BOARD MEETING

Date: Wednesday 27 March 2019

Time: 1:30pm

Venue: Te Waiora Room, DHB Administration Building,
Corner Omahu Road and McLeod Street, Hastings

Members:
Kevin Atkinson (Chair)
Ngahiwi Tomoana
Dan Druzianic
Barbara Arnott
Peter Dunkerley
Dr Helen Francis
Diana Kirton
Jacoby Poulain
Heather Skipworth
Ana Apatu
Hine Flood

Apologies:

In Attendance:
Kevin Snee, Chief Executive Officer
Executive Management Team members
John Gommans and Jules Arthur, Co-Chairs of Clinical Council
Rachel Ritchie, Chair HB Health Consumer Council
Members of the public and media

Minute Taker: Jacqui Sanders-Jones

Public Agenda

Item	Section 1: Routine	Ref #	Time (pm)
1.	Welcome and Apologies		1:30
2.	Interests Register		
3.	Minutes of Previous Meeting 27 February 2019		
4.	Matters Arising - Review of Actions		
5.	Board Workplan		
6.	Chair's Report (verbal)		
7.	Chief Executive Officer's Report – Kevin Snee	19	
8.	Financial Performance Report – Carriann Hall, ED Financial Services	20	
9.	Board Health & Safety Champion's Update – Board Safety Champion	21	

	Section 2: Governance / Committee Reports		
10.	Te Pitau Health Alliance HB Update – Helen Francis	22	2:05
11.	Māori Relationship Board – Chair, Heather Skipworth	23	2:10
12.	Pacific Health Leaders Group report – Barbara Arnott	24	2.15
13.	HB Health Consumer Council – Chair, Rachel Ritchie	25	2:20
14.	HB Clinical Council – Co-Chairs, John Gommans and Jules Arthur	26	2:25
	Section 3: For Information & Discussion		
15.	Wairoa Integrated Health Services and Community Led Commissioning update Chris Ash, Emma Foster	27	2.30
16.	Key Learnings from the NUKA System of Care for Implementation in HBDHB Bernard Te Paa & Patrick le Geyt	28	2.50
17.	Matariki HB Regional Development Strategy and Social Inclusion Strategy update Bernard Te Paa & Shari Tidswell	29	3.05
18.	**Section 4: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	**Section 5: Routine**	Ref #	**Time (pm)**
19.	Minutes of Previous Meeting 27 February 2019 (public excluded)		3.20
20.	Matters Arising (public excluded) – Review of Actions		-
21.	Board Approval of Actions exceeding limits delegated by CEO	30	-
22.	Chair's Update (verbal)		
	Section 6: For Information		
23.	Finance Risk and Audit Committee – Chair, Dan Druzianic	31	3.40
	Meeting concludes		

The next HBDHB Board Meeting will be held at
1.30pm on Wednesday 24 April 2019

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" - 13 March 2019

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair of FRAC	26.10.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	28.03.18
	Active	Iwi Chairs involved with Treaty of Waitangi Health Claim #2575	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	19.12.18
Barbara Arnott	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	26.10.17
Dr Helen Francis	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
	Active	Senior Advisor Primary Care	Health system improvement & innovation, Ministry of Health	Declare interest as and when required	The Chair	13.03.19

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Elected Board Member of the Federation of Primary Health Aotearoa New Zealand	Newly established sector wide multi-professional membership association, providing an inclusive platform for health and care integration with the people of New Zealand at the hear of the organisations objectives. No contracts held and have no financial interest in any of their work.	No conflict perceived	The Chair	10.11.18
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW Counselling Services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	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	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Whararíki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 27 February 2019, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.40PM

PUBLIC

Present: Kevin Atkinson (Chair)
Ngahiwi Tomoana (Deputy Chair)
Dan Druzianic
Dr Helen Francis
Peter Dunkerley
Diana Kirton
Barbara Arnott
Heather Skipworth
Jacoby Poulain
Ana Apatu
Hine Flood

Apology

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
John Gommans and Julie Arthur (as co-Chairs, HB Clinical Council)
Rachel Ritchie (Chair, HB Health Consumer Council)
Members of the public and media
Jacqui Sanders-Jones (Minute-taker)

APOLOGY

No apologies noted.

Chair welcomed Jacqui Sanders-Jones into the role of Board Administrator/PA to Company Secretary.

2. INTEREST REGISTER

Deletion of interest against Barbara Arnott with Hawkes Bay Air Ambulance Trust – **action**

No further changes to the interests register were advised

No board member advised of any interest in the items on the Agenda.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 19 December 2018, were confirmed as a correct record of the meeting.

Moved: **Barbara Arnott**
Seconded: **Dan Druzianic**
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Equity & Cultural Competency Workshop –** remains as an outstanding item

Item 2: **Funding of Capital Projects –** This is a paper for March FRAC meeting being prepared by Carriann Hall. Remain as an action

Item 3: **Consumer Experience Facilitator –** included on Workplan, to remain as an action

Item 4: **Wairoa Integrated Care –** included on Workplan for March, to remain as an action

Item 5: **Bowel Screening in HB –** dealt with in today's agenda. *Remove from actions*

Item 6: **It's hard to ask –** This presentation was well supported at Consumer Council. *Remove from actions*

Item 7: **Mobility Action Plan –**

a) Audit circulated to Board - Actioned. *Remove from actions.*

b) Review & discuss potential for HBDHB to fund continuation of the programme.

Commissioning leadership group is undertaking a targeted piece of work on funding paths at a workshop in early May. *Remove from actions.*

5. BOARD WORK PLAN

The Board Work Plan was noted

Progress on People Plan is due to come to Board on Dec 11 2019. Chair noted that this will be the first meeting with the new board in place and therefore proposed to bring forward to November meeting. Agreed - *Action*

6. CHAIR'S REPORT

- The Chair advised 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
Heather Blackwell	Medical Typist	Operations Directorate	36	25-Jan-19
Diane Rarere	Sterile Service Technician	Surgical Directorate	28	29-Jan-19
Anne Carr	Registered Nurse	Surgical Directorate	18	31-Jan-19
Dale Littley	Team Secretary	Operations Directorate	17	1-Feb-19
Jennifer Streeter	Family Therapist	Older Persons & Mental Health	13	8-Feb-19

- Leadership Forum on 6 March 2019. Hine noted as unable to attend on this occasion.
- Chair noted receipt of open letter from Andrew Espersen regarding proposed changes to the Mental Health Act, a copy of this letter had been sent to Board members in January.

7. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report with comments noted in addition to the report including:

- Noted that HBDHB has been experiencing a lot of industrial action with a number of different staff groups on strike. CEO commended the good planning by staff involved which mitigated the effects of strike on the organisation. CEO received positive feedback on discussions with RDA (regarding RMO industrial action) and overall hoping to move towards less staff groups taking industrial action in future months ahead.
- CSSD and sterilisation of equipment has been a highly publicised event. A review for Ministry of Health is underway and Board will be kept informed as to progress.

- Working hard to address First Specialist Appointments (FSA) for ESPi 5 targets, whilst also recognising that HBDHB need to address ED6 performance as HBDHB currently sit below national average.
- CEO looking towards improvements being seen in all these areas over the next few months especially financial.

8. FINANCIAL PERFORMANCE REPORT

The result for the month of January is $356k favourable to plan, improving the year-to-date (YTD) result to $2.1m adverse. The key drivers were summarisedwithin the report.

Comments noted in addition to the report included:

- January result better and indicator of an improved February from impact of key drivers, with forecast still heading towards achieving the $5m deficit proposed.
- Large capital expenditure due to finalisation of Endoscopy and Histology projects. Whole sector cash position is challenging, however HBDHB will continue to make good decisions oncapital spend.
- MECA settlements, on flow impact of third party providers, and holidays act will all have wider impact.

9. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Board Champions Barbara Arnott and Hine Flood provided an update

- No report for March 2019
- Christine Mildon, as Health & Safety manager has next visit to Wairoa planned for April 2019

REPORT FROM COMMITTEE CHAIRS

10. TE PĪTAU HEALTH ALLIANCE (HAWKE'S BAY)

Helen Francis as Deputy Chairof the Health Alliance spoke on matters discussed at their meeting held 13 February 2019.

Informative meeting whilst recognised a slight frustration at lack of traction of the monthly group.

Chris Ash advised that there are two tasks of redesign, including Mental Health & Addictions (currently on pause) and End of Life Care. There is some progress and small changes happening but recognises it takes time to implement.

Advantages of alliance briefly discussed; most importantly to ensure services are delivered and appropriately so. Important to gain quick wins for this hard working team. IS presentation recently raised discussion of IS resource being consumed by DHB withlittle availability for meeting requirements in primary and community care.

11. MĀORI RELATIONSHIP BOARD (MRB)

Heather Skipworth as Chair of MRB spoke to the meeting held 13 February 2019.

- Congratulated Consumer council for great presentation on disability strategy
- Alcohol harm reduction – great to see schools writing their own alcohol policies.
  Noted that there seems to be no recognition, through compensation, for use of Maori Health human resource for pieces of work for HBDHB.
- He Ngākau Aotea – similarly, human resourcing issue. Use of Maori Health resource, felt to be no recognition or compensation for involvement with this piece of work.

- Bowel Screening – Noted great presentations. At the workshop it was agreed that lowering the rate would not necessarily create better results and could in fact create harm amongst communities. As participation rate is quite low compared to other Maori health issues, it was agreed not to focus further resource onto lowering bowel screening age to 50. (40% participation for Maori in Bowel Screening for Hawke's Bay, with target being 73%). Chair suggested further discussions.
- CEO commented that Equity Plan, People Plan & CSP are all being brought together into the Strategic Plan. Bernard Te Paa, Executive Director of Health Improvement & Equity, spoke of He Ngākau Aotea being developed in a partnership approach with iwi, and looking to do this over the next few months.

12. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised the outcomes of their meeting held on 14 February 2019:

- Positive feedback to the HBDHB leadership on the handling of the recent Sterile Services event.
- Working with CEO of PHO on enhancing the connections, and CEO of HBDHB in regards to HB Health Awards - seems to be opportunities for change.
- Renal transplant presentation – received well and is a good example of what goes on for consumers, displaying how this drives health outcomes for renal patients.
- Disability Strategy well received at Consumer Council, with committee grateful to Diane Mara working with consumers in stepping forward to put this strategy together. Joint workshop with Clinical Council coming up to discuss whatPerson and Whanau Centred Care in primary and community healthcare will look like in the future..

13. HAWKE'S BAY CLINICAL COUNCIL

Co-Chairs John Gommans and Julies Arthur spoke to the report from the Council's meeting held on 13 February 2019:

- Report highlighted support for the People Plan but noted particular need for 'professional' training of clinical staff. More emphasis required in this area.
- Council supported the disability strategy wholeheartedly.
- Alcohol harm – Council noted that there is siloed screening for alcohol, violence, drugs, and discussion followed on strategies to progress a joined up approach to all screening..
- Question raised about cannabis legislation – currently not legal and therefore not actively discussed at Clinical Council as yet. .

FOR DISCUSSION / INFORMATION

14. Ngatahi Briefing End of Year Two 'Vulnerable Children's Workforce Development' Annual update –

Russell Wills & Bernice Gabrielle presented and spoke to the report.

In addition discussions included:

- 5 Wananga have been held with over 80 participants with good feedback. Mental Health Wananga received great feedback.
- 2nd April begins Self Care module.

- Chrissie Hape on governance group for training. Reviewing providers of Engaging Effectively with Maori.
- Noted that building good relationships with outside organisations has been critical to this project
- Recognised that lots of learning had occurred through the engagement with outside organisations/Maori groups and has led to the creation of respected partnerships.
- The Ngātahi Project article published in the February edition of Policy Quarterly and abstract accepted for the ITP Research Symposium at EIT on 15 April 2019.
- .https://www.victoria.ac.nz/__data/assets/pdf_file/0004/1733944/Wills_et_al.pdf
- Question raised regarding engagement with consumers and how impact on consumers has been measured. consent had been gained to interview whanau. Measures of impact at child and family level cannot be provided and although demonstrable changes in practice and visible changes for whanau are evident, measurable data does not exist.
- Question raised about when results of this project will show through, noting that Napier and Hastings have busiest rates in New Zealand for workload with tamariki and young people within the health system -Attitudes needing to be changed firstly especially in regards to male violence towards women needing more programmes for men wanting to change and looking for help. Advocacy for supporting men to become better males is required and recognised to be of high importance.
- Nuka 'Wellness Warrior' programme held brief discussion and the translation of this into Maori culture.
- The team were commended for this work and recognised for their work in supporting professionals to support whanau.
- Noted that navigation of a fragmented system would require further work but very necessary if real change is to take place and enable victims to navigate it effectively.

- Board **noted** the progress of the Ngātahi Project in the second year.

15. Bowel Screening

Following the recommendations at MRB, management were requested by HBDHB Board to further investigate the viability and appropriateness of extending the screening age for Maori to people aged 50 – 74 (currently 60 -74years).

Following further exploration with MRB joined with consideration of clinical evidence and guidance, the management recommendation was to not extend bowel screening for Maori to people 50 – 74 years and to maintain the current age rangeat this stage.

Chris Ash (ED Primary Care) highlighted to Board the five outcomes of the MRB seminar on 23 January 2019 (Section 6 of the paper) which observed the conclusions made and which has led to the recommendations to the Board.

RECOMMENDATION

It is recommended that the Board:

1. **Ratify** the management recommendation, that HBDHB should not consider extending bowel screening for Māori to people aged 50-74 years at this juncture, for the following reasons set out in clauses 6.1 - 6.5 and that:
    - The DHB's internal public health advice is that insufficient evidence currently exists to definitively conclude that the benefits of extending the screening age would outweigh the harms (section 3)
    - The extension of bowel screening is operationally unfeasible, with extended waiting time pressures generating risks to quality of care (section 4)
    - Population health information indicates that the inequity offsetting effect of an extension to the age for bowel screening would not represent value for money, when compared against interventions for the leading causes of premature mortality amongst Māori (section 5)

Notethe observations agreed at the Māori Relationship Board Seminar (6.1 - 6.5) and that no further assurance is required from management on these issues.

Adopted

16. HBDHB Draft Disability Plan

Bernard Te Paa (ED Health Improvement and Equity), Shari Tidswell (Intersectoral Development Manager) and Dr Diane Mara (Deputy Chair Consumer Council) presented the report.

The report had been circulated across various internal groups and developed with extensive engagement with consumers.

Implementation of this plan will be highly supported by the disabled community and included planning for access, and that services currently running are user appropriate.

The full support of both the Clinical and Consumer Councils was noted.

Query raised as to source of figure for '23% of people in HB with a disability'. *ACTION – Shari Tidswell to provide further information on this data*

All those involved in the development of the Plan were thanked and acknowledged.

Board noted the contents of the report and endorsed the key recommendations

17. Strategic Planning Update

Chris Ash presented an overview of the Strategic Plan for the next ten years, split with an Implementation Plan for five years, noting this will bring together the Clinical Services Plan (CSP), Equity Plan and People Plan, and will reflect learnings from The Big Listen and He Ngākau Aotea

- HB Health Sector Leadership Forum will consider the content of the first draft and how to start the process of going out to communities with the strategy development.

18. HBDHB Alcohol Harm Reduction Strategy 2017-22 (six month update)

- Team continue to engage strongly with Councils for support and direction in managing alcohol harm especially administration of issuing licences. Noted that HBDHB are currently engaged with Hastings District Council(HDC) to oppose a particular licence recently issued.
- Team looking to re-examine other key issues which continue to cause harm.

- Next 6 month update to Board will give comprehensive update on alcohol and other areas of harm, recognising the need to engage with communities in order to understand and pinpoint these areas of harm.
- Next Steps: At final steering group last year, integration was discussed as a requirement for screening and will need provider support to take forward. Currently reviewing GP dashboards and would like to see consistent messaging across primary care especially with pregnant women, with overall feeling that PHO traction needs improvement. Clinical Council provide clinical governance for this piece of work.
  Suggestion of linking up with other screening groups i.e. Violence Intervention Programme, however this would require further work to ensure best use of resource for the clinician/patients time, recognising this would be a significant change.
- The relationships between alcohol, other drugs and social harm were discussed and it was acknowledged that it was difficult to measure or indicate where and how harm reduction strategies were working in communities.
- Consumer Council Chair highly recommends continuing with lots of consumer input as this is a consumer issue and need consumers on board to effect changes with suggestion to present framework of change to them.
- Simplicity for whanau was also strongly advocated – recognising the complexities of several screenings and the logistics and emotional strain on vulnerable consumers. Coordinated access is the key driver for whanau attendance and that provider services should be centred on the person rather than offering fragmented appointments and difficult pathway to negotiate.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the substantial activity led by population health.
2. **Note** the new landscape to obtain buy-in from clinical services using a broad based social harm reduction approach, especially for screening and brief intervention.
3. **Approve** the next steps.

