BOARD MEETING

Date: Tuesday 22 March 2022

Time: 1.00pm

Venue: Zoom Meeting
(livestreamed for public meeting)

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

Apologies: Nil

In Attendance: Keriana Brooking, Chief Executive Officer
Members of the Executive Leadership Team

Minutes: Kathy Shanaghan

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	1.1 Karakia 1.2 Values Welcome and Apologies	1..00
2.	Interests Register	-
3.	Minutes of Previous Meeting held 22 February 2022	-
4.	Matters Arising – Review of Actions	-
	Section 2: Standing Management Reports	
5.	Chair's Report (verbal)	1.10
6.	Chief Executive Officer's Report	1.15
7.	Financial Performance Report – Andrew Boyd, Executive Director of Financial Services	1.20
	Section 3: Strategic Delivery	
8.	Te Ara Whakawaiora – Mental Health and Addictions – Chris Ash, Chief Operating Officer	1.25

	Section 4: Noting Reports	
9.	Hawke's Bay Health Consumer Council Report – Emma Foster, Executive Director of Planning, Funding and Performance	-
10.	**Section 5: Recommendation to Exclude the Public** Under Clause 33, New Zealand Public Health & Disability Act 2000	1.40

Public Excluded Agenda

Item	Section 6: Routine	Time (pm)
11.	Minutes of Previous Meeting held 22 February 2022 (public excluded)	1.45
12.	Matters Arising – Review of Actions (public excluded)	-
	Section 7: Standing Management Reports	
13.	Chair's Report – verbal (public excluded)	1.50
	Section 8: Other Governance Reports	
14.	Board Champions' Safety and Wellbeing Report - verbal (public excluded)	2.00
15.	Finance, Risk and Audit Committee Resolutions for Board Approval (public excluded) – Chair, Evan Davies	2.15
	Section 9: Noting Reports	
16.	Board Approval of Actions Exceeding Limits Delegated by CEO (public excluded) – Emma Foster, Executive Director of Planning, Funding & Performance	-
	Karakia Whakamutunga	2.30
	Meeting concludes	

The next HBDHB Board Meeting will be held on
Tuesday 26 April 2022 at 1.00pm

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.

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

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

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

ĀKINA IMPROVEMENT

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

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

RARANGA TE TIRA PARTNERSHIP

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

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

TAUWHIRO CARE

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

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

Board "Interest Register" - as at 15 December 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	23.11.20
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 Whararikí 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	Health Hawke's Bay	Employed with Health Hawke's Bay as General Manager Provider Networks	Discussed with HBDHB Chair to manage any potential conflict	The Chair	15.12.21
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 WEDNESDAY 22 FEBRUARY 2022
AT 1.10 PM
VIA ZOOM

(LIVESTREAMED – VIA FACEBOOK)

PUBLIC

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

Apologies: Kevin Atkinson
Joanne Edwards

Present: Keriana Brooking, Chief Executive Officer
Members of the Executive Leadership Team
Members of the Public and Media (via livestream)
Kathy Shanaghan, Executive Assistant to CEO

The Chair provided a mihimihi to Board, the staff and members of the public who were viewing the meeting via Facebook livestream.

He also acknowledged Anna Kirk, Executive Director Communications, who was attending her last Board hui as she leaving the organisation after 14 years. On behalf of the Board the Chair thanked Anna for her amazing mahi, support and commitment over a long period of time. Anna said she had enjoyed working with the DHB and had met some truly amazing people, not only staff but also patients, and she was leaving feeling she had contributed a lot and also gained a lot.

1. APOLOGIES
Apologies were received from Kevin Atkinson and Joanne Edwards.

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

3. CONFIRMATION OF PREVIOUS MINUTES
The minutes of the Board meeting held on 15 December 2021 were confirmed as a correct record of the meeting.

Moved: Peter Dunkerley
Seconded: Hayley Anderson
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES

Status updates for all actions were noted. The CEO advised that a survey of nurses was being undertaken and the information from the survey would be presented along with the refresh of the Nursing Strategy in April 2022.

STANDING MANAGEMENT REPORTS

5. CHAIR'S REPORT (VERBAL)

- 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
Fiona Field	Registered Nurse	Hospital Directorate	33	03/01/22
Jillian Harris	Care Associate	Whānau & Communities	24	05/12/21
Diann Paddick	Administrator	Hospital Directorate	13	17/12/21
Lynne Roberts	Registered Nurse	Whānau & Communities	31	26/01/22
Dr Tim Bevin	Medical Officer in Psychiatry	Mental Health Directorate	37	01/12/21
Di Mackie	Physiotherapist	Whānau & Communities	40	27/02/22
Dr Tim Frendin	Physician	Hospital Directorate	18	04/02/22

  Collectively the seven staff had provided nearly 200 years' service and the Chair thanked them for their dedication and years of service to the DHB and the community, including their whānau, and wished them well on their next journey.

- The Chair referred to the Health Reforms and advised that DHBs were working with Health New Zealand and Māori Health Authority to ensure there was a smooth transition on day one (1 July 2022).

With no further comments the Chair's report was noted.

6. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO noted the apologies of the Chief Operating Officer who was in Wairoa with the new Chief Nursing Officer working with Wairoa Hospital and the community around Heritage Lifecare's decision to close their hospital beds at Glengarry and supporting those people and their whānau, particularly those who would like to remain in Wairoa.

The CEO provided the following update in addition to her report:

- January was the first time where occupancy in the hospital was under 100 percent. Due to the reduced bed demand, oxygen upgrade in B2 was able to be undertaken.
- Planned care (elective delivery) was lower compared with the previous year, primarily due to locum availability.
- COVID-19 positive cases were increasing across the country including Hawke's Bay. Today the MoH announced 2846 new community cases across New Zealand and 143 in hospital. Hawke's Bay had 25 new cases today taking the total active cases up to 144. There were no cases in hospital in Hawke's Bay.
- The CEO advised there were sometimes discrepancy of numbers reported nationally and what was reported locally. HBDHB reported positive cases that were in Hawke's Bay isolating. For people who tested positive in Hawke's Bay and then returned to their home outside of Hawke's Bay, or who were from Hawke's Bay and isolating elsewhere, then those cases were not reported by HBDHB.

- This week Hawke's Bay had seen an increase in the number of people presenting for testing and the CEO acknowledged that people have experienced delays in getting their tests and also results. The move to Rapid Antigen Tests (RATs) would reduce the pressure on PCR testing and would also enable people to return to work if and when they were able.
- Hawke's Bay was tracking well for booster vaccinations, with just under 70 percent of the eligible population now having had their booster, however the number was less for Māori. For the 5-11 year olds, Hawke's Bay was sitting mid-range, however was in the bottom third for Māori 5-11 year olds so it was important for whānau to get their tamariki vaccinated.
- HBDHB was working with Councils around a "super moko day" for the weekend of 5-6 March to create an environment where whānau could bring their mokopuna / children to get vaccinated. These would be held in Napier, Hastings, Wairoa and Central Hawke's Bay. The CEO thanked all those whānau who had taken the time to get their children vaccinated.
- Lastly, the CEO said there was still a reasonable amount of 'business as usual' work occurring as well as the need to focus on the urgent and important work, including equity.

The Chair thanked the CEO for the mahi she was doing while maintaining business as usual.

Heather Skipworth provided feedback on her daughter's recent vaccination which she received via a drive-through. Heather said her daughter was very scared, so the vaccination was delayed until the following day when she was more at ease. Her daughter had a very good experience and Heather acknowledged the staff for the amazing work they were doing to support our community.

RECOMMENDATION

That the Board:

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

Adopted

7. FINANCIAL PERFORMANCE REPORT

This report was taken as read, noting this had been discussed at the Finance, Risk and Audit Committee (FRAC) meeting held earlier in the day. The Executive Director of Financial Services highlighted the following:

- Recruitment costs were slightly favourable year-to-date as there were a number of vacancies due to the challenges in recruiting staff
- There had been some continued supply chain disruption due to COVID which had resulted in some slippage in strategic projects

RECOMMENDATION

That the Board:

1. Note the contents of this report.

Adopted

STRATEGIC DELIVERY

8. TE ARA WHAKAWAIORA – CULTURALLY COMPETENT WORKFORCE

This report provided a progress update on the Cultural Responsiveness priorities, indicators and achievement of equity targets. In summary:

- The 2021/22 Māori workforce annual target had been set at 17.99 percent while at 31 December 2021 the actual was 16.93 percent, meaning a gap of 40 employees
- HBDHB staff who had completed Treaty on Line training (target 100 percent) had not been met (64.4 percent)
- HBDHB staff who had completed 'Engaging Effectively with Māori' Training (target 100 percent) had not been met (59.3 percent). Delivery of training had been severely impacted by COVID–19 becoming the number one priority when facilities and facilitators became unavailable
- COVID-19 had impacted on training metrics due to access and capacity issues.

Discussion occurred around the low number of staff who had completed the 'Engaging Effectively with Māori' training. The Executive Director of People and Culture said there had been a number of cancellations and the DHB was looking at doubling the number of sessions and also looking to offer the training via video online.

RECOMMENDATION

That the Board:

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

Adopted

OTHER GOVERNANCE REPORTS

9. COMMUNITY REPRESENTATIVES ON TE MATAU Ā MĀUI HEALTH TRUST

This report was taken as read.

RESOLUTION

That the Board:

1. **Reappoint** Trish Giddens to be a Trustee of Te Matau ā Māui Health Trust for a three-year term expiring March 2025.
2. **Appoint** Melissa Kaimoana to be a Trustee of Te Matau ā Māui Health Trust for a three-year term expiring March 2025.

Moved: Ana Apatu
Seconded: Heather Skipworth

Carried

NOTING REPORTS

10. HAWKE'S BAY CLINICAL COUNCIL – CHAIR'S REPORT

The Chief Medical & Dental Officer provided an overview of the matters discussed at the Hawke's Bay Clinical Council meeting on 2 February 2022.

There was a brief discussion around health pathways and whether these had a patient component. The Chief Medical and Dental Officer advised that the primary care module was a different tool to patient self-care, however it was noted that the Health Navigator website had a lot of information on self-care and self-management which people could refer to.

The Chair said the Board would be keen to receive an update on the Cardiac Business Case at some point.
Action

RECOMMENDATION
That the Board:

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

Adopted

11. HAWKE'S BAY HEALTH CONSUMER COUNCIL REPORT
This report was taken as read.

RECOMMENDATION
That the Board:

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

Adopted

12. PACIFIC POPULATION BOARD - CHAIR'S REPORT
This report was taken as read. The Acting Executive Director of Health Improvement and Equity referred to the two new appointees to the Pacific Population Board (PPB) which would bring a youth influence to the committee. He also acknowledged the work the Pacific Health team was doing under the leadership of Talalelei Taufale, Pacific Health Manager, which had grown to 12 staff.

The Chair acknowledged the work the Pacific Health team was doing including the committee's change of name which gave it the profile and mana it deserved.

RECOMMENDATION
That the HBDHB Board:

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

Adopted

13. RECOMMENDATION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board:

Exclude the public from the following items:

14. Confirmation of Previous Minutes (Public Excluded)
15. Matters Arising – Review of Actions (Public Excluded)
16. Governance Workplan (Public Excluded)
17. Chair's Report (Public Excluded)
18. Finance, Risk and Audit Committee Resolutions for Board Approval (Public Excluded)
19. Board Approval of Actions Exceeding Limits Delegated by CEO (Public Excluded)
20. Safety and Wellbeing Committee Report (Public Excluded)

Moved: **Shayne Walker**
Seconded: **Peter Dunkerley**

Carried

The Chair thanked members of the public for viewing the meeting via Facebook. He also thanked all health workers, both in the hospital and in the community, for the work they were doing and said it was amazing to see all the collaborative work being undertaken with organisations such as Ministry of Social Development and Ministry of Education.

The public section of the Board meeting concluded at 1.55pm

Signed: _____
Chair

Date: _____

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BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	22/2/22	**Cardiac Business Case** Board to receive an update	Chief Medical & Dental Officer	TBC	Update included in Cardiology paper March FRAC meeting

5

CHAIR'S REPORT

Verbal

6

HAWKE'S BAY District Health Board Whakawāteatia	**March 2022 DHB CEO BOARD GOVERNANCE REPORT**
	For the attention of: **HBDHB Board**
Document Author(s)	Keriana Brooking
Date	16 March 2022
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 penultimate version of the revised Equity Plan is now live.
Principles of the Treaty of Waitangi that this report addresses	Post Finance Risk and Audit Committee (FRAC) meeting feedback, a process has been established by the Executive Leadership Team (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	Hawke's Bay 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.
Financial/Legal Impact	Nothing for noting.
Stakeholder Consultation and Impact	I have had the following interactions in this period: • Welcomed the 2022 Resident Medical Officers • Attended the Hawke's Bay Regional Leadership Group weekly meetings • Attended the Medical Leaders, Head of Department and Medical Directors monthly meeting • Attended the COVID Vaccine DHB CE leads and MoH weekly meetings • Met with Chris Collins and toured the EIT campus, Napier • Attended the Central Region CEs meeting • Attended the Local and National Bipartite Advisory Group meetings • Attended the local Allied Health Professions Advisory Group meeting • Attended the regional Public Sector's Leadership updates • Undertook various media interviews as the All of DHBs CEO lead for Allied Health
Strategic Impact	None to note
Previous Consideration / Interdependent Papers	None to note
RECOMMENDATION: *It is recommended that the Board:* 1. *Note and acknowledge this report.*	

HOSPITAL SERVICES UPDATE

Unplanned Care

The hospital remained busy during February, with an average resourced bed occupancy at 8am just over 100 percent (101.3%), up slightly on the January 2022 average of 99.5 percent. Whilst emergency department (ED) attendances over the same period were relatively unchanged from the previous month, performance against the six-hour standard dipped slightly to 74.4 percent(compared to 76.7 percent previous month) largely due to COVID screening upon presentation and flow-on effects to the waiting room.

Planned Care

As expected, onsite elective productivity and delivery performance increased in February compared with January. Should Inter-District and outsourced activity flow through as anticipated for the month, total discharges are expected to end higher month-on-month compared with 2021.

- A net total of 1,835 referrals were received in February. This was 191 more than January, as expected due to the holiday period. In total, 1,580 patients were provided with First Specialist Assessments in February – this is 396 more patients than January.
- The number of patients overdue against the ESPI2 measure increased by 78 patients in February. The proportion waiting four months or more for their appointment sits at 36.5 percent, up slightly from 34.2 percent in January.

In respect of elective surgery, HBDHB delivered 81.0 percent of the overall Ministry of Health production planning discharge target in February (a total of 493 discharges vs 609 plan in January). However, not all discharges have been recorded and final performance is expected to be higher once discharges have been registered.

*Discharge summaries provided below provide an incomplete performance picture for Inter District Flows due to reporting processes and MoH data being relevant to the 20th of month following. Complete results will be able to be shared in full next month.

