-20
Corporate Performance Dashboard (quarterly)	Chris Ash	25-Feb-20
HB Pasifika Youth Project - final reporting and recommendations	Patrick Le Geyt	18-Mar-20
Three Waters discussion - once recieved plan from Napier council (MA 24.04.19)	Patrick Le Geyt	18-Mar-20
Provider Services Monthly Report - Executive Summary	Chris Ash	18-Mar-20
He Ngakau Aotea	Patrick Le Geyt	18-Mar-20
PHO Quarterly report to Board	Wayne Woolrich	18-Mar-20
Annual Planning report to Board	Chris Ash	18-Mar-20
Person & Whanau Centred Care - committee reports to Board	Kate Coley	15-Apr-20
Hawke's Bay Health Awards Event - REVIEW Alcohol at this event annually	Anna Kirk	15-Apr-20
Provider Services Monthly Report - Executive Summary	Chris Ash	15-Apr-20
Chief Medical & Dental Officer report to Board	Robin Whyman	15-Apr-20
Chief Nursing & Midwifery Officer report to board	Chris Mckenna	15-Apr-20
Chief Allied Health Professions Officer report to board	Andy Phillips	15-Apr-20
Comms report to Board	Anna Kirk	15-Apr-20
HIE & Pop Health Quarterly report to board	Patrick Le Geyt	20-May-20
Provider Services Monthly Report - Executive Summary	Chris Ash	20-May-20
Information Services & Service Improvement report to Board	Anne Speden	20-May-20
Corporate Performance Dashboard (quarterly)	Chris Ash	20-May-20
Provider Services Monthly Report - Executive Summary	Chris Ash	17-Jun-20
PHO Quarterly report to Board	Wayne Woolrich	17-Jun-20
Chief Medical & Dental Officer report to Board	Robin Whyman	15-Jul-20
Provider Services Monthly Report - Executive Summary	COO	15-Jul-20
Chief Nursing & Midwifery Officer report to board	Chris Mckenna	15-Jul-20
Chief Allied Health Professions Officer report to board	Andy Phillips	15-Jul-20
Alcohol Harm Reduction Strategy (6 monthly update) - moved to August 2020	Patrick Le Geyt	19-Aug-20
HB Health Awards - preparation for judging **2019**-2020	Anna Kirk	19-Aug-20
Provider Services Monthly Report - Executive Summary	COO	19-Aug-20
HIE & Pop Health Quarterly report to board	Patrick Le Geyt	19-Aug-20
Corporate Performance Dashboard (quarterly)	Chris Ash	19-Aug-20
PHO Quarterly report to Board	Wayne Woolrich	16-Sep-20
Provider Services Monthly Report - Executive Summary	COO	16-Sep-20
Information Services & Service Improvement report to Board	Anne Speden	16-Sep-20
Chief Medical & Dental Officer report to Board	Robin Whyman	21-Oct-20
Provider Services Monthly Report - Executive Summary	COO	21-Oct-20
Chief Nursing & Midwifery Officer report to board	Chris Mckenna	21-Oct-20
Chief Allied Health Professions Officer report to board	Andy Phillips	21-Oct-20
Comms report to Board	Anna Kirk	21-Oct-20
HIE & Pop Health Quarterly report to board	Patrick Le Geyt	18-Nov-20
Provider Services Monthly Report - Executive Summary	COO	18-Nov-20
Provider Services Monthly Report - Executive Summary	COO	16-Dec-20
PHO Quarterly report to Board	Wayne Woolrich	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	19 February 2020
Consideration:	For Information

RECOMMENDATION

That the Board

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

INTRODUCTION AND FINANCIAL RESULT

The health system is busy, including the DHB, management, and in particular planning & funding, which is in the midst of the formal planning period.

It has been difficult to apply concerted effort to any one thing, which has not been helped by operational issues popping up. We have limited business analyst and service improvement (process redesign) skills and roles and we are moving, in part, to address this which will help identify issues before they arise and help us more readily solve them, including by moving budgets from business as usual to change.

As pointed to in the Provider-arm report, we have seen this financial year a large increase in bed use for a small increase in multi-day in-patients – it was quite pronounced in January and we are analysing the cause. We need to know promptly as the additional bed use is costing up to $0.5M per month of cost.

The financial operating result for January and year to date was:

- January month $1.4M U
- YTD $6.9M U, within which the provider-arm is $3.6M U, and funder-arm $3.5M U, with off-sets in other areas, mainly Inter District Flows
- YTD deficit $16M
- Year end forecast $25.8M –v- $12.9M planned deficit (a $2M increase on last month)

The year to-date trend continues with the variances and their magnitude being quite consistent from month-to-month.

The results are not acceptable. They are well off plan and we appear to be an outlier to the results reported by other DHBs. Our overruns are not all uncontrollable. They require work up, some difficult decisions, and action.

There are no practicable immediate substantial actions that can be taken, but there are actions that can be taken over the next months and beyond to address not only some of the variances against budget but costs in other areas as well.

OTHER MATTERS

Other matters of interest are in the Funder and Provider reports, except for an update on:

Chief Operating Officer (COO)
The COO role – it has been renamed from Executive Director Provider Services – has been advertised and selection is timed to coincide with the appointed chief executive.

In the interim, from 30 March, Chris Ash will take over as COO, and Emma Foster will fill in for Chris as Executive Director Planning & Funding.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report January 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	February, 2020
Purpose	For Information

RECOMMENDATION:

That the HBDHB Board:

Note the contents of this report

Resolve that the Board approve the representation to the Minister of Health that Q2 cost increases between the 2018/19 and 2019/20 financial years, have only been approved where unavoidable (refer Section 14)

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

The result for the month of January is $1.4m unfavourable to plan, taking the year-to-date (YTD) result to $6.9m unfavourable. The main drivers of the adverse result for the month were:

1. $1.1m in Providing Health Services, largely driven by operating costs in Hawke's Bay Hospital, mainly in personnel and clinical supplies
2. Net $0.4m aged residential care and $0.4m pharmaceuticals, which are driving the Funding Other Providers and Income variances

They were partly offset by additional revenue from capital charge funding, IDF in-flows and other income.

	January				*Year to Date*				*Year End*	
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*	Refer Appendix
Income	51,482	51,771	(289)	-0.6%	358,249	357,651	598	0.2%	613,640	1
Less:										
Providing Health Services	29,281	28,229	(1,052)	-3.7%	181,645	177,348	(4,297)	-2.4%	307,670	2
Funding Other Providers	23,012	22,760	(253)	-1.1%	157,022	154,039	(2,983)	-1.9%	269,878	3
Corporate Services	4,778	4,957	179	3.6%	35,403	35,076	(327)	-0.9%	61,084	4
Reserves	(2,900)	(2,898)	3	0.1%	177	325	148	45.6%	817	5
	(2,689)	**(1,277)**	(1,412)	-110.6%	**(15,998)**	**(9,137)**	(6,861)	-75.1%	**(25,809)**	

Key Drivers (YTD)

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

- Income (Appendix 1)

  Capital charge funding, IDF revenue and other income improved the result for January by $0.6m. However the in-month adverse result is due to a $0.9m budget adjustment. This does not impact the overall position, but correctly transacts the additional funding for combined pharmaceuticals announced by the Government a few months ago.

- Providing Health Services (Appendix 2)

  Continuing pressure on the net cost of medical personnel and locums, nursing resources, security and patient watches, blood products and patient transport, partly offset by allied health vacancies. Demand is a significant factor and sustainable solutions are expected to come from the clinically led bed availability programme, which will take time to deliver.

- Funding Other Providers (Appendix 3)

  Pharmaceuticals, including faster than expected take-up of new pharmaceuticals and over-representation of HBDHB in some classes of pharmaceuticals, notably Pharmaceutical Cancer Treatments and we anticipate volatility going forward.

  Aged residential care costs have been over plan every month since the start of the year, driven by mix and demand factors. This is being exacerbated by high level and high cost backdated claims.

Other Performance Measures

	January				Year to Date				Year End Forecast	Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Capital spend	1,089	1,779	(690)	-38.8%	7,608	12,852	(5,244)	-40.8%	21,695	12
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,537	2,473	(64)	-2.6%	2,486	2,494	8	0.3%	2,526	2 & 4
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	3,265	2,058	1,207	58.6%	18,694	17,249	1,445	8.4%	29,239	2

- Capital spend (Appendix 12)

  Strategic projects are progressing much slower than planned. We are awaiting MoH confirmation of equity funding for the Radiology Refurbishment Project and agreement to the increase in Surgical Services Expansion Project (SSEP) costs. This is driving delays in SSEP particularly. Given demand for capital exceeds capital available, we have developed some options to ensure capital is expended.

- Cash (Appendices 11 & 13)

  The recent significant overspends have a flow on impact to cash and we are now forecasting that without an equity (cash) injection, we will breach our statutory cash limit in May. A request for $8m equity injection for 2019/20 has been sent to the Ministers of Health and Finance.

- Employees (Appendices 2 & 4)

  Employee numbers are favourable reflecting vacancies in medical and allied staff, partly offset by higher than budgeted use of nursing and support personnel driven by patient watches and bed occupancy.

- Activity (Appendix 2 and 7)

This month saw exceptionally high acute case weight discharges (CWDs) delivered. Overall activity and actions on the elective target are covered in the Provider Services report.

The latest MoH report on Elective performance is provided at Appendix 7. Whilst we are overperforming on minor procedures, our elective performance is significantly behind plan.

Forecast

We are forecasting a $25.8m deficit, against a plan of $12.9m. There are a number of risks in year, which include:

Pay Settlements – Budgets for some settlements were set assuming MoH would fund additional costs over the 2.43% Average Ongoing Cost of Settlement. Funding may not be as extensive as assumed in the budgets.

Pharmaceutical spend - PHARMAC has indicated expenditure going forward is likely to be more volatile, particularly around the uptake of newly released pharmaceuticals. We will have a clearer picture of the net impact of these following receipt of the next PHARMAC forecast due in February.

Planned Care revenue – Our forecast assumes we will receive the full planned care revenue from MoH. However this is predicated on achievement of case weighted discharges where we currently have a material shortfall.

Capitation – Recent population data supports our view that there is risk around further growth in capitation

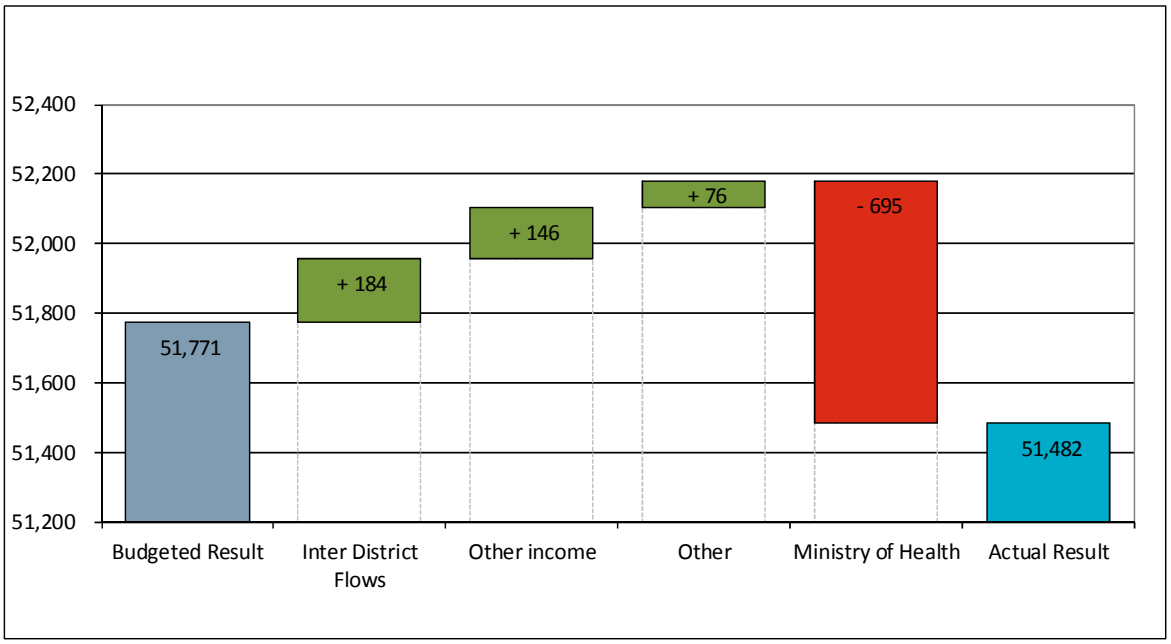
Achieving savings – Dependent on patient volumes in the second half of the year.

APPENDICES

1. INCOME

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Ministry of Health	49,090	49,785	(695)	-1.4%	343,170	343,043	127	0.0%	588,527
Inter District Flows	891	707	184	26.0%	4,914	4,952	(38)	-0.8%	8,451
Other District Health Boards	367	366	0	0.1%	2,503	2,563	(60)	-2.3%	4,290
Financing	(8)	7	(15)	-210.0%	97	49	48	97.7%	97
ACC	427	396	31	7.8%	3,118	2,860	259	9.0%	5,279
Other Government	21	27	(6)	-21.7%	308	305	3	0.9%	464
Patient and Consumer Sourced	168	104	64	61.8%	880	726	154	21.3%	1,421
Other Income	525	379	146	38.6%	3,837	3,153	684	21.7%	5,689
Abnormals	1	-	1	0.0%	(578)	-	(578)	0.0%	(578)
	51,482	**51,771**	**(289)**	**-0.6%**	**358,249**	**357,651**	**598**	**0.2%**	**613,640**

January



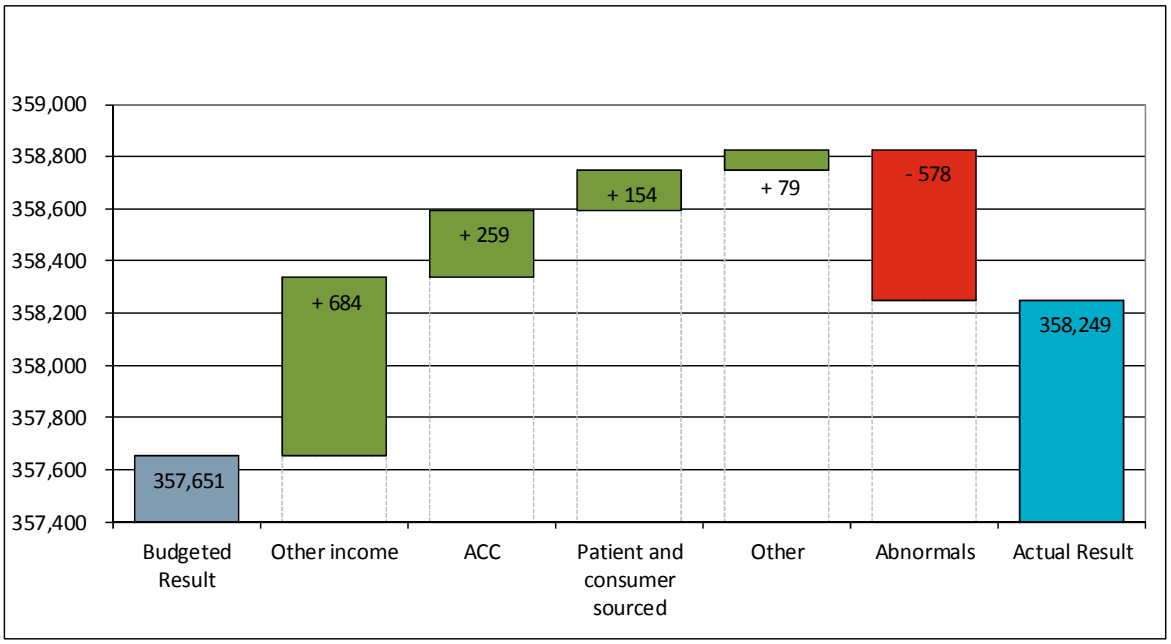
Note the scale does not begin at zero

Inter District Flows (favourable)
Normal seasonal variation, reflecting visitors into Hawke's Bay.

Other income (favourable)
Donations and a variety of other sources.

Ministry of Health (unfavourable)
Includes additional revenue as a result of revaluation of land and buildings at the end of 2018/19, largely offsetting the increase in capital charge (see Appendix 4 – Corporate Services). Main driver is a $0.9m budget correction to correctly reflect additional funding for combined pharmaceuticals announced by the Government a few months ago. This does not impact the bottom line as it also increases pharmaceutical spend (see Appendix 3 – Funding Other Providers).

Year-to-date



Note the scale does not begin at zero

Other income (favourable)
Donations and clinical trial revenue, food sales, GP Health Care income, training and accommodation.

ACC (favourable)
Elective surgery and rehabilitation.

Patient and consumer sourced (favourable)
Non residents.

Abnormals (unfavourable)
The pay equity wash-up for 2018/19 recognised in October was significantly less than provided for.

2. PROVIDING HEALTH SERVICES

	January				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	9,033	8,582	(451)	-5.3%	45,801	43,659	(2,142)	-4.9%	75,744
Nursing personnel	9,343	8,871	(472)	-5.3%	56,145	55,221	(924)	-1.7%	96,354
Allied health personnel	3,051	3,296	245	7.4%	22,133	23,444	1,311	5.6%	37,961
Other personnel	2,194	2,156	(39)	-1.8%	15,289	15,139	(149)	-1.0%	26,177
Outsourced services	658	694	36	5.2%	5,645	5,853	208	3.6%	10,068
Clinical supplies	3,529	3,178	(351)	-11.0%	25,603	23,769	(1,834)	-7.7%	42,796
Infrastructure and non clinical	1,473	1,452	(20)	-1.4%	11,030	10,263	(768)	-7.5%	18,569
	29,281	**28,229**	(1,052)	**-3.7%**	**181,645**	**177,348**	(4,297)	**-2.4%**	**307,670**
Expenditure by directorate $'000									
Medical	9,113	8,466	(647)	-7.6%	51,600	49,842	(1,758)	-3.5%	88,116
Surgical	7,078	6,667	(411)	-6.2%	41,673	41,054	(618)	-1.5%	71,202
Community, Women and Children	4,688	4,613	(75)	-1.6%	29,653	29,564	(89)	-0.3%	50,033
Mental Health and Addiction	2,191	2,169	(22)	-1.0%	13,548	12,944	(603)	-4.7%	23,028
Older Persons, NASC HB, and Allied H	1,560	1,664	104	6.3%	10,006	10,537	531	5.0%	17,370
Operations	4,046	3,820	(226)	-5.9%	27,908	26,407	(1,501)	-5.7%	48,027
Other	604	830	226	27.2%	7,257	6,999	(258)	-3.7%	9,894
	29,281	**28,229**	(1,052)	**-3.7%**	**181,645**	**177,348**	(4,297)	**-2.4%**	**307,670**
Full Time Equivalents									
Medical personnel	414.5	393.5	(21)	-5.3%	363	375	12	3.3%	378.2
Nursing personnel	1,098.2	1,042.4	(56)	-5.4%	1,050	1,020	(31)	-3.0%	1,030.4
Allied health personnel	438.7	461.1	22	4.9%	468	490	22	4.4%	498.4
Support personnel	129.1	111.5	(18)	-15.7%	126	114	(12)	-10.5%	115.8
Management and administration	266.1	259.0	(7)	-2.8%	274	277	3	1.3%	281.5
	2,346.7	**2,267.5**	(79)	**-3.5%**	**2,280**	**2,275**	(5)	**-0.2%**	**2,304.1**
Case Weighted Discharges									
Acute	2,477	1,385	1,093	78.9%	13,733	11,878	1,855	15.6%	19,957
Elective	606	472	134	28.3%	3,619	3,924	(304)	-7.8%	6,850
Maternity	150	171	(22)	-12.7%	1,095	1,198	(103)	-8.6%	2,000
IDF Inflows	32	30	2	6.9%	247	250	(3)	-1.1%	432
	3,265	**2,058**	1,207	58.6%	**18,694**	**17,249**	1,445	8.4%	**29,239**

Directorates YTD

The drivers and actions are covered in detail in the Provider Services report

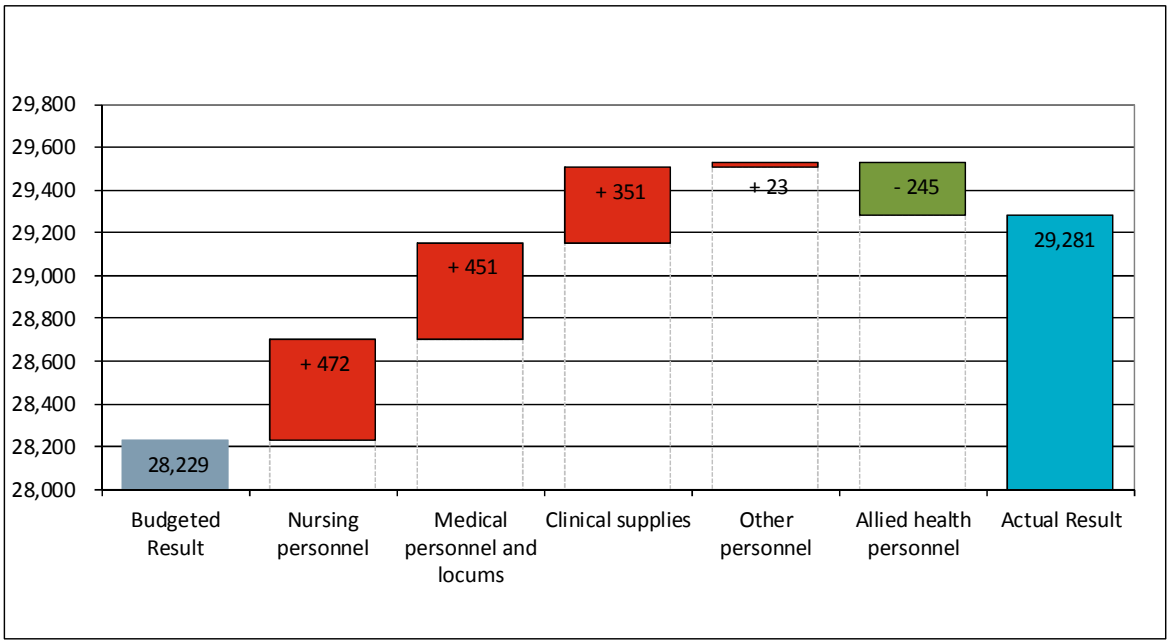
- Medical – medical staff vacancy and leave cover, nursing resource use, and outsourced radiology reads
- Operations – patient transport and blood products.
- Surgical - medical staff vacancy and leave cover, and nursing resource use, partly offset by lower than planned outsourced elective surgery
- Mental Health and Addiction – locum psychiatrist costs for vacancy and sick leave cover
- Older Persons et al – vacancies across medical, management and allied health staff, partly offset by medical staff vacancy and leave cover

Case Weighted Discharges

Case weighted discharges (CWD) are above plan by 8.4% year to date, attributable to acute patient volumes, with particularly high levels in month, partly offset by elective surgery.

Note that Elective CWD is an indicator of performance, however timing and impact of elective IDF outflows means it is not the complete result in relation to the Planned Care target - actual data from MoH is provided in section 11.

