BOARD MEETING

Date: Wednesday, 30 March 2016

Time: 1.00pm

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

Members:
Kevin Atkinson (Chair)
Ngahiwi Tomoana
Barbara Arnott
Peter Dunkerley
Helen Francis
Diana Kirton
Denise Eaglesome
Dan Druzianic
Jacoby Poulain
Heather Skipworth
Andrew Blair

Apologies: Ngahiwi Tomoana and Andrew Blair

In Attendance: Dr Kevin Snee, Chief Executive Officer
Members of Executive Management Team

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Agenda Items	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report (verbal)		
8.	Chief Executive Officer's Report • New Orientation Video	15	
9.	Financial Performance Report	16	
10.	Consumer Story (Jeanette Rendle)		

	Section 2: Reports from Committee Chairs		**Time (pm)**
11.	HB Clinical Council (Dr Mark Peterson and Chris McKenna)	17	1.50
12.	HB Health Consumer Council (Graeme Norton)	18	
13.	Māori Relationship Board (Heather Skipworth)	19	
14.	Pasifika Health Leadership Group – verbal update (Barbara Arnott) • Pacific Health Presentation	-	2.15
	Section 3: For Decision		
15.	NZ Health Partnerships Ltd	20	2.40
	Section 4: For Information		
16.	Draft HBDHB Annual Plan and Statement of Intent 2016/17 (Tim Evans)	21	2.45
17.	Draft Central Region Regional Service Plan (Tim Evans)	22	
	Section 5: Monitoring Reports		
18.	Te Ara Whakawaiora / Breastfeeding (Caroline McElnay)	23	3.00
19.	Annual Maori Plan Q2 Oct-Dec 15 (Tracee TeHuia)	24	
	Section 6: Recommendation to Exclude		
20.	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	**Section 7: Agenda Items**	Ref #	**Time (pm)**
21.	Minutes of Previous Meeting		3.20
22.	Matters Arising – Review of Actions (nil)		
23.	Board Approval of Actions exceeding limits delegated by CEO	25	
24.	Chair's Report (verbal)		
	Section 8: Review		
25.	Information Service Function Review (Tim Evans)	26	3.30
	Section 9: Reports from Committee Chair		
26.	Finance Risk & Audit Committee (Dan Druzianic)	27	
27.	HB Clinical Council (Dr Mark Peterson and Chris McKenna)	28	
	Section 10: General Business		

Next Meeting: 1.00 pm, Wednesday 27 April 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Board "Interest Register" - 24 February 2016

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of 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	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair of FRAC	
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
Barbara Arnott	Active	Trustee of the Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14

Board Meeting 30 March 2016 - Interests Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Daughter-in-law, Eve Fifield, Paediatric Registrar with HBDHB	Non-pecuniary interest: Will not take part in discussions regarding paediatric registrars	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Daughter-in-law, Eve Fifield, undertaking Community Paediatricts Training at Starship Hospital Auckland for a brief time.	Non-pecuniary interest: Will not take part in discussions regarding paediatric registrars	All employment matters are the responsibility of the CEO.	The Chair	14.12.15
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair	7.12.10
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Andrew Blair	Active	Owner of Andrew Blair Consulting Limited	Engaged from time to time to provide consultancy and advisory services to healthcare and other organisations.	Will not take part in decision relating to organistions to which he provide consultancy and advisory services.	The Chair	04.12.13
	Active	Advisor to Trustees and Management of Chelsea Hospital Trust	Engaged to provide advisory services to the Trust who own and operate the private hospital in Gisborne.	Will not take part in decisions relating to services HBDHB may from time to time engage.	The Chair	24.07.14
	Active	Advisor to Hawke's Bay Orthopaedic Group Ltd	Engaged to provide advisory services to the Group	Will not provide advice in relation to contracting, employment or relationship matters between the HBOG and HBDHB. Will not participate in any decisions made by HBDHB regarding orthopaedic services.	The Chair	19.09.15
	Active	Chair of Southern Partnership Group	Southern Partnership is to progress the facilities redevelopment of Dunedin Hospital.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	19.09.15
	Active	Director, Breastscreen Auckland Limited	Breast screening facility.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.2015
	Active	Director, St Marks Womans Health (Remuera) Limited	Womans Health facility in Auckland	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.2015
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust	The Trust has a lifestyle Contract with HBDHB signed 31 January 2015 Awarded a Green Prescription Contract with HBDHB 11 February 2015	Will not take part in any discussions or decisions relating to the Contract.	The Chair	04.02.14
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14

4

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 24 FEBRUARY 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.02PM

Present: Kevin Atkinson (Chair)
Ngahiwi Tomoana
Peter Dunkerley
Andrew Blair
Diana Kirton (from 1.36pm)
Barbara Arnott
Jacoby Poulain
Heather Skipworth
Denise Eaglesome
Helen Francis
Dan Druzianic

Apologies Nil

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Dr Mark Peterson and Chris McKenna (as co-Chairs of HB Clinical Council)
Graeme Norton (Chair, HB Health Consumer Council)
Members of the public

Minutes Brenda Crene

KARAKIA

Ngahiwi Tomoana opened the meeting with a Karakia.

APOLOGIES

Diana Kirton apologised for lateness.

INTEREST REGISTER

There were no interests advised at the meeting.

Barbara Arnott asked to have an interest removed from the Register, relating to her daughter's employment with Health Benefits Limited. **Actioned**

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

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 16 December 2015, were confirmed as a correct record of the meeting.

Moved: Barbara Arnott
Seconded: Dan Druzianic
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: The Quality Accounts had been finalised – and the action would be removed.

Item 2: Travel Plan Business Case: The Board had requested progress updates with regular reporting to include a focus on monitoring for "inequity". Advised the ToR initiates the

project's start up with reports coming to the Board soon after. These have been included on the detailed workplan. This action would be removed.

BOARD WORK PLAN

The Board Work Plan was noted.

CHAIR'S REPORT

- 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	Area	Service	Years of Service	Retired or retires on
Sue Van Dam	Registered Nurse	Older Persons & Mental Health	10	24-Jan-16
Margaret Ansell	Clinical Coder	Facilities & Operational Support	22	5-Feb-16

- During December the Letter of Expectations for 2016/17 had been received outlining the forthcoming year. An overview of funding expectations were shared.
- The Chair advised a Privacy Self-Assessment would need to be completed by the end of March 2016.
- Health Target results had been released by the MoH and results were conveyed to members.
- Liz Stockley advised the last quarter's results for smoking cessation advice had been poor and the reasons which had attributed to the decline. She understands practices have been very proactive in this area, with issues more attributed to the capture/recording of the required detail. The key is whether patients are ready to give up smoking. There is an expectation this quarters results would improve.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO's report was taken as read, acknowledging:

- The new Mental Health facility was officially opened on 23rd February by the Minister of Health, following which a number of initiatives were shared with Dr Coleman.

  The Chair commended staff and management highly within the Mental Health service for the seamless movement of patients from the old facility to the new. A wonderful job done. Allison Stevenson was present at the meeting for this acknowledgement and was requested to pass this on to all staff involved.
- ED was coping and in a better place than previously and we are hopeful to achieve target in the near future.
- Orthopaedic patients now receiving better intervention, including alternative initiatives.
- The key problems in the month of January were patients waiting longer than four months for First Specialist Appointments and elective surgery; together with patients receiving smoking advice in primary care. Anticipate these will be on track for the targetted expectations.
- Regarding Faster Cancer Treatment – there is work to be done and if the problem(s) continue, a report will be provided to the Board.
- Immunisation of children: It was the first time HB had not met the target, with 35 infants not fully up to date with their immunisations between Sept-Dec 2015 (ie, Q2).

  The pattern was reviewed and tended to indicate a blip, for no specific reason. An overview of the system(s) in place was relayed to the Board. Some parents choose to decline vaccinations but do change their minds. It was important to ensure conversations around immunisations were continued with families. The results within HB were similar to the rise seen nationally.

- A dip in the financial result for December had corrected itself in January with a favourable outcome at the end of January 2016 (refer to the finance section).
- Health and Social Care networks outlines a strategy on how we can bring organisations together to respond to the needs of the community. Effort will be required to take this forward. Need to ensure consumers are fully involved from the outset.

FINANCIAL PERFORMANCE REPORT(S)

The Financial reports for December 2015 and January 2016 were reviewed with matters highlighted in the respective reports.

- As mentioned. a dip in the financial result for December corrected itself in January with an overall favourable variance of $128 thousand.
- The Financial Performance Summary provided an analysis of factors driving the favourable variance to date.
- Overall we were very close to budget, however it will be testing to achieve the budgeted surplus for this financial year (ending 30 June 2016).

The message conveyed by the CFO was not to take anything on that is too challenging for the remainder of this financial year.

It was noted a number of the Central Region DHBs were tracking significantly below their respective plans. It was a tribute to a lot of good work being done within the HBDHB to find ourselves in a positive position.

CONSUMER STORY

No specific Consumer Story was conveyed, however feedback from customers who had experiences with booking staff and receptionists within DHB services, were shared with Board members.

Ensuring positive customer service interactions was recognised as crucial to an efficient and pleasurable customer journey. Advised that customer training is planned for staff with feedback that staff are delighted.

Consumer Council prefer to no longer receive consumer stories as part of their monthly agendas. They felt, as initiators of these stories, they could best support consumer outcomes in other ways.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

The report advised commentary on the Health literacy strategic review which mentioned that, across the sector we needed to focus on eliminating technical/medical jargon for consumers and to focus more on ensuring consumers truly understood. Consistency in this area needs to be applied across the whole health sector.

Other areas overviewed included Clinical Governance Structures (consultation); Council member portfolios of interest; the successful Respiratory Pilot; and the Health and Social Care Networks strategic direction which would ultimately improve the health outcomes for our community, and was supported by Council.

Hawke's Bay Consumer Council

The Health Literacy Review saw some rigorous discussion by consumer members who had been constantly told they needed to get more literate!. The question is how literate is the health sector! The health literacy strategic review and the development of the framework for health literacy within HB health sector will address this.

Health and Social Care Networks passed through the Consumer Meeting quickly with the direction of travel supported. In week following the Consumer Meeting however, some members felt the paper had been produced without consumer input and they advised they were prepared to roll their sleeves up and make a strong contribution going forward. This was noted by the report writer(s)

The Consumer Council structure in HB: Word has spread with most of the Central Region DHBs looking to implement something similar. The resulting structures may not be the same but Consumer Council members were looking forward to supporting and feeding into joint work for the region.

Māori Relationship Board (MRB)

The report provided included: Whanau Ora, Living Wage in HB; the MRB workplan; Maori Bachelor of Nursing Students; MRB representation on Clinical Council; Health Literacy Review; as well as Health and Social Care Networks. The content of the report was conveyed by MRB's Chair and suggestions made were acknowledged and noted by the HBDHB Board.

- Living Wage in HB: MRB challenged the DHB to implement the living wage within HBDHB, as they felt a large number of Maori were affected. In response the CFO advised there were a range of possibilities to be considered, one option may be to lift the skills, leading to improved service delivery. He noted any change would also affect a wider group of staff in care facilities. He was not saying let's do it … but there were far wider implications to be considered first.
- Meetings and Workplan: MRB sought 10 meetings per year (outside Leadership Forum attendance) and members were keen to prioritise their own workplan – reducing to no more than six items. MRB's priorities in 2016-17 were Smoking, Obesity, Alcohol and other drugs and young mothers and Children.
- MRB sought representation on Clinical Council. It was noted MRB was a governance body whereas Clinical Council were a management body reporting to the CEO. A discussion would be held to consider.
- Health and Social Care Networks**:** MRB endorsed the content of this Programme Brief pending consideration for MRBs feedback and input the strategic direction.

  Denise Eaglesome advised that Wairoa had discussed HSCN. In this regard there needs to be pre Intersectoral workshops with Wairoa needs to be Wairoa led and DHB enabled.

  Suggested that Wairoa be the first to hold an Intersectoral Wairoa Workshop with wider community DHB and MSD to promote leadership. It was noted there was also a HB Health Consumer Council member based in Wairoa.

FOR DISCUSSION AND INFORMATION

Health and Social Care Networks

Liz Stockley (leading this work) was supported by Kevin Snee and outlined the detail and intent of Health and Social Care Networks, advising keenness to discuss in more detail at the forthcoming Health Sector Leadership Forum.

The introduction of the programme was seen as a key initiative focused on improving the health and wellness of our population. It will be a significant programme of activity and of associated change management, requiring support at all organisational levels. We are, therefore, seeking support from the DHB Board to begin this journey.

As noted above Wairoa would be a great starting point and the community already have considerable leadership.

Action:

RECOMMENDATION

It was noted the Council's and MRB had supported the direction of travel for Health and Social care networks, therefore the Board were happy that management proceed with this concept (taking on board all comments raised/made) and were asked to keep the Board updated with progress periodically with timeline(s) advised for workplan(s).

Adopted

MONITORING REPORTS

Human Resource (HR) KPIs Q2 Oct-Dec 2015

Innovation in on-line leave management systems is being looked at with a view to move towards a closed loop system, with no gaps in leave captured and leave approved.

Accidents were higher than target at 119 vs 90 for the quarter. This was being focused on to raise awareness.

Action: Māori staff representation in the workforce:

This has moved little in the last quarter, an action plan needs to be produced.

Suggested actions for consideration and noting by HR:

- **Suggest including a Maori representative on specific interview panel panels.**
- **Escalate queries relating to appointments by hiring managers to have them explain their actions to either their Executive Manager or to the CEO.**
- **Include competencies /targets in all position profiles.**

Te Ara Whakawaiora / Access (ASH Rates 0-4 & 45-64 years)

Te Ara Whakawaiora Ambulatory Sensitive Hospitalisation rate targets have shown some improvements, both in terms of Māori admission rates and also in terms of the comparative rates between Māori and the total population.

This is particularly the case for the 0-4 age group. Rates for the 45-65 age group continue to show significant disparity, though rates have improved.

- Asthma a concern in Maori children vs non-Maori yet there are more levers now to reduce asthma incidence (through appropriate long term prevention/treatment). Noted some may be viral.
- Dental: Robin Whyman will be presenting to the board in the near future.
- Jacoby Poulain asked how were **"key messages delivered to families" when most were at home?**

  Action: Mark Peterson to arrange for an update to be provided.
- Improved diagnosis of heart attacks shows with good management you can either prevent or reduce severity in primary care.
- Since Wairoa is an isolated area, what would health inequities there look like? Inequities' would be narrower but it would be a useful exercise to do.

HBDHB Non-Financial Exceptions Report for Q2 Oct-Dec 2015

Our overall performance on Elective Surgery is running just above 100%. Heart and diabetes checks are at 90.3%, which is above target for the fourth successive quarter. We are making progress on Faster Cancer Treatment (continuing upward trend towards achieving this target). Shorter stays in ED shows improvement. The result for Acute Coronary Syndrome Services (high risk patients receiving an angiogram within three days) was 68.7%, which is an 18% improvement on the previous quarter.

There were significant changes made in the run up to Christmas and working with cardiology to change their rosters. Working with Capital and Coast regarding patient transfers. Regional Cardiology group networking progressing. Regional review of cardiac services would be beneficial.

❖ **Monitoring Dashboard Quarter 1 2015/16 (provided by Ministry of Health)**

The report received related to Q1 (July-Sept 2015), a significant time lag!

It was understood that patient portals were being progressed. A process was in place and 50% of patients now have access to the portal. However, the number enrolled and using the portal was quite low.

HBDHB Transform & Sustain Strategic Dashboard Q2 Oct-Dec 2015

This new report to the Board aims to deal with the impact rather than the process of our Transform & Sustain strategy. Three 'vital sign' indicators for: service quality (what our consumers say about us); population health (the gap between Māori and Non Māori death rates under 50 years old), and; use of resources (PHO break even, DHB make target surplus) are each supported by seven representative indicators.

Comments during discussions included:

- Probably need to do more analysis as to what this means in future.
- Not a comprehensive list of everything being measured.
- Delivers the triple aim and should be measuring quality of care, efficiencies and around population health. Patient experience survey.

This is work in progress which will lead to healthier lives.

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

20. Confirmation of Minutes of Board Meeting
    - Public Excluded

21. Matters Arising from the Minutes of Board Meeting
    - Public Excluded

22. Board Approval of Actions exceeding limits delegated by CEO

23. Chair's Report

24. Allied Laundry Services Ltd Report to Shareholding DHBs

25. Preliminary Budget - Presentation

Reports and Recommendations from Committee Chairs

26. HB Clinical Council
27. Finance Risk and Audit Committee

Moved: **Peter Dunkerley**
Seconded: **Dan Druzianic**
Carried

The public section of the Board Meeting closed 3.35pm

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	24/2/16	**Health & Social Care Networks:** a) Direction of travel supported by the Board and approval to proceed with the concept taking on board all comments raised by respective Committees. b) The Board requested updates on progress periodically, with **timelines** advised and included on workplan(s).	Liz Stockley Liz Stockley		Noted Actioned - timelines incorporated into workplan.
2	24/2/16	**Human Resources - Māori staff representation in the workforce:** This has moved little in the last quarter, an action plan needs to be produced. For consideration by HR: • Suggest including a Maori representative on specific interview panel panels. • Escalate queries relating to appointments by hiring managers to have them explain their actions to either their Executive Manager or to the CEO. • Include competencies /targets in all position profiles.	John McKeefry		See over the page for Status Update
3	24/2/16	**Te Ara Whakawaiora / Access:** In considering aspects of the report provided, Jacoby Poulain asked how were key messages delivered to families when most were at home? An update would be provided by the sponsor.	Mark Peterson	April	Verbal

ACTION ITEM 2 – STATUS UPDATE

The Maori staff recruitment action plan has been updated to provide for:

1. A Maori consumer on all interview panel panels.
2. Hiring managers to be asked to document in their proposal to appoint whether they have hired a Maori staff member and if not why not?

Further to the February Board meeting, a number of other additional actions have been identified and included in the updated action plan to improve the recruitment and retention of Maori staff.

This updated plan will form the basis for briefing meetings with all hiring managers.

HAWKE'S BAY DISTRICT HEALTH BOARD

WORKPLAN

Meeting Dates 2016	Papers and Topics	Lead(s)
27 Apr	Consumer Story	Kate Coley
	Surgical Waitlist Flow (p/e)	Sharon Mason
	Orthopaedic Review Closure of phase 1	Andy Phillips
	"Refreshed" Transform and Sustain Draft	Tim Evans
	Strategic Relationships (6 monthly review)	Ken Foote
	Vision Values and Behaviours	John McKeefry
	Monitoring	
	Te Ara Whakawaiora / Cardiovascular	John Gommans
17 May	**HB Health Sector Leadership Forum – venue to be confirmed**	
25 May	Consumer Story	Kate Coley
	Travel Plan update	Sharon Mason
	Child Obesity Strategic Plan (Final)	Caroline McElnay
	Health Equity Update	Caroline McElnay
	"Refreshed" Transform and Sustain Final	Tim Evans
	Integrated Shared Patient Care Record	Tim Evans
	Final Annual Plan and SOI	Tim Evans / Carina
	Final Regional Services Plan	Tim Evans / Carina
	Investment/Disinvestment Prioritisation	Tim Evans
	Monitoring	
	HBDHB Non-Financial Exceptions Report Q3 Jan-Mar16	Tim Evans
	Annual Maori Health Plan Q3 Jan-Mar 2016	Tim Evans
	Transform and Sustain Strategic Dashboard Q3 Jan-Mar16	Tim Evans
	HR KPIs Q3	Tim Evans
	HBDHB Quarterly Performance Monitoring Dashboard Q2 Oct-Dec 15 – provided by MoH	John McKeefry
29 June	Consumer Story	Kate Coley
	Suicide Prevention Plan Update	Caroline McElnay
	Youth Health Strategy	Caroline McElnay
	Health Literacy Framework	Kate Coley / Ken Foote
	Monitoring	
	Te Ara Whakawaiora / Oral Health	Sharon Mason
27 July	Consumer Story	Kate Coley
	Developing a Person Whanau Centred Culture (draft)	Kate Coley
	Staff Engagement Survey – any corrective actions	John McKeefry
	Annual Organisational Development Plan/Programme	John McKeefry
	HB Intersectoral Group (priority plan) final	Kevin Snee/Caroline

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 15
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month: As at	21 March 2016
Consideration:	For Information

8

Recommendation

That the Board
Note the contents of this report.

INTRODUCTION
In this month's Board report I will comment on our performance. The key problems in February were:

- Patients waiting for longer than four months for first specialist appointments and elective surgery
- Faster Cancer Treatment

There will also be a number of consumer stories illustrating difficulties in navigating our health care system, that can form a basis for discussion about how we could resolve them through a process of codesign.

This month we are reporting on our draft Annual Plan and Statement of Intent for next year. With a new national health strategy close to being finalised, it could be an interesting year in which we will put increasing effort into addressing some of the key public health challenges facing us and to make significant progress in developing community based services. We are also reporting on the challenges in delivering good performance in breast feeding where the benefits to children are well documented, but we seem to continually struggle to get high levels locally for a variety of reasons. A key priority for the DHB is addressing inequity and one of those is the relatively poor health of Māori. We will report on the progress being made locally which is amongst the best in New Zealand, but there is clearly no room for complacency.

Finally, we will discuss how to make better progress in relation to our information technology which is a key service which underpins all of our local services.

PERFORMANCE

Measure / Indicator	Target	Month of February	Qtr to end February	Trend For Qtr
Shorter stays in ED	≥95%	94.6%	93.8%	▲
Improved access to Elective Surgery (2015/16YTD)	100%	101.5%	-	▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	*2,440*	*457*	*66*
Patients given commitment to treat, but not yet treated (ESPI-5)	*919*	*135*	*73*

Faster Cancer Treatment*	≥85%	55.6% (Jan 2015)	72.9% (rolling 6m to Jan 2016)	▼
Increased immunisation at 8 months (3 months to February)	≥90%	---	94.6%	▲
Better help for smokers to quit – Hospital	≥95%	97.5%	98.6%	▼
Better help for smokers to quit – Primary Care *there was a change in definition at the start of 2015/16 which has an impact on the results	≥90%	75% (Quarter 2, 2015/16)	---	▼
More heart and diabetes checks	≥90%	90.3% (Quarter 2, 2015/16)	---	▬
Financial – month (in thousands of dollars)	$1,177 thousand	$1,232 thousand	---	---
Financial – year to date (in thousands of dollars)	$5,485 thousand deficit	$5,349 thousand deficit	---	---

***Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 76 people a year (11.4 a month) as patients with a high suspicion of cancer.*

Performance this month has seen an improvement in shorter stays in the ED. In elective surgery, however, too many patients are waiting longer than they should; it is expected that that this will be back to within our contractual tolerances by March.

Immunisation has improved as anticipated, however our Faster Cancer Treatment target has deteriorated. The data above relates to January. This is partly a coding issue and partly relates to some disruption of services over the holiday period. It is anticipated that it will improve significantly in the months ahead.

I have appended our feedback from the Minister of Health on our quarter two performance.

The financial result for February is a favourable variance of $55 thousand, making the year-to-date result $136 thousand favourable. With only four months of the financial year to go this is a strong position, but there remain risks to be addressed and we are very focussed on developing a sustainable position for next year.

CONSUMER STORY
This month Consumer Engagement Manager, Jeanette Rendle, will share a story from a well-known leader in the community about his experience as he attempted to navigate our complex system as he prepared for surgery. His story highlights the challenges and cultural barriers he experienced. We hope his story and experience will be used as we develop the new co-designed orthopaedic pathway.

PACIFIC HEALTH PRESENTATION
Tim Hutchins, Pasifika Navigation Service, will provide a snapshot of consumer stories to the Board relating to his work with Pacific families in his role as Navigator. These stories illustrate an array of real issues Pacific families meet when navigating the health system and the challenges the system faces to support improving Pacific health in Hawke's Bay. Pasifika Navigation Services is a provider currently contracted by Pacific Health to provide a navigation service to Pacific families presenting to ED and to work with the Population Health team to build effective relationships in community settings. Talalelei Taufale, HBDHB Pasifika Health Development Manager, and members of the Pasifika Health Leadership Group, will also be in attendance.

NEW ZEALAND HEALTH PARTNERSHIPS LIMITED
Relevant Company documents have been sent to shareholding DHBs for unanimous approval, in accordance with the Shareholders Agreement.

DRAFT ANNUAL PLAN AND STATEMENT OF INTENT 2016/17
The first draft of HBDHB's Annual Plan is currently under development and is due to the Ministry of Health by 31 March. The draft plan has been through EMT, MRB and Clinical and Consumer Councils this month.

The Minister has asked for a refreshed Statement of Intent, in which we are focusing on incorporating the New Zealand Health Strategy themes and how we measure the implementation and impact of Transform and Sustain.

Overall, the priorities within the Annual Plan have remained similar to last year with an increased focus on reducing childhood obesity, reducing unintended teenage pregnancy and shifting services into the community. A new local Māori health indicator added this year is Alcohol and Other Drugs.

TE ARA WHAKAWAIORA / BREASTFEEDING
Breastfeeding is a key priority for Hawke's Bay women and their babies. The breastfeeding indicator is reported to the Ministry of Health through the District Annual Plan and the Annual Māori Health Plan as well as being a key component in the HBDHB Maternal, Child and Youth Strategic Framework 2015-18.

We acknowledge that in Hawke's Bay we have yet to meet the Ministry's target for breastfeeding across age bands and ethnicities, with breastfeeding rates for Māori being consistently lower than other ethnicities. A review of how best to improve breastfeeding rates by supporting mothers/whānau more intensively, starting specifically in the first at six weeks of a child's life, is underway.

ANNUAL MĀORI HEALTH PLAN
HBDHB's Annual Māori Health Plan 2015-2016 quarter two report demonstrates continued improved health trends, particularly with ambulatory sensitive hospitalisation rates narrowing between Māori and non-Māori for both 0-4 years and 45-64 years, immunisation rates for four year olds, more heart and diabetes checks, and quicker access to angiograms for cardiovascular patients. However, immunisation rates for eight months and two years dropped by 4% and 0.8% in quarter two below the 95% national target and there is still significant work to do to improve Māori breastfeeding rates, breast screening rates (50-69 years), Māori under compulsory mental health treatment orders, Māori workforce recruitment and medical staff undergoing cultural training.

DRAFT CENTRAL REGION REGIONAL SERVICE PLAN 2016/17

The draft Regional Service Plan is presented to the Board for comments prior to its submission to the Ministry of Health on 31 March 2016.

DAVANTI INFORMATION SERVICE REVIEW

We commissioned an independent review of our Information Services function at the back end of 2015. The final report from Davanti Consulting has now been prepared and will be discussed in the second part of our meeting today. Davanti were asked to undertake a gap analysis, setting out where we need to improve in order to meet the Information System challenges of the future. The Board will want to agree how we take this important supporting function forward.

SUMMARY

In summary, the local health system coped reasonably well in February and we have continued our steady progress whilst putting in place some key plans for the next financial year.

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

3 - MAR 2016

8

Mr Kevin Atkinson
Chair
Hawke's Bay District Health Board
Corporate Office
Private Bag 9014
HASTINGS 4156

Dear Kevin

Quarter two health target results are now finalised and national results reflect good progress:

- Both the Improved access to elective surgery and the More heart and diabetes checks targets have been met at the national level.
- The national result for the Shorter stays in emergency departments target improved to 94 percent.
- The Increased Immunisation result of 93.7 percent is the highest coverage ever achieved for eight-month-olds.
- The Better help for smokers to quit primary care result increased to 85 percent this quarter.

Good progress has also been made against the Faster cancer treatment (FCT) health target with national achievement at 74.6 percent this quarter. The increase of 5.4 percent on last quarter is the biggest quarterly increase for the target to-date. It is also an increase of 8.8 percent on quarter two 2014/15, the first quarter that the FCT health target results were published. I appreciate the work your teams are doing to ensure sustained improvement in this target area, please ensure you continue to make this a top priority for service delivery.

When looking at Hawke's Bay DHB's results, this quarter your DHB has met the Improved access to elective surgery and the More heart and diabetes checks health targets. However, the DHB must focus on improving its results in relation to Better help for smokers to quit target.

Feedback on your DHB's results across all health target areas is provided by the Ministry's Target Champions in appendix one. More detailed results are provided in appendix two.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

I look forward to seeing good progress across the health targets and strong planning for target achievement in 2016/17 in your upcoming planning documents.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc: Dr Kevin Snee, Chief Executive, Hawke's Bay District Health Board
PHO Chairs
PHO CEOs

Appendix one - Feedback from Target Champions on your results for the quarter

Angela Pitchford, Target Champion, Shorter stays in emergency departments

I am disappointed that Hawke's Bay DHB's performance did not improve by more than 0.6 percent this quarter, especially after last quarter's drop. I have made a number of recommendations to the DHB which I will follow up with a teleconference in quarter three.

I hope to see Hawke's Bay DHB achieve the 95 percent target next quarter. I am happy to review or discuss any projects that the DHB is considering if that would be helpful.

Clare Perry, Target Champion, Improved access to elective surgery

Hawke's Bay DHB has continued to perform well during the second quarter of 2015/16, delivering 3579 elective surgical discharges. This is 15 discharges (0.4 percent) more than planned. This is a good result. Well done.

Andrew Simpson, Target Champion, Faster cancer treatment

Although you may be disappointed that your achievement dropped slightly this quarter, overall Hawke's Bay DHB has made good progress since the FCT health target was introduced. Your result of 77.6 percent also places you in the top quarter of DHBs. To maintain momentum and sustainable quality improvement, your FCT Governance Group must ensure that there is clinical engagement and a clear plan of activity. I look forward to Hawke's Bay DHB achieving further progress towards the 85 percent target next quarter.

Pat Tuohy, Target Champion, Increased immunisation

Hawke's Bay DHB remains one of the strongest performers for infant immunisation, with the target having been met in all previous quarters since December 2014. While coverage was lower this quarter at 93.3 percent, we have every confidence that your team has the capacity and capability to again reach and maintain the target coverage.

Health Hawke's Bay achieved immunisation coverage of 94.7 percent. This suggests that there are children in the DHB who are not enrolled with the PHO and have low immunisation rates. This warrants attention.

John McMenamin, Co-Target Champion, Better help for smokers to quit

The national result for the quarter two primary care target is 85 percent, an increase of 1.8 percent. Hawke's Bay DHB and Health Hawke's Bay Limited PHO did not achieve the target and DHB was the second lowest performing DHB this quarter following the decrease in performance. Please continue to improve efforts to give brief advice and offer cessation support to all PHO enrolled smokers and achieve the target.

Congratulations for achieving the hospital and maternity targets this quarter. I look forward to seeing Hawke's Bay DHB achieve all three targets.

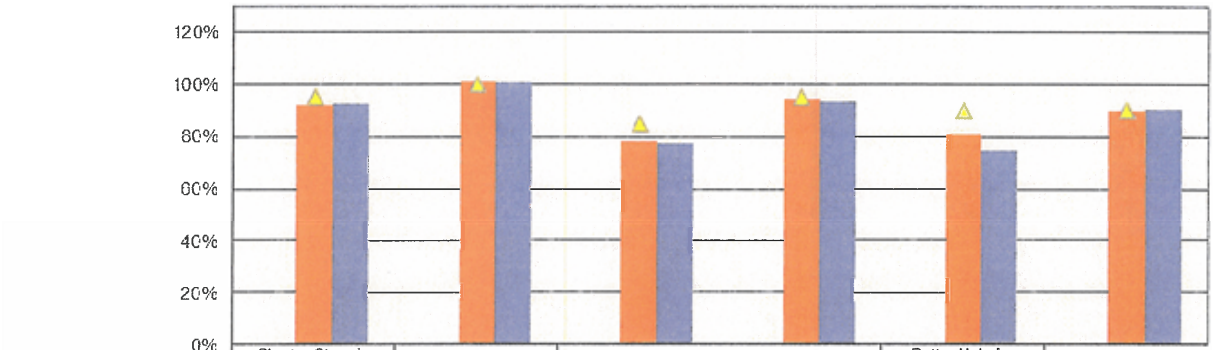
Bryn Jones, Target Champion, More heart and diabetes checks
Congratulations on maintaining the target this quarter. Your result is 90.3 percent, with the result for Māori at 86.3 percent. Please focus on addressing inequity through specific actions, as well as continuing the focus on cardiovascular risk management. Pass on my compliments to the team at Health Hawke's Bay Limited.

