BOARD MEETING

Date: Wednesday 20 May 2020

Time: 1:30pm

Venue: Zoom meeting (livestreamed for public meeting)

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

Apologies: Nil.

In Attendance:
Craig Climo, Interim Chief Executive Officer
Chris Ash, Acting Chief Operating Officer
Emma Foster, Acting Executive Director, Planning & Funding
Patrick Le Geyt, Acting Executive Director, Health Improvement & Equity
Anne Speden. Executive Director, Digital Enablement

Minute Taker: Kathy Shanaghan, EA to CEO

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	Karakia	1.30
2.	Welcome and Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting – 15 April 2020	
5.	Matters Arising - Review of Actions	
6.	Board Workplan	
7.	Chair's Report (verbal)	

8.	Chief Executive Officer's Report	1.45
9.	Financial Performance Report (Carriann Hall, Executive Director (ED) Financial Services)	1.55
10.	Health Services Report (DHB Provider Arm) Monthly Report (Chris Ash, Acting Chief Operating Officer)	2.05
11.	Board Health & Safety Champion's Update (verbal) - Board Safety Champion	2.15
12.	Planning & Funding Monthly Report (Emma Foster, Acting ED Planning & Funding)	2.20
	Section 2: Discussion / Decision	
13.	Wairoa Integrated Health System (Emma Foster, Acting ED Planning & Funding)	2.30
	Section 3: Governance / Committee Reports	
14.	Māori Relationship Board Report	2.40
15.	Hawke's Bay Clinical Council Report (no written report)	-
16.	Hawke's Bay Health Consumer Council Report	2.45
17.	Pasifika Health Leadership Group report	2.50
18.	Health Improvement & Equity and Population Health Quarterly Report (Acting ED, Health Improvement & Equity)	2.55
19.	**Section 4: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000	

Public Excluded Agenda

Item	Section 5: Routine	Time (pm)
20.	Minutes of Previous Meeting – 15 April 2020 (public excluded)	3.05
21.	Matters Arising (public excluded) – Review of Actions (public excluded)	-
22.	Board Approval of Actions exceeding limits delegated by CEO (public excluded)	-
23.	Chair's Update - verbal (public excluded)	-
24.	Planning & Funding Monthly Report (public excluded)	3.15
	Section 6: Information / Discussion	
25.	Data Clean-Up (public excluded) (ED Digital Enablement)	3.25
26.	COVID-19 Recovery Plan (public excluded) (ED Digital Enablement / Acting Chief Operating Officer)	3.35
27.	Finance Risk and Audit Committee – Chair, Evan Davies (public excluded) - Minutes 15 April 2020 - Minutes 20 May 2020	4.05
	Meeting concludes	

The next HBDHB Board Meeting will be held on
Wednesday 17 June 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 23 April 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 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	Māori Party	Candidate for Ikaroa-Rāwhiti Seat	Will manage HBDHB governance information in confidence	The Chair	18.03.20
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Whararíki 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
	Active	Hawke's Bay District Health Board	Contracted as Intersector Liaison Officer for COVID-19	Take no actions from Board meetings related to CIMS role. Report through operational structure related to CIMS role.	The Chair	02.04.20
Anna Lorck	Active	Attn! Martketing & PR	Owner & Director (Marketing & Comms, publishing).	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	09.12.19
			Communications Contractor/Advisor to multiple businesses.	Will provide a list of health related contracts to Chair and CEO. Will disclose if any conflict is related to agenda items. Will manage HBDHB governance information in confidence.	The Chair	06.04.20
	Active	Labour Party	Labour Party candidate for Tukutuki electorate	Will manage HBDHB governance information in confidence	The Chair	18.03.20
	Active	Mother	Mother is an employee of the DHB at Central Hawke's Bay Health Centre	Will advise of any perceived or real conflict prior to discussion	The Chair	04.02.20
Hayley Anderson	Active	Hawke's Bay District Health Board	Cntracted as Incident Controller for COVID-19	Take no actions from Board meetings related to CIMS role. Report through operational structure related to CIMS role.	The Chair	25.03.20
		Cranford Hospice Trust	Health Consultant - contracted with provider	Will advise of any conflict of interest. If in doubt, will discuss with HBDHB Chair	The Chair	09.12.19
David Davidson	Active	2020 End of Life Choice Act Referendum Society		Will abstain from all decisions related to end of life choice.	The Chair	28.03.20
	Active	Weem Charitable Trust	Provides support services to Cancer sufferers eg Cranford & Cancer Society	Will advise of any perceived or real conflict prior to discussion	The Chair	09.12.19
Joanne Edwards	Active	KiwiGarden Ltd	Director/CEO	Potential conflict. Will abstain from all discussions/decisions that may have some direct relevance to this interest.	Company Secretary	08.01.20
Charlie Lambert	Active	Hawke's Bay Regional Council	Council Member	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	06.04.20
Evan Davies	Active	Chair, Capital Investment Committee	DHB Capital Prioritisation	Potential conflict.	The Chair	7/01/2020

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Crown Infrastructure Partners Covid Recovery Infrastructure Programme	Sector Expert Representative - Health	Potential conflict. Will not take part in any decisions that may have some relevance to this interest and will absence himself from discussions if asked by the Chair.	The Chair	22/04/2020

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 15 APRIL 2020 AT 1.00pm
HELD VIA WEBINAR

PUBLIC

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

In Attendance: Craig Climo (Interim Chief Executive Officer)
Emma Foster (Acting Executive Director Planning & Funding)
Chris Ash (Acting Chief Operating Officer)
Rachel Ritchie, Chair HB Health Consumer Council
Kathy Shanaghan (EA to CEO)

1. The Chair opened the meeting with a Karakia. It was noted that due to the Prime Minister's live update at 1pm, the public meeting could not be livestreamed.

2. APOLOGIES
Heather Skipworth advised that she would need to leave the meeting at 2.30pm.

3. INTEREST REGISTER
No Board member advised of any interests in the items on the agenda. Heather Skipworth advised she was the Māori Party's candidate for the Ikaroa-Rāwhiti seat and asked that the interests register to be corrected to reflect that. **Action**

4. CONFIRMATION OF PREVIOUS MINUTES
The minutes of the Board meeting held on 18 March 2020 were confirmed as a correct record of the meeting.

Moved: Ana Apatu
Seconded: Peter Dunkerley
Carried

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

- **Item 4: 1737 Mental Health Phone/Text Service:** Consumer Council Chair had not received any further communications in respect to this. The Acting Executive Director (ED) Planning & Funding advised that conversations had been taking place with the provider, however due to COVID-19 that had been put on hold. Board members asked if this could continue to be followed up.
  Action: Acting ED Planning & Funding

- **Item 5: Outsourced/Private Patients requiring Intensive Care Following Surgery:** The CEO confirmed that no outsourced / private surgery would be undertaken that would require a long stay in the intensive care unit.

At the last meeting, there was discussion around the Pasifika Health Leadership Group's request for a meeting around equity and it was recommended that group meet with John Whaanga, Deputy Director-General Māori Health, while he was here meeting with the Māori Relationship Board. It was agreed to include this in the actions to ensure it did not get missed. **Action**

6. BOARD WORK PLAN

The Board work plan was noted. The Chair asked for an early heads-up of any reports which were likely to be deferred and whether the work plan might need to be reviewed in conjunction with the COVID-19 recovery plan. The CEO said he expected to have a clearer view in the next two weeks including the ability to get on with 'business as usual'.

It was noted there was no reporting around patient safety or patient quality this month with a request to see some of that reporting starting to flow through next month. **Action**

Consumer Council Chair, Rachel Ritchie, referred to agenda items for May and June and her expectation that those reports would also go through Consumer Council. The Chair confirmed that the normal process would follow with relevant reports going through all committees.

The Chair asked if a schedule could be developed for Board meetings to be held around the region over the next 12 months. **Action**

7. CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Bronwyn Goldfinch	Manager Secretarial Services	Operations Directorate	19	27-Mar-20
Robyn Madden	Registered Nurse	Surgical Directorate	38	25-Mar-20
Mary Scarrott	Payroll Administrator	Corporate Services	20	4-Apr-2020
Jennifer Watson	Alcohol & Drug Clinician	Mental Health Directorate	29	12-Mar-20
Dr Ted Ward	Intensivist	Medical Directorate	46	1-Apr-20

- A public announcement would be made tomorrow confirming the appointment of a new CEO commencing early October 2020. The Chair thanked Board members and interview panel (including Council Chairs) for their participation. He also acknowledged Craig Climo for his leadership and taking the DHB through unprecedented times, noting that Craig would continue in the role until the new CEO was in post.
- The Chair was in regular discussion with the Minister of Health and DHB Chairs. The consistent message was to continue business as usual as best we can, start preparing for recovery, and to focus on the health and wellbeing of our people.
- Meetings with regional Chairs and Leaders continued over the past month.
- On behalf of the Board, the Chair thanked front-line staff (both in the hospital and in the community), management,support and administration staff for the work they were doing during COVID-19.

8. CHIEF EXECUTIVE OFFICER'S REPORT

This report was taken as read.

RECOMMENDATION

That the HBDHB Board:

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

Adopted

9. PLANNING & FUNDING REPORT

This report was taken as read. Comments noted during discussion included:

- ESPI5 waiting times for planned care: It would be useful for future reports to include numbers as well as the percentages. **Action**
- Future design of Health of Older People. Board members would be provided with more detailed information next month
- Board members thanked Emma for a very informative report.

RECOMMENDATION

That the HBDHB Board:

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

Adopted

10. PROVIDER SERVICES REPORT TO BOARD

This report was taken as read, noting it had been discussed at the FRAC meeting earlier in the day.

The Acting Chief Operating Officer (COO) provided the following comments in addition to his report:

- Work over the last three weeks had been significant with staff bending over backwards to support COVID-19
- Senior clinicians and management had worked across departments to rapidly design a COVID Hospital which was implemented within three weeks
- A detailed recovery plan was being developed for how the communities and services impacted by COVID-19 would return to normal function. This was being led by Dr Andy Phillips

Consumer Council Chair acknowledged the amount of work undertaken to prepare for COVID-19 and passed on her thanks on behalf of the Consumer Council and community. She believed, however, that the community was not aware of how much work was involved, or the work currently being undertaken, and suggested a public communication outlining the work happening in the hospital. The Acting COO acknowledged the request, noting the need also to communicate about the teams working in primary care.
Action: Consumer Council Chair

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.
Adopted

11. BOARD HEALTH & SAFETY CHAMPION UPDATE

Heather Skipworth advised that she and Hayley Anderson would be having a zoom meeting with the Health & Safety Advisor tomorrow to get an update on the Health & Safety Strategy and the work currently in train.

REPORT FROM COMMITTEE CHAIRS

12. MĀORI RELATIONSHIP BOARD
No written report this month. It was noted that MRB was having weekly zoom meetings.

13. HAWKE'S BAY CLINICAL COUNCIL
No written report this month.

14. CONSUMER COUNCIL REPORT
Board members had received an email providing an overview of issues discussed at an informal meeting of the Consumer Council meeting on 9 April. This was taken as read. Consumer Council Chair, Rachel Ritchie, provided a brief overview.

In respect to the community wanting more communication, it was pointed out that the Communications team was providing an enormous amount of information and therefore it would be helpful to know what specific information the community was looking for and how they wanted it communicated.
Action: Rachel Ritchie to follow-up

15. PASIFIKA HEALTH LEADERSHIP GROUP
No written report this month.

FOR DECISION

16. HEALTH PATHWAYS
This report sought Board endorsement to replace Map of Medicine with HealthPathways, including sustained investment in not only the HealthPathways product, but also the resourcing and recognition of the clinical and administrative team required to support its implementation and embedding into practice.

Board members were supportive of the approach and asked to be provided with the cost benefit analysis and confirmation that this would address equity. **Action: Acting ED Planning & Funding**

RESOLUTION

That the HBHDB Board:

1. **Endorses** the replacement of Map of Medicine with replacement and implementation of Health Pathways.

MOVED: Hayley Anderson
SECONDED: Ana Apatu

Carried

INFORMATON AND DISCUSSION

17. 2020/21 ANNUAL PLAN UPDATE
This report was taken as read. The Acting ED Planning & Funding provide a high level overview noting that the timeframes had changed. The timeframes would be updated when advice received from the Ministry of Health.

Member comments included:
- It would be useful to understand the resources required for each priority and the key actions, and timeframes for those actions
- It would be helpful if the 12 priorities were listed in order of priority

Action: Acting ED Planning & Funding

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.
Adopted

GENERAL BUSINESS

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

18. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

19. Confirmation of previous minutes 18 March 2020 - Public Excluded
20. Matters Arising (Public Excluded)
21. Board Approval of Actions exceeding limits delegated by CEO (Public Excluded) – no written report
22. Chair's Update (Public Excluded)
23. Chief Executive Officer's Report (Public Excluded)
24. Planning & Funding Report (Public Excluded)
25. Digital Enablement News (Public Excluded)
26. Process for Significant Change (Public Excluded)
27. Finance Risk and Audit Committee (Public Excluded)
28. Emergency Department Extension

Moved: Shayne Walker
Seconded: David Davidson
Carried

The public section of the Board meeting closed at 2.10pm.

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

5

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	25/2/20	**HIE Quarterly Report** Next report to include an update on the following: (a) Areas where cold chain accreditation has not been achieved and the actions being taken (b) Actions being undertaken to increase CVD risk assessments (c) More emphasis around primary care smokefree	Acting ED, Health Improvement & Equity	May 2020	Agenda item May 2020. Verbal update to be provided.
2	25/2/20 15/4/20	**1737 Mental Health Phone/ Text Service (Consumer Council request)** Statistics around unanswered calls and long delays Request that this continues to be followed up	Acting ED Planning & Funding	March 2020 May 2020	Working with MoH to review performance of provider. Considering local solutions to support this vulnerable population. Item tabled at Consumer Council April 2020. Difficulty in obtaining a satisfactory response noted. Follow-up action endorsed.
3	18/3/20	**Pasifika Health Leadership Group (PHLG)** Opportunity for PHLG to meet with Deputy Director-General Māori Health, while at the DHB meeting with MRB	Acting ED Health Improvement & Equity	May 2020	Due to MRB's tight agenda and limited time constraints by the DDG Māori Health, no other committees were invited to attend. Other opportunities are being investigated.
4	15/4/20	**Interest Register for Heather Skipworth** Amend Heather Skipworth's interest to reflect she is the Māori Party's candidate for the Ikaroa-Rāwhiti seat	Administrator	April 2020	Completed
5	15/4/20	**Reports on Patient Safety and Patient Quality** Include on FRAC workplan for May	Administrator	May 2020	Agenda item for May FRAC

Action	Date Entered	Action to be Taken	By Whom	Month	Status
6	15/4/20	**Planning & Funding Report** Future reports to include numbers, as percentages, when reporting ESPI5 waiting times	Acting ED Planning & Funding	Ongoing	Noted for future reports.
7	15/4/20	**Consumer Council request:** That a communication goes out to the public outlining the work occurring in the hospital during COVID-19. Before doing this, it would be helpful to know what specific information the community was looking for and how they would like this communicated.	Consumer Council Chair		Specific information on communications provided by email to CEO 22 and 23 April. Item closed.
8	15/4/20	**Health Pathways** Cost benefit analysis, including confirmation that this will address equity, to be provided to Board members	Acting ED Planning & Funding	May 2020	Circulated to Board members 24/04/20.
9	15/4/20	**2020/21 Annual Plan Update** Update to be provided on the resources required for each priority, including the key actions and timeframes for those actions Priorities to be listed in order of priority	Acting ED Planning & Funding	May 2020	Noted, and in May report.