January



Note the scale does not begin at zero

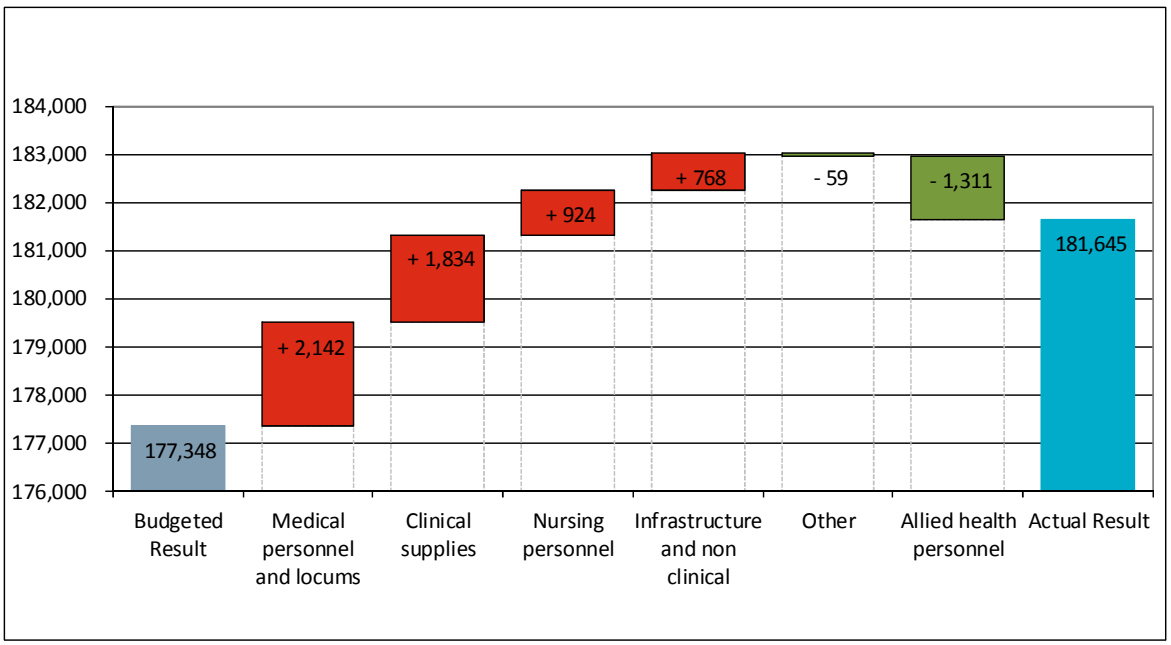
Nursing personnel (unfavourable)
Reflects higher than planned bed occupancy

Medical personnel and locums (unfavourable)
Vacancy and leave cover

Clinical supplies (unfavourable)
Planned efficiencies not achieved. Adverse blood products and patient transport costs were offset in month by favourable implants/prostheses and pharmaceuticals reimbursements

Allied health personnel (favourable)
Vacancies – mainly social workers, psychologists and technicians

Year-to-date



Note the scale does not begin at zero

Medical personnel and locums (unfavourable)
Vacancies more than offset by locum vacancy and leave cover, and additional sessions to cope with volumes.

Clinical supplies (unfavourable)
Patient transport costs, blood products (mainly Intragam) driven by demand, matching capacity to demand savings not yet achieved, diagnostic supplies, and disposable instruments, partly offset by pharmaceutical reimbursements, and lower than budgeted implants and prosthetics reflecting lower than planned elective surgery.

Nursing personnel (unfavourable)
High casual and on-call allowances and overtime payments relating to patient volumes.

Infrastructure and non-clinical (unfavourable)
Security (patient watches), Māori workforce scholarships (offset in income), and food, laundry and cleaning costs relating to patient volumes.

Allied health personnel (favourable)
Vacancies mainly in social workers, occupational therapists, psychologists, laboratory technicians, cultural workers, pharmacists and technicians, and medical radiation technologists (MRTs).

Full Time Equivalents (FTE)

FTE numbers are volatile reflecting the human resource needs of the DHB and the availability of staff, factors that change significantly from month to month. Consequently FTEs are reported on a year-to-date (YTD) basis to improve understanding of underlying trends.

FTEs are 5 (-0.2%) favourable including:

Medical personnel (12 FTE / 3.3% favourable)

- Vacancies across a number of specialties including radiologists, obstetricians, intensivists, and and orthopaedic surgeons, are significantly more than offset in outsourced medical.

Nursing personnel (-31 FTE / -3.0% unfavourable)

- Impact of patient watches and higher than planned levels of activity mainly in the wards.

Allied health personnel (22 FTE / 4.4% favourable)

- Ongoing vacancies in social workers, laboratory technicians, psychologists, and occupational therapists.

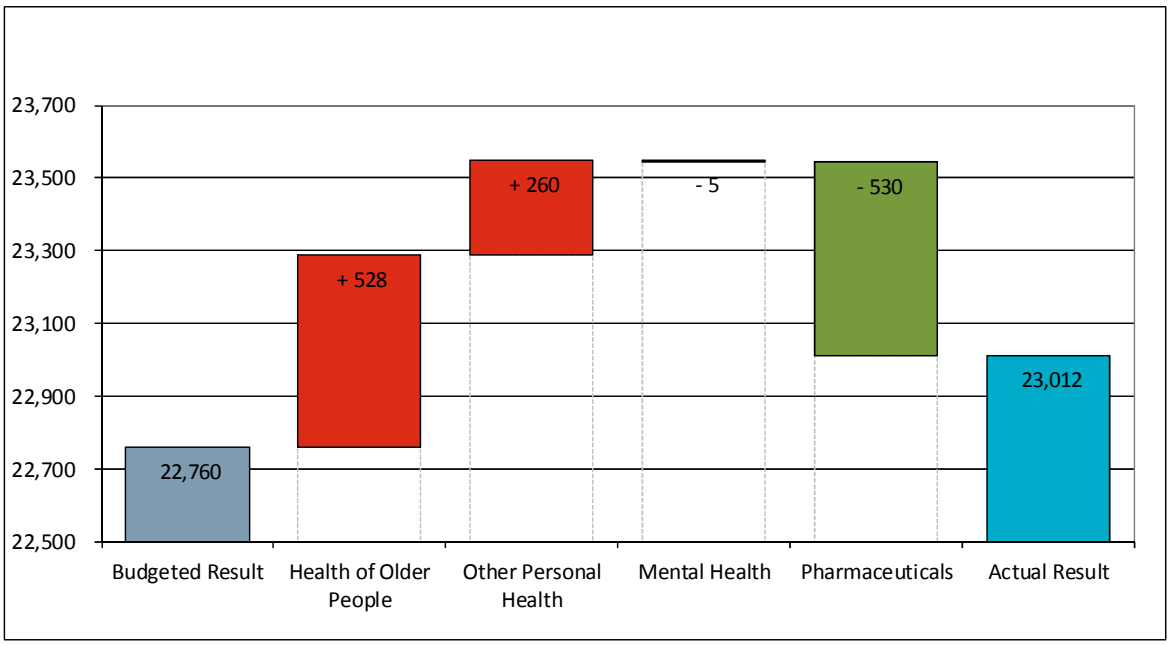
Support personnel (-12 FTE / -10.5% unfavourable)

- Pressure on kitchen staff, orderlies, and security (patient watches).

3. FUNDING OTHER PROVIDERS

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,963	4,493	530	11.8%	27,616	26,074	(1,542)	-5.9%	47,937
Primary Health Organisations	3,531	3,551	20	0.6%	25,537	25,623	86	0.3%	43,350
Inter District Flows	5,036	5,043	6	0.1%	35,005	35,299	294	0.8%	59,819
Other Personal Health	2,379	2,120	(260)	-12.3%	14,199	14,132	(66)	-0.5%	24,855
Mental Health	1,100	1,083	(17)	-1.6%	8,097	7,584	(513)	-6.8%	13,390
Health of Older People	6,659	6,131	(528)	-8.6%	44,388	42,924	(1,464)	-3.4%	76,659
Other Funding Payments	344	340	(4)	-1.2%	2,180	2,403	222	9.2%	3,880
	23,012	22,760	(253)	-1.1%	157,022	154,039	(2,983)	-1.9%	269,890
Payments by Portfolio									
Strategic Services									
Secondary Care	4,518	4,640	123	2.6%	32,030	32,483	454	1.4%	54,813
Primary Care	9,120	9,236	116	1.3%	61,836	60,354	(1,482)	-2.5%	106,881
Mental Health	1,423	1,412	(10)	-0.7%	10,389	9,887	(501)	-5.1%	17,503
Health of Older People	7,346	6,840	(506)	-7.4%	48,303	46,838	(1,464)	-3.1%	83,068
Maori Health	477	502	25	4.9%	3,580	3,573	(7)	-0.2%	6,093
Population Health	128	129	1	0.6%	886	903	17	1.9%	1,531
	23,012	22,760	(253)	-1.1%	157,022	154,039	(2,983)	-1.9%	269,890

January



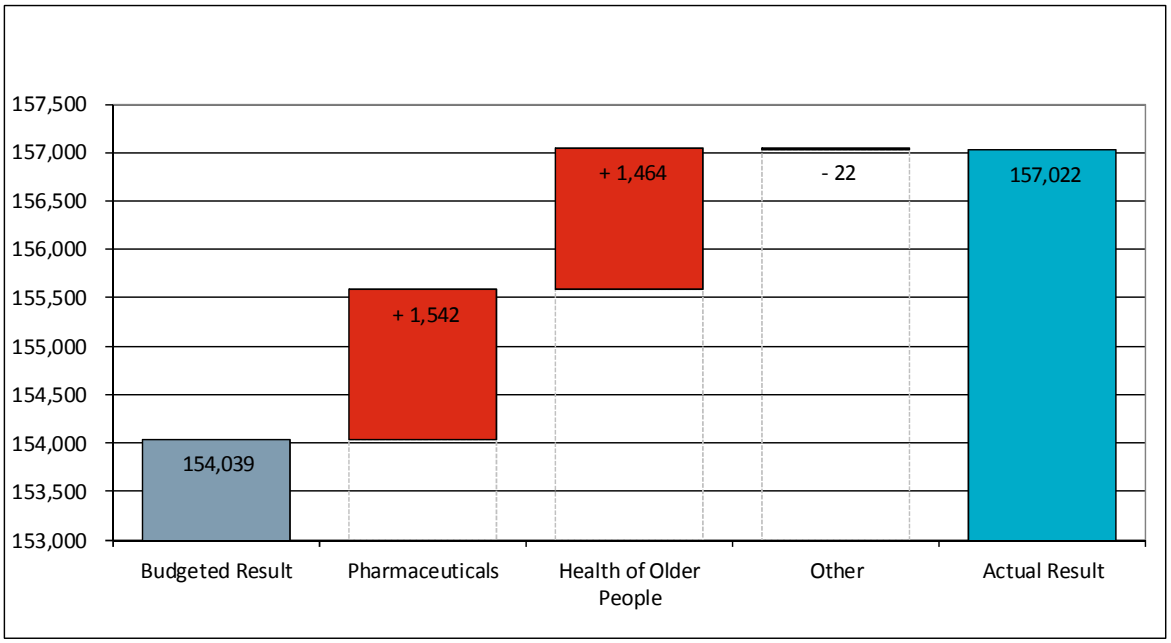
Note the scale does not begin at zero

Health of Older People (unfavourable)
Expense is partially offset by revenue with a remaining net overspend of $375k in month. This is attributable to underlying issues in terms of mix and volume in aged residential care, exacerbated by high numbers of high cost backdated claims hitting in month

Other Personal Health (unfavourable)
Rural support, adolescent dental benefits, child and youth services

Pharmaceuticals (favourable)
An adverse result for the month has been offset by a $0.9m increase to the budget that also increases income (see Appendix 1 – Income) to correctly reflect additional funding for combined pharmaceuticals. This is presentational and does not impact the bottom line.

Year-to-date



Note the scale does not begin at zero

Pharmaceuticals (unfavourable)
Drivers include faster than expected take up of new pharmaceuticals and over-representation of HBDHB in some classes of pharmaceuticals, notably Pharmaceutical Cancer Treatments. This position is corroborated by the latest forecast from PHARMAC and another update is imminent.

Health of Older People (unfavourable)
Changes in mix of care to higher cost packages, pay equity and In-Between-Travel costs.

4. CORPORATE SERVICES

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,415	1,738	323	18.6%	11,386	12,212	826	6.8%	19,597
Outsourced services	155	77	(79)	-102.8%	1,067	535	(532)	-99.5%	1,813
Clinical supplies	44	54	11	19.5%	331	384	53	13.9%	614
Infrastructure and non clinical	1,281	1,247	(34)	-2.8%	9,640	9,271	(369)	-4.0%	16,678
	2,896	3,116	220	7.1%	22,424	22,401	(23)	-0.1%	38,703
Capital servicing									
Depreciation and amortisation	1,147	1,226	79	6.4%	7,867	8,386	519	6.2%	13,671
Financing	28	3	(25)	-873.8%	165	3	(162)		229
Capital charge	707	612	(95)	-15.4%	4,947	4,285	(662)	-15.4%	8,480
	1,882	1,841	(41)	-2.2%	12,979	12,675	(305)	-2.4%	22,381
	4,778	**4,957**	179	3.6%	**35,403**	**35,076**	(327)	-0.9%	**61,084**
Full Time Equivalents									
Medical personnel	0.3	0.4	0	14.2%	0	0	(0)	-10.6%	0.3
Nursing personnel	10.0	16.3	6	38.6%	14	17	3	15.0%	16.9
Allied health personnel	-	0.4	0	100.0%	0	0	0	97.5%	0.4
Support personnel	28.2	27.8	(0)	-1.7%	29	30	0	1.4%	30.2
Management and administration	151.7	160.5	9	5.5%	161	171	10	5.8%	173.5
	190.3	**205.4**	15	7.4%	**205**	**218**	13	6.0%	**221.4**

Personnel is mainly executive staff vacancies 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.

Depreciation and amortisation reflects the extension of building lives assumed in the 30 June 2019 revaluation of land and buildings and slower than planned capital expenditure. Financing is bank overdraft interest, reflecting the cash position.

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	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	(175)	(45)	130	286.8%	-	762	762	100.0%	360
Other	(2,725)	(2,852)	(127)	-4.5%	177	(437)	(614)	-140.4%	457
	(2,900)	**(2,898)**	3	-0.1%	**177**	**325**	148	45.6%	**817**

The contingency budget reduces when use of reserves is approved. To date 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.

6. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

	January			*Year to Date*			*End of Year*		
$'000	*Actual*	*Annual Plan*	*Variance*	*Actual*	*Annual Plan*	*Variance*	*Forecast*	*Annual Plan*	*Variance*
Funding									
Income	48,791	49,222	(430)	339,063	339,608	(545)	582,007	581,833	174
Less:									
Payments to Internal Providers	26,292	26,292	-	198,066	198,066	-	338,307	338,307	-
Payments to Other Providers	22,157	22,138	(18)	150,299	149,688	(612)	257,829	258,081	252
Contribution	**343**	**791**	**(449)**	**(9,302)**	**(8,146)**	**(1,157)**	**(14,129)**	**(14,554)**	**425**
Governance and Funding Admin.									
Funding	294	294	-	2,130	2,130	-	3,603	3,603	-
Other Income	0	3	(2)	15	18	(2)	28	30	(2)
Less:									
Expenditure	289	277	(11)	2,069	2,026	(43)	3,670	3,633	(38)
Contribution	**6**	**20**	**(14)**	**77**	**122**	**(45)**	**(40)**	**0**	**(40)**
Health Provision									
Funding	25,998	25,998	-	195,936	195,936	-	334,704	334,704	-
Other Income	2,592	2,451	141	18,480	17,352	1,128	30,423	29,551	872
Less:									
Expenditure	31,628	30,537	(1,090)	221,189	214,403	(6,786)	376,767	362,601	(14,167)
Contribution	**(3,038)**	**(2,088)**	**(950)**	**(6,773)**	**(1,115)**	**(5,658)**	**(11,640)**	**1,654**	**(13,295)**
Net Result	**(2,689)**	**(1,277)**	**(1,412)**	**(15,998)**	**(9,139)**	**(6,860)**	**(25,809)**	**(12,900)**	**(12,909)**

The table above reports the result in the classifications used by the Ministry of Health and against the projections in the Annual Plan. Those projections differ from the budgets used elsewhere in this report as outlined in the table below.

7. MANAGEMENT BUDGET MOVEMENTS

Changes are made to Annual Plan projections so that managers are accountable for budgets that are relevant and up-to-date. The Management Budget is used for internal reporting and the annual plan is used for MoH and statutory reporting. The net result is the same in both budgets.

The major changes between revenue and expense lines are usually due to health provision savings programmes, or unbudgeted new funding received during the year and the associated expenditure.

	January			*Year to Date*			*End of Year*		
$'000	*Mgmt Budget*	*Annual Plan*	*Movement*	*Mgmt Budget*	*Annual Plan*	*Movement*	*Mgmt Budget*	*Annual Plan*	*Movement*
Funding									
Income	49,222	48,426	796	339,608	339,412	196	582,164	581,833	330
Less:									
Payments to Internal Providers	26,292	26,292	-	198,066	198,066	-	338,307	338,307	-
Payments to Other Providers	22,138	21,297	(841)	149,688	150,252	565	257,130	258,081	951
Contribution	**791**	**836**	**(45)**	**(8,146)**	**(8,907)**	**761**	**(13,273)**	**(14,554)**	**1,282**
Governance and Funding Admin.									
Funding	294	294	-	2,130	2,130	-	3,603	3,603	-
Other Income	3	3	-	18	18	-	30	30	-
Less:									
Expenditure	277	279	2	2,026	2,030	5	3,625	3,633	8
Contribution	**20**	**18**	**2**	**122**	**117**	**5**	**8**	**0**	**8**
Health Provision									
Funding	25,998	25,998	-	195,936	195,936	-	334,704	334,704	-
Other Income	2,451	2,517	(66)	17,352	17,330	22	29,314	29,551	(237)
Less:									
Expenditure	30,537	30,646	109	214,403	213,615	(788)	363,654	362,601	(1,053)
Contribution	**(2,088)**	**(2,131)**	**43**	**(1,115)**	**(349)**	**(766)**	**365**	**1,654**	**(1,289)**
Net Result	**(1,277)**	**(1,277)**	**0**	**(9,139)**	**(9,139)**	**0**	**(12,900)**	**(12,900)**	**0**

8. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Planned savings, including a vacancy factor, have been incorporated into operational budgets and will be managed as part of the normal operational performance reviews in 2019/20. Our focus is on sustainable changes that generate qualitative improvements that positively impact patient outcomes, such as the bed availability project. It is anticipated that in many cases these will also impact the drivers of cost, such as length of stay and therefore will have a positive impact on the financial position over the longer-term.

9. FINANCIAL POSITION

		January				
30 June 2019	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2019*	*Annual Budget*
	Equity					
188,048	Crown equity and reserves	188,742	174,697	14,046	695	174,339
(44,407)	Accumulated deficit	(60,405)	(25,510)	(34,895)	(15,998)	(29,271)
143,641		128,337	149,187	(20,850)	(15,304)	145,068
	Represented by:					
	Current Assets					
759	Bank	744	840	(96)	(15)	840
1,881	Bank deposits > 90 days	1,884	1,855	29	3	1,855
29,342	Prepayments and receivables	31,162	26,287	4,875	1,820	26,488
4,023	Inventory	4,106	3,879	227	83	3,933
-	Investment in NZHP	-	2,638	(2,638)	-	2,638
36,005		37,896	35,498	2,398	1,890	35,754
	Non Current Assets					
190,552	Property, plant and equipment	188,279	184,559	3,720	(2,274)	188,324
13,790	Intangible assets	15,757	2,893	12,864	1,967	3,412
1,189	Investments	1,189	9,002	(7,812)	-	9,002
205,532		205,224	196,453	8,771	(307)	200,737
241,537	**Total Assets**	**243,120**	**231,951**	**11,169**	**1,583**	**236,491**
	Liabilities					
	Current Liabilities					
10,208	Bank overdraft	24,087	1,217	(22,870)	(13,880)	1,828
31,318	Payables	33,837	41,289	7,452	(2,519)	47,228
53,370	Employee entitlements	53,858	37,505	(16,353)	(488)	39,576
94,895		111,782	80,011	(31,771)	(16,887)	88,633
	Non Current Liabilities					
3,001	Employee entitlements	3,001	2,754	(247)	-	2,790
3,001		3,001	2,754	(247)	-	2,790
97,896	**Total Liabilities**	**114,783**	**82,764**	**(32,019)**	**(16,887)**	**91,423**
143,641	**Net Assets**	**128,337**	**149,187**	**(20,850)**	**(15,304)**	**145,068**

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, and budgeted equity injections for 2019/20 phased to be received at the mid-point of the year due to uncertainty over timing.

The current assets variance reflects differences between estimated and actual receipt of wash-up funding such as elective surgery, and the write-off of the investment in New Zealand Health Partnerships (NZHP) at the end of last year.

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.

10. EMPLOYEE ENTITLEMENTS

30 June 2019	$'000	*January Actual*	*January Budget*	*Variance from budget*	*Movement from 30 June 2019*	*Annual Budget*
7,755	Salaries & wages accrued	6,498	6,464	(34)	1,257	9,483
1,027	ACC levy provisions	1,474	1,073	(401)	(447)	1,174
5,530	Continuing medical education	6,811	6,843	32	(1,280)	5,656
37,303	Accrued leave	37,173	21,144	(16,029)	130	21,255
4,755	Long service leave & retirement grat.	4,903	4,735	(168)	(148)	4,798
56,371	**Total Employee Entitlements**	56,859	40,259	(16,600)	(488)	42,366

Accrued leave includes provisioning 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).

11. PLANNED CARE

MoH data on Planned Care delivery is provided in the table below. Note, due to MoH timing this is only to December. 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.

Whilst Minor Procedures significantly exceed plan, Inpatient Surgical Discharges (previously known as Electives) are significantly under plan both on a discharge and on a case weight basis. The material shortfall on case weight could have a significant impact on revenue, with the YTD shortfall equating to circa $3.5m. This has not been included in our financial position on the basis that we continue to work with MoH on our recovery plans.

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	3,995.1	1,432.0	5,427.1	4,752.1	87.6%	10,490.0
Inpatient Surgical Discharges	2,746	1,027	3,773	3,327	88.2%	7,298
Minor Procedures	960	338	1,298	2,285	176.0%	2,481
Non Surgical Interventions	0	10	10	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: 2/02/2020 **NNPAC Refresh Date:** 3/02/2020
Data up to: Dec 2019 **Report Run Date:** 3/02/2020

12. 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 January was a $27.7m overdraft.

The cash low point for each month is generally incurred immediately prior to receipt of MoH funding on the 4th of the month. However January's low point was the $27.7m overdraft on 31 January. February's low point is projected to be $28.8m overdrawn on 3 February. Our statutory overdraft limit is currently $32m reflected approval of the 2019/20 Annual Plan.

HBDHB have now applied for equity support as a result of the worsening financial position.

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.

12. CAPITAL EXPENDITURE

Capital spend is largely to plan on locally funded project, but uncertainty around equity funding for strategic projects means we are underspending overall. A number of projects will not progress in any material way until MoH equity funding to contribute to the cost of Radiology Refurbishment and increased cost on Surgical Services Expansion Programme is confirmed. Once confirmation has been received, now expected by end of February 2020 at the earliest, the plan phasing will be reviewed. However we do expect delays on commencing these projects and this will likely reduce the capital spend in 2019/20. If the equity funding is declined, the capital plan will be reviewed and options presented to FRAC and Board.

Given demand for capital exceeds capital available, we have developed some options to ensure capital is expended.

See table on the next page.