Adopted

FOR MONITORING

19. People and Quality Dashboard Q2 (Oct – Dec 18) -

No issues were raised and the report was received

20. 20.0 HBDHB Performance Framework Exceptions Q2 (Oct – Dec 2018)

20.1 HBDHB Non-financial Performance Framework Dashboard Q2

Colin Hutchison (EDProvider Services) gave a brief overview, detailed as follows;

- Equity remains an important factor in these focus targets as costs of referring to A&M centres need to be considered.
- Diagnostic services areclose to capacity. Providing evening and weekend sessions to address this and reviewing referral process

- Average length of stay for electives was noted as worsening over next two months. Whilst lowering cases, it must be understood that cancers and acutes remain priority and will have impact on results.
- S29 orders (p139) has continuing high ratio of Maori to non-Maori, noted as linking increased use of cannabis to the increase in mental health issues.

21. Health FPIM Business Case –

Carriann Hall (ED Financial Services) provided some background and presented the report.

HBDHB are part of a shared national IT network for procurement and require Board support to continue on this pathway by participating in purchase and implementation of new procurement system and look for support to approve additional funding. This will impact on the future of national procurement methodology.

It was recognised that there are 10 DHBs that have urgent system risk to address (those moving to Oracle) but this is not affecting HBDHB (currently on Tech 1 solution), however HBDHB acknowledges that these DHBs are undergoing this change of system.

Chair informed a $15 - $16milion potential cost to the 20 DHBs ito develop a National Procurement Catalogue, however Carriann Hall noted that the compliance benefits with Pharmac by HDBHB continuing as part of this procurement programme will be extremely favourable for the sector.

RESOLUTION

That the HBDHB Board:

a. **Approve** the shared vision for the development and implementation of a national shared procurement catalogue, data standards, data repository, and compliance processes to improve procurement value for money; and the full participation of Hawke's Bay DHB in the implementation of this

b. **Approve** the provision of $20,309 in additional funding as the PBF determined share for Hawke's Bay DHB, to design how a shared national catalogue, chart of accounts and data repository will operate and how it would provide the compliance necessary to deliver procurement benefits as contemplated by the business case

c. **Notes:**

- that the FPIM business case recommends a single system for the 10 DHBs with immediate system risk issues and to investigate options for a national shared catalogue. This pathway preserves the potential for all DHBs to migrate to a single system in the future
- that HBDHB does not have immediate system risk issues and is not one of the 10 DHBs. HBDHB will provide a roadmap and recommendations on future development of Financial Management Information System, noting that a decision not to join Oracle will trigger an impairment review, with the potential of full impairment of $2.7m relating to HBDHB investment in National Oracle System (NOS)
- that the attached FPIM business case has been approved for release by the FPIM Governance Board (chaired by the Director-General of Health)
- that the staged approach and recommended pathway contained in the business case have been endorsed by the FPIM Governance Board
- that the recommendations have been reviewed and endorsed by Executive Director Financial Services HBDHB
- that this programme and business case has been subject to Gateway Review
- that this business case is predicated on the work being led by NZ Health Partnerships at this stage, noting that as the next stages of the programme progress further work will also be required to define and agree the operating model including the ongoing role of NZ Health Partnerships
- that Ministry of Health and NZ Health Partnerships representatives were available to join Board meetings to assist DHB decision-making processes, and a decision is requested by mid-March 2019
-

Moved: Barbara Arnott
Seconded: Peter Dunkerley
Carried.

GENERAL BUSINESS

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

22. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

22. Confirmation of Minutes of Board Meeting
23. Matters Arising from the Minutes of Board Meeting
24. Board Approval of Actions exceeding limits delegated by CEO
25. Chair's Update
26. Hawke's Bay Clinical Council
27. Finance Risk and Audit Committee Report
28. Whole of Board Appraisal Action Plan

Moved: **Heather Skipworth**
Seconded: **Diana Kirton**
Carried

The public section of the Board Meeting closed 3.40pm

Signed: _____
Chair

Date: _____

4

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	29/9/18 10/10/18	The following process was agreed to move towards addressing the areas raised by MRB (in September's Board Report) around **Equity and Cultural Competency:** Kevin Atkinson Board Chair suggested the following process which was accepted at the MRB meeting: a) That a Working Group come together to study and focus on next year's planning. b) That a Workshop be set up in the New Year (including MRB members and other representatives as required), the result of which will be clear actions and targets we can aim for.	Kevin Snee	Timing TBC	
2	28/11/18	**Funding of Capital Projects**: Carriann will come back to the Board with more detail. Raised under Chair's Report.	Carriann Hall	March 19	
3	28/11/18	Schedule **Consumer Experience Facilitator**s to attend the May 2019 Board meeting as members would like to hear about their work.	Kate Coley	May 19	Included on workplan for May 19 – to remain as an action
4	28/11/18	**Wairoa Integrated Care Demonstrator Site:** The Board requested an update at the March 2019 Board meeting.	Chris Ash / Emma Foster	Mar 19	Included on Workplan for March 19 – to remain as an action.
5	27/02/19	**HBDHB Draft Disability Plan** Query as to source of figure to support statement, '23% of people in HB with a disability'	Bernard Te Paa (Shari Tidswell)	Feb 19	Actioned - response below
6	27/02/19	**Whole of Board Appraisal Action Plan** Report of progress every six month	Ken Foote	July 19 (and every six months thereafter)	For inclusion on Workplan – July 19

Responses noted:

Item 5. This comes from the Disability Survey completed by Statistic NZ, the author of the report is the Government Statistician. It is data for East Coast so includes Tairawhiti. We can apply it to HB as the sample to the HB population, taken from the Census because it is a representative survey. Below is the link to the webpage.
http://archive.stats.govt.nz/browse_for_stats/health/disabilities/DisabilitySurvey_HOTP2013/Commentary.aspx

BOARD WORKPLAN as at 21 March 2019 (subject to change)	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Feb)				27-Mar-19	27-Mar-19
Matariki HB Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-**Mar**	13-Mar-19	10-Apr-19	11-Apr-19		27-Mar-19
Wairoa Integrated Health Services and Community Led Commissioning					27-Mar-19
Key Learnings from the Nuka System of Care for Implementation in HBDHB					27-Mar-19
Finance Report (Mar)				24-Apr-19	24-Apr-19
Hawke's Bay Health Awards Event - REVIEW Alcohol at this event annually					24-Apr-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-March-May (on hold)	10-Apr-19	10-Apr-19	11-Apr-19		24-Apr-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	10-Apr-19	10-Apr-19	11-Apr-19		24-Apr-19
Violence Intervention Programme Report Committees reviewed in July - EMT Nov - April19	10-Apr-19	10-Apr-19	11-Apr-19		24-Apr-19
Philosophies in the development of recruitment of Māori 'Values Based Recruitment'	13-Mar-19				24-Apr-19
People & Quality Dashboard Q3 (Jan-Mar 19) Feb-May-Aug-Nov (formerly HR KPI Rpt)					29-May-19
Finance Report (Apr)				29-May-19	29-May-19
HBDHB Non-Financial Performance Framework Dashboard Q3 - EMT/Board					29-May-19
HBDHB Performance Framework Exceptions Q3 Feb19 /May/Aug/Nov	8-May-19				29-May-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	8-May-19	8-May-19	9-May-19		29-May-19
Consumer Experience Facilitators -update on their work					29-May-19
Annual Plan 2019/20 SPEs to Board by end of June	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
People Plan 6 monthly Board update June-Nov 19 (action Feb19)					26-Jun-19
Finance Report (May)				26-Jun-19	26-Jun-19
People Plan Progress Update Report (6 monthly - Dec, Jun 19)	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Finance Report (Jun)				31-Jul-19	31-Jul-19
Whole of Board Appraisal (progress against actions Nov 17) - Apr-Aug					31-Jul-19
Alcohol Harm Reduction Strategy (6 monthly update) Feb - Aug	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
Annual Plan 2019/20 draft to the Board	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
People & Quality Dashboard Q4 (Apr-Jun 19) Feb-May-Aug-Nov (formerly HR KPI Rpt)					28-Aug-19
Finance Report(July)				28-Aug-19	28-Aug-19
HB Health Awards - preparation for judging 2019-2020		14-Aug-19	15-Aug-19		28-Aug-19
HBDHB Non-Financial Performance Framework Dashboard Q4 - EMT/Board					28-Aug-19
HBDHB Performance Framework Exceptions Q4 Feb19 /May/Aug/Nov	14-Aug-19				28-Aug-19
Finance Report (Aug)				25-Sep-19	25-Sep-19
Matariki HB Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-Mar	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19

HAWKE'S BAY
District Health Board
Whakawāteatia

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 19
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee Chief Executive Officer
Reviewed by:	Not applicable
Month as at	21 March 2019
Consideration:	For Information

RECOMMENDATION

That the Board

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

INTRODUCTION

This month it is difficult to start any report without reflecting on the terrible atrocity and loss of life that occurred in Christchurch earlier this month. Our deepest sympathies go to the Muslim community, their families, friends and colleagues.

It has been impressive how well the Canterbury Health System responded and how New Zealand has responded to these terrible events. We have learnt that one of our locum physicians, Dr Amjad Hamid, a Senior Medical Officer who worked at Hawke's Bay Hospital earlier this year on B2, was at the mosque at the time of the shooting and was one of the victims in the attack. He lived in Christchurch with his wife and family, worked in Hawera, but also travelled around the country as a locum. Everyone who worked with him has commented on the kindness and compassion he showed to others. Our thoughts are with his family and colleagues at this time.

In the past week a note of concern was found on the floor of Hawke's bay Hospital. This caused immense disruption in the hospital on a Saturday afternoon. The event was managed well between ourselves and police.

February also saw further significant industrial action, which was highly disruptive to our elective and acute work. We have reached agreement with a number of staff groups locally and nationally, but there are still some that remain to be settled at the time of writing.

This month's agenda covers three key pieces of strategic work. The work in Wairoa on integrated health services, the influence the Nuka system of care is having on our Hawke's bay health system, this in part supports the work in Wairoa, and finally Matariki – the Regional Development Strategy.

PERFORMANCE

The key performance exceptions of note for February 2018 are:

- **Emergency Department (ED):** Shorter stays in ED (ED6) continues below. It is clear that many DHBs are impacted adversely nationally. There are a number of measures being introduced in March aimed at improving the position as we head in to winter

- **Elective performance:** ESPI 2 (First Specialist Assessment) continues to perform poorly, however, it is our intention to bring this back on track by the end of the calendar year. For ESPI 5 (time taken to treat) this month's figure, whilst an increase, is below our plan which will get us back to under four months by December 2019.
- **Financial performance:** The result for the month of February holds the year-to-date result at $2.1m adverse. Whilst this is a good performance, there are a number risks as we move forward that are likely to worsen our position. The costs of strike action have also meant that the position is around $1m worse than it would otherwise be.
- **Faster Cancer Treatment:** The February figure was impacted by strike action.
- **Immunisation:** This is below target and there appears to be three reasons which need further exploration:
  1. A reduction of immunisations occurring in Primary care.
  2. Increased anti-immunisation activity occurring in our district, particularly in social media, with dissemination of this information occurring regularly.
  3. Our ability to track down and immunise our hard to reach families is getting far more difficult. The lack of permanent accommodation means families can move multiple times in a year.

  We are looking into this further and will have recommendations for consideration in April.

Measure / Indicator	Target	Month of February	Qtr to end February	Trend For Qtr
Shorter stays in ED	≥95%	87%	88%	▲
Improved access to Elective Surgery (2018/19YTD)	100%	70%	YTD 89%	▼

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	3,105	845	1,095
Patients given commitment to treat, but not yet treated (ESPI-5)	723	248	553

Faster cancer treatment – 62 day indicator* *(Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).*	≥90%	70% January	89% 6m to January	▼
Faster cancer treatment - 31 day indicator	≥85%	84% January	86% 6m to January	▲
Increased immunisation at 8 months	≥95%	---	90% 3m to February	▼
Better help for smokers to quit – Primary Care			88.9% 15m to February	▲
Raising healthy kids (New)			100% 6m to January	▲
Financial – month (in thousands of dollars)	(1,282)	(1,298)	---	---
Financial – year to date (in thousands of dollars)	(2,918)	(5,041)	---	---

Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*15/19 = 79%*	*113/114 = 99%*

WAIROA INTEGRATED HEALTH SERVICES AND COMMUNITY LED COMMISSIONING UPDATE

The Clinical Services Plan sets out a future in which health care delivery is increasingly centred around local populations and their priorities. On today's agenda we have a paper describing work to achieve this in the Wairoa Community. The paper is significant, not only for the approach it describes to bringing about integrated health care delivery, but also in the road map it lays out for working with the Community Partnership Group on the evolution of locally-led commissioning.

NUKA SYSTEM OF CARE – HOW HAS THIS INFLUENCED THE TRANSFORMATION OF THE HAWKE'S BAY HEALTH SYSTEM

Over the last 24 months, Hawke's Bay District Health Board, Ngāti Kahungunu Iwi Inc, Health Hawke's Bay PHO and others have formed a close working relationship with South Central Foundation (SCF) in Anchorage, Alaska, USA. The relationship exchanges have been centred on learning about the 'Nuka System of Care'. Nuka is built upon the key principles of 'relationship' and 'shared decision-making' between the health professional, the patient and the health care provider with the community they serve. The insights and learnings from Nuka have been influential in shaping strategy and approaches in forging a new path ahead in the way care - and notably primary health and social care – is delivered, such as organisational core concepts training (Leading with Heart), consumer co-design approaches, relationship centred practice, and integrated care teams and behavioural health in primary care.

MATARIKI HAWKE'S BAY REGIONAL ECONOMIC DEVELOPMENT AND SOCIAL INCLUSION STRATEGY

With the roll-out of the Provincial Growth Fund, Matariki partners are focused on developing and sharing a proposal in preparation for a regional announcement. This is alongside the work that Business Hawke's Bay's is doing to develop support structures. It will include implementing two new roles and completing the review and integration of the actions for Regional Economic Develop and Social Inclusion. As a DHB, we continue our support for key projects with our agency partners wholly advocating for greater focus of social inclusion across the work programme. An example of which is the successful Rangatahi Mai Kia Eke programme, placing 25 youth with health and mental issues into employment via a supported placement programme.

CONCLUSION

February has seen significant disruption to our services from strike action and the sterile services incident. The focus is now on moving services forward and recovering from these events.

The three key reports on today's agenda are of significant strategic importance as we work to re-shape the future models of health care delivery.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report February 2019** 20
	For the attention of: **HBDHB Board**
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Reviewed by	Executive Management Team
Month/Year	March, 2019
Purpose	For Information

8

RECOMMENDATION:

That the HBDHB Board:

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

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

As shown in the table below, the result for the month of February is $16k favourable to plan, leaving the year-to-date (YTD) result at $2.1m adverse to plan.

We have not increased our deficit over the last two months and continue to work to achieve the $5m planned deficit. However, the risks to the forecast have been well signalled and whilst we continue to work to mitigate cost pressures arising in year, we have reported a $3.6m forecast overspend against plan this month.

	February				*Year to Date*				*Year End*	Refer
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*	Appendix
Income	49,703	48,642	1,061	2.2%	388,216	385,095	3,121	0.8%	582,782	1
Less:										
Providing Health Services	23,250	22,992	(258)	-1.1%	195,342	192,221	(3,121)	-1.6%	293,636	2
Funding Other Providers	20,671	20,516	(155)	-0.8%	166,110	162,356	(3,754)	-2.3%	250,047	3
Corporate Services	4,571	3,844	**(727)**	**-18.9%**	34,274	32,888	(1,386)	-4.2%	50,569	4
Reserves	(87)	8	**95**	**1218.0%**	(2,470)	548	**3,018**	**551.1%**	(2,833)	5
	1,298	**1,282**	16	1.2%	**(5,041)**	**(2,918)**	**(2,122)**	**-72.7%**	**(8,638)**	

Key Drivers

The detail of the variances are covered in the appendices to the report. The key drivers of the YTD position are:

- Income (Appendix 1)

  Ministry of Health (MoH) income favourable through review of pay equity and In-Between-Travel (IBT) and recognition of additional funding in February, along with Immediate Relief and Care Capacity Demand Management (CCDM) funding from the nursing agreement.

- Providing Health Services (Appendix 2)

  Higher than planned nursing resource use (although below budget in February), efficiencies not yet achieved, pharmaceuticals and other clinical supplies, were partly offset by allied health vacancies, and lower than budgeted spend on elective surgery capacity.

- Funding Other Providers (Appendix 3)

  February reflects the same drivers as previous months. Efficiencies not yet achieved, and expenditure relating to the additional pay equity and IBT funding, partly offset by PHARMAC rebates.

