BOARD MEETING

Date: Wednesday, 27 July 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: -

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

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Routine	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	74	
9.	Financial Performance Report	75	
10.	Consumer Story (Kate Coley)	-	

	Section 2: Reports from Committee Chairs		
11.	HB Clinical Council (Dr Mark Peterson)	76	1.50
12.	HB Health Consumer Council (Chair, Graeme Norton)	77	
13.	Māori Relationship Board (Chair, Ngahiwi Tomoana)	78	
	Section 3: For Discussion / Decision		
14.	Transform & Sustain Refresh (Tim Evans)	79	2.15
	Section 4: Presentation		
15.	Under 19 Mental Health Wait Target (Allison Stevenson)	80	2.30
	Section 5: General Business		
	Section 6: Recommendation to Exclude		
16.	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Agenda Items	Ref #	Time (pm)
17.	Minutes of Previous Meeting		2.45
18.	Matters Arising – Review of Actions - nil		
19.	Board Approval of Actions exceeding limits delegated by CEO - nil	81	
20.	Chair's Report (verbal)		
	Section 8: Reports from Committee Chair		
21.	Finance Risk & Audit Committee (Dan Druzianic)	82	
22.	HB Clinical Council (Dr Mark Peterson)	83	
	Board only time		

Tour

Opportunity for Board members to view the following areas (in groups): Operations Centre (Jill Lowry) Emergency Department Reconfiguration (Ian Elson) Waioha – new maternity unit (Claire Caddie)	3.30pm

Next Meeting: 1.00 pm, Wednesday 31 August 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Board "Interest Register" - 30 June 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 27 July 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	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
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

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 29 JUNE 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

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

Apologies Barbara Arnott

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

Minutes Brenda Crene

KARAKIA

Ngahiwi Tomoana opened the meeting with a Karakia.

APOLOGIES

Our hearts are with Barbara Arnott who lost her dear mother.

INTEREST REGISTER

Denise Eaglesome would email a change to the Interest Register through. **Action.**

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

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 25 May 2016, were confirmed as a correct record of the meeting.

Moved: Peter Dunkerley
Seconded: Diana Kirton
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Te Ara Whakawaiora / Breastfeeding:** The additional detail requested would be included in reporting presented to the Board in September – ongoing.

Item 2: **Re MRB discussions -** Progress update provided when available.

Item 3: **Smoke Free in Primary Care:** included in CEO's report and on Clinical Council agenda. Remove action.

Item 4: **Health Partnerships – Food Services Agreement:** actioned and item to be removed.

Item 5: **MRB's Recommendations:** Healthy populations team were to consider. Advised at implementation plans are integrated, however they are kept separate in the planning phase to ensure focus is maintained. **Response to be provided from HPT.**

Item 6: **Best Start Healthy Eating and Activity:** actioned and item would be removed.

Item 7: **Transform and Sustain Strategic Dashboard:** reporting change in progress. Remove action.

Item 8: **HBDHB Non-Financial Exceptions Report Q3:** compliments passed on. Remove action.

Item 9: **MoH Dashboard for HBDHB Q2:** to July meeting, has been included on the workplan. Remove action

Item 10: **Maori Staff Employed:** reporting change communicated for TAW (monitoring) paper to FRAC in July, prior to circulation to the committees. Work was progressing on a Maori staffing strategy and The Acting Chair of MRB asked for a preview prior to release. **Action.**

BOARD WORK PLAN

On the Workplan provided for July, it was noted that the HB Integrated Palliative Care Draft paper had been moved to August leaving a fairly light Board agenda for July. The Chair asked management to review the light agenda and maybe include a further item(s). **Action**

27 July	Consumer Story	Kate Coley
	Transform and Sustain Refresh	Tim Evans
	Final HBDHB Annual Plan 16/17 SOI (on Diligent & Website)	Tim Evans
	HB Intersectoral Group Regional Plan TBC	Kevin Snee
	Under 19 mental health wait target presentation	Sharon Mason

CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retires
Barbara McPherson	Infection Control Advisor	Quality Improvement & Patient Safety	27	24-Jun-16
Peggy Kersley	Project Management Office Manager	Human Resources	25	30-Jun-16
Dr Richard Loan	Medical Officer in Psychiatry	Older Persons & Mental Health	24	29-Jun-16
Dr Philip Baker	Neurologist	Acute & Medical	33	1-Jul-16
Larraine Field	Registered Nurse	Surgical	10+	26-Jun-16

- MoH advises 2.2m NZs have been immunised against influenza thus far in 2016
- Pharmac's funding decisions was conveyed, including the recent treatment announcement for two hepatitis C drugs.

- A letter of thanks had been received from an Australian thanking the DHB and staff sincerely for the prompt and efficient care received from HB hospital and staff.
- Letter from former staff member who had recently spent time in hospital and wished to thank Dr John Gommans and staff for the wonderful care and service.
- Financial position nationally: the Chair noted that 16 of 20 DHBs in NZ had projected surplus at the beginning of the 2016/16 financial year. As at 30 April there were only 7 of the 20 in a projected surplus situation.
- Thanks were conveyed to team and staff for delivering and maintaining continuous surpluses.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report summarised as follows:

- Regarding Asset Management: it is pleasing to note the life span of clinical equipment in HBDHB has been found to be in better condition than most other DHBs.
- Poor performance in ED with winter woes and the Hospital is under pressure.
- A presentation will be provided shortly around the relationship between ED and AAU 8% attendances increased in May. The PHO are working with us around strategies in primary care and also the top 200 "frequent flyers" to ensure packages of care are put in place. There will be a visit from MoH in the near future around specialising in acute demand area.
- An overview of other areas was provided along with the encouraging financial performance, however the high cost patient alluded to the Board had not been resolved.
- HBDHB are playing a full role in addressing inequities and those that are amenable to health interventions are doing fairly well.
- Pharmacy services in the community: as part of a national initiative this is moving towards the likelihood of having more flexible contracts.
- The CRISP programme of IS work was also live regionally, and moving ahead now with a degree of confidence.
- In summary, we have made good progress across a range of key strategic priorities whilst continuing to deliver sound performance across a range of indicators. There remains some room for improvement in some areas.
- Ngahiwi Tomoana was pleased advising that many areas were looking very positive.

FINANCIAL PERFORMANCE REPORT

The Financial report for May 2016, was reviewed showing a favourable variance of $95 thousand with a year to date result of $110 thousand favourable. Forecast remains on track for a $3.990m surplus.

In Summary:

- Inter District Flows (IDFs) remain unknown.
- Elective surgery doing well with increased in-house services.
- A little behind in efficiencies (-16%) on planned activity. However there is unplanned work occurring with savings resulting.
- Capital spend a little behind but not significant as we carry this over years for large projects.
- Employee numbers are contained.
- One high cost case alluded to the board last month, has yet to be resolved.

CONSUMER STORY

Jeanette Rendle (Consumer Engagement Manager) provided a heartfelt story around excellent and caring support provided by DHB staff and the impact that had on a families experience.

The CEO advised what happened was a great example of staff living our values, however the question was whether a rest home situation may have been the best option.

FOR INFORMATION

2016 ELECTIONS AND BRIEFING FROM ELECTORAL OFFICER

Ken Foote, Company Secretary introduced the Electoral Officer (EO) Warwick Laamp who provided an overview of the up and coming elections process

A consistent approach across the country is being taken with the key areas being:

- 15 July: candidate hand-outs will be available for issue.
- Candidate briefing sessions are planned and potential candidates encouraged to attend.
- Nominations close Friday 12 August.
- There are no controls around timing for campaigning and potential candidates may commence at any time
- With Social Media more prevalent, care is definitely needed in this area. It was noted that a candidate cannot use DHB resources in campaign material, and no DHB social media channels are to be used for campaigning. Candidates are not able to have HBDHB logo appearing on any of their material and they need to be mindful and make sure they understand what their social media footprint is, and care is needed if responding to posts. The DHB will delink if this occurs.
- It will be business as usual during the election period 8 July to 8 October. This means elected member details may remain on the DHB website but not be more prominent.
- DHB staff must ensure neutrality and have a similar set of protocols to ensure no conflicts occur.
- The EO strongly recommends HBDHB staff do not nominate or second candidate nominations.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Dr Mark Peterson spoke to the report relating to the Council Meeting held 8 June 2016. A recommendation for the Board to approve a new investment prioritisation was adopted as follows:

RECOMMENDATION

That the Board

Approve $26,000 during 2016/17 (June-December 2016) from the new investment prioritisation contingency to investigate the recommendations of the Coroner's report into four suicides in Flaxmere.

Adopted

It was noted that Council supported the following initiatives at their meeting:

- Food Service team investigating and implementing the recommendations.
- The Mobility Action Programme and RFP to MoH.
- Target Champions Dr Robin Whyman's recommendations for Oral Health.

- The Board Chair noted the strong message around fluoridation advising that if and when we have received all detail around fluoride, together with the authority to act, then we could consider moving with some urgency.

Hawke's Bay Health Consumer Council

Graeme Norton Chair of Council advised the outcomes of their meeting held on 9 June 2016 in summary:

- The Youth Health Strategy was supported. At times it is hard to see how strategies are merged into others at implementation, as it is not often covered in the paperwork. However the strands connecting to whatever services that flow, need to be carefully managed.
- Positive framework – comment on health equity and framing in the positive. Enabling equity rather than eliminating inequity as we see this as an opportunity. Frame positive lasts longer. If framed negatively hard to keep energy levels up.
- The Mobility Action Programme plan was supported. This had been developed to support the RFP for pilot funding.
- National Consumer Council collective had first teleconference last week. There are four Consumer Council's operating at present, with others in the planning stage. A number of DHBs are really struggling to provide this commitment to form Consumer Councils. Graeme expressed he was keen for the Board Chair, CEO as well as the Co-chairs of Clinical Council to voice the value of Consumer Council, as many need confidence to get this over the line.

Pasifika Health Leadership Group

Talalelei Taufale Pacific Health Development Manager was in attendance and addressed the board around the Pasifika dashboard. This is part of the national plan for improving health outcomes for Pacific people in NZ and the Pasifika Health Leadership Group had adopted the dashboard as the foundation to measure and review improvements for their people. The framework compared other DHBs in NZ and HB performed well.

The Areas of Progress and the Challenges were noted and the layout of the dashboard was discussed. Board members advised they were happy with the 20 indicators and the format used. This report would be provided every six months.

RECOMMENDATION

That HBDHB Board:

1. Adopt the health priorities as per the Ministry of Health Ala Mo'ui Pathways to Pacific Health 2014-2018 as the Pasifika health priorities for HBDHB.
2. Report six monthly progress to the HBDHB using the Ala Mo'ui dashboard with local commentary provided.

Adopted

Māori Relationship Board (MRB)

Heather Skipworth (Acting Chair) provided an overview of the meeting held 8 June 2016:

- Maori Staff target was noted in the recommendations as MRB wish to push the target higher.
- Heather advised MRB would like to see the Maori Staff Strategy prior to issue to FRAC **Action.**
- Regarding the Health Equity Report provided, MRB were happy with this and like Consumer Council, MRB want to celebrate the successes.
- The Te Ara Whakawaiora Fluoride aspect of the recommendation was not adopted by MRB as they wanted to hear what the concerns were first. There will always be those campaigning against fluoride and we need to be courteous.

- MRB were pleased to see Suicide Prevention funding approved.

Ngahiwi Tomoana was keen for HBDHB to be a flagship employer.

Advised that management will look at doing significantly better but not sure whether the 25% target was realistic.

Outside of health, Iwi are working with growers to encourage their uptake of permanent Maori workers (vs utilising those from overseas). Through government agencies, Iwi and training organisations, our people are targeting areas to bring new jobs. This would involves up skilling and training potential employees.

The Board noted all nine of **MRB's recommendations** (in italics below) regarding priority actions required to further reduce health inequality in Hawkes Bay and requested the CEO to further investigate and report back on these. **Action**

2. Approve the following as priority actions required to further reduce health inequity in Hawke's Bay:
   - *a) Raise the target to Increase Māori Staff from 10% year-on-year to 25% over a five year period*
   - *b) Present the strategy to Increase Māori staff to MRB before going to the Finance, Risk and Audit Committee (FRAC).*
   - *c) Review the current HBDHB hiring protocols and processes*
   - *d) Review the conviction policy for the HBDHB and whether a conviction that is old, is relevant now*
   - *e) Broaden the scope of the target to all disciplines, not just medical, nursing and allied health*
   - *f) Shift the responsibility of achieving the target to Hiring Managers setting KPIs for monitoring*
   - *g) Senior Management monitor the progress of the target and provide monthly updates identifying why the target was achieved, or not achieved*
   - *h) Train Hiring Managers to efficiently and effectively use the Managers Toolkit*
   - *i) Māori Health Service involved in the recruitment processes from the development of position profiles, shortlisting and interview stages with a member of the team becoming a compulsory member of all hiring/selection panels*

3. MRB did not approve recommendation number 4 of the Te Ara Whakawaiora: Oral Health paper but instead approved the following actions:

   - *a) Target Champion to present information about the benefits and side effects of Fluoridation to get a clearer understanding of Fluoridation*
   - *b) HBDHB champion sugar free beverage events and challenge all other organisations to do the same.*

The Board noted items 3. a) and b) appeared practical**.**

- Ask DHB for water only in schools, as this message would be better coming through a health organisation. Now have healthy eating approved. Are looking at sugar free beverages for schools and events. The Chair asked this request be passed on. **Action for consideration**.
- DHB to consider food wastage and look at providing to homeless. This would be looked into. **Action for consideration.**

FOR DECISION

FOOD SERVICES OPTIMISATION REVIEW

Sharon Mason introduced Gavin Carey-Smith and Jill Foley who provided an overview and the request for the board to support implementation of the recommendations contained in the report. The capital involved would come through a separate process.

A discussion around software with members advised the team were investigating a number of suppliers and options used presently in NZ. If this is connected with what HBL are doing it would be looked at but we do need to go with the best option for us.

Following discussion the following recommendation was adopted.

RECOMMENDATION

That the Board:

1. Note the contents of this report.
2. Support the Food Service team in investigating and implementing the recommendations.
3. Note capital applications that arise from recommendations below will be put through the capital plan process for approval.

Adopted

YOUTH HEALTH STRATEGY 2016-19

Dr Caroline McElnay introduced Nicky Skerman (Population Health Strategist Women, Children and Youth).

The development of this strategy had been through a rigorous process to get to this point. Going forward – go back to youth consulted with and identify leaders in those groups with the intention of doing some training around governance for those identified (likely 6 in total).

Feedback included

- We have the most vulnerable whanau here in HB yet nothing was mentioned. Many whanau are now young solo mums with high risk factors. Feel this is an omission which needs addressing. Feel the solution lies there as well as with the gangs. Young mums in Wairoa need to be part of 16 to 19 year old group.
- Jacoby supported Ngahiwi as this should be applicable to all youth but there are polar differences across our community. Rex Tumu holds a forum for Rangatahi – those who want to advocate for themselves. If taking about Flaxmere 50% are single mums under 25 years old. Good opportunities to create synergies.
- What about a partnership with secondary schools?
- Focus on positive development of all youth (the whole young person) is not just about picking out the most vulnerable.

  Nicky advised the priorities would be driven by the young people around the table who would be from all ethnicities and situations.
- Nice if this group could report back regarding change. They should ID priorities and who stakeholders should be and produce an action plan. How to structure youth services going forward and what we want from them.
- Board were very supportive and interested to see how this strategy develops and adopted the following recommendation with comments raised provided to Nicky Skerman.

RECOMMENDATION

That the Board:

Endorse the Youth Health Strategy 2016-19.

Adopted

An Update on the Youth Health Strategy 2016-19 would be provided to the Board in July 2017 (this was already on the detailed workplan).

FOR DISCUSSION

SUICIDE PREVENTION AND POSTVENTION PLAN

Dr Caroline McElnay introduced Penny Thompson who provided and overview of this update on progress against the plan submitted in 2015.

Discussion summarised:

- What are the main challenges? Had not done as much community consultation as should have been done as this needs to be monitored on an ongoing basis with agencies.
- Police advise that social media was the biggest driver of suicide.

  FACEBOOK this month is now actively involved and is monitoring their site closely. They acknowledge they have a role to play. Also newspapers are naming and shaming.
- An overview of the extra work Penny would be involved with as a result of the Coroner's report was provided. 1st establish a working group to ensure all agencies/networks are linked.
- Set up an interagency governance group. Go first – sit there at a senior level.