2020 Plan		*Year to Date*		
		Actual $'000	*Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
14,465	Depreciation	7,867	8,386	519
7,230	Equity Injection not approved	(1,067)	4,466	4,144
21,695		6,800	12,852	4,663
	Other Sources			
-	Special Funds and Clinical Trials	113	-	(113)
-	Equity Injection approved	695	-	695
-		808	-	582
21,695	**Total funds sourced**	**7,608**	**12,852**	**5,244**
	Application of Funds:			
	Block Allocations			
3,075	Facilities	1,489	1,782	293
2,729	Information Services	1,386	1,467	81
3,642	Clinical Plant & Equipment	2,250	2,183	(67)
9,446		5,126	5,432	306
	Local Strategic			
500	Replacement Generators	-	292	292
-	Endoscopy Building	(3)	-	3
-	Histology and Education Centre Upgrade	(0)	-	0
2,550	Radiology Extension	239	1,487	1,248
700	High Voltage Electrical Supply	428	610	182
2,069	Seismic AAU Stage 2 and 3	187	1,464	1,277
1,500	Seismic Surgical Theatre HA37	230	875	645
200	Seismic Radiology HA27	69	117	48
1,078	MC2D Proc Rm3 Endoscopy HA57	-	580	580
2,681	Surgical Expansion	364	1,305	941
11,278		1,513	6,730	5,216
	Other			
-	Special Funds and Clinical Trials	113	-	(113)
-	Other	26	-	(26)
-		139	-	(139)
	Regional Strategic			
971	Regional Digital Health Services (formerly RHIP)	830	690	(139)
971		830	690	(139)
21,695	**Capital Spend**	**7,608**	**12,852**	**5,244**

13. ROLLING CASH FLOW

The cash flow forecast is the version that accompanied the letter to the Minister's of Health and Finance requesting $8 million of equity (cash) funding (also known as deficit support). Recognising the degradation in our financial position and that the accuracy of our forecast has historically been impacted by material volatility in timing, the forecast is more conservative than previous versions. Where cash flows are uncertain as to timing, a prudent outlook has been taken.

	Actual	January Forecast	Variance	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast
Cash flows from operating activities															
Cash receipts from Crown agencies	50,430	49,859	571	49,238	51,754	49,398	49,234	52,054	49,421	48,961	49,097	56,715	49,485	51,177	50,018
Cash receipts from donations, bequests and clinical trials	72	-	72	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	147	110	36	356	360	354	355	359	461	461	461	460	461	377	363
Cash paid to suppliers	(37,461)	(27,220)	(10,241)	(32,641)	(28,343)	(29,704)	(29,983)	(28,326)	(28,933)	(29,124)	(27,458)	(28,212)	(28,906)	(27,020)	(28,101)
Cash paid to employees	(22,343)	(22,174)	(169)	(18,806)	(18,671)	(22,822)	(19,477)	(20,152)	(23,678)	(18,752)	(18,654)	(22,038)	(19,291)	(18,378)	(26,065)
Cash generated from operations	**(9,155)**	**574**	**(9,729)**	**(1,853)**	**5,099**	**(2,775)**	**128**	**3,936**	**(2,730)**	**1,547**	**3,446**	**6,925**	**1,749**	**6,156**	**(3,786)**
Interest received	(8)	7	(15)	15	15	15	15	15	15	15	15	15	15	15	15
Interest paid	(28)	(15)	(13)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)
Capital charge paid	-	(0)	0	0	0	0	0	(3,862)	(0)	(0)	(0)	(0)	(0)	(3,767)	(0)
Net cash inflow/(outflow) from operating activities	**(9,191)**	**566**	**(9,757)**	**(1,857)**	**5,095**	**(2,779)**	**124**	**70**	**(2,735)**	**1,541**	**3,441**	**6,920**	**1,744**	**2,384**	**(3,791)**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	1	(1)	2	-	0	0	0	-	(0)	0	(0)	(0)	-	(0)	(0)
Acquisition of property, plant and equipment	(848)	(969)	121	(1,371)	(2,446)	(3,102)	(3,297)	(4,010)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)
Acquisition of intangible assets	(240)	(173)	(67)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)
Net cash inflow/(outflow) from investing activities	**(1,087)**	**(1,143)**	**56**	**(1,545)**	**(2,620)**	**(3,276)**	**(3,471)**	**(4,184)**	**(2,073)**	**(2,073)**	**(2,073)**	**(2,073)**	**(2,073)**	**(2,073)**	**(2,073)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	4,185	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	-	(357)	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3,828**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	(10,278)	(577)	(9,701)	(3,402)	2,475	(6,055)	(3,347)	(286)	(4,807)	(531)	1,369	4,847	(328)	312	(5,863)
Add:Opening cash	(18,562)	(18,562)	-	(21,460)	(24,862)	(22,387)	(28,441)	(31,788)	(32,074)	(36,882)	(37,413)	(36,044)	(31,197)	(31,525)	(31,214)
Cash and cash equivalents at end of period	**(28,841)**	**(19,139)**	**(9,701)**	**(24,862)**	**(22,387)**	**(28,441)**	**(31,788)**	**(32,074)**	**(36,882)**	**(37,413)**	**(36,044)**	**(31,197)**	**(31,525)**	**(31,214)**	**(37,077)**
Cash and cash equivalents															
Cash	4	4	(0)	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	(27,654)	(22,503)	(5,151)	(27,490)	(25,015)	(31,069)	(34,416)	(34,702)	(39,576)	(40,108)	(38,739)	(33,892)	(34,220)	(33,909)	(39,772)
Short term investments (special funds/clinical trials)	2,624	2,690	(67)	2,624	2,624	2,624	2,624	2,624	2,690	2,690	2,690	2,690	2,690	2,690	2,690
Bank overdraft	-	669	(669)	-	-	-	-	-	-	-	-	-	-	-	-
	(25,027)	**(14,760)**	**(5,887)**	**(24,862)**	**(22,387)**	**(28,441)**	**(31,788)**	**(32,074)**	**(36,882)**	**(37,413)**	**(36,044)**	**(31,197)**	**(31,525)**	**(31,214)**	**(37,077)**
Cash Low Point (before the 4th of the following month)	(28,841)	(22,863)	(5,978)	(29,072)	(28,577)	(31,549)	(39,575)	(38,446)	(39,886)	(43,412)	(40,929)	(33,927)	(40,352)	(33,909)	(40,132)

14. QUARTERLY REPORT TO THE MINISTER OF HEALTH

Quarterly Report to the Minister of Health

Quarter Ended 31 December 2019

Description	*This Year*	*Last Year*	*Variance*	*Var %*
FTEs	2,560	2,453	-108	-4.4%
	$'millions	*$'millions*	*$'millions*	*%*
Personnel Costs	61.1	54.6	-6.6	-12.1%
Outsourced Personnel	2.7	2.2	-0.6	-26.3%
Provider Arm Expenditure	97.3	91.7	-5.7	-6.2%
Expenditure on Community Provider Contracts	64.0	59.8	-4.2	-7.0%
Actual Capital Expenditure	4.2	4.1	-0.1	-3.3%

FTEs (108 increase)

Includes:	FTE
• Increase in Medical Personnel driven by RMO run-rate review and other recruitment;	21
• additional nursing resources relating to patient demand and acuity across most clinical areas, largely as a result of CCDM and NZNO settlement;	59
• net increase in actual allied health, there is significant difficulty recruiting and a number of approved positions vacant;	11
• increase in Operations as a result of increasing work loads in support of clinical staff, additional hours worked by kitchen assistants (volumes of meals), orderlies and security (patient watches);	11
• other increases including 6 additional FTE related to capital projects largely as a result of investment in Information Systems and structural change in Primary Care. There was a net zero increase in Corporate FTE.	6

Personnel Costs ($6.6m increase)

Includes:	$'m
• increases in employee pay rates from MECA settlements, partially MoH funded;	3.8
• additional staffing (see FTEs).	2.8

Outsourced Personnel ($0.6m increase)

Includes:	$'m
• increases in vacancy and leave cover;	0.5
• increases in additional sessions (SMO)	0.1

Provider Arm Expenditure ($5.7m increase)

Includes the $6.6m of personnel costs and the $0.6m of outsourced personnel noted above, partly offset by contingency budgets.

Expenditure on Community Provider Contracts ($4.2m increase)

Includes:	$'m
• increases in community pharmaceutical costs;	2.0
• increases in PHO payments for free after-hours and very low cost access services	0.9
• increases in residential care and home support;	0.6
• increases in capitated primary practice payments	0.4
• increase in mental health residential care, home support and child & youth services	0.3

Actual Capital Expenditure ($0.1m increase)

Expenditure is below plan this year as a number of projects will not progress until equity funding for the radiology extension is 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 2 of the 2018/19 and Quarter 2 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:	Chris Ash, Executive Director of Planning & Funding
Document Author:	Chris Ash, Executive Director of Planning & Funding
Month:	February 2020
Consideration:	For Noting
RECOMMENDATION **That the HBDHB Board** 1. **Note the contents of the report.**	

EXECUTIVE SUMMARY

- Annual Planning process remains on schedule, with focus currently on detailed work to respond to Ministry of Health expectations
- Feedback around the need for more person and whānau centred booking and scheduling processes, responsive to the needs of rural communities, has been the most consistent theme from the community whakarongo hui process in Wairoa
- The Central Hawke's Bay Maternal and Child Health Hub will be formally opened at Cook Street Medical Centre in March 2020

DEVELOPMENTS & INNOVATION

2020/21 Annual Planning Process

A Board workshop was held on 27th January to provide an initial steer on prioritisation for the 2020/21 plan. General agreement was reached on the basis for the areas identified by management, but with a requirement to apply extra focus on how, and how quickly, the plan would secure measurable gains in the areas of both access and equity.

Since the workshop, verbal items have been presented at Māori Relationship Board (MRB), Clinical Council and Consumer Council. All forums have provided clear indications of what they would like to see as the plans are developed over the coming months.

MRB	• He Ngākau Aotea is a foundational document and should frame the way in which the plan is constructed • Importance of the whakarongo process with our communities to shape the content of actions across the plan, not just the identified priority areas • Clear and credible action is needed to accelerate the provision of kaupapa Māori service delivery • Plans need to articulate how the health system will invest in communities to transfer power to whānau (tino raratiratanga)
Clinical Council	• Plans must address the highest clinical quality and safety risks in the system • Actions should be based in what is realistic and feasible • Addressing acute demand is a significant priority

Consumer Council	• Explicit actions are needed to bring Person and Whānau Centred Care to life in a measurable way

Clinical and Consumer Councils both questioned where in the planning cycle the opportunity exists to shape the final planning recommendations brought by management before the Board. A process to achieve this is being designed and will be agreed with Council chairs by the end of February.

Since the January workshop, the Planning Team has been facilitating the detailed work needed to respond to the requirements in the Ministry of Health Planning Guidance, ahead of a first draft of the Annual Plan due on 2nd March. The process to develop and/or refine detailed actions for the first cut annual plan will involve the Planning & Funding directorate facilitating at least ten individual workshops over a three-week period. Each of these sessions will involve up to 20 contributing attendees, selected from across clinical and corporate services within the DHB.

With the first draft of the Annual Plan completed, the next formal milestone in the planning process for 2020/21 will be the Health Sector Leadership Forum on 4th March. This will be an opportunity to revisit prioritisation in the context of the 10-year health system strategy (Whānau Ora, Hāpori Ora).

Whakarongo Hui

The DHB continues its programme of community whakarongo hui, the most recent a visit to the community of Raupunga on Thursday 13th February. This initiative has been jointly led between Planning & Funding and Māori Health and is central to the delivery of our commitments under Whānau Ora, Hāpori Ora. To date, all sessions have been well attended and lively discussions that have delivered insightful and increasingly consistent messages for the health system.

Respectful observance of tikanga and deliberate steps to honour both the manaakitanga and the koha of the stories shared by those present are critical factors. For example, each hui has been attended by at least one Executive Director and, since the new Board has come into office, one Board member. The team from the health system will respond to questions or points of clarification but, as the primary purpose is to listen to the views and perspectives being shared, most of the talking is done by the tāngata whenua. Work is therefore taking place to document the approach, so that as we roll it out into 'business as usual' the concept remains true to these intentions.

Wairoa

The co-located general practice offer from Wairoa Health opened at the beginning of December and is now 3 months into operation. The DHB site team are working closely with the operators, Queen Street Medical, to iron out any teething issues (for example, around the phone system) as the services settle into their new home. The changes have, however, resulted in a very different feel on the site – a significantly increased footfall, a 'one team' approach that was not achieved when two separate operators shared the same space, and great opportunities for clinical communication and integration with the surrounding services in the hospital.

In the last three months, DHB Provider Services has taken great steps to strengthen clinical leadership on the Wairoa site. A new Clinical Nurse Manager has been appointed who brings experience of both trauma care and rural service provision. Importantly, a senior GP from the practice has been appointed into a Clinical Lead role. She is working closely with DHB leadership to identify options for a sustainable clinical model into the future that can be developed in partnership with the community.

The programme of whakarongo hui in the communities of the Wairoa district continues, with the next planned for Wairoa town on the evening of 26 February. The stories shared by those who have attended reflect a number of consistent themes – some of which are amenable to immediate action,

others which need to be built into the approach we take to co-designing the future health system with local communities. To date, the most frequently recurring themes have been:

- Booking processes not responsive to the needs of rural communities, with issues including scheduling in line with transport, late notice cancellations, and poor communication.
- Whanau not consistently aware of what services are available, with a lack of coordination or navigation support for people with complex needs
- Very rural communities experience significant access barriers to core primary healthcare services, including pharmacy and dental care

It is worth noting that the issue of booking processes has been the most specific and recurrent theme in feedback received to date. Priority focus on developing a person and whanau centred booking system, amenable to rural need, would be the single highest impact action that could address what has been heard to date.

The DHB remains a committed partner around the Wairoa Community Partnerships Group table, with the Executive Director Planning & Funding sitting on this forum. The DHB has recently supported a collaboration between local nannies and Enabled Wairoa to develop a community respite service for grandparents and whānau dealing with the impacts of methamphetamine, which received positive media coverage.

COMMISSIONING PORTFOLIOS – EXCEPTION REPORTS

Primary Care (Health Hawke's Bay Back-to-Back Agreement)

- Free After-Hours Primary Care (Under 14s). This service is currently contracted by Health Hawke's Bay in Hastings, Central Hawke's Bay and Wairoa, but directly between the DHB and a single provider in Napier. This has resulted in differential levels of choice for these populations and, as a result, some whānau paying to have their child seen after hours. Prior to Christmas, the DHB confirmed the total revenue it receives from the Ministry of Health for these services. Health Hawke's Bay were informed of this and the DHB's intent to contract, via the PHO, to a single model across all areas of Hawke's Bay. The Planning & Commissioning Manager is currently awaiting a proposed service model from Health Hawke's Bay to enable this to be progressed.

Child, Youth & Dental

- Central Hawke's Bay Maternal & Child Hub. This development provides a space for mums and their babies to get support, services and aroha when they need it. The project has been community-led and DHB-supported, with significant involvement from partners such as local Lead Maternity Carers (LMCs) and the Parenting Centre. The Royston Trust has also funded a brand-new antenatal scanning machine for the facility. Operational from mid-February, the formal opening will take place in March.

FINANCIAL PERFORMANCE

The directorate finished Month Seven $984k adverse, and $3,494k adverse year-to-date.

- The result included a further adjustment on PHARMAC. Work is ongoing to isolate the main influencable factors within wider spend on pharmaceuticals and dispensing
- The consistent run-rate of ~$200k adverse within Health of Older People was impacted in-month by delayed invoicing, which accounted for a total in-month adverse variance of $375k
- Further work is being undertaken to understand month-to month variation in capitated services spend within the primary care portfolio.

HAWKE'S BAY District Health Board Whakawāteatia	Provider Services Monthly Report
	For the attention of: HBDHB Board
Document Owner	John Burns, Executive Director of Provider Services
Month/Year	February 2020
Reviewed By	
Purpose	Update HBDHB Board on Provider Services Performance
Previous Consideration/Discussions	Provider Services Monthly Report to the Board, December 2019

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. Note the content of the February 2020 report.

Key issues arising this month include:

BED PLANNING

A Hawke's Bay Hospital working group of senior managers undertook extensive bed planning leading into December 2019 - January 2020 to allow nursing and medical staff to take well-earned leave.

Using data analysis from the past three years it provided the basis on which to proceed as it showed patient demand should decrease in the latter part of November 2019 and continue through into February 2020.

The predicted decrease in activity did eventuate but for a very short period, and unexpected increase in patient demand for inpatient services continued from mid-December and throughout January 2020.

This continued demand has places significant pressure on staff, particularly nurses. To manage this situation, it has been agreed additional staff can be employed to cover extra workload and to prepare for the coming expected high demand winter period. This will allow for the recruitment lag of nursing staff, which generally takes approximately three months to recruit and orientate.

In order to improve the efficiency and patient management a review of bed allocations between Directorates was undertaken. The outcome of this review was a surgical ward (A2) will be assigned to the Medical Directorate.

EMERGENCY DEPARTMENT PRESENTATIONS

Emergency Department presentations show a reduction both in monthly and year-to-date (YTD) figures, there has been a slight growth in the acute cases and a significant reduction in less acute cases.

ROYSTON HOSPITAL UPDATE

Early this financial year Royston Private Hospital advised they would not have the capacity to accept referrals except for Orthopaedic cases. This restriction lasted for approximately four months and required the hospital to accommodate the cases in-house. Outsourcing to Royston has recommenced while discussions on the pricing structure with Royston continue. A meeting is scheduled for 20 February 2020 between Royston's CEO and General Manager and the CEO and COO of HB Hospital.

RENAL UPDATE

It is pleasing to report that all patients who need to be seen have been booked and will be seen by the end of February 2020.

ESPI2 – Outpatient Referrals waiting longer than 4 months

The goal of this program is to have all 19 out-patient departments with no referrals waiting longer than four months for their first specialist assessment (FSA).

Of the 19 specialities nine are now compliant, four are close to compliant and six are working towards compliance.

ESPI5 – Patients accepted for surgery are operated on within four months

In early 2019 the Board set a target of having zero patients waiting longer than four months by 31 December 2019. In February 2019 there were 539 patients overdue four months.

The number of overdues was largely due to extended sick leave of surgeons and vacancies in the anaesthetic department. The majority of the anaesthetists vacancies have now been filled and the surgeons have returned to work following sick leave so progress should be made in reducing the number of breaches. We expect to show the Board progress in next month's report.

OPHTHALMOLOGY

Over the past six months considerable attention and effort has been made to reduce the number of people waiting for ophthalmology appointments. It is pleasing to report that the number of people waiting has been reduced significantly and by June 2020 will expect to be back at Ministry guideline levels

FINANCIAL RESULT

The unexpected demand on hospital services over the summer period meant a number of additional staff were needed to resource additional beds required, this also impacted on pharmaceutical and clinical supply costs.

HAWKE'S BAY District Health Board Whakawāteatia	**TE PUNI TŪMATAWHĀNUI - HEALTH IMPROVEMENT & EQUITY DIRECTORATE | QUARTER TWO REPORT**
	For the attention of: **HBDHB Board**
Document Owner:	Patrick Le Geyt (Acting Executive Director, Health Improvement & Equity
Document Author:	Patrick Le Geyt (Acting Executive Director, Health Improvement & Equity
Month:	February 2020
Consideration:	For Noting

RECOMMENDATION

That the HBDHB Board

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

EXECUTIVE SUMMARY

This is the first quarterly Board report (2nd quarter 2019/20) from the Te Puni Tūmatawhānui, the Health Improvement and Equity (HIE) Directorate. The HIE Directorate was established in July 2018. The prime responsibility of the Directorate is to lead the health sector to progressively eliminate health inequities from within the Hawke's Bay. The Directorate accomplishes this through:

- Working collaboratively across all levels with multiple agencies to improve health outcomes for the Hawke's Bay Māori, Pasifika and high needs communities
- Leading the health systems response to the challenges identified within the inter-agency strategy, bringing together councils, MSD, education, iwi and other agencies to provide greater focus on health improvement and equity
- Developing and applying an equity framework to commission and deliver equitable health outcomes for Māori, Pasifika and other high needs populations
- Building of the health sectors' cultural competency and capability
- Ensuring that all the legislative requirements in regards to health protection e.g. drinking water standards are met and adhered to

HEALTH IMPROVEMENT AND EQUITY DIRECTORATE SERVICES

The Health Improvement and Equity Directorate has been established across a range of service areas, being Māori Health, Population (and Public) Health, Pacific Health and Intersector & Special Projects.

Māori Health Services covers a broad range of DHB activities from strategic to operational levels. It consists of two relatively small teams - Māori Health Improvement Team and Māori Health Operations Team – and attempts to influence the HBDHB's responsiveness to Māori stakeholders and consumers by focusing on:

- Māori stakeholder and community engagement
- Health equity system development, support and performance monitoring
- Māori health service commissioning and provider development
- Workforce development, including cultural safety
- Hospital based social support services

Within Te Puni Tūmatawhānui, the Population Health team have specific functions delivered out of the contract with the Ministry of Health and set out in the Population Health Annual Plan including:

- Health Promotion
- Prevention of Harm from Alcohol and Other Drugs
- Tobacco Control
- Supporting Improvement of Social Environments
- Environmental & Border Health
- Control of Communicable Disease
- Immunisation
- Well Child Promotion
- Workforce Development & Quality

The Pacific Health team continues to provide strong in-patient and community support for Pacific people as well as engaging in training to support better service delivery by services to Pacific fono. Their key focus areas include:

- Engaged Pacific communities
- Enhancing DHB and health services understanding of Pacific people
- Promoting the value of the Pacific health workforce
- Targeted initiatives to positively improve Pacific health outcomes

As a district health board, some of our biggest gains in reducing health inequities will come where we impact on those social determinants of health, the predominant areas being; housing, education, employment and economic development. The Intersector & Special Projects team have worked to develop sustainable relationships across existing and new service delivery areas focusing significantly on the determinants of health, which sees a greater focus on housing and economic development in particular, such as Matariki - Regional Economic Development Plan.

Highlights

- All eight month immunisation targets achieved across all ethnicity and deprivation groups.
- Cervical screening rates improved across all ethnicity groups. Hawke's Bay has the highest rates in the country (jointly with Wairarapa).
- HBDHB Health Equity Framework was developed and approved by the HBDHB Board in the second quarter of 2019/20. The purpose of this framework is to support the DHB to reallocate resource and develop the organisational processes that will deliver on our equity obligations to the Hawke's Bay community. The HIE Directorate is proposing to lead a process of organisational equity self-assessment, priority setting, and the development of an equity action plan. This project will deliver an equity action plan, using an organisational equity assessment against the core change principles in the Health Equity Framework.
- The Tuakana/Teina summer internships initiative saw seven medical/health science students join the Māori Health team, contributing their knowledge and skills to complete nine projects, each contributing to improving Māori health outcomes.
- Rangatahi Service Redesign Service Level Alliance (SLA) enabled rangatahi project workers to lead out on the consultation and service model redesign for youth health services in the HBDHB region.
- The Pacific Health team coordinated the highly successful Step Up for Samoa Measles fundraiser on 20 December 2019, bringing together Pacific entertainers and the wider community to support the measles effort in Samoa.
- First Water Safety Plan (for Hastings) under the new assessment framework has been received – we are likely to be the first in the country to approve a plan under the new framework.
- Haumaru Whānau team have implemented a suicide prevention pilot in collaboration with the Police and three local community providers initially for the Christmas/New Year period. The aim of the pilot was to support individuals and families/whānau who have experienced 'near miss' self-harm episodes, with a view to wrapping immediate supports around the individuals and their whānau/family.

- The Intersector and Population Health teams gained funding as part of the place based and urban development pilot. The initiative, launched by the Minister for Māori Development sees funding being provided to reduce overcrowding in whānau owned properties.

CROSS DIRECTORATE SERVICES REPORTING

Health Indicator Performance

Child Immunisation (8 months) - Target 95%: **All 95%= Māori 95%↑ Pacific 97%↑** (3 month cohort Dec 2019)
The measles outbreak has supported awareness raising about immunisation which created an increase in workload coordinating distribution of MMR vaccine and managing queries around immunisation. The HBDHB Occupational Health Service has finally achieved cold chain accreditation. There continues to be areas within the DHB where cold chain accreditation has not been achieved. The MoH announced in December 2019 access for the ability for unimmunised Pacific temporary migrant workers, including those on the RSE scheme to access MMR immunisation.