WORKPLAN as at 12 May 2020	Destination Month	EMT Member	Lead/Author	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
HIE & Pop Health Quarterly report to board	May-20	Patrick Le Geyt						20-May-20
IAR Draft Internal Audit Plan 2020/2021	May-20	Carriann Hall	Jared McGillicuddy				20-May-20	
Provider Services Monthly report	May-20	Chris Ash					20-May-20	20-May-20
Planning & Funding Report	May-20	Emma Foster						20-May-20
Data Clean-Up	May-20	Anne Speden						20-May-20
People Safety and Wellbeing Quarterly Report (FRAC) (Feb, **May**, Aug, Nov)	May-20	Carriann Hall	Tracey Paterson				20-May-20	
Patient Safety and Quality Quarterly Report (FRAC) (Feb, **May**, Aug, Nov)	May-20	Carriann Hall	Susan Barnes		13-May-20		20-May-20	
Financial/Cost Consequences of COVID-19	May-20	Carriann Hall	Chris Comber				20-May-20	
Recovery Plan	May-20	Anne Speden/Chris Ash						20-May-20
Budget 2020/2021	May-20	Carriann Hall					20-May-20	
Wairoa Integrated Health System	May-20	Emma Foster						20-May-20
Worksafe Duty Holder Review	May-20	Carriann Hall	Christine Mildon				20-May-20	
Financial Performance Report	May-20	Carriann Hall					20-May-20	20-May-20
Audit New Zealand - Arrangements Letter for the Audit of HBDHB for the 2020 Financial Year	May-20	Carriann Hall	Phil Lomax				20-May-20	
IAR Payroll Processing Review	Jun-20	Carriann Hall	Jared McGillicuddy				17-Jun-20	
IAR Annual Leave Capture Review **(May**/August/November/February) May moved to June	Jun-20	Carriann Hall	Jared McGillicuddy				17-Jun-20	
He Ngakau Aotea	Jun-20	Patrick Le Geyt						17-Jun-20
Corporate Performance Dashboard (quarterly)	Jun-20	Emma Foster		10-Jun-20	10-Jun-20	11-Jun-20		17-Jun-20
PHO Quarterly report to Board	Jun-20	Wayne Woolrich						17-Jun-20
Provider Services Monthly report	Jun-20	Chris Ash					17-Jun-20	17-Jun-20
Surgical Service Expansion Project update (6 months)	Jun-20	Carriann Hall					17-Jun-20	
Wairoa Community Health report to MRB only (quarterly Nov 19/March 20/June 20/Sept 20	Jun-20	Emma Foster	Emma Foster	10-Jun-20				
Seismic Status of HBDHB Buildings/Facilities	Jun-20	Carriann Hall					17-Jun-20	
Budget 2020/2021 (Final)	Jun-20	Carriann Hall	Chris Comber				17-Jun-20	
Capital Plan	Jun-20	Carriann Hall					17-Jun-20	
IAR RMO Rostering Review	Jun-20	Carriann Hall	Jared McGillicuddy				17-Jun-20	
IAR Primary/Secondary Data Sharing and Utilisation Review	Jun-20	Carriann Hall	Jared McGillicuddy				17-Jun-20	
Collective Insurance Renewal 2020/2021 (for information only)	Jun-20	Carriann Hall					17-Jun-20	
Three Waters discussion - once recieved plan from Napier council (MA 24.04.19)	Jun-20	Patrick Le Geyt	Nick Jones					17-Jun-20
Financial Performance Report	Jun-20	Carriann Hall					17-Jun-20	17-Jun-20
Household Management Review	Jun-20	Emma Foster					17-Jun-20	
Renal Outpatient Booking Review	Jun-20	John Gommans					17-Jun-20	
Significant Service Change - Skin Cancer Pathway	Jun-20	Emma Foster	Penny Rongotoa	10-Jun-20	10-Jun-20	11-Jun-20		17-Jun-20
Update on Medicine Reconciliation Audit	Jun-20	Andy Phillips					17-Jun-20	
Update on the Holidays Act Compliance Report	Jun-20	Carriann Hall					17-Jun-20	
Chief Medical & Dental Officer report to Board	Jul-20	Robin Whyman						15-Jul-20
Chief Nursing & Midwifery Officer report to board	Jul-20	Chris Mckenna						15-Jul-20
Service Improvement Quarterly Report	Jul-20	Anne Speden						15-Jul-20
Chief Allied Health Professions Officer report to board	Jul-20	Andy Phillips						15-Jul-20
Provider Services Monthly report	Jul-20	Chris Ash					15-Jul-20	15-Jul-20
Integrating the Equity Lens within Clinical Processes	Jul-20	Patrick Le Geyt					15-Jul-20	
Quarterly Report to Ministry of Health (April-June (**July 2020**)/July-Sept (Oct 2020)/Oct-Dec (Feb 2021)/Jan-March (Apr 2021)	Jul-20	Carriann Hall						15-Jul-20
Financial Performance Report	Jul-20	Carriann Hall					15-Jul-20	15-Jul-20
HB Health Awards - preparation for judging **2019**-2020	Jul-20	Anna Kirk			8-Jul-20	9-Jul-20		15-Jul-20
Communications Quarterly Report to Board	Jul-20	Anna Kirk						15-Jul-20
MAP initiative evaluation summary	Aug-20	Patrick LeGeyt		12-Aug-20				

WORKPLAN as at 12 May 2020	Destination Month	EMT Member	Lead/Author	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) - moved to August 2020	Aug-20	Patrick Le Geyt	Rachel Eyre	12-Aug-20	12-Aug-20	13-Aug-20		19-Aug-20
HIE & Pop Health Quarterly report to board	Aug-20	Patrick Le Geyt						19-Aug-20
Corporate Performance Dashboard (quarterly)	Aug-20	Chris Ash		14-Aug-19	14-Aug-19	15-Aug-19		19-Aug-20
People Safety and Wellbeing Quarterly Report (FRAC) (Feb, May, **Aug**, Nov)	Aug-20	Carriann Hall	Tracey Paterson				19-Aug-20	
Patient Safety and Quality Quarterly Report (FRAC) (Feb, May, **Aug**, Nov)	Aug-20	Robin Whyman	Susan Barnes		12-Aug-20		19-Aug-20	
Provider Services Monthly report	Aug-20	Chris Ash					19-Aug-20	19-Aug-20
Consumer Story/Consumer Led Outcomes quarterly updates Oct/feb/May/**Aug**	Aug-20	Kate Coley	Caryn Daum			13-Aug-20		
Matariki update to Consumer council written report	Aug-20	Patrick Le Geyt	Shari Tidswell			13-Aug-20		
IAR Annual Leave Capture Review (May/**August**/November/February)	Aug-20	Carriann Hall	Jared McGillicuddy				19-Aug-20	
Financial Performance Report	Aug-20	Carriann Hall					19-Aug-20	19-Aug-20
Cardiology Services Business Case	Aug-20	Chris Ash	Paula Balchin					19-Aug-20
PHO Quarterly report to Board	Sep-20	Wayne Woolrich						30-Sep-20
Provider Services Monthly report	Sep-20	Chris Ash					30-Sep-20	16-Sep-20
Wairoa Community Health report to MRB only (quarterly Nov 19/March 20/June 20/**Sept 20**	Sep-20	Emma Foster	Emma Foster	9-Sep-20				
Financial Performance Report	Sep-20	Carriann Hall					16-Sep-20	16-Sep-20
Chief Medical & Dental Officer report to Board	Oct-20	Robin Whyman						28-Oct-20
Chief Nursing & Midwifery Officer report to board	Oct-20	Chris Mckenna						28-Oct-20
Service Improvement Quarterly Report	Oct-20							21-Oct-20
Chief Allied Health Professions Officer report to board	Oct-20	Andy Phillips						28-Oct-20
Comms report to Board	Oct-20	Anna Kirk						28-Oct-20
Audit NZ - Interim Audit Report for y/e June 2020 (timing TBC)	Oct-20	Carriann Hall					28-Oct-20	
Provider Services Monthly report	Oct-20	Chris Ash					28-Oct-20	21-Oct-20
Audit New Zealand - Interim Audit Report for year ended June 2020	Oct-20	Carriann Hall					21-Oct-20	
Quarterly Report to Ministry of Health (April-June (July 2020)/July-Sept (**Oct 2020**)/Oct-Dec (Feb 2021)/Jan-March (Apr 2021)	Oct-20	Carriann Hall						21-Oct-20
Shareholders Representatives for Allied Laundry, TAS and NZ Health Partnerships	Oct-20	Carriann Hall						21-Oct-20
Financial Performance Report	Oct-20	Carriann Hall					21-Oct-20	21-Oct-20
Communications Quarterly Report to Board	Oct-20	Anna Kirk						21-Oct-20
People Safety and Wellbeing Quarterly Report (FRAC) (Feb, May, Aug, **Nov**)	Nov-20	Carriann Hall	Tracey Paterson				18-Nov-20	
Patient Safety and Quality Quarterly Report (FRAC) (Feb, May, Aug, **Nov**)	Nov-20	Robin Whyman	Susan Barnes		13-Nov-19		18-Nov-20	
HIE & Pop Health Quarterly report to board	Nov-20	Patrick Le Geyt						25-Nov-20
Provider Services Monthly report	Nov-20	Chris Ash					18-Nov-20	18-Nov-20
IAR Annual Leave Capture Review Update (May/August/**November**/February)	Nov-20	Carriann Hall	Jared McGillicuddy				18-Nov-20	
Corporate Performance Dashboard (quarterly)	Nov-20	Emma Foster						18-Nov-20
Financial Performance Report	Nov-20	Carriann Hall					18-Nov-20	18-Nov-20
PHO Quarterly report to Board	Dec-20	Wayne Woolrich						16-Dec-20
Provider Services Monthly report	Dec-20	Chris Ash					16-Dec-20	16-Dec-20
Surgical Service Expansion Project update (6 months)	Dec-20	Carriann Hall					16-Dec-20	
Financial Performance Report	Dec-20	Carriann Hall					16-Dec-20	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	13 May 2020
Consideration:	For Information

RECOMMENDATION

That the Board

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

INTRODUCTION AND COVID-19

Members should get a feel from the papers in this agenda that our focus has moved markedly to business as usual, being BAU in a COVID response environment.

It would be a quick and simple matter if we were able to restore facilities and activity to pre-COVID times, but the need to maintain readiness has made the process of optimising the balance of maximising throughput with readiness quite complicated and far more time consuming than the time taken to put the COVID response in place. The response still includes a case definition that sees us managing every patient with respiratory illness, including common cold symptoms, as potentially a COVID-19 patient. I am hoping that local and national additional COVID-19 testing will enable a less conservative response, which will in turn enable Hawke's Bay Hospital, and the sector generally, to see and treat more people. Seeing and treating more people is my immediate priority. More information is in the "Recovery Plan" in the public excluded section.

FINANCIALS

The DHB's operating result for April was $2M unfavourable (U). Of the main divisions, the:

1. Provider-arm was $0.36M unfavourable, and
2. Funder-arm $1.7M unfavourable.

The Provider-arm variance looks good compared to pre-COVID-19, but was basically a month in level 4 lock down, which saw greatly reduced activity and somewhat reduced cost in direct clinical supplies and outsourcing, but was more than offset by a $0.9M U personnel variance, being far more staff working than required for the number of patients.

The Funder-arm result included $1.2M U in pharmaceuticals, which appears to be the result of COVID-19 – home deliveries, monthly (not three monthly) dispensing, and perhaps some timing issues – and speaks to the challenge of categorising cost as COVID or non-COVID. Higher flu vaccination costs are another example. We have taken a cautious approach to ascribing costs to COVID-19.

It should also be noted that the operating result includes a further $0.35M loss of revenue in relation to Planned Care (electives) performance, taking us to $3.5M year-to-date (YTD) and expected $4.2M by end of the year.

Direct COVID-19 cost for the month was net $2.4m, making the actual result for April $4.4M unfavourable.

The year-to-date result was a $24.5M deficit, being $10.8M unfavourable to budget.

COVID-19 costs committed (mostly not booked) to date is $9.02M, of which $2.1M was passed through from the Ministry. Ministry funding has been $4.8M. There is no expectation that net COVID-19 costs will be funded.

Forecasting in this environment is described in the Executive Director of Financial Services' report in the FRAC agenda.

ANNUAL PLANNING

This agenda includes a paper from Planning & Funding that brings to the Board the matters from the 4 March 2020 planning hui as a further opportunity to discuss them. In the absence of our funding advice for 2020/21, it will be difficult for the Board to make decisions, but it might consider the priorities.

The Government has made a pre-budget announcement regarding total DHB funding. The increases are significant. We await our individual funding packages for the detail.

The balancing act is the bottom line desired, the flow through of costs from 2019/20, new investments the Board wants to make, the savings available, and for now the ongoing costs/constraints of COVID-19 for as long a response has to be maintained.

The Ministry of Health (MoH)has delayed annual planning due to COVID-19. At this stage we only know it will not be finalised by 30 June. I expect MoH advice soon as it too moves to get back to a more BAU footing.

WAIROA

One of the priorities management had been working on in 2019/20 is health services in Wairoa.

A proposal is in this agenda, which in essence is that:

1. The people of Wairoa are better enabled to look after their health.
2. The connection with secondary services is improved, particularly:
    a. Patient transfer to Hawke's Bay Hospital; and
    b. More convenient e.g. outpatient bookings are cognisant of time and distance between Wairoa and Hawke's Bay Hospital.

A cost estimate is in the Wairoa paper and the annual planning paper.

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

RECOMMENDATION:

That the HBDHB Board:

Note the contents of this report

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

For the month of April the operating result, the result before emergency response costs for COVID-19, is $2m unfavourable to plan and $14.3m adverse to plan year-to-date (YTD). The month result includes a further $350k revenue loss on planned care (elective surgery) activity taking estimated revenue loss as a result of Planned Care performance to $3.5m YTD.

In addition to ongoing underlying issues, the operating result was impacted by COVID-19 including loss of income, increased leave liability and high pharmaceutical claims, partially offset by those costs highly sensitive to the reduced activity, such as consumables and outsourced services.

The net impact of costs directly related to the DHB's COVID-19 response was $2.4m in month. Whilst revenue received means that the net YTD impact is $194k favourable, this is coincidental and a factor of timing, it should not be taken to mean costs are being covered by revenue. Further details are provided in a separate paper to the Finance, Risk and Audit Committee.

	April				*Year to Date*				
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		Refer Appendix
Operating Revenue	50,052	51,079	(1,026)	-2.0%	506,865	510,669	(3,804)	-0.7%	1
Less:									
Providing Health Services	25,232	25,249	17	0.1%	256,340	250,177	(6,163)	-2.5%	2
Funding Other Providers	23,050	22,162	(888)	-4.0%	224,066	220,284	(3,782)	-1.7%	3
Corporate Services	5,269	5,245	(24)	-0.5%	50,695	50,230	(465)	-0.9%	4
Reserves	97	(25)	(122)	-479.7%	420	334	(86)	-25.8%	5
Operating Result	**(3,596)**	**(1,552)**	(2,044)	-131.7%	**(24,656)**	**(10,355)**	(14,301)	-138.1%	
Plus:									
Emergency Response (COVID-19)	(2,373)	-	(2,373)	0.0%	194	-	194	0.0%	
	(5,969)	**(1,552)**	(4,417)	-284.6%	**(24,462)**	**(10,355)**	(14,106)	-136.2%	

Key YTD Drivers

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)

  Loss of Planned Care revenue of $3.5m YTD (estimated $4.2m full year), based on pre COVID-19 forecast volumes. The COVID-19 lock-down from late March is also impacting revenue that is highly sensitive to activity levels such as ACC activity

- Providing Health Services (Appendix 2)

  High patient demand prior to the pandemic lock down. In April overspends in personnel as a result of leave cancellations and staffing levels were offset by low levels of clinical outsourcing, consumables and other activity sensitive costs as a result of relatively low patient numbers

- Funding Other Providers (Appendix 3)

  Faster than expected take-up of new pharmaceuticals and changes to a higher cost/mix of care in Health of Older People are the main underlying issues. High pharmaceutical claims probably reflecting changes in prescribing due to the lock down, costs of bringing forward the vaccination programme and a nationally mandated increase in contribution to the National Haemophilia Management Group impacted the in-month result. These increases were partially offset by a reduction in inter district outflows as there was very limited transfers between DHBs during the lock down.

Other Performance Measures

	April				*Year to Date*				
	Actual	***Budget***	***Variance***		***Actual***	***Budget***	***Variance***		Refer Appendix
	$'000	*$'000*	*$'000*	*%*	*$'000*	*$'000*	*$'000*	*%*	
Capital spend	992	1,779	(787)	-44.3%	10,600	18,189	(7,589)	-41.7%	10
	FTE	*FTE*	*FTE*	*%*	*FTE*	*FTE*	*FTE*	*%*	
Employees	2,580	2,549	(30)	-1.2%	2,510	2,501	(9)	-0.4%	2 & 4
	CWD	*CWD*	*CWD*	*%*	*CWD*	*CWD*	*CWD*	*%*	
Case weighted discharges	1,149	2,222	(1,074)	-48.3%	25,316	24,251	1,065	4.4%	2

- Capital spend (Appendix 12)

  Uncertainty around equity funding for strategic projects resulted in an underspend in the early part of the year. Capital spend efforts were retasked to COVID-19 related projects from late March resulting in reductions in non-strategic projects also. In May we will do further work around the treatment of capital items purchased as a part of our COVID-19 response which could impact the capital spend.

- Cash (Appendices 11 & 13)

  The cash low point for the month was $23.4m overdrawn on 2 April immediately before funding for the month was received, and the end of month position was $7.7m overdrawn. A breach of the statutory limit was avoided and the cash position was materially improved by receipt of $20m of deficit funding in the second half of April. Deficit support (also known as equity injection) is a cash transaction and does not impact the operating result.

- Employees (Appendices 2 & 4)

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

- Activity (Appendix 2 and 7)

  Prior to March case weight discharges (CWDs) were close to plan, as high maternity and acute volumes offset low elective surgery numbers. As a result of the alert levels and readiness for a possible COVID-19 influx, CWDs were half the planned level in April

Forecast

Uncertainty over the path of the COVID-19 pandemic makes it difficult to forecast revenue and costs going forward. Consequently, a detailed forecast has not been included in the report this month.

