BOARD MEETING

Date: Wednesday, 25 October 2017

Time: 1.00pm

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

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

Apologies: -

In Attendance:
Dr Kevin Snee, Chief Executive Officer
Sharon Mason, Executive Director of Provider Services
Tim Evans, Executive Director of Corporate Services
Chris Ash, Executive Director of Primary Care
Kate Coley, Executive Director of People & Quality
Tracee Te Huia, Executive Director of Strategy & Health Improvement
Ken Foote, Company Secretary
Dr John Gommans, Chief Medical Officer, Hospital & Co-Chair Clinical Council
Dr Andy Phillips, Chief Allied Health Professions Officer & Co-Chair Clinical Council
Rachel Ritchie, Chair HB Health Consumer Council
Members of the public and media

Mintute Taker: Annie Quinlivan

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	116	
9.	Financial Performance Report	117	
10.	Board Health & Safety Champion's Update	118	
	Section 2: Reports from Committee Chairs		
11.	HB Clinical Council – Co-Chairs	119	1.40
12.	HB Health Consumer Council – Chair, Rachel Ritchie	120	1.50
13.	Māori Relationship Board – Chair, Ngahiwi Tomoana	121	2.00
14.	Pasifika Health Leadership Group Report – Barbara Arnott	122	2.10
	Section 3: Decision		
15.	Shareholder AGM Representation – Technical Advisory Services (TAS)	123	2.15
16.	Shareholder AGM Representation – Allied Laundry Services Ltd	124	
17.	Committee Structure and Meeting Schedule for 2018	125	
	Section 4: For Information / Discussion		
18.	Establishing Health and Social Care Localities in Hawke's Bay – Chris Ash	126	2.30
	Section 5: General Business		
19.	**Section 6: Recommendation to Exclude the Public**		
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Routine	Ref #	Time (pm)
20.	Minutes of Previous Meeting		2.45
21.	Matters Arising – Review of Actions		
22.	Board Approval of Actions exceeding limits delegated by CEO - nil	127	-
23.	Chair's Update		
	Section 8: Reports from Committee Chairs		
24.	HB Clinical Council – Co-Chairs	128	3.00
25.	HB Health Consumer Council – Chair, Rachel Ritchie	129	
26.	Finance Risk & Audit Committee – Chair Dan Druzianic	130	3.10

The next HBDHB Board Meeting will be held at
1.00pm on Wednesday 29 November 2017

Board "Interest Register" - 2 October 2017

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
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
Dr 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 Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW counselling services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in 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 (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective) The U-Turn Trust renamed /rebranded "Whararikì Trust" advised 30-8-17	Relationship and and may be contractural from time to time	No conflict	The Chair	5.12.16
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	5.12.16
	Active	Chair, Health Promotion Forum	Relationship	No conflict	The Chair	5.12.16
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 27 SEPTEMBER 2017, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.06 PM

PUBLIC

Present:	Kevin Atkinson (Chair) Ngahiwi Tomoana (Deputy Chair) Dan Druzianic Helen Francis Peter Dunkerley Diana Kirton Barbara Arnott Ana Apatu Hine Flood
Apologies	Heather Skipworth and Jacoby Poulain
In Attendance:	Kevin Snee (Chief Executive Officer) Members of the Executive Management Team Dr John Gommans (Co Chair HB Clinical Council) Rachel Ritchie (Chair, HB Health Consumer Council) Members of the public Brenda Crene

KARAKIA

Ngahiwi Tomoana opened the meeting with a Karakia.

APOLOGIES

Noted above

3. INTEREST REGISTER

No changes to the interests register were advised.

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

4. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 30 August 2017, were confirmed as a correct record of the meeting.

Moved: Barbara Arnott
Seconded: Diana Kirton
Carried

5. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Chaplaincy Service Costs:**

a) Hastings District Council: Jacoby Poulain was not present at the meeting but had advised HDC would review their decision (not to provide financial support) and the Chaplaincy Service would likely be given the opportunity to present to Council

b) The request for support sent in September to HB Regional Council Chair, had not yet been responded to.

c) Wairoa District Council: Hine Flood advised the Wairoa would revisit the request

d) Napier City Council: Advised they did not see this as being within their area of responsibility.

Item 2: **Messages of thanks issued to staff and the health sector** were provided to Board members. Actioned

Item 3: **Interest Register changes:** Actioned

Item 4: Correction requested within the **Gastroenterology Project Report.** Actioned.

Item 5: **Survey following the Health Awards in November** (will include alcohol questions) with feedback advised to the Board once completed. Ongoing.

Item 6: **Alcohol Policy** – Review timelines for this to be undertaken had been included on the workplan - remove item.

Item 7: **Drinking Water Governance Joint Committee Terms of Reference -** Letter was sent to Hastings District Council including the detail discussed at the previous Board Meeting. Ongoing until finalised.

Item 8: **Ngatahi Vulnerable Children's Workforce Development (**Item 18 on the Agenda)

Identifying and providing training being investigated, an update will be provided in December 2017 and has been included on the workplan. Remove action

6. BOARD WORK PLAN

The Board Work Plan was noted with changes/additions summarised:

Social Inclusion will move to the November Board meeting.

Sharon Mason advised an update on Radiology would be provided to the Board at the November meeting. Actioned: Included on the Board Workplan.

7. CHAIR'S REPORT

The Chair advised there were no retirements this month.

The fourth quarter target results had been released by the Ministry of Health who congratulated the DHB for improvements made. In summary: HBDHB Q4 results: Shorter stays in ED (HB 94.9% vs target of 95%); Improved Access to Electives (HB 101.3% vs target of 100%); Faster Cancer Treatment (HB 77.1% vs target of 85%); Increased Immunisation (HB 95% vs target of 95%); Better Help for Smokers to Quit (HB 91.0% vs target of 90%); Raising Healthy Kids (HB 95% vs target of 95%)

The Ministry has advised an additional $250k per year would be provided towards suicide prevention programmes delivered throughout NZ

A member of community had requested the DHB to survey all those still affected by Gastroenteritis Crisis and ask HBDHB to advocate strongly on their behalf. A response had been provided.

8. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report noting the Big listen, the Clinical Services Plan were advancing. It was conveyed that the Hospital and Primary care were under a lot of pressure and that health target performance had deteriorated of the past few weeks.

ED performance was reasonable but will end at 92% or below at end of September (other DHBs were experiencing similar levels).

Work needs to be done to rebalance primary care within the community. If people wish to visit their GPs they should be able to do so the same day. General Practices have seen an increase of 25-30% more visits. We need to get in behind primary care and embed ourselves alongside and change the way services are offered and not just rely on historical face to face care of patients. A total rethink of services is required.

HB targets results were provided. Helen Francis mentioned that measures reported to the Board were not the same as the SLM measures (from the PHO), specifically CVRA for Maori men 35-45. It would be good if there was some consistency with targets that primary care are set and the board has reported to it**. This will be investigated - Action**

Feedback has been coming in from surveys and the Big Listen Workshops as well as the Clinical Services Plan Workshops:

- At the recent Big Listen Workshops, simple invaluable tools were provided that inspired many attendees and reframed thinking. Tim Keogh, facilitator, develops a culture of kindness and empowering people to challenge bad behaviour and think about their own behaviour as well.
- Bullying issues are still high, with work occurring with staff and unions. There has been an impact but not enough!
- Leaders within the organisation must lead by example.
- Some staff do not feel empowered to say exactly how they feel. Some just want to hear the word "thank you".
- Examples internationally of success around staff dedication, positive outlooks and attitudes, motivation and pleasant environments were noted. High staff morale was noted in Alaska when there to view the Nuka Model of Care.

9. FINANCIAL PERFORMANCE REPORT

Tim Evans (ED of Corporate Services) spoke to the Financial Report for August 2017, which showed a favourable variance of $44 thousand with no contingency released, year to date.

Treatment of the $1.0m from the MoH for the Gastro outbreak was conveyed.

Funds covering the Care support works increase announced by the MoH had been corrected within HBDHB's budget.

Quality and financial improvement programme was noted on page 41 of the report. The Endoscopy Facility build was showing green/amber, we are now beyond flat ground with steel works and framing in place.

10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

A report was received from Board Member Helen Francis, who advised she and Peter Dunkerley had met with Kate Coley (ED People and Quality). They had been advised a new Health and Safety Advisor would commence in October. A priority made when the recruit commences will be to reinstate the Health & Safety Committees in the Hospital and undertake a stocktake of training required/offered.

Also noted by Helen and Peter was the sizeable work being undertaken within the sterile services area; and seismic matters in AAU which had no doubt been reported through to FRAC.

It was advised that the HBDHB's Safe 365 Assessment Tool would be offered to providers, as when contract renewals occur it would be helpful for the organisations applying if they were utilising this Tool.

REPORT FROM COMMITTEE CHAIRS

11. HAWKE'S BAY CLINICAL COUNCIL

Dr John Gommans spoke to the report from the Council's meeting held on 13 September 2017 who advised there was an attempt to shift how Council work and desire to move away from papers and have more engaged clinical discussions around topics that matter. For this meeting the had chosen the area of patient safety in the hospital and tried to give flavour with presentations on deteriorating patient including early warning system – fits well as the HQSC had announced upgraded requirements in this area. Sector trauma issues due to driving badly, not wearing seat belts and drinking to excess were noted and this is being closely worked through with the agencies. It was noted that a very high number of men are crashing off their bikes. All of the above affect acute flow within the hospital.

Health roundtable data and where we can better use that data to enhance the journey was presented and we need to monitor and drive this at governance to ensure the hospital is a safe place to be.

In discussion it was asked if the Board could hear more from Primary Care at a PHO level around delays in the community – driver is public health measures.

Other reports received were identified in the report provided.

12. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie the newly appointed Chair of HB Health Consumer Council outlined the Consumer meeting held on 14 September 2017, noting the reports received and endorsed and the papers received for information only.

In referring to the HB Health Sector Leadership Forum held in early September, Consumer members felt there was a lot of work still to do to ensure the consumer voice was integrated into business as usual. There had been a lot of listening undertaken but there appears to be a "brick wall" when it comes to implementing change within systems and the way we work.

The role of the Consumer Engagement Manager and Youth Consumer Council were working well, and noted the youth representatives really do have their fingers on the pulse and contribute a lot.

The HB Consumer Council Annual Plan was approved at the last meeting and it was noted that Council were progressing a "Disability Strategy for Hawke's Bay" which was underway.

It was clarified that the "Youth Strategy" around resilience was referred to as "handle the jandal" and was a new initiative.

13. MĀORI RELATIONSHIP BOARD

Ngahiwi Tomoana spoke to the meeting held 13 September 2017. The papers reviewed were provided in the report, in addition the following was summarised:

- HB Health Sector Leadership Forum was the catalyst for some great discussion. Since then a number of meetings had been held with the parties resulting in positive outcomes.
  After the board meeting there may be time to socialise thinking.
- MRB require all papers affecting Maori to be formulated from the outset with a Maori lens applied (against a checklist). The status quo is not acceptable with quantum change required.

14. REPLACEMENT OF MĀORI RELATIONSHIP BOARD MEMBER

The Board supported the following recommendation following the resignation of Tatiana Greening:

RESOLUTION

That the Board

- Appoint Beverly Te Huia to replace Tatiana Greening on the Māori Relationship Board (MRB)

Moved **Ngahiwi Tomoana**
Seconded **Helen Francis**
Carried

It was noted that any member of the public can attend MRB meetings, however would be required to leave for any public excluded aspect.

FOR DECISION

15. POSITION ON REDUCING ALCOHOL RELATED HARM

Rachel Eyre, Medical Officer of Health and Rowan Manhire-Heath, Population Health Advisor; and Carina Burgess (for Tracee TeHuia) were in attendance.

The position on reducing alcohol related harm was approved in November 2016 with 7 steps committed to be undertaken.

Key Points Included: a small change to Steering group Terms of Refetrence structure diagram with youth and Maori representation now to be included on the steering group. Have Maori, Consumer and Youth representatives across the working groups with Tracee TeHuia to chair the Steering Group. Have a strategy framework with priorities for implementation. Screening and brief intervention is about routinely asking people

regarding alcohol use as part of their health and wellbeing. Licencing decisions were being challenged as part of public health's work, as business as usual. The Strategy was developed and guided by a coalition of the willing of key stakeholders with an interest or expertise in alcohol issues.

The Alcohol Strategy was still in draft form at this time.

Feedback included:

- Please keep the pressure on around "foetal alcohol syndrome". Lot more work could be done on the prevention side.
- Quorum should consist of at least two Executive Directors.

The board then adopted the recommendation as follows:

RECOMMENDATION

That the Board

1. **Accept** this progress report on the Alcohol Harm Reduction Position Statement
2. **Support** and mandate the establishment of a Steering Group (as described with additional quorum inclusion as mentioned above) with wide DHB representation to provide oversight to the alcohol harm reduction activities across the DHB and report to the Clinical Council on a regular basis (as referenced in Appendix 1: Terms of Reference for an Alcohol Harm Reduction Steering Group).
3. **Endorse** the Strategic Framework and Priorities (as referenced in Appendix 2: 'Tackling Alcohol Harm in Hawke's Bay' Draft Strategy).

Adopted

PRESENTATIONS / DISCUSSION

16. WAIOHA BIRTHING UNIT – BENEFIT REALISATION

Chris McKenna introduced Jules Arthur (Midwifery Director) who provided a presentation to the Board.

A copy of the presentation was provided with the papers and the update was well received by the board with congratulations to all for an excellent result and a change birthing practices in HB.

17. CONSUMER STORY

Sasha Watt was introduced by the Chair. The CEO and several board members had previously met with her. She provided a heartfelt presentation which related to the Cancer Treatment provided to her husband Peter (over several years) in Hawke's Bay, Wellington and in Auckland.

Sasha desires is to make a difference following the death of her husband last year, and felt compelled to motivate the HBDHB Board to challenge management to drive Hawke's Bay Hospital to become a "Patient Centred Facility". She advised the difference in attitude, listening skills, communication and the difference in care involving multidisciplinary teams (present in other Hospitals), had such a profound and positive effect on her and her family, that those differences in care and attention could not be ignored.

Sasha believed that by publicly declaring the Board's intention for HB Hospital to become a "Patient Centred Facility" would ensure public accountability. If a goal is shared it is more likely to be achieved! She advised she would happily look forward to working with the DHB if she could be of help.

The Board and Management were moved and thanked Sasha for providing her story.

Sasha left the meeting.

Further discussions took place with the following actions noted:

Actions

- The board requested a copy of the detail to be emailed to them
- The CEO and Dr Gommans will work together to prepare a response to Sasha.

MONITORING

18. TE ARA WHAKAWAIORA / HEALTHY WEIGHT

Shari Tidswell was introduced and provided an overview of the report. The Board noted the contents of the report and thanked Shari for the update.