8

Appendix two

Quarter two 2015/16 results for your DHB

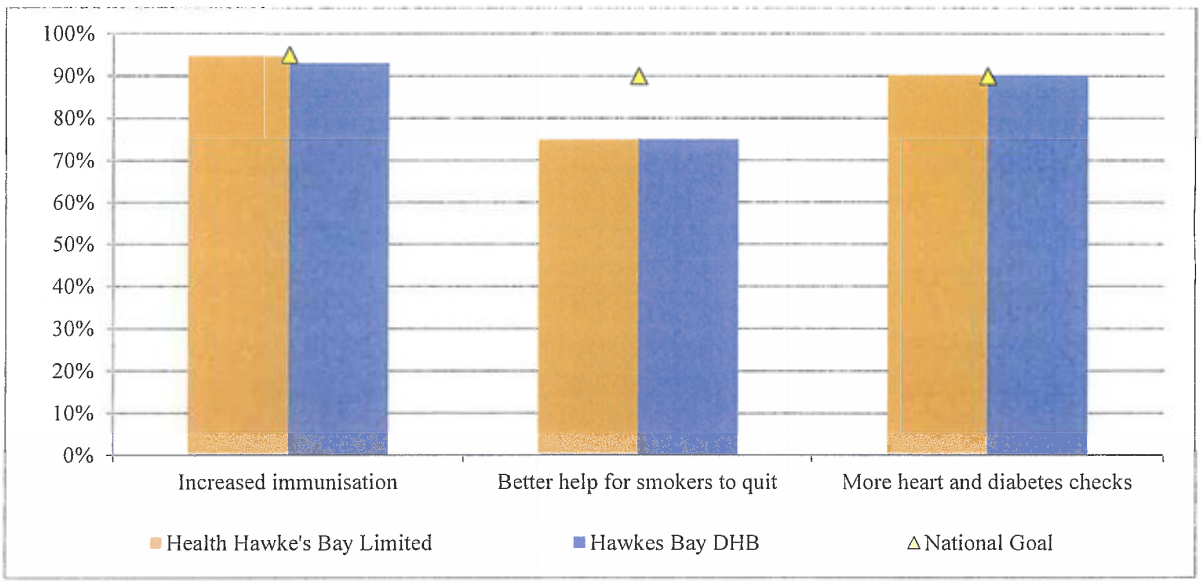
Hawke's Bay health targets quarter two 2015/16 results



	Shorter Stays in Emergency Departments	Improved Access to Elective Surgery	Faster Cancer Treatment	Increased Immunisation	Better Help for Smokers to Quit Primary Care	More heart and diabetes checks
Ranking quarter two 2015/16	15	17	4	12	19	13
Quarter one 2015/16	92.1%	100.9%	78.6%	94.5%	81.2%	90.3%
Quarter two 2015/16	92.7%	100.4%	77.6%	93.3%	75.0%	90.3%
National goal	95.0%	100.0%	85.0%	95.0%	90.0%	90.0%

Quarter two 2015/16 PHO results for the PHOs operating within your DHB

Hawke's Bay primary care health targets: Quarter 2 (October – December) 2015/16 results



	Increased immunisation	Better help for smokers to quit	More heart and diabetes checks
Health Hawke's Bay Limited	95%	75%	90%
Hawkes Bay DHB	**93% (1)**	**75%**	**90%**
National Goal	95%	90%	90%

(1) The PHO coverage for increased immunisation only includes those 8-month-olds that are enrolled in a PHO. Consequently the DHB coverage will be different to the combined PHO coverage.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, February 2016** 16
	For the attention of: **Finance Risk and Audit Committee and the Board**
Document Owner: Document Author(s):	Tim Evans, GM Planning, Informatics & Finance Finance Team
Reviewed by:	Executive Management Team
Month:	March 2016
Consideration:	For Information

9

RECOMMENDATION

That the Board
Note the contents of this report

1. GM Planning Informatics & Finance comments

Financial performance

The result for February is a favourable variance of $55 thousand, making the year to date result $136 thousand favourable.

Only the year to date part of the $1.0 million transferred to Surgical Services and the $90 thousand contributed to the corporate 3% savings plan, have been released.

Elective surgery was 5.5% above plan in February after adjusting for prior period entries, and 1.5% ahead of the health target year to date, with 81% provided in-house in comparison to the planned 75%.

Efficiency budgets have been transferred to areas with favourable variances. While this reduces the pressure to make the specific savings defined in the Sustain programme, it also reduces the risk of expenditure from underspent budgets when efficiencies have not been achieved. The transfers have been made on a year to date basis and distort the figures reported in February, however the year to date figures are not affected.

Forecast result

The forecast for the 30 June 2016 year remains at the $3.990 million budgeted surplus. Cover for vacancies and sick leave, likely costs to avoid an ESPI breach, and claw-back by MOH of PHARMAC hospital pharmacy price savings, will together be much higher than the remaining contingency. However, one off savings are expected to offset the additional costs for this year. The savings relate to:

- Intermediate care beds for health of older people
- lower Regional Health Information Project (RHIP) operating costs

- lower than expected growth in primary health care strategy costs and pharmacy payments, delayed under 13 access implementation, and unlikely expenditure of the primary mental health risk wash-up budget.

Efficiencies not achieved in the sustain programme, are expected to be offset by savings achieved elsewhere and delays in implementing new investments.

Note that the IDF and elective services wash-ups contribute uncertainty to the forecast.

Strategic Resource Redeployment (Quarter 2)

The Board approved a budget that meets the strategic requirement to shift resource from Hospital to Community, Primary, and Population health settings. The first quarter saw a significant change in the surgical directorate budget to reflect higher elective surgical activity expectations and reduced the shift out of the Hospital health setting from 0.19% to 0.07%.

The second quarter table (see below), indicates the shift in the first half of the year has been into rather than out of the Hospital health setting by 0.33%. This reflects faster cost growth in hospital services due to service improvement initiatives and unusually high locum cover requirements, and the lower level of aged community bed utilisation and timing of the engAGE programme.

	2014-15 [1] *Outturn* *$'000*	*Split %*	*2015-16* [2] *Adj Budget* *$'000*	*Split %*	*Change Split %*	*2015-16* [3] *YTD Actual* *$'000*	*Split %*	*Change Split %*
Population Health	7,524	*1.67%*	8,201	*1.77%*	*0.10%*	3,593	*1.55%*	*-0.12%*
Primary Care	94,565	*21.01%*	97,065	*20.94%*	*-0.07%*	49,189	*21.19%*	*0.18%*
Community Care	125,272	*27.83%*	129,189	*27.87%*	*0.04%*	63,719	*27.45%*	*-0.38%*
Out of Hospital sub-total	227,362	*50.52%*	234,456	*50.58%*	*0.07%*	116,501	*50.19%*	*-0.33%*
Local Hospital	173,207	*38.48%*	178,211	*38.45%*	*-0.04%*	89,856	*38.71%*	*0.22%*
Out of District	49,500	*11.00%*	50,840	*10.97%*	*-0.03%*	25,775	*11.10%*	*0.11%*
Hospital sub-total	222,707	*49.48%*	229,051	*49.42%*	*-0.07%*	115,631	*49.81%*	*0.33%*
	450,068	*100%*	463,507	*100%*		232,132	*100%*	
Corporate	39,525		41,751			22,055		
Total Expenditure	**489,593**		**505,258**			**254,187**		

1. Forecast outturn as presented to Board
2. 2015/16 adjusted budget as present to October 2015
3. Actual expenditure YTD July to December 2015

2. Resource Overview

	February				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	1,232	1,177	55	4.7%	(5,349)	(5,485)	136	2.5%	3,990	3
Contingency utilised	91	250	159	63.7%	727	2,000	1,273	63.7%	3,000	8
Quality and financial improvement	547	740	(193)	-26.1%	5,294	5,993	(699)	-11.7%	10,200	11
Capital spend	1,200	2,428	(1,228)	-50.6%	13,067	13,253	(186)	-1.4%	21,358	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,155	2,189	34	1.6%	2,119	2,165	46	2.1%	2,186	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,312	2,111	201	9.5%	18,752	18,065	687	3.8%	27,009	5

The result for February is a favourable variance of $55 thousand, with $727 thousand of the contingency utilised ($667 thousand transferred to surgical, and $60 thousand contributed to the corporate 3% savings plan year to date).

Quality and Financial Improvement (QFI) programme savings are below plan reflecting the progressive realisation of savings. Efficiency budgets have been transferred to areas that have favourable variances. The implementation and monitoring of the remaining savings plans is ongoing. Realisation of IDF savings will not be known until the 2015/16 IDF wash-up process is complete.

Capital spend is well ahead of plan year to date reflecting the catch-up of Mental Health Inpatient Unit project payments that were incurred more slowly than budgeted last year.

The FTE variance year to date reflects vacancies relating to new programmes or changes in the model of care.

Case weighted discharges were above plan in February, and are 3.8% ahead of plan year to date. High acute general surgery, and gastroenterology volumes drive the year to date variance partly offset by lower than planned maternity case weights.

3. Financial Performance Summary

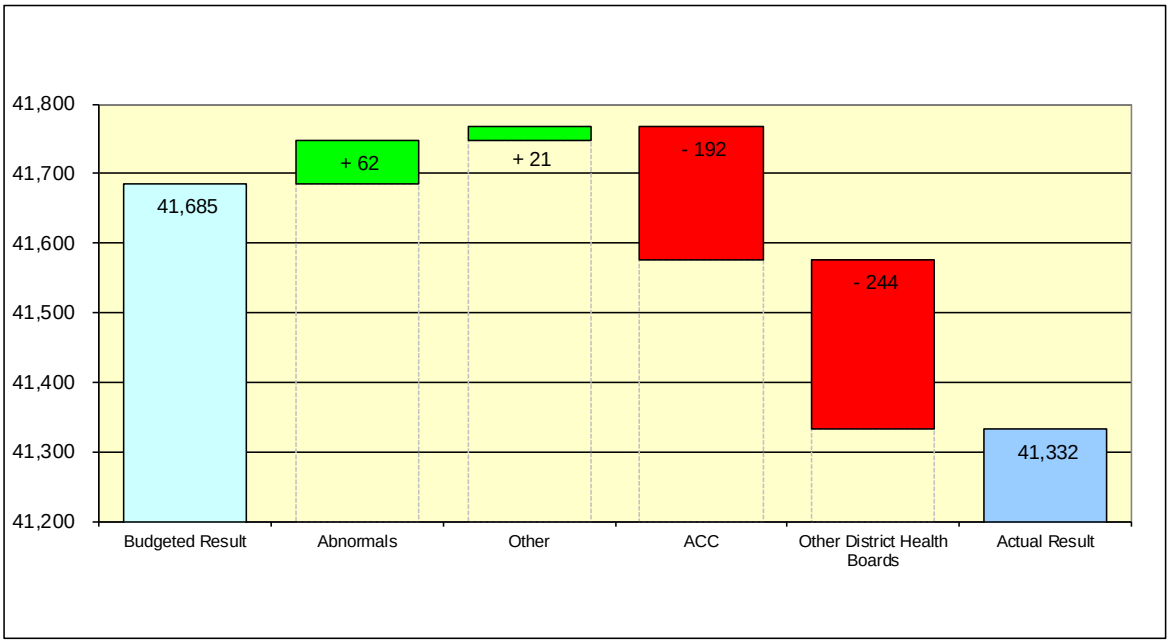
	February				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	41,332	41,685	(354)	-0.8%	332,583	333,275	(692)	0.2%	512,352	4
Less:										
Providing Health Services	18,723	18,598	(125)	-0.7%	158,272	157,682	(590)	-0.4%	240,356	5
Funding Other Providers	18,306	18,388	82	0.4%	149,026	150,052	1,026	0.7%	222,017	6
Corporate Services	2,738	3,211	473	14.7%	27,936	28,494	558	2.0%	43,510	7
Reserves	333	311	(22)	-7.0%	2,698	2,532	(166)	-6.6%	2,480	8
	1,232	**1,177**	55	4.7%	**(5,349)**	**(5,485)**	136	-2.5%	**3,990**	

Reduced income from ACC (resources reprioritised to elective surgery), and other DHBs (mostly offset by reduced costs), and costs to achieve the orthopaedic initiative and ESPI compliance, were more than offset by reduced contributions to the Regional Health Information Project (RHIP) and lower depreciation in February.

4. Income

$'000	February				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	39,528	39,530	(2)	0.0%	316,522	316,555	(33)	0.0%	488,172
Inter District Flows	624	624	1	0.1%	4,993	4,988	4	0.1%	7,487
Other District Health Boards	201	445	(244)	-54.9%	2,375	2,847	(471)	-16.5%	3,570
Financing	77	81	(4)	-5.1%	993	669	324	48.4%	1,332
ACC	314	506	(192)	-37.9%	3,421	4,137	(716)	-17.3%	5,500
Other Government	13	35	(22)	-63.5%	229	276	(47)	-17.1%	387
Patient and Consumer Sourced	135	123	12	10.0%	775	1,027	(251)	-24.5%	1,265
Other Income	378	342	36	10.4%	3,203	2,777	425	15.3%	4,582
Abnormals	62	-	62	0.0%	72	-	72	0.0%	58
	41,332	**41,685**	(354)	-0.8%	**332,583**	**333,275**	(692)	-0.2%	**512,352**

February Income



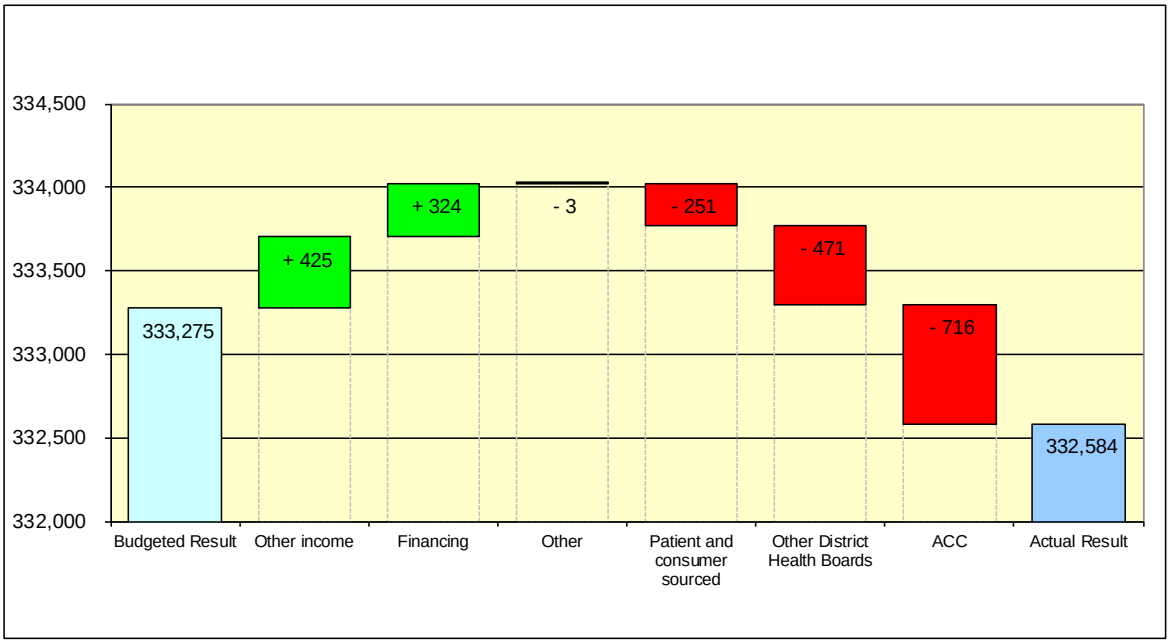
Note the scale does not begin at zero

Abnormals (favourable)
Income relating to the previous year.

ACC (unfavourable**)**
Prioritisation of elective surgery over ACC volumes.

Other District Health Boards (unfavourable)
Lower sales of cancer drugs to Tairawhiti DHB, mostly offset by lower expenditure. Lower oncology income from Mid Central DHB.

Year to date Income



Other income (favourable)
Includes clinical trial income and donations (unbudgeted).

Financing (favourable**)**
Higher cash balances than projected, and income on special fund and clinical trial balances unbudgeted.

Patient and consumer sourced (unfavourable**)**
Lower non-resident charges and patient co-payments (audiology and mental health – both offset by reduced costs).

Other District Health Boards (unfavourable**)**
Lower sales of cancer drugs to Tairawhiti DHB, partly offset by higher oncology clinic charges to Mid Central DHB. Both offset in expenditure.

ACC (unfavourable)
Prioritisation of elective surgery over ACC volumes.

5. Providing Health Services

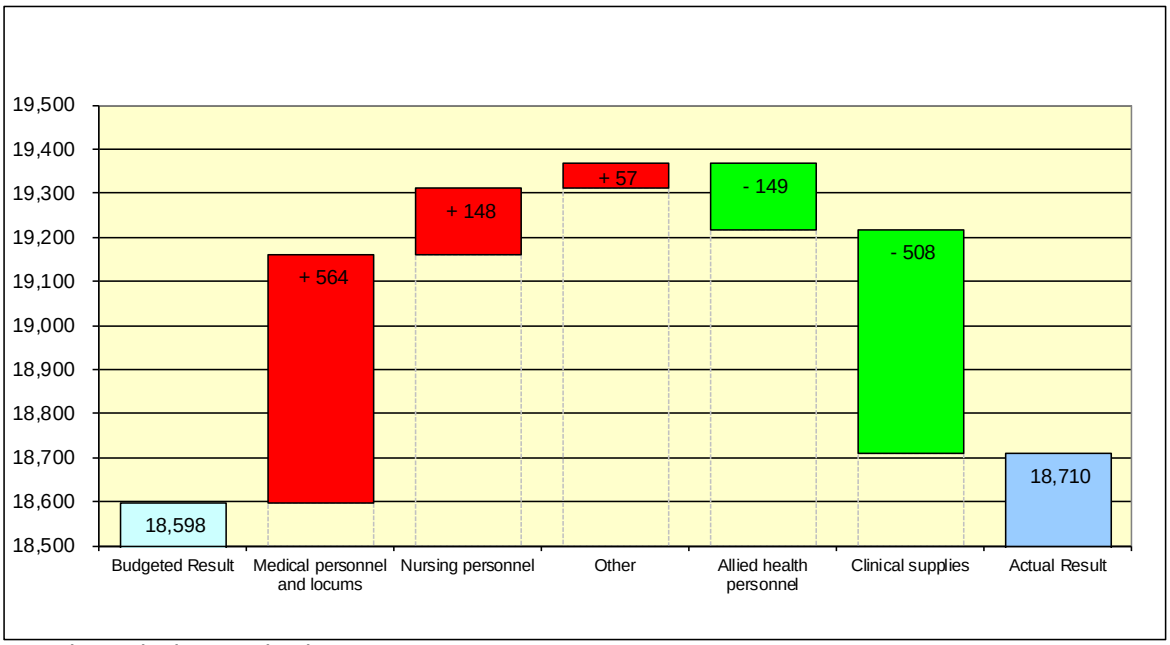
	February				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	4,677	4,113	(564)	-13.7%	38,629	37,205	(1,424)	-3.8%	57,646
Nursing personnel	5,480	5,332	(148)	-2.8%	46,237	46,523	286	0.6%	69,797
Allied health personnel	2,379	2,529	149	5.9%	19,860	21,253	1,393	6.6%	30,682
Other personnel	1,600	1,546	(54)	-3.5%	13,398	13,411	14	0.1%	20,275
Outsourced services	393	289	(104)	-36.1%	3,576	3,426	(150)	-4.4%	6,003
Clinical supplies	2,768	3,275	508	15.5%	24,274	23,509	(766)	-3.3%	37,118
Infrastructure and non clinical	1,414	1,515	101	6.7%	12,285	12,355	70	0.6%	18,822
	18,710	**18,598**	(112)	-0.6%	**158,260**	**157,682**	(577)	-0.4%	**240,343**
Expenditure by directorate $'000									
Acute and Medical	5,002	5,045	43	0.8%	43,599	42,533	(1,067)	-2.5%	65,549
Surgical Services	4,205	3,820	(385)	-10.1%	35,356	34,178	(1,178)	-3.4%	53,539
Women Children and Youth	1,485	1,523	38	2.5%	12,937	12,993	56	0.4%	19,611
Older Persons & Mental Health	2,668	2,611	(57)	-2.2%	21,706	22,265	559	2.5%	32,775
Rural, Oral and Communlty	1,643	1,715	73	4.2%	14,231	14,525	293	2.0%	21,542
Other	3,707	3,885	178	4.6%	30,430	31,189	759	2.4%	47,327
	18,710	**18,598**	(112)	-0.6%	**158,260**	**157,682**	(577)	-0.4%	**240,343**
Full Time Equivalents									
Medical personnel	297.5	295.8	(2)	-0.6%	305	303	(3)	-0.8%	303.8
Nursing personnel	895.7	905.6	10	1.1%	873	882	8	0.9%	891.7
Allied health personnel	426.4	444.9	18	4.2%	411	440	30	6.7%	445.5
Support personnel	130.4	129.5	(1)	-0.7%	130	128	(2)	-1.9%	129.4
Management and administration	248.9	245.9	(3)	-1.2%	246	245	(1)	-0.3%	247.7
	1,998.9	**2,021.7**	23	1.1%	**1,966**	**1,998**	32	1.6%	**2,018.1**
Case Weighted Discharges									
Acute	1,587	1,400	187	13.4%	13,199	12,378	821	6.6%	18,426
Elective	626	533	93	17.5%	4,244	4,084	160	3.9%	6,195
Maternity	24	149	(125)	-83.9%	1,014	1,368	(355)	-25.9%	2,035
IDF Inflows	75	29	46	159.5%	296	235	61	26.0%	353
	2,312	**2,111**	201	9.5%	**18,752**	**18,065**	687	3.8%	**27,009**

Directorates

The unfavourable result for February relates to:

- Surgical Services – orthopaedic initiative fees for service, and ESPI (waiting list) compliance.

February Expenditure



Note the scale does not begin at zero

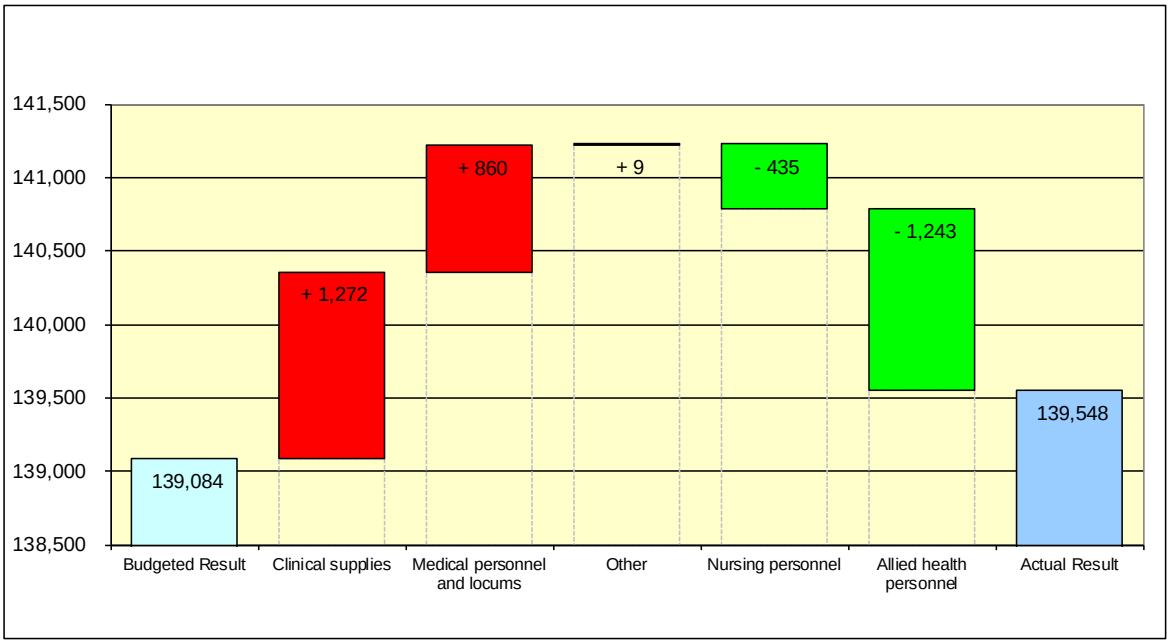
Medical personnel and locums (unfavourable)
Sick leave cover, orthopaedic initiative fees for service, and ESPI (waiting list) compliance.

Nursing personnel (unfavourable)
Year to date underspent budgets have been adjusted to offset the efficiency budgets in clinical supplies during the month of February. If budgets had not been adjusted, the variance would have been marginally favourable.

Allied health personnel (favourable)
Vacancies mainly in community support workers, psychologists and therapies.

Clinical supplies (favourable)
Year to date efficiency budgets transferred to offset savings achieved elsewhere.

Year to date Expenditure



Clinical supplies (unfavourable)
Savings targets of $1.3 million not achieved (offset elsewhere). This amount has reduced as budgets have been transferred to areas where savings have been made.

Medical personnel and locums (unfavourable)
Vacancy and leave cover, with the orthopaedic initiative and ESPI compliance costs impacting from this month.

Nursing personnel (favourable)
Lower than budgeted statutory holiday costs more than offset additional hours worked and higher than budgeted overtime.

Allied health personnel (favourable)
Vacancies mainly in mental health, and also in pharmacy, laboratory, and older person's health.

Full time equivalents (FTE)

FTEs are 32 favourable year to date, including:

Allied health personnel (30 FTE / 6.7% favourable)
- Vacancies. Recruitment to positions for new models of care, low supply of applicants, delays in staged recruitment of pharmacy facilitators, and difficulty recruiting laboratory vacancies.

Nursing personnel (8 FTE / 0.9% favourable)
- Management of low volumes in Ata Rangi, and vacancies in rural services.

Medical personnel (3 FTE / 0.8% unfavourable)
- Surgeon vacancy and sick leave cover, and obstetrician cover over the holiday period, partly offset by psychiatrist vacancies.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To January 2016

Plan for 2015/16	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	70	0	0	**70**
Non Surgical - Elective	187	0	0	**187**
Surgical - Arranged	382	0	370	**752**
Surgical - Elective	4,682	768	650	**6,100**
TOTAL	**5,321**	**768**	**1,020**	**7,109**

		YTD February 2016			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	130	130	0	0.0%
	ENT	324	279	45	16.1%
	General Surgery	657	697	-40	-5.7%
	Gynaecology	390	365	25	6.8%
	Maxillo-Facial	104	81	23	28.4%
	Ophthalmology	723	448	275	61.4%
	Orthopaedics	604	619	-15	-2.4%
	Skin Lesions	117	117	0	0.0%
	Urology	278	299	-21	-7.0%
	Vascular	101	75	26	34.7%
	Surgical - Arranged	355	254	101	39.8%
	Non Surgical - Elective	37	124	-87	-70.2%
	Non Surgical - Arranged	26	46	-20	-43.5%
On-Site	**Total**	**3846**	**3534**	**312**	**8.8%**
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	78	226	-148	-65.5%
	General Surgery	118	111	7	6.3%
	Gynaecology	0	36	-36	-100.0%
	Maxillo-Facial	40	70	-30	-42.9%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	28	0	28	0.0%
	Orthopaedics	0	16	-16	-100.0%
	Paediatric Surgery	0	0	0	0.0%
	Urology	25	16	9	56.3%
	Vascular	4	0	4	0.0%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
Outsourced	**Total**	**293**	**475**	**-182**	**-38.3%**
IDF Outflow	Cardiothoracic	48	57	-9	-15.8%
	ENT	29	28	1	3.6%
	General Surgery	27	37	-10	-27.0%
	Gynaecology	21	24	-3	-12.5%
	Maxillo-Facial	129	102	27	26.5%
	Neurosurgery	34	28	6	21.4%
	Ophthalmology	21	17	4	23.5%
	Orthopaedics	10	22	-12	-54.5%
	Paediatric Surgery	26	32	-6	-18.8%
	Skin Lesions	48	43	5	11.6%
	Urology	2	2	0	0.0%
	Vascular	11	41	-30	-73.2%
	Surgical - Arranged	102	245	-143	-58.4%
	Non Surgical - Elective	85	0	85	0.0%
	Non Surgical - Arranged	25	0	25	0.0%
IDF Outflow	**Total**	**618**	**678**	**-60**	**-8.8%**
GRAND TOTAL		**4757**	**4687**	**70**	**1.5%**

		February 2016			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	17	17	0	0.0%
	ENT	32	36	-4	-11.1%
	General Surgery	103	89	14	15.7%
	Gynaecology	46	46	0	0.0%
	Maxillo-Facial	15	10	5	50.0%
	Ophthalmology	106	57	49	86.0%
	Orthopaedics	75	79	-4	-5.1%
	Skin Lesions	15	15	0	0.0%
	Urology	56	38	18	47.4%
	Vascular	19	10	9	90.0%
	Surgical - Arranged	51	33	18	54.5%
	Non Surgical - Elective	0	16	-16	-100.0%
	Non Surgical - Arranged	2	5	-3	-60.0%
On-Site	**Total**	**537**	**451**	**86**	**19.1%**
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	32	36	-4	-11.1%
	General Surgery	27	17	10	58.8%
	Gynaecology	0	5	-5	-100.0%
	Maxillo-Facial	0	11	-11	-100.0%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	28	0	28	0.0%
	Orthopaedics	0	3	-3	-100.0%
	Paediatric Surgery	0	0	0	0.0%
	Urology	7	2	5	250.0%
	Vascular	0	0	0	0.0%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
Outsourced	**Total**	**94**	**74**	**20**	**27.0%**
IDF Outflow	Cardiothoracic	9	6	3	50.0%
	ENT	0	3	-3	-100.0%
	General Surgery	1	5	-4	-80.0%
	Gynaecology	0	3	-3	-100.0%
	Maxillo-Facial	5	11	-6	-54.5%
	Neurosurgery	5	3	2	66.7%
	Ophthalmology	0	2	-2	-100.0%
	Orthopaedics	1	3	-2	-66.7%
	Paediatric Surgery	3	4	-1	-25.0%
	Skin Lesions	3	5	-2	-40.0%
	Urology	1	0	1	0.0%
	Vascular	0	5	-5	-100.0%
	Surgical - Arranged	6	30	-24	-80.0%
	Non Surgical - Elective	12	0	12	0.0%
	Non Surgical - Arranged	2	0	2	0.0%
IDF Outflow	**Total**	**48**	**80**	**-32**	**-40.0%**
GRAND TOTAL		**679**	**605**	**74**	**12.2%**

Please Note: The data displayed is as at 7TH March 2016. IDF Events not yet captured in NMDS will not be reported above. Avastins and Skin Lesions have been manually adjusted to plan.

6. Funding Other Providers

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,150	3,155	5	0.2%	28,323	28,468	146	0.5%	42,095
Primary Health Organisations	2,605	2,855	251	8.8%	22,365	22,770	405	1.8%	33,942
Inter District Flows	3,903	3,899	(5)	-0.1%	31,253	31,189	(64)	-0.2%	46,848
Other Personal Health	1,943	1,961	18	0.9%	15,594	15,622	28	0.2%	22,154
Mental Health	1,081	1,116	34	3.1%	8,978	8,925	(53)	-0.6%	13,365
Health of Older People	5,154	4,949	(206)	-4.2%	39,458	39,591	133	0.3%	58,675
Other Funding Payments	469	454	(16)	-3.4%	3,055	3,486	431	12.4%	4,938
	18,306	18,388	82	0.4%	**149,026**	**150,052**	1,026	0.7%	222,017
Payments by Portfolio									
Strategic Services									
Secondary Care	4,032	4,161	129	3.1%	33,096	33,267	171	0.5%	47,994
Primary Care	6,805	6,924	119	1.7%	58,176	58,872	696	1.2%	87,797
Chronic Disease Management	366	376	10	2.8%	2,614	2,779	165	5.9%	3,974
Mental Health	1,081	1,112	31	2.7%	8,974	8,895	(79)	-0.9%	13,346
Health of Older People	5,241	5,035	(206)	-4.1%	40,386	40,277	(110)	-0.3%	59,946
Other Health Funding	(2)	(17)	(15)	-88.5%	(48)	(133)	(86)	-64.2%	(123)
Maori Health	584	526	(58)	-11.0%	4,114	4,211	96	2.3%	6,272
Population Health									
Women, Child and Youth	100	114	14	12.5%	879	850	(29)	-3.4%	1,354
Population Health	99	157	58	36.8%	834	1,035	201	19.4%	1,456
	18,306	18,388	82	0.4%	**149,026**	**150,052**	1,026	0.7%	222,017

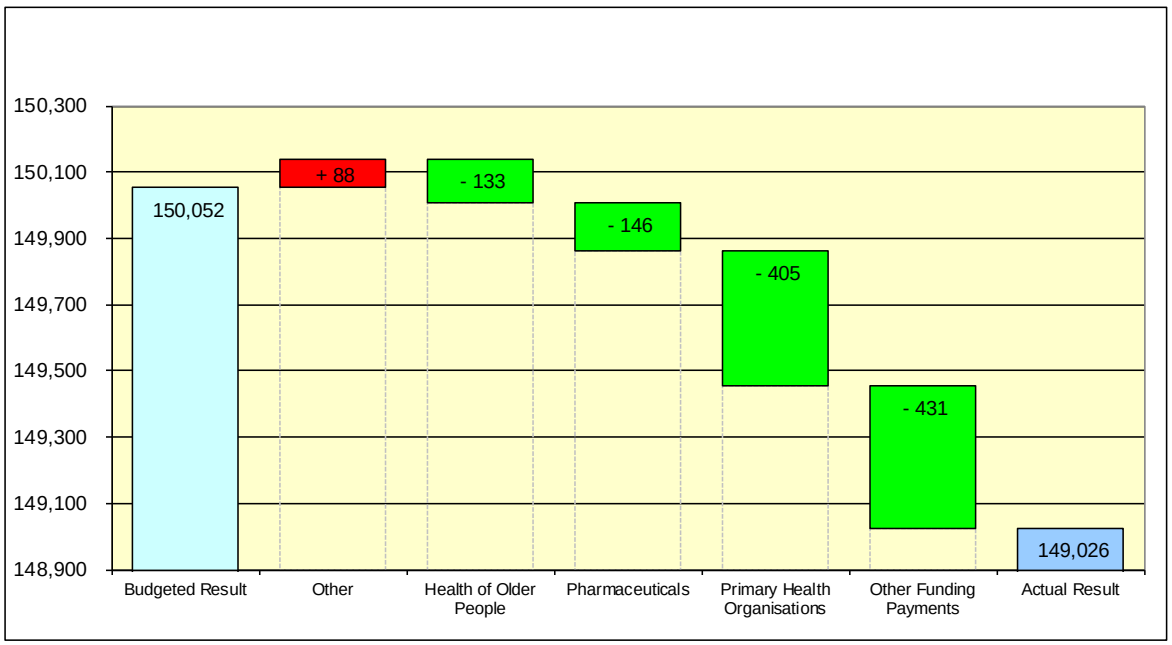
February Expenditure

Health of Older People (unfavourable)
Catch up payments relating to community support costs.