APPENDICES

1. INCOME

Excludes revenue for COVID-19	*April*				*Year to Date*			
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*	
Ministry of Health	48,287	49,066	(779)	-1.6%	486,619	489,992	(3,372)	-0.7%
Inter District Flows	697	707	(10)	-1.5%	7,160	7,074	86	1.2%
Other District Health Boards	290	366	(76)	-20.7%	3,372	3,661	(289)	-7.9%
Financing	(1)	7	(8)	-117.0%	89	70	19	27.1%
ACC	308	394	(86)	-21.8%	4,343	4,114	229	5.6%
Other Government	56	56	(1)	-1.2%	420	432	(13)	-2.9%
Patient and Consumer Sourced	83	104	(21)	-19.8%	1,229	1,037	192	18.5%
Other Income	331	378	(47)	-12.4%	4,887	4,288	599	14.0%
Abnormals	1	-	1	0.0%	(1,255)	-	(1,255)	0.0%
	50,052	**51,079**	**(1,026)**	**-2.0%**	**506,865**	**510,669**	**(3,804)**	**-0.7%**

Underlying drivers of non-covid related operating results year-to-date

- Unfavourable Ministry of Health income mainly relating to planned care (elective surgery), partly offset by capital charge funding relating to the revaluation of land and buildings at the end of 2018/19, and additional funding for social work services
- Unfavourable abnormal items including lower than expected wash-ups for PHO performance payments and pay equity 2018/19.
- Favourable ACC income including elective surgery and rehabilitation
- Favourable general income including donations and clinical trial revenue, food sales, GP Health Care income, accommodation and rent

Impact of COVID-19 on operating activities (excludes costs of managing the emergency response)

- Unfavourable other DHB and ACC income in month as low patient numbers reduced recoveries

2. PROVIDING HEALTH SERVICES

	April				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
Expenditure by type $'000								
Medical personnel and locums	6,158	5,836	(321)	-5.5%	63,763	60,501	(3,262)	-5.4%
Nursing personnel	8,711	8,295	(415)	-5.0%	79,470	78,398	(1,072)	-1.4%
Allied health personnel	3,591	3,516	(75)	-2.1%	32,214	33,609	1,395	4.2%
Other personnel	2,332	2,233	(99)	-4.4%	21,847	21,526	(321)	-1.5%
Outsourced services	597	745	147	19.8%	8,204	8,087	(117)	-1.5%
Clinical supplies	2,856	3,336	481	14.4%	35,921	33,586	(2,336)	-7.0%
Infrastructure and non clinical	988	1,288	300	23.3%	14,922	14,471	(451)	-3.1%
	25,232	**25,249**	**17**	**0.1%**	**256,340**	**250,177**	**(6,163)**	**-2.5%**
Expenditure by directorate $'000								
Medical	7,799	7,307	(492)	-6.7%	73,253	70,618	(2,635)	-3.7%
Surgical	5,167	5,724	556	9.7%	58,193	57,661	(532)	-0.9%
Community, Women and Children	4,125	4,203	78	1.8%	41,542	41,676	134	0.3%
Mental Health and Addiction	2,008	1,869	(139)	-7.4%	19,354	18,301	(1,053)	-5.8%
Older Persons, NASC HB, and Allied H	1,494	1,497	3	0.2%	14,298	14,839	541	3.6%
Operations	3,639	3,703	64	1.7%	39,214	37,553	(1,661)	-4.4%
Other	1,000	946	(53)	-5.6%	10,487	9,529	(958)	-10.1%
	25,232	**25,249**	**17**	**0.1%**	**256,340**	**250,177**	**(6,163)**	**-2.5%**
Full Time Equivalents								
Medical personnel	409.9	373.3	(37)	-9.8%	371	374	3	0.7%
Nursing personnel	1,049.4	1,057.0	8	0.7%	1,053	1,023	(30)	-2.9%
Allied health personnel	492.6	499.8	7	1.4%	474	492	18	3.6%
Support personnel	122.8	118.1	(5)	-4.0%	126	114	(11)	-9.9%
Management and administration	279.7	280.7	1	0.4%	277	278	1	0.4%
	2,354.6	**2,328.9**	**(26)**	**-1.1%**	**2,301**	**2,282**	**(19)**	**-0.9%**
Case Weighted Discharges								
Acute	969	1,451	(482)	-33.2%	18,505	16,506	1,999	12.1%
Elective	119	579	(461)	-79.5%	4,849	5,713	(864)	-15.1%
Maternity	59	160	(101)	-62.9%	1,652	1,675	(23)	-1.4%
IDF Inflows	2	32	(30)	-94.3%	310	357	(47)	-13.2%
	1,149	**2,222**	**(1,074)**	**-48.3%**	**25,316**	**24,251**	**1,065**	**4.4%**

Underlying drivers of non-covid related operating results year-to-date

- Unfavourable medical personnel and locum expenditure as vacancies were more than offset by locum vacancy and leave cover, and additional sessions to cope with volumes.
- Unfavourable clinical supplies including efficiencies not achieved, adverse blood product (mainly Intragam) costs, patient transport costs, and implants and prostheses, partly offset by pharmaceutical reimbursements.
- Unfavourable nursing personnel costs from high casual and on-call allowances and overtime payments relating to patient volumes.
- Unfavourable infrastructure and non-clinical costs including security (patient watches), Māori workforce scholarships (offset in income), and food, laundry and cleaning costs relating to patient volumes.
- Favourable allied health personnel expenditure from vacancies in social workers, technicians, psychologists, occupational therapists, laboratory technicians, cultural workers, and pharmacists.

Impact of COVID-19 on operating activities (excludes costs of managing the emergency response)

- Unfavourable personnel costs mainly as a result of an increase in leave liability with leave being cancelled or not taken as we would normally expect over Easter and staffing levels maintained despite low activity levels for risk management purposes and due to the inherent inefficiency as a result of infection control actions

- Favourable outsourced services, clinical supplies and infrastructure costs as low patient numbers during lock down reduced costs

Case Weighted Discharges (CWDs)

Underlying drivers of non-covid related operating results year-to-date

- Overall (CWDs) are above plan attributable to acute patient volumes partly offset by low elective surgery.

Impact of COVID-19 on operating activities (excludes costs of managing the emergency response)

- Due to impact of alert levels and readiness for a possible COVID-19 influx, CWDs were half the planned level in April

Full Time Equivalents (FTE)

Underlying drivers of non-covid related operating results year-to-date

- Higher than planned nursing personnel (-30 FTE / -2.9% unfavourable) reflecting the impact of patient watches and higher than planned levels of activity mainly in the wards earlier in the year.
- Ongoing vacancies in allied health personnel (18 FTE / 3.60% favourable) including social workers, psychologists, laboratory and pharmacy technicians, and occupational therapists.
- Pressure on support personnel (-11 FTE / -9.9% unfavourable) including kitchen staff, security (patient watches), and orderlies.

Impact of COVID-19 on operating activities (excludes costs of managing the emergency response)

- Higher than planned medical personnel (-37 FTE / -9.8% unfavourable) reflecting mainly cancelled leave in case the pandemic escalated, and extra shifts in case additional FTEs were needed to staff hot and cold areas.
- Lower than planned nursing personnel (8 FTE / 0.7% favourable) reflecting lower staffing in surgical wards and early supported discharge, mostly offset by higher than planned staffing in emergency, mental health and the medical wards.

3. FUNDING OTHER PROVIDERS

$'000	April Actual	April Budget	April Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance	
Payments to Other Providers								
Pharmaceuticals	4,687	3,725	(962)	-25.8%	39,590	37,248	(2,342)	-6.3%
Primary Health Organisations	3,529	3,551	22	0.6%	36,309	36,539	230	0.6%
Inter District Flows	4,043	5,043	1,000	19.8%	49,118	50,427	1,309	2.6%
Other Personal Health	3,084	2,290	(795)	-34.7%	21,233	20,496	(737)	-3.6%
Mental Health	1,160	1,083	(76)	-7.1%	11,381	10,835	(546)	-5.0%
Health of Older People	6,175	6,131	(44)	-0.7%	63,150	61,317	(1,833)	-3.0%
Other Funding Payments	372	340	(33)	-9.6%	3,284	3,421	138	4.0%
	23,050	22,162	**(888)**	**-4.0%**	**224,066**	**220,284**	**(3,782)**	**-1.7%**
Payments by Portfolio								
Strategic Services								
Secondary Care	4,267	4,640	373	8.0%	45,197	46,405	1,208	2.6%
Primary Care	9,911	8,788	(1,123)	-12.8%	89,167	86,478	(2,689)	-3.1%
Mental Health	1,582	1,412	(169)	-12.0%	14,753	14,125	(629)	-4.5%
Health of Older People	6,686	6,690	4	0.1%	68,681	66,907	(1,774)	-2.7%
Maori Health	463	502	39	7.8%	4,979	5,080	101	2.0%
Population Health	141	129	(12)	-9.3%	1,288	1,290	2	0.2%
	23,050	22,162	**(888)**	**-4.0%**	**224,066**	**220,284**	**(3,782)**	**-1.7%**

Underlying drivers of non-covid related operating results year-to-date

- Unfavourable pharmaceutical spend relating to faster than expected take up of new pharmaceuticals and over-representation of HBDHB in some classes of pharmaceuticals, notably Pharmaceutical Cancer Treatments.
- Unfavourable Health of Older People spend resulting from changes in mix of care to higher cost packages, pay equity and In-Between-Travel costs
- Unfavourable other personal health costs, mainly related to an increase in the contribution to National Haemophilia Management Group incurred in April.

Impact of COVID-19 on operating activities (excludes costs of managing the emergency response)

- High pharmaceutical claims probably reflecting changes in prescribing due to the lock down
- Favourable inter district outflows as transfers between DHBs were very limited during the lock down.

4. CORPORATE SERVICES

	April				Year to Date			
$'000	Actual	Budget	Variance		Actual	Budget	Variance	
Operating Expenditure								
Personnel	1,886	1,746	(140)	-8.0%	16,538	17,278	740	4.3%
Outsourced services	120	76	(44)	-57.6%	1,432	764	(669)	-87.6%
Clinical supplies	64	56	(7)	-13.1%	533	555	22	3.9%
Infrastructure and non clinical	1,373	1,535	161	10.5%	13,713	13,529	(184)	-1.4%
	3,444	3,414	(30)	-0.9%	32,217	32,126	(91)	-0.3%
Capital servicing								
Depreciation and amortisation	1,113	1,216	103	8.5%	11,210	11,971	761	6.4%
Financing	5	3	(3)	-90.2%	202	11	(190)	
Capital charge	707	612	(95)	-15.4%	7,067	6,122	(945)	-15.4%
	1,825	1,831	6	0.3%	18,478	18,104	(375)	-2.1%
	5,269	**5,245**	**(24)**	**-0.5%**	**50,695**	**50,230**	**(465)**	**-0.9%**
Full Time Equivalents								
Medical personnel	1.2	0.3	(1)	-321.5%	1	0	(0)	-83.6%
Nursing personnel	18.6	17.0	(2)	-9.6%	16	17	1	5.5%
Allied health personnel	0.0	0.4	0	97.2%	0	0	0	97.9%
Support personnel	31.7	30.1	(2)	-5.3%	29	30	0	1.5%
Management and administration	173.7	172.7	(1)	-0.6%	163	172	8	4.9%
	225.3	**220.5**	**(5)**	**-2.2%**	**209**	**219**	**10**	**4.6%**

Personnel is mainly executive staff vacancies offset by contracted executives in outsourced services. April was affected by higher than budgeted medical recruitment costs.

Infrastructure includes data network costs relating to the new telephone system and outsourced and deferred maintenance costs relating to facilities. In April lower utility and deferred maintenance costs, and a stock adjustment helped reverse a large part of the trend.

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, and reflects the cash position year to date and the effect of the $20m cash injection in April.

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

5. RESERVES

	April				Year to Date			
$'000	Actual	Budget	Variance		Actual	Budget	Variance	
Expenditure								
Contingency	-	105	105	100.0%	-	1,077	1,077	100.0%
Other	97	(130)	(227)	-174.3%	420	(743)	(1,163)	-156.5%
	97	**(25)**	**(122)**	**479.7%**	**420**	**334**	**(86)**	**-25.8%**

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 POSITION

30 June 2019	$'000	April Actual	April Budget	April Variance from budget	April Movement from 30 June 2019	Annual Budget
	Equity					
188,048	Crown equity and reserves	209,340	174,697	34,644	21,293	174,339
(44,407)	Accumulated deficit	(68,868)	(26,729)	(42,139)	(24,462)	(29,271)
143,641		140,472	147,967	(7,496)	(3,169)	145,068
	Represented by:					
	Current Assets					
759	Bank	727	840	(113)	(32)	840
1,881	Bank deposits > 90 days	1,884	1,855	29	3	1,855
29,342	Prepayments and receivables	24,684	26,401	(1,718)	(4,659)	26,488
4,023	Inventory	5,080	3,889	1,191	1,057	3,933
-	Investment in NZHP	-	2,638	(2,638)	-	2,638
36,005		32,374	35,623	(3,248)	(3,631)	35,754
	Non Current Assets					
190,552	Property, plant and equipment	187,239	186,874	366	(3,313)	188,324
13,790	Intangible assets	16,423	3,211	13,211	2,633	3,412
1,189	Investments	1,120	9,002	(7,881)	(69)	9,002
205,532		204,782	199,087	5,696	(749)	200,737
241,537	**Total Assets**	**237,157**	**234,709**	**2,447**	**(4,380)**	**236,491**
	Liabilities					
	Current Liabilities					
10,208	Bank overdraft	7,664	1,488	(6,176)	2,544	1,828
31,318	Payables	30,846	45,085	14,240	473	47,228
53,370	Employee entitlements	55,175	37,394	(17,781)	(1,805)	39,576
94,895		93,684	83,967	(9,717)	1,211	88,633
	Non Current Liabilities					
3,001	Employee entitlements	3,001	2,776	(226)	-	2,790
3,001		3,001	2,776	(226)	-	2,790
97,896	**Total Liabilities**	**96,685**	**86,742**	**(9,943)**	**1,211**	**91,423**
143,641	**Net Assets**	**140,472**	**147,967**	**(7,496)**	**(3,169)**	**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, budgeted equity injections for 2019/20 phased to be received at the mid-point of the year due to uncertainty over timing, and the year-to-date result.

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

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

The movement in current liabilities mainly reflects Holidays Act remediation provisioning, and the impact of the operating result on the overdraft.

7. EMPLOYEE ENTITLEMENTS

		April					
30 June 2019	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2019*	*Annual Budget*	
7,755	Salaries & wages accrued	6,096	6,879	784	1,659	9,483	
1,027	ACC levy provisions	1,642	1,139	(502)	(614)	1,174	
5,530	Continuing medical education	6,572	6,131	(441)	(1,041)	5,656	
37,303	Accrued leave	38,840	21,247	(17,593)	(1,536)	21,255	
4,755	Long service leave & retirement grat.	5,027	4,773	(254)	(272)	4,798	
56,371	**Total Employee Entitlements**	58,176	40,169	(18,007)	(1,805)	42,366	

Accrued leave includes provisioning of $13m for the remediation of Holidays Act non-compliance, in accordance with the memorandum of understanding with health sector employee representatives and the Ministry of Business, Innovation and Employment (MBIE).

8. PLANNED CARE

MoH data on Planned Care delivery is provided in the table below. Due to MoH timing this is only to March. 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 (previously known as Electives) are significantly under plan both on a discharge and on a case weight basis. In March we recognised revenue loss with a full year impact of $4.2m, based on the forecast shortfall in case weight discharges at February. Given the impact of COVID-19 on activity in the final quarter, we will be unable to achieve the forecast level of activity and it is unclear how this further potential loss in revenue will be managed by MoH.

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	5,910.7	2,118.2	8,028.8	6,994.8	87.1%	10,490.0
Inpatient Surgical Discharges	4,066	1,517	5,583	4,858	87.0%	7,298
Minor Procedures	1,403	492	1,895	3,334	175.9%	2,481
Non Surgical interventions	0	25	25	0	0.0%	38

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

NMDS Refresh Date: 6/05/2020 **NNPAC Refresh Date:** 6/05/2020
Data up to: Mar 2020 **Report Run Date:** 6/05/2020

9. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by NZ Health Partnerships (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 April was a $7.7m overdraft, a significant improvement on prior months, as a result of the deficit funding of $20m on 24th April.

The cash low point for each month is generally incurred immediately prior to receipt of MoH funding on the 4th of the month. April's low point was the $23.4m overdraft on 2 April. May's low point is projected to be $12.9m overdrawn on 31 May following the deficit funding of $20m. Our statutory overdraft limit is currently $32m reflected the approved 2019/20 Annual Plan and the deficit funding was received in time to prevent a breach of this limit.

Given the ongoing deficit, Holidays Act project and additional costs of COVID-19, the need for ongoing deficit funding will continue to be monitored.

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

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

10. CAPITAL EXPENDITURE

COVID-19 has seen a refocus of effort from locally funded projects, with the block allocations now $2.3m underspent. Note that COVID-19 costs are included in a separate report, and asset purchases relating to the emergency response will be treated as operating costs until the correct treatment is determined.

Uncertainty around equity funding means a number of projects will not progress until the funding is confirmed, with the main projects affected being the Radiology Refurbishment and Surgical Services Expansion.

See table on the next page.

2020 Plan		*Year to Date*		
		Actual	*Budget*	*Variance*
		$'000	*$'000*	*$'000*
	Source of Funds			
	Operating Sources			
14,465	Depreciation	11,210	11,971	761
7,230	Equity requirement	(22,106)	6,218	(14,261)
21,695		(10,896)	18,189	(13,500)
	Other Sources			
-	Special Funds and Clinical Trials	129	-	(129)
-	Funded Programmes	75	-	(75)
-	Equity Injection approved	21,293	-	21,293
-		21,496	-	21,089
21,695	**Total funds sourced**	**10,600**	**18,189**	**7,589**
	Application of Funds:			
	Block Allocations			
3,322	Facilities	2,200	2,858	658
3,129	Information Services	1,746	2,623	878
4,360	Clinical Equipment	2,888	3,701	813
10,810		6,834	9,183	2,349
	Local Strategic			
500	Replacement Generators	-	417	417
-	Endoscopy Building	(3)	-	3
2,550	Radiology Extension	341	2,124	1,783
700	High Voltage Electrical Supply	708	700	(8)
2,069	Seismic AAU Stage 2 and 3	709	1,827	1,118
1,500	Seismic Surgical Theatre HA37	188	1,250	1,061
200	Seismic Radiology HA27	77	167	90
1,432	Surgical Expansion	383	881	499
962	Matching Capacity to Demand	37	783	745
9,914		2,440	8,148	5,707
	Other			
-	Special Funds and Clinical Trials	129	-	(129)
-	Funded Programmes	75	-	(75)
-	Other	122	-	(122)
-		325	-	(325)
	Regional Strategic			
971	Regional Digital Health Services (formerly RHIP)	1,000	859	(142)
971		1,000	859	(142)
21,695	**Capital Spend**	**10,600**	**18,189**	**7,589**

11. ROLLING CASH FLOW

	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
	Forecast	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Cash Inflows												
Devolved MOH revenue	54,689	61,637	54,537	54,537	61,437	55,037	53,537	109,874	-	53,537	56,537	53,537
Other revenue	5,050	4,190	4,700	4,190	4,680	4,390	4,080	4,040	3,750	4,250	4,550	4,200
Total cash inflow	59,739	65,827	59,237	58,727	66,117	59,427	57,617	113,914	3,750	57,787	61,087	57,737
Cash Outflows												
Payroll	12,010	12,000	15,628	11,950	11,950	12,390	12,400	14,730	12,400	12,400	16,200	12,450
Taxes	10,946	8,700	8,300	8,700	8,600	9,200	8,800	5,600	8,800	8,800	8,800	8,800
Sector Services	28,200	26,665	26,960	26,600	26,200	27,400	28,050	26,145	15,350	26,755	27,050	18,700
Other expenditure	12,673	18,814	10,784	9,270	11,502	13,158	12,654	15,890	12,939	12,998	13,046	13,038
Total cash outflow	63,830	66,179	61,672	56,520	58,252	62,148	61,904	62,365	49,489	60,954	65,096	52,988
Total cash movement	-4,091	-352	-2,435	2,207	7,865	-2,721	-4,287	51,549	-45,739	-3,167	-4,009	4,749
Add: opening cash	-7,674	-11,764	-12,116	-14,551	-12,344	-4,478	-7,199	-11,486	40,062	-5,677	-8,843	-12,852
Closing cash	-11,764	-12,116	-14,551	-12,344	-4,478	-7,199	-11,486	40,062	-5,677	-8,843	-12,852	-8,103
Maximum cash overdraft (in month)	-11,764	-16,923	-15,860	-14,861	-15,647	-7,199	-11,486	-15,418	-5,676	-12,358	-14,975	-8,103

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

RECOMMENDATION:

That the HBDHB Board:

1. Note the content of the May 2020 report

Executive Summary

- The COVID-19 event caused a significant impact on both demand and activity across HBDHB, and most significantly for elective care. The Recovery Plan will focus at specialty level on recovering capacity to see and treat as many patients as possible, as quickly as possible.
- The need to maintain readiness has resulted in some specific issues requiring management attention, including medium-term displacement of some services from purpose-built environments, and constraints on the bed plan agreed by Board in February 2020.
- System capacity for elective work has reduced. Management is exploring options to increase total capacity as a priority.
- A number of innovations in practice have safeguarded and, in some instances, enhanced delivery over recent weeks. Service Improvement is working with Health Services to enable recovery to a 'new normal'.

