HAWKE'S BAY
District Health Board
Whakawāteatia

BOARD MEETING

Date: Wednesday 15 April 2020

Time: 1:00pm

Venue: Zoom meeting (livestreamed for public meeting)

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

Apologies: Nil.

In Attendance: Craig Climo, Interim Chief Executive Officer
Members of the public and media (livestreamed)

Minute Taker: Kathy Shanaghan, EA to CEO

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	Karakia	1.00
2.	Welcome and Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting - 18 March 2020	
5.	Matters Arising - Review of Actions	
6.	Board Workplan	
7.	Chair's Report (verbal)	
8.	Chief Executive Officer's Report	1.15
9.	Planning & Funding Report	1.25

10.	Provider Services Report	1.35
11.	Board Health & Safety Champion's Update (verbal) - Board Safety Champion	1.45
	Section 2: Governance / Committee Reports	
12.	Māori Relationship Board Report (no written report)	
13.	Hawke's Bay Clinical Council Report (no written report)	
14.	Hawke's Bay Health Consumer Council Report (no written report)	
15.	Pasifika Health Leadership Group report (no written report)	
	Section 3: For Decision	
16.	Health Pathways	1.50
	Section 4: For Information and Discussion	
17.	Annual Planning Update	1.55
18.	**Section 5: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000	

Public Excluded Agenda

Item	Section 6: Routine	Time (pm)
19.	Minutes of Previous Meeting - 18 March 2020 (public excluded)	2.00
20.	Matters Arising (public excluded) – Review of Actions (public excluded)	
21.	Board Approval of Actions exceeding limits delegated by CEO (no written report)	
22.	Chair's Update - verbal (public excluded)	
23.	Chief Executive Officer's Report (public excluded)	2.10
24.	Planning & Funding Report (public excluded)	2.20
25.	Digital Enablement News (public excluded)	2.25
26.	Process for Significant Service Change (public excluded)	2.30
	Section 7: For Information/Decision	
27.	Finance Risk and Audit Committee – Chair, Evan Davies (public excluded)	2.40
	Meeting concludes	

The next HBDHB Board Meeting will be held on
Wednesday 20 May 2020

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

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

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

ĀKINA IMPROVEMENT

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

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

RARANGA TE TIRA PARTNERSHIP

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

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

TAUWHIRO CARE

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

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

Board "Interest Register" - as at 6 April 2020

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Shayne Walker	Active	Bank of New Zealand	Employer. BNZ provides banking services to HBDHB.	Potential conflict. Will abstain from all decisions related to financial banking services.		08.01.20
	Active	Dr Rachel Walker	Wife - is a contractor to HBDHB	Potential conflict. Will abstain from decisions related to perceived conflict.	Company Secretary	08.01.20
Kevin Atkinson	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
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	Ikaroa Rāhiti Party	Candidate for Ikaroa Rāhiti	Will manage HBDHB governance information in confidence	The Chair	18.03.20
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	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 Whararikі 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
	Active	Hawke's Bay District Health Board	Contracted as Intersector Liaison Officer for COVID-19	Take no actions from Board meetings related to CIMS role. Report through operational structure related to CIMS role.	The Chair	02.04.20
Anna Lorck	Active	Attn! Martketing & PR	Owner & Director (Marketing & Comms, publishing).	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	09.12.19
			Communications Contractor/Advisor to multiple businesses.	Will disclose if any conflict is related to agenda items. Will manage HBDHB governance information in confidence	The Chair	06.04.20
	Active	Labour Party	Labour Party candidate for Tukutuki electorate	Will manage HBDHB governance information in confidence	The Chair	18.03.20
	Active	Mother	Mother is an employee of the DHB at Central Hawke's Bay Health Centre	Will advise of any perceived or real conflict prior to discussion	The Chair	04.02.20
Hayley Anderson	Active	Hawke's Bay District Health Board	Cntracted as Incident Controller for COVID-19	Take no actions from Board meetings related to CIMS role. Report through operational structure related to CIMS role.	The Chair	25.03.20
		Cranford Hospice Trust	Health Consultant - contracted with provider	Will advise of any conflict of interest. If in doubt, will discuss with HBDHB Chair	The Chair	09.12.19
David Davidson	Active	2020 End of Life Choice Act Referendum Society		Will abstain from all decisions related to end of life choice.	The Chair	28.03.20
	Active	Weem Charitable Trust	Provides support services to Cancer sufferers eg Cranford & Cancer Society	Will advise of any perceived or real conflict prior to discussion	The Chair	09.12.19
Joanne Edwards	Active	KiwiGarden Ltd	Director/CEO	Potential conflict. Will abstain from all discussions/decisions that may have some direct relevance to this interest.	Company Secretary	08.01.20
Charlie Lambert	Active	Hawke's Bay Regional Council	Council Member	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	06.04.20
Evan Davies	Active	Chair, Capital Investment Committee	DHB Capital Prioritisation	Potential conflict.	The Chair	7/01/2020

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 18 MARCH 2020, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.30pm

PUBLIC

Present: Shayne Walker (Chair)
Evan Davies (by zoom)
Hayley Anderson
Ana Apatu
Kevin Atkinson
David Davidson
Peter Dunkerley
Joanne Edwards (by zoom)
Charlie Lambert
Anna Lorck
Heather Skipworth

Apologies: Nil.

In Attendance: Craig Climo (Interim Chief Executive Officer)
Ken Foote (Company Secretary)
Members of the Executive Management Team
Rachel Ritchie, Chair (Hawke's Bay Health Consumer Council)
Kathy Shanaghan (EA to CEO)

1. Apologies were received from Robin Whyman, Chief Medical & Dental Officer, who was unwell. Board members passed on their wishes for a speedy recovery.

2. INTEREST REGISTER
The following additions were noted:
1. Heather Skipworth was confirmed as Māori Party candidate for Ikaroa Rāhiti.
2. Anna Lorck was confirmed Labour Party candidate for Tukituki electorate.

No Board member advised of any interests in the items on the agenda.

3. CONFIRMATION OF PREVIOUS MINUTES
The minutes of the Board meeting held on 25 February were confirmed as a correct record of the meeting.

Moved: **Ana Apatu**
Seconded: **Peter Dunkerley**
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES
Status updates for all actions were noted together with the following comments:

Item 2: **Emergency Q App.** Deferred to next month.
Item 3: **Disability Plan.** Update to be provided to next Consumer Council meeting.
Item 5: **1737 Mental Health Phone/Text Service.** To be discussed under Consumer Council report.

5. BOARD WORK PLAN

The Board work plan was noted. Given the priority around COVID19, the Chair acknowledged that some of these reports may move to another month. The CEO advised that rather than responding to specific questions, management was looking to provide broader perspectives of subject areas.

6. CHAIR'S REPORT

- The Chair had met with the Minister of Health last week who personally acknowledged HBDHB's performance, particularly around immunisation. Issues discussed included:
  - The need to do more work around Pasifika Health and ASH (ambulatory sensitive hospitalisation) rates 0-4 years
  - The need for an increased focus to move those performance measures that were red status to green.
- CEO recruitment. Final interviews were conducted this morning, with a decision likely to be in the next week to 10 days.
- The Chair acknowledged Heather Skipworth and Anna Lorck being confirmed as candidates for Māori Party and Labour Party respectively.

The Chair advised of the following retirements, with a letter being sent conveying the Board's best wishes and thanks for their extended years of devoted service.

Name	Role	Service	Years of Service	Retired
Gael King	Sterile Service Technician	Surgical Directorate	18	28-Feb-20
Eileen Smith	Staff Midwife	Communities Women & Children	34	13-Mar-20
Gae Redshaw	District Nurse	Communities Women & Children	25	28-Feb-20
Ken Foote	Company Secretary	Corporate Services	18	20-Mar-20

On behalf of the Board, both current and previous, the Chair thanked Ken Foote for his contribution to the DHB over the past 18 years, the last nine years of which had been in the role of Company Secretary. Ken responded saying he had seen many changes over those 18 years and had particularly enjoyed the Company Secretary role. He said it had been a privilege working for the DHB and thanked everyone for their support over the years, noting one of the things he was most proud of was being involved in the development of the Clinical Services Plan.

7. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided the following comments in addition to his report:

- The Service Improvement presentation had moved to the April meeting
- COVID-19
  - Dominating a lot of management's time
  - The DHB had acquired its own local testing capacity but it could be 4-5 weeks before the equipment arrived
  - The DHB had also ordered a further two ventilators (currently there were 38 in Hawke's Bay)
  - Testing would only be done for those people in the higher category (people with flu-like symptoms who had returned from overseas within the last 14 days)
  - The Minister of Health had issued a Ministerial direction to all DHBs to ensure there was a nationally consistent and coordinated approach to COVID19. The direction meant that DHBs were not required to seek approval from Boards to enact significant policy decisions within the COVID19 response, e.g. expenditure outside normal financial delegations. This was to ensure key actions required as part of the response were enacted quickly and efficiently

- Anna Lorck congratulated the DHB and the emergency response team for the statement released last Friday. It gave her comfort and encouraged the team to continue to release statements, and said the team has been outstanding. The Chair advised that other DHBs had provided positive feedback about the release.
- A member asked what the contingency plan was for staff illness. Board members were advised that the personnel unit within the CIMs structure had been doing a lot of work identifying people who could come into work in the event of staff illness or self-isolation. This included recently retired staff and also volunteers
- Timely advice to Board members around any confirmed cases in Hawke's Bay was discussed. It was pointed out that all confirmed cases were announced by the Ministry of Health and Board members would be informed following any national communications.

RECOMMENDATION

That the HBDHB Board receives this report and **notes that**:

1. Out-sourced surgery, in addition to plan and current forecast, has an uncertain cost due to at risk funding, but the actual expenditure may be up to $1.5M, which is necessary to get closer to plan and to mitigate a funding claw-back.
2. The opening if ward 2 as a full ward will have an estimated cost in addition to current forecast of about $0.3M in 2019/20m, and about $1.9M in a full year.

Adopted

8. FINANCIAL PERFORMANCE REPORT

This report was taken as read. It was noted that the result for the month of March was $1M unfavourable to plan, which was $0.2M better than forecast.

RECOMMENDATION

That the HBDHB Board:

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

Adopted

9. PROVIDER SERVICES REPORT TO BOARD

The CEO presented this report as the ED Provider Services was unwell. He advised that as the Australian Government was urging Australian citizens to return home as soon as possible, John Burns would be leaving the country this coming Saturday. Chris Ash had now commenced fully in the acting ED Provider Services role, although he had been transitioning into the role for the last two weeks. The CEO provided the following comments in addition to the report:

- Occupied Beds. The DHB had seen a marked increase in elderly admissions which was contributing to the growth in the daily average occupied beds. Professor Matthew Parsons had been asked to look at the whole configuration of services around older people and it was hoped to have that information in the not too distant future.
- Planned Care. Royston Hospital was not able to commit to additional volumes in terms of numbers, however the intention was to refer as much to Royston as possible. A member highlighted an issue in the past where patients had ended up in the hospital's Intensive Care Unit for up to two weeks following outsourced/private surgery and asked if any restrictions were being put in place as to the types of surgery Royston could do in light of COVID19. The CEO undertook to follow this up. **Action**

The CEO advised that the criteria for reducing or stopping planned surgery was being worked on by the Ministry, with all DHBs asked as to what the trigger points were to shut down non-acute services.

The Chair asked the CEO to convey the Board's thanks to John Burns for the leadership he had provided to not only Provider Services, but to the organisation as a whole, since his arrival in May 2019.

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.
Adopted

10. BOARD HEALTH & SAFETY CHAMPION UPDATE
Heather Skipworth advised that Hayley Anderson was inducting herself and had organised for Board Health & Safety Champions to attend next month's Safety and Wellbeing Committee meeting.

FOR DECISION

11. BED AVAILABILITY – A2
Following discussion earlier in the day, Board members considered the following resolution.

RESOLUTION

That the Board receives this report and:

1. **Approves** the permanent opening of Ward A2 as a full 24 bed ward at an estimated additional cost to current budget of$3.6M per year, being an additional cost to current forecast of about $0.3M in 2019/20, and about $1.9M in a full year.
2. **Notes** Service Improvement model will continue to enable prioritised initiatives that are clinically-led.

MOVED: Peter Dunkerley
SECONDED: Ana Apatu
Carried

As discussed earlier in the day, it was agreed that management would report periodically on:
- Performance metrics and productivity, e.g. are more patients in beds at a lower cost per patient
  - Any change in the consumer experience
  - Any equity measure

12. COMMUNITY REPRESENTATIVES ON TE MATAU A MAUI HEALTH TRUST
This report sought Board approval to appoint two community representatives on Te Matau a Maui Health Trust. Board members were provided with background information on one of the recommended appointees.

RESOLUTION

That the Board:

1. **Appoints** Malcolm Dixon and Barbara Arnott to be Trustees of Te Mata a Maui Health Trust for three-year terms commencing April 2020.

MOVED: Kevin Atkinson
SECONDED: David Davidson
Carried

REPORT FROM COMMITTEE CHAIRS

13. HAWKE'S BAY CLINICAL COUNCIL

This report was taken as read. The Chair of Clinical Council confirmed that all reports going forward would include an ethnicity lens as well as a personal and whanau centred lens.

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report
Adopted

14. HAWKE'S BAY HEALTH CONSUMER COUNCIL

The Chair of Consumer Council presented the report from the Consumer Council meeting held on 12 March 2020. She referred to the action from the Council's February meeting regarding the 1737 Mental Health / Phone Text advising that a brief response had been received, with a more substantive response coming through shortly. She also advised that a more general review was to be undertaken.

