BOARD MEETING

Date: Tuesday 26 April 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: Hayley Anderson
David Davidson
Keriana Brooking, Chief Executive Officer

In Attendance: Andrew Boyd, Acting Chief Executive Officer / Executive Director of Financial Services
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 March 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 – Andrew Boyd, Acting Chief Executive Officer	1.15
7.	Financial Performance Report – Andrew Boyd, Executive Director of Financial Services	1.20
	Section 3: Strategic Delivery	
8.	Ākina (Improvement) – Telehealth – Enabling Equitable Access to Health Services Anne Speden, Executive Director of Digital Enablement and Patrick Le Geyt, Acting Executive Director of Health Improvement and Equity and Senior Responsible Officer	1.25

9.	Nursing and Midwifery Strategy Update (Presentation) – Peta Rowden, Director of Nursing Mental Health and Addictions Karyn Bousfield-Black, Chief Nursing Officer	1.45
10.	Wairoa Oral Health Update – Emma Foster, Executive Director of Planning, Funding & Performance and Patrick Le Geyt, Acting Executive Director of Health Improvement & Equity	2.05
	Section 4: Noting Reports	
11.	Hawke's Bay Clinical Council Report – Robin Whyman, co-Chair	-
12.	Pacific Population Board – Patrick Le Geyt, Acting Executive Director of Health Improvement and Equity	-
13.	**Section 5: Recommendation to Exclude the Public** Under Clause 33, New Zealand Public Health & Disability Act 2000	2.20

Public Excluded Agenda

Item	Section 6: Routine	Time (pm)
14.	Minutes of Previous Meeting held 22 March 2022 (public excluded)	2.25
15.	Matters Arising – Review of Actions (public excluded)	
	Section 7: Standing Management Reports	
16.	Chair's Report – verbal (public excluded)	2.30
	Section 8: Other Governance Reports	
17.	Board Champions' Safety and Wellbeing Report - verbal (public excluded)	2.40
18.	Finance, Risk and Audit Committee Resolutions for Board Approval (public excluded) – Chair, Evan Davies	2.45
	Section 9: Noting Reports	
19.	Board Approval of Actions Exceeding Limits Delegated by CEO (public excluded) – Emma Foster, Executive Director of Planning, Funding & Performance	-
20.	Safety and Wellbeing Committee Report (public excluded) – Martin Price, Executive Director of People and Culture	-
	Karakia Whakamutunga	
	Meeting concludes	3.00

The next HBDHB Board Meeting will be held on
Tuesday 24 May 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 19 April 2022

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 Whariki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	The Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
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

aMINUTES OF THE HBDHB BOARD MEETING
HELD ON WEDNESDAY 22 MARCH 2022
AT 1.00 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

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 members, the staff and members of the public who were viewing the meeting via Facebook livestream. He acknowledged the community from Mahia in the north to Porangahau in the south and the work the Executive Leadership Team was doing throughout the COVID-19 environment.

1. APOLOGIES
Evan Davies for lateness (joined the meeting at 1.10pm).

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 22 February 2022 were confirmed as a correct record of the meeting.

Moved: Peter Dunkerley
Seconded: David Davidson
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES
The status update for the Cardiac Business Case was noted.

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
Margaret Papuni	Care Associate	Hospital Directorate	13	0403/22
Glennis Sowman	Administrator	Support Directorate	28	18/3/22
Bryan Dawson	Gardener/Driver/ Maintenance – Wairoa	Whānau & Communities	32	04/03/22
Dawn Rorrison	Community Dentist	Whānau & Communities	13	28/01/22
Colleen Murner	Shift Coordinator	Hospital Directorate	14	11/02/22
Stephen Bentall	Orthopaedic Surgeon	Hospital Directorate	25	23/01/22
Richard Parker	Orderly	Support Directorate	34	01/03/22
Susan Lopdell	Dental Therapist	Whānau & Communities	50	20/02/22

Collectively the above eight staff had provided a total of 209 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 the next stage of their journey. The Board and Executive Leadership Team gave Susan Lopdell a round of applause for her 50 years of service to the DHB.

- The Chair acknowledged how busy the hospital and the whole region was with COVID-19 including Police, Education and Ministry of Social Development. He referred to a recent article in Hawke's Bay Today from a Hawke's Bay general practitioner sharing the reality of the COVID-19 epidemic pressure on general practitioners and pharmacies and on behalf of the Board, thanked all health care workers, both within the hospital and the community, for the work they were doing.

- The Chair advised that the Health Reforms were still on track, with Boards ceasing to exist on 30 June 2022. He assured everyone that Board members were trying to assist HBDHB and the community to have a smooth transition into Health NZ.

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

6. CHIEF EXECUTIVE OFFICER'S REPORT

This report was taken as read. The CEO provided the following update in addition to her report:

- Last month there were less than 65 active cases in Hawke's Bay whereas now there were more than 6800 active cases.
- Vaccination rates: As at 15 March, 97 percent of the eligible population had received their first dose, 95 percent their second dose and 73 percent (18+ years) had received their booster. There were 800 Māori still to receive their second dose and half of the 5-11 age group yet to have their first dose.
- HBDHB had seen a drop off in vaccination rates in the last 2-3 weeks as people have chosen to stay home. The CEO encouraged those who were not vaccinated to get their vaccinations particularly as the borders open up.
- The CEO noted the need to see an increase in child health vaccinations such as MMR and also stressed the importance of people getting the influenza vaccination especially for Māori over 55 and non-Māori over 65.
- The CEO acknowledged all those who played a critical part to enable people to live with COVID-19 whilst isolating including welfare providers, Māori providers, pharmacies, general practices, rest homes and those who provided services into people's homes such as home support workers and district nurses.

- The DHB and PHO had been providing welfare packs to pharmacies and general practices, and fruit boxes had been sent to every provider, on behalf of the DHB, to thank them for their service at this time. Wellness parcels (fruit and confectionary) were also being delivered to all staff at the DHB.

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:

- There were still difficulties in recruiting to some positions due to borders being closed.
- A number of staff were away due to COVID-19 (either testing positive or self-isolating due to household or close contact).
- There was continued supply chain disruption due to COVID-19 which was affecting capital works. Andrew thanked facilities staff and contractors for the hard work they were doing in this difficult environment.
- Work was being done to fill those gaps as fast as possible to ensure those services could continue.

RECOMMENDATION

That the Board:

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

Adopted

STRATEGIC DELIVERY

8. TE ARA WHAKAWAIORA – MENTAL HEALTH AND ADDICTIONS

The following were in attendance for this item:

- *David Warrington, General Manager, Mental Health and Addictions*
- *Anoek Dechering, Medical Director, Mental Health and Addictions*
- *Peta Rowden, Director of Nursing, Mental Health and Addictions*
- *Frances Oliver, Director of Allied Health, Mental Health and Addictions*

This report provided a progress update on the Mental Health and Addiction Service priorities, indicators and achievement of equity targets. Te Ara Whakawaiora's focus had been on the following Mental Health and Addiction areas:

- Minimising restrictive care
  - 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)

The following comments were noted during discussion:

- Outcomes against the indictors related to actions both within the provider arm and also out the community.

- While a significant amount of work was being undertaken to improve performance and reduce inequity, the targets were still below where we would like to be.
- There had been significant staffing challenges in 2021 with a high a number of vacancies. Dr Dechering advised that approximately 40 percent of her time was currently taken up with recruitment. A Board member asked for an update on the DHB's recruitment strategy for the next meeting. Action
- David Warrington provided an update on some of the work underway to recruit staff. This included:
  - Looking at relocation packages for non-medical staff. That resulted in small results as other DHBs also struggled in this area.
  - Going to bespoke recruitment agencies to target mental health and addiction specialists from outside New Zealand (using the under-spend to fund this).
  - Looking to bring on more new nursing graduates for mental health both in secondary care and also NGOs as they were struggling as well.
- The team continued to look at service improvements while focusing on recruitment and retention issues.
- CAFS (Child Adolescent and Family Service Te Harakeke) was being relocated to Avenue Road later this year and the Crisis Hub (Te Tāwharau) was expected to be up and running by August which would see a new approach to crisis management working in partnership with MSD on site
- The DHB was also working with Te Taiwhenua o Heretaunga to enable them to provide a 24/7 crisis service so there were a number of service improvement initiatives currently underway while dealing with COVID-19
- Individuals within community families were expressing heightened levels of distress and anxiety and regional leaders were doing as much as they possibly could to ensure people had access to food, income if not working and were able to get calls from both welfare providers and primary/community clinicians. MSD, together with local government, had been doing a lot of work with the homeless community where they find themselves affected by COVID-19.
- In terms of secondary services, the DHB had a detailed service plan to assist with the COVID-19 response and was seeing teams working differently and working across areas to cover where the most acute need was required.
- In response to a question regarding the rate for Section 29 (Compulsory Treatment Orders) for Māori, members were advised that the inequity had persisted over a five-year period so was not a new trend and not one that could be attributed to COVID-19. However, the data was encouraging and hopefully over time the rate would improve given the initiatives that were being put in place.
- It was noted that seclusion readmission rates within 28 days post discharge was elevated for Māori. A member asked if future reporting could include data showing the trends. **Action**

RECOMMENDATION

That the 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.

Moved: Shayne Walker
Seconded: Heather Skipworth

Carried

NOTING REPORTS

9. HAWKE'S BAY HEALTH CONSUMER COUNCIL REPORT

The Executive Director of Planning, Funding and Performance provided an overview of the matters discussed at the Hawke's Bay Health Consumer Council meeting on 3 March 2022.

RECOMMENDATION

That the Board:

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

Adopted

10. RECOMMENDATION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board:

Exclude the public from the following items:

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)

Moved: Shayne Walker
Seconded: Peter Dunkerley

Carried

The Chair welcomed Emma Horsley, Executive Director Communications, who was attending her first meeting. Emma provided a brief summary of her background.

The Chair thanked members of the public for viewing the meeting via Facebook and on behalf of the Board, thanked everyone for their attendance today.

The public section of the Board meeting concluded at 1.42pm

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	22/3/22	**Te Ara Whakawaiora – Mental Health and Addictions** Future reporting to include trends for seclusion readmission rates within 28 days post discharge for Māori	Chief Operating Officer	TBC	

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**April 2022 DHB CEO BOARD GOVERNANCE REPORT**
	For the attention of: **HBDHB Board**
Document Author(s)	Keriana Brooking
Date	14 April 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 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 Minister Verrall who met with DHB Public Health staff and visited Te Taiwhenua o Heretaunga • 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 Ministry of Health (MoH) weekly meetings • Attended the Central Region CE's meeting • Attended the National Bipartite Advisory Group meeting • Attended the National DHB CEO meeting • As DHB CEO co-lead for Allied Health attended the National Directors Allied Health meeting • Attended the blessing for Avenue Road • Attended the farewell for National Hauora Coalition Chief Executive, Simon Royal • As acting CEO lead for Central Region COVID, attended the desk top review with the MoH of the Central Region COVID Care in the Community Response
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
During March, daily emergency department (ED) attendances were relatively unchanged compared with February. The average bed occupancy at 8am for the same period was 96.5 percent, an improvement on the previous month which recorded 101.3 percent and significantly lower compared with March 2021 - when occupancy was at 106.5 percent and overall attendance numbers were 15 percent higher. Performance against the six-hour standard was 74.8 percent for the month, an improvement on the previous month (74.4 percent) and also March 2021 (73.4 percent).

The COVID Omicron outbreak affected all but eight days of March, and COVID-positive presentations in the hospital triggered the opening of the planned COVID ward and intensive care unit in Ruakopito (the Endoscopy Building). Over this period, COVID affected a range of clinical and non-clinical staff, with more than 250 people away from work at the peak. Emergency department consultants increased their workload to provide extra cover at the front of house. This enabled faster decision making and discharging of COVID patients who did not require admission.

Planned Care
Outpatient activity remained steady throughout March, whereas onsite elective productivity and delivery performance dropped significantly as a result of activating our COVID response plan. This result was an anticipated consequence of the planned response.

- A net total of 1,903 referrals were received in February. This was 68 more than January, as expected due to the holiday period. In total, 2,104 patients were provided with First Specialist Assessments in March – a level that is consistent with the planned level of outpatient work.
- The number of patients overdue against the ESPI2 measure increased by 48 patients in March. The proportion waiting four months or more for their appointment sits at 38.8 percent, up slightly from 36.5 percent in February.

In respect of elective surgery, HBDHB delivered 65.4 percent of the overall MoH production planning discharge target in March (a total of 437 discharges vs 668 plan in March). This fall in production was expected and is the direct result of the Omicron outbreak. Further, given that there were eight days of normal production, the result will be lower in April.

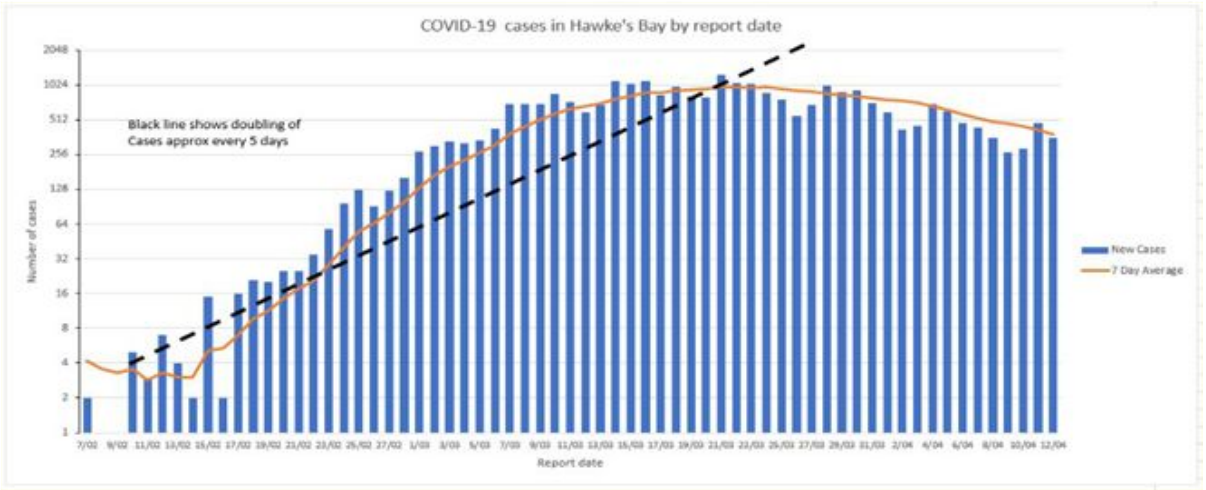
*Discharge summaries below provide an incomplete performance picture for Inter District Flows due to reporting processes and MoH data being relevant to the 20th of month following.