Activity – April 2020

With all but two days of April spent at national COVID Alert Level 4, activity reflects the full impact of lockdown and National Hospital Response Framework restrictions. For the purposes of comparison, figures refer to July 2019 – February 2020 averages ('Normal'), unless otherwise stated:

Measure	% of 'Normal'	Comments
Emergency Department ('ED') Attendances	63%	Within the smaller volumes, there was a normal mix of triage categories and referral sources
ED Conversion Rate	Normal	36.5% of attendances admitted as inpatients is above the monthly average but within the normal range

Measure	% of 'Normal'	Comments
Inpatient Occupancy	50-60%	Measured on midnight bed census, occupancy was consistently within this range
First Specialist Assessment ('FSA') referrals	36%	The reduction in referrals reflects reduced primary care activity
FSA Decline Rate	Normal	19.7% for April is consistent with the 19.5% decline rate
FSA Activity	40.5%	The change was, as expected, not consistent across all specialties. While Gastroenterology, Dermatology and Maxillofacial all saw <10% of their normal throughout, specialties such as Neurology, Vascular and Endocrine saw increased FSA activity.
FSA 'Did Not Attend' ('DNA') Rate	245%	In a normal month, around 105 patients (6.6%) do not attend a scheduled appointment. With lower activity in April, 37 DNAs represented a 16.2% rate.
Outpatient Follow-Up Activity	~90%	The maintenance of follow-ups was due to a significant uplift in virtual appointments. Again, however, the mix was not consistent across all specialties – with Ear, Nose & Throat ('ENT') (6% of normal) the most impacted.
On-site Elective Discharges (Ministry of Health Target)	22.5%	Across 19 working days in April, this equated to 4.5 per day, compared to a normal level of 20 per day.
Total On-site Surgical Activity (Elective + Acute)	~60%	Cases delivered on-site were ~ 60% of the comparable activity delivered in April 2019.

Community-based services also adapted to altered demand and modes of delivery. As an illustrative example, District Nursing (DN) saw a 25% drop in referrals during April, with General Practice referrals falling by 50%. While overall contacts reduced by ~18%, virtual (non-Face-to-Face) activity was used to maintain care to this vulnerable patient group.

	Weekly Average DN Contacts 4 Weeks pre Level 4	Weekly Average DN Contacts 4 Weeks post Level 4	Change
Face to Face	871	536	-61.5%
Virtual	142	294	+107%
% Virtual	16.3%	54.8%	

Figure 1: District Nursing Activity Change

Recovery Plan

Overarching Approach

Recovery from COVID-19 is a broad kaupapa that will need to take account of the impact on both delivery of, and demand for, health services. The broader socio-economic and psycho-social impacts of the COVID-19 pandemic are issues in which the DHB will have a significant role to play. The overarching approach to Recovery is being led in partnership between the Planning & Funding and Health Improvement & Equity directorates, with full engagement and support from Health Services.

For both the overarching approach and the recovery of health services delivery, health equity is a vital consideration. In respect of the services we provide, the immediate focus of the Health Services Leadership Team has been to:

- Recover capacity to see and treat as many patients as possible, as quickly as possible.
- Ensure service delivery plans remains consistent with national and specialty specific clinical guidance around Infection Prevention and Control and the safety of our workforce.
- Maintain the readiness of our staff and facilities to mobilise the COVID response, designed under the Coordinated Incident Management (CIMS) phase.
- Ensure the continuation of best practice adopted during CIMS, enabling us to meet future demand and 'catch up' with a backlog that accumulated both during, and prior to, COVID.

Service Improvement is partnering with Health Services Leadership Team to enable a fast recovery. Key issues addressed during the first phase of the recovery plan include:

- Emergency Department and Intensive Care Unit configuration and flow, mitigating against the need to reinstate full COVID Hospital in the event of a small outbreak.
- Reinstating alternative arrangements to recovery the inpatient bed plan approved by Board in February 2020. This is a vital consideration in respect of both acute and elective activity.
- Clear and robust plans for delivery of outpatient services, with specific focus on guidance for infection control and social distancing. May 2020 will see recovery to ~72.5% of normal capacity levels, with work ongoing to increase this further.
- Enabling full utilisation of the HBDHB Theatre Block, which is a key component of fulfilling our Ministry of Health Planned Care Discharges target. Current plans project that HBDHB will recover >80% of on-site elective surgical discharges by the end of June 2020.

Securing additional surgical capacity is a key priority, and management continues to explore a range of options.

Panui

Referral Management & Booking Review

Health Services Leadership Team has decided to commission an overarching review of our outpatient system to recommend a future approach that is equitable, person and whānau centred, reliable and sustainable. The review will be cross-cutting across specialties, and encompass:

- Referral quality management and referrer support
- Clinical triage and thresholds
- Booking and logistics
- Customer care and responsiveness

The need for such a review has been indicated from multiple sources, including event reviews, service improvement activity, internal audits, clinician feedback and direct engagements with patients and whānau. A detailed update and proposals will be provided to Board in August 2020.

Scaled Coordinated Incident Management (CIMS)

HBDHB will move from full CIMS to a scaled approach, recognising movement towards national de-escalation, on 12 May. This will allow directorates to resume a full focus on core service provision. In addition to the work of the Public Health Unit, Health Services will continue actively supporting the Age Related Residential Care (ARRC) sector, and in professional leadership for the Psychosocial recovery plan. The ability to move seamlessly back into full CIMS, if required, will be maintained.

A New Home for General Surgery Outpatients

As part of the first wave of work to recover service provision, a decision has been made to re-locate General Surgery outpatients to Villa One. As one of the DHB's largest outpatient specialties, General Surgery has been without a permanent home for some time. The new location will enable more integrated professional working and more efficient use of our senior clinical time.

Orthopaedics will remain in their temporary home in Allied Health, which has worked well due to co-location with other departments. We have worked with Allied Health, another of our biggest outpatient specialties, to limit any impact on their clinical activities.

Flaxmere Community Oral Health Service Pre-School Engagement

With restrictions on the dental services that could be provided during national COVID Alert Level 4, the Community Oral Health service used telehealth solutions to pursue a pre-school engagement initiative focused on whānau in the Flaxmere community. The approach was well received, with a 14% increase in pre-school engagement compared to the April 2019 and the Flaxmere result moving above the Hawke's Bay average. The service is evaluating sustainability options.

Partnering for Improved Māori Mental Health

Health Services has a vital role, in support of Planning & Funding colleagues who commission Mental Health & Addictions services for our district, to partner constructively with our many non-governmental ('NGO') providers. Our relationship with Oranga Hinengaro (Te Taiwhenua o Heretaunga, TToH), our largest NGO partner and main Kaupapa Māori provider, is particularly important. The Service Director has worked with the TToH Chief Operating Officer to establish the *Whakamana* partnership – aimed at significant improvements in collaboration and cooperation.

The Mental Health & Addictions directorate has also partnered with Health Improvement & Equity to co-fund a *Kaiwhakataki Hinengaro Māori* (Māori Mental Health Advisor) role, which will be advertised in the near future.

Review of Performance and Risk Management

An internal refresh of performance management has begun, led by the Health Services Leadership Team, aimed at empowering directorate decision making and securing improved focus on the areas of most significant improvement priority or risk. Activity during April has included the launch of streamlined directorate performance management reporting, commencing work with our Quality team to improve the management of complaints and incident reviews, and a refresh of the directorate risk registers.

Key Quality Measures & Statement of Performance Expectations (SPE)

Patient Seclusion in Mental Health & Addiction Services

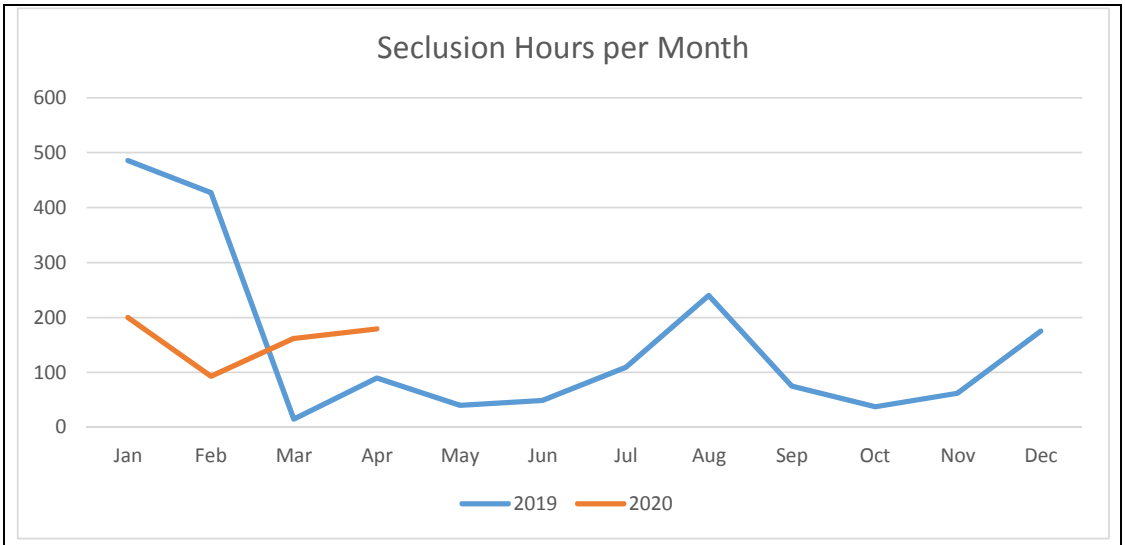


Figure 2: Mental Health & Addiction Inpatient Seclusion Hours per Month, January 2019 – April 2020

HBDHB has made significant progress in recent years, reducing annual seclusion hours from over 4,000 to just 634 in 2019. Accordingly, the annual target maximum was halved for 2020 (to 804 hours). In the period from December 2019 to April 2020, seclusion hours have averaged 162 per month – more than double the maximum level that would be required to hit the target.

The 179 hours recorded in April related to 7 events (and 7 individuals), 6 of whom identified as Māori. Each event is individually reviewed and directorate management continue to keep this measure under close scrutiny.

Faster Cancer Treatment

In April, nine patients fell into the Ministry of Health definition for measurement against the 62-day Faster Cancer Treatment health target. Of these, three were declined on grounds of capacity – an in-month result of 66.6%. Month-to-month performance against this target varies on account of a small denominator.

It is therefore useful to consider this alongside the 31-day target which measures the time from referral to a treatment decision. In April this saw 87.7% of the 65 cancer referrals given a decision on treatment within the target timeframe.

ED6

Overall performance against the 6-hour standard for patients to be seen, admitted or treated and discharged from the ED improved again, from 81.8% in March to 85.5% in April.

Within an improving set of underlying professional standards, the one marker that has declined in-month is the time from first ED medical review to specialty referral. This is consistent with the

changed departmental flow (patient streaming) and personal protective equipment ('PPE') processes that staff have had to observe.

Elective Services Performance Indicators

For ESPI2 (Outpatient Referrals Waiting Longer than 4 Months), the outpatient activity restrictions resulted in a 23% increase in the number of patients overdue. Due to decreased referral levels, however, the overall size of the waiting list actually reduced by 29 patients.

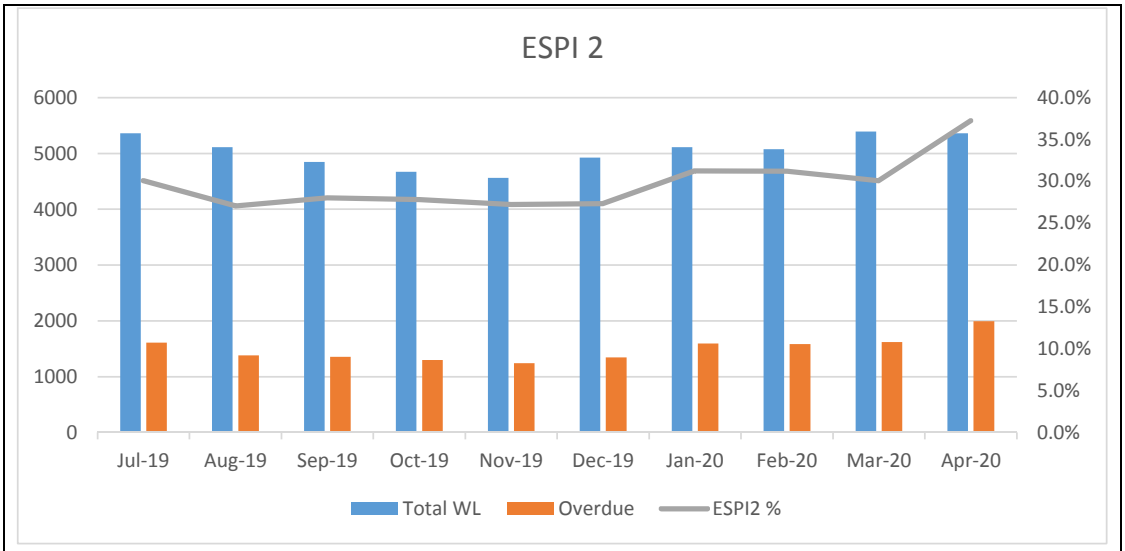


Figure 3: ESPI 2 Wait Lists and Compliance, July 2019 – April 2020

For ESPI5 (Waits for Surgery Longer than 4 Months), significantly decreased capacity in both our own theatre block and the wider sector has accelerated the growth in both size and waiting time profile that has been witnessed since October 2019. The number of people waiting in excess of 4 months has increased 29.2% on the March result, to 654 patients.

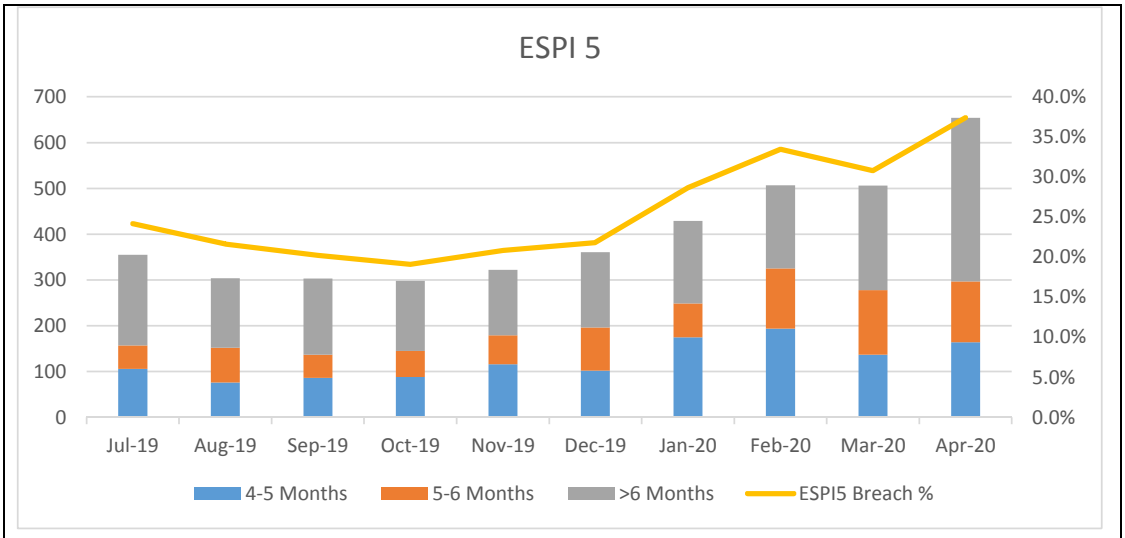


Figure 4: ESPI 5 Wait Lists and Compliance, July 2019 – April 2020

Ministry of Health Planned Care (Surgical Discharges) Target

At the end of April, actual discharges stand at 4,982 – 81.5% against the year-to-date target of 6,115. Forecast case-weight delivery for April stands at 81.9%.

Financial Performance

Financial performance for April 2020 was $355k adverse, bringing Health Services to a $5.75m adverse year-to-date position. This was better than forecast, but reflects the impact of COVID-19 operating.

While volume-related costs such as clinical supplies have fallen with reduced throughput, other volume-related reductions such as outsourcing will have a revenue impact for the DHB. A more detailed analysis of the position will be addressed in the report of the Executive Director Financial Services.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

11

Verbal

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

12

1 Executive Summary

This month has seen the COVID-19 response move into COVID-19 recovery. Most of the Planning and Funding activity has a system recovery focus and in particular, we are focusing on our vulnerable populations and our response over the next 1-2 years.