Rachel Ritchie acknowledged Ken Foote and his role in establishing the Consumer Council and the support he had given to her in particular. She passed on the committee members' thanks and appreciation.

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report
Adopted

15. PASIFIKA HEALTH LEADERSHIP GROUP

The report from the Pasifika Health Leadership Group (PHLG) meeting on 9 March 2020 was taken as read. Hayley Anderson provided a brief overview.

PHLG had requested a face to face meeting with the Board around equity for Pacific and there was discussion on the most efficient way for that to occur.

Board members discussed the DHB's recruitment policy, specifically around recruitment of Māori and Pasifika, and also whether there were any Māori and Pasifika staff employed in the HR / recruitment team. The Board were advised that the practice within the DHB was to interview all Māori applicants who met the essential criteria for a position. All interviews also had a Māori person on the interview panel. It was agreed to send a copy of the DHB's recruitment policy to the Board together with details on the ethnic diversity question and whether there was a similar policy for Pasifika. **Action**

In response to PHLG's request for a face to face meeting around equity, the Chair asked what as the most efficient way for that to occur. The GM Maori Health it was important for that group to first understand what equity was. John Whaanga, Deputy Director-General Maori Health, was meeting with the Maori Relationship Board in May and there may be an opportunity for the PHLG to meet with John while here. **Action**

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report
Adopted

INFORMATON AND DISCUSSION

16. 2020/21 ANNUAL PLAN – UPDATE

This report was taken as read. It was noted that due to COVID19, the dates for submitting Annual Plans may be moved out. Board members requested that the final Annual Plan go through MRB prior to the Board.

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.
Adopted

GENERAL BUSINESS

There was discussion around quality control of papers including the timeframe for making Board papers public. While the minimum requirement was two days prior to a meeting, Anna Lorck believed it was important for the public to have time to read papers and therefore thought papers should be available one week prior to the meeting.

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

17. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

18. Confirmation of previous minutes 25 February - Public Excluded
19. Matters Arising (Public Excluded)
22. Board Approval of Actions exceeding limits delegated by CEO (Public Excluded)
23. Chair's Update (Public Excluded)
24. Chief Executive Officer's Report (Public Excluded)
25. Hawke's Bay Clinical Council Report (Public Excluded)
26. Finance Risk and Audit Committee (Public Excluded

Moved: **Kevin Atkinson**
Seconded: **Ana Apatu**
Carried

The public section of the Board meeting closed at 3.20pm.

Signed: _____

Chair

Date: _____

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BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	27/11/19	**MRB Recommendation** October MRB report to Board contained recommendation from Te Ara Whakawaiora, which was not addressed. This endorsement of next steps to be brought back through to Board in December	Emma Foster	April 2020	**ASH Rates – 45 to 64** Since December 2019, the Planning & Funding team have been involved in exciting and vital pieces of work that are intended to reduce readmission rates for adults. Of particular importance are the chronic conditions flag with Clinical Nurse Specialists from varied services and a chronic heart failure patient survey led by the Māori Health Gains Advisor. The report due to MRB in May will provide more insight and identified opportunities specifically link to these key pieces of work. It will also table the concept of developing a Long Term Conditions Plan that focuses on prevention, integration and coordination of care.
3	25/2/20	**HIE Quarterly Report** Next report to include an update on the following: (a) Areas where cold chain accreditatioin has not been achieved and the actions being taken (b) Actions being undertaken to increase CVD risk assessments (c) More emphasis around primary care smokefree	Patrick Le Geyt	May 2020	

Action	Date Entered	Action to be Taken	By Whom	Month	Status
4	25/2/20	**1737 Mental Health Phone/ Text Service (Consumer Council request)** Statistics aroaund unanswered calls and long delays	Chris Ash	March 2020	Brief response received, with a more substantive respone to come shortly
5	18/3/20	**Outsourced/Private Surgical Patients Requiring Intensive Care Following Surgery** • Are any restrictions being put in place as to the types of surgery Royston could do in light of COVID19	Craig	April 2020	CEO to provide verbal update
6	18/3/20	**Recuitment Policy for Māori and Pasifika** • Board to be advised of DHB's recruitment policy in respect to Māori and Pasifika including whether there were any Māori and Pasifika staff employed in the HR/Recruitment team	Craig / Kathy	April 2020	Information emailed to Board members

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BOARD as at 9 April 2020	Emailed	Destination Month	EMT Member	Lead/Author	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Service Improvement / Business Intelligence (presentation)		Apr-20	Anne Speden						15-Apr-20
Annual Plan Update		Apr-20	Emma Foster						15-Apr-20
Provider Services Monthly report		Apr-20	Chris Ash					15-Apr-20	15-Apr-20
Process for Significant Service Change		Apr-20	Emma Foster						18-Mar-20
Health Pathways		Apr-20	Emma Foster	Robyn Richardson	6-May-20	6-May-20	7-May-20		15-Apr-20
Household Management Review		May-20	Emma Foster						20-May-20
Renal Outpatient Booking Review		May-20	Robin Whyman						20-May-20
He Ngakau Aotea		May-20	Patrick Le Geyt						20-May-20
Provider Services Monthly report		May-20	Chris Ash					20-May-20	20-May-20
HIE & Pop Health Quarterly report to board		May-20	Patrick Le Geyt						20-May-20
Information Services & Service Improvement report to Board		May-20	Anne Speden						20-May-20
Corporate Performance Dashboard (quarterly)		May-20	Emma Foster		6-May-20	6-May-20	7-May-20		20-May-20
Three Waters discussion - once received plan from Napier council (MA 24.04.19)		Jun-20	Patrick Le Geyt	Nick Jones					17-Jun-20
PHO Quarterly report to Board		Jun-20	Wayne Woolrich						17-Jun-20
Hawke's Bay Health Awards Event - REVIEW Alcohol at this event annually		Jun-20	Anna Kirk						17-Jun-20
Chief Medical & Dental Officer Quarterly report to Board		Jun-20	Robin Whyman						17-Jun-20
Chief Nursing & Midwifery Officer Quarterly report to board		Jun-20	Chris Mckenna						17-Jun-20
Chief Allied Health Professions Officer report to board		Jun-20	Andy Phillips						17-Jun-20
Comms report to Board		Jun-20	Anna Kirk						17-Jun-20
Significant Service Changes - Skin Cancer Pathway		Jun-20	Emma Foster	Penny Rongotoa / Emma Foster	3-Jun-20	3-Jun-20	4-Jun-20		17-Jun-20
Provider Services Monthly report		Jun-20	Chris Ash					17-Jun-20	17-Jun-20
Provider Services Monthly report		Jul-20	Chrish Ash					15-Jul-20	15-Jul-20
Chief Medical & Dental Officer report to Board		Aug-20	Robin Whyman						19-Aug-20
Chief Nursing & Midwifery Officer report to board		Aug-20	Chris Mckenna						19-Aug-20
Chief Allied Health Professions Officer report to board		Aug-20	Andy Phillips						19-Aug-20
Provider Services Monthly report		Aug-20	Chris Ash					19-Aug-20	19-Aug-20
Alcohol Harm Reduction Strategy (6 monthly update) - moved to August 2020		Aug-20	Patrick Le Geyt	Rachel Eyre	5-Aug-20	5-Aug-20	6-Aug-20		19-Aug-20
HB Health Awards - preparation for judging **2019**-2020		Aug-20	Anna Kirk	Anna Kirk		5-Aug-20	6-Aug-20		19-Aug-20
HIE & Pop Health Quarterly report to board		Aug-20	Patrick Le Geyt						19-Aug-20
Corporate Performance Dashboard (quarterly)		Aug-20	Chris Ash		5-Aug-20	5-Aug-20	6-Aug-20		19-Aug-20
PHO Quarterly report to Board		Aug-20	Wayne Woolrich						19-Aug-20
Provider Services Monthly report		Sep-20	Chris Ash					16-Sep-20	16-Sep-20
Information Services & Service Improvement report to Board		Sep-20	Anne Speden						30-Sep-20
Provider Services Monthly report		Oct-20	Chris Ash					21-Oct-20	21-Oct-20
Chief Medical & Dental Officer report to Board		Nov-20	Robin Whyman						18-Nov-20
Chief Nursing & Midwifery Officer report to board		Nov-20	Chris Mckenna						18-Nov-20
Chief Allied Health Professions Officer report to board		Nov-20	Andy Phillips						18-Nov-20
Comms report to Board		Nov-20	Anna Kirk						18-Nov-20
Provider Services Monthly report		Nov-20	Chris Ash					18-Nov-20	18-Nov-20
HIE & Pop Health Quarterly report to board		Nov-20	Patrick Le Geyt						25-Nov-20
Provider Services Monthly report		Dec-20	Chris Ash					16-Dec-20	16-Dec-20

HAWKE'S BAY
District Health Board
Whakawāteatia

CHAIR'S REPORT

Verbal

8

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report - Public**
	For the attention of: **HBDHB Board**
Document Owner:	Craig Climo, Interim Chief Executive Officer
Month as at	9 April 2020
Consideration:	For Information

RECOMMENDATION

That the Board

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

This paper takes the opportunity to introduce and provide an overlay of other matters in this agenda.
I will be speaking to management agenda items.

FINANCIAL OPERATING RESULT FOR MARCH

The result for March is as advised on 7 March:

- Actual 1.81M U (unfavourable)
- Underlying result $1.22M U compared with forecast $1.38M U

Key differences were:

1. Planned care (elective surgery) loss of revenue $3.15M U brought to account, being 9/12 of the total $4.2M at risk. Ministry of Health (MoH) the last week confirmed it still intends to apply the "rules" although may return some funding for a catch-up. The balance of the $4.2M will be written off over the next three months unless MoH advice changes.
2. $2.6M F (favourable) COVID-19 due to revenue received far exceeding actual costs to date. Information that has gone to the Board to date regarding costs are those we are committing to.

Other aspects of note:

1. The result included a Pharmac adjustment of $0.5M F. This was based on Pharmac advice re the level of rebate to be expected. It had largely been included in our forecast.
2. IDF costs were impacted by two major burns cases, with one costing $0.65M.
3. The laboratory MECA has been settled. Strike costs in March were $80k, and YTD for all strikes $0.35M.
4. Elsewhere the cost trends of the year continued at similar levels in Health of Older People (ARC), intragam. Staff costs were higher than they should be for the level of activity i.e. productivity will have dropped. We are trying to get staff on leave for welfare reasons and with the COVID-19 environment likely to continue for an extended time.

COVID-19

The Board is briefed daily at an operational level.

Overall, I would characterise ourselves as having been in catch-up mode as we prepared for what might have presented (and might still), and we are now in a tidy-up stage around our processes and arrangements. Over, the last couple of days we have moved markedly on recovery arrangements, including the hope that some adaptations to COVID-19 might become permanent e.g. virtual clinics.

Current recovery activities include:

- A psychosocial support plan for staff in the health sector has been developed and is being implemented [1]
- Developing a recovery plan for surgical services for a 24 to 36 month timeframe
- Developing a recovery plan for outpatient services
- Developing a recovery plan to exit from the 'Covid19 hospital' areas to the appropriate Covid19 state

HEALTH PATHWAYS

A paper on this is elsewhere in this agenda.

Health Pathways is a proprietary product that provides a computer-based decision tree or standard operating procedure for clinical staff dealing with common presentations to primary care. The same type of product exists for secondary services, but this proposal is for primary care only.

A benefit of the system is it requires the process for a particular presentation or pathway e.g. diabetes management to be mapped, improved, standardised, and is explicit, which inherently lends significantly to process improvement and standardisation. The information is, of course, localised, it reflects how we in Hawke's Bay manage cases and the entities to whom referrals may be made are local.

Hawke's Bay District Health Board (HBDHB), as did numerous other DHBs, had another product called Map of Medicine. That product fell over and since we have had nothing, while all other DHBs moved to Health Pathways. So we are getting back to where we should be.

The financial benefit of this type of system is universally difficult to quantify and probably best described as having this type of system is generally accepted practice and a basic tool of trade for clinicians.
The cost is material at about $358k per annum ongoing (first year establishment costs are about $50k more), the labour component of it still needs to be refined and is a major contributor of the cost. It is a cost we used to incur, but have not during the hiatus without it. The operating cost includes the product licence and a number of part-time positions to establish and maintain the currency of the information.

Borrowing Health Pathways has been necessitated by COVID-19. It had been a discrete investment in primary care that management had been planning for 2020/21 and, notwithstanding that the plan/budget is yet to be considered by the Board, I am comfortable this would be above the cut-off of investments to be accepted.

ANNUAL PLAN UPDATE

At the time of writing, and subsequent to the report elsewhere in this agenda, the Ministry had just advised that its feedback on DHB draft plans will be delayed to consider the impact of COVID-19 on DHBs and their ability to deliver, and that a revised version of DHB plans won't be required until June (it would normally be April/May).

Management will factor this into the planning timeframe.

[1] The Ministry has also a draft community psycho-social plan out for feedback. We – this DHB – has already determined that the local response will be led by the DHB mental health & addictions team.

STANDING REPORTS FROM CLINICAL COUNCIL; AND CHIEF MEDICAL OFFICER AND CHIEF NURSING & MIDWIFERY OFFICER

The Clinical Council has not met due to the COVID19 response. It's not the same function, but there is a local clinical advisory group that provides advice to the COVID19 response.