HEALTH EQUITY UPDATE REPORT 2016

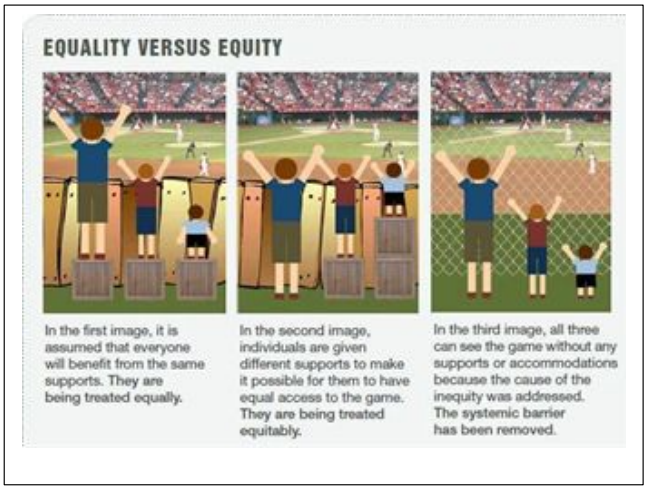
Dr Caroline McElnay provided an update (as Health Equity Champion) for the sector, which was well received by the Board.

In summary:

- The report provided a snapshot of 18 indicators compared with 49 indicators (nationally). This sub-set was grouped to show how HBDHB was doing.

  Of the 18 indicators compared: Health equity was achieved in 1 indicator; Good progress in 3; could do better in 9; with no change/or worse in 5 indicators.

  Insight into Iron Maori and how this programme provides health benefits was provided.



The board were asked, how should we be tackling?

- Behaviour and risk
- Social and economic factors
- Healthcare

Were there more areas we should add? In response, could add "sport".
Guardian impact of sport in schools was mind boggling. There were examples of schools that don't and do focus on sport.

When Caroline McElnay returns from three months sabatical, she will continue her work in this area.

MONITORING

TE ARA WHAKAWAIORA / ORAL HEALTH

Sharon Mason introduced Dr Robin Whyman (Director of Oral Health Services)

- Under 5 year old caries free indicator is now being used increasingly. Worldwide there is a growing body of evidence of the decay picture in children and the increasing their move into adulthood.
- While there has been some improvement over past years (10% or so), we have not moved the inequity. Nationally this is a challenge.
- We now obtain our targeted children through a quadruple integrated approach with Well Child therefore are not chasing mums to enrol their children.
- Jacoby a board member and first time Mum, was not contacted in the child's first year. Need to address the wider cohort rather than those not turning up.
- Improving in the dental practice areas, however we need to make sure we have early prevention. Nationwide awareness campaign – engaged soon including messaging will be helpful.
- The timeframe for fluoridation under DHBs (instead of Councils) was unknown, however a legislative change was planned within this government's term.
- There are real benefits for fluoridisation however the bigger picture needs to be understood. Robin Whyman would advise when more information was to hand around bullet point four (below).
- Denise sought Robin's help with the Wairoa Council.

RECOMMENDATION

That the Board:

1. Note the contents of this report
2. Adopted the Target Champions recommendations for Oral Health as follows:
   - That Maori health provider contracts are changed to focus on engagement of hard to reach whanau with oral health services in the early pre-school years (by June 2017)
   - That Community Oral Health Services achieve the preventative practice targets (by December 2017)
   - To implement Maternal Nutrition Programme activities and implement healthy eating/sugar reduction programmes/policies as planned in the Best Start: Healthy Eating and Activity Plan (Reported annually until 2020)
   - That Hawke's Bay DHB implements community water fluoridation as soon as necessary legislative changes enabling the DHB to act are in place.
     Yet to be confirmed, dependent upon legislative changes.

Adopted

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

22. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

24. Board Approval of Actions exceeding limits delegated by CEO

25. Chair's Report

26. Integrated Pharmacist Services in the Community

27. Regional Development Strategy

Reports and Recommendations from Committee Chairs

28. Finance Risk and Audit Committee Report

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

The public section of the Board Meeting closed 4.45 pm

Signed: _____
Chair

Date: _____

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BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	30/3/16	**Te Ara Whakawaiora / Breastfeeding:** The Board wish to understand what other DHBs are doing and also to see where HB is benchmarked (including reasons and relative demographics).	Caroline McElnay / Nick Jones	Sept	This will be included in the CEO's September report.
2	27/4/16	**Re MRB discussions:** Tracee TeHuia to arrange a discussion with NKII CEO Adele White, and invite Kevin Atkinson and Ngahiwi Tomoana to join in.	Tracee TeHuia	July	Meeting arranged for september
3	25/5/16	**MRB's Recommendation:** Consider advice and recommendations from the 11 May MRB meeting included in the Report to the May Board, as follows: • The term 'Obesity' be removed where practical within the Best Start: Healthy Eating plan. • Refrain from using the term 'Obesity' within the community • Consider linking the Best Start: Healthy Eating and Activity Plan, Youth Health Strategy and Suicide Prevention Plan together to achieve an integrated approach.	Caroline McElnay		Actioned prior to May Board Meeting report being issued. Noted by Shari in her presentation to the Board. For the Healthy populations team to consider.
	29/6/16	• A response to items raised within the MRB's May Board Report to be prepared and provided to MRB.	Nick Jones for Caroline	Aug	

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
4	25/5/16	**Maori staff employed:** Comments raised for further consideration - refer to page 11 of May 2016 minutes) to be considered/ progressed.	John McKeefry and Tracee TeHuia		All incorporated into the Te Ara Whakawaiora report to FRAC in July.
	25/5/16	**Te Ara Whakawaiora: Culturally Competent Workforce to FRAC prior to the Committees** • A "**Maori Staffing Strategy Refresh"** will be prepared.	John McKeefry "		" "
	29/6/16	Consider and **prepare response or incorporate into the Strategy** MRBs recommendations from their 13 June Meeting (page 1 of their Report to the Board) or page 63 of the Board Report report (Diligent).	"		"
	29/6/16	• MRB's Acting Chair advised MRB would like a preview of the **"Maori Staffing Strategy Refresh"** prior to release to FRAC in July.	John McKeefry to Heather Skipworth		Actioned
5	29/6/16	**Food Services Optimisation Review – suggestions from MRB in the Report to the Board on page 4.** **Water only in Schools:** Pass on immediate request for this from the HBDHB **Consider food wasteage –** leftovers for homeless.	Shari Tidswell / Caroline Deborah Chettleburg		Actioned
6	29/6/16	**Management to review the light Board Agenda in July**	EMT		Actioned
7	29/6/16	**Interest Register update**: Denise Eaglesome to email Board Administrator.	Denise Eaglesome		

HAWKE'S BAY DISTRICT HEALTH BOARD

WORKPLAN

Meetings 2016	Papers and Topics	Lead(s)
31 Aug	Consumer Story	Kate Coley
	Draft Quality Accounts	Kate Coley
	Travel Plan update – verbal	Sharon Mason
	Annual Organisational Development Plan/Programme	John McKeefry
	Community Pharmacy Strategy (board action 16/12/15)	Tim Evans/Billy Allan
	HB Integrated Palliative Care (Draft) – FROM JULY	Tim Evans / Mary Wills
	Final HBDHB Annual Plan 16/17 SOI (on Diligent & Website)	Tim Evans
	Monitoring	
	HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 16	Tim Evans
	Annual Maori Health Plan Q4 Apr-Jun 2016	Tim Evans / Tracee
	Transform and Sustain Strategic Dashboard Q4 Apr-Jun 16	Tim Evans
	Human Resource KPIs Q4	John McKeefry
	Te Ara Whakawaiora: Culturally Competent Workforce)	John McKeefry
	Maori Staffing – Refreshed Strategy)	
	Te Ara Whakawaiora: Mental Health and AOD	Sharon/Allison Stevenson
28 Sept	Consumer Story	Kate Coley
	Draft Developing a Person Whanau Centred Culture	Kate Coley
	Final Quality Accounts	Kate Coley
	Family Violence – Strategy Effectivess – for noting	Nick Jones
	Orthopaedic Review Closure of phase one FROM AUGUST	Andy Phillips
	NKII MoU Relationship Review	Ken Foote
	Mental Health Consolidation / Benefits Realisation	Sharon/Allison Stevenson
	Annual Report (interim)	Tim Evans
	Health and Social Care Networks update (6 monthly Sept-Mar17)	Liz Stockley
	Pacifika Health Leadership Group Qtly	Nick Jones
	Monitoring	
	Te Ara Whakawaiora / Obesity (National Indicator)	Nick Jones
	Breastfeeding Indicator update (board Action)	Nick Jones/Katie Kennedy
8 Oct	**Election Day**	

Meetings 2016	Papers and Topics	Lead(s)
26 Oct	Consumer Story New Patient Safety and Experience Dashboard Alcohol Renal Stage 4 Final HB Integrated Palliative Care FROM SEPTEMBER Annual Report (Final) Final External Audit Report on agenda (P/excl) External Audit Engagement Arrangements Urgent Care Service Change Proposal ***Monitoring*** Tobacco - Annual Update on Progress against the Plan (for noting)	Kate Coley Kate Coley Caroline / Rachel Ayre Sharon Mason Tim Evans / Mary Wills Tim Evans Tim Evans Tim Evans Liz Stockley Caroline McElnay
24 Nov	**HB Health Awards presentation evening**	
30 Nov	Consumer Story Final Developing a Person Whanau Centred Culture Travel Plan (quarterly update) – verbal Tobacco – Annual Update on progress against Plan ***Monitoring*** Te Ara Whakawaiora / Smoking (national Indicator) HBDHB Non-Financial Exceptions Report Q1 Jul-Sept 16 plus MoH dashboard Annual Maori Health Plan Q1 Jul-Sept 16 Transform and Sustain Strategic Dashboard Q1 Jul-Sept 16 Human Resource KPIs Q1 Staff Engagement Survey – any corrective actions	Kate Coley Kate Coley Sharon Mason / Andrea Caroline /Penny Caroline McElnay Tim Evans Tim Evans / Tracee Tim Evans John McKeefry John McKeefry
14 Dec	Consumer Story HB Workforce Plan – Discussion Document (Dec 16 – final March 17) Orthopaedic Review – Phase 2 draft FROM SEPTEMBER	Kate Coley John McKeefry Andy Phillips
22 Feb 2017	Consumer Story Orthopaedic Review – phase 3 Draft Pacifika Health Leadership Group Qtly ***Monitoring*** HBDHB Non-Financial Exceptions Report Q2 Oct-Dec16 plus MoH dashboard Annual Maori Health Plan Q2 Oct-Dec16 Transform and Sustain Strategic Dashboard Q2 Oct-Dec166 Human Resource KPIs Q2 Te Ara Whakawaiora / Access (local indicator) Te Ara Whakawaiora / Cardiology (national indicator)	Kate Coley Andy Phillips Caroline McElnay Tim Evans Tim Evans Tim Evans John McKeefry Mark Peterson John Gommans

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 74
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month: As at	19 July 2016
Consideration:	For Information

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Recommendations

That the Board
1) Note the contents of this report.

INTRODUCTION

This month is a fairly light agenda. We have finished the year well financially and are showing improvement across a number of areas. We will also report to the Board on how we intend to refresh and reinvigorate our five year strategy to maintain the pace of change. On the morning of our Board meeting there will be the launch of the Regional Economic Strategy for Hawke's Bay. The DHB has been an important contributor to this strategy and if it is well implemented, it will make an important contribution to the health of our community. It will be brought formally to the Board for endorsement next month.

PERFORMANCE

Measure / Indicator	Target	Month of June	Qtr to end June	Trend For Qtr
Shorter stays in ED	≥95%	92.6	92.5%	▲
Improved access to Elective Surgery (2015/16YTD)	100%	104.4%	-	▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,563	307	45
Patients given commitment to treat, but not yet treated (ESPI-5)	1,011	87	10

Faster Cancer Treatment*	≥85%	73.0% (May 2016)	65.2% (6m to May 2016)	▲
Increased immunisation at 8 months (3 months to May)	≥90%	---	95.2%	▲
Better help for smokers to quit – Hospital	≥95%	99.4%	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%	77.6% (Quarter 3, 2015/16)	---	---

Measure / Indicator	Target	Month of June	Qtr to end June	Trend For Qtr
More heart and diabetes checks	≥90%	89.6% (Quarter 3, 2015/16)	---	---
Financial – month (in thousands of dollars)	$8,887	$9,153	---	---
Financial – year to date (in thousands of dollars)	$3,990	$4,366	---	---

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

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*15/19 = 78.9%*	*66/114 = 57.9%*

Note: The Ministry of Health expectation for the number of people expected to be identified as high suspicion has been increased from 11.4 to 19 per month.

Performance this month has seen an improvement across a range of indicators: shorter stays in ED where have finished the year below target but have held our own in what has proved a difficult winter to date; elective admissions where we have finished the year significantly ahead of plan; Faster Cancer Treatment where we are increasing our performance in spite of the increase in expected numbers moving from 11.4 to 19 per month; immunisation and helping smokers to quit in hospital. Early indications in relation to helping smokers to quit in primary care suggest we ended the year at 83%, an improvement but not yet at the required level.

Financially we have ended the year in a good position with a favourable variance of $266 thousand for June, with the year end result $376 thousand favourable.

CONSUMER STORY

This month we will be releasing the results from the 2015/2016 national inpatient experience survey - including themes and quotes from consumers that have been discharged from hospital.

YOUNG PEOPLE REFERRED FOR NON-URGENT MENTAL HEALTH OR ADDICTION SERVICES

Child, Adolescent and Family Service (CAFS) were not meeting the target for the above key performance indicator (KPI). At times this result was at 50 percent (target 80 percent) (seen within three weeks) and 73 percent (target 90 percent) seen within eight weeks.

A clear focus was needed to shift the result to meet or better the target. A number of factors were contributing to the poor result including problems with recruitment and retention, a poor understanding of the KPI within the team, poor reporting practice. A small group was formed to address this. Once the CAFS team understood the issue and used the data to support change, results have improved so that both targets are now exceeded providing more timely access for consumers of the service.

TRANSFORM AND SUSTAIN REFRESH

The Transform and Sustain Programme was published in December 2013 and is now half-way through its five year horizon. The strategy is therefore due for a refresh. The report is on this agenda. The Board will wish to note the refresh process and endorse the first draft list of specific projects which are to be worked up to take forward our process of change and improvement as a health system.

SUMMARY

In summary, we have ended the year well, however as we move into the new year we must identify through our refreshed strategic plan how we make more progress across a number of key areas. If we can do this well and work together as whole system in this endeavour, the opportunity to improve the health of our local community will be immense.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, June 2016** 75
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, GM Planning, Informatics & Finance Finance Team
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For Information

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RECOMMENDATION

That the Board and FRAC
Note the contents of this report

1. GM Planning Informatics & Finance comments

Financial performance

The result for June is a favourable variance of $266 thousand, the year end result is $376 thousand favourable. This followed two technical adjustments between our Balance Sheet and operating costs: first, the reclassification of some Regional Health Informatics Programme costs to capital reduced operating costs by $687 thousand; second, anticipating a raised capital definition to a new $2 thousand threshold, a number of assets have been fully depreciated, increasing operating costs by $448 thousand. These numbers are provisional and subject to audit and final wash-ups.

The elective surgery health target was 34.3% ahead of plan in June, taking discharges to 4.4% favourable for the year. Our net favourable 312 discharges comprised 473 in-house, less 89 outsourced and 72 Inter District Flows.

2. Resource Overview

	June				*Year to Date*				Refer Section
	Actual	***Budget***	***Variance***		***Actual***	***Budget***	***Variance***		
	$'000	*$'000*	*$'000*	*%*	*$'000*	*$'000*	*$'000*	*%*	
Net Result - surplus/(deficit)	9,153	8,887	266	3.0%	4,366	3,990	**376**	**9.4%**	3
Contingency utilised	2,001	250	**(1,751)**	**-700.3%**	3,000	3,000	-	0.0%	8
Quality and financial improvement	1,743	1,912	**(169)**	**-8.8%**	8,703	10,200	**(1,497)**	**-14.7%**	11
Capital spend	1,471	1,892	**(421)**	**-22.3%**	17,128	21,358	**(4,230)**	**-19.8%**	16
	FTE	*FTE*	*FTE*	*%*	*FTE*	*FTE*	*FTE*	*%*	
Employees	2,261	2,249	(12)	-0.5%	2,154	2,180	26	1.2%	5 & 7
	CWD	*CWD*	*CWD*	*%*	*CWD*	*CWD*	*CWD*	*%*	
Case weighted discharges	2,746	2,277	**469**	**20.6%**	28,725	27,407	1,318	4.8%	5

The result for the year is a favourable variance of $376 thousand, with all of the contingency used.

Quality and Financial Improvement (QFI) programme savings finished at $8.7 million, or 85% of the $10.2 million target. Realisation of Inter District Flows savings will not be confirmed until the 2015/16 IDF wash-up process is complete.