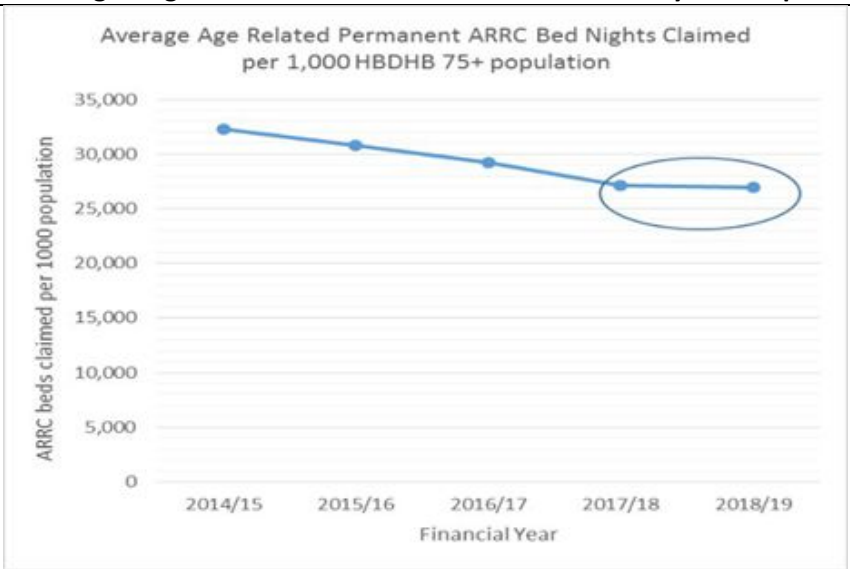
2 Development and Innovation

Integrated data analytics for Ageing Well

Matthew Parsons is a Professor of Gerentology at Waikato University. He has developed a model that supports quality of life for older people, and how/what service provision can support the best outcomes for people in the last 1000 days of life. The guidance from Matthew Parsons has indicated the importance of integrated data sources to build a system picture to enable us to understand the drivers to support the strategic direction and influence service change. The key enabler of this work is the Business Intelligence team within the Digital Enablements Directorate, and they have had significant pressure placed on them over the COVID-19 response. Planning and Funding will be working with them to support this priority piece of work.

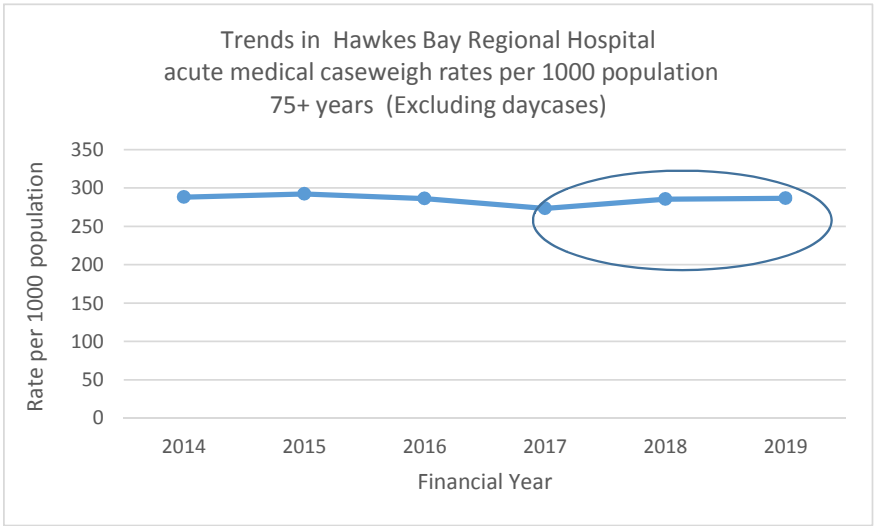
Set out on page 2 of this report are examples of how we use this information to inform decision making.

Examples of integrating data sources to benefit evidence based system improvements



When reviewing claiming data, we note when standardised for population changes, the ARRC bed nights HBDHB has been paying for, have had a steady decline until last financial year.
Linking with other data sources will support our understanding if this is the natural saturation point of our previous system improvements, or a change in the clinical complexity of those requiring age related residential care.

When reviewing hospital discharge data, we note when standardised for population changes, the hospital has experienced a slight increase in acute medical case weights over the last two years. Linking with other data sources will support our understanding if this is an impact of increasing clinical complexity, and if these interventions have improved quality of life outcomes for those hospitalised.



Funding allocation

The purpose of this section is to provide information to the HBDHB Board relating to the current allocation/utilisation of the total funding pool that HBDHB receives. You will note that on the whole, the high level percentage allocation matches the distribution of the population. This information will allow us to have strategic conversations relating to high level funding allocation, and take a planned approach to funding for equity in the future.

The questions that need to be considered are:

- What does funding for equity look like?
- What needs to occur from a funding perspective to address inequities of outcome?
- What funding allocation do we need to move toward the implementation of Whānau Ora, Hāpori Ora?

The Finance Directorate has provided us with a high level top down costing model to support the funding allocation discussion.

As the Hawke's Bay DHB does not have a full costing system that has been built to split costs out by ethnicity, region (population location) and care delivery setting, the process used is to group cost centres into pools of similar spend, then allocate a methodology to each cost pool using relevant data. The methodology used for each cost centre pool has been based on data from a number of sources, such as case weight discharges by ward, case weight discharges by specialty, emergency department presentations, GP consultations and Community Pharmacy scripts dispensed.

Where we have not been able to get data to support a methodology to split a cost centre pool, we have used population. Currently 30% of costs are still based on population allocation, we will continue to review these and update as we get appropriate data.

Please note that there are a number of limitations in using a top down approach for costing, but it is expected that it gives a broadly accurate representation for discussion. Some of these limitations can be reduced through further work in developing allocation methodologies and doing more in depth calculations into expected allocation of Ministry funding but we will not be able to "drill down" to specifics.

The below figures are based on the 2020 Budget excluding any Ministry of Health Revenue. Revenue has been allocated using 2018 census population data. We do not currently have the information to adjust this for ethnicity and region.

HBDHB Cost Allocation by Ethnicity

Percentage of Costs	27.53 %	4.09 %	3.35 %	65.02 %
Cost Percentages by Division				
Health Improvement & Equity	71.83 %	2.17 %	1.91 %	24.08 %
Primary Care	24.91 %	4.25 %	3.92 %	66.91 %
Provider Services	27.01 %	3.83 %	2.76 %	66.40 %
Tertiary	27.01 %	5.62 %	4.96 %	62.41 %
Allocation by Population	27.01 %	5.62 %	4.96 %	62.41 %

Note that the cost allocation in the above table is a mix of utilisation and allocation, for example Provider Services and Tertiary utilisation is demand driven, where as HIE and parts of Primary Care is targeted allocation. This information also wraps up high cost areas such as Pharmacy and Aged Residential Care under the Primary Care division which does skew the proportions.

HBDHB Cost Allocation by Regions (pop location)

Percentage of Costs	5.78 %	33.40 %	42.20 %	7.97 %	10.64 %
Cost Percentages by Division					
Health Improvement & Equity	5.03 %	37.43 %	49.03 %	8.50 %	- %
Primary Care	4.99 %	37.65 %	47.29 %	7.97 %	2.10 %
Provider Services	7.37 %	35.65 %	45.16 %	9.28 %	2.54 %
Tertiary	- %	- %	- %	- %	100.00 %
Allocation by Population	4.48 %	33.36 %	43.70 %	7.58 %	10.88 %

Again, this allocation reflects the population proportion. Consideration needs to be given to the cost of rural service provision to both the system as well as whānau.

HBDHB Cost Allocation Care Setting

Percentage of Costs	2.91 %	15.31 %	27.41 %	45.82 %	8.56 %
Cost Percentages by Division					
Health Improvement & Equity	100.00 %	- %	- %	- %	- %
Primary Care	- %	26.33 %	73.67 %	- %	- %
Provider Services	- %	10.75 %	- %	89.25 %	- %
Tertiary	- %	- %	- %	- %	100.00 %
Estimated Target	10.00 %	15.00 %	25.00 %	40.00 %	10.00 %

It is known that investment into addressing the determinents of health and prevention, reaps long term benefits for the individuals, whānau and the health system. Further work needs to be done in relation to international evidence relating to the appropriate funding allocation between care settings and this will be brought back to the Board once this review has been completed.

Ambulatory Sensitive Hospitalisations (ASH) Respiratory 0-4 years

Respiratory conditions for 0-4 year olds make up the highest proportion of ASH hospitalisations 55% (465 hospitalisations), of that 67% (310 hospitalisation) are Māori and Pacific tamariki.

Many issues have been identified as barriers for whānau accessing health care services. It is believed that a targeted approach, using a model of care that was culturally responsive would empower whānau to better manage tamariki respiratory health. Utilising the Te Pae Mahutonga model[1] of care, follow up will be community facing and include clinical input and support around the various determinants of health that contribute to their illness. What this looks like locally is that whānau would receive timely education that includes understanding of a respiratory care plan, whānau will be better able to recognise a deterioration in respiratory well-being and will be able to access appropriate services. Tamariki will be identified through presentation to ED or admission to the childrens ward and offered a home visit to support care of their tamariki once discharged and in the home environment and community . A focus on whānau well-being would ensure smoking cessation and referrals to "healthy homes" were accessible to all whānau. Whānau would be linked to a primary care practice and follow-up appointment with a general practitioner or nurse champion and would ideally occur within 2 weeks post discharge from ED or CHU. This programme will be run June though to October, over the winter months. This is a cost of approximately $76,000 fully absorbed.

Primary Care

Health HB and the Napier General Practice teams have used the opportunity that COVID-19 has presented to strengthen relationships within their sector and this has brought about openings for different innovations and initiatives. This improved relationship has shown its benefit during the response to COVID-19 through a coordinated Community Based Assessment Centre, and other immediate responses such as streamlining of patients, drive through vaccination clinics, separation of COVID-19 and general health pathways.

3 Exceptions

Growing well

Immunisation - There has been an unprecedented demand for Flu vaccine in Hawke's Bay this year. The move to enable local immunisation coordinators to have oversight of what is being ordered has been positive.

Living Well.

General Practice and Pharmacy - Reflections of Covid-19 to date have highlighted the vulnerability of General Practice and Pharmacy and their ability to remain financially sustainable during this crisis. General practice experienced a reduction in presentations/face to face consultations of up to 67% .

[1] Te Pae Mahutonga model was developed by Sir Mason Durie, and brings together elements of modern health promotion. https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-pae-mahutonga

Pharmacy who often supplement their income with the retail side of their business also experienced a sharp decline in foot traffic and as a result a drop in sales.

There have however, been some positive outcomes during this time. Telehealth which was in its infancy at the start of lockdown has now been embraced by general practice and seen as a legitimate way to provide a consultation that need not be face to face. Practices will find this method of communication advantageous for both patient and clinician alike. This, alongside practices who are working in the healthcare home model should experience a noticeable improvement in clinician fatigue and practice efficiencies.

Laboratory services are flexing with COVID-19. Transition into Level 3 has seen both labs continue split shifts to ensure business continuity.

Primary Mental Health Initiative - Hawke's Bay have been accepted into national Ministry of Health funded Integrated Primary Mental Health Initiative Tranche 2 with an expected roll out date of July 1. This sees the hiring of 3 new roles into primary care teams: Health Improvement Practitioners, Community Support roles and Navigators. The focus is on Maori, Pacific and Rangatahi and is in line with our local strategic direction. We will be closely monitoring progress and outcomes to ensure that the service is delivered in a way that meets what our whānau and community tells us is important to them. Funding is sustainable and rolled out over a 5 year period.

Crisis response – COVID-19 has provided us with a range of options to add to the thinking around the crisis response model for example how we have responded via national and locally based online/phone line support services. We are working in a collaborative way with the Ministry of Health, our Patient Advisory Group, Māori providers and our community to reconfigure the services to meet the needs of our community now and into the future. The focus will be on immediate response to "client crisis" that will include both mental and social well being interventions.

The learnings from our *COVID-19 mental health response* have been significant. We have seen:

- redistribution of services and the way in which services have been provided – showing what is possible virtually (actioning referrals and addressing backlog)
- strengthening of NGO provider network and the link between NGO network and DHB provider has strengthened – attributed to ongoing and proactive support provided by DHB to this network in response to COVID-19
- the formation of psycho social response (whole of sector support) has created an opportunity to strengthen links with social service providers
- the housing of the homeless has created an opportunity to support these clients – previously not known to our services and coordinate their care.

We have also identified areas that need further work and consideration through this pandemic such as:

- resilience levels low in staff and clients
- heightened support and variety of supports required to meet demand and prevent additional demands on inpatient services
- alert levels 3-2 still provide challenges for residential community based services in the management of transmission. We are working through how this may be addressed.

Aging Well

COVID-19 has emphasised the vulnerability of older people in our community and the impact that this has on our health system. Due to the numbers and frailty of our older people we need to continue to take a planned approach to managing outbreaks, adapting to new approaches to supporting our older people both in their homes and in residential facilities, and focussing on our vulnerable population for future design and delivery. It is important that we balance human rights, socialisation and the mental wellbeing of our older people with the need to protect the broader population. COVID-19 system recovery will have a strong focus on frail and older people, and the vulnerable populations within that group.

Corporate Performance

The Corporate Performance Report will be presented in June (one month later than scheduled); the Ministry of Health had suspended reporting due to the impact of COVID-19. Please note that the report will also be a shortened version as some data is not available for Q3 as a result of COVID-19.

HAWKE'S BAY District Health Board Whakawāteatia	**Wairoa Integrated Health System**
	For the attention of: **HBDHB Board**
Document Owners	Emma Foster Executive Director Planning & Funding (Acting) Lisa Jones, Portfolio Manager, Planning & Funding Karyn Bousfield, Chief Nursing and Midwifery Officer (Acting)
Month/Year	May 2020
Reviewed By	Patrick Le Geyt, Executive Director Health Improvement and Equity (Acting) Charrissa Keenan, Programme Manager, Māori Health
Purpose	For noting and agreement
Previous Consideration/Discussions	November 2018 Board meeting March 2019 Te Pītau Health Alliance (Hawke's Bay) Governance Group meeting December 2019 Māori Relationship Board February 2020 Board meeting

RECOMMENDATION:

It is recommended that the Board:

1. **Note** this update on activity and planned actions.
2. **Agree** to the accountability measures outlined below.
3. **Agree** to further invest to implement the Wairoa localities model as part of the 2020/21 Annual Plan.

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Wairoa Integrated Health System

Executive Summary

In summary to respond to whānau in Wairoa there are four areas that we need to implement:

1. Integrated Health Care – Community led wellness model that enables targetting of resources to respond to population health needs. This also includes navigation across health and social system, and care coordination for vulnerable whānau within those communites. Integrated Health Care develops the role of Rural Nursing, who will work in partnerhsup with the Community Coordinators to provide focussed, targetted, community health care.
2. An acute model of care that supports prompt retrievel to Hawke's Bay Hospital, and safe and sustainable acute services.
3. A seamless health journey and structured whānau centred interactions along with health services that are delivered in a way that reduces time wasted in the system for whānau.
4. A Wairoa health system dashboard for community, governance and management.

Background

Wairoa is an isolated rural community, with a small population covering a large geographical area. Its population has a high percentage of Māori and has higher health needs across most indicators than the rest of Hawke's Bay. It is also a thriving community with enormous potential.

In 2016 Hawke's Bay District Health Board (HBDHB) commissioned KTV Consulting to facilitate a process with Wairoa whānau and community, to provide a Health Needs Assessment (HNA) for Wairoa District.

The recommendations were broken down into four areas (please note the full report as attachment 1):

1. Responding Better to the Population
2. Delivering Consistent High Quality Care
3. Being More Efficient at What We Do
4. Best Value for Public Health System Resources

In summary we have completed/partially completed 64% of the 16 recommendations. After reviewing our progress to date against the HNA recommendations we have more work to finish in the area "Delivering Consistent High-Quality Care". In particular improving transport options, consumer focused booking and frontline consumer service training are issues that remain today, as we have heard through our recent Wairoa community whakarongo process. In the area "Being More Efficient at What We Do" we still have work to do in integrating our health system.

A significant amount of work has gone into "Responding Better to the Population" through the Wairoa Community Partnership Group and through the community whakarongo process

We have reviewed population health outcomes identified as focus areas in the HNA report to see if there has been any improvement. There have been significant improvements in children's respiratory infection hospitalisations, cellulitis, diabetes and coronary heart disease hospitalisations, teenage pregnancy rates have fallen and suicide rates have improved.

There remain health challenges; smoking rates remain significantly higher in Wairoa compared to other localities and particularly for Māori.
Dying too early from heart disease and cancer remain a greater challenge in Wairoa than other areas in Hawke's Bay.

There is a widening gap in equity in oral health status of 5-year- old's in Wairoa. This points to the need to shift the value of health and wellbeing out of the hands of the health system and in to the hands of the community and the whānau that make up that community.

Transformation of the Wairoa health system – One integrated health system

Wairoa has one community hospital with a single co-located GP practice, one Māori provider, one rest home, one Whānau Ora provider, and two Post Treaty Settlement Entities. The transformation of the health system

in Wairoa must start with building on the existing capacity within Wairoa – its health providers, intersector partners, community leaders and whānau.

The largest health workforce in Wairoa is whānau and we will work in partnership with whānau to be active members of their own health care team, along with building health literacy. Achieving equitable health outcomes for Wairoa whānau is a priority for our health system. We have committed to working with the Wairoa community, and our intersectoral partners to tackle the underlying causes of inequity that exist in Wairoa, including the added complexity of Wairoa's rurality.

Wairoa whānau have told us that navigation of the health system is one of the biggest barriers to care. It is important that whānau have seamless care across services, to reduce waste of time for whānau. This includes having well-coordinated service delivery, appointments and sensible travel arrangements as well as increasing the use of technology enabled care, where appropriate.