GENERAL BUSINESS

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

19. RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

20. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

22. Board Approval of Actions exceeding limits delegated by CEO

23. Chair's Update

24. National Oracle System

25. After Hours Concept

26. HB Clinical Council

27. Finance Risk and Audit Committee Report

Moved: **Peter Dunkerley**
Seconded: **Diana Kirton**
Carried

The public section of the Board Meeting closed 3.30pm

Signed: _____
Chair

Date: _____

5

BOARD MEETING - MATTERS ARISING
(Public)

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1	29 Mar 17 28 June 17 30 Aug 17	**Chaplaincy Service Costs:** Letters were sent (at end of June) to the four local Council Mayors seeking support with Chaplaincy costs. Four LTAs declined. Letter sent to Chair of HBRC. Copy of letters to be provided to several board members (Jacoby and Hine) to follow up. Ongoing.	Admin		Actioned Feedback circulated
2	30 Aug 17 27 Sept 17	**HB Drinking Water Governance Joint Committee – Terms of Reference.** Item 17 on the Agenda a) The matters and questions raised will be addressed within the documentation and discussed between the respective parties. b) Ongoing until finalised	Ken Foote		Initial meeting of agency representatives scheduled for 24 October 2017
3	27 Sept 17	**SLM Measures / Consistency with Targets:** Helen mentioned that measures reported to the Board were not the same as the SLM measures (from the PHO), specifically CVRA for Maori men 35-45. It would be good if there was some consistency with targets that primary care are set and the board has reported to it. - To be investigated	Tim Evans		SLMs and contributory measures will be in the non-financial report and a SLM report will be provided quarterly which can go to the Board. This won't be until next month, however, to align with quarterly reporting to the Board. Actioned.
4	27 Sept 17	**Consumer Story – Sasha Watt** a) The board to be provided with the detail. b) A response to be provided to Sasha.	Anna Kirk CEO/CMO Hospital		Actioned

HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
29 Nov	Surgical Expansion Detailed Business Case	S Mason / Janet Heinz
	Best Start Healthy Eating & Activity Plan update (6 mthly)	Tracee TeHuia
	Social Inclusion	Tracee TeHuia
	Ka Aronui Ki Te Kounga / Focussed on Quality "Quality Accounts"	Kate Coley
	Monitoring	
	HR KPIs Q1 July-Sept 17	Kate Coley
	HBDHB Non-Financial Exceptions Report Q1 Jul-Sept 17 + MoH dashboard Q4	Tim Evans
	Te Ara Whakawaiora – smoking (national Indicator)	Tracee TeHuia
	Annual Māori Plan Q1 Dashboard	Tracee TeHuia
	PHLG update on Tupaias' (Pasifika Health Navigators) and the Pacific Workforce Strategy	Tracee TeHuia
	Pasifika Health Plan Q1 Dashboard	Tracee TeHuia
13 Dec	Audit NZ Final Management Report on the audit of HBDHB for y/e June 2017	Tim Evans
	Consumer Story reinstated *(once work undertaken)*	Kate Coley
	The Big Listen – update (Presentation)	Kate Coley
	Clinical Services Plan presentation of first draft	Tracee TeHuia
	Transform and Sustian *TBC as timelines very tight*	Tracee TeHuia
	Ngatahi Vulnerable Children's Workforce Development - progress since August Report	Tracee TeHuia / Russell Wills
Jan 2018	**No Meeting**	
28 Feb	Feedback Consumer Story Workshop December (by Councils) Board action	Kevin Snee
	Transform and Sustain Strategic Dashboard (6 monthly)	Tracee TeHuia
	Quality Annual Plan – 2017-18 6 month progress report	Kate Coley
	People Strategy	Kate Coley
	Te Ara Whakawaiora / Culturally Competent Workforce incorporating Building a Diverse Workforce	Kate Coley
	Implementing the Consumer Engagement Strategy	Kate Coley
	Clinical Services Plan	Tracee TeHuia
	Monitoring	
	HR KPIs Q2 Oct-Dec 17	Kate Coley
	Maori Annual Plan Q2 Dashboard	Tracee TeHuia
	Pasifika Health Plan Q2 Dashboard	Tracee TeHuia
	HBDHB Non-Financial Exceptions Report Q2 Oct-Dec 17 + MoH dashboard Q1	Tim Evans

Mtg Date	Papers and Topics	Lead(s)
28 Mar	Establishing Health and Social Care Localities in HB Recognising Consumer Participation Policy Amendment Oncology Model of Care ***Monitoring*** Te Ara Whakawaiora – Breastfeeding (national indicator)	Chris Ash Kate Coley Sharon Mason /A Stevenson Chris McKenna
25 Apr	Transform and Sustain Monthly Report and A3 Overview	Tracee TeHuia
30 May	Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18) ***Monitoring*** HR KPIs Q3 Oct-Dec 17 Maori Annual Plan Q3 Dashboard Pasifika Health Plan Q3 Dashboard HBDHB Non-Financial Exceptions Report Q3 Oct-Dec 17 + MoH dashboard Q2	Tracee TeHuia Kate Coley Tracee TeHuia Tracee TeHuia Tim Evans

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 116
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	17 October 2017
Consideration:	For Information

8

RECOMMENDATION

That the Board

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

INTRODUCTION

In September we continued to see significant pressure in our health system, with high patient and staff sickness, which has given rise to problems of reduced flow in our hospital impacting on the Shorter Stays in Emergency Department (ED6) target and causing some delays in surgery. Staff continue to cope well and have maintained their focus on delivering good quality patient care.

One of our key pieces of work last month was 'The Big Listen', which ran from 25 September to 3 October. During the week of the listening sessions we heard from over 1,000 people ranging from staff members, consumers and leaders from across the sector. Over 1500 surveys were filled out by staff members and over 850 completed by consumers. Currently work is underway by April Strategy to analyse and review all of the information and bring it back to the sector. The initial review will be shared with staff and consumers.

At the end of November the final results of 'The Big Listen', with identified priorities for our consumers and staff and a new behavioural framework to support the embedding of our values, will be available.

The main agenda item for the Board to consider today relates to an update on locality developments.

PERFORMANCE

Measure / Indicator	Target	Month of September	Qtr to end September	Trend For Qtr
Shorter stays in ED	≥95%	88.8%	91.4%	▼
Improved access to Elective Surgery (2017/18YTD)	100%	-	100.9%	▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,881	370	3
Patients given commitment to treat, but not yet treated (ESPI-5)	1,064	160	11

Faster cancer treatment* *(The FCT Health Target definition has changed for 2017/18 financial year. Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).*	≥90%	100% (August 2017)	87.7% (6m to August 2017)	▼
Increased immunisation at 8 months (3 months to end of September)	≥95%	---	94.5%	▼
Better help for smokers to quit – Primary Care	≥90%	90.2% (15m to September)	---	▲
Better help for smokers to quit – Maternity	≥90%	---	85.7% (Quarter 4, 2016/17)	▼
Raising healthy kids (New)	≥95% (by Dec 2017)	---	98% (6m to August)	▬
Financial – month (in thousands of dollars)	5	(55)	---	---
Financial – year to date (in thousands of dollars)	(2,124)	(2,049)	---	---

***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%	*10/19 = 53.0%*	*84/114 = 74%*

This month's ED6 performance has deteriorated further with patient flow through the hospital being problematic again, due to high ED attendances and continued staff sickness. This has shown signs of improvement in October. We continue to deliver our elective plan and our numbers of patients waiting longer than four months have reduced significantly as anticipated. There is no new data on helping smokers to quit in pregnancy, however smoking advice in primary care continues above target.

Faster cancer treatment remains close to target, although the problem of identifying the right number of people remains. Raising Healthy Kids data has not been updated.

Our financial performance for September shows a $60k unfavourable variance but overall for the first quarter this represents a $75k favourable variance, with no contingency used to date. This is a very good performance, but it is still early days.

SHAREHOLDER REPRESENTATIVES TO ATTEND ANNUAL GENERAL MEETINGS
The Board will need to appoint shareholder representatives to attend and vote on behalf of HBDHB, at forthcoming Annual General Meetings for both CTAS and Allied Laundry Services Ltd. Recommendations are included in the papers.

ESTABLISHING HEALTH AND SOCIAL CARE LOCALITIES IN HAWKE'S BAY
The establishment of functioning health and social care localities is one of the critical clusters of projects within the DHB's Transform & Sustain programme.

The paper presents a proposal for a stock-take and reinvigoration of the approach, following the transfer of the work stream to the new Executive Director of Primary Care, Chris Ash. This is particularly important as strong localities, with the ability to orchestrate local service integration and effectively influence funding policy, will be central to the DHB's objective of increasing the proportion of system resource focused on community health and wellbeing.

The paper details some positive work to date in Central Hawke's Bay and Wairoa localities, much of which has been founded on increasing trust and intersectoral relationship building. It also sets out the case for greater pace, and the need for support to establish this approach across all localities in Hawke's Bay.

CONCLUSION
This month our health system continues under pressure with high levels of community and staff sickness. We have coped reasonably well and in October some of the pressures appear to be abating.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, September 2017** 117
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, Executive Director Corporate Services Phil Lomax, Financial Accountant
Reviewed by:	Executive Management Team
Month:	October 2017
Consideration:	For Information

RECOMMENDATION

That the Board and FRAC

1. Note the contents of this report

1. Executive Director Corporate Services' comments

Financial performance

The first quarter result is $75 thousand favourable to plan, with September $60 thousand unfavourable reflecting higher surgical costs including electives.

Adjustments made to the Annual Plan in agreement with MOH, the pay-equity settlement and gastroenterology funding, have been incorporated into budgets from September.

Impairment of Receivables

HBDHB provides for the future write-off of bad debts, based on expected losses for the DHB's pool of debtors. The expected losses have been determined by an analysis of the DHB's losses in previous periods to establish a collective impairment provision, augmented by the review of specific debtors.

The outstanding balances and the amount provided for doubtful debts by nature of debtor at 30 September 2017 is tabled below.

Nature of debt	**Outstanding** *$'000*	**Overdue** *$'000*	**Provision** *$'000*
ACC	807	107	-
Corporate clients	222	51	30
Private clients	21	11	2
Dental	27	22	18
District Health Boards	317	291	-
Loan equipment	10	8	4

Medical practitioners	124	2	6
Ministry of Health	4,846	426	-
Meals on Wheels	57	4	7
Ineligible patients	324	296	208
Other	28	19	3
Procurement debtors	70	4	5
Private insurers	9	7	6
TOTAL	**6,862**	**1,248**	**289**

Gain and loss on sale

HBDHB incurs gains and losses on the sale of assets to the extent they return more than book value or last for less than their planned life. Management reviews the lives of assets whenever there is reason to believe they may differ from plan, and consequently the gains and losses are seldom material. Gains and losses for 2016/17 were $31 thousand and $133 thousand respectively, and for 2017/18 are $2 thousand and $19 thousand respectively year to date. There are approximately 500 asset disposals per annum, with less than 15% resulting in a gain or loss, and the remaining assets used for longer than their projected lives.

2. Resource Overview

	September				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	(55)	5	(60)	-1227.6%	(2,049)	(2,124)	75	3.5%	1,500	3
Contingency utilised	-	250	250	100.0%	-	750	750	100.0%	3,000	8
Quality and financial improvement	790	868	(78)	-9.0%	1,530	2,091	(561)	-26.8%	10,812	11
Capital spend	1,724	1,993	(268)	-13.5%	3,576	5,978	(2,401)	-40.2%	23,920	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,265	2,323	58	2.5%	2,246	2,329	84	3.6%	2,319	5 & 7

No contingency was released in September.

Identified savings plans, 98% of the Quality and Financial Improvement (QFI) programme, were 73% achieved September year to date. The shortfall is mainly in IDFs, residential care, and staffing and vacancy management.

The capital expenditure plan was phased evenly across the year, as detailed projected planning was not complete at the time the budget was set. The under-spend to September reflects the early stage of planning and ordering of capital items that should catch up later in the year.

The FTE variance reflects vacancies across a number of areas.

Case weighted discharge data will be excluded from the report until coding is more up to date.

3. Financial Performance Summary

	September				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	45,540	46,648	(1,109)	-2.4%	135,002	135,346	(345)	0.3%	555,115	4
Less:										
Providing Health Services	21,263	20,986	(277)	-1.3%	64,683	64,578	(106)	-0.2%	262,971	5
Funding Other Providers	20,042	21,219	1,177	5.5%	59,204	59,701	497	0.8%	238,664	6
Corporate Services	4,061	4,082	21	0.5%	12,288	12,122	(166)	-1.4%	47,702	7
Reserves	228	356	127	35.8%	875	1,070	195	18.2%	4,278	8
	(55)	**5**	**(60)**	**-1227.6%**	**(2,049)**	**(2,124)**	**75**	**-3.5%**	**1,500**	

Income
Lower than budgeted In-Between-Travel (IBT) and elective services funding partly offset by higher income from other DHBs and ACC. The year to date variance is mainly budget changes to reflect the incorporation of Pay-Equity funding into the Annual Plan.

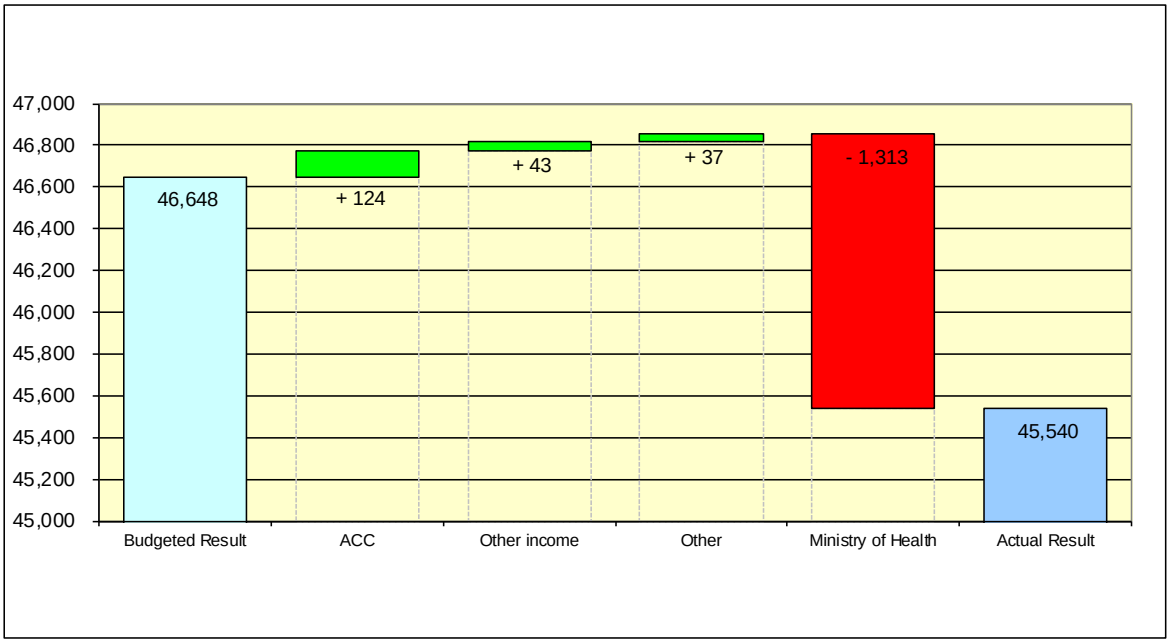
Providing Health Services
Higher than budgeted elective surgery costs, as vacancies offset unachieved efficiencies.

Funding Other Providers
Release of 2016/17 provisions and recovery of funding not needed by providers more than offset higher home care costs. The year to date variance is mainly budget changes to reflect the incorporation of Pay-Equity expenditure into the Annual Plan.