Capital spend is $4.2 million behind plan. The catch-up of Mental Health Inpatient Unit project payments budgeted last year, has been more than offset by low spend in IT, and later than planned purchase of some large clinical equipment items as they go through the trial process.

The Full Time Equivalent variance year to date reflects vacancies in allied health personnel, relating to new programmes or changes in the model of care.

Case weighted discharges were 20.6% ahead of plan in June, and 4.8% ahead of plan year to date. High acute general surgery, gastroenterology, and paediatric inpatient acute volumes are partly offset by low maternity, and internal medicine acute case-weights.

3. Financial Performance Summary

	June				*Year to Date*				
$'000	***Actual***	***Budget***	***Variance***		***Actual***	***Budget***	***Variance***		Refer Section
Income	52,932	52,187	746	1.4%	516,666	513,298	3,369	-0.7%	4
Less:									
Providing Health Services	22,182	20,035	**(2,148)**	**-10.7%**	242,315	237,286	(5,029)	-2.1%	5
Funding Other Providers	17,754	17,517	(237)	-1.4%	222,737	224,184	1,447	0.6%	6
Corporate Services	5,150	5,460	**310**	**5.7%**	46,092	44,197	(1,895)	-4.3%	7
Reserves	(1,307)	288	**1,595**	**553.2%**	1,156	3,641	**2,485**	**68.2%**	8
	9,153	**8,887**	266	3.0%	**4,366**	**3,990**	**376**	**9.4%**	

Income (see section 4)
Funding for the increased capital charge resulting from the 2014/15 land and building revaluations contributes $3 million of the favourable variance. Additional MOH funding for palliative assessment care co-ordination and a cancer nurse coordinator are the other main causes.

Providing Health Services (see section 5)
A combination of medical vacancy and leave cover costs, outsourcing of 9% of elective surgery to Royston to meet the health target and for ESPI compliance, and non-achievement of some of the efficiency targets, resulted in a $5 million (2.1%) unfavourable variance.

Funding Other Providers (see section 6)
Demographic changes driving increased costs in home support ($0.8 million) were more than offset by slower than planned pharmacy medicine use reviews, low access payments, and delayed new investments expenditure.

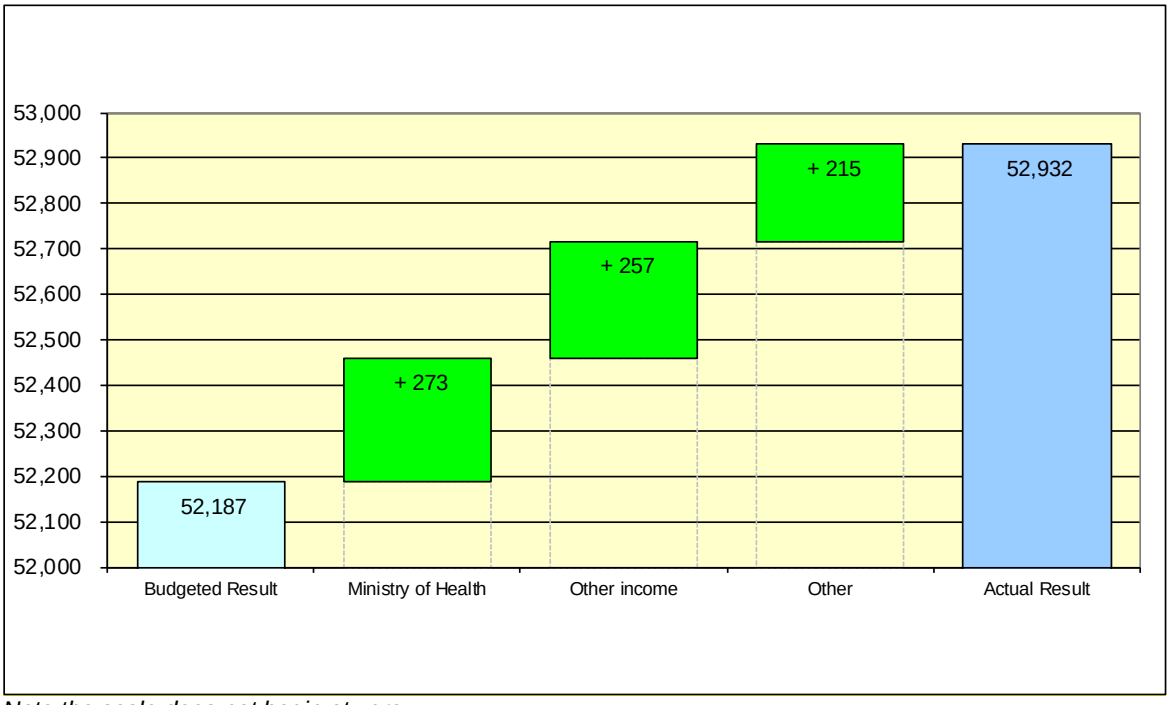
Corporate Services (see section 7)
The additional capital charge cost, $2.7 million unfavourable, was partly offset by $0.5 million of lower nurse training costs (probably incurred but charged to nursing departments instead of training budgets). Non-current asset adjustments provided the remaining variance.

Reserves (see section 8)
Release of the contingency, $1.9 million, and delayed new investment are behind the result.

4. Income

$'000	June Actual	June Budget	June Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance	
Ministry of Health	50,403	50,130	273	0.5%	491,733	488,220	3,513	0.7%
Inter District Flows	624	624	0	0.0%	7,489	7,483	7	0.1%
Other District Health Boards	288	340	(52)	-15.3%	3,348	4,323	(974)	-22.5%
Financing	150	83	66	79.5%	1,419	1,008	411	40.8%
ACC	590	509	82	16.0%	5,611	6,164	(553)	-9.0%
Other Government	64	35	29	84.5%	403	414	(11)	-2.7%
Patient and Consumer Sourced	166	124	42	33.7%	1,313	1,520	(207)	-13.6%
Other Income	600	343	257	75.1%	5,244	4,166	1,078	25.9%
Abnormals	48	-	48	0.0%	105	-	105	0.0%
	52,932	**52,187**	746	1.4%	**516,666**	**513,298**	3,369	0.7%

June Income

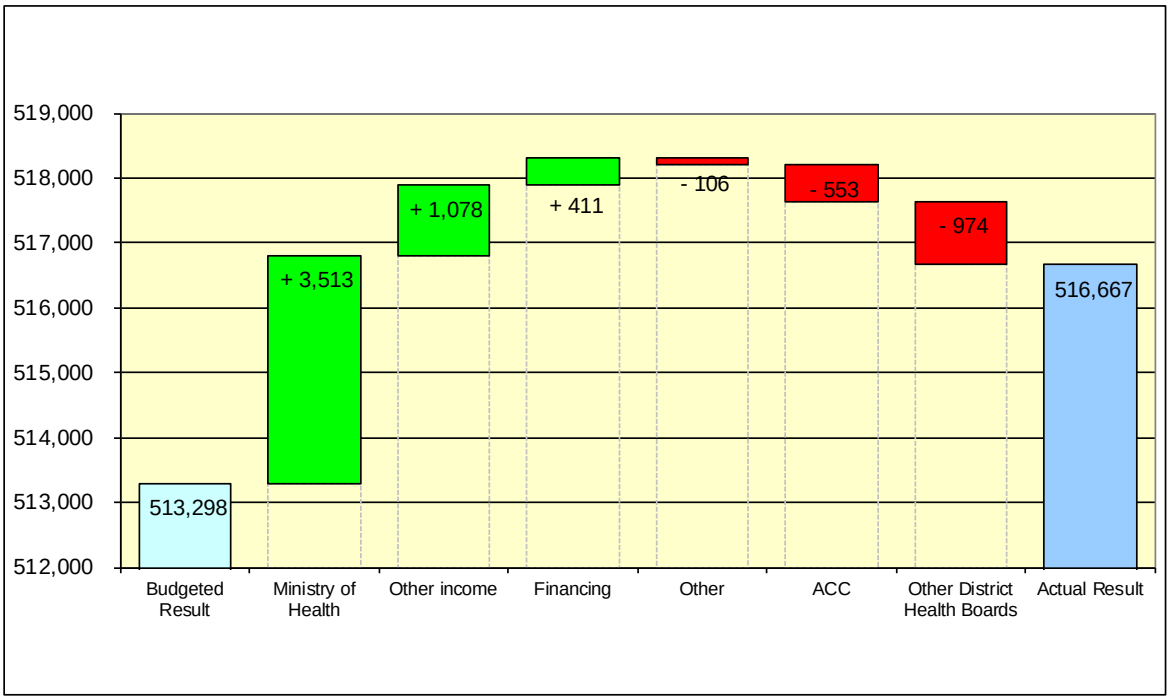


Note the scale does not begin at zero

Ministry of Health (favourable)
Additional income for the Wairoa GP practice (capitated), Maori health (SUDI) and GP/DN services.

Other income (favourable)
A variety of income sources across a large number of departments.

Year to date Income



Note the scale does not begin at zero

Ministry of Health (favourable)
Includes the $2.996 million funding for additional capital charge relating to the 2014/15 land and building revaluations, palliative assessment care co-ordination and cancer nurse coordinator funding.

Other income (favourable)
Includes $541 thousand clinical trial income and donations (unbudgeted), with the remaining variance from a variety of sources and a large number of departments.

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

ACC (unfavourable)
Mainly prioritisation of elective surgery over ACC volumes earlier in the year.

Other District Health Boards (unfavourable**)**
Lower sales of cancer drugs to Tairawhiti DHB, offset in expenditure.

5. Providing Health Services

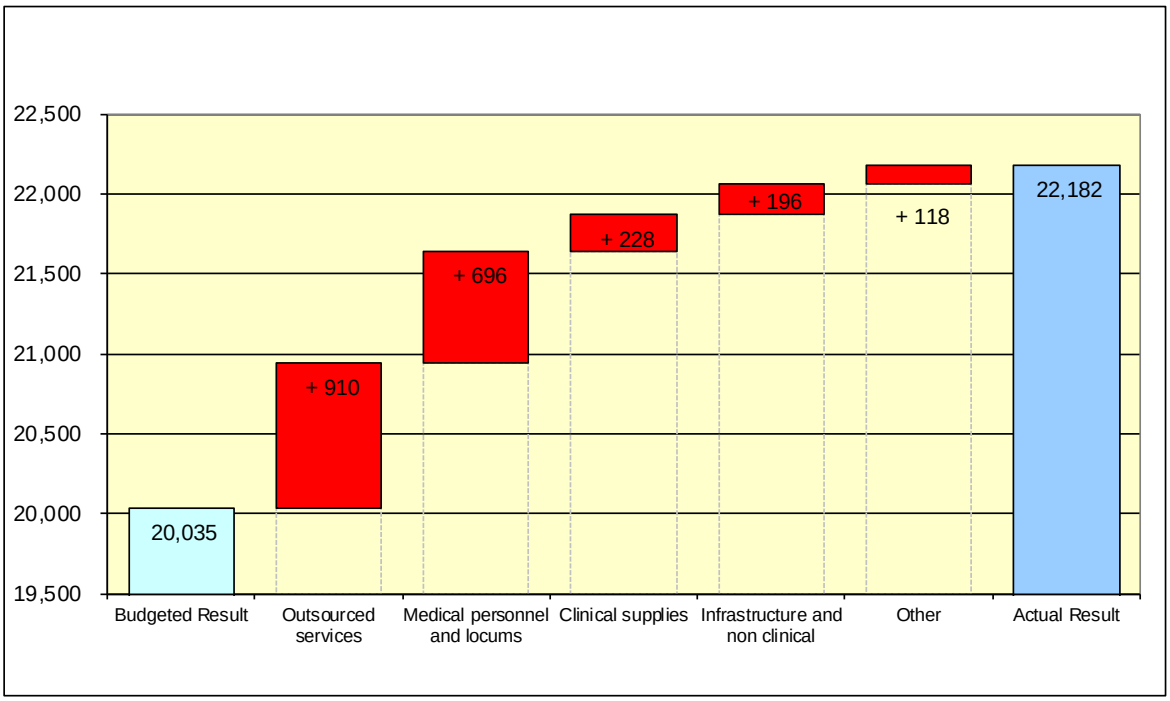
	June				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
Expenditure by type $'000								
Medical personnel and locums	5,177	4,481	**(696)**	**-15.5%**	57,743	54,882	**(2,861)**	**-5.2%**
Nursing personnel	6,247	6,082	(164)	-2.7%	70,654	70,583	(71)	-0.1%
Allied health personnel	2,815	2,802	(14)	-0.5%	30,772	32,356	1,585	4.9%
Other personnel	1,688	1,747	60	3.4%	20,324	20,280	(44)	-0.2%
Outsourced services	1,381	472	**(910)**	**-192.9%**	7,349	5,300	**(2,049)**	**-38.7%**
Clinical supplies	3,161	2,933	**(228)**	**-7.8%**	36,628	35,326	(1,302)	-3.7%
Infrastructure and non clinical	1,714	1,518	**(196)**	**-12.9%**	18,845	18,559	(286)	-1.5%
	22,182	**20,035**	**(2,148)**	**-10.7%**	**242,315**	**237,286**	**(5,029)**	**-2.1%**
Expenditure by directorate $'000								
Acute and Medical	6,030	5,272	**(759)**	**-14.4%**	66,270	63,699	(2,571)	-4.0%
Surgical Services	5,132	4,403	**(729)**	**-16.6%**	54,827	51,350	**(3,477)**	**-6.8%**
Women Children and Youth	1,821	1,675	**(147)**	**-8.8%**	19,811	19,635	(176)	-0.9%
Older Persons & Mental Health	2,871	2,810	(61)	-2.2%	32,786	33,401	615	1.8%
Rural, Oral and Communlty	2,046	1,889	**(157)**	**-8.3%**	21,943	22,103	160	0.7%
Other	4,282	3,986	**(296)**	**-7.4%**	46,679	47,098	420	0.9%
	22,182	**20,035**	**(2,148)**	**-10.7%**	**242,315**	**237,286**	**(5,029)**	**-2.1%**
Full Time Equivalents								
Medical personnel	313.5	308.5	(5)	-1.6%	305	303	(3)	-0.9%
Nursing personnel	914.3	924.2	10	1.1%	888	890	3	0.3%
Allied health personnel	447.7	457.6	10	2.2%	420	444	**23**	**5.3%**
Support personnel	164.4	133.2	**(31)**	**-23.4%**	135	129	(6)	-4.5%
Management and administration	251.4	253.3	2	0.8%	248	246	(2)	-0.7%
	2,091.2	**2,076.9**	**(14)**	**-0.7%**	**1,996**	**2,012**	**16**	**0.8%**
Case Weighted Discharges								
Acute	1,828	1,640	**188**	**11.5%**	20,189	18,824	**1,365**	**7.3%**
Elective	675	443	**232**	**52.4%**	6,557	6,195	**362**	**5.8%**
Maternity	219	164	**56**	**34.0%**	1,588	2,035	**(447)**	**-22.0%**
IDF Inflows	24	30	(7)	-22.2%	391	353	38	10.8%
	2,746	**2,277**	**469**	**20.6%**	**28,725**	**27,407**	**1,318**	**4.8%**

Directorates

The unfavourable result for June relates to:

- Surgical Services – major joint elective surgery outsourced to Royston, partly offset by a higher theatre stock level count.
- Acute and Medical – Includes medical vacancy and leave cover; catch-up payments for radiology reporting, staffing up in ED nursing, reduced leave taken in ED/AAU.