- Inter District Flow (IDF) activity shows 59 discharges in March against a plan of 69 discharges (85.5 percent).
- On-site activity was significantly down this month (as expected due to the Omicron response), with 274 discharges in March against a plan of 483 representing 56.7 percent of plan.
- Outsourced activity was in line against the plan with 94 discharges so far registered against the plan of 104 (90.4 percent). Again, this is an incomplete month-end position as, like IDF activity, there is a normal delay in offsite discharges being registered.
- Overall, the waiting list for surgery has increased by 183 to 2,479 with 45.6 percent of these patients waiting more than the ESPI5 measure of four months. This equates to 155 more patients compared with February (42.5 percent overdue) and is the result of a sustained number of patients listed for surgery coupled with the reduction in the number of procedures performed.

COVID UPDATE

The Government announced on 13 April New Zealand would move down to the orange setting of the COVID-19 protection framework from 11.59pm Wednesday 13 April, in time for the school holidays and Easter weekend. Nationally there is still pressure across the hospital network and some regions have not yet reached their Omicron Peak.

- The isolation period for COVID-19 cases and their household contacts is 7 days.
- Household contacts will need to have a rapid antigen test at day 3 and day 7 of their isolation period. If they become symptomatic, they should also get a test and, if the result is positive, they are required to isolate for 7 days from that point.
- Day 0 is the day someone tests positive or becomes symptomatic (whichever comes first).
- Recovered cases no longer need to self-isolate if they become a household contact within 90 days after having the virus.
- Where possible, outpatient appointments are shifting to virtual consultations, with patients being contacted directly to discuss their appointments or planned care clinical assessments.
- Vaccine passes are no longer required. There are no indoor or outdoor capacity limits and the seated and separated rule for hospitality venues is lifted. Facemask requirements in indoor settings remain unchanged.
- 16 and 17-year olds can now get a booster vaccination six months after completing their primary course (for those aged 18+ the wait time is 3 months).



RECRUITMENT AND RETENTION INITIATIVES TO SUPPORT OUR WORKFORCE IN RURAL COMMUNITIES

A previous update was provided on 15 February 2022 which noted the need for the DHB to provide additional nursing support in rural communities, with current challenges specific to the Glengarry aged residential facility in Wairoa.

A range of initiatives have been scoped to support recruitment and retention of our health care associate and nursing workforce in Wairoa. The cost estimate for all the initiatives is approximately $560,000 in operational funding. The initiatives include:

- Establishment of ongoing education fund across DHB provided and funded services and a Nurse Educator role.
- Two part-time nurse specialty roles (total 1.0 FTE) in areas requiring additional support (long term conditions and palliative care).

- Establishment of two supernumerary roles for nurse entry to practice (NETP) positions as well as travel and accommodation incentives.
- An additional clinic on wheels (two vehicles with full clinical kit to support rural healthcare delivery).

It is likely total funding requested to operationalise the plan will not be available from within existing budgets, and phasing of the initiatives will be required. The recruitment and retention initiatives for rural workforce is being piloted in Wairoa first and, pending the evaluation, will be expanded for other professional scopes and to other rural communities (Central Hawke's Bay).

It is important to note that one of the ongoing challenges in Wairoa is quality accommodation. The hostel has been noted as unsuitable either for NETP nurses who are on placement in Wairoa, or for permanently appointed staff looking for permanent accommodation. We are working closely with the Facilities team on opportunities for a refurbishment as part of capital works within this financial year (2021/22).

PACIFIC HEALTH LOCALITY PLANNING

Pacific Health is leading the development of a Pacific health locality plan for Hawke's Bay. This will guide the transition of Pacific Health into the health reforms. The plan will build on the foundational success of HBDHB's equity investment 2021 and the high rates of Pacifica COVID vaccination uptake. The plan will be led by the Pacific community, and is inclusive of Pacific workers in the Regional Seasonal Employment Scheme (RSE). Partnering for success with health services and wider agency groups will also underpin this plan. Key components of the Pacific locality plan include:

- Locality establishment
- Locality approach
- Implementation
- Funding
- Additional support

Furthermore, over the next three years, strategic resourcing provided by the Ministry of Health will be utilised to strengthen the capacity and capability development of Pacific providers and Pacific community church groups. The strategic resourcing will also be utilised to develop a Pacific mental health roadmap for implementation.

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	April 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 Board: **Note** the contents of this report	

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

The operating result is $2.6m favourable year to date. Vacancies, challenges implementing some funding strategies, increased non-MoH income, and supply chain issues contribute favourably to the result, and are partly offset by challenges identifying efficiencies and outsourcing to cover covid related surgical capacity issues.

The surplus/(deficit), including COVID-19 and Holidays Act, is $7.4m favourable year to date. The result includes COVID-19 income relating to costs incurred in prior years and recognised in February, and additional project costs relating to Holidays Act remediation.

$'000	March Actual	March Budget	March Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast	Refer Appendix
Operating Revenue	60,502	59,632	870	1.5%	540,399	534,327	6,073	1.1%	718,554	1
Less:										
Providing Health Services	32,190	31,746	(444)	-1.4%	264,384	269,224	4,840	1.8%	359,954	2
Funding Other Providers	26,341	26,455	114	0.4%	231,715	229,854	(1,861)	-0.8%	310,865	3
Corporate Services	6,118	6,090	(29)	-0.5%	50,105	50,115	10	0.0%	68,391	4
Reserves	(1,112)	(1,408)	(296)	-21.0%	6,620	173	(6,447)		11,010	5
Operating Result	**(3,035)**	**(3,250)**	215	6.6%	**(12,425)**	**(15,039)**	2,614	17.4%	**(31,666)**	
Plus:										
Emergency Response (COVID-19)	(332)	-	(332)	0.0%	5,500	-	5,500	0.0%	4,168	
Holidays Act Remediation	(250)	(293)	43	14.6%	(2,951)	(2,256)	(694)	-30.8%	(3,714)	
	(3,618)	**(3,543)**	(75)	-2.1%	**(9,876)**	**(17,295)**	7,419	42.9%	**(31,212)**	

Forecast

The forecast deficit for the year is $31.2m, $3.2m adverse to plan. This is a $2.3m improvement on last month, driven mainly by lower expenditure from reserves. The variance from plan comprises:

- Revenue $5.1m favourable including higher revenue from MoH, other DHBs, and ACC, which are offset by the funding or providing of health care services they relate to.
- Providing Health Services $2.2m favourable mainly due to challenges filling vacancies and new positions, mostly in allied health. Favourable personnel costs are partly offset by high outsourced elective surgery (mitigated by lower in-house surgery due to reduced capacity relating toCOVID-19), and higher than budgeted patient transport costs (COVID-19 requirements).
- Funding other providers $0.7m adverse mainly pharmacy services, primary care expenditure funded by additional MoH income, and crisis respite in mental health, partly offset by underspends in residential care and home support for older persons, and Whānau Ora services.
- Corporate $0.5 adverse as unbudgeted capital charges relating to the $25m equity injection in June 2021, were offset by lower depreciation (capital expenditure slippage), and staff vacancies.
- Reserves $12.7m adverse reflecting unidentified savings, and provisioning for MECA settlements, partly offset by lower spend expected on investment initiatives.
- COVID $4.2m favourable due to MoH funding prior year expenditure, partly offset by additional staff costs.
- Holiday's Act remediation $0.7m adverse due to higher project costs.

Not included in the forecast, because they relate to a prior period, or there is current uncertainty over the amount, 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-19 funding that is unlikely to be spent.

Other Performance Measures

	March				Year to Date				Year End Forecast	Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Capital spend	1,235	3,338	(2,103)	-63.0%	17,597	30,461	(12,864)	-42.2%	29,275	12
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,742	2,915	173	5.9%	2,763	2,853	90	3.1%	2,890	2 & 4

- Capital spend (Appendix 10)

  Capital spend to February is at 57 percent of plan (last month 59 percent). This is caused by slippage in strategic projects, and delivery issues relating to COVID-19 in the facilities and clinical equipment blocks.

- Cash (Appendices 9 & 11)

  The cash low point for the month was $6.8m overdrawn on 3 March (the previous month was $9.6m overdrawn on 3 February).

- Employees (Appendices 2 & 4)

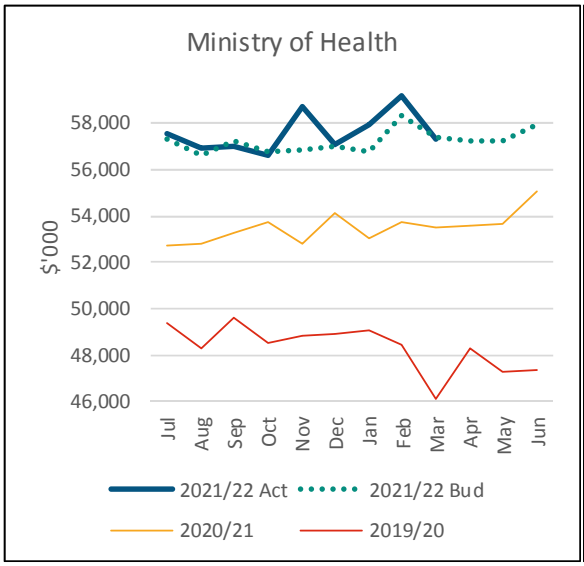
  The lower than planned employee FTE numbers reflect the continuing challenges recruiting to vacant and new positions.

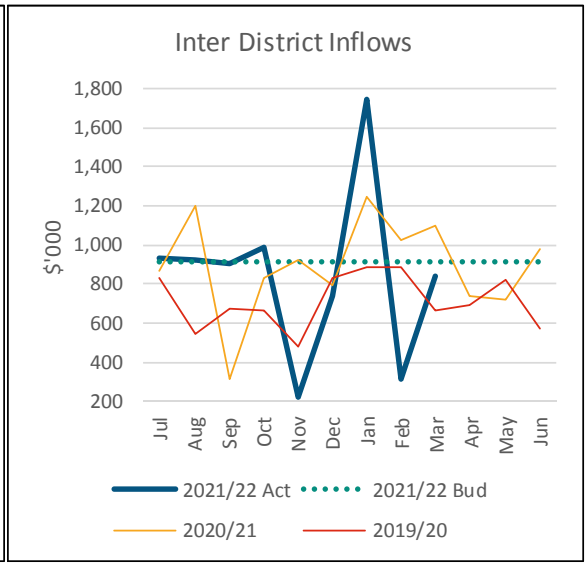
APPENDICES

1. OPERATING REVENUE

MoH revenue to fund new or additional services, the provision of COVID-19 tests to primary providers, back-dated price increases for ACC rehabilitation services, and increased service provision to other DHBs contribute to the favourable result.

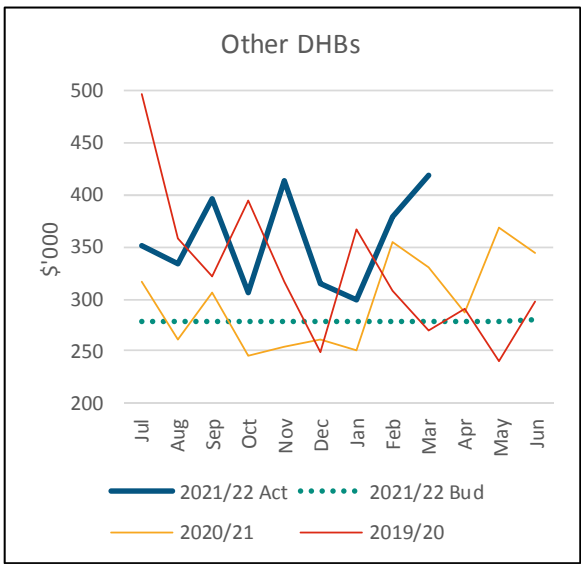
Excludes revenue for COVID-19	*March*				*Year to Date*				*Year End*
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*
Ministry of Health	57,361	57,429	(68)	-0.1%	518,523	514,482	4,041	0.8%	690,121
Inter District Flows	842	913	(71)	-7.8%	7,606	8,221	(615)	-7.5%	10,347
Other District Health Boards	418	278	140	50.1%	3,213	2,506	707	28.2%	4,165
Financing	24	4	20	562.0%	167	33	134	409.5%	178
ACC	1,171	478	693	145.1%	4,995	4,216	779	18.5%	6,365
Other Government	33	35	(2)	-5.8%	366	332	34	10.2%	457
Abnormals	1	-	1	0.0%	6	-	6	0.0%	6
Patient and Consumer Sourced	129	121	8	6.9%	1,049	1,087	(38)	-3.5%	1,353
Other Income	522	373	149	40.1%	4,474	3,448	1,025	29.7%	5,563
	60,502	**59,632**	870	1.5%	**540,399**	**534,327**	6,073	1.1%	**718,554**

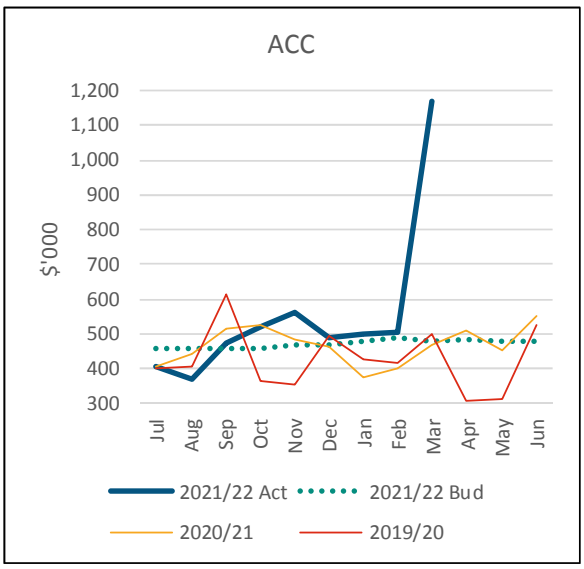




Ministry of Health ($4.0m favourable YTD)
Additional sustainability funding relating mainly to MECA settlements, and funding for new services.

