BOARD MEETING

Date: Tuesday 2 March 2021

Time: 2.00pm

Venue: Te Waiora Room, DHB Administration Building, s
Corner Omahu Road and McLeod Street, Hastings
(livestreamed for public meeting)

Members:
Shayne Walker (Chair)
Hayley Anderson
Ana Apatu
Kevin Atkinson
David Davidson
Evan Davies
Peter Dunkerley
Joanne Edwards
Charlie Lambert
Heather Skipworth
Renee Brown (Board Observer)
Panu Te Whaiti (Board Observer)

In Attendance: Keriana Brooking, Chief Executive Officer
Members of the Executive Leadership Team
Robin Whyman and Julie Arthur, co-Chairs, Hawke's Bay Clinical Council

Minute Taker: Kathy Shanaghan, EA to CEO

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	Karakia	2.00
2.	Welcome and Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting – 2 February 2021	
5.	Matters Arising - Review of Actions	
6.	Board Workplan	

	Section 2: Standing Management Reports	
7.	Chair's Report (verbal)	2.10
8.	Chief Executive Officer's Report	2.15
9.	Financial Performance Report – Carriann Hall, Executive Director Financial Services	2.20
	Section 3: Strategic Delivery	
10.	Hawke's Bay DHB Quarter 2 Health System Performance Dashboard – Emma Foster, Executive Director of Planning, Funding & Performance	2.25
11.	Draft Annual Plan 2021/22 – Emma Foster	2.35
12.	Ākina (Continuous Improvement) – e Referrals - Anne Speden, Executive Director of Digital Enablement, David Gardner, Medical Head of Deparment, Claire Caddie, Service Director, Natalie Brown, Service Improvement Lead	2.50
13.	Health Hawke's Bay Update – Wayne Woolrich, CEO Health Hawke's Bay	3.00
	Section 4: Other Governance Reports	
14.	Review of Hawke's Bay Health Consumer Council – Dr Andy Phillips, Chief Allied Health Professions Officer	3.10
	Section 5: Noting Papers	
15.	Māori Relationship Board Report – Chair, Ana Apatu	
16.	Hawke's Bay Clinical Council Report – Co-chair, Julie Arthur	
17.	Strategic Workplan – Emma Foster	
18.	COVID-19 Vaccine and Immunisation Programme Rollout Progress Report – Chris McKenna, Chief Nursing & Midwifery Officer and Patrick Le Geyt, Acting xecutive Director of Health Improvement & Equity	
19.	**Section 6: Recommendation to Exclude the Public** Under Clause 33, New Zealand Public Health & Disability Act 2000	3.20

Public Excluded Agenda

Item	Section 7: Routine	Time
20.	Minutes of Previous Meeting – 2 February (public excluded)	3.25
21.	Matters Arising – Review of Actions (public excluded)	-
	Section 8: Standing Management Papers	
22.	Chair's Report - verbal (public excluded)	3.27
23.	Chief Executive Officer (public excluded) - Hawke's Bay DHB Position Statement of Institutional Racism - ICU Training Accreditation – Interim Remediation Plan	3.40
	Section 9: Strategic Delivery	
24.	Strategic Capital Projects Status Report (public excluded) – Emma Foster	4.10
25.	Draft Annual Plan 2021/22 (public excluded) – Emma Foster	4.20
26.	Strategic Planning and Budgeting over a Multi-year Timeframe - Options Paper (public excluded) – Emma Foster	4.35
27.	Integrated Clinical Workforce – Budget Setting 2021/22 (public excluded) – Dr Robin Whyman, Chris McKenna and Dr Andy Phillips	4.55
	Section 10: Other Governance Reports	
28.	Finance, Risk and Audit Committee Meeting – 17 February 2021 (public excluded) – Chair, Evan Davies	5.05

	Section 11: Noting Papers	
29.	Board Approval of Actions Exceeding Limits Delegated by CEO (public excluded) – Emma Foster	
30.	Hawke's Bay Clinical Council Report – Co-chair Julie Arthur (public excluded)	
31.	Safety & Wellbeing Committee Minutes – 18 February 2021 (public excluded)	
32.	Karakia Whakamutunga	
	Meeting concludes	5.15

The next HBDHB Board Meeting will be held on
Tuesday 30 March 2021

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

Karakia

Hei Aratākina te Hui (to start)

E Io i runga i te Rangi Whakarongo mai titiro iho mai E Io i runga i te Waitai, i te Wai Moana, i te Wai Maori Whakapiri mai whakatata mai E Io i runga i a Papatuānuku Nau mai haere mai Nōu e Io te aō nei Whakatakina te mauri ki runga ki tēna taura ki tēna tauira Kia eke tārewa tu ki te Rangi Haumie Hui E tāiki e.	The waters of life connect us to all nations of this world. Sharing skills of one another and an understanding that throughout the hui we are courageous in our decisions that set and implement decisions.

Karakia whakamutunga (to finish) Unuhia

Unuhia, unuhia te uru tapu nui o Tāne Kia wātea, kia māmā te ngākau, te wairua, Te tinana, te hinengaro i te ara takatū. Koia rā e rongo, whakairia ki runga Kia wātea, kia wātea, āe rā, kua wātea!	Release, release the sacred knowledge of Tāne To clear and to relieve the heart, the spirit, The body and the mind of the bustling path. Tis Rongo that suspends it up above To be cleared of obstructions, yes, tis cleared.

Board "Interest Register" - as at 19 February 2021

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Shayne Walker	Active	Dr Rachel Walker	Wife - is a contractor to HBDHB	Potential conflict. Will abstain from decisions related to perceived conflict.	CEO	08.01.20
	Active	Daughter	Employed with Kahungunu Executive	Will abstain from all funding decisions related to Kahugnunu Executive. Work with CEO and Deputy Chair regarding any contract delegations	CEO / Deputy Chair	23/11/2020
Kevin Atkinson	Active	No interests to declare				
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	Iron Māori Events Ltd	Director. Company has two lifestryle contracts with HBDHB.	Potential conflict. Will abstain from all discussions/decisions that may have some direct relevance to this interest.	The Chair	21.10.20
	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
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	The Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Hayley Anderson	Active	Hawke's Bay District Health Board	Contracted as Incident Controller	Potential conflict. Will advise of any conflict of interest.	The Chair	16.09.20
		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	Hastings Rotary Club	President	Unlikely to be any conflict of interest. If in doubt, will discuss with HBDHB Chair	The Chair	11.09.20
	Active	Weem Charitable Trust	Provides support services to Cancer sufferers eg Cranford & Cancer Society	Will advise of any perceived or real conflict prior to discussion	The Chair	09.12.19
Joanne Edwards	Active	KiwiGarden Ltd	Director/CEO	Potential conflict. Will abstain from all discussions/decisions that may have some direct relevance to this interest.	The Chair	08.01.20
Charlie Lambert	Active	Centre for Women's Health Research Centre, Victoria Univesity	Part-time Researcher	Potential conflict. Will not take part in any decisions that may have some relevance to this interest and will stand down from any interaction with staff.	The Chair	15.07.20
	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, Executive Steering Group, Dunedin Hospital		No conflict perceived	The Chair	17.02.21
	Active	Chair, Capital Investment Committee	DHB Capital Prioritisation	Potential conflict.	The Chair	07.01.20

MINUTES OF THE HBDHB BOARD MEETING
HELD ON TUESDAY 2 FEBRUARY 2021 AT 2.00PM

PUBLIC

Present: Shayne Walker (Chair)
Evan Davies (Deputy Chair) – via zoom
Hayley Anderson
Ana Apatu
Kevin Atkinson
David Davidson
Peter Dunkerley
Joanne Edwards
Heather Skipworth
Renee Brown (Board Observer)
Panu Te Whaiti (Board Observer)

In Attendance: Keriana Brooking, Chief Executive Officer
Members of the Executive Leadership Team
Robin Whyman, co-Chair Hawke's Bay Clinical Council
Members of the Public and Media (via livestream)
Kathy Shanaghan, Executive Assistant to CEO

1. Heather Skipworth opened the meeting with a karakia.

The Chair gave a mihimihi and acknowledged Heather Skipworth for her karakia, Board members for their presence and the start of a new year, Panu Te Whaiti and Renee Brown as Board Observers, management and those working in the hospital and across the community. He also welcomed member of the public, Mr Kitchin, to the meeting.

2. APOLOGIES
An apology was received from Julie Arthur, co-Chair Hawke's Bay Clinical Council.

3. INTEREST REGISTER
No amendments to the interest register were noted. No Board member advised of any interests in the items on the agenda.

4. CONFIRMATION OF PREVIOUS MINUTES
The minutes of the Board meeting held on 16 December 2020 were confirmed as a correct record of the meeting.

Moved: Ana Apatu
Seconded: Hayley Anderson
Carried

5. MATTERS ARISING FROM PREVIOUS MINUTES
Status updates for all actions were noted.

6. BOARD WORK PLAN
The new revised governance workplan was noted with the following amendment:

- Pasifika Health Leadership Group (bi-monthly, not monthly). **Action**

STANDING MANAGEMENT REPORTS

7. CHAIR'S REPORT (VERBAL)

- Prior to the Chair commencing his report, Ana Apatu congratulated Board Observer Panu Te Whaiti for completing her governance training and presented her with a certificate in recognition of this. It was noted that Panu was one of a small group of National DHB Board representatives who attended all of the governance sessions.

- 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
Paul Davies	Recruitment Project Leader	People Directorate	10	22/12/20
Sherry Sharp	Registered Nurse	Medical Directorate	26	18/12/20
Moira Gillespie	Clinical Nurse Specialist – Oncology	Medical Directorate	15	24/12/20
Arita Sheridan	Needs Assessor	Older Persons & Mental Health Directorate	22	7/1/21

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

- The Chair referred to the Health and Disability System Review and advised that the Board had taken the position to provide feedback to Central Government on the reforms.
- The Chair advised that HBDHB had been asked to appear before the Select Committee on 24 February as part of the 2020/21 Annual Review.

8. CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer (CEO) took her report as read, highlighting the following:

- The new reporting template for governance reports, which included on the front page the following headings:
  - Health Equity Framework
  - Principles of the Treaty of Waitangi
  - Risk Assessment
  - Financial/Legal Impact
  - Stakeholder Consultation and Impact
  - Strategic Impact

  The CEO advised that in future the Board would not receive separate reports from the Executive unless they related to a separate matter or had a financial consequence, and instead updates would be included in the CEO's report.
- Today's pack included an overview of the COVID-19 vaccine and immunisation rollout programme. Progress reports would be provided to the Board monthly.
- Dr Ashley Bloomfield had confirmed his availability for the Chaplaincy fund raiser event in the evening of 19 March 2021 (the previous fund raiser was deferred due to COVID-19 levels). He had also agreed to spend the day at the DHB and a programme was being developed which would also include a meeting with the Board.

Comments from Board members included:

- Hayley Anderson asked if the Board could receive an update on the Health Care Home model to get an understanding of the strategy and implementation in Hawke's Bay, including the expected outcomes.

The CEO advised that a report from the PHO was scheduled to come to the Board (probably March) which would include this information. **Action**

- Heather Skipworth suggested having a discussion around Māori Data Sovereignty and what that means. **Action**
- Peter Dunkerley requested further detail around the work being done to improve the oxygen supply in the hospital. The CEO undertook to provide a further update in next month's report. **Action**
- Heather Skipworth congratulated the Executive Leadership Team for including the 'Principles of the Treaty of Waitangi' in their reports.

RECOMMENDATION

That the HBDHB Board:

1. **Note** and acknowledge this report.

Adopted

9. FINANCIAL PERFORMANCE REPORT

The Executive Director (ED) Financial Services took this report as read highlighting that due to changes in timing for FRAC and Board, the report included the result for December 2020. January's result would be included in the report for FRAC on 17 February.

RECOMMENDATION

That the HBDHB Board:

1. **Note** and acknowledge the financial position summarised in this report and the risk highlighted.

Adopted

STRATEGIC DELIVERY

10. STRATEGIC WORKPLAN

Karyn Bousfield, Clinical Lead, Planning Funding & Performance, was in attendance for this item.

This report provided an update on the Strategic Model of Care and the Annual Plan 2021/22. Emma Foster, ED of Planning, Funding & Performance, introduced the report and Karyn Bousfield provided an overview of the content. If Board members had any feedback on the Model of Care, then they were welcome to provide this to Emma over the next month.

The Chair sought confirmation that the model of care re-design included the role of nurses in secondary and primary care.

The ED of Planning, Funding & Performance provided an overview of the annual planning process for 2021/22 advising that the guidelines from the Ministry of Health (MoH) this year had been quite descriptive around the narrative, with the focus on COVID-19 and equity outcome actions. This was a significant departure from previous years as it didn't include 'business as usual' actions. The working draft of the 2021/22 Annual Plan would come to the Board on 2 March 2021.

RECOMMENDATION

That the HBDHB Board:

1. **Note** and acknowledge this report.

Adopted

11. STRATEGIC CAPITAL PROJECTS

This report was moved to public excluded.

12. ĀKINA (CONTINUOUS IMPROVEMENT) – TELEHEALTH OPPORTUNITIES

Anne Speden, ED of Digital Enablement, Patrick Le Geyt, Acting ED Health Improvement & Equity (HIE), Claire Caddie, Service Director, Sonya Smith, Wairoa Health Centre Manager and Ben Duffus, Head of Innovation and Strategic Partnership, were in attendance for this item.

Board members received a one-page paper providing a summary of telehealth opportunities at HBDHB. MoH funding of $283k had been secured for specific priority population groups including Māori and Pacific, low socio-economic, rural, elderly, disabled, those with mental health and addiction needs and others who may be excluded from using digitally-enabled health services. Wairoa and the wider rural communities were given as an example of where telehealth would improve access to care for patients in those areas. Another potential example of where the money could be spent in Wairoa was antenatal.

Sonya Smith advised that Wairoa had been zooming with Otago University for three years and this was another technology that could be used more which could avoid patients having to travel to Hastings.

The Chair thanked the team for their presentation and also on the strong team approach.

OTHER GOVERNANCE REPORTS

13. BOARD HEALTH & SAFETY CHAMPIONS' UPDATE

Evan Davies advised that as he and Charlie Lambert had only just taken over the role of Health & Safety Champions it was too early in the process to provide an update, however there were clearly ongoing issues they needed to focus on. He said their predecessors had done great work and he and Charlie looked forward to attending the Health, Safety & Wellbeing Committees and talking to staff. Charlie said he was unable to attend a meeting in Wairoa last week but would be attending the next one.

The Chair advised that Board members had a conversation earlier in the day around staff wellbeing and patient safety and would be happy to be involved in further discussions around how members might support staff.

NOTING REPORTS

14. COVID-19 VACCINE AND IMMUNISATION PROGRAMME ROLL-OUT PROGRESS REPORT

Chris McKenna, Chief Nursing & Midwifery Officer, Patrick Le Geyt, Acting ED HIE and Ngaira Harker, Nurse Director Māori Health, were in attendance for this item.

This report was the first update to the Board to inform planning for the COVID-19 vaccine and immunisation programme roll-out nationally and in Hawke's Bay. Nurse Director Ngaira Harker provided the following comments in addition to the report:

- The MoH had established a COVID-19 vaccination group to centrally manage the immunisation programme across DHBs
- Ngaira was coordinating the vaccination rollout in Hawke's Bay
- A HBDHB COVID-19 Vaccine and Immunisation Governance Group had been established along with working groups to support local planning and delivery of the vaccines in line with MoH requirements
- Each working group would have an identified team lead to support and progress each of the seven workstreams (pillars)
- Feedback had been provided to MoH to support a series of questions regarding our local requirements including how this would be rolled out for the first-tier cohort (employees at ports and airports). Meetings have occurred with the Port and Airport to look at how that would work
- The Doctors Napier and Hastings Health Centre would be delivering the vaccinations which were expected to commence mid-February

- A national communications strategy, together with FAQs, was being developed to support the rollout to encourage update of the vaccine and to address concerns people may have. The DHB was also developing its own communications, including meeting with Port workers to give them a chance to ask questions
- Monthly updates would be provided to the Board on the preparation and delivery of the vaccine. Updates would also be provided on any risks and/or delays that may impact on the DHB's ability to deliver and support the vaccination rollout in Hawke's Bay

Comments noted during discussion included:
- People need to be aware of the different vaccines
- The more information provided would allow people to make an informed decision and hopefully minimise the number who choose not to vaccinate

RECOMMENDATION

That the HBDHB Board:

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

Adopted

15. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board:

Exclude the public from the following items:

16. Confirmation of Previous Minutes 16 December 2020 - Public Excluded
17. Matters Arising (Public Excluded)
18. Chair's Report (Public Excluded)
19. Strategic Planning and budgeting Over a Multi-Year Timeframe (Public Excluded)
20. Strategic Capital Projects Status Report (Public Excluded)
21. Finance Risk and Audit Committee Meeting 29 January 2021 (Public Excluded)
22. Board Approval of Actions Exceeding Limits Delegated by CEO (Public Excluded)

MOVED: Shayne Walker
SECONDED: Ana Apatu

Carried

The Chair thanked members of the public for viewing the meeting via Facebook and also to Mr Kitchen for attending the meeting.

The public section of the Board meeting concluded at 3.00pm.

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

5

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	21/10/20	**Support for Elderly People** Discuss with Annie Aranui (MSD) what social support is available for elderly people who are discharged from hospital	CEO	November	Completed.
2	2/2/21	**Governance Workplan** Change Pasifika Health Leadership Group report to bi-monthly	Kathy	March	Completed
3	2/2/21	**PHO Report** To include update on Health Care Home model (implementation in Hawke's Bay and expected outcomes)	HHB CEO	March	Included in report to Board 2 March 2021
4	2/2/21	**Māori Data Sovereignty** Board to receive an update on what Māori Data Sovereignty means	CEO/ED DE		Completed
5	2/2/21	**Oxygen Supply at HB Hospital** Further information to be included in CEO's next report	CEO	March	Verbal update to be provided at 2 March meeting

FINANCE RISK AND AUDIT COMMITTEE		BOARD		
FINANCE	**Frequency**	**STANDING MANAGEMENT PAPERS**	**Public/Public Excluded**	**Frequency**
Financial Performance Report	Monthly	Chairs Report	Public / Public Excluded	Monthly
Annual Plan Budget (Feb-June)	Monthly	Chief Executive Officers Report	Public / Public Excluded	Monthly
Capital Plan Financials (March/June/Sept/Dec)	Quarterly	Balanced Scorecard	Public	Monthly
Insurance	Annually	Financial Performance Report	Public	Monthly
OUTPUT PERFORMANCE		**STRATEGIC DELIVERY**		
Balanced Scorecard	Monthly	Strategic Workplan	Public Excluded	Monthly
Annual Plan Performance/Health System Priorities (March/May/August/ Nov)	Quarterly	Strategic Capital Projects	Public/Public Excluded	Monthly
Provider Services Performance (Mar/June/Sept/Dec)	Quarterly	Annual Plan Performance/Health System Priorities(March/May/August/Nov)	Public	Quarterly
Public Health Performance (April/July/October/Jan)	Quarterly	Ākina	Public	As required
Funded Services Performance (April/July/Oct/Jan)	Quarterly	PHO Report	Public	1/4ly/6 mthly
Annual Plan (May)	Annually	Annual Plan (May)	Public	Annually
Annual Report (Oct)	Annually	Annual Report (October)	Public	Annually
CLNICAL QUALITY AND PATIENT SAFETY		**CAPITAL PROJECTS**		
Quality and Patient Safety and Standard Dashboard (May/August/Nov/Jan)	Quarterly	Capital Investment / Business Cases	Public Excluded	As required
PEOPLE HEALTH AND SAFETY		**OTHER GOVERNANCE PAPERS**		
People & Staff Safety and Standard Dashboard (May/Aug/Nov/Jan)	Quarterly	Health & Safety Champions	Public/Public Excluded	Monthly
RISK MANAGEMENT		Annual Reports: Allied Laundry/NZHP/TAS	Public	Annually
Risk Management Report and Exceptions (Mar/June/Sept/Dec)	Quarterly	External Audit	Public/Public Excluded	As required
AUDIT AND COMPLIANCE		**NOTING PAPERS** ***(Discuss by exception)***		
External Audit	As per schedule provided	Māori Relationship Board	Public/Public Excluded	Monthly
Internal Audit	As per agreed timetable	Clinical Council	Public/Public Excluded	Monthly
External Provider Audits (April/July/Oct/Jan	Quarterly	Consumer Council	Public/Public Excluded	Monthly
Audit Actions Update (May/August/Nov/Jan)	Quarterly	Pasifika Health Leadership Group	Public/Public Excluded	Bi-Monthly
		Te Pitau	Public/Public Excluded	Monthly
		Amounts Exceeding Delegation	Public Excluded	Monthly

PUBLIC EXCLUDED

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**JANUARY 2021 DHB CEO BOARD GOVERNANCE REPORT**
	For the attention of: **HBDHB Board**
Document Author(s) Document Owner	Keriana Brooking
Date	24 February 2021
Purpose/Summary of the Aim of the Paper	To provide a monthly strategic and operational update to the Board of HBDHB
Health Equity Framework	The Executive Leadership team (ELT) met in February and completed half the work necessary to agree the work effort and reconfirm the delivery/accountability/monitoring leads for the Equity Action Plan. It was accepted at the workshop that there are action statements, which as an organisation we have no working definitions e.g., cultural safety or health intelligence. Quickly identifying those and making it clear to our senior leaders and staff what we mean and therefore what we expect of them will form part of the Equity Action Plan document. It was indicated in the Board CEO February Report that the 2021/22 investment options using the Health Equity Framework will be provided for Board decision in March 2021. In discussion with the team, this has been rescheduled to April 2021 board meeting.
Principles of the Treaty of Waitangi that this report addresses	Post FRAC meeting feedback, a process has been established by ELT to group review this section of ELT produced papers to ensure all elements of the principles of Te Tiriti are explored and documented in this section for each paper.
Risk Assessment	The DHB continues to carry a high degree of clinical, financial and equity risk with ongoing service demand risks in primary care, aged residential care facilities, acute services and inpatient services. From the staff to the Executive, daily decisions are being made to keep our people and services safe. Strategic improvements and investment decisions (including disinvestment) will feature as Board decision papers over the coming months.
Financial/Legal Impact	Nothing for noting
Stakeholder Consultation and Impact	I have had the following interactions in this period: • Met with the DHB clinical nurse specialists for Respiratory • Tour of the Renal Department including a sit down with two at-home-dialysis patients who supported an improvement in the training space for teaching people at-home-dialysis • Met with the Medical Heads of Department • Attended a zoom with Hawke's Bay Leadership Group to discuss our regional response to COVID-19 Resurgence

	• Met with Annie Aranui (as Hawke's Bay Public Sector Regional lead re Workforce for the local Health and Disability System • Attended the 90th Anniversary of the 1931 Earthquake Civic Service in Napier • Attended MRB, the Clinical Council and Consumer Council • Along with Anna Kirk and Shayne Walker met with Craig Cooper, Editor of Hawke's Bay Today • Met with Anna Lorck, MP for Tukituki • Met with HBDHB Lead clinicians for Stroke • Attended a zoom meeting with Minister Henare and Minister Davis to discuss with National Iwi Leaders Forum Māori and the roll out of the COVID-19 Vaccine • Opened the DHB Allied Health Leadership training • Attended Te Pitau Alliance meeting • Attended the DHB Safety and Wellbeing Committee meeting • Chaired the National Immunisation Implementation Advisory Group for the COVID-19 vaccine • Open Ngākau Ora and facilitated the DHB Values and Behaviours section
Strategic Impact	Work continues to prepare the organisation for our part in the Health and Disability System Review changes. The Executive remain thoughtful about: ➢ those areas we should not lose sight of during change (people, infrastructure, community, equity, improvement, safety) ➢ where we may need to move quickly to respond ➢ not pre-empting too much therefore "exhausting" effort in an already busy environment We will be working actively with the Board and broader governance over the coming months with a Board workshop scheduled for 17 March 2021.
Previous Consideration / Interdependent Papers	None to note

RECOMMENDATION:
It is recommended that the (Governance Committee):
1. Note and acknowledge this report.

HOSPITAL SERVICES UPDATE

Emergency and Non-Elective Care

The ED6 Health Target result for January was 72.3 percent (down from 78.6 percent in December). The position is reflective of continuing increased lengths of stay (especially for older patients), and an increase in the number of patients with multiple admissions to hospital. These factors cause access block back into the Emergency Department (ED).

Recruitment is underway to bring additional nursing and medical staff into the ED team to address the impacts of a full department, while work has commenced with primary care partners to look at actions that may alleviate bed day demand.

Planned Care

HBDHB planned care delivery was really strong in January 2021, although this performance continues to be set in the context of continuing elevated referral demand.

- A total of 2,252 referrals were received in January, slightly down on the average received over the previous three months (2,358) and 10 percent lower compared to the January 2020 (2,521).
- In total, 1,358 patients were provided with First Specialist Assessments in the month of January. This, as usual during the holiday period, was a drop compared with activity in November and December but 13 percent higher than January 2020. As a result, the overall waiting list size remained fairly static ending the month at 5,461 (down 28 patients). However, the proportion of the waiting list who have been waiting for four months or more grew (from 26.6 percent to 29.2 percent). This equates to 1,593 patients overdue – although the DHB remains within the trajectory for the Ministry of Health Improvement Action Plan.

In respect of elective surgery, the DHB continued to over-perform against its Ministry of Health production planning discharge target in January with a result of 111.2 percent. Caseweight discharges were not as high, at 93.4 percent of plan, due to a high volume of on-site discharges with low caseweight, and lower than planned numbers for both outsourced delivery and Inter District Flow.

- Inter District Flow activity was 71.1 percent of plan (54 discharges vs 76 plan)
- On-site activity continues its record of over-delivery (523 discharges vs 382 plan)
- Outsourced delivery was only 56 discharges (50.5 percent of the 112 plan)

Overall the waiting list for surgery reduced by 110 patients from December, ending the month at 2,188. However, of these, 29.4 percent of patients have now waited more than four months. This is a significant increase month-on-month and equates to an extra 88 patients, now overdue.

Ngākau Ora

It's with a great deal of satisfaction that Hawke's Bay DHB held its first Ngākau Ora staff orientation programme on 22 and 23 February. Ngākau Ora, or Leading with HeĀRT, is based on Southcentral Foundation Nuka core concepts programme and grounded on our organisational values and culture to support developing quality relationships with our whānau, community and each other.

It covers topics such as organisational values and behaviours, respectful relationships, understanding equity, models of thinking and unconscious bias, effectively engaging with Maori, effectively engaging with Pasifika and relationship centred practice and relational styles. Ngākau Ora has been endorsed as an organisational mandatory study training for all new and current staff. The intent is that over the next three years every new staff member and current members will attend this two-day programme.

Balanced Scorecard

Due to the quality and the quantity of feedback received from the February FRAC meeting on the draft Balanced Scorecard, I have agreed to provide the next iteration to the March FRAC, coming to the April Board meeting.

Our People and Culture team have been reviewing Programme Incubator - our programme to encourage students to consider a career in health. On reflection it became apparent that the programme had huge potential and could appeal to more than just high school students. With that in mind, the Recruitment team have refreshed its look and feel and intention. The premise has always been about encouraging students to consider a career in health – now it's about working with anyone to "create a health career" …whatever that may look like!

An exciting first step is teaming up with the Ministry of Social Development to introduce a Health Administration Cadet Programme, the pilot for which will begin on 1 March and will see 10 cadets employed onsite for an 8-week intensive training programme to develop skills in health administration roles. They'll work with buddies in the Reception and Health Records teams and be given an extensive orientation into these positions. The opportunities for cadets after the programme are significant and they'll leave the programme with transferrable skills and potential ongoing employment. Emma Ellison, our recruitment manager, will present this to the Board at our April meeting under the Ākina section.