The Chief Medical Officer and Chief Nursing & Midwifery Officer also advise that there is nothing to report re patient safety. That there is "little new" at this stage and the level of events and complaints is "low" which reflects general activity.

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HAWKE'S BAY District Health Board Whakawāteatia	**PLANNING & FUNDING MONTHLY REPORT**
	For the attention of: **HBDHB Board**
Document Owner:	Emma Foster, Executive Director of Planning & Funding (Acting)
Document Author:	Emma Foster, Executive Director of Planning & Funding (Acting)
Month:	April 2020
Consideration:	For Noting
RECOMMENDATION **That the HBDHB Board** 1. Note the contents of the report	

[1] Executive Summary

This month has seen much of the Planning and Funding business as usual work go on hold due to the COVID-19 response. There is some BAU that continues, such as project management for Interventional Cardiology, Linac service development and annual planning.

Core planning and commissioning business will be looking at initiatives and opportunities to ensure that changes made as a result the COVID-19 immediate response, which are positive for our community, our focus on equity and changing our funding models, become embedded as 'way we work' in the recovery and future phases.

[2] Development and Innovation

Analysis of Access to Planned Care by Ethnicity 20/3/2020
The Planning and Commissioning Manager in partnership with the Business Intelligence Unit completed an analysis of the Planned Care – Inpatient Surgical Interventions by ethnicity for HB domiciled patients. The table below provides a summary of the equity issues relating to the Planned Care interventions in Hawke's Bay and what actions we will be taking to address these. Please note the attached report that shows the statistics behind this summary.

Initially there will be the need to understand the drivers and then prioritise actions to address these. These actions will make up the broader Three Year Planned Care Plan (the Plan). The Board will receive a quarterly report from Planning & Funding to show progress towards achieving the equity focussed actions that have been identified in the Plan.

Equity Issue	Actions
ESPI 2 Access to Elective Outpatient First Specialist Appointments(FSA) Age standardised rates (ASR) analysis of referrals received by ethnicity for the last 3 years indicate there is	Identify medical specialties with highest level of inequitable referral rates For each specialty work with clinicians and community:-

no significant difference in Surgical FSA Specialist referral rates between ethnic groups. However for Medical Specialities FSA referral rates are significantly lower for Maori and Pacific compared to the Other (Non Maori Non Pacific) ethnicity group.	• to understand the impactors • prioritise specialties for localisation via HealthPathways ensuring that the process has a strong focus on improving equity
Waiting times for FSA There is no difference in the % of patients waiting outside the 4 month guidelines for a First Specialist assessment by ethnicity.	No action
Decline rates The % FSA referrals declined is not significantly different by ethnicity	No action
ESPI 5 Waiting times for Planned care treatment (i.e Surgery) 30.6 % of Maori given certainty for surgery are waiting longer than the guidelines of 4 months in the last 12 months. This rate is significantly higher compared to 26.4 % for Pacific peoples and 25.1 % in Non Maori non Pacific.	• Identify surgical specialties with highest inequity • Understand the impactors via use of clinical audit as appropriate • As informed through above actions develop an action plan to address
Access to surgery /treatment HB Māori ASR rates of planned inpatient surgical interventions have been higher compared to Other (Non Maori Non Pacific) rates since 2015/16 (but not statistically higher). Pacific rates of access to surgery are similar to Non Maori Non Pacific.	No action
Decline rates Maori and Pacific who are put forward for surgery have lower decline rates to be given certainty for Surgery/treatment compared to the Other ethnic group (non Māori Non Pacific).	No action
Ethnicity Data Capture Hawke's Bay DHB performs well in the MOH KPI's for Data quality of ethnicity capture. The existing quality framework for ethnicity data capture at HB DHB follows closely the HISO -10001- Ethnicity Data Protocol 2017.This gives us assurance of its accuracy.	The archived HB DHB Ethnicity data capture Guidelines Policy to be reviewed and reactivated

Matthew Parsons update

HBDHB P&F is working with Matthew Parsons, Professor, Gerontology to guide us in our modelling which will lead into future design relating to Health of Older People in HB.

Funding allocation

Work is underway to provide the Board with high level information relating to funding allocation. This initially will be between rural vs urban and Māori v's non Māori. This will be based on reasonably high level assumptions, and in some case existing utilisation.

[3] Exceptions

Primary Care

Free After Hours Primary Care (Under 14s) – This service is currently contracted by Health Hawke's Bay in Hastings, Central Hawke's Bay and Wairoa, but directly between the DHB and a single provider in Napier. This has resulted in differential levels of choice for these populations and, as a result, some whānau paying to have their child seen after hours. Prior to Christmas 2019 it was agreed that HBDHB's intent was to contract, via the PHO, to a single model across all areas of Hawke's Bay. Due to the immediate COVID-19 response we have not agreed the proposed service model we will be focusing on. This is a priority in the next few weeks.

Central Hawke's Bay Maternal & Child Hub – the formal opening of the fully operational hub was scheduled for 20 March, however due to COVID-19 the decision was made to cancel the official opening. Services available out of the hub will include Plunket, Pregnancy Help, Midwifery services including ante natal classes and Parent Centre. To have this community-led and DHB-supported project come to fruition is a testament to the commitment of all those involved. This has been postponed until Post COVID-19.

Immunisation - There has been a move nationally to ensure local immunisation coordinators have oversight of what numbers are being ordered and by whom in their region. This move is in response to a maldistribution of flu vaccine nationally, and will ensure that our providers delivering to these populations are prioritised in the vaccine distribution process.

Mental Health and Addictions

Accommodation for long stay in patients – continues to be a focus. Providers of residential MH services are working collaboratively to support integrated approaches to facilitate relocation of these patients.

NGO provider network established to provide coordinated support and information sharing, this has been particularly relevant and supportive through the COVID-19 response. The CDEM structure stood up a welfare function, of which a psycho-social advisory group is being formed to develop strategies to support consumers and staff in managing the impact of the pandemic.

Referred Services

Laboratory services are flexing with COVID

- DHB laboratory is managing COVID swab processing in coordination with Public Health
- SCL is working in partnership with the DHB and providers around increased demand for home blood sample collections for those in isolation
- Southern Community Laboratory contact expires 30 June 2020; work is underway regarding a short term rollover during COVID and then a contract variation

Community Pharmacies are managing well considering excessive demand for services before Level 4 implemented

- Pharmacies are reducing opening hours in the new environment; while the DHB is supporting these pharmacy 'clusters' as per the Pharmacy Pandemic plan. Pharmacies have been asked to coordinate hours together to maintain access to services
- NOTE: Hawke's Bay DHB does not have a contract with any community pharmacy requiring them to remain open evenings or weekends or STATS. The need for this type of contracting will be under ongoing review during this time.

Planned Care and Long Term Conditions

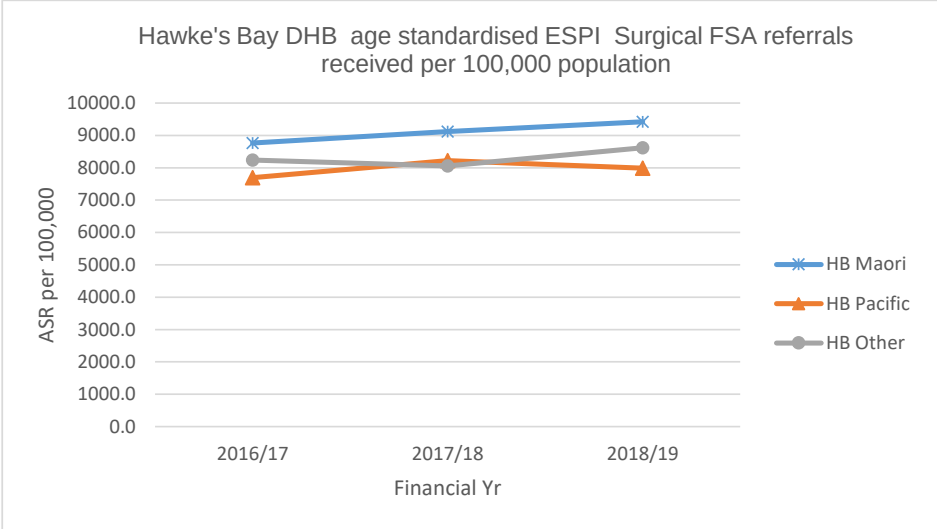
In the past 18 months, a Chronic Conditions Flag has been established with the support of Clinical Nurse Specialists, Business Intelligence Team, Health HB and the Planning and Funding Team. The group were in the final stages of developing meaningful tableau reports to inform integrated practice. The work completed to date is now being utilised to identify vulnerable populations with chronic conditions during this COVID-19 pandemic. This is allowing the health sector to be proactive with an at risk population.

Surgical specialties

Age standardised FSA referrals received rates per 100,000 population by ethnicity

All surgical specialties-

		ASR per 100,00	LCL	UCL	Volume
HB total	2016/17	8338.2	8200.5	8477.4	16943
	2017/18	8379.3	8241.9	8518.2	17197
	2018/19	8753.7	8614.5	8894.4	18466
HB Maori	2016/17	8767.0	8482.5	9058.4	3737
	2017/18	9115.6	8830.9	9406.9	4022
	2018/19	9421.8	9134.2	9716.1	4198
HB Pacific	2016/17	7695.4	6979.8	8462.4	459
	2017/18	8219.8	7494.8	8993.9	513
	2018/19	7987.8	7286.9	8736.6	506
HB Other	2016/17	8235.5	8063.5	8409.7	12645
	2017/18	8059.5	7890.2	8231.2	12558
	2018/19	8621.4	8446.9	8798.0	13727



HB DHB recieves statistically significantly higher ESPI surgical referrals for Maori compared to HB Other ethnic groups

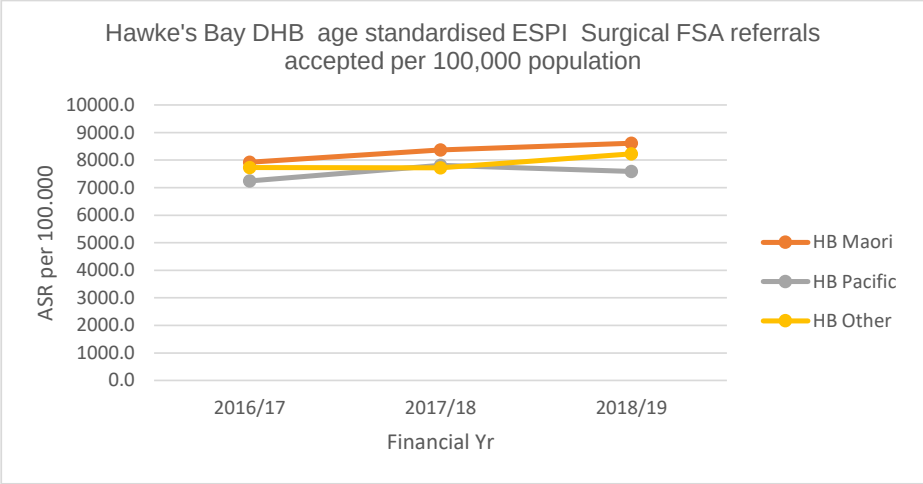
There is no statistical difference between referrals received for HB Pacific and HB Other

Surgical specialties

Age standardised FSA referrals accepted rates per 100,000 population by ethnicity

All surgical specialties-

		ASR per 100,00	LCL	UCL	Volume
HB total	2016/17	7811.9	7678.8	7946.5	15909
	2017/18	7996.2	7862.0	8131.9	16409
	2018/19	8332.1	8196.3	8469.4	17579
HB Maori	2016/17	8196.1	7921.3	8477.8	3498
	2017/18	8645.4	8368.1	8929.3	3814
	2018/19	8890.3	8611.0	9176.3	3963
HB Pacific	2016/17	7240.9	6545.5	7987.7	431
	2017/18	7814.5	7107.3	8570.8	488
	2018/19	7588.5	6906.7	8317.9	482
HB Other	2016/17	7727.8	7561.4	7896.5	11891
	2017/18	7722.9	7557.0	7891.1	12005
	2018/19	8227.5	8057.1	8400.2	13100



HB Maori rates of FSA referrals accepted for Surgical specialties are higher compared to HB Other ethnic group . This difference was statistically significantly in 2016/17 and 2017/18 but not in 2018/19

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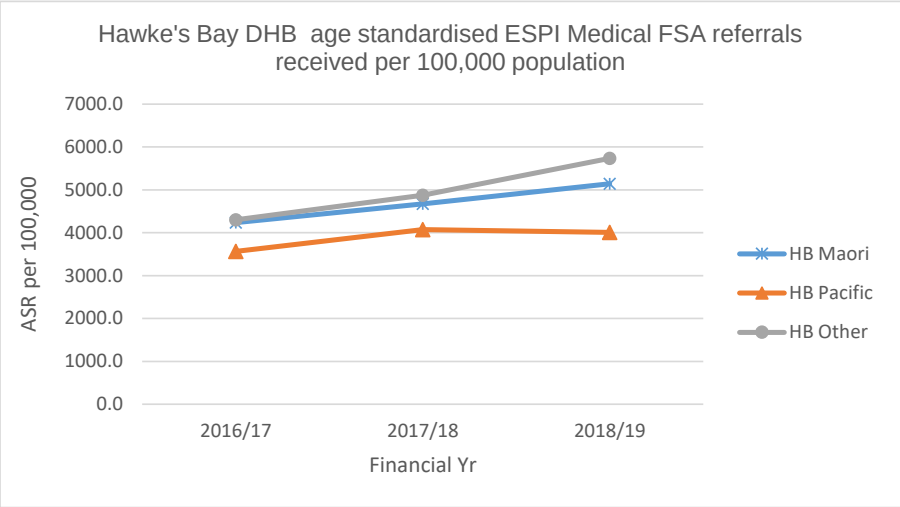
Medical specialties