- Inter District Flow ('IDF') activity is currently sitting at 27 discharges in February. In comparison, January's IDF activity was below plan at 34 discharges.
- On-site activity reporting is sitting just under plan this month, with the 413 discharges in February representing 92.8 percent of plan. The variance is largely due to more onsite theatre capacity designated to our equity priority of dental, which is not captured within the planned care target.
- Outsourced activity data is tracking below plan with 53 discharges registered into the system. The target is 95.
- Overall, the waiting list for surgery reduced in February by 56 to 2,296. Of these, 42.5 percent of patients have now waited more than the ESPI5 measure of four months. This equates to 18 fewer patients compared with January.

A total of 86.4 percent of plan has been delivered as at the end of February (4,330 discharges vs 5,009 plan), and 79.7 percent by case weight. Forecast year-to-date is expected to be around 88 percent for discharges and 90 percent for case weight. The main challenge continues to be availability of human resource, coupled with COVID-19 preparedness activity such as B2 oxygen upgrade works and mobilising Ruakopito Ward into a dedicated COVID ward.

COVID UPDATE

As expected, community transmission of COVID-19 continues to rise across our rohe. Within the past week we have seen notified cases jump significantly. Based on our most recent modelling, we are anticipating Hawke's Bay to reach a peak in early April.

As at Tuesday 15 March 2022, there were 6860 active cases in Hawke's Bay. Of those, 1,111 were new cases including 640 in Hastings, 326 in Napier, 82 in Central Hawke's Bay and 59 in Wairoa. Total cases for the outbreak so far are 9,069.

While it is an uncertain time for many, it is important to remind ourselves that our health and welfare system has been preparing for this COVID-19 resurgence for quite some time.

Within our own DHB setting there has been a significant flex-up to our hospital COVID response model with the mobilising of Ruakopito in early March as our first COVID ward and the reassigning of Waioha as our dedicated maternity unit for COVID positive māmā. Ata Rangi is dedicated to COVID negative patients and can also support water births. Our paediatric and mental health inpatient teams also have COVID care models in place that are working well.

The COVID Directorate has also faced and overcome logistical challenges with the rollout of Rapid Antigen Tests (RATs) to community collection sites, while vaccinating teams continue the mahi to encourage vaccine uptake.

As at 15 March, vaccination rates are:

- 97 percent of the eligible population has had 1 dose
- 95 percent of the eligible population has had 2 doses
- 73 percent of the eligible population (18+) has had a booster

In terms of workforce, our focus has now firmly turned to the next phase of our preparedness model which is mobilising both clinical and non-clinical staff into redeployment roles where the need is, both within the hospital, primary care and welfare settings.

I am heartened by the unity and leadership across our rohe to help ensure communities not only stay well informed, but are preparing for COVID. I would also like to acknowledge our general practice colleagues and welfare locality hub providers for their continued support to those isolating in need.

7

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report** For the attention of: **HBDHB Board**
Document Owner	Andrew Boyd, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Date	March 2022
Purpose	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	None identified
Strategic Impact	Achieving a sustainable underlying financial position will support the DHB to achieve its strategic objectives
Previous Consideration / Interdependent Papers	Interdependency with papers on the Strategic Planning and Budgeting over a multiyear timeframe

RECOMMENDATION

It is recommended that the Finance Risk and Audit Committee:

1. **Note** the contents of this report
2. **Endorse** the draw down of funding offered by the Ministry of Health (MoH) of $2.550m from the Capability Uplift Portfolio (refer appendix 1)

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

The operating result is $2.4m favourable year-to-date. Vacancies and reduced clinical supply costs exacerbated by COVID-19, and lower than projected IDF and residential care costs, mostly offset by challenges identifying efficiencies, underpin the result. Vacancies drive the February month result.

The surplus/(deficit), including COVID-19 and Holidays Act, is $7.5m favourable year-to-date and $1.5m favourable for the month of February. The result includes COVID income relating to costs incurred in prior years, and additional project costs relating to Holidays Act remediation.

Forecast

The forecast deficit for the year is $33.5m, $5.5m adverse to plan. This is a $1.2m improvement on last month driven mainly by vacancies. The variance from plan comprises:

- Revenue $0.8m favourable including higher revenue from other DHBs and other income, partly offset by lower revenue from MOH and IDFs.
- Providing Health Services $4.0m favourable mainly due to challenges filling vacancies and new positions together with lower clinical supplies due to capacity constraints and lower level of elective activity.
- Funding other providers $0.3m adverse mainly pharmacy services, primary care expenditure funded by additional MOH income, and crisis respite in mental health, partly offset by underspends residential care and home support for older persons, and Whānau Ora services.
- Corporate on budget as unbudgeted capital charges relating to the $25m equity injection in June 2021, were offset by lower depreciation (capital expenditure slippage), financing and staff travel costs.
- Reserves $13m adverse reflecting unidentified savings, and provisioning for MECA settlements.
- COVID $3.9m favourable due to MOH funding prior year expenditure, partly offset by additional staff costs.
- Holiday's Act remediation $0.8m adverse due to higher project costs.

Not included in the forecast are a number of items that are likely to improve the end of year result:

- Funding received in December 2021 for the nurse equity settlement, that will not be attributed to the 2021/22 year. This is the difference between equity payments that will be made over both 2020/21 and 2021/22, and the provision for 2020/21 settlement costs.
- Release of further investment reserves; and
- PHARMAC COVID funding that is unlikely to be spent.

	February				*Year to Date*				*Year End*	
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*	Refer Appendix
Operating Revenue	61,125	60,576	549	0.9%	479,897	474,695	5,202	1.1%	714,239	1
Less:										
Providing Health Services	26,973	28,732	1,759	6.1%	232,194	237,478	5,284	2.2%	358,120	2
Funding Other Providers	25,493	25,834	341	1.3%	205,374	203,399	(1,975)	-1.0%	306,957	3
Corporate Services	5,533	5,548	15	0.3%	43,987	44,025	39	0.1%	67,714	4
Reserves	1,953	640	(1,313)	-205.2%	7,732	1,581	(6,151)	-389.2%	15,122	5
Operating Result	**1,171**	**(179)**	1,350	755.3%	**(9,390)**	**(11,789)**	2,399	20.4%	**(33,674)**	
Plus:										
Emergency Response (COVID-19)	120	-	120	0.0%	5,832	-	5,832	0.0%	3,927	
Holidays Act Remediation	(250)	(231)	(19)	-8.2%	(2,701)	(1,964)	(737)	-37.5%	(3,763)	
	1,042	**(410)**	1,451	354.2%	**(6,258)**	**(13,753)**	7,494	54.5%	**(33,510)**	

7

Other Performance Measures

	February				Year to Date				Year End Forecast	Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Capital spend	3,714	3,338	375	11.2%	16,361	27,123	(10,761)	-39.7%	31,378	12
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,786	2,889	102	3.5%	2,767	2,845	79	2.8%	2,890	2 & 4

- Capital spend (Appendix 10)

  Capital spend to February is at 59% of plan (last month 52%). This is caused by slippage in strategic projects, and delivery issues relating to COVID in the facilities and clinical equipment blocks.

- Cash (Appendices 9 & 11)

  The cash low point for the month was $9.6m overdrawn on 3 February (the previous month was $3.7m overdrawn on 31 January).

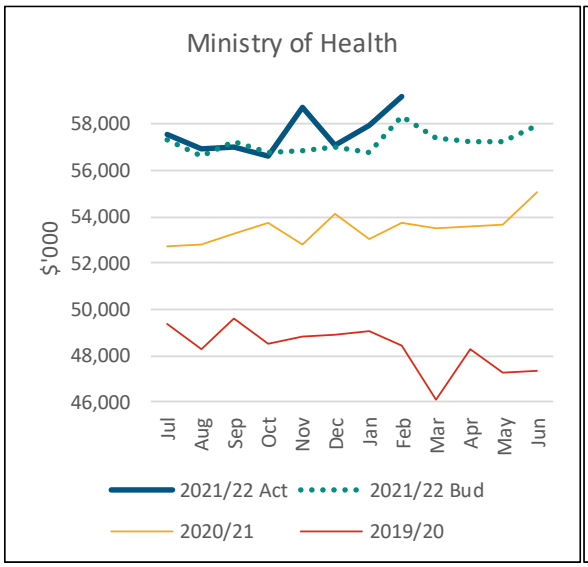
- Employees (Appendices 2 & 4)

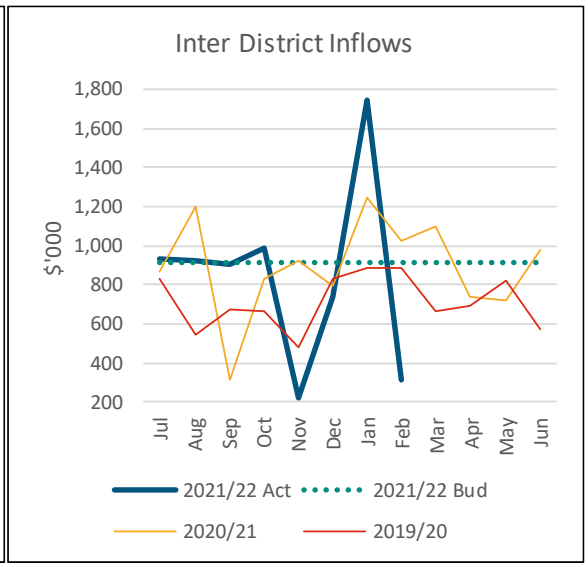
  The lower than planned employee FTE numbers reflect the continuing challenges recruiting to vacant and new positions.

APPENDICES

1. OPERATING REVENUE

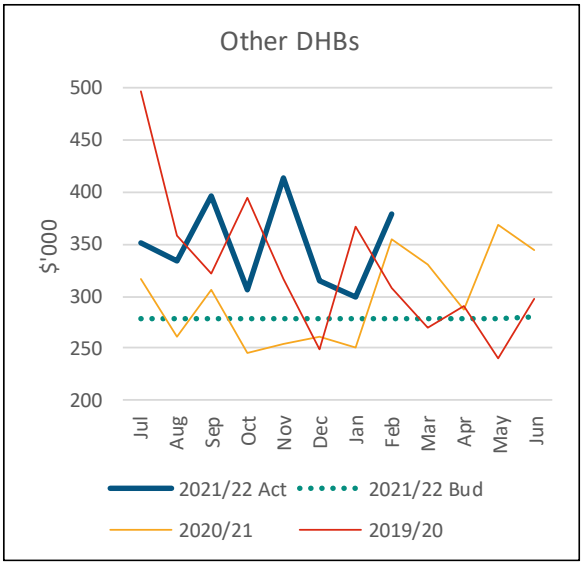
Excludes revenue for COVID-19	February				Year to Date				Year End
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*
Ministry of Health	59,208	58,343	865	1.5%	461,162	457,053	4,109	0.9%	686,701
Inter District Flows	311	913	(602)	-65.9%	6,764	7,308	(544)	-7.4%	10,418
Other District Health Boards	379	278	100	36.0%	2,795	2,228	568	25.5%	4,064
Financing	17	4	13	354.6%	143	29	114	390.5%	169
ACC	507	489	18	3.7%	3,824	3,738	86	2.3%	5,636
Other Government	32	35	(3)	-9.8%	333	297	36	12.1%	454
Abnormals	-	-	-	0.0%	5	-	5	0.0%	5
Patient and Consumer Sourced	158	121	38	31.1%	920	967	(47)	-4.8%	1,304
Other Income	513	392	120	30.7%	3,952	3,076	876	28.5%	5,488
	61,125	**60,576**	**549**	**0.9%**	**479,897**	**474,695**	**5,202**	**1.1%**	**714,239**

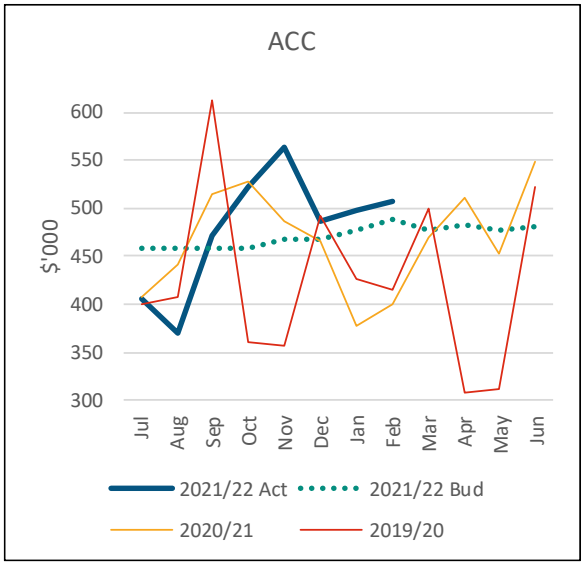




Ministry of Health (\$4.1m favourable YTD)
Additional sustainability funding relating mainly to MECA settlements, and funding for new services.

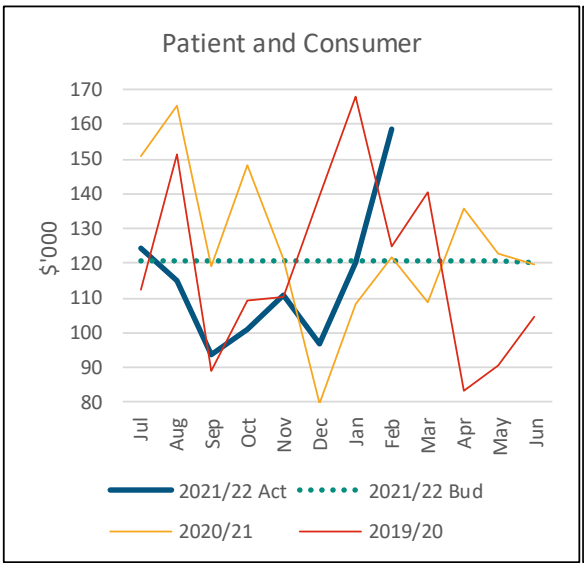
Inter District Flows (\$0.5m adverse YTD)
Inter District Flows are inherently volatile due to the small volume and high cost. Provisioning in January is now considered too high, and has been adjusted in February.

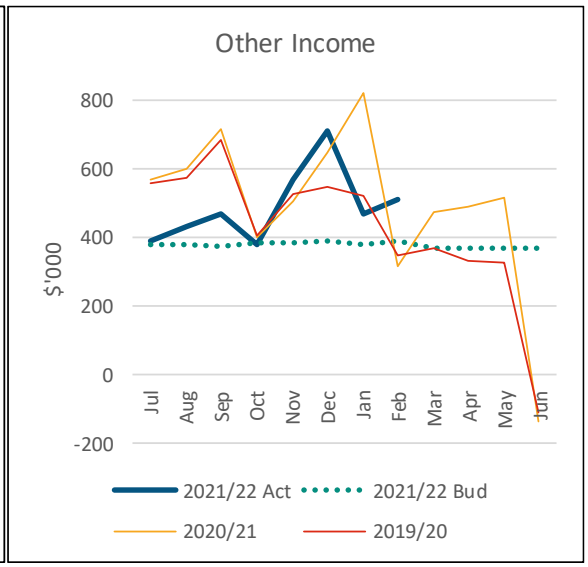




Other District Health Boards ($0.6m favourable YTD)
Mid Central DHB for oncology clinics, Capital & Coast Health for neurosurgery clinics, Tairawhiti DHB for pharmaceutical cancer treatments (PCTs), and a number of DHBs for patient transport reimbursements.