INTENSIVE CARE TRAINING ACCREDITATION

As the Board has been advised the College of Intensive Care Medicine of Australia and New Zealand has withdrawn training accreditation to Hawke's Bay Hospital's Intensive Care Unit due to infrastructure issues of the unit.

Management is working with its facilities team on a workable solution that meets the standards set by the College for training. Losing training accreditation would not affect the current intake of registrars in the unit, but would affect the next intake of trainees in 2022. We are hopeful a workable interim accreditation solution can be found and will update the Board as that progresses.

In the meantime, the team continues to deliver its high standard of patient care to support Hawke's Bay Hospital and the wider health system.

COVID-19

The recent community cases in Auckland resulted in a very swift response to level 2 across the Hawke's Bay health system with virtual appointments made, infection prevention and control measures taken and changes to the Hawke's Bay Hospital visitor policy for three days.

The Public Health Unit is managing numerous issues and continues to work hard on keeping our border safe. A new team lead has been appointed to strengthen our testing requirements for border workers. Our highest risk continues to be for COVID-19 to enter our community through Napier Port and Airline staff returning from overseas flights.

We are exploring an option of setting up a non-booked testing pathway for mass testing should it be required. We continue to provide psychosocial support to the community and to work with Civil Defence Emergency Management. The COVID resurgence plan is nearing completion having had broad input from across the DHB.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report January 2021**
	For the attention of: **HBDHB Board**
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Date	March, 2021
Purpose/Summary of the Aim of the Paper	To provide a monthly update on the key financial metrics
Health Equity Framework	As a part of the suite of consolidated reporting, provide financial information to support decision making around health equity
Principles of the Treaty of Waitangi that this report addresses	Through providing information on the overall financials, supports debate around the Treaty Principle of 'Options: Providing for and properly resourcing kaupapa Māori health and disability services'
Risk Assessment	The report provides summary information on the risks
Financial/Legal Impact	As per the report
Stakeholder Impact	N/A
Strategic Impact	Achieving a sustainable underlying financial position will support the DHB to achieve its strategic objectives
Previous Consideration / Interdependent Papers	This has interdependencies with papers on the Annual Plan and Annual Report

RECOMMENDATION

It is recommended that the HBDHB Board:

Note the contents of this report.

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

The Operating Result for January was $112k adverse to plan and $243k adverse to plan year to date (YTD). When considering the total position including COVID-19 and Holidays Act, receipt of revenue related to COVID-19 expenditure in month gives an overall favourable variance of $19k in month and the overall YTD position is unchanged from last month at $3.3m adverse.

An adverse Operating Result was expected for January, as ongoing factors relating to dependency and occupancy meant that annual leave assumptions built into budgets, (based on leave taken in prior years) were not met in the areas responding to acute activity and the need to provide cover for junior doctors

(RMOs) due to college changes continued to impact. These factors largely impacted Providing Health Services.

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast	Refer Appendix
Operating Revenue	55,826	56,522	(696)	-1.2%	389,399	386,271	3,127	0.8%	664,985	1
Less:										
Providing Health Services	28,756	27,878	(878)	-3.1%	191,428	187,389	(4,039)	-2.2%	332,293	2
Funding Other Providers	14,105	15,318	1,213	7.9%	167,078	166,946	(132)	-0.1%	286,614	3
Corporate Services	4,725	5,124	400	7.8%	35,157	36,413	1,257	3.5%	61,560	4
Reserves	2,299	2,148	(151)	-7.0%	4,397	3,942	(455)	-11.5%	3,377	5
Operating Result	**5,941**	**6,053**	(112)	-1.9%	**(8,661)**	**(8,418)**	(243)	-2.9%	**(18,858)**	
Plus:										
Emergency Response (COVID-19)	377	-	377	0.0%	(1,293)	2	(1,295)		(2,014)	
Holidays Act Remediation	(246)	-	(246)	0.0%	(1,777)	-	(1,777)	0.0%	(2,972)	
	6,072	**6,053**	19	0.3%	**(11,731)**	**(8,416)**	(3,315)	-39.4%	**(23,844)**	

The Covid-19 budget is non-zero because part of the revenue budget has been transferred to capital expenditure, where the cost will be incurred.

Risks, Opportunities & Issues

The forecast shows the expected position without mitigations, to show the extent of the financial risk. We do have further (one-off) flexibilities to deploy as we come into the second half of the year to close the forecast gap to achieving plan. However, delivering the planned Operating Result continues to be vulnerable to internal and external forces discussed in previous reports and these risks are being closely monitored.

Other Performance Measures

	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast	Refer Appendix
	$'000	*$'000*	*$'000*	*%*	*$'000*	*$'000*	*$'000*	*%*	*$'000*	
Capital spend	1,463	3,577	(2,114)	-59.1%	8,231	21,045	(12,814)	-60.9%	45,058	12
	FTE	*FTE*	*FTE*	*%*	*FTE*	*FTE*	*FTE*	*%*	*FTE*	
Employees	2,705	2,593	(112)	-4.3%	2,628	2,616	(11)	-0.4%	2,643	2 & 4

- Capital spend (Appendix 10)

  Variances on strategic capital projects are the main drivers of the underspend to date, this is partly due to uncertainty of timing of expenditure at planning and partly a result of slippage. Block allocations are expected to be fully utilised by the end of the year.

- Cash (Appendices 9 & 11)

  The cash low point for the month was $19.1m overdrawn on 19 January, within the $35m statutory limit and in line with the $19.2m forecast. As a result of the deficit position and the expectations around capital plan delivery in 2021/22, as a part of annual planning consideration is being given to the requirement for an equity (cash) injection in 2021/22, as this will need to be signaled to MoH.

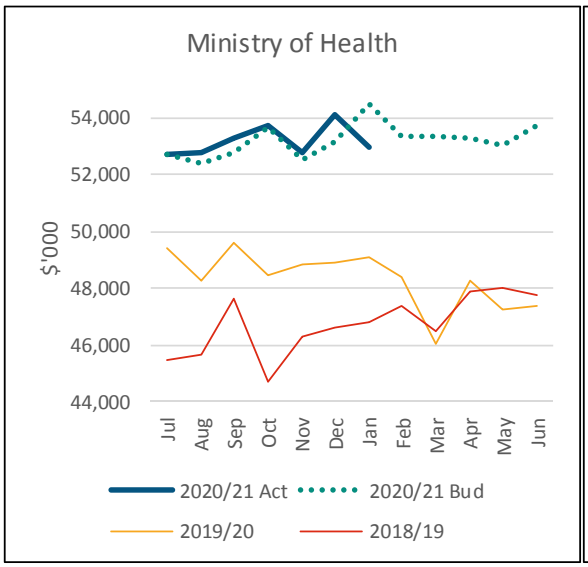
- Employees (Appendices 2 & 4)

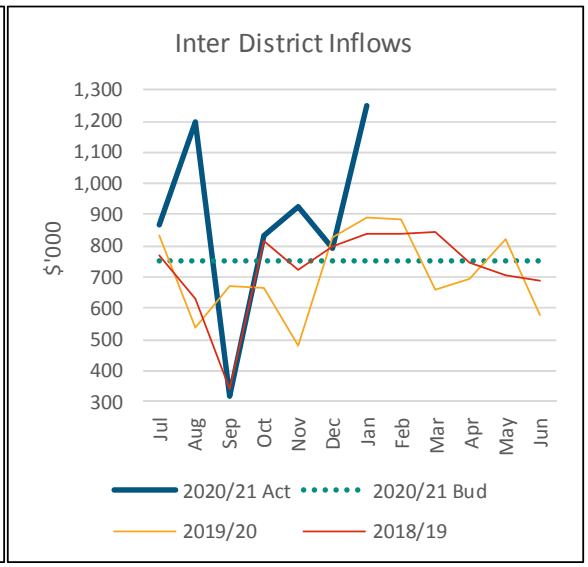
  Higher than planned nursing and support numbers reflect the acute delivery issues in Providing Health Services. These were partly offset by vacancies across allied health, and management and administration. Vacancies in medical personnel, are likely to be covered by locums that are not counted as FTEs. While this has a net favourable impact on FTE, it also causes a net adverse variance on cost.

APPENDICES

1. OPERATING REVENUE

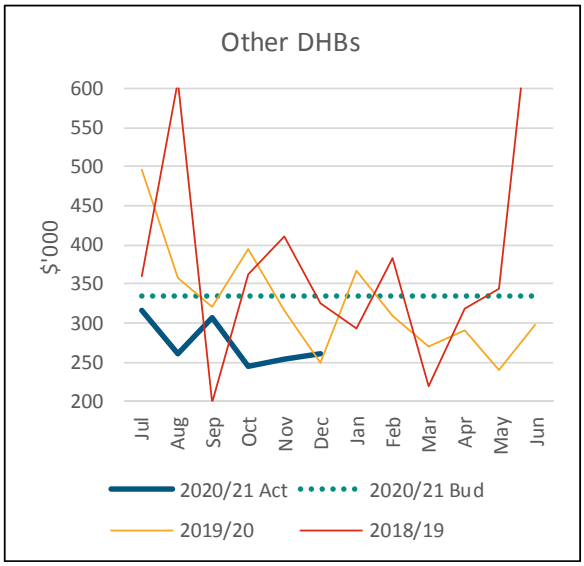
Excludes revenue for COVID-19	*January*				*Year to Date*				*Year End*
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*
Ministry of Health	53,009	54,499	(1,490)	-2.7%	372,436	371,828	608	0.2%	638,071
Inter District Flows	1,249	752	496	66.0%	6,177	5,266	911	17.3%	9,442
Other District Health Boards	251	334	(83)	-24.9%	1,894	2,339	(444)	-19.0%	3,438
Financing	8	4	4	97.4%	58	24	34	142.8%	74
ACC	377	424	(48)	-11.2%	3,218	3,084	135	4.4%	5,679
Other Government	(2)	22	(24)	-108.8%	249	326	(77)	-23.7%	419
Abnormals	-	-	-	0.0%	200	-	200	0.0%	200
Patient and Consumer Sourced	108	108	0	0.3%	893	757	137	18.0%	1,470
Other Income	826	379	447	118.2%	4,273	2,648	1,624	61.3%	6,192
	55,826	**56,522**	(696)	-1.2%	**389,399**	**386,271**	3,127	0.8%	**664,985**

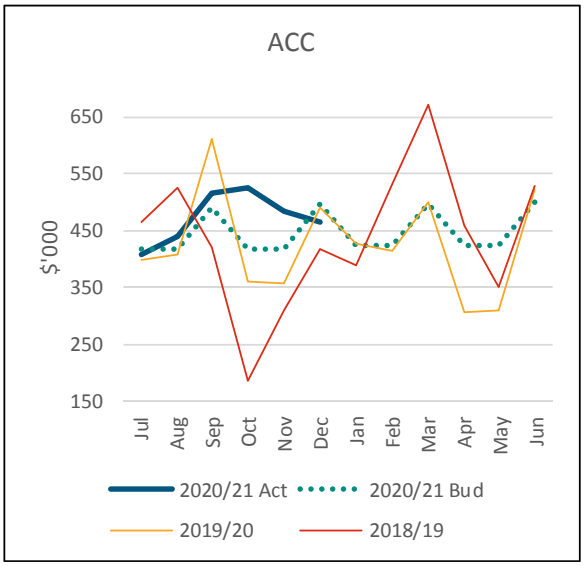




Ministry of Health ($0.6m favourable YTD)
Mental health funding, training revenue, and family planning funding, all offset in expenditure. January was affected by an adjustment to pharmaceuticals increasing both the income and expense budget to recognise YTD growth.

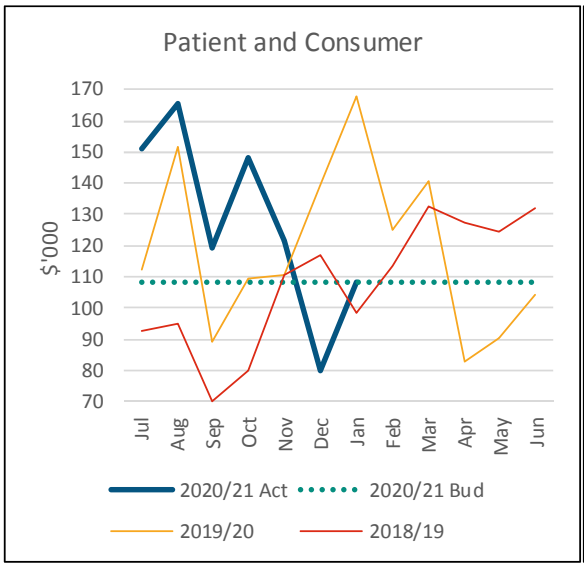
Inter District Flows ($0.9m favourable YTD)
Inter District Flows are inherently volatile due to the small volume and high cost.

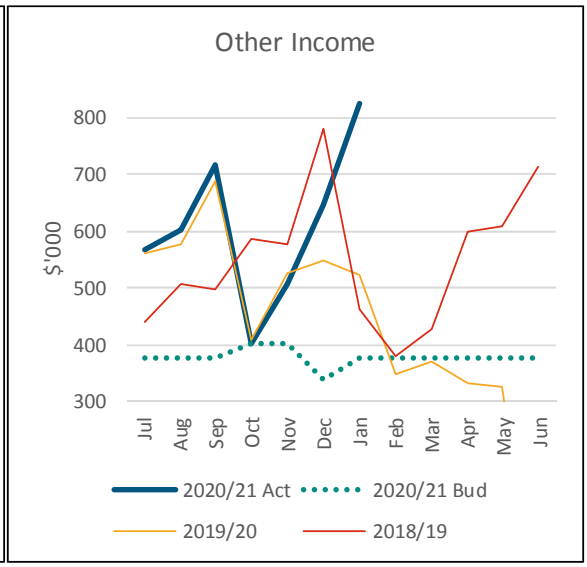




Other District Health Boards ($0.4m adverse YTD)
Ongoing reduced revenue from Tairawhiti DHB for pharmaceutical cancer treatments (PCTs), partly offset by increased revenue from Mid Central DHB for oncology clinics.

ACC ($0.1m favourable YTD)
Some reduction in rehabilitation services provided to ACC over the Christmas period.



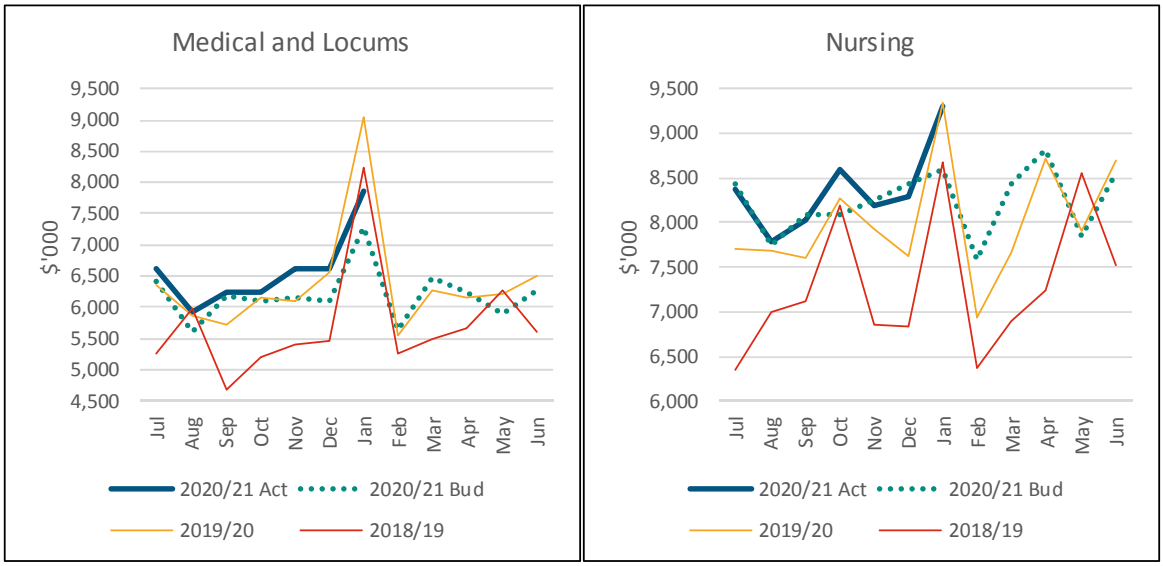


Patient and Consumer ($0.1m favourable YTD)
Non-resident charges, and meals on wheels, partly offset by reduced audiology income (hearing aids).

Other income ($1.6m favourable YTD)
Clinical equipment relating to COVID-19 transferred by MOH to the DHB is half of the favourable result. The year to date numbers include the return on investment in Allied Laundry Services, provision of nurse training services to EIT, unbudgeted donations and clinical trial income, residential accommodation (Springhill), and a wide range of income items across the DHB. The diversity and volatility of income sources and a conservative approach to budgeting, means this has traditionally tracked favourably and we expect that to continue.

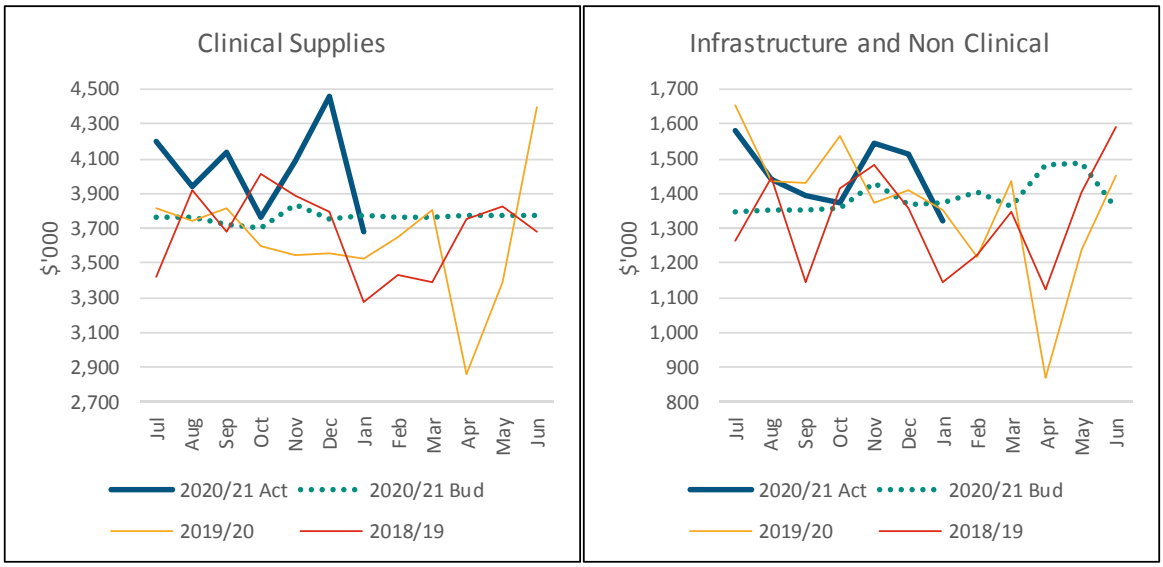
2. PROVIDING HEALTH SERVICES

	January				Year to Date				Year End
	Actual	Budget	Variance		Actual	Budget	Variance		Forecast
Expenditure by type $'000									
Medical personnel and locums	7,870	7,269	(601)	-8.3%	46,124	43,821	(2,302)	-5.3%	79,792
Nursing personnel	9,303	8,592	(710)	-8.3%	58,554	57,623	(930)	-1.6%	99,592
Allied health personnel	3,129	3,287	158	4.8%	23,997	24,857	859	3.5%	42,568
Other personnel	2,242	2,210	(32)	-1.4%	16,177	16,369	192	1.2%	27,918
Outsourced services	1,091	1,245	154	12.4%	7,316	7,983	667	8.3%	15,248
Clinical supplies	3,676	3,774	98	2.6%	28,259	26,312	(1,948)	-7.4%	48,096
Infrastructure and non clinical	1,445	1,500	55	3.7%	11,001	10,424	(576)	-5.5%	19,078
	28,756	**27,878**	(878)	-3.1%	**191,428**	**187,389**	(4,039)	-2.2%	**332,293**
Expenditure by directorate $'000									
Medical	8,873	8,159	(714)	-8.7%	56,494	52,790	(3,704)	-7.0%	96,389
Surgical	6,932	6,706	(226)	-3.4%	45,165	44,238	(927)	-2.1%	79,298
Community, Women and Children	4,257	4,409	152	3.4%	29,403	29,949	546	1.8%	51,358
Mental Health and Addiction	2,053	2,037	(16)	-0.8%	13,847	13,629	(218)	-1.6%	23,867
Older Persons, NASC HB, and Allied H	1,450	1,470	19	1.3%	10,090	10,296	206	2.0%	17,790
Operations	4,173	3,993	(180)	-4.5%	29,566	28,694	(872)	-3.0%	50,463
Other	1,018	1,105	87	7.8%	6,863	7,793	930	11.9%	13,127
	28,756	**27,878**	(878)	-3.1%	**191,428**	**187,389**	(4,039)	-2.2%	**332,293**
Full Time Equivalents									
Medical personnel	408.9	402.6	(6)	-1.6%	383	395	12	3.0%	398.4
Nursing personnel	1,197.4	1,080.7	(117)	-10.8%	1,111	1,065	(46)	-4.3%	1,070.0
Allied health personnel	471.1	490.0	19	3.9%	495	513	18	3.5%	520.6
Support personnel	135.6	116.4	(19)	-16.5%	132	119	(12)	-10.5%	121.0
Management and administration	281.8	285.8	4	1.4%	286	295	10	3.2%	300.8
	2,494.8	**2,375.6**	(119)	-5.0%	**2,407**	**2,388**	(19)	-0.8%	**2,410.8**



Medical personnel and locums ($2.3m adverse YTD)
The cost of locums covering vacancies and medical staff on leave, exceeds the savings from vacancies. Acute occupancy and in-house elective activity (offset in Outsourced Services) also contribute to cost pressures.

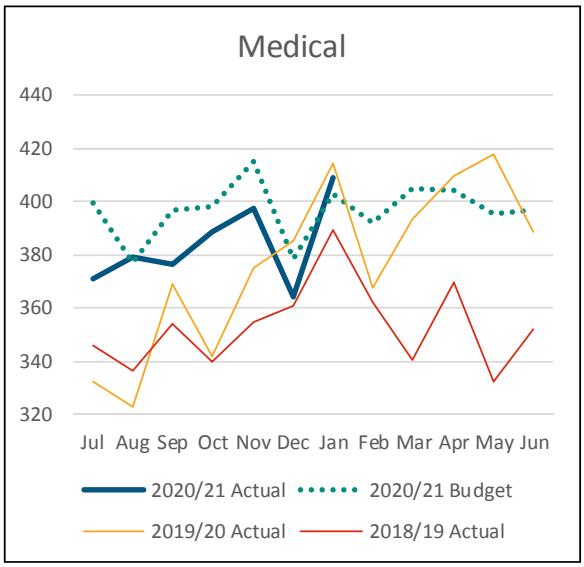
Nursing ($0.9m adverse YTD)
Additional staffing to manage occupancy/additional bed capacity and length of stay issues, along with high numbers of patient watches. Lower than planned utilisation of leave over Christmas.

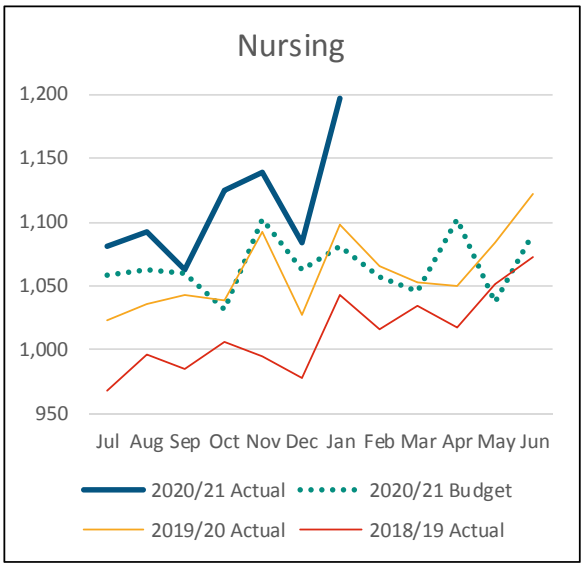


Clinical supplies ($1.9m adverse YTD)
Clinical supply costs reduced as anticipated in last month's report. As a result of COVID impacts on supply chains internationally, an understandably conservative approach to stock management was taken prior to Christmas shut downs by suppliers, meaning excess stock was utilised in January. Underlying drivers of costs are planned care volumes provided in house (partly offset in outsourced services), patient transport costs, and cost impacts on manufacturing and international supply chains caused by COVID issues.

Infrastructure and non clinical supplies ($0.6m adverse YTD)
Laundry, external security, cleaning and food costs reflect patient throughput year-to-date, although on a comparative basis HBDHB appears to be efficient in laundry utilisation. Adverse minor hardware costs (timing issue), and favourable domestic travel costs offset.

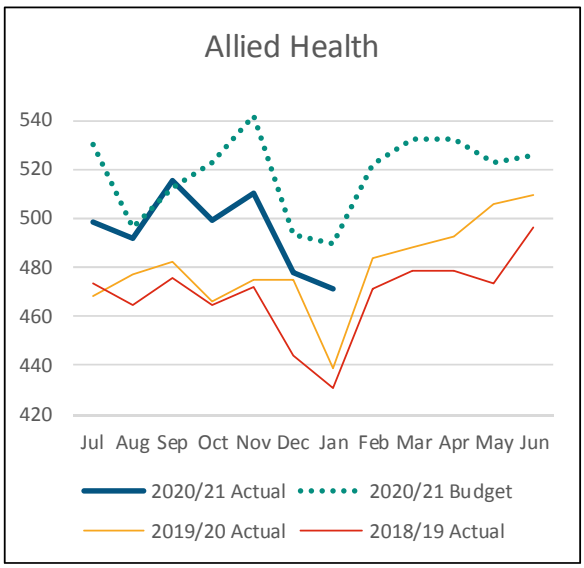
Full Time Equivalents (FTE)

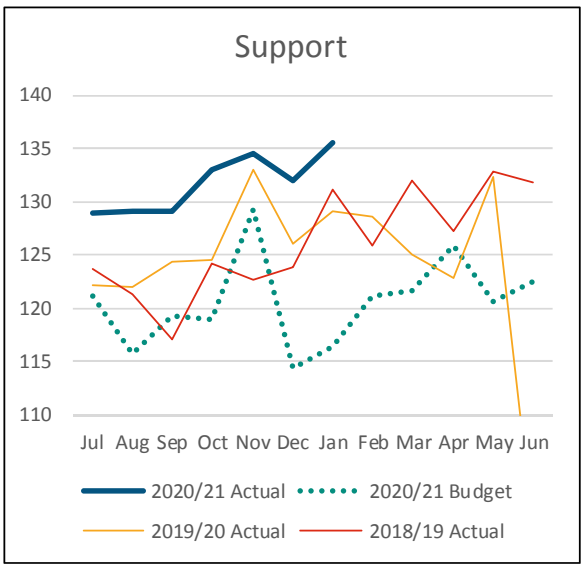




Medical personnel (12 FTE / 3.0% favourable)
Specialist vacancies covered by locums where available. Lower than planned utilisation of leave increased FTE numbers.

Nursing personnel (-46 FTE / -4.3% adverse)
Additional staffing to manage occupancy/additional bed capacity and length of stay issues, along with high numbers of patient watches. Lower than planned utilisation of leave.