Primary Health Organisations (favourable)

Delayed implementation of lower cost access services and skin lesion removals.

Year to date Expenditure



Health of Older People (favourable)
Lower community support costs (demand driven).

Pharmaceuticals (favourable)
Lower payments to pharmacies (demand driven).

Primary Health Organisations (favourable)
Lower access payments (delayed implementation).

Other Funding Payments (favourable)
Other funding payments reflects later than planned implementation of new investments, and delay of the Whanau Manaaki programme.

7. Corporate Services

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,145	1,182	37	3.1%	9,656	9,761	106	1.1%	14,630
Outsourced services	83	86	3	3.5%	783	692	**(91)**	**-13.2%**	1,161
Clinical supplies	27	0	(26)	-5501.8%	87	4	**(83)**	**-2162.0%**	88
Infrastructure and non clinical	252	575	**323**	**56.2%**	5,395	5,612	217	3.9%	8,311
	1,507	1,844	**337**	**18.3%**	15,920	16,069	149	0.9%	24,191
Capital servicing									
Depreciation and amortisation	1,076	1,212	**136**	**11.2%**	8,728	9,049	321	3.6%	13,550
Financing	155	155	0	0.3%	1,301	1,305	4	0.3%	1,953
Capital charge	-	-	-	0.0%	1,987	2,071	84	4.1%	3,816
	1,231	1,367	**136**	**10.0%**	12,016	12,425	409	3.3%	19,320
	2,738	**3,211**	**473**	**14.7%**	**27,936**	**28,494**	558	2.0%	**43,510**
Full Time Equivalents									
Medical personnel	-	-	-	0.0%	1	-	(1)	0.0%	-
Nursing personnel	13.9	16.4	2	15.1%	12	16	5	29.2%	16.5
Allied health personnel	-	-	-	0.0%	0	-	(0)	0.0%	-
Support personnel	8.6	9.4	1	8.3%	9	9	0	0.7%	9.4
Management and administration	133.3	141.4	**8**	**5.7%**	132	141	**9**	**6.5%**	142.5
	155.8	**167.1**	**11**	**6.8%**	**153**	**167**	**14**	**8.1%**	**168.4**

Infrastructure and non-clinical supplies includes lower than expected payments for the Regional Health Information Project.

Depreciation and amortisation costs reflects the later than budgeted opening of the new mental health inpatient unit.

8. Reserves

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	159	159	0	0.0%	1,273	1,273	0	0.0%	92
Transform and Sustain resource	44	40	(4)	-11.3%	323	310	(13)	-4.2%	859
Other	130	112	(17)	-15.3%	1,102	949	**(153)**	**-16.1%**	1,529
	333	**311**	(22)	-7.0%	**2,698**	**2,532**	**(166)**	**-6.6%**	**2,480**

The Other category includes loss on disposal of assets and TAS audits relating to 2014/15.

9. Financial Performance by MOH Classification

$'000	February Actual	February Annual Plan	February Variance	Year to Date Actual	Year to Date Annual Plan	Year to Date Variance	End of Year Forecast	End of Year Annual Plan	End of Year Variance
Funding									
Income	39,760	39,767	(6) U	318,687	318,819	(132) U	491,592	491,789	(197) U
Less:									
Payments to Internal Providers	21,118	21,118	(0) U	174,976	174,975	(0) U	262,678	262,678	(0) U
Payments to Other Providers	18,306	18,388	82 F	149,026	150,052	1,026 F	222,017	224,462	2,445 F
Contribution	**336**	**260**	**76 F**	**(5,315)**	**(6,208)**	**893 F**	**6,898**	**4,649**	**2,248 F**
Governance and Funding Admin.									
Funding	262	262	-	2,092	2,092	-	3,140	3,140	-
Other Income	4	3	1 F	30	20	10 F	40	30	10 F
Less:									
Expenditure	206	251	45 F	1,702	2,026	324 F	2,650	3,049	398 F
Contribution	**59**	**13**	**46 F**	**420**	**86**	**334 F**	**530**	**121**	**408 F**
Health Provision									
Funding	20,856	20,856	0 F	172,883	172,883	0 F	259,538	259,538	0 F
Other Income	1,568	1,916	(349) U	13,866	14,436	(570) U	20,720	21,479	(759) U
Less:									
Expenditure	21,587	21,869	282 F	187,204	186,682	(522) U	283,695	281,797	(1,898) U
Contribution	**837**	**903**	**(67) U**	**(455)**	**637**	**(1,092) U**	**(3,437)**	**(781)**	**(2,656) U**
Net Result	**1,232**	**1,177**	**55 F**	**(5,349)**	**(5,485)**	**136 F**	**3,990**	**3,990**	**-**

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

10. Management Budget Movements

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

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2015/16 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

$'000	February Mgmt Budget	February Annual Plan	February Movement	Year to Date Mgmt Budget	Year to Date Annual Plan	Year to Date Movement	End of Year Mgmt Budget	End of Year Annual Plan	End of Year Movement
Funding									
Income	39,767	39,570	197 F	318,819	317,313	1,506 F	491,789	489,518	2,271 F
Less:									
Payments to Internal Providers	21,118	21,158	40 F	174,975	175,477	502 F	262,678	263,334	656 F
Payments to Other Providers	18,388	18,192	(197) U	150,052	148,548	(1,504) U	224,462	222,194	(2,268) U
Contribution	**260**	**220**	**40 F**	**(6,208)**	**(6,712)**	**504 F**	**4,649**	**3,990**	**659 F**
Governance and Funding Admin.									
Funding	262	262	-	2,092	2,092	-	3,140	3,140	-
Other Income	3	3	-	20	20	-	30	30	-
Less:									
Expenditure	251	261	10 F	2,026	2,107	80 F	3,049	3,170	121 F
Contribution	**13**	**3**	**10 F**	**86**	**6**	**80 F**	**121**	**(0)**	**121 F**
Health Provision									
Funding	20,856	20,896	(40) U	172,883	173,385	(502) U	259,538	260,194	(656) U
Other Income	1,916	1,662	254 F	14,436	14,009	427 F	21,479	20,865	613 F
Less:									
Expenditure	21,869	21,605	(264) U	186,682	186,172	(510) U	281,797	281,060	(738) U
Contribution	**903**	**953**	**(50) U**	**637**	**1,221**	**(584) U**	**(781)**	**0**	**(781) U**
Net Result	**1,177**	**1,177**	**(0) U**	**(5,485)**	**(5,485)**	**(0) U**	**3,990**	**3,990**	**(0) U**

11. Quality and Financial Improvement Programme

Row Labels	Sum of Planned Savings	Count of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings
CORPORATE	**1,360**	**14**	**907**	**889**
Green	1,360	14	907	889
Health Services	**7,000**	**77**	**4497**	**3889**
Amber	2,704	12	1802	1302
Green	3,415	57	2107	2316
Red	882	8	588	271
Maori Health	**82**	**1**	**55**	**48**
Green	82	1	55	48
POPULATION HEALTH	**70**	**2**	**46**	**41**
Green	70	2	46	41
STRATEGIC SERV	**1,688**	**2**	**488**	**427**
Green	1,688	2	488	427
Grand Total	**10,200**	**96**	**5993**	**5294**

We are $699 thousand behind in our savings plans year to date.

The eight red programmes are (full year planned savings in brackets, and no savings have been achieved unless stated otherwise):

- Radiology duplicate testing ($45 thousand);
- Reduction in harm from falls ($50 thousand);
- Reduction in pressure sores ($20 thousand);
- Surgical Services savings ($400 thousand) – theatre overtime and clinical supplies has contributed $216 thousand.
- Contributions to the $1 million additional savings requirement:
    - Rural, Oral and Community ($103 thousand);
    - Mental Health ($94 thousand);
    - Women, Child and Youth ($98 thousand);
    - Older Persons Health and Allied Health ($60 thousand);
    - Laboratory ($55 thousand)
    - Other ($76 thousand)

Corporate, Maori Health, Population Health and Strategic Services

All green

Health Services

There are 12 amber programmes

Acute and Medical (5 projects): Savings of $455 thousand against a $1.033 million full year plan.

COO (2 projects): Savings of $276 thousand against a $726 thousand full year plan.

Older Persons Health and Allied Health (1 project): Savings of $459 thousand against $689 thousand full year plan.

Rural, Oral and Community (3 projects): Savings of $18 thousand against a full year target of $114 thousand.

Mental Health and Addiction (1 project): Savings of $94 thousand against a full year target of $141 thousand.

12. Financial Position

30 June 2015	$'000	February Actual	February Budget	Variance from budget	Movement from 30 June 2015	Annual Budget
	Equity					
120,014	Crown equity and reserves	102,965	108,540	5,574	(17,048)	108,183
(32,388)	Accumulated deficit	(20,689)	(25,895)	(5,206)	11,699	(16,420)
87,626		82,277	82,645	368	(5,349)	91,763
	Represented by:					
	Current Assets					
14,970	Bank	17,590	(693)	(18,283)	2,620	8,756
1,703	Bank deposits > 90 days	1,741	1,564	(178)	39	1,564
17,862	Prepayments and receivables	8,641	18,026	9,385	(9,221)	18,146
3,881	Inventory	3,868	3,793	(75)	(13)	3,845
1,220	Non current assets held for sale	1,220	-	(1,220)	-	-
39,635		33,060	22,690	(10,370)	(6,575)	32,310
	Non Current Assets					
148,434	Property, plant and equipment	153,082	163,213	10,131	4,648	166,016
2,298	Intangible assets	1,858	1,725	(133)	(440)	2,217
7,301	Investments	8,932	8,887	(44)	1,630	9,351
158,033		163,871	173,825	9,954	5,838	177,583
197,668	**Total Assets**	**196,931**	**196,515**	**(416)**	**(737)**	**209,894**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	0	-	(0)	(0)	-
29,960	Payables	33,764	35,622	1,858	3,804	35,540
35,239	Employee entitlements	36,047	33,340	(2,707)	808	32,660
65,199		69,812	68,963	(849)	4,612	68,200
	Non Current Liabilities					
2,342	Employee entitlements	2,342	2,407	65	-	2,431
42,500	Term borrowing	42,500	42,500	-	-	47,500
44,842		44,842	44,907	65	-	49,931
110,042	**Total Liabilities**	**114,654**	**113,870**	**(784)**	**4,612**	**118,131**
87,626	**Net Assets**	**82,277**	**82,645**	**368**	**(5,349)**	**91,763**

The variance from budget for:

- Crown equity and reserves relates to the reversal of revaluation reserves for assets disposed of prior to 30 June 2015, to comply with Audit NZ's recommendations, and to a lower valuation of land and buildings than estimated at 30 June 2015;
- Bank reflects lower capital spend and the receipt of wash-ups
- Prepayments and receivables reflect the accrual for wash-ups. This amount will continue to increase until wash-ups are received sometime after 30 June 2016.
- Property, plant and equipment relates to the revaluation and later payments for the MHIU over the project life;
- Employee entitlements – see below

13. Employee Entitlements

30 June		*February*				*Annual*
2015	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2015*	*Budget*
7,916	Salaries & wages accrued	8,252	6,749	(1,503)	336	5,482
1,370	ACC levy provisions	1,575	924	(651)	205	1,176
4,951	Continuing medical education	6,133	5,669	(464)	1,182	4,860
19,383	Accrued leave	18,342	18,520	177	(1,040)	19,649
3,962	Long service leave & retirement grat.	4,087	3,886	(201)	125	3,925
37,582	**Total Employee Entitlements**	38,389	35,747	(2,642)	808	35,091

14. Treasury

Liquidity management

The surplus cash of all DHBs is managed by NZ Health Partnerships Limited under a sweep arrangement facilitated by Westpac. The DHB provides forecast cash flow information to NZHPL, to allow them to invest the funds at the most advantageous rates, and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due.

Debt management

The term debt facility with MOH is for $42.5 million, and is fully drawn. A further $5 million relating to the disposal of the Napier site, is available for the mental health build, and is likely to be drawn down in the last quarter of calendar 2016. The DHBs interest exposure is managed through a spread of maturity dates, rather than the use of derivative financial instruments, and the average cost of borrowing is currently 4.58%. No debt will become current until the 2017/18 financial year, and $25 million is for terms longer than five years.

The drawdown of $6.5 million in June 2012 increased the amount maturing in March 2019 to $11.5 million. This was done to take advantage of the low interest rate applying to that maturity, but it also puts the balance for that year above the $10 million limit set in the Treasury Management Policy.

Foreign exchange risk management

No material transactions occurred during the month. No transactions met the criteria that would trigger the requirement to arrange foreign exchange rate cover.

15. Capital Expenditure

2016 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,872	Depreciation	8,728	9,049	321
3,990	Surplus/(Deficit)	(5,349)	(5,485)	(136)
(113)	Working Capital	11,241	10,616	(624)
17,749		14,619	14,180	(439)
	Other Sources			
-	Special funds and clinical trials	78	-	(78)
5,000	Borrowings	-	-	-
5,000		78	-	(78)
22,749	**Total funds sourced**	**14,698**	**14,180**	**(517)**
	Application of Funds:			
	Block Allocations			
3,856	Facilities	1,831	2,434	603
3,000	Information Services	680	1,700	1,020
5,200	Clinical Plant & Equipment	1,955	3,185	1,230
-	Minor Capital	26	27	1
12,056		4,492	7,345	2,854
	Local Strategic			
665	Renal Centralised Development	43	388	345
848	New Stand-alone Endoscopy Unit	138	306	168
5,654	New Mental Health Inpatient Unit Development	6,552	3,769	(2,783)
2,035	Maternity Services	1,693	1,366	(328)
100	Upgrade old MHIU	-	67	67
9,302		8,427	5,895	(2,531)
	Other			
-	Special funds and clinical trials	78	-	(78)
-	Transform and Sustain	3	-	(3)
-	Other	68	12	(55)
-		149	12	(136)
21,358	***Capital Spend***	***13,067***	***13,253***	***186***
	Regional Strategic			
1,391	RHIP (formerly CRISP)	1,630	927	(703)
1,391		1,630	927	(703)
22,749	**Total funds applied**	**14,698**	**14,180**	**(517)**

The year to date budget excludes any funding brought forward from last year, however the year to date actual column includes expenditure against that funding.

Monthly Project Board Report
Feb 2016

HAWKE'S BAY District Health Board

New Mental Health Unit Development

Project Director: G Carey-Smith (Acting)

Overall Project Progress	Overall Status	Time Status	Financial Status
85%	G	G	G

Phase: Service & Facility Implementation

Formal approval of the Business Case was received in April 2013 from the Minister of Health for a replacement mental health facility. The project will provide four key deliverables:
1). Service redesign of acute mental health services to align with the HBDHB 2012 Mental Health Model of Care. Includes for investment in alternatives to inpatient care, with an increased focus on care provided in the community.
2). A replacement mental health inpatient unit on the Hawke's Bay Regional Hospital site.
3). A replacement mental health sub-acute facility, co-located with the inpatient unit.
4). A replacement of the Recovery Centres to move to a Day programme (co-located with the inpatient unit) and some services within the community.
The project programme spans over a 30 month period and occur in 2 phases. The first phase including service & transition planning, facility design & tendering was completed on time with the main construction contract approved at the 25 June 2014 Board Meeting. Phase 2 is now underway and includes the main build construction contract together with the implementation of transition management to the new service delivery model.

Project Budget Status

Total Approved Project Budget	**$ 19,800,000**	Total 15/16 Total Forecast Spend	$ 7,272,000
Total Project Spend to Date	$ 16,871,984	Total 15/16 Spend to Date	$ 6,552,000
Percentage of Total Spend vs Budget	85%	Percentage 15/16 Spend vs Forecast	90%

The building tender process was completed and approval received at the 25 June 2014 Board Meeting for the letting of a contract with the successful tenderer. A good tender price plus savings from the site development projects has provided an overall saving to budget of $2.2M resulting in the total project budget being reduced to $19.8M. The new figures are reflected in the graph below. The 2015/16 Total Forecast Spend against 15/16 Spend to Date is consistent with plan.

Deliverable Dates

Phase 2 Facilities: Design & Tendering Stage	Jul-14	√	Phase 2 / Stage 2 of Service Transition begins	Apr-15	√
Site Works	Sep-14	√	HBT, unplanned respite implemented & embedded	Jul-15	√
Main Construction	Oct-15	√	Design and IT decisions made re CMHT	Oct-15	√
Commissioning & Building Fit-out	Nov-15	√	Revised policies, process, performance indicators	Nov-15	√
Decant Relocate Staff	Dec-15	√	Acute Unit "Goes Live"	Jan-16	√
Project Handed over for 'Go Live'	Jan-16	√	IT solutions, reporting in place	Jun-16	
Property Disposal	(Settlement Dependant)		TOR Phase 3 commences	Mar-16	

Key Achievements this period

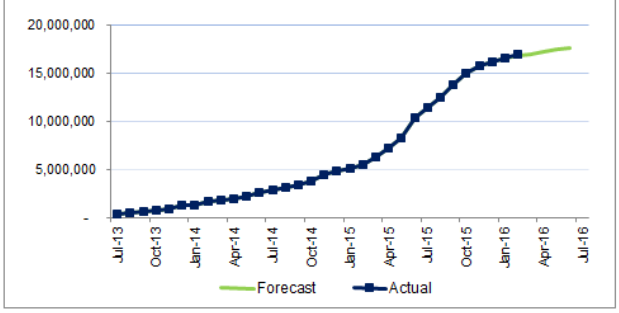
Planning for Phase 3 commenced.
SPOE continues in co-design phase. Established sub-groups working well to task. Recommendations made for staffing & timing of implementation.
Continue to work with vendor to confirm the feasibility for IS developments needed to support the new model of care. IS systems necessary to support operations.
Focus continues on integration across services, embedding Vision & Behaviour statement and strengthening community mental health.
Review of Transition to Nga Rau Rakau commenced.

Planned Activities next period

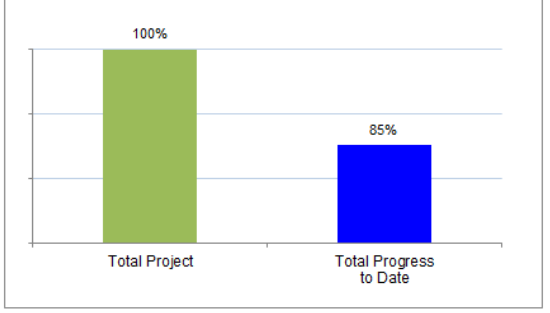
Embedding, integration & review of changes implemented; includes reporting, procedures, Vision & Behaviour statement, patient journey
SPoE - progressing towards implementation
IDP - Working group meeting weekly. Recruitment of lead priority, position description developed, getting ready for advertising.
Implementation of 1 Assessment: 1 Plan
Strengthen Community Mental Health; recruitment of Manager, Case Load management, Key worker role, Review of meeting framework.
Any building defects are managed as required over the next 12 months. Final external landscaping, parking and other works are to be finalised.

Risks & Issues of Note	Mitigation & Resolutions
Ensure project costs remain safely within budget parameters	Regular assessments and tight control of project costs and contingency spend
Service delivery model not fully "owned" by service providers	Ongoing development and implementation of MoC. Staying true to MoC as founding document.
Timely alignment of any Community Contracts	Service Re-design & Transition Management completed in timely manner
Engagement with wider consumers	Partnership Advisory Group ongoing.
Ability to secure adequate clinical resources in timely manner	Dependent on availability within current market but extending possible catchment area
Potential Inability of IS to deliver IT requirements & adequate resourcing to support implementation of Model of Care	Ongoing engagement with IS resource and potential provider to establish timeline & any funding requirements

Forecast vs Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	February Forecast	Variance	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget	Feb Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	40,271	40,942	(671)	43,886	44,725	40,858	42,758	43,876	42,407	51,446	43,734	42,407	42,407	43,864	42,517
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	54	-	54	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	2,868	428	2,440	428	448	448	469	436	441	433	500	438	446	435	456
Cash paid to suppliers	(23,324)	(25,162)	1,837	(25,520)	(25,082)	(25,046)	(24,687)	(28,950)	(20,652)	(26,583)	(27,610)	(28,541)	(24,179)	(25,814)	(24,033)
Cash paid to employees	(14,598)	(14,019)	(579)	(18,262)	(15,303)	(14,719)	(16,215)	(14,102)	(19,758)	(15,245)	(15,189)	(17,856)	(14,469)	(16,743)	(14,482)
Cash generated from operations	**5,271**	**2,189**	**3,081**	**531**	**4,788**	**1,542**	**2,325**	**1,259**	**2,439**	**10,051**	**1,435**	**(3,551)**	**4,206**	**1,744**	**4,459**
Interest received	77	86	(9)	88	84	86	82	81	80	67	66	80	72	75	68
Interest paid	(14)	0	(14)	(98)	(419)	(261)	(190)	(0)	(0)	(98)	(420)	(271)	(213)	(14)	(94)
Capital charge paid	-	-	-	-	-	-	(3,910)	-	-	-	-	-	(4,142)	-	-
Net cash inflow/(outflow) from operating activities	**5,333**	**2,275**	**3,058**	**522**	**4,453**	**1,366**	**(1,693)**	**1,339**	**2,518**	**10,019**	**1,081**	**(3,743)**	**(77)**	**1,805**	**4,433**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	5	-	5	-	-	-	0	0	0	0	0	0	1,220	0	0
Acquisition of property, plant and equipment	(1,135)	(1,378)	243	(1,665)	(1,544)	(1,390)	(3,328)	(3,078)	(3,078)	(3,078)	(3,078)	(1,753)	(1,753)	(1,753)	(1,753)
Acquisition of intangible assets	(65)	(121)	56	(65)	(50)	(20)	(20)	(375)	(375)	(375)	(376)	-	-	-	-
Acquisition of investments	(741)	(116)	(625)	(479)	0	0	(348)	-	-	(285)	-	-	(285)	-	-
Net cash inflow/(outflow) from investing activities	**(1,936)**	**(1,615)**	**(320)**	**(2,209)**	**(1,594)**	**(1,410)**	**(3,696)**	**(3,453)**	**(3,453)**	**(3,738)**	**(3,454)**	**(1,753)**	**(818)**	**(1,753)**	**(1,753)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	5,000	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	(357)	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**5,000**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	3,397	660	2,737	(1,687)	2,859	(44)	(5,747)	(2,114)	(935)	6,281	(2,373)	(496)	(895)	52	2,679
Add:Opening cash	15,933	15,933	-	19,331	17,643	20,502	20,458	14,711	12,597	11,662	17,944	15,571	15,075	14,180	14,232
Cash and cash equivalents at end of year	**19,331**	**16,593**	**2,737**	**17,643**	**20,502**	**20,458**	**14,711**	**12,597**	**11,662**	**17,944**	**15,571**	**15,075**	**14,180**	**14,232**	**16,911**
Cash and cash equivalents															
Cash	7	7	-	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	16,225	13,474	2,751	14,538	17,397	17,353	11,606	9,495	8,560	14,842	12,468	11,973	11,078	11,130	13,809
Short term investments (special funds/clinical trials)	3,098	3,112	(13)	3,098	3,098	3,098	3,098	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	(0)	-	(0)	(0)	(0)	(0)	(0)	-	-	-	-	-	-	-	-
	19,331	**16,593**	**2,738**	**17,643**	**20,502**	**20,458**	**14,711**	**12,597**	**11,662**	**17,944**	**15,570**	**15,075**	**14,180**	**14,232**	**16,911**

Draw-down of the revenue banking in 2015-16 is $0.8 million.

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 17
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs
Reviewed by:	Not applicable
Month:	March, 2016
Consideration:	For Information

RECOMMENDATION

That the Board

Note the contents of this report

Council met on 9 March 2016, an overview of issues discussed/agreed in the Public Section of the meeting.

It should be noted that the Clinical Counicl had a number of invited guests from Hutt Valley DHB in attendance to understand how our Clinical Council works, with a view to establishing a Council within their DHB.

DAVANTI IS REVIEW

The Clinical Council received a cover page report and presentation on the IS Review undertaken by the Davanti Group at the end of 2015. A number of recommendations were proposed and Clinical Council provided feedback on those recommendations.

Points raised by Council members included:

- Ensure clear strategic direction is developed for IS in the HB health sector (and the region)
- Establish operational standards and guidelines to ensure more effective customer focussed service is achieved.
- Ensure the needs of multiple stakeholders were understood and considered as part of this review.

It was noted that there was still an element of scepticism from clinical staff about IS in several areas:

- Over promising and under delivering.
- The IS Department are perceived as a "blockers" not "enablers".

Clinicians need to see that the outcomes of this review were going to make a difference for them in terms of health services and delivering health care to consumers.

Clinical Council agreed with the general approach and the report was accepted and would like to be kept informed of progress.

MOH MOBILITY ACTION PLAN

Andy Phillips, Chief Allied Health Professions Officer (CAHPO) provided a presentation on the Mobility Action Programme (MAP) with the aim is to support people with musculoskeletal conditions to fulfil their health potential and increase independence, through improved access to high quality advice, assessment, diagnosis and treatment. The MAP would include self-management education and rehabilitation programmes - increasing the indiviuals ability to carry out daily activities and improve function.

It was recommended that as a DHB we should apply to the MOH for funding to implement this approach across the sector as it aligns well with a number of key pieces of work underway. The CAHPO was still in the formative stage and working up an expression of interest around the principles. Further discussions will be had with the steering group, if we choose to go through to the RFP stage.

A number of questions/comments were raised by Council and commented on as follows:

- The cost of the programme would be around $350,000 for two years.
- There would be a national evaluation. Advised we may want to have some additional items in the evaluation to fulfil the aims of the programme. Some things could be added locally which would better inform the success of the programme and compare it with others.
- There may not be an obligation for the Ministry to fund, however there is an obligation to our patients. We need to be careful around expectations!
- There will be criteria to meet for the walk in clinic before consumers can access the “free” service. It will be targeted and we need to be certain what it is for, and not just for any physio condition!
- As the DHB is one of the largest employers in Hawke’s Bay, will there be a walk in clinic for staff? This was not the main objective and would need some thought. There would be benefits in keeping staff at work.

Clinical Council were generally supportive of the overall approach.

DRAFT COMPLEMENTARY THERAPIES POLICY

The first draft of the policy was presented to Clinical Council. The policy was at a formative stage and for complementary therapists who practice on or renting DHB premises. Clinical Council provided comment and feedback on the draft policy and it was agreed that a further version would be presented back at a future meeting.

DRAFT ANNUAL PLAN AND STATEMENT OF INTENT

A presentation was received by Council on progress of the first draft of the HBDHB Annual Plan and refresh of the statement of intent 2016/17. The refresh will focus on incorporating the NZ Health Strategy and how we will measure the implementation and impact of transform and sustain, projects and the vision and values dashboard.

The first draft of the annual plan is due to the Ministry by 31 March. New or increased areas of focus include:

- Reducing childhood obesity has been introduced as a National Health Target
- Reducing Unintended Teenage Pregnancy is a National Priority
- The focus for Stroke has extended to cover timely transfer to inpatient rehabilitation
- Increased emphasis on plans to shift services into the community e.g. Health and Social Care networks, District nursing, engAGE, Pharmacy Facilitators etc.

With less focus on:

- More Heart and Diabetes checks is no longer a health target but remains a priority; and
- nationally there is less focus on child and maternal health activity such as antenatal education and LMC enrolment. However, these remain as activities relating to outcomes such as increasing breastfeeding rates and reducing SUDI in our Annual Plan.

Local Maori Health Priorities:

- Māori Workforce
- Obesity
- Alcohol (which includes other drugs) NEW

The draft was supported by the Clinical Council. The Chair commented that the draft is comprehensive and more succinct.

URGENT CARE ALLIANCE

An update was provided to Clinical Council. At this moment we are in the middle of the expressions of interest process which closes on 21 March 2016. A number of meetings have been held with health providers which had generated good discussion on both out of hours cover and urgent care during the day. A future proposal will be presented in May taking into consideration all the feedback generated.

A concern was raised that with the ever increasing demands on ED, we needed to establish a model in primary care that would reduce pressure within the hospital and what the congtingency would be if there were no suitable applicants. At the moment we are likely to have a satisfactory response. However from a structural point of view the key will be the need for behavioural change which would not happen overnight.

MONITORING AND COMMITTEE REPORTS

A number of performance and committee reports were tabled and noted by Clinical Council. This included the Annual Māori Health Plan Q2 Dashboard and Te Ara Whakawaiora / Breastfeeding which was also being presented to the March Board Meeting.

OURHEALTH HAWKE'S BAY Whakawateatia	**HB Health Consumer Council** 18
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton, Chair
Reviewed by:	Not applicable
Month:	March 2016
Consideration:	For Information

12

RECOMMENDATION

That the Board

Note the contents of this report

Consumer Council met on 11 March 2016, an overview of issues discussed/agreed at the meeting is provided below.

OBESITY STRATEGIC PLAN CONSULTATION

Consumer Council and the Population Health team have been experimenting on different ways of engaging with each other to strengthen consumer involvement in service design. This 30 minute workshop shared the stocktake done by Population Health on children 5-10 as well as maternal nutrition given that the focus of effort was likely to be early years.

General discussion regarding change of diet from 30-40 years ago to now and environmental factors that have impacted on this:

- Home environment / whānau
- Journey to and from school - bombarded by marketing / branding
- School selling items, availability and access
- Sugary drinks to/from school and at home
- Food insecurity
- Not eating is a problem – low energy and can't engage at school or exercise
- Sleep deprivation
- Poor education on healthy food, how to prepare food in a healthy way

Key messages:

- Change the environment and make the healthy choice easier
- Settings based programmes have shown results in New Zealand e.g. schools and workplaces
- Take a whole of community approach
- Focus on prevention in the early years, Maori, Pasifika and high deprivation communities
- Support whānau to achieve sustainable behaviour change
- Establish a leadership group to influence positive changes in the community
- Establish a pathway to support over-weight people to reduce risks

Where Consumer Council wishes to get is being confident that services strongly reflect community input and have best chance of making a difference.

YOUTH HEALTH STRATEGY CONSULTATION

Members of Consumer Council are actively involved in strategy development. We are also actively recruiting someone to take the lead on Consumer Council for youth health. This workshop was a chance to share where the process was up to and provide input and feedback.

One member who has considerable understanding of community alcohol and drug services lamented the inadequacy of these services for youth. Considerable detail has been provided to the population health lead on this and the chair undertook to raise it as part of his report to the Board. It is part of a consistent theme around youth services where there was quite a lot of emphasis and resource in earlier age groups and for adults but the youth segment often seems to languish.

It is hoped that this youth strategy can highlight the issues and rally support behind services.

DAVANTI IS REVIEW PRESENTATION

Members of Consumer Council had been privy to the full Davanti Report following permission from the relevant GM. Given the sensitivies within the report discussion was taken in public excluded.

When the public meeting resumed the outcome of the in-committee discussions were tabled:

Resolution:

That the Consumer Council:

- Notes that Council feedback has been reflected in the review.
- Notes and supports the findings and recommendations of the Davanti IS Review.
- Reinforces the view that consumer needs and expectations of HBDHB IS systems and information are currently not being met.
- Strongly recommend that consumers be adequately represented on any governance / steering groups being established to oversee implementation of the recommendations from the review.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 19
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth (Deputy Chair)
Reviewed by:	Not applicable
Month:	March, 2016
Consideration:	For Information

13

RECOMMENDATION

That the Board

Note the content of this report.

MRB met on 17 March 2016 however there were not enough members in attendance to form a quorum. Therefore, below is an overview of issues discussed at the meeting.

HEALTH AND SOCIAL CARE NETWORKS

MRB supported the overarching principles and the long term direction of the Health and Social Care Networks model although stated strongly that the advice MRB provided at the February meeting needed to be taken into consideration. There are concerns that the Health and Social Care Networks model could perpetuate inequity if equity is not at the helm of development. Therefore MRB reiterated the need to ensure equity is one of the key principles for the development. Furthermore MRB noted the absence of a clear definition of 'ngā mea Māori' (The Māoriness) throughout the model.

MĀORI BACHELOR OF NURSING STUDENTS

MRB have repeatedly raised the issue about EIT and the way it operates with students who have withdrawn or drop out. The key discussion was raised around nursing students. What was highlighted some time ago was the issue of year three Māori nurses dropping out and why this was occurring. MRB question pastoral care and support. In addition, MRB viewed that Māori nurses who had graduated weren't necessarily getting jobs. It was a concern that students had accumulated debt to the levels they had for no gain. Finally, the discussion about returning of fees was raised for students who had decided to withdraw after the policy timeframe for refund of two weeks. MRB felt that this policy was unfair and needed reviewing. Chris McKenna (Chief Nursing Officer) met with EIT and identified that under special circumstances students could apply for a refund outside the two week timeframe. However, Chris also stated that this is not applied for general. See the Academic Statute and Regulations below:

a) If a student withdraws before or during the first two weeks of a programme, he/she receives a full refund.

b) If a student withdraws after that period in the course, (whether failing or passing at that point), and has experienced exceptional circumstances, e.g. serious whānau illness requiring the student's time, death in the family, complex issues such as child custody legal action etc., the student may apply for a partial or full refund.

c) If a student is unsuccessful in a course or a number of courses which may mean the student cannot continue in the programme, and there are no exceptional circumstances, normally there is no refund of fees.

MRB agreed to take this kaupapa off the DHB table and manage it through a Ngāti Kahungunu Iwi Inc. (NKII) process with EIT direct.