Smokefree

Primary care enrolled patients SBA - Target 90%: All 69.2% ↓ Māori 66.1% ↓ Pacific 64.4% ↓ (Q2)
Secondary care SBA - Target 90%: **All 99%** ↑. No other data captured

The Primary Care contract with the PHO has only been running since late November 2019 and is too early to tell if their new system will be effective. Liaison with PHO Managers to access data as it becomes available. Currently awaiting first round of reporting. DHB Smokefree Co-ordinator meeting regularly with PHO to maintain strong engagement. Smokefree Service continues to support clinicians and staff with smokefree education. Frequent audits of patient files where smokefree breaches are identified reminds clinicians of SBA responsibilities.

Screening

Cervical screening participation - Target 80%: All 74.5% ↑ Māori 74.9% ↑ Pacific 75.4% ↑, Asian 60.3% ↑ (Nov 2019)
Note there is an increase population growth of 13% across New Zealand; participation has only increased across New Zealand by 7% - participation rates across New Zealand are falling.

Discussed with Kahungunu Executive to provide a monthly cervical screening clinic in Wairoa, and this will commence in February 2020. A Māori Co-ordinator has been seconded to assist in increasing Māori participation. Working with three general practices; Heretaunga Health, Hastings Health Centre and Totara Health on their Karo Cervical Screening report which shows mismatches between the NCSP-Register and their PMS.

Breast screening participation - Target 70%: **All 73.2%, Māori 70.1%,** Pacific 68.3%, (October 2019)
Commenced preparation for the BSA Mobile visit to Central Hawke's Bay early March 2020.

Bowel screening participation - Target 60%: **All 65.9%↓,** Māori 49.9%↓, Pacific 51.4↓% (September 2019)
We have seen a slight decrease in NBSP participation, this remains above target; both Māori and Pacific participation rates have also decreased. Discussions continuing regarding contracting for community engagement and outreach.

Māori Health

Memorandum of Understanding with Ngāti Kahungunu Iwi Inc

HBDHB Māori Health and Ngāti Kahungunu Iwi Inc are currently reviewing the Memorandum of Understanding (MOU) between both parties. The MOU needs to be refreshed and inclusive of the WAI2575 Kaupapa Health Inquiry findings, Post Treaty Settlement Group environment in the Hawke's Bay region and the Māori Relationship Board terms of reference and committee makeup.

HBDHB Health Equity Framework

The purpose of this framework is to support the DHB to reallocate resource and develop the organisational processes that will deliver on our equity obligations to the Hawke's Bay community under te Tiriti o Waitangi and the Health and Disability Act.

The framework is a modified and localised version of the Institute of Health Improvement (IHI) equity framework for health care organisations. It consists of five core change principles that need to be applied throughout the organisation to achieve health equity. These principles, which are based on international best practice, are designed to reallocate resource and concentrate actions around things we know will have the biggest impact on achieving equitable health outcomes. It is also designed to make sure we are taking a 'whole of systems' approach to improving health inequity.

The five core change principles are:

- Make health equity a strategic priority
- Develop structures and processes to support health equity work
- Deploy strategies to address the multiple determinants of health
- Eliminate institutional racism within the organisation
- Develop partnerships with community organisations

Figure 1: The Hawke's Bay Health Equity Framework

The HIE Directorate is proposing to lead a process of organisational equity self-assessment, priority setting, and the development of an equity action plan. This project will deliver an equity action plan, using an organisational equity assessment against the core change principles in the Health Equity Framework. The equity action plan will be focused around reorienting organisational systems to deliver on our health equity commitments.

An organisational equity assessment is an internal review looking at how well we are currently performing against the principles of the Health Equity Framework. It is designed be completed biannually, contributing to a cycle of continuous organisational improvement. The scope of the review includes all aspects of the DHB including governance, management and provider-arm functions.

The purpose of this first review is to:

- Assess the readiness of the organisation to implement change
- Identify systems-focused priority actions for organisational equity development (which will then translate into an equity action plan)

- Provide a baseline assessment, against which change arising from the Health Equity Framework can be monitored over time

An assessment tool (Appendix One), consisting of a series of organisational indictors against the Health Equity Framework, has been developed by the Health Improvement and Equity Directorate and will be the basis of the organisational equity assessment. These indicators have been developed through consensus by a core project team and are based on international best practice and HBDHB strategic documents (Whānau Ora Hāpori Ora and the Clinical Services Plan).

The Health Improvement and Equity Directorate are developing an organisational equity assessment toolkit to support future organisational equity assessments. However in the interim, a baseline assessment is planned for March/April 2020 with data collection being undertaken in a three tiers process:

- Online self-assessment survey completed by all executive directors, third-tier managers, and clinical directors, and commissioning managers
- Key informant interviews with key senior managers
- Review of key organisational documents and policies

The output of the organisational equity assessment will be a report assessing current performance against the Health Equity Framework and identifying priority areas for improvement. This will be used to benchmark current performance and as the basis for developing a set of equity actions that each directorate are committed to undertaking, with a two-year timeframe for delivery on actions.

Kaupapa Māori Health Service Redesign Projects

The HBDHB strategic direction 2019-2029 sets out a vision of 'whānau ora, hāpori ora' by creating a health system that works together to deliver whānau centric, kaupapa Māori models of care, that are equitable, integrated, and wellbeing focused. By reorientating current resources, Māori Health are working on a number of service changes to meet this strategic objective.

Kaupapa Māori Maternal Health (First 1000 Days): Māmā Māori and their pēpi have poorer maternal and child health outcomes than non-Māori mothers and their children. This approach seeks to contribute to the delivery of high quality maternity care and support to ensure māmā Māori and their pēpi receive the care they need. The key objectives of the service in terms of benefits to Māori mothers, fathers, and caregivers and their whānau are a service that provides access to:

- pregnancy and parenting advice, support, and care
- health and social support
- mental health and relationship counselling support
- cultural support
- programmes delivered upon te ao Māori principles and practices
- services in the home and a community based facility

Māori Health are working with providers in Wairoa and Napier to codesign and implement this service from July 2020.

Kaupapa Māori Oral Health Services: Māori experience greater inequities in access to dental care and disproportionate oral health outcomes across all age groups compared to non-Māori. The redesign of the oranga niho service presents an opportunity to align with this strategic vision by strengthening oral health care as an integral part of the health landscape and to explore new integrated models of oral health care. The key objectives of the service in terms of benefits to the service user are:

- A service that provides essential dental care to enable whānau to be and stay 'orally fit'
- A service that values good oral health across generations by focusing on the whole whānau
- A service that is culturally relevant and responsive to whānau Māori
- A service that is integrated to ensure wider health needs of whānau are met

The service will deliver Packages of Care across Wairoa, Napier, Hastings and Central Hawke's Bay as outlined below:

- Develop oral health plans for individuals and their whānau
- Carry out dental treatment according to the oral health plan
- Discharge whānau to a community dentist upon completion of their respective oral health plans
- Deliver an integrated approach with primary health care to ensure any unmet health needs are addressed
- Provide a strong focus on oral health education, promotion and prevention
- Ensure a culturally and clinically competent workforce

HBDHB will release a Request For Proposal (RFP) in March 2020 with service implementation commencing October 2020.

Integrated Care Teams: Ambulatory Sensitive Hospitalisation (ASH) rates are an indicator of unmet health needs at primary care levels. For some time the HBDHB has experienced unprecedented demand in the form of emergency department presentations and amenable hospitalisations. More needs to be done in primary care to reduce the demand, especially for Māori, Pacific and older people.

The Clinical Services Plan (CSP) and Whānau Ora Hāpori Ora Strategy establish a firm commitment to prioritising and designing services to meet the needs of populations with the poorest health and social outcomes. Māori prefer holistic approaches when addressing illness and health and Integrated Care Teams (ICT), a key theme from the Nuka System of Care (Primary Care), are the preferred model for providing integrated health and care services in primary care centres and the community, co-ordinating with a range of other services. The relationship between Māori providers and Primary Care are critical to the development of a unique Hawke's Bay integrated care model. Māori providers play a highly important role of engagement with whānau and communities who do not necessarily respond to traditional health care system approaches.

Māori Health and Health Hawkes Bay PHO are pooling resources to implement ICT between Māori health providers and Primary Care providers (GPs). The role of Māori providers is the Home Visiting team, outreach primary care nurses and health coaches that extends care and support into whānau homes and other community settings. These teams will work with an identified cohort of consumers with an in-practice team of GP, Practice Nurse, Health Care Assistant and Behaviourist/Primary Mental Health. This approach will be rolled out in Wairoa and Hastings in early 2020 with practices and providers in Napier on boarding late 2020.

Rangatahi Service Redesign Service Level Alliance

The Rangatahi Service Redesign Service Level Alliance was led by rangatahi project workers with support from Māori Health and Planning & Funding. They developed an innovative Instagram rangatahi survey, Pacific youth survey/focus groups, and rangatahi Māori focus groups with a combined total of over 700 responses/voices recorded. Rangatahi feedback shows support for a model of care where rangatahi feel services 'know' them, can be 'trusted', and make them feel 'safe'. Based on these requirements, it is proposed that Te Pītau support a model of care for rangatahi that is:

1. Fixed and flexible
2. Integrated and co-located with social providers
3. Strong in cultural foundations
4. Rangatahi-led and delivered wherever possible
5. Inclusive of health programmes that are impacting most on rangatahi wellbeing

Tuakana/Teina summerships – growing the future Māori workforce

The HBDHB has a dedicated Māori Workforce Development Action Plan 2018-2023. The HBDHB also has a Māori workforce development programme called Tūruki, and is working towards increasing the total Māori health workforce to meet population need, and to increase the skill mix of Māori health professionals. Efforts to grow the future Māori health workforce have been strengthened through the success of the Tuakana/Teina summership programme.

The initiative saw seven medical/health science students join the Māori Health team, contributing their knowledge and skills to complete nine equity projects, each contributing to improving Māori health outcomes. The summer internship initiative demonstrates an innovative approach to growing the capacity and capability of the future Māori workforce and of establishing career pathway opportunities that will support Kahungunu hoki mai – their return home.

Te Ara Whakawaiora

The HBDHB is strongly focused on improving equity for Māori, Pacific and high needs communities that experience poorer health outcomes. The Hawke's Bay Health Equity Report clearly demonstrates that Māori do not experience the same health status as non-Māori. In 2014, the HBDHB Māori Health Service introduced Te Ara Whakawaiora (TAW), a Māori health equity improvement programme to provide special focus on quality improvement against a range of national and local health indicators where significant inequities exist between Māori and non-Māori.

By appointing DHB Executive Management Team (EMT) "Indicator Champions" to provide technical support to "Indicator Leads" in the implementation of activities in the plan, it was intended to create faster traction in achieving the annual Māori health targets, and reduce health disparities. The Indicator Champions were tasked to provide the HBDHB Board with six monthly TAW reports on the implementation progress of activities under these indicators along with recommendations for improvement.

The TAW performance reports are provided quarterly and focus on the areas of; child health, workforce development/cultural competency, mental health and adult health.

In November 2019, the Māori Relationship Board responded to the report for adult health, with the following key points noted for each area.

1. ASH rates for Māori adults across all specialties have increased in the Hawke's Bay, higher than both the national and local Pacific rates (age standardised). As the report stated, this means that there should be greater equity focus on ASH-related activities if we are to impact significantly on a specialty by specialty basis. Access rates for all specialties should be reviewed including; cardiology, respiratory conditions and cellulitis.
2. Coronary heart disease remains the top cause of Years of Life Lost in the Hawke's Bay and are a headline objective within the Hawke's Bay Health Strategy 2019-2029. In the five years to 2018, 80% of Māori were CV risk assessed against a target of ≥90%. To August 2019 this had fallen slightly to 78.3% compared to 83% for others, who had also fallen. The HBDHB delivery of services in the area of CVD are below minimum standards, and while we are seeking to employ more technical staff to improve this area, this still remains challenging. While we seek to improve early detection and treatment for these diseases, prevention remains the most successful intervention for these issues.
3. Smokefree remains a significant contributor to amenable mortality. Work being undertaken in this area originates out of the Smokefree national target work. We currently have almost 50% of all Māori women who are pregnant smokefree, which is a significant distance from the national target of ≥90%, but on a growth trajectory. This improvement has occurred due to better early intervention by all health professionals, some marketing work that is occurring that focusses directly on Māori mothers and utilisation of social media to target Māori women directly, getting them engaged onto smokefree programmes. This has been further enhanced by incentivising mothers and providing them with courses and support to increase their knowledge of what better parenting might look like.

The Māori Relationship Board made the following recommendations to the Board:

1. Accept recommendations from the report and actively work to address equity in the next 12 months.
2. A working group made up of population health, primary care, leads within the medical directorate and Māori Health plan to inform the activities and measures that will inform activities and indicators within the annual plans of both primary and secondary services, the SLM and TAW plan for the 2020-21 cycle.

Population Health

Alcohol Harm Reduction

As part of delivering the Alcohol Harm Reduction Plan we have been working with Hawke's Bay Go Bus (Regional Transport) to remove all alcohol advertising from their buses and create a range of alcohol free events. This has resulted in specific branding being developed with a clear communications plan being implemented. Hopu te Kōrerorero alcohol harm reduction festive season campaign sought to provide support for organisations who wanted advice in hosting more alcohol free/responsible events. This was supported by staff from the team, with an evaluation report being prepared. We have been working with the Emergency Department and Business Intelligence teams to develop better data related to ED attendances where alcohol has been a factor. This reporting is required to be provided to the Ministry of Health and Youth SLM and will lead to development of professional development programmes for frontline staff in how to better deal with alcohol related harm issues.

Suicide Prevention

This cross-directorate work has been jointly led by the Māori Health and Intersector teams through the Haumaru Whānau team. To date, we have revised the Suicide Prevention Actions 2020 to align with He Tapu Te Oranga O ia Tangata – focusing on place based upstream approaches to reduce the potential for self-harm. This has culminated in the collective Suicide Prevention Community Pilot currently being implemented and described earlier. This will also feed into the revamping of our organisational family harm approach, which has been picked up by this Directorate for review and consideration. While this has been presented to the Māori Relationship Board, the final version has yet to be completed for consideration at a Governance level.

Child Health

This programme of work is a combination of child health action areas across a range of activities, led by Māori Health, Child, Women and Community and ourselves. The Tuai Kopu programme supports hapū mama to access health care services and practitioners in a whānau centric way, in alignment with our 'whānau voice' approach to providing services. We recently appointed a co-ordinator to bring services up to speed with the project objectives.

The Best Start Healthy Eating and Activity Plan is under review, with the aim to provide better support and guidance to ECEs and Kohanga Reo in terms of nutritional advice. As an update, there have been no new cases of Rheumatic Fever, with the school based swabbing programme still being delivered out of Flaxmere Schools.

Drinking Water

The Hastings District Council have submitted a new Water Safety Plan under a new framework for assessment which is taking a substantial amount of time to process compared to the previous method of assessment.

Environmental Health

The weekly recreational water summer monitoring programme is continuing. Public health warnings for microbiological exceedance have been issued for Waipatiki Beach lagoon, Nuhaka and Wairoa rivers. Algal Bloom warnings have been issued for six sites in our region.

Communicable Disease

Immunisation staff have assisted the Child Health team with measles contact tracing after hours and during the Xmas/New Year period. An investigation in conjunction with the Ministry for Primary Industries was undertaken regarding a disease outbreak at a local eating establishment.

Intersector Development

The Intersector team is a newly formed team, commencing activities from July 2019. To date the appointment of a Manager (Henry Heke, Head of Intersector Development & Special Projects) has enabled the team to establish a work programme and work towards achievement of its various performance indicators. Areas for specific focus for the team have included:

Intersector Framework
A stocktake has been developed to identify all work being undertaken by the DHB with regards to intersector work and how that might align with shared information about key contacts and purpose for intersector meetings, groups and relationships. This work is informing how the team will cover across the various sectors and bring health knowledge and focus. To date those areas include; housing, social development, local government, suicide prevention, oral health, Māori development and local economic development.

Matariki - Regional Economic Development Strategy
A key component of the work for the Intersector and Special Projects team is support for the implementation of the above cross-sector programme. As the single largest collective of social agencies, councils and business representatives across the district, this forum has the greatest potential for implementing cross-sector action. The team is currently supporting development of two sections (Pou) of the action plan, those being the health and social services section and the community leadership sections of the plan. This will result in a far clearer set of actions being identified for the team to carry out.

Pacific Health

Hospital Based Support Services
The Pacific Health team have for the second quarter been balancing their focus on DNA and bowel screening outreach work, along with a spike in complex cases that has required in-depth support. These complex cases included; three palliative cases, birth of triplets and a bowel cancer colonoscopy. All cases have included Fanau Ola approaches as some of the families required support to transition between services, housing, social welfare and health literacy needs. We are supporting elders who require support to inform and transition smoothly between services while supporting medical staff and other agencies to support each case.

DNA Targets 5.8%: **All 5.8%,** Pacific 15.2↓
Pacific DNAs increased over the November and December 2019 period due to high demand for Pacific support services in the community and a seven-day notification period for the team. We are working with booking services to receive referrals in a more timely fashion. Bowel screening targets have not been achieved due to the additional workload (noted above). A targeted approach for December was more successful and will need to continue into 2020.

Community Engagement
The Step Up for Samoa community engagement was hosted by the Pacific community, supported by Pacific Churches, Hastings District Council, health and social service providers (including the Health Improvement and Equity Directorate) and local Pacific businesses. All Pacific leaders acknowledged the need to bring the various Pacific communities together on a regular basis, to promote issues (including health issues) across the community. Unfortunately, while measles focussed health messages were shared at the event we were unable to vaccinate on-site. Future events should include the ability to promote and offer health checks, including at events and forums and this is currently being coordinated with the health sector for the next major Pacific community event; the Hawke's Bay Secondary School Cultural Festival on 4 April 2020. Planning is also underway for influenza immunisations in the community with Pacific elder groups during May-July 2020.

Cultural Competency Training
The Engaging Pasifika Workshop training was recently delivered to hospital based social workers and community dieticians with both sessions being well received. Feedback and evaluations will inform Pacific actions for annual planning purposes. The current programme has been revised in consultation with Hutt Valley DHB with the subconscious bias section removed. While Engaging with Pasifika training courses have successfully raised awareness, removal of the subconscious bias section reduced barriers towards targeted actions, specifically for Pacific that will make a difference.

We wish to acknowledge and are grateful for the input of managers and staff for releasing staff to attend these sessions. Delivery of the course is both refreshing, challenging and eye opening, allowing staff to share their challenges, enabling us all to come together, provide opportunities to examine actions and processes moving forward.

Pacific Youth Survey
As part of the Pacific Health Leadership Group action areas, a survey of Pacific youth has been developed and carried out which identifies what their aspirations and concerns are growing up in the Hawke's Bay. This has resulted in a document being developed which we are currently working on with Hawke's Bay school principals, with a view to delivering these findings to the PHLG early 2020.

FINANCIAL PERFORMANCE

The Health Improvement & Equity Directorate was noted as favourable in the last quarter to December 2019.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

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Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**
	For the attention of: **HBDHB Board**
Document Owner:	Ana Apatu (MRB Chair)
Month:	February 2020
Consideration:	For Information

Recommendation:

That HBDHB Board:

1. **Note** the content of this report.
2. **Adopts** the recommendation to adopt a thirteenth strategic priority of investment into primary care and Kaupapa Māori models of delivery.

MRB met on 12 February 2020. An overview of issues discussed and recommendations at the meeting are provided below.

INTRODUCTIONS

Shayne Walker, HBDHB Chair, addressed MRB challenging members of the need for leadership from MRB to challenge and to provide solid recommendations, advice, guidance and direction to the Board to address health inequities within the Māori community.

Ana Apatu chaired the MRB meeting and acknowledged Heather Skipworth for her leadership as the former chair of MRB. Heather thanked members for their support during her tenure as Chair.

MRB WORK PLAN

The MRB 12 month workplan was discussed. The MRB workplan is where MRB have the ability to influence and provide recommendations to the Board on significant health inequities within Māori communities. Therefore members discussed future items for the workplan.

- Methamphetamine was highlighted as an area that has not had much DHB coverage or attention but which has had a significant impact in Māori whānau and communities.
- Gang communities were also seen as an important issue where there is poor engagement and access to health services for outstanding health issues.
- Wai2575 Kaupapa Health Enquiry – MRB would like to know MOH and DHB response to the highlighted issues.
- Mental Health and Addictions review – MRB want to know how MOH and DHB are responding to the highlighted issues.
- Whānau Ora – how is HBDHB moving to a whānau ora service model as espoused in the CSP and Strategic Plan.
- Oranga Tamariki - MRB want to know the DHB response to the various enquiries and their own internal enquiry. They would like to know what changes have been made internally to improve the maternal service experience for whānau.

BOARD PLANNING SESSION

Chris Ash, Executive Director and Kate Rawstron Head of Planning & Strategy Projects (Planning & Funding) provided a presentation on the planning session held with the Board.

MRB discussion noted:

- MRB should be given the opportunity to set strategic priorities with HBDHB Board
- MRB have stated previously, i.e. CSP and Whānau Ora Hapori Ora, the need for their inclusion at the initial pre-prioritisation stage to influence the planning cycle noting priorities and opportunities for whānau/community co-design
- Acknowledgement of partnership between iwi and DHB is a dual obligation that both parties need to uphold

MRB also made a number of statements related to the 12 strategic priorities:

- Locality development were seen as important, particularly Wairoa and Napier, however HBDHB should not restrict to just these two communities
- To enact community and whānau-led, will require a new way of working with communities, whānau and NGOs.

Key messages noted:

- He Ngakau Aotea primary lens to construct the plan
- There needs to be a focussed in the plan on moving towards kaupapa Māori models of delivery.
- There needs to be an additional priority of more investment in communities to take work away from clinical services

RECOMMENDATION:

Recommendation that the Board adopts a thirteenth strategic priority of investment into primary care and Kaupapa Māori models of delivery.

TE ARA WHAKAWAIORA – MENTAL HEALTH (NATIONAL AND LOCAL INDICATORS)

David Warrington (Service Director MH&AS) and Peta Rowden (Nurse Director MH&AS) spoke to the report.

MRB noted that:

- Section 29 of the Mental Health Act compulsory treatment orders (CTOs) have Māori overrepresented.
- A major diagnosis is schizophrenia. Although Māori show they are disproportionately overrepresented for those treated under a CTO, the numbers are not dissimilar to those treated under a CTO although Māori experience more schizophrenia/type illness at a rate of almost three-times than that of non-Māori.
- CAFS have been constrained in the past to recruit and retrain at the level of expertise required. Work is underway to recruit, grow systems, people and processes. Workforce is seen as a national issue.

MRB requested that:

- Members requested regular monitoring report be provided to MRB
- MH&AS work with Māori Health to include additional indicators that are important in measuring mental health wellbeing of Māori

The authors were congratulated on their report.

RESOLUTION:

It is recommended that the Māori Relationship Board:

1. **Note** this report provides a progress update as part of Te Ara Whakawaiora reporting for mental health and addictions.
2. **Endorse** the next steps and recommendations.
3. **Recommend** regular quarterly mental health monitoring reports be provided to MRB,

   and

   - MH&AS work with Māori Health to include additional indicators that are important in measuring mental health wellbeing of Māori.

Moved: Hine Flood
Seconded: Heather Te Au-Skipworth
Carried

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TE RAU ORA PRESENTATION

Tio Sewell, Karina Cootes and Zack Makoare were welcomed and provided a presentation on National Māori Suicide Prevention and Postvention Programme – 'Te Au'.