4. Income

$'000	September				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	43,262	44,574	(1,313)	-2.9%	128,414	129,224	(810)	-0.6%	530,367
Inter District Flows	711	693	18	2.6%	2,191	2,079	112	5.4%	8,314
Other District Health Boards	347	333	14	4.2%	1,099	999	100	10.0%	3,996
Financing	58	74	(16)	-21.5%	193	221	(29)	-12.9%	885
ACC	611	487	124	25.5%	1,467	1,318	149	11.3%	5,273
Other Government	25	22	3	15.9%	108	103	5	5.0%	413
Patient and Consumer Sourced	122	104	18	16.8%	308	313	(4)	-1.3%	1,406
Other Income	404	361	43	11.8%	1,219	1,090	129	11.9%	4,394
Abnormals	-	0	(0)	-100.0%	2	1	1	234.9%	67
	45,540	**46,648**	**(1,109)**	**-2.4%**	**135,002**	**135,346**	**(345)**	**-0.3%**	**555,115**

September



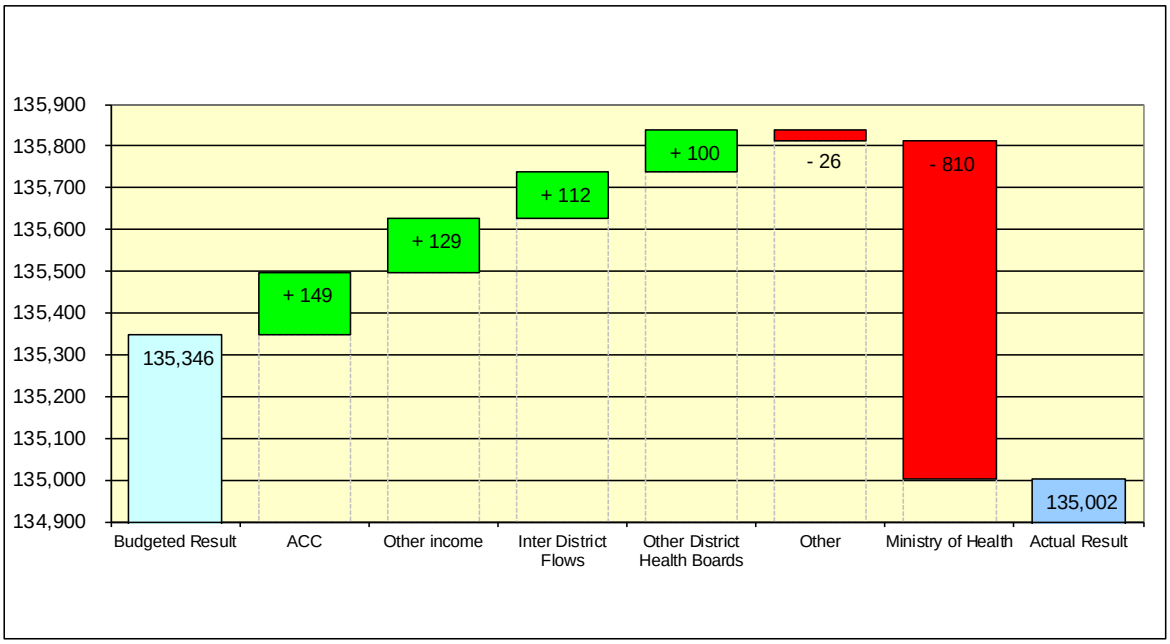
Note the scale does not begin at zero

ACC (favourable)
Community nursing and ACC surgical electives.

Other Income (favourable)
Otago University funding for the Wairoa Inter-Professional education programme, and donations and clinical trial income.

Ministry of Health (unfavourable)
The budget has been adjusted in September to include first quarter pay-equity funding (offset in other provider expenditure), and is budgeted monthly for the remainder of the year. This reflects a change made to the Annual Plan by agreement with MOH.

Year to Date



ACC (favourable)
Non acute rehabilitation, ACC surgery, and community nursing.

Other Income (favourable)
Special funds and clinical trials income, rent from surplus properties, and various cost recoveries.

Inter District Flows (favourable)
Reflects latest available information from other DHBs.

Other District Health Boards (favourable)
Patient transport reimbursements, including cover for Nelson-Marlborough DHB while their service was down.

Ministry of Health (unfavourable)
Lower than budgeted In-Between-Travel (IBT), and elective services funding.

5. Providing Health Services

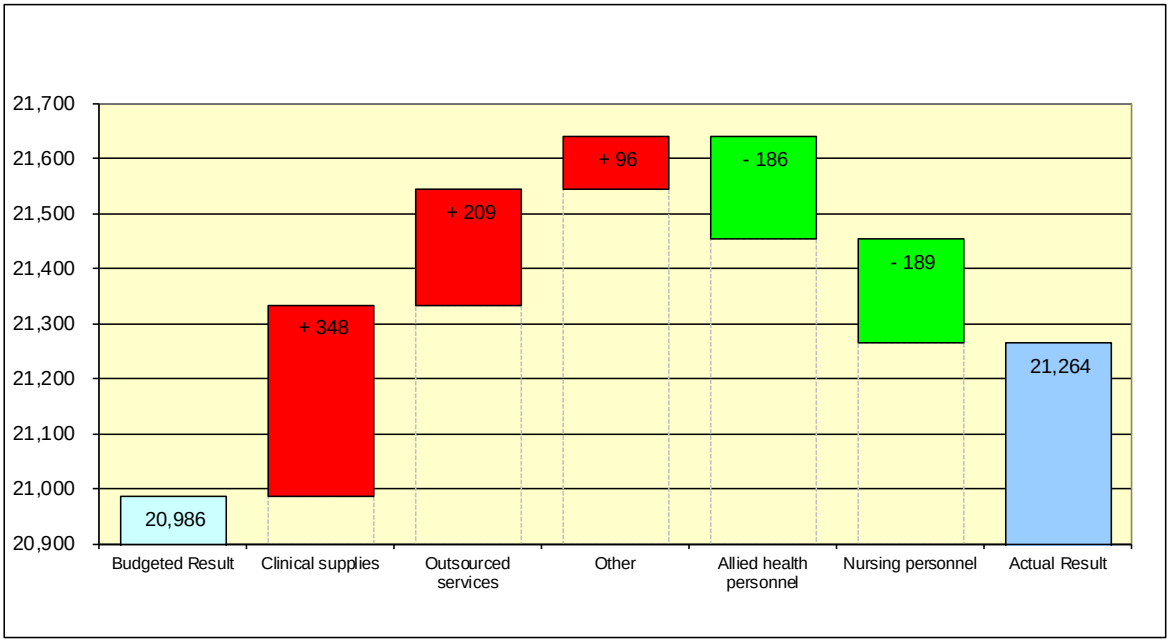
	September				Year to Date				Year End Forecast
	Actual	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		
Expenditure by type $'000									
Medical personnel and locums	4,779	4,718	(61)	-1.3%	14,427	14,551	124	0.9%	62,154
Nursing personnel	5,938	6,127	189	3.1%	18,175	18,878	703	3.7%	76,283
Allied health personnel	2,737	2,923	**186**	**6.4%**	8,490	9,052	**562**	**6.2%**	36,745
Other personnel	1,933	1,926	(7)	-0.3%	5,874	6,013	140	2.3%	24,031
Outsourced services	850	641	**(209)**	**-32.6%**	2,296	1,922	**(374)**	**-19.5%**	7,733
Clinical supplies	3,248	2,900	**(348)**	**-12.0%**	10,184	8,928	**(1,256)**	**-14.1%**	35,154
Infrastructure and non clinical	1,778	1,751	(28)	-1.6%	5,237	5,232	(4)	-0.1%	20,871
	21,263	**20,986**	**(277)**	**-1.3%**	**64,683**	**64,578**	**(106)**	**-0.2%**	**262,971**
Expenditure by directorate $'000									
Medical	5,549	5,446	(103)	-1.9%	17,194	16,743	(451)	-2.7%	68,974
Surgical	4,763	4,404	**(359)**	**-8.2%**	14,012	13,748	(264)	-1.9%	55,473
Community, Women and Children	3,406	3,453	47	1.4%	10,477	10,672	194	1.8%	42,759
Older Persons, Options HB, Menta	2,670	2,762	92	3.3%	8,239	8,571	332	3.9%	34,925
Operations	3,060	3,128	68	2.2%	9,424	9,551	127	1.3%	38,499
Other	1,815	1,793	(22)	-1.2%	5,337	5,293	(44)	-0.8%	22,340
	21,263	**20,986**	**(277)**	**-1.3%**	**64,683**	**64,578**	**(106)**	**-0.2%**	**262,971**
Full Time Equivalents									
Medical personnel	322.2	330.1	8	2.4%	311	328	16	4.9%	345.2
Nursing personnel	905.4	934.2	29	3.1%	909	939	30	3.2%	916.4
Allied health personnel	466.0	479.3	13	2.8%	462	481	18	3.8%	478.4
Support personnel	132.8	135.2	2	1.8%	132	136	4	3.1%	136.0
Management and administration	272.2	273.5	1	0.5%	269	275	7	2.4%	271.7
	2,098.6	**2,152.2**	**54**	**2.5%**	**2,083**	**2,158**	**75**	**3.5%**	**2,147.7**

Case weighted discharges were not up to date when the report was prepared, and have been removed from the table.

Directorates

- The September Surgical result is driven by outsourced services (Royston) implants/prostheses, disposable instruments, and unachieved efficiencies

September



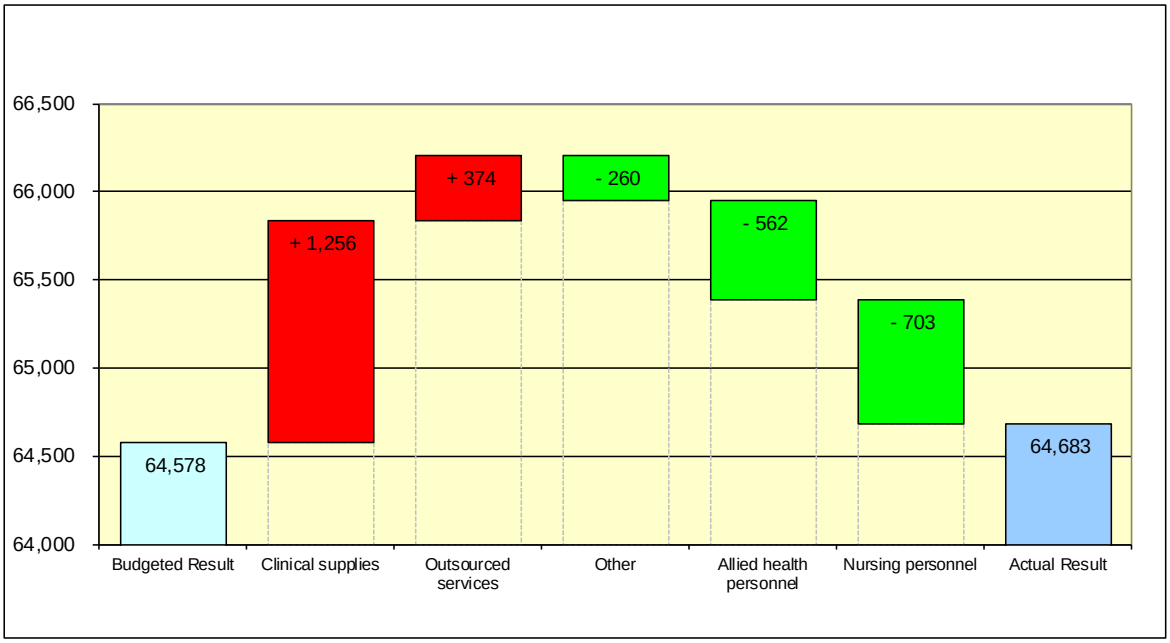
Clinical supplies (unfavourable)
Efficiencies not achieved, disposable instruments, and implants and prostheses.

Outsourced services (unfavourable)
Outsourced elective surgery to Royston.

Allied health personnel (favourable)
Vacancies, mainly psychologists, laboratory technicians, social workers and anaesthetic technicians.

Nursing personnel (favourable)
Senior nurse vacancies.

Year to date



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Efficiencies not achieved, instruments and equipment (including disposables), implants and prostheses, and pharmaceuticals (biologics).

Outsourced services (unfavourable)
Royston elective surgery.

Allied health personnel (favourable)
Vacancies, mainly psychologists, case manager and social workers, technicians, therapists and mental health and community workers.

Nursing personnel (favourable)
Difficulty recruiting to new senior nursing positions.

Full time equivalents (FTE)

FTEs are 75 favourable year to date including:

Medical personnel (16 FTE / 4.9% favourable)

- Vacancies mainly in CWC (Community, Women and Child), Older Persons/Mental Health, Surgical, and Medical services. Includes a number of new positions.

Nursing personnel (30 FTE / 3.2% favourable)

- Mostly vacant senior nursing positions across a wide range of departments. Includes a number of new positions.

Allied Health Personnel (18 FTE / 3.8% favourable)

- Mostly technicians, mental health workers, social workers and case managers, and psychologists.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To September 2017

Plan for 2017/18	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	13		57	**70**
Non Surgical - Elective	67		120	**187**
Surgical - Arranged	545		152	**697**
Surgical - Elective	5,186	754	680	**6,620**
TOTAL	**5,811**	**754**	**1,009**	**7,574**

		YTD September 2017			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	51	51	0	0.00%
	ENT	103	123	-20	-16.30%
	General Surgery	224	220	4	1.80%
	Gynaecology	129	135	-6	-4.40%
	Maxillo-Facial	48	54	-6	-11.10%
	Ophthalmology	222	222	0	0.00%
	Orthopaedics	134	163	-29	-17.80%
	Orthopaedics - Major Joints	70	70	0	0.00%
	Skin Lesions	41	41	0	0.00%
	Urology	134	132	2	1.50%
	Vascular	44	48	-4	-8.30%
	Surgical - Arranged	163	131	32	24.40%
	Non Surgical - Arranged	10	3	7	233.30%
	Non Surgical - Elective	19	17	2	11.80%
On-Site	**Total**	**1392**	**1410**	**-18**	**-1.30%**
Outsourced	ENT	27	30	-3	-10.00%
	General Surgery	56	65	-9	-13.80%
	Gynaecology	1	0	1	0.00%
	Maxillo-Facial	8	4	4	100.00%
	Ophthalmology	58	38	20	52.60%
	Orthopaedics	1	0	1	0.00%
	Orthopaedics - Major Joints	26	24	2	8.30%
	Skin Lesions	1	0	1	0.00%
	Urology	11	11	0	0.00%
	Vascular	4	1	3	300.00%
Outsourced	**Total**	**193**	**173**	**20**	**11.60%**
IDF Outflow	Cardiothoracic	24	20	4	20.00%
	ENT	18	9	9	100.00%
	General Surgery	18	14	4	28.60%
	Gynaecology	2	6	-4	-66.70%
	Maxillo-Facial	36	44	-8	-18.20%
	Neurosurgery	9	19	-10	-52.60%
	Ophthalmology	8	11	-3	-27.30%
	Orthopaedics	11	5	6	120.00%
	Paediatric Surgery	25	18	7	38.90%
	Skin Lesions	14	11	3	27.30%
	Urology	3	2	1	50.00%
	Vascular	3	4	-1	-25.00%
	Surgical - Arranged	43	35	8	22.90%
	Non Surgical - Arranged	12	12	0	0.00%
	Non Surgical - Elective	24	26	-2	-7.70%
IDF Outflow	**Total**	**250**	**236**	**14**	**5.90%**
TOTAL		**1,835**	**1,819**	**16**	**0.90%**