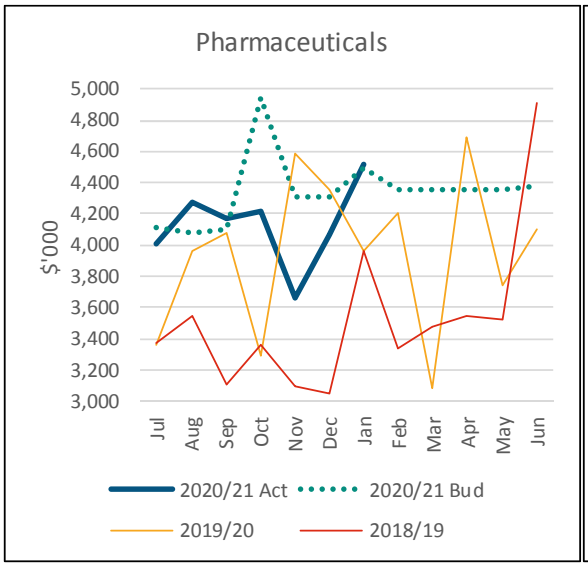


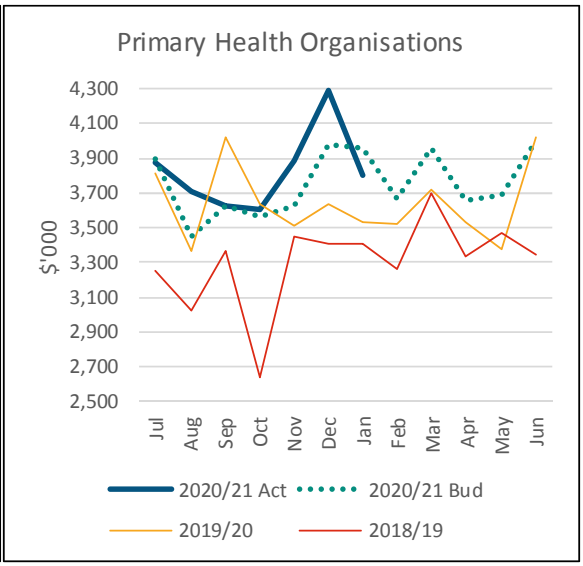
Allied health personnel (18 FTE / 3.5% favourable)
Ongoing vacancies including technicians, cultural workers, social workers, health promotion workers, dental therapists, and pharmacists.

Support personnel (-12 FTE / -10.5% unfavourable)
High patient activity and dependency drive higher orderly and kitchen assistant costs. The operations directorate is being supported through service improvement and other actions to manage these issues.

3. FUNDING OTHER PROVIDERS

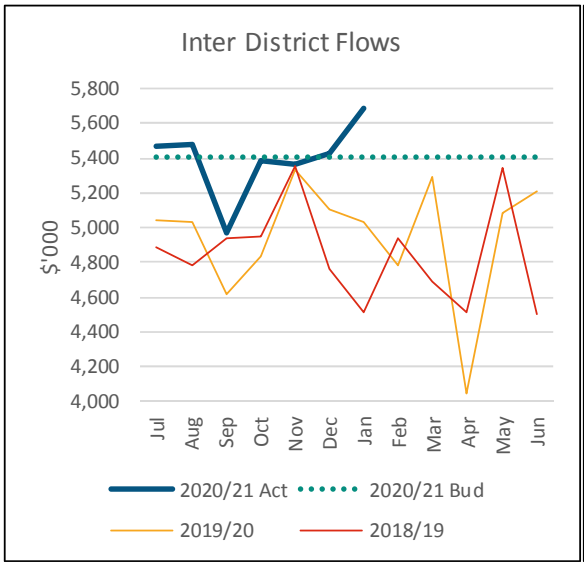
$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	4,512	4,494	(18)	-0.4%	28,912	30,348	1,435	4.7%	50,204
Primary Health Organisations	3,800	3,961	161	4.1%	26,802	26,110	(692)	-2.6%	45,864
Inter District Flows	5,691	5,411	(280)	-5.2%	37,781	37,878	97	0.3%	64,556
Other Personal Health	(7,602)	(7,276)	325	4.5%	15,836	15,132	(704)	-4.7%	27,366
Mental Health	1,389	1,806	417	23.1%	9,127	8,511	(616)	-7.2%	14,669
Health of Older People	5,976	6,605	630	9.5%	45,820	46,242	422	0.9%	79,303
Other Funding Payments	338	316	(22)	-7.1%	2,799	2,725	(74)	-2.7%	4,653
	14,105	15,318	1,213	7.9%	**167,078**	**166,946**	(132)	-0.1%	286,614
Payments by Portfolio									
Strategic Services									
Secondary Care	(4,295)	(4,411)	(116)	-2.6%	35,630	35,304	(327)	-0.9%	60,646
Primary Care	9,452	9,711	259	2.7%	65,443	65,995	553	0.8%	113,214
Mental Health	1,708	2,132	424	19.9%	11,385	10,811	(574)	-5.3%	18,555
Health of Older People	6,606	7,268	662	9.1%	49,976	50,231	256	0.5%	86,195
Maori Health	505	510	5	0.9%	3,659	3,730	71	1.9%	6,377
Population Health	128	107	(21)	-19.4%	986	875	(111)	-12.7%	1,629
	14,105	15,318	1,213	7.9%	**167,078**	**166,946**	(132)	-0.1%	286,614

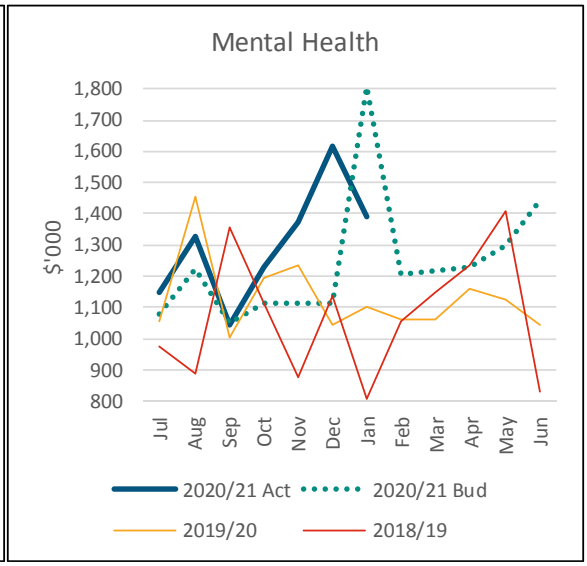




Pharmaceuticals ($1.4m favourable YTD)
Reflects latest PHARMAC projections.

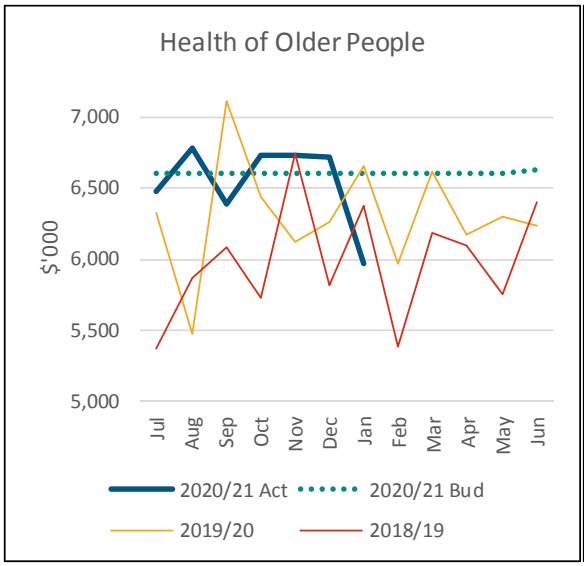
Primary Health Organisations ($0.7m adverse YTD)
Increasing activity in primary care services relating to patient subsidies, mostly offset by a monthly wash-up of activity by MOH resulting in additional funding included under revenue.

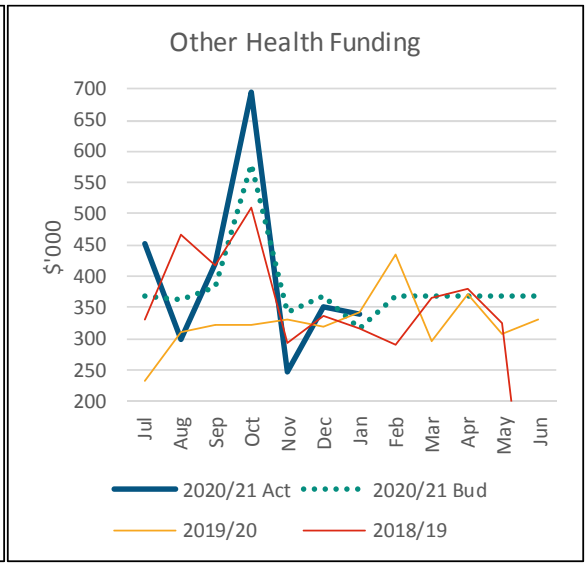




Inter District Flows ($0.1m favourable YTD)
Inter District Flows are inherently volatile due to the small volume and high cost.

Mental Health ($0.6m adverse YTD)
Home-based support and community residential, offset in revenue. From November includes primary integrated mental health and addiction costs that are offset by additional MOH revenue.





Health of Older People ($0.4m favourable YTD)
Reduction in provision for outstanding home support costs as these have now been negotiated.

Other Health Funding ($0.1m adverse YTD)
Minor variances.

4. CORPORATE SERVICES

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,544	1,597	53	3.3%	12,067	12,264	196	1.6%	21,180
Outsourced services	41	65	24	36.5%	387	457	71	15.4%	737
Clinical supplies	53	57	4	7.0%	346	396	50	12.5%	644
Infrastructure and non clinical	1,327	1,493	167	11.2%	10,456	10,164	(292)	-2.9%	18,446
	2,965	3,212	247	7.7%	23,256	23,281	24	0.1%	41,007
Capital servicing									
Depreciation and amortisation	1,332	1,307	(25)	-1.9%	8,887	8,783	(105)	-1.2%	15,335
Financing	14	25	11	44.2%	116	164	48	29.4%	252
Capital charge	414	580	166	28.7%	2,897	4,186	1,289	30.8%	4,966
	1,760	1,912	152	8.0%	11,900	13,132	1,232	9.4%	20,553
	4,725	**5,124**	400	7.8%	**35,157**	**36,413**	1,257	3.5%	**61,560**
Full Time Equivalents									
Medical personnel	1.3	1.3	0	0.2%	1	1	(0)	-3.9%	1.1
Nursing personnel	13.0	19.1	6	32.1%	18	19	1	6.8%	19.6
Allied health personnel	1.5	1.5	(0)	-0.5%	1	2	1	48.3%	1.6
Support personnel	27.3	28.8	2	5.3%	29	30	2	6.0%	30.7
Management and administration	166.7	166.7	(0)	0.0%	173	177	4	2.1%	179.4
	209.8	**217.5**	8	3.5%	**221**	**229**	8	3.3%	**232.4**

Capital charge continues to be the driver of the favourable performance and reflects the lower equity balance than projected in the plan. Feasibility costs relating to capital projects drives more than the YTD variance for Infrastructure and non clinical costs, being partly offset by lower than budgeted corporate training costs.

5. RESERVES

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Investment reserves	213	151	(62)	-41.2%	1,167	1,607	440	27.4%	2,258
Efficiencies	-	(125)	(125)	-100.0%	-	(874)	(874)	-100.0%	(665)
Other	2,086	2,122	36	1.7%	3,230	3,209	(21)	-0.7%	1,784
	2,299	**2,148**	(151)	-7.0%	**4,397**	**3,942**	**(455)**	-11.5%	**3,377**

Investment reserves includes provisions for annual plan investment, the Digital Enablement reserve and aged residential care growth. As plans are finalised, budgets are moved to the appropriate areas.

The majority of the $4.1m planned efficiencies for the year are already embedded in budgets. Of the remaining $1.5m, there are delivery risks but we do anticipate progress on some areas in the second half.

Taking a prudent approach, investment reserves are only being released as expenditure is incurred, whilst planned efficiencies are being fully reflected in the result.

6. FINANCIAL POSITION

30 June 2020	$'000	January Actual	January Budget	Variance from budget	Movement from 30 June 2020	Annual Budget
	Equity					
208,983	Crown equity and reserves	211,615	241,870	(30,255)	2,632	254,399
(107,310)	Accumulated deficit	(119,041)	(97,382)	(21,659)	(11,731)	(101,147)
101,673		92,574	144,487	(51,914)	(9,099)	153,252
	Represented by:					
	Current Assets					
1,198	Bank	1,105	759	346	(93)	759
1,449	Bank deposits > 90 days	1,467	1,881	(414)	18	1,881
20,896	Prepayments and receivables	22,151	22,496	(345)	1,255	22,725
4,626	Inventory	4,680	4,989	(309)	54	5,040
28,168		29,403	30,125	(722)	1,235	30,405
	Non Current Assets					
190,156	Property, plant and equipment	188,747	215,983	(27,236)	(1,410)	228,349
15,978	Intangible assets	16,224	4,904	11,320	246	5,258
1,341	Investments	1,437	1,120	317	96	1,120
207,475		206,408	222,007	(15,599)	(1,068)	234,727
235,644	**Total Assets**	**235,811**	**252,132**	**(16,321)**	**167**	**265,132**
	Liabilities					
	Current Liabilities					
14,430	Bank overdraft	19,102	2,087	(17,014)	(4,671)	10,159
36,438	Payables	36,194	42,697	6,504	244	40,697
79,814	Employee entitlements	84,653	56,390	(28,263)	(4,839)	54,784
-	Current portion of borrowings	-	3,430	3,430	-	3,172
130,682		139,949	104,605	(35,344)	(9,267)	108,812
	Non Current Liabilities					
3,289	Employee entitlements	3,289	3,040	(249)	-	3,068
3,289		3,289	3,040	(249)	-	3,068
133,971	**Total Liabilities**	**143,238**	**107,645**	**(35,593)**	**(9,267)**	**111,880**
101,673	**Net Assets**	**92,574**	**144,487**	**(51,914)**	**(9,099)**	**153,252**

Variances from budget:
Crown equity and reserves reflects the capital spend against plan, and its effect on equity drawdowns, as does non-current assets and bank overdraft.

The accumulated deficit reflects re-estimation of the Holidays Act remediation provision at 30 June 2020 (as does employee entitlements), and the difference from the 2019/20 result projected in the 2020/21 plan.

7. EMPLOYEE ENTITLEMENTS

30 June 2020	$'000	*January* *Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2020*	*Annual Budget*
8,709	Salaries & wages accrued	8,790	6,033	(2,757)	(82)	4,267
1,058	ACC levy provisions	1,356	1,930	574	(298)	1,948
6,493	Continuing medical education	8,826	-	(8,826)	(2,333)	-
61,594	Accrued leave	63,733	46,314	(17,418)	(2,139)	46,436
5,249	Long service leave & retirement grat.	5,237	5,153	(83)	12	5,201
83,103	**Total Employee Entitlements**	87,942	59,431	(28,512)	(4,839)	57,852

Accrued leave includes provisioning for remediation of Holidays Act non-compliance, not allowed for when the plan was prepared. The budget for continuing medical education leave is included in accrued leave. As a result of COVID-19 impact, Continuing Medical Education, which would have ordinarily been forfeited in January 21, will be held over until the 2021/22 financial year.

8. PLANNED CARE

MoH data to December is provided below. Funding is largely determined on performance against Inpatient Caseweight Delivery and this report shows 97.5% of plan was achieved to the end of December. This is a step improvement on prior months as a result of delivery of planned actions to achieve the target by end of year. The financial forecast and YTD result continues to assume we will achieve the delivery targets by the end of the year.

2020/21 Year to Date Contracted Volume Summary

	Base YTD Planned Volume	Additional YTD Planned Volume	Total YTD Planned Volume	Actual Delivery	YTD Delivery %	2020/21 Total Planned Volume
Inpatient Caseweight Delivery	4,175.5	1,440.7	5,616.2	5,476.7	97.5%	10,899.8
Inpatient Surgical Discharges	2,770	1,056	3,826	3,592	93.9%	7,427
Minor Procedures	1,084	459	1,543	2,650	171.7%	2,984
Non Surgical interventions	20	41	61	0	0.0%	118

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: 1/02/2021 **NNPAC Refresh Date:** 1/02/2021
Data up to: Dec 2020 **Report Run Date:** 1/02/2021

9. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by NZHP under a sweep arrangement facilitated by BNZ. The DHB provides forecast cash flow information to NZHP to allow it to invest the funds at the most advantageous rates and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due. The cash balance at the end of January was a $19.1m overdrawn (December was $43m in funds due to the way business days fall).

The cash low point for each month is generally incurred immediately prior to receipt of MoH funding on the 4th of the month. February's low point is projected to be $22m overdrawn on 3 February. The DHBs statutory overdraft limit is $35m.

The main cash risks are the remediation of the Holidays Act, the net impact of COVID-19 and the requirement to move to 10 day payment terms.

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

The block allocations are underspent at the end of December reflecting evenly spread budgets across the year, and lead times for the delivery of projects. The forecast shows most of the slippage is expected to be recovered in year. Actions to maximise capital in year are being considered in February.

Slippage on strategic projects and the interim asset plan, impacted by funding agreements and COVID-19 has eliminated the funding gap in year.

Note: Strategic projects that are partially funded by MoH, have no costs recognised in the DHB funded category until the MoH funded category has been exhausted, the assumption being that we will drawdown on MoH capital first.

The other category includes capital projects that are funded from sources other than the capital programme i.e. special funds (donations and bequests), MOH seed funding for programmes requiring property, plant and/or equipment to launch, and preliminary project costs that will either be capitalised or expensed dependent on whether the project goes ahead.

See table on the next page.

	Year to Date			End of Year Forecast		
	Actual	Budget	Variance	Forecast	Budget	Variance
	$'000	$'000	$'000	$'000	$'000	$'000
Source of Funds						
Operating Sources						
Depreciation	8,887	8,783	105	15,360	15,255	105
	8,887	8,783	105	15,360	15,255	105
Other Sources						
Special Funds and Clinical Trials	-	-	-	2	-	2
Funded Programmes	-	-	-	240	-	240
Sale of Assets	614	415	199	614	415	199
Equity Injection approved	738	-	738	24,772	24,772	-
Equity Injection to be approved	-	-	-		-	-
Source to be determined	-	-	-	(10,177)	4,617	(14,794)
	1,767	415	1,352	15,036	29,804	(14,768)
Total funds sourced	**10,239**	**9,198**	**1,042**	**30,811**	**45,059**	**(14,248)**
Application of Funds:						
Block Allocations						
Facilities	950	1,801	851	2,833	3,088	255
Information Services	1,269	2,166	897	3,617	3,755	138
Clinical Equipment	1,418	2,258	840	3,942	3,872	(70)
	3,636	6,224	2,588	10,392	10,715	324
MOH funded Startegic						
Seismic Radiology HA27	6	58	52	46	100	54
Surgical Expansion	566	3,075	2,509	3,434	4,200	766
Main Electrical Switchboard Upgrade	0	1,749	1,749	1,600	4,000	2,400
Mobile Dental Unit	0	800	800	800	1,600	800
Angiography Suite	0	1,250	1,249	2,600	3,000	400
Replacement Generators	(12)	-	12	(2)	-	2
Endoscopy Building (Procedure Rooms)	43	1,250	1,206	3,000	3,000	(0)
Radiology Extension	729	2,049	1,320	1,819	4,559	2,740
Seismic AAU Stage 2	1,244	1,203	(41)	1,264	2,063	799
Seismic Surgical Theatre HA37	7	1,050	1,042	1,107	2,100	993
Linear Accelerator	-	-	-	200	250	50
	2,584	12,483	9,899	15,869	24,872	9,003
DHB funded Strategic						
Surgical Expansion	-	-	-	-	1,953	1,953
Main Electrical Switchboard Upgrade	-	-	-	-	200	200
Cardiology PCI	5	-	(5)	400	1,000	600
Interim Asset Plan	517	2,280	1,763	2,569	5,390	2,821
Digital Transformation	97	-	(97)	189	870	681
	619	2,280	1,661	3,158	9,413	6,255
Other						
Special Funds and Clinical Trials	43	-	(43)	43	-	(43)
Funded Programmes	1,064	-	(1,064)	1,064	-	(1,064)
Other	285	58	(227)	285	58	(227)
	1,392	58	(1,334)	1,392	58	(1,334)
Capital Spend	**8,231**	**21,045**	**12,814**	**30,811**	**45,058**	**14,247**

11. ROLLING CASH FLOW

	Jan-21			Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	Actual	**Forecast**	**Variance**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**	**Forecast**
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Cash Inflows															
Devolved MOH revenue	1,731	1,731	0	58,443	61,416	57,462	58,416	60,562	60,664	60,664	64,764	61,164	59,664	122,328	0
Other revenue	5,391	5,801	410	7,332	7,000	6,200	6,650	6,237	6,400	6,450	6,450	6,300	6,300	5,440	5,800
Total cash inflow	7,122	7,122	410	65,776	68,416	63,662	65,066	66,799	67,064	67,114	71,214	67,464	65,964	127,768	5,800
Cash Outflows															
Payroll	13,896	13,766	130	14,008	16,180	13,750	13,680	17,880	13,750	13,680	16,230	13,700	13,680	17,950	13,680
Taxes	13,403	12,400	1,003	9,329	9,200	9,200	9,200	9,200	9,200	9,200	9,200	9,200	9,200	6,000	12,400
Sector Services	28,948	29,108	-160	29,956	27,050	25,300	27,200	27,293	24,228	26,617	27,646	29,512	27,288	26,802	25,950
Other expenditure	12,979	14,484	-1,505	15,641	15,556	15,638	14,167	21,267	19,569	15,669	15,669	13,613	17,069	17,067	12,015
Total cash outflow	69,227	69,227	-531	68,934	67,986	63,888	64,247	75,640	66,747	65,166	68,745	66,025	67,236	67,819	64,045
Total cash movement	-62,104	-62,226	-122	-3,159	430	-227	819	-8,841	317	1,948	2,469	1,439	-1,272	59,949	-58,245
Add: opening cash	43,017	43,017	0	-19,087	-22,246	-21,816	-22,043	-21,224	-30,065	-29,748	-27,799	-25,331	-23,892	-25,164	34,784
Closing cash	-19,087	-19,209	-122	-22,246	-21,816	-22,043	-21,224	-30,065	-29,748	-27,799	-25,331	-23,892	-25,164	34,784	-23,461
Maximum cash overdraft (in month)	-19,103	-19,209	106	-22,246	-27,128	-22,043	-22,303	-30,065	-32,875	-30,058	-32,714	-26,497	-28,524	-33,033	-23,461

9

HAWKE'S BAY District Health Board Whakawāteatia	**Hawke's Bay DHB QTR 2 Health System Performance Dashboard**
	For the attention of: **HBDHB Board**
Document Owner	Emma Foster, Executive Director Planning, Funding & Performance
Document Author(s)	Lisa Jones, System Lead Planning and Performance Planning, Funding and Performance
Date	March 2021
Purpose/Summary of the Aim of the Paper	This is the second Quarterly Health System Performance Dashboard for the 20/21 year. This Dashboard covers performance in the five health system priorities: • *First 1000 days (FTD)* • *Mental Health and Addiction (MHA)* • *Long term conditions (LTC),* • *Frail and Older People (FOP)* • *A Responsive Health System (RHS).*
Health Equity Framework	This dashboard provides an equity lens across the Hawke's Bay District health system performance and provides a summary report for Maori and Pacific equity performance. The Equity Framework consists of four stages. This report addresses stage four – monitor progress and measure effectiveness.
Principles of the Treaty of Waitangi that this report addresses	We continue to assess the opportunities to improve our equity performance reporting in partnership with Maori and our governance partners.
Risk Assessment	
Financial/Legal Impact	N/A
Stakeholder Consultation and Impact	
Strategic Impact	Performance monitoring is a key aspect of strategic management in the health sector.
Previous Consideration / Interdependent Papers	Qtr 1 20/21 Health System Performance Dashboard (November 2020 Board meeting).

RECOMMENDATION:

It is recommended that the Board:

1. **Note and acknowledge** the Qtr2 Health System Performance Dashboard

EXECUTIVE SUMMARY

This is the second quarterly Health System Performance Dashboard for the 20/21 year. This provides performance reporting across the Hawke's Bay District Health Board's five health system priorities: First 1000 days (FTD), Mental Health and Addiction (MHA), Long term conditions (LTC), Frail and Older People (FOP) and a Responsive Health System (RHS).

Changes have been made to the Dashboard and reporting, based on Board feedback.
We have introduced a flag to indicate the influence the DHB has on the overall performance of each Measure/KPI (DI: (Direct Influence) and IO: (Influence only e.g. via commissioning services, letters of expectation). To support early signals of overall poor performance in improving equity, we have introduced a summation of the % of indicators reaching target for Total, Maori and Pacific within each Health System Priority area and a summary of top five above and under performance for Maori and Pacific.
We also have a programme of work that will show all performance measures reported by ethnicity.
An exception report has been developed to give the Board more information of the underlying issues and actions planned to improve performance for stubborn red and newly red performance measures.

OUTCOMES EXPECTED

Hawke's Bay DHB's Board is well informed of the performance of key areas across the health system priority areas and understands its inequity risks.