ACC ($0.1m favourable YTD)
Favourable surgical and oncology income offset by adverse rehabilitation income. The latter is caused by capacity constraints in AT&R caused by bed challenges in the community that can take patients, and the work to establish isolation beds in B2, that moved B2 patients into AT&R.



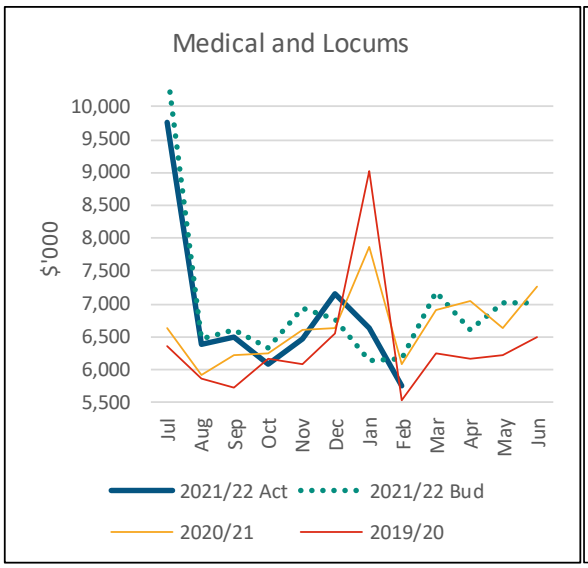


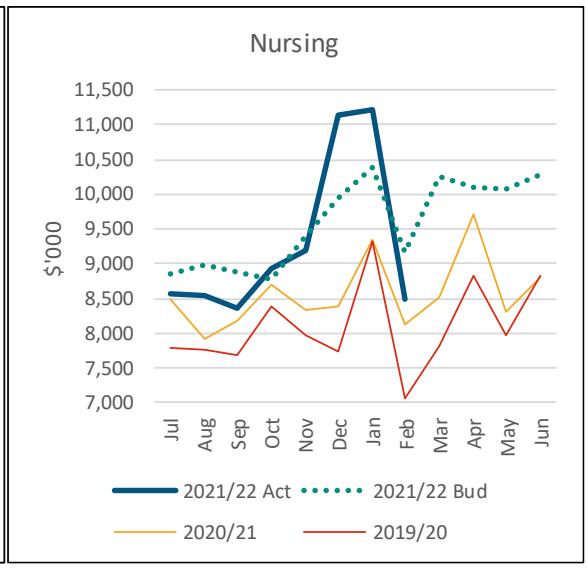
Patient and Consumer (close to budget YTD)
Reduced audiology co-payments, partly offset by increased non-resident charges.

Other income ($0.9m favourable YTD)
Donations and clinical trial income, provision of COVID tests to primary providers, MSD cadetship revenue and reimbursement for staff involved in the NZ Medical Assistance Team deployment to Fiji for the COVID response, partly offset by reduced traffic through Zacs.

2. PROVIDING HEALTH SERVICES

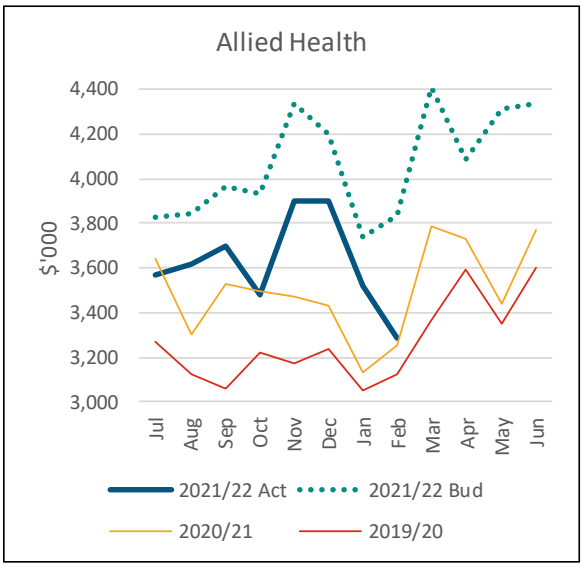
	February				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,758	6,165	407	6.6%	54,753	55,936	1,182	2.1%	83,337
Nursing personnel	8,488	9,172	684	7.5%	74,455	74,401	(54)	-0.1%	115,239
Allied health personnel	3,283	3,833	550	14.4%	28,959	31,674	2,715	8.6%	45,685
Other personnel	2,339	2,468	129	5.2%	19,445	20,059	614	3.1%	30,261
Outsourced services	1,798	1,422	(375)	-26.4%	10,324	10,328	4	0.0%	16,183
Clinical supplies	3,604	4,158	555	13.3%	31,767	32,983	1,216	3.7%	48,469
Infrastructure and non clinical	1,705	1,514	(191)	-12.6%	12,491	12,098	(393)	-3.2%	18,945
	26,973	**28,732**	1,759	6.1%	**232,194**	**237,478**	**5,284**	**2.2%**	**358,120**
Expenditure by directorate $'000									
Hospital	15,757	16,265	507	3.1%	133,843	135,537	1,694	1.2%	205,875
Whanau and Communities	5,694	6,213	519	8.4%	50,587	51,670	1,083	2.1%	77,991
Mental Health and Addictions	1,921	2,108	186	8.8%	17,475	18,115	641	3.5%	27,282
Support	2,392	2,399	7	0.3%	20,622	20,261	(361)	-1.8%	31,504
Other	1,209	1,748	539	30.8%	9,667	11,894	2,227	18.7%	15,467
	26,973	**28,732**	1,759	6.1%	**232,194**	**237,478**	**5,284**	**2.2%**	**358,120**
Full Time Equivalents									
Medical personnel	386.1	419.5	33	8.0%	409	423	14	3.3%	429.9
Nursing personnel	1,216.5	1,184.4	(32)	-2.7%	1,178	1,173	(5)	-0.4%	1,186.5
Allied health personnel	529.9	597.0	67	11.2%	528	581	53	9.1%	591.5
Support personnel	134.6	130.7	(4)	-3.0%	133	128	(5)	-4.2%	130.5
Management and administration	300.6	323.8	23	7.2%	295	309	13	4.3%	316.0
	2,567.7	**2,655.5**	**88**	**3.3%**	**2,543**	**2,613**	**70**	**2.7%**	**2,654.3**

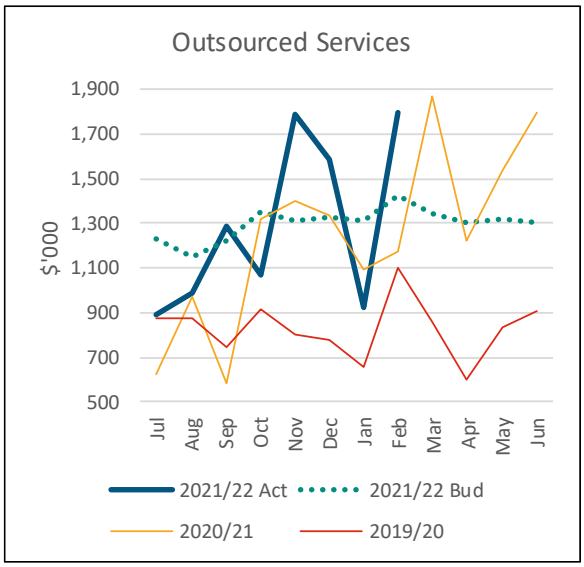




Medical personnel and locums ($1.2m favourable YTD)
Vacancies and low use of continuing medical education leave (CME) reflecting COVID-19 restrictions - partly offset by locum cover. The high budget in July, and the low budget in January in comparison to prior years, reflects the change in entitlement date for CME from 1 January to 1 July of each year.

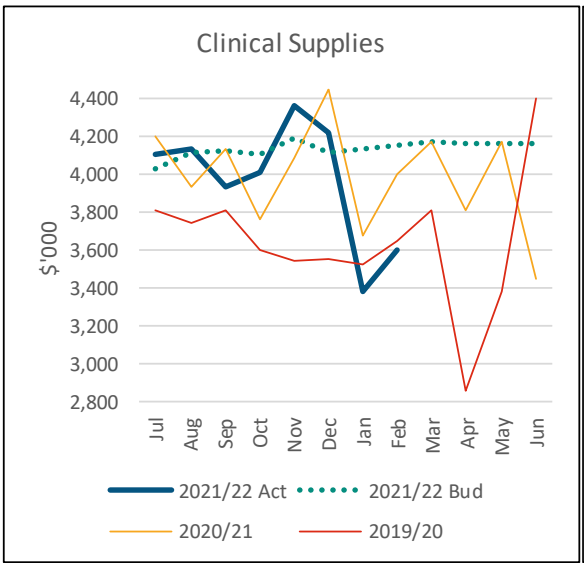
Nursing ($0.1m adverse YTD)
Close to budget.

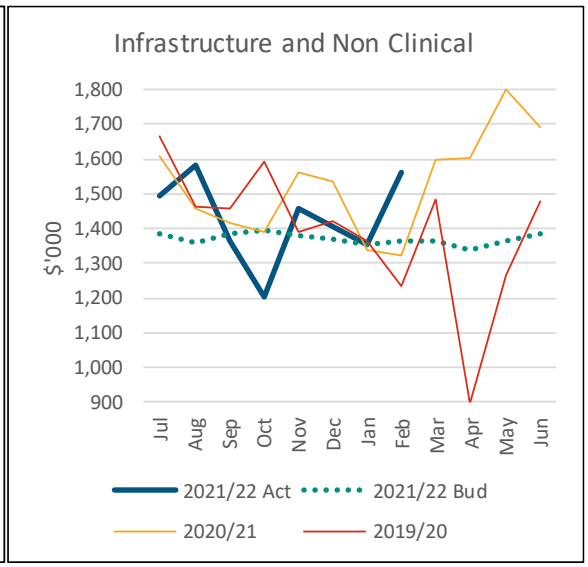




Allied Health (\$2.7m favourable YTD)
On-going vacancies in social workers, therapists, psychologists, community support workers, medical imaging technologists, pharmacists, technicians, and health promotion workers.

Outsourced services (close to budget YTD)
High elective surgery volumes through Royston were more than offset by low elective clinical procedures at other providers, lower radiology scans and lithotripsy procedures.

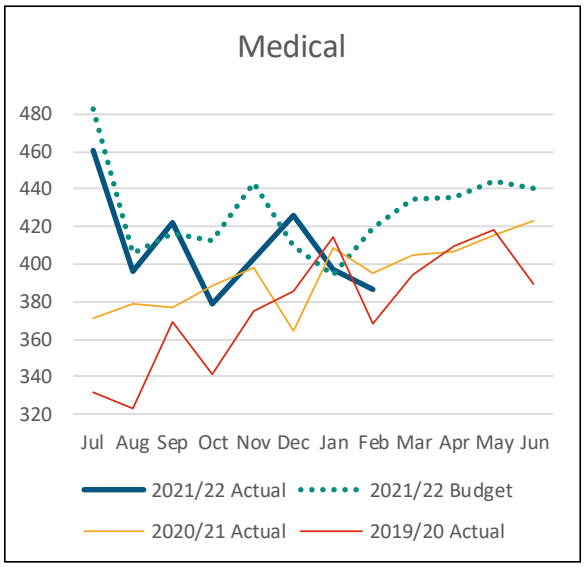


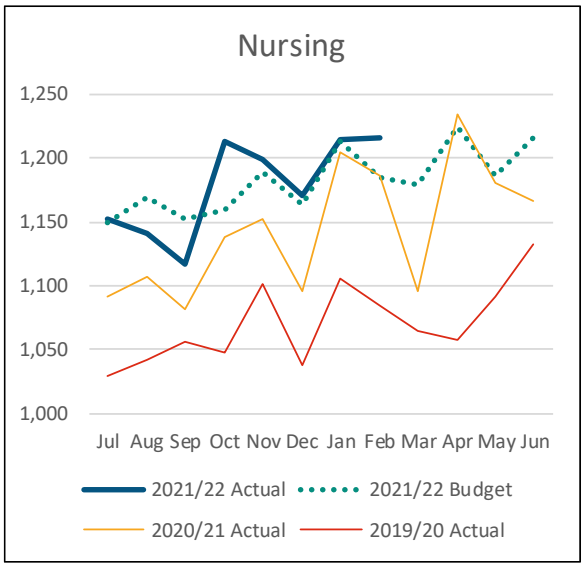


Clinical supplies (\$1.2m favourable YTD)
Lower costs for implants and prostheses (lower elective volumes). Higher costs for patient transport (increased flights), are offset by lower costs for blood intragam, pharmaceuticals and health promotion.

Infrastructure and non-clinical supplies (\$0.4m adverse YTD)
Security and cleaning partly offset in staff travel costs.

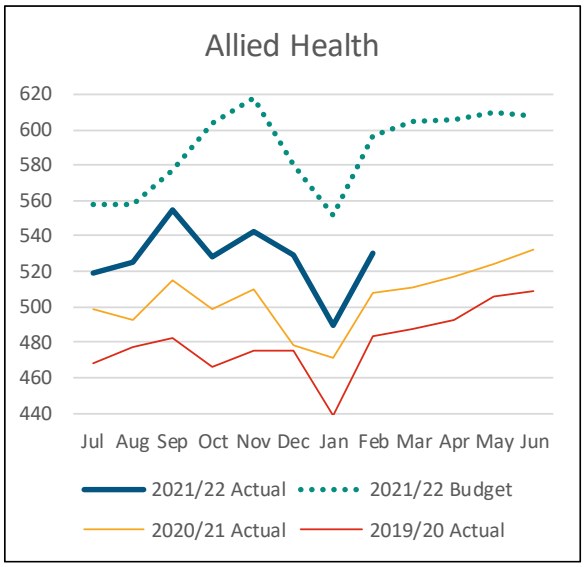
Full Time Equivalents (FTE)

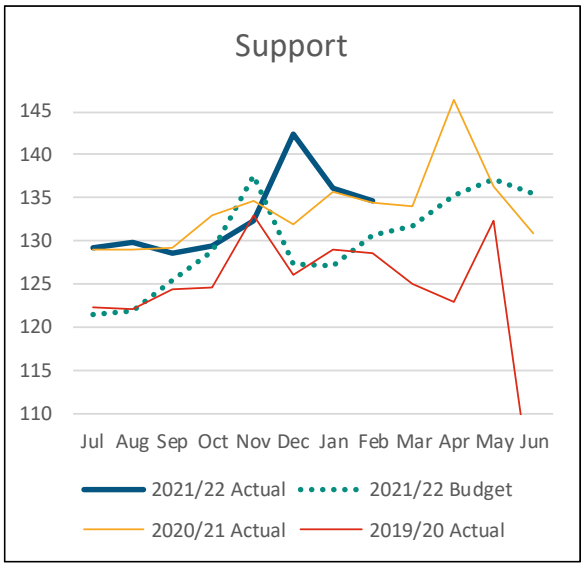




Medical personnel (14 FTE / 3.3% favourable)
Recruitment challenges and long lead times to onboard medical staff, marginally offset by higher leave costs. High costs in July relate to entitlements for continuing medical education leave.