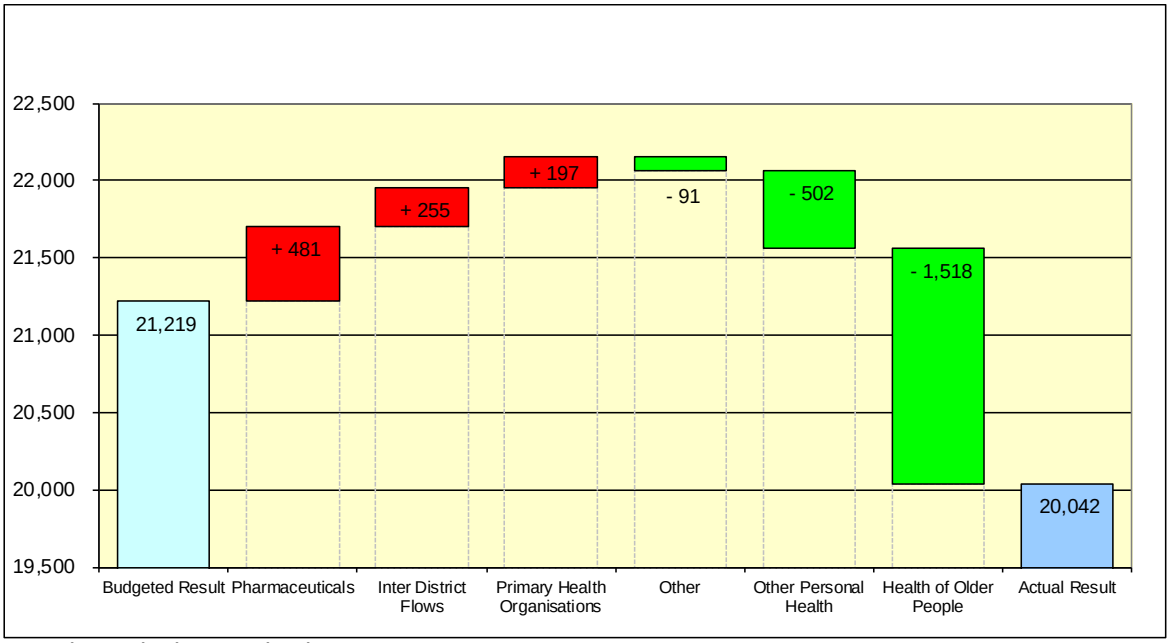
		Sep-17			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	17	17	0	0.00%
	ENT	39	42	-3	-7.10%
	General Surgery	60	63	-3	-4.80%
	Gynaecology	44	48	-4	-8.30%
	Maxillo-Facial	23	17	6	35.30%
	Ophthalmology	70	60	10	16.70%
	Orthopaedics	35	52	-17	-32.70%
	Orthopaedics - Major Joints	27	28	-1	-3.60%
	Skin Lesions	17	17	0	0.00%
	Urology	49	41	8	19.50%
	Vascular	15	16	-1	-6.30%
	Surgical - Arranged	48	47	1	2.10%
	Non Surgical - Arranged	3	1	2	200.00%
	Non Surgical - Elective	2	5	-3	-60.00%
On-Site	**Total**	**449**	**454**	**-5**	**-1.10%**
Outsourced	ENT	7	12	-5	-41.70%
	General Surgery	12	25	-13	-52.00%
	Gynaecology	1	0	1	0.00%
	Maxillo-Facial	7	3	4	133.30%
	Ophthalmology	50	38	12	31.60%
	Orthopaedics	1	0	1	0.00%
	Orthopaedics - Major Joints	8	10	-2	-20.00%
	Skin Lesions	0	0	0	0.00%
	Urology	2	4	-2	-50.00%
	Vascular	4	0	4	0.00%
Outsourced	**Total**	**92**	**92**	**0**	**0.00%**
IDF Outflow	Cardiothoracic	7	8	-1	-12.50%
	ENT	4	4	0	0.00%
	General Surgery	5	4	1	25.00%
	Gynaecology	1	3	-2	-66.70%
	Maxillo-Facial	12	19	-7	-36.80%
	Neurosurgery	2	8	-6	-75.00%
	Ophthalmology	2	4	-2	-50.00%
	Orthopaedics	1	2	-1	-50.00%
	Paediatric Surgery	10	7	3	42.90%
	Skin Lesions	6	4	2	50.00%
	Urology	0	1	-1	-100.00%
	Vascular	1	2	-1	-50.00%
	Surgical - Arranged	20	14	6	42.90%
	Non Surgical - Arranged	5	6	-1	-16.70%
	Non Surgical - Elective	6	10	-4	-40.00%
IDF Outflow	**Total**	**82**	**96**	**-14**	**-14.60%**
TOTAL		**623**	**642**	**-19**	**-3.00%**

Note: This report was run on 9th October 2017. Skin Lesions and Avastins are reported to plan. Data is subject to change.

6. Funding Other Providers

$'000	September Actual	September Budget	September Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	4,210	3,729	(481)	-12.9%	11,110	11,187	77	0.7%	44,792
Primary Health Organisations	3,164	2,966	(197)	-6.7%	8,976	9,112	136	1.5%	36,463
Inter District Flows	4,642	4,387	(255)	-5.8%	13,088	13,210	123	0.9%	51,801
Other Personal Health	1,349	1,851	502	27.1%	5,241	5,555	314	5.7%	22,968
Mental Health	936	947	11	1.2%	2,822	2,840	18	0.6%	11,196
Health of Older People	5,502	7,020	1,518	21.6%	17,008	16,781	(228)	-1.4%	67,128
Other Funding Payments	241	320	80	24.9%	960	1,017	56	5.6%	4,317
	20,042	21,219	1,177	5.5%	**59,204**	**59,701**	497	0.8%	238,664
Payments by Portfolio									
Strategic Services									
Secondary Care	4,044	3,827	(217)	-5.7%	11,506	11,481	(25)	-0.2%	45,218
Primary Care	8,306	8,202	(104)	-1.3%	24,075	24,823	748	3.0%	100,045
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,252	1,266	14	1.1%	3,740	3,797	57	1.5%	14,890
Health of Older People	5,850	7,306	1,457	19.9%	18,013	17,691	(322)	-1.8%	70,579
Other Health Funding	47	33	(14)	-42.1%	114	100	(14)	-14.0%	400
Maori Health	445	478	34	7.0%	1,423	1,435	12	0.8%	6,053
Population Health	99	107	8	7.5%	333	375	42	11.2%	1,477
	20,042	21,219	1,177	5.5%	**59,204**	**59,701**	497	0.8%	238,664

September



Note the scale does not begin at zero

Pharmaceuticals (unfavourable)
Expenditure is volatile and the month reflects partial reversal of the favourable result last month.

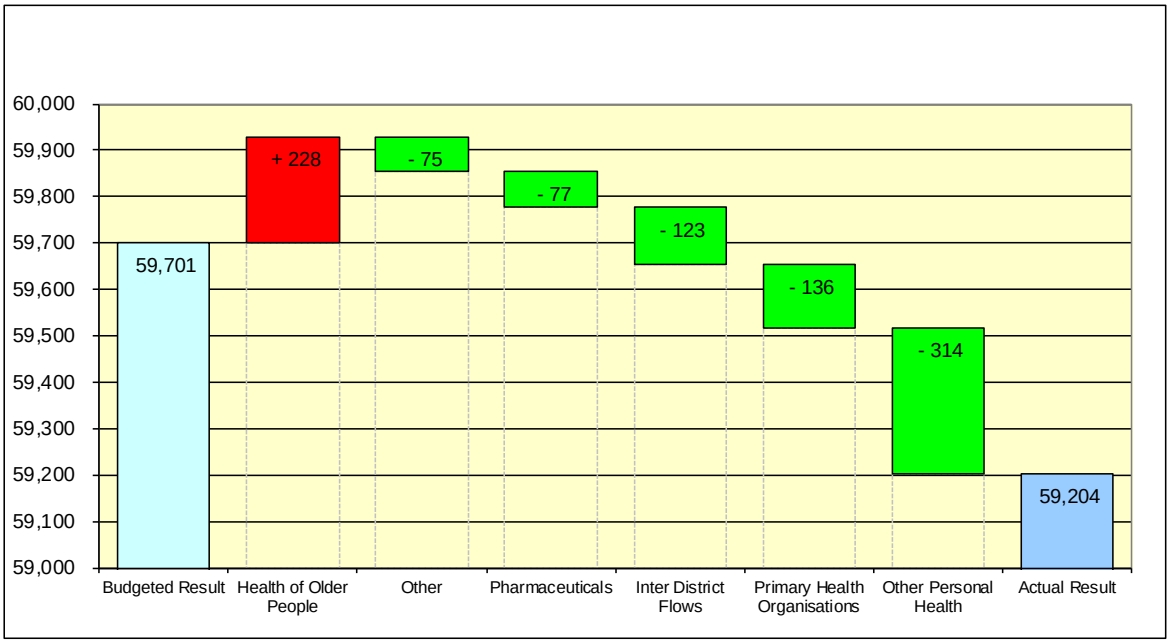
Inter District Flows (unfavourable)
Discharges of long stay Hawke's Bay resident patients by other DHBs, and efficiency targets.

Primary Health Organisations (unfavourable)
Performance payment, offset by additional MOH income.

Other personal health (favourable)
Immunisation, recovery of funding for school based services, models of care and free GP annual review.

Health of older people (favourable)
The budget has been adjusted in September to include the first quarter pay-equity payments (offset in revenue), and is budgeted for monthly for the remainder of the year. This reflects a change made to the Annual Plan by agreement with MOH. The year to date variance (below) is consequently much smaller.

Year to Date



Health of older people (unfavourable)
Higher than budgeted home support costs.

Pharmaceuticals (favourable)
Pharmaceutical cancer treatments.

Inter District Flows (favourable)
Release of the provision for undischarged long stay patients in August.

Primary Health Organisations (favourable)
Lower payments for under sixes, under thirteens and very low cost access.

Other personal health (favourable)
Recovery of funding for school based services. Includes release of provisions from 2016/17.

7. Corporate Services

$'000	September Actual	September Budget	September Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,368	1,269	**(99)**	**-7.8%**	3,953	3,952	(2)	0.0%	15,767
Outsourced services	96	68	(28)	-41.7%	264	203	**(61)**	**-30.2%**	812
Clinical supplies	155	198	43	21.6%	(158)	(203)	(45)	-22.3%	(354)
Infrastructure and non clinical	617	767	**150**	**19.5%**	2,668	2,823	**155**	**5.5%**	9,746
	2,236	2,302	66	2.9%	6,727	6,774	47	0.7%	25,971
Capital servicing									
Depreciation and amortisation	1,120	1,075	(44)	-4.1%	3,446	3,233	**(213)**	**-6.6%**	13,272
Capital charge	705	705	-	0.0%	2,115	2,115	-	0.0%	8,459
	1,825	1,780	(44)	-2.5%	5,561	5,348	(213)	-4.0%	21,731
	4,061	**4,082**	21	0.5%	**12,288**	**12,122**	(166)	-1.4%	**47,702**
Full Time Equivalents									
Medical personnel	0.3	0.3	(0)	-16.3%	0	0	0	9.9%	0.3
Nursing personnel	15.5	15.1	(0)	-2.3%	13	15	2	15.6%	14.9
Allied health personnel	0.8	0.4	(0)	-99.8%	1	0	(1)	-149.2%	0.4
Support personnel	9.0	9.1	0	1.9%	9	9	0	3.4%	9.1
Management and administration	140.6	145.4	5	3.3%	139	146	7	4.7%	146.5
	166.2	**170.4**	4	2.5%	**162**	**171**	**9**	**5.3%**	**171.2**

Personnel in September assumes training costs will match income. Infrastructure for both September and year to date relates mainly to data network, CRISP and IT maintenance costs.

Outsourced services mainly relate to work accident costs. Depreciation is partly accelerated depreciation of some lower value IT assets, and higher capitalisation of assets in 2016/17 than was allowed for in depreciation budgets for 2017/18.

8. Reserves

$'000	September Actual	September Budget	September Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	250	250	-	0.0%	750	750	-	0.0%	3,000
Transform and Sustain resource	(13)	102	**115**	**113.0%**	106	307	**201**	**65.3%**	1,227
Other	(8)	4	13	297.8%	19	13	(6)	-47.0%	51
	228	**356**	**127**	**35.8%**	**875**	**1,070**	**195**	**18.2%**	**4,278**

No contingency was used during the first quarter of the 2017/18 financial year. Transform and Sustain reflects project costs being incurred in later periods than budgeted.

9. Financial Performance by MOH Classification

	September			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	42,773	44,071	(1,298) U	127,099	127,659	(561) U	524,431	524,124	307 F
Less:									
Payments to Internal Providers	25,300	25,300	-	74,091	74,441	350 F	285,018	283,900	(1,118) U
Payments to Other Providers	20,042	21,219	1,177 F	59,204	59,701	497 F	238,664	238,724	60 F
Contribution	**(2,569)**	**(2,448)**	**(121) U**	**(6,197)**	**(6,484)**	**286 F**	**749**	**1,500**	**(751) U**
Governance and Funding Admin.									
Funding	274	274	-	823	823	-	3,294	3,294	-
Other Income	3	3	-	8	8	-	30	30	-
Less:									
Expenditure	252	253	1 F	704	743	40 F	3,215	3,324	108 F
Contribution	**24**	**24**	**1 F**	**127**	**87**	**40 F**	**108**	**(0)**	**108 F**
Health Provision									
Funding	25,026	25,026	-	73,268	73,618	(350) U	281,724	280,606	1,118 F
Other Income	2,764	2,575	189 F	7,895	7,680	216 F	30,654	30,089	565 F
Less:									
Expenditure	25,301	25,171	(129) U	77,142	77,026	(117) U	311,736	310,695	(1,040) U
Contribution	**2,489**	**2,429**	**60 F**	**4,021**	**4,272**	**(251) U**	**642**	**-**	**642 F**
Net Result	**(55)**	**5**	**(60) U**	**(2,049)**	**(2,124)**	**75 F**	**1,500**	**1,500**	**(0) U**

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, or unbudgeted new funding received during the year and the associated expenditure.

	September			Year to Date			End of Year		
$'000	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	44,071	43,783	288 F	127,659	127,348	311 F	524,431	524,124	307 F
Less:									
Payments to Internal Providers	25,300	25,018	(282) U	74,441	74,160	(282) U	285,018	283,900	(1,118) U
Payments to Other Providers	21,219	21,196	(23) U	59,701	59,527	(174) U	238,664	238,724	60 F
Contribution	**(2,448)**	**(2,431)**	**(17) U**	**(6,484)**	**(6,338)**	**(145) U**	**749**	**1,500**	**(751) U**
Governance and Funding Admin.									
Funding	274	274	-	823	823	-	3,294	3,294	-
Other Income	3	3	-	8	8	-	30	30	-
Less:									
Expenditure	253	275	21 F	743	833	90 F	3,215	3,324	108 F
Contribution	**24**	**2**	**21 F**	**87**	**(2)**	**90 F**	**108**	**(0)**	**108 F**
Health Provision									
Funding	25,026	24,744	282 F	73,618	73,337	282 F	281,724	280,606	1,118 F
Other Income	2,575	2,537	38 F	7,680	7,566	114 F	30,654	30,089	565 F
Less:									
Expenditure	25,171	24,847	(324) U	77,026	76,685	(340) U	311,736	310,695	(1,040) U
Contribution	**2,429**	**2,434**	**(5) U**	**4,272**	**4,217**	**56 F**	**642**	**-**	**642 F**
Net Result	**5**	**5**	**-**	**(2,124)**	**(2,124)**	**-**	**1,500**	**1,500**	**(0) U**

11. Quality and Financial Improvement Programme

The efficiency savings plan of 10.8 million is almost fully identified ($10.6 million) to specific schemes.

The table below shows the $10.6 million of general efficiency plans have been identified to date, and that $1.5 million of savings have been achieved against a year to date target of $2.1 million.