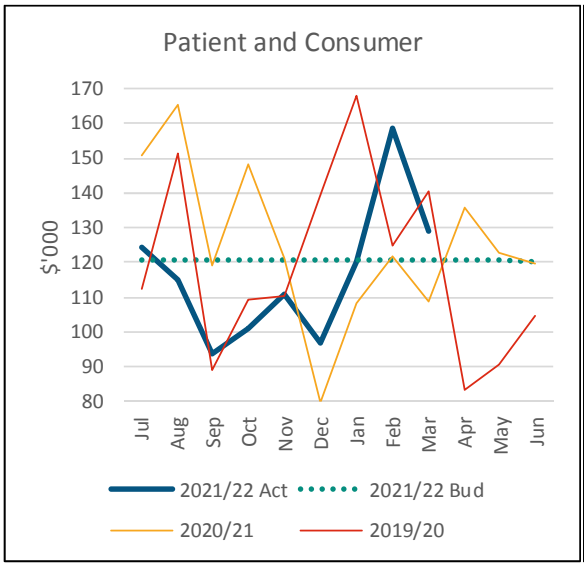
Inter District Flows ($0.6m adverse YTD)
Inter District Flows are inherently volatile due to the small volume and high cost.

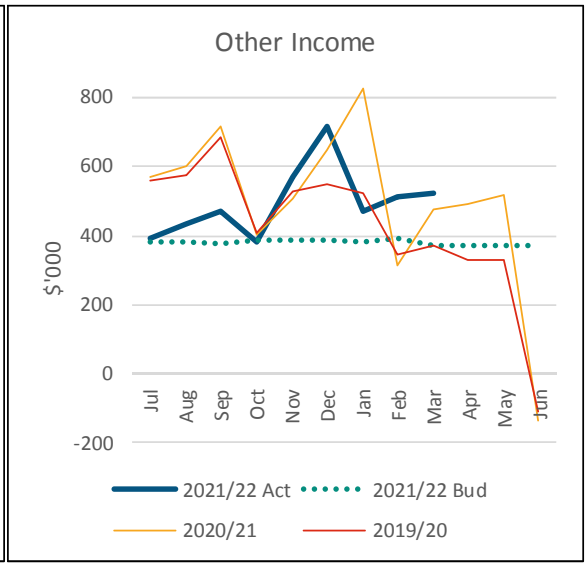




Other District Health Boards ($0.7m favourable YTD)
Mid Central DHB for oncology clinics, Capital & Coast Health for neurosurgery clinics, Tairawhiti DHB for pharmaceutical cancer treatments (PCTs), and a number of DHBs for patient transport reimbursements.

ACC ($0.8m favourable YTD)
The increase in March is from back payments resulting from a price increase for non- acute rehabilitation services.



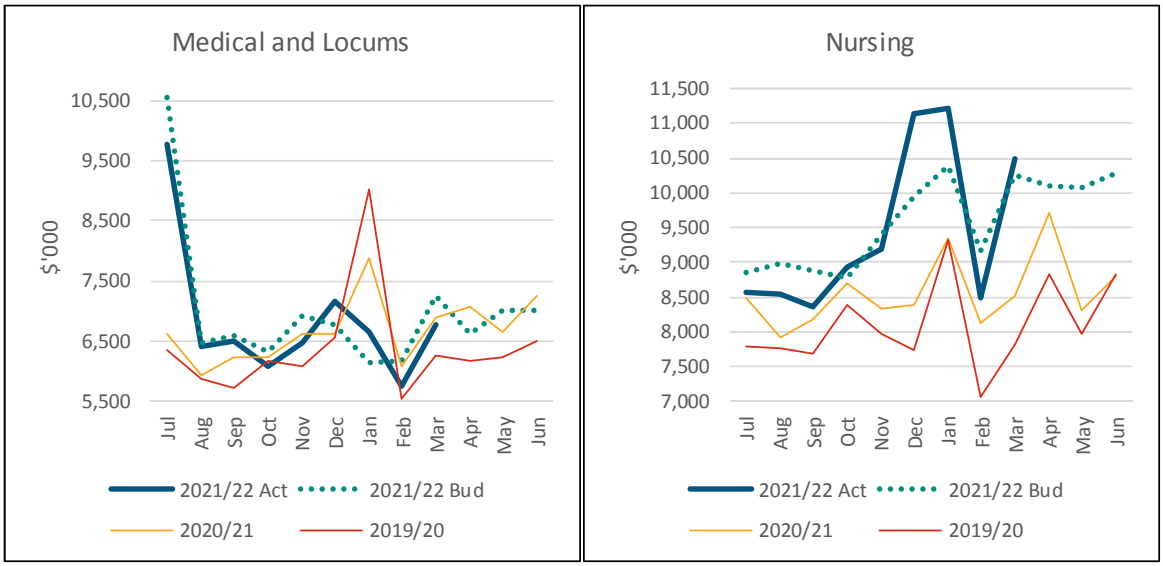


Patient and Consumer (close to budget YTD)
Reduced audiology co-payments, mostly offset by increased non resident charges.

Other income ($1.0m favourable YTD)
Mainly the provision of Covid tests to primary providers, partly offset by reduced traffic through Zacs.

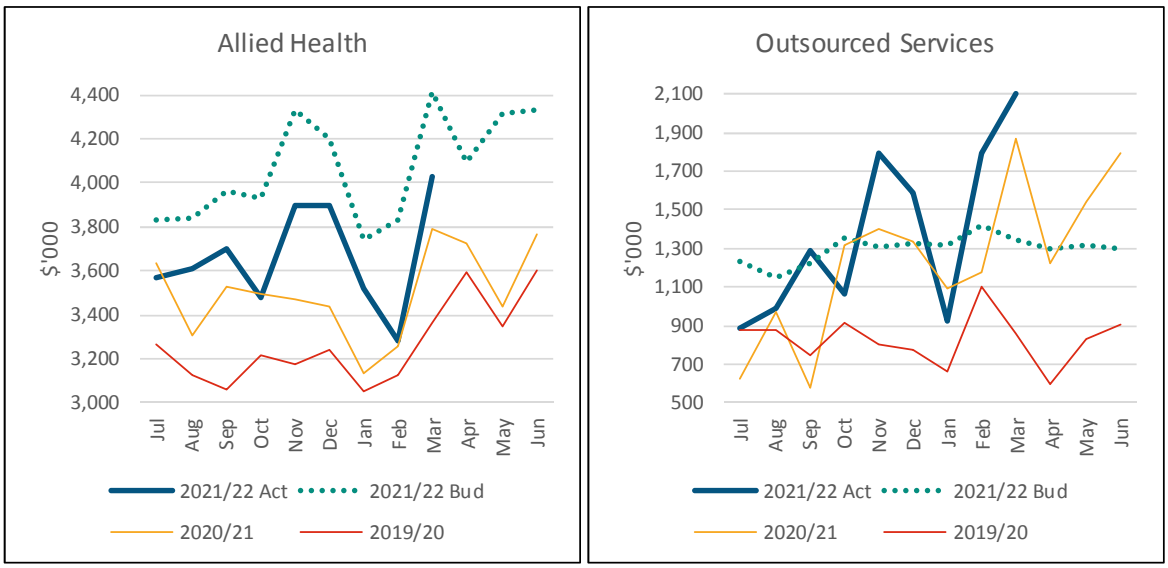
2. PROVIDING HEALTH SERVICES

Outsourcing electives to cover COVID-19 related reduced surgical capacity drives the $0.4m adverse result in March, and recruitment challenges drive the $4.8m favourable result Year-to-Date.



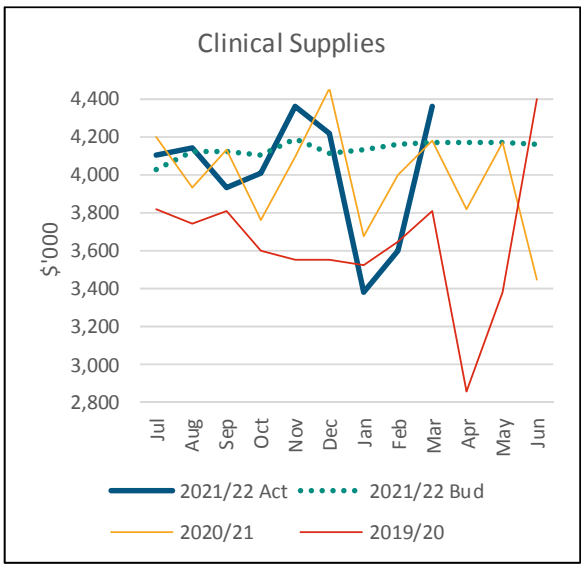
Medical personnel and locums ($1.6m favourable YTD)
Vacancies and low use of continuing medical education leave (CME) reflecting COVID-19 restrictions - partly offset by locum cover. The high budget in July, and the low budget in January in comparison to prior years, reflects the change in entitlement date for CME from 1 January to 1 July of each year.

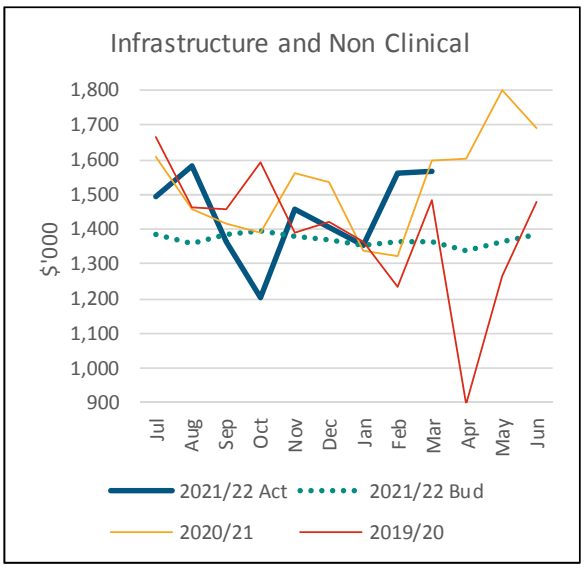
Nursing ($0.3m adverse YTD)
Vacancies more than offset by increased leave entitlements, overtime and allowances reflecting the current challenges filling rosters.



Allied Health ($3.1m favourable YTD)
On-going vacancies in social workers, therapists, psychologists, community support workers, pharmacists, medical imaging technologists, technicians, and health promotion workers.

Outsourced services (0.8m adverse YTD)
Outsourced elective surgery has increased to help cover the reduced surgical capacity in the hospital, caused by beds being needed for COVID-19. Lower volumes in October and January reflect holiday periods.

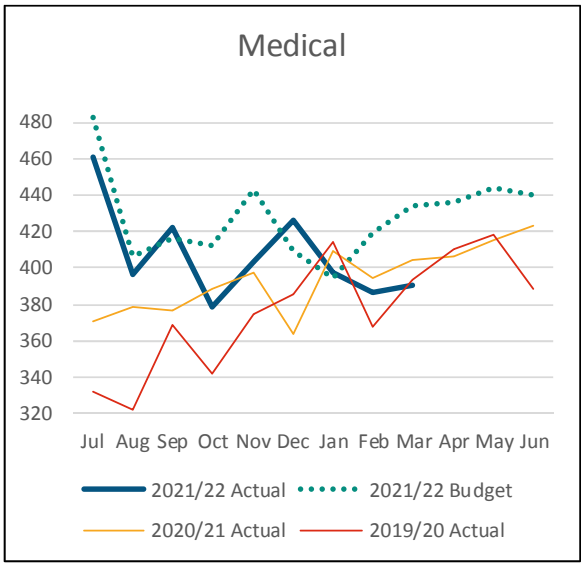


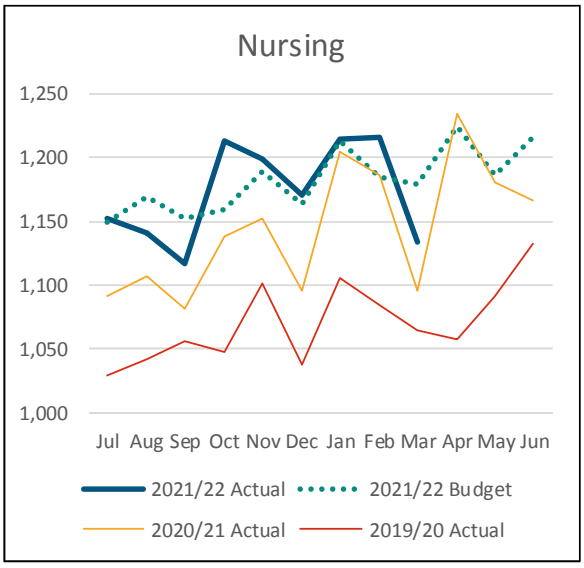


Clinical supplies ($1.0m favourable YTD)
Reduced disposable instruments, treatment disposables, and pharmaceuticals over January/February have returned to more normal levels in March. Patient transport costs drive the variance from budget in March.

Infrastructure and non clinical supplies ($0.6m adverse YTD)
Security, cleaning, food and laundry partly offset in staff travel costs.