Nursing personnel (-5 FTE / -0.4% adverse)
Vacancies more than offset by additional leave and overtime costs.



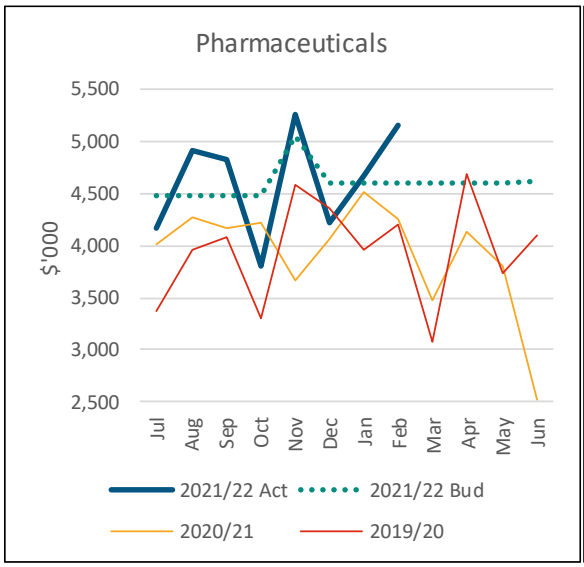


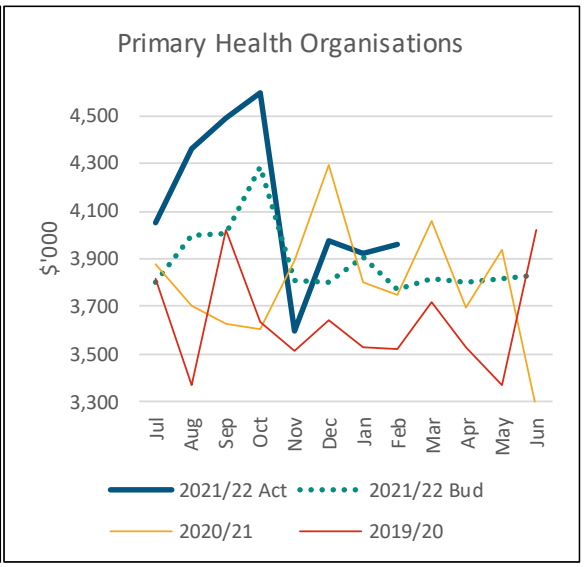
Allied health personnel (53 FTE / 9.1% favourable)
Ongoing challenges filling vacancies including therapists, social workers, community support workers, pharmacists, technicians, psychologists, and health promotion staff.

Support personnel (-5 FTE / -4.2% adverse)
Kitchen assistants, orderlies, and additional security driven by patient activity and dependency. Partly offset by sterile supply vacancies.

3. FUNDING OTHER PROVIDERS

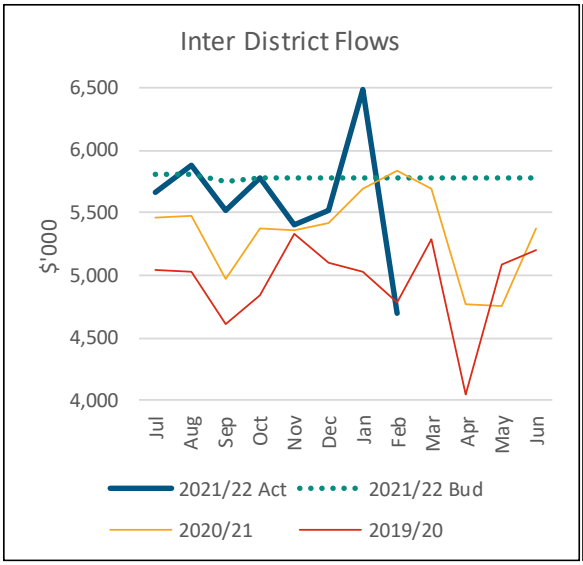
$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	5,159	4,595	(565)	-12.3%	37,015	36,757	(258)	-0.7%	55,431
Primary Health Organisations	3,958	3,771	(187)	-5.0%	32,956	31,392	(1,564)	-5.0%	48,217
Inter District Flows	4,702	5,781	1,079	18.7%	44,981	46,271	1,289	2.8%	68,106
Other Personal Health	2,801	2,644	(157)	-5.9%	20,813	18,957	(1,855)	-9.8%	31,332
Mental Health	1,207	1,479	273	18.4%	11,953	11,584	(368)	-3.2%	17,832
Health of Older People	6,917	6,863	(54)	-0.8%	53,820	54,918	1,098	2.0%	80,662
Other Funding Payments	749	701	(48)	-6.9%	3,836	3,519	(317)	-9.0%	5,377
	25,493	25,834	341	1.3%	205,374	203,399	(1,975)	-1.0%	306,957
Payments by Portfolio									
Strategic Services									
Secondary Care	3,626	4,793	1,167	24.3%	42,234	43,306	1,072	2.5%	64,251
Primary Care	10,976	10,204	(772)	-7.6%	83,238	79,815	(3,423)	-4.3%	123,716
Mental Health	1,874	1,810	(64)	-3.5%	14,727	14,230	(497)	-3.5%	21,929
Health of Older People	7,971	7,973	2	0.0%	59,256	60,086	830	1.4%	88,417
Maori Health	950	957	6	0.7%	5,136	5,149	13	0.3%	7,475
Population Health	96	98	2	2.0%	784	814	30	3.7%	1,170
	25,493	25,834	341	1.3%	205,374	203,399	(1,975)	-1.0%	306,957

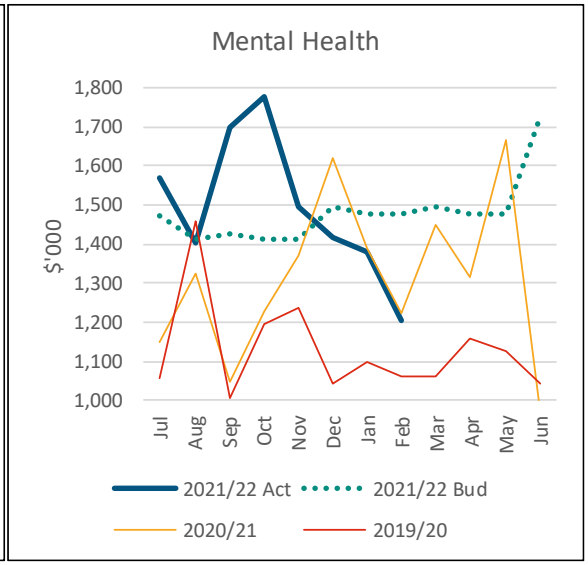




Pharmaceuticals ($0.3m adverse YTD)
Based on latest available PHARMAC forecasts and community and hospital pharmacy activity. Similar volatility to previous years.

Primary Health Organisations ($1.6m adverse YTD)
Services for under 13s, services to community services card holders, PHO performance payments, low cost access, first contact services, and discharge pathway funding.

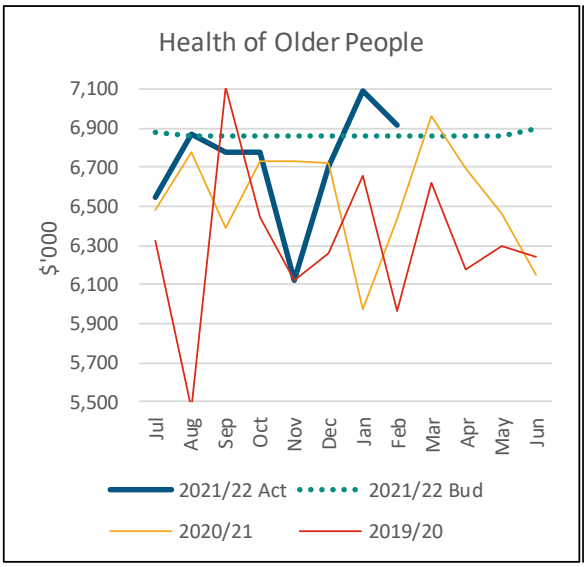


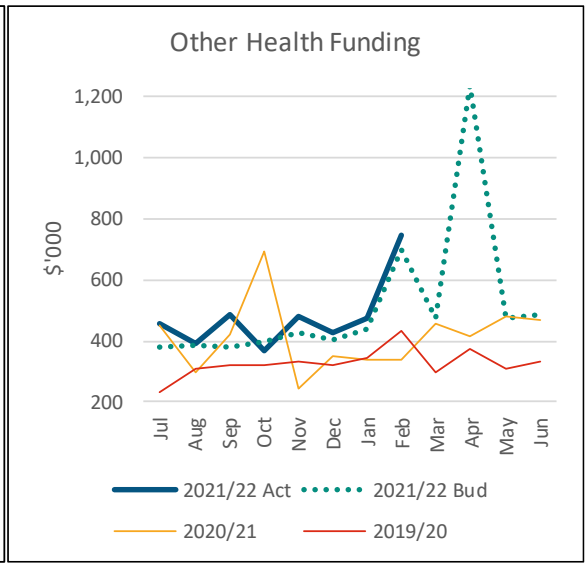


Inter District Flows ($1.3m favourable YTD)
Inter District Flows are inherently volatile due to the small volume and high cost. Provisioning in January is now considered to be too high, and has been adjusted in February.

Other Personal Health ($1.9m adverse YTD)
Mainly additional professional pharmacy advisory services. Also includes payments to the PHO for chronic conditions, and specialist behaviour support services.

Mental Health ($0.4m adverse YTD)
Mainly additional expenditure funded by more MOH revenue under operating revenue above. The peak in October relates to catch-up provisioning for packages of care, and the reduction since relates to reassessment of that provisioning.





Health of Older People ($1.1m favourable YTD)
Capacity constraints including staffing issues. November includes a reassessment of provisioning for outstanding costs between July and November, and January includes high levels of residential care.

Other Funding Payments ($0.3m adverse YTD)
Higher than planned Whānau Ora and public health infrastructure costs every second month. The budget was adjusted in January to reflect the transfer of funding from reserves for the implementation of He Oranga Motuhake including set-up funding in April.

4. CORPORATE SERVICES

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,622	1,770	148	8.4%	14,283	15,035	752	5.0%	22,607
Outsourced services	56	158	102	64.6%	464	563	99	17.6%	687
Clinical supplies	243	132	(111)	-84.4%	1,267	1,037	(230)	-22.2%	1,862
Infrastructure and non clinical	1,819	1,747	(72)	-4.1%	13,068	12,979	(89)	-0.7%	19,699
	3,740	3,807	67	1.8%	29,082	29,615	533	1.8%	44,855
Capital servicing									
Depreciation and amortisation	1,301	1,387	86	6.2%	11,035	11,578	543	4.7%	16,905
Financing	2	21	19	90.1%	9	166	157	94.5%	71
Capital charge	490	333	(157)	-47.0%	3,860	2,667	(1,194)	-44.8%	5,882
	1,793	1,741	(52)	-3.0%	14,905	14,410	(494)	-3.4%	22,859
	5,533	**5,548**	**15**	**0.3%**	**43,987**	**44,025**	**39**	**0.1%**	**67,714**
Full Time Equivalents									
Medical personnel	0.9	0.8	(0)	-17.9%	1	1	(0)	-0.7%	0.8
Nursing personnel	7.0	6.2	(1)	-14.4%	7	5	(2)	-28.1%	5.7
Allied health personnel	2.5	1.6	(1)	-55.0%	1	2	0	14.8%	1.6
Support personnel	28.2	30.2	2	6.6%	27	30	3	10.6%	30.6
Management and administration	180.2	194.7	15	7.5%	187	194	7	3.6%	197.3
	218.8	**233.4**	15	6.3%	**223**	**232**	**9**	**3.8%**	**236.0**

Low recruitment costs due to challenges recruiting staff DHB wide, and vacancies in corporate services drive favourable personnel costs. Lower than planned depreciation and amortisation expenditure reflects the lower than planned capital spend year-to-date.

The capital charge budget does not allow for the $25m equity injection for deficit support received in June 2021, after the budget was set.

5. RESERVES

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Investment reserves	641	641	0	0.0%	3,139	7,877	4,738	60.2%	7,833
Efficiencies	-	(922)	(922)	-100.0%	-	(6,785)	(6,785)	-100.0%	-
Other	1,313	921	(392)	-42.5%	4,593	488	(4,105)	-841.2%	7,289
	1,953	**640**	(1,313)	-205.2%	**7,732**	**1,581**	**(6,151)**	-389.2%	**15,122**

Investment reserves include reserves for funding envelope growth, equity, pay equity, and a number of small reserves for specific purposes. As plans for the use of the reserves are finalised, the budgets are being moved to the appropriate areas. A large proportion of reserves are expected to be used for ongoing investments, meaning any underexpenditure earlier in the year will not be spent, and can be used to offset the shortfall in efficiencies year-to-date.

Efficiencies will be imbedded into budgets as the savings plans are identified.

Other includes additional salary costs based on settlements to date, including nurses pay equity payments, and additional sabbatical costs to correct miscalculations in historical payments. Also includes transfer of additional budget for pharmaceutical costs.

6. FINANCIAL POSITION

30 June 2021	$'000	February Actual	February Budget	Variance from budget	Movement from 30 June 2021	Annual Budget
	Equity					
253,745	Crown equity and reserves	265,705	271,284	(5,579)	11,960	278,467
(135,621)	Accumulated deficit	(141,879)	(144,907)	3,028	(6,258)	(159,199)
118,124		123,826	126,377	(2,551)	5,701	119,268
	Represented by:					
	Current Assets					
574	Bank	2,651	4	2,647	2,077	4
1,451	Bank deposits > 90 days	1,460	2,055	(595)	9	2,055
22,480	Prepayments and receivables	38,543	19,936	18,607	16,063	20,048
4,975	Inventory	5,447	4,551	896	473	4,569
29,480		48,101	26,547	21,554	18,621	26,675
	Non Current Assets					
208,941	Property, plant and equipment	213,568	223,942	(10,374)	4,627	230,151
16,514	Intangible assets	17,154	13,614	3,540	640	13,238
1,673	Investments	1,350	1,341	8	(324)	1,341
227,128		232,072	238,897	(6,826)	4,943	244,731
256,608	**Total Assets**	**280,173**	**265,444**	**14,729**	**23,565**	**271,406**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	14,214	14,214	-	26,762
40,876	Payables	50,503	32,264	(18,239)	(9,627)	32,451
94,519	Employee entitlements	102,754	89,300	(13,454)	(8,236)	86,636
-	Current portion of borrowings	-	-	-	-	3,000
135,395		153,258	135,778	(17,480)	(17,863)	148,849
	Non Current Liabilities					
3,089	Employee entitlements	3,089	3,289	200	-	3,289
3,089		3,089	3,289	200	-	3,289
138,484	**Total Liabilities**	**156,347**	**139,067**	**(17,280)**	**(17,863)**	**152,138**
118,124	**Net Assets**	**123,826**	**126,377**	**(2,551)**	**5,701**	**119,268**

Variances from budget:

Lower than budgeted capital expenditure year-to-date has lowered both the bank overdraft and noncurrent assets in comparison to budget.