- Corporate Services (Appendix 4)

  Mainly relating to costs as a result of industrial action over the last few months.

- Savings Plans (Appendix 8)

  Shortfall on savings plans of $3.5m are included in the YTD position and discussed further below.

Forecast

Whilst we remain committed to our plan and continue to work to mitigate cost pressures arising in year, there are a number of factors which have resulted in reporting an $8.6m forecast deficit ($3.6m forecast overspend against plan).

These factors include the cost of industrial action to date, the impact of unfunded pay awards, capping of in-between travel revenue, Inter District Flows (IDFs) and challenges in achieving savings programmes.

As highlighted previously, our forecast excludes:

- Pay settlements above levels assumed in the budget and potential flow-on effect to contracts. It also makes no assumption about future industrial action;
- Impairment review of the $2.7m investment in the Health Finance, Procurement and Information Management System (FPIM), formerly NOS, as a result of the FPIM business case (awaiting FPIM decision from Cabinet);
- Impairment review of the $1.6m investment in web-based patient administration system, part of the Regional Health Information Project (RHIP);
- Potential for increased provisioning for employee entitlements as a result of Holidays Act as a reliable estimate has not been made.

It also assumes that our total Combined Pharmaceutical Budget expenditure will be in line with the PHARMAC forecast and does not reflect potential building valuation changes.

Our forecasting in February indicates the risks over the remaining four months of the year, excluding further industrial action and impairment discussed above. These risks are:

- Other factors increase the use of locums or other flexible resource;

- IDF outflows deteriorate in the last quarter as other DHB's catch up on coding;
- Unexpected or early increase in activity as we move toward winter;
- PHARMAC forecast materially changes (next refresh expected in April); and
- Planned efficiencies fall short of forecast

We continue to work to deliver the actions agreed to mitigate cost pressures and gaps in directorate savings plans, including structured leave management, nursing rosters, primary care prioritisation and review of expenditure in Health of Older People.

Other Performance Measures

	February				Year to Date				Year End Forecast	Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Savings plans	505	982	**(477)**	**-48.6%**	4,158	7,701	**(3,543)**	**-46.0%**	6,953	8
Capital spend	796	1,150	**(354)**	**-30.8%**	10,843	12,859	**(2,016)**	**-15.7%**	17,933	12
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,447	2,408	(39)	-1.6%	2,400	2,424	25	1.0%	2,441	2 & 4
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,333	2,297	37	1.6%	20,142	19,545	597	3.1%	29,239	2

- Savings Plans (Appendix 8)
  - Achievement of the $14.2m saving plan is a significant factor in financial performance. Savings plans have been identified for $11.7m (83%). And the identified savings removed from operational budgets amounts to $5.7m.

  - On a straight line basis YTD savings of $9.4m should have been achieved by the end of February, and $4.2m has been made. To adjust for timing, a further $1.7m of the savings required has been accrued centrally. This is matched by assuming budgeted contingency of $666k and a further $1.066m relating to the new investments reserve, will not be spent. We will drop out this timing adjustment next month, it will not impact on the overall result.

- Capital spend (Appendix 12)
  - Capital spend is behind budget in the block allocations. This currently more than offsets additional costs relating to strategic projects, and capital spend is expected to be close to plan at year end.

- Cash (Appendices 11 & 13)
  - Cash improved slightly and February's low point was $9.7m overdrawn. We forecast $12m overdrawn by year end. This is within our current statutory limit of $27m. Interest is expected to come in $0.2m less than planned as a result.

- Employees (Appendices 2 & 4)
  - Employee numbers are favourable YTD reflecting challenges filling vacancies in medical and allied health positions, mostly offset by high use of nursing resources.

- Activity (Appendix 2)
  - YTD CWD are ahead of plan, driven by acute general surgery, acute internal medicine, and orthopaedic surgery.

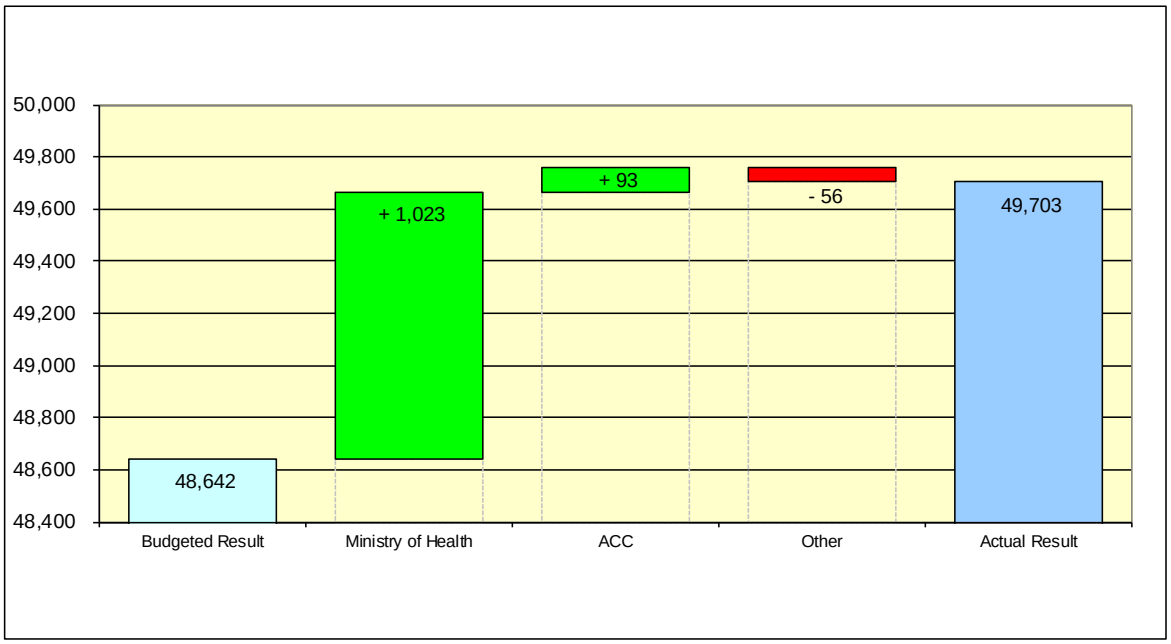
  - Elective discharges show a shortfall on achieving the Ministry of Health target. However, the DHB expects it will receive all of the base elective surgery funding by meeting the case weighted discharge (CWD) target.

APPENDICES

1. INCOME

$'000	February				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	47,409	46,385	1,023	2.2%	370,089	366,989	3,100	0.8%	555,968
Inter District Flows	839	762	77	10.1%	5,767	6,097	(331)	-5.4%	8,827
Other District Health Boards	383	354	29	8.2%	2,941	2,811	131	4.7%	4,370
Financing	15	55	(41)	-73.7%	242	442	(200)	-45.3%	292
ACC	532	439	93	21.2%	3,251	3,553	(302)	-8.5%	4,775
Other Government	31	43	(12)	-27.5%	345	461	(116)	-25.1%	557
Patient and Consumer Sourced	114	106	8	7.1%	777	837	(60)	-7.2%	1,158
Other Income	381	498	(117)	-23.5%	4,233	3,888	345	8.9%	6,265
Abnormals	(0)	-	(0)	0.0%	571	17	554	3261.3%	571
	49,703	**48,642**	1,061	2.2%	**388,216**	**385,095**	3,121	0.8%	**582,782**

Month of February

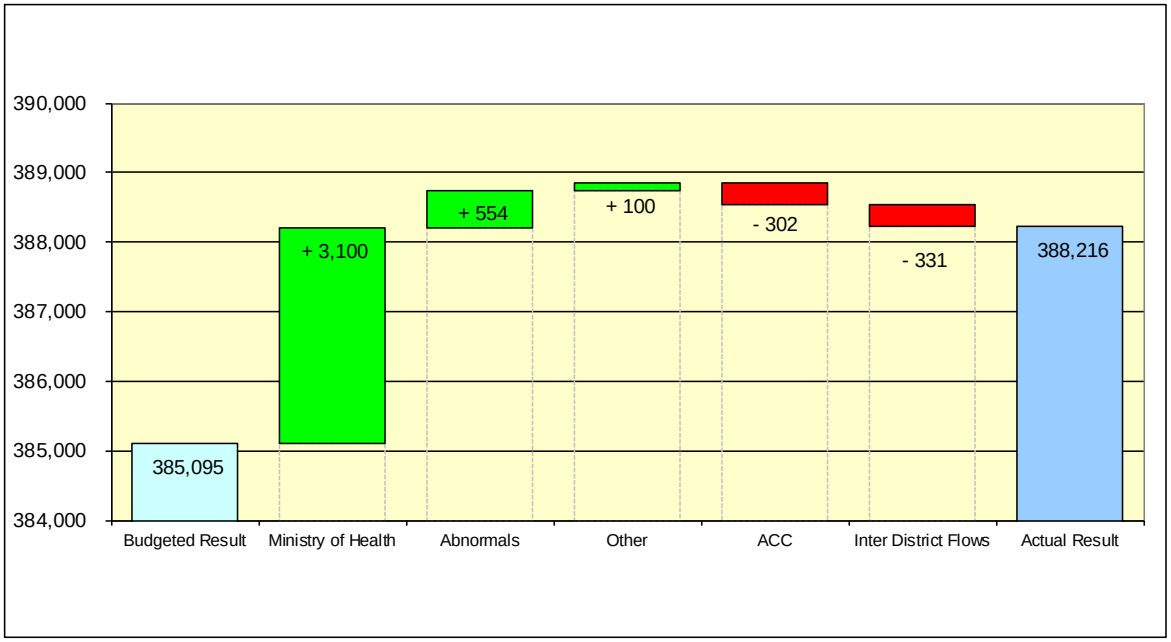


Note the scale does not begin at zero

Ministry of Health (favourable)
Review of the recognition of funding relating to In-Between-Travel (home support), and pay equity (residential care), indicated we are likely to receive more funding than anticipated, and income has been adjusted accordingly.

ACC (favourable)
Lower elective surgery income reflecting capacity constraints, partly offset by rehabilitation income.

Year to Date



Note the scale does not begin at zero

Ministry of Health (favourable)
Pay equity and In-Between-Travel income offset in related expenditure (Appendix 4). Also includes immediate relief funding, funding relating to the nursing pay settlement and capital charge funding.

Abnormals (favourable)
Prior year wash-ups and accruals no longer required. All recognised in September.

ACC (unfavourable)
Reduced elective surgery income due to capacity constraints, partly offset by increased rehabilitation income.

Inter District Flows (unfavourable)
IDF inflow unfavourable variance reducing as a result of IDFs relating to visitors to Hawke's Bay over the summer months.

2. PROVIDING HEALTH SERVICES

	February				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,292	4,908	**(384)**	**-7.8%**	45,802	45,652	(150)	-0.3%	67,761
Nursing personnel	6,381	6,489	107	1.7%	57,506	55,398	(2,108)	-3.8%	86,109
Allied health personnel	3,261	3,498	**236**	**6.8%**	24,062	25,941	**1,879**	**7.2%**	36,473
Other personnel	2,068	1,999	(69)	-3.4%	16,728	16,533	(195)	-1.2%	24,842
Outsourced services	1,000	1,019	19	1.9%	6,575	8,105	**1,530**	**18.9%**	11,423
Clinical supplies	3,478	3,280	**(198)**	**-6.0%**	29,774	25,966	**(3,808)**	**-14.7%**	44,694
Infrastructure and non clinical	1,771	1,800	30	1.6%	14,896	14,627	(269)	-1.8%	22,335
	23,250	**22,992**	(258)	-1.1%	**195,342**	**192,221**	(3,121)	-1.6%	**293,636**
Expenditure by directorate $'000									
Medical	6,199	5,967	(231)	-3.9%	55,194	51,859	**(3,334)**	**-6.4%**	82,230
Surgical	5,353	4,992	**(361)**	**-7.2%**	42,563	42,682	119	0.3%	65,050
Community, Women and Children	3,705	3,900	195	5.0%	31,084	31,037	(48)	-0.2%	47,160
Mental Health and Addiction	1,832	1,794	(38)	-2.1%	13,957	13,923	(34)	-0.2%	21,108
Older Persons, NASC HB, and Alli	1,537	1,602	65	4.0%	10,485	10,983	498	4.5%	15,837
Operations	3,223	3,328	105	3.1%	28,213	27,419	(794)	-2.9%	42,184
Other	1,401	1,409	9	0.6%	13,846	14,317	471	3.3%	20,069
	23,250	**22,992**	(258)	-1.1%	**195,342**	**192,221**	(3,121)	-1.6%	**293,636**
Full Time Equivalents									
Medical personnel	362.0	353.0	(9)	-2.5%	355	367	12	3.2%	366.8
Nursing personnel	1,015.6	976.9	(39)	-4.0%	998	970	(28)	-2.9%	979.8
Allied health personnel	471.1	489.3	18	3.7%	461	492	**30**	**6.2%**	495.3
Support personnel	145.2	137.6	**(8)**	**-5.5%**	143	137	(5)	-3.8%	138.9
Management and administration	273.1	273.0	(0)	0.0%	270	276	6	2.1%	277.4
	2,266.9	**2,229.8**	(37)	-1.7%	**2,227**	**2,242**	15	0.7%	**2,258.1**
Case Weighted Discharges									
Acute	1,776	1,525	**252**	**16.5%**	14,953	13,402	**1,551**	**11.6%**	19,957
Elective	319	591	**(272)**	**-46.1%**	3,585	4,514	**(929)**	**-20.6%**	6,850
Maternity	207	147	**61**	**41.4%**	1,431	1,344	**87**	**6.5%**	2,000
IDF Inflows	32	35	(4)	-10.1%	173	285	**(112)**	**-39.3%**	432
	2,333	**2,297**	37	1.6%	**20,142**	**19,545**	597	3.1%	**29,239**

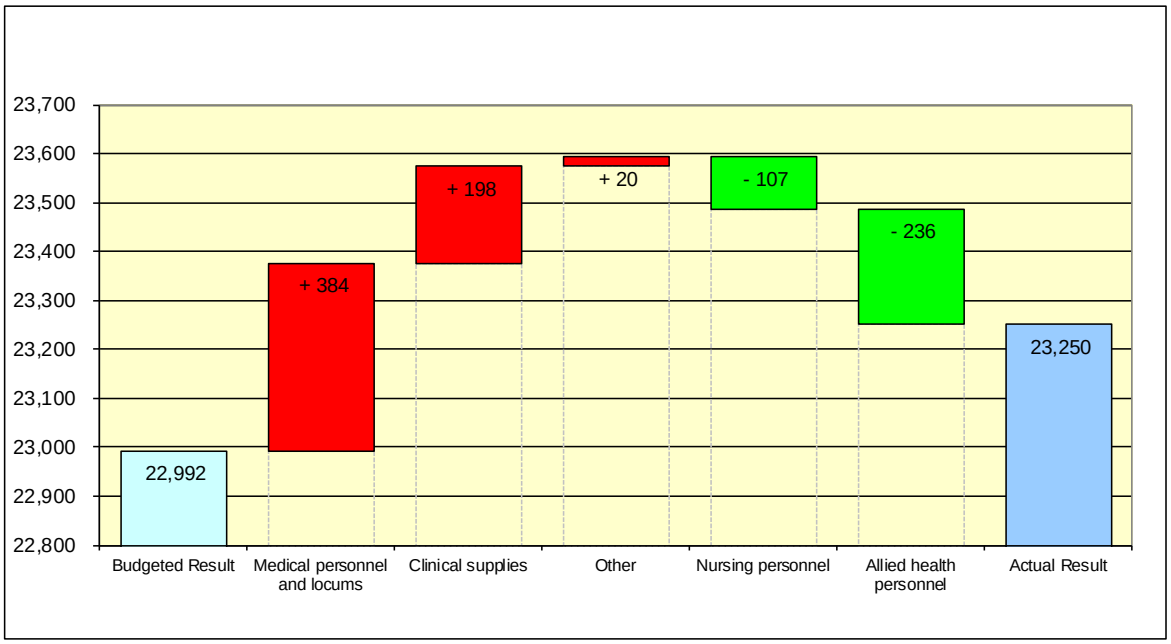
Directorates YTD

- Medical (YTD) – nursing resource use, pharmaceuticals (mainly biologics), radiology reads (radiologist vacancies), and locum vacancy cover. Note that Providing Health Services does not receive rebates relating to hospital medicines as we cannot separately identify them
- Surgical (February) – extra SMO and nursing resource to increase activity, as well as additional external capacity coming online. Other drivers include cost of implants and prosthetics, write-off of capital equipment and lower ACC elective revenue.

Case Weighted Discharges

Acute discharges were significantly above plan both month and YTD, including general medicine, general surgery, and orthopaedics. Correspondingly, electives are below plan in February, and remain below plan YTD across all specialties, with elective activity on site, constrained by finite capacity and acute demand. IDF inflows have picked up to reflect increased visitors during the summer months.