APPENDICES

Health System Performance Dashboard QTR 2 20/21
Highlights of Strategic Priorities as at Qtr 2 20/21 : Overall
Highlights of Strategic Priorities as at Qtr 2 20/21 : Maori
Highlights of Strategic Priorities as at Qtr 2 20/21 : Pacific
Health System Performance Qtr 2 Exception report

Health System Performance Dashboard as at 2020/2021 Q2

First 1000 days

	Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
FTD-1	% of women booked with an LMC by week 12 of their pregnancy (Māori)	≥ 80%	N/A	37.0%	N/A	↑	147
FTD-2	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	≥ 90%	83.0%	80.0%	-	↑	2
FTD-3	SLM Number of Māori babies who live in a smoke-free household at 6 weeks post-natal	≥ 68%	N/A	31.0%	N/A	↑	192
FTD-4	% of new-borns enrolled in general practice by 3 months of age	≥ 85%	84.0%	64.0%	89.0%	↑	8
FTD-5	% of infants exclusively breastfed at 3 months	≥ 70%	DSA	DSA	DSA	↑	-
FTD-6	% of eight-month-olds olds fully immunised	≥ 95%	90.0%	87.0%	92.3%	↑	27
FTD-7	% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years	≥ 95%	90.4%	85.5%	97.0%	↑	26
FTD-8	% of preschool children (aged 0-4 years of age) enrolled in and accessing community oral health services (Yr1)	≥ 95%	DSA	DSA	DSA	↑	DSA
FTD-9	Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years (Māori)	≤ 8,205	N/A	6,496	N/A	↓	0
	OVERALL TARGETS MET		**0%**	**14%**	**67%**		

Mental Health and Addictions

	Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
MHA-1	% of zero-19 year olds seen within 3 weeks of referral Mental health provider arm	≥ 80%	78%	79%	79%	↑	11
MHA-2	% of zero-19 year olds seen within 3 weeks of referral Addictions (provider arm and non-government organisation(NGO))	≥ 80%	77%	68%	0%	↑	1
MHA-3	% of zero-19 year olds seen within 8 weeks of referral Mental health provider arm	≥ 95%	93%	92%	95%	↑	14
MHA-4	% of zero-19 year olds seen within 8 weeks of referral Addictions (provider arm and NGO)	≥ 95%	83%	74%	0%	↑	4
MHA-5	Community services transition (discharge) plans: % of clients discharged from community MH&A will have a transition (discharge) plan	≥ 95%	73.4%	-	-	↑	74
MHA-6	% of clients discharged will have a quality transition or wellness plan	≥ 95%	95%	-	-	↑	-
MHA-7	% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan	≥ 95%	62%	-	-	↑	115
MHA-8	% reduction in the rate of Māori under s29 orders per 100,000 population	≤ 395	N/A	399	N/A	↓	1
MHA-9	Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	≤ 64	62.3	77.1	22.1	↓	0
	OVERALL TARGETS MET		**25%**	**0%**	**20%**		

Responsive Health System

	Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
RHS-1	% of Māori population enrolled in the PHO	≥ 95%	N/A	87%	N/A	↑	3517
RHS-2	% of children (aged 0-12 years of age) overdue for their scheduled examinations with Community Oral health service (Yr1)	≤ 10%	DSA	DSA	DSA	↓	0
RHS-3	% utilisation of DHB funded dental services by adolescents for school Year 9 up to and including 17 years (Yr1)	≥ 85%	DSA	DSA	DSA	↑	DSA
RHS-4	% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	67.0%	58.0%	58.0%	↑	994
RHS-5	% of women aged 25-69 years who have had a cervical screening event in the past 36 months	≥ 80%	DNA	DNA	DNA	↑	0
RHS-6	% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP information system.	≥ 95%	96.4%	96.6%	100.0%	↑	-
RHS-7	% of patients with accepted referrals for Computed Tomography (CT) scans who receive their scan, and scan results are reported, within 6 weeks (42 days)	≥ 95%	89.0%	-	-	↑	44
RHS-8	% of patients with accepted referrals for MRI scans who receive their scan, and the scan results are reported, within 6 weeks (42 days).	≥ 90%	51.0%	-	-	↑	248
RHS-9	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),	≥ 90%	86.0%	83.0%	87.0%	↑	1
RHS-10	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)	≥ 70%	79.0%	78.0%	79.0%	↑	0
RHS-11	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	≥ 70%	52.8%	-	-	↑	55
RHS-12	% of patients waiting over four months for FSA (ESPI 2)	≤ 0%	26.0%	27.0%	28.0%	↓	1,310
RHS-13	% of patients waiting over 120 days for treatment (ESPI 5)	≤ 0%	23.0%	25.1%	24.6%	↓	517
RHS-14	% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment.	≤ 0%	26.0%	-	-	↓	968
RHS-15	Did not attend (DNA) rate across first specialist assessments	≤ 6%	6.0%	12.0%	12.3%	↓	83
RHS-16	Planned care interventions for people living within the HBDHB region. Inpatient Surgical Discharges.	≥ TBC	3,952	-	-	↑	234
RHS-17	Planned care interventions for people living within the HBDHB region. Minor procedures and Non-Surgical.	≥ TBC	2,650	-	-	↑	-
RHS-18	% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)	≥ 95%	88%	-	-	↑	1
RHS-19	% of ACS patients undergoing coronary angiogram - door to cath within 3 days	≥ 70%	75.4%	82.4%	100.0%	↑	-
RHS-20	% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)	≥ 12%	7.0%	7.0%	-	↑	4
RHS-21	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	≥ 85%	90.9%	96.0%	86.0%	↑	-
RHS-22	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two	≥ 90%	88.0%	95.0%	0.0%	↑	2
	OVERALL TARGETS MET		**28%**	**42%**	**40%**		

Long term conditions

	Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
LTC-1	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	≥ 90%	DNP	DNP	DNP	↑	0
LTC-2	Acute rheumatic fever initial hospitalisation rate per 100,000	≤ 1.5	-	N/A	N/A	↓	0
LTC-3	% of the eligible population will have had a CVD risk assessment in the last five years	≥ 90%	82%	79%	77%	↑	4,370
LTC-4	% of people with diabetes who have good or acceptable glycaemic control (HbA1c<64mmols)	≥ 60%	32%	27%	26%	↑	1560
LTC-5	Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years	≤ 3,510	4,334	7,906	8,713	↓	416
LTC-6	% of patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	50%	50%	55%	↑	5
LTC-7	% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	≥ 60%	DNO	DNO	DNO	↑	DNO
LTC-8	Acute readmissions to hospital	≤ 11.80%	11.73%	11.73%	11.65%	↓	-
	OVERALL TARGETS MET		**20%**	**20%**	**20%**		

Frail and Older people

	Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
FOP-1	% of 65+ year olds immunised - flu vaccine	≥ 75%	DSA	DSA	DSA	↑	0
FOP-2	% of older patients given a falls risk assessment	≥ 90%	91%	-	-	↑	0
FOP-3	% of older patients assessed as at risk of falling receive an individualised care plan	≥ 90%	96%	-	-	↑	0
FOP-4	Number of Needs Assessment and Service Coordination (NASC) completed assessments (first assessment, reassessments and 3 year routine assessments).	≥ 449	467	-	-	↑	0
FOP-5	Acute bed days per 1000 population (in the last 12 months) 65 years + (Māori and Pacific) and 75 years + (Other)	≤ 2,002	1,780	1,754	1,366	↓	0
FOP-6	The average number of subsidised permanent Health of Older People (HOP) and Long Term Support - Chronic Health Conditios (LTS-CHC) residential beds per night per 1,000 of the 65+ population.	≤ 35	33.84	-	-	↓	-
FOP-7	Acute readmission rate: 75 years +	≤ 12.0%	12.2%	11.6%	10.5%	↓	0
	OVERALL TARGETS MET		**83%**	**100%**	**100%**		

Key

Green	Target achieved or exceeded
Amber	Within 0-5% of target
Red	More than 5% below target
N/A	Not relevant for the target
DNP	Data not Provided (data not from internal sources, not released to us)
DNO	Data not Obtainable (does not exist)
DNA	Data not Available (data from external sources, not released to us yet)
DSA	Bi-Yearly/Seasonal/Annual (data NOT captured every quarter)

Themes

IO	Influence only
DI	Direct Influence

HIGHLIGHTS of Strategic Priorities as at 2020/2021 Q2

MĀORI EQUITY - TOP 5

Top Performance

FTD-9	Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years (Māori)
RHS-19	% of ACS patients undergoing coronary angiogram - door to cath within 3 days
RHS-21	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
FOP-5	Acute bed days per 1000 population (in the last 12 months) 65 years + (Māori and Pacific) and 75 years + (Other)
RHS-10	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)

Under Performance

RHS-9	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),
FTD-6	% of eight-month-olds olds fully immunised
RHS-1	% of Māori population enrolled in the PHO
FTD-7	% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years
FTD-2	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.

TREND MOVEMENTS (BASED ON TOTALS)

Leaving Red for Amber

MHA-1	% of zero-19 year olds seen within 3 weeks of referral Mental health provider arm
RHS-4	% of women aged 50-69 years receiving breast screening in the last 2 years
RHS-22	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Leaving Green for Amber

FTD-4	% of new-borns enrolled in general practice by 3 months of age
MHA-2	% of zero-19 year olds seen within 3 weeks of referral Addictions (provider arm and non-government organisation(NGO))
RHS-9	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),

Newly Green

LTC-8	Acute readmissions to hospital
RHS-6	% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP information system.
RHS-10	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)
RHS-19	% of ACS patients undergoing coronary angiogram - door to cath within 3 days

Newly Red

RHS-1	% of Māori population enrolled in the PHO
RHS-18	% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)

TREND ENDURES (last 4 Quarters)

Consistent Green

MHA-6	% of clients discharged will have a quality transition or wellness plan
FOP-2	% of older patients given a falls risk assessment
RHS-21	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.

Stubborn Red

FTD-1	% of women booked with an LMC by week 12 of their pregnancy (Māori)
FTD-6	% of eight-month-olds olds fully immunised
LTC-3	% of the eligible population will have had a CVD risk assessment in the last five years
LTC-5	Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years
MHA-5	Community services transition (discharge) plans: % of clients discharged from community MH&A will have a transition (discharge) plan
MHA-7	% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan
RHS-11	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date
RHS-12	% of patients waiting over four months for FSA (ESPI 2)
RHS-13	% of patients waiting over 120 days for treatment (ESPI 5)
RHS-14	% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment.
RHS-20	% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)
PTSQ-1	% of patients admitted, discharged or transferred from an emergency department (ED) within six hours.

Key

- Stubborn Red: In Red for the last 4 periods
- Newly Red: the current period is Red
- Leaving Green for Amber: Moved from Green (previous period) to Amber (current period)
- Leaving Red for Amber: Moved from Red (previous period) to Amber (current period)
- Newly Green: the current period is in Green
- Consistent Green: In Green for the last 4 periods

HIGHLIGHTS of Strategic Priorities as at 2020/2021 Q2

PACIFIC EQUITY - TOP 5

Top Performance

MHA-9	Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000
RHS-19	% of ACS patients undergoing coronary angiogram - door to cath within 3 days
FOP-5	Acute bed days per 1000 population (in the last 12 months) 65 years + (Māori and Pacific) and 75 years + (Other)
RHS-10	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)
FOP-7	Acute readmission rate: 75 years +

Under Performance

LTC-3	% of the eligible population will have had a CVD risk assessment in the last five years
PTSQ-1	% of patients admitted, discharged or transferred from an emergency department (ED) within six hours.
RHS-4	% of women aged 50-69 years receiving breast screening in the last 2 years
LTC-6	% of patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
FTD-3	SLM Number of Māori babies who live in a smoke-free household at 6 weeks post-natal

TREND MOVEMENTS (BASED ON TOTALS)

Leaving Red for Amber

MHA-1	% of zero-19 year olds seen within 3 weeks of referral Mental health provider arm
RHS-4	% of women aged 50-69 years receiving breast screening in the last 2 years
RHS-22	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Leaving Green for Amber

FTD-4	% of new-borns enrolled in general practice by 3 months of age
MHA-2	% of zero-19 year olds seen within 3 weeks of referral Addictions (provider arm and non-government organisation(NGO))
RHS-9	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),

Newly Green

LTC-8	Acute readmissions to hospital
RHS-6	% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP information system.
RHS-10	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)
RHS-19	% of ACS patients undergoing coronary angiogram - door to cath within 3 days

Newly Red

RHS-1	% of Māori population enrolled in the PHO
RHS-18	% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)

TREND ENDURES (last 4 Quarters)

Consistent Green

MHA-6	% of clients discharged will have a quality transition or wellness plan
FOP-2	% of older patients given a falls risk assessment
RHS-21	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.

Stubborn Red

FTD-1	% of women booked with an LMC by week 12 of their pregnancy (Māori)
FTD-6	% of eight-month-olds olds fully immunised
LTC-3	% of the eligible population will have had a CVD risk assessment in the last five years
LTC-5	Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years
MHA-5	Community services transition (discharge) plans: % of clients discharged from community MH&A will have a transition (discharge) plan
MHA-7	% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan
RHS-11	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date
RHS-12	% of patients waiting over four months for FSA (ESPI 2)
RHS-13	% of patients waiting over 120 days for treatment (ESPI 5)
RHS-14	% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment.
RHS-20	% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)
PTSQ-1	% of patients admitted, discharged or transferred from an emergency department (ED) within six hours.

Key

- Stubborn Red: In Red for the last 4 periods
- Newly Red: the current period is Red
- Leaving Green for Amber: Moved from Green (previous period) to Amber (current period)
- Leaving Red for Amber: Moved from Red (previous period) to Amber (current period)
- Newly Green: the current period is in Green
- Consistent Green: In Green for the last 4 periods

Appendix 4: Health System Performance Dashboard QTR 2 20/21 Exception report

First 1000 days

ID	Indicator description	Performance Exception Report Flag	Underlying reason (or reasons) for under performance.	Key action/s to address under performance	Time frames for completion
FTD 1	% of women booked with an LMC by week 12 of their pregnancy (Māori)	Stubborn Red	Understanding the importance of booking with a midwife. Ease of access into booking with a midwife	Undertake a consumer survey of under 20 years old mums and identify areas for improvement in engagement with LMC's. Identify any data collection issues that may be a contributor to poor performance	2021/22
FTD-2	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	Māori Equity Top 5 under performance	Incomplete list of DHB midwives informing the reporting. Increase in un-booked women presenting in late labour	Review the local performance report for accuracy. Carry out an audit of all pregnant women who smoke to identify issues with screening. Implement improvements and address any workforce training needs	2021/22
FTD-6	% of eight-month-olds fully immunised	Stubborn Red/ Māori Equity Top 5 under performance	Timeliness of referrals to outreach. Increase in decline rate. Increase in numbers of babies in temporary accommodation unable to be located	Work with the PHO to improve timeliness of referrals to outreach immunisation service (OIS) for those children overdue with a priority for Māori children Increase number of referrals to OIS	2021/22
FTD-7	% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years	Māori Equity Top 5 under performance	Changes to scheduling of national immunisation events leading to confusion and vaccination fatigue by caregivers	Identify where scheduling impacts occur and investigate opportunities for improvement, to ensure that parents of children aged 12 to 24 mths are fully engaged throughout the immunisation cycle Publish promotional messages re immunisations relating to the Childhood Immunisation Schedule; on HBDHB website and Facebook page	Annual Plan Actions in 2021/22 Year

Long Term Conditions

ID	Indicator description	Performance Exception Report Flag	Underlying reason (or reasons) for under performance.	Key action/s to address under performance	Time frames for completion
LTC-3	% of the eligible population will have had a CVD risk assessment in the last five years	Stubborn Red	Even though the PHO has trialled an incentive to general practice to increase CVD RISK assessment, volumes have not improved. We also need to consider our unenrolled population and how to reach them	Embed a community CVD outreach screening programme for Māori via sports clubs, workplace, marae, and community and link in with general practice	2021/22 Work with HB Rugby Union and HB Netball Assoc to incentivise CVDRA for all players. Q1 Organise summer and event based wananga: Q2 Prepare for rugby and netball season Q3 Evaluate and report on activity Q4
LTC-5	Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years	Stubborn Red	Capacity and demand in primary care Capacity and demand for FSA	The pulmonary rehab programme has been extended to include patients with heart failure. This has been implemented with associated monitoring of outputs and outcomes Audit of re-admission rate, ED presentation and length of hospital stay for people with HF who have attended a programme Establish HealthPathways team and ensure COPD pathway is included in early phase of pathway localisation Implementation of Health Coaches in primary care and associated training in LTC	2020/21 Q1 with audit at Q4 2020/21 Q4

Mental Health and Addictions

ID	Indicator description	Performance Exception Report Flag	Underlying reason (or reasons) for under performance.	Key action/s to address under performance	Time frames for completion
MHA-5	Community services transition (discharge) plans: % of clients discharged from community MH&A will have a transition (discharge) plan	Stubborn Red	Timeliness of completion of discharge plans and recording within ECA (data entry quality and completion)	All clients presented to MDT for discharge have; -transition plans updated prior to or within the MDT meeting Monitor completion of transition plans and address barriers for completion	2021/22 Q3,Q4
MHA-7	% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan	Stubborn Red	Timeliness of completion of discharge plans and recording within ECA (data entry quality and completion)	All clients presented to MDT for discharge have; -transition plans updated prior to or within the MDT meeting Monitor completion of transition plans and address barriers for completion	2021/22 Q3,Q4

Responsive Health System

ID	Indicator description	Performance Exception Report Flag	Underlying reason (or reasons) for under performance.	Key action/s to address under performance	Time frames for completion
RHS-1	% of Māori population enrolled in the PHO	Māori Equity Top 5 under performance Newly RED	Migration in and out, cultural responsiveness and capacity of general practice to enrol are thought to be the drivers behind this poor performance	Cultural responsiveness: Practices covering 80% of HB Maori population would have completed or are progressing year 1 objectives of the Hawke's Bay Primary Care Cultural Responsiveness Framework	2021/22 Q4
RHS-9	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive)	Māori Equity Top 5 under performance	Inequitable access	Reconciliation of forecast modelling data, to identify the drivers and address equitable access	2020/21 Q3

ID	Indicator description	Performance Exception Report Flag	Underlying reason (or reasons) for under performance.	Key action/s to address under performance	Time frames for completion
RHS-11	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	Stubborn Red	Understanding the demand and capacity for colonoscopy Surveillance Guidelines not implemented	Reconciliation of forecast modelling data and identifying the drivers Investigate options to implement new surveillance guidelines	2020/21 Q3 2020/21 Q4
RHS-12	% of patients waiting over four months for FSA (ESPI 2)	Stubborn Red	Demand and capacity Increase in GP referrals	Monitor all specialties against their forecasted trajectories to reduce overdue wait lists	Targets set in 21/22 Annual Plan
RHS-13	% of patients waiting over 120 days for treatment (ESPI 5)	Stubborn Red	Data discrepancy - MoH aware that HBDHB will complete an audit of all discrepancies and validate coding issue	Complete data audit to determine where the coding issue occurs. Have the audit reviewed and validated by MoH	2020/21 Q4
RHS-14	% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment	Stubborn Red	Current patient pathway is resource intensive	Review patient pathway to improve access to follow up appointments	2020/21 Q4
RHS-18	% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)	Newly Red	Data discrepancy - MoH and HBDHB are working together to audit data.	Appropriate coding and process changes to be made to data collection. Check quarter 3 data to ensure data quality issues has been rectified to improve performance indicator	2020/21 Q3

ID	Indicator description	Performance Exception Report Flag	Underlying reason (or reasons) for under performance.	Key action/s to address under performance	Time frames for completion
RHS-20	% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)	Stubborn Red	Hawke's Bay patients are less likely to be accepted for stroke clot retrieval because of our more prolonged transport times/delays (60-120 minutes) e.g. without access to CT Perfusion scans they must reach Wellington or Auckland within 6 hours of stroke onset Hawke's Bay Patients out of hours (i.e. 73% of the time (123 of 168 hours per week) are all assessed by the Wellington Neurologists via the regional telestroke service	The regional service will become 24/7 to further enhance HBDHB patient's access to Wellington specialist neurologists for decision making in normal working hours (27% of the week) Education via telestroke simulation exercise with local medical and nursing staff in ED interacting with Wellington Neurologists to enhance decision making and streamline the process for acute stroke patient assessment and management	1 March 2021 2 sessions held November 2020

HAWKE'S BAY District Health Board Whakawāteatia	**Hawke's Bay DHB Annual Plan 21/22 (First Draft of Actions)**
	For the attention of: **HBDHB Board**
Document Owner	Emma Foster, Executive Director Planning, Funding & Performance
Document Author	Lisa Jones, System Lead Planning and Performance Planning, Funding and Performance
Date	March 2021
Purpose/Summary of the Aim of the Paper	Provide the current working draft 2021/22 Annual Plan actions for information and feedback to Board. The draft Annual Plan is due for submission to the Ministry of Health, 5 March 2021. The Ministry of Health have flagged strongly there is a move away from the inclusion of "business as usual" actions in the 2021/22 Annual Plan. They are asking for one or two actions in each focus area on: 1. Embedding COVID-19 recovery/learnings into our operations, and 2. Equity outcome actions
Health Equity Framework	The Annual Plan actions for the 21/22 year have a specific focus on equity outcome actions.
Principles of the Treaty of Waitangi that this report addresses:	The work to assess the proposed actions in the annual plan against the five principles is underway. This includes a matrix of intent against the principles and the outcome of this assessment will be presented in annual plan reporting at the April Board meeting.
Risk Assessment	Nil
Financial/Legal Impact	N/A
Stakeholder Consultation and Impact	Actions have been completed with strong stakeholder engagement.
Strategic Impact	This detail work plan is linked to our overall health strategy, Whānau Ora, Hāpori Ora.
Previous Consideration / Interdependent Papers	N/A

RECOMMENDATION:

It is recommended that the Board:

1. **Note and endorse** the Annual Plan Draft Actions for submission to the MOH

EXECUTIVE SUMMARY

Annual Plan

The Draft Annual Plan has been developed through a structured process that incorporates a system leadership structure. This allows stakeholders to be actively involved in the work up of the actions. The actions are required to be evidence based with a clear rationale for inclusion. The rationale is based on whānau voice, health policy and health intelligence. This year the process also incorporated a significant focus on addressing the 'stubborn reds' from our Health System Performance Dashboard.

The actions are generally part of a wider system change programme and are not developed in isolation of planning or priority development.

The Ministry of Health have been clear that this is not a business as usual plan, as in the past, but specific focus on embedding COVID-19 learnings and Equity outcome actions.

For noting, last year the number of actions totalled 380 and this year we have reduced them to 232. This is due to the tighter guidelines for inclusion.

The full draft needs to be completed by the 31st March 2021, and will based on the actions attached as an Appendix to this document.

Appendix attached: Draft Annual Plan Actions

2.5.1 Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
Engagement and obligations as a Treaty partner		Establish a MOU with each Post Treaty Settlement Group in the HBDHB region.	Q4	MOUs established
		Establish a Treaty Partnership Board between HBDHB and Post Treaty Settlement Groups in the HBDHB region.	Q4	Treaty Partnership Board established
		Promote MoH led Governance training opportunities to Māori DHB Board members.	Q4	Training opportunities communicated
Whakamaua: Māori Health Action Plan 2020-2025		Whakamaua Action 1.4: Māori Relationship Board feedback included into the "Service Specific Model of Care" for the LINAC project. (EOA Māori)	Q1	Feedback included
		Whakamaua Action 1.4: Māori Relationship Board endorsement of the "Service Specific Model of Care" for the LINAC project. (EOA Māori)	Q1	LINAC "Service Specific Model of Care" endorsed by MRB
		Whakamaua Action 3.1 Action 1a: Register HBDHB with KiaOra Hauroa. (EOA Māori)	Q2	Registered with KiaOra Hauroa
		Whakamaua Action 3.1 Action 1b: Initiate relationship building, through first contact, for students that identify HBDHB as their first or second preference for future roles. (EOA Māori)	Q3	All students contacted
		Whakamaua Action 3.1 Action 2a: Partner with MBIE to develop a Cadetship programme, targeted for Māori entering the workforce. Obtain approval from MBIE to deliver Cadetship programme. (EOA Māori)	Q1	Cadetship programme approved by MBIE
		Whakamaua Action 3.1 Action 2b: Implement Cadetship programme. (EOA Māori)	Q1	Cadetship programme implemented
		Whakamaua Action 3.1 Action 3a: Develop a campaign to promote health as a career to Māori. (EOA Māori)	Q2	Campaign developed
		Whakamaua Action 3.1 Action 3b: Deliver a campaign to promote health as a career to Māori. (EOA Māori)	Q3	Campaign delivered
		Whakamaua Action 3.3 Action 1a: Develop a leadership training programme which incorporates HBDHB values and Kahungunu Tikanga. (EOA Māori)	Q2	Leadership programme developed
		Whakamaua Action 3.3 Action 1b: Pilot leadership training programme to selected participants. (EOA Māori)	Q3	Pilot completed
		Whakamaua Action 4.4 Action 1: Partner with community organisation to establish marae and community based clinics. (EOA Māori, Pacific)	Q2	80% of Maori enrolled with HHB have access to IPMHAS within their enrolled general population
		Whakamaua Action 4.4 Action 1: Provide access for 80% of Maori within their enrolled general practice. (EOA Māori, Pacific)	Q4	80% of Maori enrolled with HHB have access to IPMHAS within their enrolled general population
		Whakamaua Action 4.7 Action 1: Establish a smoking cessation support process for whānau of tamariki admitted for ASH related respiratory illnesses. (EOA Māori)	Q1	Process documented
		Whakamaua Action 4.7 Action 2: Implement a smoking cessation support process for whānau of tamariki admitted for ASH related respiratory illnesses. (EOA Māori)	Q2	Implement documented process
		Whakamaua Action 4.9 Action 1a: Establish an initiative to build the capacity of rangatahi in Māori health providers to deliver a; by, for, and with rangatahi approach. (EOA Māori)	Q1	Initiative established
		Whakamaua Action 4.9 Action 1b: Implement the initiative to build the capacity of rangatahi in Māori health providers to deliver a; by, for, and with rangatahi approach. (EOA Māori)	Q2	Initiative implemented
		Whakamaua Action 4.9 Action 2: Build the capacity of iwi providers in Wairoa to increase access to health for whānau living in rural communities. (EOA Māori)	Q1	Initiative established
		Whakamaua Action 5.6 Action 1a: Undertake whānau voice activities with tangata whaikaha to inform health system and service improvements. Create an engagement plan. (Aligns to Whakamaua Action 1.1). (EOA Māori)	Q1	Engagement plan completed

The is the first working draft of the Annual Plan 21/22 for HBDHB. Please note that some activities are a "work in progress" and are currently being developed. (23 February 2021).