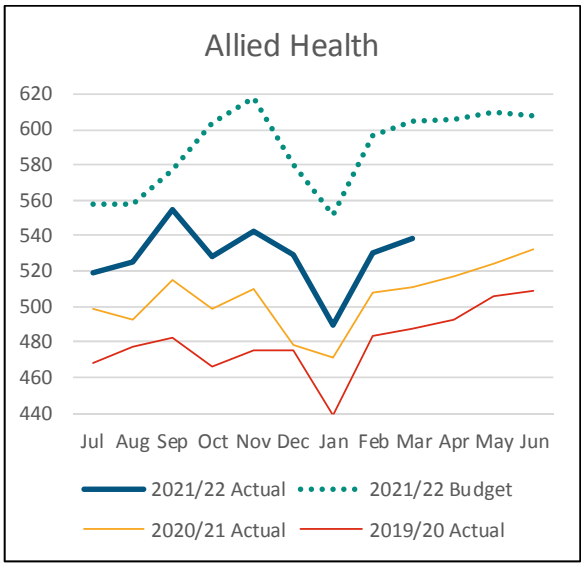
Full Time Equivalents (FTE)

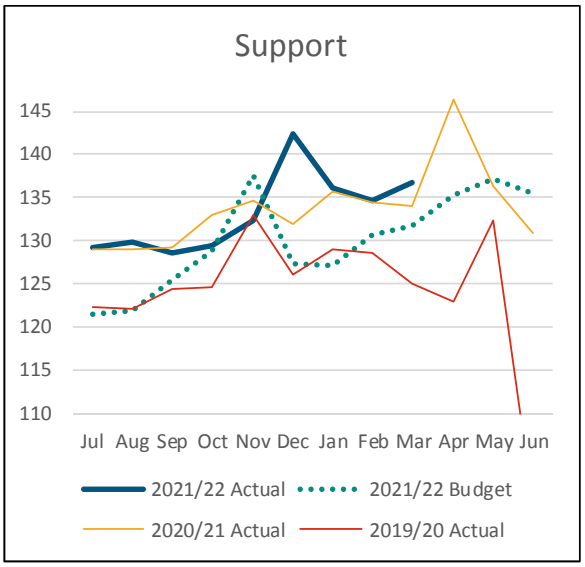




Medical personnel (17 FTE / 4.1% favourable)
Recruitment challenges and long lead times to onboard medical staff, marginally offset by higher leave costs. High costs in July relate to entitlements for continuing medical education leave.

Nursing personnel (1 FTE / 0.1% favourable)
Vacancies more than offset by additional leave and overtime costs.





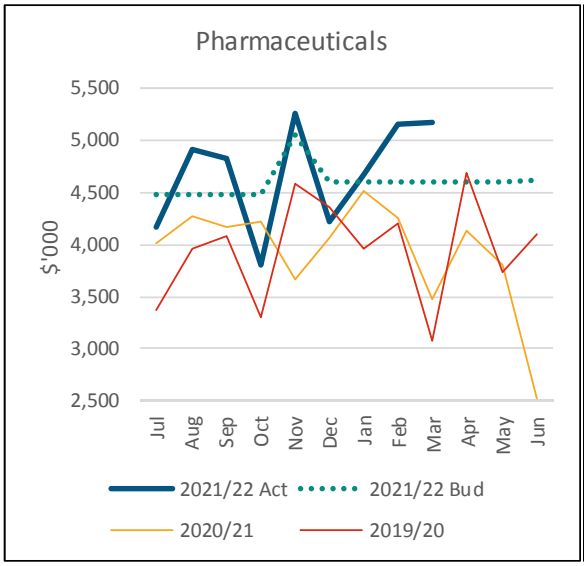
Allied health personnel (54 FTE / 9.3% favourable)
Ongoing difficulty filling vacancies including therapists, social workers, community support workers, pharmacists, psychologists, technicians, health promotion staff, and medical imaging technologists.

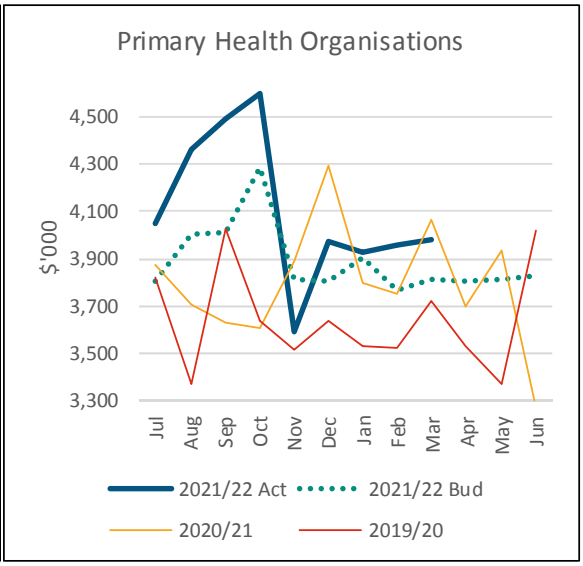
Support personnel (-5 FTE / -4.2% adverse)
Kitchen assistants, orderlies, and additional security driven by patient activity and dependency. Partly offset by sterile supply vacancies.

3. FUNDING OTHER PROVIDERS

Higher than budgeted year-to-date spend is offset by additional operating revenue above.

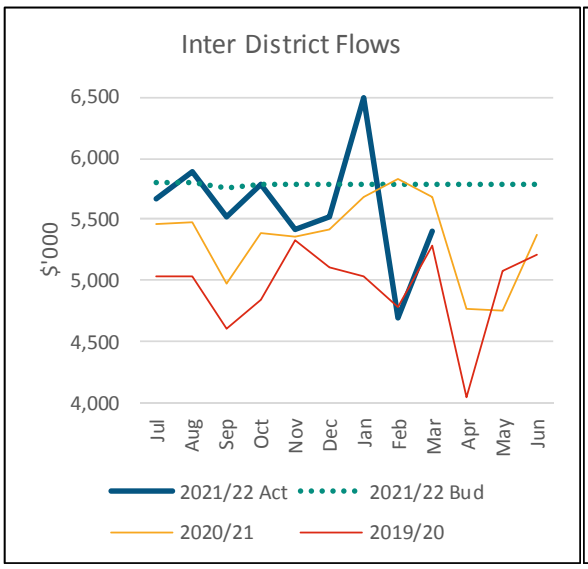
$'000	March Actual	March Budget	March Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	5,172	4,605	(567)	-12.3%	42,187	41,362	(825)	-2.0%	56,508
Primary Health Organisations	3,983	3,813	(170)	-4.4%	36,938	35,205	(1,733)	-4.9%	49,294
Inter District Flows	5,401	5,781	380	6.6%	50,383	52,052	1,669	3.2%	67,726
Other Personal Health	2,361	3,106	745	24.0%	23,174	22,063	(1,111)	-5.0%	32,446
Mental Health	2,186	1,515	(671)	-44.3%	14,139	13,100	(1,039)	-7.9%	18,708
Health of Older People	6,616	7,057	441	6.2%	60,436	61,975	1,539	2.5%	80,568
Other Funding Payments	622	578	(44)	-7.6%	4,458	4,097	(361)	-8.8%	5,616
	26,341	26,455	114	0.4%	**231,715**	**229,854**	(1,861)	-0.8%	310,865
Payments by Portfolio									
Strategic Services									
Secondary Care	4,639	5,153	514	10.0%	46,873	48,458	1,586	3.3%	63,386
Primary Care	11,237	11,017	(220)	-2.0%	94,475	90,832	(3,643)	-4.0%	127,632
Mental Health	1,970	1,825	(145)	-7.9%	16,697	16,055	(642)	-4.0%	22,258
Health of Older People	7,666	7,624	(42)	-0.5%	66,922	67,710	788	1.2%	88,793
Maori Health	735	738	2	0.3%	5,872	5,887	15	0.3%	7,626
Population Health	94	98	4	4.5%	878	913	35	3.8%	1,170
	26,341	26,455	114	0.4%	**231,715**	**229,854**	(1,861)	-0.8%	310,865

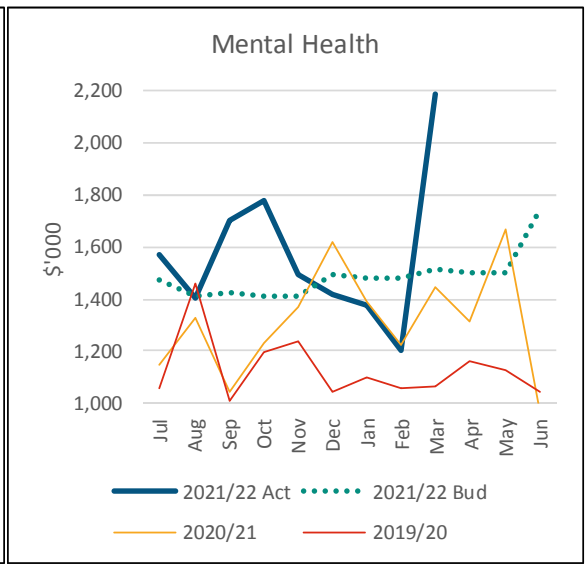




Pharmaceuticals ($0.8m adverse YTD)
Based on latest available PHARMAC forecasts and community and hospital pharmacy activity.

Primary Health Organisations ($1.7m 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.

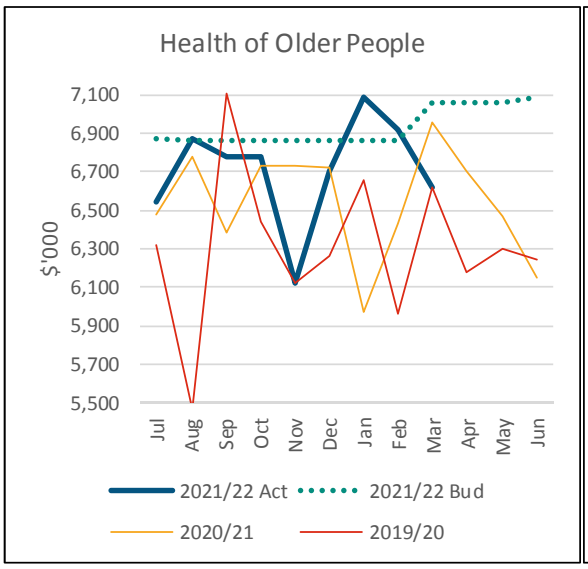


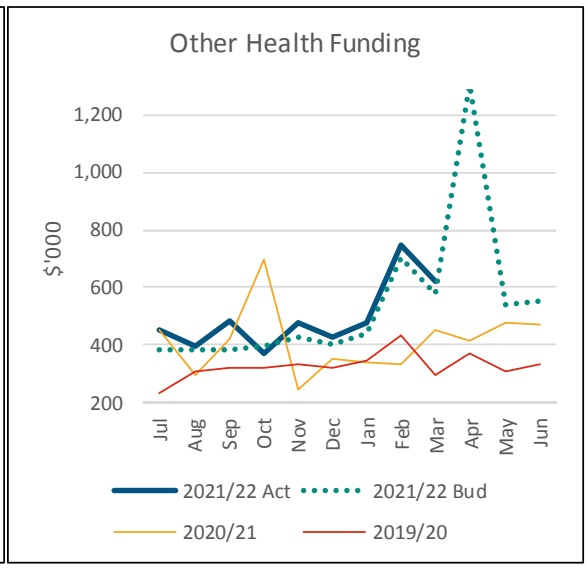


Inter District Flows ($1.7m favourable YTD)
Inter District Flows are inherently volatile due to the small volume and high cost.

Other Personal Health ($1.1m adverse YTD)
Mainly additional professional pharmacy advisory services. Also includes payments to the PHO for chronic conditions, and specialist behaviour support services.

Mental Health ($1.0m adverse YTD)
Mainly additional expenditure funded by additional MoH revenue under operating revenue above. March includes new funding for the PHO, and the cessation of the transfer of pay equity funding to a separate category in Health of Older People for reporting to MoH, as it is no longer required. Stopping the transfer increases expenditure in Mental Health and reduces expenditure in Health of Older People, and gives a more accurate picture of where expenditure is being incurred.





Health of Older People ($1.5m favourable YTD)

Capacity constraints including staffing issues. November included a reassessment of provisioning for outstanding costs between July and November, and January includes high levels of residential care.

Other Funding Payments ($0.4m 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	March Actual	March Budget	March Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	2,124	2,127	4	0.2%	16,407	17,163	756	4.4%	22,315
Outsourced services	81	70	(11)	-15.3%	545	634	89	14.0%	713
Clinical supplies	98	142	44	31.1%	1,365	1,179	(186)	-15.8%	1,885
Infrastructure and non clinical	1,897	1,845	(52)	-2.8%	14,965	14,824	(140)	-0.9%	20,664
	4,199	4,185	(15)	-0.4%	33,282	33,800	518	1.5%	45,577
Capital servicing									
Depreciation and amortisation	1,428	1,547	119	7.7%	12,463	13,124	661	5.0%	16,875
Financing	1	25	24	95.3%	10	191	181	94.6%	73
Capital charge	490	333	(157)	-47.0%	4,350	3,000	(1,350)	-45.0%	5,867
	1,919	1,905	(14)	-0.7%	16,824	16,315	(508)	-3.1%	22,814
	6,118	**6,090**	(29)	-0.5%	**50,105**	**50,115**	10	0.0%	**68,391**
Full Time Equivalents									
Medical personnel	0.7	0.8	0	8.7%	1	1	0	0.4%	0.8
Nursing personnel	9.1	6.3	(3)	-44.9%	7	6	(2)	-30.4%	5.7
Allied health personnel	6.1	1.6	(4)	-277.4%	2	2	(0)	-20.2%	1.6
Support personnel	28.4	30.9	2	8.1%	27	30	3	10.3%	30.6
Management and administration	193.7	200.4	7	3.4%	188	195	7	3.6%	197.3
	238.0	**240.0**	2	0.8%	**225**	**233**	8	3.5%	**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	March Actual	March Budget	March Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Investment reserves	(1,250)	(71)	1,179	1665.2%	1,889	7,806	5,918	75.8%	4,668
Efficiencies	-	(1,121)	(1,121)	-100.0%	-	(7,905)	(7,905)	-100.0%	-
Other	138	(217)	(354)	-163.5%	4,731	271	(4,460)		6,343
	(1,112)	**(1,408)**	(296)	21.0%	**6,620**	**173**	**(6,447)**		**11,010**

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 included are the net effect of unusual items not covered by budgets.