June Expenditure



Note the scale does not begin at zero

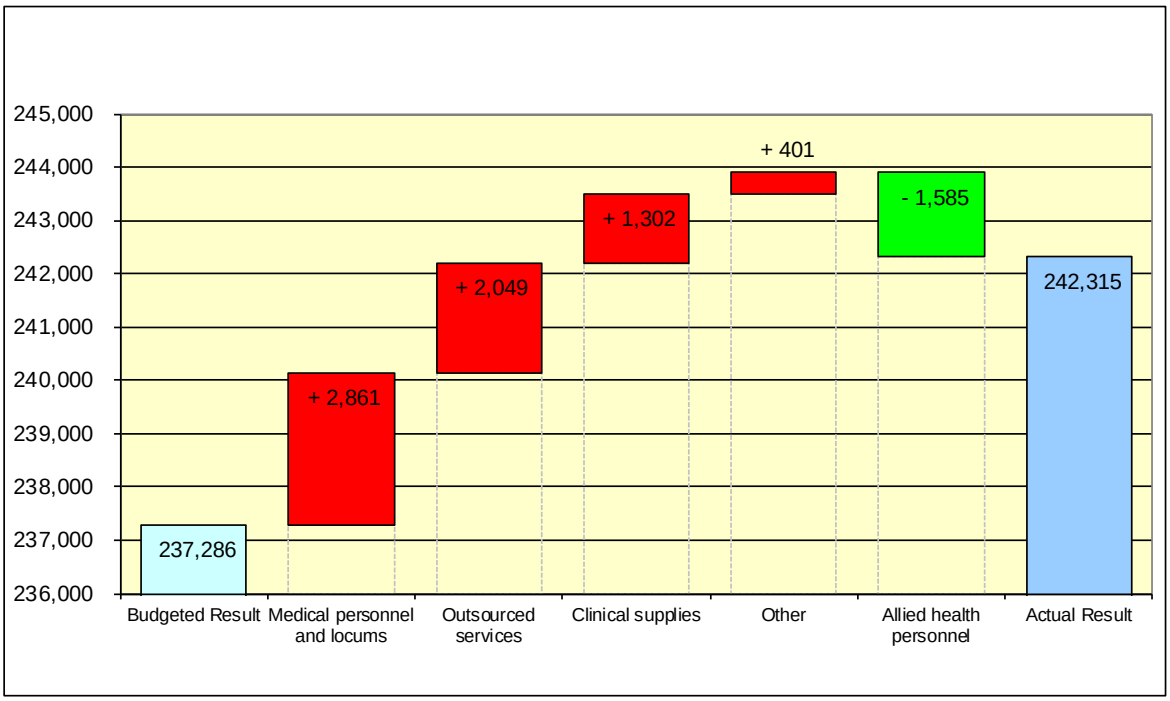
Outsourced services (unfavourable)
Mainly outsourcing to Royston to meet the major joint target and ESPI compliance.

Medical personnel and locums (unfavourable)
Vacancy and leave cover, and some extra sessions.

Clinical supplies (unfavourable)
The higher theatre stocktake count covers the efficiency budget requirement in June. Renal supplies, dressings, dental and diagnostic supplies and other consumable items drive the variance.

Infrastructure and non-clinical (unfavourable)
Facility costs, information technology systems and telecommunications costs.

Year to date Expenditure



Note the scale does not begin at zero

Medical personnel and locums (unfavourable)
Mainly vacancy and leave cover.

Outsourced services (unfavourable)
Outsourcing to Royston to meet the major joint target and ESPI compliance, mostly incurred since March.

Clinical supplies (unfavourable)
Savings targets not achieved.

Allied health personnel (favourable)
Vacancies mainly in mental health, but also across pharmacy, laboratory, and community dental.

Full time equivalents (FTE)

FTEs are 16 favourable year to date, including:

Allied health personnel (23 FTE / 5.3% 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.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To June 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 June 2016			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	196	195	1	0.5%
	ENT	455	420	35	8.3%
	General Surgery	959	1050	-91	-8.7%
	Gynaecology	572	550	22	4.0%
	Maxillo-Facial	143	122	21	17.2%
	Ophthalmology	1163	675	488	72.3%
	Orthopaedics	872	932	-60	-6.4%
	Skin Lesions	178	176	2	1.1%
	Urology	444	450	-6	-1.3%
	Vascular	156	112	44	39.3%
	Surgical - Arranged	524	382	142	37.2%
	Non Surgical - Elective	95	187	-92	-49.2%
	Non Surgical - Arranged	37	70	-33	-47.1%
On-Site	**Total**	**5794**	**5321**	**473**	**8.9%**
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	171	366	-195	-53.3%
	General Surgery	231	180	51	28.3%
	Gynaecology	14	58	-44	-75.9%
	Maxillo-Facial	43	113	-70	-61.9%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	108	0	108	0.0%
	Orthopaedics	52	25	27	108.0%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	3	0	3	0.0%
	Urology	44	26	18	69.2%
	Vascular	13	0	13	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**	**679**	**768**	**-89**	**-11.6%**
IDF Outflow	Cardiothoracic	74	85	-11	-12.9%
	ENT	42	43	-1	-2.3%
	General Surgery	51	55	-4	-7.3%
	Gynaecology	28	36	-8	-22.2%
	Maxillo-Facial	175	153	22	14.4%
	Neurosurgery	57	42	15	35.7%
	Ophthalmology	33	26	7	26.9%
	Orthopaedics	19	33	-14	-42.4%
	Paediatric Surgery	49	47	2	4.3%
	Skin Lesions	70	64	6	9.4%
	Urology	7	4	3	75.0%
	Vascular	14	62	-48	-77.4%
	Surgical - Arranged	160	370	-210	-56.8%
	Non Surgical - Elective	132	0	132	0.0%
	Non Surgical - Arranged	37	0	37	0.0%
IDF Outflow	**Total**	**948**	**1020**	**-72**	**-7.1%**
		7421	**7109**	**312**	**4.4%**

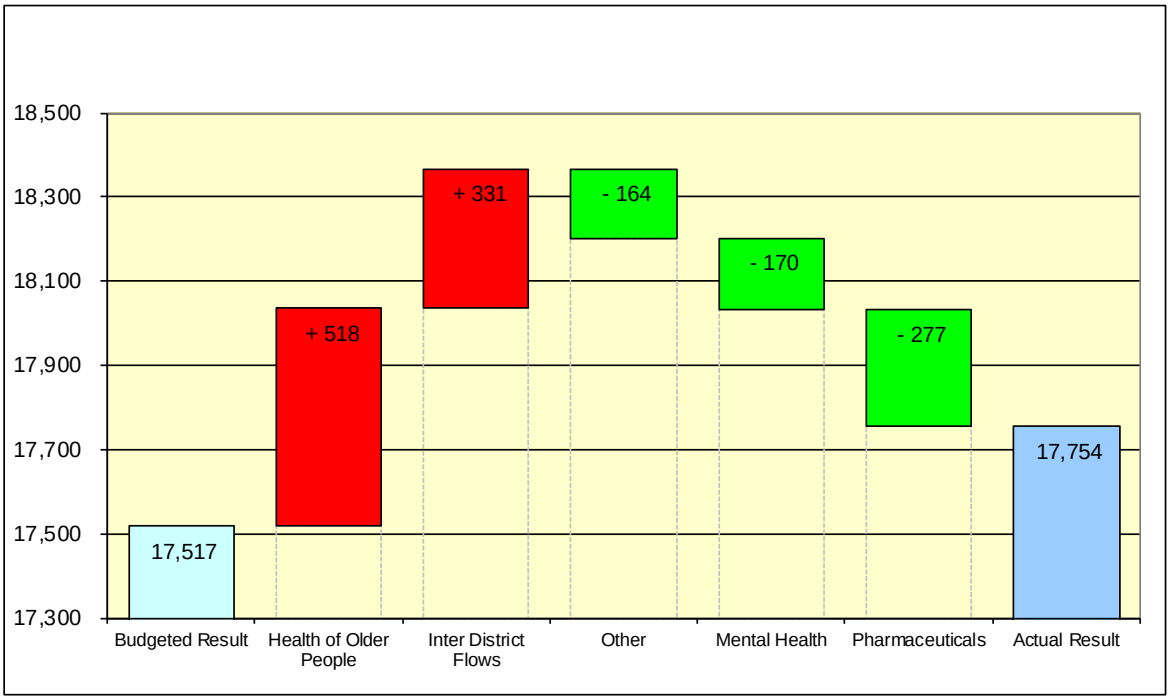
		June 2016			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	15	13	2	15.4%
	ENT	24	29	-5	-17.2%
	General Surgery	81	73	8	11.0%
	Gynaecology	46	38	8	21.1%
	Maxillo-Facial	7	8	-1	-12.5%
	Ophthalmology	115	47	68	144.7%
	Orthopaedics	81	64	17	26.6%
	Skin Lesions	11	12	-1	-8.3%
	Urology	44	31	13	41.9%
	Vascular	16	7	9	128.6%
	Surgical - Arranged	55	26	29	111.5%
	Non Surgical - Elective	5	13	-8	-61.5%
	Non Surgical - Arranged	3	5	-2	-40.0%
On-Site	**Total**	**503**	**366**	**137**	**37.4%**
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	2	29	-27	-93.1%
	General Surgery	35	14	21	150.0%
	Gynaecology	4	4	0	0.0%
	Maxillo-Facial	0	9	-9	-100.0%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	54	0	54	0.0%
	Orthopaedics	22	1	21	2,100.0%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	0	0	0	0.0%
	Urology	5	2	3	150.0%
	Vascular	3	0	3	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**	**125**	**59**	**66**	**111.9%**
IDF Outflow	Cardiothoracic	7	7	0	0.0%
	ENT	1	4	-3	-75.0%
	General Surgery	3	5	-2	-40.0%
	Gynaecology	4	3	1	33.3%
	Maxillo-Facial	2	12	-10	-83.3%
	Neurosurgery	2	3	-1	-33.3%
	Ophthalmology	2	2	0	0.0%
	Orthopaedics	1	3	-2	-66.7%
	Paediatric Surgery	4	4	0	0.0%
	Skin Lesions	0	5	-5	-100.0%
	Urology	0	1	-1	0.0%
	Vascular	0	5	-5	-100.0%
	Surgical - Arranged	17	29	-12	-41.4%
	Non Surgical - Elective	9	0	9	0.0%
	Non Surgical - Arranged	2	0	2	0.0%
IDF Outflow	**Total**	**54**	**83**	**-29**	**-34.9%**
		682	**508**	**174**	**34.3%**

Please Note: The data displayed is as at 11th July 2016. IDF Events not yet captured in NMDS will not be reported above

6. Funding Other Providers

$'000	June Actual	June Budget	June Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance	
Payments to Other Providers								
Pharmaceuticals	3,252	3,529	277	7.9%	41,657	42,244	587	1.4%
Primary Health Organisations	3,111	3,065	(45)	-1.5%	33,982	34,611	629	1.8%
Inter District Flows	4,230	3,899	(331)	-8.5%	47,222	46,784	(438)	-0.9%
Other Personal Health	334	477	142	29.9%	21,702	22,441	739	3.3%
Mental Health	950	1,120	170	15.2%	13,234	13,392	158	1.2%
Health of Older People	5,489	4,971	(518)	-10.4%	60,250	59,409	(841)	-1.4%
Other Funding Payments	389	456	67	14.7%	4,691	5,304	613	11.6%
	17,754	17,517	(237)	-1.4%	**222,737**	**224,184**	1,447	0.6%
Payments by Portfolio								
Strategic Services								
Secondary Care	2,351	2,660	309	11.6%	48,040	48,346	305	0.6%
Primary Care	7,987	7,915	(72)	-0.9%	91,837	93,186	1,349	1.4%
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%
Mental Health	1,187	1,116	(71)	-6.3%	13,468	13,346	(121)	-0.9%
Health of Older People	5,303	5,058	(245)	-5.0%	60,548	60,438	(110)	-0.2%
Other Health Funding	-	(17)	(17)	-100.0%	(49)	(200)	(151)	-75.5%
Maori Health	647	529	(118)	-22.3%	6,322	6,318	(4)	-0.1%
Population Health								
Women, Child and Youth	151	115	(36)	-31.4%	1,393	1,307	(86)	-6.6%
Population Health	128	141	13	9.2%	1,178	1,442	265	18.3%
	17,754	17,517	(237)	-1.4%	**222,737**	**224,184**	1,447	0.6%

June Expenditure



Note the scale does not begin at zero

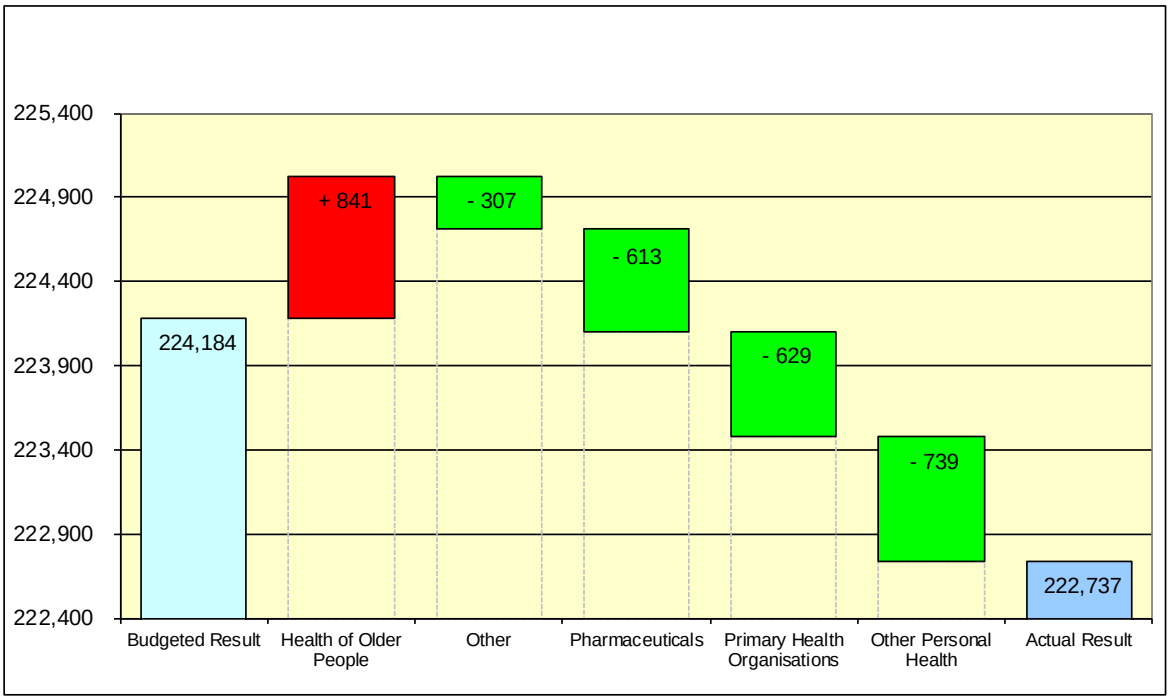
Health of Older People (unfavourable)
Home support and Aging in Place offset by additional MOH income.

Inter District Flows (unfavourable)
Includes provisioning for IDFs.

Mental Health (favourable)
Service contract completed, allowing reversal of expenditure accruals.

Pharmaceuticals (favourable)
Slower than planned response from pharmacies relating to medicine use reviews (MUR).

Year to date Expenditure



Note the scale does not begin at zero

Health of Older People (unfavourable)
Home support and Aging in Place.

Pharmaceuticals (favourable)
Slower than planned response from pharmacies relating to medicine use reviews (MUR).

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

Other Personal Health (favourable)
Timing of new investment expenditure.

7. Corporate Services

$'000	June Actual	June Budget	June Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance	
Operating Expenditure								
Personnel	715	1,305	590	45.2%	14,238	14,881	644	4.3%
Outsourced services	155	86	(69)	-79.5%	1,203	1,038	(165)	-15.9%
Clinical supplies	36	0	(35)	-7427.2%	167	6	(161)	-2812.9%
Infrastructure and non clinical	393	712	320	44.9%	7,987	8,389	402	4.8%
	1,298	2,104	806	38.3%	23,595	24,313	719	3.0%
Capital servicing								
Depreciation and amortisation	1,576	1,212	(365)	-30.1%	13,695	13,872	177	1.3%
Financing	228	160	(67)	-41.9%	2,018	1,957	(62)	-3.2%
Capital charge	2,047	1,983	(64)	-3.2%	6,783	4,055	(2,728)	-67.3%
	3,851	3,355	(496)	-14.8%	22,497	19,883	(2,614)	-13.1%
	5,150	**5,460**	310	5.7%	**46,092**	**44,197**	(1,895)	-4.3%
Full Time Equivalents								
Medical personnel	0.1	-	(0)	0.0%	0	-	(0)	0.0%
Nursing personnel	12.4	16.6	4	25.3%	12	16	5	28.9%
Allied health personnel	1.1	-	(1)	0.0%	0	-	(0)	0.0%
Support personnel	10.3	9.6	(1)	-7.2%	9	9	(0)	-0.7%
Management and administration	146.2	146.1	(0)	0.0%	136	142	6	4.0%
	170.1	**172.4**	2	1.3%	**158**	**168**	10	5.9%

Personnel reflects over accrual of $488 thousand of nurse training (charged to nursing departments instead of training budgets) and $138 thousand of recruitment costs, released in June.

Infrastructure and non-clinical includes $687 thousand of RHIP costs reclassified to capital expenditure as recommended by Central TAS, partly offset by additional business as usual costs.

Assets that originally cost less than $1 thousand were fully depreciated in June, reclassifying $447 thousand dollars from capital to operating.

Funding for the additional capital charge relating to the 2014/15 land and building revaluation was received in May (see section 3). The provision for capital charge expenditure has been adjusted to offset the receipt of the funding. The net effect of the funding and expenditure is nil.