Age standardised FSA referrals received rates per 100,000 population by ethnicity

All Medical specialties-

		ASR per 100,00	LCL	UCL	Volume
HB total	2016/17	4144.8	4047.1	4244.1	8128
	2017/18	4660.2	4556.6	4765.4	9192
	2018/19	5416.1	5307.0	5526.7	11525
HB Maori	2016/17	4239.0	4044.1	4440.8	1846
	2017/18	4672.1	4471.8	4879.0	2128
	2018/19	5145.4	4937.0	5360.2	2376
HB Pacific	2016/17	3564.9	3091.5	4088.7	215
	2017/18	4076.7	3545.9	4660.7	242
	2018/19	4005.5	3509.3	4550.2	253
HB Other	2016/17	4303.3	4175.2	4433.8	6028
	2017/18	4872.7	4734.8	5013.0	6776
	2018/19	5735.0	5589.4	5882.9	8872



Hawke's Bay Other ethnic group have the highest FSA referral received rates for ESPI Medical specialties

HB Other ethnic group has statistically significant higher rates compared to HB Maori in 2018/19

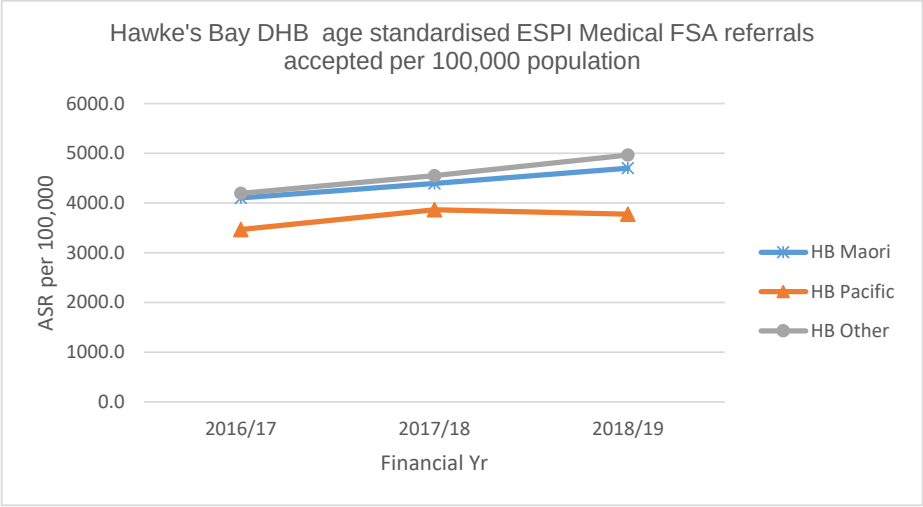
HB Pacific have the lowest referral received rates and these are statistically significantly lower than HB Other rates across the 3 years

Medical specialties

Age standardised FSA referrals accepted rates per 100,000 population by ethnicity

All Medical specialties-

		ASR per 100,00	LCL	UCL	Volume
HB total	2016/17	4034.4	3937.9	4132.5	7896
	2017/18	4360.0	4260.0	4461.5	8659
	2018/19	4716.7	4614.2	4820.8	9786
HB Maori	2016/17	4102.6	3910.8	4301.3	1786
	2017/18	4393.6	4199.0	4594.9	1990
	2018/19	4700.3	4500.5	4906.5	2154
HB Pacific	2016/17	3466.7	3000.0	3983.9	209
	2017/18	3864.5	3347.2	4435.3	228
	2018/19	3774.7	3290.8	4307.7	236
HB Other	2016/17	4194.1	4067.5	4323.2	5864
	2017/18	4548.8	4416.3	4683.8	6393
	2018/19	4964.5	4827.8	5103.6	7373



HB Pacific age standardised referrals accepted statistically significant lower compared to HB Other ethnic group in 2016/17 and 2018/19.
HB Pacific age standardised referrals accepted are statistically significant lower compared to HB Maori in 2018/19
HB Maori rates are slightly lower compared to HB other but are not statistically significantly lower

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

RECOMMENDATION:

That the HBDHB Board:

1. Note the content of the April 2020 report

Executive Summary

- Provider Services has transitioned from normal operating into its role within the Coordinated Incident Management System (CIMS). This includes a number of senior staff designated lead roles in CIMS - enabling swift progress on key elements of the pandemic plan, but creating an impact on the delivery of some 'business as usual' activities.
- Senior clinicians and management leads have worked across departments to rapidly design a 'COVID Hospital' within the existing estate. The plan was brought together and implemented within 3 weeks.
- The Government's move to COVID Alert Level 4 has entailed significant impacts on activity within Hawke's Bay Hospital. For the whole of March, hospital bed occupancy is down ~13% on the same period last year, while elective operations are down ~20%. The whole month figures mask the extent of the reductions, which accelerated in the last two weeks of the month.
- Limits placed on our capacity will have a particular impact on elective services and performance against our key indicators – ESPI2, ESPI5 and the Elective Discharges (Planned Care) target. A detailed Recovery Plan is being developed that will seek to deliver maximum mitigation against these impacts, including use of private sector options.

Clinical Preparedness & Facilities Configuration (COVID Hospital)

Clinicians have worked intensively with management leads to agree and configure a 'COVID Hospital' and patient flow within the existing hospital estate. The approach includes:

- A designated 'COVID Intensive Care Unit' on the ground floor of Ruakopito, with a maximum additional capacity of 19 care spaces

- A 'Respiratory Admissions Unit' based in the Paediatric ward, allowing the management of up to 25 undifferentiated ('warm') patients in separate rooms
- A 'hot' ward, capable of housing confirmed COVID patients – the current planned location is within Day Surgery

The co-located nature of these facilities would support reduced risk of cross-infection, efficient use of staffing, and provide a good deal of public reassurance about patient management within the hospital in the event of a significant outbreak. Staff engagement across DHB clinical and support functions enabled multiple areas to be safely moved over the course of a single weekend, with both the COVID ICU and the Respiratory Admissions Unit now operational.

Alongside changes to estate configuration, significant work has taken place to prepare staff for receipt of patients with COVID -19 symptoms. In March, training was delivered to over 300 staff in the correct use of Personal Protective Equipment (PPE). Meanwhile, theatre teams have worked through simulated scenarios for handling COVID positive patients. Modified Intensive Care training courses were delivered to 101 doctors and 55 nurses in the last fortnight of March.

Work is now being concluded to effect facilities and transfer arrangements for the screening, triage and streaming of patients from the front door of the Emergency Department into the COVID Hospital. This will become increasingly important, from an infection prevention and control standpoint, as the number of daily presentations to ED increases – which, over the winter months, will include a significant component of undifferentiated respiratory illness.

Hospital Activity

Inpatient Activity

Activity across Hawke's Bay Hospital has dropped significantly over the course of March, as the full extent of COVID management arrangements came into force.

The Emergency Department has seen daily presentations drop from a weekday average of ~130 in the preceding 3 months to ~105. Prior to implementation of COVID Alert Level 4 on 26th March, average daily presentations were already down, at ~117 per day.

For the period from 26th – 31st March, however, this fell significantly to a daily average of ~60. The proportion of those presentations in triage categories 1-3 has increased slightly on the year-to-date level since the Level 4 measures were brought into play.

With no significant change to the conversion rate (percentage of ED presentations admitted) and discharges continuing at a steady rate, the overall inpatient occupancy has steadily declined, and now stands at <50% of the maximum resourced beds.

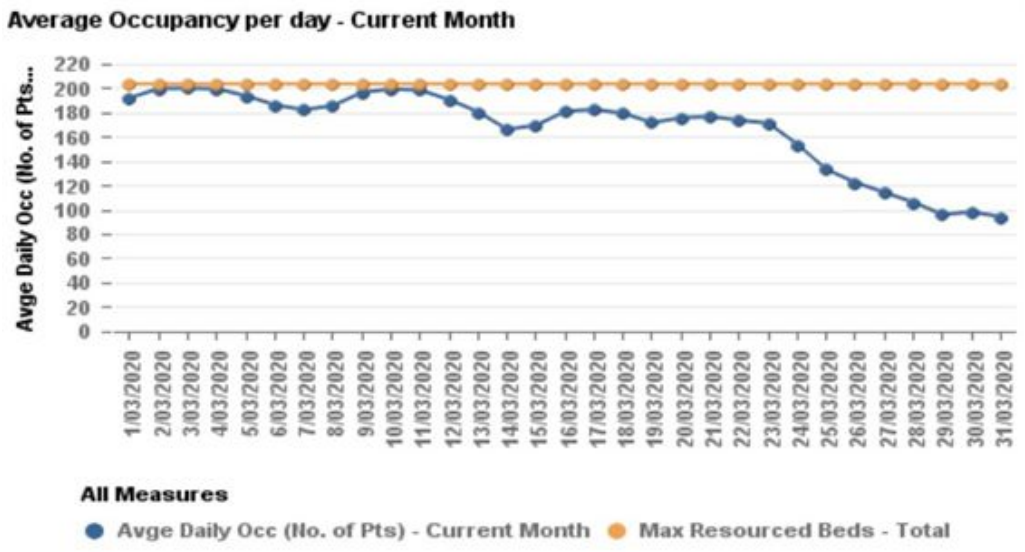


Figure 1: Average Inpatient Bed Occupancy per Day (March 2020)

Elective Activity

The area of delivery that has been most significantly impacted by the COVID situation is our elective work. The current operating position, which will have a material impact on both ESPI5 and performance against the surgical discharges (Planned Care) target, is the result of four principal factors:

1. The Government's move to COVID Alert Level 4 has required the DHB to align many of its activities with 'Orange Alert' level in the COVID-19 National Hospital Response Framework. This includes prioritisation of urgent, non-deferrable electives, and the postponement of outpatient activity
2. Clear specialty-specific guidance has been issued to clinicians from colleges and professional bodies about what work should be undertaken, and what should be postponed, so long as community transmission of COVID-19 remains a risk
3. The reconfiguration of the clinical estate has significantly compromised the physical capacity to undertake elective work – with Endoscopy and Day Surgery particularly affected
4. The work to train and redeploy elements of the workforce to operate within the COVID Hospital has affected some key groups, both in training time and potentially in ongoing availability. Anaesthetics, for example, will be providing three consultant anaesthetists and six anaesthetic registrars into the pool of staff running the COVID ICU.

It should be noted that, while the DHB is largely operating in line with 'Orange Alert' in the National Hospital Response Framework, our underlying position would actually align to 'Yellow Alert' were it not for the COVID Alert Level 4 restrictions. Movement to 'Yellow Alert' would provide greater ability to process certain streams of elective work, and in anticipation of this a significant programme of activity is underway to develop the Recovery plan (see below).

As capacity to see and treat has declined, so too has demand (new referrals). This is at least partly related to significant reductions in the volume of contacts in primary healthcare. Across March, all specialties except Gynaecology and Paediatric Medicine have seen a decline in referrals. The decline has been most significant in 'Dental' and 'Ear, Nose & Throat' (ENT).

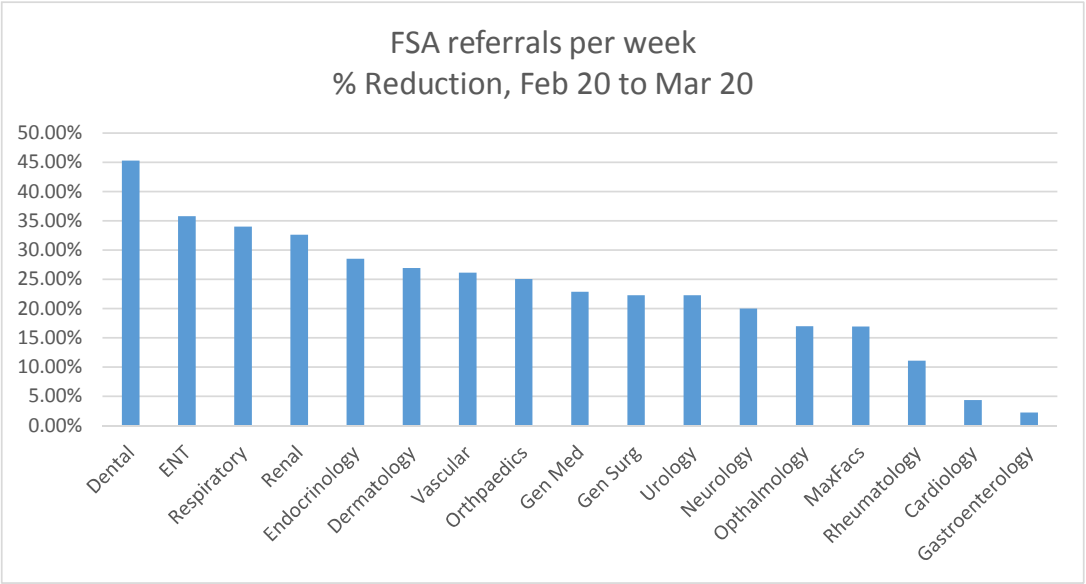


Figure 2: Percentage reduction in average FSA referrals per week, (February to March 2020)

Recovery Plan

Within the CIMS structure, a dedicated Recovery function is assigned to plan for how the communities and services impacted by the incident will return to normal function. Andy Phillips, Chief Allied Health Professions Officer, is the designated Recovery Manager.