Prepayments and receivables include MoH billings of $17.6m, $12.9m for December and January non-devolved revenue now overdue, and $2.3m for equity injections, with the remainder current non-devolved revenue.

Payables include the receipt of $9.9m from MoH for nurse pay equity funding in December, that is being treated as income in advance, pending further information to determine when it will be recognised as revenue. Capital project accruals amount to $3.9m, and accruals for unbilled older persons and mental health residential care make up most of the remaining variance.

The other YTD variances from budget relate to variability in working capital (current assets – current liabilities) and are expected to be short term.

7. EMPLOYEE ENTITLEMENTS

30 June 2021	$'000	February Actual	February Budget	Variance from budget	Movement from 30 June 2021	Annual Budget
17,532	Salaries & wages accrued	17,610	15,801	(1,809)	(78)	13,825
1,160	ACC levy provisions	1,774	95	(1,679)	(614)	190
6,727	Continuing medical education	9,049	3,343	(5,706)	(2,322)	1,743
67,169	Accrued leave	72,392	68,143	(4,250)	(5,223)	68,945
5,019	Long service leave & retirement grat.	5,018	5,208	189	1	5,222
97,608	**Total Employee Entitlements**	105,843	92,589	(13,254)	(8,236)	89,925

Growth in projected backpays based on settlements to date, the timing of ACC levies different from that projected, and annual leave and continuing medical leave provisioning relating to COVID factors.

8. PLANNED CARE

MoH data to January is tabled below. Funding is largely determined on performance against inpatient caseweight delivery and this report shows 83.3% of plan was achieved to the end of January (87.2% in December). The financial forecast and YTD result assumes achievement of delivery targets by the end of the year.

2021/22 Year to Date Contracted Volume Summary

	Base YTD Planned Volume	Additional YTD Planned Volume	Total YTD Planned Volume	Actual Delivery	YTD Delivery %	2021/22 Total Planned Volume
Inpatient Caseweight Delivery	4,810.6	1,685.1	6,495.8	5,412.5	83.3%	10,945.1
Inpatient Surgical Discharges	3,188	1,212	4,400	3,854	87.6%	7,427
Minor Procedures	1,258	535	1,793	2,857	159.3%	2,984
Non Surgical interventions	21	49	70	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: 6/03/2022 **NNPAC Refresh Date:** 7/03/2022
Data up to: Jan 2022 **Report Run Date:** 7/03/2022

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 February was $9.6m in overdraft (January was $3.7m in overdraft).

The cash low point for each month is generally incurred immediately prior to receipt of MoH funding on the 4th of the month, and March's low point is projected to be $9.5m overdrawn on 3 March.

The main cash risks are Holidays Act remediation payments, the net impact of COVID-19 expenditure, and the timing of MoH equity injections for capital projects.

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

Capital spend to February is at 59% of plan (last month 52%). This is caused by slippage in strategic projects, and delivery issues relating to covid in the facilities and clinical equipment blocks.

	--------- Year to Date --------			--- End of Year Forecast ----			-------- Life of Project --------		
	Actual	Budget	Variance	Forecast	Budget	Variance	Forecast	Approved	Variance
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Source of Funds									
Operating Sources									
Depreciation	11,035	11,578	(543)	16,905	17,702	(797)			
	11,035	11,578	(543)	16,905	17,702	(797)			
Other Sources									
Special Funds and Clinical Trials	105	-	105	105	-	105			
Funded Programmes	91	-	91	91	-	91			
Finance Leases (Clinical Equipment)			-	-	620	(620)			
Equity Injection		-	-	15,710	22,657	(6,947)			
Equity (Prior year expenditure)	2,518	-	2,518	2,518	-	2,518			
	2,715	-	2,715	18,425	23,277	(4,852)			
Total funds sourced	**13,750**	**11,578**	**2,172**	**35,330**	**40,979**	**(5,650)**			
Application of Funds:									
Block Allocations									
Facilities	699	1,339	640	2,366	2,000	(366)			
Information Services	2,056	1,999	(57)	3,114	3,000	(114)			
Clinical Equipment	805	1,999	1,195	3,275	3,000	(275)			
	3,560	5,338	1,778	8,756	8,000	(756)			
MOH funded Startegic									
Surgical Services Expansion Project	3,296	3,296	-	3,296	3,296	-	20,843	20,843	-
Radiology Facilities Redevelopment	471	1,677	1,206	700	2,490	1,790		25,100	25,100
Main Electrical Switchboard Upgrade	1,275	2,074	799	2,235	3,114	879	4,000	4,000	
Planned Care Procedure Rooms x 4	62	964	902	1,000	1,924	924	1,924	1,924	
Mobile Dental Clinics	918	908	(10)	1,536	1,536	-	1,600	1,600	-
Angiography Suite Replacement	1,266	1,704	438	1,638	2,888	1,250	1,750	3,000	1,250
Procedure Rooms Upgrade Endo Building	1,045	1,763	718	1,970	2,827	857	2,143	3,000	857
Seismic Upgrade Acute Admissions Unit S	0	324	324	0	490	490	2,960	3,450	490
Seismic Upgrade Surgical Services Expans	1,107	2,060	953	2,335	3,093	758			-
Linear Accelerator	-	500	500	-	1,000	1,000	33,156	33,156	-
Fast Track Rapid Health Capital	-	-	-	1,000	2,600	1,600	2,600	2,600	-
	9,442	15,270	5,828	15,710	25,258	9,548	70,976	98,673	27,697
DHB funded Strategic									
Surgical Services Expansion Project	230	1,036	805	1,886	3,204	1,318	-	-	-
Radiology Facilities Redevelopment	510	510	-	510	510	-	-	-	-
Replacement Generators	826	1,417	591	2,430	2,430	0	4,430	4,430	-
Health System Catalogue	343	857	514	363	857	494	657	657	-
Mental Health Crisis Hub	53	567	514	100	567	467	567	567	-
Interim Asset Plan	898	2,128	1,230	1,988	3,913	1,925	-	-	-
	2,859	6,515	3,655	7,276	11,481	4,205	5,654	5,654	-
Other									
Special Funds and Clinical Trials	105	-	(105)	105	-	(105)			
Funded Programmes	91	-	(91)	91	-	(91)			
Other	9	-	(9)	9	-	(9)			
	206	-	(206)	206	-	(206)			
Capital Spend	**16,068**	**27,123**	**11,055**	**31,948**	**44,739**	**12,791**	**76,630**	**104,327**	**27,697**

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11. ROLLING CASH FLOW

	Feb-22			Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
	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	74,629	74,629	-0	62,099	62,099	59,848	82,099	59,848	59,848	60,560	59,848	60,560	60,560	59,848	60,560
Other revenue	9,587	9,999	-413	11,310	10,460	11,220	11,030	11,030	11,410	11,220	10,650	11,220	10,840	10,840	10,650
Total cash inflow	84,216	84,629	-413	73,409	72,559	71,068	93,129	70,878	71,258	71,780	70,498	71,780	71,400	70,688	71,210
Cash Outflows															
Payroll	16,419	16,499	80	18,330	15,300	15,280	19,830	15,300	18,280	15,350	15,280	19,780	15,350	15,280	15,280
Taxes	13,005	13,218	213	11,200	11,400	11,200	12,600	11,200	11,200	11,400	11,200	11,200	9,400	14,400	11,400
Sector Services	34,758	34,862	104	31,948	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000
Capital expenditure	2,063	1,395	-668	2,000	1,600	1,600	2,000	1,600	1,600	2,000	1,600	2,000	1,600	1,600	1,600
Other expenditure	12,276	14,443	2,167	16,899	16,508	16,508	16,508	16,466	16,508	16,508	16,507	16,508	16,508	16,508	16,480
Total cash outflow	78,521	80,416	1,896	80,377	75,808	75,587	81,938	75,566	78,588	76,258	75,587	80,488	73,858	78,788	75,760
Total cash movement	5,696	4,213	1,483	-6,968	-3,249	-4,520	11,191	-4,688	-7,330	-4,478	-5,089	-8,708	-2,458	-8,100	-4,550
Add: opening cash	-3,717	-3,717	0	1,979	-4,989	-8,238	-12,757	-1,566	-6,254	-13,585	-18,063	-23,152	-31,860	-34,318	-42,418
Closing cash	1,979	496	1,483	-4,989	-8,238	-12,757	-1,566	-6,254	-13,585	-18,063	-23,152	-31,860	-34,318	-42,418	-46,969
Maximum cash overdraft (in month)	97	-9,604	9,701	-9,604	-8,238	-12,757	-23,235	-6,254	-13,585	-18,063	-23,152	-34,841	-36,011	-42,418	-51,756

Cash balances decline over the next twelve months reflecting operating deficits expected over that time period.

MINISTRY OF HEALTH
MANATŪ HAUORA

Appendix 1

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

11 March 2022

Hawke's Bay District Health Board
Private Bag 9014
Hastings 4156

Attention: Keriana Brooking

Dear Keriana

Offer to Fund: Data and Digital

Thank you for submitting Data and Digital Investment Brief/s seeking funding from the Capability Uplift Portfolio that was approved via Budget 21.

The Capability Uplift portfolio was created to support delivering an appropriate level of digital capability to underpin the health system and subsequent transformation and in recognition of existing baseline funding constraints and competing investment demands.

I have received advice from the Ministry's review team and the Capability Uplift Governance Group recommending providing an Offer to Fund in the following cases:

Reference	Investment Brief	Capital Value
21-NAC-002	Network Devices Refresh	$ 500,000
21-NAC-003	WiFi Network Refresh	$ 300,000
21-NAC-004	HUB Room Refresh	$1,000,000
21-NAC-005	Unified Communications Upgrade and Winterms Replacement	$ 650,000
21-AAN-002	Data Warehouse Migration	$ 100,000
	Total	**$2,550,000**

This Offer to Fund is subject to the conditions set out below:

- Confirmation of the ability of the DHB to fund any one-off and ongoing operating costs associated with these investments including capital charge and depreciation without impacting on the DHB deficit position
- Confirmation that the investment made meets the current accounting definitions for capital investment
- Confirmation that that you are confident in spending the allocated budget within the financial year the funding relates to

- An implementation plan and specific value measures to be provided by the DHB and agreed with the Ministry Portfolio team within three weeks of confirmation that you wish to take up the Offer to Fund
- Provision of full monthly status reporting by the 7th working day of the following month for the duration of implementation
- Note that the Ministry, in conjunction with the Capability Uplift Governance Group, reserve the right to reallocate funding if progress against the agreed implementation plan is delayed and achievement of the value measures is at risk
- Note that funding is for Yr1 (FY 21/22) capital funding only

Please provide written confirmation that you wish to take up the offer of funding within two weeks of the date of this letter and that all conditions are able to be met to CapabilityUplift@health.govt.nz.

I look forward to your acceptance of this offer and wish you well with the implementation.

Yours sincerely

Shayne Hunter
Deputy Director-General Data and Digital
Ministry of Health

	Te Ara Whakawaiora – Mental Health and Addictions February 2022
	For the attention of: **HBDHB Board**
Document Author(s)	David Warrington, General Manager, Mental Health & Addictions Robert Walker, Kaiwhakataki Hinengaro Māori, Mental Health & Addictions Peta Rowden, Director of Nursing, Mental Health & Addictions Anoek Dechering, Medical Director, Mental Health & Addictions Frances Oliver, Director of Allied Health, Mental Health & Addictions Cecily Miller-Heperi, Consumer Advisor, Mental health and Addictions
Document Owner	Chris Ash, Chief Operating Officer
Date	February 2022
Purpose/Summary of the Aim of the Paper	To provide the Executive Leadership Team (ELT) and governance groups with a progress update on the Mental Health and Addiction Service priorities, indicators, and achievement of equity targets. Te Ara Whakawaiora's focus has been on the following Mental Health and Addiction (MH&A) areas: • Minimising Restrictive Care (HQSC QI Programme) ○ Reducing the number of Māori subject to an indefinite compulsory treatment order (Section 29) of the Mental Health Act (1992). ○ Seclusion • Improving discharge and transition plan for children, youth, and adults • Shorter waiting times for non-urgent referrals (youth)
Health Equity Framework	The presented data seeks to provide a meaningful understanding of mental health outcomes and inequities within this data. It seeks to identify determinants of those inequities; review existing structural, and health and disability service interventions; and report new interventions, designed to promote equitable health outcomes. The rate of compulsory treatment; restrictive care practice (seclusion) and readmission within 28 days post discharge from inpatient care is elevated for our Māori whaiora. Improving Māori health outcomes and reducing health inequities remains a priority for Mental Health and Addiction services, with a focus on co-design of solutions.

Principles of the Treaty of Waitangi that this report addresses	Mental Health and Addiction Group is committed to delivering a service compliant with He Mana to Te Tiriti O Waitangi, Mana whakahaere, Mana motuhake, Mana tangata, Mana Māori. The principles of Te Tiriti o Waitangi will guide inclusive work towards the identified action points through – Māori leadership and strong partnerships with whaiora and whānau at every phase of service design and evaluation – Recognition of contribution of mātauranga Māori – Continued focus on equity – Collaboration with Māori health partners, Te Taiwhenua o Heretaunga, and community groups in service delivery – Engagement with the priorities of the Mental Health and Wellbeing commission e.g. • increased access and choice of mental health and addiction services • repeal and replacement of the Mental Health Act 1992.
Risk Assessment	Not applicable
Financial/Legal Impact	Not applicable
Stakeholder Consultation and Impact	The Partnership Advisory Group (PAG) and appointed Consumer Advisor are involved in service development and quality improvement initiatives to ensure that consumer voice is heard at all levels.
Strategic Impact	**Mental Health and Addictions Priorities – whole of system** Mental Health and Addictions inpatient services continue to experience a protracted period of time when high occupancy levels and a high number of patients awaiting residential placement, impact on the flow of clients through the acute service. It is recognised locally, regionally and nationally that access to services across the whole Mental Health and Addictions spectrum is limited in both scope, diversity and capability to manage demand. This can be broken down into services required to meet the needs of five distinct whaiora groups. Appendix one outlines the activities that the DHB is undertaking to meet demand for each of these groups. **Strategic priorities include:** **Patient flow** High and Complex Needs continuum of care to meet the spectrum of need for inpatient and community settings, including long stay whaiora requiring accommodation and support. Sub-acute step down inclusive of extended programs of rehabilitation for regional whaiora returning home. Review of patient flow across agencies and services including NGO partners (commencing March 2022) Psychogeriatric inpatient provision

	Quality care Continued roll out of a new model of crisis care in Te Tawharau in partnership with Māori health provider, MSD and Peer Support Relocation of services to community settings: Te Harakeke CAFS and Te Ara Manapou Implementation of recommendations from Te Harakeke CAFS service review Opportunities for early intervention including partnership with Te Uru Mātai - Integrated Primary Mental Health Programme; scoping of an Early intervention for Psychosis service; and development of a Dialectical Behaviour Therapy programme **Workforce** Recruitment campaign commencing March 2022 with focus on all Mental Health and Addiction Staff
Previous Consideration / Interdependent Papers	Te Ara Whakawaiora – Mental Health and Addictions Governance Report February 2021

RECOMMENDATION:
It is recommended that the HBDHB Board:
1. *Note and acknowledge the content of the report.*
2. *Approve / Endorse the activities to address performance.*
3. *Discuss and provide direction on the indicators reported on, and provide updated indicators.*

EXECUTIVE SUMMARY

Te Ara Whakawairoa (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly by champions to ensure improvements are made and sustained.

