# Hawke's Bay Health
# Consumer Council Meeting

**Date:** **Thursday, 4 June 2020**

**Meeting:** **4.00 pm to 6.00 pm**

**Venue:** **Zoom Meeting**

**Council Members:**

Rachel Ritchie (Chair)
Malcolm Dixon (Co-Deputy Chair)
Dr Diane Mara (Co-Deputy Chair)
Sami McIntosh
Deborah Grace
Daisy Hill
Sarah Hansen
Dallas Adams
Les Cunningham
Denise Woodhams
Tumema Faioso
Jim Henry
Gerraldine Tahere
Oliver Taylor
Angie Smith

**Apologies:**

**In Attendance:**

Emma Foster, Interim Executive Director – Planning & Funding
Susan Barnes, Patient Safety & Quality Manager
Caryn Daum and Nancy Barlow – Consumer Experience Facilitators
Debs Higgins, Clinical Council Representative
Wayne Woolrich – CEO Health Hawke's Bay
Council Administrator

**Public**

| Item | Section 1 – Routine | Time (pm) |
|---|---|---|
| 1. | Karakia Timatanga (Opening) / Reflection | 4:00pm |
| 2. | Apologies | |
| 3. | Interests Register | |
| 4. | Minutes of Previous Meeting (Public) | |
| 5. | Matters Arising – Review Actions (Public) | |

| Item | Section 1 – Routine | Time (pm) |
|---|---|---|
| 6. | Consumer Council Workplan | |
| 7. | Consumer Council Board Report for May (for information) | |
| 8. | Planning & Funding Report to Board for May (for information) | |
| 9. | Provider Services Report to Board for May (for information) | |
| 10. | Chief Executive Officer's Board Report for May (Public) (for information) | |
| 11. | Chair's Report (verbal) – Rachel Ritchie<br>11.1 Terms of Reference 2018 | |
| 12. | Consumer Experience Facilitators Report – Nancy Barlow / Caryn Daum | |
| 13. | Committee Representatives Feedback<br>13.1 Consumer members on Committees – Groups list | |
| **Item** | **Section 2 – For Discussion/Or Approval** | **Time (pm)** |
| 14. | Consumer Council Membership Update – Rachel Ritchie (10 min verbal) | 4.30pm |
| 15. | Planned Care - Penny Rongotoa (20 min presentation / verbal update) | 4.40pm |
| 16. | Telehealth Recovery - Wayne Woolrich/Rebecca MacKenzie (20 min verbal) | 5.00pm |
| 17. | Emergency Q - Chris Petersen (10 min verbal – Question & Answer session) | 5.20pm |
| 18. | **Section 3 – Recommendation to Exclude the Public** | **5.30pm** |

**Public Excluded**

| | **Section 3 – Routine** | |
|---|---|---|
| 19. | Minutes of Previous Meeting (Public Excl) | 5.30pm |
| 20. | Matters Arising – Review Actions (Public Excl) | |
| 21. | Chairs Report to Board May (Public Excl) (For information) | |
| 22. | Consumer Council Annual Plan 2019/20 – Progress Report:<br>• Objective 5 – Facilitate and promote the implementation of a "Person and Whanau Centred Care" approach and culture to the delivery of health services, in partnership with the Clinical Council | 5.35pm |
| 23. | Topics of Interest – Member Issues / Updates | 5.45pm |
| 24. | Karakia Whakamutunga (closing) | 6.00pm |

**NEXT MEETING:**
**Thursday, 2 July 2020**
Boardroom, HBDHB Corporate Office, Cnr Omahu Road & McLeod Street, Hastings or zoom (TBA)

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

## ĀKINA IMPROVEMENT

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

| | ✔ | ✘ |
|---|---|---|
| **Positive** | Has a positive attitude, optimistic, happy<br>Encourages and enables others; looks for solutions | Grumpy, moaning, moody, has a negative attitude<br>Complains but doesn't act to change things |
| **Learning** | Always learning and developing themselves or others<br>Seeks out training and development; 'growth mindset' | Not interested in learning or development; apathy<br>"Fixed mindset, 'that's just how I am', OK with just OK |
| **Innovating** | Always looking for better ways to do things<br>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<br>Says 'thank you', recognises people's contributions | Nit picks, criticises, undermines or passes blame<br>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<br>Takes time to answer questions and to clarify | 'Tells', dictates to others and dismisses their views<br>Judgmental, assumes, ignores people's views |
| **Communicates** | Explains clearly in ways people can understand<br>Shares information, is open, honest and transparent | Uses language / jargon people don't understand<br>Leaves people in the dark |
| **Involves** | Involves colleagues, partners, patients and whanau<br>Trusts people; helps people play an active part | Excludes people, withholds info, micromanages<br>Makes people feel excluded or isolated |
| **Connects** | Pro-actively joins up services, teams, communities<br>Builds understanding and teamwork | Promotes or maintains silo-working<br>'Us and them' attitude, shows favouritism |