Discussion noted:

- MRB suggested this type of programme is where HBDHB should focus more energy as it was truly community led and whānau centred; by whānau for whānau and creates whānau resiliency without dependency on the health system
- MRB liked this concept of engaging whānau champions to work within their own whānau within '1000 whānau homes'
- MRB recognised that Te Rau Ora were working in several Māori communities but acknowledged Wairoa, which has had high suicide rates, is not currently under the programme
- The programme provides confidence to communities who have little opportunity to access providers

MRB suggested:

- Te Rau Ora work with Māori Health to spread the programme to '1000 Kahungunu' homes in HBDHB region
- Māori Health look to how we engage with local partners/leaders, working with hauora providers to grow this kaupapa

	Hawke's Bay Clinical Council (Public)
	For the attention of: **HBDHB Board**
Document Owner:	Jules Arthur (Co-Chair) Dr Robin Whyman (Co-Chair)
Month:	February 2020
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

- **Note** the contents of this report

Council met on 12 February 2020. An overview of matters discussed is provided below:

1. Clinical Governance Committees

The meeting reviewed the Clinical Governance Committees, their membership and how they report to Council. It was agreed to design a template report format to provide a standardised approach to the reporting, covering all key elements of information Clinical Council would like to have, eg how the committee is achieving its key objectives, key issues, identified risks, themes identified and mitigation. This will support Clinical Council to have effective oversight of the clinical risks and identify themes across the health system with a view to monitoring and assuring responsiveness to improving consumer experience and consumer outcomes.

2. Annual Planning Process 2020/2021

Kate Rawstron, Head of Planning and Strategic Projects, joined the meeting to provide a verbal update on the Board workshop held on 27 January 2020. It was noted that the Health Leadership Forum is holding a planning day on 4 March. Clinical Council wishes to ensure its voice is considered in the planning cycle and requests the opportunity to provide clinical input into the draft plan.

3. Chief Pharmacist Responsibilities

The meeting held a detailed discussion on the interim proposal to cover the functions of the Chief Pharmacist position after the decision was made in 2019 to leave the position vacant. The key functions of this senior leadership position include professional clinical leadership, sector coordination and advising on strategic direction and pharmacy service delivery. These have direct impacts on delivery outcomes for whānau serviced by the HB health system.

The Planning and Commissioning Manager (Referred Services) and the Chief Allied Health Professions Officer have developed a robust plan to ensure all functions are covered and are working in partnership with the pharmacy sector. The DHB is fortunate the Planning and Commissioning Manager has a pharmacy background.

Risks identified are:

- Clinical Governance – there are a number of clinical governance committees that are less well served without a Chief Pharmacist position;
- a potential conflict of interest – the Planning and Commissioning Manager managing the pharmacy contract and having a professional role in delivering some of the functions funded by that contract;
- Medicines Safety – Clinical Council believes this is a key clinical concern with potential harm to some patients.

Clinical Council:

- endorsed the recommendations for the transition phase;
- endorsed ensuring a pharmacist representative on Clinical Council and endorsed the request that we ask the HB branch of the Pharmaceutical Society of NZ to elect a nominee to be a member of Clinical Council (recommendation to be made to the Chief Executive Officer of DHB and PHO);
- agreed that Clinical Council work with that nominee to seek advice on how to advance the Medicines Safety Plan with urgency.

4. Committee Reports

Verbal reports were provided by the following Clinical Committees:

- Patient Safety and Risk Management Committee
- Professional Standards and Performance Committee.

5. Next meeting

The next meeting of the Hawke's Bay Clinical Council is on 11 March 2020.

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council**
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie (Chair)
Month:	February 2020
Consideration:	For Information

RECOMMENDATION

That the **HBDHB Board:**

1. **Note** the content of the report.

Council met on Thursday 13 February 2020. An overview of matters discussed follows.

1. **Update on operational and administrative changes**. A significant portion of the meeting was spent discussing and bringing members up to speed with the changes at executive level, the changes for the Executive and administrative support for our Council and the current status of the operational review process for the Home Help letter and the Renal appointments. We also welcomed a new member from Wairoa, Angie Smith.

   Our executive support going forward is to be split between the Executive Director of Planning and Funding (Chris Ash) and Susan Barnes, Patient Safety and Quality Manager in the Clinical Directorate. Administrative support I understand will come from Susan Barnes and her team.

2. **1737 Mental Health phone/ text service. F**urther correspondence has been received by Council that doesn't address the 'wait time' concern raised. Further request of the provider for the statistics around 'unanswered and long delay before answering 'has been made. Council are aware an offer has been made by a board member for support with this follow-up. An opportunity for DHB contract management to respond has been provided first. As I understand it each DHB nationally contributes to funding this national service.

3. **Pharmacy Subsidy Scheme-Communication Plan.** Di Vicary, Interim Chief Pharmacist, presented the plan and received feedback with ideas on how to reach consumers. In short, the subsidy scheme has been in place for over 25 years- yet many consumers have no idea about it; and its rules around 'family/ whanau' are not fit for purpose. Many pharmacists have made it their role in the past to verbally inform customers of the scheme but that has not been sustained and there is now a void of knowledge and information about the scheme.

   It appears no funding is provided separately for any communications to community/consumers and this is all left for the DHB in-house communications resource. Council resolved to support the case for more support of a national communications plan for this scheme and will write to the relevant person at the Ministry.

   This is an important financial benefit for consumers burdened by illness and yet it is not communicated. I expect this to be an ongoing area of interest. Next steps will be to monitor the response from Ministry and uptake from the current comms plan.

4. **Planning for 20/21.** Kate Rawstron presented on the revised process being followed for the 20/21 plan. The key positive points from Council perspective were appreciation that 'input' is being sought earlier and 'real' input is sought rather than the set 'MOH Annual Plan' that has been presented in the past. Discussion was had around the 'principles' that Consumer Council would like to see included.

   Embedding Person and Whanau Centred Care across the system is a main driver for the Council and they would like to see this applied as a lens through which projects are viewed. The Council's view is that this approach aligns with both community-led development (1 of 6 strategic goals) and equity (1 of 6 strategic goals). The change of service model inherent in PWCC has proven improved health outcomes.

   While this is 'longer term' view than the 20/21 currently before us, we would want our executive support to propose a 'stepped' approach to implementation. That would include advice around what is 'best' use of resource for the required outcome for the 20/21 year. In other words, as a governance committee we do not have the 'activities or projects' as a list at our fingertips ready to go but do have a view about what those should look like.

   Our monitoring framework is 'changes for consumers on the ground'.

   Council wish to stay very closely connected to the planning process to ensure meaningful consumer voice in developing and prioritising the activities.

5. **Updates and Reports** were received from:
   - Clinical Council rep observer;
   - End of Life Care consumer representative and HB Cancer Network Group - ex council member;
   - Annual Plan - Objective 3 'Actively participate in agreeing the priority actions for implementation arising from the Strategic Plan (Whanau Ora Hāpori Ora);
   - Clinical Governance Committees had not met over the December/January period to report back.

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Health Leadership Group – Chairs Report**
	For the attention of: **HBDHB Board**
Document Owner:	Traci Tuimaseve, Chair of PHLG
Reviewed by:	Talalelei Taufale, Pacific Health Development Manager Patrick Le Geyt, Acting Executive Director, Health Improvement & Equity Directorate
Month:	February 2020
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

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

The Pasifika Health Leadership Group (PHLG) met on 27 January 2020. An overview of the issues discussed and/or agreed at the meeting is provided below.

PEOPLE AND QUALITY DASHBOARD

Jim Scott, (HR Workforce Analyst) provided data quality report that detailed diversity and staff turnover for Pacifica.

It is encouraging to note that the gap is down from 8 to 4 staff. The goal is to achieve target year on year till 2025/2026 which will then be representative of target to population.

The discussion noted key actions to follow up:

- Identify the location/directorate and representation of Pacific staff – to address high needs
- Further information sought that outlines why five resigned over the past 12 months
- Requested data be supplied as to why 7 out of 12 applicants were not interviewed through the recruitment process

ENGAGING PASIFIKA WORKSHOP

Talalelei shared the above presentation. The presentation has been developed in collaboration with regional partners Hutt Valley and Capital Coast DHBs. It provides an insight into the journey of Pacific to Aotearoa, Hawke's Bay and highlights the differences between specific Pacific ethnic groups and Pacific models of care. The programme also recognises the role of subconscious bias awareness of your own cultural awareness and guides conversations across services. Staff who have been through the programme and who self tested found the course valuable.

PACIFIC HEALTH UPDATE REPORT

Talalelei was thanked for his report which was taken as read; noting:

- DNA focus remains a priority – some spikes over November/December and investigating these anomalies
- Community engagement – Step Up for Samoa benefit concert for measles fundraiser came together at very short notice to become a well-attended event. Church and Pacific community leaders congratulated Talalelei and the team and encouraged more of the community activities moving forward.

PHLG WORK PLAN

The PHLG's focus is to support and drive key priorities as identified in the Work Plan over the next six months to 30 June 2020. These priorities include:

Priority 1 - Engaged Pacific Communities

- 4 April – Pasifika Polyfest Secondary School Festival Flaxmere
- 13 April – Event scheduled for RSE workers and the community
- Pasifika Youth Survey data will inform the Rangatahi review

Priority 2 – Enhancing DHB and health services understanding of Pacific people

- Ongoing Engaging with Pasifika training targeted at specific services with Pacific needs
- Is there an opportunity to fastrack for Pasifika the DHB consumer experience survey

Priority 3 – Promoting the value of the Pacific health workforce

- Meeting with Chairs of HBDHB Baord and PHLG to discuss Board member for PHLG
- People & Quality Dashboard become a quarterly agenda item
- Collate Pacific consumer views of service's.

Priority 4 – Targeted initiatives to positively improve Pacific health outcomes

- Appointment from Board to PHLG
- A greater liaison with other providers and community on how we can connect with upcoming events and sharing of information
- Corporate Performance report to become a quality agenda item.

HAWKE'S BAY District Health Board Whakawāteatia	**Governance Appointments and Meeting Schedule for 2020**
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Craig Climo, Interim Chief Executive Officer
Month:	February 2020
Consideration:	For Decision

RECOMMENDATION

That the Board

1. Note the contents of this report and appendices.
2. Confirm the continuation of the Governance Structure set out in Appendix 1, and an extended meeting time for FRAC.
3. Approve all HBDHB Board Member Appointments as detailed in Appendix 2.
4. Note the appointments of the three Health Hawkes Bay Ltd Board Members to the Te Pitau Health Alliance Governance Group.
5. Confirm the 2020 Annual Governance Calendar at Appendix 3.
6. Discuss/agree the HBDHB Board Health & Safety Champion Schedule for the next three years (refer Appendix 4).
7. Approve the interim appointments of the Ngāti Kahungunu nominated members (and ADH representative) to the Maori Relationship Board (assuming nominations are received prior to 25 March 2020).
8. Approve a six month extension to the current appointment of Rachel Ritchie as Chair of the HB Health Consumer Council.
9. Endorse the appointments of Oliver Taylor and Angela Smith to Consumer Council.
10. Approve the continued appointment of Ken Foote as the HBDHB nominated Director on the Board of Allied Laundry Services Limited for the next 3 years, subject to the conditions set out below.

HBDHB GOVERNANCE STRUCTURES

The HBDHB Governance Structures are set out in some detail in both the HBDHB Governance Manual and in the Board Induction Pack. For convenience, a copy of the current diagrammatic view of Hawkes Bay Health Sector Governance Structures are attached as **Appendix 1** to this report. This current structure was largely adopted in 2013 and was last formally reviewed in October 2018.

A detailed report on this was submitted to the January Board meeting, setting out the background and evolution to the existing structures, and identifying recent observations. The outcome of discussions on this were generally to leave the structures as they are, at least for the time being. The only change agreed as a result of the recent observations was to increase the length of the FRAC meetings, by starting an hour earlier.

Given that neither of these decisions were recorded in the minutes, it is recommended that the Board formally confirm the continuation of the current governance structure and the agreed earlier start time for FRAC

MEMBERSHIPS/APPOINTMENTS

With the Board decision to leave the governance structures unchanged, over recent weeks the Chair has been discussing appropriate appointments with Board members. From these discussions, the Chair has prepared the attached schedule (**Appendix 2**) for Board approval.

TE PITAU HEALTH ALLIANCE GOVERNANCE GROUP

Health Hawkes Bay Ltd Board have advised that they have appointed the following three directors to the Te Pitau Health Alliance Governance Group:

- Bayden Barber (Chair)
- Chrissie Hape
- Leigh White

The Deputy Chair of the Te Pitau Governance Group is appointed by HBDHB from the three HBDHB appointed members.

MEETING SCHEDULE 2020

A draft meeting schedule for 2020 is attached at **Appendix 3**. This schedule reflects current understanding of the most recent discussions/agreements between Board members. Once finalised, this calendar needs to be confirmed.

Apart from exceptions to work around public holidays etc, meetings are normally held:

- MRB – 1st Wednesday of the month at 9.00am
- Clinical Council – 1st Wednesday of the month at 3.00pm
- Consumer Council – day after 1st Wednesday of the month (usually the 1st Thursday) at 4.00pm
- FRAC/Board – 3rd Wednesday of the month:
  - FRAC - 09.00am
  - Board Only Time – 12.30pm
  - Lunch – 1.00pm
  - Board – 1.30pm

BOARD HEALTH & SAFETY CHAMPION

The role and responsibilities of the HBDHB Board Health & Safety Champion were covered during Induction and are set out in the HBDHB Governance Manual in Appendix 9. There are two members appointed to the role at any one time, with overlapping terms of 6 months.

An appointment schedule for the term of this Board is attached at **Appendix 4**. This schedule needs to be completed and agreed.

MAORI RELATIONSHIP BOARD

It was noted in last month's paper that:

'It is now over 5 years since the MoU between NKII and HBDHB was agreed, and the ToR of MRB amended to accommodate the provision that:

- *The relationship (envisaged by the MoU) will be primarily managed and maintained:*
  - *On behalf of NKII through the NKII designated Kahungunu Health Sector Representatives on MRB*
  - *On behalf of HBDHB, through the HBDHB members appointed to MRB.*

In addition to the potential impact of Wai 2575 and changes to the related legislative policy framework, much has changed over the past 5 years that has led to the identified need to review the current MoU between HBDHB and NKII. These other issues have included discussions around the Nuka model of care, commitments to equity and kaupapa models made in the Clinical Services Plan, Whanau voice and the more recent development of He Ngakau Aotea. The outcome of any review of the MoU could have a consequent impact on the role and functions of MRB, and also therefore on the membership.

Given that previous appointments will terminate in March 2020, it is recommended that 'new' members be appointed on an interim basis, pending the outcome of the review of the MoU and clarification on the role and membership of MRB in the future.

The membership provisions in the Terms of Reference for the Maori Relationship Board are:

Members of MRB:

- *Will be appointed for any period that terminates no later than four months after the end of the term of the HBDHB Board that appointed them. (Note: The full term of a Board is three years).*
- *Members may be reappointed by the 'new' Board.*

The appointment of a Board member to MRB terminates if the member ceases to be a member of the Board.

Remuneration will be based on the Cabinet Fees Framework which provides for payment for each member's attendance at meetings or workshops, up to a maximum of ten per year.

Composition:

- *Chairman of Ngāti Kahungunu Iwi Incorporated, or alternate*
- *No less than two and no more than six HBDHB Board members, at least two of whom should be Māori*
- *Community members (up to six nominated by NKII or from the community)*
- *One Ahuriri District Health Representative.*

HBDHB Board members who are not committee members may attend this committee as observers, and with the approval of the committee chair, have the right to speak.

In accordance with the ToR, Ngāti Kahungunu iwi Inc are currently considering nominations for interim community members and for the interim ADH representative. These nominations could be received prior to the Board meeting on 25 February 2020, in which case it is recommended that these nominations be approved by the Board, and the named representatives appointed in the interim.

CONSUMER COUNCIL CHAIR

Rachel Ritchie's term as Chair of Consumer Council is due to end on 31 March 2020.

The Terms of Reference for Council includes the provision that:

The Chair shall be appointed by the HBDHB Board on the recommendation of the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the Health Hawke's Bay Board) following consultation with Council members. Appointments shall be for terms ending no later than four months after the end of the term of the HBDHB Board that appointed them (Note: The full term of a Board is three years).

Given the recent significant changes in Board membership, and the pending appointment of a new HBDHB CEO, the CEOs of HBDHB and HHB Ltd (with endorsement from the Board of HHB Ltd) recommend to the Board a six month extension to Rachel's appointment, such that a full report and decision on her reappointment or replacement may be deferred until August/September 2020. This recommendation has been raised with Rachel, and she would be happy to extend as recommended should this be approved.

It is therefore recommended that the Board approve this six month extension to Rachel's appointment as Chair of Consumer Council.

CONSUMER COUNCIL MEMBERS

The membership provisions of the Terms of reference for Consumer Council include:

Members shall be appointed by the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the respective boards), following consultation with the consumer and community groups in each of the areas of interest, as appropriate.

Members shall be appointed for terms of two years. Members may be reappointed but for no more than three terms.

Following a recent robust recruitment process led by the Consumer Council Chair, the following were recommended for appointment:

- Oliver Taylor (Youth)
- Angela Smith (Wairoa)

In accordance with the ToR, the CEOs of HBDHB and HHB Ltd having approved these appointments, now submit them for Board endorsement.

CLINICAL AND CONSUMER COUNCIL MEETINGS
Although the Terms of Reference for Clinical and Consumer Councils do not provide for HBDHB Board Members to be members, Board Members are always welcome to attend meetings of these Councils, just as they are for all other HBDHB advisory groups.

ALLIED LAUNDRY SERVICES LIMITED
HBDHB is an equal shareholder in Allied Laundry Services Ltd, along with MidCentral DHB, Capital & Coast DHB, Hutt Valley DHB, Whanganui DHB and Taranaki DHB. Allied Laundry provide full linen and laundry services to the shareholding DHBs as well as Wairarapa DHB.

Directors
The Constitution of the Company provides for shareholders to appoint Directors to the Board and that the Directors 'shall annually appoint one of their number as chairperson'.

The Company Shareholders Agreement provides additional detail to this:

6. DIRECTORS

6.1 Appointment of Directors

a) Where the number of Shareholders is four or less, each Shareholder shall appoint a maximum of two Directors (Shareholder Directors), who may be Board Members or employees of the Shareholder.

b) Where the number of Shareholders is five or more, each Shareholder shall appoint one Director (Shareholder Directors), who may be a Board Member or employee of the Shareholder.

c) Where the number of Shareholder Directors is seven or less, the Directors may, with the unanimous approval of all Shareholders by Special Resolution, appoint additional Independent Directors, such that the total number of Directors at any time does not exceed eight.

d) Independent Directors shall not be Board Members or employees of any Shareholder.

e) Shareholder Directors shall remain Directors until replaced by the Shareholder.

f) Independent Directors shall be appointed for a period not exceeding twelve months, but may be reappointed for up to a maximum of five years.

g) Directors Fees shall be paid by the Company at levels approved by Shareholders each year at the Annual General Meeting of the Company.

6.2 Duties to Shareholders

The parties recognise that the directors of the Company have been appointed by the Shareholders of the Company and are subject to the obligations imposed by the Constitution of the Company.

6.3 Best Interest of the Company

Pursuant to clause 14.3 of the Constitution of the Company, a Director must act in a manner which the Director believes is in the best interest of the Company. The Directors will interpret the best interests of the Company as the Objectives of the parties set out in Clause 3 and Policies set out in Clause 4 of this Agreement subject to the obligations of the Directors under the Companies Act 1993.

The primary objective within Clause 3 of the Shareholder Agreement is:

3.1 Reduce Laundry Cost

Each party will enter into a Service Agreement with the Company for the provision of its laundry services with the objective of providing best value laundry services to the parties, by achieving the lowest possible cost for the service, without compromising safety, quality, customer service or business sustainability.

Shareholder Expectations of Directors
Other Objectives in Clause 3 and Policies in Clause 4 consolidate a 'co-operative' intent in which Directors balance their Companies Act responsibilities to the Company, with their Shareholders Agreement responsibilities to act in the best interests of their Shareholders across a range of factors.

Practically this intent within HBDHB has been reflected in expectations that appointed Directors (whether Board members, staff or other) will:

- Ensure the Company meets its responsibilities to HBDHB under the Shareholders Agreement
- Provide quarterly verbal updates to the Chair and CEO on the performance of the Company.
- Maintain a 'no surprises' policy of informing the Chair and CEO of any significant issues
- Attend Board meetings as required to answer questions and/or provide information requested by members.
- Attend the HBDHB Board meeting at which the Company Annual Report is tabled and notice of the AGM provided.

HBDHB Appointed Directors
Ken Foote was appointed as one of two HBDHB appointed Directors in July 2012, along with David Ritchie. Ken was subsequently elected Chair of the Allied Laundry Board in November 2013 and has remained so ever since. Despite David Ritchie leaving the HBDHB Board in December 2010, he remained an HBDHB appointed Director until March 2015, when Capital & Coast and Hutt valley DHBs joined as Shareholders and the number of Directors per Shareholder reduced to one.

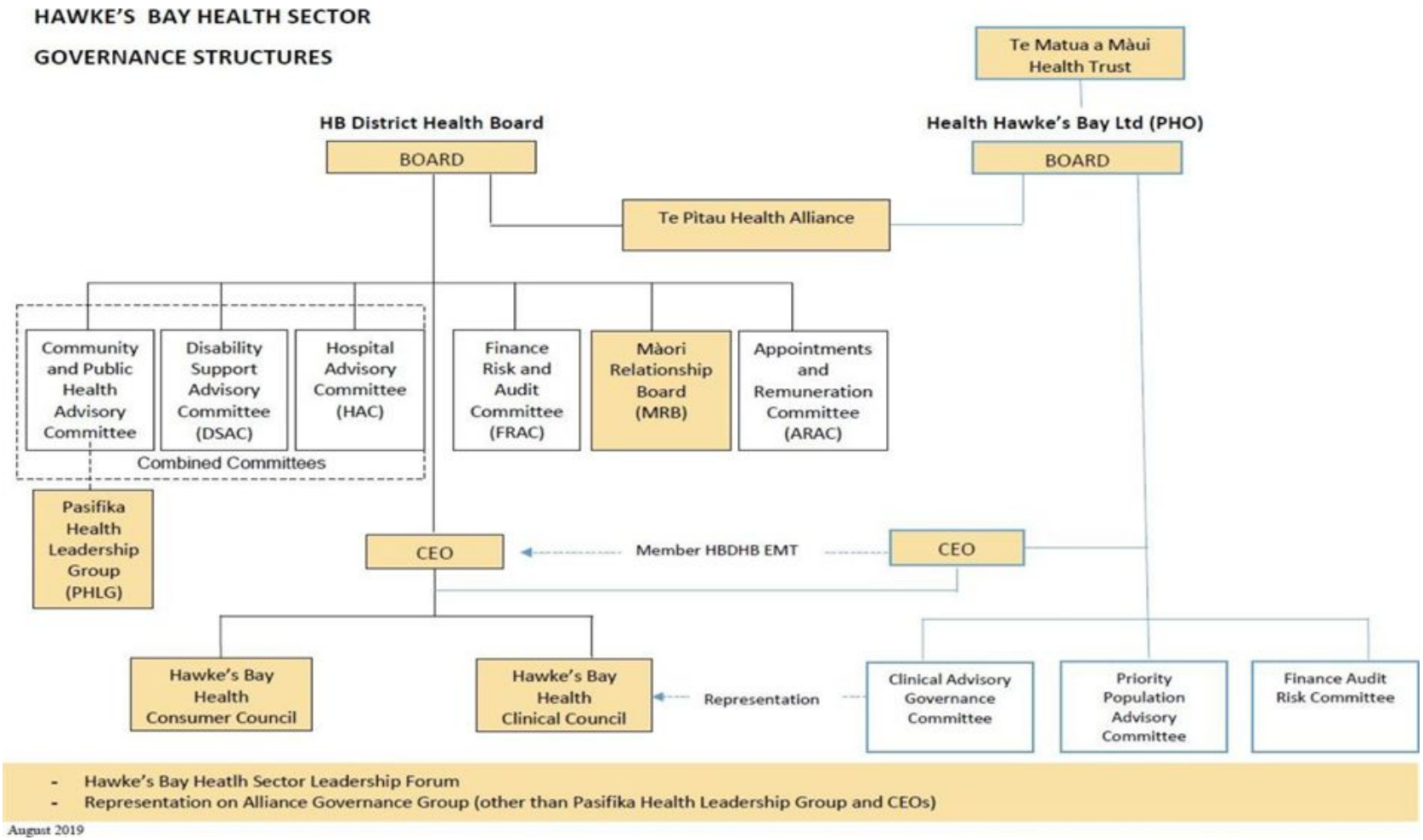
Whilst the Shareholders Agreement provides that '*Shareholder Directors shall remain Directors until replaced by the Shareholder'* this issue has been brought to the Board due to Ken's change in circumstance, with his position as Company Secretary being dis-established from 20 March 2020. Ken has indicated a strong desire to remain on the Board despite no longer being employed by HBDHB. There are no legal or administrative reasons why this could not occur, and there would be no cost or risk to HBDHB, with Directors fees, expenses and liability insurance all being covered by Allied.