Provider services general efficiencies are 83% of the year to date identified plans. The large items in the $171 thousand shortfall are medical nurse savings, vacancy management in Community, Women and Child, the surgical overflow ward and the surgical directorate's non recurrent schemes.

Strategic Planning general efficiencies are at 55% of the year to date identified plans. IDF outflows makes up $168 thousand of the shortfall and reflects the lead time for referral practice changes. Increased residential care volumes comprise a further $146 thousand of the shortfall, but may improve as the effect of the pay equity is better understood.

Service	2017/18 Annual Savings Plans	YTD Savings Planned	YTD Savings Achieved	YTD Var	% YTD Planned Savings Achieved	% of Annual Plan YTD
Corporate	996,999	124,610	110,230	-14,380	88%	12%
Provider Services	4,727,848	998,182	826,910	-171,272	83%	21%
Strategic Planning	4,598,000	826,080	455,098	-370,982	55%	18%
Strategy and Health Improvement	285,440	141,768	137,684	-4,084	97%	50%
Grand Total	**10,608,287**	**2,090,639**	**1,529,922**	**-560,717**	**73%**	**20%**

12. Financial Position

30 June 2017	$'000	September Actual	September Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
	Equity					
149,751	Crown equity and reserves	149,751	149,751	-	-	149,394
(7,406)	Accumulated deficit	(9,455)	(6,597)	2,858	(2,049)	(2,973)
142,345		140,296	143,154	2,858	(2,049)	146,421
	Represented by:					
	Current Assets					
16,541	Bank	14,409	17,902	3,493	(2,132)	15,536
1,690	Bank deposits > 90 days	1,654	1,755	101	(36)	1,755
26,735	Prepayments and receivables	22,878	22,492	(386)	(3,857)	22,951
4,435	Inventory	4,390	4,354	(36)	(45)	4,419
625	Non current assets held for sale	625	625	-	-	-
50,025		43,956	47,127	3,171	(6,069)	44,661
	Non Current Assets					
152,411	Property, plant and equipment	152,637	153,986	1,348	227	160,576
1,820	Intangible assets	1,697	1,918	221	(123)	2,962
10,701	Investments	10,701	11,372	671	-	12,105
164,932		165,036	167,276	2,240	104	175,642
214,957	**Total Assets**	**208,992**	**214,403**	**5,411**	**(5,965)**	**220,302**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
35,447	Payables	32,911	35,192	2,282	(2,536)	35,762
34,528	Employee entitlements	33,148	33,362	214	(1,380)	35,381
69,975		66,059	68,555	2,496	(3,916)	71,143
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,694	57	-	2,739
2,638		2,638	2,694	57	-	2,739
72,612	**Total Liabilities**	**68,696**	**71,249**	**2,553**	**(3,916)**	**73,882**
142,345	**Net Assets**	**140,296**	**143,154**	**2,858**	**(2,049)**	**146,421**

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2016/17 result, and the 2017/18 variance from budget;
- Property, plant and equipment mainly reflect the lower than budgeted capital spend;
- Payables reflects lower funding wash-up accruals from MOH.
- Employee entitlements – see below

The opening balance for investments and payables has been updated to reflect the results of Allied Laundry Services for 2016/17.

13. Employee Entitlements

30 June 2017	$'000	*September* *Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2017*	*Annual Budget*
7,853	Salaries & wages accrued	7,459	6,537	(922)	(394)	7,756
522	ACC levy provisions	389	125	(264)	(133)	501
4,869	Continuing medical education	4,419	4,961	542	(450)	5,553
19,819	Accrued leave	19,389	20,078	689	(430)	19,883
4,103	Long service leave & retirement grat.	4,130	4,355	225	27	4,426
37,165	**Total Employee Entitlements**	35,786	36,057	271	(1,380)	38,119

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 DHB has no interest rate exposure relating to debt.

Foreign exchange risk management

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

15. Capital Expenditure

See next page.

2018 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
14,440	Depreciation	3,446	3,233	(213)
5,000	Surplus/(Deficit)	(2,049)	(2,124)	(75)
(2,479)	Working Capital	1,986	5,118	3,131
16,961		3,383	6,226	2,843
	Other Sources			
-	Special funds and clinical trials	193	-	(193)
1,220	Sale of assets	-	-	-
5,000	Borrowings	-	-	-
6,220		193	-	(193)
23,181	**Total funds sourced**	**3,576**	**6,226**	**2,650**
	Application of Funds:			
	Block Allocations			
3,183	Facilities	456	1,025	568
3,125	Information Services	26	800	774
5,464	Clinical Plant & Equipment	918	675	(244)
11,772		1,401	2,499	1,098
	Local Strategic			
2,460	MRI	-	-	-
500	Renal Centralised Development	353	270	(82)
3,000	New Stand-alone Endoscopy Unit	1,406	1,576	170
710	New Mental Health Inpatient Unit Development	85	33	(52)
100	Maternity Services	-	-	-
400	Upgrade old MHIU	9	125	116
400	Travel Plan	61	61	(1)
400	Histology and Education Centre Upgrade	48	389	340
1,100	Fluoroscopy Unit	-	-	-
-	Surgical Expansion	-	750	750
200	Education Centre Upgrade	-	-	-
-	Radiology Extension	-	125	125
-	Fit out Corporate Building	-	150	150
9,270		1,963	3,479	1,516
	Other			
-	Special funds and clinical trials	193	-	(193)
1,000	New Technologies/Investments	-	-	-
-	Other	19	-	(19)
1,000		213	-	(213)
22,042	***Capital Spend***	***3,576***	***5,978***	***2,401***
	Regional Strategic			
1,139	RHIP (formerly CRISP)	-	249	249
1,139		-	249	249
23,181	**Total funds applied**	**3,576**	**6,226**	**2,650**

Monthly Project Board Report

Sep 2017

HAWKE'S BAY District Health Board

Improving Endoscopy Services. Phase 3
Service transition and Facilities Development.

Project Manager Facilities Development: Trent Fairey

Overall Project Progress	Quality & Safety Risk Status	Time Status	Financial Status
31%	G	Y	G

Phase 3: Service transition & Facility Development

Formal approval of the Business Case was received in December 2016 from the Hawke's Bay District Health Board for the construction of a stand-alone Gastroenterology Service building (improving Endoscopy services).
Phase 1 Service & Facility Planning, and Phase 2 Design & Tendering of service facility have been completed on time and within budget.
Phase 3 Service Transition and Facility construction is now underway. This phase concentrates on the construction of the facility to enable the service transition in late 2018. Trialling a new shift in endoscopy unit to cover the additional RN responsibilities associated with managing the end to end process for endoscopy services. Reviewing the equipment to support care delivery pre and post endoscopy.
A fourth and final phase of the project will complete the Improving Endoscopy Services programme, focusing on the development of the service and delivery of the bowel screening programme.

Project Budget Status

Total Approved for Capital Budget	**$ 11,670,000**	Total 17/18 Forecast Spend	**$ 6,300,000**
Total Project Spend to Date	$ 3,647,738	Total 17/18 Spend to Date	$ 1,406,266
Percentage of Total Spend vs Budget	31%	Percentage 17/18 Spend vs Forecast	22%

Project initiation was completed on the 27th February 2017 on approval of the site specific safety plan. Project total spend is behind projections due to delay with weather and screwpile installation. Contingency funds will be required to support the extensive screw pile failures and the significant changes to the foundation design. At present these changes are contained within the approved funding for the project, the contingency allowed for such issues in the original plan is adequate to cover the projected costs.

Deliverable Dates

Geotechnical design and Testing	Complete	Internal construction - Building Services	May-18
Site specific safety plan review and approval	Complete	Furniture , Fittings and Equipment installation	Jun-18
Earthworks and Excavation	Complete	Building services commissioning	Jul-18
Foundation construction	Complete	Facility Sign off & Certificate of Public Use	Aug-18
Structural Steelwork installation	Oct-17	Service Training and Transition to Staged start up	Sep-18
Concrete floor structures	Dec-17	Full operational capacity available and Service Go Live	Oct-18
Exterior and Roof Cladding	Mar-18	Post Implementation Review & Post Occupancy Evaluations	Feb-19

Key Achievements this period

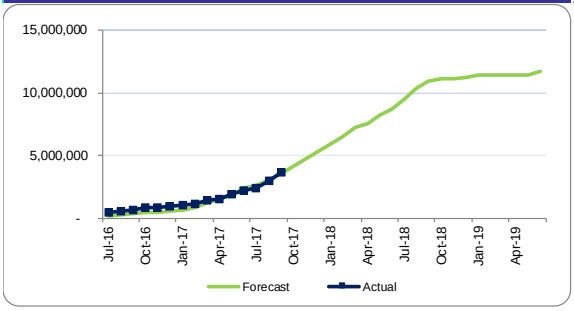
Grid A through to D Structural steel installation has been completed, Grids D through to G are under construction with completion of this section to program.
No accidents reported in this period, 2nd Quarter H&S Audit pass mark of 96.4%. Independent H&S auditing continues with Safe on Site for the HBDHB.

Planned Activities next period

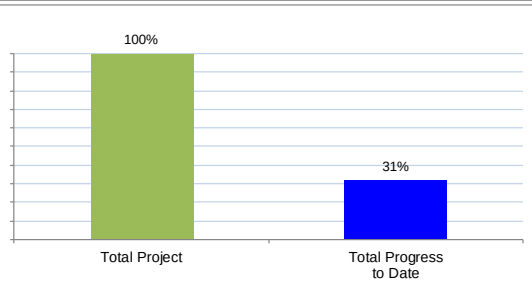
Completetion of Structural steel in Grids D through to G, Manufacture of Grids G through to K
Completion of service tunnel between theatre block and Endoscopy building.
Installation of stage 2 Buckling Resistant Braces
Completion of foundation walls in Grids G to K.

Risks & Issues of Note	Mitigation & Resolutions
Redesign of the Endoscopy Units Level 1 to support the theatre expansion project.	Negotiations continue with GEMCO construction to mitigate the extention of contruction time for this variation.
Re-calibration of construction programme to recover for lost construction time. Late start up due to unresolved geotechnical conditions, cyclone weather issues and screw pile installation failures.	Project Programme has been revised at the completion of the foundation section. The initial loss of 21 days due to geotechnical issues and inclement weather has remained as projected. This has now been integrated into the current programme and reissued to the construction team. Completion date for construction is scheduled for the the 20th of July 2018. Staged start up and go live of the facility is planned for spring 2018.

Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	September Forecast	Variance	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	42,675	49,324	(6,648)	50,882	48,086	44,703	45,742	47,725	44,801	44,726	47,660	48,223	44,365	43,638	52,459
Cash receipts from donations, bequests and clinical trials	(124)	-	(124)	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	238	440	(202)	505	447	445	471	477	471	471	477	472	440	446	440
Cash paid to suppliers	(26,408)	(27,546)	1,138	(27,599)	(27,876)	(27,464)	(27,638)	(24,799)	(27,860)	(27,775)	(26,627)	(27,715)	(28,113)	(26,670)	(29,968)
Cash paid to employees	(15,031)	(15,683)	652	(15,900)	(18,872)	(15,325)	(23,370)	(16,232)	(16,052)	(16,344)	(19,035)	(16,017)	(15,532)	(20,705)	(15,683)
Cash generated from operations	**1,350**	**6,535**	**(5,185)**	**7,889**	**1,784**	**2,360**	**(4,795)**	**7,170**	**1,359**	**1,078**	**2,475**	**4,963**	**1,160**	**(3,291)**	**7,249**
Interest received	58	74	(16)	74	74	74	74	74	74	74	74	74	74	74	74
Capital charge paid	(705)	0	(705)	0	0	0	(4,230)	0	0	0	0	(4,230)	0	0	0
Net cash inflow/(outflow) from operating activities	**703**	**6,608**	**(5,906)**	**7,962**	**1,858**	**2,434**	**(8,952)**	**7,243**	**1,433**	**1,152**	**2,549**	**807**	**1,234**	**(3,217)**	**7,322**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	(0)	-	(0)	-	-	625	-	-	-	-	-	(0)	-	-	-
Acquisition of property, plant and equipment	(1,713)	(1,320)	(393)	(1,601)	(1,875)	(1,906)	(2,011)	(1,993)	(2,431)	(2,168)	(2,614)	(2,270)	(1,839)	(1,839)	(1,839)
Acquisition of intangible assets	(11)	(83)	71	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(83)	(84)	(83)	(83)	(83)
Acquisition of investments	-	0	(0)	-	-	0	-	-	0	-	-	0	-	-	0
Net cash inflow/(outflow) from investing activities	**(1,724)**	**(1,402)**	**(322)**	**(1,684)**	**(1,958)**	**(1,363)**	**(2,094)**	**(2,076)**	**(2,513)**	**(2,251)**	**(2,697)**	**(2,354)**	**(1,922)**	**(1,922)**	**(1,921)**
Cash flows from financing activities															
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	-	-	(357)	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	(1,022)	5,206	(6,228)	6,279	(100)	1,071	(11,045)	5,168	(1,081)	(1,098)	(148)	(1,905)	(688)	(5,139)	5,401
Add:Opening cash	17,084	17,084	-	16,063	22,342	22,242	23,313	12,268	17,435	16,355	15,257	15,109	13,204	12,517	7,378
Cash and cash equivalents at end of year	**16,063**	**22,291**	**(6,228)**	**22,342**	**22,242**	**23,313**	**12,268**	**17,435**	**16,355**	**15,257**	**15,109**	**13,204**	**12,517**	**7,378**	**12,779**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	13,160	19,260	(6,100)	19,311	19,212	20,282	9,237	14,405	13,324	12,226	12,078	10,174	9,486	4,347	9,748
Short term investments (special funds/clinical trials)	2,797	3,026	(229)	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026
Bank overdraft	102	-	102	-	-	-	-	-	-	-	-	-	-	-	-
	16,063	**22,291**	**(6,228)**	**22,342**	**22,243**	**23,313**	**12,268**	**17,436**	**16,355**	**15,257**	**15,109**	**13,205**	**12,517**	**7,378**	**12,779**

The operating forecasts for 2017/18 year are based on the draft budget completed in June 2017, adjusted for facilities forecasts of capital spend. Changes have been made to the phasing of some major cash-flows based on best estimates of when they will occur e.g. elective services revenue, IDF wash-up and the rest home worker's pay equity settlement.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council**	119
	For the attention of: **HBDHB Board**	
Document Owner:	Dr John Gommans (Chair) and Dr Andy Phillips (Co-Chair)	
Reviewed by:	Not applicable	
Month:	October 2017	
Consideration:	For Information	

11

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Endorsed** the Ka Aronui Ki Te Kounga / Focussed on Quality "Quality Accounts"

Council met on 11 October 2017, an overview of issues discussed and/or agreed at the meeting are provided below:

Whole of System Flow Data

A presentation was provided on Health Roundtable (HRT) data for secondary care referred from primary care on acute hospital bed days, long-term conditions, ED attendances and admissions, ratio of triage categories and by ethnicity (it did not include Maternity or Mental Health data). The Co-chair advised that the purpose of this data collection is not for judgement but to start conversations and reflect on the levels of variation across practices.

The data demonstrated significant variations between practices that may reflect the needs of the different populations served. The data suggested that an increased focus is required on supporting people with long term conditions.

Reflection on Patient Flow Presentations (from today and last month's meeting on acute flow)

The Co-chairs have been working to ensure that Clinical Council is more engaged with clinical issues driving quality, efficiency, equity and clinical practice as the key clinical governance body for the Board.

Discussion confirmed a consensus that the size of the agenda needs to be appropriate to allow robust discussion and give a better balance between secondary and primary care issues.