## TAUWHIRO CARE

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

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

# Interest Register

## Hawke's Bay Health Consumer Council

**13.12.2019**

| Name<br>Consumer Council Member | Interest<br>eg Organisation / Close Family Member | Nature of Interest<br>eg Role / Relationship | Core Business<br>Key Activity of Interest | Conflict of Interest<br>Yes / No | If Yes, Nature of Conflict:<br>- Real, potential, perceived<br>- Pecuniary / Personal<br>- Describe relationship of Interest to |
|---|---|---|---|---|---|
| Rachel Ritchie (Chair) | Put the Patient First | Involved when group was active | Advocating for Diabetes Patients | Unsure | Real / potential / Perceived |
| | Sainsbury Logan and Williams, Solicitors | Employee | legal services | Yes | Potential/real as provides legal advice to some health care providers |
| Malcolm Dixon (Deputy Chair) | Hastings District Councillor | Elected Councillor | | No | |
| | Scott Foundation | Allocation Committee | | No | |
| | HB Medical Research Foundation Inc | Hastings District Council Rep | | No | |
| James Henry | Health Hawke's Bay Ltd | Facilitator | Part-time role. Improving lifestyles for people with chronic illness. | No | |
| Sarah de la Haye | Nil to declare | | | | |
| Sami McIntosh | HBDHB | Registered Nurse | Hospital | Yes | Employee |
| Deborah Grace | Isect Ltd | Director | IT Security Awareness | No | |
| Dr Diane Mara (Deputy Chair) | Napier Family Centre | Chair | Social Service Organisation | Yes | Perceived/possible conflict as NFC has a small contract for PND from HBDHB |
| | IHC Member Council | Member | | No | |
| | Anglican Diocese Standing Committee | Lay Member | | No | |
| | PACIFICA Inc Pacific Women's Council : Tiare Ahuriri Branch | Branch Chair | Development Leadership for Pacific Women | No | |
| Denise Woodhams | Nil to declare | | | | |
| Geraldine Tahere | Nil to declare | | | | |
| Les Cunningham | Strive Rehabliitation @ Hawke's Bay Trust | Trustee | | No | |
| Tumama Faioso | Nil to declare | | | | |
| Daisy Hill | Nil to declare | | | | |
| Oliver Taylor | Interpreting Team Assistant | Co-ordinating interpreting services. | Could provide interpreting services for the hospital. | | |
| Angela Smith | DHB Board Chair | Related | Advocating for Wairoa and Maori | Yes | Real |

**MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL**
**HELD VIA ZOOM ON THURSDAY, 7 MAY 2020 @ 4PM**

**PUBLIC**

**Present:**
Rachel Ritchie (Chair)
Dr Diane Mara (Co-Deputy Chair)
Malcolm Dixon (Co-Deputy Chair)
Sarah Hansen
Deborah Grace
Dallas Adams
Les Cunningham
Sami McIntosh
Denise Woodhams
Tumema Faioso
Gerraldine Tahere
Daisy Hill
Oliver Taylor
Angie Smith

**In Attendance:**
Wayne Woolrich, CEO Health Hawke's Bay
Susan Barnes, Patient Safety & Quality Manager
Emma Foster, Executive Director - Planning & Funding (Acting)
Lisa Jones, Portfolio Manager, Planning & Funding
Nancy Barlow & Caryn Daum - Consumer Experience Facilitators
Debs Higgins – Clinical Council representative
Toni McGill – Administrator

**Apologies:**
James Henry
Craig Climo, CE
Chris Ash, Acting COO



## SECTION 1: ROUTINE

### 1. KARAKIA TIMATANGA (OPENING) / REFLECTION
Rachel Ritchie (Chair) welcomed everyone to the meeting and introduced Lisa Jones, Portfolio Manager Planning & Funding and Toni McGill, Administrator for Consumer Council
A Karakia was given by Gerraldine Tahere.

### 2. APOLOGIES
Apologies from Jim Henry.

### 3. INTERESTS REGISTER
No conflicts of interest noted for items on today's agenda.

### 4. CONFIRMATION OF PREVIOUS MINUTES
The minutes of the Hawke's Bay Health Consumer Council meeting held on 23 March 2020 were confirmed as a correct record of the meeting.

Moved: Deborah Grace
Seconded: Malcolm Dixon
**Carried**

## 5. MATTERS ARISING AND ACTIONS

Updates for all actions were noted together with the following comments:

***Item 1: 1737 Support Line***

The ED P&F (Acting) has requested a response from Homecare Medical. This Contract is a national contract, not a local contract. Jill Garrett, Portfolio Manager P&F has been promised a response from MOH middle of May. In the meantime, a local 0800 line has been set up. Jill Garrett's persistence and hard mahi in moving this forward was acknowledged by Council members.

**Action: Update on response from MOH from Acting EDP&F – June meeting**

***Item 2: Communication Plan***

The Consumer Engagement Facilitators have progressed the work on the Comms plan with a further meeting planned with the CC Chair next week. This followed the cancellation of this meeting at the commencement of lockdown.

**Action: Update on progress from CEF's – June Meeting**

***Item 3: Vulnerable Adult Policies / Guidelines***

The Patient Safety & Quality Manager is progressing with sourcing copies of this policy from other DHBs. The Disability Working Group did not meet in April, therefore nothing to report. Suggestions were made as follows:- 1) DHB & disability sector relook at the Disability Policy and 2) a copy of the Welfare report be sourced from the Hastings DC (from Allison Banks) as a reference.