Given his significant and relevant skills, knowledge and experience, and his undoubted value to the Company (being elected chair for the past six years and leading the Company through a period of significant expansion and change):

It is recommended that Ken Foote continue to be the HBDHB appointed Director to Allied Laundry, on the understanding/conditions that:

- This appointment be terminated and/or formally reviewed in March 2023, following the election/appointment of a 'new' HBDHB Board in December 2022.
- Ken continues to meet the shareholder expectations of Directors as listed above.

APPENDIX 1 – HB HEALTH SECTOR GOVERNANCE STRUCTURES



APPENDIX 2 – BOARD MEMBER APPOINTMENT SCHEDULE

	1	2	3	4	5	6	7	8	9	10	11
Board Member	**Finance, Risk & Audit Committee**	**Hospital Advisory Committee (Statutory Committee)**	**Community, Public Health Advisory Committee (Statutory Committee)**	**Disability & Support Advisory Committee (Statutory Committee)**	**Màori Relationship Board**	**Appointments & Remuneration Committee**	**Te Pitau Health Alliance**	**HB Drinking Water Governance Joint Committee**	**HB Medical Research Foundation**	**HB Rescue Helicopter Trust Appointments Panel**	**Cranford Hospice Trust Appointments Panel**
S Walker	√	√	√	√	√	**Chair**		√			
E Davies	**Chair**	√	√	√		√					
K Atkinson	√	√	√	√						√	√
P Dunkerley	√	√	√	√		√					
A Apatu	√	√	√	√	**Chair**		√	√			
H Skipworth	**Dep Chair**	√	√	√	√	√	**Dep Chair**				
H Anderson	√	√	**Chair**	√					√		
A Lorck	√	√	**Dep Chair**	√							
D Davidson	√	√	√	√							
C Lambert	√	√	√	√	√		√				
J Edwards	√	√	√	√	√	√					
Notes from Terms of Reference	Board Chair PLUS up to all other Board Members but no less than 2. Up to 2 independent non-Board members Chair of FRAC shall not be Board Chair	All Board Members Chair notional as committee does not meet	All Board Members Committee does not meet Chair 'sponsors' Pasifika Health Leadership Group	All Board Members Chair notional as committee does not meet	Between 2 to 6 Board members, at least 2 of whom should be Màori Chair to be one of the HBDHB Màori Board Members. HBDHB to consult NKII on Chair appointment	Board Chair to be Committee Chair Plus up to 4 additional Board Members To ensure appropriate diversity	3 Board Members Deputy Chair to be appointed from these 3 Chair is PHO Chair	2 Board Members	1 Board Member	HBDHB Chair or nominee	HBDHB Chair or nominee

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APPENDIX 3 – 2020 ANNUAL GOVERNANCE CALLENDAR

SEE ATTACHED SEPARATE DOCUMENT (A3 COPIES PROVIDED AT MEETING)

APPENDIX 4 – BOARD HEALTH & SAFETY CHAMPION SCHEDULE

HBDHB BOARD HEALTH & SAFETY CHAMPION SCHEDULE

Dates	Member	Dates	Member
December 19 - May 20	Heather Skipworth	**March 20 - August 20**	Hayley Anderson
June 20 - November 20	Peter Dunkerley	**September 20 - February 21**	Anna Lorck
December 20 - May 21	Charlie Lambert	**March 21 - August 21**	Evan Davies
June 21 - November 21	David Davidson	**September 21 - February 22**	Ana Apatu
December 21 - May 22	Shayne Walker	**March 22 - August 22**	Joanne Edwards
June 22 - November 22	Kevin Atkinson		

NOTES:

Schedule based on 6 monthly rotations with 3 months overlap

Full Role Description contained in Schedule 9 to HBDHB Governance Manual

APPENDIX 3 - 2020 Draft Annual Calendar

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sun			1								1	
Mon			2			1 QUEENS BIRTHDAY					2	
Tue			3			2			1		3	1
Wed	1 NEW YEARS DAY		4 Leadership Forum	1 MRB Clinical Council		3 MRB Clinical Council	1 MRB Clinical Council		2 MRB Clinical Council		4 MRB Clinical Council	2 MRB Clinical Council
Thu	2 Day after New Year		5 Board Induction	2 Consumer Council		4 Consumer Council	2 Consumer Council		3 Consumer Council	1	5 Consumer Council	3 Consumer Council
Fri	3		6	3	1	5	3		4	2	6	4
Sat	4	1	7	4	2	6	4	1	5	3	7	5
Sun	5	2	8	5	3	7	5	2	6	4	8	6
Mon	6	3	9 PHLG	6	4	8	6	3	7	5	9 PHLG	7
Tue	7	4	10	7	5	9	7	4	8	6	10	8
Wed	8	5	11 MRB Clinical Council	8	6 MRB Clinical Council	10	8	5 MRB Clinical Council	9	7 MRB Clinical Council	11	9
Thu	9	6 WAITANGI DAY	12 Consumer Council	9	7 Consumer Council	11	9	6 Consumer Council	10	8 Consumer Council	12	10
Fri	10	7	13	10 GOOD FRIDAY	8	12	10	7	11	9	13	11
Sat	11	8	14	11	9	13	11	8	12	10	14	12
Sun	12	9	15	12	10	14	12	9	13	11	15	13
Mon	13	10	16	13 EASTER MONDAY	11 PHLG	15	13 PHLG	10	14 PHLG	12	16	14
Tue	14	11	17	14	12	16	14	11	15	13	17	15
Wed	15	12 MRB Clinical Council	18 FRAC BOARD	15 FRAC BOARD	13	17 FRAC BOARD	15 FRAC BOARD	12	16 FRAC BOARD	14	18 FRAC BOARD	16 FRAC BOARD
Thu	16	13 Consumer Council	19	16	14	18	16	13	17	15	19	17
Fri	17	14	20	17	15	19	17	14	18	16	20	18
Sat	18	15	21	18	16	20	18	15	19	17	21	19
Sun	19	16	22	19	17	21	19	16	20	18	22	20
Mon	20	17	23	20	18	22	20	17	21	19	23	21
Tue	21	18	24	21	19	23	21	18	22	20	24	22
Wed	22	19	25	22	20 FRAC BOARD	24	22	19 FRAC BOARD	23	21 FRAC BOARD	25	23
Thu	23	20	26	23	21	25	23	20	24	22	26	24
Fri	24	21	27	24	22	26	24	21	25	23 HB ANNIVERSARY	27	25 XMAS DAY
Sat	25	22	28	25	23	27	25	22	26	24	28	26 BOXING DAY
Sun	26	23	29	26	24	28	26	23	27	25	29	27
Mon	27 BOARD PHLG	24	30	27 ANZAC DAY	25	29	27	24	28	26 LABOUR DAY	30	28 public holiday in lieu
Tue	28	25 FRAC BOARD	31	28	26	30	28	25	29	27		29
Wed	29	26		29	27		29	26	30	28		30
Thu	30	27		30	28		30	27		29		31
Fri	31	28			29		31	28		30		
Sat		29			30			29		31		
Sun					31			30				
Mon								31				
Tue												

http://www.vertex42.com/ExcelTemplates/yearly-calendar.html

EXECUTIVE MANAGEMENT MEETINGS	Boardroom	Every Tuesday from 9am (or Monday if public holiday)
FRAC	Boardroom	9.00am-12.30pm Third Wednesday of month
BOARD	Boardroom	01.30-4.00pm Third Wednesday of month
MAORI RELATIONSHIP BOARD	Boardroom	9.00am-noon 1st Wednesday of each month except Jan (& Feb/Mar in 2020)
CLINICAL COUNCIL	Boardroom	3.00-5.30pm 1st Wednesday of each Month except Jan (& Feb/Mar 2020) - (joint mtgs 1-5pm offsite)
CONSUMER COUNCIL	Boardroom	4.00-6.00pm 2nd Wednesday of each Month except Jan (& Feb/Mar 2020) - (joint mtgs 1-5pm offsite)
PASIFIKA HEALTH LEADERSHIP GROUP	Boardroom	4.30-6.30pm - Jan then 2nd Monday evenings 2 monthly from March

HAWKE'S BAY District Health Board Whakawāteatia	**Corporate Performance Report – Q2**
	For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Executive Director, Planning & Funding
Document Author(s)	Kate Rawstron, Head of Planning & Strategic Projects
Reviewed by	
Month/Year	February 2020
Purpose	For Information/Monitoring
Previous Consideration Discussions	Q1 Corporate Performance Report – November 2019
Summary	The Corporate Performance Report aims to provide enhanced strategic and operational oversight to aid the Board and senior management to monitor and manage the Hawke's Bay health system's overall performance, using a 'balanced scorecard' approach around our HB Health Strategy goals
Contribution to Goals and Strategic Implications	To monitor key performance indicators across the HB health system including HB Health Strategy goals.
Impact on Reducing Inequities/Disparities	The Corporate Performance Report will monitor equity across the majority of indicators where data is available.
Consumer Engagement	Nil
Other Consultation /Involvement	Executive Leadership Team, Senior Managers, Business Intelligence, Planning and Funding Directorate, Corporate Services via the Quarterly Performance Reporting Process
Financial/Budget Impact	Nil
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that **HBDHB Board**:

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

HAWKE'S BAY District Health Board Whakawāteatia

Corporate Performance Report

Author:	**Kate Rawstron**
Designation:	**Head of Planning & Strategic Projects**
Date:	**17 February 2020**

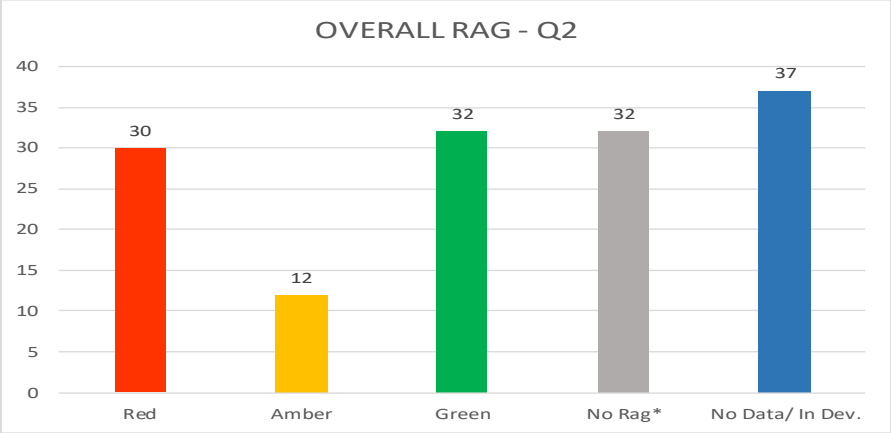
CORPORATE PERFORMANCE REPORT

The Corporate Performance Report aims to provide enhanced strategic and operational oversight to aid the Board and senior management to monitor and manage the Hawke's Bay health system's overall performance. It is aligned to the Hawke's Bay Health Strategy and the health system goals and is reported quarterly.

- To give systematic visibility and support our goal of achieving equity for Māori, Pasifika & those with unmet need, all indicators are reported by ethnicity where data is available.
- Where there is a target, for ease of interpretation a RAG status (i.e. red, amber, green) has been provided. Consideration may wish to be given to setting targets for any indicators without targets.
- Where possible, indicators have a trendline covering a three-year period commencing 1 July 2017, with quarterly markers shown in red.

Q2: Performance at a Glance

TOTAL OF 143 Performance Measures
87 Annual Plan Performance Measures
+ 4 Financial Measures
+ 52 Local Performance Measures

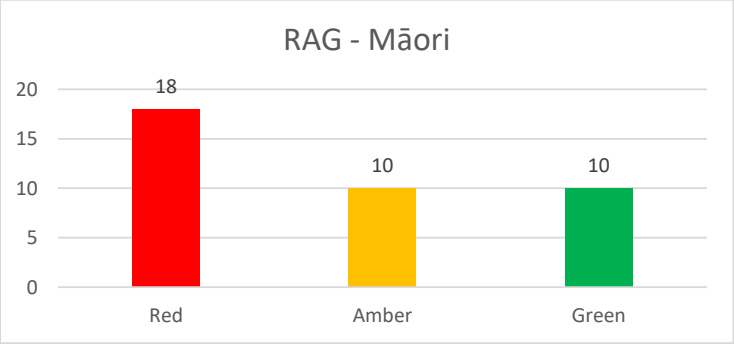


* Measure not reported this quarter so no RAG result

RAG KEY:

Red = More than 5% below target
Amber = Within 0-5% of target
Green = Target achieved or exceeded

ACROSS ALL AVAILABLE INDICATORS where data is available



HBDHB ANNUAL PLAN PERFORMANCE MEASURES

Also included in this new format is a Performance Measures dashboard. Performance measures are a subset of the total Corporate Dashboard, are agreed as part of our Annual Plan, and form our statutory non-financial monitoring and reporting as a DHB to the Ministry of Health and the Crown. This dashboard looks at our overall performance for the quarter and reports by exception areas where further focus and discussion is required.

RECOMMENDATION:

It is recommended that the Māori Relationship Board, Consumer Council and Clinical Council:

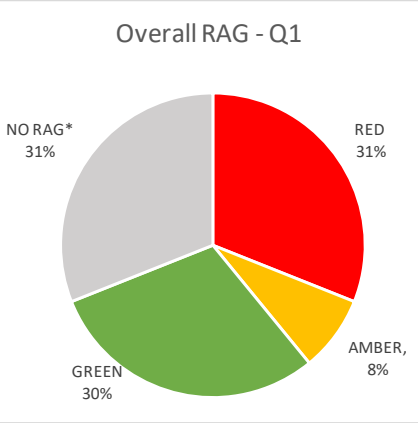
1. **Note** the its contents of this report

ATTACHMENTS:

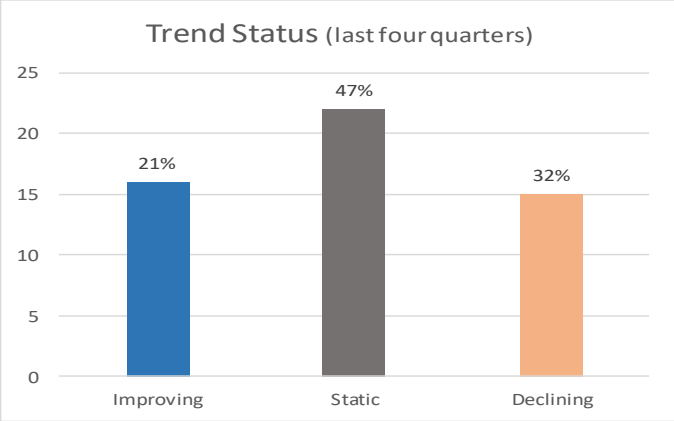
- Corporate Performance Report 2020 Q2

HBDHB ANNUAL PLAN PERFORMANCE MEASURES– Quarter 2 2019/2020

OVERALL PERFORMANCE



* No target set to determine RAG

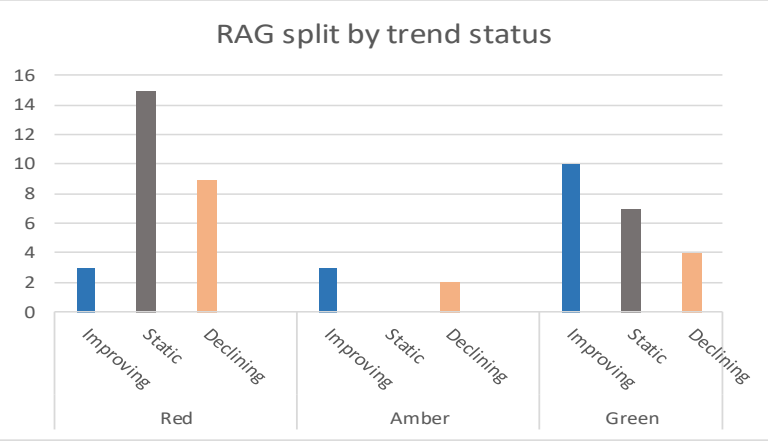


NOTE: Includes RED, AMBER, GREEN status only

EXCEPTION REPORTING

- See the Te Ara Whakawaiora Quarterly Report

  – Mental Health



EQUITY

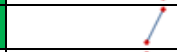
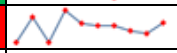
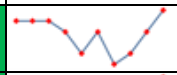
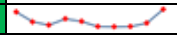
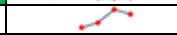
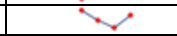
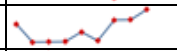
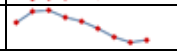
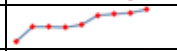
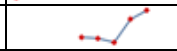
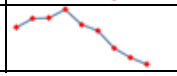
Equity Gap - Top 10		Difference*
Red RAG		* Between Māori & Total as a %
Primary care enrolments	% of pregnant women booked with a Lead Maternity Carer by week 12 of their pregnancy *	-18%
ASH	Reduce ASH 45-64 - ASH rate per 100,000 45-64 years **	-102%
Long term conditions	Proportion of people with diabetes who have had a good or acceptable glycaemic control (HbA1C indicator) *	-18%
Mental health	Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000 *	-25%
	Rate of s29 orders per 100,000 population **	-254%
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments **	-86%
Amber RAG		
Hospital stay	Total acute hospital bed days per capita (per 1,000 population) *	-27%
Green RAG		
Primary care enrolments	% of new-borns enrolled in general practice by 6 weeks of age *	-16%
Older people	Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 75-79 years *	-49%
	Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 80-84 years *	-48%
Stoke	% of potentially eligible stroke patients who are thrombolysed 24/7 *	-100%

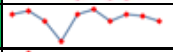
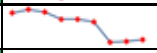
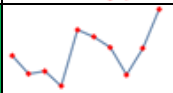
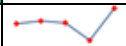
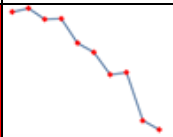
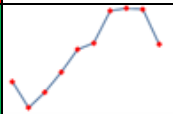
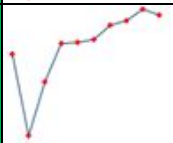
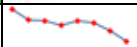
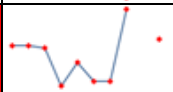
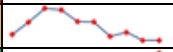
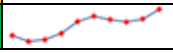
OURHEALTH HAWKE'S BAY Whakawāteatia

Corporate Performance Report

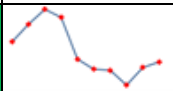
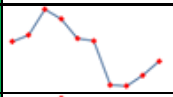
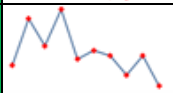
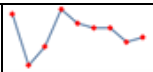
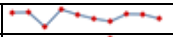
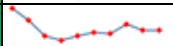
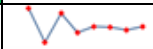
Quarter 2 (1 October - 31 December 2019)

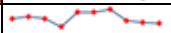
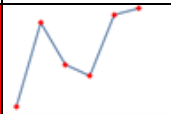
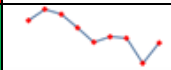
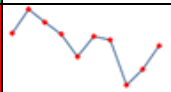
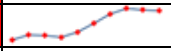
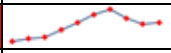
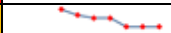
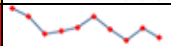
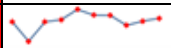
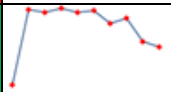
Key	
Green	Target achieved or exceeded
Amber	Within 0-5% of target
Red	More than 5% below target
*	HBDHB Annual Plan
**	DHB Annual Plan & Te Ara Whakawaiora

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
	Primary care enrolments	% of HB population enrolled in the PHO *	≥90%	98%	99.4%	93.2%	98.7%		
		% of Wairoa population enrolled in PHO	90%	99.1%	n/a	n/a	96.2%		
		% of Central Hawke's Bay population enrolled in PHO	90%	94.7%	n/a	n/a	96.0%		
		Number of general practices with closed books					4		Out of 23 practices, 19 are either taking new patients or taking new patients under certain conditions
		% of new-borns enrolled in general practice by 6 weeks of age *	≥55%		64.0%	86.0%	76.0%		
		% of new-borns enrolled in general practice by 3 months of age *	≥85%	90.0%	82.0%	93.0%	91.0%		
		% of pregnant women booked with a Lead Maternity Carer by week 12 of their pregnancy *	80%	64.0%	53.0%	36.0%	65.0%		
	System-wide pharmacy services	Placeholder. To be developed in 2020. Will include community, general practice and hospital pharmacy							
	Immunisation	% of 8 month olds will have their primary course of immunisation (6 week, 3 month & 5 month events) on time *	≥95%	92.0%	95.6%	96.6%	95.0%		
		% of 4 year olds fully immunised *	≥95%	91.0%	92.5%	100.0%	95.0%		
		% of boys and girls fully immunised - HPV vaccine *	≥75%	76.0%	Data in Q1 2021				
		% of 65+ year olds immunised - influenza vaccine *	≥75%	58.0%	Data in Q1 2021				
	Oral health	% of children caries free at 5 years of age **	≥61%	62.0%	Data in Q3 2020				
		Mean 'DMFT' score at year 8 *	≤0.73	76.0%	Data in Q3 2020				
		% of pre-school children enrolled in and accessing community oral health services**	95%	tbc	Data in Q3 2020				
		% of enrolled preschool and primary school children overdue for their scheduled examinations *	≤10%	10%	Data in Q3 2020				
		% utilisation of DHB funded dental services by adolescents for school Year 9 up to and including 17 years*	≥85%	tbc	Data in Q3 2020				