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Whakamaua Action 5.6 Action 1a: Undertake whānau voice activities with tangata whaikaha to inform health system and service improvements. Undertake engagement. (Aligns to Whakamaua Action 1.1). (EOA Māori)	Q2	Engagement completed
		Whakamaua Action 5.6 Action 1a: Undertake whānau voice activities with tangata whaikaha to inform health system and service improvements. Document and Engagement report. (Aligns to Whakamaua Action 1.1). (EOA Māori)	Q3	Engagement report completed
		Whakamaua Action 8.2: Consult with the Post Treaty Settlement Group on "how to communicate on equitable health outcomes" at a local and regional level, to our communities. (EOA Māori)	Q4	Consultation completed
		Whakamaua Action 8.5: Mental Health and Addicitions - review existing regional service level agreements and funding models for these services. (EOA Māori)	Q3	[TBC]
		Whakamaua Action 8.5: Analyse the access, outcomes and equity for regional services from a regional perspective. (EOA Māori)	Q4	[TBC]
		Whakamaua Action 8.5: Identify opportunities for improvement in the delivery of MH&A services. (EOA Māori)	Q4	[TBC]
		Whakamaua Action 6.1 [WORDING OF IDENTIFIED ACTIONS IN PROGRESS] (EOA Māori)	[TBC]	[TBC]

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2.5.2 Improving sustainability (confirming the path to breakeven)

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
Short term focus 2021/22		Development of a HB health system masterplan, including infrastructure, investment, workforce and facilities to support system transformation. Action 1: Completion of planning - phase 1.	Q1	[TBC]
		Development of a HB health system masterplan, including infrastructure, investment, workforce and facilities to support system transformation.	Q4	[TBC]
		National Analytics - Utilising "workforce planning and forecasting performance report" we will undertake local modelling supporting innovative models of care and scope of practice of the workforce to support system sustainability.	Q4	[TBC]
		Production planning - Increase minor procedures community skin lesions in primary care (ref Planned Care).	Q4	[TBC]
Medium term focus (three years)		Breakeven over three years: Cost growth reduction in inpatients - Front door streaming.	Q2	[TBC]
		Breakeven over three years: Cost growth reduction in inpatients - AAU utilisation and hours of operation.	Q4	[TBC]
		Breakeven over three years: reduce length of stay - review the inpatient medical model of care.	Q4	[TBC]
		Breakeven over three years: productivity gain - review the design and delivery of the laboratory service and agree next steps.	Q4	[TBC]
		Breakeven over three years: reduce length of stay through enhancing the delirium support team, build on the CNS delirium role based on demand.	22/23 Q2	[TBC]
		Breakeven over three years: growth reduction in ED through the redevelopment of the MH&A crisis model for HB to enable crisis response in alternate settings such as the home or other community based settings.	22/23 Q2	[TBC]
		Cost reduction over three: Acute demand management across the system leading to transformational change. This includes community and primary based acute demand responses as well as streamlining our acute demand system and processes within hospital services. Action 1: Coordinated primary options review to encompass more activity and care outside of the hospital, focussing specifically in areas that have the biggest equity impact such as cardiac, skin conditions and respiratory.	Q2	[TBC]
		Cost reduction over three: Acute demand management across the system leading to transformational change. This includes community and primary based acute demand responses as well as streamlining our acute demand system and processes within hospital services. Action 2: Increased utilisation of advanced nursing roles across the acute demand model across the system.	Q4	[TBC]

2.5.3 Improving maternal, child and youth wellbeing

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
Maternity care		Integrated Service Models: Contract with all community radiology providers for maternity related ultrasound.	Q1	# contracts
		Integrated Service Models: Analyse consumer usage of community based maternity ultrasound.	Q3	Analysis documented
		Perinatal/Maternity review: Develop a promotional campaign.	Q1	Campaign developed
		Perinatal/Maternity review: Develop a plan to implement the WCTO Clinical Leadership recommendations.	Q1	Plan developed
		Perinatal/Maternity review: Implement a maternal mental health workforce development programme.	Q3	Programme implemented
		Primary Birthing: Identify and document stakeholders and resource.	Q1	Stakeholder and resources documented
		Primary Birthing: Map virtual consultation pathway and identify the technology required.	Q2	Pathway documented, technology identified
		Primary Birthing: Implement trial virtual consultations.	Q3	# of virtual consultations
		Primary Birthing: Consumer and clinical evaluation via Survey Monkey.	Q4	Evaluation completed
		Screening Programmes: Following the perinatal and maternity mortality review recommendations; report on the implementation of NOC/NEWS charts.	Q1	Reported provided
		Screening Programmes: Following the perinatal and maternity mortality review recommendations; identify the engagement with midwives, and outcomes for wahine Māori (under 20 years of age). (EOA Māori)	Q2	Summary and document completed
		Screening Programmes: Engage with consumers to collect whānau voice, with hapū Māmā under 20 years of age. Identify areas for improvement. (EOA Māori)	Q4	Improvement initiatives documented
		Workforce: Introduction of mini whakawhanaungatanga to welcome new staff. Embed this quarterly practice. Normalise the use of Te Reo and waiata. (EOA Māori)	Q2	Increased Te Reo usage and understanding
		Workforce: Launch midwifery recruitment and retention programme for HBDHB to support attracting Māori midwives to the Hawke's Bay area. The recruitment programme would includes aspects such as; return to practice, retraining into the speciality of midwifery, and providing a new midwifery coach to provide clinical support. (EOA Māori)	Q4	Midwifery recruitment and retention programme implemented
		Integrate social work practice into the Tuai Kōpu programme.	Q2	Social workers actively working with hapū māmā
		Provide cultural and advocacy support for wahine hapū and their whānau through engagement in the Tuai Kōpu programme. Evaluate support provided.	Q4	Evaluation complete
Immunisation		Coordinate a communication approach with iwi, for the distribution of key immunisation messages to iwi and hapū.	Q1	Messages communicated to the public
		Evaluate Measles campaign to determine whether the campaign demonstrated an increased uptake for Māori and Pacific. (EOA Māori, Pacific)	Q2	Evaluation documented
		Using transitional housing "data" sources; audit outcome of our "first contact attempt" for immunisation outreach. (EOA Māori, Pacific)	Q4	Audit completed
		Publish promotional messages re Measles, 'Flu, COVID, and other immunisations relating to the Childhood Immunisation Schedule; on HBDHB website and Facebook page.	Q4	Messages communicated to the public
		Improve the process of primary care referral to the outreach immunisation service (OIS) to minimise overdue immunisations. (EOA Māori, Pacific)	Q4	Process documented
		Identify where scheduling impacts occur and investigate opportunities for improvement. The aim is to ensure children aged 12 to 24 months do not fall behind their immunisation schedule.	Q4	Investigation complete
Youth health and wellbeing		Establish relationship via a collaborative working model with HB Pasifika Youth, within the HB Pasifika Youth Health and Wellbeing Project. (EOA Pacific)	Q2	Relationship established Regular catch-ups scheduled
		Increase the access to TeleHealth options. HBDHB will embed the use of SchoolAppsNZ via the HB School Based Health Service RNs, with students.	Q2	Increase usage of SchoolAppsNZ
		Evaluate the provision of Sexual Health services to the LGBTQIA2+ community. Engage with the LGBTQIA2+ community to identify opportunities for service improvement.	Q2	Evaluation documented
Family violence and sexual violence		[WORDING OF IDENTIFIED ACTIONS IN PROGRESS]	[TBC]	[TBC]

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2.5.4 Improving mental wellbeing

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
Improving mental wellbeing		Mental Health & Addictions (Crisis Model): Evidence the adoption of Pathways of care relating to the crisis model. (EOA Māori, Pacific)	Q1	MH04 Pathways adopted
		Mental Health & Addictions (Crisis Model): Peer support workforce established to support the Police Liaison Service and Crisis Hub Teams (TToH-Police-MSD-HBT-EMH Services). (EOA Māori, Pacific)	Q1	MH04 Peer support workforce in place
		Mental Health & Addictions (Crisis Model): Develop a training program focused on cultural and clinical safety to support the crisis hub workforce (working with PHO leads- Kaupapa Māori Leads - Clinical Leads-Technology Leads). (EOA Māori, Pacific)	Q2	MH04 Training program developed
		Mental Health & Addictions (Crisis Model): Services are relocated at one site for the delivery of the crisis model (307 Omahu Road). (EOA Māori, Pacific)	Q3	MH04 Relocation of services
		Mental Health & Addictions (Post Discharge Follow Up) Action 1: Improve Data Entry Quality Standardise data completion within ECA. (EOA Māori, Pacific)	Q1	MH07 Fixed agenda Item on Business Leads meetings
		Mental Health & Addictions (Post Discharge Follow Up) Action 1: Improve Data Entry Quality Complete spot audits to monitor compliance of data entry completion. (EOA Māori, Pacific)	Q2	MH07 Spot audits completed
		Mental Health & Addictions (Post Discharge Follow Up) Action 1: Improve Data Entry Quality Clinical Coordinators review in-patient unit discharges daily. (EOA Māori, Pacific)	Q3	MH07 Agenda item within 1:1 meetings with clinical coordinators
		Mental Health & Addictions (Post Discharge Follow Up) Action 1: Improve Data Entry Quality Ensure timely communication between unit and community staff re discharges (within agreed timeframes). (EOA Māori, Pacific)	Q4	MH07 Key workers attending CPM
		Mental Health & Addictions (Post Discharge Follow Up) Action 2: Use data to inform improvements for follow up processes. Table gaps in delivery, at each team meeting. (EOA Māori, Pacific)	Q1	MH07 Gaps in delivery tabled in agenda meetings
		Mental Health & Addictions (Post Discharge Follow Up) Action 2: Use data findings to improve follow up processes Identify barriers to meeting target. (EOA Māori, Pacific)	Q2	MH07 Analysis completed
		Mental Health & Addictions (Post Discharge Follow Up) Action 2:Use data findings to improve follow up processes Review breaches at individual service level. (EOA Māori, Pacific)	Q3	MH07 # breaches
		Mental Health & Addictions (Post Discharge Follow Up) Action 2: Use data findings to improve follow up processes Consolidate all improvement activities into standard practice. (EOA Māori, Pacific)	Q4	MH07 Improvements against target/number of breaches
		Mental Health & Addictions (Primary): Recruit and retention plan implemented to facilitate the full complement of staffing aligned to Tranche 1 & 2 population coverage (IPMHAS). (EOA Māori, Pacific)	Q2	MH04 Recruitment and retention plan implemented
		Mental Health & Addictions (Primary): Evaluation of Tranche 1 and 2 completed (IPMHAS). (EOA Māori, Pacific)	Q3	MH04 Evaluation completed
		Mental Health & Addictions (Primary): Extend HBDHB Specialist services, to provide clinical support to the teams recruited to the Integrated Primary Mental Health and Addictions Service (IPMHAS). (EOA Māori, Pacific)	Q4	MH04 Service extended
		Mental Health & Addictions (Primary): Evaluate program. Evaluation used to inform service improvements to ensure target population coverage - Tranche 3 (IPMHAS). (EOA Māori, Pacific)	Q4	MH04 Target population coverage at 80%
		Mental Health & Addictions (Stubborn Reds): Trial new system of referral pathways (identified in Q2 2021-22) Respond to findings from CAFs review (due for completion July 2021). This is inclusive of an implementation of the recruitment plan. (EOA Māori, Pacific)	Q4	MH03 Response completed
		Mental Health & Addictions (Stubborn Reds): Discharge Plans: All clients to be presented to MDT for discharge: - transition plans to be updated prior to meeting, or - transition plans to be updated within the meeting. (EOA Māori, Pacific)	Q4	MH02 % Transition plans completed on time
		Mental Health & Addictions (Police Liaison Service) - CNS MH and the Peer support workforce support the adoption of appropriate pathways of care. (EOA Māori, Pacific)	Q2	MH05 Reduced use of Mental Health Act s29 (Māori, Pacifica)
		Lead the development of a Mental Health Suicide Prevention framework with all agencies within HB. (EOA Māori, Pacific)	Q2	MH04 Develop framework

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FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Mental Health & Addictions (Mental Health Act s29) Continuation of activities to reduce Māori on compulsory treatment orders in partnership with Oranga Hinengaro Te Tai Whenua O Heretaunga team. (EOA Māori, Pacific)	Q4	MH05 Reduced use of Mental Health Act s29 (Māori, Pacifica)
		Following the development of the Mental Health Suicide Prevention framework; deliver appropriate training to relevant parties. (EOA Māori, Pacific)	Q4	MH04 Training program roll out developed

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2.5.5 Improving wellbeing through prevention

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
Communicable Diseases		Develop clear pathways for a culturally responsive approach to COVID-19; prevention, case and contact follow-up. Communicate pathways with whānau and the community, providing opportunities for feedback. (EOA Māori, Pacific)	Q4	[TBC]
		Rheumatic Fever local review recommendations; Develop a transition plan. Develop new pathways/preventative approaches, IF evidence supports this initiative. Implement and evaluate transition plan, and potential pathways/preventative approaches.	Q4	[TBC]
Environmental sustainability		Establish gross greenhouse gas emissions reductions targets for HBDHB Action 1: Engage with Māori Health team to apply a Ngati Kahungunu environmental and equity lens. (EOA Māori)	Q2	HBDHB executive leadership team has established and endorsed gross greenhouse gas reductions targets for HBDHB, with input from Māori and Pacific Health teams
		Establish gross greenhouse gas emissions reductions targets for HBDHB Action 1: Engage with Māori Health team to apply a Ngati Kahungunu environmental and equity lens. (EOA Māori)	Q4	HBDHB executive leadership team has established and endorsed gross greenhouse gas reductions targets for HBDHB, with input from Māori and Pacific Health teams
		Establish gross greenhouse gas emissions reductions targets for HBDHB Action 2: Engage with Pacific Health team to apply a Pacific environmental and equity lens. (EOA Pacific)	Q2	HBDHB executive leadership team has established and endorsed gross greenhouse gas reductions targets for HBDHB, with input from Māori and Pacific Health teams
		Establish gross greenhouse gas emissions reductions targets for HBDHB Action 2: Engage with Pacific Health team to apply a Pacific environmental and equity lens. (EOA Pacific)	Q4	HBDHB executive leadership team has established and endorsed gross greenhouse gas reductions targets for HBDHB, with input from Māori and Pacific Health teams
		Establish and document gross greenhouse gas emissions reductions targets for HBDHB.	Q4	HBDHB executive leadership team has established and endorsed gross greenhouse gas reductions targets for HBDHB, with input from Māori and Pacific Health teams
Antimicrobial resistance		AMR Action Plan Action 1: Review the broad spectrum antibiotic use within primary care and ARRC focusing on both general and equitable utilisation. (EOA Māori, Pacific)	Q2	Review completed
		AMR Action Plan Action 2: Subject to review indicating an issue with utilisation, provide a minimum of one broad spectrum antibiotic best practice message to primary care and/or ARRC clinicians. (EOA Māori, Pacific)	Q4	Number of clinicians provided education and individual data (subject to review highlighting utilisation issue/s)
		Develop with the IPC Advisory Group an agreed reporting template for ICNET data (community and hospital) that will drive future activity planning.	Q2	Approved reporting template
		Establish a MDT antimicrobial stewardship hospital team that will undertake ward rounds.	Q4	Quarterly reporting on the number of ward rounds undertaken
Drinking water		Report on progress of activities outlined in the Drinking Water Planning and Reporting Document 2021/22.	Q4	Ministry of Health reporting template is completed in Q2 and Q4
		Develop an action plan with Ngati Kahungunu, seeking to address drinking water quality within smaller communities. (EOA Māori)	Q4	Action plan developed
Environmental and border health		Undertake activities as outlined in the Environmental and Border Health Exemplar 2021/22.	Q4	Ministry of Health reporting template is completed in Q2 and Q4
		Participate in the TANKS Plan Change hearing and appeal process. Seek to gain adoption for the inclusion of Public health messages within the final TANK plan change document.	Q4	Status report completed in Q2 and Q4

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FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Undertake activities as outlined in the Maritime and Aviation border orders and guidance material provided by the Ministry of Health.	Q4	Activities are undertaken as per the legislative requirements
Healthy food and drink environments		Explore the development of a Water Only policy to assist with increased compliance to the HBDHB Health Food and Drink Policy.	Q2	Direction determined
		Provide guidance to assist HBDHB contractors, developing their own Healthy Food and Drink policies.	Q4	[TBC]
		Deliver the Healthy Active Learning program to identified organisations, within the 1-4 decile community.	Q4	Promotional resource delivered
		Establish the Health and Education partnership group. This group will co-ordinate health and wellbeing initiatives; with a focus on equity and responsiveness in decile 1-4 Early Learning Services and Schools.	Q4	Group established
Smokefree 2025		Provide an incentivised Smokefree program (Wahine Hapū) to all pregnant women. (EOA Māori, Pacific)	Q4	CW09 # Smokefree pregnant women after receiving a Smokefree program. # Booked onto Smokefree program. # CO validated while receiving a Smokefree program. # self-validated Smokefree pregnant women. # of incentive packages distributed to pregnant women after receiving program. # smoking Whanau living with pregnant women booked onto Smokefree program.# Smokefree Whanau after receiving Smokefree program. # Whanau CO validated while receiving a Smokefree program. # self validated Smokefree Whanau. # of incentive packages distributed to Whanau after receiving program. # Maori booked onto Service. # Pacifica booked onto Service.
		Provide Smokefree resources or training (annually) to high needs General Practices. (EOA Māori, Pacific)	Q4	PH04 # of people referred to Stop Smoking services by primary care. # of training sessions provided to primary care practices. # of practices receiving stop smoking training sessions. >60% of practices engaged are high needs.
		Participate in Waitangi day, Matariki, World Smokefree Day and the Ngati Kahungunu Annual General Meeting; to proactively promote smoke free messaging. (EOA Māori, Pacific)	Q4	N/A # of events participated. >70% of events have a Maori focus. # of people participating in activities
		Respond to all complaints relating to a breach of the Smokefree Environments and Regulated Products (Vaping) Amendment Act. (EOA Māori, Pacific)	Q4	N/A % of complaints responded to

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FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Utilising the CO free homes program currently delivered in Wairoa; extend the programme to Central Hawke's Bay and areas with a high population of Pacifica. (EOA Māori, Pacific)	Q4	CW09 # Smokefree pregnant women after receiving a Smokefree program. # Booked onto Smokefree program. # CO validated while receiving a Smokefree program. # self-validated Smokefree pregnant women. # of incentive packages distributed to pregnant women after receiving program. # smoking Whanau living with pregnant women booked onto Smokefree program.# Smokefree Whanau after receiving Smokefree program. # Whanau CO validated while receiving a Smokefree program. # self validated Smokefree Whanau. # of incentive packages distributed to Whanau after receiving program. # Maori booked onto Service. # Pacifica booked onto Service. # of CO monitors distributed to LMC and HBDHB midwives
		Deliver an 8 week smoking cessation program to women (aged 19 years through to 40 years). (EOA Māori, Pacific)	Q4	CW09 # women Smokefree at 1, 4 , 8 weeks. # of Pacifica. # of Smokefree Pacifica
Breast Screening		Offer bespoke initiatives/incentives to identified unscreened wahine Māori and Pasifika women to have a mammogram. (EOA Māori, Pacific)	Q4	PV01 Coverage increased by 2% for wahine Māori and Pasifika women (combined)
		Refer wahine Māori and Pasifika women, that do not confirm their Breast Screening Appointments (Mobile Unit) to additional support services. (EOA Māori, Pacific)	Q4	PV01 Increased uptake of mammograms (via BSA Mobile Unit) for wahine Māori and Pasifika women (combined)
Cervical Screening		Refer wahine Māori and Pasifika women, within focused geographical areas containing large pockets of unscreened and under-screened wahine Māori and Pasifika women to additional support services. (EOA Māori, Pacific)	Q4	PV02 Increased uptake of cervical screening for wahine Māori and Pasifika women (combined), by 1.5%
		Offer bespoke initiatives/incentives to identified unscreened wahine Māori and Pasifika women to have a cervical smear. (EOA Māori, Pacific)	Q4	PV02 Increased uptake of cervical screening for wahine Māori and Pasifika women (combined), by 1.5%
		Expand our referral process to support higher engagement in colposcopy services. (EOA Māori, Pacific)	Q4	Increase in colposcopy appointment attendance
Reducing alcohol related harm		Reducing alcohol related harm: Publish a "Healthy Start Workforce" module onto Ko Awatea. The "Healthy Start Workforce" module focuses on alcohol and tobacco exposure during early life.	Q2	Module published
		Transition key messages from the Healthy Start Workforce module (online computer based training) into the Tuai Kōpū programme.	Q4	[TBC]
		Implement the localisation of the national Māori Wardens well-being programme developed in partnership with Te Hiringa Hauora and Wātene Māori and other key stakeholders. (EOA Māori)	Q4	Increase local hui DHB support and/or facilitate Increase well-being initiatives offered Narrative: Feedback from Wardens and stakeholders
Sexual and reproductive health		Determine and agree a process, for the receipt of timely locally sourced syphilis surveillance data.	Q2	[TBC]
		Implementation of the Tō Kōhu plan is completed per agreed schedule. Tō Kōhu is the HBDHB's localised sexual health strategy and action plan.	Q4	Implementation completed per schedule
		Subject to receipt of timely data; utilise information for future local STI initiatives.	Q4	[TBC] (subject to access to timely data)
Cross Sectoral Collaboration including Health in All Policies		Document and agree an approach for increasing adoption of "Health in All Policies" in health promotion cross sectoral collaborations.	Q2	Documented and endorsed approach

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FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Implement "Health in All Policies" approach as part of HBDHB submissions management process.	Q4	Advice and direction provided
		Cross sectoral collaboration. Deliver on strategies to support Pacific health and wellbeing through leveraging cross sector collaboration opportunities. (EOA Pacific)	Q4	[TBC]

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2.5.6 Better population health outcomes supported by strong and equitable public health and disability system

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
Delivery of Whānau Ora		[WORDING OF IDENTIFIED ACTIONS IN PROGRESS]	[TBC]	[TBC]
Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025		Embed a process for the dissemination of Health messages in English and Pacific languages across different mediums of communication. The process would include opportunities for Pacific families to provide feedback to the HBDHB. (EOA Pacific)	Q2	[TBC]
		Subject to Business Case approval; implement an integrated Pacific Hub of clinicians and navigators. The Pacific Hub team would be based within the hospital, and work across Primary and Secondary Care for the Pacific community. (EOA Pacific)	Q2	[TBC] (subject to business case approval)
		Recruit 5 new Pasifika staff through the Pasifika programme for administration staff entry. (EOA Pacific)	Q2	5 new Pasifika staff employed
		Develop and disseminate resources outlining Pasifika cultural practices and protocols to HBDHB staff. (EOA Pacific)	Q3	Resources available
		Subject to Business Case approval; implement a Pacific Village Community Wellbeing by the Integrated Pacific Hub. The HUB will provide health literacy and outreach work in traditional and non traditional community based settings focussing on improving health outcomes. (EOA Pacific)	Q4	[TBC] (subject to business case approval)
		Deliver Engaging Pasifika training to support non-Pacific services to work better with Pacific families and their communities. (EOA Pacific)	Q4	[TBC]
Health outcomes for disabled people		[WORDING OF IDENTIFIED ACTIONS IN PROGRESS]	[TBC]	[TBC]
Planned care		Achieving Planned Care SP 1: (B2) Create two packages of care (Dermatology and Infusion), in community and primary care settings.	Q3	Document two service transition/change documents
		Achieving Planned Care SP 2: (G4) Look at all specialities to identify and agree priority focus areas. Focus on; inequities, FSAs and planned surgery. (EOA Māori)	Q1	SS07 Planned Care Measure 1 SS07 Planned Care Measure 2 Priority focus areas documented
		Achieving Planned Care SP 3: (G5) Create an Access Policy. A key aspect of the policy, is the clarification of parameters and criteria for the planned care continuum.	Q3	Policy developed
		Achieving Planned Care SP 4: Report against the capacity planning projects; itemised in the three year Planned Care Plan (2020/2023).	Q4	Report
		Achieving Planned Care SP 5: Complete a "current state" review of planned care. Liaise with other DHBs to look at opportunities to improve HBDHB systems and processes within Planned Care Plan (2020/2023, G3).	Q4	Review complete
		Achieving Planned Care Strategy: Review decision making processes, throughout the various Covid-19 Alert Levels; to determine the appropriate triggers to discontinue FSA's.	Q1	SS07 Planned Care Measure 1 SS07 Planned Care Measure 2 COVID-19 Alert Level FSA specific criteria matrix documented
		Planned Care (SS07 A): Reduce the number of patients on the overdue waitlist for ESPI 2.	Q1	SS07 Planned Care Measure 2 60% reduction in overdue waitlist (base set at 2150 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change
		Planned Care (SS07 A): Reduce the number of patients on the overdue waitlist for ESPI 2.	Q2	SS07 Planned Care Measure 2 67% reduction in overdue waitlist (base set at 2150 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Planned Care (SS07 A): Reduce the number of patients on the overdue waitlist for ESPI 2.	Q3	SS07 Planned Care Measure 2 75% reduction in overdue waitlist (base set at 2150 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change
		Planned Care (SS07 A): Reduce the number of patients on the overdue waitlist for ESPI 2.	Q4	SS07 Planned Care Measure 2 92% reduction in overdue waitlist (base set at 2150 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change
		Planned Care (SS07 B): Reduce the number of patients on the overdue waitlist for ESPI 5.	Q1	SS07 Planned Care Measure 3 33% reduction in overdue waitlist (base set at 610 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change
		Planned Care (SS07 B): Reduce the number of patients on the overdue waitlist for ESPI 5.	Q2	SS07 Planned Care Measure 3 49% reduction in overdue waitlist (base set at 610 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change
		Planned Care (SS07 B): Reduce the number of patients on the overdue waitlist for ESPI 5.	Q3	SS07 Planned Care Measure 3 72% reduction in overdue waitlist (base set at 610 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change
		Planned Care (SS07 B): Reduce the number of patients on the overdue waitlist for ESPI 5.	Q4	SS07 Planned Care Measure 3 83% reduction in overdue waitlist (base set at 610 as at July 2020) Note: MoH want to review trajectories in March 2021 so the performance measure is subject to change
		Planned Care (SS07 C): Evaluate proposed ophthalmology extended service model.	Q2	SS07 Planned Care Measure 4 Evaluation report
Acute demand		Implement initiative to extend after hours services within Radiology.	Q1	Initiative implemented
		Create an Acute Demand Plan, integrating consumer feedback.	Q2	SS10 Acute Demand Plan documented
Rural health		Review and document the COVID-19 response within Central Hawke's Bay. Look at opportunities around increasing swabbing numbers, and include in the resurgence plan. (EOA Māori, Pacific)	Q2	[TBC]
		Address inequities to healthcare for Māori and Pacific in Wairoa, through increasing Telehealth opportunities. Focus on improving access to healthcare in the areas of; Cancer services, Obstetrics, Stroke Rehabilitation, and Mental Health. (EOA Māori, Pacific)	Q2	[TBC]
		Establish reporting mechanisms to track the uptake of Telehealth in Wairoa.	Q2	[TBC]
		Implement the recommendations of the review. Prioritise those relating specifically to Māori and Pacific. Include the recommendations into the resurgence plan for Central Hawke's Bay. (EOA Māori, Pacific)	Q4	[TBC]
Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022		Liaise with organisations supporting priority populations (Māori, Pasifika and Quintile Five), to encourage the adoption of ACP within their system processes and practices. (EOA Māori, Pacific)	Q4	SS04 Organisations contacted
		Subject to funding opportunities, develop service design options for Kaupapa Māori health services supporting Māori Kaumātua to age well. (EOA Māori)	Q4	SS04 Service design options documented (subject to funding opportunities)

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FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Commence a review of the Hawke's Bay Health System model of care for dementia.	Q4	SS04 Document
		Utilise health outcome data to support continuous improvement conversations in our community based restorative services with a focus on inequity. (EOA Māori, Pacific)	Q4	SS04 [TBC]
Health quality & safety (quality improvement)		Consumer engagement: Upload consumer engagement QSM data using the SURE framework.	Q4	[TBC]
		Consumer engagement: Contribute to the review and re-establishment of the Consumer Council Governance Committee.	Q4	[TBC]
		Consumer engagement: Contribute to the Consumer Council based on skill set.	Q4	[TBC]
		Hand hygiene: Train staff to undertake hand hygiene audit to ensure all areas have hand hygiene auditor in place.	Q2	Training completed
		Hand hygiene: Train staff to undertake hand hygiene audit to ensure all areas have hand hygiene auditor in place.	Q4	Training completed
		Hand hygiene QSM: Complete QSM hand hygiene data submission.	Q1	[TBC]
		Hand hygiene QSM: Complete QSM hand hygiene data submission.	Q2	[TBC]
		Hand hygiene QSM: Complete QSM hand hygiene data submission.	Q3	[TBC]
		Hand hygiene QSM: Complete QSM hand hygiene data submission.	Q4	[TBC]
		Hand hygiene visibility: Raise visibility of good hand hygiene practices as part of PPE training.	Q1	[TBC]
		Hand hygiene visibility: Raise visibility of good hand hygiene practices as part of PPE training.	Q2	[TBC]
		Hand hygiene visibility: Raise visibility of good hand hygiene practices as part of PPE training.	Q3	[TBC]
		Hand hygiene visibility: Raise visibility of good hand hygiene practices as part of PPE training.	Q4	[TBC]
		Improving Equity: Follow up on recommendations from work by Tuakana/Teina summership students on understanding experiences of Māori men experiencing gout. Consider "current state" resources for use and socialise across the sector. (EOA Māori)	Q4	SS13 Narrative report on progress
Te Aho o Te Kahu - Cancer Control Agency		Cancer Action Plan Activities: Develop a Lung Cancer Service improvement plan with a focus on equity. (EOA Māori, Pacific)	Q1	Lung cancer service improvement plan
		Cancer Action Plan Activities: Develop a Prostate Cancer Service improvement plan with a focus on equity. (EOA Māori, Pacific)	Q2	Prostate cancer service improvement plan
		Cancer Action Plan Activities: Agree service delivery model for Radiation Oncology service.	Q3	Service delivery model
		Cancer Action Plan Activities: Develop a Bowel Cancer Service improvement plan with a focus on equity. (EOA Māori, Pacific)	Q4	Bowel cancer service improvement plan
		FCT: Review and analyse the Faster Cancer Treatment data. Develop and submit a plan for how HBDHB could achieve FCT targets.	Q4	Plan developed
		FCT: Review data. Identify issues. Develop a response plan, that seeks to address identified issues. Report results to the MoH quarterly.	Q4	Report results via the MoH Portal quarterly