**Action: Lisa Jones, Portfolio Manager contact CC Chair & CC Deputy Co-Chair direct to discuss progressing further – June meeting**

***Item 4: Electives Update***

ED P&F (Acting) informed members that due to COVID-19 Electives have been put on hold over the past 6 weeks. Going forward the plan is to increase volumes.

**Action: Planned Care Strategy update from EDP&F (Acting) – June meeting**

***Item 5: Mental Health & Addiction Service Re-Design – standing item for consumer input***

No CC meeting held in April and not discussed in May meeting. On hold until June.

***Item 7: Staff Update***

Toni McGill, EA to ED P&F (Acting) to undertake CC administration going forward. Closed

***Item 10: New Member Orientation***

No CC meeting held in April, not discussed in May meeting. On hold until June.

***Item 11: Induction Manual Review***

No CC meeting held in April, not discussed in May meeting. On hold until June.

***Item 13: Connecting with Consumers around Pharmacy and Medicines***

The Chair and Di Vicary have prepared a letter to be sent to the MoH regarding the pharmacy subsidy card. This letter has been included with the May papers.

**Action: Further HB Community Pharmacists Letter (relating to the same topic). On hold pending advice from Di Vicary that Pharmacists have headspace to receive it. Ongoing**

## 6. CONSUMER COUNCIL WORK PLAN

There were no items on the Consumer Council Workplan for May 2020.

## 7. CONSUMER COUNCIL'S BOARD REPORT

The Chairs report to Board in March was provided for information.

**Action: Administrator to ensure the CE Report to Board and Consumer Council Report to Board are in papers to members pre-meeting.**

## 8. CHIEF EXECUTIVE OFFICER'S BOARD REPORT

The Chief Executive Officer's report to the Board in March was provided for information. The report was taken as read. The CC Chair noted that some members were able to attend the 3 informal Board zoom meetings that took place during the lockdown period. The main areas of concern were raised at these meetings.

## 9. CHAIR'S REPORT

The Chair acknowledged the challenges the community, DHB & PHO staff and consumers have faced during the course of this pandemic. She asked the members to share some of their experiences of the last two months.

- CEO Health Hawke's Bay acknowledged member Deb Higgins who has been significantly involved in the set up of CBAC's, best practice swabbing techniques following MOH guidelines and other front lines services. Wayne stated there have been significant learnings around clinically - primary and secondary working well together, consumer engagement and communication, equity, planning and now moving through to the recovery stage. Learnings in post COVID will be put into place in the contracting of providers, supporting new models of care in GP practices and urgent care facilities. Deb also shared her experience of the COVID time being incredibly stressful.
- Tumema shared her experiences working in one of the Community Hubs that is providing support to our most vulnerable. This work has included work with vaccinations, unemployment, food packs, Easter food packs, health related problems. Over 800 people have been serviced over a 5 weeks period. Community champions are referring names of whanau and referrals are coming into the 0800 number. Very rewarding and lots of learnings.
- Malcolm stated the Hastings District Council have made over 5000 phone calls during this period and reminded the members that the Rapid Response Fund is currently accepting applications from community organisations.

The Chair reinforced that members of the Consumer Council were ready and willing to invest and be part of Consumer Focus groups for the recovery plan, and in fact this was vital. The next step plan is for a potential review for our work at Council also. This was signalled earlier in the year and the COVID period has reinforced this. The Chair explained we went from a longer term/strategic focus to a short-term community feedback focus for that period. The Consumer Council TOR will be placed on the June agenda with a view to reviewing our work and ensuring it is in line with this remit.

## 10. CONSUMER EXPERIENCE FACILITATORS REPORT

The Way Finding presentation was presented to the Disability Reference Groups around the signage (Andrea Beattie project lead). Presentations to other groups have been scheduled. Feedback from the Disability Reference Group has been given to the project lead. There has been an offer from "Blind Low Vision" to look at the signage and provide feedback. Once all feedback is gathered in it will be bought back to Consumer Experience Committee.

The design company BAND are working on ensuring that those that have different needs (ie: dyslexia) will be communicated with through this signage. A concern about the time lag between actions and feedback getting through all working groups in a timely manner was raised.

Items 6 to 10 - Noted
Moved: Geraldine
Seconded: Malcolm Dixon
**Carried**

**SECTION 2:**

**11. RECOMMENDATION TO EXCLUDE THE PUBLIC**

The Chair moved that the public be excluded from the following parts of the meeting:

17. Minutes of Previous Meeting (Public Excluded)
18. Matters Arising – review of actions
19. Consumer Council Annual Plan 2019/20 – progress report – objective 4 – Monitor and assist initiatives that make health easy to understand within the community"
20. Annual Plan – Emma Foster, EDP&F
21. Services Change Report – Emma Foster, EDP&F
22. Recovery Plan – Emma Foster, EDP&F
23. Topics of Interest – Member Issues / Updates

The meeting closed AT 4.34PM.