A good rural health system is required in Wairoa. It should be designed to meet the needs identified by the Wairoa community and whānau and built on accessible and sustainable primary care, responsive secondary care processes and services, integrated rural outreach approaches and whānau ora models of wellbeing. Care will be provided by the most appropriate member of the health care team, in the most appropriate setting. This could be general practice, Māori provider, acute services or in their own home, shared space or virtually.

We want to ensure our workforce in Wairoa is representative of the community, they will have knowledge and skills to provide the care required now and into the future for Wairoa whānau. Built into this is a need for a sustainable pipe-line of clinicians that have a rural focus and specialist generalist skill set to ensure the depth and breadth of care is delivered.

A digitally-enabled health system joins people, information, processes and technology to deliver better health outcomes. This is particularly important in Wairoa due to its rural isolation.

What have Wairoa whānau told us?

A number of service gaps and strengths have been identified by whānau and clinicians.
Main themes and areas for improvement include: workforce, navigation, acute services, transport, traditional Māori health services and older people services. Areas that participants reported are currently working well include, maternity services, strong Māori workforce, assertion of bilingual application, strong community leadership through the Community Partnership Group, community and provider desire for engagement and change.

Wairoa whānau want a community led wellness model supported by health services when required. From a health service perspective, they have told us that they want to "*be able to access quality health and medical care when they need it. Knowing where, and how to access services has been identified as being a critical factor for Wairoa whānau".*

Whānau preferences and priorities	**Health system issues in Wairoa**
• Wairoa whānau want a quality health system that they can trust. • Wairoa whānau want access to primary care services when they need it. • Wairoa whānau want to be respected, listened to and heard. • Wairoa whānau want to have one clinical connection in relation to their health care. They don't want to repeat their story and don't want to deal with a different person each time they touch the system.	• The model of care is unclear, which is resulting in fragmentation, waste and distrust within the community. • Services are largely unplanned and poorly coordinated, and prioritisation of services is being determined from Hastings. • Inconsistencies in the workforce to meet the clinical requirements with a mixed model of primary care, emergency and hospital level services. • Lack of community engagement to fully understand their preferences, requirements and priorities.

• Wairoa whānau want to be transported to Hastings when they need it, in a timely way. • Wairoa whānau want efficient access to safe urgent and emergency care.	• We have had, via the clinical reporting and complaints processes, adverse events and poor clinical outcomes for whānau.

Enabling change

We have identified there are four areas that we can respond to promptly to support our Wairoa whānau, and to start the implementation of our localities model. Ultimately, we want one co-ordinated health system built on:

- Community Engagement
- Integrated Care Teams including outreach rural nursing clinics
- Community Co-ordination and Community wellbeing programmes (kaupapa Māori)
- A responsive community hospital coordinated between primary health and secondary care in Hawke's Bay Hospital
- Monitoring System Performance

There are four key rural areas in the greater Wairoa district that require a refreshed approach to the co-ordination and provision of health services, which are linked back to base in Wairoa township. These are:

- Mahia
- Nuhaka
- Tuai/Waikaremoana
- Raupaunga

1. <u>Integrated Health Care (what)</u>

There is only one hospital, one GP practice and one Māori provider serving a relatively small population. Therefore, coordinating a seamless approach or an integrated care model should not be too difficult to achieve.

Integrated care is best defined by the service user – the consumer:

"*My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes.*"

Integrated Care Teams (ICT) feature heavily within the Clinical Services Plan (CSP). The CSP states that primary care will incorporate the principles of Nuka ICT teams with multidisciplinary teams providing integrated health and care services in primary care centres and the community. HBDHB will work through a combination of direct investment, workforce realignment, and implementation support to the development of ICTs in primary care.

In Wairoa a co-design approach will be adopted with a range of providers (including whānau ora, general practice, kaupapa Māori and other primary healthcare providers) and the communities they serve. This approach will build on successful recent examples of how such workforce development and integration has been achieved in the HB health system, such as, Clinical Pharmacy Facilitators.

Community Coordinators

Important factors in a community's success is the vitality of its leadership and, in this respect, community coordinators play an important role. Community Coordinators manage the boundary between different organisations and the community. They identify and respond to community needs, have a good understanding of what support exists and ensure there are strong community networks in operation. They offer advice and support to a myriad of groups and individuals assisting them in accessing resources, developing initiatives and delivering programmes for the benefit of the community, such as supporting the coordination of rural community clinics and providing transport to treatment.

Community Co-ordinators are not a new phenomenon to health. Local Area Coordinators, as part of NASC Disability Support, have been trialled in rural communities throughout New Zealand. Local Area Co-ordinators provide accurate and timely information about local communities, supports and services, use local community networks to develop practical solutions to meet their goals and support needs and enhance access to supports and services.

Whānau want to build their own capability around a wellness model. Their desire is this will be led out by Iwi/Hapu but supported by local health service provision that is safe and sustainable, and enabled by technology. This means we need to change the way we view our role within our rural communities. Rather than being the provider of health, we are health providers who supplement the community owned wellness model.

Community co-ordination has been a key theme from all whānau/community feedback. This will be delivered through Te Whare Maire o Tapuwai, Tātau, Ngati Pahuwera and Wairoa Taiwhenua (NKII).

Nursing

The nursing workforce is critical to the development of ICTs, given its size and developing scope, and needs purposeful planning for Wairoa. This development is enabled by regulatory and legislative changes that support new ways of working and will increase their contribution by broadening of scope. Examples of this includes registered nurse prescribing, the ability to verify death and provide sick certificates. Nurse roles such as the Rural Nurse Specialist (RNS) could be further rolled out. These nurses work in partnership with the community coordinators, and provide comprehensive nursing services, including long term condition management, primary care locally, and capitalise on the recent legislative changes to support improved access for whānau. Nurse Practitioners have also seen legislative changes that mean they are now able to do more such as completing applications for benefits. Pipeline planning is essential and must also factor in increasing our Māori nursing workforce across services.

Actions	Timeframes	Cost
Develop and implement ICTs through Community Coordination	1 October 2020	2020/21 new investment ($400,00)
Develop and implement ICTs through nursing workforce and capability	1 December 2020	2020/21 new investment ($400,000)
In partnership with communities – prioritise phasing for implementation of ICT's	1 October 2020	Potential infrastructure costs such as IT, Health Promotion

2. Acute services

A decision needs to be made regarding the specifications of acute services provided in Wairoa. Currently we are funded to the Level 2 ED specification but know we are not meeting the requirements to provide a Level 2 service, including the medical workforce type. HBDHB needs to plan for what is safe and sustainable to provide in Wairoa and what the retrieval processes are, informed by destination policies. This will ensure patients receive appropriate care, by the appropriate clinical team in the appropriate clinical setting.

Actions	Timeframes	Cost
Acute model of care for Wairoa to be completed	August 2020	Within existing

3. Co-ordination with Hastings

Work needs to be undertaken to understand the dynamics and detail of the current outpatient appointment booking processes and transport and travel processes. From this, recommendations need to be made and implemented to improve patient flow and access to services.

Actions	Timeframes	Cost
Complete a review for referral, booking and transport processes	September 2020	2020/21 new investment ($400,000)

4. Monitor performance of the health system against population health outcomes and service/quality performance

We are in the process of developing a Wairoa health system dashboard. This will form our regular reporting to HBDHB and to the Wairoa community as part of our accountability and Treaty Responsiveness framework. We propose the following indicators are utilised as part of this process:

- Faster Cancer treatment performance
- ESPI performance for Wairoa residents
- Timely Outpatient appointments for Wairoa residents
- Ambulatory sensitive hospitalisations (0-4 years and 45-64 years)
- Utilisation of primary care services
- Smoking quits
- Utilisation of aged residential care facilities
- Equitable access to homebased support services
- Equitable access to mental health and addictions service
- Whānau satisfaction

Please note all of these indicators will be reported on from an ethnicity and rurality perspective.

Communications to whānau will be through the Whānau-voice led, Quality and Health improvement Cycle (Appendix 2). The purpose of this cycle is to provide structure to all parts of the system and their role in responding to whānau voice. It also allows whānau to see that we will listen, respond and action to what they tell us. Together with Wairoa health system dashboard these processes will form part of our Treaty responsiveness approach and monitoring.

Attachment 1:

Wairoa Health Needs Assessment 2016 – review/status report

RECOMMENDATIONS AND STATUS:

Responding Better to the Population

Recommendation	Status
Develop a suitable health and social service model through effective involvement and consultation with Wairoa community, iwi and and health and social service funders and providers.	Community Partnership Group established for this purpose. Tātau Tātau and Ngati Pahuwera both have their own strategies which link into health gain outcomes. This is an area where the DHB needs to focus its energy and attention to ensure that we working in partnership to meet the health outcome expectatoins of the Wairoa community.
The Wairoa Intersectoral Leadership Group (WILG) to include broader intersectoral collaborative representation	The Community Partnerhsip Group have reviewed and agreed the updated terms of reference. This includes social and health sector partners, but strong whanāu/community voice remains at the centre and with the stronger mandate
Shared outcome and results based accountability model for Wairoa	As part of the strategic change process. Would expect that this would come from the CPG. Planning and Funding, since the function has been reignited is looking at how to implemement the RBA contracting model with Wairoa as an early adopter,
Active consumer and Iwi engagement in providing inputs towards the development of health models and outcomes frameworks focussed on addressing the health needs and services gaps as identified in the HNA	The DHB continues its programme of community whakarongo process. 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. The next steps are to take action, check back in to ensure we have heard correctly, and then monitor performance of the changes.
A transistion team consisting of key representitives to work with Wairoa health leadership on the configuration and design of the community ownership model.	This is phase two of strengthening the health leadership model in Wairoa. Phase one has been completed February 2020.
A communication strategy for Wairoa district to foster public awareness pf the health system and design and galvernise support from stakeholders across the district for health system development	Partially completed, need to work on a more strucutured method using population health approaches.

Delivering Consistent High Quality Care

Recommendation	Status
Support the development of a local clinical governance group	Developed. Refinement required to ensure the quality improvement cycle is informed effectively by way of good incident reporting, adeverse event reviews and implementation of recommendations, feedback and complaints to inform improvements and use of data.

Recommendation	Status
Provide NUKA model training	A number of people from Community Organisations in Wairoa have gone to Alaska so the Nuka experience and wisdom can be shared from them.
Ensure allocation of resources to improve transport options for consumers/customers and whanau for timely access to health care services within and outside Wairoa district	This has been a theme that has come up regularly. This needs to be picked up as a specific service improvement initiative. HBPHO with red cross as a service provider now run community buses from Mahia and Tuai to and From the Hospital and Healthcare centre He Korowai Manaaki Research project are supporting Wairoa's most vulnerbale group(pregnant women) needing transport assistance for USS and specialist follow up and are lobbying for change within NTA to address this gap.
Institute customer service training for all frontline staff and incorporate KPIs and direct customer feedback part of performance review process	To be completed

Being More Efficient at What We Do

Recommendation	Status
Centralise information management systems to support service intergration and coordination utlising existing and adopting to new technologies	Technology is available to support health pathways. Next steps is to engage clinical leadership, along side process support to pilot.

Best Value for Public Health System Resources

Recommendation	Status
Explore commission function for Wairoa commnuity model	Ongoing, as part of the wider peice of work with Wairoa CPG.
Provide consolidated financial overview of funded services	Completed.

SERVICE RESPONSE TO KEY HEALTH PROBLEMS IN WAIROA DISTRICT

Health issue	Recommendation	Response:
Smoking: Wairoa Maori smoking prevalence rates are higher compared to Maori rates nationally. Smoking prevalance rates in Wairoa remain 1.6 times the over the Hawke's Bay rates and 1.9 times over the national rates.	Develop a Wairoa Smokefree action plan that considers whanau based approaches. This plan to include improved coordination, resources and support.	In July 2016, the Ministry of Health realigned the national stop smoking services. Hawke's Bay has a stop smoking service called Te Haa Matea (breathe easy) a partnership between Te Kupenga Hauora Ahuriri, Te Taiwhenua o Heretaunga, Choices Heretaunga and HBDHB – Smokefree Service. The DHB Smokefree Service recognised a gap in cessation services for Wairoa and work with Kahungunu Executive to provide Stop Smoking Practitoner training, Carbon Monoxide monitors (Smokerlyzers), free Nicotine Replacement Therapy and smokefree resources. The DHB Smokefree Coordinator, Wairoa provides cessation support to hospital patients, pregnant women and their whanau and the wider whanau who smoke. The DHB Smokefree Coordinator partners with Kahungunu Executive for Smokefree health promotion at events including World Smokefree Month of May and Tame Your Taniwha Challenge. *Action:* • Review of system wide Smokefree services in Wairoa.
Diabetes: Wairoa District Diabetes hospitalisation rates were 70% higher compared to overall HB rates and 50% higher than national rates (2013-14)	Have health care services which are acceptable to Māori. Establish improved coordination, integration, pathways and linkages between providers. Use transformational programmes that focus on physical activity and nutirition challenges facing Wairoa Population	Hospitalisations rates for Wairoa residents with diabetes have reduced, and are no longer significantly higher than other localities in HB. In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents guide the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc. The four objectives under the plan include: supporting healthy eating environments, delivery of prevention programmes, intervention pathways and supporting leadership in healthy weight. The national target (Raising Healthy Kids) has been in place for 18 months and Hawke's Bay performs well in our consistent achievement of this target.

		HBDHB is developing a second measurement point for BMI in children of 8-year olds in school settings. This pilot which will provide whānau referrals for obese children, resources for whānau and support for schools. Integration and alignment of healthy weight activity with wider wellbeing approaches and cross service delivery has been a feature of the healthy weight approach. Through working with the oral health under 5 caries free project, Wellchild Tamariki Ora (WCTO), Before School Check (B4SC) and Breastfeeding support services. Kahunungu Executive has refocused services to have a wellness approach to focusing on the determinists of health, and therefore has a direct impact on diabetes. *Action*: • Consider dietetic support for Wairoa community. • Review the availability of speciality diabetes services in Wairoa. • Ensure HealthPathways localisation process is relevant for Wairoa's whānau and service delivery model.
Cellulitis: Wairoa has higher hospitalisation rates amoung 0-74 years for cellulitis compared to other district	Integrated pathways between providers to support health literacy. Whānau ora workers based in the community and with primary care providers	Hospitalisations rates for Wairoa residents with cellulitis has reduced, and is no longer significantly higher than other localities in HB. The implementation of the principles of the NUKA system will strengthen the integrated pathways. HBDHB's Skin Programme aims to raise awareness of skin problems, provide appropriate resources to families/whānau to care for skin, prevent skin infections and infestations, facilitate access to early treatment, enhance help-seeking behaviour, and reduce stigma and discrimination for tamariki with skin problems. A 2014 audit showed high rates of skin problems among tamariki Māori, and children living in high deprivation areas. Skin infections include, cellulitis, scabies, impetigo, infected dermatitis, and boils. HBDHB has responded with a number of activities to provide better support to tamariki and their whānau. Key activities include:

		• Skin Standing Orders for Public Health Nurses and School Based Māori health provider nurses have been developed. However, these orders do not include the provision of medication, and while nurses will encourage whānau to seek help from their primary care practitioner, barriers to access to care may prevent whanau from doing so. Expanding these Standing Orders is being explored, but will require resource of time and workforce development. • Development of appropriate information, and resources for early childhood education centre (ECE) staff and whānau. These resources include flip charts in te reo Māori, and Pacifica. *Context: Admissions for rural population can occur where in urban areas patients can be managed from home through the CPO program. The distance that rural patients often need to travel for follow up treatment on consecutive days, can mean that they are admitted.*
Gastroenteritis: Wairoa has higher hospitalisation rates amoung 0-74 years for gastroenteritis and dehydration compared to other districts	Stronger population health integration within the community. Community awareness and response. Public health support for rural water supply testing and infrastructure	Volumes have increased across HB for 0-74 gastroenteritis hospitalisation, and now there is no siginficiant difference across the district. Māori Health and Public Health are activitly with communities around water quality and supply.
Respiratory Infection: Top reason for acute hospitalisation for 0-14 year older in Wairoa District is respiratory infections/inflammations, whooping cough, acute bronchiolitis, bronchitis and asthma.	Whānau ora approach. Integrated service provision with housing, social care and health providers.	The hospitalisation rates for 0-14-year olds in Wairoa have declined over the last 5 years. In 2017, a review of the ASH 0 – 4 years respiratory care pathway was undertaken to understand more about the interactions and experiences of tamariki and their whānau prior to and after they presented to ED for a respiratory related illness. The review involved a case file audit, an analysis of ASH respiratory data, a review of care pathways and referral processes, and stakeholder and whanau interviews.

		Three main findings of the review were: • No clear respiratory care pathway for tamariki 0 – 4 years. • no specific respiratory care programmes for children being delivered in the community • The majority of tamariki and their whānau received no follow-up in the community post presentation to ED and admission to hospital. The respiratory working group is undertaking a number of activities to progress actions to address system and service barriers to access to respiratory care for whānau. A child respiratory care pathway, with appropriate processes is being developed for primary and secondary care services. The pathway will better support information flow between services, follow up care in the community by Respiratory Nurse Champions. Small improvements in processes is already reporting positive results. Changes to the way patient information is managed in secondary care has led to a considerable increase in the number of referrals to the Child Healthy Housing Programme. The Working Group will continue to progress actions from the review over 2018. Some service specific issues relating to Wairoa such as tightening discharge summary processes are being implemented as well as increased investment in WCTO visits and training. *Action:* • Ensure HealthPathways localisation process is relevant for Wairoa's whānau and service delivery model. • Model of Care and interventions for the 45+ years in relation Chronic Obstructive Pulmonary Disease (COPD), including smoking cessation.
Cardiovascular diseases: Maori have higher rate of heart disease then non maori.	Uses different models, primarily focussing on models that are whanau centred, to increase access, uptake and utlisation.	Hospitalisation rates have reduced, but early deaths from cardiovascular disease remains. *Action*: A review is underway looking at screening, outreach and upstreaming programmes.