Clinical Governance Structure Update

It has taken some time to embed these committees and some advisory groups are not yet functioning. It was acknowledged that structurally the hospital governance is strong and there is a need to augment primary care governance, as well as ensuring consumer engagement on these committees and advisory groups.

A further issue raised related to those who hold leadership positions as part of their job e.g. Chief Medical Officers, Chief Allied Health Professions Officer who also chair some of the advisory groups. It was agreed that for good governance there needed to be delegations or relinquishing some of the chair roles. This is an opportunity for leadership development for other staff and succession planning.

Ka Aronui Ki Te Kounga / Focussed on Quality "Quality Accounts" (FINAL)

The final version of the Quality Accounts was tabled. Following a brief discussion, minor change to be made to better intertwine the HBDHB values in the stories.

The Clinical Council **endorsed** the Quality Accounts in principle.

Waioha Primary Birthing Unit – Benefits Realisation

A presentation was provided with a more clinical context on “Great Expectations – Waioha Turning 1”. Waioha is doing well in its first year. Another report will be provided in July 2018, after two years.

Reports were noted form the following Committees:

- HB Radiology Services Committee
- HB Laboratory Services Committee
- HB Nursing Midwifery Leadership Council Update (including Nursing & Midwifery Dashboard)
- Infection Prevention & Control Committee

Reports provided for information only:

- Havelock North Gastro Review – 6 monthly update
- Update on Establishing Health and Social Care Localities in Hawke's Bay
- Implementing the National Bowel Screening Programme in Hawke’s Bay

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** 120
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie, Chair
Reviewed by:	Not applicable
Month:	October, 2017
Consideration:	For Information

12

RECOMMENDATION

That the Board

Note the contents of this report

Note that Consumer Council accepted and endorsed the following paper:

- 2017 Quality Accounts

Presentation and papers received included:

- Establishing Health and Social Care Localities in HB and;
- Implementing Bowel Screening in Hawke's Bay

Updates were received from the following meetings:

- NZ Consumer Councils meeting
- Youth Consumer Concil meeting

Council met on 12 October 2017. The following is an overview of the meeting.

1. 2017 Quality Accounts

Were endorsed (in principle as requested). While there were some suggestions to make the accounts increasingly meaningful for consumers the council felt the accounts had moved significantly since the first set were drafted which was pleasing.

2. Establishing Health and Social Care Localities in HB (update) *and* Implementing Bowel Screening in Hawke's Bay

Feedback by email was encouraged as time constraints prevented discussion. The feedback was:

- Include consumer representation on the bowel screening advisory group - (currently 17 clinical and management participants)
- Include ongoing consumer input in the Establishing Health and Social Care Localities project; and include how that input impacts the project so that the influence of the consumer voice can be seen by council.

3. NZ Consumer Councils Meeting

Graeme Norton, Ken Foote and I attended the 2nd annual meeting of this formative group. Most consumer council's around the country are at a more initial stage of development and are more focused at an operational level. The exception would be Canterbury which does have more of a governance role. I grew a significant appreciation for the role consumer council has in Hawke's Bay with executive support and a true governance structure. Thanks go to those with the initiative and drive to put our consumer council in place.

Graeme continues to take the group mandate forward with ongoing discussions with Ministry of Health and other groups around a more formal NZ consumer council structure.

4. Youth Consumer Council

- Have resolved to increase their numbers as the co- chair has been appointed president of the Student Association Board at EIT and doesn't want to constrain progress of the council;
- Ran a workshop last month and the feedback was the youth felt constrained about what they wanted to say with adults present. Resolved to run it differently next time;
- Are supporting and profiling an non-profit organisation called ' Pursuit' which dresses job-seeking under-privileged youth and young adults.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 121
	For the attention of: **HBDHB Board**
Document Owner:	Ngahiwi Tomoana (Chair)
Reviewed by:	Not applicable
Month:	October 2017
Consideration:	For Information

13

RECOMMENDATION

That the HBDHB Board

Review the contents of this report; and

Note that MRB:

1. **Endorsed** Ka Aronui ki te Kounga/ Focused on Quality (Final) for publication **pending** MRBs recommended changes, as follows:
   - Measuring success – work with MRB on what success will look like when Māori requirements are achieved and how to measure these requirements to ensure that what we are doing is supporting Māori wellness
   - Structure of the report – use this opportunity to promote Our Values. Re-order the report to profile Our Values.
2. **Noted** the contents of the Consumer Engagement Strategy and that it was endorsed by HB Health Consumer Council, noting the matters yet to be resolved and the proposed action plan.
3. **Supported** ED People and Quality's request to put the Implementing the Consumer Engagement Strategy on hold until a future date to allow time to investigate the implementation of the Clinical Services Plan and The Big Listen, particularly the use of different techniques to better engage.

MRB met on 11th October 2017. An overview of issues discussed and recommendations at the meeting are provided below.

The following reports and papers were discussed and considered:

GENERAL MANAGER (GM) MĀORI HEALTH REPORT

Science Academy Roll-out and Science Wānanga

There will be more science programmes with the programme now included in the Diversity Plan. We want to widen the scope and look further afield. The key is to achieve 25% of youth interested in science in schools.

Engaging Effectively with Māori (EEM)

The DHB provides online Treaty of Waitangi (TOW) training that staff are required to complete annually. In addition, there are individual registration requirements. We need to have cognisance of the next steps so staff don't fall over by measuring if and how staff are implementing the TOW

principles into their daily practice. Dr James Graham, Senior Advisor Cultural Competency as part of his role is to develop the framework for EEM that will include assessing the competency of the services. Patrick LeGeyt (Acting GM Māori Health) is looking at including three aspects into service plans; 1) Cultural competency targets 2) Māori workforce recruitment targets and 3) Activities eliminating inequities relevant to services.

19 New Graduates for Nursing entry to Practice (NetP)

The two key appointments of Donna Foxall, Nurse Educator NetP and Ngaira Harker, Nursing Director Māori have made significant progress in nursing. In addition, the co-sponsorship of Aria Graham and the fantastic Nursing Directors, one who is of Māori descent and the other of Pacific heritage. There is still some work needed in midwifery with better support of our Māori midwives. The recruitment of a Māori midwife leadership is underway with Beverly Te Huia having been involved in the recruitment process.

Tracee Te Huia (Executive Director Strategy & Health Improvement Directorate) commended Chris McKenna (Chief Nursing & Midwifery Officer) for her contribution and efforts driving nursing and the recruitment of Māori nurses, and also for her courage challenging people whose practices discriminate Māori. The impacts of these appointments need to be captured.

KA ARONUI KI TE KOUNGA / FOCUSED ON QUALITY (FINAL)

MRB **endorsed** Ka Aronui ki te Kounga/ Focused on Quality (Final) for publication **pending** MRBs recommended changes, as follows:

- Measuring success – work with MRB on what success will look like when Māori requirements are achieved and how to measure these requirements to ensure that what we are doing is supporting Māori wellness
- Structure of the report – use this opportunity to promote Our Values. Re-order the report to profile Our Values.

Discussions included:

- Measuring success – the method for measuring and ensuring Taha Wairua (spiritual); Taha Māori requirements will be achieved and is unclear. These may include Te Reo, Taha Wairua, Taha Atua, Mana Tangata, whanaungatanga. There are a number of models to measure spirituality, as well as individual and whānau wellness
- Structure of the report – a missed opportunity to promote 'Our Values' and how we are partnering. The more we talk about how we are living 'Our Values' embodies people into 'Our Values' and in turn start to live by 'Our Values' too.
- Workforce Diversity on page 32 was discussed briefly. N Raihania feedback the statement referring to 'equitable to Hawke's Bay population' limits the opportunity for Māori to be employed as it sets a cap or ceiling on Māori employment. The 'hospital utilisation population' is the equity target rather than the Hawke's Bay population. It was clarified the 25% was not a cap or ceiling.

Kate Coley (Executive Director, People and Quality) will incorporate the comments of MRB and include into the document.

IMPLEMENTING THE CONSUMER ENGAGEMENT STRATEGY

Kate Coley (Executive Director, People and Quality) spoke briefly to the Implementing the Consumer Engagement Strategy taking the opportunity to put a pause on this paper to look at how we've gone through Clinical Services Plan and The Big Listen and how we use different techniques to better engage.

MRB **noted** both the contents of this paper and the Consumer Engagement Strategy endorsed by HB Health Consumer Council, and the matters yet to be resolved and proposed action plan. MRB also **supported** Kate's request to put this paper a hold until a further date to allow Kate to investigate

the implementation of the CSP and The Big Listen, particularly the use of different techniques to better engage.

Most whānau will be resistant about sharing their story because the consumers feel their stories are not heard. Engaging with the right people is key to obtaining significant facts to form the full picture.

Kate Coley (Executive Director, People and Quality) will incorporate MRBs comments and include into the document.

CHECKLIST PRIOR TO PAPERS PRESENTING AT MRB

Ken Foote (Company Secretary) spoke to an example paper from 2012 that talks about reporting responsibilities. The Board Overview was introduced in 2013 and provided a checklist of what the authors were required to right about. This overview highlights 'impacts to inequity'. The standards have slipped and we are now using different language.

MRB requested the current template and policy be updated to include how papers submitted to committees and governance boards impact Māori, identify that Māori have been involved in the co-design, identify what are the inequities, and how does this address social complexity, as well as identifies today's impacts.

Ken will circulate the policy and template to MRB once updated and then request approval by EMT.

The following matters were also discussed and considered:

Information Paper 'NUKA Kahungunu Delegation 2017'

The 'NUKA Kahungunu Delegation 2017'paper that I wrote was tabled. I provided an outline of the paper and the following matters were discussed breifly:

- Look at how we infuse Kahungunu model with the NUKA model
- Ongoing discussions on the November contingent travelling.

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Health Leadership Group** 122
	For the attention of: **HBDHB Board**
Document Owner:	Barbara Arnott, Chair of CPHAC
Document Author(s):	Caren Rangi, Chair of PHLG
Month:	October 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

- Note the contents of this report.

The Pasifika Health Leadership Group met on 9 October. Items addressed noted:

WORKFORCE

Workforce development is a priority for the PHLG and they would like to establish a Pacifica Workforce KPI. The PHLG are keen to understand what the HBDHB Workforce Strategy is in relation to meeting the needs of Pacific health noting the following:

- Pasifika Workforce - What workforce development is in place for existing Pacific staff?
- How is the HBDHB improving the capability of existing workforce in health areas demonstrating the greatest need, e.g. ED, Mental Health Services, long term conditions?
- How is the HBDHB improving the existing capacity of existing workforce to reflect the Hawke's Bay Pacific population in health areas demonstrating the greatest need.

While they are encouraged by the intentions of the NetP programme to become more inclusive of Pacific, they have requested to see the plan for this to occur.

MENTAL HEALTH FOR PASIFIKA

The PHLG continues to be concerned about mental health services for the Pasifica community. PHLG would like to know what the strategy is for best meeting the needs for Pasifica in mental health services and identify where PHLG can best provide support.

PASIFIKA HEALTH SERVICE

The PHLG acknowledge the progress already made by the new Pasifika Health Service (PHS). As a new team establishing themselves there is an opportunity to wrap around the service an evaluation component to capture best practice of what works for Pasifika. PHLG also acknowledge the recent addition of Olive Tanielu as Pacific Liaison Nurse (0.6FTE) for secondary services.

The PHLG note that the priority for the HBDHB for the PHS in moving forward are:

1. That the Pacific community can easily recognise where it sits in the HBDHB structure
2. PHS retains it's developed linkages with the Population Health Service
3. PHS continues to develop and strengthen it's linkages with the Māori Health Service.

NOVEMBER BOARD MEETING

The PHLG will work with the Pasifika Health Service to present at the Board Meeting in November opportunities to strengthen immediate gains, identify and plug gaps, as well as opportunities for future growth.

HAWKE'S BAY District Health Board Whakawāteatia	**Central Regions Technical Advisory Services Ltd Annual General Meeting** 123
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Approved by:	Chief Executive
Month:	October, 2017
Consideration:	For Decision

RECOMMENDATION

That the Board

- Note the Annual Report for TAS for the year ended 30 June 2017.
- Appoint Kevin Atkinson as the HBDHB representative to attend the TAS Annual General Meeting to be held Wednesday 6 December 2017, with Kevin Snee appointed as his Alternate.

15

ATTACHMENTS

A Notice of Meeting
B Minutes of 2016 AGM
C Annual Report 2016/17

AGM REPRESENTATIVE

As HBDHB is a shareholder in TAS, the Board has the right to be represented and vote at the AGM coming up on 6 December 2017.

As the Chair of HBDHB, it is recommended that Kevin Atkinson be appointed to represent HBDHB at this meeting. Should Kevin for any reason be unable to attend, it is also recommended that Kevin Snee be appointed as his Alternate.

Notice of TAS Annual General Meeting

3.30pm, Wednesday 6 December, 2017
Front+Centre, 69 Tory Street, Wellington

Notice is hereby given that the Annual General Meeting of Shareholders of Central Region's Technical Advisory Services Ltd (TAS) is to be held on 6 December at 3.30pm.

Agenda

1. Apologies
2. Minutes - *To review and accept the minutes of the AGM held 6 December 2016*
3. Directors' report on the year ended 30 June 2017 - *To receive the report*
4. Financial Statements and Report - *To receive, consider and adopt the Company's financial statements for the year ended 30 June 2017, along with the Independent Auditor's Report*
5. Auditors - *To record the continuance of KPMG as the Company's auditors for the 2017/18 financial year*
6. General - *Any other business*

Minutes of
Annual General Meeting of Shareholders
of
Central Region's Technical Advisory Services Limited

Held on 6 December 2016 commencing at 3.30pm in the TAS Boardroom, Level 3, New Zealand Language Centre House

Present: **Directors:**

Dr Jan White (Chair), Murray Bain, Wendy McPhail, Kathryn Cook

Shareholder Representatives:

Andrew Blair (Capital and Coast District Health Board), Dr Ashley Bloomfield (Hutt District Health Board), Dot McKinnon (Whanganui District Health Board), Kevin Atkinson (Hawkes Bay District Health Board), Dot McKinnon (MidCentral District Health Board), Kevin Atkinson (Proxy for Wairarapa District Health Board)

Also in Attendance:

Dr Kevin Snee (Chief Executive, Hawke's Bay District Health Board), Sally Webb (Chair of RGG), Adri Isbister, Ed Louden, Partner KPMG, Richard Catto, Director Healthcare, KPMG, Sonia Isaac, Director Audit, KPMG

Graham Smith (TAS Chief Executive), Lucy Haberfield (GM, Business Support Services), Gail Holman (Minute Secretary), Tricia Sloan (GM Planning and Collaboration)

1. Apologies:

Deryck Shaw, TAS Board, Sir Paul Collins, Chair, Wairarapa DHB, Julie Paterson, CE Wanganui DHB

2. Minutes:

Resolved: *That the minutes of the Annual General Meeting held on 7 December 2015 be accepted as a true and accurate record of that meeting.*

Carried: all

3. Financial Statements and Reports:

Resolved: *That the Company's financial statements for the year ending 30 June 2016, together with the Auditor's report and the Directors' Annual Report, be received and adopted.*

Carried: all

KPMG Representatives left the meeting

4. Auditors:

Resolved: *That the continuation of KPMG as the Company's auditors be approved and recorded.*