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FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		LINAC: Develop LINAC business case for approval.	Q1	Business Case approved
		LINAC: Subject to successful negotiation of tender contracts, commence construction.	Q4	Tender contracts awarded (subject to successful negotiation)
		Refer to Whakamaua Action 4.7: Actions 1 and 2. (EOA Māori)	Q4	Refer Whakamaua Action 4.7: Actions 1 and 2
		Following the Nuhaka Cancer hui (20/21), progress prioritised actions to address equity. (EOA Māori)	Q4	Prioritised actions documented
		Undertake consumer engagement with Māori and Pasifika to understand how to improve cancer services. (EOA Māori, Pacific)	Q4	SS01 SS11 Consumer feedback documented
		Explore the implementation of HISO-10038.4-20/21 (Cancer Multidisciplinary Meeting Data).	Q4	Document
Bowel screening and colonoscopy wait times		Bowel Screening Programme: Submit a proposal to implement new bowel screening surveillance guidelines.	Q1	SS15 Proposal document
		Bowel Screening Programme: Evaluate the Oranga Tonutanga pilot, designed to increase kaumatua Māori participation in the bowel screening programme. (EOA Māori)	Q2	SS15 Evaluation report
Health workforce		Action A1: Undertake delivery of Ngakau Ora four times per year which incorporates engaging effectively with Māori, relationship centred practice and unconscious bias. (EOA Māori)	Q4	Deliver Ngakau Ora 4 times
		Action A2: Undertake Values Based recruitment training four times per year for all managers and staff who attend interview panels which embeds our values, incorporates Kahungunu Tikanga and ensures the cultural safety of our staff selection processes. (EOA Māori)	Q4	Deliver Values Based recruitment training 4 times
		Action B1: Undertake delivery of a new model of change management whereby zoom or face to face meetings are initiated when engaging with unions, to deliver the initial change paper rather than through email to build the union relationship and ensure robust consultation.	Q4	Face-to-face or Zoom sessions provided for initial change paper discussions with Unions
		Action B2: Undertake delivery of monthly face to face and zoom Bipartite meetings which incorporate discussions on working differently when required.	Q4	Face-to-face and Zoom sessions provided for Bipartite meetings
		Action C1: Define and document core training for each professional/specialty area.	Q4	Core training defined and documented
		Action C2: 50% of the core training identified for professional/speciality areas, is updated and deployed by accessible computer based training.	Q4	50% of core training updated and deployed
		Identify the factors that lead to stress/fatigue for HBDHB staff. Determine potential costs and risk to the organisation. Determine options to; reduce factors causing stress/fatigue, and build staff resilience for better self management.	Q4	Options documented
		Determine additional/alternative approaches for situations where staff are either; presented with aggressive behaviour when working alone in the community, or when faced with aggressive behaviours onsite; to reduce the adverse impact on the safety and wellbeing of our staff and other "participants".	Q4	Approaches documented
Data and digital enablement		Complete the design phase of our integrated medication prescribing solution.	Q4	Delivery of a design and implementation plan
		Implement the Inpatients and Surgery components of our Advanced Hospital Analytics solution (called SystemView).	Q4	Inpatients and Surgery components in use for Service Improvement initiatives. Reduction in ad-hoc reporting requests
		Enhance our Data Sharing Platform locally to remove the dependency on our legacy patient administration system for information and enable real-time decision-making. This supports the regional and national approach to integrate our data.	Q4	Daily extracts of data from our Patient Administration System have been replaced with a near real-time feed into the Data Sharing Platform
		Enhance Telehealth Services for Mental Health services in Napier/Hastings. (EOA Māori, Pacific)	Q4	Increased availability of telehealth services enabling an optimisation of patient care including reducing our DNA rates

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FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Complete the design phase of our Smart Referrals programme.	Q4	Delivery of a design and implementation plan to optimise through connected end-to-end workflow, measured by a reduced reliance on paper-based processes
Implementing the New Zealand Health Research Strategy		Undertake a health research symposium at Hawke's Bay DHB to explore development of health research environment that supports the New Zealand Health Research Strategy.	Q4	[TBC]

2.5.7 Better population health outcomes supported by primary health care

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
Primary care		Cultural responsiveness: Practices covering 80% of HB Maori population would have completed or are progressing year 1 objectives of the Hawke's Bay Primary Care Cultural Responsiveness Framework. (EOA Māori)	Q4	[TBC]
		Telehealth: Embed Telehealth technology in General Practice, using health care home methodology.	Q4	Practices report increase in access of Telehealth by their enrolled population
		Review access and usage of Pacific adolescents within the School Based Health Service delivered at High Schools. Document opportunities for improvement, and where feasible implement within the year. (EOA Pacific)	Q4	Increased adoption from Pacific people within School Based Health Services
Pharmacy		Subject to a successful business case for a Pacific Village Wellness approach, undertake a feasibility study with other Portfolio Managers to determine if funding can be realised to employ a Pacific Pharmacist within the Pacific Health Team. (EOA Pacific)	Q4	Completion of feasibility review (subject to business case approval)
		Promotion to our Kaumātua, that community pharmacy is a safe location for receiving 'flu vaccination. We will do this via presentations to Kaumātua groups. (EOA Māori)	Q4	CW05 Number of presentations delivered
Reconfiguration of the National Air Ambulance Service Project - Phase Two		Determine roles and responsibilities in relation to clinical versus contractual roles; and responsibilities between HBDHB and NSO.	Q2	Roles and responsibilities framework documented
Long term conditions		Cardiopulmonary Pilot: Apply critical thinking to programme reports which contributes to the final evaluation, and potential service improvement. (EOA Māori, Pacific)	Q1	SS05 Narrative progress # patients
		Cardiopulmonary Pilot: Apply critical thinking to programme reports which contributes to the final evaluation, and potential service improvement. (EOA Māori, Pacific)	Q2	SS05 Narrative progress # patients
		Cardiopulmonary Pilot: Apply critical thinking to programme reports which contributes to the final evaluation, and potential service improvement. (EOA Māori, Pacific)	Q3	SS05 Narrative progress # patients
		Cardiopulmonary Pilot: Evaluate cardio-pulmonary rehab pilot conducted during 20/21, focusing on equity and outcomes. (EOA Māori, Pacific)	Q4	SS05 Evaluation report
		Community Pharmacy: Implement a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event. (EOA Māori, Pacific)	Q1	SS07 SS05 # pharmacies contracted
		Community Pharmacy: Implement a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event: Monitor patients through service. (EOA Māori, Pacific)	Q2	SS05 # patients
		Community Pharmacy: Implement a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event: Monitor patients through service. (EOA Māori, Pacific)	Q3	SS05 # patients
		Community Pharmacy: Implement a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event: Analyse customer profile and uptake. (EOA Māori, Pacific)	Q4	SS05 Analysis documented
		Embed a community CVD outreach screening programme for Māori via sports clubs, workplace, marae, and community and link in with general practice: Work with HB Rugby Union and HB Netball Assoc to incentivise CVDRA for all players. (EOA Māori)	Q1	SS13 SS05 # participants in wananga # participants who are enrolled in GP # screened for CVD risk
		Embed a community CVD outreach screening programme for Māori via sports clubs, workplace, marae, and community and link in with general practice: Organise summer and event based wananga. (EOA Māori)	Q2	SS13 SS05 # participants in wananga # participants who are enrolled in GP # screened for CVD risk
		Embed a community CVD outreach screening programme for Māori via sports clubs, workplace, marae, and community and link in with general practice: Organise summer and event based wananga: Prepare for rugby and netball season. (EOA Māori)	Q3	SS13 SS05 # participants in wananga # participants who are enrolled in GP # screened for CVD risk

FOCUS AREA		ACTIVITY	MILESTONE	MEASURE
		Embed a community CVD outreach screening programme for Māori via sports clubs, workplace, marae, and community and link in with general practice: Evaluate and report on activity. (EOA Māori)	Q4	SS13 SS05 # participants in wananga # participants who are enrolled in GP # screened for CVD risk % of eligible population having had a CVRRA in last years
		Hepatitis C Action 1: Increase awareness of Hepatitis C in the community.	Q4	Increase in screening for Hepatitis C
		Hepatitis C Action 2: Support access to diagnosis and treatment.	Q4	Increase in screening for Hepatitis C
		Hepatitis C Action 3: Collaborate with regional provider to increase awareness, and support access to diagnosis and treatment.	Q4	Increase in screening for Hepatitis C
		Rangatahi diabetes awareness: Develop a culturally appropriate pathway for public health nurses to use to support rangatahi who have been identified through HEADSS assessment as having family history of diabetes. This is a joint initiative between Pacific Health, Māori Health, rangatahi, population health, school based nursing, healthy learning programme and diabetes services. (EOA Māori, Pacific)	Q2	SS13 CW12 Completed pathway
		Rangatahi diabetes awareness: Pilot pathway in selected school/s. (EOA Māori, Pacific)	Q4	SS13 CW12 Pilot complete in selected school/s
		Introduce a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event (angina and MI) plus for new patients with atrial fibrillation. (EOA Māori, Pacific)	Q1	SS05 Number of pharmacies taking up contract
		Introduce a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event (angina and MI) plus for new patients with atrial fibrillation. (EOA Māori, Pacific)	Q2	SS05 # Patients
		Introduce a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event (angina and MI) plus for new patients with atrial fibrillation. (EOA Māori, Pacific)	Q3	SS05 # Patients
		Introduce a community pharmacy coronary heart disease navigation and support service for Māori and Pacific for up to 1 year post hospital event (angina and MI) plus for new patients with atrial fibrillation. Analyse customer profile and uptake. (EOA Māori, Pacific)	Q4	SS05 Analysis documented
		Embed a community CVD outreach screening programme for Māori via community settings (e.g. sports clubs, workplace, marae, and community), and refer to general practice as appropriate. (EOA Māori, Pacific)	Q4	SS13 SS05 # participants in wananga # participants who are enrolled in GP # screened for CVD risk % of eligible population having had a CVDRA in last years
		Health Hawke's Bay will provide to general practices; ongoing monthly reporting, monitoring a range of clinical and qualitative accountability measures and will work with practices on stratification data to identify a reasonable target to ensure those with the greatest need have care plans developed with the multidisciplinary team. (EOA Māori, Pacific)	Q4	SS13 SS05 80% of general practices are using stratified data

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HAWKE'S BAY
District Health Board
Whakawāteatia

ĀKINA (CONTINUOUS IMPROVEMENT)
e-REFERRALS

12

Presentation

UPDATE

March 2021

Ka Hikitia

It will be lifted

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

PROVIDERS ARE WELL-EQUIPPED TO SERVE MĀORI

Kei ngā kaiwhakarato ngā āheinga katoa hei tautoko tika i te iwi Māori.

SERVICES ARE ACCESSIBLE WHERE AND WHEN MĀORI NEED THEM

E wātea ana ngā ratonga ki a Ngāi Māori ā mea wā, ki mea wāhi.

CARE PROVIDED TO MĀORI IS OF HIGH QUALITY

He kounga te manaakitia o te iwi Māori.

RESOURCES ARE AVAILABLE FOR MĀORI TO MANAGE THEIR HEALTH AND WELLBEING

E wātea ana ngā rauemi ki te iwi Māori e taea ai tōna anō hauora me tōna anō oranga te whakahaere.

HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

Ka Hikitia Strategy Building Blocks

HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

Partnership Contracting

- Four practices with highest number of enrolled Māori have transitioned to Priority Population Partnership (PPP) agreements

  Queen Street (Wairoa combined)
  Tōtara Health
  The Doctors Napier
  Hauora Heretaunga

- 51% of Māori are enrolled with a PPP agreement practice
- Practice PPP Plans combine quality improvement, Māori health and HCH elements into a single plan
- PPP Plans include a mix of contractual, population health and qualitative measures with an equity focus
- All practices will be transitioned to PPP agreements this calendar year

HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

Health Care Home Programme

Health Care Home 2021

- 13 of 17 practice groups engaged in HCH programme
- Covering **93%** of our Enrolled Population and **96%** of our Maori Enrolled Population
- Enhanced HCH Model of Care (MoC) released with strong focus on equity
- Early adopters repeating "Scoping the Gap" using the Enhanced MoC

	Owner Engagement				Telehealth Phase						Establishment			Implementation Phase				
Practice:	EOI	Practice modelling	Contract issued, signed and returned	Change Team established	Contract issued, signed and returned	Change Team Established	Lean Concepts Training	Change Management	Clinical Triage workshop	Telehealth Action Plan	Whole of Practice	Scoping the Gap	Practice Action Plan	Regular Change Team meetings	Monthly HCH/ HHB meetings	Quarterley Review meeting	Review Scoping the Gap - 6 monthly	Review Action Plan - 6 monthly
Tranche 1a																		
Te Mata Peak Practice	✔	✔	✔	✔							✔	✔	✔	✔				
Totara Health	✔	✔	✔	✔							✔	✔	✔	✔				
Hauora Heretaunga	✔	✔	✔	✔							✔	✔	✔	✔				
Tranche 1b																		
The Doctors Napier	✔	✔	✔	✔			✔	✔	✔	✔	✔	✔	✔					
Tranche 2																		
Hastings Health Centre	✔		✔	✔			✔	✔	✔	✔								
Queen Street Practice (Wairoa)	✔		✔	✔			✔	✔	✔	✔								
Tamatea Medical Centre, Dr Eastcott and Shakespeare Rd Medical Centre	✔		✔	✔			✔	✔	✔	✔	✔	✔	✔					
Taradale Medical Centre	✔		✔	✔			✔	✔	✔	✔	✔	✔						
The Doctors Hastings	✔		✔	✔			✔	✔	⊘	⊘								
TukiTuki Medical Centre	✔		⊘	✔			✔	✔	✔	✔								
Telehealth Module																		
Central Medical					✔	✔	✔	✔	✔									
Greendale Family Health Centre					✔	✔	✔	✔	⊘	✔								
Maraenui Medical Centre					✔	✔	✔	✔	⊘	✔								

13

Cultural Responsiveness Curriculum

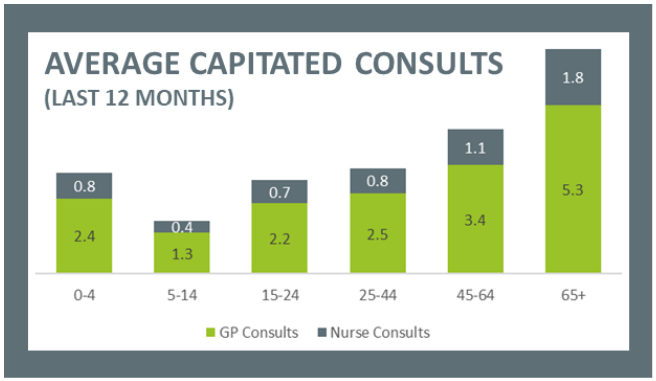
- Identify, define, develop, and implement a cultural responsiveness structure internally
- Ascertain the level of competency and responsiveness of all staff the organisation and the people we serve.
- This is based on Te Ao Māori paradigm, it's principles, philosophy and culture. These include the following;
    - The development of a Cultural Responsiveness Curriculum for General Practice and Primary Mental Health Services
    - In-house cultural training - Karakia, Mihi, Mihi Whakatau, Pōhiri, Poroporoaki, Te Reo & Waiata.
    - In-depth Wānanga training - Hui, Akoranga and Kauhau will be provided with relevant kaupapa to support staff prior to wānanga.

HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

Other Equity Strategies

- Undergoing Policy Reviews internally
- Employed a Specialist Māori Health Team (5 FTE)
- Health Hawke's Bay team has increased to 45 staff – 40% Māori
- Developed a Rangatahi Internship & summership to
  - Increase the Māori & Pasifika Primary Health workforce.
  - Grow young Māori & Pasifika youth in secondary school.
  - Attract and build Relationships/Partnership with Whānau, Hapū and Iwi Māori including strengthening GP Whanaungatanga.
- Targeted approach to outreach CVDRA services starting with the Hawke's Bay rugby union, Marae, and work settings.

HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui



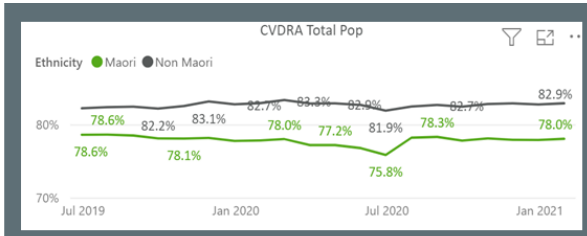
HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

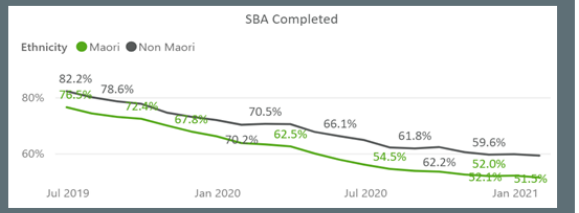
167,357

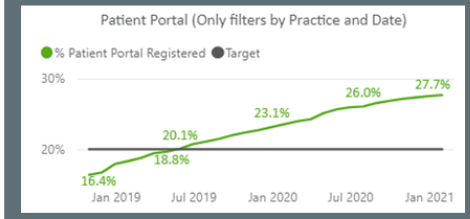
PATIENTS ENROLLED WITH HEALTH HAWKE'S BAY

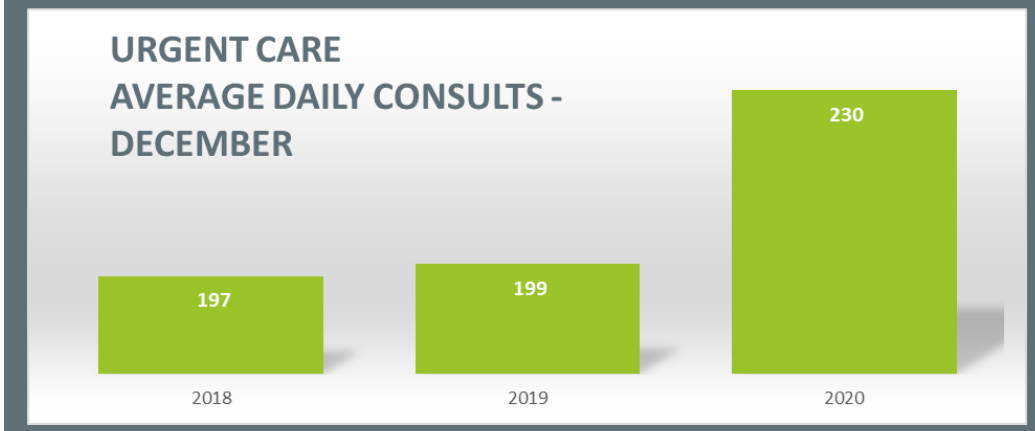
93.5%

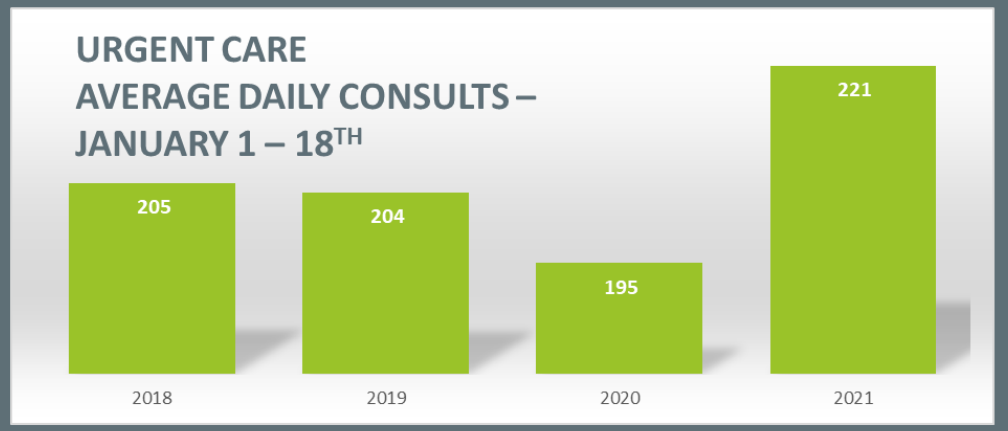
Estimated HB Population











Primary Mental Health

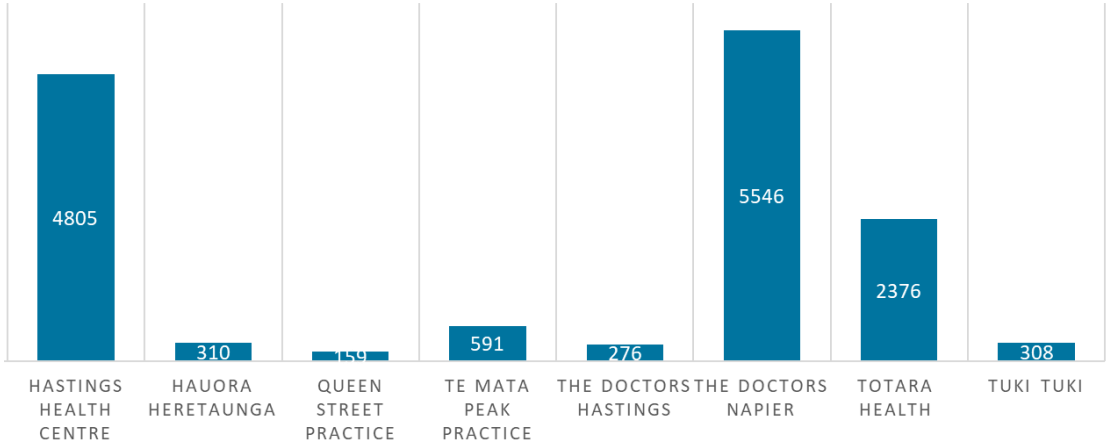
- Implementing Integrated Primary Mental Health and Addictions Service into General Practices
- 17 full time roles supporting 68,000 of our population this financial year increasing to 42.5 full time roles across the whole population by June 2023
- Prioritising access for Māori, Pacifica and Youth
- Some delays due to national training bottleneck but planning to be fully staffed by Q3
- Steering group with broad representation is reviewing existing mental health program
    - Address inequity for Māori and rural residents
    - Deliver better value for money
    - Address the needs of people with moderate to severe mental health issues

HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

COVID-19

- 14,375 COVID-19 swabs in last 6 months
- 600 tests done in General Practices on the busiest day
- The Designated Swabbing Practices are The Doctors Napier and Hastings Health Centre
- Queen Street Practice and Tuki Tuki Medical have been working with the HBDHB rural teams to provide swabbing to the rural communities
- All other Hawke's Bay practices are able to swab their own patients however most chose to refer to designated swabbing practices
- Biggest learnings – Telehealth

HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

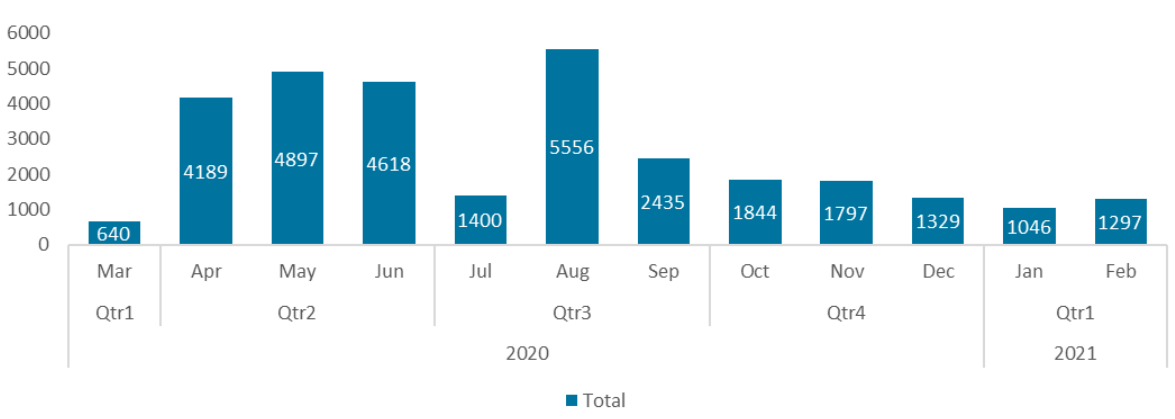


NUMBER OF COVID-19 TESTS BY SWABBING CENTRE

AUGUST 2020 – FEBRUARY 2021

NUMBER OF COVID-19 SWABS IN PRIMARY CARE BY MONTH

MARCH 2020 – FEBRUARY 2021



HEALTH HAWKE'S BAY
Te Oranga o Te Matau-a-Māui

HAWKE'S BAY District Health Board Whakawāteatia	**REVIEW OF HAWKE'S BAY HEALTH CONSUMER COUNCIL - MARCH 2021**
	For the attention of: **HBDHB Board**
Document Author(s)	Andy Phillips, Chief Allied Health Professions Officer
Date	March 2021
Purpose/Summary of the Aim of the Paper	To provide the Board with a review of consumer council and management response to the recommendations made
Health Equity Framework	Health equity will be the principal purpose of consumer council going forward Consumer council will be part of the governance structure supporting health equity work The new ToR will ensure that those with lived experience of greatest health need will drive consumer voice Consumer council will partner with community organisations in seeking out and using whanau voice
Principles of the Treaty of Waitangi that this report addresses	Community representatives who have lived-experience will advocate on behalf of our communities such as; disability, mental health and addictions, gang whānau and rangatahi. Consumer council will adopt high level principles from the Two-Tier Treaty Governance paper to support a pathway for HBDHB and Māori to work together collectively. Consumer council will adopt a community partnership model that allows communities to make their own decisions around what would benefit those most. The terms of reference for consumer council will be redrafted from an equity and Treaty position to prevent perpetuating the continuation of privileging the most advantaged populations. Consumer council will ensure that Māori consumer voice is heard. The work programme for consumer council will align with the governance joint work programme and list of strategic priorities that address the systemic issues faced by those most in need.
Risk Assessment	Nil significant
Financial/Legal Impact	Nil significant
Stakeholder Consultation and Impact	MRB were consulted on this review
Strategic Impact	Aligns with Health and Disability System Review
Previous Consideration / Interdependent Papers	Review discussed at Consumer Council and Executive Leadership Team

RECOMMENDATION:
It is recommended that the Board Approve the Management Actions arising from this review:

1. The Purpose and Functions sections of Consumer Council Terms of Reference (ToR) will be updated and modified to reflect the findings of this review and recommendations from MRB.

2. The CEO of HBDHB will confirm specific executive, management and secretarial support roles for consumer council, consistent with the Health and Disability System Review

3. Consumer Council will be engaged in specific activities requiring consumer input pending appointment of new members and chair in July 2021.

Management Response to Consumer Council Review

Situation
This paper provides a management response to a review of the Hawke's Bay Health System Consumer Council

Background
The CEOs of HBDHB and HHB commissioned a review into the structure, function and purpose of Consumer Council. There had been significant concern expressed from many directions about the work of consumer council. Lack of clarity on the work to be done had led to conflict within council.

Assessment
The conclusions made from the review were:

- Ensure the 'consumer voice' is heard at the governance level of the Hawkes Bay health system
- The general purpose of providing input at this level is to provide:
  - A consumer perspective, advice and support on the development and implementation of strategy and system change
  - Promotion, support and coordination of appropriate consumer engagement and participation policies and practices throughout the sector at all levels
  - Consumer input and oversight to clinical governance activities involving clinical quality, patient safety and consumer experience
- Structure created to achieve the above purpose is appropriately mandated, enabled, and resourced.
- It is people that make things happen, not structures.
- There are no current legal reasons to change the current model.
- The level of engagement with, and support provided to, the PHO was variable but generally limited. There is potential for this relationship to be enhanced, and for consumer engagement in primary care to be promoted.
- The Terms of Reference need to be updated to better reflect the current environment and priorities including : Provide a consumer perspective, advice and support on the development and implementation of strategy and system change ; Promotion, support and coordination of appropriate consumer engagement and participation policies and practices throughout the sector at all levels ; Consumer input and oversight to clinical governance activities involving clinical quality, patient safety and consumer experience
- Need for Council to develop 'partnership' relationships with other health sector governance bodies and be seen to be supporting change and progress and adding value where appropriate. Opportunities were identified for enhancing relationships along these lines with: MRB; PHLG; Clinical Council; PHO Priority Population Committee; Te Pitau Health Alliance Governance Group
- Members needed to operate at a more strategic governance level, rather than the wider 'lived experience' level indicated in the current Terms of Reference, and also that there could be fewer members given that there would no longer be a requirement to ensure all health 'areas of interest' were represented. Nine members in total was suggested as an ideal number.
- With a 'higher level governance role', the agenda for Council meetings would need to be set at the appropriate level. This then should enable Council to complete its business within the monthly schedule indicated in the current Terms of Reference, so no change was proposed for this, nor for the reporting or minutes sections.
- Elements of concern and frustration have been expressed about a perceived lack of

organisational commitment and enabling management support. The Group noted recent limited progress from the most recent HBDHB Board papers on a number of these issues; Person & Whānau Centered Care (in partnership with Clinical Council); Consumer Engagement Strategy - promotion and implementation across the sector; Recognising Consumer Participation Policy - no provisions in budgets; Health Literacy (Making Health Easy to Understand); Patient Journey Workshop Action Plans – no action

- Council should have the following support: Executive sponsor and senior management; Management including liaising with the Council Chair, facilitating governance support functions (appointments, payments, agendas etc.) and acting as the coordinator of other organisational roles supporting Council issues; Secretarial; HHB Liaison – A senior member of staff to be appointed to provide ongoing liaison with Council, the Chair and the relevant directorate.