8. Reserves

$'000	June Actual	June Budget	June Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance	
Expenditure								
Contingency	(1,159)	159	1,318	828.1%	-	1,910	1,910	100.0%
Transform and Sustain resource	110	42	(68)	-162.7%	564	476	(88)	-18.5%
Other	(258)	87	346	395.8%	592	1,255	663	52.8%
	(1,307)	**288**	1,595	553.2%	**1,156**	**3,641**	2,485	68.2%

The remaining contingency was released in June. Within the other category are: the new investment budget of $1.3 million remained unspent at year end to cover over-expenditure in service provision; less the $310 thousand for the seventh and eighth SMOs (FACEM) in the emergency department; less $150 thousand for actuarial adjustments to employee provisions; and less $107 thousand of feasibility costs and loss on sale written-off.

9. Financial Performance by MOH Classification

$'000	June Actual	June Annual Plan	June Variance	Year to Date Actual	Year to Date Annual Plan	Year to Date Variance
Funding						
Income	50,863	50,496	367 F	495,147	491,789	3,358 F
Less:						
Payments to Internal Providers	22,992	22,037	(955) U	266,791	263,091	(3,701) U
Payments to Other Providers	17,754	17,517	(237) U	222,737	224,184	1,447 F
Contribution	**10,117**	**10,942**	**(825) U**	**5,619**	**4,514**	**1,104 F**
Governance and Funding Admin.						
Funding	263	263	-	3,140	3,140	-
Other Income	3	3	-	40	30	10 F
Less:						
Expenditure	232	256	24 F	2,732	3,049	317 F
Contribution	**33**	**9**	**24 F**	**448**	**121**	**327 F**
Health Provision						
Funding	22,729	21,774	955 F	263,652	259,951	3,701 F
Other Income	2,067	1,688	379 F	21,479	21,479	1 F
Less:						
Expenditure	25,792	25,526	(266) U	286,832	282,076	(4,756) U
Contribution	**(996)**	**(2,064)**	**1,068 F**	**(1,701)**	**(646)**	**(1,055) U**
Net Result	**9,153**	**8,887**	**266** F	**4,366**	**3,990**	**376** F

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.

	June			*Year to Date*		
$'000	***Mgmt Budget***	***Annual Plan***	***Movement***	***Mgmt Budget***	***Annual Plan***	***Movement***
Funding						
Income	50,496	50,299	197 F	491,789	489,518	2,271 F
Less:						
Payments to Internal Providers	22,037	22,491	454 F	263,091	263,334	243 F
Payments to Other Providers	17,517	17,350	(167) U	224,184	222,194	(1,990) U
Contribution	**10,942**	**10,458**	**484 F**	**4,514**	**3,990**	**524 F**
Governance and Funding Admin.						
Funding	263	263	-	3,140	3,140	-
Other Income	3	3	-	30	30	-
Less:						
Expenditure	256	267	10 F	3,049	3,170	121 F
Contribution	**9**	**(2)**	**10 F**	**121**	**(0)**	**121 F**
Health Provision						
Funding	21,774	22,228	(454) U	259,951	260,194	(243) U
Other Income	1,688	1,672	16 F	21,479	20,865	613 F
Less:						
Expenditure	25,526	25,469	(57) U	282,076	281,060	(1,016) U
Contribution	**(2,064)**	**(1,570)**	**(494) U**	**(646)**	**0**	**(646) U**
Net Result	**8,887**	**8,887**	**-**	**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	Sum of monthly savings
CORPORATE	**1,360**	**14**	**1360**	**1360**	**113**
Green	1,360	14	1360	1360	113
Health Services	**7,000**	**70**	**7000**	**5503**	**595**
Amber	2,466	10	2466	1752	148
Green	4,035	53	4035	3751	447
Red	499	7	499	0	0
Maori Health	**82**	**1**	**82**	**82**	**0**
Green	82	1	82	82	0
POPULATION HEALTH	**70**	**2**	**70**	**70**	**0**
Green	70	2	70	70	0
STRATEGIC SERV	**1,688**	**2**	**1688**	**1688**	**1017**
Green	1,688	2	1688	1688	1017
Grand Total	**10,200**	**89**	**10200**	**8703**	**1726**

The $1.497 million savings shortfall year to date is all in Health Services where we have achieved 85% of our year to date savings plan target. The gap in the savings plan for Health Services has largely been covered by additional savings made in other programmes not on the original savings plan. These include delayed staff appointments and intense management of all discretionary spend e.g. travel.

Health Services

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

- Acute and Medical:
  - Radiology duplicate testing ($45 thousand)
  - Share of the additional $1million savings ($131 thousand)
- Chief Operating Officer:
  - Reduction in harm from falls ($50 thousand)
  - Reduction in pressure sores ($20 thousand)
  - Caeserian rates ($15 thousand)
- Facilities and Operational Support:
  - Nutrition and Food ($148 thousand)
  - Patient transport - NTA ($90 thousand)

The ten amber programmes are:

- Acute and Medical (4 projects):
  - Year to date savings of $981 thousand against a $1.387 million target, 71% attained.
- Chief Operating Officer (2 projects):
  - Year to date savings of $521 thousand against a $726 thousand target, 72% achieved.
- Additional $1 million savings (4 projects):
  - Year to date savings of $249 thousand against a target of $353 thousand 71% achieved

Corporate, Maori Health, Population Health and Strategic Services

All green

12. Financial Position

30 June 2015	$'000	June Actual	June Budget	June Variance from budget	June Movement from 30 June 2015	Annual Budget
	Equity					
120,014	Crown equity and reserves	102,608	108,183	5,574	(17,406)	108,183
(32,388)	Accumulated deficit	(10,973)	(16,420)	(5,447)	21,415	(16,420)
87,626		91,635	91,763	127	4,009	91,763
	Represented by:					
	Current Assets					
14,970	Bank	15,537	8,756	(6,781)	567	8,756
1,703	Bank deposits > 90 days	1,739	1,564	(175)	36	1,564
17,862	Prepayments and receivables	20,697	18,146	(2,551)	2,836	18,146
3,881	Inventory	4,293	3,845	(449)	412	3,845
1,220	Non current assets held for sale	1,220	-	(1,220)	-	-
39,635		43,487	32,310	(11,176)	3,851	32,310
	Non Current Assets					
148,434	Property, plant and equipment	151,944	166,016	14,072	3,510	166,016
2,298	Intangible assets	2,037	2,217	180	(261)	2,217
7,301	Investments	9,777	9,351	(427)	2,476	9,351
158,033		163,758	177,583	13,825	5,725	177,583
197,668	**Total Assets**	**207,245**	**209,894**	**2,649**	**9,577**	**209,894**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
29,960	Payables	35,641	35,540	(101)	5,680	35,540
35,239	Employee entitlements	35,127	32,660	(2,466)	(113)	32,660
65,199		70,767	68,200	(2,567)	5,568	68,200
	Non Current Liabilities					
2,342	Employee entitlements	2,342	2,431	89	-	2,431
42,500	Term borrowing	42,500	47,500	5,000	-	47,500
44,842		44,842	49,931	5,089	-	49,931
110,042	**Total Liabilities**	**115,609**	**118,131**	**2,522**	**5,568**	**118,131**
87,626	**Net Assets**	**91,635**	**91,763**	**127**	**4,009**	**91,763**

The variance from budget for:

- The movement between Crown equity and reserves and accumulated deficit 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. The movement from 30 June 2015 reflects the 2015/16 result;
- Bank reflects lower capital spend and the receipt of wash-ups and Pharmac rebates
- Prepayments and receivables reflect the accrual for wash-ups.
- Property, plant and equipment relates to the lower than estimated revaluation of land and buildings at 30 June 2015, and lower than budgeted capital spend for 2015/16;
- Employee entitlements – see below

13. Employee Entitlements

30 June		June				Annual
2015	$'000	Actual	Budget	Variance from budget	Movement from 30 June 2015	Budget
7,916	Salaries & wages accrued	7,052	5,482	(1,570)	(864)	5,482
1,370	ACC levy provisions	1,684	1,176	(508)	314	1,176
4,951	Continuing medical education	5,405	4,860	(545)	454	4,860
19,383	Accrued leave	19,114	19,649	535	(269)	19,649
3,962	Long service leave & retirement grat.	4,214	3,925	(289)	252	3,925
37,582	**Total Employee Entitlements**	37,469	35,091	(2,378)	(113)	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	13,695	13,872	177
3,990	Surplus/(Deficit)	4,366	3,990	(376)
(113)	Working Capital	1,450	(113)	(1,563)
17,749		19,512	17,749	(1,763)
	Other Sources			
-	Special funds and clinical trials	203	-	(203)
5,000	Borrowings	-	5,000	5,000
5,000		203	5,000	4,797
22,749	**Total funds sourced**	**19,715**	**22,749**	**3,034**
	Application of Funds:			
	Block Allocations			
3,856	Facilities	3,587	3,769	182
3,000	Information Services	937	2,890	1,953
5,200	Clinical Plant & Equipment	2,882	5,226	2,344
-	Minor Capital	26	27	1
12,056		7,432	11,911	4,480
	Local Strategic			
665	Renal Centralised Development	188	665	477
848	New Stand-alone Endoscopy Unit	432	848	416
5,654	New Mental Health Inpatient Unit Development	6,795	5,654	(1,141)
2,035	Maternity Services	2,075	2,107	31
100	Upgrade old MHIU	-	100	100
9,302		9,490	9,374	(117)
	Other			
-	Special funds and clinical trials	203	-	(203)
-	Transform and Sustain	3	-	(3)
-	Other	0	73	73
-		206	73	(133)
21,358	***Capital Spend***	***17,128***	***21,358***	***4,230***
	Regional Strategic			
1,391	RHIP (formerly CRISP)	2,587	1,391	(1,196)
1,391		2,587	1,391	(1,196)
22,749	**Total funds applied**	**19,715**	**22,749**	**3,034**

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
Jun 2016

HAWKE'S BAY District Health Board

New Mental Health Unit Development

Project Director: G Carey-Smith

Overall Project Progress	Overall Status	Time Status	Financial Status
94%	G	G	G

Phase 3: Service & Facility Establishment

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 some services within the community and a Day programme (co-located with the inpatient unit).

The project programme includes 3 Phases. Phase 1 'Service & Facility Planning, Design & Tendering' and Phase 2 'Service and Facility Implementation' have been completed on time and within budget. Phase 3 is now underway to complete the establishment of service elements that align with the Mental Health Service Model of Acute Care so the service can operate in an integrated manner, aligned to the cultural pathway; to ensure consumers and staff have successfully transitioned to the new services with new ways of operating.

Project Budget Status

Total Approved Project Budget	**$ 18,300,000**	Total 15/16 Total Forecast Spend	**$ 7,272,000**
Total Project Spend to Date	$ 17,114,984	Total 15/16 Spend to Date	$ 6,795,000
Percentage of Total Spend vs Budget	94%	Percentage 15/16 Spend vs Forecast	93%

The tender process was completed and project approval at a total cost of $19.8M received on the 25 June 2014 Board Meeting. Continued value engineering and management during the porject has resulted in an overall saving of $1.5M resulting in the total project budget being reduced to $18.3M. 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

Nga Rau Rakau Intensive Services Stabilisation	Oct-16	Documented End to End Integrated Pathway	Oct-16
Intensive Day Programme Stabilisation, Handover	Oct-16	IT System Changes	Oct-16
SPoE (Single Point of Entry Acute Coordination Function	Oct-16	Vision-Behaviour Statement & Oranga Ake Cultural Pathway	Oct-16
One Plan Assessment	Oct-16	Completion Evaluation	Nov-16
Electronic Discharge & GP Referal	Oct-16	As-Built Documentation & Defects Sign Off	Dec-16
Key Worker Function	Oct-16	Phase 3 Project Completion Documentation	Dec-16
Revised Procedures & Overarching Policies	Oct-16	Post Implementation Review & Post Occupancy Evaluations	Feb-17

Key Achievements this period

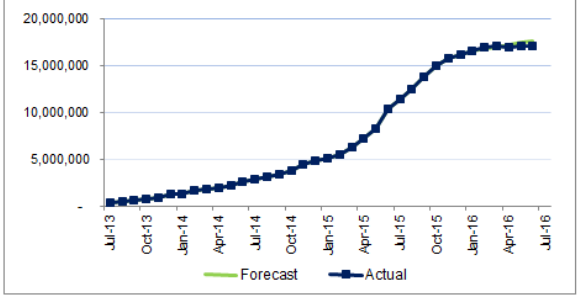
Ongoing development and implementation work for IDP and SPoE. Development work for 1 Assessment: 1 Plan has been commenced by vendor. Internally, continue to work with IS re developments needed to support the new model of care and implement SPoE and ensure IS systems necessary to support operations.
Focus continues on integration across services, embedding Vision & Behaviour statement and strengthening community mental health.
Review of Transition to Nga Rau Rakau continues.

Planned Activities next period

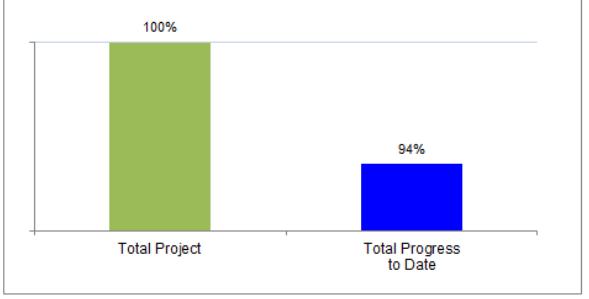
Ongoing embedding, integration & review of changes implemented; includes reporting, procedures, Vision & Behaviour statement, patient journey.
SPoE - progressing towards implementation.
IDP - Recruitment of lead priority. Operating Model to be reviewed and approved.
Implementation of 1 Assessment: 1 Plan planned for mid August.
Strengthen Community Mental Health; Case Load management, Key worker role, Review of meeting framework continues.
As-Built Documents are drafted and are under final reviewing.
Any building defects are being managed as required over the next 12 months.

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 changes to support service delivery	Service Re-design & Transition Management completed in timely manner
Engagement with wider consumers	Partnership Advisory Group ongoing.
Ability to secure & retain adequate human resources in timely manner	Dependent on availability within current market as well as freeing up & supporting capacity and capability internally.
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

Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	June Forecast	Variance	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget	Feb Budget	Mar Budget	Apr Budget	May Budget	Jun Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	44,678	42,638	2,040	43,353	41,833	54,282	43,211	41,833	41,884	43,291	45,354	41,866	43,112	41,833	52,994
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	(52)	-	(52)	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	(3,594)	443	(4,036)	396	415	407	472	412	419	408	428	435	427	435	431
Cash paid to suppliers	(25,890)	(24,118)	(1,773)	(26,988)	(24,888)	(28,041)	(24,891)	(25,061)	(25,541)	(24,672)	(21,670)	(25,530)	(25,160)	(24,131)	(29,369)
Cash paid to employees	(16,943)	(16,139)	(804)	(14,132)	(19,777)	(15,269)	(15,218)	(17,875)	(14,503)	(16,748)	(14,517)	(19,592)	(15,372)	(17,994)	(15,685)
Cash generated from operations	**(1,800)**	**2,825**	**(4,625)**	**2,628**	**(2,417)**	**11,379**	**3,574**	**(691)**	**2,259**	**2,279**	**9,595**	**(2,822)**	**3,007**	**144**	**8,371**
Interest received	150	82	68	81	80	67	66	80	72	75	68	75	73	75	73
Interest paid	84	(190)	274	(330)	(330)	(95)	(41)	(69)	(160)	(359)	(325)	(139)	(60)	(14)	(150)
Capital charge paid	(2,047)	(3,910)	1,863	-	-	-	-	-	(3,665)	-	-	-	-	-	(3,996)
Net cash inflow/(outflow) from operating activities	**(3,614)**	**(1,193)**	**(2,421)**	**2,378**	**(2,667)**	**11,350**	**3,600**	**(680)**	**(1,494)**	**1,994**	**9,338**	**(2,885)**	**3,020**	**204**	**4,298**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	616	0	616	0	0	0	0	0	1,220	0	0	0	0	0	0
Acquisition of property, plant and equipment	(1,453)	(2,608)	1,155	(3,003)	(3,003)	(3,003)	(3,003)	(2,028)	(3,028)	(2,028)	(2,028)	(2,028)	(2,028)	(2,028)	(2,032)
Acquisition of intangible assets	(17)	-	(17)	-	-	-	-	-	-	-	-	-	-	-	-
Acquisition of investments	(541)	(348)	(193)	-	-	(285)	-	-	(285)	-	-	(285)	-	-	(284)
Net cash inflow/(outflow) from investing activities	**(1,396)**	**(2,956)**	**1,561**	**(3,003)**	**(3,003)**	**(3,288)**	**(3,003)**	**(2,028)**	**(2,093)**	**(2,028)**	**(2,028)**	**(2,313)**	**(2,028)**	**(2,028)**	**(2,316)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	5,000	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	(357)	(357)	-	-	-	-	-	-	-	-	-	-	-	-	(357)
Net cash inflow/(outflow) from financing activities	**(357)**	**(357)**	**-**	**-**	**-**	**-**	**-**	**5,000**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**
Net increase/(decrease) in cash or cash equivalents	(5,367)	(4,507)	(860)	(625)	(5,670)	8,062	596	2,292	(3,587)	(34)	7,310	(5,198)	992	(1,824)	1,624
Add:Opening cash	23,090	23,090	-	14,972	14,347	8,677	16,739	17,336	19,627	16,040	16,006	23,316	18,118	19,110	17,286
Cash and cash equivalents at end of year	**17,723**	**18,583**	**(860)**	**14,347**	**8,677**	**16,739**	**17,336**	**19,627**	**16,040**	**16,006**	**23,316**	**18,118**	**19,110**	**17,286**	**18,910**
Cash and cash equivalents															
Cash	4	7	(3)	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	14,223	15,478	(1,255)	11,245	5,575	13,637	14,233	16,525	12,938	12,904	20,214	15,016	16,007	14,184	15,808
Short term investments (special funds/clinical trials)	3,013	3,098	(85)	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	35	(0)	35	-	-	-	-	-	-	-	-	-	-	-	-
	17,276	**18,583**	**(1,307)**	**14,347**	**8,677**	**16,739**	**17,335**	**19,627**	**16,040**	**16,006**	**23,316**	**18,118**	**19,109**	**17,286**	**18,910**