Carried: all

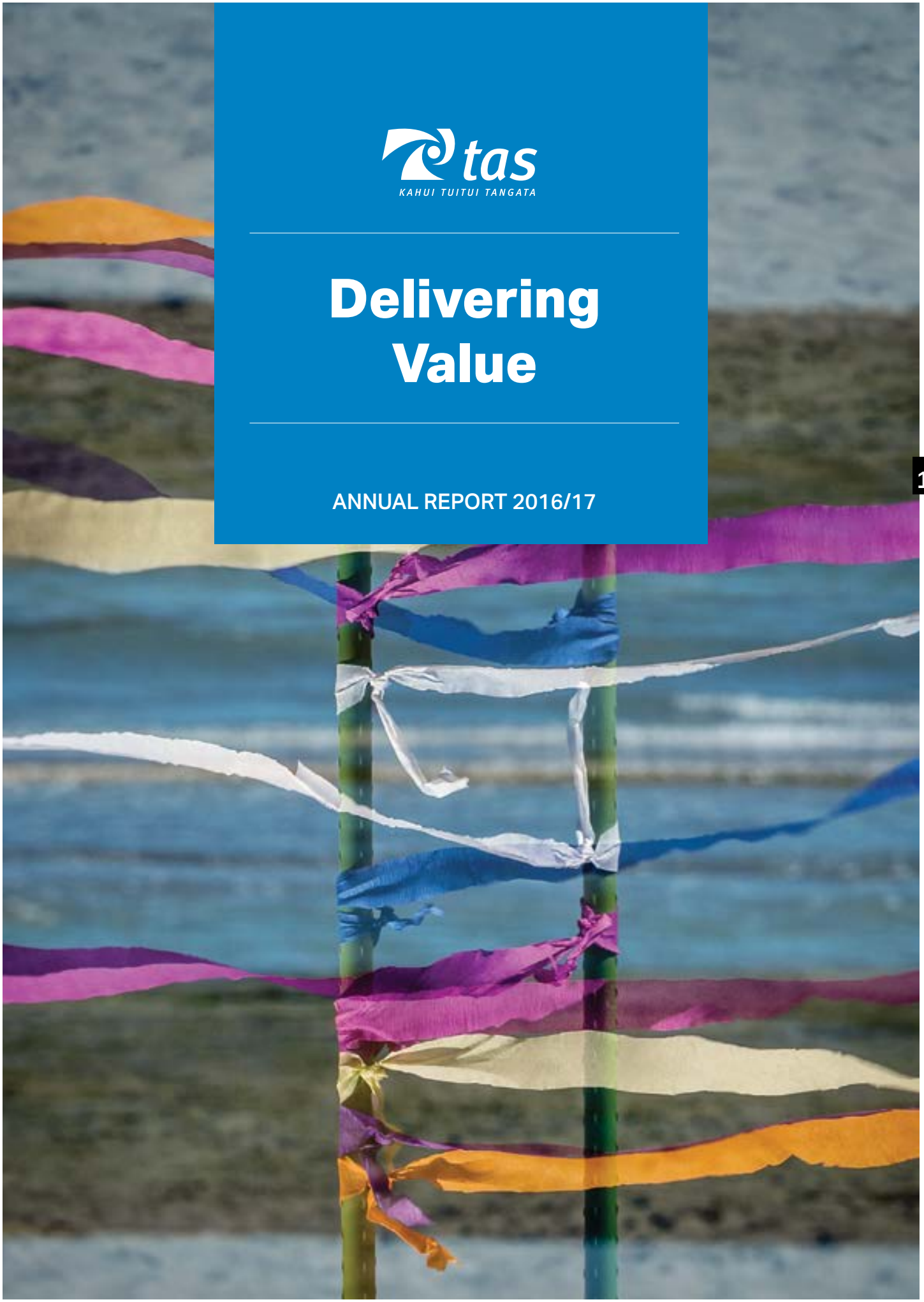
KPMG Representatives rejoined the meeting

5. General:

Kevin Atkinson, on behalf of the six shareholding DHBs, congratulated TAS on its achievements over the past year, especially in regards to the CRISP/RHIP programme and thanked the Board for its strong leadership of the organisation.

No other business was recorded.

The meeting concluded at 3:45 pm.


tas
KAHUI TUITUI TANGATA
Delivering Value
ANNUAL REPORT 2016/17

Our Annual Report Photos

The photos in this years' Annual Report represent the culture and personality of TAS. They were taken around the Wellington region and many of them are featured as artwork in our meeting and collaboration space Front+Centre.

Acknowledgement: Justin Blakie, Photographer

Photo: 'With Flying Colours' (front & back cover)

Photo: 'Energy in motion'

Contents

About TAS

Photo: 'Team work'

15.3

TAS is a professional services organisation that provides a range of strategic, advisory and programme management services to the health sector.

We are owned by the six Central Region District Health Boards (Capital & Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui and Hawke's Bay) and were established in 2001 as a joint venture company under equal joint ownership.

In 2011 DHB Shared Services (DHBSS) integrated with TAS creating a combined regional and national service offering.

TAS now provides services to the six Central Region District Health Boards (DHBs), the twenty national DHBs and a number of other organisations in the health sector. We have a range of subject matter expertise and experience across our service areas including:

- National programme management
- Education and support
- Audit and assurance services
- Planning and collaboration
- Business insights and analysis
- Strategic workforce services.

We have some unique points of difference which enable us to deliver quality services to our customers:

- An extensive network of sector relationships
- Expertise in analysing how the health system is performing
- Ability to implement on-the-ground solutions in a complex environment.

Our Vision

Supporting our partners to deliver the best health outcomes to all New Zealanders.

At TAS we are united by our passion to help our customers deliver the best healthcare they can for all New Zealanders.

Our Values

We are committed to building a values based, high achieving organisation across all of our relationships and activities. Our corporate values are central to how we work at TAS.

Aspiration

Courage

Professionalism

Integrity

CHAIR AND CHIEF EXECUTIVE REPORT

Dr Jan White
Chair

Graham Smith
Chief Executive

We are pleased to present the annual report for TAS for the financial year 1 July 2016 – 30 June 2017.

Our objective at TAS is to be a trusted and respected strategic partner to the DHBs and wider New Zealand health sector. The health sector is complex in nature and taking a shared approach is not always a straightforward endeavour. Our role is to help providers work together in common ways to optimise care for all New Zealanders.

Over the past year we have remained on track with this journey, ensuring that the services we offer are performing well and seeking opportunities to add new value, particularly in the area of workforce strategy, whole of system performance analysis and facilitating cross sector collaboration.

Some of the highlights from the work we have been involved with over the past year include:

- Nine multi-employer collective agreements renegotiated between DHBs and unions
- Agreement of the five year vision for integrated pharmacy services
- Further developing the interRAI assessment tools and services to improve the lives of vulnerable people
- Go live of the Central Regions Clinical Portal and Radiology Information Systems
- Supporting the engagement between DHBs and Primary Care leaders
- Expanding our Audit services to include the Northern Region Alliance of DHBs
- Assisting the DHBs with the $2 billion Pay Equity Settlement for Care and Support Workers.

In terms of our development as an organisation, a significant step forward is the implementation of an Information Services Strategy to centralise our approach to health data management and enable an enterprise wide approach to delivering analysis and reporting to customers.

April saw the TAS team make the move from our old office premises to a new location in Tory Street. This enabled us to house our people together on one floor (rather than being split over three floors) in a modest but professional and modern environment. It also presented the opportunity to open a purpose built meeting and collaboration space on the ground floor of our new building. The venue has been named Front+Centre to reflect its core purpose of bringing health sector stakeholders together for collaboration and networking, and to play on its central Wellington location. Front+Centre is available for our DHB customers, health sector stakeholders, TAS staff and the broader Wellington professional market to hire. The

Facilitating collaboration plays a large role in how we achieve success for our customers

feedback we have received so far on the level of service and facilities at Front+Centre, and the opportunities to connect across the health sector has been excellent.

Looking ahead, we have developed a new strategic plan to take us through the next three years to 2020. This process has provided the opportunity to reflect on how far TAS has come as an organisation and what role we will need to play going forward to meet the needs of our stakeholders.

New Zealand's health sector presents a complex landscape. DHBs are under more pressure to manage costs in the face of increasing demand for services, consumers are becoming a more powerful voice in future DHB thinking and there is a broader focus on the social determinants of health leading to the desire for cross agency, public service alignment.

TAS must support DHBs and other customers to collectively understand and cooperatively plan for these short and long-term challenges.

TAS must also continue to evolve our services to adapt and thrive in this environment. To achieve this, a key aspect of our focus over the next three years will be developing our business intelligence capability from a whole of health system perspective. Sector wide analysis of health performance will play a significant role in enabling better policy, operational and investment decision making. We also expect that our customer base will broaden as the desire for cross agency services, integrated models of care and health services delivery drives an extension into the social services sector. Enabling collaboration and supporting the development of aligned priorities and actions will be critical.

From an internal perspective, we need to ensure that our own business structure, operating processes, investment decisions and skills reflect the evolving core and specialist services we provide for our customers. As funding pressures increase, staying true to our corporate values of integrity, professionalism, aspiration and courage and maintaining a high quality, value for money service, will be key to our success.

Over the last three years TAS has grown from two merged organisations (TAS and DHBSS) to a more cohesive company that is highly regarded for its work. The organisation is now in a position to significantly grow the value and scope of our services. It is exciting to be taking this next step into the future.

We'd like to take this opportunity to thank our TAS staff and Board for their support through this journey and our customers and stakeholders for their commitment to TAS and the sector.

Dr Jan White
Chair

Graham Smith
Chief Executive

15.3

BOARD OF DIRECTORS

Dr Jan White (Chair)

A medical doctor by training, Jan has worked in medical and general management for over 20 years in both Australia and New Zealand. She has held a number of senior posts including six years as Chief Executive of the Waikato District Health Board and seven years as Chief Executive of the Accident Compensation Corporation (ACC). She is also on the Boards of PHARMAC and Worksafe New Zealand.

Murray Bain

Murray is an experienced company director who is currently Chair of the Open Polytechnic, Chair of Top Energy, Deputy Chair of TSB Bank and a Director of TSB Capital.

In the past, Murray has held Chief Executive roles in the Foundation for Research Science and Technology and the Ministry of Science and Innovation and, prior to that, senior management positions in IT, finance and banking in the Trust Bank Group and roles as Chief Operating Officer in ACC and Assistant Governor at the Reserve Bank of New Zealand.

Kathryn Cook

Kathryn is the Chief Executive of MidCentral District Health Board (MDHB). Prior to joining MDHB, she was a Partner within KPMG Australia's Health, Ageing and Human Services practice, where she was lead partner of the Victorian practice. Previously Kathryn was Chief Executive of Western Health, Victoria and has also held a range of policy and leadership positions in the Western Australian and Victorian Departments of Health, and the New Zealand Ministry of Health.

Deryck Shaw

Deryck is Chair of Lakes District Health Board, President New Zealand Football, Director New Zealand Health Partnerships and Deputy Chair of New Zealand Māori Arts and Crafts Institute. He is a former member of the Waikato District Health Board, Chair of Waiariki Institute of Technology and Board Member of Institutes of Technology Polytechnics New Zealand. A Chartered Member of the NZ Institute of Directors, Deryck has had a 30 year career as the Director of Strategic Planning consultancy firm APR Consultants Ltd.

Wendy McPhail

Wendy has over 20 years senior management experience, most recently as Chief Executive for the New Zealand owned Office Products Depot Co-operative.

She has extensive technology, strategy and change management expertise. Wendy was the former Deputy Chair of the Auckland Museum Trust Board and holds community and private governance roles.

INTEREST REGISTER 1 JULY 2016-30 JUNE 2017

Name	Board/Organisation
Dr Jan White (Chair)	• Member of PHARMAC Board • Member of Worksafe New Zealand Board
Murray Bain	• Chair, Top Energy • Deputy Chair, TSB Bank • Director TSB Group Capital Ltd • Director TSB Group Investments Ltd • Chair, Open Polytech NZ • Shareholder and Director, Oryx Technologies Ltd • Shareholder and Director, M I Bain & Associates Ltd
Kathryn Cook	• Chief Executive, MidCentral District Health Board • Lead Chief Executive, Central Region Māori Health • Lead Chief Executive, National Infrastructure Programme (Infrastructure as a Service) • Lead Chief Executive, Central Region Health Informatics Programme
Deryck Shaw	• Member of the DHB Executive • Chair of Lakes District Health Board • Director Spectrum Health • Trustee Lakes DHB Charitable Trust • Deputy Chair of NZ Māori Arts and Crafts Institute • Owner and Director of APR Consultants Ltd • Majority owner and Director of Principal Holdings Ltd • Co-owner of APR Group • Partner, Shaw Property Partnership • Chair NZ Walking Association Inc • National Executive Member of NZ Football • President NZ Football • Board Member Health Partnership Ltd • Director, Great Value Accommodation Ltd • Board Member Oceania Football Confederation Executive Committee • Member of FIFA's Stakeholder Committee
Wendy McPhail	• Advisory Board Member to The Marketing Company • Principal Consultant and Director, Wendy McPhail Consulting Limited • Director Great Sleep Company

15.3

Key Results

In 2016/17 we set ourselves stretch targets aimed at demonstrating where we have added value. We have performed well against these overall business measures, showing improvements on the previous years' results.

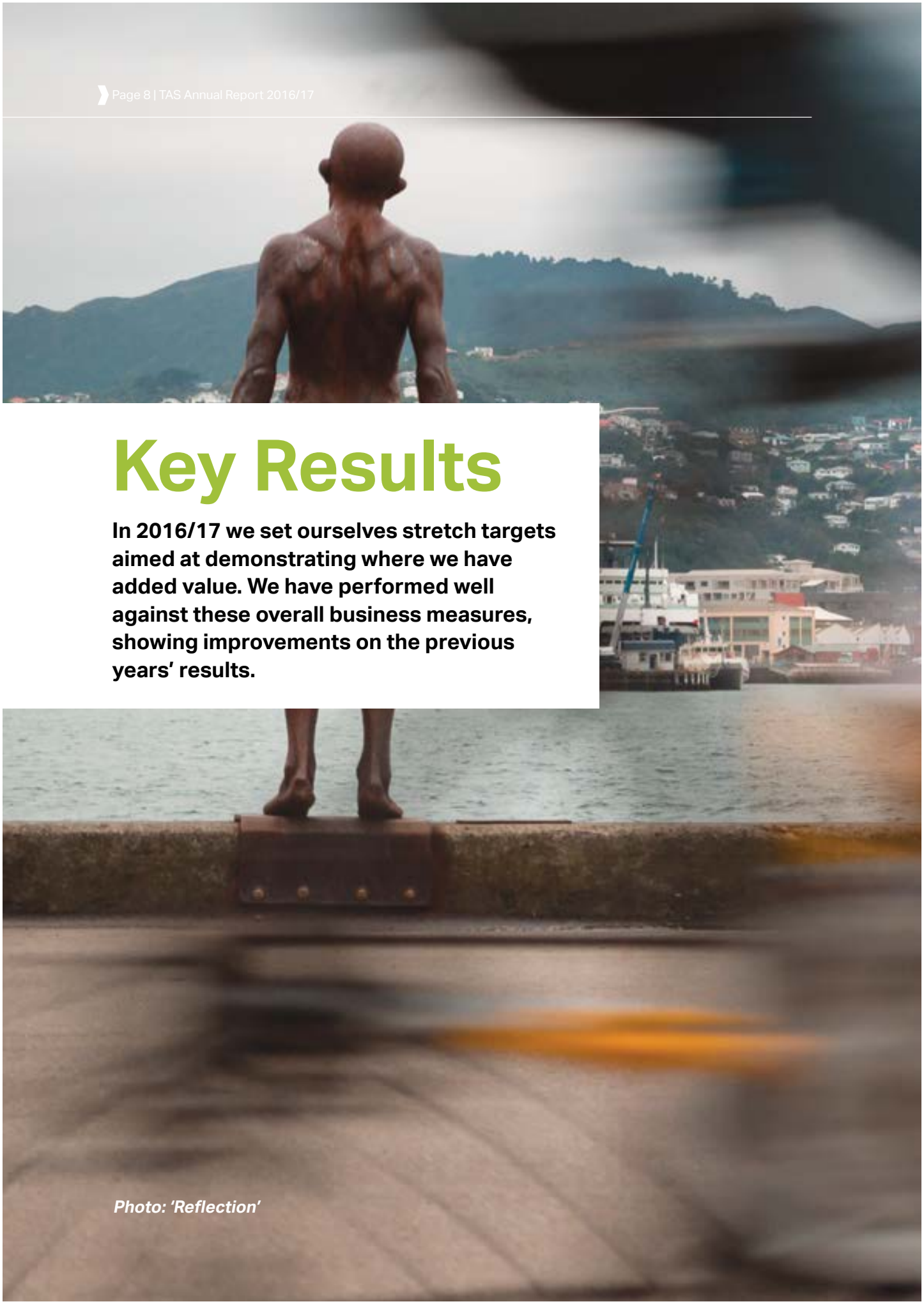


Photo: 'Reflection'

	2015/16	2016/17
New investment	1.7M	**2.8M**
Customer Satisfaction	>91% of customers agree/strongly agree that TAS services are of a high professional standard	**95%**
Customer Advocacy	>45% of customers rate 8 or more out of 10 (likelihood to recommend TAS)	**47%**
People Engagement	66% staff engagement index	**68.4%**

CASE STUDY

A day in the life of an interRAI educator

QUICK FACTS

- 22% of home care clients report feeling lonely
- 10% of New Zealanders over 65 years old have been assessed with interRAI, compared to 7% of Canadians over 65 years old
- 4 interRAI tools used in New Zealand: Long Term Care Facilities (LTCF), Contact Assessment (CA), Community Health Assessment (CHA) and Home Care Assessment (HC)

Melissa Hall talks about what attracted her to becoming an interRAI educator and what she loves about her job*.