Confirmed: _____
Chair

Date: 7 May 2020

# HB HEALTH CONSUMER COUNCIL - MATTERS ARISING (Public)



| Action | Date Entered | Action to be Taken | By Whom | Month | Status |
|---|---|---|---|---|---|
| 1 | 10/10/19 | **1737 Support Line**<br>• Response from MOH to Jill Garrett, Portfolio Manager expected Late May. Update brought to June meeting. | ED Planning & Funding | | **For June update** |
| 2 | 12/12/219 | **Communication Plan**<br>• Work ongoing. Further progress report to be brought to June meeting. | Consumer Engagement Facilitators (CEF) | | **For June update/ presentation** |
| 3 | 12/12/19 | **Vulnerable Adult Policies/ Guidelines**<br>• Source copies from other DHBs – ongoing<br>• Disability Working Group update CC<br>• Portfolio Mgr P&F progress with CC Chair & Co-Deputy Chair | S Barnes<br>D Mara<br>Lisa J | Feb-20<br>May-20<br>May 20 | **Ongoing**<br>**Ongoing** |
| 4 | 12/02/20 | **Electives Update**<br>• Planned Care Strategy update by Acting EDP&F relating to increase in elective volumes going forward. | ED Planning & Funding | May 20 | **For June update** |
| 5 | 12/02/20 | **New Member Orientation**<br>• Facilitation of learning sessions to be discussed with Chair<br>• Induction session to be held for new members. Chair to be invited to attend. | S Barnes<br>CEF | Feb-20<br>TBC | **On hold until June meeting** |
| 6 | 12/02/20 | **Induction Manual Review**<br>• Review of manual (to be co-ordinated with Council re-set)<br>• Electronic copy of manual to be sent to all members | CEF<br>CEF | May-20<br>May-20 | **On Hold until June meeting**<br>**On Hold until June meeting** |

| | | | | | |
|---|---|---|---|---|---|
| 7 | 12/02/20 | **Connecting with Consumers around Pharmacy and Medicines**<br>• MOH letter has been provided. Further HB Community Pharmacists letter (relating to the same topic) to be provided. On hold pending advice from Di Vicary that Pharmacists have headspace to receive it. | Chair | June 20 | **Ongoing** |
| 9 | 12/03/20 | **Projects Update**<br>• To be provided in May | ED Planning & Funding | Apr-20 | **Closed** |
| 10 | 07/05/20 | **Consumer Council TOR/Reset**<br>• To be reviewed to ensure our work is in line with these | Admin | June 20 | **Item for June agenda** |

## GOVERNANCE WORKPLAN PAPERS

Updated: May 2020 for June 2020 meeting

| CONSUMER MEETING - June 2020 | Emailed | EMT Member | Lead/Author | EMT Meeting Date | MRB Meeting Date | Clinical Council Meeting Date | Consumer Council Meeting Date | FRAC Meeting date | BOARD Meeting date |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

| CONSUMER MEETING - July 2020 | Emailed | EMT Member | Lead/Author | EMT Meeting Date | MRB Meeting Date | Clinical Council Meeting Date | Consumer Council Meeting Date | FRAC Meeting date | BOARD Meeting date |
|---|---|---|---|---|---|---|---|---|---|
| HB Health Awards - preparation for judging 2019-2020 | | Anna Kirk | | | | 1-Jun-20 | 2-Jul-20 | | 15-Jul-20 |

| CONSUMER MEETING - August 2020 | Emailed | EMT Member | Lead/Author | EMT Meeting Date | MRB Meeting Date | Clinical Council Meeting Date | Consumer Council Meeting Date | FRAC Meeting date | BOARD Meeting date |
|---|---|---|---|---|---|---|---|---|---|
| Alcohol Harm Reduction Strategy (6 monthly update) | | Patrick Le Geyt | Rachel Eyre | 4-Aug-20 | 5-Aug-20 | 5-Aug-20 | 6-Aug-20 | | 19-Aug-20 |
| Matariki Update to Consumer Council (written report) | | Patrick Le Geyt | Shari Tidswell | | | | 6-Aug-20 | | |

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Hawke's Bay Health Consumer Council** |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Rachel Ritchie (Chair) |
| Month/Year: | May 2020 |
| Consideration: | For Information |
| **RECOMMENDATION:** **That the HBDHB Board:** 1. **Note** the contents of the report. | |

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

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

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

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

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

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

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

4. **Members retiring after June 2020**

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

5. **1737 Mental Health line**

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

8

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **PLANNING & FUNDING MONTHLY REPORT** XX |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Emma Foster, Executive Director of Planning & Funding (Acting) |
| Document Author: | Emma Foster, Executive Director of Planning & Funding (Acting) |
| Month: | May 2020 |
| Consideration: | For Noting |