Month of February



Note the scale does not begin at zero

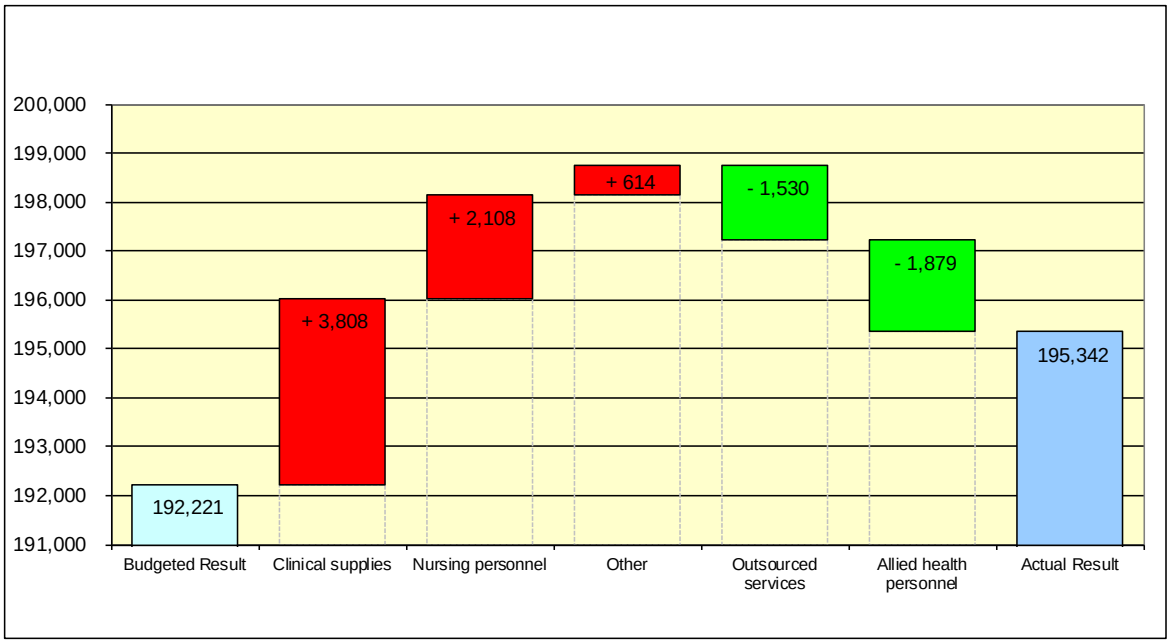
Medical personnel and locums (unfavourable)
Vacancy cover and outsourced radiology reads due to radiologist vacancies.

Clinical supplies (unfavourable)
Shortfall on savings plan.

Nursing personnel (favourable)
Ordinary time, allowances, overtime and penals continued to overspend, but were more than offset by lower than budgeted leave entitlements, training costs and professional membership fees.

Allied health personnel (favourable)
Vacancies including psychologists, health promotion workers and medical radiation technologists.

Year to Date



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Challenges achieving planned efficiencies, pharmaceuticals including biologics, treatment disposables including blood and blood intragam, and patient transport.

Nursing personnel (unfavourable)
Number of hours worked greater than planned and price paid for hours worked also greater than planned. The drivers of this are multifactorial including patient volume and acuity, custom and practice, number of vacancies and challenges meeting leave savings without backfill.

Outsourced services (favourable)
Expected to be less favourable in future months as actions underway to manage elective surgery volumes impact.

Allied health personnel (favourable)
Continuing national issue with recruitment and retention.

Full Time Equivalents (FTE)

FTEs are 15 (0.7%) favourable YTD including:

Medical personnel (12 FTE / 3.2% favourable)
- Vacancies in radiology, Wairoa GPs, and psychiatrists.

Nursing personnel (-28 FTE / -2.9% unfavourable)
- High than budget staffing in acute areas (Emergency Department, Intensive Care Unit and General Medicine), and the surgical inpatient wards.

Allied health personnel (30 FTE / 6.2% favourable)
- Vacancies in therapies, medical radiation technologists, social workers, occupational therapists, pharmacists, health promotion workers, psychologists, community support workers, and laboratory technicians.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To February 2019

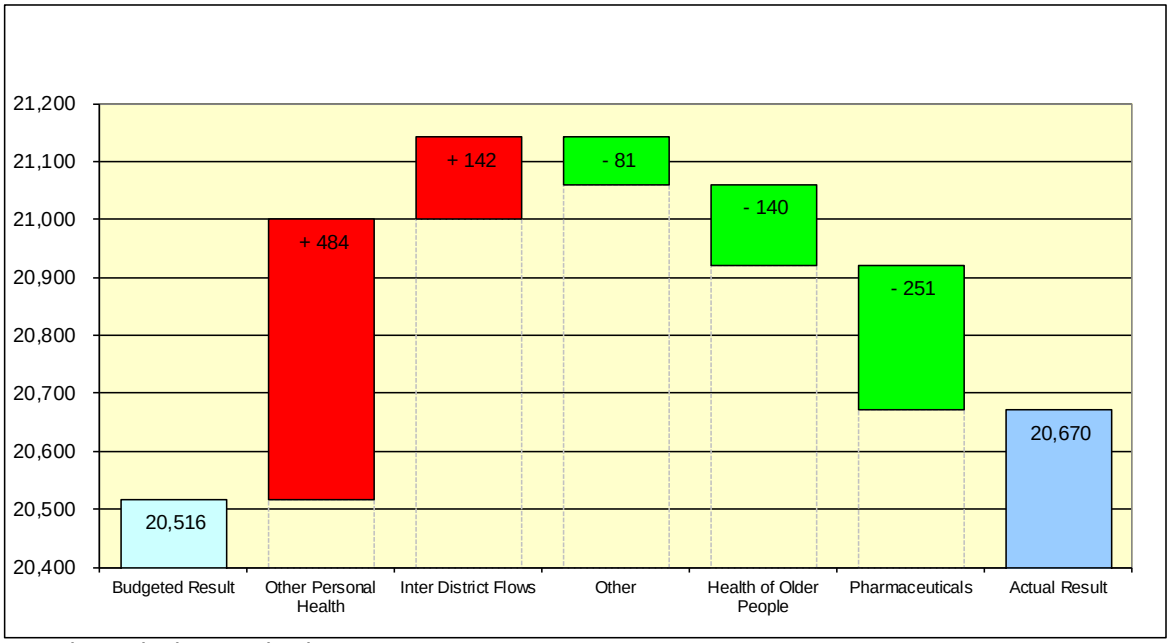
	February 2019				YTD February 2019				Full Year Plan
	Actual	Plan	Variance	%	Actual	Plan	Variance	%	
Anaesthetics	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**	**4**
Cardiothoracic	4	10	-6	0.0%	**64**	**77**	**-13**	**0.0%**	**119**
Avastins	0	17	-17	-100.0%	**125**	**127**	**-2**	**-1.6%**	**201**
ENT	47	64	-17	-26.6%	**367**	**471**	**-104**	**-22.1%**	**740**
General Surgery	94	114	-20	-17.5%	**795**	**842**	**-47**	**-5.6%**	**1324**
Gynaecology	32	61	-29	-47.5%	**401**	**451**	**-50**	**-11.1%**	**708**
Maxillo-Facial	26	43	-17	-39.5%	**223**	**321**	**-98**	**-30.5%**	**507**
Neurosurgery	2	8	-6	0.0%	**51**	**60**	**-9**	**0.0%**	**95**
Ophthalmology	85	114	-29	-25.4%	**795**	**845**	**-50**	**-5.9%**	**1328**
Orthopaedics	73	99	-26	-26.3%	**751**	**727**	**24**	**3.3%**	**1145**
Paediatric Surgery	4	7	-3	0.0%	**35**	**53**	**-18**	**0.0%**	**85**
Skin Lesions	13	22	-9	-40.9%	**122**	**160**	**-38**	**-23.8%**	**254**
Urology	53	53	0	0.0%	**329**	**390**	**-61**	**-15.6%**	**618**
Vascular	21	29	-8	-27.6%	**146**	**212**	**-66**	**-31.1%**	**333**
Non Surgical - Arranged	4	12	-8	-66.7%	**82**	**92**	**-10**	**-10.9%**	**144**
Non Surgical - Elective	11	13	-2	-15.4%	**92**	**95**	**-3**	**-3.2%**	**148**
TOTAL	**469**	**666**	**-197**	**-29.6%**	**4378**	**4923**	**-545**	**-11.1%**	**7753**

Please note: This report was run on 7 March 2019
The volumes by specialty now include both Elective and Arranged discharges rolled into one.
Data is subject to change.

3. FUNDING OTHER PROVIDERS

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,334	3,584	250	7.0%	26,855	28,657	1,802	6.3%	41,197
Primary Health Organisations	3,265	3,327	62	1.9%	25,814	25,639	(175)	-0.7%	39,568
Inter District Flows	4,939	4,797	(142)	-3.0%	39,132	38,376	(756)	-2.0%	58,140
Other Personal Health	2,397	1,912	(484)	-25.3%	15,749	14,053	(1,695)	-12.1%	23,207
Mental Health	1,056	1,058	2	0.2%	8,208	8,463	255	3.0%	12,573
Health of Older People	5,390	5,529	140	2.5%	47,393	44,498	(2,894)	-6.5%	71,015
Other Funding Payments	291	308	17	5.6%	2,960	2,669	(291)	-10.9%	4,347
	20,671	20,516	(155)	-0.8%	**166,110**	**162,356**	(3,754)	-2.3%	250,046
Payments by Portfolio									
Strategic Services									
Secondary Care	4,655	4,236	(420)	-9.9%	35,727	33,886	(1,841)	-5.4%	52,913
Primary Care	8,340	8,375	35	0.4%	64,307	64,782	475	0.7%	99,253
Mental Health	1,279	1,343	65	4.8%	10,209	10,748	539	5.0%	15,717
Health of Older People	5,600	5,829	229	3.9%	49,823	46,820	(3,003)	-6.4%	74,676
Other Health Funding	133	133	(0)	0.0%	1,067	1,066	(0)	0.0%	-
Maori Health	505	495	(9)	-1.9%	3,941	4,040	100	2.5%	5,912
Population Health	160	104	(55)	-53.1%	1,037	1,014	(23)	-2.2%	1,574
	20,671	20,516	(155)	-0.8%	**166,110**	**162,356**	(3,754)	-2.3%	250,046

Month of February



Note the scale does not begin at zero

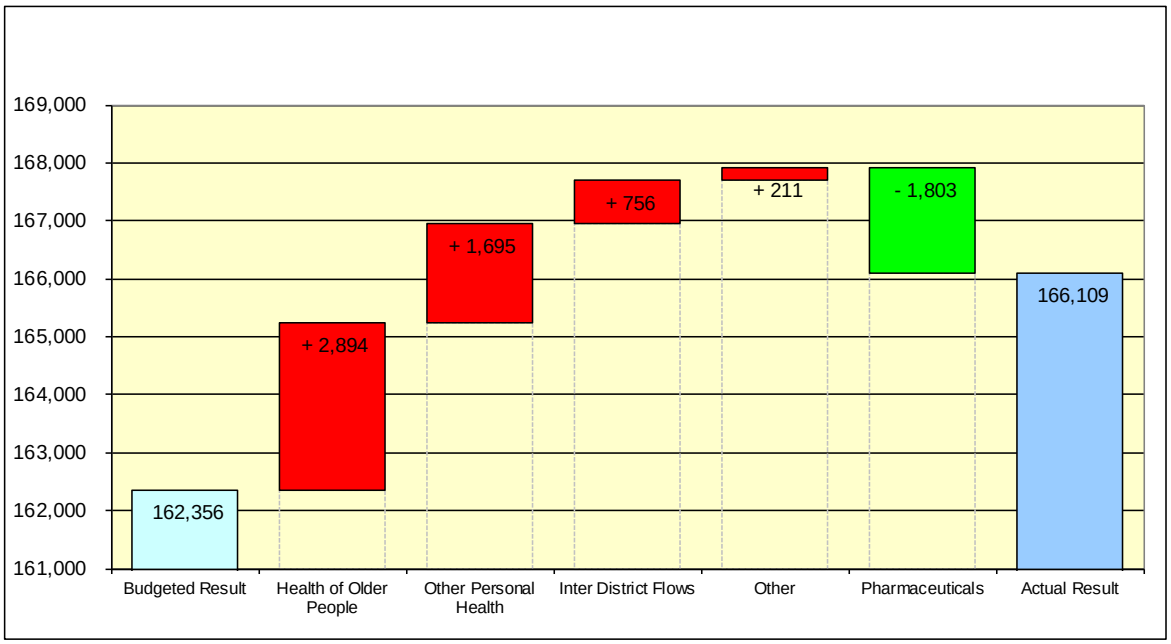
Other Personal Health (unfavourable)
Efficiencies not yet achieved.

Inter District Flows (unfavourable)
Continued pressure on IDF outflows.

Health of Older People (favourable)
Lower community health services and support. Higher home support costs are offset by lower residential care costs, after adjusting for pay equity and In-Between-Travel that are partly offset in income.

Pharmaceuticals (favourable)
Pharmaceutical rebates in line with PHARMAC forecasts.

Year to Date



Health of Older People (unfavourable)
Pay equity (residential care) and In-Between-Travel (home support) partly offset in income.

Other Personal Health (unfavourable)
Efficiencies not yet achieved.

Inter District Flows (unfavourable)
Higher volumes earlier in the year.

Pharmaceuticals (favourable)
Pharmaceutical rebates in line with PHARMAC forecasts.

4. CORPORATE SERVICES

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,983	1,336	**(647)**	**-48.4%**	12,298	11,799	(500)	-4.2%	17,960
Outsourced services	101	65	(36)	-55.8%	603	568	(35)	-6.1%	909
Clinical supplies	(2)	(10)	(7)	-77.0%	62	(100)	**(162)**	**-162.6%**	106
Infrastructure and non clinical	799	632	**(167)**	**-26.4%**	6,983	6,475	**(508)**	**-7.8%**	9,900
	2,881	2,023	**(857)**	**-42.4%**	19,947	18,742	**(1,204)**	**-6.4%**	28,875
Capital servicing									
Depreciation and amortisation	1,035	1,166	**131**	**11.2%**	8,628	8,905	278	3.1%	13,374
Financing	-	-	-	0.0%	-	-	-	0.0%	-
Capital charge	655	655	0	0.0%	5,700	5,241	**(459)**	**-8.8%**	8,320
	1,690	1,821	**131**	**7.2%**	14,328	14,146	(182)	-1.3%	21,694
	4,571	**3,844**	**(727)**	**-18.9%**	**34,274**	**32,888**	(1,386)	-4.2%	**50,569**
Full Time Equivalents									
Medical personnel	0.0	0.3	0	84.2%	0	0	0	8.6%	0.3
Nursing personnel	16.1	15.0	(1)	-7.9%	13	16	3	19.5%	15.8
Allied health personnel	0.2	0.4	0	49.5%	0	0	0	49.5%	0.4
Support personnel	9.5	7.8	(2)	-20.9%	9	8	(1)	-17.2%	8.0
Management and administration	153.9	154.7	1	0.6%	150	158	**8**	**5.2%**	158.0
	179.8	**178.2**	(2)	-0.9%	**173**	**183**	**10**	**5.5%**	**182.5**

High in-month personnel costs reflects the cost of industrial action, mainly staff cover. High infrastructure and non clinical costs YTD mainly relate to software licences. The additional capital charges YTD relate to the June 2018 land and buildings revaluation, and is offset by the accrual of additional MOH income in appendix 1. YTD clinical supplies variance is mainly planned efficiencies yet to be achieved.

5. RESERVES

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	38	38	0	0.0%	527	527	0	0.0%	-
Efficiencies	(217)	-	217	0.0%	(1,733)	0	1,733		(1,750)
Other	91	(30)	**(121)**	**-404.4%**	(1,264)	21	1,285	**6087.9%**	(1,083)
	(87)	**8**	**95**	**1218.0%**	**(2,470)**	**548**	**3,018**	**551.1%**	**(2,833)**

The contingency budget reduces when the Executive Management Team (EMT) approves expenditure where no source of funding has been identified. Contingency can still be released for unusual or unexpected events up to the remaining balance of the contingency, currently $700k.

Transfers out of the original $4m contingency YTD include:

- New nursing initiatives $1m;
- Executive Director Provider Services contingency $300k; and
- Cost pressure adjustments to budgets $2m.

The accrual for unachieved savings (recognising savings are more likely to increase incrementally rather than being achieved evenly over the year), appears as a negative expense amount in the efficiency line. Similar accruals to budget have been made (CEO contingency $467k, Executive Director Provider Services contingency $200k and new investments reserve $1.066m) that offset the unachieved savings accrual. We will stop documenting a timing difference from next month. The forecast reflects further mitigations including structured leave management and nursing rosters.