MRB DRAFT WORKPLAN 2016-17

MRB made the observation that the meeting agendas are heavy.

PAPERS AND PRESENTATIONS FOR MRB

The importance for an equity lens to be applied to all reports and presentations to MRB was raised again. By applying an equity lens, will enable presenters and report writers to identify how inequity is being addressed and provide structure so that presentations are more focused. Tracee Te Huia (GM Māori Health) advised that she had organised for DHB seniors to attend an Equity Training in February. It was attended by 26 staff members. Next steps is to develop the process for how the DHB will ensure equity is a core principle in developments and projects.

OBESITY PREVENTION STRATEGY

MRB provided the following feedback regarding the Obesity Prevention Strategy:

- We need an equity lens on this strategy, how are we watching for any unintended consequences.
- The strategy is a starting point but there is a need to have teenage youth involved who are our future parents and leaders.
- Engage with the Māori Women's Welfare League.
- Investigate the cultural aspect of food because part of 'Manaaki' (a Māori custom) is to feed the people. Food is used to take a process from sacred to normal. We need more education on the right foods on marae, and other meetings places.
- Nutritional advice to Māori homes and communities is not evident and we need more of that.
- Obesity is a national priority but there is no reference to the severity locally. It would have been useful to see the local information, the geographical spread and if we are improving or not. This would provide a more targeted approach and strategic alignment. It would also be valuable to see where we align with other DHB initiatives, what they are doing and how do we measure against them.
- This is not just a DHB issue it is a community issue so we need to involve hapū and iwi.
- EIT are running a marae cooking programme at Pukemokimoki Marae in Napier so it would be beneficial to promote the healthy eating messages.
- The issue is that sugary and takeaway foods are more affordable so obesity ties into the living wage discussion. People can't necessarily afford good food i.e. meat. Addiction ties into obesity.
- We need to stop siloing the issues that are bad; addiction, sexual health, oral health, obesity, smokefree, and suicide etc. then employing a person every time we find a priority. It's about employing the whānau into good lifestyles. When we change the whānau environment we change the way they look at themselves and opt for good decisions as a by-product.

DRAFT ANNUAL PLAN AND STATEMENT OF INTENT

The following feedback was provided by MRB regarding the Māori Health Annual Plan:

- We need to be cautious of the wording being used and the message communicated. The perception received today was that the DHBs primary aim is to achieve targets and there is little mention of reducing inequity which is actually the DHBs vision.

- In terms of Whānau Ora and the impacts on children, where does this appear in the Annual Plan? It is easy to monitor and report how many women have had a smear but how do we capture and measure the social impacts?
- Because of the social impacts of poverty, such as obesity, are evidence that we need to really consider the living wage proposal. We need to walk the talk.

YOUTH HEALTH STRATEGY 2016-19 CONSULTATION

MRB provided the following feedback on the strategy:

- Again it wasn't clear how this strategy was going to reduce inequity for Rangatahi (Youth)
- Integrate the Suicide Strategy and what it means for a youth to be healthy. In fact, let us stop siloing out disease and issues that leads to more fragmented services. We need to take care of the whole person and their whānau.
- There is information being held by hapū and iwi at present that may support the development of this strategy.
- It's really key to the youth voice in the development process and not just an educated Rangatahi but those who are struggling yet know what's needed.
- Rangatahi are our leaders for tomorrow. Let us develop these leaders. They need to be in our workforce plan across the health sector and not just in Tūruki strategy.

HAWKE'S BAY District Health Board Whakawāteatia	**NZ Health Partnerships Limited Shareholder Approval** 20
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee, Chief Executive
Document Author:	Ken Foote, Company Secretary
Month:	March 2016
Consideration:	For Decision

RECOMMENDATION

That as a shareholder of NZ Health Partnerships Ltd, the Board approve the Company's:

- Statement of Intent – 1 July 2015 to 30 June 2019
- Statement of Performance Expectations – 1 July 2015 to 30 June 2016
- Annual Plan 2015/16

15

ATTACHMENTS

- Letter to Shareholders from the Chair
- Statement of Intent – July 2015 to 30 June 2019
- Statement of Performance Expectations – 1 July 2015 to 30 June 2016
- Annual Plan 2015

BACKGROUND

NZ Health Partnerships Ltd was incorporated in 2015 to take over many of the functions and activities previously undertaken by Health Benefits Ltd. NZ Health Partnerships is a multi-parent Crown subsidiary that is led, supported and owned by New Zealand's 20 DHBs. Established and operated as a cooperative undertaking, NZ Health Partnerships' purpose is to enable DHBs to collectively maximise shared service opportunities for the National Good.

SHAREHOLDERS AGREEMENT

Clause 3.2 of the NZ Health Partnership Ltd Shareholders Agreement (Signed by all 20 DHBs) states:

"3.2 Decisions requiring unanimous approval of Shareholders:
All shareholders must unanimously approve in writing:
(a) The adoption of the Company's:
I. Strategic Plan;
II. Annual Plan; and
III. Annual Budget."

The attached request for approval of these documents is consistent with the intent of this clause, albeit late in the year due to the recent company startup.

CONSULTATION

You will note in the attached covering letter from the Chair of the Company that these documents have been widely consulted on and feedback provided. In particular the letter states:

"As a result of this feedback, we have amended all documents to reflect the recommended changes."

22 February 2016

Draft Accountability Documents for 2015/16 for approval.

Dear Shareholders

I am pleased to enclose the draft NZ Health Partnerships Statement of Intent (SOI) 2015-2016 to 2018-2019, Statement of Performance Expectations (SPE) 2015-2016 and Annual Plan 2015/16, for your approval.

The SOI outlines the company's strategic intentions for the next four years while the SPE defines the reportable classes of outputs, outlines how NZ Health Partnerships intends to assess performance, details expected benefits, funding and expenditure and provides the prospective financial statements. The Annual Plan provides shareholders and the organisation with a comprehensive approach on how it will seek to achieve the Statement of Performance Expectations and continue to develop our new cooperative model.

We are grateful to our Shareholders, Treasury, Ministry of Health, and Audit New Zealand for their feedback. As a result of this feedback we have amended all documents to reflect the recommended changes. The SOI is intended to be a more enduring document whereas the detailed information relating to our performance is included in the Annual Plan and SPE. Being a new entity created on 1 July 2015, both accountability documents reflect the position of NZ Health Partnerships in its current life cycle, and will be updated as the organisation matures.

Once the SOI and SPE have been approved, they will be tabled in Parliament, as per the Crown Entities Act. The Annual Plan is an internal document, and progress will be reported to shareholders as per the Shareholders' Agreement.

To assist us in planning the final steps for the approval of the documents, we ask that you confirm receipt of the accountability documents and when you would expect to have the documents approved. If you have any queries regarding the accountability documents, please email Jo Hogan on Jo.Hogan@nzhealthpartnerships.co.nz

Kind regards

Peter Anderson
Chair

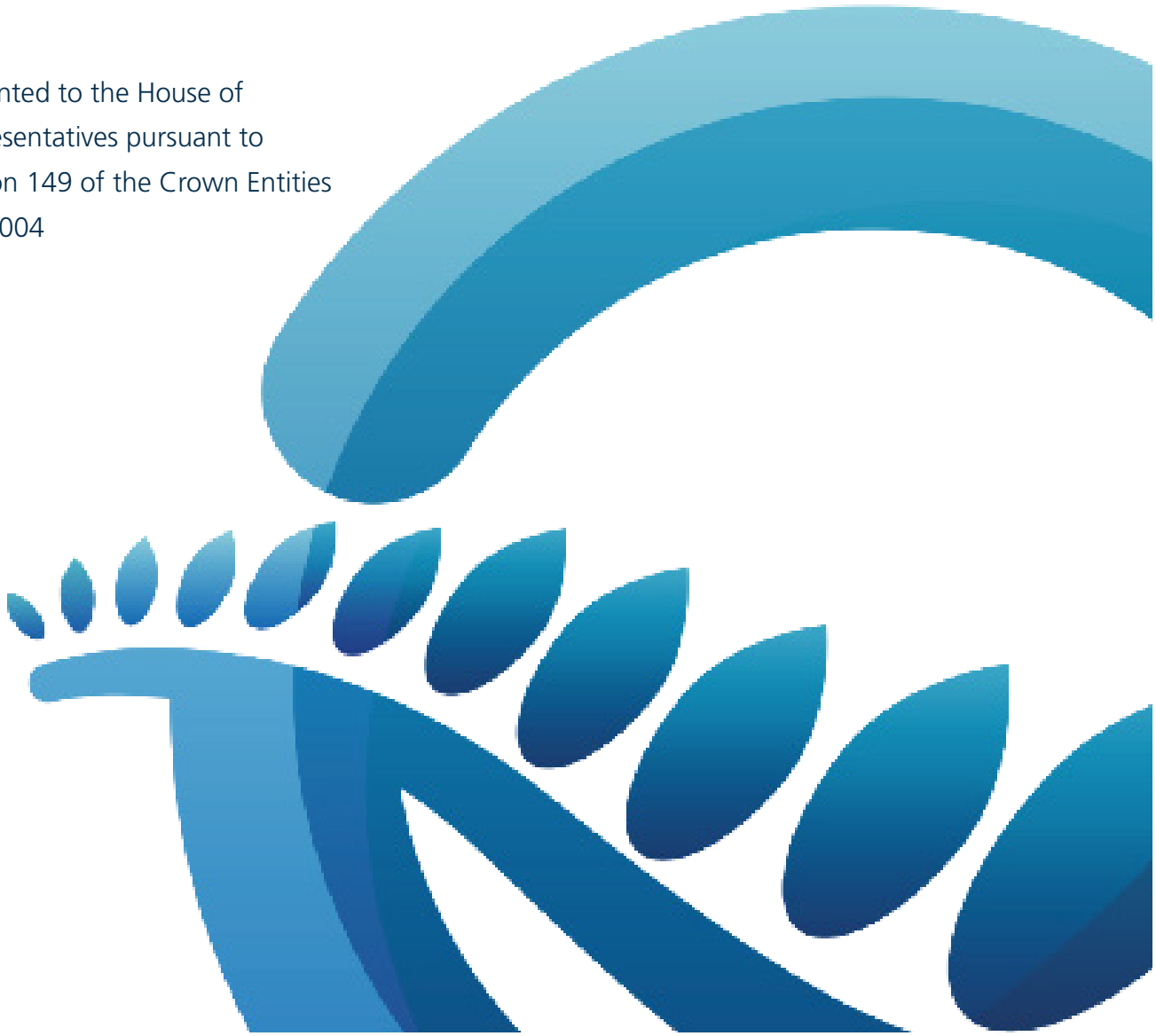
NZ Health Partnerships Ltd
Level 2, Building 2 Central Park
660 – 670 Great South Road, Penrose, Auckland, 1061
PO Box 11-410 Ellerslie, Auckland 1542
Ph: 09 487 4900

NZ HEALTH PARTNERSHIPS

STATEMENT OF INTENT

1 July 2015 to 30 June 2019

Presented to the House of Representatives pursuant to section 149 of the Crown Entities Act 2004



CONTENTS PAGE

SHAREHOLDERS' FOREWORD

We are 20 District Health Boards (DHBs), but one New Zealand health system. By working together we will more effectively protect and provide for the future health and wellbeing of New Zealanders.

NZ Health Partnerships represents this shared commitment to work together.

While it has inherited a portfolio of work, NZ Health Partnerships is a new company; and it is our company. Its programmes and services are developed and managed by the sector, for the sector.

This document sets out NZ Health Partnerships' strategic intent over the next four years.

As shareholders we have provided direction that in the short term NZ Health Partnerships will refocus its current programmes and services to align with the operating model and DHBs' expectations.

This work will include the implementation of a National Good Mechanism that recognises the differences between DHBs and provides flexible options to optimise participation in all initiatives.

NZ Health Partnerships intends to implement a range of continuous improvement tools and processes, develop its culture and people, communicate transparently and build strong relationships with DHB leaders and other stakeholders.

In short, NZ Health Partnerships intends to build trust, through its performance and the way it operates.

As shareholders we commit to providing an environment of positive DHB guidance and support to enable the Company to evolve into a successful organisation that delivers significant value sector-wide.

Signed on behalf of the Shareholders

Jenny Black
Chair of DHB Chairs

Ron Dunham
National Chair of DHB Chief Executives

STATEMENT OF RESPONSIBILITY

The Statement of Intent (SOI) has been prepared by the Board of NZ Health Partnerships in accordance with Part 4 of the Crown Entities Act 2004.

The Statement of Intent sets out the strategic intentions of NZ Health Partnerships for the four year period from 1 July 2015 to 30 June 2019.

In signing this information, we acknowledge that we are responsible for the information on strategic intentions for NZ Health Partnerships.

Signed on behalf of the Board

Peter Anderson
Chair

Terry McLaughlin
Chair of the Finance , Risk, Audit and Compliance Committee

Countersigned

Joanne Hogan
Interim Chief Executive

Geoff Goodwin
General Manager Corporate Services

WHO WE ARE

NZ Health Partnerships Limited is a multi-parent Crown subsidiary, owned by the 20 District Health Boards (DHBs). On 1 July 2015 NZ Health Partnerships became operational and the staff, programmes, services, assets and liabilities of Health Benefits Limited were transferred over to it by way of the Health Sector (Transfers) Act.

Our Purpose

NZ Health Partnerships was established and is operated as a co-operative undertaking. Our purpose is to enable DHBs to collectively maximise shared services opportunities for the benefit of the sector.

To achieve our purpose we work with our DHBs as shareholders, co-creators and customers. In partnership we identify, develop and implement initiatives for the sector's mutual benefit and ultimately to help improve health outcomes for all New Zealanders.

We work with other organisations that will contribute to shared service opportunities for the DHBs. Together as a sector we ensure an integrated and collaborative approach progressing initiatives for the National Good[1].

1. National Good, as per the Shareholders Agreement, refers to the significant sector-wide gains in any or all the following areas: quality, scalability, cost-effectiveness, capability and consistency.

THE WAY WE WORK

Our Values

The values that underpin how we work and our engagement with our shareholders are:

- Respect
- Transparency
- Accountability
- Commitment.

Our Principles

The NZ Health Partnerships Shareholders' Agreement enshrines a number of principles that are fundamental to the successful governance and operations of NZ Health Partnerships. NZ Health Partnerships and the DHBs as shareholders have committed to a number of parallel principles which govern how we work with each other.

We are a co-operative undertaking

NZ Health Partnerships operates as a co-operative undertaking that is accountable to all of our shareholders equally. Our programmes and day-to-day activities are focussed on enabling the optimal participation in our initiatives and deriving qualitative and quantitative benefits for DHBs.

We will honour our commitments

We will act in a fiscally responsible manner, honour our formal reporting requirements and any other commitments made to our shareholders.

As co-creators we commit to partnering with DHBs, using the relevant capabilities and expertise of the sector, to identify, prioritise, develop and implement shared service initiatives.

We have a shared intention and commitment

With our shareholders we have a shared intention to build and maintain an enduring relationship based on mutual trust to provide optimal outcomes for the sector and better health outcomes for all New Zealanders. This shared intention and commitment is manifested in NZ Health Partnerships, which affirms its own need to build trust and enduring relationships with DHBs. Together we will deliver high quality, cost-effective healthcare services without compromising patient safety or quality of care.

We are committed to openness, honesty and transparency

NZ Health Partnerships and the DHBs are committed to ensuring openness, transparency, and fairness in all dealings and communications between each other.

DHBs will support the operation of the NZ Health Partnerships through the provision of appropriate personnel and resources; and will provide accurate and timely data and other information to each other. NZ Health Partnerships will in turn provide accurate and timely information to its shareholders.

All parties will always show respect for each other's viewpoints – including differences. Where differences are identified, NZ Health Partnerships and the DHBs will act in good faith to resolve those differences.

We will not act inconsistently with the needs and purpose of the sector

NZ Health Partnerships and the DHBs will not, directly or indirectly, act against the interests of any individual Shareholder, group of shareholders or the National Good. We will not act in a way that prevents, or restricts, the maximisation of benefits to our shareholders, irrespective of whether a particular DHB is receiving services under a programme or business case.

Governance and Accountability

The shareholders of the NZ Health Partnerships and own and govern the entity by way of an Independent Board. Board comprises of four regional DHB representatives and three independent Directors. It is chaired by an independent Director. The Board meet monthly and the Finance, Audit and Risk Committee meet quarterly. Within the parameters of the Annual Plan, the Board is responsible for delivery of its portfolio of initiatives, core budget and performance of programmes and services. Programmes and services have their own governance groups and will be led by a DHB Chief Executive Sponsor. The role of the Sponsor is to provide strategic direction for the programmes and services, remove roadblocks and lead change into DHBs on behalf of all the DHBs Chief Executives. This will give the shareholders greater transparency of the activities undertaken by NZ Health Partnerships with regards to the programmes of work. The scope of the CE Sponsors work will be approved by NZ Health Partnerships Board.

STRATEGIC INTENTIONS

Through our DHB shareholders, we are contributors to the government's goal of having an effective, integrated and innovative health and disability sector that enables New Zealanders to live longer, healthier and more independent lives.

NZ Health Partnerships supports a multi-agency, cross-sector and integrated approach for the DHBs to fulfil the expectation of the Minister of Health to implement regional and national shared services.

Our 2015/16 intentions

The focus of NZ Health Partnerships in its first year of operation is to ensure our current portfolio of programmes and services are fit for purpose, are aligned to our shareholders' expectations and overseen by DHB-agreed governance and engagement structures. Internally we will focus on building our peoples' capabilities and aligning our culture to work collaboratively with DHBs. The performance measures of NZ Health Partnerships will be a blend of both the strategic themes of the organisation and delivery against its output classes.

The strategic themes of NZ Health Partnerships are:

THEME ONE: Develop and deliver Shared Services initiatives to our shareholders

NZ Health Partnerships will:

- Continue to develop and implement its in-flight programmes
- Implement best practice programme methodology
- Support DHBs for local implementation
- Manage the services and contracts for the business cases we have implemented.

THEME TWO: Planning and Portfolio Optimisation

NZ Health Partnerships will:

- Refocus our current programmes and services to align with our operating model and shareholders' expectations
- Operationalise the National Good Mechanism. This is a set of levers which will provide flexible options to optimise DHB participation in initiatives while catering for the interest of, and impacts on, individual DHBs
- Develop a centralised approach to managing vendor performance and a detailed services catalogue.

THEME THREE: Building joint capability in the sector

NZ Health Partnerships will:

- Draw on sector expertise for the delivery of its programmes and services
- Utilise DHB expertise in the design and implementation of shared services initiatives.

Our Long-Term Strategic Intentions

NZ Health Partnerships is a high performing organisation that is delivering value to its shareholders

What we intend to achieve:

NZ Health Partnerships is viewed by its shareholders as the centre of excellence for the development, implementation and management of shared service initiatives. Our programmes and services deliver quality and financial improvements to the DHBs.

To achieve this we will:

- Develop and implement a range of improvement tools and techniques to continuously improve our business. This includes identifying and adopting new and innovative approaches to problem solving to achieve the best possible outcome for our shareholders
- Optimise and refocus our portfolio to reflect the strategic focus of the shareholders. Our structure will be lean and able to drive and adapt to large scale changes
- Cultivate a culture that is shaped to achieve our strategic goals. Our values of respect, transparency, accountability and commitment towards our stakeholders will be reflected in our organisational culture
- Effectively translate our business strategy through the support a powerful People Plan. The focus of our People Plan will be to attract, retain and develop our employees. The secondment of DHB expertise will ensure the requirements of our customers are reflected in our work
- Actively manage our performance through dynamic quarterly reporting and portfolio level scorecards
- Integrate our plans to develop multidimensional strategies to achieve performance targets in a collaborative manner. The alignment of our planning cycle with the DHBs will be a catalyst for sector-wide strategies.

In four years we will know we are successful when:

- We deliver seamless, high quality programmes and services within agreed timeframes.
- We consistently achieve our performance targets as set out in its Statement of Performance Expectations and Annual Plan
- Our annual benefits targets are met or exceeded.

NZ Health Partnerships is strongly connected with the organisations in its operating framework

What we intend to achieve:

- NZ Health Partnerships has positive and enduring relationships with all stakeholders throughout its portfolio.
- While DHBs are our primary focus, NZ Health Partnerships continues to engage and build relationships with range of wider sector stakeholders, including the Ministry of Health, key vendors, PHARMAC and existing DHB shared service agencies. We will engage the right stakeholder at the right time.

To achieve this we will:

- Ensure key governance forums are reviewed and aligned with the NZ Health Partnerships Governance Charter. DHB membership reflects regional representation and expertise requirements. The functions, roles and responsibilities of each forum are effectively communicated to our stakeholders
- Develop consistent communication tools and approaches for each programme and service. Communications to DHBs are timely, informative and consistent
- Align our planning and reporting cycle with the DHBs to allow transparent and consistent sharing of information

- Improve our understanding of our customers. To ensure the success of NZ Health Partnerships, a deep knowledge of each DHBs unique characteristics and circumstances is required to provide tailored business solutions that best suit their needs
- Implement a relationship framework between the NZ Health Partnerships senior leadership team and DHB Chief Executives and Chief Financial Officers
- Implement the necessary internal processes to facilitate a customer-centric culture to further sector-wide benefits.

In four years we will know we are successful when:

- Our stakeholders understand the purpose and role of NZ Health Partnerships in the health sector. They are well-informed about our programmes of work and their progress
- We effectively leverage the expertise of public and private organisations to ensure the seamless delivery of programmes and services to the sector
- Our governance bodies are fit for purpose and membership is effective. Membership will comprise of regional DHB representation and will be role based to allow the appropriate mix of operational, financial and clinical expertise.

NZ Health Partnerships is viewed as a trusted organisation

What we intend to achieve:

NZ Health Partnerships is viewed as a trusted organisation by its employees and stakeholders. We are perceived as an innovative, credible and transparent organisation that operates with integrity and respect.

To achieve this we will:

- Consistently report to our shareholders on our performance against our Statement of Performance Expectations and Annual Plan. Quarterly reports will be sent to our shareholders, the Minister of Health and Minister of Finance
- Co-create our strategic direction with the DHBs at the Annual Hui. This will provide the DHBs with greater transparency of the activities we will undertake on their behalf
- Communicate with our shareholders regularly and openly to ensure there are no surprises
- Build a culture of respect, transparency, accountability and cooperation with DHBs. We will listen to and act on feedback from our employees and stakeholders
- "Walk the talk"- the behaviour and day-to-day actions of our employees and senior leadership team reflect the purpose and values of NZ Health Partnerships.

What success will look like:

- NZ Health Partnerships is viewed by the DHBs as a trusted advisor and safe pair of hands for the development and implementation of shared service initiatives
- We continuously receive positive feedback from our stakeholders, in particular our DHBs
- We have a proven track record of delivering high quality programmes and services to the DHBs.

OPERATING ENVIRONMENT

Functions and Activities

NZ Health Partnerships' core business is to deliver programmes and services to DHBs that enable them to realise financial and quality improvements. NZ Health Partnerships, in collaboration with DHBs, achieves its purpose and outcomes through its key functions:

- **Shared Service Opportunities**

  Subject to shareholder agreement, NZ Health Partnerships will identify, quantify, prioritise, validate and design solutions for shared services opportunities. These will be presented to DHBs as business cases for their consideration and approval.

- **Contract Negotiation and Management**

  Subject to DHB approval, we will enter into negotiations with Preferred Respondents to negotiate commercially astute programme and service Agreements. Agreements are drafted for DHB consideration and approval. Once Agreements have been signed, we manage the contracts, performance and relationship of the vendors and suppliers on behalf of the DHBs.

- **Change Management**

  NZ Health Partnerships will work with the DHBs to deliver transformational business, people and systems changes within complex environments. We will act as an enabler for successful change and behaviour adoption that supports the realisation of benefits. In recognising that the needs of each DHB are different, we will identify individual change requirements and needs. Some DHBs may be in a position to manage their own change and support the change in others.

- **Implementation of Services**

  A joint delivery model will be employed for the implementation of services whereby the DHBs will lead the implementation of the solutions into their organisation. NZ Health Partnerships will provide support to ensure successful and cost-effective deployment. This could include:

  - Detailed role based impact assessments
  - Training needs assessments
  - Development of training collateral
  - Online training delivery
  - Business readiness assessments.

- **Benefits Reporting**

  NZ Health Partnerships manages the reporting of all benefits generated across the sector. This includes reporting benefits achieved by NZ Health Partnerships' initiatives, All of Government, and local and collaborative DHB procurement.

15

Continuous Improvement

Fostering a culture of continuous improvement across our organisation is paramount to our success. Feedback from our shareholders, and internal feedback loops, will provide further focus for our performance improvement activities.

Risk and Issue Management

NZ Health Partnerships recognises that risk and issue management is essential for the delivery of its programmes of work. NZ Health Partnerships' Risk Management Policy is consistent with project and programme best practice.

The aim of our risk and issue management processes is to improve the quality of decision making to minimise and mitigate adverse impacts. This requires a strong risk-aware culture, based on the following principles:

- A proactive approach to risk identification and management
- Open sharing of risk information across NZ Health Partnerships
- The support of information systems and processes for collating, analysing and disseminating risk information/intelligence
- Understanding compound risks and how the effects of risk in one area may impact on other parts of the organisation, our shareholders and the sector as a whole
- Regular communication and engagement with DHBs to keep all stakeholders informed about risks and issues, portfolio status and progress.

Strategic Risks

NZ Health Partnerships' strategic risks include those that may have an adverse impact:

- **Scale and complexity of activities:** our programmes and services are being, and have been, implemented nationally. These national programmes and services touch all parts of the NZ health system. NZ Health Partnerships will work closely with the DHBs, their subsidiaries and the service providers to put in place proactive and detailed change plans to mitigate risks during design and implementation.
- **Multiple delivery partners:** our programmes and services have many delivery partners spanning both the public and private sector. Best practice methodology and the development of a centralised vendor performance management framework will ensure alignment and effective integration.
- **Resource pressure:** NZ Health Partnerships will effectively engage with the sector to build collaborative programme teams, including seconding and embedding DHB subject matter experts in our work. This will enable NZ Health Partnerships to avoid the risk of not delivering the programmes within agreed budgets and quality criteria. This approach will also help build capability in the sector.
- **Shareholder constraints:** the DHBs are facing many challenges such as ageing populations, the rising cost of technology and growing demand for health services, all of which lead to tightening financial constraints. DHBs are also managing a large number of complex change programmes at any one time. Aligning and integrating our planning cycle with DHBs will help alleviate resource pressures and improve financial forecasting.

Strategic Partnerships

The DHBs will interact with NZ Health Partnerships in a number of different ways, including as:

- **Shareholders:** DHBs are the shareholders of the NZ Health Partnerships. They own and govern the entity by way of an Independent Board.
- **Co-creators:** DHBs will work with NZ Health Partnerships to identify, prioritise and develop shared services opportunities.
- **Customers:** DHBs will receive services provided by NZ Health Partnerships under separate business case implementation agreements.

In recognition of the multi-tiered relationship, NZ Health Partnerships will introduce an active stakeholder management system to foster stronger strategic relationships with our shareholders. Other organisations we will continue to build relationships with include:

healthAlliance NZ Ltd

healthAlliance and NZ Health Partnerships will work together on the implementation of the National Infrastructure Platform for the four Northern Region DHBs.

healthAlliance (FPSC) Ltd

healthAlliance (FPSC) Ltd is the provider of the National Procurement Service and it manages the DHB DataHub which are key enablers for the National Oracle Solution programme.

Existing DHB Shared Services Agencies

NZ Health Partnerships will work with DHB shared service organisations such as Central TAS, HealthShare and the South Island Alliance to leverage existing sector knowledge and expertise, and ensure greater alignment across the sector.

Ministry of Health

The Ministry will monitor and support the DHBs to deliver against the Minister of Health's Letter of Expectations, health policy and strategy. Through the DHBs, the Ministry will enable NZ Health Partnerships to implement regional and national shared services.

National Health IT Board

The National Health IT Board plays an advisory role to the programmes and services of NZ Health Partnerships, in particular those with a large technology component such as the National Infrastructure Platform.

PHARMAC

NZ Health Partnerships, healthAlliance and DHBs will work with PHARMAC to help manage its transition to medical device management, including the assessment, prioritisation and procurement of medical devices.

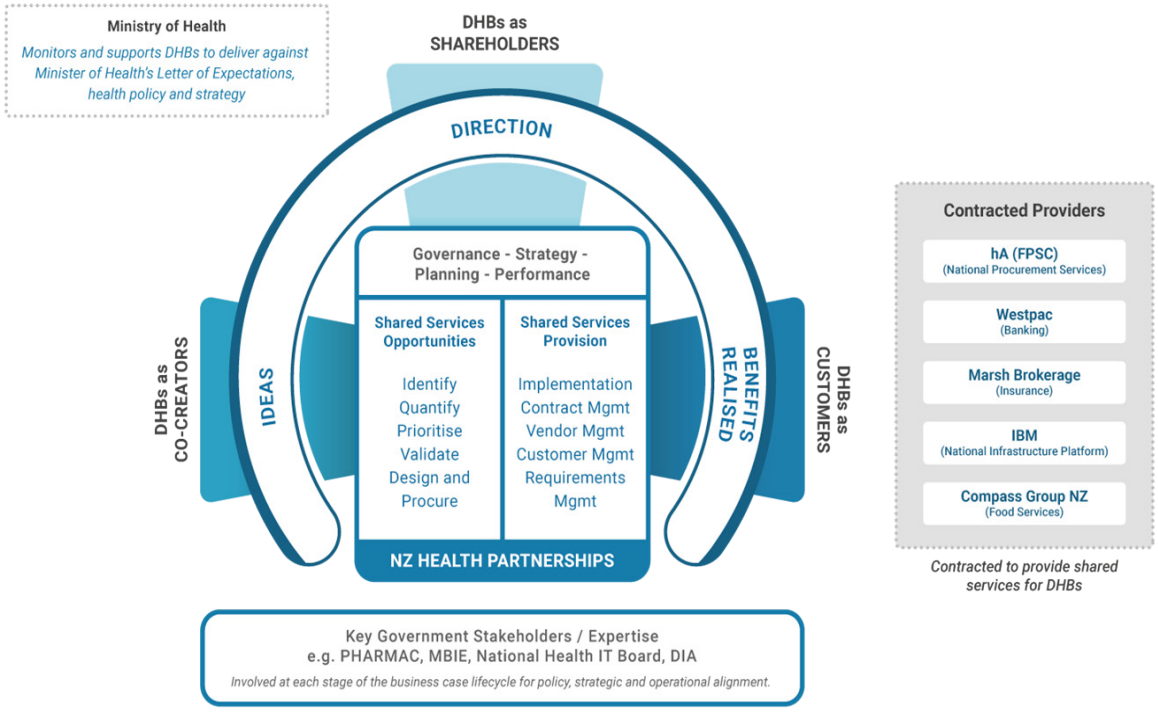
Ministry of Business, Innovation and Employment (MBIE)

NZ Health Partnerships, healthAlliance and DHBs will continue to support All-of-Government procurement initiatives to ensure the health sector maximises the benefits from these contracts. NZ Health Partnerships will also assist MBIE in identifying any shortfalls in uptake of national contracts and work with the National Procurement Service and DHBs to address them.

Commercial Organisations

Support from commercial partners is integral to the delivery of shared services for all our programmes and on-going services. These contractual relationships will be managed and monitored by NZ Health Partnerships on behalf of the sector.

NZ Health Partnerships Operating Model



Statutory and Compliance Requirements

As a Crown Entity subsidiary, NZ Health Partnerships is required to comply with a variety of legislation including the:

- Companies Act 1993
- New Zealand Public Health and Disability Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989
- Official Information Act 1982

The company will establish mechanisms to ensure it meets its legal compliance obligations.

Dividend Policy

NZ Health Partnerships' dividend policy is to retain any surplus for reinvestment in initiatives that are consistent with the purpose of NZ Health Partnerships and likely to generate benefits or efficiencies for DHBs or the wider health sector.

Treaty of Waitangi

NZ Health Partnerships recognises the special relationship between Maori Iwi and the Crown under the Treaty of Waitangi and is committed to the recognition of the Government's requirements in regard to the Treaty of Waitangi. NZ Health Partnerships will endeavour to apply the relationship-enhancing Treaty principles of participation, protection and partnership in all its engagements with Maori organisations and staff.

OUR PERFORMANCE

The success of NZ Health Partnerships will ultimately be measured by its ability to deliver fit for purpose programmes and services that meet our shareholders' expectations and enable them to realise benefits. NZ Health Partnerships will measure its performance against two output classes:

- **Output Class 1: Programmes** comprises the in-flight programmes managed by NZ Health Partnerships. The purpose of the output class is to ensure that NZ Health Partnerships' programmes are well-managed and co-ordinated.

- **Output Class 2: Services** comprises the services delivered by NZ Health Partnerships. The purpose of the output class is to ensure NZ Health Partnerships' services are high performing and deliver the DHBs both qualitative and quantitative benefits. As the inflight programmes are implemented and activity becomes business-as-usual, they will be transitioned from programmes to services.

Assessing Performance by Output Class

Numerous performance measures underpin our outcomes framework. These are not just about NZ Health Partnerships' performance, rather they are measures of how the organisation, its shareholders and the health sector work collaboratively to achieve better outcomes. Performance against output class measures will be assessed as:

- **Achieved:** the measure has been achieved within its target date
- **Partially Achieved:** the activities and inputs have been completed; however, the measure was not achieved within the target date
- **Not Achieved:** the measure has not been completed.

The perspectives that will underpin the performance of our output classes are quality, financial and timeliness.

Quality

This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement.

Financial

This will report performance against the projected costs and benefits for each output class.