**RECOMMENDATION**

**That the HBDHB Board**

1. Note the contents of the report

## 1 Executive Summary

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

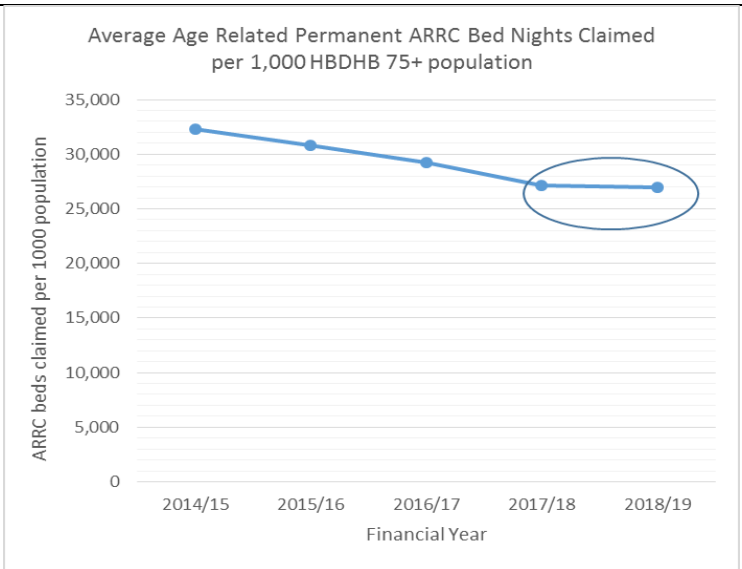
## 2 Development and Innovation

### Integrated data analytics for Ageing Well

Matthew Parsons is a Professor of Gerentology at Waikato University has developed a model that supports quality of life for older people, and how/what service provision can support the best outcomes for people in the lsat 1000 days of life. The guidance from Matthew Parsons has indicated the importance of integrated data sources to build a system picture to enable us to understand the drivers to support the strategic direction and influence service change. The key enabler of this work in the Business Intelligence team within the Digital Enabliments Directorate, and they have had significant pressure placed on them over the COVID-29 resposne. Planning and Funding will be working with them to support this priority piece of work.

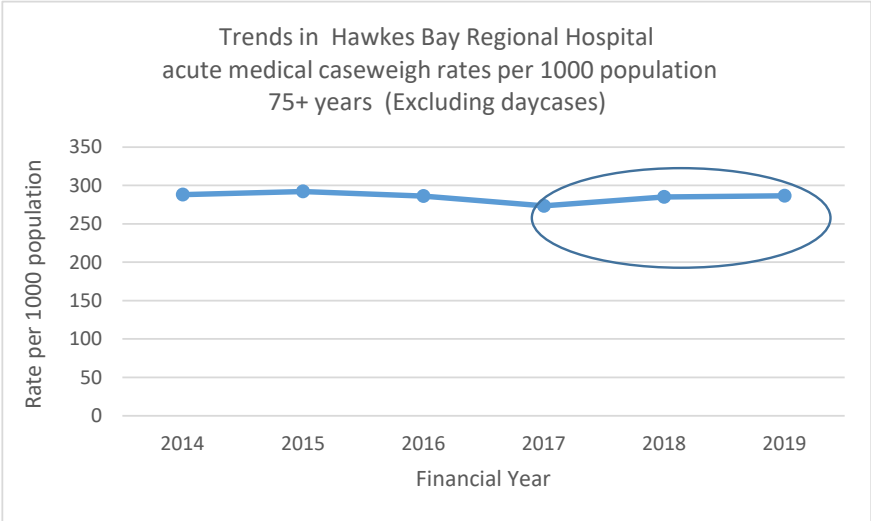
Below is an example of how we use this information to inform decision making.

**Examples of integrating data sources to benefit evidence based system improvements**




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

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




## Funding allocation

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

The questions that need to be considered are:

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

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

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



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

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

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

## HBDHB Cost Allocation by Ethnicity

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

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

## HBDHB Cost Allocation by Regions (pop location)

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

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

## HBDHB Cost Allocation Care Setting

| Allocation Methodology | Health Promotion | Community | Primary Care | Hospital | Out of Area |
|---|---|---|---|---|---|
| **Percentage of Costs** | **2.91 %** | **15.31 %** | **27.41 %** | **45.82 %** | **8.56 %** |
| **Cost Percentages by Division** | | | | | |
| **Health Improvement & Equity** | **100.00 %** | **- %** | **- %** | **- %** | **- %** |
| **Primary Care** | **- %** | **26.33 %** | **73.67 %** | **- %** | **- %** |
| **Provider Services** | **- %** | **10.75 %** | **- %** | **89.25 %** | **- %** |
| **Tertiary** | **- %** | **- %** | **- %** | **- %** | **100.00 %** |
| | | | | | |
| **Estimated Target** | **10.00 %** | **15.00 %** | **25.00 %** | **40.00 %** | **10.00 %** |

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

### Ambulatory Sensitive Hospitalisations (ASH) Respiratory 0-4 years

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

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

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

### Primary Care

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

## 3 Exceptions



### Growing well

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

### Living Well.

*General Practice and Pharmacy* - Reflections of Covid-19 to date have highlighted the vulnerability of General Practice and Pharmacy and their ability to remain financially sustainable during this crisis. General practice experienced a reduction in presentations/face to face consultations of up to 67% . Pharmacy who often supplement their income with the retail side of their business also experienced a sharp decline in foot traffic and as a result a drop in sales.

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

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

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

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

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

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

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

- resilience levels low in staff and clients

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

## Aging Well

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

## Corporate Performance

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

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

RECOMMENDATION:

**That the HBDHB Board:**

1. Note the content of the May 2020 report

**Executive Summary**

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

**Activity – April 2020**

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

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

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

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

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

Figure 1: District Nursing Activity Change

**Recovery Plan**

*Overarching Approach*

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

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

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

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

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

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

**Panui**

*Referral Management & Booking Review*

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

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

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

*Scaled Coordinated Incident Management (CIMS)*

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

*A New Home for General Surgery Outpatients*

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

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

*Flaxmere Community Oral Health Service Pre-School Engagement*

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

*Partnering for Improved Māori Mental Health*

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

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

*Review of Performance and Risk Management*

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

**Key Quality Measures & Statement of Performance Expectations (SPE)**

*Patient Seclusion in Mental Health & Addiction Services*

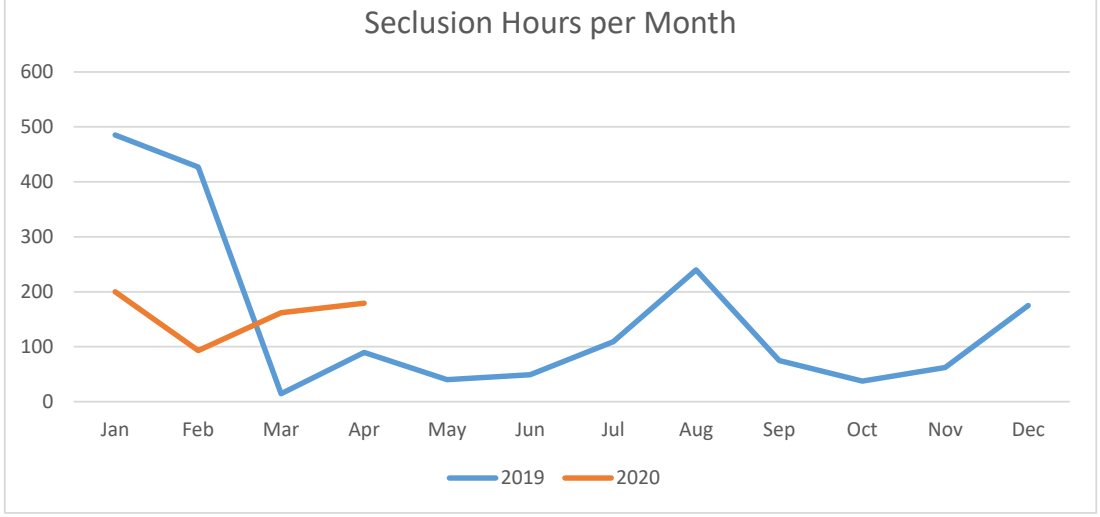



Figure 2: Mental Health & Addiction Inpatient Seclusion Hours per Month, January 2019 – April 2020