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

10

CONSUMER STORY

Verbal Presentation

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 76
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs
Reviewed by:	Not applicable
Month:	July, 2016
Consideration:	For Information

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Supported** the purpose and principles paper and business case for the establishment of Health & Social Care networks. Clinical Council supports the recommendation made by EMT to move forward with Wairoa and Central Hawke's Bay
- **Supported** the implementation plan for Clinical Governance Committees Structure
- **Supported** the development of a position statement on reducing alcohol related harm.
- **Supported** ongoing work of the last days of life care planning
- **Supported** the principles of the Transform & Sustain refresh and the next steps

Council met on 13 July 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- ***Health & Social Care Networks***

  Clinical Council received a paper with regards to the Health & Social Care Networks development which they had previously given feedback on. Clinical Council noted that the Steering Group is now the Executive Management Team (EMT), with an operational working group which includes direct reports to EMT, members of EMT and consumers. The documents in the papers are about the overall programme and how the DHB can manage the network process and are not about how each network is going to be managed. This will be up to the networks as they develop. EMT have endorsed these papers with a strong recommendation that they want us to get on with Wairoa and Central Hawke's Bay. Clinical Council endorsed these principles.

  Following feedback the purpose and principles document was simplified as a two page document with vision, key messages, design principles and what the service will look like for consumers. In the geographic localities proposal we are now looking at four localities Wairoa, Central Hawke's Bay, Napier and Hastings.

Feedback:

- Under issues *(last bullet point on page 3)* regarding not wanting inequities between the networks, would like to see this raised more strongly. We want the same outcomes for populations experiencing inequities outside of the communities of interest.
- The rural nature of Wairoa and Central Hawke's Bay and Wairoa and the urban nature of Napier and Hastings - what about the hinterland which is quite rural but based on the Hawke's Bay District Council have we considered where they might fit? The localities are about where the population of providers is based
- One of the challenges that comes through on reading the purpose and principles is that it is really important to be careful which consumers are engaged and involved and how that will drive the network.
- Development of Health & Social Care networks needs to occur at the same time as the "Clinical Services Plan".

- ***Implementation of Clinical Governance Committees Structure***

  A high level implementation plan and principles with regards to the implementation of a new Clinical Governance Committee structure was discussed with the Clinical Council. The intention of the new structure is to ensure that assurance is provided to Clinical Council in matters relating to quality and patient safety from across the sector. The intention is to ensure there is representation across all of the committees from across the sector, including consumers and a variety of clinical leaders. It is envisaged that the implementation of this structure will take a period of time to fully embed.

- ***Reducing Alcohol Related Harm***

  Rachel Eyre, Medical Officer of Health asked the Clinical Council for endorsement on the proposed approach of developing a HBDHB position statement on eliminating alcohol related harm and advice on the process for engaging across the DHB and sector.

  Feedback:

  - The idea of a position statement is powerful as it's an engagement process, we see the leadership of our people in the video. Dr Paul Quigley from Wellington presented at the Grand Round last month and talked about the good work done in Wellington how they worked with the Council around licensing, hours and data collection. Forming those relationships and how we implement the strategies is important. The best way to control alcohol is about simple strategies and access.
  - Family violence national statistics show only 33% of Police call outs are alcohol or drug related, 60% are sober, we need to be careful about perpetuating a stereotype.
  - We would be remiss as health professionals not to have a position statement but also we need grass roots community led initiatives and need the relationships and knowledge to support communities to do what they want to do in their own community.
  - Need to have consistent messaging like with Smokefree and safe sleeping

- ***Last Days of Life***

  Clinical Council were provided with a summary update and were asked to endorse the work going forward.

  The HBDHB working group has formulated a plan and tool kit based on the national guidance "Te Ara Whakapiri - Principles and Guidance or the Last Days of Life". The working group has accepted and supported a trial in aged residential care facilities. GPs are also supporting the facilities as part of the trial. After the trial, which will be for three months information will be collated and evaluated and recommendations will be made for adopting the Last Days of Life care plan across all aged residential care facilities and in medical/surgical wards

- ***Transform and Sustain Refresh***

  The programme has been reviewed and the strategy itself and the 24 statements assessed and scored on whether they had progressed or not. Meetings were held with EMT, Health Services Leadership Team, Project and Change Managers and the Health Sector Leadership Forum and this enriched our understanding.

  Six priorities where identified that we need to do better:

  1. Person and Whanau Centred Care
  2. Heath and Social Care Networks
  3. Whole of Public Sector Delivery
  4. Information System Connectivity
  5. Financial Flows and Models
  6. Investing in Staff and Changing Culture

This was a real opportunity to do a stock take, complete benefits mapping for the programme and the scoping of new projects. The stocktake, benefits and scoping will continue until September with initiation of new projects from October.

Others reports provided for information and discussion included:

- ***Primary Care Smoking Target***

  The results are disappointing for the overall figure for Hawke's Bay being 82%. There are some individual practices which are now over 90% which is fantastic. The Ministry of Health will now allow any interactions with a consumer in terms of providing advice to quit to be captured in general practice and attributed against the target. Previously the work had be done in general practice or by a PHO Team. The work previously being done by the Smokefree Team unless it was under the direction of the PHO, Quit Line and the work in the hospital was not being captured in this target, even though they were working with the same consumers. There have been 14 practices which have met the target, 3 practices with no change and 5 down in coverage rates.

- ***Renal Stage 4 Facility Build***

  Presentation received on the progress of the project to date.

  The project has a budget of $2,140,000 and is currently running ahead of schedule. Administration staff from Ballantyne House will be located in the old Mental Health Unit while the build is underway, they will move around November 2016. Currently out for tender and will complete this by end of August with project sign off by the end of October, to enable a start construction in November. At this stage we have allowed for an 11 month build, expecting to be in the new facility in early 2018

- ***Budget Update***

  A short budget update following the Government budget announcements in May and how this affects the DHB.

OURHEALTH HAWKE'S BAY Whakawateatia	**HB Health Consumer Council** 77
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton, Chair
Reviewed by:	Not applicable
Month:	July 2016
Consideration:	For Information

12

RECOMMENDATION

That the Board
Review the contents of this report; and

Note that Consumer Council:

- **Supported** the purpose and principles paper and business case for the establishment of Health & Social Care networks.
- **Supported** the development of a position statement on reducing alcohol related harm.
- **Supported** the principles of the Transform & Sustain Refresh but with some strong recommendations around integration of the 6 priorities.

Council met on 14 July 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

TRANSFORM AND SUSTAIN REFRESH

Members were presented with the 6 priorities being:

1. Person and Whānau Centred Care
2. Heath and Social Care Networks
3. Whole of Public Sector Delivery
4. Information System Connectivity
5. Financial Flows and Models
6. Investing in Staff and Changing Culture

In addition those priorities had with them a range of suggested or proposed "projects" intended to advance the priorities. There was quite robust input from members at the time of this item and a debrief at the end of the meeting.

Whilst supporting the 6 priorites 3 challenges were relayed as follows:

1. The need to see that these priorites are addressed as part of an integrated whole. In members experience we were not necessairily very good at bringing these pieces together and having a holistic view and approach; they are fundamentally interconnected.
2. That others within the health sector were already addressing these issues and some are further ahead. We need to learn from them and lessen the need to reinvent the wheel.

3. To expect others to join us in whole of public sector delivery we must first be as good as we can be in practicing integrated care ourselves. Members believe we are still strongly siloed (with of course some wonderful exceptions).

REDUCING ALCOHOL RELATED HARM

The alcohol harm video was played with the understanding that this was developed for decision makers rather than a broader public. We then workshopped two questions

1. Do we agree that the DHB should have a position statement on alcohol?
2. What do we think is critical in developing of future actions?

Feedback follows:

- It is a very difficult question because it is an industry that has widespread acceptance, it is widely available in the community and in homes and employs tens of thousands of people. Organisations do need to make a stand. Like we have had businesses that have gone Smokefree. The DHB needs to start with themselves being alcohol free eg. no alcohol at the Health Awards.
- If you want any agreement or buy-in you have to work with the people. Expecting an 18 year old not to drink is not going to happen. It is silly to position yourself in a place that is never going to happen. Work with the 18-25 year olds about the consequences and brain development etc. It is important to have a position that is understanding of the social norms. It will take a generation to make the change.
- Good video. Would have liked to have seen more included around family, children only shown at a distance. It was more about the impact and information, the hospital and professional workers. It would have had more punch and resonated if it included impact on the family. Smoking as an example took decades if we think where we have come from, you could smoke everywhere, it was a social norm. The same pathway can happen with alcohol.
- There is not a lot of information about fetal alcohol syndrome and the link of cancer to alcohol.
- Get the ones you are targetting to help develop the plan, ask them what worked for them.
- We need to ask why are people doing these things? Alcohol can't be looked at on its own you need to look at the reasons why e.g. depression, no job, family issues etc all those other things that cause people to drink.
- We need to show more visibly people having fun without the need of alcohol.
- It is a society problem. We can lead by example and get people starting to dialogue.
- Good first step. There is opportunity to look at community led interventions. What primary health can do as well, what are harmful effects of drink and what can be done to reduce the harm. Fetal alcohol disorder is an area that is under resourced. This DHB has run FASD information days for the last couple of years in the education centre and they are also packed, people from community agencies including Ministry of Social Development staff from Gisborne so they can pass the messages on. There is a ground swell for change and raising awareness of intervention. It's about everyone having the conversations.

Overall

We need to accept that it is a societal problem. What we can do is lead by example and as a health board is make statements about the impact of harmful drinking and what it does and try to get people thinking. We won't be able to change behaviours overnight but if we do nothing we are condoning it.

The consumer council endorsed the proposed for HBDHB to develop a position statement on reducing alcohol related harm.

HEALTH & SOCIAL CARE NETWORKS

Council considered the principles paper and business case. Feedback follows.

- Where we came from this is huge progress and the Wairoa model has been very encouraging.
- Central Hawke's Bay are happy with the progress and ground swell down there.
- It is important to hand it over to the community to drive, let them decide what their needs are and how it is best delivered.
- We had a conversation earlier around transform and sustain. The message we gave very clearly was the need to look at the whole and not the parts and that they are all fundamentally interrelated. Whole of public sector delivery should be sitting inside a health and social care network and if it is person and whanau centred it has a better chance of working. Getting the communities to own what their outcomes needs to be.
- There was a model that was in place which was broken down and Māori are now re-building the model of Whānau Ora. It is a perfect mode/framework which can be used to bring all of those other sectors together.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 78
	For the attention of: **HBDHB Board**
Document Owner:	Ngahiwi Tomoana (Chair)
Reviewed by:	Not applicable
Month:	July, 2016
Consideration:	For Information

13

RECOMMENDATION

That the Board

Note the contents of this report.

PURPOSE

The purpose of this report is to provide an overview of the discussions undertaken at the MRB meeting held on the 13 July 2016.

Fluoridation

MRB asked that the Te Ara Whakawaiora: Oral Health Champion proceed with the Fluoridation presentation instead of delaying it until 2017 when legislative requirements for DHBs is established. MRBs preference to be educated and better informed earlier rather than later is so that members are able agree their stand on the matter.

Māori Workforce Target

The core issues impeding our ability to achieve the Māori workforce target need to be identified. DHB needs to look at the system structure to identify whether it is a discriminator. MRB stated that unless we have a heart to want to make a difference with this target it won't happen. The Chair stated that this is a Chief Executive Officer (CEO) Key Performance Indicator (KPI) and therefore we expect this issue to be performance managed from that level. Unless Hiring Managers agree and adopt the policy and target the strategy is flawed from the outset. Perhaps DHB could better sell the story on why we are increasing Māori staff numbers. This might help Hiring Managers buy in.

Increasing Māori Staff Representation Presentation

John McKeefry (General Manager Human Resources) provided a presentation on 'Increasing the Māori staff' target.

MRB and Māori Providers who were in attendance for the workshop offered the following advice:

- Would like to see the midwifery workforce as part of the strategy as Māori midwifery representation is less than 2% in DHBs. The GM HR will look into this with the Chief Nursing Officer.
- MRB raised again the importance of formal coaching, pastoral care and Tuakana/Teina support for Māori nursing students.

- Recruitment panels needs strengthening to ensure they understand the need to employ more Māori and why
- Structural issues will impinge on Māori recruitment. The barriers of the recruitment process need to be better identified through forensic audits.

Reducing Alcohol Related Harm – Position Statement and Questions

MRB noted the contents of the report and provided the following feedback about the Position Statement:

- Develop a more punchier and upbeat Position Statement
- The Position Statement is too generic and needs an equity lens applied
- Stronger wording is needed in terms of replacing 'reducing' with eliminating inequity. Elimination of inequity is to be our starting point
- The Statement needs to connect with community and whānau values so that community take responsibility. Youth leadership needs to be included into the statement development
- At a service level, there should be an expectation for anyone engaging with whānau that are challenged with alcohol related harm that they are competent to do so and are effective and engaging with them.

MRB agreed there was definitely an appetite to tackle the issues of alcohol related harm in our community. Ideas to get buy-in and commitment to actions from across our DHB, how to engage intersectorally and work with communities were provided:

- A community led strategy supported by Iwi should be considered
- Rather than re-inventing the wheel, build on existing groups who are already addressing the issues of alcohol in the community, such as Patu, Iron Māori, Hikoi for Life, U-Turn Trust, Māori Women's Welfare League and other NGOs, and back these groups to give them additional support and training
- Build whānau leadership and role modelling. If there is a breakdown at that whānau level, it doesn't matter what we develop it will not make a difference unless we focus on building whānau leadership and role modelling in a positive way
- Use a strengths based approach with whānau.
- This strategy needs to align with other behavioural services like mental health, sexual abuse, drugs and alcohol, counselling, smoking, over eating, etc., so that whānau are better serviced. Whānau don't delve into substance abuse because they like it, they do it to feel normal. They've been down trodden and encountered trauma. Clinicians need to be more skilled at working with trauma to get to the core of the problem as to why communities are keeping themselves numb.
- Ensure services are culturally appropriate and staff are culturally competent.
- The information is too quiet, the messages need to be much stronger especially for pregnant mums, there's not enough education going on.

Last Days of Life Care Plan and Tool Kit

MRB reviewed the Care Plan and Tool Kit and endorsed the ongoing work. The following feedback was provided:

- Enduring Power of Attorney (EPOA) and Advanced Care Plan (ACP) as lead in to the Last Days of Life Care Plan so the journey becomes smoother
- Preparatory conversations with whānau need to be skilled and effective
- MRB asked how the Last Days of Life Care Plan and Tool Kit fits and ties together with the DHBs position on the End of Life, Medically Assisted Dying and ACPs

- Great to see the Spiritual Care Assessment Tool (FICA) and having it as a central part of the strategy, its important
- Recommend having a workshop with our Marae, leaders and spiritual leaders about this process so it becomes more well-known and available to Māori communities.

Leigh White (Portfolio Manager Long Term Conditions, Planning, Funding and Performance HBDHB) was commended for her attempt to apply the Health Equity Assessment Tool (HEAT) however MRB advised the assessment did not clearly identify the health equity issues or how the proposed activity would address or improve the issues. Some examples of how they could be were provided.