Timeliness

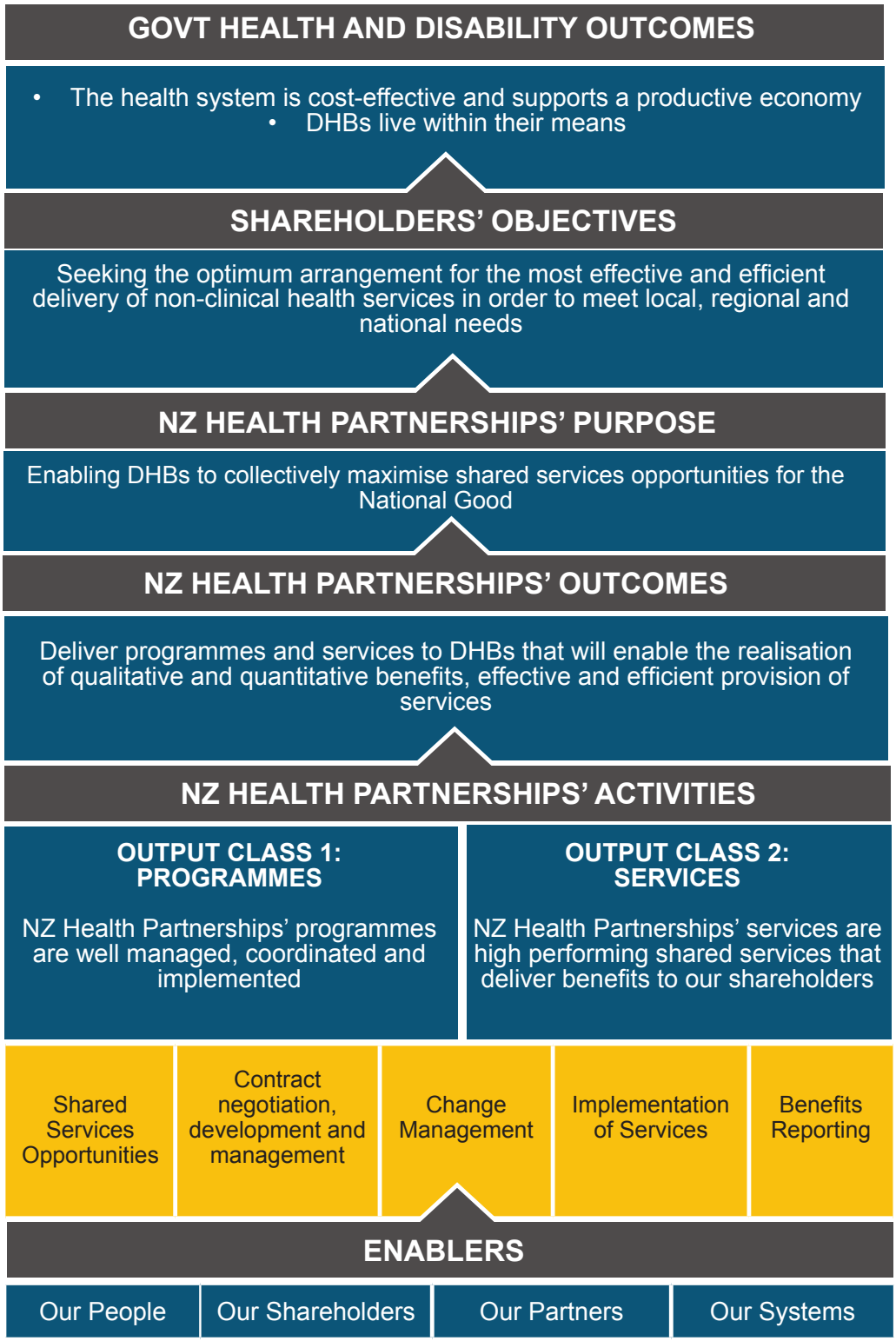
The programmes and services described in each output class will have progress measured against agreed milestones to ensure they deliver on schedule.

The performance of output classes will be reported through:

- Quarterly reporting to our shareholders, the Ministry of Health and Treasury
- Bi-annual financial reporting to shareholders Annual Report.

Our Outputs Framework

The diagram below shows how the organisational activities and performance of NZ Health Partnerships contribute to our shareholders' objectives.



ORGANISATIONAL HEALTH & CAPABILITY

Our People

Critical to the success of NZ Health Partnerships are the staff it employs. It must continue to retain, attract and develops high quality staff to ensure successful programme and service delivery. The organisation aims to cultivate an effective joint health sector workforce by providing the opportunity to build capacity as we implement our programmes.

We aim to be a workplace where staff are treated fairly and with respect, are supported, have strong personal development opportunities, and are well managed.

Supporting staff with strong systems and processes will enable delivery against our strategic objectives. Quality performance feedback and targeted professional development will underpin our workforce strategy. Confident, motivated and capable staff will empower the organisation to perform at its best and continually lift organisational health.

NZ Health Partnerships recognises that the complexity of our programmes of work will require us to engage consultants and contractors.

Building our people capability

To develop our workforce and to ensure we have the right people, the focus of NZ Health Partnerships will be:

- Optimising workforce capacity to deliver results
- Developing all its people to meet the challenge of change within the NZ health sector
- Identifying and developing capable leaders who will provide a strong force for promoting internal organisational change
- Integrating our shareholders' workforce more effectively and efficiently, encouraging understanding about a 'common toolkit' of skills, and improving the sector's ability to shift staff into national, regional and local levels of strategic implementation.

Good Employer

To ensure the Company meets its Good Employer obligations prescribed in the Crown Entities Act Part 3 section 118, NZ Health Partnerships provides equal employment opportunities to:

- Enhance the abilities of individual employees
- Recognise the aims, aspirations and employment requirements of women, and the cultural differences of ethnic or minority groups
- Recognise the employment requirements of people with disabilities.

The organisation has an organisational and team culture that recognises the diversity of New Zealand society and brings a perspective appropriate to a company dedicated to contributing to improved health outcomes for all New Zealanders.

IT Strategy

Policies and procedures for NZ Health Partnerships have been developed in relation to our Information Technology. The provision of financial, IT and payroll services have been contracted externally to healthAlliance NZ, who support NZ Health Partnerships. The performance of Output Class 1: Programmes is dependent on the effective performance of software assets, namely the National Oracle Solution and National Infrastructure Platform.

Process in relation to acquisitions

In the event that NZ Health Partnerships was to enter into a process to acquire shares or interest in companies, trusts and partnerships, excluding Crown entity subsidiaries, it will seek a resolution in writing from its Class A shareholders. NZ Health Partnerships will comply with relevant sections of the Crown Entities Act if it were to consider the acquisition of shares or interest in a Crown entity or a subsidiary of a Crown entity.

DIRECTORY

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Auditor-General

The Auditor-General pursuant to section 15 of the Public Audit Act 2001. Andy Burns of Audit New Zealand was appointed to perform the audit on behalf of the Auditor-General.

Banker

Westpac Banking Corporation

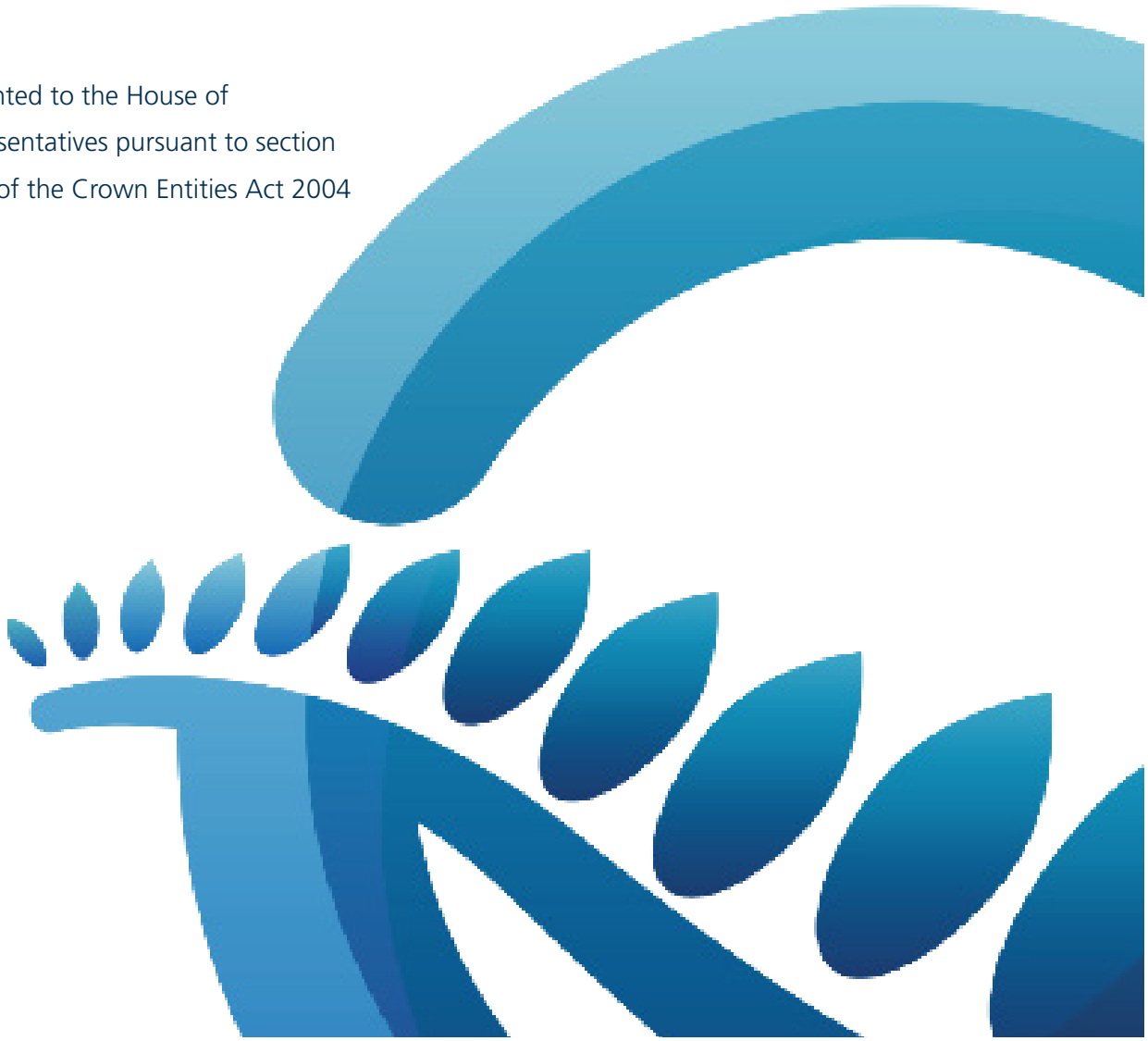
15

NZ HEALTH PARTNERSHIPS

STATEMENT OF PERFORMANCE EXPECTATIONS

1 July 2015 to 30 June 2016

Presented to the House of Representatives pursuant to section 149L of the Crown Entities Act 2004



CONTENTS PAGE

OUR PURPOSE

ENABLING DHBS TO COLLECTIVELY MAXIMISE SHARED SERVICES OPPORTUNITIES FOR THE NATIONAL GOOD

OUR VALUES

RESPECT

TRANSPARENCY

ACCOUNTABILITY

COMMITMENT

STATEMENT OF RESPONSIBILITY

The Statement of Performance Expectations (SPE) has been prepared by the Board of NZ Health Partnerships in accordance with Part 4 of the Crown Entities Act 2004.

In signing this information, we acknowledge our responsibility for the information contained in the Statement of Performance Expectations, and confirm the appropriateness of the assumptions underlying the prospective operations and financial statements of NZ Health Partnerships.

Signed on behalf of the Board

Sue Suckling
Interim Chair

Terry McLaughlin
Chair of the Finance, Audit and Risk Committee

Countersigned

Joanne Hogan
Interim Chief Executive

Geoff Goodwin
General Manager, Corporate Service

CHAIR'S FOREWORD

NZ Health Partnerships is a new organisation that continues to evolve.

Our focus for 2015/16 is establishing strong foundations from which the company can build.

This includes embedding new DHB-agreed governance structures for Programmes and Services. We will also work with shareholders to operationalise the National Good Mechanism which, recognising that one size does not fit all, applies greater flexibility to the design and development of shared services solutions.

With these fundamentals in place and in line with the clear direction from our shareholders, we will draw on sector expertise to help re-scope our core Programmes to ensure they are aligned to DHB demand and requirements.

In 2015/16 we will also develop a centralised approach to managing vendor performance and a detailed Services catalogue.

Internally we will build the capabilities of our people and a culture of continuous improvement and customer focus.

While the strategic intent of 2015/16 is to set the Company up for success, we recognise that we must add value and continue to generate benefits each day.

We will measure our performance against two output classes: Programmes and Services. To enhance transparency, in 2015/16 we will introduce quarterly reporting to our shareholders, the Ministry of Health and Treasury.

On behalf of the NZ Health Partnerships Board I'd like to thank our shareholders for their time and support as we continue the journey toward building an expert and trusted organisation.

Sue Suckling
Interim Chair

OUR FOCUS

The focus of NZ Health Partnerships in its first year of operation is to ensure our current portfolio of programmes and services are fit for purpose, embody the DHB-agreed governance and engagement structures, and are aligned to our Shareholders' expectations. Internally we will focus on building our peoples' capabilities and aligning our culture to work collaboratively with DHBs. The performance measures of NZ Health Partnerships will be a blend of both the strategic themes of the organisation and delivery against its output classes. The strategic themes of NZ Health Partnerships are:

THEME ONE: Develop and deliver Shared Services initiatives to our Shareholders

NZ Health Partnerships will:

- Continue to develop and implement its in-flight programmes
- Implement best practice programme methodology
- Support DHBs for local implementation
- Manage the services and contracts for the business cases we have implemented.

THEME TWO: Planning and Portfolio Optimisation

NZ Health Partnerships will:

- Refocus our current programmes and services to align with our operating model and Shareholders' expectations
- Operationalise the National Good Mechanism. This is a set of levers which will provide flexible options to optimise DHB participation in initiatives while catering for the interest of, and impacts on, individual DHBs
- Develop a centralised approach to managing vendor performance and a detailed services catalogue.

THEME THREE: Building joint capability in the sector

NZ Health Partnerships will:

- Draw on sector expertise for the delivery of its programmes and services
- Utilise DHB expertise in the design and implementation of Shared Services initiatives.

PART 1

OUR PERFORMANCE

MEASURING PERFORMANCE

The success of NZ Health Partnerships will ultimately be measured by its ability to deliver fit for purpose programmes and services that meet our Shareholders' expectations and enable them to realise benefits. NZ Health Partnerships will measure its performance against two output classes: Programmes and Services. Progress will be measured by internal and external reporting such as quarterly reporting to our Shareholders, the Ministry of Health and Treasury; and Annual Reports.

Assessing Performance by Output Class

Numerous performance measures underpin our outcomes framework. These are not just about NZ Health Partnerships' performance, rather they are measures of how the organisation, its shareholders and the health sector work collaboratively to achieve better outcomes. Performance against output class measures will be assessed as:

- **Achieved:** the measure has been achieved within its target date
- **Partially Achieved:** the activities and inputs have been completed; however, the measure was not achieved within the target date
- **Not Achieved:** the measure has not been completed.

The perspectives that will underpin the performance of our output classes are quality, financial and timeliness.

Quality
This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement.

Financial
This will report performance against the projected costs and benefits for each output class.

Timeliness
The programmes and services described in each output class will have progress measured against agreed milestones to ensure they deliver on schedule.

The performance of output classes will be reported through:

- Quarterly reporting to our Shareholders, the Ministry of Health and Treasury
- Bi-annual financial reporting to Shareholders
- Annual Report.

Dependencies

Alongside the assumptions, achieving deliverables is reliant on a number of critical dependencies. The main dependencies are:

- Securing the appropriate funding and resources in order to progress programmes and services
- Collaboratively working alongside the DHBs to make available the information required to inform decisions
- Achieving approvals in a timely manner by the programme and service governance bodies at appropriate stages.

Risk and Issue Management

NZ Health Partnerships recognises that risk and issue management is essential for the delivery of its programmes of work. NZ Health Partnerships' Risk Management Policy is consistent with project and programme best practice.

The aim of our risk and issue management processes are to improve the quality of decision making to minimise and manage adverse impacts. To do this requires a strong risk-aware culture, based on the following principles:

- A proactive approach to risk identification and management
- Open sharing of risk information across NZ Health Partnerships
- The support of information systems and processes for collating, analysing and disseminating risk information/intelligence
- Understanding compound risks and how the effects of risk in one area may impact on other parts of the organisation, our shareholders and the sector as a whole
- Regular communication and engagement with DHBs to keep all stakeholders informed about risks and issues, portfolio status, and progress.

Benefits Realisation

Benefits realisation is one of the fundamental measures of success for our current programmes and services. All business cases are predicated on the delivery of significant benefit to the sector. For the purposes of the NZ Health Partnerships programmes and services, a benefit is the measurable improvement resulting from an outcome which is perceived as an advantage by a stakeholder, including financial, quality and productivity improvements.

NZ Health Partnerships is responsible for the Benefits Management Framework design and to support District Health Boards (DHBs) to operationalise, manage and report on these in their business. We provide the tools, methodologies and active support to ensure that the change implemented successfully delivers benefits as outlined in the business case.

NZ Health Partnerships will continue to report realised benefits as provided by the DHBs and reporting entities.

Benefits Classification

The accurate categorisation of benefits allows effective benefits tracking and reporting, and a sector level view of benefits across programmes and services. Benefits are categorised as Budgetary and Non-Budgetary Benefits.

A *Budgetary Benefit* the incremental annual change, primarily cash, which has a clearly defined impact on the Statement of Comprehensive Income. These benefits result in a budget line reduction, compared to the prior year. Examples include a reduction in the price of an item as a result of procurement activity, and a reduction in FTEs.

A *Non-Budgetary Benefit* refers to cash/cost avoidance and qualitative benefits.

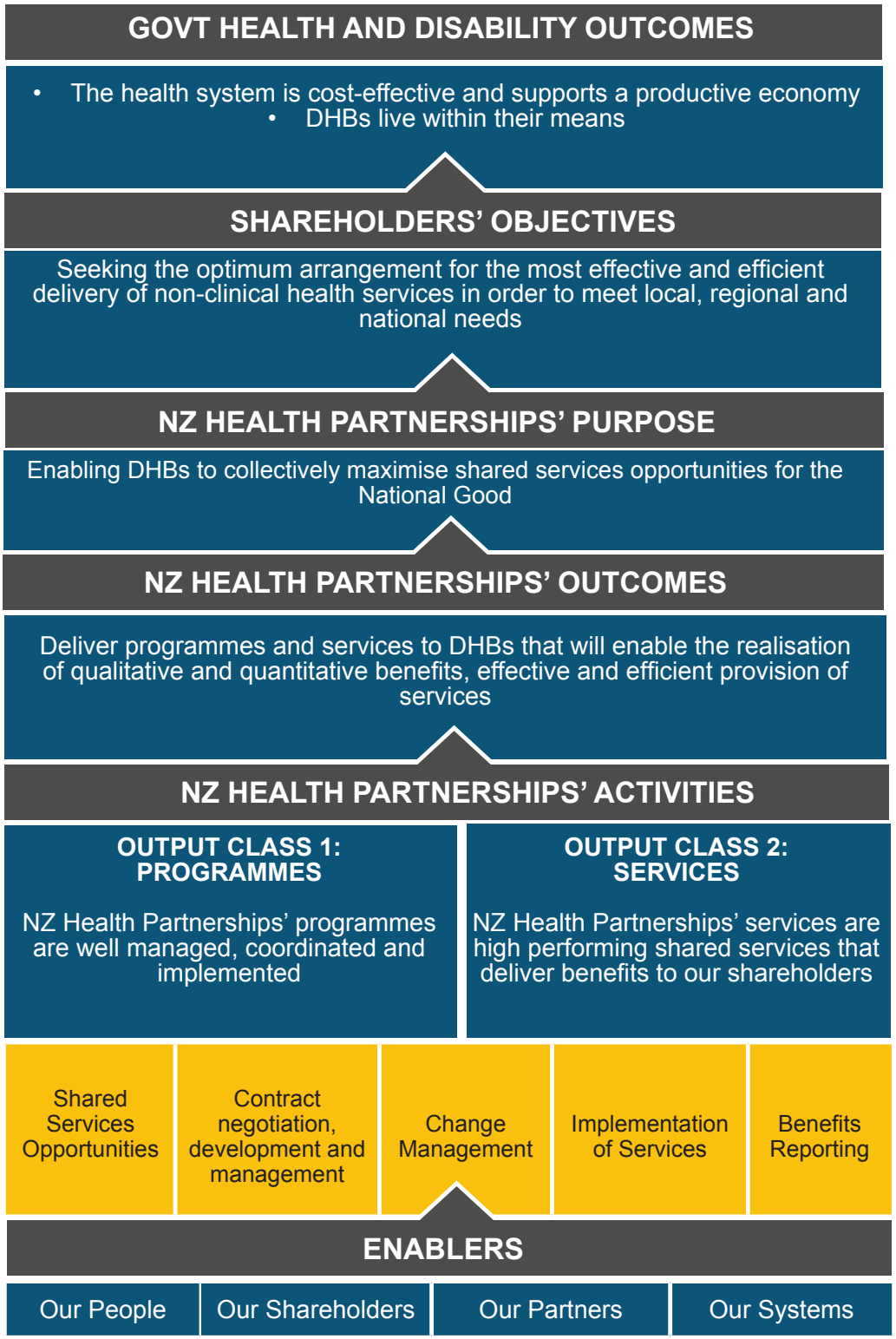
- Cash/Cost Avoidance: Cash/cost that would have been spent now totally avoided or reallocated as result of the business case. Examples include capital expenditure avoided by a procurement deal obtaining better pricing, avoiding an investment or an increase in cost.
- Qualitative: Benefits that accrue from associated activity as a result of a business case and need to be reported in some way. These may be able to be quantified but this may prove to be too difficult to do reliably. Examples include increased process efficiencies and improved clinical safety.

	15/16 Estimated $000	16/17 Estimated $000	17/18 Estimated $000	18/19 Estimated $000
OUTPUT CLASS 1: PROGRAMMES				
National Oracle Solution				
Budgetary	0	309	1,289	444
Non-Budgetary	0	0	309	1,289
National Infrastructure Platform				
Budgetary	0	0	0	0
Non-Budgetary	0	0	0	0
Food Services				
Budgetary	10	4,110	4,460	4,810
Non-Budgetary	400	1,960	480	470
Linen and Laundry				
Budgetary	300	600	0	0
Non-Budgetary	0	300	900	900
Total Annual Gross Benefits				
Budgetary	310	5,019	5,749	5,254
Non-Budgetary	400	2,260	1,689	2,659
OUTPUT CLASS 2: SERVICES				
National Procurement Service				
Budgetary	27,300	27,300	27,300	27,300
Non-Budgetary	6,000	27,300	27,300	27,300
Banking				
Budgetary	0	0	0	0
Non-Budgetary	925	925	925	925
Insurance				
Budgetary	0	0	0	0
Non-Budgetary	5,283	3,170	3,170	3,170
Other Procurement				
Budgetary	7,331	4,228	2,580	721
Non-Budgetary	10,997	6,341	3,869	1,081
Total Annual Gross Benefits				
Budgetary	34,631	31,528	29,880	28,021
Non-Budgetary	23,205	37,736	35,264	32,476
TOTAL GROSS ANNUAL BENEFITS	**58,546**	**76,543**	**72,582**	**68,410**
TOTAL CUMULATIVE GROSS BENEFITS	**58,546**	**135,089**	**207,671**	**276,081**

The financial benefits outlined in Table 1 will be re-quantified once the current programmes have been re-scoped to align with our shareholders' expectations. Activity is underway to re-baseline the benefits for the Food Services and National Infrastructure Platform initiatives.

Our Outputs Framework

The diagram below shows how the organisational activities of NZ Health Partnerships contribute to our shareholders' objectives.



OUTPUT CLASS 1: PROGRAMMES

This output class comprises the in-flight programmes managed by NZ Health Partnerships: the National Infrastructure Platform, National Oracle Solution, Food Services, and the Linen and Laundry programme. The purpose of the output class is to ensure that NZ Health Partnerships' programmes are well-managed and co-ordinated.

Performance Measure	Target	Type	Target Date
Programme governance and engagement review	• Programme governance and engagement groups reviewed and aligned to the new governance charter	Quality	Quarter 3

National Infrastructure Platform

The National Infrastructure Platform (NIP) programme aims to achieve qualitative, clinical and financial benefits for DHBs through a national approach to IS infrastructure consumption. The national approach is driven by converging the 40 infrastructure facilities into a single infrastructure platform delivered from two data centre facilities.

Performance Measure	Target	Type	Target Date
Implementation Roadmaps	• A detailed roadmap has been developed identifying strategic implementation milestones	Quality	Quarter 2
Independent Quality Assurance	• Conduct quality assurance reviews of the NIP programme	Quality	Quarter 4
Best Practice Processes	• Best practice readiness processes developed and shared with DHBs • Individual readiness workshops have taken place with each DHBs findings published	Quality	Quarter 4

National Oracle Solution

The National Oracle Solution will design and build a single financial management information system ready for DHB implementation. The designing of the processes and the system of the National Oracle Solution programme will be done through a co-creation approach with the sector, leveraging existing DHB expertise.

Performance Measure	Target	Type	Target Date
DHB support for solution design	• Key stakeholders and sector specialists are involved in a series of workshops to validate the detailed design of the National System • DHBs approve the solution design of the finance system	Quality	Quarter 2
Build Phase planning complete	• Completion of the financial system Build Phase, including its release to the sector • Phase completion is signed off by the appropriate governance groups	Timeliness	Quarter 4
Stage Gate passed	• Completion of all agreed artefacts for the November Stage Gate • Stage Gate passed following approval by relevant governance bodies	Timeliness Quality	Quarter 2

Linen and Laundry Services

Performance Measure	Target	Type	Target Date
Identify strategic options	• Facilitate meetings for the DHBs open to considering a collective arrangement for outsourced Linen and Laundry services	Quality	Quarter 2

Food Services

The Food Services programme seeks to implement a comprehensive food solution to the DHBs. The solution will deliver national nutritional standards, a centralised electronic menu management system and improved visibility of food services spend across the sector.

NZ Health Partnerships also undertakes contract and vendor management of the Food Services Agreement on behalf of the DHBs.

Performance Measure	Target	Type	Target Date
Implementation	• Successful implementation occurs for DHBs that have entered into the Agreement	Timeliness Quality	Quarter 4
Contract KPIs	• 100% Tier 1 contract KPIs are met or action plans are in place • Notice of Exemption for the hospitals and nominated DHB premises are issued	Quality	Quarter 4
Continuous Improvement and Innovation	• Lessons learned from the mobilisation and implementation of the Food Services to DHBs are captured and Continuous improvement of the methods (processes, systems and resources) though which the Services are delivered to DHBs	Timeliness Quality	Quarter 4

15

FINANCIAL PERSPECTIVE

	2015/16 $000's
Revenue	
National Oracle Solution	7,028
National Infrastructure Platform	3,385
Food Services (funded through Management Services budget)	501
Linen and Laundry (funded through Management budget)	-
Total Revenue	10,914
Expenditure	
National Oracle Solution	7,028
National Infrastructure Platform	3,385
Food Services	501
Linen and Laundry	-
Total Expenditure	10,914
Net Surplus	**0**

OUTPUT CLASS 2: SERVICES

This output class comprises the services delivered by NZ Health Partnerships: Management Services, National Procurement Service, Collective Insurance and Shared Banking. The purpose of the output class is to ensure NZ Health Partnerships' services are high performing and deliver the DHBs both qualitative and quantitative benefits. As the inflight programmes implement and activity becomes business-as-usual, they will be transitioned from programmes to services.

Management Services

Management Services refers to the central function within NZ Health Partnerships that implements initiatives relating to organisational change, cultural alignment, strategy, programme management and stakeholder communication and engagement. These activities will act as an enabler for NZ Health Partnerships implement its three strategic themes throughout the organisation.

Performance Measure	Target	Type	Target Date
Services governance and engagement review	• Services governance and engagement groups reviewed and aligned to the new governance charter	Quality	Quarter 3
Customer satisfaction	• >75% of customers surveyed rate the quality of their working relationship with NZ Health Partnerships as "Good" or "Very Good"	Quality	Quarter 4
Use of DHB expertise	• >300 days per annum of DHB Subject Matter Experts engaged across the NZ Health Partnerships portfolio	Quality	Quarter 4
Budget Management	• Actual spend for Management Services is <95% of the budget	Financial	Quarter 4

National Procurement Service

The National Procurement Service is the off-system procurement service provided to all 20 DHBs. The National Procurement Service is currently provided by healthAlliance FPSC Ltd.

Performance Measure	Target	Type	Target Date
Independent Review of the National Procurement Service	• Conduct independent quality assurance of the National Procurement Service	Quality	Quarter 2
Action Plans	• Action Plans developed to address priority areas for improvement identified in the Independent Review of the National Procurement Service	Quality	Quarter 3

Collective Insurance

This service is responsible for managing the insurance requirements for all 20 DHBs and 15 associated joint agencies and subsidiaries that have elected to join the Collective Insurance Service. The objective of the service is to obtain insurance for the 20 DHBs and participants at the most cost-effective price, taking into account the terms and conditions, market dynamics and the strategic intentions of the DHBs.

Performance Measure	Target	Type	Target Date
Appropriate Insurance Coverage achieved	• Appropriate Insurance coverage achieved for DHBs and joint agencies (DHB owned, partially owned or organisations with which DHBs have strategic relationships) in the following areas policy areas: material damage business interruption, liability, personal accident, travel, and motor vehicle	Quality	Quarter 4
New Broker appointed	• Successful completion of secondary procurement process to appoint new Broker	Quality	Quarter 4
Insurance coverage delivers benefits for DHBs and Joint Agencies	• $5.283 million of benefits realised during financial year 2015/16, including savings from Fire Service levies	Financial	Quarter 4

Shared Banking

Shared Banking and Treasury Services ("The Sweep") functions as a sector cash manager. NZ Health Partnerships invests funds held in a restricted range of investments to optimise the return on funds.

Performance Measure	Target	Type	Target Date
Shared Banking Independent Internal Audit completed	• Audit completed with no issues rated as 'significant', as defined in the Shared Banking Internal Compliance: Internal Audit Report	Quality	Quarter 3
NZ Health Partnerships joining the existing Shared Banking arrangement	• NZ Health Partnerships has joined the Shared Banking arrangement • NZ Health Partnerships entry has been approved by the appropriate governance bodies	Timeliness	Quarter 4
Tender process for new Shared Banking arrangement commenced	• Procurement process to appoint new banker has commenced	Quality Timeliness	Quarter 4

FINANCIAL PERSPECTIVE

	2015/16 $000's
Revenue from DHBs	
Shared Banking	
Interest Revenue from Shared Banking Facility	24,000
Shared Banking Operations	360
Management Services (including Collective Insurance)	5,499
National Procurement Service	10,920
Integrator	350
Total Revenue	41,129
Expenditure	
Shared Banking	
Finance Cost Shared Banking	24,000
Shared Banking Operations	360
Management Services (including Collective Insurance)	5,341
National Procurement Service	10,920
Integrator	350
Total Expenditure	40,971
Net Surplus	**158**

PART 2

PROSPECTIVE FINANCIAL STATEMENTS

PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE BY OUTPUT CLASS

FOR THE YEAR ENDED 30 JUNE 2016

	Budget $000's
Revenue:	
Output Class 1: Programmes	10,914
Output Class 2: Services	41,129
Total Revenue by Output Class	52,043
Expenditure:	
Output Class 1: Programmes	10,914
Output Class 2: Services	40,971
Total Expenditure by Output Class	51,885
TOTAL	**158**

PROSPECTIVE STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

FOR THE YEAR ENDED 30 JUNE 2016

	Budget $000's
Revenue:	
Revenue from DHBs	22,505
Interest Revenue	
NZ Health Partnerships	200
Shared Banking	24,000
Other Revenue	5,338
Total Revenue	52,043
Expenditure:	
Personnel costs	4,095
Depreciation and amortisation expense	2,112
Finance costs	
NZ Health Partnerships	0
Shared Banking	24,000
Other expenses	21,678
Total Expenditure	51,885
Surplus/ (Deficit)	**158**
Other comprehensive revenue and expense	0
Total Other Comprehensive Revenue and Expense	0
TOTAL COMPREHENSIVE REVENUE AND EXPENSE	**158**

PROSPECTIVE STATEMENT OF FINANCIAL POSITIONS

AS AT 30 JUNE 2016

	Budget $000's
ASSETS	
Current Assets:	
Cash and cash equivalents	
NZ Health Partnerships	1,722
DHB Shared Banking Facility	191,028
Receivables	6,955
Investments – Shared Banking	90,000
Total Current Assets	289,755
Non-Current Assets*:	
Property, plant, and equipment	1,720
Intangible assets	61,730
Total Non-Current Assets	63,450
Total Assets	**353,205**
LIABILITIES	
Current Liabilities:	
Payables	6,888
DHB Shared Banking Facility	281,028
Employee entitlements	215
Total Current Liabilities	288,131
Non-Current Liabilities:	
Employee entitlements	0
Total Non-Current Liabilities	0
Total Liabilities	**288,131**
Net Assets	**65,074**
EQUITY	
Contributed Capital	64,916
Accumulated surplus / (deficit)	158
Total Equity	**65,074**

15

*__Note:__ Under Non-Current Assets, Capital Expenditure mainly relates to the National Oracle Solution programme. The National Oracle Solution is not a single asset, but a bundle of assets that are both tangible such as IT hardware and intangible, such as software, policy manuals, process documentation, process maps, standard operating procedures, reference materials and intellectual property. Through the development of the programme, the assets that are created by the National Oracle Solution programme will be held in Work in Progress (WIP) part of Intangible Assets. The construction is expected to last around 18 months. National Oracle Solution programme will be recognised as tangible or intangible assets when it is in the location and condition necessary for it to be capable of operating in the manner intended by management.