The "Other" category comprises the net impact of an ongoing review of accruals relating to the prior year. If the variance remains favourable it will be a one-off benefit.

6. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

	February			*Year to Date*			*End of Year*		
$'000	*Actual*	*Annual Plan*	*Variance*	*Actual*	*Annual Plan*	*Variance*	*Forecast*	*Annual Plan*	*Variance*
Funding									
Income	47,167	46,037	1,130	366,439	363,383	3,056	550,731	537,477	13,254
Less:									
Payments to Internal Providers	25,543	25,543	-	207,456	206,996	(459)	310,814	309,025	(1,789)
Payments to Other Providers	20,230	19,894	(336)	160,166	157,383	(2,783)	240,455	233,452	(7,003)
Contribution	**1,394**	**599**	**794**	**(1,182)**	**(997)**	**(186)**	**(539)**	**(5,000)**	**4,461**
Governance and Funding Admin.									
Funding	285	285	-	2,312	2,312	-	3,424	3,383	40
Other Income	3	3	-	20	20	-	30	30	-
Less:									
Expenditure	269	282	13	2,116	2,404	287	3,289	3,413	125
Contribution	**18**	**5**	**13**	**216**	**(71)**	**287**	**165**	**-**	**165**
Health Provision									
Funding	25,259	25,259	-	205,143	204,684	459	307,391	305,542	1,849
Other Income	2,430	2,507	(77)	20,989	20,923	67	30,870	30,594	276
Less:									
Expenditure	27,802	27,088	(714)	230,207	227,459	(2,748)	346,524	336,136	(10,388)
Contribution	**(114)**	**677**	**(791)**	**(4,075)**	**(1,853)**	**(2,222)**	**(8,264)**	**-**	**(8,264)**
Net Result	**1,298**	**1,282**	**16**	**(5,041)**	**(2,920)**	**(2,120)**	**(8,638)**	**(5,000)**	**(3,638)**

The table above reports the result in the classifications used by the Ministry of Health and against the projections in the Annual Plan. Those projections differ from the budgets used elsewhere in this report as outlined in the table below.

7. MANAGEMENT BUDGET MOVEMENTS

Changes are made to Annual Plan projections so that managers are accountable for budgets that are relevant and up-to-date. The Management Budget is used for internal reporting and the annual plan is used for MoH and statutory reporting. The net result is the same in both budgets.

The major changes between revenue and expense lines are usually due to health provision savings programmes, or unbudgeted new funding received during the year and the associated expenditure.

$'000	February			Year to Date			End of Year		
	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	46,037	44,680	1,357	363,383	358,254	5,129	546,225	537,477	8,748
Less:									
Payments to Internal Providers	25,543	24,906	(638)	206,996	205,907	(1,090)	310,784	309,025	(1,759)
Payments to Other Providers	19,894	19,364	(531)	157,383	155,130	(2,253)	237,871	233,452	(4,420)
Contribution	**599**	**410**	**189**	**(997)**	**(2,782)**	**1,786**	**(2,430)**	**(5,000)**	**2,570**
Governance and Funding Admin.									
Funding	285	276	9	2,312	2,278	34	3,424	3,383	40
Other Income	3	3	-	20	20	-	30	30	-
Less:									
Expenditure	282	277	(5)	2,404	2,284	(120)	3,554	3,413	(140)
Contribution	**5**	**2**	**4**	**(71)**	**14**	**(85)**	**(100)**	**-**	**(100)**
Health Provision									
Funding	25,259	24,621	637	204,684	203,562	1,122	307,360	305,542	1,819
Other Income	2,507	2,432	74	20,923	20,437	486	31,299	30,594	704
Less:									
Expenditure	27,088	26,210	(878)	227,459	224,151	(3,308)	341,128	336,136	(4,992)
Contribution	**677**	**844**	**(166)**	**(1,853)**	**(152)**	**(1,700)**	**(2,469)**	**-**	**(2,469)**
Net Result	**1,282**	**1,256**	**26**	**(2,920)**	**(2,920)**	**(0)**	**(5,000)**	**(5,000)**	**(0)**

8. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Savings plans are transferred to operational budgets as they are agreed. Living within budget will indicate that directorates are achieving their savings targets.

The table below shows $11.7m of savings have been identified, and $5.7m of identified savings has been removed from operational budgets.

Savings targets have been budgeted evenly through the year at directorate level. However, the savings are more likely to grow incrementally as schemes are identified and implemented. The mismatch between budget and likely achievement obscures the underlying operational performance of the DHB, and savings are being accrued at a consolidated level to overcome this. The amount accrued YTD is $1.7m, matched by reserves and contingency.

	Target	Current Year Identification					Savings Delivered / Forecast				Recurrency	
Division	2018/19 Savings Target $'000	2018/19 Identified Saving $'000	%	2018/19 Budget Adjusted	2018/19 Savings WIP	2018/19 Un-identified Savings	YTD Actual	YTD Plan	Var	2018/19 Forecast	2019/20 Identified Saving $'000	%
Strategic	-	-	- %	-	-	-	-	-	-	-	-	- %
Primary Care	4,673	4,790	103 %	869	3,921	(117)	1,541	3,115	(1,574)	2,449	4,689	100 %
Provider Services												
Medical	1,820	1,866	103 %	1,634	232	(46)	398	1,213	(815)	740	554	30 %
Surgical	1,450	807	56 %	766	41	643	155	967	(811)	257	812	56 %
CWC	1,049	804	77 %	804	-	245	323	699	(376)	504	105	10 %
OPMH	865	1,100	127 %	1,100	-	(235)	627	577	50	1,015	865	100 %
Operations	893	564	63 %	298	267	329	124	595	(471)	260	192	21 %
Facilities	232	246	106 %	246	-	(14)	127	155	(28)	188	232	100 %
COO	235	(1,170)	(498)%	(1,370)	200	1,405	23	157	(134)	108	200	85 %
Total Provider Services	*6,544*	*4,216*	*64 %*	*3,476*	*740*	*2,328*	*1,777*	*4,363*	*(2,585)*	*3,072*	*2,960*	*45 %*
HI&E	402	435	108 %	435	-	(33)	235	268	(33)	324	184	46 %
People & Quality	105	126	120 %	124	3	(21)	52	70	(18)	100	105	100 %
Information Services	254	272	107 %	18	254	(18)	10	169	(159)	103	254	100 %
Financial Services	1,430	1,238	87 %	158	1,080	192	116	953	(838)	255	1,116	78 %
Executive	112	28	25 %	28	-	84	6	75	(69)	18	-	- %
Capital Servicing	632	632	100 %	632	-	-	421	421	-	632	632	100 %
Timing Adjustments	-	-	- %	-	-	-	-	(1,733)	1,733	-	-	- %
Totals	**14,152**	**11,738**	**83 %**	**5,740**	**5,997**	**2,414**	**4,158**	**7,701**	**(3,543)**	**6,953**	**9,940**	**70 %**
Annual Leave Savings Total		*1,499*		*1,499*	*-*	*-*	*378*	*862*	*(484)*	*1,009*	*-*	

NB: these are included in the above Division & Directorate figures.

9. FINANCIAL POSITION

30 June 2018	$'000	February Actual	February Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
	Equity					
164,706	Crown equity and reserves	164,706	175,069	(10,363)	-	174,711
(15,982)	Accumulated deficit	(21,023)	(13,893)	(7,130)	(5,041)	(15,973)
148,723		143,683	161,175	(17,493)	(5,041)	158,738
	Represented by:					
	Current Assets					
7,444	Bank	840	5,491	(4,651)	(6,604)	2,313
1,885	Bank deposits > 90 days	1,855	1,901	(46)	(30)	1,901
25,474	Prepayments and receivables	27,386	24,900	2,486	1,913	25,045
3,907	Inventory	3,794	4,493	(698)	(113)	4,520
2,293	Investment in NZHP	2,638	-	2,638	345	-
-	Non current assets held for sale	-	625	(625)	-	625
41,003		36,513	37,411	(897)	(4,490)	34,404
	Non Current Assets					
175,460	Property, plant and equipment	177,455	182,894	(5,439)	1,995	185,018
1,479	Intangible assets	1,582	3,628	(2,046)	103	4,147
9,280	Investments	10,267	11,798	(1,531)	987	11,798
186,220		189,304	198,320	(9,016)	3,085	200,963
227,223	**Total Assets**	**225,818**	**235,731**	**(9,913)**	**(1,405)**	**235,368**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	6,108	-	(6,108)	(6,108)	-
35,817	Payables	35,043	35,926	883	774	36,249
40,064	Employee entitlements	38,365	35,918	(2,447)	1,699	37,579
75,881		79,516	71,844	(7,672)	(3,635)	73,828
	Non Current Liabilities					
2,619	Employee entitlements	2,619	2,712	93	-	2,802
2,619		2,619	2,712	93	-	2,802
78,500	**Total Liabilities**	**82,135**	**74,555**	**(7,579)**	**(3,635)**	**76,629**
148,723	**Net Assets**	**143,683**	**161,175**	**(17,493)**	**(5,041)**	**158,738**

Crown equity and reserves include changes in the 2017/18 result subsequent to the preparation of the 2018/19 budget. It also includes the $4m reduction to the 30 June 2018 revaluation reserve due to the seismic upgrades required in the theatre block.

Bank and bank deposits > 90 days reflects special funds and clinical trials, and the bank overdraft reflects the operating cash position at the end of the month. The higher prepayments and receivables balance reflects PHARMAC rebates and elective surgery funding to be received from MOH.

Lower than budgeted non-current assets reflects the reclassification of the investment in New Zealand Health Partnerships (NZHP) to current assets, and the reduction in planned capital spend from the annual plan to the current management budget.

10. EMPLOYEE ENTITLEMENTS

30 June 2018	$'000	February Actual	February Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
10,004	Salaries & wages accrued	6,321	5,960	(361)	3,683	7,756
1,157	ACC levy provisions	1,674	809	(865)	(517)	532
5,945	Continuing medical education	6,530	7,421	891	(586)	6,456
21,348	Accrued leave	22,017	20,109	(1,908)	(669)	21,199
4,230	Long service leave & retirement grat.	4,441	4,331	(111)	(211)	4,438
42,683	**Total Employee Entitlements**	40,984	38,629	(2,355)	1,699	40,380

Leave balances in hours are 2.5% lower than at the start of the financial year. However, their value has increased 3.1% reflecting salary increases since that date.

11. 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 low point for each month is generally incurred immediately prior to receipt of MOH funding on the 4th of the month. February's low point was a $9.7m overdraft incurred on 1 February, and next month's low point is likely to be the $10.4m overdraft that occurred on 1 March. The forecast low for the end of the financial year is $12.0m overdraft, which is within our statutory limit of $27m.

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.

12. CAPITAL EXPENDITURE

Capital spend for the month is under budget, mainly in the block allocations for facilities, information services and clinical plant and equipment. The budget approved by the Board in June assumed even phasing across the year, whereas expenditure is likely to be more randomly spread reflecting immediate needs and procurement lead times.

See table on the next page.

2019 Updated Plan (Sep 18)		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,652	Depreciation	8,628	8,905	278
(5,000)	Surplus/(Deficit)	(5,041)	(2,920)	2,120
11,688	Working Capital	8,155	7,003	(1,152)
20,340		11,742	12,988	1,246
	Other Sources			
-	Special Funds and Clinical Trials	39	-	(39)
-	Funded Programmes	4	-	(4)
-		42	-	(42)
20,340	**Total funds sourced**	**11,785**	**12,988**	**1,203**
	Application of Funds:			
	Block Allocations			
3,347	Facilities	1,343	2,261	918
3,400	Information Services	1,106	2,271	1,165
3,225	Clinical Plant & Equipment	1,510	2,092	582
9,972		3,959	6,624	2,665
	Local Strategic			
100	Replacement Generators	-	33	33
26	Renal Centralised Development	24	26	2
2,872	Endoscopy Building	3,093	2,822	(271)
350	Travel Plan	266	233	(33)
1,263	Histology and Education Centre Upgrade	1,310	1,263	(47)
150	Radiology Extension	2	-	(2)
50	Fit out Corporate Building	-	10	10
500	High Voltage Electrical Supply	36	250	214
700	Seismic Upgrades	-	100	100
1,950	Surgical Expansion	1,890	1,497	(393)
7,961		6,621	6,235	(386)
	Other			
-	Special Funds and Clinical Trials	39	-	(39)
-	Funded Programmes	4	-	(4)
-	Other	221	-	(221)
-		263	-	(263)
17,933	***Capital Spend***	***10,843***	***12,859***	***2,016***
	Regional Strategic			
1,945	RHIP (formerly CRISP)	597	129	(467)
1,945		597	129	(467)
	National Strategic			
462	NOS (Class B shares in NZHPL)	345	-	(345)
462		345	-	(345)
20,340	**Total funds applied**	**11,785**	**12,988**	**1,203**

13. ROLLING CASH FLOW

	Actual	February Forecast	Variance	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast
Cash flows from operating activities															
Cash receipts from Crown agencies	47,450	47,061	389	48,022	47,566	47,234	47,587	46,961	46,260	53,713	47,033	47,356	47,260	47,537	47,700
Cash receipts from donations, bequests and clinical trials	2	-	2	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	(841)	499	(1,339)	506	506	512	506	495	501	502	529	495	489	492	515
Cash paid to suppliers	(23,858)	(25,450)	1,592	(28,200)	(28,182)	(26,542)	(28,877)	(28,298)	(26,087)	(28,196)	(26,714)	(27,801)	(27,770)	(27,216)	(24,576)
Cash paid to employees	(18,958)	(18,443)	(515)	(17,440)	(18,044)	(20,928)	(17,812)	(17,219)	(23,028)	(17,963)	(20,933)	(17,791)	(17,265)	(18,137)	(18,887)
Cash generated from operations	**3,795**	**3,667**	**129**	**2,888**	**1,846**	**276**	**1,404**	**1,939**	**(2,354)**	**8,055**	**(86)**	**2,259**	**2,714**	**2,676**	**4,753**
Interest received	15	10	4	10	10	10	10	10	10	10	10	10	10	10	10
Interest paid	-	(15)	15	(15)	(13)	(15)	(26)	(26)	(34)	(14)	(16)	(15)	(15)	(15)	(15)
Capital charge paid	(655)	(0)	(655)	(0)	(0)	(0)	(4,670)	(0)	(0)	0	(0)	(0)	(5,970)	(0)	(0)
Net cash inflow/(outflow) from operating activities	**3,155**	**3,662**	**(507)**	**2,883**	**1,843**	**272**	**(3,282)**	**1,922**	**(2,378)**	**8,051**	**(91)**	**2,254**	**(3,261)**	**2,671**	**4,748**
Cash flows from investing activities															
Acquisition of property, plant and equipment	(726)	(1,478)	753	(1,931)	(1,476)	(1,885)	(1,286)	(1,732)	(1,732)	(1,732)	(1,732)	(1,732)	(1,732)	(1,732)	(1,732)
Acquisition of intangible assets	(70)	(115)	45	(115)	(115)	(115)	(115)	(156)	(156)	(156)	(156)	(156)	(156)	(156)	(156)
Acquisition of investments	36	-	36	-	-	-	-	-	-	-	-	-	-	(0)	-
Net cash inflow/(outflow) from investing activities	**(760)**	**(1,593)**	**834**	**(2,046)**	**(1,591)**	**(2,000)**	**(1,401)**	**(1,888)**	**(1,888)**	**(1,888)**	**(1,888)**	**(1,888)**	**(1,888)**	**(1,889)**	**(1,888)**
Cash flows from financing activities															
Equity repayment to the Crown	-	-	-	-	-	-	(357)	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	2,395	2,070	325	836	252	(1,729)	(5,040)	34	(4,267)	6,163	(1,980)	366	(5,150)	782	2,860
Add:Opening cash	(5,801)	(5,801)	-	(3,406)	(2,569)	(2,317)	(4,046)	(9,086)	(9,052)	(13,319)	(7,156)	(9,136)	(8,770)	(13,920)	(13,137)
Cash and cash equivalents at end of period	**(3,406)**	**(3,732)**	**325**	**(2,569)**	**(2,317)**	**(4,046)**	**(9,086)**	**(9,052)**	**(13,319)**	**(7,156)**	**(9,136)**	**(8,770)**	**(13,920)**	**(13,137)**	**(10,278)**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	(9,225)	(6,613)	(2,612)	(5,451)	(5,199)	(6,927)	(11,968)	(11,934)	(16,201)	(10,038)	(12,017)	(11,652)	(16,801)	(16,019)	(13,159)
Short term investments (special funds/clinical trials)	2,690	2,877	(187)	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877
Bank overdraft	3,124	-	3,124	-	-	-	-	-	-	-	-	-	-	-	-
	(3,406)	**(3,732)**	**325**	**(2,570)**	**(2,318)**	**(4,046)**	**(9,087)**	**(9,053)**	**(13,320)**	**(7,157)**	**(9,136)**	**(8,771)**	**(13,920)**	**(13,138)**	**(10,278)**

Note the cash-flow assumes achievement of the forecast result.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Te Pītau Health Alliance Governance Group** 22
	For the attention of: **HBDHB and Health Hawke's Bay Ltd Boards**
Document Owner:	Bayden Barber, Chair
Author:	Ken Foote, HBDHB Company Secretary
Month:	March, 2019
Consideration:	For Information

RECOMMENDATION

That the Boards:

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

The Health Alliance Governance Group met on Wednesday 13 March 2019.