Wairoa Health Needs Assessment Draft Report

MRB and the Providers received the draft report for planning and consultation purposes. The Wairoa Providers were supportive of the draft. While the report highlighted there has been no improvement in the health of Wairoa for some time, the Providers were positive because these issues are finally highlighted for future planning and development purposes. Fragmentation has always been the issue in Wairoa and the Providers agree for the project to be effective, the services and community will need to collaborate. The entire objective of this assessment is to work more collaboratively for the betterment of the Wairoa people. A final report will be distributed once feedback is attained from relevant parties.

HBDHB Whānau Centric Model

George Mackey provided an overview of the Whānau Centric model that he and Des Ratima drafted following MRBs April workshop. Critical factors of the model include leadership and role modelling positive behaviour from the top to the bottom e.g. having the CEO walking the halls and talking to staff and staff knowing management cares. A process to imbue whānau values in the organisation. Causing a change in the attitudes particularly where the decisions are made because this is where unconscious bias may occur. We need to find innovative solutions and avoid reverting back to the same mechanisms that are ineffective for Māori. We need to identify the root causes instead of applying 'band aid' solutions.

Whānau Centric is about having whānau at the centre of everything. The challenges at an organisational level would be how to involve whānau, hapu and the community to contribute to the development of strategies and solutions, involve Providers who will action these solutions, and involve whānau in policy design and funding decisions.

It was suggested that the DHB look at the model in conjunction with the Wairoa Health Needs Assessment and pilot the model in the Wairoa community.

Workshop with Māori Provider

Transform and Sustain Refresh Presentation

Tim Evans (General Manager Planning, Informatics and Finance HBDHB) provided a brief presentation on the update of the Transform and Sustain Refresh. Tim was accompanied by Kate Rawston (Project Manager Officer, Human Resources HBDHB).

The six priorities are really broad and may lose sight of accelerating Māori health outcomes. The Transform and Sustain programme needs to keep inequity at the forefront of all project development. It needs to be a principle in everything we do and we should be able to measure effectiveness against the inequity elimination strategy. The programme needs to connect with communities and whānau. As an example of information technology solutions leading to 'text to remind' for patient appointments in Wairoa outside of the cell phone range, that won't work.

Health and Social Care Networks – Purpose and Principles

MRB **reviewed** the Purpose set out for the development of the networks and the Principles against which the networks will be developed. The following feedback was provided:

- Inequity should be a main driver of the programme and the actions have to reflect the purpose. We need to ensure eliminating inequity is evident in the actions and should be endorsed by the Board
- A Tikanga Based Approach (TBA) should be considered in the approach. A TBA could be a core principle of the Health and Social Care Networks development. An Action Plan has not been outlined yet to demonstrate how TBA will be implemented. MRB should be involved with the development of the Action Plan.
- The framework is very clinically focused as opposed to a holistic approach. Patient experience needs to help drive this development. Cultural competence in service delivery is paramount.
- The steering group to apply the HEAT and send the report to MRB to provide feedback
- It will be interesting to see the connection between Transform and Sustain, the Wairoa Health Needs Assessment and the Health and Social Care Networks, and whether whanau, patients and people are at the heart of this development. Currently this is not evident.

MRB **endorsed** the Purpose and Principles on the basis that the following recommendations be actioned:

1. Apply the HEAT to the Purpose and Principles noting MRBs reservations about the unintended consequences that will need to be identified as part of the development and flag any risks that may be identified during the process.
2. Reapply the HEAT in a years' time once the forming stage is complete to ensure what we said we wanted to achieve, we measure.
3. Define the Purpose once an explanation of the Practices are established and are clear
4. Ensure eliminating inequity is evident in the actions that are yet to be developed. The action plan needs to be endorsed by MRB.

MRB Representative on the HB Clinical Council Appointed

MRB received two Expressions of Interest for the Clinical Council. A motion was moved to appoint Kerri Nuku as the principal representative with Ana Apatu as the back-up. Kerri attended her first meeting that afternoon.

HAWKE'S BAY District Health Board Whakawāteatia	**Transform & Sustain Refresh 2016** 79
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans, GM Planning, Informatics and Finance Tim Evans, Kate Rawstron and Peggy Kersley
Reviewed by:	Sharon Mason, Tracee Te Huia, Kate Rawstron and EMT
Month:	July, 2016
Consideration:	For Information

14

RECOMMENDATION

That the Board

Note the contents of this report.

OVERVIEW

A refresh of the Transform & Sustain Programme.

BACKGROUND

The Transform & Sustain Programme was published in December 2013 and is now half-way through its five year horizon. The Strategy is therefore due a refresh, but not a rewrite. This refresh needs to ensure that Transform & Sustain is a living framework generating fresh and appropriate change in our health system right up to its planned end in June 2018.

In 2017 we will need to start work on an inclusive process to co-create a new strategic framework to commence from June 2018 (start of the planning year) or December 2018 (5 years after publication of Transform & Sustain).

EMT are asked to note the content of the report, and the future work proposed to fully develop new projects proposed and review projects in flight.

OURHEALTH
HAWKE'S BAY
Whakawāteatia

Transform & Sustain Refresh

8 July 2016

Content

1. Background and Context

The Transform & Sustain Programme was published in December 2013 and is now half-way through its five year horizon. The Strategy is therefore due a refresh, but not a rewrite. This refresh needs to ensure that Transform & Sustain is a living framework generating fresh and appropriate change in our health system right up to its planned end in June 2018.

In 2017 we will need to start work on an inclusive process to co-create a new strategic framework to commence from June 2018 (start of the planning year) or December 2018 (5 years after publication of Transform & Sustain).

2. Looking forward

2.1 Identifying our priorities

As a health community we have identified and validated six priority areas in the refresh. These are areas where we need to focus our effort over the next two years because we have not yet achieved the outcomes we intended back in December 2013. . These priority areas are:

- Person and Whanau centred Care (people as partners in their healthcare).
- Health & Social Care networks (creating strong primary and community care clusters).
- Whole of Public sector delivery (delivering effectively with public sector partners).
- Information System Connectivity (IS supporting multi-professional, patient centred service).
- Financial flows and models (incentivising and funding the right behaviours).
- Investing in Staff and Changing culture (equipping staff for a changing world).

The process for identifying these six priority areas was designed not only to be rooted in the original Transform & Sustain Strategy, but also to engage and seek endorsement from a wide range of stakeholders.

To initiate the refresh the Project Management Office identified 24 statements about expected outcome in the Transform & Sustain document. These were scored by each Executive Management Team (EMT) member for achievement. Scores were aggregated and a clear pattern emerged. In about a third of the outcomes we were doing well, in a third making some progress, and a third not yet making the change we had intended.

In a subsequent workshop our Health Services Leadership team identified their eight “least progress “outcomes. These were mapped onto the EMT scoring and a strong degree of consensus was clear. In discussing the issues and possible solutions five summary headings emerged (the first five priority areas). EMT decided to add to these the need for continued Organisational Development to the list because we need to develop ourselves to face the challenges of change. So Investing in Staff and Changing Culture became our sixth priority.

A workshop with front line project leaders and change managers was used to validate the priority areas by confirming that all of the issues and problems they identified fitted to our six priority areas.

A “World Café” exercise at Waipatu Marae engaged the wider health sector Leadership Forum in confirming priorities and enriching the description of solutions and future project plans.

2.2 Filling our order book

One of the key reasons for a refresh was to fill the "order book" of forward projects to the end of the planning period. Our visual summary report highlights that we currently have a healthy number of active change projects in the Transform & Sustain programme, but from mid-2016-17 change activity will diminish.

We don't want to be starting projects simply to give the appearance of movement. However we do have an agenda to transform our health community, and intrinsic capacity to change. Currently that capacity is fully occupied, in the foreseeable future it will not be. Our future effort to change has to be purposeful and focussed, otherwise we risk wasting scarce resources.

So, filling the order book is not a random project generation exercise. We have identified our priority areas, those where we have made least progress so far, and have shaken from our collective intelligence the outlines of project work we need to make change happen in those areas. We have identified Executive leads, and we now need to refine and create clear Terms of Reference including success criteria and method in each of these projects. The list below shows 21 proposed new projects and 9 projects previously "pencilled in" but to be developed.

In addition 5 projects "pencilled in" to the Transform & Sustain overview report have been removed.

Further work will now be undertaken as EMT members attributed to lead in each of the priority areas will be supported by the Project management Office (Kate Rawstron). This will be a systematic approach occur the next few months. It will be used as an opportunity for the new Project Management Office to review existing projects, place more discipline and focus on clearly identifying the problems we are trying to fix, the rationale for projects, and the measurement of projected benefits. Kate's draft programme of stocktaking, benefits mapping, and scoping of new projects is set out at Appendix 1. It's discipline will likely result in amendment both to the proposed list of new projects and to projects now in train.

Table 1: Proposed new projects

Person & Whanau centred care	Source	SRO	PS	PM	Intention	April 2016 "At a glance" status	Start/ Finish
Implement Health Literacy Framework include "clearly set out responsibility of consumers for their own health"	EMT 01.03.16				3. Health Literacy	Project planned but not started.	
Advanced Care Planning in Primary Care.	EMT 01.03.16				2. Consumer Engagement	New not yet in report.	
Leadership development in Maori Community	EMT 01.03.16, L'ship Forum 17.05.16				1. Maori Engagement	New not yet in report.	
Standard Quality controlled out patient leaflets	EMT 01.03.16				3. Health Literacy	New not yet in report.	
Patient Experience Survey. Local development.	EMT 01.03.16				2. Consumer Engagement	Need to clarify that this is the existing "patient experience" project "Not yet Started"	
Develop/Implement consumer engagement strategy	On "at a Glance" report.				2. Consumer Engagement	Project planned but not started.	

Health & Social Care Networks	Source	SRO	PS	PM	Intention	April 2016 "At a glance" status	Start/ Finish
Health & Social Care Network stage 2 (Roll out and universal model/ Community Capacity assessment)	L'ship Forum 17.05.16/TE				8. Primary Health Care	New not yet in report.	
Invest in School Health Teams	EMT 01.03.16				4. Multi Agency	New not yet in report.	
Urgent Care Alliance Year 2	EMT 01.03.16				9. Urgent Care	Project planned but not started.	
Single point of entry/ Call Centre for Health & Social Services	L'ship Forum 17.05.16				4. Multi Agency	New not yet in report.	

Whole of Public Sector delivery	Source	SRO	PS	PM	Intention	April 2016 "At a glance" status	Start/ Finish
Most Vulnerable Families/Whanau. Coordinated funding, shared data, collective action.	EMT 01.03.16, L'ship Forum 17.05.16				4. Multi Agency	Project planned but not started.	
Talent development for low decile children.	EMT 01.03.16				4. Multi Agency	New not yet in report.	
Integrated Palliative care model designed and implemented	EMT 01.03.16				6. Patient experience	New not yet in report.	
Obesity taskforce to address Obesogenic environments.	EMT 01.03.16				3. Health Literacy	New not yet in report.	

Information System Connectivity	Source	SRO	PS	PM	Intention	April 2016 "At a glance" status	Start/ Finish
ManageMyHealth clinical portal	EMT 01.03.16				8. Primary Health Care	Project planned but not started.	
Shared Care record (To define, but linking ManageMyHealth, Map of Medicine, and Orion, and adding OneHealth)	EMT 01.03.16				Enabler	Project planned but not started.	
E prescribing [check current status with Gina]	EMT 01.03.16				6. Patient experience	New not yet in report.	
Orion Clinical Workstation (to separate from CRISP) implementation	EMT 01.03.16				Enabler	New not yet in report.	
Implement patient internet booking (Ubook) in every speciality.	EMT 01.03.16				6. Patient experience	New not yet in report.	
DHB Document Management System	EMT 21.06.16				Enabler	New not yet in report.	
Telephone Successor system	EMT 21.06.16				Enabler	New not yet in report.	
Event reporting system (whole sector)	EMT 01.03.16				5. Clinical Quality systems	Project planned but not started.	
Primary care consults and supported self care technology solutions	EMT 01.03.16				7. Rural services	New not yet in report.	
Community I.T. training effective use of IT for lifestyle change, long term condition support	L'ship Forum 17.05.16				2. Consumer Engagement	New not yet in report.	
Implement Review of Information Services	TE.	SM	TE	TR	Enabler	New not yet in report.	

Financial Flows & Business Models	Source	SRO	PS	PM	Intention	April 2016 "At a glance" status	Start/ Finish
Releasing patient time-reduced Bed Days	EMT 01.03.16				6. Patient experience	New not yet in report.	
Develop Private Radiology Opportunities	EMT 01.03.16				11. Business models	New not yet in report.	
Price Volume Schedule in active use	EMT 01.03.16				11. Business models	New not yet in report.	

Investing in Staff & Changing Culture	Source	SRO	PS	PM	Intention	April 2016 "At a glance" status	Start/ Finish
Organisational Development Programme future years -ensure ideas incorporated					Enabler	Project planned but not started.	
Living wage ladder then universal terms of HBDHB employment					Enabler	New not yet in report.	

In one priority area, “Financial Flows and Business Models”a further conversation will need to identify at least one more substantive project. In another, “Investing in Staff and Changing Culture”, the umbrella Organisational Development Programme will need to be developed into a clear and detailed work plan.

Table 2: Projects pencilled in to be deleted

Note "at a glance" pencilled in projects to be removed:	
Treaty of Waitangi responsiveness	Too general, not a project, covered in other responses.
Clinical Pathways Programme optimisation	Now BAU, needs targets and KPIs for delivery and
Maternity opportunity gain period	Bedding in of new service, BAU
Gastroenterology Phase 3	Phase 2, new build and service transition will likely take whole plan time horizon.
Health and Social Care Networks CHB/Wairoa	Included in H&SC programme and successor phase

2.3 Streamlining our Intentions

In the earliest exercises EMT and Leadership team agreed that the phrasing of some of our eleven intentions was unnecessarily wordy and sometimes prescriptive of the solution.

The following changes have been suggested or informally adopted:

Table 3: Changed titles for some intentions

Original Intention	*Proposed rewording*	*Reasoning*
Transform Patient involvement	Transform Consumer Engagement	Potential patients need to be engaged with as much as current or past patients. Consumer is a more inclusive noun.
Transform Health Promotion and Health Literacy	Transform Health Literacy	Health Promotion is Business As Usual for our Population Health Department Health Literacy is the transformational concept.
Transform Clinical Quality through clinical governance	Transform Clinical Quality	Governance is important but Quality can, and should, also be improved by other means.
Transform Patient Experience through Better Clinical Pathways	Transform Patient Experience	Clinical pathways are only one tool for radically improving our patients' experience.
Transforming through integration of Rural services	Transform Rural Services	Integration is helpful, but there are other ways to change the way we deliver services to our rural communities.

3. Looking back

3.1 Our achievements

During the past two and a half years (From December 2013 to 30 May 2016) we have completed 47 projects under the Transform & Sustain programme. We currently have 27 live projects in progress.

As part of our standard approach each project has planned objectives in its initiating Terms of Reference, and a Project Completion Evaluation. A project Completion Evaluation notes: the justification for closure; the status of planned objectives and deliverables, and benefits realised; and lessons learnt (both on what went well and what went wrong).