- **Indicator 1: Rate of Section 29 Compulsory Treatment Orders**

The rate of use of Section 29 for Māori in September 2021 in Hawke's Bay was 418 per 100 thousand, compared to 130 per 100 thousand for New Zealanders of other ethnicity. This suggests a 3.2-fold risk that Māori in Hawke's Bay will be subject to Compulsory Treatment Order compared to New Zealanders of other ethnicity.

- **Indicator 2**: Reduction in the use of seclusion

In 2021, 3149 hours of seclusion were used during admission to psychiatric inpatient care in Hawke's Bay. This comprised a total of 176 seclusion events involving 74 whaiora. Of the total events, 146 of those involved 59 whaiora identifying as Māori. The average number of hours for a seclusion event involving a whaiora identifying as Māori was 19.5 hours compared to 16.1 hours for whaiora who did not identify as Māori.

- **Indicator 3:** Improving mental health using wellness and transition (discharge) planning.
  - Follow-up within seven days of discharge,
  - 95% of clients discharged will have a quality transition or wellness plan.

Follow-up within seven days of discharge was completed for 67.3% of whaiora which is below target: Of the total number of Māori discharged, 64.0% were followed up within this period. Post discharge follow-up work is carried out by both Hawke's Bay DHB and Te Taiwhenua o Heretaunga (TTOH) Community Mental Health and Addiction teams. Clinical vacancies (especially TTOH); self-discharges; lost to follow-up; discharge out of area all impact on ability to meet target.

- **Indicator 4:** Shorter waits for non-urgent mental health and addiction services (0-19 years)
  - Mental Health: seen within three weeks (>80%); seen within eight weeks (>95%)
  - Addictions: seen within three weeks (>80%); seen within eight weeks (>95%)

Wait times for mental health and addiction services indicate that they are within 5% of target for seeing people within eight weeks. The mental health arm is on target for seeing whaiora within three weeks.

- **Determinants of inequitable health outcomes identified in this report include**
  - Socio-economic factors e.g.
    - *availability and capacity of housing and support services;*
    - *social risk factors for the development of mental health and addiction disorder*
    - *social deprivation*
  - Intermediary pathway e.g.
    - *higher rates of mental health and addiction disorder for Māori than non-Māori.*
    - *estimated point prevalence of schizophrenia for Māori is significantly higher than for non-Māori*
  - Health and disability services e.g.
    - *patient flow through Mental Health and Addiction sector*
    - *workforce recruitment and retention throughout the sector*

BACKGROUND

Te Ara Whakawairoa (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly by champions to ensure improvements are made and sustained. This report focuses on key actions being taken to improve Mental Health and Addiction Services for Māori.

The indicators included in this report are an ongoing priority focus for the Mental Health and Addiction Directorate, which contribute to improving the health outcomes for Māori in Hawke's Bay. These include:

- **Indicator 1:** Rate of Section 29 Compulsory Treatment Orders (≤81.5%)
- **Indicator 2:** Reduction in the use of seclusion
- **Indicator 3:** Improving mental health using wellness and transition (discharge) planning.
  - Follow up within seven days of discharge,
  - 95% of clients discharged will have a quality transition or wellness plan.
- **Indicator 4:** Shorter waits for non-urgent mental health and addiction services (0-19 years)[1]
  - Mental Health: seen within three weeks (>80%); seen within eight weeks (>95%)
  - Addictions: seen within three weeks (>80%); seen within eight weeks (>95%)

WHY ARE THESE INDICATORS IMPORTANT?

Data gathered across the New Zealand mental health and addiction sector shows continuing and persistent inequity in quality of care for Māori. This is evidenced by:

- Māori have higher rates of mental health disorder and addiction disorder than non-Māori;
- Māori are more likely to have an undiagnosed mental health disorder;
- The outcomes for Māori who access mental health services are poorer;
- Māori are more likely to be admitted to hospital and readmitted after discharge; to be secluded during admission; and to be compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992[2].

HAWKE'S BAY DHB MENTAL HEALTH AND ADDICTION WORKFORCE

Hawke's Bay DHB has faced two significant recruitment and retention workforce challenges over the last year, this has included the impact of COVID and the implementation of Te Uru Mātai - Integrated Primary Mental Health Programme which resulted in seven clinical staff exiting specialist services. COVID has had multiple impacts from staff exiting because of vaccine mandates and border closures to recruitment difficulties. Also, the demand and expectation on clinical staff have seen some exit from publicly funded services into private practice.

[1] Wait times are monitored by our Mental Health Key Performance Indicator Programme for Child & Youth (referral to first and third in-scope activity) and Adult (first in-scope activity). The Ministry of Health indicator for wait times changed in July 2021 to wait times for 0-25 year olds (first in-scope activity).
[2] Cunningham, R., Kvalsvig, A., Peterson, D., Kuehl, S., Gibb, S., Mckenzie, S., Thornley, L. and Every-Palmer, S. (2018) Stocktake Report for the Mental Health and Addiction Inquiry. Wellington: University of Otago.

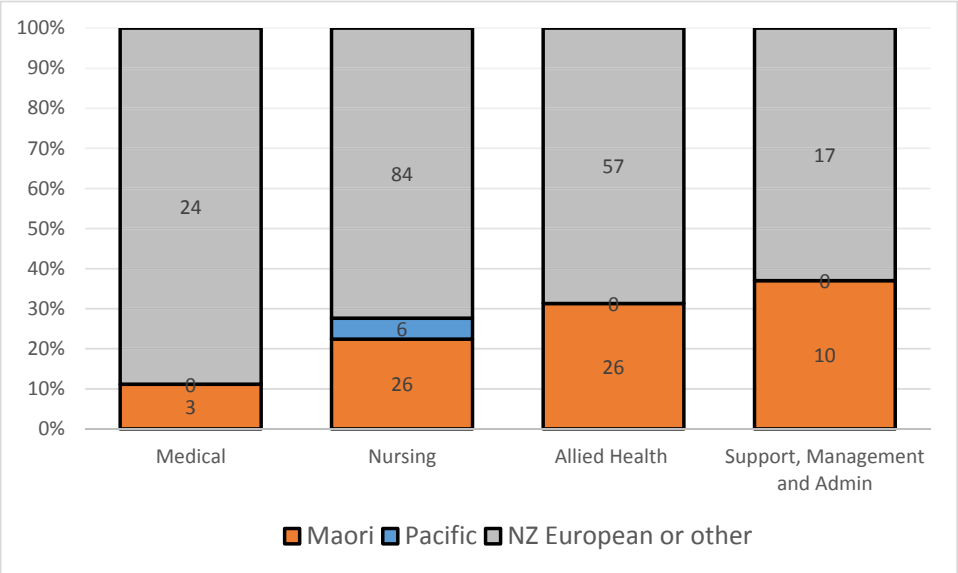

Figure 1.0: Proportion of each occupational group in Mental Health & Addiction Group by ethnicity based on average workforce numbers January to December 2021

Note: *Hawke's Bay District Health Board's target for Māori representation in the workforce is 17.99%. Of the total HBDHB workforce 16.92% identify as Māori. For Mental Health and Addictions 26% of the workforce identify as Māori (range 24-28% from January to December in 2021). Across occupational groups, this comprises 22.4% of nursing workforce (n=26/116); 31.3% of allied health workforce (n=26/83); 11.1% of psychiatry workforce (n=3/27) and 37.0% (n=10/27) of support, management and administration.*

COVID STATEMENT

Mental Health and Addiction Services continue to experience high demand and complexity which is reflected nationally and regionally. The impact of COVID-19 has led to further demand and significant workforce challenges. This has been highlighted at regional and national level with additional support being worked through to address demand.

8

INDICATOR ONE: RATE OF SECTION 29 COMPULSORY TREATMENT ORDERS
Outcome expected: Reduce rates of Section 29 Compulsory Treatment Orders for Māori (≤81.5%)
Performance Status: Off Track

Use of Section 29, Compulsory Treatment Orders (CTO) requires that a person with a mental health disorder must receive hospital-based treatment and observation. Patients can be sectioned if their own health or safety are at risk, or to protect other people.

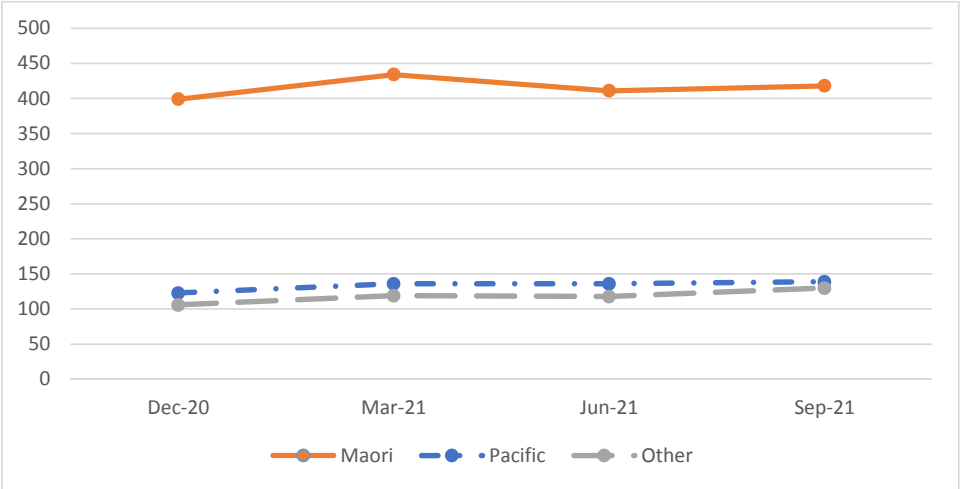

Figure 2: Hawke's Bay DHB rate per 100,000 population subject to Section 29 Compulsory Treatment Order by ethnicity – Māori vs Non-Māori Population

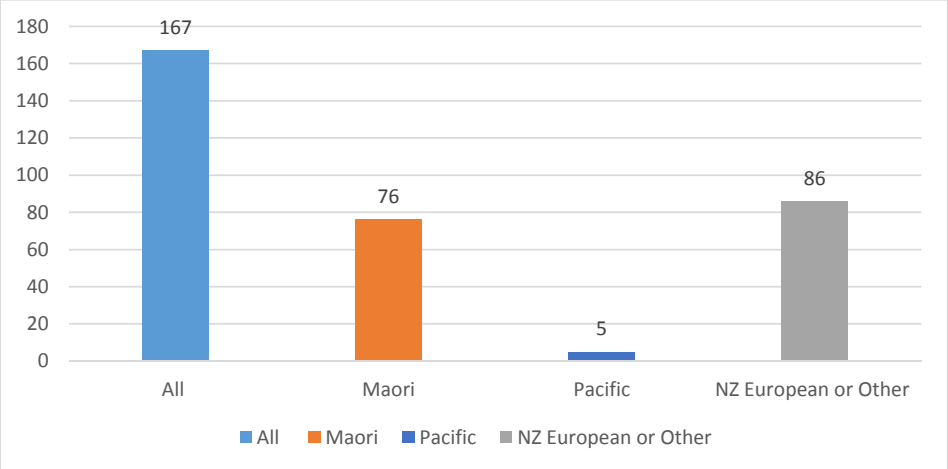

Figure 3: Actual number of whaiora subject to Section 29 Compulsory Treatment Order for 12 months ending September 2021 – Māori vs Non-Māori Population

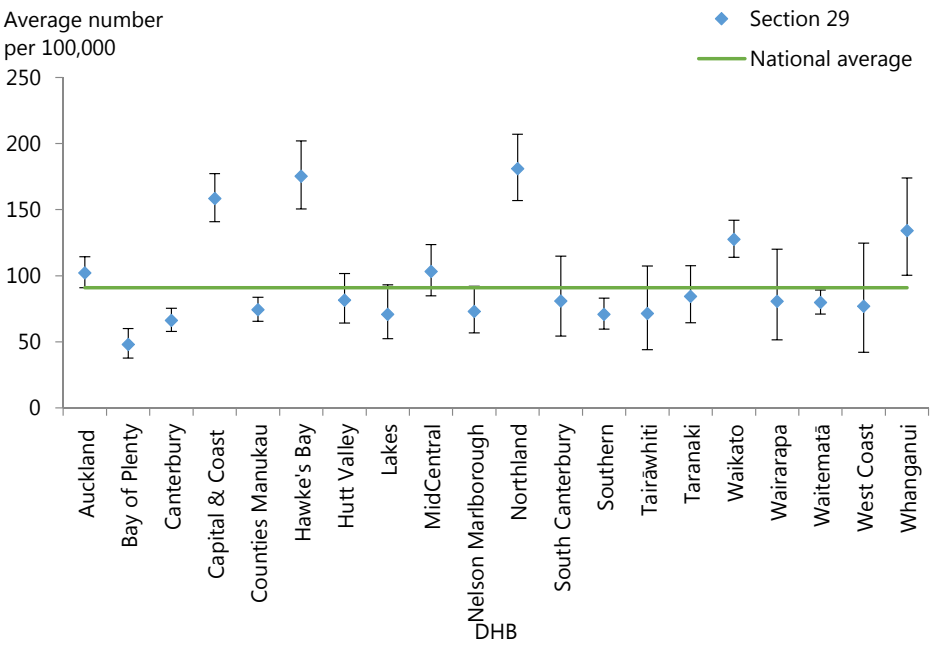

Figure 4:Average rate per 100,000 population (all ethnicities) on a given day subject to a community treatment order (section 29 of the Mental Health Act), by DHB, 1 January to 31 December 2020 (extracted from Ministry of Health (2021) Note data is for 2020

Note: *On average Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori[3]. The rate of use of Section 29 for Māori in the 12 months to September 2021 in Hawke's Bay was 418 per 100 thousand, compared to 138 per 100 thousand for other ethnicity. This indicates a 3-fold risk that Māori in Hawke's Bay will be subject to Compulsory Treatment Order compared to Hawke's Bay other ethnicity group. In 2020, the national average rate for people subject to Compulsory Treatment Order was 91 per 100,000. Current data identifies 167 individuals cared for by Hawke's Bay DHB on a Compulsory Treatment Order. This is made up of 76 individuals who identify as Māori and 91 individuals who identify as other ethnicities.*

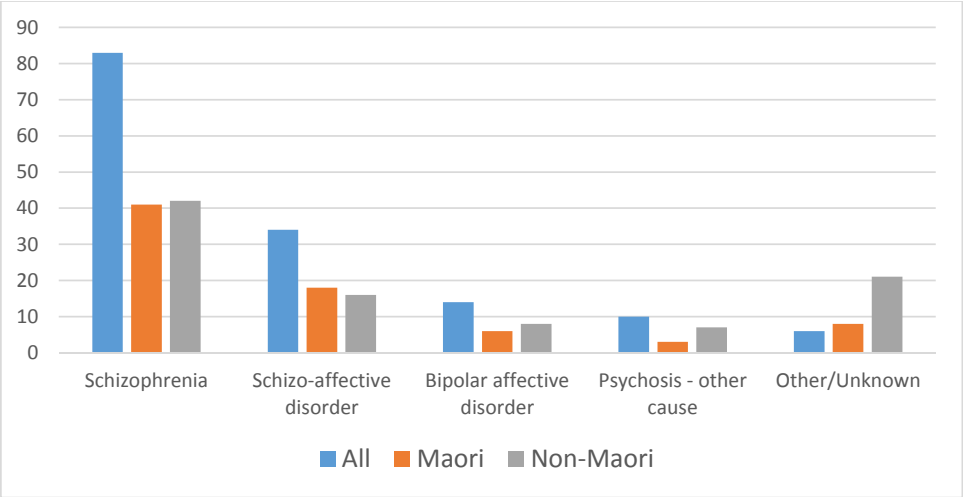

Figure 5: Actual number of people by diagnosis subject to Section 29 Compulsory Treatment Order in 2021 – Māori vs Non-Māori Population - Hawke's Bay

[3] Ministry of Health (2021) Office of the Director of Mental Health and Addiction Services 2020 Regulatory Report. Wellington: Ministry of Health.