As part of recovery, a wellness hub and psychosocial support plan have been developed and implemented for staff. Advice has been provided to support people unable to be with their whānau at the end of their lives.

Given the nature of the COVID-19 incident, the Recovery plan is suitably detailed to manage the smooth transition of service capacity at varying levels of escalation and over a potentially prolonged period of time. The current expectation is that Provider Services will return to 'Yellow Alert' in the National Hospital Response Framework at the end of the national lockdown period.

Planning is urgently underway to use all appropriate capacity as soon as it is available to see outpatients and perform elective operations for patients in clinical priority order. Options to utilise private facilities for both outpatient clinics and operating capacity are being investigated.

The Recovery plan will have significant equity implications and will be thoroughly assessed for equity impact in partnership with the Health Improvement & Equity directorate.

Panui

Referral Management & Booking Review

This has been identified as a priority area by management and the Board, on account of both waiting list management (referral thresholds and data quality) and community 'whānau voice' considerations. There is a strong equity dimension to this work. Activity to scope the review has stalled during March, largely on account of the movement into CIMS. This will be picked up alongside the process of developing the Recovery plan.

Waiting List Data Cleansing

Work has progressed well in partnership with Digital Enablement in March. At the end of the month, 17 of 19 departments have 'clean' lists with over 85% of referrals now having a defined next step.

'Virtual Visiting'

Movement to COVID Alert Level 4 has introduced significant restrictions to the hospital visiting policy. Digital Enablement have worked with our ward teams to enable 'virtual visiting' options for whānau who are unable to physically visit their loved ones in hospital.

Staff Welfare – Rest & Recuperation

Throughout the month, Operations Directorate have worked with their teams in Chaplaincy and ZACS Café to enable ongoing provision of facilities for staff to rest and recuperate away from the clinical frontline. We have worked closely with those teams and with staff using the facilities to ensure the arrangements comply with physical distancing and infection prevention guidance.

Statement of Performance Expectations (SPE)

ED6

Overall performance against the 6 hour standard for patients to be seen, admitted or treated and discharged from the Emergency Department improved from 77.8% in February to 81.8% in March. Again, performance changed as the COVID effects were felt by the Hospital, as Figure 3 (below) demonstrates.

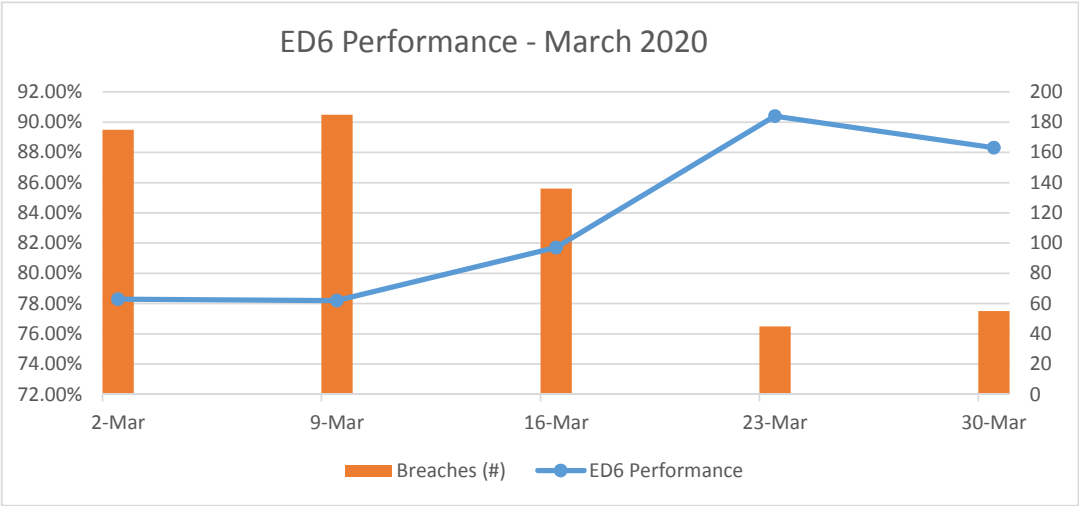


Figure 3: Weekly ED6 Target Performance during March 2020

It is important to recognise that the hospital is not operating under normal conditions at present – delays experienced in the Emergency Department due to the need to identify possible COVID cases have added to the time taken to process some patients. Analysis will be taking continuing, however, to understand the performance in terms of the internal professional standards (first review, referral, specialist review) and identifying further opportunities to reduce waits.

ESPI2 – Outpatient Referrals Waiting Longer than 4 Months

March performance has seen a small growth in the number of patients waiting over target, although the true impact resulting from the current operating environment will only be truly apparent in the April figures. Mitigation plans enacted by specialties have included movement to telephone and virtual clinic models. Furthermore, the scale of the impact will be offset by reduced referral volumes – although it could reasonably be expected that there will be a delay effect, with increased demand flowing through when COVID restrictions are lifted.

Detailed work is being undertaken as part of the Recovery plan, on which a fuller briefing will be provided to Board in the coming weeks.

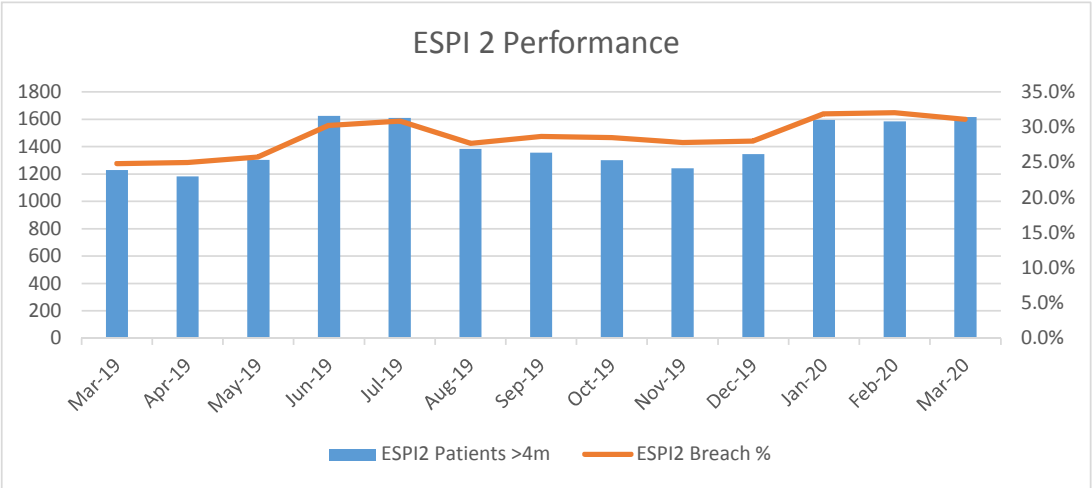


Figure 4: ESPI 2 Performance, March 2019- March 2020

ESPI5 – Waits for Surgery Longer than 4 Months and Planned Care (Surgical Discharges)

COVID restrictions will have a significant impact on elective surgery, with currently only urgent, non-deferrable cases being undertaken. In the last week of the month, elective activity through our own theatre complex was running at ~20% of normal levels (30 cases vs ~125). The majority of this work was cancer surgery. The impact did not translate into ESPI5 performance, with waits >4 months remaining static despite a decrease of 35 discharges on February numbers.

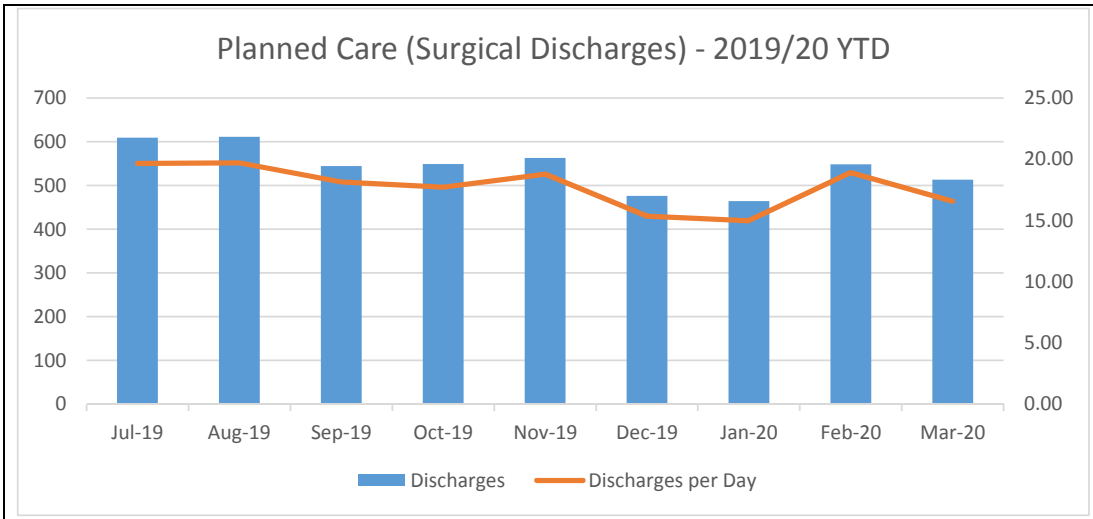


Figure 5: Planned Care Performance, 2019/20 Year to Date

The year to date delivery of 4,847 discharges places the DHB at 86.8% of target performance. The forecast prior to COVID measures taking effect was for a full-year delivery of ~95%. Detailed modelling is taking place as part of the Recovery plan, but were activity to continue at National Hospital Response Framework 'Orange Alert' levels until year end, it is estimated that delivery could be as low as 70% on both discharges, and similar for case-weights.

Quality Measures

Due to constraints on support staff resulting from CIMS, March updates are not yet available for this report on the following important quality markers:

- Patient seclusion in Mental Health & Addiction services
- Readmission rates
- Faster Cancer Treatment

An update, covering the period up until 30th April, will be provided in the May report.

Financial Performance

Financial performance for March 2020 was $970k adverse, bringing Provider Services to a $5.4m adverse year-to-date position. A more detailed analysis of the position will be addressed in the report of the Executive Director Financial Services.

HAWKE'S BAY
District Health Board
Whakawāteatia

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

11

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**HealthPathways** For the attention of: **HBDHB Board (April)**
Document Owner	Emma Foster, Executive Director Planning and Funding (acting)
Month/Year	April 2020
Reviewed By	Robyn Richardson, Planning & Commissioning Manager Karyn Bousfield, Nurse Director Primary Care
Purpose	To agree the investment proposal to replace Map of Medicine with Streamliners "HealthPathways"
Previous Consideration/Discussions	Nil

RECOMMENDATION:

That the HBDHB Board:

a) Endorse the replacement of Map of Medicine with replacement and implementation of HealthPathways.

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EXECUTIVE SUMMARY / INTRODUCTION

With the recent situation regarding COVID-19, Streamliners offered Hawke's Bay the opportunity of accessing the full suite of HealthPathways in order to stay in line with the rest of New Zealand, around COVID-19 information and to be able to localise our own COVID-19 pathways/pages. Hawke's Bay clinicians have been very receptive to this, with 1216 site visits and 585 COVID-19 pathway views over the first three days after access was supplied by Health Hawke's Bay to their networks.

The purpose of this paper is to assist Hawke's Bay District Health Board (HBDHB) to make a decision on whether to go ahead now with replacement of Map of Medicine with HealthPathways and seek commitment from HBDHB for a sustained investment in, not only the HealthPathways product but also the resourcing and recognition of the clinical and administrative team required to support its implementation and embedding into practice.

Hawke's Bay Health sector has now dropped behind the rest of the country in that we do not have an easily assessable, well communicated, clinically governed, up-to-date and monitored Clinical Pathway programme. This impacts on efforts to reduce demand on secondary services, the ability to streamline and standardise care across the district, and also to support expanded workforce roles within primary care such as nurses working with Standing Orders, and having the required decision support pathways for community nurse prescribing.

Cost savings are not directly recouped initially. The savings would be long term, coming as a result of reduced overall demand for specialists which allows for redirection of funds elsewhere.

STRATEGIC ALIGNMENT AND EQUITY

Implementing HealthPathways has strong alignments to our strategic goals; digitally enabled system; high performing and sustainable system; highly skilled and capable workforce as well as providing opportunities to support equity and person and whānau centred care by adapting the standard pathways and localising them to meet the needs of our community.

We will ensure that pathways for disease states with known inequities are localised early in the implementation processes. Localisation provides the opportunity to focus on inequities and guide clinician decision making. It also provides the opportunity to ensure clinicians are aware of all of the options available to patients including services from Māori providers and not for profit organisations.

Analysis coming through as part of our 3 Year Plan for Planned Care is showing inequity in referrals for Specialist Medical Assessments. This information will help guide us in our plan for localisation of pathways.

BACKGROUND

What is a Clinical Pathways programme?

Clinical pathways are a set of decision trees that work through how to manage various diseases. A programme is essentially a governed and monitored system of clinical pathways based on best practice, developed and agreed to by clinicians across the sector.

What is HealthPathways?

An IT platform with a huge suite of built in resources, providing easy access to a Clinical Pathways Programme. HealthPathways encompasses Community HealthPathways and Hospital HealthPathways, however this paper is only in regard to the initial product Community Pathways.