	Budget $000's
Non-Current Assets:	
Property, plant and expenditure	
Leasehold Improvement	18
Furniture and office Equipment	69
Information Technology	1,633
Total Property, plant and expenditure	1,720
Intangible Assets	
Work In Progress	57,412
Acquired Software	4,318
Total Intangible Assets	61,739
TOTAL NON-CURRENT ASSETS	**63,450**

PROSPECTIVE STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2016

	Notes	Budget $000's
Balance at 1 July 2015		**64,916**
Total Comprehensive Revenue and Expense for the year		158
Owners Transactions		
Issue of B class shares		0
BALANCE AT 30 June 2016		**65,074**

15

PROSPECTIVE STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 30 JUNE 2016

	Actual $000's
Cash flows from Operating Activities:	
Receipts from DHBs	24,485
Receipts from other revenue	3,358
Interest received from Shared Banking Facility	24,000
Payments to suppliers	(21,728)
Payments to employees	(4,095)
Interest paid	(24,000)
Goods and services tax (net)	50
Net Cash Flow from Operating Activities	2,070
Cash flows from Investing Activities:	
Funds from Deposit	90,798
Purchase of property, plant, and equipment	20
Purchase of intangible assets	(9,216)
Funds to Deposit	(139,000)
Net Cash Flow from Investing Activities	(57,398)
Cash flows from Financing Activities:	
B class shares	0
Proceeds from borrowings	0
Repayment loan	0
Net Cash Flow from Financing Activities	0
Net (decrease)/increase in cash and cash equivalents	**(55,328)**
Cash and cash equivalents at the beginning of the year	248,078
Cash and cash equivalents at the end of the year	192,750

NOTES TO THE PROSPECTIVE FINANCIAL STATEMENTS

The prospective financial statements are based on policies and approvals in place as at 1st July 2015. Under the Health Sector (Transfers) Act 1993, effective 1 July 2015, all of Health Benefits Limited (HBL) assets and liabilities, including all employment and commercial agreements, have transferred to NZ Health Partnerships Limited by Order in Council.

The prospective financial statements set out NZ Health Partnerships activities and planned performance. The use of this information for other purposes may not be appropriate. These prospective financial statements have been prepared on the basis of assumptions of future events that NZ Health Partnerships reasonably expects to occur and associated actions that NZ Health Partnerships reasonably expects to take at the date that this information was prepared.

1. Statement of Accounting Policies

REPORTING ENTITY

NZ Health Partnerships Limited was established on the 16th June 2015 and became operational on the 1st July 2015. NZ Health Partnerships is a multi-parent Crown subsidiary, owned by the 20 District Health Boards, which have equal core shareholding and voting rights. NZ Health Partnerships is domiciled in New Zealand.

NZ Health Partnerships primary objective is to operate as a co-operative undertaking, and enable DHBs to collectively maximise shared services opportunities for the national good.

BASIS OF PREPARATION

Statement of compliance

These prospective financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004. These include the requirement to comply with NZGAAP.

The prospective financial statements have been prepared to comply with Public Benefit Entity Standards (PBE Standards) for a Tier 1 entity. NZ Health Partnerships is adopting the PBE

Standards for the first time. This includes Public Benefit Entity Reporting Standard 42 *Prospective Financial Statements* (PBE FRS 42).

The prospective financial statements have been prepared for the special purpose of the *Statement of Performance Expectations 2015/16* of NZ Health Partnerships for its shareholders. They have not been prepared for any other purpose and should not be relied upon for any other purpose.

These statements will be used in our Annual Report as the budgeted figures.

The *Statement of Performance Expectations* narrative informs the prospective financial statements and the document should be read as a whole.

The preparation of prospective financial statements in conformity with PBE FRS 42 requires the Board and management to make good judgements, estimates, and assumptions that affect the application of policies and reported amounts of assets and liabilities, income, and expenses.

The prospective financial statements were approved on 1 July 2015. The Board is responsible for the prospective financial statements presented, including the assumptions underlying the prospective financial statements and all other disclosures. The *Statement of Performance Expectations* is prospective and as such contains no actual operating results. It is not intended that these prospective financial statements will be updated.

Measurement base

The prospective financial statements have been prepared on a historical cost basis.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

2. Summary of Significant Accounting Policies

The following accounting policies, which significantly affect the measurement of financial performance and of financial position, have been consistently applied.

2.1 Revenue

The specific accounting policies for significant revenue items are explained below:

NZ Health Partnerships is funded through revenue received from the DHBs, which is restricted in its use for the purpose of NZ Health Partnerships meeting its objectives as specified in the statement of intent. Revenue is recognised as revenue when earned and is reported in the financial period to which it relates.

Interest Revenue

Interest revenue is recognised using the effective interest method. Interest revenue on an impaired financial asset is recognised using the original effective interest rate.

2.2 Leases

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight - line basis over the lease term. Lease incentives received are recognised in the surplus/deficit as a reduction of rental expense over the lease term.

2.3 Borrowing Costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

2.4 Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks and other short-term highly liquid investments with original maturities of three months or less. All investments are held in New Zealand.

2.5 Receivables

Receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

2.6 Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

2.7 Property, plant and equipment

Property, plant and equipment consist of the following asset classes: leasehold improvements, furniture, office equipment and information technology.

Property, plant and equipment are shown at cost, less any accumulated depreciation and impairment losses.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to NZ Health Partnerships and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset and are reported in the surplus or deficit.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to NZ Health Partnerships and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as follows:

Asset Type	Useful Life	Rate
Leasehold improvements	5 – 14 years	7% - 20%
Furniture and office equipment	1.5 – 9.5 years	10.5% - 67%
IT Hardware	2.5 – 5 years	20% - 40%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an asset is reviewed and adjusted if applicable, at each financial year end.

2.8 Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with development and maintenance of NZ Health Partnership's website is recognised as an expense when incurred. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and an appropriate portion of relevant overheads.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Asset Type	Useful Life	Rate
Acquired computer software	2.5 – 3 years	33% - 40%
National Oracle Solution system intangible assets	5 - 15 years	16.67% - 20%

2.9 Impairment of property, plant, and equipment and intangible assets

NZ Health Partnerships does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash generating assets

Property, plant and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information.

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

2.10 Payables

Short-term payables are recorded at their face value.

2.11 Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date and annual leave earned to but not yet taken at balance date.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense is recognised where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave and sick leave, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- The present value of the estimated future cash flows.

2.12 Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

2.13 Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless NZ Health Partnerships has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

2.14 Equity

Equity is measured as the difference between total assets and total liabilities.

2.15 Goods and services tax

All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

2.16 Income tax

NZ Health Partnership is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

2.17 National Oracle Solution rights

The National Oracle Solution rights represent the DHBs right to access, under a Service Agreement, shared Finance, Procurement and Supply Chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, previously facilitated by Health Benefits Limited now NZ Health Partnerships, whereby all 20 DHBs will move to a shared services model for the provision of Finance, Procurement and Supply Chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely. The fund established by Health Benefits Limited now NZ Health Partnerships through the on-charging of depreciation on the National Oracle Solution assets to the DHBs will be used to, and is sufficient to, maintain the National Oracle Solution assets standard of performance or service potential indefinitely.

As the National Oracle Solution rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

2.18 Financial Instrument Risks

NZ Health Partnerships activities expose it to credit risk, cash flow risk and liquidity risk. NZ Health Partnerships policy does not allow any transactions that are speculative in nature to be entered into. It has policies and procedures to ensure risks are low.

3. Critical Accounting Judgements and Estimates

In preparing these prospective financial statements NZ Health Partnerships has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

General Assumption – cost levels

These figures have been based on the assumption that interest rates and general cost levels will remain at similar levels to those at the time of the Statement of Performance Expectations' preparation.

Estimating useful lives and residual values of property, plant and equipment

At each balance date, the useful lives and residual values of property, plant and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by NZ Health Partnerships Limited, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. NZ Health Partnership's minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;

- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

DHB Shared Banking Facility

NZ Health Partnerships has exercised its judgement regarding the DHB Shared Banking Facility and has accounted for the arrangement as though it is acting as principal as it has the potential to be exposed to credit risk from the arrangement. The related party nature of the arrangement makes the agency/principal distinction more difficult. NZ Health Partnerships consider presenting the DHB Shared Banking Facility as principal; will ensure transparent and consistent information is presented about the arrangement in NZ Health Partnership's financial statements.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to NZ Health Partnerships.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

NZ Health Partnerships has exercised its judgement on the appropriate classification of equipment leases, and has determined no lease arrangements are finance leases.

Capitalisation of National Oracle Solution costs

The National Oracle Solution programme is a significant part of NZ Health Partnerships' savings initiatives. The National Oracle Solution programme is set to improve the way goods and services are made available to DHBs for purchasing, ordering, delivery storage and payment. A national approach to these services will combine the purchasing power of DHBs, create visibility of stock and ensure a common financial language across the health sector.

Through the development of the National Oracle Solution programme, the assets that are created by the National Oracle Solution programme will be held in Work in Progress (WIP). The construction is expected to last around 18 months and during this period there will be progressive deployments of functionality leading to a gradual realisation of benefits. The

National Oracle Solution programme is not a single asset, but a bundle of assets that are both tangible such as IT hardware and intangible, such as software, policy manuals, process documentation, process maps, standard operating procedures, reference materials and intellectual property. The costs that are directly associated with the development of the National Oracle Solution programme will be recognised as tangible or intangible assets when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. Direct costs include project development employees, contractors, consultants and apportionment of the relevant overheads.

Indirect costs are recognised as expenses when incurred and include travel, training and recruitment costs. The National Oracle Solution has spent the majority of its capital budget.

Amortisation

The amortisation of the assets will begin once the asset is available for use (commissioned into the fixed asset register) and will cease at the date that the asset is de-recognised. The carrying value of an intangible asset with a finite life is amortised on a straight line basis over its useful life. The useful lives of National Oracle Solution intangible assets have been estimated to be 15 years (life of the contract).

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Auditor-General

The Auditor-General pursuant to section 15 of the Public Audit Act 2001. Andy Burns of Audit New Zealand was appointed to perform the audit on behalf of the Auditor-General.

Banker

Westpac Banking Corporation

15

NZ HEALTH PARTNERSHIPS

Annual Plan 2015/16

15

Contents

15

List of Acronyms and Abbreviations

AoG	All of Government
CE	Chief Executive
Central TAS	Central Technical Advisory Services Limited
DHB	District Health Board
DIA	Department of Internal Affairs
hA	healthAlliance NZ Limited
hA FPSC	healthAlliance FPSC Limited (subsidiary of hA NZ)
MBIE	Ministry of Business, Innovation and Employment
MoH	Ministry of Health
NOS	National Oracle Solution (formerly Finance, Procurement and Supply Chain [FPSC] programme)
NPS	National Procurement Service
PHARMAC	Pharmaceutical Management Agency
NIP	National Infrastructure Platform
SOI	Statement of Intent
SPE	Statement of Performance Expectations

Executive Summary

NZ Health Partnerships is a new organisation that is still evolving, and will continue to evolve over the coming years. It is important that strong foundations are in place. The foundations will ensure the organisation is built into a value-adding, fit for purpose organisation that is well-connected to all the key players in its operating model and its performance exceeds its shareholders' expectations.

Our shareholders have stressed the importance of building an expert and trusted organisation. The strategic intentions for the 2015/16 year and the activities set out in the Annual Plan will help the organisation set these foundations. In 2015/16 NZ Health Partnerships will focus on its existing portfolio of programmes and services to ensure they are fit for purpose and aligned to the needs and expectations of our shareholders. No new initiatives will be considered this financial year.

The Annual Plan is intended as a partner document to the NZ Health Partnerships Statement of Intent (SOI) and Statement of Performance Expectations (SPE). The SOI and SPE outline what NZ Health Partnerships will achieve including financial and non-financial performance measures, while the Annual Plan details how these performance measures and targets will be met.

2015/16 Programmes and Services Summary

The scope of NZ Health Partnerships' work is aligned under two output classes around which this document is structured.

NZ Health Partnerships' output classes for 2015/16 are:

- Output Class 1: Programmes
- Output Class 2: Services.

While fundamentally the Programmes and Services are at the core of NZ Health Partnerships, the Company will also seek to implement shareholder agreed Governance and Engagement structures in the 2015/16 financial year. Internally we will focus on building our capability and aligning our culture to work more collaboratively with DHBs.

Output Class 1: Programmes

- National Infrastructure Platform (NIP): The focus for NIP has largely shifted from business case work to supporting DHB-led implementation. From a programme perspective however, business case approval continues to be sought from one DHB and business case re-baselining will be completed in 2015/16.
    - The service is an IBM-hosted and managed Infrastructure as a Service solution. Once established, agencies will no longer need to buy and maintain their own ICT infrastructure including servers, storage and Data Centres. This service is fully aligned with the government's *ICT Strategy and Action Plan to 2017.*
- National Oracle Solution: This programme covers NZ Health Partnership's work with DHBs on the detailed design and build of a national Finance, Procurement and Supply Chain (FPSC) solution. The primary focus is the common finance system, which will be available to all DHBs to migrate onto, in a timeframe that they will prioritise against their existing risk profile and investment strategy.
- Food Services: The scope of the Food Service offering includes the provision of patient meals, meals-on-wheels, cafeteria services, ward supplies and function catering and vending machines

by Compass Group.

- Linen and Laundry: NZ Health Partnerships supports regional laundry initiatives, provides contract renewal support to DHBs and has developed a national linen catalogue for handover as a national procurement category.

Output Class 2: Services

- National Procurement Service: healthAlliance (FPSC) Ltd is contracted by NZ Health Partnerships to procure both clinical and non-clinical products for all 20 District Health Boards. The Service also includes supplier and contract management.
- The Shared Banking function centralises shared banking services through NZ Health Partnerships and Westpac New Zealand Limited. Shared banking was implemented throughout 2012/13 and is now in the business as usual phase.
- The Insurance function provides insurance brokering services alongside affordable and appropriate insurance policy coverage for all DHBs. Insurance is also in the business as usual phase and this involves the insurance broker obtaining appropriate coverage each financial year, with no material changes to terms and conditions.

Benefits

The NZ Health Partnerships work plan for 2015/16 identifies approximately $58.546 million in benefits for the 2015/16 financial year which will be delivered through the two output classes. Also, NZ Health Partnerships and the DHBs will be co-developing a Benefits Management Framework to ensure consistent reporting across the sector.

Who we are

NZ Health Partnerships Limited is a multi-parent Crown subsidiary, owned by the 20 District Health Boards (DHBs). On 1 July 2015 NZ Health Partnerships became operational and the staff, programmes, services, assets and liabilities of Health Benefits Limited were transferred over to it by way of the Health Sector (Transfers) Act 1993.

Our Purpose

NZ Health Partnerships is DHB owned and supported. Established as a co-operative undertaking, NZ Health Partnerships' purpose is to enable DHBs to collectively maximise shared services opportunities for the national good.

To achieve our purpose we work with our DHBs as shareholders, co-creators and customers. In partnership we identify, develop and implement initiatives for the sector's mutual benefit and ultimately to help improve health outcomes for all New Zealanders.

We work with other organisations that will contribute to shared service opportunities for the DHBs. Together as a sector we ensure an integrated and collaborative approach progressing initiatives for the national good.

Our Vision

In partnership with DHBs we identify, develop and implement initiatives for the Sector's mutual benefit and ultimately to help improve health outcomes for all New Zealanders.

Our Values

The values that underpin our engagement with our shareholders are:

- Respect
- Transparency
- Accountability
- Commitment

Our Principles

In the NZ Health Partnerships Shareholders' Agreement, DHBs have agreed to a number of principles that are fundamental to the successful governance and operations of NZ Health Partnerships. NZ Health Partnerships has committed to a number of parallel principles. These govern how we work with each other and the DHBs.

- **WE ARE A CO-OPERATIVE UNDERTAKING**
  NZ Health Partnerships operates as a co-operative undertaking and we are accountable to all of our shareholders equally. Our programmes and day-to-day activities are focussed on enabling them to participate in and derive benefits from our work for the National Good.

- **WE WILL HONOUR OUR COMMITMENTS**
  NZ Health Partnerships recognises that we are DHB-led and owned; and that DHBs are also our customers. We will act in a fiscally responsible manner, honour our formal reporting requirements

and any other commitments made to our shareholders.

As co-creators we commit to partnering with DHBs, using the relevant capabilities and expertise of each party, to identify, prioritise and develop shared service initiatives.

- **WE HAVE A SHARED INTENTION AND COMMITMENT**
  Our shareholders have a shared intention to build and continue a long-term enduring relationship based on mutual trust to provide optimal outcomes for the Sector and better health outcomes for all New Zealanders. This shared intention and commitment is manifested in NZ Health Partnerships, which affirms its' own need to build trust and enduring relationships with DHBs. Together we will deliver high quality, cost-effective healthcare services without compromising patient safety or quality of care.

- **WE ARE COMMITTED TO OPENNESS, HONESTY AND TRANSPARENCY**
  NZ Health Partnerships and the DHBs are committed to ensuring openness, promptness, consistency and fairness in all dealings and communications between each other.

  DHBs will support the operation of NZ Health Partnerships through the provision of appropriate personnel and resources; and will provide accurate and timely data and other information to each other. NZ Health Partnerships will in turn provide accurate and timely information to its shareholders.

  All parties will always show respect for each other's viewpoints – including differences. Where differences are identified, NZ Health Partnerships and the DHBs will act in good faith to resolve those differences.

Governance and Accountability

The DHB shareholders own and govern the entity by way of an Independent Board. The Board comprises of four regional DHB representatives and three independent Directors. It is chaired by an independent Director. The Board meet monthly and the Finance, Audit and Risk Committee meet quarterly. Within the parameters of the Annual Plan, the Board is responsible for delivery of its portfolio of initiatives, core budget and performance of programmes and services.

The Board of Directors will appoint the Chief Executive (CE). The CE is responsible for leading the day-to-day operations of the organisation, supported by an executive leadership team.

Programmes and services have their own governance groups and will be led by a DHB CE Sponsor. The role of the Sponsor is to provide strategic direction for the programmes and services, remove roadblocks and lead change into DHBs on behalf of all the DHB Chief Executives. This will give the shareholders greater transparency of the activities undertaken by NZ Health Partnerships with regards to the programmes of work. The scope of the CE Sponsors work has been approved by the NZ Health Partnerships Board.

Governance and Co-creation Principles

The following principles have been established with our shareholders:

Governance

- NZ Health Partnerships will align and integrate its planning cycle with DHBs
- Within the scope of the Annual Plan, the NZ Health Partnerships Board has responsibility for and the delegated authority to drive and deliver the portfolio of work
- The NZ Health Partnerships Board will delegate operational management of the services lifecycle and the portfolio of opportunities, programmes and services to its executive leadership team
- Governance and engagement processes and groups need to be fit for purpose to ensure the right people are involved at the right time
- DHB Chief Executives will play an active role in sponsoring portfolio initiatives, building alignment within the Sector and being responsible for realising benefits associated with their DHBs' investments
- Chairs and Chief Executives will take responsibility for ensuring that the required DHB decision making processes are in place to endorse NZ Health Partnerships plans and escalations
- Terms of reference for each governance group will provide clarity of accountabilities and decision rights.

Co-creation and Engagement

- The co-creation process will ensure that NZ Health Partnerships initiatives align with DHBs' goals and objectives
- DHBs help drive the co-creation process to develop innovative solution designs, contractual arrangements and deployment options which maximise the National Good and ensure optimal participation
- DHB category and subject matter experts will be embedded in the initiatives within the NZ Health Partnerships portfolio
- NZ Health Partnership management undertakes to engage regularly with DHBs and keep all stakeholders informed about portfolio status, progress, risks and issues
- DHBs will be actively engaged, proactive in sharing information and communicating questions and issues.

Legislative Framework

NZ Health Partnerships is as a multi-parent Crown subsidiary, owned by the 20 DHBs and is subject to the Companies Act 1993 and the Crown Entities Act 2004. This accountability and legislative framework gives NZ Health Partnerships the following features:

- The ability to have a mix of commercial and non-commercial objectives, allowing the company to operate in a commercial manner within a public sector environment.
- Crown input through an accountability framework that includes producing and reporting against a SOI, SPE and an Annual Report.

As shareholders, DHBs endorse the strategic direction and intent of NZ Health Partnerships, and monitor its performance.

Statutory Requirements

Certain provisions in the Crown Entities Act apply automatically by virtue of NZ Health Partnerships being a multi-parent Crown subsidiary.

The Crown Entities Act has rules and restrictions relating to acquisition of securities, borrowing, guarantees, indemnities and derivative transactions. NZ Health Partnerships has been granted exemptions for the right to have:

- A banking overdraft facility of $200,000.
- A standby working capital facility of $50,000,000 for the purpose of providing shared banking arrangements with DHBs.

In addition NZ Health Partnerships will:

- Act as a 'good employer' where 'good employer' has the same meaning as in section 118 of the Crown Entities Act 2003;
- Regard to any whole-of-government direction that would apply to the entity;
- Under the Public Audit Act 2001, the Controller and Auditor-General is the auditor of the company; and
- Be subject to the Official Information Act 1982 and the Ombudsmen Act 1975.

Acquisitions and Disposals

It is possible that the Board will seek to acquire or form companies to enact initiatives intended to deliver benefits and gains for DHBs. This will require our shareholders' approval (under the Crown Entities Act) given NZ Health Partnerships has no powers to form or acquire companies. This power will need to be considered when and if a business case is developed that requires the formation of an entity to deliver upon an initiative that delivers gains for the sector.

Major Transactions

NZ Health Partnerships will from time to time enter into transactions or commitments which constitute, or might constitute a "major transaction" for the purposes of section 129 of the Companies Act 1993. A major transaction will require the approval of all shareholders as outlined in the NZ Heath Partnerships Constitution.

Dividend Policy

NZ Health Partnerships dividend policy is to retain any surplus for reinvestment in initiatives that are consistent with the purpose of NZ Health Partnerships and likely to generate benefits or efficiencies for DHBs or the wider Sector. The Board reserves the right to amend the dividend policy at any time but would only do this with the agreement of shareholders.

Treaty of Waitangi

NZ Health Partnerships recognises the special relationship between Maori Iwi and the Crown under the Treaty of Waitangi and is committed to the recognition of the Government's requirements in regard to the Treaty of Waitangi.

NZ Health Partnerships will endeavour to apply the relationship-enhancing Treaty principles of participation, protection and partnership in all its engagements with Maori organisations and staff.

What We Do

The *What We Do* section covers the mechanisms and frameworks that are in place in NZ Health Partnerships to enable us to meet our shareholders expectations. The main areas covered are our core functions and activities.

Function and Activities

NZ Health Partnerships' core business is to deliver programmes and services to DHBs that enable them to realise financial and quality improvements. While the organisation's primary focus is on creating efficiencies in administrative, support and other procurement activities, most of our work has direct or indirect links to clinical services. The activities NZ Health Partnerships undertakes to achieve this are:

- **CONTRACT NEGOTIATION AND MANAGEMENT**
  Subject to DHB approval, we will enter into negotiations with Preferred Respondents to negotiate commercially astute programme and service agreements. Agreements are drafted for DHB consideration and approval. Once Agreements have been signed, we manage the contracts, performance and relationship of the vendors on behalf of the DHBs, and undertake reporting of KPIs and data analysis to support the management of the contract.

- **CHANGE MANAGEMENT**
  NZ Health Partnerships will work with the DHBs to deliver transformational business, people and system changes within complex environments. We will act as an enabler for successful change and behaviour adoption that supports the realisation of benefits. In recognising that the needs of each DHB are different, we will identify individual change requirements and needs. Some DHBs may be in a position to manage their own change and support the change in others.

- **IMPLEMENTATION OF SERVICES**
  A joint delivery model will be employed for the implementation of services whereby the DHBs will lead the implementation of the solutions into their organisation. NZ Health Partnerships will provide support to ensure successful and cost-effective deployment. This may include:
    - Detailed role based impact assessments
    - Training needs assessments
    - Development of training collateral
    - Online training delivery
    - Business readiness assessments.

- **BENEFITS REPORTING**
  NZ Health Partnerships consolidates the reporting of all benefits generated across the sector, in particular across the programmes and services implemented by NZ Health Partnerships. This includes reporting benefits achieved by NZ Health Partnerships' initiatives, All of Government, and local and collaborative DHB procurement.

- **CONTINUOUS IMPROVEMENT**
  Fostering a culture of continuous improvement across our organisation is paramount to our success. Feedback from our shareholders, and internal feedback loops, will provide further focus for our performance improvement activities.

Operating Principles

NZ Health Partnerships is required to operate within the functions, powers and constraints outlined in this document. Within this framework, the organisation has considerable discretion in how it goes about its day to day operations. Comprehensive operational policies and procedures have been developed concerning the manner in which NZ Health Partnerships conducts its operational processes.

NZ Health Partnerships operating principles are that it:

- Maintains an appropriate business model that is sustainable, cost-effective and meets the on-going shared service needs of its stakeholders.
- Has a clear governance and decision-making framework in place which articulates the respective roles and responsibilities of NZ Health Partnerships, DHBs and their regional governance structures.
- Maintains effective relationships with stakeholders that are mutually supportive and productive.
- Provides high-quality shared services effectively and efficiently.
- Has a sustainable, competent and engaged workforce.
- Maintains effective systems to establish a baseline of performance and cost data for the measurement of gains to the Sector.
- Maintains appropriate monitoring tools and performance issue resolution processes for initiatives as they are implemented.
- Develops and maintains policies appropriate for the business including risk management policies.

Strategic Intentions for 2015/16

The focus of NZ Health Partnerships in its first year of operation is to ensure our current portfolio of programmes and services are fit for purpose, embody the DHB-agreed governance and engagement structures, and are aligned to our shareholders' expectations. Internally we will focus on building our peoples' capabilities and aligning our culture to work more collaboratively with DHBs. The performance measures of NZ Health Partnerships will be a blend of both the strategic themes of the organisation and delivery against its output classes.

The strategic themes of NZ Health Partnerships are:

THEME ONE: Develop and deliver Shared Services initiatives to our Shareholders

NZ Health Partnerships will:

- Continue to develop and implement its in-flight programmes
- Implement best practice programme methodology
- Support DHBs for local implementation
- Manage the services and contracts for the business cases we have implemented.

THEME TWO: Planning and Portfolio Optimisation

NZ Health Partnerships will:

- Refocus our current programmes and services to align with our operating model and shareholders' expectations
- Operationalise the National Good Mechanism. This will provide flexible options to optimise DHB participation in initiatives while catering for the interest of, and impacts on, individual DHBs
- Develop a centralised approach to managing vendor performance and a detailed services catalogue.

THEME THREE: Building joint capability in the sector

NZ Health Partnerships will:

- Draw on sector expertise for the delivery of its programmes and services
- Utilise DHB expertise in the design and implementation of shared services initiatives.

Strategic Partnerships

In addition to our shareholders, NZ Health Partnerships works collaboratively with various public and sector organisations to ensure the successful delivery of programmes and services. These include healthAlliance NZ Ltd, healthAlliance (FPSC) Ltd, PHARMAC, Ministry of Health, Treasury, Ministry of Business, Innovation and Employment (MBIE), Department of Internal Affairs, National Health IT Board, Central TAS and HealthShare.

NZ Health Partnerships also has a number of commercial relationships. Key private sector vendors for the delivery of our programmes and services include IBM, Compass Group, Spotless (Taylors), OneLink and Oracle.

Managing in a Changing Environment

The *Managing in a Changing Environment* section covers the internal NZ Health Partnerships enablers that are in place to assist us in delivering programmes and services, and to ultimately meet our shareholders expectations. The main areas covered are:

- Risk management
- Change Management
- Stakeholder Engagement and Communication
- Our People.

Risk Management

NZ Health Partnerships acknowledges that risk management requires an effective system to provide the context for risk evaluation. NZ Health Partnerships' strategic choices will define both its and other stakeholders' exposure to risk as well as levels/degree of acceptable risk. NZ Health Partnerships is accordingly committed to working closely with its key stakeholders to ensure transparency, alignment and consistency in risk management approach and processes.

Mitigation Principles

The aim of our risk management principles is to improve the quality of decision making, eliminate risk, and minimise adverse impacts. To achieve this requires developing a strong risk-aware culture, involving:

- A proactive approach
- Open sharing of risk information across NZ Health Partnerships and DHB executives
- Understanding how the effects of risks in one area may impact on other parts of the organisation, our shareholders, the Crown business partners and stakeholders
- Balancing the costs of managing identified risks against the anticipated benefits.

Risk Management Objectives

OBJECTIVE ONE: Implement a portfolio-wide Risk Management Framework

Establishing a successful and effective Risk Management Framework across all the programmes and services will ensure NZ Health Partnerships has the right mitigation strategies in place to reduce the impact of risks.

ACTIONS:

- Hold monthly risk review sessions with programmes and services to ensure that risk mitigation and management plans are in place
- Risk Management toolkit is developed and ready for use by programmes and services
- Risk and Issue Management policy is reviewed and approved by the Board

#	Performance Measure	Target	Evidenced by	Type	When By
1	Risk Management Toolkit	• The development of a Risk Management Toolkit for programmes and services to effectively manage their risks and issues	• Risk Toolkit is internally reviewed and published	Quality	30 June 2016

Change Management

NZ Health Partnerships works with DHBs to deliver transformational business, people and system changes within complex environments. Full realisation of programme benefits is dependent on robust change management to ensure solutions are supported, adopted and sustained. Effective change management will support DHBs and service providers, so that they: understand the reasons for and impact of change, are prepared for change, can facilitate the acceptance and adoption of changes within their organisation and the constructs of each programme.

NZ Health Partnerships' role is to ensure that organisations understand the steps to successful change, have the tools and practices that will underpin change, build awareness and energy for the change, can harness early adopters, can leverage the lessons learned from other change programmes and organisations and effectively transition from programme to service. In many cases DHBs will lead their own change particularly with respect to structural change or consultation.

The focus for this year is quality delivery of existing programmes. We aim to provide support that is fit for purpose – meeting the requirements of individual DHBs whilst working in a co-operative ecosystem. Agility in our approach, based on strong productive working relationships, will underpin our work.

We recognise that to be effective there are both internal and external change management activities that will need to be undertaken. This means changing the way that we work to better meet our customers' needs. There is strong crossover between the change management, communication and engagement and people sections of this annual plan.

Change Management Objectives

OBJECTIVE ONE: Creating Awareness and Knowledge

Enabling successful change involves engaging the stakeholder communities to create awareness and knowledge in relation to proposed changes, ensuring impacted communities understand what, why, how and when changes will happen, facilitating understanding and appetite for change, managing the change curve, and reducing resistance.

ACTIONS:

- Key governance forums are effectively transitioned and all stakeholders are aware of functions, roles and responsibilities.
- Consistent communications, tools and approaches developed for each programme.

OBJECTIVE TWO: Developing a Customer Service Culture

Understanding our customers and enabling successful change requires a deep knowledge of each DHBs context underpinned by productive relationships. Collaborative approaches to programmes determine the 'to be' state, and detailed customer based impact assessments provide the basis for customised change support.

ACTIONS:

- Build a knowledge base of DHBs
- Ensure communication to DHBs is aligned to communications tools and applications
- NZ Health Partnerships internal change to build a customer focus.

OBJECTIVE THREE: Tailored change solutions

In recognising that the needs of each DHB are different we will work with DHBs to identify their individual change requirements and needs. Some DHBs may be in a position to manage their own change and to support the change in others. Some may need specific change support to manage the many change elements required for successful transition to new ways of working and realisation of benefits.

ACTIONS:

- Develop a structured change approach drawing on knowledge base
- Overarching documentation to support change will be developed
- Develop tools and templates such as change plans, communication plans, self-assessment tools and readiness assessments
- Document lessons learnt
- Provide DHBs with user guides, cheat sheets and quick reference tools.

#	Performance Measure	Target	Evidenced by	Type	When By
2	Change Approach	• The development of a Change Approach that meets sector expectations as critiqued by sector governance groups	• Change Approach signed off by NZ Health Partnerships Board and distributed to the sector	Quality	31 March 2016
3	Change Toolkit	• The development of Version 1 of a Change Toolkit for the sector to support effective change	• Change Toolkit is reviewed and approved by the programme steering committees	Quality	30 June 2016

Stakeholder Engagement and Communications

NZ Health Partnerships has a multi-tiered relationship with DHBs which demands timely and transparent communications to support decision making and as a means of building mutual trust.

At a broadcast level, communications will continue to focus on the existing portfolio of programmes and services including the National Oracle Solution, Linen and Laundry Programme, National Infrastructure Platform, Food Services, Shared Banking, Insurance and National Procurement. We will also report on some of the internal business process and people initiatives which focus our efforts on meeting shareholder expectations.

A number of communications channels such as the NZ Health Partnerships website and Programme extranet will be further developed to improve transparency and support any DHB-led change.

Quarterly portfolio scorecards will be introduced as the primary reporting mechanism to our shareholders. These will facilitate executive-level discussions with the DHBs and allow for a cohesive approach to achieving performance measures.

In 2015/16, we will also introduce an active stakeholder management system to foster stronger strategic relationships with our shareholders.