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

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

*Faster Cancer Treatment*

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

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

*ED6*

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

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

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

*Elective Services Performance Indicators*

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

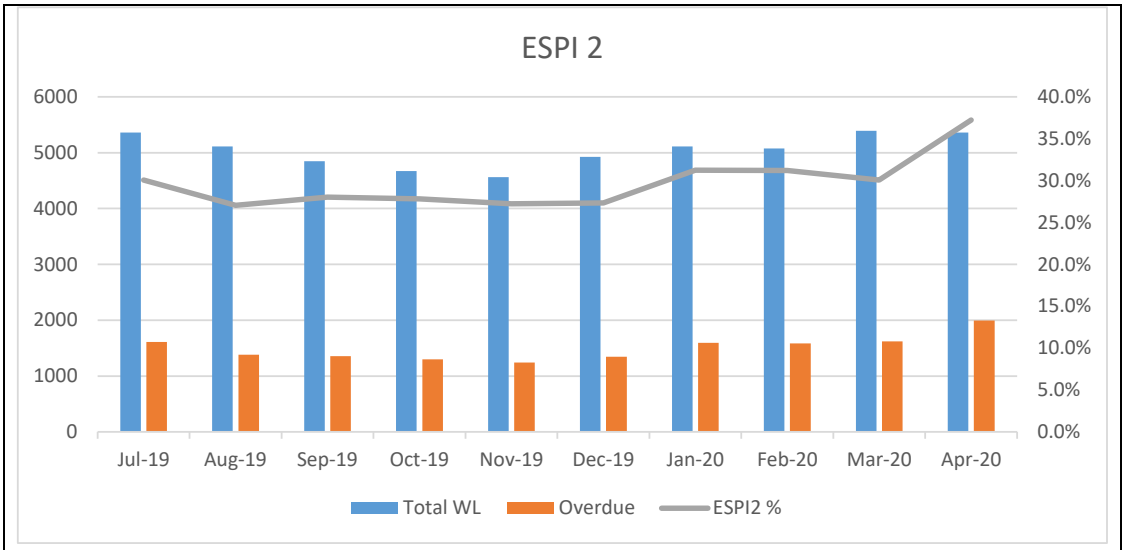



Figure 3: ESPI 2 Wait Lists and Compliance, July 2019 – April 2020

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

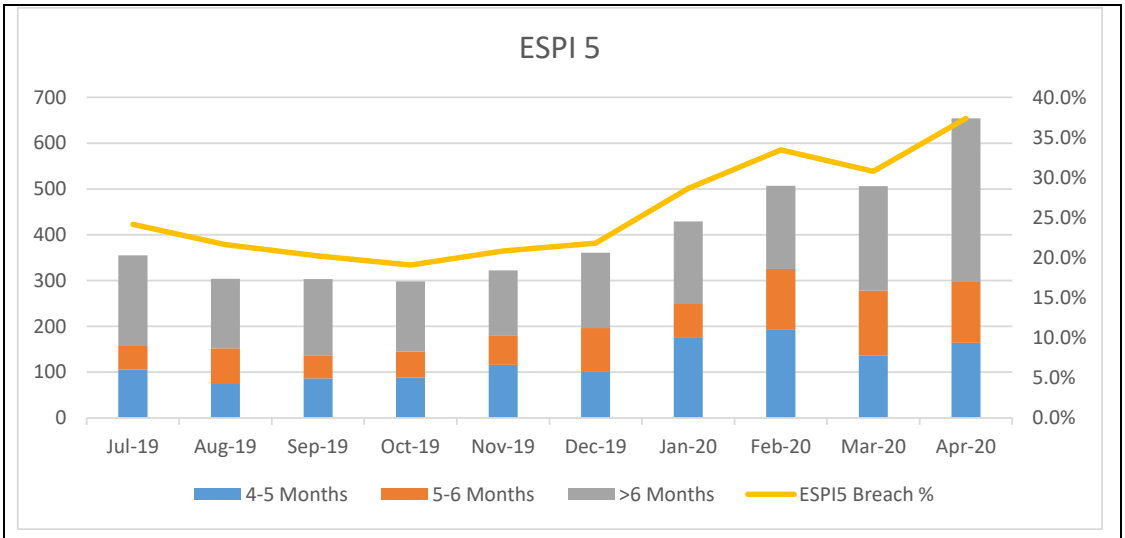



Figure 4: ESPI 5 Wait Lists and Compliance, July 2019 – April 2020

*Ministry of Health Planned Care (Surgical Discharges) Target*

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

**Financial Performance**



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

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

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Chief Executive Officer's Report - Public** |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Craig Climo, Interim Chief Executive Officer |
| Month as at | 13 May 2020 |
| Consideration: | For Information |



**RECOMMENDATION**

**That the Board**

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

**INTRODUCTION AND COVID-19**

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

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

**FINANCIALS**

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

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

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

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

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

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

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

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

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

**ANNUAL PLANNING**

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

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

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

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

**WAIROA**

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

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

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

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




# Chairs Report (verbal)

## June 2020

# TERMS OF REFERENCE

## Hawke's Bay Health Consumer Council

## August 2018

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

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

**2**

| | |
|---|---|
| **Reporting** | The Council will report to the CEOs of HBDHB and Health Hawke's Bay, and through the CEOs to the respective HBDHB and Health Hawke's Bay boards.<br><br>A monthly report of Council activities and recommendations will be placed on HBDHB and Health Hawke's Bay websites once approved. |
| **Minutes** | Minutes will be circulated to all members and Chair of the Council, within one week of the meeting taking place.<br><br>Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc, on request. |

# CONSUMER EXPERIENCE FACILITATORS REPORT

## June 2020

**Consumer/Patient and their Whanau Experience**

- Korero Mai co-design work in Wairoa is on hold due to COVID To date:
  Staff survey, staff/consumer observations and consumer interviews have been undertaken.
  Due to a recent change in key clinical staff, the working group were due to connect with HQSC again in April, again delayed by COVID
  Focus groups that had been organised will need to be rescheduled due to travel restrictions and social distancing.
- Inpatient Experience Survey. Survey due to be sent out for a 'test run' in May, we have invited Council members, staff and consumers to participate and provide feedback.
- Working with Digital Enablement to find a suitable solution to capture patient advised disabilities within DHB systems.
- Complaints management while the Complaints Advisor was away. Issues related to change in procedures due to COVID escalated for follow up and timely response to consumers. Support provided to services to respond to outstanding consumer complaints.



**Community Engagement**

- Wayfinding presentation to Disability Reference Groups on hold. Will reschedule once meetings resume. Organisations from these groups each busy managing day to day operations at this point
- Reference information about Covid-19 shared with community contacts, to ensure groups have accurate, up to date information.
- Asked to be DHB reps for the Civil Defence Emergency Management Disability Support Network, to ensure these groups received information from the DHB and to raise any concerns back to the DHB.
  Attended regular zoom meetings for the four groups, Residential Services, Vocational Services, Supported Living Network and the Independent Living Advocacy group. With the change in alert level, the groups have coalesced into one and we continue to be involved. Issues raised included PPE access, PPE use information and ensuring all services received relevant communications from the DHB. This has been a great networking opportunity with groups sharing initiatives, resources and working together to adapt how they deliver services depending on lockdown levels. One area of concern raised was for people with disabilities who are usually able to lead their lives without regular care from disability services that may have found themselves unable to manage within the Covid environ, and how quickly they would become known to any agency and from there access help and support.

**Health Literacy**

Assist services review their documents

- Safe Handling Policy
- Safety - community visits
- Staff - Return to work safety plan
- Posters/information

External

- Worked with Sport HB Coordinator to recommend programmes and resources for specific groups within the disability community rather than parents/caregivers having to look through all of the information to see what might be suitable (not always clear from the name of the resource/programme)