Significant issues discussed and agreed included:

END OF LIFE CARE REDESIGN

A process to manage End of Life (EoL) care service redesign was presented and discussed. Issues raised during discussion included:

- High quality redesign will be dependent on a level of objective data and intelligence that is not wholly in place
- Stakeholders across these services currently hold expectations relating to a number of resource commitments that are not necessarily deliverable
- The equity domain of the Mauri Compass in this area will require further work
- The importance of a whānau perspective
- The need for a significant cultural shift
- The importance of Advance Care Planning (ACP)
- The political sensitivity of a redesign process.

Agreement reached by the Governance Group included:

- That engagement should commence with interested parties to brief on the service redesign kaupapa, and that such engagement should be concluded prior to a formal process to seek Expressions of Interest to form the SLA
- That the redesign process should involve a wide range of stakeholders, including Whānau Ora providers and in alignment with the Te Pītau Mauri Compass, from the very outset
- That the Terms of Reference for relevant existing groups operating in the EoL and palliative care space should be reviewed, in order to clarify:
  - Respective accountabilities for clinical governance and service redesign
  - The proposed inter-relationship between such groups.

FINANCIAL FLOWS IN GENERAL PRACTICE

Following a presentation on PHO funding, the Group discussed the issue of targeting available resource at priority populations and incorporating equity principles into the rollout of new initiatives such as Health Care Home (HCH). Other issues discussed included:

- Transforming primary care will require the thought leadership and significant input from General Practice in particular
- The ongoing work by the PHO to reduce bureaucracy and therefore waste in administrative claiming systems.

A more detailed explanation of HCH will be presented to next month's meeting of the Governance Group.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board** 23
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth (Chair)
Document Author:	Jacqui Sanders-Jones
Month:	March 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

Note the contents of this report.

The Māori Relationship Boad met on 13 March 2019. An overview of matters discussed is provided below:

PANDORA POND WATER QUALITY

Discussions at MRB last year included the environmental changes in Pandora Pond. Public Health was asked to update board members as to what environmental actions were occurring for Ahuriri estuary and Pandora Pond. Dr Nick Jones, Public Health Specialist, from Population Health and Malcolm Miller from Hawkes Bay Regional Council (HBRC) were welcomed to the table and agreed to provide monthly updates.

MRB raised issues about the effect that poor water quality is having on our population, especially the most vulnerable. This catchment area is used for swimming, gathering kai moana, healing and cleansing by our Māori communities. MRB highlighted to HBRC the need for MRB to have involvement and visibility of the progress being made to address the water quality at Ahuriri and Pandora Pond.

The Public Health team will continue to advocate and inform MRB and HBRC of health risks to physical wellbeing, whilst the impact on spiritual and cultural wellbeing would be an area which MRB can have opportunity for influence and support for the mana whenua of Ahuriri. HBRC appreciate the need to learn a lot more about the Māori world view in regards to the use of this natural resource.

Overall consensus that Napier City council should be involved with further discussions on this topic.

Matariki Regional Development Strategy & Social Inclusion Strategy update

Bernard Te Paa, Executive Director of Improvement & Equity provided an update, supported by Shari Tidswell, Intersectoral Development Manager.

Paper focused on realigning deliverables in the social inclusion strategy with a greater focus on intersectoral developments, achieved through the establishment of project groups to readdress current projects.
Shared good news story of 25 young people with mental health challenges who were successfully placed into employment. This was seen as a heartening outcome. Hoping to expand on the number

of employers involved. The Hastings population is the main focus this year with the aim to upscale to Napier.

MRB asked for further analysis on what were the key findings of this approach and how the key learnings can influence other employers within the region.
The Chair acknowledged the good work of 1000 rangatahi project, and requested to know who the employers are who currently participate in the programme, what are the numbers are going on from work experience to sustained employment. This outcomes report will be delivered to MRB in May.

VALUES BASED RECRUITMENT & PEOPLE PLAN UPDATE

JB Heperi Smith, Senior Advisor of Cultural Competency, provided a presentation 'Values Based Recruiting' which was supported by People and Quality.

The main objective is to attain Cultural Competency for all staff through the application of local tikanga built on our DHB core values.

The presentation addressed the whole recruitment system. It was proposed that Māori Health should be informed as soon as the recruitment process begins, especially as part of the interview process and assisting with all parts of the recruitment process. Discussion followed regarding application of the Maori cultural competency in recruitment in a large organisation like the HBDHB.

MRB agreed this had great application of Māori values and encouraged presentation of this to managers as it sends a clear message. The General Manager of Māori Health supported this and that it will be introduced in April as part of managers training and is part of a bigger picture. The training will be made available to MRB at the workshop in April. The MRB Chair encouraged DHB Board members to attend the training as well.

MRB Workshop April 2019 Equity & Cultural Competency

It was agreed that the April MRB meeting to be used as a workshop for Equity & Cultural Competency.

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Health Leadership Group** 24
	For the attention of: **HBDHB Board**
Document Owner:	Barbara Arnott, Chair of CPHAC
Document Author(s):	Caren Rangi, Chair of PHLG
Reviewed by:	Bernard Te Paa, Executive Director, Health Improvement & Equity Directorate
Month:	March 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

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

The Pasifika Health Leadership Group (PHLG) met on 11 March 2019. An overview of the issues discussed and/or agreed at the meeting is provided below.

PACIFIC YOUTH HEALTH AND WELLBEING PROJECT

A progress report was provided by Diane Mara (Pacific Research Consultant) and Amataga Iuli (DHB Pacific Health Promoter). The survey is a strengths based survey for students to inform on how best to improve health services for all Pacific young people in Hawke's Bay. Thirteen of the 15 schools have so far been surveyed with participation by 362 students. Expectation is to survey 450 students. Focus groups are being planned and 80 Pacific school leaders have volunteered. Together with the focus groups and analysis of the survey data, a report will be tabled to PHLG in August 2019 for recommendation.

PACIFIC HEALTH UPDATE REPORT

The Pacific Health Update report was taken as read.

- Talalelei Taufale, Amataga Iuli and Kerry Gilbert (Suicide Prevention Coordinator) attended a 2-day Te Rau Ora conference run by Le Va for Māori and Pasifika, with attendance from the Ministry of Health and Sir Mason Durie.

- Talalelei Taufale and Bernard Te Paa visited with Elizabeth Powell (General Manager, Pacific Health Development) and Dr David Schaaf (Manager Health Gain & Workforce, Pacific Health Development at Counties Manukau DHB to view their navigation service which has evolved into a nurse practioner team with social worker support made up from four different Pacific ethnic groups.

PHLG WORK PLAN

The PHLG met in February 2019 to workshop the Work Plans for 2018/19 and 2019/20. The meeting held today identified portfolio leads for each of the four goals with each lead identifying two to three clear strategies outlined to inform the Work Plans going forward. This will be tabled at the May meeting for endorsement.

1 **Engaging with Pacific communities (Mabel and Ina)**
The PHLG will engage regularly and meaningfully with Pasifika communities, to understand the health needs of Pacific people, families and communities, and to utilize this information in our advice to the DHB

2 **Enhancing DHB and health services understanding of Pacific people (Panu)**
The PHLG will contribute to the positive development of the DHB workforce to enhance their understanding of Pacific people, by supporting and advising on workforce development of the non-Pacific workforce.

3 **Promoting the value of the Pacific health workforce (Traci)**
The PHLG will support and advise on opportunities to promote and profile the value of the Pacific health workforce in Hawke's Bay

4 **Monitoring and advising on initiatives to improve Pacific health outcomes (Caren)**
The PHLG will support and advise on DHB and community initiatives focused on improving Pacific health outcomes in Hawke's Bay.

CHANGE OF CHAIR

Caren requested that a new Chair / Co-Chair be considered as her other work load was keeping her busy and felt she was unable to commit to the time required as Chair for PHLG. It was agreed to rotate a new Chair and include a Deputy Chair.

Traci Tuimaseve was nominated for Chair
Nominated by Panu Te Whaiti
Seconded by Mabel Aiolupotea
Carried

Panu Te Whaiti was nominated for Deputy Chair
Nominated by Caren Rangi
Seconded by Ina Graham
Carried

Caren Rangi was acknowledged and honoured for her commitment as Chair since the inception of the PHLG. Caren has also been instrumental in leading the development and implementation of the Pacific Health Action Plan.

HB HEALTH CONSUMER COUNCIL REPORT

Late paper

13

HAWKE'S BAY
District Health Board
Whakawāteatia

HB Clinical Council Report

Late paper

HAWKE'S BAY District Health Board Whakawāteatia	**Wairoa Integrated Health System and Community Led Commissioning** 27 For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Executive Director, Primary Care Bernard Te Paa, Executive Director, Health Improvement and Equity
Document Author(s)	Emma Foster, Dep ED, Primary Care Wietske Cloo – Acting SD CWC Laurie Te Nahu – Māori Health Ngaire Harker – Māori Health Patrick Le-Geyt, GM Māori Health
Reviewed by	Executive Management Team
Month/Year	March 2019
Purpose	The purpose of this report is to provide an update on planned activity and actions, and will form a regular report on progress.
Previous Consideration Discussions	November 2018 Board meeting
Summary	The future model of system delivery and community led comissioning for Wairoa requires us to focus on the following three areas 1. Supporting the Community Partnership Group ("CPG) to provide effective governance, advocacy, promotion and strengthen equity within the system, and promote and raise the profile of the successes and the gaps. 2. One health system to address health inequity and acknowledgement of mana whenua – we work with our primary care partners to develop one system, that is overtly linked to the secondary health system, that we have high quality staff now and in the future, diverse workforce representative of the community that it serves, effective systems and processes, and appropriate facilities 3. Together we develop and evaluate services to improve health and wellbeing of the Wairoa community through preventative and educational programmes that support equitable outcomes for Māori.
Contribution to Goals and Strategic Implications	Clinical Services Plan 2018: 1. Place-based planning 2. Evolving primary healthcare 3. Working with whānau to design the services they need 4. Relevant and holistic responses to support mental wellbeing. 5. Keeping older people well at home and in their communities

15

	6. Specialist management of long term conditions based in the community 7. Kaupapa Māori Models of Health
Impact on Reducing Inequities/Disparities	It is clear that we need to take a Māori approach for Wairoa if we are to achieve equity amongst our population.
Consumer Engagement	The Wairoa Community Partnership Group is led, owned and delivered in Wairoa, for Wairoa, by Wairoa. The purpose of this group is: *United leadership for a joined up community led, Government partnered to community design, investment and decision making that will influence 'all whānau across the Wairoa district are thriving'*
Other Consultation /Involvement	As above
Timing Issues	NA
Announcements/ Communications	NA

RECOMMENDATION:

It is recommended that HBDHB Board:

1. **Note** the content of the report

HAWKE'S BAY
District Health Board
Whakawāteatia

Wairoa Integrated Health Services and Community Led Commissioning

Author(s):	Emma Foster
Designations:	Deputy Executive Director, Primary Care
Date:	3rd January 2019

OVERVIEW

The Clinical Services Plan 2018, sets a blue print for transformational change within our district. Wairoa, as an early adopter, will start the journey towards implementing some of the Clinical Service Plan 'just do it' activities. The purpose of this report is to provide an update on planned activity and actions, and will form a regular report on progress.

The Wairoa Health Needs Assessment 2016 informed the DHB that the health system in Wairoa is disjointed and not coordinated around the needs of the population. An integrated health and social service model, among other things, was recommended.

The future model of system delivery and community led comissioning for Wairoa requires us to focus on the following three areas

1. Supporting the Community Partnership Group ("CPG) to provide effective governance, advocacy, promotion and strengthen equity of deliverywithin the system, and promote and raise the profile of the successes and the gaps.
2. One health system "community system approach" to address health inequity – we will work Wairoa whānau and with our primary care, Māori Health and other community provider partners and to develop one system, that is overtly linked to the secondary health system, that we have high quality staff now and in the future, effective systems and processes, and appropriate facilities
3. Together we co-design , develop,evaluate services and provide recommendationsto improve health and wellbeing of the Wairoa community through preventative and educational programmes.

The primary aim of the whole of community system approach is to embed wellness based focus aimed at preventation and health promotion, which are culturally appropriate. It is aimed at preventing, reducing or delaying health and social care long term interventions.

To enable integrated health system in Wairoa we need to work cohesively to achieve:

- Interoperable systems and integrated clinical records
- Shared highly skilled, generalist workforce that can work in a Interprofessional Collaborative Practice Model.
- Fully functioning integrated teams. Broaden the interprofessional competencies to better achieve the Triple Aim (improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care), with particular reference to population health.
- Internal referral processes in place/clinical pathway change leading to care closer to home

- Risk stratification and care plans for all high risk patients.
- Wairoa Community Partnership Group take collective responsibility for commissioning decisions.
- Culturally appropriate delivery of services .

PLANNING

To assist with the development and implementation process a timeline/workflow has been broken down into themes.

- Whānau voice – community engagement and development through existing community resources who have links into the community and whānau, can proactively manage relationships/conversations between the health system and the community (from an individual and system perspective). They can also support the CPG (from a health service perspective) to empower whānau to take control of their care and ensure that local Wairoa whānau have the ability to inform future community and service developments.

- Māori voice – inline with treaty obligations and CSP ensure involved in all levels of development and implementation

- Community Partnership Group capacity and capability – this includes the development of shared outcomes, development of a 'backbone' structure to support decision making, and whānau voice and formal information sharing to allow for the formal commissioning function to be community led. The Clinical Services Plan (2018) confirms that "whānau are equal partners in planning and co-design of services" (pg 13). Page 18 continues this theme by describing place-based planning, alongside community partnerships and development and social commissioning.

- Health sector leadership – to ensure that the integrated Wairoa health system is implemented effectively, and has strong clinical, cultural and managerial leadership there needs to be review of the leadership required, with a focus on system wide leadership and growing Wairoa local talent.

- Community health services – focussing on assessment and care management, strengthen community nursing and community outreach and social support services, integrated interprofessional generalist teams (as per Clinical Serivces Plan 2018), referral coordination managed at a local level to ensure that integrated teams can support whānau more effectively in their journey throughout the health system.

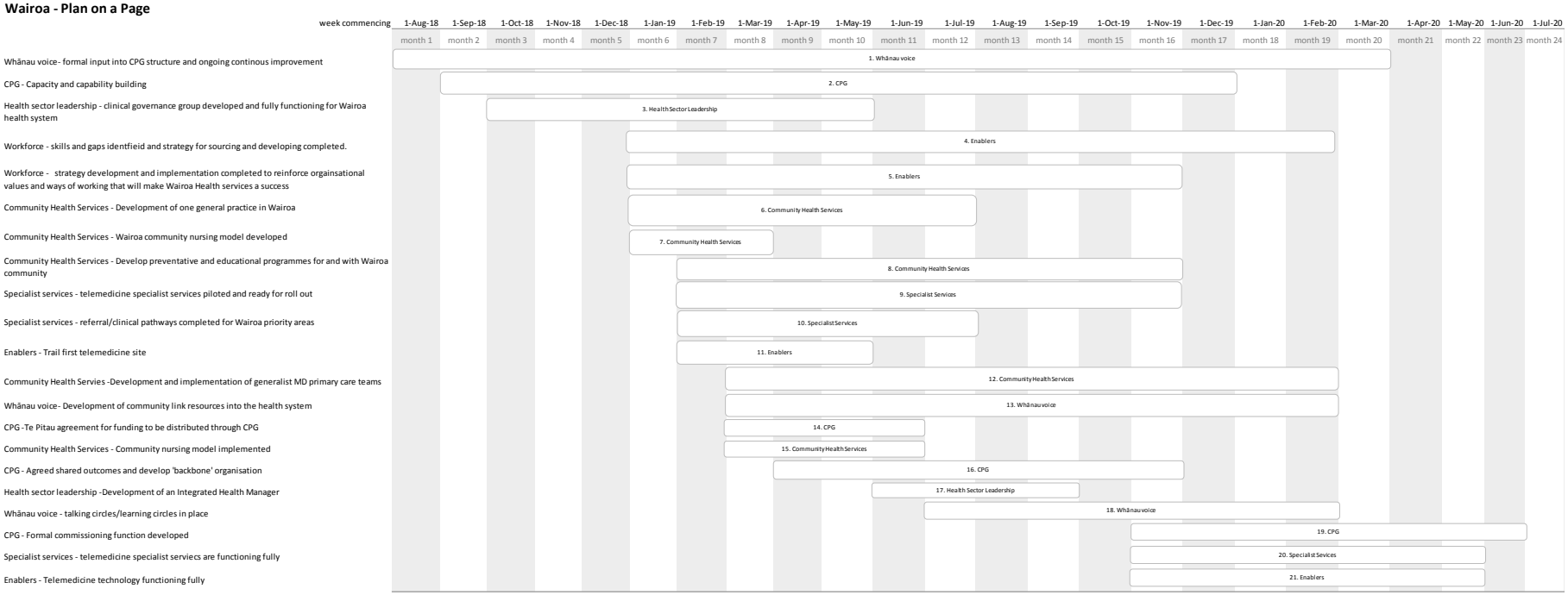
  It is important to understand the culture change required for this change management process – that Wairoa community health services are in the business of building trusting, long term relationships with the community so that it over time it can have a meaningful impact on how they live their lives. We have pockets of this already occurring and we need to build on this to make it Wairoa system wide.