While DHBs are our primary focus, NZ Health Partnerships will continue to engage and build relationships with range of wider Sector stakeholders, including the Ministry of Health and the National Health Board, the Department of Internal Affairs, the Ministry of Business, Innovation and Employment, PHARMAC, TAS and key vendors.

In line with new programme and service governance structures, we will also look to engage more proactively with clinicians.

Stakeholder Engagement and Communications Objectives

OBJECTIVE ONE: Reporting to relevant stakeholders
Provide relevant, transparent and timely reports on programmes, operational services and other key developments to our shareholders.

ACTIONS:
- Develop an overarching NZ Health Partnerships Communications Plan and Policy; as well as aligned plan for each Programme and Service.
- Produce monthly portfolio-level newsletter update
- Support Programme and Services CEO sponsors to communicate with their peers
- Tactical and operational communication as necessary through two 'communications windows' each week
- Facilitate formal reporting through the quarterly balanced scorecards
- Review and update key communication channels including the website and Programme extranet.

OBJECTIVE TWO: Embed customer-focus as a core value and operational priority.

ACTIONS:
- Launch an annual shareholder / customer satisfaction survey. (Once the baseline is established, develop an action plan to improve satisfaction in 2016/17)
- Embed cultural change initiatives, including actions to increase awareness of the issues and priorities of our DHB-customers
- Implement a relationship management framework between NZ Health Partnership's Executive Leadership Team members and DHB Chief Executives and Chief Financial Officers

OBJECTIVE THREE: Actively manage all communications and engagement risks and issues.

ACTIONS:
- Maintain a communications issues and risk register, including key messages
- Respond to all Official Information Act requests and other statutory body requests for information e.g. Health Select Committee, Cabinet Committee
- Ensure Programme and Service communication plans and messaging are agreed with relevant vendors and the communications leads at participating DHBs.

#	Performance Measure	Target	Evidenced by	Type	When By
4	Communications Plan	• The development of an overarching Communications Plan and aligned Programme and Service Plans	• Overarching Plan signed off by NZ Health Partnerships Board; allied plans signed off by Programme and Service governance	Quality	31 March 2016
5	Customer Focus	• Conduct a comprehensive and detailed baseline customer/ shareholder satisfaction survey	• Survey covers satisfaction of shareholders in relation to all programmes and services • Survey conducted, analysed and outcomes communicated • Planning underway to lift ratings in 2016/17	Quality	30 June 2016
6	Communications and Engagement Risk and Issues	• Communications issues and risks are identified, along with mitigation messaging	• Communications is a subcategory in the Corporate Issues and Risk register • Programme and Service issues and risk registers include communications considerations	Quality	31 December 2015

Our People

Critical to the success of NZ Health Partnerships is the staff it employs and the development of a joint health sector workforce, utilising and seconding DHB experts, to enable co-implementation of our programmes. The organisation aims to create a professional workplace where staff deliver on commitments, treat colleagues fairly and with respect, are strongly supported and well managed, and have personal development opportunities.

Capability

A strong and committed workforce is critical to delivering our portfolio of work and progress our strategic areas of focus. We recognise the importance of our people and creating a strong team who can work collaboratively with DHB colleagues and professionally with vendors.

To develop our workforce and to ensure we have the right people, the focus of NZ Health Partnerships will be to:

- Optimise workforce capability and capacity to deliver results.
- Develop leaders to meet the challenge of change within the NZ health sector and within NZ Health Partnerships.
- Integrate our shareholders' workforce more effectively and efficiently, encouraging the development of a 'common toolkit' of skills, and improving the sector's ability to contribute expertise to shared service initiatives and retain the intellectual property within the sector.

People Plan

A responsibility of NZ Health Partnerships is to 'develop a sustainable, competent and engaged workforce.' Our People Plan identifies the various activities NZ Health Partnerships will seek to complete in order to build a competent, engaged workforce in an organisation with a culture of collaboration and high performance.

Organisational Culture

Cultural themes for focus underway are:

- Collaboration as a working style, meaning co creation and greater involvement of DHBs to ensure the work of NZ Health Partnerships is fit for purpose and aligned with the Sector's needs.
- Customer focussed orientation defining DHBs as customers, shareholders and co-creators.
- Professionalism. In addition to developing this customer orientation, we also need to assure the sector that we have the expertise and skills required to build and run successful shared services on their behalf. This means that we identify the critical competencies that we should employ permanently to complement the skills available in the sector.
- Delivering in our role as change agents, enabling DHB access to increased benefits.

Competencies and Capability to deliver

NZ Health Partnerships recruits staff to deliver on the strategic objectives of the organisation and does this through robust recruitment processes and performance management framework. The organisation requires an agile workforce with the ability to flex in terms of size and skills depending on the number and complexity of programmes and services in our portfolio at any point in time while retaining Intellectual Property. It is important that we retain staff to ensure the relationship and trust built with the sector is maintained.

Training and Development

Training and education are available to NZ Health Partnerships staff to further their development and expertise. Increasing emphasis will be put on interpersonal, communication and engagement skills.

#	Performance Measure	Target	Evidenced by	Type	When By
7	People Plan	• Comprehensive People Plan completed	• People Plan has been reviewed and approved by the NZHP CE	Quality	31 December 2015
8	Performance management	• People performance management process implemented	• Staff have set their bi-annual performance measures for 2015/16	Quality	31 December 2015

Good Employer

To ensure that the company meets its Good Employer obligations prescribed in the Crown Entities Act Part 3 section 118, NZ Health Partnerships provides equal employment opportunities to:

- Enhance the abilities of individual employees.
- Recognise the aims, aspirations and employment requirements of women, and the cultural differences of ethnic or minority groups.
- Recognise the employment requirements of people with disabilities.

NZ Health Partnerships has an organisational and team culture that recognises the diversity of New Zealand society and brings a perspective appropriate to an organisation dedicated to contributing to improved health outcomes for all New Zealanders.

Measuring Performance

The success of NZ Health Partnerships will ultimately be measured by its ability to deliver fit for purpose programmes and services that meet our shareholders' expectations and enable them to realise benefits. NZ Health Partnerships will measure its performance against two output classes: Programmes and Services.

The following information will be made available by NZ Health Partnerships to relevant audiences:

- **STATEMENT OF INTENT**
  From 2016/17 a draft SOI will be prepared and provided to our shareholders for comment. The final SOI will be presented to shareholders on or before 31 May each year.

- **STATEMENT OF PERFORMANCE EXPECTATIONS**
  From 2016/17 a draft SPE will be prepared and provided to our shareholders for comment. The final SPE will be presented to shareholders on or before 31 May each year.

- **ANNUAL PLAN**
  Following the Annual Shareholders Hui, NZ Health Partnerships will develop an Annual Plan for the incoming financial year. The Annual Plan will be developed in collaboration with the DHBs and will ensure consistency and transparency. The final Annual Plan will be presented to shareholders on or before 31 May each year.

- **ANNUAL REPORT**
  An annual report and audited set of financial statements will be prepared according to the processes required by the Crown Entities Act. Final copies of the annual report will be provided to shareholders within 15 working days of receiving the NZ Health Partnerships Audit Report from the Auditor General.

- **QUARTERLY REPORTING**
  NZ Health Partnerships will also report to the Board and its shareholders (DHB Chairs and Chief Executives) on a quarterly basis on its performance respective to its Annual Plan and SOI.

- **SECTOR COMMUNICATIONS**
  Each month NZ Health Partnerships will communicate with its shareholders on its general progress and performance.

Assessing Performance against Measures

Numerous performance measures underpin our outcomes framework. These are not just about NZ Health Partnerships' performance; rather they are measures of how the organisation, its shareholders and the health sector work collaboratively to achieve better outcomes. Performance against output class measures will be assessed as:

- **Achieved:** the measure has been achieved within its target date
- **Partially Achieved:** the activities and inputs have been completed; however, the measure was not achieved within the target date
- **Not Achieved:** the measure has not been completed.

The perspectives that will underpin the performance of our output classes are:

- **QUALITY**
  This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement.

- **FINANCIAL**
  This will report performance against the projected costs and benefits for each output class.

- **TIMELINESS**
  The programmes and services described in each output class will have progress measured against agreed milestones to ensure they deliver on schedule.

Assumptions

All statements in this document, particularly the costs, benefits and Forecast Statements of Service Performance for Output Classes 1 and 2 are based on a number of assumptions. Any changes to the assumptions outlined below will have a direct impact on the costs, benefits and Forecast Statements of Service Performance.

The main assumptions are:

- The provision of key data received from DHBs for each Programme is timely and accurate.
- The Programmes will remain on the current expected timelines.
- Approval processes within the Sector for each initiative occur as scheduled, with no undue delay.
- Benefits reported by DHBs to NZ Health Partnerships are accurate.
- Service partners are able to achieve their commitments to delivering benefit targets.
- Risk management strategies in place are adequate to mitigate major identified risks.
- The end state of the transition process NZ Health Partnerships is currently engaged in does not result in significantly different outcomes.

NZ Health Partnerships Benefits

A performance measure for the programmes and services is the level of qualitative and quantitative benefits that can be realised by the DHBs. NZ Health Partnerships will provide aggregated sector benefit and performance reporting based on information provided by NZ Health Partnerships programmes, DHB identified and realised benefits and other third party benefit providers such as healthAlliance and MBIE. NZ Health Partnerships' ability to provide this information to its stakeholders is dependent on complete, timely and accurate input from these stakeholders. The benefits reported by NZ Health Partnerships are owned by the DHBs.

NZ Health Partnerships will develop an overarching Benefits Management Framework with the DHBs which will allow for consistent and accurate reporting across the Sector. This will go hand-in-hand with training provided to DHBs on reporting benefits as per the agreed methodology.

Key Benefits Definitions

For the purposes of NZ Health Partnerships programmes, a benefit is defined as a clear improvement in economic outcome derived from the proposal being considered.

Benefits can be made up of two parts: Budgetary and Non-Budgetary (includes cash avoidance and qualitative benefits). All cash benefits (and associated cash costs) are included in the calculation of a business case's Net Present Value.

- **BUDGETARY BENEFITS**
  Budgetary is defined as the incremental annual change, primarily cash, which has a clearly defined impact on the Statement of Comprehensive income (SCI) and includes any depreciation impact. These benefits result in a budget line reduction, compared with the prior year.

- **NON-BUDGETARY BENEFITS**
  Non-Budgetary benefits are defined as those that form part of the business case that do not meet the definition of Budgetary. There are three general components to Non-Budgetary benefits: cash avoidance, cumulative and qualitative benefits.
  - **Cash Avoidance**
    Cash that would have been spent is now totally avoided or reallocated as a result of the business case.
  - **Cumulative**
    Cumulative benefits are those that are carried forward from previous years, whether they are budgetary or non-budgetary in nature.
  - **Qualitative**
    Qualitative benefits accrue from associated activity as a result of a business case and need to be reported in some way. These may be able to be quantified but this may prove to be too difficult to do reliably.

Benefits Estimates

Benefits estimates are likely to change as programmes advance through their lifecycle and more detailed information is gathered and analysed. At the feasibility study and indicative case for change stages, benefits estimates are sector-wide. Only at the detailed business case stage can more accurate benefit estimates be given by DHB.

Table 1: Estimated Total Gross Benefits for Output Class 1 & 2, from FY15/16 to FY18/19

	15/16 Estimated $000	16/17 Estimated $000	17/18 Estimated $000	18/19 Estimated $000
OUTPUT CLASS 1: PROGRAMMES				
National Oracle Solution				
Budgetary	0	309	1,289	444
Non-Budgetary	0	0	309	1,289
National Infrastructure Platform*				
Budgetary	-5,407	-13,336	-12,137	-6,402
Non-Budgetary	11,330	12,569	15,317	18,345
Food Services*				
Budgetary	10	4,110	4,460	4,810
Non-Budgetary	400	1,960	480	470
Linen and Laundry				
Budgetary	300	600	0	0
Non-Budgetary	0	300	900	900
Total Annual Gross Benefits				
Budgetary	-5,097	-8,317	-6,388	-1,148
Non-Budgetary	11,730	14,829	17,006	21,004
OUTPUT CLASS 2: SERVICES				
National Procurement Service				
Budgetary	27,300	27,300	27,300	27,300
Non-Budgetary	6,000	27,300	27,300	27,300
Shared Banking				
Budgetary	0	0	0	0
Non-Budgetary	925	925	925	925
Insurance				
Budgetary	0	0	0	0
Non-Budgetary	5,283	3,170	3,170	3,170
Other Procurement				
Budgetary	7,331	4,228	2,580	721
Non-Budgetary	10,997	6,341	3,869	1,081
Total Annual Gross Benefits				
Budgetary	34,631	31,528	29,880	28,021
Non-Budgetary	23,205	37,736	35,264	32,476
TOTAL GROSS ANNUAL BENEFITS	**64,469**	**75,776**	**75,762**	**80,353**
TOTAL GROSS CUMULATIVE BENEFITS	**64,469**	**140,245**	**216,007**	**296,360**

*The financial benefits outlined in Table 1 will be re-quantified once the current programmes have been re-scoped to align with our shareholders' expectations. Activity is underway to re-baseline the benefits for the Food Services and National Infrastructure Platform initiatives.

#	Performance Measure	Target	Evidenced by	Type	When By
9	Benefits Management Framework	• Approach to define benefits realisation is complete	• Benefits Management Framework has been reviewed by stakeholder groups	Quality	31 December 2015
10	Benefits Realisation Plans	• All programmes and services have developed Benefits Realisation Plans	• Benefits Realisation Plans have been reviewed by appropriate programme/ services bodies • Benefits Realisation Plans include year on year expected benefits	Quality	30 June 2016
11	Monthly benefits reports	• Monthly reports are provided to the Board on reported benefits realised	• Concise Board reports	Quality Timeliness	30 June 2016
12	Quality Assurance	• Independent audit of benefits reporting has commenced for the year ending 30 June	• Action plans are in place for the areas of improvement identified in 2015 Visits to the DHBs are scheduled to test benefits reported for FY 2015/16	Quality Financial	30 June 2016

15

Output Class 1: Programmes

This output class comprises the in-flight programmes managed by NZ Health Partnerships: the National Infrastructure Platform, the National Oracle Solution, Food Services, and the Linen and Laundry programme. The purpose of the output class is to ensure that these programmes are well-managed and co-ordinated.

National Infrastructure Platform

A number of work-streams will enable DHBs to undertake successful consumption of NIP services. These work-streams include: detailed Business Case re-baselining and approval, completion of Readiness Plans for all participating DHBs and establishing the Service Integrator function performance, service level agreements, contract management etc.

#	Performance Measure	Target	Evidenced by	Type	When By
13	Best practice readiness processes developed and shared with DHBs	• Individual readiness workshops take place with each DHB findings published	• Develop best practice readiness processes with the DHBs • Best practice readiness workshops are held with DHBs and the sector	Quality	30 June 2016
14	Phase 1: Investigation, assessment and options	• Assessment of the current commercial and delivery position of the programme • Identification of options to move forward, and choices for future steps.	• The detailed final report has been received by the NZ Health Partnerships Board and next steps identified	Timeliness	31 December 2015
15	Readiness Plans	• Plans have been developed with the DHBs to identify their readiness for service implementation	• Readiness Plans completed for all participating DHBs points defined and agreed	Quantity Timeliness	30 June 2016
16	Programme governance and engagement review	• Programme governance and engagement groups reviewed and aligned to the new governance charter	• Terms of Reference for programme governance groups are approved and signed off	Quantity Timeliness	31 December 2015
17	Independent Quality Assurance of NIP	• Conduct quality assurance review of the NIP programme	• Reports provided to the appropriate governance bodies • Action plans developed and implemented for high priority areas	Quality	30 June 2016

National Oracle Solution

The scope of the National Oracle Solution programme is to develop an Oracle finance system for implementation by all the DHBs. The go forward deliverables of this programme were agreed by the sector by way of the Business Change Case which was approved by all DHBs in early 2015.

Following approval of the Business Change Case, the programme moved into the detailed design validation phase prior to commencement of the build of the National System. Design validation is due for completion at the end of Quarter 2, at which time a Stage Gate will be navigated to ensure:

- DHB support for solution design
- Agreement for the proposed operating model
- Detailed plan for the build phase, with defined costs
- A clear understanding of the implementation roadmap, evaluation and readiness criteria.

Post the passing of the Stage Gate the programme will move into the full build phase of the National Oracle Solution. The build phase will deliver a system that is ready for DHB implementation. All Stage Gates will be signed off by the Programme Steering Committee and the NZ Health Partnerships Board.

#	Performance Measure	Target	Evidenced by	Type	When By
18	Programme is subject to appropriate review at each Stage Gate	• Quality assurance review of information and artefacts at each Stage Gate review as per the Product Database	• Review completed and predefined quality expectations met as per the Product Database	Quality	Within one month of the stage gate due date
19	Build phase plan complete	• The plan for the Build phase is complete	• All elements of the Build Phase Plan are complete • The Plan is approved by the appropriate governance bodies	Quality	31 December 2015
20	Programme Stage Gates passed	• The Stage Gate for Quarter 2 has been passed by the appropriate governance bodies	• Review completed and predefined quality expectations met as per the Product Database	Quality Timeliness	31 December 2015
21	Programme Benefits Realisation Plan complete	• Benefits Realisation Plan complete	• All elements of the Build Phase Plan are complete • The Plan is approved by the appropriate governance bodies	Financial	30 June 2016
22	Technology Build is commenced	• The programme has approval to commence the build of the technology	• Formal handover of key deliverables the Technology workstream to the Business Solutions workstream • Commencement of Technology build is approved by the appropriate governance bodies	Quality Timeliness	31 March 2016

Further performance measures and Stage Gates will be defined following the Quarter 2 Stage Gate, and will be included in the NZ Health Partnerships 2015/16 Annual Plan as an addendum.

Food Services

NZ Health Partnerships and the Sponsor CEO will facilitate collective discussions and the application of the National Good Mechanism to optimise DHB participation in Food Services and maximise National Good.

#	Performance Measure	Target	Evidenced by	Type	When By
23	Business Case Validation	• Food services operating costs for re-baselined for 2014/2015 • 100% of DHB food services operating costs re-baselined and approved	• DHBs have provided re-baselined data	Quality Financial	30 May 2016
24	DHB Commitment: Food Services Agreement participation	• All DHB have passed resolutions in regards participating in the Food Services Agreement	• Detailed Board resolutions received by NZ Health Partnerships in regards to DHB participation in the Food Services Agreement	Quality	30 May 2016
25	Participation Agreement	• 100% of DHBs who have aligned to the Food Services programme have executed Participation Agreement	• All required contractual documentation regarding participation executed • Participation Agreement signed for all Food Services participants	Quality	30 May 2016
26	National Nutritional standards	• All DHBs accept the requirement for alignment with national contract standards (nutritional, performance management)	• DHBs endorse the application of the Nutritional Standards • Where DHBs will not join the Compass Food services model, actions are put in place to align to their existing services to the Standards	Quality	30 June 2016
27	DHB Implementation	• Implementations are completed for all DHBs to agreed contractual schedule	• Southern, Tairawhiti, Auckland, implementations completed within agreed timeframes, cost, and quality	Quality Timeliness	30 June 2016
28	Governance	• All Participating DHBs have an established, operating governance model in place	• Membership confirmed • Supporting governance artefacts are in place	Quality	31 December 2015
29	Quality Assurance	• Reporting framework for service management process agreed and established • Robust performance management framework operational for all KPIs	• Consistent reporting framework • 100% of KPIs reported and managed in accordance with the KPI methodology	Quality	Quarterly
30	Continuous Improvement and Innovation	• Continuously improve the methods (processes, systems and resources) though which the Services are delivered to DHBs	• Presentation of at least one innovative idea per annum per DHB/nationally. • Presentation of innovative ideas that will yield demonstrable savings and/or service	Quality	April 2016

#	Performance Measure	Target	Evidenced by	Type	When By
			improvements, which must be supported by a researched and practical implementation plan		

Linen and Laundry

In the second quarter of 2015/16, Auckland, Counties Manukau, Waitemata, Waikato, Lakes and Nelson Marlborough DHBs will be out of contract with Taylors and need to guarantee their on-going linen and laundry supply arrangements. To achieve the best outcome, arrangements need to be escalated to ensure that between October and November, continuity of service is agreed with Taylors.

NZ Health Partnerships will facilitate the attainment of the below performance measures in collaboration with the DHBs.

#	Performance Measure	Target	Evidenced by	Type	When By
31	National Linen Catalogue	• Agreement to implement national linen catalogue from participating DHBs	• DHBs have formalised their commitment and alignment with the Linen and Laundry initiative	Quality	30 June 2016
32	Future Operating model	• Identification and agreement of the future long term linen strategy for all interested DHBs	• Board resolutions received agreeing strategic direction and their involvement	Quality	30 June 2016

15

Output Class 2: Services

This output class comprises the services delivered by NZ Health Partnerships: Management Services, National Procurement Service, Collective Insurance and Shared Banking. The purpose of the output class is to ensure NZ Health Partnerships' services are high performing and deliver the DHBs both qualitative and quantitative benefits. As the in-flight programmes are implemented and activity becomes business-as-usual, they will be transitioned from programmes to services.

National Procurement Service

- Shift the focus from low value initiatives to more strategic procurement activity
- Develop clearer KPIs to be agreed with the Strategic Procurement Group and service to be more closely monitored through formal quarterly reporting processes
- Focus on improving FY14/15 return on service costs
- Planning process for FY16/17 to be focussed on further increasing DHBs value for money.

#	Performance Measure	Target	Evidenced by	Type	When By
33	Review performance of the National Procurement Service	• Undertake an independent review of hA National Procurement Service • Understand how effective the National Procurement Service is in meeting Sector needs • Agree future ownership of Procurement Strategy for Sector	• Report presented to the NZ Health Partnerships Board on the findings of the review.	Quality	End September 2015
34	Action Plans	• Action Plans developed to address priority areas for improvement identified in the Independent Review of the National Procurement Service	• Action plans developed and activities underway to implement associated activities	Quality	31 March 2016
35	FY16/17 Planning Activity – National Procurement Service	• Facilitate planning activity to detail, service catalogue, service goals, costs and estimated benefits from the National Procurement Service • Planning to be completed to enable DHBs to submit their annual financial plans to MoH	• DHBs fully engaged and agree FY16/17 service goals, costs and estimated benefits	Quality	31 March 2016
36	Develop agreed hA FPSC reporting templates	• A comprehensive monthly reporting template has been developed for hA FPSC to report OPEX and CAPEX savings	• Reporting template is developed • hA FPSC report monthly using the developed template	Quality	31 December 2015
37	Develop Supplier Relationship Model	• Develop a Supplier Relationship Model to align other agencies involved in procurement activity (i.e. PHARMAC) to ensure clarity between agencies on relationships between	• Approval attained from the appropriate governance bodies	Quality	30 June 2016

#	Performance Measure	Target	Evidenced by	Type	When By
		suppliers and DHBs.			
38	Contract Management within the National Procurement Service	• Contract management is in place for all in-scope categories within the National Procurement Service	• Establishment of contract management plans for all in-scope categories and contracts • Quarterly reports on contract lapses	Quality Financial	30 June 2016
39	National procurement initiatives deliver agreed benefits to DHBs	• $27.9 million of (OPEX) benefits realised during financial year 2015/16	• Benefits delivered are signed off by the DHBs	Financial	30 June 2016

15

Delivery of the benefits target is dependent on a number of initiatives and undertakings that are planned for the FY15/16 year. These are included in Annual Procurement Plans agreed by each DHB. These also include:

- Continued co-operation between healthAlliance and PHARMAC on medical device categories and clear allocation of activities across categories and contracts.
- Continued rollout of "All of Government" and syndicated procurement initiatives – this includes procurement initiatives undertaken by the Ministry of Business, Innovation and Employment and other public sector entities.
- Procurement initiatives undertaken by individual DHBs, for out of scope categories.

Shared Banking

NZ Health Partnerships provides Shared Banking and Treasury Services ("The Sweep") functions as a sector cash manager. NZ
Health Partnerships invests funds held in a restricted range of investments to optimise the return on funds.

#	Performance Measure	Target	Evidenced By	Type	When By
40	Independent Quality Assurance of Shared Banking Service	• No issues rated 'significant' as defined in the EY Shared Banking Internal Compliance: Internal Audit Report and Ernst & Young	• Annual EY Audit Report	Quality	30 June 2016
41	Optimising the return on District Health Board funds	• Average weighted sweep interest rate achieved by placing funds on term deposit is at least 0.15% above the sweep on-call rate in the absence of material adverse factors	• Monthly average weighted sweep rate achieves target	Quantity/ Timeliness	30 June 2015
42	Tender process for new shared banking arrangement successfully commenced	• Successful commencement of procurement process to appoint new banker within expected timeframes	• Procurement process is on target and meeting expected milestones.	Quantity/ Timeliness	30 June 2016

*Please note these performance measures are not included in the SPE. It potentially enables calculation of the on-call interest rate payable under the Shared Banking and Treasury services transaction and is therefore commercially sensitive.
NZ Health Partnerships and the DHBs will during the 2015/16 and 2016/17 years complete a tender process to replace the current Sweep arrangement with Westpac.

This process is scheduled to commence in October 2015 and conclude in December 2016. The Westpac arrangements expire on 2 April 2017.

Costs and Benefits

We have assumed costs will remain constant however they will increase over time due to cost pressure. Benefits are based on the Line Fee savings only as NZ Health Partnerships is currently re-benchmarking the benefits from optimising the interest rate return to reflect changes in the interest rate environment. Once this exercise is complete and approved by DHBs, benefit numbers will be updated.

The results of the banking tender may also impact costs and benefits in future years.

Insurance

This service is responsible for managing the insurance requirements for all 20 DHBs and 15 associated joint agencies and subsidiaries that have elected to join the Collective Insurance Service. The objective of the service is to obtain insurance for the 20 DHBs and participants at the most cost-effective price, taking into account the terms and conditions, market dynamics and the strategic intentions of the DHBs.

#	Performance Measure	Target	Metric	Type	When By
43	Appropriate Insurance coverage achieved for DHBs and Joint Agencies (DHB owned, partially owned)	• Insurance coverage in the following policy areas: material damage business interruption, liability, indemnity, travel and motor vehicle	• Insurance coverage obtained for 2016/17, with no materially adverse changes to terms and conditions	Quality	30 June 2016
44	Refinements to the Insurance programme are developed and agreed with DHBs	• Completed assessments of DHB Collective insurance requirements in Professional Indemnity, Environmental, Cyber and Extortion, along with any other refinements	• DHBs agree to recommendations put forward by NZ Health Partnerships and the Insurance Working Group	Quality	31 March 2016
45	Insurance coverage delivers benefits for DHBs and Joint Agencies	• $5.283 million of benefits realised during financial year 2015/16	• Benefits delivered	Quantity/ Timeliness	30 September 2015
46	Insurance Broker has appropriate information to market DHB risk to insurers	• Documented insurance underwriter's reports	• All DHBs that have major building and infrastructure assets valued at over $100 million will have current underwriters reports	Quantity/ Timeliness	30 June 2016
47	Existing arrangement with Broker is rolled over for a further 12 month period.	• Arrangements agreed with existing broker to extend agreement to 30 June 2017	• Existing broker contracted for 2016/17 year	Quantity/ Timeliness	31 October 2015
48	DHB Insurance Collective signs up to All of Government Broker Panel arrangement	• Issues relating to DHB Insurance Collective signing up are removed by negotiation with Ministry of Business, Innovation and Employment	• Memorandum of Understanding and AoG Risk Financing and Intermediary Services Agreement executed	Quantity/ Timeliness	30 June 2016
49	New Broker appointment	• Successful completion of secondary procurement process to appoint new Broker	• New Broker agreement in place with a member of the All of Government panel, commencing 1 July 2017	Quantity Timeliness	30 June 2016

All DHBs and their joint agencies are required to complete their Annual Insurance Declaration by 1 February 2016. All campuses and buildings valued at over $100 million will have independent underwriting reports completed.

NZ Health Partnerships and the DHBs are required to join the All of Government Broker panel arrangement. Some negotiation with the Ministry of Business, Innovation and Employment will be required to ensure there are no changes to how the DHB Collective programme operates as a result.

Due to time constraints, the arrangements with our existing Broker will be rolled over for a further 12 months, expiring 30 June 2017. A secondary procurement process will run to decide on a new Broker to commence 1 July 2017 once NZ Health Partnerships and DHBs are signed up to the All of Government arrangement.

Other Activity

The service will continue its ongoing work to analyse the impact of the 13 May 2015 Supreme Court decision on Fire Service Levy calculation and the Fire Service Review being undertaken by the Department of Internal Affairs.

Management Services

While fundamentally the Programmes and Services are at the heart of NZ Health Partnerships, and the primary focus for 2015/16, NZ Health Partnerships will also implement new Governance and Engagement structures as agreed with our shareholders. Internally we will also focus on building our peoples' capabilities and aligning our culture to work collaboratively with DHBs.

Success with these measures will demonstrate to our shareholders and customers how NZ Health Partnerships has responded to their request for a change in organisational culture and focus. The success of this service will be measured in the following ways:

#	Performance Measure	Target	Evidenced by	Type	When By
50	Services governance and engagement review	• Service governance and engagement groups reviewed and aligned to the new governance charter	• Terms of Reference for programme governance groups are approved and signed off	Quality	31 March 2015
51	Customer participation rates	• All DHBs have passed resolutions on their position on participating in NZ Health Partnerships Shared Services	• Detailed Board resolutions received by NZHP in regards to DHB participation in Shared Services	Quality	30 June 2016
52	Use of DHB Expertise	• Establish baseline of days per annum of DHB Subject Matter Experts (SMEs) engaged across the NZ Health Partnerships portfolio	• Number of days of DHB SME resources used within NZ Health Partnerships	Quality	30 June 2016
53	Budget Management	• Actual spend for Management Services is 95% of the budget	• Actual vs. Budget spend on Management Services	Financial	30 June 2016
54	Employee Retention	• Establish a baseline of employee turnover as a % of average total staff on a rolling annual basis	• Number of fixed-term and permanent staff resigning from NZ Health Partnerships	Quality	30 June 2016
55	Employee Engagement	• Establish baseline across all elements of the IBM Kenexa Best Workplaces survey	• IBM Kenexa Best Workplaces survey	Quality	30 June 2016
56	Training	• Establish baseline of Actual Spend on training for priority skills as a % of average Total Training budget	• Actual vs. Budget spend on Training, conferences and courses	Financial	30 June 2016
57	Process Maturity improvements	• Process maturity improvements identified for the 2015/16 financial year	• Required activity undertaken to embed improvements into NZ Health Partnerships	Quality	30 June 2016

#	Performance Measure	Target	Evidenced by	Type	When By
58	Shareholder Satisfaction	• Establish baseline of shareholders who rate their satisfaction with NZ Health Partnerships as partnerships as “Good” or “Very Good”	• Responses from annual survey	Quality	30 June 2016
59	Sector Communication	• Establish baseline of the sector who rate the quality communication from NZ Health partnerships as “Good” or “Very Good”	• Responses from annual customer survey	Quality	30 June 2016
60	Vendor Engagement	• Establish baseline of vendors surveyed who rate their engagement/ relationship with NZ Health partnerships as “Good” or “Very Good”	• Responses from annual customer survey	Quality	30 June 2016

Financial Statements

1.1 Prospective Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2016

30 JUNE 2016

			Budget *$000's*
Revenue:			
Revenue from DHBs			22,505
Interest revenue	-	NZ Health Partnerships	200
		Shared banking	24,000
Other revenue			5,338
Total revenue			52,043
Expenditure:			
Personnel costs			4,095
Depreciation and amortisation expense			2,112
Finance costs	-	NZ Health Partnerships	0
		Shared banking	24,000
Other expenses			21,678
Total Expenditure			51,885
Surplus/ (Deficit)			158
Other Comprehensive revenue and expense			0
Total Other Comprehensive Revenue and Expense			0
TOTAL COMPREHENSIVE REVENUE AND EXPENSE			**158**

15

1.2 Prospective Statement of Financial Position

As at 30 June 2016

	Budget *$000's*
ASSETS	
Current Assets:	
Cash and cash equivalents	
NZ Health Partnerships	1,722
DHB Shared Banking Facility	191,028
Receivables	6,955
Investments – shared banking	90,000
Total Current Assets	289,755
Non-Current Assets:	
Property, plant, and equipment	1,720
Intangible assets	61,730
Total Non-Current Assets	63,450
Total Assets	**353,205**
LIABILITIES	
Current Liabilities:	
Payables	6,888
DHB Shared Banking Facility	281,028
Employee entitlements	215
Total Current Liabilities	288,131
Non-Current Liabilities:	
Employee entitlements	0
Total Non-Current Liabilities	0
Total Liabilities	**288,131**
Net Assets	**63,450**
EQUITY	
Contributed Capital	64,916
Accumulated surplus / (deficit)	158
Total Equity	**65,074**

* The balances in these accounts primarily represent the amounts held by NZ Health Partnerships in respect of the DHB shared banking arrangements. The offset for these accounts, being the amount that is payable to the DHBs, is classified as accounts payable.