Note: *The most common diagnosis in the cohort of whaiora subject to Compulsory Treatment Order is Schizophrenia or Schizo-affective disorder. The diagnoses for both disorders were in place for 50.4% of Māori whaiora, compared to 49.5% of whaiora of other ethnicities. There is a significantly increased prevalence of schizophrenia in Māori, compared with New Zealanders of other ethnicity. The estimated twelve-month New Zealand prevalence of schizophrenia for Māori (0.97%) is significantly higher than for other ethnicities (0.32%)[4]. There is emerging evidence that Māori rangatahi are twice as likely to present with first episode psychosis[5]. Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment.*

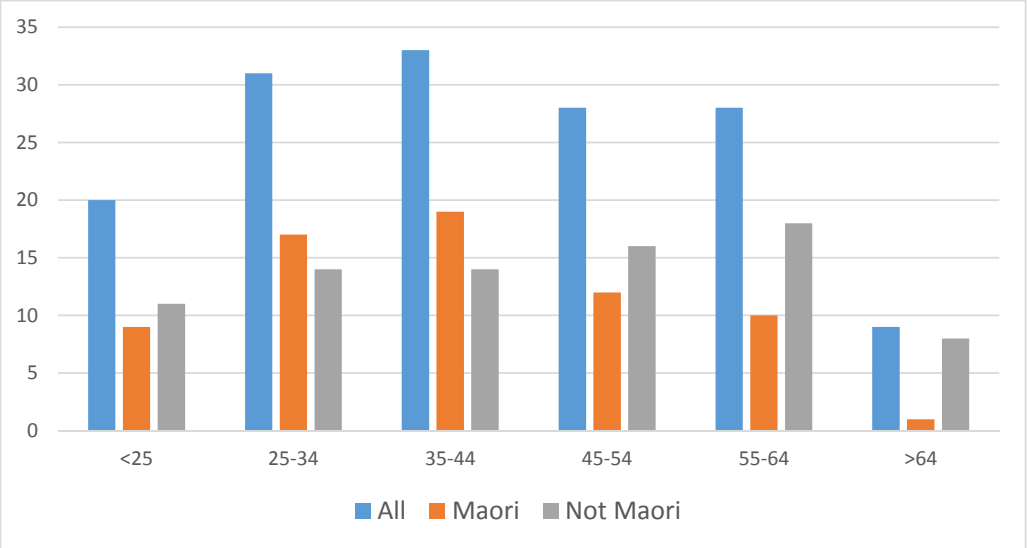

Figure 6: Actual number of people subject to Section 29 Compulsory Treatment Order in 2021 by age group – Māori vs Non-Māori Population – Hawke's Bay

Note: *Māori whaiora subject to Compulsory Treatment Order are a younger demographic than whaiora of other ethnicities. In the current data, 66.1% of Māori whaiora were aged under 45 years, compared to 48.1% of other ethnicities. Assertive services, especially at initial onset of psychosis, which support functional gain are crucial to generating positive outcomes. Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies, including cultural and social agencies, to provide a more holistic, integrated and comprehensive response.*

SOLUTIONS

Activities	Complete	In progress	Stopped	New
Engagement of lived experience workforce (peer support) in Police Liaison and Crisis Services (Te Tawharau).				
Research project to investigate the experiences of Māori tangata whaiora who are subject to Compulsory Treatment Orders (MH(CAT)Act 1992) and their whānau, and the barriers preventing them from receiving treatment on a voluntary basis. Project in recruitment phase				
Pilot led by Kaiwhakataki Hingengaro Māori and in partnership with population health to pilot vaping as an alternative to tobacco smoking for people receiving inpatient care				

[4] Kake, T.R., Arnold, R., & Ellis, P. (2008) Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. *Australian and New Zealand Journal of Psychiatry,* 42, 11, 941-949.
[5] Petrovic-Van Der Deen, F.S., Cunningham, R, Manuel, J. et al (2020) Exploring indigenous ethnic inequities in first episode psychosis in New Zealand – A national cohort study. *Schizophrenia Res*, 223, 311-318.

Kaiwhakataki Hingengaro Māori and Consumer Advisor working in partnership with non-government organisations to facilitate feedback on the repeal and replacement process for the Mental Health (Compulsory Assessment and Treatment) Act (1992).				
Re-engagement with Regional Personality Disorder Service for consultation and education Development of Talking Therapies competence framework				
Project to scope the need for and advice on best practice service for 13 to25-year-olds presenting with first episode psychosis commences in March 2022.				
Review of the systems, processes, capacity and capability across the care continuum specifically focusing on High and Complex Needs and patient flow. We have the MoH, our NGO partners, HSEG, NASC and Capital and Coast DHB Residential Rehab Services all on board supporting this review and are currently finalising the Terms of reference.				

RECOMMENDATIONS AND NEXT STEPS

- Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders
  - *Monitor Compulsory Treatment Orders (CTOs) by ethnicity and continue with actions which have contributed to a decrease in CTOs for Māori.*
  - *Partner with police; education of nurses and key workers to support whānau to understand legal issues and the process of CTO courts.*
  - *Explore written material which is used to explain these processes to whānau in other centres, with a view to using locally, if appropriate.*
- Re-establish the CTO review meetings
  - *Formulate a Terms of reference to ensure purpose and appropriate membership.*
  - *Set meetings.*
  - *Engagement with DAMHS and District Inspector*
- Staff to attend mandatory and MH specific training to assist in appropriate engagement / approaches with consumers / whānau (focus on least restrictive models of care)
  - *Engaging Effectively with Māori training*
  - *Safe Practice Effective Communication (inpatient / security)*
  - *Sensory modulation*
  - *De-escalation and Breakaway (community / NGO)*
  - *Trauma informed care*

8

INDICATOR TWO: REDUCTION IN THE USE OF SECLUSION
Outcome expected: 0 hours per month
Performance Status: Off Track

In 2016, the DHB agreed a plan to decommission a Seclusion Room by Jan 2019 and eliminate the use of seclusion by Jan 2021. This was to be achieved by reducing seclusion hours by 804 hours per year between 2016 and 2021.

"Seclusion should not be used as 'time out' as a component of a consumer's plan to modify unwanted behaviour. Seclusion may only be used to manage safety" - Page 9 'NZ Standard 8134.2:2008 - Health & Disability Services (Restraint Minimisation and Safe Practice)'

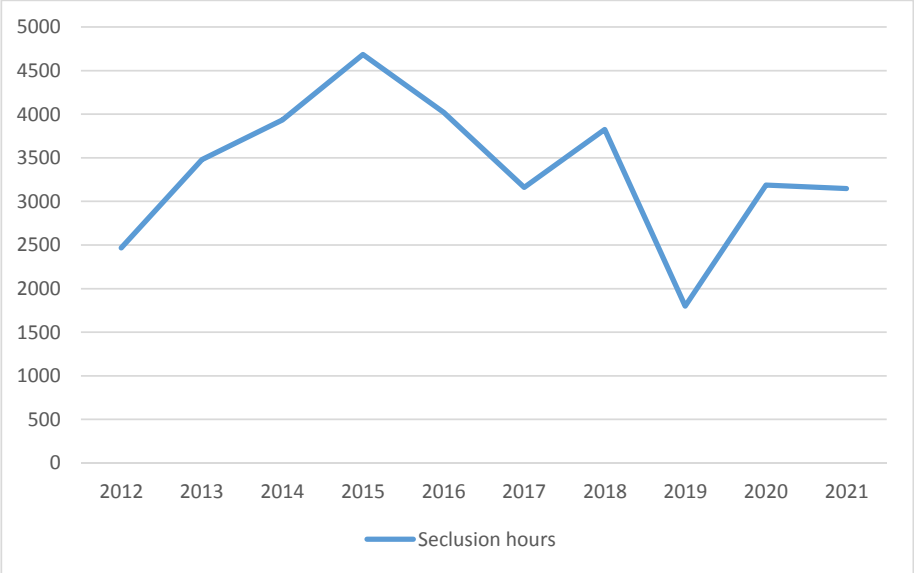

Figure 7: Total number of seclusion hours per year 2012-2021

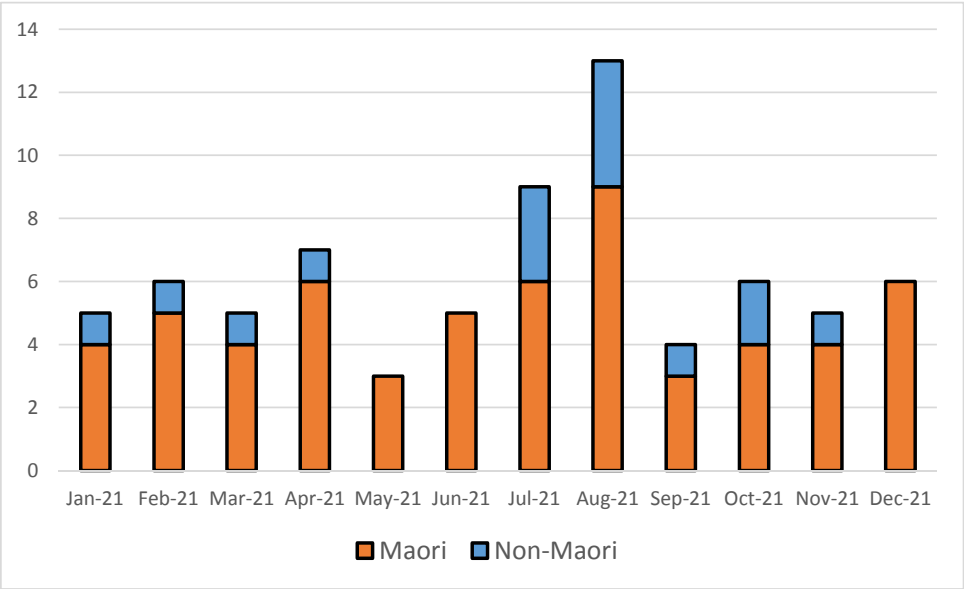

Figure 8: HBDHB Seclusion hours by Month (Jan 2021 – Dec 2021) – Māori vs Non-Māori Population

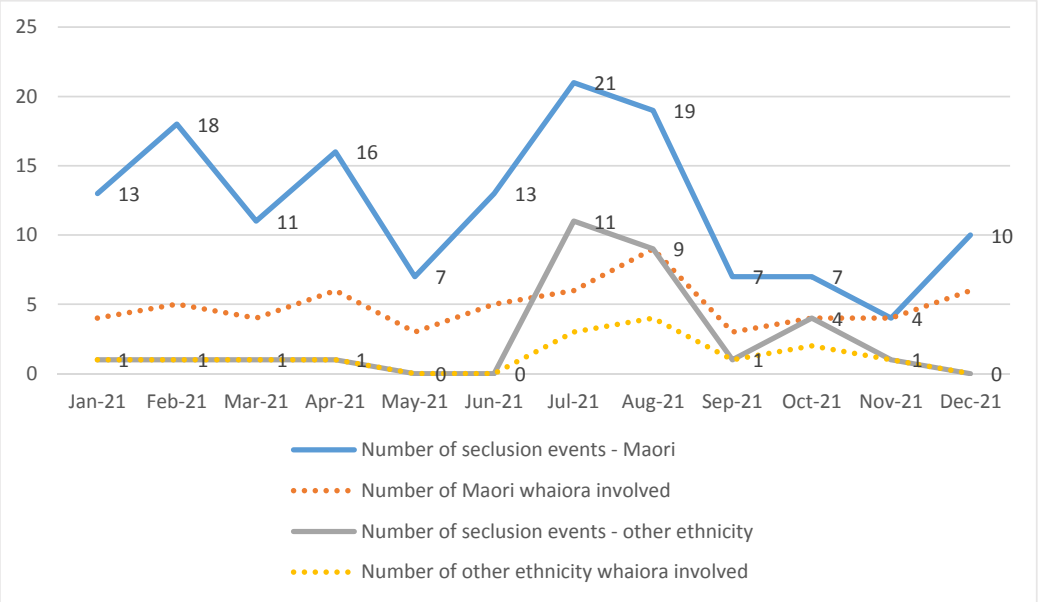

Figure 9: Actual number of whaiora and actual number of seclusion events by month (Jan 20 – Dec 20) – Māori vs Non-Māori Population

In 2021, there was a total of 176 seclusion events in Hawke's Bay involving 74 whaiora. Of the total events, 146 of those involved 59 whaiora identifying as Māori. The average number of hours for a seclusion event involving a whaiora identifying as Māori was 19.5 hours compared to 16.1 hours for whaiora who did not identify as Māori.

Ngā Rau Rākau had significant staffing challenges issues through 2021 including skill mix and high vacancies. Review of seclusion events identified trends in events escalating from access to tobacco; intoxication on admission; and staff training. This is reflected in current activity to address performance. However, there is a trend of reduced rates from September 2021: this aligns with commencement of use of low stimulus as an alternative to seclusion and ongoing staff education.