6. FINANCIAL POSITION

30 June 2021	$'000	March Actual	March Budget	Variance from budget	Movement from 30 June 2021	Annual Budget
	Equity					
253,745	Crown equity and reserves	265,997	272,569	(6,572)	12,252	278,467
(135,621)	Accumulated deficit	(145,497)	(148,449)	2,953	(9,876)	(159,199)
118,124		120,500	124,119	(3,619)	2,376	119,268
	Represented by:					
	Current Assets					
574	Bank	5,627	4	5,623	5,053	4
1,451	Bank deposits > 90 days	1,460	2,055	(595)	9	2,055
22,480	Prepayments and receivables	34,221	22,054	12,167	11,741	20,048
4,975	Inventory	5,085	4,556	530	111	4,569
29,480		46,393	28,669	17,724	16,913	26,675
	Non Current Assets					
208,941	Property, plant and equipment	213,415	225,630	(12,215)	4,474	230,151
16,514	Intangible assets	17,103	13,519	3,583	589	13,238
1,673	Investments	1,350	1,341	8	(324)	1,341
227,128		231,867	240,491	(8,623)	4,739	244,731
256,608	**Total Assets**	**278,260**	**269,160**	**9,101**	**21,652**	**271,406**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	20,775	20,775	-	26,762
40,876	Payables	51,376	32,311	(19,065)	(10,500)	32,451
94,519	Employee entitlements	103,296	88,666	(14,630)	(8,777)	86,636
-	Current portion of borrowings	-	-	-	-	3,000
135,395		154,671	141,751	(12,920)	(19,277)	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**	**157,760**	**145,040**	**(12,720)**	**(19,277)**	**152,138**
118,124	**Net Assets**	**120,500**	**124,119**	**(3,619)**	**2,376**	**119,268**

Variances from budget:

Prepayments and receivables include $27.5m relating to MoH, and $2.2m for ACC.

Payables include the receipt of $11.1m from MoH for services yet to be provided, including $9.9m for nurse pay equity funding, treated as income in advance pending further information to determine when it will be recognised as revenue. Capital project accruals amount to $2.7m, and accruals for unbilled older persons and mental health residential care make up most of the remaining variance.

Capital expenditure slippage has contributed to an improved cash position.

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	March Actual	March Budget	March Variance from budget	March Movement from 30 June 2021	Annual Budget
17,532	Salaries & wages accrued	17,418	15,169	(2,249)	114	13,825
1,160	ACC levy provisions	1,884	119	(1,765)	(724)	190
6,727	Continuing medical education	8,906	2,943	(5,963)	(2,179)	1,743
67,169	Accrued leave	73,141	68,513	(4,628)	(5,972)	68,945
5,019	Long service leave & retirement grat.	5,036	5,211	175	(17)	5,222
97,608	**Total Employee Entitlements**	106,385	91,955	(14,430)	(8,777)	89,925

Variances from budget:
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-19 factors.

8. PLANNED CARE

MoH data to February is tabled below. Funding is largely determined on performance against Inpatient Caseweight Delivery and this report shows 84 percent of plan was achieved to the end of February (83.3percent in January). 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	5,475.5	1,918.2	7,393.8	6,209.7	84.0%	10,945.1
Inpatient Surgical Discharges	3,629	1,380	5,009	4,407	88.0%	7,427
Minor Procedures	1,434	612	2,046	3,247	158.7%	2,984
Non Surgical interventions	24	56	80	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: 4/04/2022 **NNPAC Refresh Date:** 4/04/2022
Data up to: Feb 2022 **Report Run Date:** 4/04/2022

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 March was $5.0m in funds (February was $2.0m 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, however April's low point is projected to be $7.4m overdrawn on 29 April.

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 57 percent of plan (last month 59 percent). This is caused by slippage in strategic projects, and ongoing delivery issues relating to COVID-19 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	12,463	13,124	(661)	16,875	17,702	(828)			
	12,463	13,124	(661)	16,875	17,702	(828)			
Other Sources									
Special Funds and Clinical Trials	107	-	107	107	-	107			
Funded Programmes	91	-	91	91	-	91			
Finance Leases (Clinical Equipment)			-	-	620	(620)			
Equity Injection	9,734	-	9,734	16,722	22,657	(5,935)			
Equity (Prior year expenditure)	2,518	-	2,518	2,518	-	2,518			
	12,450	-	12,450	19,439	23,277	(3,838)			
Total funds sourced	**24,913**	**13,124**	**11,789**	**36,313**	**40,979**	**(4,666)**			
Application of Funds:									
Block Allocations									
Facilities	816	1,523	707	2,370	2,019	(351)			
Information Services	2,202	2,249	47	3,114	3,000	(114)			
Clinical Equipment	1,303	2,249	946	2,513	3,000	487			
	4,321	6,022	1,700	7,998	8,019	21			
MOH funded Startegic									
Surgical Services Expansion Project	3,277	3,277	-	3,277	3,277	-	20,843	20,843	-
Radiology Facilities Redevelopment	474	1,879	1,405	700	2,490	1,790	-	25,100	25,100
Main Electrical Switchboard Upgrade	1,328	2,334	1,006	1,929	3,114	1,185	4,000	4,000	
Planned Care Procedure Rooms x 4	140	1,125	985	882	1,924	1,042	1,924	1,924	
Rapid Fast Tracked Projects	29	-	(29)	29	2,600	2,571	2,600	2,600	
Data and Digital	9	-	(9)	2,550	2,550	-	2,500	2,550	
Mobile Dental Clinics	919	1,048	129	1,536	1,536	-	1,600	1,600	-
Angiography Suite Replacement	1,322	1,964	642	1,638	2,888	1,250	1,750	3,000	1,250
Procedure Rooms Upgrade Endo Building	1,099	2,029	929	1,845	2,827	982	2,143	3,000	857
Seismic Upgrade Acute Admissions Unit S	0	366	365	0	490	490	2,960	3,450	490
Seismic Upgrade Surgical Services Expans	1,174	2,318	1,144	2,335	3,093	758	-	-	-
Linear Accelerator	-	583	583	-	1,000	1,000	33,156	33,156	-
	9,772	16,923	7,151	16,722	27,789	11,067	73,476	101,223	27,697
DHB funded Strategic									
Surgical Services Expansion Project	265	1,577	1,312	1,521	3,204	1,683	-	-	-
Radiology Facilities Redevelopment	510	510	-	510	510	-	-	-	-
Replacement Generators	864	1,619	755	2,180	2,430	250	4,430	4,430	-
Health System Catalogue	343	857	514	363	857	494	657	657	-
Mental Health Crisis Hub	58	567	509	100	567	467	567	567	-
Interim Asset Plan	946	2,386	1,440	1,988	3,913	1,925	-	-	-
	2,986	7,517	4,531	6,661	11,481	4,820	5,654	5,654	-
Other									
Special Funds and Clinical Trials	107	-	(107)	107	-	(107)			
Funded Programmes	91	-	(91)	91	-	(91)			
Other	6	-	(6)	6	-	(6)			
	204	-	(204)	204	-	(204)			
Capital Spend	**17,283**	**30,461**	**13,178**	**31,585**	**47,289**	**15,704**	**79,130**	**106,877**	**27,697**

11. ROLLING CASH FLOW

	Mar-22			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-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	66,746	62,099	4,647	62,986	59,848	82,099	59,848	59,848	60,560	59,848	60,560	60,560	59,848	60,560	60,560
Other revenue	16,354	11,310	5,044	9,304	11,220	11,030	11,030	11,410	11,220	10,650	11,220	10,840	10,840	10,650	11,410
Total cash inflow	83,100	73,409	9,691	72,290	71,068	93,129	70,878	71,258	71,780	70,498	71,780	71,400	70,688	71,210	71,970
Cash Outflows															
Payroll	18,489	18,330	-159	15,411	15,280	19,830	15,300	18,280	15,350	15,280	19,780	15,350	15,280	15,280	18,350
Taxes	10,654	11,200	546	12,231	11,200	12,600	11,200	11,200	11,400	11,200	11,200	9,400	14,400	11,400	11,400
Sector Services	32,197	31,948	-249	38,890	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000
Capital expenditure	2,645	2,000	-645	1,600	1,600	2,000	1,600	1,600	2,000	1,600	2,000	1,600	1,600	1,600	2,000
Other expenditure	16,116	16,899	783	16,522	16,508	16,508	16,466	16,508	16,508	16,507	16,508	16,508	16,508	16,480	16,508
Total cash outflow	80,101	80,377	276	84,654	75,587	81,938	75,566	78,588	76,258	75,587	80,488	73,858	78,788	75,760	79,258
Total cash movement	2,999	-6,968	9,967	-12,364	-4,520	11,191	-4,688	-7,330	-4,478	-5,089	-8,708	-2,458	-8,100	-4,550	-7,288
Add: opening cash	1,979	1,979	-0	4,978	-7,386	-11,905	-714	-5,402	-12,733	-17,211	-22,300	-31,008	-33,466	-41,566	-46,117
Closing cash	4,978	-4,989	9,967	-7,386	-11,905	-714	-5,402	-12,733	-17,211	-22,300	-31,008	-33,466	-41,566	-46,117	-53,405
Maximum cash overdraft (in month)	97	-9,604	9,701	-7,386	-11,905	-22,382	-5,402	-12,733	-17,211	-22,300	-33,989	-35,159	-41,566	-50,904	-54,837

Cash balances decline over the next 12 months reflecting operating deficits expected over that time period.

ĀKINA (IMPROVEMENT)

Presentation

NURSING AND MIDWIFERY STRATEGY UPDATE

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Wairoa Oral Health Update April 2022**
	For the attention of: **HBDHB Board**
Document Owner	Emma Foster, Executive Director, Planning, Funding & Performance Patrick Le Geyt, Executive Director, Health, Improvement & Equity
Document Author	Panu Te Whaiti, Portfolio Manager, Planning, Funding & Performance
Document Reviewer	Charrissa Keenan, Programme Manager, Te Wahanga Hauora Māori
Date	13 April 2022
Purpose/Summary of the Aim of the Paper	The purpose of this paper is to: • Report the results, learnings, and successes of Tō Waha – Wairoa • Provide an update on the progress toward a long-term dental solution for Wairoa.
Health Equity Framework	Application of the Health Equity Framework to identify: • Health issues impacting inequitably on Māori in Wairoa • Whānau voice activities to gather whānau priorities and preferences, and • Recommend and action co-designed solutions
Principles of the Treaty of Waitangi that this report addresses:	The following principles of Te Tiriti O Waitangi inform this kaupapa: • Equity: Improving oral health outcomes for Māori • Active Protection: Targeted Strategies and actions with timeframes • Partnership: Consultation with Māori Governance, with whānau and consumer voice • Options that incorporate Māori models of health
Risk Assessment	• Rural workforce sustainability • Lack of private Dentist market • Sustainable solution for Wairoa whānau • The impact poor oral health can have on other conditions
Financial/Legal Impact	• HBDHB is obligated to provide access to oral health care for children and adolescents 5 to 18 years of age. • HBDHB provide emergency dental care services in response to improving national equity of access in the context of an overall oral health work plan.
Stakeholder Consultation and Impact	Wairoa Māori Leaders. Wairoa Whānau Voice – survey and kanohi ki te kanohi. Wairoa CPG Implementation Group.
Strategic Impact	Equity as a priority for Māori and high need groups.
Previous Consideration / Interdependent Papers	23 July, 2021 - Oral Health Board Paper: actions within board paper have been completed or are part of the medium-term solution, until a sustainable oral health service can be sourced.

RECOMMENDATION:
It is recommended that the HBDHB Board:
1. *Note the final report documenting the results, learnings, and successes of Tō Waha Wairoa.*
2. *Note a dental locum service for Wairoa will be delivered for 12 months.*
3. *Note HBDHB will continue to work with Wairoa to develop and deliver a long term, low cost, whānau oral health service.*

TŌ WAHA – WAIROA

In January 2022, the Wairoa community, in partnership with dental volunteers, health, social and local government providers, and the Hawke's Bay DHB, worked collaboratively to deliver oral health care to Wairoa whānau with urgent dental needs. The initiative was in response to the lack of access to dental care, and the increasing unmet oral health needs among the Wairoa adult population. The final report is attached.

Key results:

From 17 to 22 January 2022, Tō Waha took place at the Hawke's Bay DHB Community Oral Health Service, located next to Wairoa College. Over a 5.5 day period, utilising five dental chairs, and a volunteer dental and community workforce, Tō Waha involved:

- 307 dental appointments
- 677 dental treatments (248 fillings, 365 extractions, and 64 hygiene)
- 104 stop smoking engagements
- 95% of patients identified as Māori, 4% Other, and 1% Pacific
- 54% of patients were female, 46% male
- 45% of patients were aged between 18 – 39 years
- 39% of patients were aged between 40 – 59 years

Key success factors of Tō Waha include:

- Authentic partnership: Tō Waha was able to transform good relationships into effective partnerships, working together with one purpose to better whānau oral health.
- Cultural authenticity: rich cultural norms within the Tō Waha model meant that it was a place that did not just look after people's teeth, but a place where the wairua of people was nourished.
- Community driven: because communities know their communities best, and have the knowledge about how to best work together for the benefit of whānau.
- Kaupapa integration: creating an environment where integrated approaches occur between oral and primary health care through greater collaboration, information sharing, and coordination of care.
- The 'meke dental team' – transforming whānau attitudes and beliefs creating positive new dental experiences.
- Shifting to essential rather than emergency dental care: making oral health prevention, education, and promotion core elements of the model to ensure whānau oral health gains are long term.

Wairoa locum dental service

With support from the Wairoa Māori Leaders, and the CPG Implementation Group, HBDHB has committed to deliver a locum dental service for at least 12 months while the long-term solution is developed. The locum dental service will incorporate Tō Waha models of delivery to:

- Provide essential dental care for whānau aged 18 year
- Utilise a dental workforce that is committed to high quality cultural and clinical oral health outcomes
- Prioritise equitable access to affordable dental care
- Deliver holistic and integrated approaches wherever possible.