Management Response to the Recommendations

It is acknowledged that the review was conducted by a select group of primarily past or current members of consumer council looking through the lens of the current terms of reference. The review did not comprehensively address the value provided, achievements, benefits or improvements to the most vulnerable populations or the evaluations of clinical council, MRB, Pasifika Leadership group, Executive Leadership Team or HBDHB or HHB Boards. The Health and Disability Review requires the health system to place consumers, whanau and communities at the heart of the system and there is a question whether consumer governance, in the current format is the best approach to gain a consumer led system. In particular, we need to understand more clearly the relationship of consumer council to Māori and Pacific communities and how MRB and PHLG view the proposed 'partnership' relationships.

MRB were consulted as part of this review and expressed the need for Māori consumer voice to feature strongly within the Consumer Council. MRB emphasised the need for specific Māori voices and communities from local level be listened to and addressed. MRB understands that communities within the Hawke's Bay region require different support from one another. MRB would like a commitment from the HBDHB to listen and address Māori consumer voice.

MRB members emphasised the need for community representatives who have lived-experience to advocate on behalf of our communities such as; disability, mental health and addictions, gang whānau and rangatahi. The Two-Tier Treaty Governance paper is a leading report that supports a new pathway for the Crown and Māori to work together collectively. It was recommended that Consumer Council adopt high level principles from this paper. Wairoa has a template for a community partnership model. MRB members believe this would benefit other communities within the Hawke's Bay as this allows communities to make their own decisions around what would benefit those most.

The terms of reference for consumer council will need to be redrafted from an equity and Treaty position to prevent perpetuating the continuation of privileging the most advantaged populations. In particular, the consumer council needs to ensure that Māori consumer voice is heard. The work programme needs to align with the governance joint work programme and list of strategic priorities that address the systemic issues faced by those most in need.

Management Actions Arising From the Review:

1. The review and management response will be shared with the Boards of HBDHB and HHB for their discussion.

2. The Purpose and Functions sections of Consumer Council Terms of Reference (ToR) will be updated and modified to reflect the findings of this review and recommendations from MRB.

3. The CEO of HBDHB will confirm specific executive, management and secretarial support roles for consumer council, consistent with the Health and Disability System Review

4. Consumer Council will be engaged in specific activities requiring consumer input pending appointment of new members and chair in July 2021.

FINAL REPORT

HAWKES BAY HEALTH CONSUMER COUNCIL REVIEW

DECEMBER 2020

Graeme Norton

Chair

For and on behalf of the Review Group

REVIEW BRIEF & PROCESS

Given the desire of the CEOs of both Hawkes Bay District Health Board (HBDHB) and Health Hawkes Bay Limited (HHB) to ensure that all advisory committees were utilising members' time effectively and that committees were serving the needs of the health system, on 20 October 2020 a review of the role and structure of the Consumer Council was initiated.

The 'brief' for this review is attached as **Appendix 1**

Details of the Review Group established to undertake the review, the process followed by the group and the documents it received, are attached as **Appendix 2**

The current Terms of Reference for Consumer Council, as the key document subject to the review, is also attached at **Appendix 3,** along with the current Terms of Reference for the Consumer Experience Committee at **Appendix 4**

This report sets out the findings, conclusions and recommendations of the Review Group.

BACKGROUND

The Hawkes Bay Health Consumer Council was established in June 2013 in response to a number of factors combining at that time, to provide the opportunity and requirement to review how HBDHB engages with consumers at an organisational level. These factors included:

- Concerns over the value of the then existing Consumer Group Committee
- Consumer engagement and participation being recognised as an emerging field of health research and practice
- Health Quality & Safety Commission initiating a 'Partners in Care' programme, seeking to provide a means of ensuring those quality dimensions important to consumers and whānau are incorporated into the way in which we design, deliver, and evaluate health services
- Recognition by the HBDHB Board that the board committees needed to be more strategically focused and the level of 'consumer voice' raised within this
- The acknowledged success of the functioning and structure of the Clinical Council, which had been established in 2010, and the belief that this model could be appropriate also for consumer/community stakeholder engagement.

The need to enhance this level of consumer engagement was acknowledged and incorporated into the HBDHB strategy at the time – Transform and Sustain.

Whilst initially established as the HBDHB Consumer Council, HHB subsequently 'adopted' the Council in 2015, so it became HB heath sector wide.

The 'Purpose' within the Terms of Reference for Council reflected the above early factors and have subsequently been amended to include a focus now on:

- Provide a strong and viable voice for the community and consumers on health service planning and delivery
- Enhance service integration and the promotion of equity
- Ensure services are organised and provided to meet the needs of all consumers
- Receive and disseminate information to and from the DHB. HHB Ltd, consumer groups and communities
- Encourage and advise on best practice, innovation, and quality improvement

More recently however, the role and function of Consumer Council has become confused, with a number of changes in both senior management roles and governance processes within HBDHB, and changes in the way Consumer Council has operated. Despite consumer engagement becoming more common at service design and project levels within HBDHB and HHB, Consumer Council members remain concerned about the general level of organisational commitment to the Consumer Engagement Strategy. They have also become more concerned (and somewhat frustrated) with the limited progress on significant strategic goals, particularly Person & Whānau Centered Care.

This review seeks to address these issues and concerns.

GENERAL FINDINGS

Specific findings under each issue required to be addressed by the review brief are set out below. The Review Group did however come to some significant general conclusions:

- There is a real need to ensure the 'consumer voice' is heard at the governance level of the Hawkes Bay health system
- The general purpose of providing input at this level is to provide:
  - A consumer perspective, advice and support on the development and implementation of strategy and system change
  - Promotion, support and coordination of appropriate consumer engagement and participation policies and practices throughout the sector at all levels
  - Consumer input and oversight to clinical governance activities involving clinical quality, patient safety and consumer experience
- To be effective, any structure created to achieve the above purpose, needs to be appropriately mandated, enabled, and resourced.
- It is people that make things happen, not structures.

SPECIFIC FINDINGS

1. **The legislative requirement for District Health Boards to have Committees reporting to Board**

The Review Group reviewed and discussed the HBDHB Board papers and process that led to the creation of the current HBDHB governance structures. It was acknowledged that the New Zealand Public Health and Disability Act 2000 contained the requirement for DHBs to establish three statutory committees (Hospital Advisory Committee, Community and Public Health Advisory Committee, Disability Support Advisory Committee). Also acknowledged however, was the HBDHB Board process and logic followed in establishing the Clinical and Consumer Councils to effectively and practically 'replace' these committees, noting that all legal requirements are still technically being met.

It was also noted, that in recent years, many other DHBs have visited HBDHB to view this governance structure in operation and have subsequently modified their own structures along similar lines.

The Group therefore concluded that there were no current legal reasons to change the current model.

2. **The opportunities for Consumers to advise Health Hawke's Bay PHO**

Despite HHB 'adopting' the Consumer Council a number of years ago, it was acknowledged that the subsequent level of engagement with, and support provided to, the PHO was variable but generally

limited. It was agreed that there is certainly potential for this relationship to be enhanced, and for consumer engagement in primary care to be promoted.

3. The Purpose, Functions and Level of Authority of Council

Rather than any radical change, given the general findings around purpose identified above, the Group concluded that the current Terms of Reference just need to be 'updated' to better reflect the current environment and priorities. Key issues to be reflected in such modifications include:

- **Provide a consumer perspective, advice and support on the development and implementation of strategy and system change, including:**
  - Whānau Ora Hāpori Ora Goals:
    - Community Led System – An integral component
    - Embed Person and Whānau Centered Care – Champion/Work with Clinical Council
    - Equity for Māori as a Priority; Also, Equity for Pasifika and Those with Unmet Needs – Advocate and advise/partner with and support MRB & PHLG
    - High Performing and Sustainable System – Consumer perspective/input into clinical quality, patient safety and consumer experience
    - Highly Skilled and Capable Workforce – Promotion of person and whānau centered care models and practices
    - Digitally Enabled Health System – Input and support to technology solutions (telemedicine etc.) and access to electronic health information and records
  - Clinical Services Plan
    - Place based planning – requires consumer engagement
    - Evolving primary Health Care – to meet consumer needs (eg NUKA models)
    - Working with Whānau to Design the Services they Need – Direct involvement in partnership with MRB and PHLG
    - Relevant and holistic responses to support mental wellbeing – to meet consumer needs
    - Keeping older people well at home and in their communities - requires consumer engagement
  - HHB Strategy – Ka Hikitia
    - Support the co-design approach
  - Health & Disability System Review – Key Areas for Change
    - Ensuring consumers, whānau and communities are at the heart of the system – consumers, whānau and communities need to have a part in the decision making about the design and delivery of treatment services at all levels
- **Promotion, support and coordination of appropriate consumer engagement and participation policies and practices throughout the sector at all levels**
  - Champion and support committed implementation of the Consumer Engagement Strategy, noting in particular the table of 'Level of Consumer Engagement' on page 4 (Refer **Appendix 5**)
  - Support and facilitate effective two-way communications between the 'system' and consumers, consumer groups and communities
- **Consumer input and oversight to clinical governance activities involving clinical quality, patient safety and consumer experience**
  - Requires a partnership approach with Clinical Council – reactivation of the Consumer Experience Committee
  - Promote and support collection, analysis, and action on consumer feedback

The Group did not identify any reason why the current level of authority for Council should change. It was agreed that Council should remain an advisory body, providing appropriate advocacy, advice, and support to both HBDHB and HHB Boards and CEOs.

4. Where does Council best 'fit' within HB health sector governance structures

The discussion around 'fit' resulted in the conclusion that there are significant benefits in the current structure – technically reporting through the respective CEOs to the Boards, but practically reporting directly to the Boards (at least the HBDHB Board currently). The opportunity exists to enhance the relationship with the HHB Board and refresh the understanding about the role and relationship with the HBDHB Board

Given the outcomes from discussions on role, the Group identified the need for Council to develop 'partnership' relationships with other health sector governance bodies and be seen to be supporting change and progress and adding value where appropriate. Opportunities were identified for enhancing relationships along these lines with:

- MRB (Note 1)
- PHLG
- Clinical Council
- PHO Priority Population Committee
- Te Pitau Health Alliance Governance Group

- Note 1. The Review Group chair met with members of MRB at its December meeting and sought their input into what collaboration might look like. A summary of MRB viewpoints/advice is contained within the minutes of their December meeting.

5. The adequacy and appropriateness of the other Terms of Reference components, including Membership, Chair, Meetings, Reporting and Minutes

Most of the discussion around this issue centered on the changes in the environment since Council was first established, particularly the development of the Consumer Engagement Strategy and the increasing participation of consumers in service design and project teams, outside the activities of Council (although many Council members were involved as individuals). This, together with previous decisions around modifying the purpose, resulted in agreement that the role of Council needed to be 'lifted' to the level of governance.
This in turn indicated that Members needed to operate at a more strategic governance level, rather than the wider 'lived experience' level indicated in the current Terms of Reference, and also that there could be fewer members given that there would no longer be a requirement to ensure all health 'areas of interest' were represented. Nine members in total was suggested as an ideal number.
With a 'higher level governance role', the agenda for Council meetings would need to be set at the appropriate level. This then should enable Council to complete its business within the monthly schedule indicated in the current Terms of Reference, so no change was proposed for this, nor for the reporting or minutes sections.

6. The development, advancement and/or implementation of issues covered by the ToR Functions

Since its establishment, Consumer Council has 'taken the lead' on a number of issues of significance, most of which have been set out in various HBDHB strategic documents. In recent times however, elements of concern and frustration have been expressed about the limited progress made in

advancing these strategies, mostly due to a perceived lack of organisational commitment and enabling management support. The Group noted recent limited progress from the most recent HBDHB Board papers on a number of these issues (Refer **Appendix 2**)
Specific issues include:

- Person & Whānau Centered Care (in partnership with Clinical Council)
- Consumer Engagement Strategy - promotion and implementation across the sector
- Recognising Consumer Participation Policy - no provisions in budgets
- Health Literacy (Making Health Easy to Understand)
- Patient Journey Workshop Action Plans – no action

Concern was also expressed about Clinical Council members' recent inability to participate in the Consumer Experience Committee (Refer **Appendix 4**)

7. The level and appropriateness of executive, management and secretarial support required to directly and indirectly support Council to achieve its Purpose and Functions

A comment noted during a Review Group discussion was:

"Council is a governance body, it needs to be 'enabled' – that is mandated, adequately resourced, and fully supported with management and Board commitment. If we don't have these things, no one should be surprised if things don't happen".

These comments were fully supported by the Group, following a brief review of what has happened over the past 12 – 18 months. Looking forward however, the Group concluded that the Council should have the following support:

- Executive sponsor and senior management
- Management including liaising with the Council Chair, facilitating governance support functions (appointments, payments, agendas etc.) and acting as the coordinator of other organisational roles supporting Council issues.
- Secretarial
- HHB Liaison – A senior member of staff to be appointed to provide ongoing liaison with Council, the Chair and the relevant directorate.

Where that support comes from should be guided by the Council's purpose and functions set out in "Specific Findings" Section 3 above.

RECOMMENDATIONS

A. **That the Purpose and Functions sections of Consumer Council Terms of Reference (ToR) be updated and modified to reflect the findings of this Review**
B. **That the Membership section of the ToR be changed to reflect the updated 'governance' level role of Council - ie 8 members (plus the Chair) selected due to their ability to engage with, promote and represent a 'health consumer voice' at a strategic governance level**
C. **That HBDHB and HHB Boards be provided with a copy of this review, discuss their expectations, and provide feedback**
D. **That the requirement for Council to develop/enhance partnership relationships with other governance groups (as above) be added to the ToR**
E. **That specific executive, management and secretarial support roles be confirmed**
F. **That HBDHB and HHB management commit to providing appropriate prioritisation, resources, and support to advance the issues recently promoted by Council**

APPENDIX 1

HAWKES BAY HEALTH CONSUMER COUNCIL – REVIEW BRIEF

The Brief is to conduct a full review of Consumer Council, including:

- The legislative requirement for District Health Boards to have Committee's reporting to Board
- The opportunities for Consumers to advise Health Hawke's Bay PHO
- The Purpose, Functions and Level of Authority of Council
- Where does Council best 'fit' within HB health sector governance structures
- The adequacy and appropriateness of the other Terms of Reference components, including Membership, Chair, Meetings, Reporting and Minutes
- The development, advancement and/or implementation of issues covered by the ToR Functions
- The level and appropriateness of executive, management and secretarial support required to directly and indirectly support Council to achieve its Purpose and Functions

The output of the Review will be a report with recommendations to HBDHB and HHB PHO CEOs, to be delivered by 20 December 2020.

The Review will be coordinated by a Review Group comprising:

- Graeme Norton (Chair)
- Andy Phillips
- Three current or recent past members of consumer council
- Primary Care Representative
- IWI representative
- Management Support

The Review Group will brief and consult with a Reference Group comprising the remaining ongoing members of consumer council and support

APPENDIX 2

HAWKES BAY HEALTH CONSUMER COUNCIL – REVIEW PROCESS

REVIEW GROUP

Following the release of the Review Brief, the Review Group was established:

Graeme Norton (Chair)
Andy Phillips
Three current or recent past members of consumer council

- Rachel Ritchie
- Deborah Grace
- Oliver Taylor

Primary Care Representative

- Carina Burgess

IWI representative

- Ana Apatu

Management Support

- Ken Foote (Peak Management & Mediation Ltd)

Meetings of the Review Group were subsequently held on:

- 5 November 2020
- 19 November 2020
- 25 November 2020

A summary of the Review Groups discussions and findings were presented to the Reference group on 7th December 2020, with comment and feedback received in subsequent days either in writing or via individual meetings with the Chair and incorporated into the final report as appropriate.

DOCUMENTS REVIEWED

During the process, the Review Group received and/or discussed a number of relevant documents. These included:

- HBDHB Board papers relating to the establishment of Consumer Council (June 2013) and HBDHB Governance Evolution 2010 - 2020
- Health Quality and Safety Commission (HQSC) 'Guide for DHBs for Engaging with Consumers'
- HBDHB Strategy – Whanau Ora Hapori Ora
- Relevant extracts from HB Health Sector Clinical Services Plan
- Ministry of Health – A Framework for Health Literacy (2015)
- HBDHB Board paper – Health Literacy Framework (Nov 2016)
- Patient Journey Workshops Action Plan (Dec 2017)
- HBDHB Board paper – Implementing the Consumer Engagement Strategy (June 2018)
- HBDHB endorsed 'Consumer Engagement Strategy' (June 2018)
- Consumer Council 'Guide for Consumer Representatives' (Nov 2018)
- Recognising Consumer Participation Policy (June 2019)
- Relevant extracts of HBDHB Draft Clinical Governance Manual (June 2019)
- HBDHB Board Paper – Person & Whanau Centered Care (June 2019)
- Health & Disability System Review – Summary of Final Report (March 2020)
- HHB Ka Hikitia Update (Oct 2020)
- Consumer Council Annual Plans (2018 – 2021

APPENDIX 3

TERMS OF REFERENCE

Hawke's Bay Health Consumer Council

August 2018

Purpose	The Hawke's Bay Health Consumer Council (Council) works collaboratively with the Hawke's Bay District Health Board (HBDHB) and Health Hawke's Bay governance and management teams, and the Hawke's Bay Clinical Council to develop effective partnerships in the design and function of an effective health system in Hawkes Bay that meets the needs of the people. Through true partnership, the Council provides a strong and viable voice for the community and consumers, on health service planning and delivery. The Council seeks to enhance consumer engagement and experience through service integration across the sector, the promotion of equity and ensuring that services are organised and provided to meet the needs of all consumers. Through effective processes and communications, the Council receives, considers and disseminates information from and to HBDHB, Health Hawke's Bay, consumer groups and communities. The Council also has a quality improvement role to advise and encourage best practice and innovation.
Functions	The functions of the Council are to: • Ensure, coordinate and enable appropriate consumer engagement across the Hawke's Bay, Central Region and national health systems. • Identify, advise on and promote a 'Partners in Care' approach to the implementation of 'Person and Whanau Centered Care into the Hawkes Bay health system, including input into the development of health service priorities and strategic direction, the reduction of inequities, and the enhancement of consumer engagement, patient safety, clinical quality and making health easy to understand. • Participate, review and advise on reports, developments and initiatives relating to Hawkes Bay health services and the availability and/or dissemination of health-related information. • Ensure regular communication and networking with the community and relevant consumer groups. • Link with special interest groups, as required for specific issues and problem solving. For the avoidance of doubt, the Council will not: • Provide clinical evaluation of health services • Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes exists. • Be involved in the HBDHB or Health Hawke's Bay contracting processes.
Level of Authority	The Council has the authority to give advice and make recommendations to HBDHB and Health Hawke's Bay senior management and Board.

APPENDIX 3

Membership	There shall be fourteen (14) members on the Council, plus an independent Chair. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible services and care from the Hawke's Bay health sector. Although appointed to reflect the consumer voice in a particular area of interest, they will not be regarded as representatives of any specific organisation or community. Members will be appointed to reflect the following areas of interest: • Women's health • Child health • Youth health • Older persons health • Chronic conditions • Mental health • Alcohol and other drugs • Sensory and Physical disability • Intellectual and Neurological disability • Rural health • Maori health • Pacific health • Primary health • High deprivation populations When making appointments, consideration must be given to maintaining a demographic balance that generally reflects that of the population. Members shall be appointed by the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the respective boards), following consultation with the consumer and community groups in each of the areas of interest, as appropriate. Members shall be appointed for terms of two years. Members may be reappointed but for no more than three terms. Remuneration shall be paid based on the Cabinet Fees Framework applicable to HBDHB Statutory Committees.
Chair	The Chair shall be appointed by the HBDHB Board on the recommendation of the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the Health Hawke's Bay Board) following consultation with Council members. Appointments shall be for terms ending no later than four months after the end of the term of the HBDHB Board that appointed them (Note: The full term of a Board is three years). The Chair may be paid additional fees and allowances, depending on the level of commitment involved in addition to Council meetings.

APPENDIX 3

Meetings	Meetings will be held monthly, excluding January, or more frequently at the request of the Chair. Meetings will generally be open to the public but may move into "public excluded" where appropriate, and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee. A standing reciprocal invitation has been extended to the Hawke's Bay Clinical Council for a representative to attend all meetings.
Reporting	The Council will report to the CEOs of HBDHB and Health Hawke's Bay, and through the CEOs to the respective HBDHB and Health Hawke's Bay boards. A monthly report of Council activities and recommendations will be placed on HBDHB and Health Hawke's Bay websites once approved.
Minutes	Minutes will be circulated to all members and Chair of the Council, within one week of the meeting taking place. Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc., on request.

APPENDIX 4

TERMS OF REFERENCE

CLINICAL GOVERNANCE

CONSUMER EXPERIENCE COMMITTEE

SEPTEMBER 2018

Purpose	Oversee the development and implementation of strategies, systems, policies, processes and actions that will contribute to the continuous improvement of consumer experience within the HB health system.
Functions	• Lead and promote a culture of continuous improvement of consumer experience within the HB health system • Consult as necessary to develop and recommend an overall integrated strategy for improving consumer experience • Develop, enhance and confirm appropriate systems and surveys to be used to gather indicators of consumer experience • Agree targets, monitor and analyse consumer experience performance indicators • Report on performance and recommend and/or initiate improvement actions • Ensure all relevant information, requests for feedback and improvement actions are well communicated throughout the sector, and implemented as appropriate • Ensure decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care)
Level of Authority	The Committee reports to, and has the authority to provide advice and recommendations to, the Hawkes Bay Clinical Council and Hawkes Bay Health Consumer Council. To assist it in this function the Committee may: • Request reports and presentations from particular groups • Establish sub-groups as necessary to investigate and report back on particular matters • Request the commissioning of audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders. **Delegated Authority** The Committee has delegated authority to Make decisions and issue directives/guidelines on consumer experience issues (other than strategy) that:

APPENDIX 4

	▪ Relate directly to the function of the Committee as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within current budgets. All such decisions and/or directives will be binding on all clinicians or other staff who provide and/or refer to public health services funded (in whole or part) by the HBDHB or HHB Ltd.
Membership	**Membership** • Three (3) Clinical Council representatives • Three (3) Consumer Council representatives • Health Services Directorates representative • PHO representative **Tenure** Until replaced by the group being represented
Chair	Co-Chairs • One appointed by Clinical Council from the three Clinical Council representatives • One appointed by Consumer Council from the three Consumer Council representatives Co-Chairs of the Committee shall not be a Chair or Co-Chair of either of the two Councils
Quorum	A quorum will be a minimum of two members from each of the two Councils plus one other member
Meetings	Meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs. Meetings shall be held at times and in locations that suit the membership, and the availability of relevant consumer experience survey information Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical Council and Consumer Council following each meeting of the Committee. A formal annual report shall be submitted within 3 months of the end of each financial year (30 June) A precis of the annual report shall be communicated to the sector, once received by both Councils.

APPENDIX 4

Minutes	The minute secretary shall be a Consumer Experience Facilitator. Minutes and action plans will be circulated to all members within one week of the meeting taking place.

APPENDIX 5

CONSUMER ENGAGEMENT STRATEGY

EXECUTIVE SUMMARY

Consumer engagement refers to the wide range of approaches in which consumers are involved in the planning, service delivery and evaluation of healthcare. Done well, it contributes to fostering a relationship led culture of person & whānau centered care. It supports active, ongoing partnerships, relationships and communication that benefits consumers, staff and will ultimately transform the system.

This strategy is not a detailed work plan. It provides a clear direction for the future and a framework for making decisions. It provides guidance around types and levels of engagement and the benefits of engaging. The goal being that consumer engagement is embedded in all of the ways we work with consumers and is a key driver for achievement of the 'Triple Aim'.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture', rather than additional work on top of an already demanding workload. It should be linked to other organisational plans and build on existing skills and the work we are already doing. Effective consumer engagement supports the Hawke's Bay Health Sector vision of "*Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

PURPOSE

The goal of this strategy is to strengthen and embed consumer participation at all levels in the health sector, ensuring consumers are active partners in their own care and how we design, deliver and improve services. It is a driver for improving experience of care, quality and safety of care, health outcomes and best value. The strategy also exists to build knowledge and educate health sector staff about the value of consumer engagement.

Ultimately, our aim is to create a relationship and values led culture which puts our consumers and their whānau at the center of everything that we do, and one that is respectful of, and responsive to their needs, preference, and values. Consumer engagement is one enabler of a person & whānau centered culture and this strategy sits alongside others to achieve culture change.

WHAT IS CONSUMER ENGAGEMENT?

Consumer engagement refers to the wide range of strategies in which consumers/whānau are involved in their care planning, service delivery and evaluation of healthcare. It can be at an individual, service, governance or community level. Engagement should always be mana enhancing building strong and sustainable relationships.

Consumer refers to patients and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system. The term also includes those who might use services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services.

WHY ENGAGE WITH CONSUMERS?

Consumer engagement done well fosters a culture of person and whānau centered care. It supports active, ongoing partnership, relationships and communication that will benefit consumers, staff and ultimately transform the system.

There is evidence to support the benefits of engaging with consumers. These include improvements, such as removal of inequities, more responsive services, improved clinical quality outcomes, and improved patient experience. In addition, safer care, less waste, reduced length of stay, lower costs, better consumer and health provider satisfaction and staff retention.

Consumer Engagement supports the New Zealand Triple Aim framework (right) for quality improvement at individual, population and system levels. One of its aims is improved health and equity for all populations. Hawke's Bay is a great place to live, but not everyone has the same opportunity to be healthy. Health inequities exist in some parts of our community. Successful consumer engagement will focus on how to be effective within this broader context.

Without proactive consumer engagement, the drive for change is usually either motivated through system failures (e.g. adverse events) or from external advocacy to improve the quality and safety of care. Waiting until there is a problem creates avoidable costs for consumers (physical, psychological and economic) and organisations (review processes, staff morale and more expensive treatments).

HOW DO WE ENGAGE?

Engaging with consumers can and should happen at different levels depending on the situation, and as early as possible. How we engage will be determined by the purpose, timeframes and level of impact of different projects, initiatives or programmes of work. Many will require multiple engagement methods at multiple levels.

Principles of engagement

The principles of partnership, participation and protection underpin the involvement of Māori and the wider community. In addition to these core principles there are a number of other guiding principles in relation to effectively embedding consumer engagement at all levels alongside the shared values and behaviors of our sector.

These are:

1. **Being open and honest -** Consumer engagement is more successful when all parties involved are mutually respectful, listen actively and have the confidence to participate in full and frank conversations.

2. **Providing support -** Support for consumer engagement means being welcoming when meeting consumers, valuing their expertise, considering their cultural needs and acknowledging and taking their viewpoints seriously.

3. **Being real -** Consumers and providers know when we are simply going through the motions of consulting with consumers. Consumer engagement needs to be genuine. All parties should know the purpose of why engagement is taking place and real possibilities for change and improvement.

4. **Patient and whānau focus -** All consumer engagement needs to keep the focus on patient and whānau centered care. It is important that providers and staff are supported to maintain their focus on patient/family/whānau as a core aspect of care.

5. **Making health easy to understand** – all engagement needs to done in a way that meets the needs of the consumer, is easy to understand and so that they can contribute as an active partner in the engagement.