Note: *In February 2022, Ngā Paerewa Health and Disability Services Standard came into effect. It sets the health and disability standard for less restrictive practice, aiming for a restraint and seclusion-free environment, in which people's dignity and mana are maintained.*

SOLUTIONS

Activities	Complete	In progress	Stopped	New
Leadership towards organisational change: *Appointment of Kaiwhakataki Hingengaro Māori,* *Appointment of New Clinical Nurse Manager for Ngā Rau Rakau* *Clinical Nurse Specialist within the Police Liaison service*				
Improving relationships and collaboration with NGO partners and other stakeholders to improve flow				
Full inclusion of lived experience *Peer support workforce represented in Te Ara Manapou (Maternal mental health and addiction service); Te Tawharau (Crisis Hub); and Police Liaison Service*				
Using data to inform practice *Improving systems and processes within Ngā Rau Rākau*				

Ongoing reporting to PRIMHD				
Workforce development *Appointment of Nurse Educator in ED now in place* *Whole group Sensory Modulation training roll out commenced December 2021* *Talking therapies competence framework*				
Use of seclusion and restraint reduction tools *Increased therapeutic content in the inpatient setting with appointment of Occupational Therapy assistant* *Use of low stimulus area as alternative intervention*				
New activity being developed (using the HBDHB Equity Framework) – Annual plan activities *Ongoing development of Crisis Hub (working across sectors to respond to whanau in crisis)* *Scoping of Restraint Co-ordinator role with Nurse Educator scope*				

RECOMMENDATIONS AND NEXT STEPS

- Continue the work already in train as listed above.

8

INDICATOR THREE: IMPROVING MENTAL HEALTH USING WELLNESS AND TRANSITION (DISCHARGE) PLANNING

Acute inpatient post-discharge community care, more commonly referred to as *7-day follow-up*, measures the percentage of acute inpatient discharges that are followed up in the community within the seven days immediately following discharge. Whaiora leaving inpatient care with a formal discharge plan, involving linkages with community services and supports, are less likely to need early readmission. Research indicates that service users have increased vulnerability immediately following discharge.

A) Follow up post discharge: contact within seven days of discharge.

Outcome expected: HBDHB target 90%
Performance Status: Off track

	Māori			Pacific			Other		
	Overnight discharges	**Contact within 7 days after discharge date**		**Overnight discharges**	**Contact within 7 days after discharge date**		**Overnight discharges**	**Contact within 7 days after discharge date**	
	Total Number	*Number*	*%*	*Total Number*	*Number*	*%*	*Total Number*	*Number*	*%*
June-December 2020	134	98	73.1%	4	4	100%	125	95	76.0%
June-December 2021	**161**	**103**	**64.0%**	**8**	**5**	**62.5%**	**126**	**95**	**75.4%**

Table 1: Contact 7 days post discharge date

Note: *Post discharge follow-up work is carried out by both Hawke's Bay DHB and Te Taiwhenua o Heretaunga Community Mental Health and Addiction teams. For DHB services Clinical Coordinators take a lead on tracking discharge follow-up in respective teams. Clinical vacancies (especially TTOH); self-discharges; lost to follow-up; discharge out of area all impact on ability to meet target.*

Note: *A review of the Central Co-ordination Service has been completed to look at flow of referrals and prioritisation processes. The current CCS is dependent on 1.0 fte across sites, which has been identified as insufficient. Recommendations made from this review will be considered for implementation for the last quarter of 2022.*

B) Clients Discharged from Inpatient services will have a quality transition or wellness plan[6]
Clients discharged from Community services will have a quality transition or wellness plan
Audited files will meet good practice standards

Outcome expected: 95% target for each
Performance Status: -

The data collected for this measure relates to the percentage of plans (transition/wellness/discharge) updated within two weeks of discharge from service and is gathered from a single documentation process, this electronic data extraction does not accurately reflect the actual discharge plans within patient files. To evidence this an audit was completed in quarter three 2021 whereby 25 current files were reviewed. Results were that 24/25 (96%) had a documented plan in place.
Improvements to the electronic capture of how data is collected for this specific target would also help toward better understanding performance.

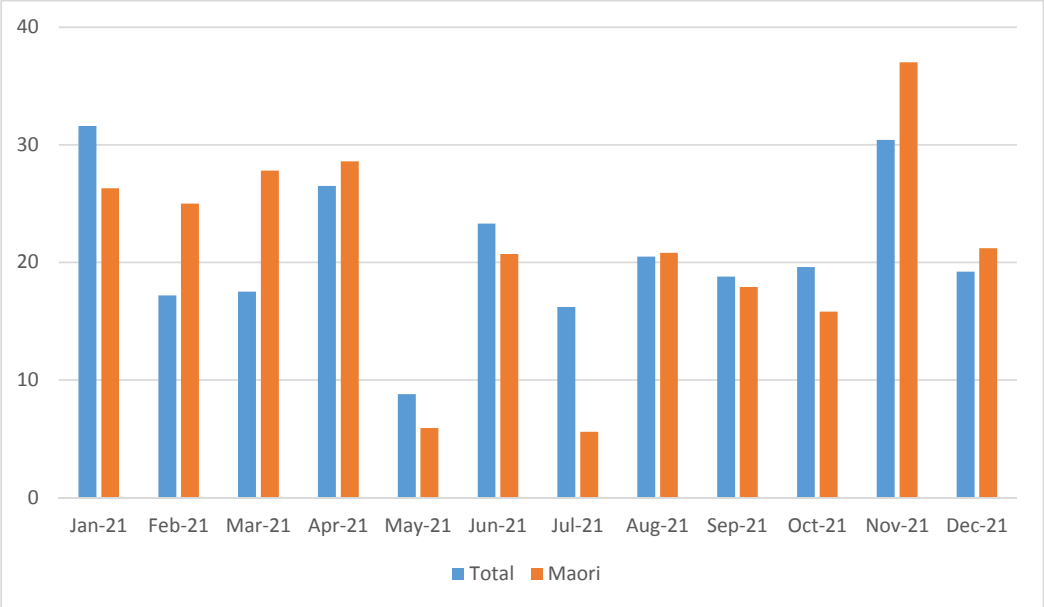

Figure 10: Percentage of whaiora readmitted within 28 days post discharge from January 2021 to December 2021 Māori vs Non-Māori Population

NOTE: *Graph 3.4 included for additional information. The overall readmission rate January to December 2021 was 21.0% for all discharges and 21.6% for Māori whaiora. Different models of care adhere to different patterns of admission: in some circumstances short admissions, as required, may be in line with appropriate care delivery.*

SOLUTIONS

Activities	Complete	In progress	Stopped	New
This indicator now forms part of the annual plan: *Address adherence to data entry guidelines to ensure quality and consistency of capture* *Individual team performance monitoring*				

[6] *In 2020, the reporting of this indicator changed. The reporting now includes all whaiora open to community teams (children, youth, and adults). Currently ethnicity data is not available for this indicator, however the DHB is working with MoH to gain ethnicity data for this indicator.*

RECOMMENDATIONS AND NEXT STEPS:

- Continue to ensure this indicator has a focus within the annual plan activities
- Complete audit at team level to identify were targets are not being met.

8

INDICATOR FOUR
Shorter waits for non-urgent mental health and addiction services – (0-19yrs)[7]
Outcome expected: Seen within three weeks (>80%); seen within eight weeks (>95%)

a) **Mental Health (Provider Arm):**
Performance Status 3W: On track ending 30th September 2021
Performance Status 8W: Within 5%

b) **Addictions Service:**
Performance Status 3W: Off track
Performance Status 8W: Within 5%

	Wait Times (0-19 years)					
12 Months ending	3W - MH Provider Arm & Addiction			8W - MH Provider Arm & Addiction		
	Māori	Pacific	Other	Māori	Pacific	Other
30/06/20	76.4%	76.2%	74.6%	88.6%	100.0%	91.3%
30/09/20	77.9%	79.0%	78.3%	90.7%	94.7%	93.6%
31/12/20	78.2%	71.4%	76.3%	90.8%	85.7%	91.9%
31/03/21	78.6%	78.6%	72.5%	97.0%	92.9%	95.1%
	3W - MH Provider Arm Only					
	Māori	Pacific	Other			
30/06/21	76.6%	75.0%	69.2%			
30/09/21	88.5%	100.0%	85.3%			

Figure 11: Percentage of people seen within three weeks (3W) and eight weeks (8W) of referral in mental health and addiction services

Note: *Te Harakeke CAFS team were under considerable pressure through the reporting period – a combination of COVID-19,increased demand on services and lower staffing levels due to vacancies contributed to ability to meet demand. A review of Te Harakeke CAFS service has now been completed (July 2021) and an external Change Manager commenced work with the team in September 2021. The CAFS service improvement project work included a review of the model of care encompassing addictions; establishing a Clinical Coordinator role to support caseload management and any related capacity issues, as well as the service moving off the Hastings campus site in July 2022.*

SOLUTIONS

This indicator now forms part of the annual plan activities with actions identified to improve performance.

Activities	Complete	In progress	Stopped	New
Trial new model of care planned for 2022				

[7] The MoH changed this indicator from July 2021. The indicator is now 0-25 years. The above table provides information for the four quarters prior to this change (Reporting period 3 months in arrears)

• Address access issues that create barriers to engagement ○ Relocation to community site and co-location with child development service ○ Workshops and feedback survey completed with community partners ○ Cultural support available to the team, with dedicated Kaitakawaenga for service				
Recruitment plan implemented & leadership structure revised: staffing almost complete				
Workstreams established to look at a) specific clinical pathways b) role of keyworker				
Completion of Real Skills Plus under Whāraurau, a national centre for Infant, Child and Adolescent Mental Health (ICAMH) workforce development, to establish workforce development plan				

RECOMMENDATIONS AND NEXT STEPS:

- Continue to ensure this indicator has a focus within the annual plan activities

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8

Recommendations from the Champion

(Taken from current activities to address performance)

Indicator	Key Recommendations	Responsible	Timeframe
Indicator 1	• Re-establish CTO review meetings • Staff attendance of mandatory and MH specific Training • Support the continuation of activities within the HQSC-Quality Improvement Initiative as listed under current activity to address performance.	Dr Anoek Dechering Peta RowdenDr Greg Young Robert Walker Frances Oliver	Ongoing Current / Ongoing
Indicator 2	• Stand up the Police Liaison Peer support workforce & Crisis Peer support workforce • Appoint Kaiwhakahaere Hinengaro Māori • Development / implement the Crisis Hub Model	David Warrington Peta Rowden Anoek Dechering Sheldon Reddie	Completed Completed Partial completion
Indicator 3	• Improve data entry quality and compliance • Use data findings to improve follow up processes	Community Mental Health Leads: Liam Jackson Di Cowan John Conneely	Quarterly revision
Indicator 4	• Implement recruitment plan • Te Harakeke CAFS Rebuild • Trial new referral Pathways	David Warrington Peta Rowden Anoek Dechering-Raes Liam Jackson Robbie Walker Frances Oliver	Current/ongoing

Note: These recommendations are largely unchanged from the previous year as the impact of Workforce, Patient Flow and COVID has been significant.

APPENDIX 1

Table 1.0 Update on mitigation strategies

Whaiora Group		Progress to date
Whaiora requiring specialised, secure services at regional service level		Regional working group formed December 2020 based off the Technical Advisory Service (TAS) review of regional provision of mental health and addictions specialised services. Francis Group appointed to complete review. Initial meetings started with regional portfolio managers. Meetings are now monthly with CCDHB and HBDHB specifically.
Whānau in Crisis		Te Tawharau will roll out this year with partnership working from Hawke's Bay District Health Board, TToH, Police, MSD, to provide services to meet the needs of whānau in crisis, including a crisis respite facility
Long stay clients with high and complex needs requiring long-term accommodation and support		Ngā Tai Oranga, Regional Personality Disorder Service, repurchased
		Intersector group established to find solutions to this client cohort- DHB-MSD-Kainga Ora Strengthen internal process to facilitate discharge planning
		MH&A Executive Oversight and Support Group established to support issues outside of specialist services remit, for example NGO capacity and capability
		Increase bed capacity within NGO sector
		Bed allocation prioritisation system to timely discharge: - Inpatient - MHAS- disability + home based clients.
		Older Persons Mental Health: - Review potential for psychogeriatric bed provision indicates between 7-10 dedicated beds. Business case required
	Scoping	Increase clinical capacity within NGO sector and the capability to manage higher levels of complexity
		Much of the strategies for LSC will be addressed in a whole of sector review of patient placement and flow into supported residential placement scheduled to start March 2022
Sub-acute step down inclusive of extended programs of rehabilitation for regional clients returning home		Review and revise current provision of Respite services (planned adult and acute youth respite)
	Scoping	Partner with ACC-DSS-DHB to establish a dedicated therapy-based facility to meet the needs of this cohort of clients'
		POC to support bespoke solutions for individual clients
	22-25	Long-term rehab facility: Step down from regional services Step down from acute inpatient services
In addition: • Tranche 1:3 implemented of the Integrated Primary Mental Health and Addictions Service • Extension of Kaupapa Māori Community based MH&A services (inclusive of Wairoa)		

HAWKE'S BAY District Health Board Whakawāteatia	**Hawke's Bay Health Consumer Council** **Chairs Report to Board**
	For the attention of: **HBDHB Board**
Document Owner	Emma Foster, Executive Director, Planning, Funding and Performance
Date	March 2022

RECOMMENDATION:
It is recommended that the **HBDHB Board**:
1. **Note** the contents of this report

Consumer Council met on Thursday 3 March 2022. An overview of matters discussed follows.

1. **Update on the COVID Vaccinations and COVID Testing – Hawke's Bay**
   The COVID Directorate provided an update to the Council on the following areas:
   - Angela Taylor, HBDHB Team Leader COVID Testing, gave the Council an update on the recent status of COVID testing in Hawke's Bay.
   - Adrienne Whelan, Community MIQ Service Coordinator Manager, gave the Council an update on the recent status of COVID vaccinations in Hawke's Bay. Main points below:

2. **Update on Health Quality & Safety Commission Quality Safety Markers**
   Susan Barnes, Patient Safety & Quality Manager HBDHB, gave an update on the Consumer Engagement Quality Marker. This is a framework to measure what successful consumer engagement looks like and how it improves the quality and safety of services. It is based on a scoring system.

3. **Presentation – Health Insights**
   Lisa Jones, System Lead – Performance & Insights Planning Funding & Performance gave a powerpoint presentation explaining how and why a "Health Status Review" is developed and presented. The reason these reviews are completed is to give a broader understanding of the health status of a community and the reasons behind the health status, and therefore this information supports our localities planning.

HAWKE'S BAY
District Health Board
Whakawāteatia

10

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

11. Confirmation of Previous Minutes (Public Excluded)
12. Matters Arising – Review of Actions (Public Excluded)
13. Chair's Report (Public Excluded)
14. Board Champions' Safety and Wellbeing Report (Public Excluded)
15. Finance, Risk and Audit Committee Resolutions for Board Approval (Public Excluded)
16. Board Approval of Actions Exceeding Limits Delegated by CEO (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).