Cancer: Cancer is the top cause of death in the Wairoa District.	Address whānau appropriate screening, management and support and information.	*Action*: A review is underways looking at screening, outreach and upstreaming programmes.
Oral Health problems: Wairoa District has the hightest ASH hospitalisation rates in 0-4 year olds for dental conditions. Some improvements in the oral health status of 5 year olds, still poor compatred to other HB TLAs.	Promote collaboration aound primary care roviders. Work with Wairoa DC to promote water flurodation.	Oral Health and ASH 0-4 years respiratory investigations (2017) have included Wairoa whanau interviews, interviewing for the kaupapa Maori Maternal Wellbeing Program is underway at present and includes a Wairoa cohort. The challenge is now upon the DHB to support these voices into active consumer particpation and representation in service design and improvment. Wairoa childrens oral health status has deteriorated relative to overall Hawke's Bay children's status. Inequities have widened between Wairoa Maori children and Non Maori non Pacific. Lift the Lip programme at the 15 month imms visit. This could also be an oportunity to provide a mini health check. HBDHB continues to advocate for Fluoride in Wairoa Water supply.Legislative changes allow health to take a greater role. *Action:* A system wide review and reset on the hospital and Community Oral health system with a focus on reseting to focus on vulnerable populations.
Sexual health: Teenage birth rates in Wairoa District are 2.5 times those in Napier City sand twice the overall HB rate. The health implications of this stiutaiton for both mother and child particualry in community with high siongle parenthood are enormous and often challenging to the health sector.	Develop a youth health strategy and secure funding for sexual health acorss HB. Promote collaborative approaches between health and education for sexuality programmes to be included in the school curriculum and workforce development training.	Teenage birth rates have declined and are no longer signifcantly different to the rest of the district. Sexual health review completed, with actions agreed and investment plan developed. This is also integrated into the Rangatahi re-design which will be implemented in 20/21.

Suicide prevention: Wairoa District have intentional self harm mortality rates that are 3.3 times those of CHB, 2.8 times those of Hastings Ditrcti and 1.9 times those of Napier City rates	Develop and implement a coordinated Wairoa suicide prevention and postvention post	Suicide rates in Wairoa have declined by 41%, and there is no significant difference to the rest of the district. Some shared promotional events but no plan developed yet. Review HB suicide plan and see if it relates to Wairoa.

Attachment 2:

Whānau voice led quality and improvement process

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

Recommendation:

That HBDHB Board:

1. **Note** the content of this report.
2. **Note** the actions requested.
   - **a)** Review Wairoa's access to information across government sectors during COVID-19
   - **b)** **20/21 Annual Plan**- Interim ED of Planning & Funding Directorate to report back to MRB
   - **c)** **Covid- 19 Review** -MRB endorses a Māori Lead Covid Recovery Review

The Māori Relationship Board members met via a Zoom meeting on 6 May 2020.

1. JOHN WHAANGA – UPDATE ON COVID 19

John Whaanga provided an update around the disruption Covid-19 has had over the last two months and identified some benefits it has had on our Māori communities and the focus moving forward over the following 12-24 months.

Benefits

- Māori support packages.
- Increase in vaccinations for our over 65 and most vulnerable.
- Increased services to provide support to our Kaumatua and those most at risk.
- Engagement with Māori providers and local Iwi to increase the capacity and capability to respond to Covid-19.

Focus over the next 12- 24 months

- Mobilisation of services and whānau packs are areas that need to continue into the new "normal" going forward.
- Continuous engagement with social support and other agencies.
- Huge focus on accessible and appropriate primary health care service that are free to our people.
- Collating ethnicity information.
- Overview of the whole of government and sector area and how to join the two together, ensuring that there is a strong Māori equity and Treaty focus.
- PPE and supplies - this will increase in the coming months ahead.
- Border control.
- Isolation.

What does that new normal look like in the next 9-12months for the health sector?

- Continued surveillance and community testing.
- Increased vaccination.
- Good access to primary health care services.
- Restriction on our tikanga practices (harirū and Hongi).
- Stronger communication.

Moving Forward:

John recommended as a DHB that there is an opportunity to look at what did and did not happen during Covid-19 and to put an equity lens across it.

- What happened during Covid 19?
- What changed?
- What were the opportunities and benefits?
- What were areas that did not work very well?
- What does the new normal look like?
- How we manage a return back to a new normal?
- How do we gauge what has been lost or what the impact on the Māori Health inequities pre-lockdown, during and post-lockdown? It is important to understand this as there will be a lot of recovery work to address those that have missed out on; appointments, services, operations etc. Ensure Māori health equity becomes a strong focus.

John acknowledged both our Māori community and Māori organisations who have stepped up to be on the front line to support our most vulnerable.

Opportunities for HBDHB and MRB regarding Equity, Te Tiriti and WAI2575

- The Māori Health Action Plan is a document that will be used as a baseline engagement with DHBs.
- Work underway to identify how to provide definition around performance.
- A large piece of work will be what equitable and Tiriti performance is within the Hawke's Bay DHB – this is being undertaken across all of New Zealand.
- Senior leadership team signed off late 2019 Treaty position statements that clearly articulate whole of Ministry responsibility towards Tiriti and Māori health equity.
- Planning underway with Ministry directorates on how they will meet Tiriti and Maori responsibilities linked to each individual's KPIs,

WAI 2575

- Do not envisage a WAI2575 Plan in the next five years, but a Māori Health Action Plan focussing on Oranga Paiora.
- Driver for all of our work is our Treaty and our Māori Equity Framework which underpins the Māori Health Action Plan for the next 5 years. This is the same framework used to develop the Māori Covid-19 Response Plan and the same framework that will be used to move forward which will include a WAI2575 workstream.

MRB thanked John and his team for being available to korero on the impact and challenges facing Māori during Covid-19 and an outline of a way forward.

2. 2020/2021 ANNUAL PLAN UPDATE

Emma Foster - Interim ED of Planning & Funding Directorate provided an overview of the draft Annual Plan noting also that the timeframes had changed. Emma presented a diagram that illustrated the Health System Priorities that came out of the strategic planning process and Whānau Ora - Hapori Ora which has been mapped back to the Annual Planning priorities. Evidence on these key priorities can be provided.

Next step is to cost up each priority area and how they will fit within the funding, noting the main priority is around investment to address inequities.

- 84% of actions that have been identified have an equity focus attached.
- Currently working on a system-wide recovery from a Covid respective

Discussion noted:

- The hospital is one part of the system with responsibility to halt the flow into the hospital and focus on our broader community.
- Four cost drivers note; hospital demands, health of older people, pharmaceuticals, capitation.
- Communities taking responsibility for their own wellbeing is essential and with a connected network of whānau, leaders and community champions to support this. Having a mobilised community network is a foundation to be built on for the health and wellbeing of our whānau.
- Treaty-based governance needs to be clearer on the Plan.
- The most vulnerable are; children, elderly, those with chronic disease, mental health.

The Chair advised it is important that these equity priorities be monitored and reported as KPIs to MRB.
ACTION: Interim ED of Planning & Funding to report back to MRB

Emma was thanked for her presentation and discussion.

3. **COVID-19 REVIEW.** Following on from John Whaanga's presentation, MRB discussed the opportuninties to learn from the sectors response to COVID-19, particularly from a Māori health equity perspective, and how best to capture this.

   Action: MRB endorses a Māori-led Covid Recovery Review

HAWKE'S BAY CLINICAL COUNCIL

No written report

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

RECOMMENDATION:
That the HBDHB Board:

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

Consumer Council met on Thursday, 7 May 2020 by zoom. An overview of the meeting follows.

1. **Regroup**
   As this was the first formal meeting for members of the Council and Executive since the March meeting and subsequent lockdown, there was a focus on bringing the group back together after a stressful period. Community experiences were shared and there were heartening themes of communities and individuals rising to look after each other which I comment on later.

2. **Informal meetings**
   There was much energy for and contribution to the 3 informal zoom meetings held during the lockdown and these were used to find consistent threads of feedback from the wider community. These meetings were an important container for some of members to be heard as growing anxiety was apparent in some areas. The focus moved from the standard longer-term strategic approach of the Council to shorter term feedback. It was considered in the extenuating circumstances that this was appropriate. Feedback on communication messages was provided at the April Board meeting. Our thanks for the uptake where that was possible.

   Finally, there is strong appetite to ensure consumer input into settling the new normal, particularly around patient interaction through the videoconferencing, teleconferencing and other alternative modes in both primary and secondary settings. Whilst it is very encouraging to see the changes in this area in response to the crisis, the Council recommendation is that settling into a new normal should be driven with meaningful consumer engagement alongside the clinical, management, and system input. This is consistent with a partnership approach and to move away from 'about us, without us'. For example, suitability across patient demographics, accessibility, individual needs and care/consult requirements will mean that one size will not fit all services nor patients and whānau.

3. **Post COVID commentary**
   There is consistent feedback and advice that the impact of lockdown and the flow on effects on employment etc is and will continue to result in increased stress in our community and greater demand for mental health services.

As noted previously in this report we recommend the consumer voice be engaged in any reviews to ensure their perspective is heard and captured. A small focus group of consumers has been arranged to work with the PHO to provide input into the settling of the new normal for primary care and GP practices. There is support from the Planning and Funding Directorate for a similar approach to be taken with other reviews too.

The activity initiated in the community by the community to care for themselves was very heartening. A great example of how communities and individuals have significant capability, creativity and motivation to look after themselves and a reminder that 'doing to' is the old compliance model, and 'empowering' and 'doing with' holds significantly greater upside for health outcomes.

4. **Members retiring after June 2020**

Malcolm Dixon and James Henry retire after 6 years as Council members. Samitoatoa (Sami) McIntosh also retires after qualifying as a nurse and working for the DHB. Their input and different perspectives have been invaluable to the Council work over their time. The process of inviting further applications will follow shortly.

5. **1737 Mental Health line**

I include this item as there was particular Board interest in it when first raised. Management from Planning and Funding directorate is continuing to chase this concern along as a progressive (rather than passive) response has not yet been received. What has become clear is the difficulty in having consumer input from a regional perspective heard and acted on by a provider of a service under a national contract. Our youth representative who first raised this issue and our MH&A lead member, whilst clearly preferring a definitive response, are aware of and comfortable with the ongoing push for real uptake.

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:	May 2020
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

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

The Pasifika Health Leadership Group (PHLG) met on 22 April 2020 for a COVID-19 briefing. An overview of the meeting is provided below.

1. Tīhei Mauri Ora
   Hayley Anderson acknowledged, in both her CIMS Incident Controller and DHB Board role, how very proud she is of what the team has accomplished with the amount of; leg work, the Facebook posts, the boots on the ground, the staggering amount of work over 7-days a week, mostly without breaks. This has been noticed by the Board and felt it important that this message was passed on at today's meeting.

   It was noted that:
   - The gains made under the umbrella of TMO must not be lost as we shift into recovery phase.
   - A lot of coordination was required to engage intersector agencies and businesses
   - There is a strong desire to see TMO networks continue. We talk about community-led and whanau-driven and this has been a great model. We know when a community takes ownership of their wellbeing, they have a part to play in that wellbeing and good things occur. They can tackle anything using this approach, such as child health, family harm etc. When community are involved and supported, community then lead.
   - Need to ensure continuity of community work progresses, similar to the work currently underway in Wairoa
   - There are approximately 7000 Pasifika living in Hawke's Bay with 1,000 considered vulnerable. TMO hubs are actively working together to deliver welfare needs, such as food parcels to the most vulnerable.
   - A Welfare Triage System be applied to support Pacific whānau and provide advice on how they navigate the system
   - A whānau ora wraparound approach is consistently being fine-tuned and currently provides; a 48hr follow-up post food parcel delivery, health checks (e.g. Flu vaccinations), advice to those on benefits so they are fully aware of entitlements by connecting with MSD along with other interagency groups

2. An Equity Advisory Group has been established to provide expertise that will process issues and provide constructive advice. Membership of the Group will include both Pasifika and Māori participation. This Group will form part of the overall recovery position.

3. Messaging around social distancing and hygiene to our Pacific and Māori whānau needs to be delivered more widely such as; via printed material e.g. flyers, mail-outs and radio due to lack of internet access in some communities.

4. Discussions across intersector agencies and HBDHB are underway to support the RSE community with their health and wellbeing and later, testing, quarantine and future repatriation requirements.

5. From an equity perspective members were advised that capacity to test across remote communities would need to be raised with the Ministry and DHB Public Health Unit.

The Chair spoke to the extraordinary level of work underway. We need to be conscious of the need to stay safe and look after our wellbeing. The Chair requested his acknowledgement be passed on to the Pacific Health team and others who are working to support Pasifika in this current environment. Patrick Le Geyt was thanked for incorporating Pasifika within the Tīhei Mauri Ora model.

HAWKE'S BAY District Health Board Whakawāteatia	**TE PUNI TŪMATAWHĀNUI - HEALTH IMPROVEMENT & EQUITY DIRECTORATE 3RD QUARTER 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:	May 2020
Consideration:	For Noting

RECOMMENDATION

That the HBDHB Board

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

EXECUTIVE SUMMARY

This is the 3rd Quarter Board Report (Jan-Mar 2020) from the Te Puni Tūmatawhānui, the Health Improvement and Equity (HIE) Directorate. From the last month of Quarter Three, the HIE Directorate, with its strong focus on population health, has been heavily involved In HBDHB COVID-19 responses with many staff deployed across the CIMS working groups and community outreach interventions. Whilst COVID-19 has caused a hold on many of the HIE Directorate activities it has also provided a much needed focus and provided an opportunity to lead and contribute collaboratively to HBDHB's pandemic response.

Highlights

- All immunisation, smoking and cancer screening in general, performance declined slightly against targets
- Public Health Unit hybrid model involving staff from both Health Improvement and Equity Directorate (HIE) and Communities Women and Children's Directorate (CWC) has led successful tracking and tracing of COVID-19 cases
- Māori and Pacific Flu Prioritisation Plan has increased health sector collaboration and improved influenza vaccination rate for priority population groups
- Tīhei Mauri Ora Māori and Pacific Pandemic Response has established a vast community network across Hawke's Bay of community support hubs, community coordinators and community champions providing support packages, in collaboration with Civil Defence, and critical information and messaging to vulnerable populations. It has processed approximately 9,000 referrals of vulnerable people in less than two months
- CIMS Equity Advisory Group has established a centralised function to address equity concerns and provide expert advice to the health sector
- A First 1000 Days collaborative working group has started developing an actionable work plan
- 115 Māori workforce development scholarships were delivered to the health sector in Hawke's Bay

CROSS DIRECTORATE SERVICES REPORTING

Health Indicator Performance

Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities.

MOH COVID-19 Level 4 guidelines put a pause on outreach screening, smoking cessation and immunisations services and consequently impacted on performance against targets in Q3 2020/21.

Immunisation
Immunisation can prevent a number of vaccine-preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of vaccine-preventable diseases and preventing spread to vulnerable people. The immunisation target of increasing eight month coverage supports early enrolment of infants in general practice and on-going engagement with primary care and well child services.

Child Immunisation (8 months) – Target 95%: All 90.2% ↓ Māori 90.9% ↓ Pacific 97.5% ↑
Coverage this quarter affected by families who have always declined immunisation.
Going into Covid-19 Alert 4 toward the end of March and continuing into April also meant that outreach was unable to visit hard to reach families to opportunistically immunise. We continue to work alongside all providers working with whānau to allow whānau to choose the most appropriate provider for them.

Smokefree
This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.

Primary Care Enrolled Patients Smoking Brief Advice – Target 90%: All 67% ↓ Māori 63% ↓ Pacific 63% ↓
Secondary Care Smoking Brief Advice – Target 95%: All 96.6% ↑ Māori 96.7% ↑ Paci c 97.6% ↑

1 January 2020 started with an increase in tobacco prices by 10%. Number of hospital and community smokefree referrals were steady throughout the period January and February with a slight increase in Wahine Hapu (pregnant women) referrals at the beginning of March as an additional incentive of vaping was introduced. Submission on the Smokefree Environments and Regulated Products (Vaping) Amendment Bill completed.

Covid-19 has temporarily diverted the focus to become smokefree due to issues such as unemployment, drop in income, mortgage repayments, food security, poor health, increased anxiety and smoking.
Te Haa Matea (HB Stop Smoking Services) downgraded smokefree support throughout Covid-19 Alert Level 4 due to self-isolating, working from home and no home visits.

Cervical Screening
In New Zealand, approximately 160 women develop cervical cancer each year – and about 50 die from it. A cervical screening test detects abnormal changes in the cells of the cervix. Having regular tests can reduce a woman's risk of developing cervical cancer by 90%. All women between 25 and 69 who have ever been sexually active should have regular smear tests.

Cervical screening participation – Target 80%: All 74.1% ↓Māori 74.4% ↓Pacific 76.2% ↑

The decline in screening coverage is attributed to Covid-19, across New Zealand coverage has declined in all ethnicities.

The Population Health Screening Kaiawhina and Pacific Community Support Worker continue to work in collaboration with Te Taiwhenua o Heretaunga and Choices outreach nurses offering smears in the community. Our Kaiwhakarere continues to provide support to women attending Colposcopy appointments.

Breast Screening
Breast cancer is New Zealand's third most common cancer and accounts for more than 600 deaths every year. The risk of being diagnosed with breast cancer increases with age. Every two years, free mammograms are targeted towards eligible woman aged 45 to 69 years.

Breast screening participation - Target 70%: All 72.4% Māori 69.1% ↓ Pacific 65.8% ↓
The Breast Screening Aotearoa (BSA) Mobile visited Wairoa and Waipukurau. All mammograms were cancelled by BSA at the fixed sites in Hawke's Bay when Covid-19 Alert Level 4 was activated. At Alert Level 3 our providers will gradually begin offering mammograms again but appointments will be prioritised.