- Specialist services which include virtual and telemedicine capacity, referral and clinical pathways developed for Wairoa priority areas. We want to encourage specialist services to support our integrated interprofessional generalist teams in managing patients with particular conditions, rather than referral out. The Clinical Services Plan (2018) outlines the future "emphasis on prevention and proactive self-management, and the majority of specialists clinicans will operate as 'wraparound'specialists integrated with primary care instead of 'destination' specialists requiring consumers to attend hospital" (pg vii).

- Enablers – Workforce (highly skilled, generalist workforce supported by speciality teams) Information technology (facilities is an enabler but not included in this work programme).

The Clinical Services Plan (2018) is explicit about “growing our workforce, creating new roles and supporting clinicans to work to the depth and breadth of their respective scopes, and make use of expanded practice roles such as Nurse Practitioner, and RN/Pharmacist prescribers, embedding cultural competency and person and whānau centred care; and the implementation of modern ICT to enable sharing of information and new ways of delivering services” (pg vii).

Wairoa - Plan on a Page



Next steps

Progress to acnieveing our end state will be staged, much of the intenseive activity will be in the next 9 months, actions will be agreed and reported on regularly to ensure Senior Management and the Governance Board are aware of progress.

Key Actions	Description	Timeframe
CPG capability and capacity	• Pool budgets (initiallyas a shadow year) – bring all pots of money for prevention, primary, secondary and mental health into one single budget so that it can be deployed flexibly. • Develop a commissioning strategy in partnership with the CPG for Wairoa.	July 2019
Health sector leadership	• Support the development of the Wairoa wide clinical governance structure. • Review of integrated leadership for Wairoa	May 2019 May 2019
Community health services	• Progress towards 1 general practice system • Wairoa community nursing model developed • Develop integrated interprofessional generalist team model • Develop preventative and educational programmesfor an with Wairoa community	June 2019 May 2019 April 2019 October 2019
Specialist services	• Referral/clinical pathways completed for top 5 Wairoa priorty areas. • Telemedicine pilot area identified and engaged	July 2019 August 2019
Enablers	• Workforce skills and gaps identified, and strategy for sourcing and developing completed • Interoperable systems and integrated clinical records.	May 2019 July 2019
Communications	• Agree a communications strategy for this programme of work	May 2019

Conclusions

The approved Clinical Services Plan establishes a firm commitment to priroitiseing and designing services to meet the needs of populations with the poorst health and social outcomes. The best place to start implementing some of the transformational changes identified in the Clinical Services Plan is Wairoa. This community, as an early adopter, are ready for improvements and changes in services and this report will be a regular update for both actions in Wairoa, and actions against the Clincial Services Plan commitments.

RECOMMENDATION:

It is recommended that the HBDHB Board;

1. **Note** the content of the report

Commissioning Services for Wairoa[1]

Key Interventions	Shared Workloads	Risk stratification & care planning	Community links	Referral Management	Integrated Clinical Records	Clinical Pathways
Protection *Tauwhiro – High quality care*	Put in place monitoring, research and evaluation mechanisms to track the progress of health and social sector organisations against this expectation	Health practitioners using and analysing administrative data to inform their practice; using evidence based innovations, and tailoring professional development in delivering equitable health-care	Develop place-based-planning with the community and the whānau at the centre of all services	Strengthen performance improvement, monitoring and accountability mechanisms to ensure that the organisation is on track to achieve equity of health outcomes for Māori	Require the development of clinical guidelines and decision-making tools that focus on achieving health equity for Māori	Ensure that clinical practice aligns with Code-of –Rights which includes Māori models of health and wellbeing, clinical pathways, guidelines and tools, and health innovation
Participation *Ākina – Continuous improvement*	Build and maintain a health workforce responsive to the healthcare needs and aspirations of Māori	Health organisations are committed to building relationships with Māori to collaboratively design, implement and evaluate initiatives that ensure delivery of high quality health care that meets their needs and aspirations	Establish community level plans that promote and build healthy, safe and resilient whānau	Work with other Māori health organisations to benefit Māori and ensure iwi leaders have meaningful representation	Regulatory authorities will have appropriate representation of Māori at all levels of governance to ensure genuine partnership and participation	Support community initiatives that meet the health needs and aspirations of Māori, individuals, and whānau
Partnership *Raranga te Tira – Working together*	Establish arrangements for health sector organisations, both providers and funders, holding them accountable for delivering equitable outcomes	Health practitioners are committed to supporting community initiatives that meet the health needs and aspirations of Māori individuals and whānau	Bringing local leaders together, to address health and social issues and improve outcomes for individuals and whānau	Actively seek out partners beyond the health sector to all for better service integration, planning and support for Māori	Equitable health outcomes requires performance data to be analysed by ethnicity, deprivation, age, gender, disability and location, measuring progress toward achieving health equity for Māori	Share individual contributions of fellow colleagues to the organisations performance in achieving health performance for Māori
Equity *Kauanuanu – Respect each other, staff, patients, consumers*	Set the expectation that equity is an integral component of quality, and health leaders have expertise in health equity as a core competency	The organisation actively partners with providers beyond the health sector to allow equitable service integration, planning and support for communities and whānau	Communities are activated with the tools and support to take ownership of their local service network	Ensure that all the operating policies align with the health equity intent of the legislative, regulatory and system policy frameworks	Support a system that focusses on clinical pathways of care that ensure equitable health outcomes for Māori	Use evidence-based innovations that achieve health equity for Māori

[1] *Māori Health Gains Advisor, February, 2019, Te Puni Tumatawhanui, HBDHB*

HAWKE'S BAY District Health Board Whakawāteatia	**Nuka System of Care – How has this influenced the transformation of the HB health system** 28
	For the attention of: HBDHB Board
Document Owner	Patrick Le Geyt, General Manager, Māori Health Service
Document Author(s):	Patrick Le Geyt, General Manager, Māori Health Service Wayne Woolrich, CEO, Health Hawkes Bay Chris Ash, Executive Director, Primary Care
Reviewed by:	Executive Management Team
Month:	March, 2019
Purpose	The paper provides an update on learnings from the Nuka System of Care that are influencing the health system in Hawkes Bay.
Previous Consideration Discussions	Nuka System of Care and HB Health System paper presented to EMT in December 2018
Summary	Over the last 24 months, Hawkes Bay DHB and other key stakeholders have invested in learning from the Nuka System of Care. This paper is designed to highlight the insights and learnings we have gained and provide an update on key aspects of the Nuka System of Care that are being adopted within the HB health system.
Contribution to Goals and Strategic Implications	Improving health and equity A community led health system Patient and whānau centred care Living the values A smart system
Impact on reducing inequities/disparities	Implementation of learnings from Nuka will have great potential for improving Māori and Pacific health outcomes and reduce health inequities in the district

RECOMMENDATION:

It is recommended that HBDHB Board:

1. **Note** the content of the report

16

INTRODUCTION

Over the last 24 months, Hawkes Bay DHB, Ngāti Kahungunu Iwi Inc, Health HB PHO and others have formed a close working relationship with South Central Foundation (SCF) in Anchorage, Alaska, USA, The relationship exchanges have been centred on learning about the 'Nuka System of Care'[1]. The insights and learnings from Nuka have been influential in shaping strategy and approaches in forging a new path ahead in the way care - and notably primary health and social care – is delivered. This paper is designed to highlight the insights and learnings we have gained and provide an update on key aspects of the Nuka System of Care that are being adopted within the HB health system.

BACKGROUND

The Nuka System of Care is a holistic, population-based health care system owned, developed and operated by the Native Alaskan people of South Central Foundation (SCF) in Alaska, USA. The Alaskan people took control of their health care system from the federal Indian Health Service and became 'customer-owners' who tailored the system to meet their needs through a self-determined process. Care is mostly prepaid with urban centre and rural outreach delivery using a tailored patient-centred medical home model. Relationships with consumers, communities and staff are critical.

The Nuka System of Care is recognised as one of the most successful and innovative primary care systems in the world. SCF has attracted huge attention from health administrators across world health systems and has been awarded the Malcolm Baldridge National Quality Award twice. Alongside positive world class health outcomes for the community, positive organisational outcomes are achieved through stable values-driven leadership and strong organisational culture. Overall Nuka demonstrates that health inequities are not inevitable when self-determination is enabled.

SCF's Nuka System of Care is based on four simple philosophies:

1. Customer Ownership
    - Customer-owners are treated as equals and share decision-making for their health and wellness.
    - Healthcare is a service, of which they are the customers, and they own their health and the health care system

2. Relationship
    - The relationship between the primary care team and the customer-owner is the most important means to effect change.
    - Recognising customer-owners are ultimately in control of their own lifestyle choices and health care decisions, Nuka system of care focuses on understanding each customer-owner's unique story, values and influencers to support them in their journey to wellness.

3. Whole System Transformation
    - The customer-ownership and relationship impact the entire system, not just health care delivery.
    - All five work systems within the Nuka system of care – medical, behavioural, dental, tribal and health care support, were designed.

[1] Nuka is an Alaskan Native word for 'strong, giant structures and living things'.

4. Ownership
    - Leadership decision-making are aligned to the organisational principles and 'core concepts' of building and developing positive relationships.

SOUTH CENTRAL FOUNDATION AND HAWKES BAY DHB

SCF has attracted huge attention from health administrators across world health systems. From 2007 to 2016, they received 1752 requests from health administrations interested in how they transformed a flagging health system to one of the world's most innovative systems achieving improved health outcomes. New Zealand has not been exempt with 26 enquiries alone.

Over the last 24 months Hawkes Bay DHB, Ngāti Kahungunu Iwi Inc, Health HB PHO, Te Taiwhenua o Heretaunga and others have formed a relationship and invested in sending three delegations, as well as individual visits, of governance, management, clinicians and community leaders to learn about Nuka.

In October 2018, HBDHB and Ngāti Kahungunu Iwi Inc held the inaugural NZ Nuka System of Care Conference. The conference was shaped around the key Nuka components deemed transferrable to the Hawkes Bay context including:

- Engaging community (to own and design the health system and using voice of consumer to drive improvement)
- Integrated Care Delivery (From Theory to Practice: Integrated Care Teams in Action)
- Behavioral Health (Introduction and Advanced Implementations and Applications)
- Quality Improvement (Improvement Culture; Tools and Processes; Using Data for Improvement)
- Wellness Warriors (an Alaskan native response to domestic violence, child abuse and neglect)
- Core Concepts (intensive and continuous training in organisational values and culture)

HEALTH SYSTEM CONTEXTS

SCF and HBDHB generally operate in different contexts. The US does not have a universal health care system providing health care to the entire population. Health care is funded by a mix of public funded programmes[2] and private health insurance. Health care is largely delivered privately by private sector business, including not-for-profit groups, as well as some government owned facilities. The Commonwealth Fund 2014 survey of health systems of 11 developed countries, including New Zealand, found the US health system the most expensive and worst performing in terms of health access, efficiency and equity.[3]

SCF is an Alaskan native owned health care organisation funded by a mix of federal government bulk funding and health insurance claims. SCF provide a broad spectrum of primary health care and related services. They also jointly own and manage, with the Alaska Tribal Health Consortium, the Alaska Native Medical Centre, which includes a 150-bed hospital providing inpatient, specialty and tertiary medical services. Most of the hospital services are available to the entire Alaska Native and American Indian population of Alaska. The SCF geographical service area covers 172,844 square kilometres in Alaska. They employ 2,161 staff, has annual operating budget of US$350m (NZ$473m), and services a population of around 55,000 across Alaska.

[2] Medicare, Medicaid, Children's Health Program, Veteran's Health Administration, Indian Health Service
[3] Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally. The Commonwealth Fund. 2014.

The New Zealand health system is a universal and largely publicly funded system. Health care is delivered through a mix of government owned (secondary/tertiary) and privately owned (primary care) providers. HBDHB is the primary funder of health services in Hawkes Bay with smaller contributions from the Ministry of Health, ACC, Insurance and consumers. Primary health care is largely delivered by independent general practice providers, geographically spread across HB, that provide a limited set of services.

Description	South Central Foundation	HB Health System
Ownership	Alaskan tribal ownership 'customer-owners'	Government owned (secondary/tertiary) Privately owned (primary care)
Population	55,000 Alaskan native and American Indian peoples	155,000 (76% NZ European, 26% Māori, 4% Pacific, 4% Asian)
Geographic area (sq. km)	172,844	14,164
Funding (total)	US$350m (NZ$473m)	NZ$600m
Funding (source)	Medical insurance 53% Federal government funded 43% Grants 6%	MOH funded 80% Fee for Service 12% ACC/Insurance 8%

KEY FEATURES OF NUKA SYSTEM OF CARE IN CLINICAL SERVICES PLAN

Despite the differences in organisational ownership structures, funding sources and population there are key features of the Nuka system that have been identified as transferrable to the HB context. The HBDHB Clinical Services Plan (CSP) - *Transforming Our Health System - Clinical Services Plan: the next 10 years*, establishes a firm commitment 'incorporating the guiding principles of the Nuka System of Care' including:

1. Incorporating the guiding principles of the Nuka System of Care whilst giving primacy to Māori indigenous thinking, values and solutions
    a. Create a local system that is co-designed by our own communities and whānau, and is completely in tune with our Hawke's Bay culture
    b. Developing our own model that embeds kaupapa Māori practice and builds on the strength of iwi led services

2. Active involvement of consumers in the on-going development of primary care

3. Multi-disciplinary teams providing integrated health and care services

4. Extending or up-skilling primary care teams to include behaviourists

CUSTOMER-OWNERS – CONSUMER CO-DESIGN PARTNERSHIPS

A key driver of transformation in Alaska was consumer co-design of their own health system and services. SCF embarked upon whole-system transformation and redesign and was largely drawn from asking the people what they wanted from a health care system. SCF employed over 10 strategies to listen to the customer-owners and conducted extensive interviews, surveys and focus groups with community members and tribal leadership about the shortcomings of the old system and

ideas for change. The 'Nuka System of Care' emerged completely from community feedback and formed the basis for SCF operating values and principles.

'Consumer Co-Design' has been identified as a key principle in shaping the transformation of the HB health system. HBDHB, has committed to improving consumer input into health system design with The Big Listen, Korero Mai and the development of the Clinical Services Plan (CSP). The CSP promises to include 'the voice of the consumer' in service redesign and ultimately aims to work *with* whānau rather than doing *to*, and *for*, them. It will become a core principle of service commissioning and the norm of 'the way we do things in HB'.

RELATIONSHIP CENTRED PRACTICE

The customer-owners told SCF they were tired of unfriendly and rude staff, long waiting times and seeing different health professionals every time. They wanted to be treated with courtesy, respect their opinions and understand their culture. It also highlighted the importance their health providers had an in-depth understanding of being empathetic and respectful and how to have meaningful relationships.

SCF also recognised that, as most health care occurs at the lower end of acuity, it is the customer that is in control and makes health care decisions. Whilst it is standardized, provider-driven health care model that may effectively influence outcomes for the small percentage of health care related to short-term and high-acuity problems, it isn't necessarily the best model for the majority of health care. Those conditions mostly afflicting Alaskan Natives, such as chronic illnesses, long-term conditions, prevention and wellness, it is the customer – not the provider or health system – that has the most control over the outcome.

SCF emphasise that customer owners should actively share responsibility for their and their families' health and wellbeing. The customer, they state, decides whether to attend the appointment with the provider, pick up the medicine the provider prescribes, whether to take it as prescribed, whether to share it with a neighbour, whether to split it in half so it lasts longer, whether to stop taking it in a few days, whether to exercise, what to eat, whether to drink too much, whether to smoke, etc. All of these things are determined by the individual and families' everyday choices, which are strongly influenced by their values, culture, communities and environment and mostly decided in time spent away from health clinics and beyond the scrutiny of health professionals.