1.3 Prospective Statement of Changes in Equity

For the year ended 30 June 2016

	Notes	Budget $000's
Balance at 1 July 2015		**64,916**
Total Comprehensive Revenue and Expense for the year		158
Owner Transactions		
Issue of B class shares		0
BALANCE AT 30 June 2016		**65,074**

1.4 Prospective Statement of Cash Flows

For the year ended 30 June 2016

	Actual $000's
Cash flows from Operating Activities:	
Receipts from DHBs	22,5055
Receipts from other revenue	5,338
Interest received	24,000
Payments to suppliers	(21,678)
Payments to employees	(4,095)
Interest paid	(24,000)
Goods and services tax (net)	50
Net Cash Flow from Operating Activities	2,120
Cash flows from Investing Activities:	
Funds from Deposit	90,798
Purchase of property, plant, and equipment	20
Purchase of intangible assets	(9,216)
Funds to Deposit	(139,000)
Net Cash Flow from Investing Activities	(57,398)
Cash flows from Financing Activities:	
B class shares	0
Proceeds from borrowings	0
Repayment loan	0
Net Cash Flow from Financing Activities	0
Net (decrease)/increase in cash and cash equivalents	(55,278)
Cash and cash equivalents at the beginning of the year	248,078
Cash and cash equivalents at the end of the year	192,800

Notes to the Prospective Financial Statements

The prospective financial statements are based on policies and approvals in place as at 1st July 2015. Under the Health Sector (Transfers) Act 1993, effective 1 July 2015, all of Health Benefits Limited (HBL) assets and liabilities, including all employment and commercial agreements, have transferred to NZ Health Partnerships Limited by Order in Council.

The prospective financial statements set out NZ Health Partnerships activities and planned performance. The use of this information for other purposes may not be appropriate. These prospective financial statements have been prepared on the basis of assumptions of future events that NZ Health Partnerships reasonably expects to occur and associated actions that NZ Health Partnerships reasonably expects to take at the date that this information was prepared.

Statement of Accounting Policies

Notes to the Prospective Financial Statements

The prospective financial statements are based on policies and approvals in place as at 1st July 2015. Under the Health Sector (Transfers) Act 1993, effective 1 July 2015, all of Health Benefits Limited (HBL) assets and liabilities, including all employment and commercial agreements, have transferred to NZ Health Partnerships Limited by Order in Council.

The prospective financial statements set out NZ Health Partnerships activities and planned performance. The use of this information for other purposes may not be appropriate. These prospective financial statements have been prepared on the basis of assumptions of future events that NZ Health Partnerships reasonably expects to occur and associated actions that NZ Health Partnerships reasonably expects to take at the date that this information was prepared.

Statement of Accounting Policies

REPORTING ENTITY

NZ Health Partnerships Limited was established on 16 June 2015 and became operational on 1 July 2015. NZ Health Partnerships is a multi-parent Crown subsidiary, owned by the 20 District Health Boards, which have equal core shareholding and voting rights. NZ Health Partnerships is domiciled in New Zealand.

NZ Health Partnerships primary objective is to operate as a co-operative undertaking, and enable DHBs to collectively maximise shared services opportunities for the national good.

BASIS OF PREPARATION

Statement of compliance

These prospective financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004. These include the requirement to comply with NZGAAP.

The prospective financial statements have been prepared to comply with Public Benefit Entity Standards (PBE Standards) for a Tier 1 entity. NZ Health Partnerships is adopting the PBE Standards for the first time. This includes Public Benefit Entity Reporting Standard 42 *Prospective Financial Statements* (PBE FRS 42).

The prospective financial statements have been prepared for the special purpose of the *Statement of Performance Expectations 2015/16* of NZ Health Partnerships for its shareholders. They have not been prepared for any other purpose and should not be relied upon for any other purpose.

These statements will be used in our Annual Report as the budgeted figures.

The *Statement of Performance Expectations* narrative informs the prospective financial statements and the document should be read as a whole.
The preparation of prospective financial statements in conformity with PBE FRS 42 requires the Board and management to make good judgements, estimates, and assumptions that affect the application of policies and reported amounts of assets and liabilities, income, and expenses.
The prospective financial statements were approved on 1 July 2015. The Board is responsible for the prospective financial statements presented, including the assumptions underlying the prospective financial statements and all other disclosures. The *Statement of Performance Expectations* is prospective and as such contains no actual operating results. It is not intended that these prospective financial statements will be updated.

Measurement base
The prospective financial statements have been prepared on a historical cost basis.

Presentation currency and rounding
The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Summary of Significant Accounting Policies

The following accounting policies, which significantly affect the measurement of financial performance and of financial position, have been consistently applied.

Revenue
The specific accounting policies for significant revenue items are explained below:

NZ Health Partnerships is funded through revenue received from the DHBs, which is restricted in its use for the purpose of NZ Health Partnerships meeting its objectives as specified in the Statement of Intent. Revenue is recognised as revenue when earned and is reported in the financial period to which it relates.

Interest Revenue
Interest revenue is recognised using the effective interest method. Interest revenue on an impaired financial asset is recognised using the original effective interest rate.

Leases
Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus/deficit as a reduction of rental expense over the lease term.

Borrowing Costs
Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Cash and cash equivalents
Cash and cash equivalents includes cash on hand, deposits held at call with banks and other short-term highly liquid investments with original maturities of three months or less. All investments are held in New Zealand.

Receivables

Receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Property, plant and equipment

Property, plant and equipment consist of the following asset classes: leasehold improvements, furniture, office equipment, and information technology.

Property, plant and equipment are shown at cost, less any accumulated depreciation and impairment losses.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to NZ Health Partnerships and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset and are reported in the surplus or deficit.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to NZ Health Partnerships and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as follows:

Asset Type	*Useful Life*	*Rate*
Leasehold improvements	5 – 14 years	7% - 20%
Furniture and office equipment	1.5 – 9.5 years	10.5% - 67%

IT Hardware	2.5 – 5 years	20% - 40%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.
The residual value and useful life of an asset is reviewed and adjusted if applicable, at each financial year end.

Intangible assets

Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Staff training costs are recognised as an expense when incurred.
Costs associated with maintaining computer software are recognised as an expense when incurred.
Costs associated with development and maintenance of NZ Health Partnership's website is recognised as an expense when incurred. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and an appropriate portion of relevant overheads.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired computer software	2.5 – 3 years	33% - 40%
FPSC system intangible assets	5 - 15 years	6.67% - 20%

Impairment of property, plant, and equipment and intangible assets

NZ Health Partnerships does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash generating assets
Property, plant and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information.

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Payables

Short-term payables are recorded at their face value.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date and annual leave earned to but not yet taken at balance date.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense is recognised where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave and sick leave, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- The present value of the estimated future cash flows.

Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless NZ Health Partnerships has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Equity

Equity is measured as the difference between total assets and total liabilities.

Goods and Services Tax

All items in the financial statements are presented exclusive of Goods and Services Tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

NZ Health Partnership is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

FPSC rights

The FPSC rights represent the DHBs right to access, under a service level agreement, shared Finance, Procurement and Supply Chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, previously facilitated by Health Benefits Limited now NZ Health Partnerships, whereby all 20 DHBs will move to a shared services model for the provision of Finance, Procurement and Supply Chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely. The fund established by Health Benefits Limited now NZ Health Partnerships through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Financial Instrument Risks

NZ Health Partnerships activities expose it to credit risk, cash flow risk and liquidity risk. NZ Health Partnerships policy does not allow any transactions that are speculative in nature to be entered into. It has policies and procedures to ensure risks are low.

Critical Accounting Judgements and Estimates

In preparing these prospective financial statements NZ Health Partnerships has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

General Assumption – cost levels

These figures have been based on the assumption that interest rates and general cost levels will remain at similar levels to those at the time of the Statement of Performance Expectations' preparation.

Estimating useful lives and residual values of property, plant and equipment

At each balance date, the useful lives and residual values of property, plant and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by NZ Health Partnerships Limited, and expected disposal proceeds from the future sale of the asset.
An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. NZ Health Partnership's minimises the risk of this estimation uncertainty by:

- physical inspection of assets
- asset replacement programs
- review of second hand market prices for similar assets
- analysis of prior asset sales.

DHB Shared Banking Facility
NZ Health Partnerships has exercised its judgement regarding the DHB Shared Banking Facility and has accounted for the arrangement as though it is acting as principal as it has the potential to be exposed to credit risk from the arrangement. The related party nature of the arrangement makes the agency/principal distinction more difficult. NZ Health Partnerships consider presenting the DHB Shared Banking Facility as principal; will ensure transparent and consistent information is presented about the arrangement in NZ Health Partnership's financial statements.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification
Determining whether a lease agreement is finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to NZ Health Partnerships.
Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.
NZ Health Partnerships has exercised its judgement on the appropriate classification of equipment leases, and has determined no lease arrangements are finance leases.

Capitalisation of National Oracle Solution costs
The National Oracle Solution programme is a significant part of NZ Health Partnerships' savings initiatives. The National Oracle Solution programme is set to improve the way goods and services are made available to DHBs for purchasing, ordering, delivery storage and payment. A national approach to these services will combine the purchasing power of DHBs, create visibility of stock and ensure a common financial language across the health sector.
Through the development of the National Oracle Solution programme, the assets that are created by the National Oracle Solution programme will be held in Work in Progress (WIP). The construction is expected to last around 18 months and during this period there will be progressive deployments of functionality leading to a gradual realisation of benefits. The National Oracle Solution programme is not a single asset, but a bundle of assets that are both tangible such as IT hardware and intangible, such as software, policy manuals, process documentation, process maps, standard operating procedures, reference materials and intellectual property. The costs that are directly associated with the development of the National Oracle Solution programme will be recognised as tangible or intangible assets when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. Direct costs

include project development employees, contractors, consultants and apportionment of the relevant overheads.
Indirect costs are recognised as expenses when incurred and include travel, training and recruitment costs. The National Oracle Solution has spent the majority of its capital budget.

Amortisation
The amortisation of the assets will begin once the asset is available for use (commissioned into the fixed asset register) and will cease at the date that the asset is derecognised. The carrying value of an intangible asset with a finite life is amortised on a straight line basis over its useful life. The useful lives of FPSC intangible assets have been estimated to be 15 years (life of the contract).

Appendix 1

NZ Health Partnerships will receive of $6 million of core funding from the DHBs in the 2015/16 financial year. The funding was approved by the Shareholders and the Board. The detailed explanation and breakdown for the funding is provided below:

1. The updated Budget has been driven bottom up on a strict validated assumptions basis based on either historical spend or currently contracted terms and conditions from 1 July 2015.

2. The Core funding is being used to fund the following activities:
    a. **Core & Insurance** - Core operations of NZ Health Partnerships, including the collective Insurance function are budgeted at $4,461k and will be explained further in the row analysis below. They also cover the provision of the Office and Corporate environment to all NZ Health Partnerships team members including the provision of Premises, IT and Communications.
    b. **Food Integrator** – These are the budgeted costs of $208k which are associated with the on-going management of the Food Contract. They primarily relate to Staff dedicated to this activity or a proportion of support and / or supervisory staff.
    c. **Food Implementation** – These are the budgeted costs of $465k which relate specifically to contract staff involved in the implementation of the Food Contract in the current 5 DHBs who have signed up and business case validations for additional DHBs to sign up.
    d. **Disestablished of Food and Laundry Programme -** These are the board approved costs related to the disestablishing of the Food and Laundry Programme and the relevant contractual redundancy or notice period for employees and contractors. The cost of disestablishing the programme was $252k.
    e. **Transition and hA FPSC** – These costs of $455 specifically relate to the costs of transition and specific costs in relation to the DD work on hA FPSC including a budget of $80k for the Buddle Findlay work on hA FPSC Due Diligence.

3. The explanation for the budgeted expenditure types are as follows:
    a. Salaries and Wages – This item represents the most significant budgeted item for NZ Health Partnerships and is made up of the fully loaded (including KiwiSaver and ACC).
    b. Course Fees Conference & Membership – The costs relate to a Staff Development budget of 3% of the Salaries and Wages Budget.
    c. Recruitment Expense – This relates to the costs of recruiting into the roles within NZ Health Partnerships excluding the Chief Executive role.
    d. Contractors – These costs relate to contractors within NZ Health Partnerships including the current Chief Executive and three other specific contractors working on implementations and contractors filling temporary roles.
    e. Finance & Payroll Bureau- This represents the contracted costs we pay hA NZ to provide our Transactional Accounting processes and the Payroll and HR Kiosk system including all licensing, support and resources costs. These costs relate to all staff / contractors / consultants of NZ Health Partnerships not just those working in core
    f. Information Technology –These cost are also charged by hA NZ to provide and support the Desktop and IT environment with NZ Health Partnerships
    g. Rents- These costs relate to the full premises costs for 100% of Level 2, Building 2 at Central Park, 35% of Level 3. Building 3 at Central Park and costs in relation to visitors Car Parks at Central Park. All Staff Car Parks are charged out.

h. Staff Travel – Domestic & International – A key driver of this cost is the Budget in relation to the Insurance Marketing Trip to the UK for three DHB representatives at a cost of $70k.
i. Information Technology – This represents the licensing costs associated with the IT Environment including any local costs incurred directly by NZ Health Partnerships
j. Telecommunications – These costs are for all Telecoms within NZ Health Partnerships including Fixed Line charges, Data Charges and all Mobile Devices costs.
k. Audit and Legal Fees – The Audit Fees for NZ Health Partnerships historically have been $125K; additionally we have also had an Internal Audit Programme focussed on Benefits reporting which is budgeted to cost $60k. The remainder of the costs relate to Corporate Legal advice.
l. Assurance Fees – We have budgeted for 2 Gateway reviews @ $75k per review for NIP and the National Oracle system Build. In addition we have budgeted for costs in relation to ongoing Programme IQA
m. Insurance – This is the cost of full insurance cover for NZ Health Partnerships as approved by the Board
n. IT Depreciation – This cost is driven by the IT Assets owned by NZ Health Partnerships.
o. Board Members Fees – These have been calculated based upon the levels previously paid to HBL Directors. This also include the cost for the Interim Chair's services rendered in regards to recruitment of a permanent Chief Executive, costs of transition and specific costs in relation to the DD work on hA FPSC.

	Final Budget *$000's*
Revenue:	
Revenue from DHBs	6,000
Total revenue	6,000
Expenditure:	
Employees Costs	
Salary & Wages	2,407
Course fess, Conference & Memberships	72
Recruitment	96
Total	2,575
Outsourced Services	
Contractors	1,132
Finance & Payroll Bureau- hA NZ	83
Information Technology-hA NZ	66
Total	1,281
Other Expenditure	
Rents	379
Staff Travel Domestic & international	146
Staff Accommodation and Meals	12
Information Technology	65
Telecommunications	112
Bank Charges	2
Audit & Legal Fees	241
Assurance Fees	456
Insurance	53
Stationery and Supplies	30
Reception and Catering	13
Information Technology Depreciation	124
Other Office Expenses	27
Board Members Fees	291
Board Members Expenses	35
Total	1986
Total Expenditure	5,842
Surplus/ (Deficit)	158

Draft HBDHB Annual Plan and Statement of Intent 2016/17

and Draft Central Region Regional Service Plan

(separate document)

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Breastfeeding (National Indicator)** 23
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Nicky Skerman, Population Health Strategist
Reviewed by:	Executive Management Team (EMT); HB Clinical Council, Consumer Council and Maori Relationship Board
Month:	March 2016
Consideration:	For Information

RECOMMENDATION

That the Board:

Note the contents of this report.

18

OVERVIEW

The national GMs Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators in 2013. As a result, individual EMT members agreed to providing a championship role for the Māori Health Plan areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from Caroline McElnay, Champion for the Breastfeeding National Indicator.

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month for each.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Breastfeeding *National Indicator*	Improve breastfeeding rate for children at:		Caroline McElnay	Nicky Skerman	**Mar 2016**
	6 weeks,	>75%			
	3 months;	>60%			
	6 months of age	>65%			
Cardiovascular *National Indicator*	Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission.	70% of high risk	John Gommans	Paula Jones	**Apr 2016**
	Total number (%) with complete data on ACS forms	>95% of ACS patients			
Oral Health *National Indicator*	The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday	>66%	Sharon Mason	Patrick LeGeyt	**Jun 2016**
Smoking *National Indicator*	Percentage of pregnant Māori women that are	>90%	Caroline McElnay	Shari Tidswell	**Dec 2016**

	smokefree at 2-weeks postnatal				

MĀORI PLAN INDICATOR:

Full and exclusive breastfeeding of infants at 6 weeks (≥ 75%), 3 months (≥ 60%) and full, exclusive and partial at 6 months (≥ 65%).

WHY IS THIS INDICATOR IMPORTANT?

The HBDHB is committed to non-differential targets and significant inequality is seen in this indicator. This indicator is seen to best indicate the health systems performance in the early years of a child's life.

Hawke's Bay DHB acknowledges breastfeeding as a key priority for Hawke's Bay women and their babies. The breastfeeding indicator is reported to the Ministry of Health through the District Annual Plan and Annual Māori Health Plan and is a key component in the HBDHB Maternal Child Youth Strategic Framework 2015-18.

For the 12 month period from 1 June 2014 to 31 May 2015, 36% of babies born in Hawke's Bay were identified as Māori. The Hawke's Bay birthing population has a significantly higher proportion of Māori women compared to the national average. The rate of live births to women under 18 years in Hawke's Bay is consistently higher than the New Zealand average, the teenage pregnancy rate in Hawke's Bay is three-times higher for Māori than for non-Māori.

Breastfeeding

Breastfeeding has a range of advantages for both mother and child. These include; health, nutrition, immunological, developmental, psychological, social and economic benefits. The recognised benefits for mothers who breastfeed include a decreased risk of; breast cancer, ovarian cancer, postpartum bleeding and possibly a decreased risk of hip fractures and osteoporosis in the post-menopausal period.

Despite the health benefits for both mother and child, breastfeeding rates in New Zealand remain low compared to those in the early 20th century. The most common reasons given for not breastfeeding include insufficient milk supply and the need to return to work.

We acknowledge that in Hawke's Bay we struggle to meet the Ministry's targets for breastfeeding across the age bands and ethnicities with breastfeeding rates for Māori being consistently lower than other ethnicities.

The Māori Health Service and the Women, Child and Youth Portfolio are exploring different ways to support breastfeeding, as clearly the current systems and supports are not improving the breastfeeding rates at either six weeks or three months. Several targeted strategies are being considered, an example being the incentivising of Lead Maternity Carers (LMC)/midwives to improve the breastfeeding rates for women engaged in their care. The involvement of LMC midwives in the development of any new actions is essential, and challenging, due to the nature of contracting directly with the Ministry and at a local level engagement with the LMC group.

A concerted effort has been made in the last six months to engage LMC/midwives in both governance and operational forums to ensure the messages we convey are taken back to their operational meetings.

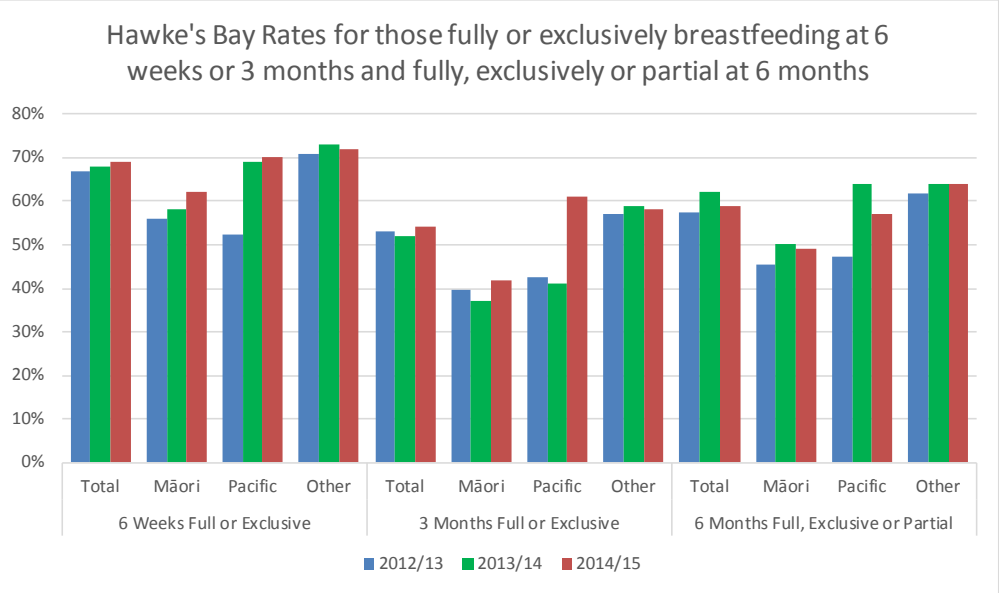
Monitoring progress in breastfeeding rates is hampered by the lack of a central collection point of data in New Zealand. Breastfeeding data at discharge post-delivery is collected by each DHB, breastfeeding rates at two weeks are collected by LMCs and are reported directly to the Ministry of Health under section 88 and is only provided to DHBs bi-annually with a 12 month delay in data.

Breastfeeding data as reported for the annual Māori Health Plan

The most recent data provided for the Māori Health Plan by the Ministry is shown below as Table 1. As per Table 1, breastfeeding rates for Māori at six weeks, three months and six months show minimal variability over the three year time period shown. There is however, no significant improvement and an obvious drop off between six weeks and three months.

Data outlined in Table 1 is Plunket only data. Prior to September 2015 this was the only source of Ministry level breastfeeding data available excluding all DHB contracted Well Child/Tamariki Ora (WC/TO) provider data. From September 2015 all Ministry level breastfeeding data includes both Plunket and WC/TO data. Tables 2 below provides a baseline for future comparison.

Table 1



*Plunket Data

Table 2

		Target	Dec-15
Breastfeeding at 6 weeks	Total	75%	68%
	Māori		58%
	Pacific		74%
Breastfeeding at 3 months	Total	60%	54%
	Māori		46%
	Pacific		62%
Breastfeeding at 6 months	Total	65%	56%
	Māori		46%
	Pacific		57%

*QIF data (Quality Improvement Framework).
Breastfeeding at 6 weeks: Source: National Maternity Collection
Breastfeeding at 3 months and 6 months: Source: WCTO NHI dataset

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR?

Breastfeeding

1. **Mama Aroha Talk Cards Training and Resource Development**
   One of the overwhelming themes identified in a breastfeeding stakeholder workshop held in August 2014 was ensuring "consistent messaging around breastfeeding resources and advice". The Mama Aroha talk cards have been developed by a Tairawhiti Māori midwife and lactation consultant and supported by the Ministry of Health to ensure all health professionals such as LMC/midwives and WC/TO providers working with new mothers are giving consistent and appropriate advice the same.

   A workshop on the Mama Aroha Breastfeeding support talk cards was held in 2015 and saw 56 local health professionals attend that included' LMC, WC/TO staff, midwifery students, peer support counsellors, antenatal educators and hauroa providers. Excellent feedback was gained with the highly visual and evidence based talk card sets presented to each attendee to use in health care, home, education and community settings.

   A recent follow on from the training has been local collaboration with Amy Wray of Mama Aroha to develop a user-friendly and motivating resource based on the talk cards to be handed out to all mothers delivering in Hawke's Bay as a take home breastfeeding support.

   Based on the Mama Aroha Talk Card, the Hawke's Bay Breastfeeding Group and the Breastfeeding Governance Group developed a resource combining key messages that support the establishment and continuation of; breastfeeding, safe sleep and smokefree. This resource will be used as an educational tool by the community safe sleep coordinator, and will also be handed out to all parents birthing in the HBDHB maternity unit and in the community.

2. Hawke's Bay Breastfeeding Governance Group

The Breastfeeding Governance Group meets quarterly. Their role is to provide a collaborative approach to improving breastfeeding rates in Hawke's Bay. A review of membership is underway to include strategic level representation from stakeholders outside of health (e.g. MSD, Early Childhood Education).

3. Hawke's Bay Breastfeeding Group

An operational group, contributing to the support of breastfeeding in the community, providing resourcing and updates to health professionals and ensuring that the World Health Organisation Breastfeeding Code is upheld and responding to breaches.

4. Workforce Development and Capacity Building Activities

La Leche League NZ (LLLNZ) peer counsellor training delivered by Choices Kahungunu Health Services to community providers across Hawke's Bay. Mama Aroha Talk Card training will be offered to local health professionals over the next year.

5. Well Child/Tamariki Ora Community Breastfeeding Supports

There are loan schemes in place at Kahungunu Executive and Te Taiwhenua o Heretaunga for breastfeeding equipment. These loan schemes ensure all women can access breastfeeding pumps and equipment regardless of cost (e.g. 70 loans were registered over 2015). Central Hawke's Bay Plunket also have six sets of breast pumps they hire out regularly.

Plunket's breastfeeding support in Central Hawke's Bay includes seven breastfeeding peer counsellors that are La Leche League trained. The service receives referrals from the Central Hawke's Bay lactation consultant as well as self-referrals.

To increase early engagement, a Breast Buddy programme has been initiated. Couples who attend antenatal classes are provided the opportunity to sign up to have a "Breast Buddy" contact them before the baby is born which then establishes a relationship, encourages parents to be able to ask for help after the birth. Since the programme was initiated, 100% of couples have signed-up, which is very encouraging. Furthermore, the peer support counsellors are advocates in the community for breastfeeding, providing advice, promoting breastfeeding at local events/social gatherings and playgroups. They also organised the Big Latch On in Central Hawke's Bay in 2015.

6. Breastfeeding Baby Cafes

Baby cafés or support services are run weekly in Napier, Hastings and Wairoa supported by lactation consultants and peer support trainers. Central Hawke's Bay has access to an 'on call' lactation consultant and a strong peer support network. The cafés are run from community locations and work in collaboration with midwives and well child providers.

7. Celebration of World Breastfeeding Week 1-7 August 2015

Big Latch On events organised and supported by Hawke's Bay Breastfeeding Group at local cafés (Hastings and Napier) for the first time.

8. Healthy First Food Promotion

The Healthy First Foods Workshop package (train the trainer) has been provided to two local WC/TO providers. Phase Two is now in progress with all Hawke's Bay WC/TO providers to receive training. The Healthy First Foods programme promotes the optimum timing for solids initiation to infants, including healthy first food preparation, whilst maintaining breastfeeding.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

- Ongoing training and resourcing of Mama Aroha Talk Cards and Parent resource
- Possible incentivisation programme for midwives

RECOMMENDATIONS FROM TARGET CHAMPION

The first six weeks after a baby is born is critical to establishing successful breastfeeding. There are multiple factors that impact whether this occurs, for example; consistent messaging, health professional engagement and enrolment processes, and level of support from whānau and health professionals. It is essential that for any sustainable change to occur in the rates of breastfeeding, efforts must be focussed in the antenatal and early postnatal periods (in addition to other activities already established).

We need to have a radical relook at different ways to improve breastfeeding rates and particularly focus on achieving the 6 week target. This could include looking at specific ongoing support for mothers/whanau who often leave the maternity unit in the first 48 hours post delivery before breastfeeding is established. This support needs to be prioritised towards Maori mothers as the drop off in breastfeeding rates for them in the first six weeks is significant. Additionally, discussions around incentivising LMC and growing LMC involvement in breastfeeding leadership should be seriously considered. These approaches will require a review of how specific funding to support breastfeeding is currently spent.

CONCLUSION

Further work is required to develop and implement effective ways of supporting women to breastfeed.

Caroline McElnay
Director, Population Health

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Dashboard Q2 (Oct – Dec 2015)** 24
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tracee Te Huia, General Manager Māori Health Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team (EMT); HB Clinical Council, Consumer Council and Maori Relationship Board
Month:	March 2016
Consideration:	For Monitoring

RECOMMENDATION

That the Board:

Note the contents of this report.

19

CONTENTS OF THE REPORT

This is a report on:

- The Māori health indicators agreed as part of the development of 2015 /16 Annual Māori Health Plan.

A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 4) to represent this.

As this report is for the period ending December 2015, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 15-16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

PERFORMANCE HIGHLIGHTS

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (71.4%) and the lowest disparity gap between Māori and European (2.4% gap).
2. Immunisation rates for Māori under 2 year olds continue to exceed expected targets of ≥ 95% with 96.1% of all Māori 2 year olds immunized in Quarter 2.
3. Immunised rates for Māori 4 year olds has increased from 93.3% in Q2 to 94.2% in Q2 above the expected target of ≥ 90%.
4. ASH Rates overall are declining for both 0-4 years and 45-64 years with a significant narrowing of disparity gap for 0-4 year old group.
5. Advice to pregnant smokers increased above the expected target of ≥90% up from 87.7% in Quarter 1 to 96.2% in Quarter 2.
6. The number of Māori enrolled in the PHO has risen from 95.9% in Quarter 1 to 97.2% in Quarter 2 above the expected performance target of 97%.
7. Cultural Training for HBDHB staff has increased from 64% in Quarter 1 to 66% in Quarter 2. Medical staff increased significantly from 14% in Quarter 1 to 19% in Quarter 2.

Areas of progress

1. Heart and Diabetes Checks are continuing to improve towards the expected target and have increased from 85.8% in Quarter 1 to 86.3% in Quarter 2.
2. Breast Screening has improved from 66.6% in Quarter 1 to 68.4% in Quarter 2.

Challenges

1. Breastfeeding rates for Māori at 6 weeks, 3 month and 6 months continues to decrease and remain below expected performance targets.
2. Māori women who are smoke free at 2 weeks post natal decreased by 9% from 62% in Quarter 1 to 53% in Quarter 2 well below the expected performance target of ≥ 86%.
3. Immunisation rates for 8 month old Māori dropped below the expected target of ≥ 95%; down from 96.7% in Quarter 1 to 93.3% in Quarter 2.
4. Māori under Mental Health Act compulsory treatment orders has risen 6.7 from 189.3 per 100,000 population in Quarter 1 to 196. There remains a significant inequality between Māori and non-Māori.
5. Māori Workforce remained static in Quarter 2 at 12.3% and is below the expected target of 14.3%

Please note:

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

ANNUAL MĀORI HEALTH PLAN, QUARTER 2 OCTOBER - DECEMBER 2015 DASHBOARD REPORT

Access to Care
PHO Enrolment and ASH rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment	94.7%	95.9%	97.2%	96.5%	≥ 97%	65		↑
0-4 years (6m)	82.0%	95.0%	82.0%	73.0%	≤ -	-		↓
45-64 years (6m)	100.0%	100.0%	98.0%	66.0%	≤ -	-		↓

Child Health
Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	69.0%	62.0%	66.0%	≥ 75%	-		↑
At 3 months	54.0%	45.0%	45.0%	55.0%	≥ 60%	-		↑
At 6 months	59.0%	55.0%	54.0%	66.0%	≥ 65%	-		↑

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation (8 Months)	95.9%	96.7%	92.6%	93.3%	≥ 95%	-6		↑
Immunisation (2 years)	95.0%	95.9%	95.1%	92.9%	≥ 95%	0		↑
Immunisation (4 years)	-	93.3%	94.2%	91.1%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	52.4%	56.5%	65.1%	≥ 75%	0		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	-	-	-	0.6	≤ 2.6	0		

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate	65.3%	65.3%	Yearly Data, Update in Q3		≥ 82%	-		↑

SUDI

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Rate per 100,000	4.6	2.9	Update not available		≤ 0.5	-		

Indicator Legend
- Target attained
- Within 10% of target
- 10-20% away from target
- Greater than 20% away from target

Time Series Key:
- Target
- Actual

Cardiovascular Disease

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Heart & diabetes checks	83.9%	85.8%	86.3%	91.7%	≥ 90%	-416		↑
Quick access to angiograms	66.7%	38.5%	60.0%	68.7%	≥ 70%	-2		↑
Completion of registry data	12.5%	91.7%	71.4%	84.1%	≥ 95%	-5.0		↑

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs)	73.8%	74.4%	74.1%	76.5%	≥ 80%	-520		↑
Breast screening (50-69 yrs)	67.2%	66.6%	68.4%	75.8%	≥ 70%	-55.5		↑

Smokefree

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal	58.0%	62.0%	53.0%	73.0%	≥ 86.0%	0		↑
Pregnant smokers Brief Advice to Quit	100.0%	87.7%	95.2%	96.5%	≥ 90.0%	0		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000)	-	189.3	196.0	93.4	≤ 81.5	46		↓

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.7%	2.7%	2.6%	2.9%	≥ -			
Management & Administration	15.7%	16.8%	16.5%	-	≥ -			
Nursing	10.1%	10.5%	10.6%	-	≥ -			
Allied Health	11.9%	12.6%	12.6%	-	≥ -			
Support Staff	26.7%	28.1%	28.2%	-	≥ -			
Māori staff - HBDHB	11.6%	12.3%	12.3%	-	≥ 14.3%			↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9%	14%	19%	-	≥ -			
Management & Administration	43%	78%	79%	-	≥ -			
Nursing	41%	68%	70%	-	≥ -			
Allied Health	59%	74%	77%	-	≥ -			
Support Staff	12%	38%	36%	-	≥ -			
Māori staff - HBDHB	40%	64%	66%	-	≥ 100%			↑

Te Ara Whakawaiora Priorities

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Obesity (B4SC Healthy Weight for 4yrs)	-	26%	52%	56%	≥ 50%	-		↑
DNA's		11.70%	14.90%	5.30%	≤ 7.50%			↓
Oral Health (% Caries Free at 5yrs)	38.70%	38.70%	-	-	≥ 65%	-		↑

19

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:

22. **Confirmation of Minutes of Board Meeting**
- Public Excluded

22. **Matters Arising from the Minutes of Board Meeting**
- Public Excluded

23. **Board Approval of Actions exceeding limits delegated by CEO**

24. **Chair's Report**

25. **Information Services Function Review**

Reports and Recommendations from Committee Chairs

26. **Finance Risk and Audit Committee**

27. **HB Clinical Council**

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).

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
ED	Emergency Department
ECA	Electronic Clinical Application

ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
EoIs	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Maori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Maori Health Service
MOPS	Maintenance of Professional Standards
MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding

MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RIS/PACS	Radiology Information System Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent

SUR	Service Utilisation Report
TAS	Technical Advisory Service
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date