6. **Culturally appropriate:** - all engagement needs to meet the needs, values and be culturally appropriate to the consumer.

Levels of engagement

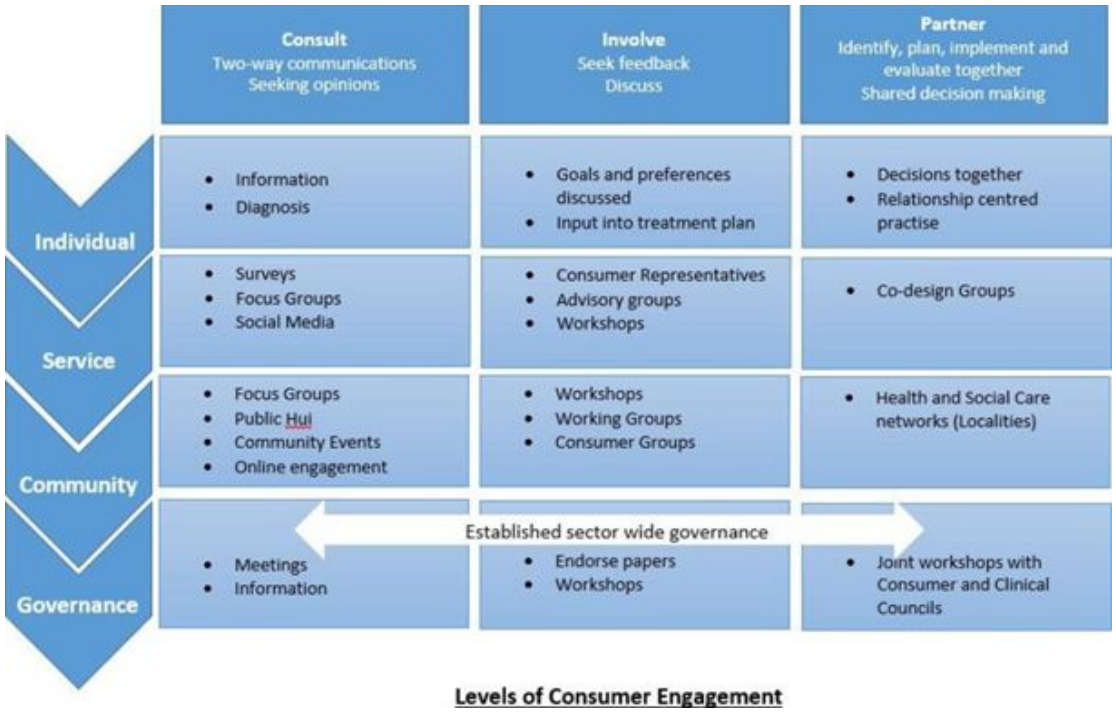
Individual engagement includes consulting, involving and partnering with consumers in shared decision making about their own health. Put another way – *"my say in decisions about my own care and treatment".* It is easy to see and value the role of consumers at an individual level – engaging in and contributing to decisions about their own care, or that of loved ones. This is covered in more detail within the work being undertaken in the making health easy to understand framework, engaging effectively with Māori, and relationship centered practice training.

Collective engagement includes collaborating, involving and partnering with individuals or groups of consumers at a service, community or governance level. Put another way – *"my" or 'our say' in decisions about planning, design and delivery of services".*

As seen in the below diagram, consumers can be engaged collectively in various ways, at multiple levels including:

- As partners when redesigning services through co-design groups
- As members of committees, advisory and governance groups
- Through workshops, working groups, steering groups, focus groups and public hui's
- Through consumer and patient experience surveys and feedback mechanisms
- Involvement in consumer interviews, patient stories, patient journey mapping

APPENDIX 5

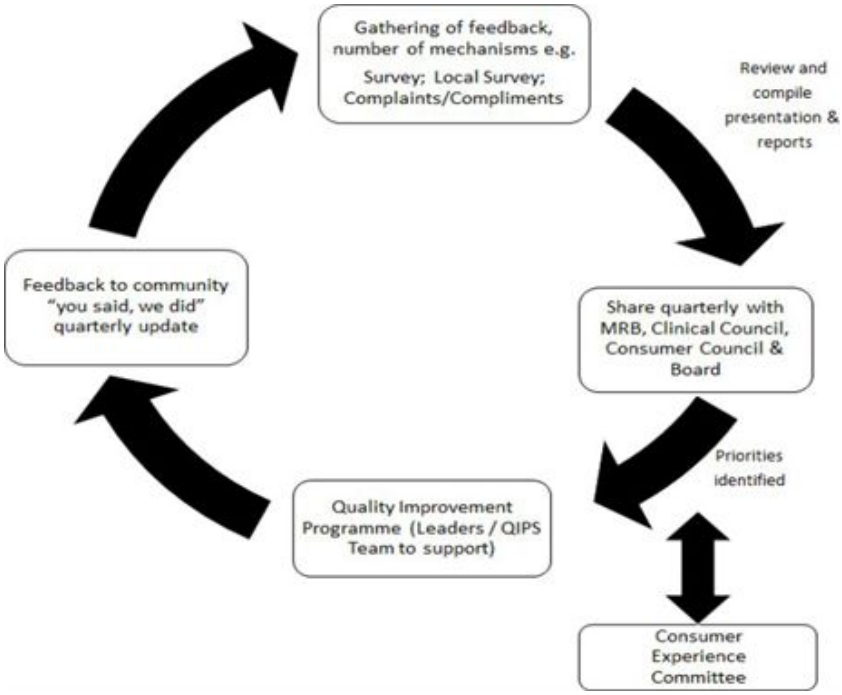


Levels of Consumer Engagement

UTILISING CONSUMER FEEDBACK

One form of engagement with consumers relates to feedback that we receive through various formats, including complaints, patient experience surveys, focus groups and huis. To ensure that this is effectively used to support system design improvements and changes the following process will be followed:

APPENDIX 5


Gathering of feedback, number of mechanisms e.g. Survey; Local Survey; Complaints/Compliments
Review and compile presentation & reports
Share quarterly with MRB, Clinical Council, Consumer Council & Board
Priorities identified
Consumer Experience Committee
Quality Improvement Programme (Leaders / QIPS Team to support)
Feedback to community "you said, we did" quarterly update

APPENDIX 5

LINKS TO OTHER STRATEGIES

It is important to acknowledge other strategies and frameworks that link to the implementation of this strategy:

- The Quality Improvement and Safety framework "Working in Partnership for Quality Healthcare in Hawke's Bay" (2013) outlines priorities that support consumer engagement in Hawke's Bay.

- Patients and Whānau at the center and services developed around the needs of our patients is a core principle of Hawke's Bay Health System – Transform and Sustain 2013 – 2018

- Youth involvement is a core principle of The Youth Health Strategy 2016 – 2019 in building health system resiliency through youth participation in governance, leadership, design and delivery of work.

- The Mai Māori health strategy focuses on engaging better with whānau and responding to the needs of Māori in the way they prefer services and care.

- The Pasifika Health Action Plan 2014 – 2018 supports a collaborative approach with pacific communities.

- Significant consumer input will be required to make a 'health literate sector' a reality.

- The People Strategy will address the development of a culture for the health sector that will need to include respecting and communicating effectively with consumers

- The development of Health and Social Care Localities includes significant requirements to consult with and engage local communities in decision making.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**
	For the attention of: **HBDHB Board**
Document Owner:	Ana Apatu (MRB Chair)
Month:	February 2021
Consideration:	For Information
Recommendation: That HBDHB Board: 1. **Note** the content of this report.	

The Māori Relationship Board met on 3 February 2021. An overview of issues discussed at the meeting are provided below.

MATTERS ARISING

1. **Maternity Uplift Internal Review** – members were advised that the Review had been split into two parts; (1) Uplift Internal Review and (2) Cultural Review of the HBDHB Maternity Services.
   Beverley Te Hui commented that the findings from the cultural review should influence the way we work across the DHB workplace. This will also assist our Māori staff with maintaining their mana in the workplace. The estimated completion date for this programme of work is August 2021.

2. **Methamphetamine & Mental Health & Addictions** – A meeting was held with the five project leads from Provincial Growth Fund to discuss how best to support this programme. MRB suggested that for these programmes to remain sustainable, the DHB could play a role to support these groups such as providing workforce development and clinical support.

3. **COVID-19 Review / TMO Review** - Updates were requested for the MRB March meeting. Members requested the TMO Review identify a permanent role for a Māori emergency response team as Māori communities have not been prioritised in climate emergencies.

4. **Primary Care Action –** Henry Heke updated MRB on the Manage my Health in Central Hawke's Bay. The PHO will engage with the TukiTuki Medical Centre to ensure they adopt this application. There are approximately 3000 whānau in Central Hawke's Bay who are unable to enrol with a GP practice. Currently, whānau from Central Hawke's Bay have to travel to Hastings for GP appointments. There is opportunity to be gained by ensuring Central Hawke's Bay practice works in partnership with Taiwhenua Heretaunga staff.

   Keriana Brooking challenged Māori Health to identify what primary health care system will work best with our whānau e.g. community drop in centres within Māori communities that are available at any time. This is an opportunity to transform services to better serve our whānau.

Other briefings provided to MRB noted:

- **Treaty Governance Board update –** Two meetings have been held with the Post Settlement Group Entity members, one for Governance and one for Managers. Governance members requested that MRB be involved in the development of this partnership.
  Patrick communicated that the Treaty Partnership Board is an opportunity to demonstrate Te Tiriti o Waitangi. Patrick informed MRB that this new board wants the input of MRB's knowledge and expressed their confidence in the way things are going. The Treaty Partnership Board acknowledged and expressed their appreciation for MRB.
  MRB will be operable for a further 6-12 months and during this time the Treaty Governance Board would like to develop this journey together.

- **PHO Update** – Henry Heke from Health Hawke's Bay PHO introduced his team. Henry informed MRB that the PHO CEO has resigned and a new role has been advertised.
  Henry advised there are currently 19 job vacancies within the PHO and a cultural responsiveness curriculum is being developed
  Henry acknowledged that the PHO has plenty of work to complete with 27 practices in primary care

MRB WORK PLAN

Two items were added to the work plan:

1) Water quality concerns for Māori communities
2) Lack of dentists available in Wairoa.

SECTION 2: FOR INFORMATION AND DISCUSSION

STRATEGIC MODEL OF CARE

Emma Foster (Executive Director Planning, Funding & Performance) was welcomed and congratulated by MRB for her successful appointment to the Executive Director of Planning, Funding & Performance. Emma provided a verbal update on the Strategic Master Planning Report. Emma noted the DHB had a requirement to construct a strategic direction which was developed through Whānau Ora, Hāpori Ora, approximately two years ago. There is a requirement to merge this into a ten-year Model of Care plan. This model incorporates a vast range of matters, including the Master Plan (infrastructure, facilities, workforce, business modelling etc).

Key messages noted:

- Members highlighted whānau should not have to change in order to receive quality health care, the system should change to better suit whānau needs. A member recommended that Dr Jess Berenson-Shaw as someone who has experience in transformational change across the health sector and would be invaluable to support this programme of work
- Members expressed that Māori need to be present throughout the planning process. MRB supports Emma's work and recommends having a Māori co-facilitator to ensure that a cultural lens is present throughout strategic planning

MRB and Planning, Funding & Performance support the development of strategic planning.

	Hawke's Bay Clinical Council (Public)
	For the attention of: **HBDHB Board**
Document Owner:	Jules Arthur (Co-Chair) Dr Robin Whyman (Co-Chair)
Month:	February 2021
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

- **Note** the contents of this report

Council met on 3 February 2021. An overview of matters discussed is provided below:

1. Resignation

Members were informed of the resignation of Debs Higgins after five years as an appointed Senior Nurse (primary care) on Clinical Council. Ms Higgins has recently taken on a role with Awhina Plunket which means she will not be able to attend Council meetings. As Ms Higgins was Clinical Council's representative to the HB Consumer Council, a new representative will be selected.

Ms Higgins' contribution was acknowledged and a letter of thanks has been sent.

2. Chief Executive Officer Report

Keriana Brooking informed members that the DHB is to begin the planning process for the next financial year, with budget allocations being notified by the Ministry in May. Planning will take account of the Health and Disability System Review and other strategic issues.

Keriana reported that planning for the distribution of COVID-19 vaccines is now a focus that will take a lot of organisation and time – alongside business as usual campaigns such as MMR and influenza.

She noted the mid-point surveillance audit for certification had been held the previous week and some of the recommendations will require change and cost. We have a strategic and operational issue of overflow everywhere from wards, ed, urgent care.

Keriana reported that a positional document on institutional racism had been drafted and would be shared with Council members for feedback.

She noted she remains concerned about patient safety and staff safety. There was a discussion about how people in the sector feel valued with comment that the workforce is still exhausted. Keriana is committed to being very clear about what safe staffing is.

She informed the meeting that she and the Chair were meeting with the Editor of *HB Today* to set up a series of articles to better inform what the DHB does and the risk that is carried on behalf of the community.

Council noted the CEO's report and requested regular updates to Council on the implementation of the COVID 19 vaccine.

3. Clinical Council Annual Plan and Work Plan for 2020/21

There was a further discussion of the Council's the annual plan and how Clinical Council can effectively measure cultural safety. It was agreed the organisation needs to find its "common language" for cultural safety. It was suggested a further conversation with the Cultural Advisor would be useful.

Keriana enquired why the sixth domain of quality was not included in the annual plan and suggested the use of the circle format may be more useful than the list format.

It was agreed to add the COVID-19 vaccination programme and the Health and Disability system review to the Work Plan.

An updated work plan will be emailed to members for consideration so that it can be approved at the March meeting.

4. Clinical Council Terms of Reference

Membership of Clinical Council was discussed with agreement that the inclusion of the Medical Director and Nurse Director of the PHO would be beneficial along with the inclusion of the Senior Advisor, Cultural Competence. There was a further discussion about how to ensure Maori representation on Clinical Council. Council also discussed the role of the Clinical Lead Planning and Funding with the Council and the overall size of Council.

Council members requested that the Chairs undertake further discussion with individual members prior to the March meeting and return the Terms of Reference with a view to them being accepted at the March meeting.

5. Reporting Committees

Clinical Council received quarterly reports from the Patient Safety and Risk Management Committee and the Radiology Advisory Group.

Clinical Council approved the Radiology Advisory Group's revised Terms of Reference.

No issues were raised that require noting to the Board.

6. Next meeting

The next meeting of the Hawke's Bay Clinical Council is on 3 March 2021.

HAWKE'S BAY District Health Board Whakawāteatia	**Strategic Workplan** For the attention of: **HBDHB Board**
Document Author(s) Document Owner	Emma Foster, Executive Director Planning, Funding and Performance
Date	March 2021
Purpose/Summary of the Aim of the Paper	Provide the Board with the strategic delivery work programme for the next nine months.
Health Equity Framework	The Health Equity Framework is a basis for all system transformation programmes. This means the process identifies: • health issues • co-designs solutions • actions solutions • monitors progress utilising whānau voice as the core driver, alongside the organisation values and principles of Te Tiriti o Waitangi.
Principles of the Treaty of Waitangi that this report addresses	System transformation will be informed by the principles of Te Tiriti o Waitangi, as determined in the health context.
Risk Assessment	NA
Financial/Legal Impact	NA
Stakeholder Consultation and Impact	The strategic workplan based on system transformation priorities identified in previous reports to the Board along with Hawke's Bay health system priorities.
Strategic Impact	As above
Previous Consideration / Interdependent Papers	Strategic planning and budgeting over a multi-year timeframe – options paper (FRAC, February 2021)
RECOMMENDATION: It is recommended that the Board: 1. **Note** and acknowledge the strategic workplan which informs system transformation	

EXECUTIVE SUMMARY

The purpose of the strategic workplan section is to provide the Board with an opportunity to discuss, provide direction, endorse and/or approve the system transformation/system design at a high level. This transformation will support sustainable, best for people, best for system, performance.

The workplan below is based on the Hawke's Bay DHB's Strategic Model of Care (including its Clinical Services Plan) and the Hawke's Bay Health system priorities.

Each report will provide further detail relating to equity impact, cost benefit, performance and outcome expectation.

WORKPLAN

Month	Strategic priority
April 2021	Hawke's Bay Health System Master Plan Equity Investment
May 2021	Service Improvement
June 2021	Hawke's Bay Hospital System Transformation
July 2021	Mental Health and Addictions System – Hawke's Bay specific
August 2021	Hawke's Bay Community System
September 2021	Hawke's Bay Health System Master Plan
October 2021	Hawke's Bay Hospital System Transformation
November 2021	Mental Health and Addictions System (Hawke's Bay System priorities)
December 2021	Hawke's Bay Community System

HAWKE'S BAY District Health Board Whakawāteatia	**COVID-19 VACCINE AND IMMUNISATION PROGRAMME ROLL-OUT PROGRESS REPORT FEBRUARY 2021**
	For the attention of: **HBDHB Board**
Document Owner	Chris McKenna - Chief Nursing and Midwifery Officer (Lead Sponsor) Patrick Le Geyt – Acting Executive Director, Health Improvement & Equity (Co-Sponsor)
Document Author(s)	Ngaira Harker – Nurse Director Māori Health (COVID-19 Operational Lead)
Date	March 2021
Purpose/Summary of the Aim of the Paper	Monthly update COVID-19 Vaccine roll-out Hawkes Bay District Health Board
Health Equity Framework	The COVID Vaccination Programme overarching equity for Māori is a priority as well as Pacific and high needs populations groups. This will require specific actions to meet the needs of these identified groups, resourcing and implementing those actions, and monitoring and tracking the results for the identified groups.
Principles of the Treaty of Waitangi that this report addresses	Te Tiriti o Waitangi and equity are the overarching principles of the immunisation strategy. These principles are integrated across the pillars and enablers of the strategy. We are partnering with respective Iwi, Māori Relationship Boards, Māori providers and communities to develop, design, implement, and monitor the vaccination programme.
Risk Assessment	In line with Ministry of Health's COVID-19 Risk Register.
Financial/Legal Impact	A funding model is being developed by MOH.
Stakeholder Consultation and Impact	Ongoing - in line with COVID-19 Strategy.
Strategic Impact	May have some impact on workforce requirements.
Previous Consideration / Interdependent Papers	N/A

RECOMMENDATION:
It is recommended that the Māori Relationship Board:
1. Note the COVID-19 Vaccination and Immunisation progress report.

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EXECUTIVE SUMMARY

This report outlines the monthly progress to date for the COVID-19 Vaccination Immunisation programme.

BACKGROUND

A COVID vaccination project structure for Tier 1 has been completed and sits under the CIMS structure. The Tier 1 project structure mirrors the programme structure outlined by the Ministry of Health. Chris McKenna, Chief Nursing Officer is Senior Responsible Owner for the programme with support from Patrick Le Geyt, Acting Executive Director Health Improvement & Equity. There is oversight from a governance group with responsibility for the overall delivery of the programme. Programme management is provided by Nurse Director Ngaira Harker and Andrea Jopling was onboarded as Project Lead in early February.

The COVID-19 Vaccination roll-out for Tier 1 of the national programme commenced 20 February 2021. This is in line with the scheduled range of the Tier 1 MOH 15-day national roll-out plan (Appendix A). HBDHB COVID-19 Tier 1 vaccination roll-out dates are confirmed.

HAWKE'S BAY TIER 1 COVID-19 VACCINATION SCHEDULE – BORDER WORKERS

Tier 1a

We have worked closely in planning for port with Iwi representatives. JB Heperi-Smith met with Hawke's Bay harbour leaders to discuss their respective roles in the COVID vaccination roll-out. Harbour leaders were appreciative of support and guidance within a cultural context. Kaumatua will be onsite at the Port to open and lead proceedings to support the vaccination roll-out.

Border workers at the Port of Napier are confirmed to commence vaccination. The COVID-19 vaccination roll-out at the Port of Napier will continue over two weeks from commencement to completion of all port border worker vaccinations. The second Pfizer vaccination will be delivered on site in 21 days as per guidelines.

The development and planning for this event is in partnership with the Napier Port Management and The Doctors Napier (the lead provider for Port of Napier). Consultation with port leaders and workers to support and prepare for the roll-out has been ongoing pre-event, and will continue throughout the vaccine event and post-event.

The Tier 1a vaccination delivery dates for airport workers and health protection officers are to be confirmed by The Doctors Napier, Hastings Health Centre and Napier Health Centre. These providers will be delivering on-site.

Tier 1b
Households of border worker's vaccine roll-out will commence following confirmation of the number of family members in the household. This data is to be collated at the border worker's vaccination sites. This approach is in line with the national operational guidelines re: vaccinating household contacts (See Table 1)

TABLE 1: VACCINATION SITES TIER 1

Site	Target Group	Site Lead	Estimated number to vaccinate
Port of Napier	For eligible port staff, customs staff and port contractor employees	Andrea Halpin, The Doctors Napier	250- 270
The Doctors Napier	Skyline Aviation staff, border worker household contacts, health protection officers	Andrea Halpin, The Doctors Napier	50, plus household contacts to be confirmed
Hastings Health Centre	Small number of airline staff, some border worker household contacts	Andrew Lesperance, Hastings Health Centre	TBC

VACCINATION WORKFORCE DEVELOPMENT
Training requirements to meet the vaccination schedule are in progress. Online training for Tier 1 vaccinator and administrator workforce has commenced and is scheduled to be completed by 26 February. Fiona Jackson, Team Leader Immunisation is leading management of workforce requirements.

Access to training has been impacted by delays in employment of an IMAC representative for Hawke's Bay DHB and the regional IMAC representative for the region to support and advise on vaccination workforce development. Despite this delay, we have confirmed the vaccination workforce is ready to support Tier 1 roll-out. It is important to acknowledge and thank the

- commitment from the public health nurses to complete online requirements prior to the 2 March vaccination delivery date. This has required additional training outside of work hours
- HBDHB Immunisation team who have completed over the last week vaccinator assessment at the Napier Health Centre to authorise vaccination certification for the Napier Health Centre nursing team

A workforce plan to support delivery for Tier 2 (frontline workers) and Tier 3 roll-out is in development. A priority is to ensure workforce models meet the needs for capacity and capability across the region.

MOH Tier 1 OPERATIONAL GUIDELINES
Guiding the delivery of HBDHB Tier 1 COVID-19 roll-out are the MOH Tier 1 operational guidelines. This document provides guidance to establish and manage a COVID-19 vaccination site, including guidelines for the vaccination workforce. This document is designed to assist District Health Boards (DHBs) and providers maintain public safety and ensure consistent and equitable COVID-19 vaccination practices are in place across New Zealand. It provides a comprehensive checklist to ensure we are prepared and meet requirements to support successful delivery. The guidelines have provided added assurance in newly created clinics and in supporting consistency for providers.

COMMUNICATION
- Tier 1 communication to border worker and whānau of border workers has been developed and distributed by the Ministry of Health recently to DHBs. This has been in response to DHBs requesting more targeted information to support requests from border workers and leaders about the Pfizer vaccine and the immunisation process. Additional communication requests and a communication plan for our rohe is now in development
- A Q&A session for border workers at the port is scheduled for 23 February. This will be filmed to support future use

MĀORI ENGAGEMENT

- Tuesday 16 February - Patrick Le Geyt, Ngaira Harker and JB Heperi-Smith held a hui with Ngāti Kahungunu Iwi Inc. (NKII) Board in relation to COVID readiness throughout the rohe of Ngāti Kahungunu. NKII board members were very receptive with working alongside the HBDHB COVID-19 Vaccination roll-out plan. For Ngāti Kahungunu, the COVID-19 vaccination roll-out is a significant time for Iwi and New Zealanders. NKII will provide the necessary support and manaakitanga to celebrate the first roll-out of the vaccine in the Hawke's Bay. The iwi support the tier approach for the vaccination roll-out with emphasis and focus on our whānau pounamu (vulnerable whānau) with Kaumātua being priority
- Thursday 18 February - JB Heperi-Smith, Andrea Jopling, Dr Nick Jones, Ngaira Harker and Fiona Jackson met with Hawke's Bay harbour leaders to discuss their respective roles in the COVID vaccination roll-out. Harbour leaders were appreciative, providing guidance within cultural context of their Māori and Pasifika workforce
- Friday 19 February - Patrick Le Geyt sent a communication email to all Māori providers in HBDHB region to inform of the COVID-19 Vaccination roll-out plan.
- Friday 19 February - Harbour Board co-lead David Pons and the Harbour Board Cultural Advisor Te Kaha Hawaikirangi to further support in planning for the Q&A meeting next Thursday 25 February. A general consensus that support for Māori and Pasifika would need to be culturally-led to ensure a positive outcome for vaccinations was agreed. Post this Q&A, a plan for the Iwi engagement for the port workers first vaccination day will be developed

NEXT STEPS

We will update the Board on any potential risks and/or delays in detail that may impact on our ability to deliver and support COVID-19 vaccination roll-out in Hawke's Bay.

RECOMMENDATIONS

That the Māori Relationship Board note the COVID-19 Vaccination and Immunisation roll-out progress report.

Appendix A: DHB 15 day roll-out plan

Below provides a 15 day view for rolling out the Pfizer vaccine to Phase 1a cohort: Border, MIQ / MIF workforce. It lists the DHB's where Border and MIQ facilitates are located, day in the cycle they will commence and approximate population numbers to be vaccinated over the period.

***Day 1**: Auckland, Counties Manukau, Waitemata; **Day 3:** Capital & Coast; **Day 5**: Canterbury; **Day 7**: Waikato, Lakes; **Day 9**: Remaining Tier 1a DHB's (9).*

This 15 day plan will see 9.6% of available vaccines utilised.

DHB	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	Day 15
Auckland	3 MIQ facilities, 1 Border – Port. 2,520 to be vaccinated														
Counties Manukau	2 MIQ facilities, 1 Border – Airport. 3,360 to be vaccinated														
Waitemata	2 Border – Ports. 160 to be vaccinated														
Capital & Coast			2 MIQ facilities, 1 Border – Port, 1 Border – Airport. 775 to be vaccinated												
Canterbury					6 MIQ facilities, 1 Border – Airport, 1 Border – Port. 2,090 to be vaccinated										
Waikato							1 MIQ facility, 1 Border – Port. 325 to be vaccinated								
Lakes							1 MIQ facility. 270 to be vaccinated								
Bay of Plenty									1 Border – Port. 455 to be vaccinated						
Hawkes Bay									1 Border – Port. 210 to be vaccinated						
Nelson Marlborough									3 Border – Ports. 360 to be vaccinated						
Northland									1 Border – Port. 140 to be vaccinated						
South Canterbury									1 Border – Port. 140 to be vaccinated						
Southern									2 Border – Ports. 335 to be vaccinated						
Tairawhiti									1 Border – Port. 100 to be vaccinated						
Taranaki									1 Border – Port. 100 to be vaccinated						

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 33, New Zealand Public Health and Disability Act 2000

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

20. Confirmation of previous minutes 2 February 2021 (Public Excluded)
21. Matters Arising – Review of Actions (Public Excluded)
22. Chair's Report (Public Excluded)
23. From the Chief Executive Officer (Public Excluded)
    - Hawke's Bay DHB Position Statement of Institutional Racism
    - ICU Training Accreditation – Interim Remediation Plan
24. Strategic Capital Projects Status Report (Public Excluded)
25. Draft Annual Plan 2021/22 (Public Excluded)
26. Strategic Planning and Budgeting over a Muli-year Timeframe – Options Paper (Public Excluded)
27. Integrated Clinical Workforce – Budget Setting 2021/22 (Public Excluded)
28. Finance, Risk and Audit Committee Meeting – 17 February 2021 (Public Excluded)
29. Board Approval of Actions Exceeding Limits Delegated by CEO (Public Excluded)
30. Hawke's Bay Clinical Council Report (Public Excluded)
31. Safety and Wellbeing Committee Minutes – 18 February 2021 (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).