Attachments – Tō Waha - Wairoa

Ko te amorangi ki mua,
Ko te hāpai ō ki muri
A community-driven approach to better oral health

Ko te amorangi ki mua, ko te hāpai ō ki muri
A community-driven approach to better oral health

Te Wahanga Hauora Māori | Te Puni Tūmatawhānui

Hawke's Bay District Health Board

ACKNOWLEDGEMENTS

'Ko te amorangi ki mua, Ko te hāpai ō ki muri' – Tō Waha was a collective effort of the Wairoa community, with the support of many behind the scenes to help contribute to its success.

The strategic support from the Wairoa Māori Leaders, and the Wairoa Community Partnership Group, and their commitment to ensuring Wairoa whānau have access to the health care they deserve.

The Wairoa community: Kahungunu Executive, Te Whare Maire O Tapuwae, Waikaremoana, Rongomaiwahine, Ngāti Pahauwera, Tātau Tātau o te Wairoa, Wairoa Taiwhenua, Enabled, Wairoa District Council, Sport HB, Queen Street Practice, Wairoa Hospital, Tairawhiti REAP.

The financial support from the Royston Health Trust, and the Princess Alexandra Medical Trust. Thank you for seeing the value of this kaupapa and the difference it makes to communities. Tremains Real Estate and the Māori Oral Health Quality Improvement Group for denture support. Also, special mention to GRS Generators, and QRS – Quality Roading Services Wairoa.

Tō Waha dentists & their teams: Justin Wall, Chris Shepherd, June Fraser, Gawin Liang, Helen Lloyd; Hyrum Martin, Terrence Reid, Joon Han, Annie Van Wichen, Martin & Wendy Geddes; Nicholas Cutfield & his team Bridget Rattray, Ally Rose Calvert, Caroline Cash, & Maddy Clarke; Isha Woodham & her team Rebecca Walker, Sarah Smith, & Ana Tomoana.

Tō Waha oral health community: Andrea Pinto, Lerlene Wright, Juliet Russell, Phillipa Gillies, Gemma Still, Andrea Dagg, Aimee Powdrell, Nikki Turipa, Rawinia Wilcox - Dental Assistants. Lantyn Paku, Sowmya Achar, Lucy Cabot, Jenna Ward, Lalaine Sabino - Hygienists.

Tō Waha community team: Esta Wainohu, Piripi Ropitini, Denise Eaglesome, Reremoana Houkamau, Lenny Ferris, Kiri Gilbert, Sue Thompson, Rick Tahuri, Richard Niania, Mary Jarden, Helena Macgregor, Sara Bird, El Maadi Te Aho, Michelle Tuhi, Jazz Thornton, Anne Hurley, Aqua Ahuriri, Cathy Bellamy, Skye Pohio, Susan Hawken, Kiwi Smith, Yuanita Hema, Jamie Te Amo, Audra Brown, Audrey Tolua, Janayah Lewis, Caroline Karekare, Whetu Kapene, Kimiora Hubbard, Laytoia Tipuna, Gene Waihape, Mohaka Hooper, Rata Te Amo, Victoria Wihape, Naomi Wilson, Austin King, Karleigh Watson-Walker, Tina Wagner, Raiha Campbell, Jasmine Wagner, Jackie Kereru, Rubyanne Edwards, Ardy Moeau, Sam Payne, Vilma Hape, and, Letisha Ngatai.

A special acknowledgement to Wairoa College; Jo Vennell and her staff Lissina Betsford and Shannon Harris.

The Hawke's Bay DHB team: COHS for your clinical advice, support, organisation of resources, and workforce. Our clinical team for your nursing and pharmacy expertise. The Measles, Smoking Cessation, Bowel Screening, Rangatahi, and the Tō Waha research teams.

Ngā mihi anō hoki ki te whānau ō Hinemihi marae. Nei te mihi ki a koutou mō te manaakitanga.

Finally, the fabulous Tō Waha project team: Sarah Paku, Karen Paku, Hine Flood, Charrissa Keenan, Justin Nguma, and Ina Graham.

Ka tukua ēnei kupu whakamihi atu ki a koutou katoa. Ngā mihi maioha mo te manaaki ki ngā whānau o Wairoa.

CONTENTS

ACKNOWLEDGEMENTS....2
EXECUTIVE SUMMARY....4
INTRODUCTION....5
Te Tiriti o Waitangi and Tikanga-ā-Wairoa....5
Wairoa whānau voice....5
Whānau participation....6
Key results....6
TŌ WAHA SUCCESS FACTORS....6
Authentic partnerships....6
Tiaki te wairua o te tangata....7
Community driven....7
Reaching whānau....7
No empty chairs....8
Collective commitment to the kaupapa through integration....8
The 'meke' dental team....9
Shifting to essential rather than emergency....10
Hygiene care....10
Post care korero....10
Tō Waha Wairoa – a trusted brand....11
Tō Waha Financial Support....11
FUTURE ASPIRATIONS....11
What's important....11
Where to locate the dental service in Wairoa....12
CONCLUSION: TŌ WAHA: AN EVOLVING MODEL FOR ACHIEVING EQUITY....13
Unmet need....13
Do it, now....13
Enabling communities....13
Where to from here....13
REFERENCES....14

EXECUTIVE SUMMARY

In January 2022, the Wairoa community, in partnership with dental volunteers, health, social and local government providers, and the Hawke's Bay DHB, worked collaboratively to deliver oral health care to people with urgent dental needs. The initiative was in response to the lack of access to dental care for adults living in the Wairoa district.

Over a 5.5-day period, utilising five dental chairs, and a volunteer dental and community workforce, 307 dental appointments were filled resulting in 677 dental treatments. Ninety five percent of patients identified as Māori, four percent other, and one percent Pacific. Forty five percent were aged between 18 to 39 years of age.

Key success factors of Tō Waha include:

- Authentic partnership: Tō Waha was able to transform good relationships into effective partnerships, working together with one purpose to better whānau oral health.
- Cultural authenticity: rich cultural norms within the Tō Waha model meant that it was a place that did not just look after people's teeth, but a place where the wairua of people was nourished.
- Community driven: because communities know their communities best, and have the knowledge about how to best work together for the benefit of whānau.
- Kaupapa integration: by creating an environment where integrated approaches could occur between oral and primary health care through greater collaboration, information sharing, and coordination of care.
- Shifting to essential rather than emergency dental care: making oral health prevention, education, and promotion core elements of the model to ensure whānau oral health gains are long term.

'Ko te amorangi ki mua, Ko te hāpai ō ki muri' – the community leading at the front, with the support of kaimahi in the back. Tō Waha deliberately empowers the community to lead and drive the kaupapa for their whānau. However, partner organisations are still required to ensure its success. Tō Waha was organised in 12 weeks, which demonstrates that the health system has the ability to direct resources and capacity to communities for their immediate benefit, and to make equity health gains.

Tō Waha is designed as a different way to approach and coordinate dental care by, with, and for communities. Tō Waha demonstrates what can be achieved when activities are established on foundations of tikanga Māori and community driven. When this happens, whānau are empowered, the community and staff are working as one team, and whānau outcomes are maximised.

Tō Waha exposes the severity and prevalence of dental disease in Māori and high need communities. 'Good Oral Health, For All, For Life', will not be achieved across these communities within current dental services. Tō Waha is an equity response that quickly connects dentists with high numbers of those most in need, elevates oral health, and creates new and positive dental experiences.

Whānau voice was gathered to find out whānau experiences of Tō Waha, and aspirations for a future oral health service in Wairoa. A total of 259 people completed a survey, a response rate of 94%, and 29 one on one interviews were completed. Findings show 96% of whānau had an 'awesome' dental experience at Tō Waha, with the kaupapa and kaimahi major contributors of this. Affordability was identified as important in a future model that 'looked and felt like' Tō Waha. Wairoa whānau are bearing the financial and physical burden of not having a local dental service, so identifying a long-term dental solution must be the priority.

There is a willingness, and readiness among the community, wider stakeholders, and dental partners, to continue to work collaboratively together to achieve oral health outcomes for Wairoa whānau. Tō Waha is a platform for making the transformational change required to achieve oral health equity for Māori under Te Tiriti o Waitangi; and Pae Ora, the right of Māori to live with good oral health, that is essential for a good quality life.

INTRODUCTION

In January 2022, the Wairoa community, in partnership with dental volunteers, health, social and local government providers, and the Hawke's Bay DHB, worked collaboratively to deliver oral health care to Wairoa whānau with urgent dental needs. The initiative was in response to the lack of access to dental care, and the increasing unmet oral health needs among the Wairoa adult population.

The lack of access to local and regular dental care is not a new problem for the Wairoa community. The Wairoa Community Partnership Group (CPG), a leaders group focused on improved whānau outcomes by investing in models and strategies that are Wairoa led, informed, and operationalised, identified barriers to access to dental care, and prioritised identifying a solution. As adult dentistry mainly sits outside publicly funded dental care, and with the only dental clinic operating in Wairoa being for children and adolescents, the CPG sought support from Hawke's Bay DHB to help find a solution to this health problem.

Hawke's Bay DHB offered to work alongside the community to hold a Tō Waha event in Wairoa as an interim initiative in lieu of a long-term solution being identified. Tō Waha was originally developed in 2019 when the New Zealand Defence Force (NZDF) reached out to Hawke's Bay DHB offering to provide free dental care as part of the it's deployment training. Over a period of 10 days, 702 dental appointments were filled resulting in 1297 dental treatments. This event became more than just about dental care, and lead to the evolution of Tō Waha from a one-off NZDF event, to a community-driven model for achieving oral health outcomes.

Te Tiriti o Waitangi and Tikanga-ā-Wairoa

When working with Māori communities, tikanga based hui and korero are essential to ensure iwi and Māori leaders are afforded due mana and partnership in decision-making. In October 2021, a hui was held with Wairoa Māori leaders seeking agreement to hold Tō Waha. There was unanimous support from the group and agreement that Kahungunu Executive, the Māori Health Provider in Wairoa, would take a lead role to work alongside Hawke's Bay DHB to plan and deliver the kaupapa. Kahungunu Executive was pivotal for coordinating and communicating plans with the Wairoa community, as well as being involved in the organisation of the event with Hawke's Bay DHB. It also set the tikanga for implementation of the kaupapa, so pōwhiri, te reo, karakia, waiata, manaakitanga were embedded throughout. Ensuring this cultural foundation was pivotal for the development of a model that would be respectful of, and responsive to, Maori values, beliefs, and traditions.

Hawke's Bay DHB has the responsibility to deliver health care to the people of Hawke's Bay, and as part of that responsibility possesses the resources, capacity, and capital that communities do not have. Therefore, it was imperative that as a Te Tiriti o Waitangi partner, Hawke's Bay DHB would minimise any financial or other burden on the community by providing access to the necessary resources to deliver Tō Waha. This enabled the Wairoa community to concentrate on bringing the most valuable resource to the kaupapa, its people.

Wairoa whānau voice

Aligned with the CPG's priority for whānau voice to influence change, Tō Waha provided an opportunity to gather information about whānau perceptions of their oral health, their experiences of Tō Waha, and their aspirations for a future oral health service for Wairoa. Two research methods were used to gather whānau voice 1) a survey, and 2) one on one interviews. Using an iPad, the survey consisted of ten short questions that all patients were invited to complete at post care[1]. One on one interview participants were identified from the survey which asked respondents if they were interested in expanding on their responses by talking to one of the Tō Waha research team.

[1] Post care – a post treatment korero where every patient receives advice regarding any wound care, oral health education (five key messages), and resources (toothbrush, floss, toothpaste) to support ongoing good oral health practices.

Whānau participation

A total of 259 of 277 whānau completed the Tō Waha survey, representing a 94% response rate. This is extraordinarily high compared to other surveys across all platforms. Kaiāwhina responsible for inviting patients to complete the survey often knew and were connected to the respondents, so these relationships may have encouraged whānau to complete the survey. Alternatively, whānau may have felt strongly about sharing their feelings about Tō Waha. A total of 240 or 87% of survey respondents provided comments about their Tō Waha experience showing a prevailing intention from whānau to share their views.

A total of 70 or 29% of respondents indicated they would be willing to participate in a one on one interview, however only 29 interviews were completed before an information saturation was reached. Again, this shows an unprecedented response from Māori to participate in research. Interviews were carried out by three University of Otago 4th Year Medical Students during their internship with Hawke's Bay DHB. The qualitative interview responses were written down verbatim, typed up in their raw form, and reviewed and analysed by four experienced health researchers. The data was thematically analysed by grouping, and re-grouping responses based on similarities, differences, or frequency. Not all the survey and interview findings are presented in this report i.e. self-perceptions. A full report on whānau voice will be published later.

Key results

From 17th to 22nd January 2022, Tō Waha took place at the Hawke's Bay DHB Community Oral Health Service, located next to Wairoa College. Over a 5.5-day period, utilising five dental chairs, and a volunteer dental and community workforce, Tō Waha involved:

- 307 dental appointments
- 677 dental treatments (248 fillings, 365 extractions, and 64 hygiene)
- 104 stop smoking engagements
- 95% of patients identified as Māori, 4% Other, and 1% Pacific
- 54% of patients were female, 46% male
- 45% of patients were aged between 18 – 39 years
- 39% of patients were aged between 40 – 59 years

TŌ WAHA SUCCESS FACTORS

Tō Waha is purposefully designed to introduce a different way to approach and coordinate dental care by, with, and for communities. Tō Waha demonstrates what can be achieved when activities are established on foundations of tikanga Māori, that are culturally authentic and community driven. When this happens, a model is created where whānau are empowered, the community and staff are working as one team, and whānau outcomes are maximised.

Authentic partnerships

A key feature and success of the Tō Waha model is the intentional empowering of communities. Rather than treating the opportunity merely as a one-off dental event, Tō Waha was able to transform good relationships into effective partnerships, working together with one purpose to better whānau oral health. This shift in 'focus' that occurred among community providers facilitated a change toward an integrated service model. This meant that competing and/or cross-purpose agendas could be put aside, and community stakeholders were able to work together for the benefit of their whānau. This was important because the kaupapa went beyond a dental treatment, to a new model for working together in a connected and culturally authentic way.