While unavoidable disruption in our Project Management Office succession, and some inevitable loss in the fog of war mean that we do not have a complete set of project evaluation forms, the following highlights are taken from the evaluations on 33 completed projects:

Engagement with Māori

- The Memorandum of Understanding between the District Health Board and Ngati Kahungunu was refreshed.
- We have entered into High Trust contracting arrangements including our most advanced work with Te Taiwhenua o Heretaunga

Consumer Engagement

- The Consumer Council has been established in a governance model that is now being studied and copied by other Health communities in New Zealand
- Consumer Stories have become a standard part of our Board Meeting agenda, enriching our conversation and highlighting with personal resonance some things we need to improve and others we can be proud of

Health Literacy

- A joint stock-take of resources prepared the way for more coordinated work between PHO and DHB health promotion functions
- A literature review and recommendations paper set out the health literacy opportunities for Hawkes Bay health system

Multi-Agency working

- The Intersectoral Leadership Forum has been established, and is beginning to be used a s a platform for coordinated effort

Clinical Quality

- Our clinical quality and safety framework has been established
- We now prepare, report to District Health Board, and publish annual Quality Accounts

Patient Experience

- We procured Map of Medicine as our Clinical Pathway tool, completed a trial pathway with MidCentral DHB, and prepared an implementation framework
- The Clinical Pathways programme was launched, we established Hawkes' Bay processes to agree, edit and publish Hawkes' Bay Clinical Pathways
- The Pathways programme was made part of our Funder's Business As Usual
- A new mental Health facility on the Regional Hospital site was completed
- Our Mental Health service model was redesigned with users and carers to ensure our new building supports best clinical practice
- Working with the Francis Group we have made our operating theatres more productive and safer: 65 more operations per week, a 5% to 8% increase year on year to 2014-15; planned sessions used more for planned work; start times and surgical teams more consistent; a new orthopaedic model; the preadmission programme revived and partly rolled out
- Our Kaitakawaenga support was introduced to achieve 50 contacts each month, and help reduce non-attendance at appointments by 10%
- Data collection and process on Cancer pathways were improved so we can measure progress to the national Faster Cancer Treatment target, enhancing Multi-Disciplinary working and empowering patients and families in decision making
- The Business Case for our new Maternity and Birthing Unit was completed
- The Business Case for stage 4 Renal services, to co-locate outpatient services in the new Ballantyne House Haemodialysis unit was completed
- We designed a new Gastroenterology model of care, and completed the Business Case to develop a dedicated Gastroenterology unit

Rural Services

- The Wairoa Health Centre was extended and re-modelled, we began to develop the more integrated Wairoa services which this enables
- DHB and Health Hawkes' Bay PHO worked together to make painstaking progress on integrating Central Hawkes' Bay services
- We made systematic gains in refurbishing and remodelling the Napier Health Centre and realising more of its potential to provide services locally. Developing Nurse led clinics in 10 specialties, increasing from 40 to 78 clinicians providing services, and achieving Out Patient attendees up by 28% in two years

Primary Care

- The alignment of District Nursing and General Practice Teams was started by developing the model and piloting it in Hastings Health Centre and Totara Health
- The new District Nursing/General Practice model was rolled out across Hastings
- We improved the nutritional status of our community and patients through community screening, social marketing, and workforce development
- A reporting framework was created and adopted to support General Practices to understand their enrolled population's Emergency Department attendance, readmission rates, and unnecessary hospitalisation

Urgent Care

- We set out a consensus view on the need for change and the better integration of our fragmented urgent care system
- An Urgent Care Alliance, consumer led and involving clinicians across the sector, has been taking the development of specific integrative services forward. A number of service initiatives, including a Request for Proposals are now in process

Out of Hours Inpatient Care

- The Joy Farley report set out our key hospital flow and discharge problems
- In response a cluster of projects have been completed under the banner of "Aim 24/7" including creating 4 Emergency Department observation beds; piloting a Clinical Nurse Specialist to coordinate complex discharges; establishing a Medical Day unit
- Radiology services have been improved with a "single point of contact" duty radiologist, streamlined process in MRI and CT scanning with acute referrals treated in a 24 hour timeframe; MRI throughput increased; Community Referred access Criteria, and a robust data baseline for future business cases

Business Models

- A Systems Improvement Opportunities exercise commissioned from PwC helped us to build a culture of working with front line staff on improving efficiency and firmly linking clinical quality with financial effectiveness as much as contributing to our Sustain savings target
- Work with services and senior clinicians helped us improve control and profile for Inter District Flow costs, encouraging doctors to share knowledge and best practice, and treating more patients locally when clinically appropriate

In a series of enabling strands we have also used project structure to deliver our bigger more complex efficiency targets, the workplace travel plan, and our upgrade to Windows 8.0 and Microsoft office 2013, and our parts of Organisational Development Programme.

This is a run through some of the things the programme and project structure of Transform & sustain has helped to deliver. It is not a complete list of everything achieved in the Hawkes Bay health community in the past two and a half years because:

- ⇒ Innovative work often gets done as routine work in the Business As Usual work of practicing managers and clinicians
- ⇒ Some projects have not yet closed, but are already delivering tangible outcomes and benefits
- ⇒ Other agencies and organisations are constantly doing things which have impacts on the health of Hawkes' Bay
- ⇒ Transform & Sustain is not a command and control philosophy. Good things just happen when you create the right culture and don't worry about who takes the credit.

3.2 Some lessons learnt

Our retiring Programme Management Office leader, Peggy Kersley, set out some of the themes from the project completion and evaluation reports and from her experience of dealing on the front line with projects. Since these are reflections set down without fear or favour by an experienced manager as she leaves the field of battle with honour we should give them considerable weight. We need to learn from what went well and what didn't as we go forward into the second half of the programme.

What has worked well and needs to continue:

- A well-defined programme structure with clearly defined roles and responsibilities. This includes:
    - Strong Chief Executive Officer leadership. CEO as the Sponsor of the programme with a sound understanding of project management methodology and an appreciation of its value as a tool to support delivery. (This is rare element missing in most organisations and which is identified in all studies as a most important factor the makes or breaks programme success).

- Strong professional and line support from General Manager Human Resources to problem solve barriers and ensure appropriate escalation.
- Strong logistical Programme Directorship provided by the Programme Director (high level executive function) to lead programme delivery, issues resolution, resourcing and funding and overall integration of programme activities into Business As Usual
- An Executive Management Team as the sponsoring group for the programme who generally buy-in to the Programme Management approach and provide "Senior Responsible Ownership" for every project in the programme so that each has ownership and "air cover" when it comes into the Executive Team's discussions.
- Monthly CEO, Programme Director, Programme Management Office Manager meetings to review progress, discuss specific issues, themes, and patterns, and to identify actions and responsibilities to overcome obstacles (CEO/ Programme Director leadership).
- A Transform & Sustain Programme Steering Group chaired by the Programme Director. The group includes representatives of key stakeholders: (Finance, Human Resources, Health Services, Primary Sector, Funder, Māori Services, Information Systems, and Programme Management Office)
- Acquisition of dedicated project managers with the capacity and capability to properly manage projects e.g. (AIM 24/7, Customer Focussed Booking, Operation Productivity, etc.)
- Use of Project and "Project Lite" frameworks to establish clear roles and responsibilities for all projects in scope

- Transparent & Clear reporting
  - To EMT which highlight risks and successes and provide a helicopter view of organisational change. These enable to enable Senior Responsible Ownership (Executive Team level) to drive results and resolve issues in a timely way
  - To Clinical and Consumer Councils, to inform and engage
  - To FRAC and Board to give insight to progress, and risks
  - To the Health Service's Senior Leadership Forum to provide an overview of project activity

- Well-developed project management tools and templates that support effective project management

- Project Completion Evaluations which include: Capture of lessons learned and allocation of responsibilities to ensure benefits tracking and realisation going forward.

What has not worked well and needs to be improved:

- Failure to get early stakeholder engagement to define and quantify the problem or opportunity that we are trying to address before rushing to implement solutions.
- Lack of shared understanding by Executive and Senior Managers of the value of project management, our local project methodology and their role. This includes knowing when, and how, to mobilise projects formally.
- Prematurely moving to implement poorly designed solutions that have not been properly assessed or tested to ensure they are fit for purpose
- Closing out project frameworks too soon and before the project 'product" is sufficiently embedded or refined to arrive at benefits achievement.
- Inadequate Project Manager capacity and skill development through structured career development pathways including ongoing training such as PMI PMP or PRINCE2 certifications
- Limited access to "Microsoft Project" software for project managers.
- A lack of unambiguous formal release of Project Team members to do project work
- Poor individual accountability and time management compromising the timely completion of tasks
- Poor organisational understanding of the problem before solutions are identified resulting in a tendency to jump to solutions.

- Lack of good solution process that identifies all options and evaluates these to identify the best solution and full costs of implementation before obtaining approval to proceed
- Insufficient Business Case, and general, writing capability
- Need for more commitment to appropriate Project Management resources, a virtual team is not fully adequate
- Lack of assurance that we have the resources optimally joined up and deployed to deliver on project priorities

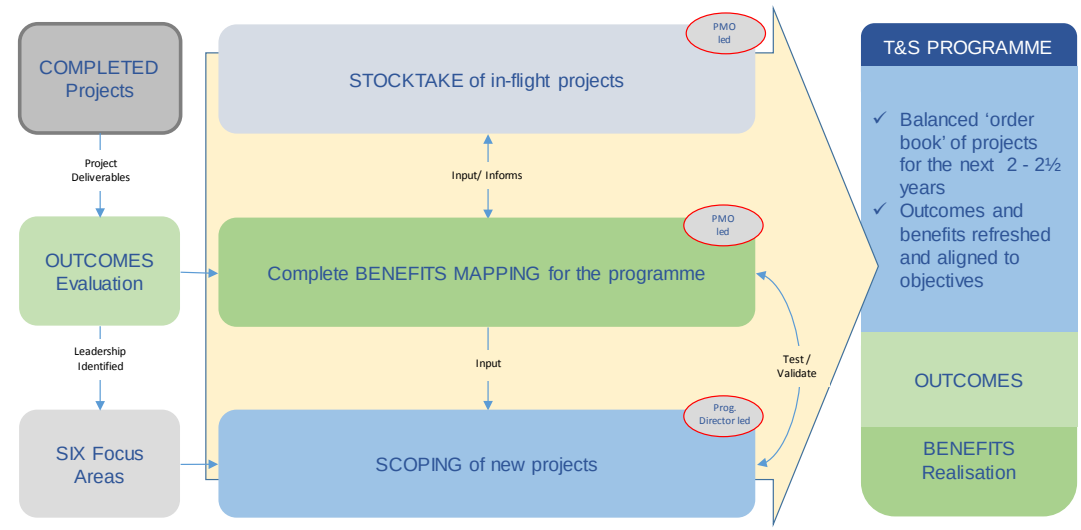
Tim Evans
Programme Director Transform & Sustain
6 July 2016

Appendix 1

PMO approach to project development

DRAFT

Approach Overview



STOCKTAKE

Why do a STOCKTAKE?

The programme is now half-way through it's give year horizon and a large number of projects were forecast to complete by the end of the 15/16 financial year. Whilst a large number have been completed, some projects have needed to extend their timelines due to unforeseen challenges, emergence of new requirements or the need to include an additional phase of activity to complete initial scope. By completing a stocktake of all in-flight projects the programme can re-baseline key delivery milestones and ensure newly initiating projects are scoped and initiated in alignment with the current programme of work.

BENEFITS MAPPING

Haven't we already done BENEFITS MAPPING?

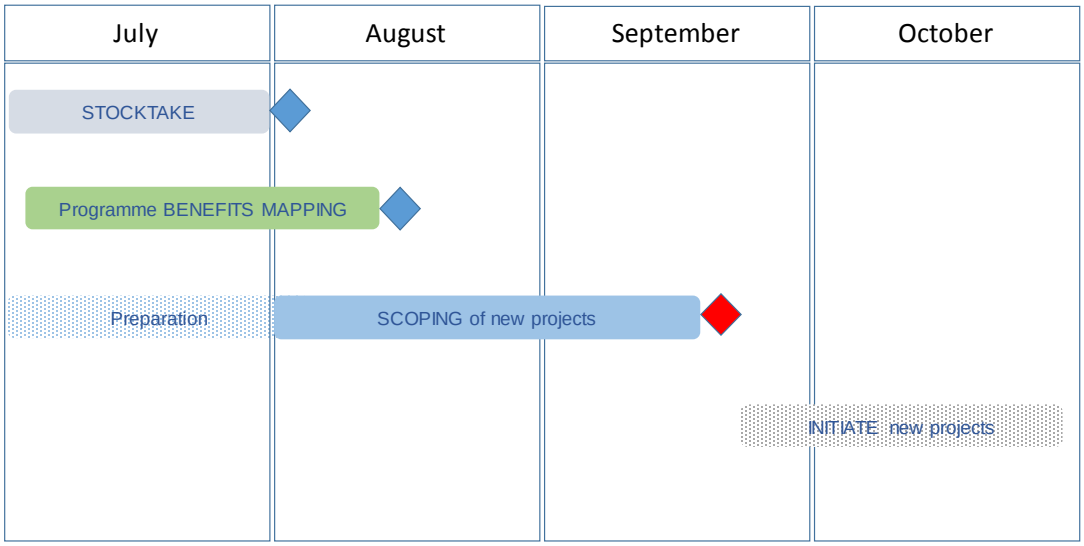
When the Transform and Sustain strategy was developed it was agreed that it would be 'emergent' and that the programme's intentions and project would be adaptive. Whilst all projects have required a clear line of sight back to the mission and triple aim, it has only been in more recent times that defined programme KPIs have been fully identified and reported on. This, combined with the outcomes evaluation during the first phase of the refresh, will now allow us to link project deliverables to the outcomes, benefits and objectives of the programme thereby enabling more effective steerage of overall programme delivery to achieve our target outcomes and benefits.

SCOPING

SCOPING of what new projects?

The first phase of refresh activity identified six focus areas where, by the mid-point of the programme, we have not achieved the progress we had hoped. Following further elaboration of each of these areas a number of potential projects have been proposed which now need to be further tested, refined and finally documented in Terms of Reference. Following this the forward work-plan for the programme can be refreshed and validated to ensure inter-dependencies, sequencing and outcome-driven benefits are identified and managed appropriately to enable successful delivery.

High level timeline



STOCKTAKE — STOCKTAKE of all in-flight projects to reconfirm deliverables, benefits and milestones

Activity led by: Programme Management Office

	Task/activity	Start	Finish	Outputs
1	Refresh TS in-flight project register	7-Jul	8-Jul	Updated Register
2	Issue comms to advise stocktake exercise will be taking place	11-Jul	11-Jul	Emailed comms
3	Review of each in-flight project completed by PMO	11-Jul	15-Jul	
4	Confirm (by a meeting or email) with Project Manager & Sponsor the objectives, deliverables, benefits and milestones	18-Jul	22-Jul	**Baselined** deliverables, benefits and milestones Updated ToR(s)
5	Work with PM & PS to close out any gaps and update ToR (**as needed**)	20-Jul	26-Jul	
6	Update current programme A3 roadmap	27-Jul	1-Aug	Refreshed A3 Roadmap
➢	Information used as input into **BENEFITS MAPPING** (see next slide)			
➢	Information used as input into **Refresh Checkpoint**	20/09	20/09	
	Stocktake activity completed			

BENEFITS MAPPING Complete programme level BENEFITS MAPPING to link objectives to outcomes, benefits and KPIs

Activity led by: Programme Management Office

	Task/activity	Start	Finish	Outputs
1	PMO to build initial draft of the programme Benefits Map	7-Jul	20-Jul	Initial Mapping
2	Reconcile against baseline information (confirmed during **STOCKTAKE** – see previous slide)	21-Jul	27-Jul	
3	Key stakeholders engaged (via workshop) to close out any gaps / missing information	25-Jul	28-Jul	Draft Benefits Map
4	Syndicate draft Benefits Map to TS Steering Group for review	29-Jul	29-Jul	
5	Programme Benefits Map finalised and approved by SG	1-Aug	5-Aug	Updated Benefits Map
6	Hold playback workshop with stakeholders (**if necessary only**)	1-Aug	5-Aug	
7	Draft Benefits Map used to validate new project benefits	1-Aug	24-Aug	Project Alignment
8	Programme Benefits Map finalised and approved by SG/EMT	15-Aug	16-Aug	Finalised Benefits Map
➢	Benefits Map used as input into **Refresh Checkpoint**			
	Benefits Mapping activity completed			

SCOPING SCOPING of new projects which need to be initiated to ensure full programme outcomes are achieved

Activity led by: T&S Programme Director

	Task/activity	Start	Finish	Outputs
1	Appoint roles e.g. SRO, Project Sponsor, Project Manager	1-Jul	15-Jul	
2	Identify key stakeholders for each proposed project	18-Jul	22-Jul	Stakeholder Map
3	Hold scoping workshop(s) – grouped or by individual project	1-Aug	24-Aug	Inputs to ToR
4	Test / validate projects against programme benefits	1-Aug	24-Aug	Project alignment
5	High level draft Terms of Reference (per project)	1-Aug	31-Aug	Draft ToR(s)
6	Update programme A3 roadmap / work plan	1-Sep	15-Sep	Draft Work Plan
➢	**Refresh Checkpoint** – EMT decision to proceed	20-Sep	20-Sep	Agreed Work Plan
	Refresh activity completed			
	Establish Steering Group (per project)	TBD	TBD	
	Complete / Sign-off Terms of Reference (per project) etc	TBD	TBD	Final ToR(s)

The Refresh Checkpoint is a key decision point for the programme and should include:

- A final list of new projects to be approved for initiation
- Review and agreement that the TS 'order book' (i.e. forward work plan of in-flight projects and 'new' projects to be initiated is balanced, feasible, is aligned to the objectives of the programme and will deliver the desired outcomes and benefits.

14

UNDER 19 MENTAL HEALTH WAIT TARGET

Presentation

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:

17. Confirmation of Minutes of Board Meeting
- Public Excluded

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

19. Board Approval of Actions exceeding limits delegated by CEO

20. Chair's Report

Reports and Recommendations from Committee Chairs

21. Finance Risk and Audit Committee Report

22. 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