The decision that a Clinical Pathways programme was required for Hawke's Bay was made some years ago hence this paper does not include rationale for implementation of a Clinical Pathways Programme per se, as this has already been well discussed and agreed. Local clinician's across the health system are expressing a strong desire to have a pathway tool established across the system, both in primary care and hospital services. The benefit and the requirement for clinicians to access HealthPathways has been proven in the first full week of COVID-19 response, where clinicians 48% of the access was to COVID-19 pages with the remaining 52% to the wider, non-localised pathways.

Clinical pathways are a key element in the delivery of agreed standards of care, maximising quality and safety, ensuring clinical effectiveness and managing cost of care delivery, as well as enhancing the patient experience of care. International evidence[1] supports clinical pathways as being integral to delivering high standards of care consistent with the most up to date clinical guidelines. [2]

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[2] Rotter T, Kugler J, Koch R, Gothe H, Twork S, van Oostrum JM, Steyerberg EW.A systematic review and meta-analysis of the effects of clinical pathways on length of stay, hospital costs and patient outcomes. *BMC Health Services Research 2008 Dec 19;8:265.* http://www.ncbi.nlm.nih.gov/pubmed/19094244

Luhrs CA, Meghani S, Homel P, Drayton M, O'Toole E, Paccione M, Daratsos L, Wollner D, Bookbinder M. Pilot of a pathway to improve the care of imminently dying oncology inpatients in a Veterans Affairs Medical

In 2013 a decision was made to invest in the implementation of a clinical pathways programme. This was led and funded by HHB which then transitioned to HBDHB. At the time, multiple vendors for a web based, password protected product to support this, were considered. Map of Medicine became the preferred vendor and HealthPathways the second option. Hawke's Bay joined a central region collaboration in the pathways program development with Mid Central and Whanganui DHBs. This involved sharing of licensing fees and some resources and support roles.

In 2018 Map of Medicine ceased operating and the opportunity to invest in an alternative provider was explored. A financial decision was made to pause investment as an in-year cost saving (200k) and to revisit investment in pathways either independently or as part of a regional initiative at a later date. During that pause, Mid Central and Whanganui made the decision to pursue HealthPathways but Hawke's Bay chose not to go ahead.

In June 2019 clinical council members suggested that the DHB explore the option of returning to Clinical Pathways in collaboration with Health Hawke's Bay. This resulted in the decision to draft this investment proposal to outline the investment required to support program implementation.

HEALTHPATHWAYS

There is now a plethora of literature around the benefits of using HealthPathways. All New Zealand health jurisdictions except Hawke's Bay have now chosen to go with "HealthPathways" run by Christchurch based firm Streamliners. A large number of Australian health areas have also chosen to follow suit. This system was first used in Canterbury in 2008 and is now very well tested and evaluated. Canterbury has now furthered this with implementing internal hospital pathways via Hospital HealthPathways and a number of pathways have now been developed within that space.

The HealthPathways work programme can perform two functions within the health system a) as a manual to reduce variation and free up hospital specialist capacity and b) as a vehicle for system change to build relationships between clinicians across primary and secondary care and to focus re-design activity and put evidence informed change into practice.

OPTIONS

Continue with the Status quo

- No up to date agreed, monitored and communicated clinical pathways for clinicians to use
- Inconsistent patient assessment and management in primary care. Workforce relying on clinical pathways from a number of sources and/or using localised (MoM)pathways which are not updated
- Continued waste and variation e.g. inappropriate referrals, general practice not supported to work at top of scope
- Continued organisational risk in terms of patient harm associated with inability to free up hospital specialists

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Center. *J Pain Symptom Manage. 2005. Jun;29(6):544-51.* http://www.ncbi.nlm.nih.gov/pubmed/15963862

Rotter T, Kinsman L, James E, Machotta A, Gothe H, Willis J, Snow P, Kugler J.

Implement HealthPathways

- Immediate access to a whole suite of evidence based, tested and proven resources (including standing orders)
- Community Nurse prescribing and associated decision-making would be supported best practice
- The required team can be resourced substantially from current internal FTE
- Ability to create localised pathways that guide clinical best practice for reducing the equity gap in our district.

FINANCIAL INVESTMENT

	Status quo	Implementation of Community HealthPathways
COST	Nil	Total (including Streamliners license/maintenance and FTE) First year (incl set up) $400,167 Annual cost thereafter $357,983

FTE costs for HealthPathways in the above table are 50% of the full cost of the recommended team with the assumption that 50% will be absorbed from within current budget/FTE across DHB and PHO.

Financial modelling does not quantify cost savings as these are not directly recouped. The savings would come as a result of reduced overall demand for specialists which allows for redirection of funds elsewhere.

Of note, the Australian Centre of Health Services Innovation (AusHNI), in an economic analysis of the impact of Community HealthPathways in Mackay, Queensland (Pop:125,000), estimated a saving of A$3,600,000 annually. They also stated that 6 gold-standard pathways would pay off initial investment within a year in system wide savings.

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Plan Update**
	For the attention of: **HBDHB Board, Finance Risk and Audit Committee, Maori Relationship Board, Pasifika Health Leadership Group, Hawke's Bay Clinical Council, Hawke's Bay Health Consumer Council**
Document Owner	Emma Foster, Executive Director of Planning & Funding (Acting)
Month/Year	April 2020
Purpose	For Noting
Previous Consideration/Discussions	• Board planning session 27th January 2020 • Health Forum 4th March Leadership 2020
RECOMMENDATION: **That the HBDHB Board:** 1. Note the contents of the report	

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EXECUTIVE SUMMARY

The purpose of this paper is to outline how the annual plan development links into previous Board discussions and agreements (attachment 1). It will also outline the population health evidence as to why the priority areas have been recommended. In addition, we have outlined the timeframes required to complete the 20/21 Annual Plan.

BACKGROUND

Hawke's Bay District Health Board is required to produce an Annual Plan under section 38 of the NZPHD Act. This section sets out the DHBs' planned performance for the financial year providing accountability directly to the Minister of Health.

A **Statement of Intent (SOI)** is prepared under section 139 of the Crown Entities (CE) Act 2004 as amended by the Crown Entities Amendment Act 2013 with a four year outlook. This is tabled in Parliament at least once every three years. This was done in the 19/20 planning year so is not required this year.

A **Statement of Performance Expectations (SPE)** is prepared annually under section 149C of the CE Act as amended by the CE Amendment Act 2013. This includes forecast financial statements and is tabled in Parliament annually.

The Planning Guidelines issued by the MoH for the DHB Annual Plan encourages the development of a single (but modular) document incorporating the SOI and SPE and our processes are designed to operate in this way. It is also worth noting that from 2020/21 the public health unit (PHU) plans are integrated in the DHB Annual Plans.

The Minister's Letter of Expectations:

- The annual Minister's Letter of Expectations is used to communicate the Government's key priorities to DHBs.
- The Minister's expectations for DHB operations for the forthcoming financial year generally requests that DHBs work to ensure the sector is stable, strategic, and performing strongly.
- The Letter of Expectations complements, and is read alongside the annual planning guidance prepared for DHBs, and must be addressed in the DHB accountability documents; **specifically, the Government's key priorities must feature prominently in the DHB annual plan core content.**
- The priorities reflected in the letter form the basis of the Ministry review of the DHB annual planning documents to ensure that Government's priorities are being incorporated into DHB planning.

PRIORITIES

No.	Priority	Evidence for the focus
1	**Localities -Wairoa**	• Poorest health outcomes of all the HB localities • Geographical distance and isolation create barriers for Wairoa people to access health services • High Māori population (65 %) • High premature mortality rates particularly Heart Disease and Cancer • High Smoking rates 28% versus 16% HB • Poor oral health outcomes • Higher prevalence of long term conditions diabetes, renal failure, chronic heart disease
2	**Mental Health and Addiction** Rationale: Good mental health and wellbeing is vital for children to thrive. It is increasingly recognised that social and emotional development in childhood has lifelong consequences and has a direct influence on future educational and employment opportunities Mental illness is common both within Hawke's Bay and in New Zealand as a whole. Those with mental illness are also at increased risk of physical health conditions, have lower rates of employment, and are more likely to have unmet health need	• Hawke's Bay has one of the highest prevalence rates of Methamphetamine use in New Zealand • Hawke's Bay has significantly higher Hazardous drinking prevalence rates compare to national rates • Suicide rates in HB have increased more recently • The prevalence of psychological distress among adults in Hawke's Bay is amongst the highest of any DHB in the country and there is no signs of improvement • Mood and/or anxiety disorders are common within Hawke's Bay, and show no signs decreasing - people living in our most deprived communities have higher rates than those living in least deprived areas • Māori continue to be admitted to inpatient mental health facilities at over double the rate of non-Māori

3	**Cancer Care Pathways (including LINAC)**	• Hawke's Bay has higher premature mortality rates for cancer compare to national rates • Large inequities exist in cancer outcome i.e. (Māori, Pacific peoples, people who live in rural and deprived areas, people with a mental illness and disabled people) • Māori are 20 percent more likely to get cancer and nearly twice as likely to die from cancer as non-Māori • Lung cancer has a high burden on Māori • Inequities exist in early detection and screening for cancer with detection of cancer later in Māori • Once diagnosed, Māori have worse survival rates for almost all cancers
4	**Cardiology (including Cardiology Project)**	• Hawke's Bay has higher premature cardiovascular mortality rates compared to national rates • There are significant gains to be made for Māori Life expectancy by eliminating early deaths from Ischemic Heart disease • Māori and Pacific have higher rates of avoidable hospitalisations (ASH) rates for Myocardial Infarction, Heart failure, Chest pain and Angina • Inequities exist in early detection ad screening
5	**Radiology** HBDHB's Radiology department is at risk of losing its status as an accredited radiology provider from IANZ. IANZ first noted concerns in 2012 and issued strong recommendations to do with staffing levels, patient privacy and safety and the need to replacement equipment in a planned way (specifically MRI, Fluoroscopy, Angiography units) . These progressed to corrective actions (CARs) in 2017 and noted again in the 2018 surveillance visit.	• The urgent replacement of critical equipment (work horses of the department) which have reached end of life, to maintain service provision and commitment to quality care, and meet increasing demand • Retaining International Accreditation New Zealand (IANZ) accreditation - loss of key contracts e.g. ACC, inability to recruit and retain staff if lost • Seismic strengthening work to bring the facility up to code as an 'Importance Level 4 building' (i.e. essential to post-disaster recovery or associated with hazardous facilities)
7	**Bed Availability** Rationale: optimise end to end patient journey to maximise the availability of beds when required	• Medical patients spend longer in hospital if they have a stay in a surgical ward • High numbers of "on the day cancellations" of elective surgery • Medical and Surgical teams less efficient due to placement of patients (i.e. Medical teams walk around Surgical wards to see patients) • Patients have higher readmission rates • Patients queuing in ED waiting for bed (ED6 target impacted)

	Bed Availability (cont…)	• Additional capacity purchased not planned and switched on and off • Variance to budget unpredictable (increase in casual staff hours) • Unplanned and reactive approach is costly with unclear process • Staff welfare and morale impacted
8	**Planned Care (including Surgical Expansion)**	• Access to planned care (incl elective surgery) has an important impact on quality of life, reducing morbidity and disability in the population and supporting independence in older age e.g. Ophthalmology and Orthopaedics • Currently Māori and Pacific have significantly higher acute hospitalisation rates compared to Non Māori Non Pacific including Ambulatory sensitive hospitalisations which reflect a less than optimal access pathway for Māori and Pacific to Planned Care
9	**First 1,000 days** Rationale: The first 1000 days of life has the largest impact on building health capacity over the life course Many challenges in adult hood have their roots in the early years of life, including major public health problems such as obesity, heart disease and mental health problems	• Increasing number of Hawke's Bay babies born to Māori Pacific and mother living in higher deprivation areas • Māori Mothers are younger and more vulnerable • 40 % of Hawke's Bay tamariki Māori 0-4 years live in a household receiving a main benefit • Māori mothers have higher smoking rates • ASH rates in 0-4 year are higher for Māori and Pacific for Respiratory conditions • In equities exist in oral health status of 5 years • Breastfeeding rates in Hawke's Bay at 6 weeks, 3 months and 6 months are persistently below the national average rate • Persistent high levels of obesity in HB children and persistent equity gap for Māori and Pacific • High rates of family violence and over half of the victims of serious assault causing injury are a current partner or past partner of the offender
10	**Localities - Napier**	• Health outcomes for people living in high deprivation areas of Napier Maraenui, Marewa, Onekawa and Tamatea are some of the poorest in Hawke's Bay • There is a high proportion of Māori living in these areas (59 % in Maraenui, 42 % Onekawa 42 % Marewa and 30 % Tamatea) • A high % of children and young people in Napier are Māori • Avoidable Hospitalisations (ASH) in the 45-64 year age group are the highest in Maraenui, Marewa and Onekawa south. Top conditions are Angina and Chest pain, Myocardial infarction, Cellulitis and COPD • ASH rates in 0-4 year olds are also highest in Maraenui, Marewa and Onekawa South. Top conditions are Respiratory, Cellulitis and Dental • Māori and Pacific children in Napier have poor Oral health compared to non-Māori and Non-Pacific

11	**Health pathways**	• Increased the ability to reduce demand on secondary services • Ability to streamline and standardise care across the district, and also to support expanded workforce roles within primary care such as nurses working with Standing Orders, and having the required decision support pathways for community nurse prescribing. • Localisation provides the opportunity to focus on inequities and guide clinicians decision making. • Provides the opportunity to ensure clinicians are aware of all of the options available to patients including services from Māori providers and not for profit organisations