The authentic partnership approach was also key to ensuring that clinicians were able to focus solely on the technical skills for which they are trained, and the community- facing organisations could use their skills to work

with the community. This enabled the community to give whānau a different kind of dental experience focused on a range of positive outcomes, and not just the usual dominant clinical model.

Tiaki te wairua o te tangata

Only whānau can determine the cultural authenticity of a kaupapa. When asked to rate their overall Tō Waha experience, of the 259 survey respondents, 100% answered the question.

- 96% of whānau rated their experience as 'Awesome',
- 3% 'Okay', and
- 1% 'It could have been better'.

Whānau were asked to qualify their rating which resulted in 240 responses or a 93% completion rate. The high response rate indicates that this was not a usual health experience and that the collaborative effort resulted in something extraordinary happening in the Tō Waha model.

The 'kaupapa' was identified as a key theme by respondents as they shared kupu [words] such as '*manaakitanga*', '*whānaungatanga*', '*meke*', and feeling, '*the aroha'* to describe their Tō Waha experience. Whānau described an environment that was '*awesome*' and '*amazing*', and that the incorporation of local tikanga into the everyday activities added to the experience as a patient described *'…I was very fortunate to be able to be part of the morning karakia, waiata, and whakapakari tinana*'.

The rich cultural norms within the Tō Waha model meant that it was a place that did not just look after people's teeth, but a place where the wairua [spiritual and mental wellbeing] of people was nourished.

'*He pukenga kē tera te tiaki I te wairua o te tangata I runga I te ngakau whakaiti. 'Iti te kupu, nui te korero'*
[It is a skill to look after the wairua of people with true intent. Although small, it made a big difference].

'*The people and surroundings were excellent…I just love the experience*'

'*The whole atmosphere from the time you walk in*'

With over 40 volunteers from local Māori health, social, and local agencies, as well as community and primary health care workers, this multi-skilled, multi-disciplinary, culturally connected group were essential to creating the look, feel, and overall success of the kaupapa.

Community driven

The DHB could have taken a typical system-centric approach, but communities know their communities best, and have the knowledge about how to best work together for the benefit of whānau. This community driven approach allowed locals to step outside their usual role, and participate in a number of roles overseeing the day to day running of the event including patient appointments, patient support, outreach, and coordination roles. Local volunteers were given brief training and once oriented into the role, Hawke's Bay DHB stepped back, and whānau took the lead. This made a difference to the whānau experience as they expressed, '*it was good to see faces I know*' and '*because I knew most of the kaimahi'.*

.

Reaching whānau

A key part of the kaupapa being community driven was how the dental appointments were allocated. It was agreed by the Wairoa community that dedicated days would be offered to whānau living in the Wairoa town area, and

those residing in the wider district respectively. Local providers with connections to whānau agreed on which of them were best positioned to reach those most in need.

The Wairoa district extends out to three main rural areas, Mahia, Tuai/Lakes Waikaremoana, and Raupunga/Mohaka. Community Coordinators employed by iwi-organisations in those areas were able to identify whānau to register for Tō Waha. This ensured whānau living in these rural isolated areas had priority access to dental appointments. Community Coordinators also volunteered as kaimanaaki at Tō Waha which enabled them to support their whānau in the lead up to the event, and on the day of their appointment.

There were many advantages to this approach:

- Ownership and decision making into the appointment process.
- Target and successfully reach the very high need whānau with urgent or high unmet oral health needs.
- An equitable approach to distribute appointment allocation across the region.
- Capitalise on the strengths within communities by utilising their intelligence and relationships.

No empty chairs

The community-led nature of the event was key to locating and finding whānau to ensure there were always people ready to receive treatment. The majority of visits were filled through confirmed appointments, and a low did not attend (DNA) rate of only 6% was achieved. However, walk-ins and a waitlist were used to fill any unexpected empty chairs, and where possible accommodate those who needed urgent dental care. The fact that there were no empty chairs reflects the success that can be achieved when community people with pre-existing strong relationships with local whānau are empowered to engage whānau in such a kaupapa.

Collective commitment to the kaupapa through integration

Dentistry is typically separated from general health care. These two 'health care' systems are made up of separate funding, workforce, service delivery, accountability and models of care. Tō Waha removed this barrier by creating an environment where integrated approaches could occur through greater collaboration, information sharing, and coordination of care.

Knowledge integration

An example of this improved integration occurring at Tō Waha was 'knowledge integration'; the sharing of information between general, oral and primary health care (NMOHCS, 2013). A high number of registration forms were received from whānau with chronic conditions. Primary care nurses and a pharmacist reviewed patient information, then were able to contact the patient or GP for further information where needed, share appropriate information with the kaimanaaki and/or dentist who was then able to have a well-informed korero with the patient about their health and dental treatment needs.

This integrated model ensured care was tailored more around the patient, and the dentist was able to get the best outcome for the patient through timely and clinically safe dental care. Tō Waha showed an integration approach where the primary care workforce can play an increased role in the early detection, prevention, and management of oral health care for people with chronic conditions.

Physical integration

Another example of improved integration is the 'physical integration' which refers to general and dental health services being located at the same site, and developing integrated practices (NMOHCS, 2013). Tō Waha involved a range of primary health care workers, and health promoters including bowel screening, smoking cessation, measles, and Covid vaccinators who worked together to achieve as much positive health outcome as possible at every interaction.

An example of this at Tō Waha was the close alignment of smoking cessation. Evidence shows smoking negatively affects oral health and dental treatment outcomes. Smoking Cessation Specialists were made available to provide one on one smoking cessation advice to patients preparatory to their receiving dental treatment. All patients were asked if they smoke tobacco or vape on the registration form. Of the completed forms 99 (32%) identified as smokers, and 33 (11%) vapers. Of these 132 (43%) patients who smoked or vaped, 48 (36%) identified as wanting help to quit, and were registered on the Quit Smoking programme. All patients identified as Māori, which is significant in terms of potential health gains for whanau Māori and the protection of whakapapa.

Tō Waha is a kaupapa that supports holistic models of health. It provides an opportunity to include primary health care services that are necessary to keep populations healthy. Tō Waha demonstrates the value of aligning dental alongside primary care and vice versa. Tō Waha showed this approach worked for whānau:

'Really stoked from start to finish…even got [my measles] shot' (W6).

'Got to learn about diabetes today which was quite informative' (W17)

'[Received] *help with my health issues*'

'*Awesome help with my teeth and health…tooth was extracted and a booster shot received*''.

Whānau identified breast screening, mental health illness supports and suicide prevention as other services they would have benefitted from if they were present at the event.

The 'meke' dental team

Tō Waha is a model that entirely, and unapologetically, prioritises whānau who have been neglected, traumatized, and/or forgotten by the dental system. Dentists volunteering for Tō Waha are extremely appreciated, because they know this reality, and understand that for many whānau 'good' oral health is unattainable. Tō Waha dentists are special because they undo years of generational disengagement from a dental system that whānau Māori have found uncaring and misunderstood (HBDHB, 2019). As expressed by an interviewee, '*[there is] ...a stigma of dentists, but the services here resolved this for me' (W24).* Tō Waha can transform whānau attitudes and beliefs toward dental care creating positive new dental experiences:

'The staff are talking to you and not at you or down on you' (W17).

'I didn't want to come in at all, [but] they made me feel comfortable and I don't think I fear the dentist anymore'.

'My last dental experience was horrible so [it] took a lot to come in. The Tō Waha whānau was awesome, the atmosphere was positive and relaxing'.

'The team were extremely friendly and made me feel comfortable, even when I was ashamed of my teeth they complimented me'.

'Absolutely amazing, I can't believe how great they were'.

There is a real willingness in the private dental sector to participate in socially targeted initiatives that benefit high need communities. Creating opportunities for them to serve in communities has benefits for whānau, but also provides dentists with clinical and cultural experiences working alongside Māori communities. Tō Waha dental

kaimahi expressed, '*a great experience…feeling energized and reminded of why we love dentistry* (D1)', and '*I walked out feeling part of the community*' (DA1). All the dentists that participated were willing to donate their time again.

Tō Waha dentists were purposefully identified through a number of networks 1) Tō Waha Flaxmere participants, 2) local NZ Dental Association Branch, and 3) national networks such as the Māori Oral Health Quality Improvement Group, and Te Ao Marama Dental Association. In total, 12 dentists donated their time to Tō Waha with four closing their private practices for periods of time to attend. There were a further nine dentists who were willing to donate their time to the kaupapa but the timing did not suit and they were unable to attend.

Shifting to essential rather than emergency

Essential to the Tō Waha model was the focus on oral health prevention, education and promotion. Oral health prevention is essential to maintain good oral health and is the key to shifting away from the current model of emergency dental care. However, when it comes to dental care, whānau commonly use words like 'pain', 'can't eat', and 'sore' to describe their oral health (HBDHB, 2019), which leads to a common behaviour of seeking out care when there is a problem, rather than for maintaining good oral health. To maximise the benefits for whānau to enjoy long term good oral health and elevate the focus on oral health in the home and community, Tō Waha incorporated three main kaupapa: hygiene care, post care, and Tō Waha branding.

Hygiene care

In the early stages of the kaupapa development, it was agreed that hygiene care should be an essential part of the Tō Waha model. Prevention practices such as professional cleaning and scaling treatments as well as the oral health education are crucial to achieving equitable oral health outcomes for Māori and '*Good oral health, for Life'*. Furthermore, hygiene care is essential to move away from behaviour patterns of only accessing dental care for pain, toward maintenance of oral health. Hygiene care is especially important for patients with co-morbidities such as diabetes as poor oral health can undermine general health, and vice versa. To support this desired outcome, 25% of appointments were allocated for hygiene appointments.

'*My oral health has a better chance with the attention I have received today. [The] dental experience how to brush, floss, rinse, learning a lot today from this opportunity'.*

'I also had the hygienist clean, and was able to ask questions in keeping my teeth and mouth healthy'.

'I received great advice on cleaning my teeth'.

Post care korero

Every patient after receiving their dental treatment, received a 'post care' korero. Utilising local trained whānau who volunteered as kaiāwhina, patients were given an oral health package to help them and their whānau on a path of good oral health. This package included:

- Information about wound care post treatment, pain relief and who to contact if concerned.
- Motivational support, encouraging good oral health in the home.
- Oral health resources for the whole whānau including age appropriate toothbrushes and toothpaste.
- Motivational messaging to establish a change in behaviour and follow the key five oral health messages to support good oral health for the whole whānau.

'*The awesome post care people*', were key to the overall Tō Waha model providing whānau with the necessary education, information, and tools to encourage them to make long term changes.

Tō Waha Wairoa – a trusted brand

Given its name by Hawke's Bay DHB Kaumatua Hawira Hape, Tō Waha signifies the importance of our mouths in every aspect of our lives in terms of how we speak, eat, smile and how we generally feel about ourselves. But because of the positive experience of whānau, and the holistic approach to the kaupapa, Tō Waha has become a trusted brand in the community. While the Tō Waha logo was developed in 2019 for Tō Waha Flaxmere, the look and overall feel of the brand was made with direct input from Wairoa for their community. Because of how the kaupapa was developed, and the visibility and success of the event in the community, Tō Waha is now a trusted brand among whānau in Wairoa.

Tō Waha Financial Support

While Hawke's Bay DHB was able to support Tō Waha by providing access to dental clinics, project capacity, and a dental support workforce, the costs involved in running the event were not readily available. On behalf of the Wairoa community, Hawke's Bay DHB sought the financial support of two main local charities, the Royston Health Trust, and the Princess Alexandra Medical Trust. Both have a primary purpose of improving the health of the people of Hawke's Bay by providing resources that will benefit the health and wellbeing of whānau and communities. Having previously supported the Tō Waha Flaxmere event and seen the tangible health difference it made in the community, the Royston Health Trust agreed to support another Tō Waha kaupapa. In total, $48,086 was received from the Trusts and was used for: dental supplies, accommodation and travel for dental volunteers, oral health resources, transportation of the mobile dental units, Tō Waha merchandise, and catering.

Additional financial support

Hawke's Bay DHB also sought additional financial support for those whānau who would require dentures. With cost as a primary barrier to accessing dentures, financial support was obtained from Tremains Real Estate ($3,000) and the Māori Oral Health Quality Improvement Group ($5,000). Based on clinical advice and feedback, it was agreed that a small number of patients would be offered denture support based on the high number of extractions they received. Six patients with a combined total of 73 teeth removed, were identified.

Gathering whānau voice at Tō Waha was important for understanding whānau experiences of Tō Waha, as well as local aspirations for a long-term dental solution. The Māori Oral Health Quality Improvement Group kindly funded $1600 for koha for whānau participating in these research activities.

FUTURE ASPIRATIONS

The CPG is clear about its commitment to long term transformational change that empowers whānau to thrive. Tō Waha provided an opportunity to gather the voice of whānau to inform decision making that supports their aspirations for a future oral health service for Wairoa.

What's important

Whānau were given a selection of eight options with the ability to select more than one response, and provide additional comments. 99% of respondents completed the question with 7% or 18 providing additional comments.

Low cost, and a dental service for the whole whānau were identified as important in a future oral health service by 74% and 66% of whānau respectively. Whānau expressed that the physical and financial impacts have '*been really hard*' and '*people are really hurting*' (W25); a local dental service will be a '*huge mental relief*' (W-F1). But it needs to be affordable. To date whānau have been carrying the financial burden of having to take time off work, borrow a car, or find a licenced driver. But commonly, whānau faced the barrier of not having enough money for petrol let alone the dental treatment. Whānau know that a local dental service '*will be more accessible than going to Hastings or Gisborne. This will save heaps for whānau… [but] our hope is that these services will also be affordable'* (F-M27). There was an acceptance that dental care is not free, but making services available in Wairoa and making them affordable will definitely '*encourage more people to seek [dental] care*' (W-F7).