'Person and Whānau Centred Care' and 'Relationship Centred Practice' are health care approaches developed in response to the learnings from Nuka and consumer feedback and are endorsed by HBDHB Consumer Council, Māori Relationship Board and Clinical Council. Person and Whānau Centred Care is about acknowledging the consumers as individuals, that have whānau and support networks, and that taking into account their preferences, cultural perspectives and social environments as vital to achieving shared decision making and better health outcomes. Furthermore, 'Relationship Centred Practice' builds upon Person and Whānau Centred Care with a recognition that in order to achieve person centred care, and the intended health outcomes, you must build strong, collaborative relationships with the consumer and their whānau. The role of the health provider is to work collaboratively in partnership with the consumer and their whānau and support them with the knowledge, skills and confidence to manage their own health.

CORE CONCEPTS – LEADING WITH HEART

SCF invested heavily in organisational systems and culture. All SCF leadership and staff receive intensive and continuous training in organisational values and culture with a three day 'Core Concepts' training.

Core Concepts focuses on developing behaviours and actions needed to build relationships, including communication tools on how to 'listen and respond to story'. It develops an understanding of your own story, how it may impact relationships, relational styles and the value of compassion and empathy. It also encourages employees to engage fully in their jobs and the people they work with, which also increases positive outcomes across the organization.

In HB, consumers have also provided strong feedback about respectful relationships with their providers. There are a number of key investments, strategies and trainings aimed at improving culture and cultural competency, including the The Big Listen, HBDHB People Strategy, Effectively Engaging with Māori Training, Engaging with Pacifika and Relationship Centred Practice. However most of these approaches are not core training, are delivered in siloes and not integrated.

HBDHB aims to improve organisational culture based on a core concept style of staff training entitled: 'Leading with the HEART'. Induction/Orientation Day into HBDHB is the opportunity to train new staff in the 'way we do things around here'. Similarly, staff already employed in the health system would also be expected to undergo regular core concepts training.

The draft programme could include the following contents using the learning circles and check-in processes:

- Our values and behaviours
- Equity training
- Unconscious Bias training
- Engaging Effectively with Māori cultural competency training
- Relationship Centred Practice training
- Engaging Pasifika cultural competency training programme
- Self-Care for Health Professionals
- Other tools from SCF core concepts

Here are the acronyms we have developed for 'Leading with Heart':

L – Listening to our Communities
E - Equity is the Norm
A - Addressing the Determinants of Health
D – Delivering Patient and Whānau Centred Care
I – Improving Health Outcomes
N – Nurturing Environment
G – Growing our Workforce

W – Whānau and Community Co-Designed Services
I – Integrated Health Teams
T - Timely and Accessible Services
H – Helping Each Other

HE – He Kauanuanu (Respect)
A – Akina (Improvement)
R – Raranga te Tira (Partnership)
T – Tauwhiro (Care)

Leading with Heart will be a 2 day programme run on a monthly basis aimed at new and existing staff. HBDHB has 3,200 staff and, along with new staff, will mean a monthly throughput of 100-150 staff per month. With Education Centre building refurbishment happening over the next 12 months,

the programme will be limited to new staff initially. We'll be keen on logging interest from outside DHB staff and determining how we can logistically make this happen.

INTEGRATED CARE TEAMS – EVOLVING PRIMARY CARE

Alaskan Native people prefer holistic approaches when addressing illness and health. Primary care is therefore delivered with smaller 'Integrated Care Teams' (ICT), with a strong emphasis on long term relationships. Customer owners choose their own primary care teams and stay with them to ensure continuity of care.

ICT work in shared open spaces that helps foster greater team work. ICT's include primary care GPs, nurse who coordinates care, medical assistant, an administrative assistant and behavioural health consultant. ICT's ensure customer owners see the right person – the GP for new issues, the nurse coordinator for monitoring and the pharmacist for prescriptions. It circumvents the GP as the bottleneck that limits access to care. Every two ICT have full access tribal doctors or traditional healers as well as nurse practitioners, chiropractors, midwives, massage therapists, acupuncturists, dieticians, pharmacists and specialists.

Same day appointments are guaranteed for customer owners. In order to achieve this SCF broadened its communications channels with customer owners, reducing its reliance on face-to-face consultations and increasing use of phone, text and email. The teams use face to face for more serious issues and phone consultations for minor ailments, and use of phone, text and email for routine monitoring and some preventative screening. From 2008 to 2015, SCF experienced a 25% decrease in visits to the primary care centre with customer satisfaction rates at 96%.

In HB, Integrated Care Teams feature heavily within the CSP. The CSP states that primary care will incorporate the principles of Nuka ICT teams with multidisciplinary teams providing integrated health and care services in primary care centres and the community.

HBDHB Primary Care Directorate and Health Hawkes Bay PHO will work through a combination of direct investment, workforce realignment, and implementation support to the development of ICTs in primary care. A co-design approach will be adopted with a range of providers (including whanau ora, general practice, kaupapa Maori and other primary healthcare providers) and the communities they serve. This approach will build on successful recent examples of how such workforce development and integration has been achieved in the HB health system, such as, Clinical Pharmacy Facilitators.

The nursing workforce is critical to the development of ICTs, given its size and developing scope. This development is being enables by regulatory and legislative changes that support new ways of working and will increase their contribution, including:

- RN Prescribing
- Nurse Practitioner development
- Mental Health credentialing
- Utilisation of Standing Orders
- Nurse Entry to Practice, specific to primary healthcare
- Increasing Māori nursing workforce in primary healthcare
- Legislative changes allowing nurses (RN and/or NP) to:
    - Provide sick certificates
    - Verify death
    - Complete application process for benefits

The CSP states that HBDHB will 'incorporating the guiding principles of the Nuka System of Care whilst giving primacy to Māori indigenous thinking, values and solutions

- Create a local system that is co-designed by our own communities and whānau, and is completely in tune with our Hawke's Bay culture
- Developing our own model that embeds kaupapa Māori practice and builds on the strength of iwi led services

Therefore the role of Māori providers and kaupapa Māori models of care are also critical to the development of a unique HB integrated care model. Māori providers play a highly important role of engagement with whānau and communities who don't necessarily respond to traditional health care system approaches. There are successful examples of primary care integration with Māori providers, such as #Whanau, Te Taiwhenua o Heretaunga and Queen St Medical/Kahungunu Executive in Wairoa, that need to be learned and adopted system wide approach to integrated care. Their integration and partnership with primary care is therefore pivotal, especially in areas of high Māori population and deprivation – Wairoa, Hastings and Napier.

BEHAVIORAL HEALTH SERVICES

A key part of ICT teams is the inclusion of behavioural health practitioners. Behavioural Therapists work across a broad range of health needs from teenage life skills development, individual counselling and therapy, addiction services (detox, residential, counselling etc.), crisis support to chronic mental illness case management support. The major condition presenting to behaviour therapists is Attention Deficit Hyperactivity Disorder (ADHD), which is also most common for Māori children.

Behavioural Health services are organised around brief intervention, focused intervention and long term intervention approaches according to assessed need. Brief interventionists only have 3-4 booked appointments per day, with provision made for walk-ins and ensuring customer-owners have guaranteed appointments on the day.

In HB, the CSP identifies the growing need for integration of 'behaviourists' within primary care. Similar to Nuka, Behaviourists will become a key part of primary care teams as a better first line mental wellbeing service, providing early intervention as part of holistic primary care services and, ultimately, reducing referrals to specialist services. It is an opportunity to increase equity, providing direct support for the most vulnerable people.

Alongside a nursing workforce that has enhanced knowledge and competency in mental health, HBDHB are also committed to supporting the development of capabilities and capacity that can support behavioural health need. This is important in demonstrating a commitment to relationship-based healthcare, recognising the interplay of wider determinants of health on physical illness, and normalising attention within society on the psychological dimension of wellness.

The HB health system already have an array of 'behaviourists' within the existing workforce. Such approaches, however, have been traditionally under-resourced, not valued for the holistic model to which they operate, and diluted by a focus in the commissioned service offer on alternative, episodic approaches to wellbeing (e.g. packages of care). The first step will be to undertake comprehensive mapping of where behavioural health skills reside in our care system, and how these are resourced.

In the next twelve months, however, we will be working with identified partners to co-create the Hawke's Bay model and put it in place in our demonstrator sites. Throughout this process, we will keep close alignment to the review of Community Mental Health & Addictions, which itself will need

to demonstrate close mapping to the findings of the national inquiry into mental health and addictions.

WORKFORCE DEVELOPMENT

SCF has a large emphasis on 'growing its own' and ensuring customer owners are the workforce. More than 50% of SCF's employees are Alaska Native/American Indian people with 65% of managers are Alaska Native/American Indian people as well. SCF invests heavily in its human capital with a number of leadership development programmes to help grown leaders from within. There are foundations programme to help entry-level staff move into management positions, special programmes for particular categories of staff to move into leadership roles and an executive leadership experience programme aimed at helping Alaskan Native employees prepare for executive leadership roles. With RAISE programme of youth internships it offers 80 internships places per annum that allows 80 young people to explore careers in health. There are summer and winter programmes for high school students to help them complete their education. Many of SCF's current employees have come through the workforce development programmes.

HBDHB People Plan is equally committed to growing the Maori and Pacific workforce. HBDHB aim to ensure the staff and organization reflect the community which we serve and the growing Māori population. In 2019, the Maori workforce has grown to 14.8% and aims to increase year on year until it is equitable with the Hawkes Bay population. The new Maori Workforce Action Plan is centred improving organisational and staff cultural competency, recruitment and retention of Maori staff and improving the development of Maori into management and leadership positions.

Based on the learnings of the SCF programme RAISE, Māori Health have developed an 8 week internship programme (Tuakana – Teina) for recent school leavers and summer internships for university students. The internship programme enhances the workforce development pipeline and sustainability in growing the future Māori workforce.

HAWKE'S BAY District Health Board Whakawāteatia	**Matariki HB Regional Economic Development and Social Inclusion Strategy** 29
	For the attention of: **HBDHB Board**
Document Owner	Bernard Te Paa, Executive Director Equity and Health Improvement
Document Author(s)	Shari Tidswell, Intersector Development Manager
Reviewed by	Executive Management Team
Month/Year	March 2019
Purpose	This report provides and update on progress for the Matariki Strategies and the HBDHB's contribution to these.
Previous Consideration Discussions	This is reported six monthly.
Summary	The emphasis has shifted for the Matariki forum with partner agencies working on and sharing proposals for the Provincial Growth Fund (PGF). The Executive Leadership and Governance Groups are discussing alignment and their role in the PGF process. Business Hawke's Bay continues to work on establishing the supporting structure for the forum, with all staff support in place. HBDHB continues to support current projects and there has been particular success for the Rangatahi Ma Kia Eke project.
Contribution to Goals and Strategic Implications	Improving Health and Equity. Contributing to an intersectoral approach
Impact on Reducing Inequities/Disparities	Matariki as a cross-sector initiative focusses on the impacts of economic development in reducing equity amongst our communities.
Consumer Engagement	Completed in the development of both Strategies and the ongoing development of projects.
Other Consultation /Involvement	Not applicable for this report.
Financial/Budget Impact	Not applicable for this report.
Timing Issues	Not applicable
Announcements/ Communications	Link to the Matariki website on the Hawke's Bay DHB website

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report.
2. **Endorse** the key recommendations.

17

Board Six Month Update
Matariki – Regional Economic Development and Social Inclusion Strategies.

Author(s):	Shari Tidswell, Intersector Development Manager
Designations:	As above
Date:	**March, 2019**

OVERVIEW

Matariki includes two regional strategies designed to achieve regional development via economic development and social inclusion. Through the delivery of projects, these complementary strategies will support the regional, economic vision:

> *"Every household and every whānau has activity engaged in, contributing to and benefiting from a thriving Hawke's Bay economy."*

And social inclusion vision:

> *"Hawke's Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has the opportunities that result in equity of outcomes."*

Underpinning this is the understanding that regional economic growth and supporting equitable opportunities for individuals, whānau and community go hand in hand.

An intersectoral approach is being used to deliver actions to support the strategies, including; community, Iwi, hapū, business and Government partners. The leadership structure reflects this approach with a two tiered leadership structure – Governance and Executive Leadership Groups, with membership including Iwi and Hapū governance and executive representatives.

Governance Group membership includes; five council (Mayors and Chair), five Māori leadership representatives and five business leaders providing leadership and overall direction for Matariki.

The Executive Leadership Group consists of senior officials and managers from all stakeholder groups including Government agencies. This group provides operational direction, project support and monitors progress on the strategy's actions. Administrative support is provided via Business Hawke's Bay.

HBDHB is the lead and/or contributing agency for the following actions:

Regional Economic Development

- Contributor - Project 1,000 (placing 1,000 youth into work)
- Contributor - coordinating infrastructure

Social Inclusion

- Lead agency – Social Responsible Employers
- Co-lead agency – Housing
- Contributor – Whānau centric places connected to the community
- Contribute – Develop a new sustainable operating system

PROGRESS ON ACTIONS LED OR CONTRIBUTED TO BY HBDHB

The Regional Growth Fund is stepping up with scheduling of Ministerial announcements in 'surge regions' including Hawke's Bay. Matariki partners have been working on proposals including a joint proposal from the local territorial authorities. The Executive Leadership Group is providing a process for reviewing funding applications – this will require proposals to demonstrate how they contribute to Matariki actions. The process for reviewing youth employment programmes has received positive feedback from central government.

The HBDHB continues to provide 'in kind' support for the Social Inclusion Working Group and via this support, has completed:

- Updates to the Executive Leadership Group
- Integrated the actions table from both strategies
- Updating of the Matariki website to reflect the aligned strategies https://www.hbreds.nz/
- Presented the Clinical Services Plan to the Governance and Executive Leadership Groups

The HBDHB is contributing to actions as noted below:

Theme	Action	Update
Social Inclusion		
Growing social responsible employers and enterprise	Support the employment of people with challenges that may impact on their capacity to obtain and retain employment.	• HBDHB and MSD lead this action • Rangatahi Ma Kia Eke project has placed 25 youth and has secured another year of funding • Evaluation is underway • HBDHB has completed a Disability Plan which will reduce barriers for people with disabilities
Whānau, households and communities driving social inclusion	Develop a new sustainable operating system to deliver social support services.	• HBDHB and Oranga Tamariki lead this action • Clinical Services Plan – co-design process is an example of moving to a sustainable operating system for health • HBDHB are members of the Wairoa Community Partnership Group, this is supporting an integrated/community-based response for funding services in Wairoa
	Review Housing Coalition's Terms of Reference	• HBDHB and TToH lead this action • Completed
	Undertake an analysis of social housing	• HBDHB and TToH lead this action • This is now part of a Government activity - HBDHB will contribute
	Develop a plan to address issues affecting housing supply and consider innovative approaches	• HBDHB and TToH lead this action • Currently working with Government policy and housing programme

Theme	Action	Update
Regional Economic Development		
Improve pathways to and through employment	Project 1,000	• HBDHB are key partners • Supporting the delivery of Rangatahi Ma Kia Eke with partner agencies; TPK, MSD, EIT, HDC, and OT • Establishing a support pathway for youth "failing drug test" • Working with TToH and Work and Income to provide referrals and support
	Ensure all major infrastructure development projects are optimising local employment	• HBDHB are key partners • Employment in building projects – working with Contracts Team and Facilities to support this process
	Increase the number of youth with driver licences	• Completed a map of driver licensing and provides support to develop the project plan

COMMENTS

Progress has been gradual due to the focus on the Provincial Growth Fund and the time required for Business Hawke's Bay to establish the supporting structure. The Governance and Executive Leadership Groups are operational and meeting regularly.

The Minister's expectations include intersectoral work. Matariki provides a framework for intersectoral work. Work on the Annual Plan for 2019/2020 includes links to Matariki actions and projects, which will support the Social Inclusion Strategy to be delivered and continues to deliver projects in the Regional Economic Development Strategy.

Through our membership on Matariki, we continue to grow our cross-sector opportunities and relationships.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
HBDHB continues to contribute to Governance and ELG	• Attend monthly meetings and contribute to actions	Kevin Snee Kevin Atkinson	Ongoing
Continue to support actions areas with 'in kind' support	• Support the ready for work actions. • Contribute to the work delivering whānau centric approaches • Complete the Housing Actions	Shari Tidswell	1 July 2019

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report.
2. **Endorse** the key recommendations.

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:

19. Confirmation of Minutes of Board Meeting 27 February - Public Excluded
20. Matters Arising from the Minutes of Board Meeting - Public Excluded
21. Board Approval of Actions exceeding limits delegated by CEO
22. Chair's Update
23. Finance Risk and Audit Committee

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).