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
Community Led System	Child health	% of infants exclusively or fully breastfed at 3 months **	≥60%	57%	Data in Q3 2020				
		% of obese children identified in the Before School Check (B4SC) will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions **	≥95%	96.0%	100.0%	-	99%		
	Screening	% of women aged 50-69 years who received breast screening in the last two years *	≥70%	74.0%	70.3%	69.2%	73.3%		
		% of women aged 25-69 years who have had a cervical screening in the past 3 years *	≥80%	76.0%	No Data				
	Better help for smokers to quit	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking *	≥90%	85%	100.0%	-	100.0%		
		Number of Māori babies who live in a smoke-free household at 6 weeks post-natal *	≥21.9%	45%	No Data Available				
		% of PHO enrolled patients who smoke who have been offered help to quit by a health practitioner in the last 15 months *	≥90%	85%	68.1%	65.2%	69.2%		A new remuneration plan was introduced to general practices November 5th 2019 offering FFS for every successful episode of SBA. is expected to increase the volumes. If there is not a noticeable increase by June 2020 a reassessment of the plan will be undertaken.
	ASH	Reduce the difference between Māori and other rate for Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 0 - 4 years **	Māori ≤8313	8750	8494	15493	7448		The rate for Māori reduced this quarter but also dopped for non-Māori meaning the gap has not changed- more analysis required to understand link between activity and impact on specific cohorts
		Reduce ASH 45-64 - ASH rate per 100,000 45-64 years **	Māori ≤ 9341	9328	9426	7928	4673		Activity underway to help reverse trend include focusing on HF patients to ascertain how to support patients to attend appointments, improving the Cardiology journey, progressing with the Chronic Conditions Flag to identify people with more than one chronic condition.
	Long term conditions	% of eligible population will have had a CVD risk assessment in the last 5 years *	≥90%	86%	No Data Available				
		Proportion of people with diabetes who have had a good or acceptable glycaemic control (HbA1C indicator) *	≥60%	42%	30.4%	26.6%	37.3%		HHB CNS facilitated an education session October 2019 with outside guest speaker Janine Bycroft. The session was oversubscribed and extremely well received.
		Proportion of population seen by Mental Health and Addiction Services - child & youth (0-19 years) *	≥4.3%	5.3%	4.1%		3.8%		
		Proportion of population seen by Mental Health and Addiction Services - adult (20-64 years)*	≥5.4%	5.3%	11.0%		5.6%		

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
Pūnaha Ārahi Hāpori - Comm	Mental health	Proportion of population seen by Mental Health and Addiction Services - older adult (65+)	≥1.15%	1.1%			1.0%		
		% of zero-19 year olds seen within 3 weeks of non-urgent referral - Addictions (provider arm & NGO)**	≥80%	75.0%	79.9%	70.0%	75.2%		
		% of zero-19 year olds seen within 3 weeks of non-urgent referral - Mental health provider arm **	≥80%	67.0%	77.8%	100.0%	83.3%		
		% of zero-19 year olds seen within 8 weeks of non-urgent referral - Addictions (provider arm & NGO) **	≥95%	92.0%	93.1%	100.0%	93%		
		% of zero-19 year olds seen within 8 weeks of non-urgent referral - Mental health provider arm **	≥95%	89.0%	95.2%	100.0%	95.2%		
		% of clients with an open referral to MH&A services of greater than 12 months have a wellness plan *	≥95%	99.3%			77.9%		See this month's TAW report on Mental Health
		% of audited files meet acceptable practice - wellness plans *	≥95%	89.0%	No Data Available				
		% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan *	≥95%	64.3%			72.5%		See this month's TAW report on Mental Health
		% of audited files have a transition (discharge) plan of acceptable standard *	≥95%				90.0%		See this month's TAW report on Mental Health
		% of clients discharged from community MH&A will have a transition (discharge) plan *	≥95%	78.5%	No Data Available				
		% of audited files have a transition (discharge) plan of acceptable standard *	≥95%	97.0%	No Data Available				
		Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000 *	Māori ≤ 75	80	89	16	71		
		% of ED presentations for 10-24 year olds which are alcohol related *	Māori ≤14.3%	14.6%	No Data Available				
		Rate of s29 orders per 100,000 population **	Māori ≤10% reduction	395	425	139	120		See this month's TAW report on Mental Health
		Number of hours mental health clients spent in seclusion	0	1569			275		
		% of all DHB inpatient service users seen with at least one outcome collection (HoNOS)	80%	95%			89.0%		
		% of all DHB community service users seen with at least one outcome collection (HoNOS)	80%	78%			73.0%		The data for the 01 Oct - 31 Dec period will likely be available around a 6 Feb 2020. Community team leaders are highlighting this issue with team clinicians in their one to one meetings.

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
	Reduce incidence of first episode of rheumatic fever	Acute rheumatic fever initial hospitalisation rate per 100,000 * (12 month measure)	≤1.5 per 100,000	tbc	No Data Available				
	Older people	Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 75-79 years *	≤130	127.5	193.30	83.30	129.60		
		Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 80-84 years *	≤170	169.1	241.70	275.00	163.20		
		Better access to acute care for older people - Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) - 85+ years *	≤225	227.5	250	100	218.1		
		Better community support for older people - % of people having home assessments who have indicated loneliness *	≤23%	tbc	Data not available currently				
		Better community support for older people - rate of carer stress: informal helper expresses feelings of distress = YES, expressed as a % of all home care assessments *	≤26%	tbc	Data not available currently				
		Better community support for older people - Acute readmission rate for 75+ year olds *	≤11%	12.3%	11.6%	9.7%	Data not available currently		
		Increased capacity and efficiency in needs assessment and service coordination services - Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency *	tbc	tbc	Data not available currently				
		Clients with a Change in Health, End-stage, Signs and Symptoms (CHESS) score of four or five at first assessment *	11%	tbc	Data not available currently				
		Average age of first entry to aged residential care		82.8	74.5	75.0	82.8		
		Aged residential care occupancy rate		90.0%	Data not available currently				
		% of older patients given a falls risk assessment *	≥90%	91.1%			91.1%		
		% of older patients assessed as at risk of falling receive an individualised care plan *	≥90%	92.4%			92.4%		
	Amenable mortality	Relative rate between Māori and Non-Māori Non-Pasifika (NMNP)*	≤2.15	2.45	No Data Available				

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
	Urgent care	% of patients admitted, discharged or transferred from ED within 6 hours *	≥95%	88%	82.3%	82.2%	79.0%		Performance has improved quarter on quarter - various activity continuing to be progressed.
		Number of ED presentations			3,415	658	10,941		
		Admissions from ED - conversion rate					16.0%		
		Placeholder: Urgent care in primary care - to be developed							
	Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments **	Total ≤5%, Māori & Pasifika ≤9%	Total 5.9%, Māori 11.3%, Pasifika 13.3%	11.9%	14.3%	6.4%		
	Faster cancer treatment	% of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat *	≥85%	85%			85.6%		
		% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks *	≥90%	95%			84.4%		Performance has improved quarter on quarter and efforts to improve further continue.
	Planned care	% of services report YES (that more than 90% of referrals within the service are processed in 15 calendar days or less) ESPI 1 *	100%	68%			50.0%		
		% of patients waiting over four months for a FSA ESPI 2 *	0%	30%			28.0%		
		% of patients in Active Review with a priority score above the Treatment Threshold ESPI 3 *	0%		Not used by DHB				
		% of patients waiting over 120 days for treatment ESPI 5 *	0%	27%			22.0%		
		% of patients prioritised using an approved national or nationally recognised prioritisation tool ESPI 8 *	100%		Not used by DHB				
		Ophthalmology: Number of patients waiting more than or equal to 50% longer than the intended time for an ophthalmology appointment *	0%				502		
		Acute readmission rates to hospital	≤11.8	11.9%	12.1%	11.4%	11.9%		
		% of ACS patients undergoing coronary angiogram, door to cath, within 3 days **	>70%	61%	58.3%	-	50.0%		
		% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF *	≥85%	66%	80.0%	-	73.9%		
		% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 30 days of discharge **	>95%	97%	94.4%	-	95.4%		

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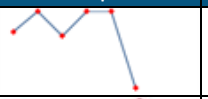
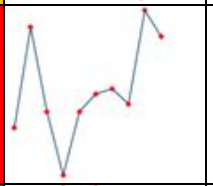
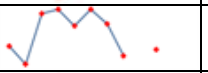
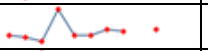
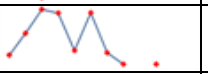
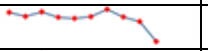
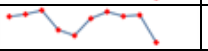
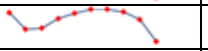
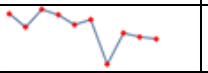
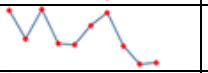
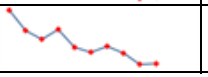
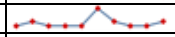
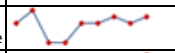
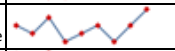
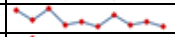
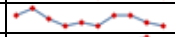
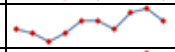
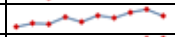
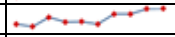
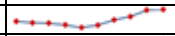
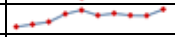
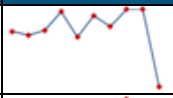
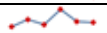
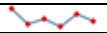
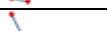
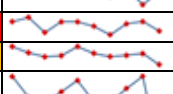
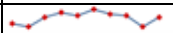
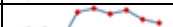
					Māori	Pasifika	Total	Total Population	
He Rauora Hōhou Tangata, Hōhou Whānau - Embed Person and Whānau Centred Car	Cardiovascular	% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 3 months **	>99%	100%	83.3%	100.0%	95.9%		
		Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed at discharge aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes) *	>85%	55%	100.0%	-	64.5%		
	Stroke	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission *	≥80%	73%	75.0%		54.0%		
		% of potentially eligible stroke patients who are thrombolysed 24/7 *	10%	9%	0.0%		10.0%		
		% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway *	80%	80%	79.0%	50.0%	74.0%		
		% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge *	≥60%	tbc			69.0%		
	Quicker access to diagnostics	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks) *	≥95%	92%			69.0%		
		% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks) *	≥90%	90%			69.0%		
		% accepted referrals for elective coronary angiography completed within 90 days *	≥95%	100%			80.4%		
		% of participants to have received their colonoscopy within 45 calendar days of their FIT result being recorded in the NBSP information system *	≥95%	NA	No Data Available				
		% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive) *	≥90%	95%			91.1%		
		% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days) *	≥70%	69%			40.2%		
		% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date *	≥70%	55%			43.4%		

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
	Hospital stay	Total acute hospital bed days per capita (per 1,000 population) *	≤390	410	521		410		
		Patient occupancy rates - overall					90.7%		
		Patient occupancy rates - HB Soldiers' Memorial Hospital					92.2%		
		Patient occupancy rates - Wairoa					55.4%		
		Patient occupancy rates - CHB					89.4%		
		Patients not in home ward			No Data Available				
	Patient experience	Number of SAC 1 and 2 serious adverse care events					7		
		Number of grade 3 patient pressure injuries - hospital		4			1		
		Number of grade 4 patient pressure injuries - hospital		0			0		
		Number of grade 3 patient pressure injuries - community		3			Not available		
		Number of grade 4 patient pressure injuries - community		2			Not available		
		Number of hospital acquired MDRO infections		1			1		
		Number of surgical site infections		0			0		
		Number of HAI staphylococcus aureus BSIblood infections		5			5		
		Number of compliments		196			193		
		Number of complaints		119			156		
		Placeholder: % of clinical staff who have clinical orientation at a local level							
		Number of patients that answer 'NO' to the inpatient experience survey question 'Did a member of staff tell you about medication side effects to watch for when you went home' *	≥17%	22%	No Data Available				
	Ethnicity profile	% of staff who are Māori - DHB	16.66%	14.54%	15.65%				
		% of staff who are Māori or Pasifika - DHB	1.76%	1.51%		1.63%			
		% of staff who are Māori or Pasifika - general practice	26%	3.7%			Not available		
		Placeholder: % of staff who are Māori or Pasifika - aged residential care, Māori health providers - to be developed							
		Placeholder: % of staff who are Māori or Pasifika - total DHB, general practice, aged residential care, Māori health providers - to be developed							

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
Ngā Kaimahi Tōtika - Highly Skilled and Capable Workforce	Recruitment	% turnover of staff - DHB		2.9%			3.7% 12.39% (12mth)		
		% of job applications received Māori- DHB		21.0%	18.8%				
		% of job applications received Pasifika- DHB		1.6%		1.85%			
		% of applicants who were interviewed v applied Māori- DHB		35.6%	38.52%				
		% of applicants who were interviewed v applied Pasifika- DHB		14.3%		41.67%			
		% of interviewees who were hired v interviewed Māori- DHB		50.0%	51.06%				
		% of interviewees who were hired v interviewed Pasifika- DHB		100.0%		40.0%			
	Staff wellbeing	% of employees with 1-2 years annual leave owing	15%	23.9%			22.82%		
		% of employees with 2+ years annual leave owing	0%	5.2%			4.41%		
		% of sick leave taken		2.6%			2.94% 3.39% (12mth)		
		% of staff who have had influenza vaccination					0 for this quarter		
		Number of staff using EAP services		48			56		
		Average days lost due to injuries		20.27			19.29		
		Number of employee events reported					210.00		
		Number of employee near miss events reported					35.00		
		Number of verbal abuse events reported by staff		12			18		
		Number of physical abuse/assaults against staff reported		16			14		
		Number of hazard events reported		7			3		
bled Health System	Improving the quality of identity	New NHI registrations in error *	>1% and ≤3%	5.1%			0.90%		
		Recording of non-specific ethnicity in new NHI registrations *	>0.5% and ≤2%	1.3%			0.5%		
		Update of specific ethnicity value in existing NHI records with a non-specific value *	≤2%	0.1%			0%		
		Invalid NHI data updates *	tbc	NA			NA		

Health System Goal	Focus Area	Indicator	Target	Baseline	Māori Mana Taurite Equity for Māori, Pasifika & Unmet Need			Trendline (Quarterly markers, commencing Q1 2017/18)	Action Commentary Reason not achieving target and planned actions to get on track (for indicators in red only)
					Māori	Pasifika	Total	Total Population	
Pūnaha Tōrire - Digitally Ena	quality of identity data within the NHI and data submitted to national collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures *	≥90% and ≤95%	NA			NNPAC 91% NBRS 59% NMDS85%		
		National collections completeness *	≥94.5% and ≤97.5%	NA			NMDS 104% NNPAC 103% PRIMHD 84%		
		Assessment of data reported to the national minimum set (NMDS) *	≥75%	84.1%			87.90%		
He Paearu Teitei Me Ōna Toiūtanga - High Performing and Sustainable System	Financial performance		**Budget**	**Sep-19**					
			$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	
		Income	50,445	51,267				614,548	The adverse financial position is a result of a number of exceptional and on-going issues including pharmaceutical costs, MECA settlements, strike costs, provider services operating costs (including medical staff and clinical supplies) and aged residential care. The position is being closely reviewed by management and the Board.
		Less expenditure	53,973	56,381				629,897	
		Financial Performance	**-3,528**	**-5,114**				**-15,349**	
		Other performance measures							
		Capital spend	1,779	1,368				21,695	
		Employees (FTE)	2,493	2,480				2,502	
		Case weighted discharges	2,287	2,644				29,239	

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Mental Health and Addictions**
	For the attention of: **Māori Relationship Board**
Document Owner	Patrick Le Geyt, General Manager, Māori Health, Te Puni Tūmatawhānui
Champion(s)	John Burns, Executive Director of Provider Services
Document Author(s)	David Warrington, Service Director, Mental Health & Addictions Peta Rowden, Nurse Director, Mental Health & Addictions Anoek Dechering, Clinical Director, Mental Health & Addictions
Reviewed by	Charrissa Keenan, Programme Manager, Māori Health Justin Nguma, Senior Population Advisor, Māori Health
Month/Year	February 2020
Purpose	To provide the Executive Leadership Team and governance groups with an update on the services delivered under the Mental Health and Addiction priority indicators, and the progress made towards achievement of health equity targets.
Previous Consideration Discussions	Reported annually
Summary	Mental health and addiction are significant problems in Hawke's Bay. While the health system alone cannot fix these problems, it can take responsibility for its part in providing the necessary help and support for people and their whānau when they need it. Te Ara Whakawaiora (TAW) is an accountability mechanism used by Hawke's Bay District Health Board to monitor equity achievement against four priority health areas, which are: Child Health; Māori workforce development and cultural competency; Ambulatory Sensitive Hospitalisations 45-64 years, and Mental Health and Addictions. This TAW report provides a progress report on achievement of equity targets for Māori experiencing mental health and addictions. There are three national and local indicators specific to this health priority: 1. Reduction in the number of Māori subject to an indefinite compulsory treatment order (Section 29) of the Mental Health Act (1992). 2. Improving discharge and transition plans for youth. 3. Shorter wait times for non-urgent referrals (youth). **Indicator 1: Reduction in Compulsory Treatment Orders (CTO)** A review on the performance of CTO's and models of care for both acute and community services has been completed. A greater focus on recovery approaches is being embedded to build resilience for people with low-prevalence conditions and/or high needs and to be more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment.

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	Key recommendations: re-establish the CTO review meetings; and mandatory and specific training to assist in appropriate engagement / approaches with consumers / whānau. **Indicator 2: Improving discharge and planning for youth** MH&AS has met the expected target under this indicator. The lower number of referrals may have contributed to this outcomes with less demands on the capacity on staff to complete plans on time. **Key recommendation:** To maintain equity achievement activities will future activities will involve follow-up care for those discharged from CAFS and AOD services; CAFS service review; and Increase collaboration with NGOs, Primary Care and community service providers. **Indicator 3: Shorter wait for non-urgent mental health and addiction services** Capacity and capability (including skill mix) demands on the team have impacted on the ability to meet the national target of 80% (<3 weeks) and 95% (<8 weeks) for mental health services and wait times. **Key recommendations:** CAFS service review and scoping of potential for alternative options to admission for youth.
Contribution to Goals and Strategic Implications	Mental Health and Addiction 2019-20 Service Plan; Hawke's Bay DHB Strategy 2019-2029; 2018 Mental Health and Addictions Inquiry and recommendations.
Impact on Reducing Inequities/Disparities	A comprehensive, equity focused approach to eliminate barriers to access to care for whaiora Māori, and improve mental health and addiction outcomes.
Consumer Engagement	The Partnership Advisory Group are involved in service development and quality improvement initiatives to ensure that consumer voice is heard at all levels. The consumer advisor and family advisor are also fully engaged with quality improvement work.
Other Consultation /Involvement	Mental Health and Addiction Staff; Kaitakawaenga; Police Liaison Clinical Nurse Specialist; Director of Area Mental Health Service (DAMHS)
Financial/Budget Impact	MH&AS have and/or plan to invest in the following areas: 1. Appointment of a Continuous Improvement Manager. Invaluable in turning data into information and action. 2. Change in personnel and increase FTE of 0.1 - 0.2 for the Director of Area Mental Health Service. Enabling more of a focus on Māori under CTOs and Seclusion. 3. Agreement with Māori Health to jointly fund Māori role at directorate level for MH&A to help drive equity. 4. Appointment of new Consumer Advisor – successful candidate is Māori.
Timing Issues	Not applicable
Announcements/ Communications	Not applicable
Māori Health Service review	It is not clear how equity for Māori is going to be achieved in the proposed next steps. This must be explicit, and at the forefront of all decision making. Actions must be specific and actions targeted toward improving access to care for Māori are elevated and evidenced.

RECOMMENDATION:

It is recommended that the Māori Relationship Board:

1. **Note** this report provides a progress update as part of Te Ara Whakawaiora reporting for mental health and addictions
2. **Endorse** the next steps and recommendations.

HAWKE'S BAY District Health Board Whakawāteatia

MENTAL HEALTH & ADDICTION

Author/s:	David Warrington & Peta Rowden
Designation:	Service Director & Nurse Director
Date:	January 2020

OVERVIEW

Te Ara Whakawaiora (TAW) is an accountability mechanism used by Hawke's Bay District Health Board to monitor equity achievement against priority health areas. Equity Champions are required to report annually on respective indicators to the Executive Leadership Team and Governance Boards on implementation progress of activities. There are four priority health areas including:

- Child Health
- Māori Health Workforce
- Ambulatory Sensitive Hospitalisations (ASH) 45-64 years
- Mental Health and Addictions

This TAW report provides an update on activities, achievements, and recommendations for improving equity of health outcomes for Māori experiencing mental health and addictions. Note, this report is part of the 2019 reporting cycle, however due to the timing and changes at ELT and Board meetings, the report was deferred to the first available meeting for 2020.

MĀORI HEALTH PLAN INDICATOR: ADULT HEALTH

This report provides an update on the following indicators for Adult Health:

MENTAL HEALTH					
Mental Health and AOD *National and Local Indicators*	1. Rate of section 29 Compulsory Treatment Orders per 100,000 population	≤81.5%	John Burns	David Warrington	FEB 2020 Reporting as follows: • MRB Mtg 12 Feb 2020 (Papers to Board Administrator by 4 Feb 2020) • BOARD Mtg 26 Feb 2020 (Papers to Board Administrator by 18 Feb 2020)
	2. Improving mental health using transition planning (discharged) from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services with a transition (discharge) plan	≥95%			
	3. Shorter waits for non-urgent mental health and addiction services Mental Health: • % seen within 3 weeks • % seen within 8 weeks Addictions: • % seen within 3 weeks • % seen within 8 weeks	 ≥80% ≥80% ≥95% ≥95%			

WHY ARE THESE INDICATORS IMPORTANT?
Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. The CTO requires that a person with a mental health disorder must receive hospital based treatment and observation. Patients can be sectioned if their own health or safety are at risk, or to protect other people. Māori have higher rates of use of Section 29 compared to non-Māori showing that more than half of whaiora on CTO are Māori. Monitoring CTO rates is important to provide data for teams in order to prepare for clients with CTO and for staff to respond appropriately.

The percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan is an indicator of integration with primary care. The current data shows improvement is needed in the partnership between primary and secondary services.

The MOH monitoring framework expects that the proportion of people aged 0 to 19 years requiring non-urgent Mental Health or Addiction Services (MH&AS) are seen within acceptable timeframes of three weeks of referral to face-to-face appointment. HBDHB data shows youth are waiting longer for appointments indicating barriers to access to care.

Inequity in Outcomes in Mental Health Status for Māori, along with a number of other indicators, this data shows continuing and persistent inequity in quality of care for Māori. This is evidenced by:

- Māori have disproportionately higher rates of access to Mental Health Services than non-Māori.
- Māori have disproportionately higher rates of use of Section 29 compared to non-Māori on average.
- Estimated twelve-month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%[i]). See **
- Hospitalisation rate and readmission rate is disproportionately higher for Māori.

INDICATOR 1: Rate of Section 29 Compulsory Treatment Orders
New Zealand has very high rates of compulsory treatment orders under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a compulsory treatment order which represents a significant disparity as highlighted by the Office of the Director of Mental Health. As shown in Figure 1 below, Māori CTO rates have over the years continued to show higher trends when compared with non-Māori.

There are regional and local differences, not necessarily related to population mix, which HBDHB needs to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in the Mental Health and Addiction Service Development Plan 2019-2020 including other actions in the plan that relate to addressing disparities or self-management.

Broadly, with regard to prognosis in the treatment of schizophrenia, there are two key factors which impact significantly, including (a) longer duration of untreated psychosis and (b) higher functional impairment. Assertive services, especially at the initial onset of psychosis are crucial to support functional gain and generating positive outcomes.