Having access to the Breast Screening database enables us to provide information on a woman's screening status when we are in contact with our priority group women.

Bowel Screening
Bowel cancer, also called colon, rectal or colorectal cancer, is the second highest cause of cancer death in New Zealand. Bowel screening saves lives by detecting bowel cancer early, when it can often be successfully treated.

Bowel screening participation – Target 60%: All 65%, Māori 48.9% ↓ Pacific 49.8% ↓ (February 2020)
Discussions regarding contracting for community engagement and outreach continue.

Workforce
Māori Workforce - The target 16.66%: ↑ 15.9% Māori (March 2020) signifies a gap to the target of 24 people down from 32 in Q2.

Currently, the percentage of staff identifying as Māori within HBDHB as at 2020 is 15.90%. DHB targeted Māori workforce currently sits at 16.66%. We require a further 24 Māori staff to reach this target. We have commenced a recruitment strategy with HR to support value based recruitment and training inclusive to support recruitment managers to consider Māori workforce development in recruitment decisions. Staffing currently remains high in service level roles with low workforce percentage in allied health, medical staff and leadership.

Pacific Workforce - The target 1.76%: Pacific 1.62% ↓ signifies gap to the target of 5 people up from 4 in Q2.

Māori Health

Flu Vaccination Prioritisation Plan COVID Māori and Pacific
Māori generally have higher rates of chronic conditions and comorbidities and are likely to have an increased risk of infection should a community outbreak of COVID-19 occur. Despite innovative initiatives taking place across New Zealand, data indicates there are still considerable equity gaps in influenza vaccination rates between Māori and non-Māori.

The MOH have provided DHBs with increased funding aimed at the establishment and maintenance of innovative vaccination services to Māori, particularly at-risk groups, and improving Māori influenza vaccination rates.

The HIE Directorate has established a collaborative approach involving Māori health providers, outreach immunisation team, population health, pharmacy, PHO, and a Māori health led programme to collaboratively drive increased rates of not only Māori but Pacifica influenza vaccination to 90%.

Plan and actions from this group:

- Increase the communications to DHB, GP practices, pharmacies and providers to proactively prioritise the flu vaccine for those most at risk
- Promote and actively encourage Māori and Pacific who are eligible to get the flu vaccine to do so
- Ensure equitable access and supply in areas with high Māori population – prioritise access for Māori and Pacific to the flu vaccine
- Increase the vaccinator workforce and make it easier for clinical personnel to be qualified more quickly through online training
- Work with Māori providers to provide vaccine services for Māori and Pacific communities
- A funding application has been submitted to the MOH (4 May) to boost further resources to support growth and resourcing for acceleration flu vaccination rates

In March 2020, HBDHB has implemented the aforementioned plan and is seeing improved results. Current flu vaccine 59% Māori and 51% Pacific (over 65 years) has increased and exceeded previous year's rates and continues to track upwards.

First 1000 days

Māori Health, in a partnership approach with Planning & Funding, NKII, Population Health, Pacific Health, Child Health, Maternity, and Primary Care is developing a programme of work to support the implementation of First 1000 days. Guided by He Ngakau Aotea and with strategic guidance from the NKII, the group is working together to ensure a greater focus and accountability on equitable health outcomes for tamariki Māori and Pacific. The Te Ara Whakawaiora Child Health indicators are being reviewed to align with priorities and elevate decision-making that will result in tangible health gains for tamariki and will be presented at the June Board reporting.

Principles underlying our actions include:

- Targeted toward Māori mothers and their whānau in line with commitments to achieve equitable maternal health outcomes
- Targeted towards high needs communities using a localities based approach
- Aligned with activities to achieve Pae Ora – via Mauri Ora, Whānau Ora and Wai Ora
- Prevention and early intervention
- Community partnerships
- Evidence based
- Utilising existing resources as first option

An integrated approach to Rongoā Māori and Pharmacy Care

As part of the 2019-20 annual planning activity for pharmacy services, a 'Greener Approach' to integrated Pharmacy and Rongoā care was agreed by the Pharmacy Strategic Implementation Group (PSIG). This approach is consistent with MOH rongoā guidelines and national rongoā governance body – Te Kāhui Rongoā Trust. The aim of the Greener Approach is the development and use of traditional and modern pharmaceutical medicines and practices within the framework of conventional health care system in Aotearoa, where both clinicians, rongoā practitioners and community pharmacists support whānau on their wellness journey. To date, without distribution of Expressions of Interest, two community pharmacists have requested to be involved, located in Maraenui and Flaxmere.

Tō Waha – a new model of oral health care for whānau Māori

The HIE Directorate are leading a new model of oral health care that is whānau-focused and wellbeing-centric. Based on the learnings from the Tō Waha initiative held in 2019, interviews with whānau, literature about Māori models of health, and local dental data, the new service will be:

- Aligned with *He Ngakau Aotea* and *Whānau Ora, Hāpori Ora* incorporating matauranga Māori principles and practices to ensure a responsive and culturally appropriate service to whānau Māori
- Targeted to young parents and pregnant women aged between 18 to 30 years and their whānau

- Provides packages of care including assessment, hygiene and treatment in order to get and stay whānau orally fit
- Integrates primary health care to improve long term good oral health outcomes
- Utilising existing oral health funding
- Delivered across the region.

A procurement process will be undertaken and a service in place in the 2020/21 financial year.

Integrated Care Teams
HBDHB, in partnership with Health Hawke's Bay, are supporting Te Taiwhenua o Heretaunga in the provision of primary health care services to be delivered within Integrated Care Teams ('ICT'). ICT is a relationship focused, whānau centric, wellbeing approach that ensures the health needs of whānau are systematically identified and appropriately managed. To achieve this purpose, the ICT will be positioned within Te Ao Māori, encompassing Ngakau Aotea as a kaupapa and commitment to support whānau to thrive and achieve their full potential. Based on learnings from the South Central Foundation model, the ICT is a partnership between the provider and whānau as a client-owner. Services will be focused on investing in the future of whānau through improved integration and enhanced responsiveness to client-owner and their whānau, hapū and iwi.

Outcomes expected of Integrated Care Teams for their enrolled populations, include:

- Reduced ED Presentations
- Reduced ASH related hospitalisations
- Smoking quits
- Consumer satisfaction

The new service will be in place by end of 2020.

HBDHB Health Equity Framework
The organisational equity assessment was put on hold due to COVID-19 and will be an HIE Directorate recovery plan priority in the 4th Quarter. It will begin with an internal review looking at how well we are currently performing against the principles of the health equity framework. 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 changes arising from the Health Equity Framework can be monitored over time

The baseline assessment will be undertaken in a three tier 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 6 month timeframe for delivery on actions.

Māori Workforce Development

Tūruki Scholarships 2020

- Māori Health has an increased focus on higher level learning with post-grad study to support our leadership growth
- Twenty applicants ($48k) approved for a range of health degrees and post-graduate study

Health Workforce NZ (HWNZ) Scholarships 2020

- HWNZ provide DHBs with funding for Māori workforce development (Levels 2-5). Total Scholarship allocation in 2020 has been 95 applicants ($183k). These scholarships support current employees working within Māori Health, DHB and providers throughout the region.

The Development Hub - Wahine Toa Programmes – Pipeline Growth

Māori Health are currently working with the Development Hub, an organisation aimed at supporting young Māori and Pacifica mothers into the workforce. We are designing and delivering the wellness package over six- weeks and working with the group to look at health opportunities within the workforce.

Māori Health Providers Database/HWNZ & Turuki Funding Toolkit

A Māori Health Providers database for 2020 is completed. Key aim is to develop a tool kit to support understanding of HWNZ funding and to support targeted workforce development priorities.

NETP/NESP (Nurse Entry to practice programs)

Māori Health are supporting a review of training within the NETP/NESP HBDHB programme for Māori and Pacific graduates. Cultural supervision data from 2019 provided three key themes for Māori and Pacifica new graduates. They included:

- Desire to connect with new graduate peers and newly graduated NETP/NESP nurses for debrief and support
- Pastoral care in the form of work/life/study balance
- Structured cultural competency and practical ongoing training options and support i.e. Te Reo Māori, Tikanga Māori guidance and application

This review will inform the current Tuakana/Teina model designed by the NETP Nurse Educator. Delivery of this new component of the programme will commence September 2020 following approval from Nurse Directors and Nurse Educator manager.

Population Health

MOH Increase on Core Public Health Funding

The MOH have consulted and provided funding options to improve core public health funding for DHBs and regional public health units. The five funding options were based on two likely scenarios of $8m and $4m nationally. They requested two preferred options and HIE selected Option 1 ($324k or $162k) as our first funding allocation preference with Option 2 ($307k or $153k) as our second preference. Both options provided the larger percentage funding increases. MOH will notify DHBs of the intended funding allocation in the forthcoming months.

Public Health Unit COVID-19 Pandemic Response

The HBDHB Public Health Unit (PHU) is a 'hybrid model' made up of roles and functions from within both the Health Improvement and Equity Directorate and Communities Women and Children's Directorate. The communicable disease management, a core function of the PHU, has been activated in Hawke's Bay utilising the resources of both directorates forming a 'virtual' PHU team. This process followed the HBDHB and Public Health Emergency Response Plans, Pandemic Influenza Plan, PH COVID-19 Operational Plan along with significant direction from the Ministry of Health.

The PHU response sits within the CIMS Operations Section and is guided by the HBDHB *Public Health Emergency Response Plan,* which was last updated in November 2019. The Response Plan identifies key functions for the PHU and links to other parts of the CIMS. It includes non-overlapping operational teams to deliver case and contact tracing and the management of business as usual. With Medical Officers of Health and leadership rosters providing continuity between operational teams and CIMS roles.

On 17 March 2020, the Government announced funding of $40 million (out of $500 million earmarked for Health) to boost Public Health capacity/capability, especially around contact tracing as part of the pandemic response.

Service objectives:
1. To prevent, reduce and delay community transmission within New Zealand.
2. To ensure services are provided to those who need them most.
3. To prepare for mitigation measures as may be required during sustained/widespread community transmission ("manage it' phase).

Strategies:
1. Prevent outbreaks and sustained community transmission of COVID-19 in New Zealand by case finding, intensive contact tracing, isolation of cases, quarantine of contacts and other containment measures.
2. Work in partnership with the National Close Contact Service (NCCS) to achieve a nationally consistent and effective contact tracing and containment approach.
3. Apply an equity focus to the design and delivery of services and to response decisions.
4. Prioritise services to geographical areas with high densities of vulnerable populations, including areas of socioeconomic deprivation.
5. Engage with vulnerable communities and population groups to ensure they are well informed about and prepared for the potential impacts of COVID-19.
6. DHBs and their PHUs to engage with and coordinate services with other health care providers and the community.
7. Show kindness.

Response priorities:
- Scale up capacity for contact tracing, case and contact management and other containment measures. This may include assisting with such in other PHU areas
- Work closely and in partnership with the Ministry of Health's NCCS and/or any similar service
- Ensure persons in self isolation (e.g. recent arrivals and contacts of confirmed cases) are monitored and well supported in the community
- Apply compliance and enforcement for containment measures, where appropriate
- Arrange facilities and staff to support medium/large scale quarantine, if required

COVID-19 Contact Tracing Audit

In April 2020, MOH contracted Allen & Clarke to provide an independent assessment into how well positioned the PHUs are for successful rapid contact tracing, what works well and what changes or resources might be required to ensure rapid and nationally consistent contact tracing. In addition, MOH is seeking to review the operating models used in different PHUs to determine national consistency.

Three PHUs were identified for follow up of these issues: Auckland Regional Public Health Unit, Hawke's Bay District Health Board and Southern District Health Board. These PHUs were identified as they cover a large urban area (Auckland), a large rural and remote area (Southern) and have a high percentage of Māori (Hawke's Bay). Each of these PHUs have also dealt with a cluster of cases.

Overall, the Rapid Response Report by Allen & Clarke indicated a great activation response to COVID 19 meeting the service specifications. However the report highlights the need to improve:
- the readiness for event of this potential size,
- planning and modelling for cases and workforce for the next alert levels,

- cultural responsiveness,
- the link between PHU, National Close Contact Service (NCCS) and Healthline needs to be strengthened with a better end to end national system.

One of the elements of the national system is National Contact Tracing System (NCTS), which is under development, being implemented 18 May 2020. HBDHB PHU is contributing to testing and training before national implementation.

CIMS Equity Advisory Group

The HIE Directorate established the HBDHB CIMS Equity Advisory Group (EAG) to provide expert Māori and Pacific health equity advice to the HBDHB CIMS COVID-19 pandemic response. The functions of the Group are to:

- Respond to equity issues within the CIMS emergency response structure
- Provide advice to CIMS to ensure an equitable pandemic response for Māori and Pacific
- Make recommendations to improve the equity response of CIMS
- Share whānau Māori and Pacific health experiences and issues that CIMS should know about

The EAG has enabled a centralised approach to equity advice and equity leadership. It provides a structured process to address the diverse equity concerns, demands and questions of HBDHB leadership, management and service delivery. HIE plan to continue to provide operative equity advice with EAG post-COVID-19.

Intersector and Pacific Health

Tīhei Mauri Ora Māori Pandemic Response

Tīhei Mauri Ora (Iwi/Pacifica) (TMO) as developed in partnership with Ngāti Kahungunu Iwi Inc. and the HBDHB. TMO is a Māori and Pacific response to support whānau pounamu during COVID-19 response. TMO has been stood up as an essential service (welfare) in response to the COVID-19 Emergency Response Centre; a collaborative approach involving central and local government agencies and local territorial authorities including the; HBDHB; Health Hawkes Bay; Ngāti Kahungunu Iwi Inc. (NKII), Te Puni Kōkiri, Ministry of Social Development and NZ Police, in partnership with Ngā Taiwhenua o Ngāti Kahungunu, Wairoa District Council, Napier City Council, Hastings District Council, Central Hawke's Bay District Council, Māori Health and business providers.

TMO has received a variety of funding from government and resources from local iwi, supermarkets and food producers. NKII have been instrumental in providing both leadership, funding and resources.

TMO utilises the CDEM Welfare Group triage process both proactively engaging with communities and reactively responding to identified needs. It has received 1,850 Māori, 438 Pasifika, 450 Multicultural and 58 Other, making a total of 2,796 whānau referrals. This represents a total of 8,780 individual whānau members made up of 6,067 Māori, 2071 Pasifika, 600 MCA and 192 Other.

The majority of requests have come from the communities of Flaxmere and Mareanui which are areas of concern for the HBDHB targeted localities. The services in which Whānau Pounamu are seeking are as follows.

- 812 Food Parcels
- 716 Hygiene Packs
- 693 Kai-hau-kai (Fish)
- 229 Other support packages

TMO has demonstrated that community led approaches can lead to improved health and social outcomes and provides an opportunity to continue exploring other options of community involvement in health related issues. Community leaders and coordinators play an important role in managing the boundary between different organisations and the community.

They offer advice and support to a myriad of groups and individuals assisting them in accessing resources, developing initiatives and delivering programmes for the benefit of the community. It is an anticipated that TMO will continue for a further 6-8 weeks or until the social needs start to decline.

Healthy Homes Initiative
The HBDHB currently delivers the MOH funded Healthy Housing Initiative programme. The programme in Hawke's Bay is known as the Child Healthy Housing Programme (CHHP).

The combination of increased rental costs and reduced supply of affordable housing is resulting in more demand for public housing. However, public housing waiting lists are increasing and public housing tenants are remaining in public housing homes for longer. As a consequence, more families are having to move in with other families/family members (in either rental or whānau owned homes) and CHHP is increasingly identifying household crowding as a key issue for whānau.

In December 2019, funding of $310K over 2019/20 and 2020/21, as part of the Hastings Place Based Housing and Urban Development Pilot led by the Ministry for Housing and Urban Design, was confirmed to contribute to preventing and reducing homelessness in Hastings for whānau who have children with serious health conditions. Within the wider pilot programme, HBDHB has been successful with a proposal contributing towards workstream four: Reducing the number of tāmariki living in unhealthy homes or at risk of homelessness.

This service specification provides for a two-year programme piloting accessory portable sleeping quarters located on up to five whānau-owned properties, where there is severe overcrowding. This is a short-term solution to provide additional safe sleeping/living space while whānau are waiting to be placed in public housing or locate other suitable housing. Support services for the whānau will be provided. HBDHB will work with partners to deliver the programme. The programme will also investigate innovative longer-term solutions, where large or multiple whānau want to live together safely.

Haumaru Whānau Collective Suicide Prevention Pilot
The purpose of the Haumaru Whānau Collective Suicide Prevention Pilot is to assist local whānau in distress and to prevent suspected self-inflicted deaths, self-harm, suicidal ideation, or family harm incidents in the Hawke's Bay region. This is a pilot programme and ran from 13 December 2019 to 28 February 2020. This pilot was successful in securing dollar for dollar co-funding between HBDHB and NZ Police. Due to the success of this pilot a three month extension has been requested to extend the programme. The partnership included three community-based groups; Talk to me Community Trust, Inspire in Education and Tu Tangata Man Up, Legacy Diamonds and Youth Nation.

The key outcomes included:

- For Hawke's Bay suspected self-inflicted death statistics continue to remain static or decrease per month in comparison to the previous 12 months

FINANCIAL PERFORMANCE

The Health Improvement & Equity Directorate was noted as favourable in the last quarter to March 2020.

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:

20. Confirmation of previous minutes 15 April 2020 (Public Excluded)
21. Matters Arising (Public Excluded)
22. Board Approval of Actions Exceeding Limits Delegated by CEO (Public Excluded)
23. Chair's Report (Public Excluded)
24. Planning & Funding Report (Public Excluded)
25. Data Clean-Up (Public Excluded)
26. Recovery Plan (Public Excluded)
27. Finance Risk and Audit Committee (Public Excluded)
    - Minutes 15 April 2020
    - Minutes 20 May 2020
28. Hawke's Bay Health Consumer Council Report (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).