# COMMITTEE REPRESENTATIVE FEEDBACK

13

## Consumer Council Members

## Representation on Committees/Groups etc

Updated December 2019

| Committees | Member | Meeting Frequency |
|---|---|---|
| Consumer Experience Committee | Diane Mara<br>Deborah Grace<br>Les Cunningham | Quarterly |
| Clinical Effectiveness & Audit Committee | Malcolm Dixon | Quarterly |
| Patient Safety & Risk Management Committee | Rachel Ritchie | Quarterly<br>Feb; May; Aug; Nov |
| Professional Standards & Performance Committee | Sami McIntosh | Quarterly |
| Information Services Committee | Current ToR makes no provision for consumer rep | |
| Clinical Advisory & Governance Committee | PHO Committee / no specific consumer rep | |
| Clinical Council | Les Cunningham | Monthly |

| Other Groups / Projects / Areas of Interest | Member | Meeting Frequency |
|---|---|---|
| Advance Care Planning | | |
| After Hours Care | Geraldine Tahere<br>Les Cunningham | |
| Aged Care Group | | |
| Alcohol Reduction | Les Cunningham | |
| Connecting Care (MH) | Deborah Grace | |
| Cultural Competency – Medical Council | Geraldine Tahere | |
| Disability Reference Group (Hastings) | Sarah Hansen | |
| Disability Steering Group | Diane Mara | |
| End of Life Care | Gerraldine Tahere | |
| Family Violence Intervention | Denise Woodhams | |
| Health Care Home | Denise Woodhams | |
| Heart Action Plan | Les Cunningham | |
| Integrated Pharmacy Strategy | Denise Woodhams | |
| Maternal Mental Health | | |
| Partnership Advisory Group (PAG) | Deborah Grace | |
| Patient at Risk Advisory Group | | |
| Pharmacy Design | Denise Woodhams | |
| Radiology Expansion Programme | | |
| Radiology Refurbishment Project | | |
| Rangatahi Service Redesign | | |

| Other Groups / Projects / Areas of Interest | Member | Meeting Frequency |
|---|---|---|
| Serious Illness Conversation | Gerraldine Tahere | |
| Signage/Patient Journeys | | |
| Surgical Expansion | | |
| Virtual Consumer Consultation Group | | |
| Older Persons Early Supported Discharge | Les Cunningham | |
| PHO Funding Review | Denise Woodhams | |
| Medical and Surgical Advisory Groups (FLOW, Acute Admissions and Surgical) | Les Cunningham | |
| NASC Advisory Group | Les Cunningham | |


# Consumer Council Membership Update (verbal)

14

## June 2020

# Planned Care Presentation

## June 2020

15

| | | | |
|---|---|---|---|
| To | HBDHB Consumer Council | Author | Rebecca Mackenzie |
| Reporting Manager | Peter Satterthwaite | Peer Reviewed | Wayne Woolrich |
| Title | Consumer Input into embedding Telehealth in Hawkes Bay post Covid-19 | Date | May 2020 |

## For Approval

### Proposal

Health Hawkes Bay (HHB) proposes working alongside the Consumer Council to embed Telehealth across Hawkes Bay to ensure that all consumers in Hawkes Bay can access a good quality service, which meets their needs and that costs are consistent and fair.



### Background

HHB was in relatively early stages of implementing Health Care Home (HCH) when the Covid-19 environment arrived. The measured approach of commencing three or four practices at a time and implementing the entire HCH model of care was disrupted when General Practices were required by the Ministry of Health to implement Telehealth overnight to commence business on 23 March 2020. This was achieved with remarkable speed by practices and enabled by HHB providing hardware, background processes, recommendations for charging etc.

Now that the dust is settled, HHB sees the opportunity to improve the service provided, integrate into the HCH model, and, include consumers in that process.

### Current Issues

There are a number of issues that have been identified by consumers so far. These include

- Perceived inconsistency in practice charges
- Variation in charges across different practices
- Variation in the offerings and quality of telehealth services provided by practices
- Digital exclusion - lack of access to appropriate devices, device security, lack of information on charges from Telco provider i.e. who pays for data use? Lack of internet access for rural consumers
- Privacy
- IT security

## Next steps

1. Consumer Council visit to Hauora planned for 3 June 2020 to observe HCH in action and provide feedback
2. Compile & Share lessons learned from General Practice from implementing Telehealth quickly
3. Convene focus group made up of Consumer Council members and ensuring adequate representation by Māori
4. In preparation for focus group, ask consumer council members to gather feedback, stories and examples of issues from their networks. HHB will provide a list of focus areas to initiate discussion
5. Focus group will be facilitated by HHB and Consumer Council Rep
6. Outputs from focus group to feed into Telehealth Embedding plan
7. Ongoing feedback from consumers could be captured by a consumer council rep and fed in to embedding process. Alternatively, focus group could be re-convened if required

## Recommendation

Included in these next steps and in recognition of HHB's commitment to consumer engagement, it is strongly recommended that a consumer council representative is engaged in addition to the focus group to provide regular consumer input into the process of embedding Telehealth across General Practices in Hawkes Bay. This would be utilised on an 'as required' basis, acknowledged as per an agreed rate. (eg $40/per hour as per HQSC framework recommendations, or $50 grocery vouchers for sessions up to 2 hours). The purpose would be to provide advice and act as a conduit between consumers, Consumer Council and Health Hawkes Bay – as per point 7 above.

# Emergency Q

## June 2020

OURHEALTH
HAWKE'S BAY
Whakawateatia

# Recommendation to Exclude the Public

**Clause 32, New Zealand Public Health and Disability Act 2000**

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

20. Minutes of Previous Meeting (Public Excluded)
21. Matters Arising – review of actions
22. Chairs Report to Board May
23. Consumer Council Annual Plan 2019/20
    Progress Report – Objective 5
24. Topics of Interest - Member Issues and Updates

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).