PROCESS

13

Activity	**Date: 2020**
DHBs submit draft Annual Plan to the Ministry	2-Mar
INTERNAL: Health Leadership Forum Planning Day	4-Mar
Feedback to DHBs on first draft Plans and release of guidance for any additional confirmed Government priorities	9-Apr
INTERNAL: Draft to Board	April
INTERNAL: Annual Plan to Board for review	May
INTERNAL: Annual Plan signed off by Board	June Tbc
Final Plans due to the Ministry	Tbc
DHB Board signed SPE to be published on DHB websites	Before end of June
Ministry approval of SLM plan	31-Jul
Any outstanding 2020/21 SPEs tabled with 2019/20 Annual Reports	December

Attachment 1

ANNUAL PLAN Planning Priorities

- Cross Sectoral Collaboration including Health in All Policies
- Delivery of Whānau Ora
- Disability
- Disability Action Plan
- Engagement and obligations as a Treaty partner
- Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori
- Māori Health Action Plan – Shifting cultural and social norms
- Māori Health Action Plan – Strengthening system settings
- Workforce

Exercise 1 (HLD)

- Family violence and sexual violence
- Immunisation
- Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services
- Maternity and early years (9)
- Maternity and Midwifery workforce
- Maternal mental health services

- Addiction
- Mental Health and Addiction System Transformation (2)
- Mental health and addictions improvement activities

- Pacific Health Action Plan
- Improving Quality
- Acute Demand
- Pharmacy

- Long-term conditions including diabetes (4)
- New Zealand Cancer Action Plan 2019 – 2029 (3)
- Bowel Screening and colonoscopy wait times
- Breast Screening
- Cervical Screening
- Reducing alcohol related harm
- Smokefree 2025

- Planned Care (5) (7) (8)
- Primary health care integration (11)
- Rural health (1) (10)

- Healthy Ageing

- Care Capacity Demand Management (CCDM)
- Data and Digital
- Implementing the New Zealand Health Research Strategy

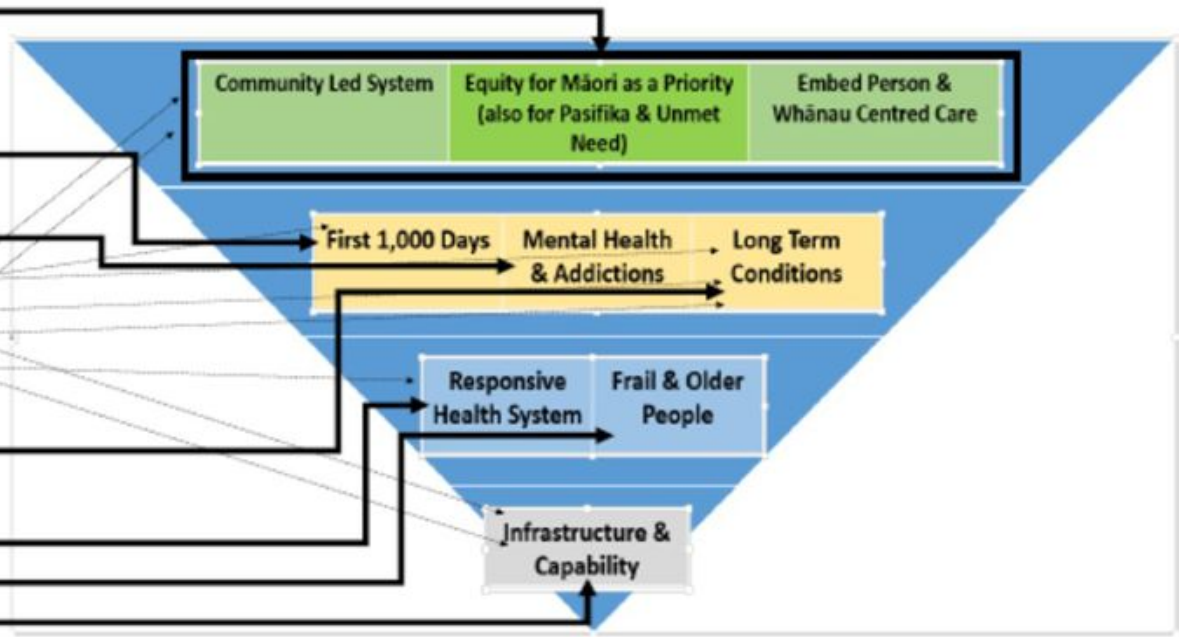
*Priorities 6 & 12 removed (MAU & rolled to 21/22 respectively)

Additional Māori Planning Priorities

- Healthy food and drink
- School-Based Health Services — School Age / School Based Cluster
- Sexual health

- Antimicrobial Resistance (AMR)
- Communicable Diseases
- Delivery of Regional Service Plan (RSP) priorities and relevant national service plans
- Drinking water
- Environmental and Border Health (note that the drinking water section is separate)
- Environmental sustainability
- Improved out year planning processes
- Savings plans – in-year gains
- Savings plans – out year gains
- Working with sector partners to support sustainable system improvements

OUR HEALTH SYSTEM PRIORITIES



Key

20/21 DHB PLANNING PRIORITIES

No.	PRIORITY NAME	SYSTEM PRIORITY
1	Localities - Wairoa	Responsive Health System
2	Mental Health & Addiction community redesign	Mental Health & Addictions
3	Cancer care pathways (including LINAC)	Long Term Conditions
4	Cardiology (including Cardiology Project)	Long Term Conditions
5	Radiology	Responsive Health System
6	Laboratory configuration	
7	Bed Availability	Responsive Health System
8	Planned Care (including Surgical Expansion)	Responsive Health System
9	First 1000 days	First 1,000 Days
10	Localities - Napier	Responsive Health System
11	Health pathways	Responsive Health System
12	Long Term Asset Management Plan (LTAMP/ Interim Asset Plan (IAP)	

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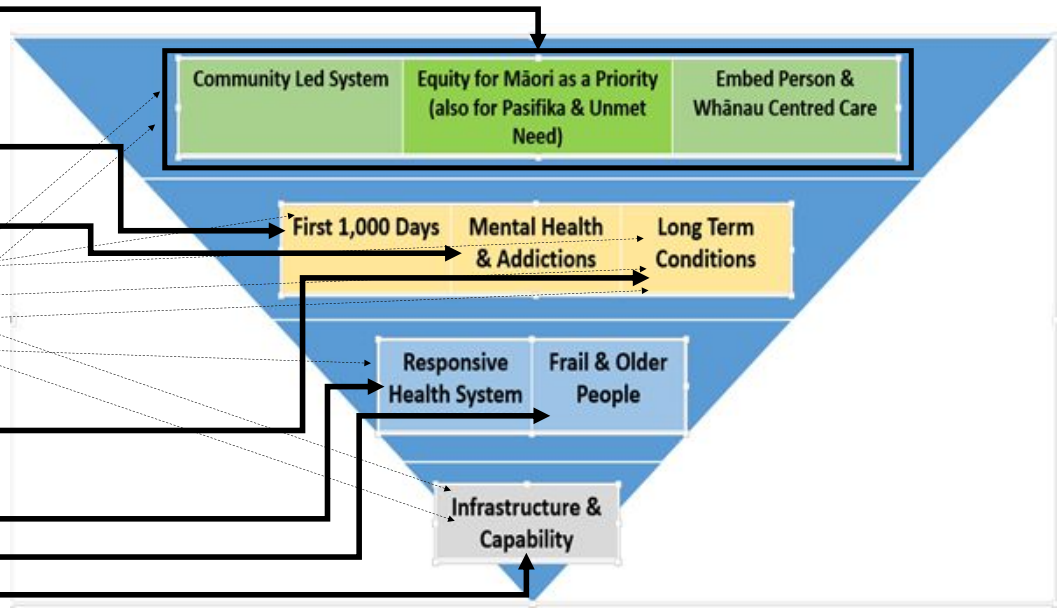
OUR HEALTH SYSTEM PRIORITIES



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13

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Shayne Walker
Chair
Hawke's Bay District Health Board
shaynewalker@windowslive.com

Tēnā koe Shayne

Letter of Expectations for district health boards and subsidiary entities for 2020/21

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2020/21.

DHBs make positive differences in the lives of New Zealanders and I look forward to working with you and your new Board to deliver the wider changes we need to improve outcomes. Strong and sustained leadership provides a foundation for high-performing DHBs and is critical to overall sector performance.

The Government intends to deliver long term, sustainable change to support improved wellbeing for New Zealanders. In the coming months we will receive the final report from the New Zealand Health and Disability System Review. Many of you have contributed to the review, and I thank you for that. The interim report aligned strongly with our Government's priorities and the changes we have underway to deliver better outcomes for Māori and improving equity and wellbeing. I expect you to be prepared and ready to implement Government decisions resulting from the review.

Wellbeing and equity underpin my priorities. Appendix one details expectations for the five system priorities:

- improving child wellbeing
- improving mental wellbeing
- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

This letter will outline my expectations for a range of matters that contribute to performance across these priority outcomes.

Governance

The DHB Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance and delivery on the Government's priorities.

I expect you to hold your Chief Executive (CE) and senior leadership team to account for their financial performance and on the delivery of equitable health outcomes for your population.

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As Chair, you will need to provide leadership and direction to the Board, providing guidance and support to members to ensure they effectively govern the DHB. Please ensure that you have a process in place to review the performance of the Board on a regular basis.

Sustainability

Every DHB must clearly demonstrate how strategic and service planning will support improved system sustainability, including models of care and the scope of practice of the workforce. You should address how your DHB will work with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost increases and deficit levels.

Please ensure that your 2020/21 planning documents clearly identify your DHB's approach to financial and clinical sustainability at both a strategic level and operationally across each of my priority areas.

Service performance

I expect you to challenge and support your CE and senior leadership team to identify ways to respond to the challenges the DHB faces, including timely, high quality delivery of planned care, reducing the length of emergency department stays and increasing immunisation coverage. You will oversee progress on the plans they develop to address these issues.

You need to ensure that workforce and delivery plans support innovative models of care and don't merely add FTE to maintain existing approaches. I expect this to be supplemented with other activities, such as managing annual leave liabilities and maximising productivity in theatres and wards.

Achieving equity

Achieving equity in health outcomes and ensuring fairness in access to and experience of care is essential. I will always expect you to consider equity as you develop plans across priority areas and to prioritise resources to achieve equity across population groups. This will include improving health outcomes for Maori and Pasifika, and an explicit focus on addressing racism and discrimination in all of its forms across all aspects of your operations.

Embedding Te Tiriti o Waitangi and achieving pae ora (healthy futures) for Māori

Māori-Crown relations are a priority for this Government, and I expect your DHB to meet your Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I expect you to develop your plans in partnership with your iwi/Māori partnership boards and include a statement from the Chair of the partnership board in your annual plan alongside statements from yourself and your CE.

Achieving pae ora (healthy futures) for Māori is an important goal for the entire health and disability system. While this includes achieving equity in health outcomes for Māori, responding to our obligations under the Treaty of Waitangi goes beyond that. A critical aspect is enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. I expect your plan to specify how you will work with iwi and Māori communities in your district to achieve this goal.

Financial performance and responsibility

The 2018/19 and 2019/20 budgets have provided the largest increases in funding that DHBs have ever had. To improve service and financial performance, you must focus on good

decision-making within your sphere of control and influence. Most of the issues driving costs are within the control of the DHB, including the number and mix of full-time equivalent staff.

A central challenge in the public health system is to deliver a wide range of quality health services to New Zealanders while remaining within budget. You will be aware of your DHB's financial position and my expectation is that you and your Board will deliver improved financial management and performance; this is especially true for those DHBs that have struggled in recent years.

The In-Between Travel (IBT) appropriation will be devolved from 1 July 2020. I expect you to work with the Ministry of Health (the Ministry) to ensure a seamless transition of responsibilities. The Ministry has an ongoing stewardship responsibility to ensure that all IBT obligations are met.

Capital investment

Timely delivery of the business cases prioritised for investment from the Budget appropriation should be a strong focus. You must comply with financial performance expectations for capital investments requiring Crown equity. You will also be expected to deliver a business case within the budget parameters set, and ensure all investments are procured in a timely manner.

Business cases for high priority projects should continue to be developed irrespective of their immediate investment status and I will seek your assurance that this work is progressing.

I expect all DHBs to follow the guidelines for construction procurement developed by the Ministry of Business, Innovation and Employment. I also expect DHBs to support the initiatives being developed under the Construction Accord. Information on these initiatives will be provided as the work develops.

The Government is supporting a range of capital infrastructure initiatives. The wider public good from our capital projects must be realised, which requires adherence to certain principles. An example is the NZ Green Building Council (NZGBC) Green Star rating for new building developments. Capital builds ought to meet a 5-star standard in the absence of any other mature standard, and this aim should be written into design thinking from the outset. This should result in longer term efficiencies, both financial and environmental. During 2020/21, you will need to engage with the Ministry and other partners as we continue to evolve approaches to sustainable facility design.

National Asset Management Plan

I would like to thank your DHB for supporting the first iteration of the National Asset Management Plan (NAMP) and ask that you continue to engage with the NAMP work as we develop and implement the next phases. Please continue to strengthen your DHB's asset management approach, including focusing on critical service assets, embedding asset management practices and ensuring you appropriately govern service improvement and asset performance.