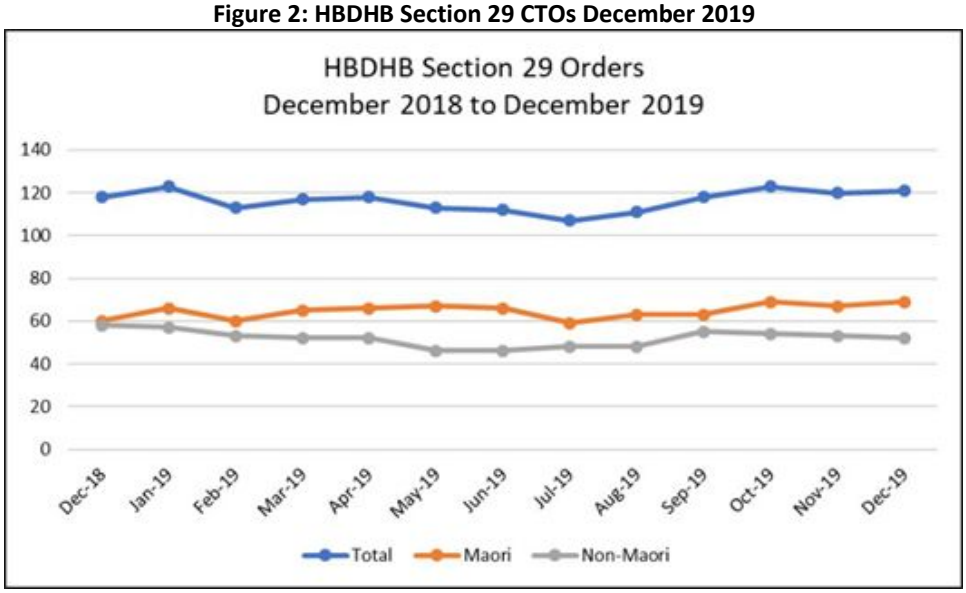
Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies, including cultural and social agencies, so as to provide a more holistic, integrated and comprehensive response.

Figure 1: Rate of section 29 CTO

	Per 100,000 Population				
	12 months to:	**Target**	**Māori**	**Non-Māori**	**Pacific**
2018/19	Sep-18	375	392	120	126
	Dec-18	375	395	119	109
	Mar-19	375	407	123	141
	Jun-19	375	420	120	123
2019/20	Sep-19	375	425	120	139

The following graph shows the actual number of people in Hawke's Bay subject to Section 29 Compulsory Treatment Order each month from December 2018 to December 2019.

Figure 2: HBDHB Section 29 CTOs December 2019



**** With the** estimated twelve-month prevalence of schizophrenia for Māori (0.97%) being significantly higher than for non-Māori (0.32%[ii]) it is of interest to note that a snapshot of the data as of 27 January 2020 shows a total of 150 individuals on a CTO. This is made up of 80 individuals who identify as Māori and 70 individuals who identify as non-Māori. 70% of the total number have a diagnosis of Schizophrenia or Schizophrenia type illness. The data also shows that 75% of Māori under a CTO have a diagnosis of Schizophrenia or Schizophrenia type illness and for non-Māori this is 64%. It shows that whilst Māori are disproportionately overrepresented for those treated under a CTO the numbers are not widely dissimilar to non-Māori with regards to those treated under a CTO with a diagnosis of Schizophrenia or Schizophrenia type illness bearing in mind Māori experience Schizophrenia at a rate of almost 3 times that of non-Māori.

Investigation into the higher prevalence rate of Schizophrenia for Māori than non-Māori is warranted exploring potential causes and contributors such as diagnostic bias, lack of cultural competency, or a predisposition to schizophrenia for Māori that is different for non-Māori.

CHAMPION'S REPORT: ACTIVITY THAT WILL OCCUR TO IMPROVE OUTCOMES OF THIS INDICATOR
A review of the Mental Health and addiction Service (MH&AS) performance on CTO had been previously completed and provide a baseline understanding of the actions required to reduce the numbers of people under CTO. As a result, MH&AS are reviewing the models of care for both acute and community services. This includes a determined focus on recovery approaches that build resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment.

In 2019, the MH&AS Directorate Leadership team (DLT) initiated regular meetings to review all consumers in Hawke's Bay who were subject to CTO Section 29. The focus was to begin with Māori who were on indefinite orders and then work to review all consumers. Significant risks and challenges were identified for an NGO provider due to their clinical capacity and capability. It was noted that the NGO had high numbers of high-risk patient subject to the MHA and that often review of these cases were not being completed. There has also been a change to the DAMHS role and investment of a further 0.1 FTE for this position which will allow for more dedicated work to be done around understanding the overrepresentation of Māori subject to CTOs and what can be done to improve this statistic

A key non-government organisation (NGO) partner has also had significant capacity and capability issues. During the last few years, there have been challenges in DLT's ability to recruit a permanent consultant psychiatrist to work with the NGO. This was due to clinical risk concerns as well as concerns around the case load and work load. Locum psychiatrists as a result have provided the clinical oversight for two years and since the latter portion of 2019, we have had to transfer the clinical reviews to the DHB service. This has placed significant pressure on DHB service and NGO.

Building relationships and having meaningful partnerships across the health sector would enhance access through integration of hospital and community services, especially with Kaupapa Māori services and primary health. The DLT, in partnership with Māori Health has agreed and are working towards a Māori specific role at Directorate level to assist and advise on how to achieve equity for Māori in key areas of Mental Health and Addiction.

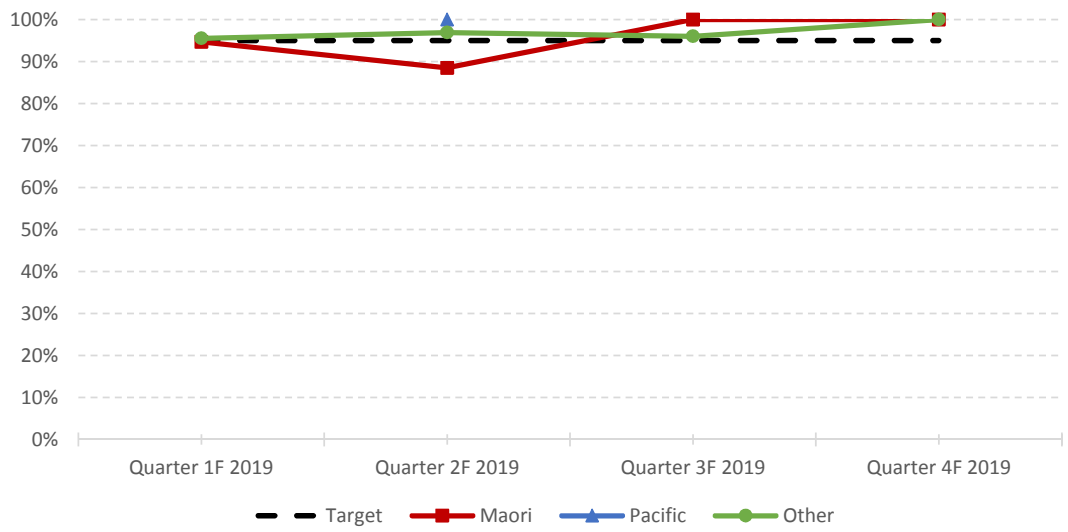
NEXT STEPS AND RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	• Monitor Compulsory Treatment Orders (CTOs) by ethnicity and continue with actions which have contributed to a decrease in CTOs for Māori; • Partner with police; education of nurses and key workers to support whānau to understand legal issues and the process of CTO courts. • Explore written material used to explain these processes to whānau in other centres, with a view to using locally, if appropriate • Establish and recruit to Māori specific role to DLT to assist and advise on achieving equity.	DLT	July 2020
Re-establish the CTO review meetings	• Formulate Terms of reference to ensure purpose and appropriate membership • Set up meetings • Engage with DAMHS and District Inspector	DLT	March 2020
Staff to attend mandatory and MH specific training to assist in appropriate engagement / approaches with consumers / whānau	• Engaging Effectively with Māori • Sensory modulation • De-escalation and Breakaway (community / NGO) • Trauma informed care • Safe Practice Effective Communication (inpatient / security)	Team managers	December 2020

INDICATOR 2: Improving mental health using transition planning (discharged) from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services with a transition (discharge) plan (≥95%)

This indicator requires that after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and/or referrer. CAFS is meeting the KPI on transition planning. Improvement over time has largely been driven by regular review of reporting, and correcting occasions when a discharge plan has not been completed. For children / youth who identify as Māori, the target of >95% had not been reached in quarter 1 and 2 of 2019 but there was improvement for Quarter 3 and 4; increasing to 100% achieved. The target for Pacific has been achieved, however data shows low referral volumes, as has the non-Māori / non-Pasifika populations as shown in the figure below.

Figure 3: Percentage of Clients Discharged from CAFS and Youth Alcohol and Other Drug (AOD) Services with a Transition (Discharge) Plan



	Percentage of Clients discharged from CAFS and Youth Alcohol and Other Drugs (AOD) Services with a Transition (Discharge) Plan								
	NEW ZEALAND MĀORI			PACIFIC ISLANDER			OTHER ETHNICITY		
	No. referrals closed	No. transition plans done	% transition plans done	No. referrals closed	No. transition plans done	% transition plans done	No. referrals closed	No. transition plans done	% transition plans done
Q1F 2019	19	18	94.7%	0	0		66	63	95.5%
Q2F 2019	26	23	88.5%	2	2	100.0%	64	62	96.9%
Q3F 2019	7	7	100.0%	0	0		25	24	96.0%
Q4F 2019	6	6	100.0%	0	0		10	10	100.0%

CHAMPION'S REPORT: ACTIVITY THAT WILL OCCUR TO IMPROVE OUTCOMES OF THIS INDICATOR
CAFS have been under considerable pressures with increased demand (referrals / presentations) and reduced resources due to high vacancy rates. The risk to CAFS being able to provide safe and timely services has been highlighted as a risk but the MH&AS is working on plans / strategies to mitigate risk.

Every CAFS clinician who has primary responsibility for a case completes the core transition document. The completed transition plans are communicated to the primary referrer. Regular auditing of exceptions assists in identification of the small number of cases in which transition plans were not completed, which are then corrected.

NEXT STEPS AND RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) services.	Formalise implementation of Transition Planning Checklist as per standard practice. Amend discharge documentation to include standard prompts to primary referrer. Introduce "error flag" in patient administration system to prompt completion.	CAFS CM & ACNM	June 2020
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy.		March 2020
CAFS service review	MH&AS have been given approval for review of CAFS service. The review will focus on: • Scope • Model of care • Staffing and/ skill mix Reviewers are currently being sought.	DLT	June 2020
Increase collaboration with NGOs, Primary Care and community service providers	Enhance capability at PHC level to reduce demand on secondary services.	CAFS CM & ACNM	June 2020
	Deliver group therapies in primary care, to increase access to evidenced-based interventions		June 2020

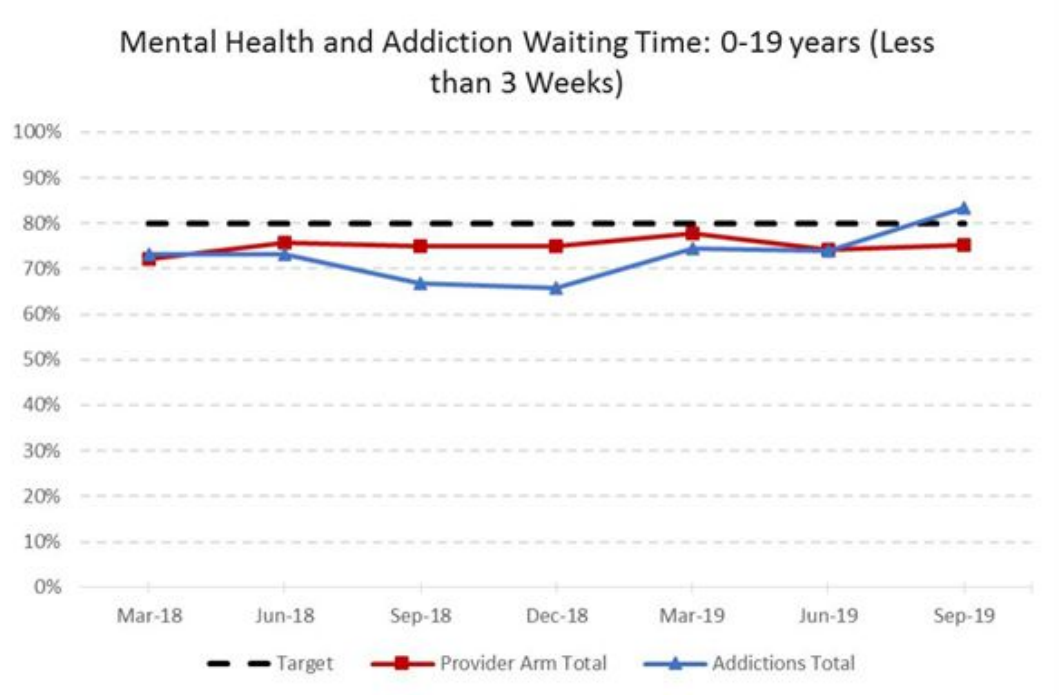
INDICATOR 3: Shorter waits for non-urgent mental health and addiction services
This indicator is defined as the time between receiving the referral to the time the child / family are seen face to face by a health practitioner. It should be noted that if there is an acute need, the young person is seen the same day.

The goal of the KPI is largely to provide a measure of service responsiveness. If a family do not attend a planned appointment, then this counts against the KPI. Similarly, family preferences (i.e. over school holidays, later appointments due to travel or other commitments) are also considered, which can impact on the KPI. This calls for a need to adjust our service delivery and being responsive to whānau needs including time and setting conveniences.

CAFS have faced some challenges, locally and nationally where some settings have shifted clinical practice, where referrals are seen quickly (meeting the KPI) but the subsequent contact is scheduled at a significantly later period. This creates a need to monitor both the initial appointments and timeliness of subsequent appointments.

Due to challenges faced by CAFS regarding capacity and capability (including skill mix) the national target of 80% (<3 weeks) and 95% (<8 weeks) for mental health wait times has not been met. The data shows that Māori are seen earlier than non-Māori; with the exception of Pasifika (100%) due to lower presenting referrals.

Figure 4: Mental Health and Addiction Waiting Time



Mental Health Provider Arm									
<3 weeks					<8 weeks				
Target	Total	Māori	Pacific	Other	Target	Total	Māori	Pacific	Other
80.0%	75.2%	79.9%	70.0%	71.6%	95.0%	93.3%	93.1%	100.0%	93.1%

Provider Arm & NGO (Alcohol and Drug)									
<3 weeks					<8 weeks				
Target	Total	Māori	Pacific	Other	Target	Total	Māori	Pacific	Other
80.0%	83.3%	77.8%	100.0%	87.0%	95.0%	95.2%	93.1%	100.0%	100.0%

CHAMPION'S REPORT: ACTIVITY THAT WILL OCCUR TO IMPROVE OUTCOMES OF THIS INDICATOR

A significant amount of procedural and administrative work has been initiated to ensure proactive management of referrals. CAFS have appointed a Triage Clinician with the prime focus on ensuring that referrals are triaged, processed and allocated in a timely manner. Timeliness and responsiveness are crucially affected by matching capacity to demand. The reality however, is that referral volumes to CAFS have significantly increased since 2008. Capacity, capability and the lack of skilled clinicians to undertake choice assessments and subsequent therapeutic treatment modalities has posed challenges for the team to meet this KPI.

Access issues impact on the wait times KPI. Efforts to address this have included:

- Telephone contact with the family shortly after referral to introduce the service and to ensure the proposed appointment time works for the family.
- Kaitakawaenga support is available to the team. At referral, families who may benefit from support are identified by the Kaitakawaenga and supported to engage with the services where needed.
- CAFS are seeking to engage with young people in settings familiar to the young person (i.e. at schools and through other agencies where the young person or family already have relationships).

NEXT STEPS AND RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
CAFS service review	MH&AS have been given approval for review of CAFS service. • Scope • Model of care • Staffing and / skill mix Reviewers are currently being sought.	DLT	June 2020
Alternatives to admission	Scoping of potential for alternative options to admission for youth to be developed e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	CAFS CM	June 2020

Māori Health Review

The Māori Health Service has reviewed the contents of this report; an analysis of the information is provided and advice to ensure equity focused activities over the coming year. The proposed next steps and recommendations identify a range of activities to improve service cultural and clinical responsiveness, sector collaboration, and models of care and health service design. But, it is not clear how equity for Māori is going to be achieved in the proposed next steps. This must be explicit, and at the forefront of all decision making. Actions must be specific and actions targeted toward improving access to care for Māori are elevated and evidenced.

While this report primarily focuses on the three specified indicators, the role and impact of wider mental health and addiction services and activities cannot be isolated from this work. As iterated in the Mental Health and Addictions inquiry, while the current system has valuable strengths, the mental health and addictions system is under pressure and unsustainable (2018). There are key projects underway that have the ability to alleviate the pressure on current MH&AS and contribute to improved service delivery to whaiora and whānau, but to achieve this requires a whole systems approach to ensure a continuum of care that is culturally and clinically responsive. The impending Mental Health and Rangatahi Redesign projects, as well as government investment in mental health in the primary care setting, present opportunities for the MH&AS to reduce demand on secondary services. These have not been considered in this plan.

Indicator 1: The report describes the disproportionate and inequitable distribution of CTO between Māori and non-Māori. Since 2018, the rate for non-Māori has remained relatively stable at around 120, well below the target of 375 per 100,000. On the other hand the rate for Māori has steadily increased over the same period at 392 to 425 per 100,000. The CTO rate in relation to the 81% target is not clear. The service is still gathering information to gain a greater understanding of the high levels of inequity observed under this indicator. To do so the service might need to address a number of questions which should have been asked earlier on in the initial planning of activities focused on this indicator[1]. Answers to these questions will

[1] *For example:*

- *How well, if at all do we understand the factors which contribute to the rates of CTO for Māori?*
- *How are the different clinical approaches used by staff likely to influence their diagnosis of mental health among Māori as opposed to non-Māori patients? Is this influence also likely to be observed in the prescription of antipsychotic medicine?*
- *How adequate is the understanding of the clinical staff of the Māori cultural explanatory health models and responsiveness to the cultural health expectations of Māori patients and their whānau?*
- *What type of services are provided to patients/whānau at the community and at service level and how well are we doing it?*

provide the service with a better understanding of where the intervention efforts need to be focused on better outcomes including the nature of sectors and agencies to collaborate with to provide a more holistic, integrated and comprehensive response. Furthermore, the proposed next steps provide an opportunity to incorporate a strong quality improvement approach to give more purpose and tangible results from proposed meetings and health literacy activities, as well as implement learnings from the CTO review.

Indicator 2: The MH&AS has indicated that there are workforce pressures impacting negatively on the ability to ensure ≥95% of young people using Child and Adolescent Mental Health Services and Youth Alcohol and Other Drug services have a transition discharge plan. Despite this, it is positive to see a 100% completion rate has been achieved for rangatahi Māori in quarters 3 and 4. But, it should be noted that the number of completions has dropped signifcantly for both Māori (68%) and other (72%) compared to Q1 and Q2. It is not clear why or the implications of this decline on current and future completion rates. It is also unclear why other young people were more likely to receive a transition discharge plan than rangatahi Māori and what actions are in place to avoid this differential treatment. The proposed activities ensure a robust process for ensuring discharge plans are completed, however equity for rangatahi Māori needs to be explicit to avoid a generic approach.

Indicator 3: the report presents wait time data for both mental health (provider arm), and alcohol and drug services (provider arm and NGO partners). Wait times for mental health services at <3 weeks are close to meeting the 80% and 95% targets, and equity for Māori is being achieved i.e. higher numbers of Māori seen earlier. Access to alcohol and drug support is below the 80% and 95% targets for Māori at 3 and 8 weeks and is 9.2% and 6.9% respectively behind the other population group. A number of activities have been undertaken to put in place the necessary processes and people to ensure timeliness is achieved (such as kaitakawaenga support), but a main challenge is the increase in referrals and the lack of capacity to meet the ongoing demand. It is pleasing to see innovative approaches to improve timeliness and access to care such as exploring whaiora-centric activities that take services to rangatahi in setting that they prefer.

RECOMMENDATION:

It is recommended that the Māori Relationship Board:

1. **Note** this report provides a progress update as part of Te Ara Whakawaiora reporting for mental health and addictions
2. **Endorse** the next steps and recommendations

REFERENCES

Kake, Arnold and Ellis. Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. Australia NZ J Psychiatry. 2008 Nov: 42(11):941.

- *What can we do differently to improve the nature of services currently provided at the community and service level to reduce the high number of Māori under CTO?*
- *What are the wrap around services needed to bring to enhance the care and suport for whānau?*
- *How well have we been handling the transition of patients from hospital to CTO and vice versa?*

Appendix 1: Mental Health and Addiction Service Plan 2019/2020												
Categories Tick which of these categories is the MAJOR reason for this activity					**Short Term Outcome** (What we want to achieve)	**Activities** What we will do to achieve outcomes If requiring funding (mark with an (F)	**Key Performance Measures** Include population measures and organisational performance measures			**Method of Delivery**	**Funding**	**Month**	**Lead**
Strategic Change	Clinical Risk	Savings	Workforce	Local Improvement			**Quantity** *(How many #)*	**Quality** *(How well %)*	**Short Term Outcome Indicators (***Is anyone better off #/%) Include performance indicators /SLMs*	Registered Project or Quality Improvement Initiative or Continuous Improvement or BAU	New Investment or Operational Budget?		
	✓			✓	**Reduce inequity and improve mental health wellbeing – Focus will be on Suicide Prevention**	• Police liaison service roll out • Implementation of suicide prevention training for workforce (sustainability) • Improve cultural competencies in MH&AS workforce i.e. engaging effectively with Māori, recruitment. • Contribution to strengthening and improving pre and post prevention pathways with aim of co-design to include all stakeholders with aim to improve access to services for Māori.	• Police Liaison position will be recruited permanently. • Regular police / DHB liaison meetings • Adopt a suicide prevention framework / strategy • Training and development of staff for person's with personality disorders 90% of consumer's prescribed antipsychotic medication will attend and be monitored through metabolic clinics.	• 100% clinical staff attend suicide prevention training • Improved relationship with Police and first line responders • Clinical pathways implemented for people in custody • Good outcomes outlined through quality meetings e.g. MH Clinical Risk Events and Quality Improvement meeting. • All recommendations from reviews are discussed and actioned as appropriate / with timeframes.	• Reduction in suicide for people known to / engaged with service • An improved coordinated response from Police and first line responders. • An improved integration with Kaupapa Māori Services. • Improved access rates for Māori to the right service, in a timely manner.	BAU	Operational budgets New Investment	June 2020	DLT / Managers / Leaders

	✓			✓		• Standardise post incident review processes to collect, analyse and ensure recommendations /learnings from adverse events are disseminated and implemented across the service • Establish wellness clinic across CMH to improve metabolic monitoring for those people prescribed anti psychotics and methadone. • Consideration to be given to a dedicated position in the Directorate to support equity for Māori. • Consider the principles and implementation of the Hua Oranga (Mason Drury) – Māori outcome measure. • Kaupapa Māori Sensory Modulation package to be implemented. • Reduce the use of seclusion for Māori • Reduce the use of the MHA (especially indefinite CTO orders S29)	• 90% of consumer's will be register and have regular access to GP follow up. • Register in place for all review recommendations to be listed, discussed and action plans formulated. • Good representation at the LRT / Fusion meetings • Hua Oranga to be nationally mandated and socialised and implemented. • Consumers will be provided with sensory modulation package as an alternative to the mainstream package.	• Feedback and consider implementation of LRT / Fusion recommendations • 100% of staff will be trained in Hua Oranga when it is implemented. • Māori Sensory Modulation package will be provided as an alternative option to consumers.	• Reduction in seclusion and the use of the MHA (especially indefinite CTO orders) for Māori. • Improved transition plans between services. Improved outcomes for Māori and Pasifika.				

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

21. Confirmation of previous minutes 18 December 2019 (Public Excluded)
22. Matters Arising (Public Excluded)
23. Board Approval of Actions exceeding limits delegated by CEO
24. Chair's Update (Public Excluded)
25. Chief Executive Officer's Report (Public Excluded)
26. Hawke's Bay Clinical Council Report (Public Excluded)
27. Chief Medical Officer Verbal Update (Public Excluded)
28. Planning & Funding Report (Public Excluded)
29. Finance Risk and Audit Committee (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).