The remaining areas were closely rated as important by whānau identifying both access in terms of regular hours, evening appointments, location and features of the model such as prevention and kaupapa Māori. Additional comments from whānau did not identify any new areas of importance, but emphasised affordability and not having to travel outside the Wairoa district.

ANSWER CHOICES	RESPONSES	
Regular hours	50.19%	129
Low cost	73.93%	190
Access (location, mobile)	44.36%	114
Kaupapa Māori	41.25%	106
Evening appointments	43.97%	113
A dental service for the whole whānau	65.76%	169
Prevention (cleaning, scaling)	49.03%	126
Location	44.36%	114
Total Respondents: 257		

Where to locate the dental service in Wairoa

Whānau were asked their preferences for where the dental service should be located. A total of 99% of whānau responded to the question. 37% or 94 thought the service should be located at the DHB Community Oral Health Clinic on Black Street, 20% opted for a totally new clinic in the community and 20% the old clinic located at Locke Street. The remaining responses chose a fixed and mobile model (13%), or at the hospital at 9.5%. The main preference of having the service located at Black Street could align with whānau whakaaro about having a service for the whole whānau or it could also possibly be because it was the first option listed on the survey. It could also be because Black Street was the location of Tō Waha and the positive association between the venue and whānau.

The interviews provided further insights into the preferences of whānau. There were mixed views about the location across all options however the overriding consistent whakaaro was that the service and the model was more important that the location. Where it made sense, whānau want to see the dental service aligning with schools, other health services, where existing resources already exist, that is easily accessible for kaumatua, and mokopuna are included. But as articulated by an interviewee:

'*The most important thing, irrespective of the location, is doing something like Tō Waha. Provide services that bring joy to the people*' (W-F28).

ANSWER CHOICES	RESPONSES	
At the DHB Community Oral Health Service (10 Black St)	37.30%	94
A totally new dental clinic in the community	19.84%	50
A totally new dental clinic at the hospital	9.52%	24
A fixed clinic with a mobile unit	13.10%	33
At the existing community dental clinic (Locke St)	4.37%	11
At the existing community dental clinic (Locke St)	15.87%	40
TOTAL		**252**

CONCLUSION: TŌ WAHA: AN EVOLVING MODEL FOR ACHIEVING EQUITY

Tō Waha is not a perfect model and continually seeks to determine what works well and what does not, by listening to whānau priorities and preferences, and feedback from the community.

Unmet need

Over 400 registrations were received from whānau seeking a dental appointment. Based on the number of dental chairs and clinician availability, there were not enough appointments available. To mitigate this over demand, those whānau who identified high dental need i.e. pain, infection, swelling, and/or broken teeth, were given priority. Based on this criteria, not everyone who completed a registration form was offered a dental appointment. This resulted in unavoidable disappointment among those who missed out. Those with very limited financial means, were also prioritised where possible. This meant that whānau such as DHB and Provider employees were excluded. This was not always received well, but with limited dental appointments, and high demand, priority had to be given to those most in need.

Do it, now

Tō Waha exposes the severity and prevalence of dental disease in Māori and high need communities. 'Good Oral Health, For All, For Life', cannot and will not be achieved across these communities by the individual, or the community and hospital dental services alone. The magnitude of this unmet need is beyond what can be provided by individual private dentists. However, as a collective, Tō Waha is a relatively quick solution to bring together numbers of dentists to high numbers of people. Tō Waha is an equity response for those most in need, elevates oral health, and creates new and positive dental experiences. It builds a culturally responsive and community engaged oral health workforce.

Enabling communities

'Ko te amorangi ki mua, Ko te hāpai ō ki muri' – the community leading at the front, with the support of kaimahi in the back. Tō Waha deliberately empowers the community to lead and drive the kaupapa for their whānau. However, partner organisations are still required to contribute to ensure its success. The role of the Crown was to be an enabler, under the united leadership of the CPG and local Māori leaders. As mentioned earlier, government agencies have access to resource, capacity and capital that communities do not have. Behind the scenes, Hawke's Bay DHB provided project management support, knowledge and sharing of dental processes and IT systems (e.g. access to DHB digital x-ray), help to secure funding, coordination with the dental workforce, access to dental supplies through DHB procurement channels, fund capacity to support the lead Provider in Wairoa, engage suppliers and stakeholders, and other logistical help. From start to finish, Tō Waha was organised in 12 weeks showing it could be stood up quickly. It demonstrates that the health system does have the ability to flex and re-direct resources and capacity to communities for their immediate benefit, and to make equity health gains.

Where to from here

With these concluding learnings 1) unmet need in Wairoa, 2) an effective model to get health results, and 3) the system enabling communities, the real opportunity lies ahead to guarantee the Wairoa community access to a long term, low cost, integrated whānau oral health service. There is a willingness and readiness among the community, wider stakeholders, and dental partners, to continue to work collaboratively together to achieve oral health outcomes for Wairoa whānau. Tō Waha is a platform for making the transformational change required to achieve oral health equity for Māori under Te Tiriti o Waitangi; and Pae Ora, the right of Māori to live with good oral health, that is essential for a good quality life.

REFERENCES

1. HBDHB. (2019). Tō Waha – An integrated whānau centred collaborative approach. HBDHB.
2. Ministry of Health. (2015). Tatau Niho Māori: Oral Health of Māori 2009. Ministry of Health: Wellington.
3. Ministry of Health. (2009). Our Oral Health. From the 2009 Zealand Health Survey. Ministry of Health: Wellington.
4. Ministry of Health. (2006). *Good Oral Health for All, For Life: The strategic vision for oral health in New Zealand.* Wellington: Ministry of Health.
5. National Māori Oral Health Coordination Service. (2013). Nga Ara Tika: Integrated Practice Guidelines in the oral and primary care settings. Māori Oral Health Quality Improvement Group.
6. New Zealand Ministry of Health. (2010). Key findings of the 2009 New Zealand Oral Health Survey. Wellington (New Zealand): Ministry of Health.
7. Robson B, Harris R. (eds). (2007). *Hauora: Māori standards of Health IV. A study of the years 2000-2005*. Wellington: Te Roopu Rangahau Hauora a Eru Pomare

OURHEALTH HAWKE'S BAY Whakawateatia	**REPORT FROM HB CLINICAL COUNCIL (Public) APRIL 2022**
	For the attention of: **HBDHB Board**
Document Author Document Owner(s)	Gemma Newland (Executive Assistant to Chief Allied Health Professions Officer) Dr Robin Whyman (Chair) and Brendan Duck (Deputy Chair)
Date	April 2022
Purpose/Summary of the Aim of the Paper	Provide Board with an overview of matters discussed at HB Clinical Council meeting on 6 April 2022.
Health Equity Framework	The Hawke's Bay Clinical Council works in partnership with a whole of system approach to ensure Hawke's Bay health services are achieving equity in health outcomes through the provision of services that are culturally safe, appropriate in addressing inequities and accessible to Tangata Whenua.
Principles of the Treaty of Waitangi that this report addresses:	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system; committed to Te Tiriti o Waitangi and achieving equity for Tangata Whenua and other populations, in the provision of health care in the Hawkes' Bay District.
Risk Assessment	Risks associated with the issues considered by the Clinical Council include replacement of the emergency paging system with digital technology based in iPhones and delays in medical credentialing.
Financial/Legal Impact	
Stakeholder Consultation and Impact	Stakeholder engagement is the basis of discussion of issues at the Clinical Council.
Strategic Impact	None identified
Previous Consideration / Interdependent Papers	None identified
RECOMMENDATION: It is recommended that the Board: *1.* **Note** the contents of this report	

11

1. Clinical Governance Planning

Council agreed with the plans to temporarily suspend Clinical Council after the June meeting until regional clinical governance systems are implemented by Health NZ and the Maori Health Authority. Health Hawke's Bay's Clinical Advisory Group (CAG) and the recently formed Health Services Clinical

Governance Committee (HSCGC) will cover governance requirements for primary care and the hospital and provider services until the Health NZ governance structures are confirmed and locality planning is in place.

Susan Barnes, Patient Safety & Quality Manager, has facilitated two workshops to begin the formation of the focused hospital and provider services clinical governance group in preparation for the transition to Health NZ. The Health Services Clinical Governance Committee (HSCGC) has been formed to provide clinical governance support across hospital and provider services. Terms of reference are in draft form and it is expected that any groups that currently report to Clinical Council, will report to this new committee in the interim. The committee is supported by clinicians and a Chair for HSCGC will be nominated before the next meeting.

Patient Safety and Risk Management Committee shared minutes from the February meeting. The hospital's outdated pager system was identified as a patient safety risk, but an active quality improvement project is underway and is described in this report.

The minutes highlighted the enormous pressure on leadership teams, but noted they have maintained patient safety and quality standards and audits during this busy time and were commended by the group.

Safety1st now has three months of data to use to develop reports which are proving valuable. The programme now has ongoing work in the background to make continuous improvements and refine the information collected.

The Professional Standards and Performance Committee Report noted that incomplete medical credentialing was raised as a risk issue and concerns were also noted about difficulties with access to DHB's policies, pathways and procedures on Our Hub.

The medical credentialing group is currently working with People and Culture to remediate delays in the SMOs credentialing processes before SMOs commence practice. The process is almost back up to date, and the outstanding appointments affect known SMOs with employment history at the DHB. Six new Senior Medical Officers will be joining the DHB in the next two months. The DHB medical credentialing policy has been updated and is now with the policy and procedure committee for final approval. This will ensure the medical credentialing policy and procedures are consistent with current practice.

Council celebrated 27 nurses who are now able to prescribe after completing an education pathway.

2. Pager Replacement Project

Ben Duffus, Head of Innovation and Strategic Partnership from Digital Enablement, presented the pager replacement project within the hospital to Council. This project has been implemented to significantly improve the functioning of the pager system during emergencies. The new system (Cortex) will be more efficient and work through automated contact to iPhones carried by RMOs and SMOs via an app. Progressive roll out of this will be commence in May through a parallel system and then progressive retirement of the pager technology.

3. Q2 Patient Safety and Quality Report

Patient Safety and Quality data was provided to Council for the period up to 31 December 2021. Data quality remains high and there were no unexpected or outlying indicators.

Health Round Table (HRT) data was provided up to the end of December 2021. The trends identified were consistent with previous reports, and no significant deterioration in the indicators was reported.

Inequities of ethnicity were identified to be largely about access to care, rather than quality of care. Noted success stories were hip fractures being operated on within two days (incidents which are associated with a high mortality risk), a reduction in pressure injuries and hospital falls and hospital acquired infections have also decreased.

Reporting of ACC treatment injuries were discussed. A nurse coordinator is now leading this process which has resulted in positive feedback on the additional support and improved rates of reporting of ACC treatment injuries at HBDHB.

Clinical Council noted that the Health and Disability Certification audit, which was due in May, has been deferred for six months by MOH due to COVID-19. Two high risk action items from the previous certification; audit (quality systems and clinical governance and developing and implementing a robust risk framework), remain a focus of specific improvement activities.

4. End of Life Choice Act Implementation

Council received a report on experiences with the End of Life Choice Act at the DHB following its enactment on 7 November 2021. A small number of assisted dying events have occurred within the hospital in the period since November, with each proceeding smoothly. There have also been opportunities for improvement identified. Community-based assisted dying events are facilitated and governed through the Ministry of Health and not overseen by the DHB.

Council acknowledged the work Sally Houliston from the Patient Safety and Quality team has undertaken to ensure a policy and procedures for the DHB are in place and in ensuring teams in the hospital have been supported.

HAWKE'S BAY District Health Board Whakawāteatia	**Pacific Population Board – Chairs Report**
	For the attention of: **HBDHB Board**
Document Owner:	Traci Tuimaseve, Chair, Pacific Population Board
Reviewed by:	Talalelei Taufale, Pacific Health Manager
Month:	April 2022
Consideration:	For information

RECOMMENDATION

That the HBDHB Board

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

The Pacific Population Board (PPB) met on 11 April. An overview of the items discussed and/or agreed at the meeting is provided below.

Hawke's Bay DHB Quarter 2 21/22 Health System Performance Dashboard
Planning Funding & Performance spoke to the above dashboard with a strong focus on red performance indicators.

Members queried what local sector response could assist in improving these indicators going forward and lift performance. Some outstanding work has been achieved by Pacific and Māori providers and we need to ensure sustainable funding remains in place to continue to build on the work in our communities.

The next round of information planning (Qtr 3) will request business leads to advise on actions to reduce the impact of red indicators.

We are currently at the peak of community COVID (Omicron) cases, however as COVID dips there is opportunity to utilise the COVID workforce to support the stubborn transitioning of red indicators to green.

One of the responses to COVID-19 was from culturally-led services across Aotearoa which recorded significantly more positive results than those not led with a cultural lens. Both the Minister and Ministry are encouraging DHBs to take these successful COVID-models forward to reduce inequities.

The PPB recommended that:
1. Pacific Health approaches are enabled to lead and shape Pacific performance targets.
2. Existing funding is targeted to support the implementation of Pacific models of care.
3. Regular monitoring and feedback of key lead reports.

PPB NOMINATIONS
Members agreed that the nomination process will be put 'on hold' until a clear direction from NZ Health Reform is advised.

PACIFIC HEALTH REPORT

Members took the report as read, noting:

- COVID has been busy and part of the response has been community distribution of Rapid Antigen Test kits (RATS) which was successful.
- An approach has been agreed to develop a Pacific locality roadmap for Hawke's Bay and a working group formed. A project plan is underway which will be implemented over the following weeks with a final paper by July 2022.
- Opportunities are being addressed for unregulated Pacific staff and community members to upskill and become certificated vaccinators

Health Reforms

The Pacific Population Board supports the coordination and submission of a Hawke's Bay Pacific locality approach that will build on the existing Pacific village equity approach and COVID vaccination success.

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

14. Confirmation of Previous Minutes (Public Excluded)
15. Matters Arising – Review of Actions (Public Excluded)
16. Chair's Report (Public Excluded)
17. Board Champions' Safety and Wellbeing 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)

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).