Service user councils

Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality and Safety Commission (the Commission) has provided guidance to support an effective approach – 'Engaging with consumers: A guide for district health boards' and 'Progressing consumer engagement in primary care'. I am aware that many DHBs already

have strong service user councils and I want to strengthen this across all districts and regions.

The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.

My priority areas

I have clearly communicated my priorities for the health system. I expect your annual plans to address these priorities to meet the needs of all population groups, especially those groups that experience the most significant inequities. The actions you commit to in your plan must contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention. Appendix one details expectations for the five system priorities, which will be further described in the planning guidance your DHB receives from the Ministry.

I look forward to engaging with you on your planning intentions, receiving your planning documents for 2020/21 and working with you as your DHB delivers on your commitments. I appreciate you are receiving this letter at a time when our system is facing emerging pressures from COVID-19. I am pleased to see the way the sector has worked together during the early response phase and I know DHBs will continue to support our collective system response.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Appendix one: Ministerial planning priority areas

Improving child wellbeing

The Child and Youth Wellbeing Strategy and Programme of Action (the Strategy) launched in August 2019 provides a clear pathway to ensuring New Zealand is the best place in the world for children and young people to live. I expect your annual plans to reflect how you are working to improve the health and wellbeing of infants, children, young people and their whanau. Your plans should focus on improving equity of outcomes (especially for Māori); on children and young people of interest to Oranga Tamariki; and children with greater need, including children and young people with disabilities.

I expect DHBs to increase childhood immunisation rates, especially for Māori. The recent measles outbreaks remind us of the impact of communicable diseases on our communities and the health sector and the importance of achieving full immunisation. I expect DHBs to work closely with their primary care providers to prioritise immunisation, including a renewed focus on robust pre-call and recall processes and immunisation outreach services.

I expect DHBs to focus on family and sexual violence screening, early intervention and prevention to ensure victims and families receive effective and timely health care and perpetrators are supported to break the cycle of family and sexual violence.

High quality maternity care is fundamental to ensure children get the best possible start in life. As part of their commitment to the Midwifery Accord signed in April 2019, I expect DHBs to implement a plan to improve recruitment and retention of midwives. You should use Care Capacity Demand Management (CCDM) work to ensure optimal staffing in maternity facilities.

Working with a full range of stakeholders, the Ministry has developed a comprehensive Maternity Action Plan to support a flexible, innovative and sustainable maternity system. I expect DHBs to work with all elements of the maternity system to ensure responsiveness to Māori and equitable access to quality maternity care, including maternal and infant mental health services.

Improving mental wellbeing

He Ara Oranga: Report on the Government Inquiry into Mental Health and Addiction and the Government's response, has set a clear direction for mental wellbeing in New Zealand. Supported by the investments announced in the 2019 Wellbeing Budget, we have a unique opportunity to improve the mental health and wellbeing of New Zealanders. Your leadership will drive system transformation in the mental health and addiction sector.

Collective action is needed to achieve equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes, including Pacific peoples, youth and Rainbow communities. You will work with the Ministry, the Initial Mental Health and Wellbeing Commission and the Suicide Prevention Office to support system transformation and the rollout of the Government's priority initiatives.

The mental health and addiction system must respond to people at different life stages and levels of need. I expect DHBs to work individually and collectively on mental health and addiction promotion, prevention and early intervention at the primary and community level. At the specialist end of the continuum you should ensure those with the most need have access to sustainable quality mental health and addiction services.

Improving New Zealanders' mental wellbeing will require collaboration with communities and non-government organisations (NGOs). I consider that DHBs have a social responsibility to

support the sustainability of NGOs and to empower communities to engage in the transformation of New Zealand's approach to mental health and addiction. This includes offering your expertise at no charge to NGOs and community organisations to support participation in new service delivery, particularly for communities who experience disproportionately poorer outcomes.

I expect you to contribute to the development of a sustainable and skilled workforce. You must invest to diversify, train and expand both the existing and new workforces. You should focus on training workforces to support the Government's primary mental health and addiction initiatives and communicate proactively with the Ministry about opportunities to expand coverage to reach underserved populations.

Improving wellbeing through prevention

Environmental sustainability

Ensure that you continue to contribute to our Government's priority of environmental sustainability, including green and sustainable facility design as noted above in the section on Capital Investment. I expect your annual plan to reflect your work to progress actions to mitigate and adapt to the impacts of climate change and enhance the co-benefits to health from these actions.

Antimicrobial resistance

I am concerned about the increasing threat of antimicrobial resistance (AMR) to our health security. DHBs have a key role in minimising this threat. The issues are systemic and require long-term planning and sustained actions.

I expect your annual plan to reflect actions that align with the objectives of the New Zealand Antimicrobial Resistance Action Plan and demonstrate you are working towards a sustainable approach to containing AMR.

Smokefree 2025

Smoking remains a major preventable cause of premature death, morbidity and health inequities. My expectation is that you work towards achieving Smokefree 2025. I expect to see effective community-based wrap-around interventions to support people who want to stop smoking, with a focus on Māori, Pacific people, pregnant women and those on a low income. The interventions should reflect your regional and programme provider collaborative efforts.

Bowel Screening

The National Bowel Screening Programme remains a priority for this Government. DHBs are expected to achieve national bowel screening targets (where applicable) and consistently meet diagnostic colonoscopy wait times. It is crucial that symptomatic patients are not negatively impacted by screening demand. DHBs must work individually and collectively to develop a sustainable endoscopy workforce, including support of training positions for nursing and medical trainees to meet growing demand in this area.

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

National Cancer Action Plan

On 1 September 2019 the Prime Minister, Rt Hon Jacinda Ardern and I launched the National Cancer Action Plan and its four key outcomes. DHBs have an important responsibility to drive the necessary changes and deliver of these outcomes.

I have established a National Cancer Control Agency, which will report to me on the implementation of the Cancer Action Plan. You will work with and take direction from the Agency to reach national standards of care and improve quality.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the general population. Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.

Accessibility means that your DHB provides a barrier-free environment, including information and communications for the independence, convenience and safety of a diverse range of people. This includes people who may have access needs, including disabled people, older people, parents and carers of young children and travellers.

Enabling disabled people to access health services includes ensuring that all key public health information and alerts are translated into New Zealand Sign Language. It means consulting disabled patients (including people with sensory, intellectual or physical impairments) on their preferred means of communication for appointment notifications and the like.

As with previous years, your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities. DHBs also need to implement policies and procedures to collect information about disabled people within your patient population. DHBs should also ensure contracts with providers reflect the requirement to either ensure accessibility or put in place plans to transition to a more accessible service.

Healthy ageing

If our ageing population continues to grow as current trends suggest, the number of people with dementia, and the associated financial and social consequences, will grow commensurately. This Government is determined to make a positive difference in the lives of people with dementia, their families, whānau, friends and communities. I expect your DHB to work with your region to implement the regional dementia priorities.

Please ensure the DHB develops models of care to identify frail and vulnerable older people in community settings, in particular Māori and Pacific peoples, and provides supports to restore function and prevent the need for acute care.

Workforce

I expect DHBs to develop bargaining strategies that progress the Government Expectations on Employment Relations in the State Sector.

I expect bargaining strategies to progress consistent employment arrangements and support agile, innovative workforces to deliver services. Employment arrangements should encourage people to grow, develop and thrive in a work environment that supports transdisciplinary teams and innovative models of care. I expect commitments made in bargaining to be met, including working party commitments, Accords or programmes, such as the CCDM programme.

DHBs have an essential role in training our future workforce and providing learning and development opportunities for current workforces. I expect you to continue to utilise current workforces to support innovative and transdisciplinary practice across models of care and enable people to work to their full scope of practice.

DHBs must create environments in which all health and disability workforces thrive. DHBs should facilitate healthy and culturally reinforcing working environments that support health equity outcomes for all.

Workplace violence

I am concerned about what appears to be increased levels of violence in the health workplace. In accordance with the Health and Safety Act 2016, DHBs are responsible for the health and safety of their staff, patients and visitors. I expect DHBs to keep staff, patients and visitors safe by implementing appropriate policies, procedures and training to maintain public trust and confidence in the health and disability sector.

Health Research Strategy implementation

Research and innovation, analytics and technology are all crucial to achieving an equitable, sustainable health system and better patient outcomes.

The New Zealand Health Research Strategy (2017-2027) is the key platform for us all and it is important to implement the strategic priorities. In the next year, we should focus on developing a flourishing research and innovation culture in our DHBs in both primary and secondary care.

I have asked the Ministry to work with you and other stakeholders to build up DHB people and resources to support and enhance research, innovation and analytics so the system can make better use of the evidence and innovation and contribute to the Health Research Strategy objectives. Please work with the Ministry to design and invest in the programme of work with a focus on creating regional research and analytics networks that support staff engaged with research and innovation.

National Health Information Platform (nHIP/Hira)

Digital health services are important to me and to all New Zealanders and I expect DHBs to ensure the digital services you use are safe, secure, integrated, reliable and provide appropriate access to data and information.

I also expect you to support the Ministry in developing and designing nHIP/Hira services and to prioritise nHIP/Hira implementation activities in your annual plan.

Planned care

The refreshed approach to deliver elective and arranged services, under a broader planned care programme, will build on the development of the three-year plan you started in 2019/20. Timely access to planned care remains a priority. I urge you to take advantage of the increased flexibility in where and how you deliver these services; to ensure improved equity

of access and sustainability of service delivery; and to provide services that meet your population's health care needs, support timely care and make the best use or your workforce and resources.

I am particularly concerned, across many DHBs, about the number of people waiting beyond expectations for first specialist assessments, planned care interventions, ophthalmology follow-ups and diagnostic radiology services. Please ensure you have appropriate plans in place to support timely care.

Measuring Health System Performance

The System Level Measures (SLM) programme provides a framework for continuous quality improvement and integration across the health system. I intend to build upon the SLM framework by publicising local progress in responding to my national priorities from quarter one 2020/21. I expect DHBs to work with all health system partners to agree local actions and the contributory measures needed to make a tangible impact on health system performance. This will require broadening of alliances to include partners beyond the primary health organisations (PHOs). Equity gaps are evident in all SLMs and in nearly all districts. Where equity gaps exist, I expect local actions and contributory measures to focus on addressing these gaps.

Care Capacity Demand Management

I continue to expect significant progress on implementing all components of the CCDM programme this year, including detailed plans for full implementation in all units in nursing and midwifery by June 2021. Full implementation includes annual FTE calculations and agreed budgeted FTE in place. I expect timely reporting, including your assessment on progress towards meeting the June 2021 deadline for full implementation of CCDM. It is vital that nurses and midwives see the impact of CCDM FTE increases and effective variance response management on safe staffing levels and that the core data set drives quality improvement. It remains my expectation that CE performance expectations include delivering CCDM expectations within agreed timelines.

Better population health outcomes supported by primary health care

Primary care

Primary care makes a significant contribution to improving health outcomes and reducing demand on hospital services. Continuing to improve primary health care remains a priority for this Government.

DHBs must work with their primary care partners and lead their alliance(s) to develop and implement models of care that improve equity for Māori and other high needs populations through services that target the needs of these populations. I expect these new models of care to use broader multi-disciplinary teams, strengthened inter-professional collaboration and improved integration between secondary, primary and community care. I expect high-quality information and data to be shared through formal agreements and used to support decision-making, particularly in improving outcomes for Māori.

Long-term conditions

As I have previously advised, I expect DHBs to explicitly require improvements in performance and reporting on long-term conditions in their contracts with PHOs. DHBs should incentivise PHOs to improve equity, reduce the burden of long-term conditions, demonstrate improvements in primary care settings and increase accountability for effectively managing long-term conditions, especially diabetes.

Pharmacy

Progress has been made on the strategic vision of the Pharmacy Action Plan 2016. I expect this progress to accelerate as you work with the pharmacy sector to develop funding models and models of care that are equity focused and centred on service users. Please ensure your DHB enables pharmacist vaccinators to deliver a broader range of vaccinations to improve access.

Rural workforce

DHBs with rural communities should build on 2019/20 and improve access to services for rural people. I expect you and your rural alliance partners, including rural hospitals, to explore the opportunities to use the Ministry's rural workforce initiatives to strengthen your rural workforce and improve the sustainability of rural services.

Supporting delivery of the Māori health action plan

The sector has recently engaged in the development of a Māori Health Action Plan to further implement He Korowai Oranga: the Māori Health Strategy and improve Māori health outcomes. I expect all DHBs to demonstrate delivery and implementation of this plan in 2020/21 planning documents.

Improving wellbeing through public health service delivery

Public Health Units (PHUs) are key to protecting and improving health and you should ensure that your DHB has strong and sustainable public health capability and capacity. I expect to see PHU plans integrated with DHB Annual Plans where appropriate in 2020/21.

Over the next year, a programme is underway to develop criteria and to confirm the accountability arrangements for public health service delivery. I encourage your PHU and DHB to get involved in this process and support the programme.

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 previous minutes 18 March 2020 (Public Excluded)
20. Matters Arising (Public Excluded)
21. Board Approval of Actions Exceeding Limits Delegated by CEO (no written report)
22. Chair's Update (Public Excluded)
23. Chief Executive Officer's Report (Public Excluded)
24. Planning & Funding Report (Public Excluded)
25. Digital Enablement News (Public Excluded)
26. Process for Significant Service Change (Public Excluded)
27. Finance Risk and Audit Committee (Public Excluded)

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).