Q: Tell us about interRAI and how you got into the role?

interRAI is the assessment tool we use in New Zealand to assess a client's or resident's needs in aged residential care and home care. I am one of 24 interRAI Educators who train Registered Nurses and other health professionals in the use of interRAI before they can assess clients on their own.

Like most of the interRAI educators, I'm a Registered Nurse. My first experience of nursing was with elderly patients, before I moved into a rehabilitation unit for younger people under 65. Then I spent 13 years in operating theatres, before I became an interRAI Educator.

Q: What does a typical day at work entail?

We have up to eight trainees on a course, and we work hard to have everyone competent within eight weeks. This usually involves three full days in a classroom, often in Wellington, where I live, or sometimes I travel to the training venue. Many of my colleagues are based in other parts of New Zealand, so chances are there is an educator local to you.

When I am not travelling or teaching, I work from the TAS office in Wellington marking assessments, supporting my group of trainees, answering questions, or planning for the next course. We work with any number of trainees in different stages of their training. There are a few milestones trainees need to pass before they become competent assessors. I also go on site visits, where I visit trainees in their facilities to support them during or after training.

Q: What do you love most about your job?

interRAI educators are a hardworking and passionate bunch, with a keen interest in supporting trainees and a real dedication to quality. I very much enjoy working with my colleagues and have a lot of respect for everyone's work.

Q: If you could change one thing about New Zealand's aged care or retirement industries, what would it be and why?

I love it when I see providers who bring the community into the facilities, like the Baby Buddies in Auckland. There are some great examples out there, and I wish there were more because it can be so beneficial for residents.

In the end, this is what we are here for, clients and residents, and their wellbeing. interRAI was developed to improve the quality of life for the people we assess. The assessments are all about the person, and interRAI produces a lot of valuable data for care planning and clinical decision making.

> **interRAI was developed to improve the quality of life for the people we assess. In the end, this is what we are here for.”**
>
> MELISSA HALL | interRAI Educator

*Excerpts from story for InSite magazine

STRATEGIC OBJECTIVE

VALUE

Photo: 'Creating Momentum'

Delivering Value

TAS is focused on delivering the best possible return on investment for our stakeholders.

In 2016/17 we did this through increasing the volume and quality of services we delivered without increasing budgets, extending the value add within existing services lines and exploring opportunities for new areas of value.

Regional Health Informatics (RHIP)

The Regional Health Informatics Programme (RHIP) is about building the organisational and technological capability to deliver the right information to the right people through a range of information channels, including a fully integrated patient information management solution and electronic health record in the Central Region. The programme is entering the transition phase from programme activity to ongoing operational support.

The programme has delivered:

- A regional Clinical Portal that provides clinical user access to a suite of tools for patient care
- A regional Radiology Information System that provides a workflow tool for managing the patient through radiology encounters

- A regional picture archiving and communication system (PACS) that stores images captured through multiple modalities
- A Healthcare Practitioner system that provides a unique identifier for each practitioner and practice in the region
- A Patient Administration System that has been built to a regionally agreed functional specification for managing the patient through their hospital event
- A service management model to support the first DHB to come onto the regional solution.

The key deliverables have been achieved and the programme is working with the Service Delivery Provider at Capital & Coast District Health Board to ensure service continuity is maintained and the ongoing support model is set up to provide sustainable support for the regional solution.

Primary Care Integration

Primary Care Integration focuses on developing integrated approaches to service delivery across primary care, community pharmacy services and aged residential care. In 2016 the DHB National Executive agreed to establish a national primary care integration team, supported by TAS. The purpose of the team was to support DHBs with strategic advice, enabling the sector to discuss and deliberate the key issues facing primary care and to provide DHBs with negotiation and contractual advice around the national primary care agreement.

During the year TAS organised three Primary Care Leaders' Forums and supported DHBs in a number of discussions on the national primary care agreement. A working group was also established with aged residential care to look for opportunities to better support primary care services for residents in aged care facilities.

The analytical and operational support provided by TAS has enabled the DHB programme steering group to focus on addressing strategic issues with external stakeholders.

Audit and Assurance

TAS audit and assurance services cover provider audits, certification audits and internal audits in the public and private health sector. We undertake around 300 audits per year and over the last 12 months have continued to build scale across these services.

A significant milestone was gaining approval from the Ministry of Business Innovation and Employment as a Tier 2 provider for audit and a Tier 3 provider for assurance.

The Department of Internal Affairs also approved TAS to join a security panel to provide certification and assurance to government agencies and we expanded our provider audit programme to the Northern Region Alliance of DHBs.

300 audits undertaken

interRAI Services

TAS manages interRAI assessment tools and services in New Zealand on behalf of the Ministry of Health (MoH). interRAI is a suite of clinical assessment tools developed by an international collaborative to improve the quality of life of vulnerable people. The interRAI tools in use in New Zealand are focused on the health of older people.

Over the last year TAS has supported the planning of two pilots of new interRAI tools and the national roll out of the Palliative Care tool.

Home and Community assessors have access to four interRAI tools depending what is appropriate for their client. The Long Term Care Facility tool is used in residential care.

The interRAI National Data and Reporting Centre began publishing a quarterly suite of individual reports for the 675 aged residential care facilities in New Zealand. These reports are provided for all aged residential care providers, individual facility managers and DHBs. They provide comparisons with similar facilities and developments over time. The Centre also published its second Annual Report with key data from interRAI assessments.

117,626 interRAI patient assessments completed (new and re-assessments)

956 interRAI assessors achieved competency

675 aged residential care facilities receiving a quarterly aggregated data and benchmarking report

306 interRAI assessors attended skills booster sessions

Health of Older People

TAS works across the health of older people sector supporting DHBs in the delivery of aged residential care, home and community support services.

Over 2016/17 we represented the 20 DHBs on three matters of national significance to the health of older people:

- A $2 billion Pay Equity Settlement for Care and Support Workers resolved an historical inequity dispute, delivering pay rises between 15% and 50% for some 55,000 care and support workers. Alongside access to increased training and qualifications this will result in lower staff turnover and a more highly qualified workforce over time.
- Some 30,000 workers in home and community support working on piecemeal contracts have been moved onto contracts with guaranteed hours. This increases certainty, stability and brings training opportunities for the workers and opportunities for increased efficiencies for providers.
- The in-between travel settlement resulted in recognition that the time spent by home and community support workers travelling between clients was in fact work and as such should be compensated. An annual $58M settlement and process for compensation resulted.

15.3

Community Pharmacy

TAS facilitates the DHBs national community pharmacy programme, supporting the delivery of integrated pharmacy services to our communities.

In 2016/17 we facilitated agreement of the five year vision for integrated pharmacy services in the community with key stakeholders including the MoH, DHBs, PHARMAC, pharmacists, the primary care sector and consumers. A process is now in place to help DHBs work on delivery of services under the new vision over the next twelve months.

A stocktake of pharmacist services outside of the community pharmacy services agreement was also undertaken to inform the development of local service commissioning. This was approached collaboratively with input from DHBs, the MoH, the pharmacy sector and Primary Health Organisations.

We also supported DHBs to implement an extension of the current Community Pharmacy Services Agreement for 2017/18, which included three new services - smoking cessation, integrated care for mental health consumers through the Long Term Conditions service and workforce development for pharmacists.

99% of pharmacy owners signed voluntary variation for contract extension 2017/18

97% of pharmacy owners signed voluntary variation of interim solution for pharmacy margins

40 unique locally commissioned DHB pharmacy services identified

Strategic Workforce Services

Our strategic workforce services encompass several key areas of focus – workforce development, safe staffing and healthy workplaces and employment relations.

In 2016 TAS developed a workforce visualisation tool to enable DHBs to have access to a standard set of DHB workforce data. This provides an interactive approach to workforce information to inform planning at the national, regional and local level.

A coordinated multi-stakeholder approach to the development of the medical imaging workforce was also facilitated in order to respond to the changing workforce, demand and technology drivers.

Twenty DHB Chairs and Chief Executives endorsed a shared approach to talent management and leadership development through the implementation of the State Services Commission leadership and talent framework. This provides leadership and talent opportunities across the DHBs and public sector agencies.

TAS manages the Care Capacity Demand (CCDM) programme on behalf of a number of partners. In February 2017 the programme intellectual property (IP) was invested by key parties to the MoH.

The key parties included DHBs, New Zealand Nurses Organisation (NZNO) and the Public Services Association (PSA).

This decision acknowledges the New Zealand partnership approach to the programme's development, recognising the importance of the work and the investment that has been made by all parties. It is potentially a world first for a country's public hospitals and health unions to invest the IP of their joint safe staffing framework with the Ministry of Health.

TAS also facilitated the development and implementation of new CCDM Staffing Methodology web based software. This enables DHBs to have one of the most sophisticated global processes for calculating an acuity and demand based nursing and midwifery roster.

CCDM programme standards were developed to replace three other assessment documents. They are a partnership/bipartite self-assessment and can be used at the beginning, middle and for business as usual. There are five programme standards, 22 criteria and guidance notes to support DHBs in meeting the standards.

TAS manages the 20 DHBs' national employment relations programme, acting as their representative in employment agreement negotiations, providing local and regional advice and support and helping them to implement Employment Law legislation.

In 2016/17 we provided advocacy and settlement on national and regional Multi Employer Collective Agreements between DHBs and unions. The most high profile of these negotiations focused on junior and senior doctors.

TAS also facilitated an employment relations conference 'Gaining the Edge' for DHB ER and HR professionals. The conference looked at the year ahead in relation to collective bargaining, industrial relations frameworks and the tools and processes available to HR and ER professionals in health.

Care Capacity Demand Staffing methodology software a finalist in vendor accolades

Care Capacity Demand Programme recognised internationally as best practice

9 Multi Employer Collective Agreements negotiated between DHBs and NZ Unions

95 people attended Gaining the Edge employment relations conference

All DHBs and regional training hubs have access to the workforce visualisation tool

Our organisation is very satisfied with current services - continue to employ smart people. ”

The analysis presented yesterday prompted a really good discussion, I do not think that would have happened a couple of years ago. Just shows me what a difference occurs when folk get used to data as a QI. ”

Thanks for your WCTO Report. It's always interesting to read these reports, and to be encouraged by the regional and local leadership, innovation and integration underway. ”

The Front+Centre team are simply wonderful. They're helpful and friendly, and go out of their way to solve any problem I have. Visitors of mine have commented how their positive attitudes enhance what is an attractive, modern and functional venue space. ”

Great positive take on the key issues which focuses attention on the actual priorities for our people. ”

tas
KAHUI TUITUI TANGATA

STRATEGIC OBJECTIVE

CUSTOMER

Photo: 'Synergy'

Getting closer to our customers

TAS has a broad network of relationships which affords it a unique position in the health sector.

Ensuring strong stakeholder engagement enables us to add value to our customers through facilitation of partnerships, collaboration and developing a deep understanding of the complex environment they are operating in.

15.3

Stakeholder Engagement

In 2016/17 we continued to strengthen engagement with our stakeholders facilitating a number of collaborative approaches to enhance our service delivery across national DHB programmes including;

- Establishing forums for networking and sharing local innovation and success amongst primary care portfolio managers. Feedback from this group has demonstrated that this is of high value to them and improves collaboration and knowledge sharing.
- Coordination of 20 DHBs' input into the review of the medical vocational training funding model being led by Health Workforce New Zealand.
- Establishment of the Workforce Strategy Group and delivery of their first annual work plan – a collaborative 20 DHB approach to workforce development which partners with sector stakeholders to deliver a whole of workforce approach.
- Leadership and coordination of 20 DHBs in pay equity negotiations and the Holidays Act compliance project.
- Facilitation of a substantive and integrated submission on behalf of DHBs for the development of the Healthy Ageing Strategy, representing aged care, pharmacy, primary care and workforce sectors.

96% of customers say the work TAS does adds value to my organisation

Customer Satisfaction

Our annual customer satisfaction survey is a key forum for us to formally ask for feedback and gauge how we are performing against the expectations of our customers. Our customer satisfaction remains at a high level. Overall, 95% of customers rate TAS services as being of a high professional standard and 96% report our work adds value to their organisation.

In January, as part of our 2020 strategic plan development, we undertook qualitative research with the six Central Region District Health Board Chairs and Chief Executives. This enabled us to gain deeper insight into some of the challenges and opportunities the sector is facing including;

- The importance of DHBs connection with and responsibility to their local communities
- The challenges of shifting organisational culture in health to focus on patient centric services
- The need to attract strong leadership and management talent into health
- Driving genuine business, patient accountability and performance throughout DHBs.

This research gave us further clarity on how we can evolve the role of TAS to keep delivering value to stakeholders.

95% of customers agree that TAS services are of a high professional standard

95% of customers agree TAS provides appropriate and relevant advice

CASE STUDY

A whole of system approach to cardiac services

Ischaemic Heart Disease (IHD), also known as coronary heart disease, is the second leading cause of death in New Zealand. According to the 2014-15 Health Survey, 4.6% of the NZ population over 15 had been diagnosed with IHD. That's approximately 169,000 of your fellow Kiwis.

While deaths from IHD have declined over the past 30 years, our ageing population, new medication, modern interventions and technology advances mean that the number of people surviving heart attacks and living with heart disease is increasing. This in turn increases the demand on health services.

Research also shows health outcomes and timeliness of interventions from cardiac disease are significantly affected by ethnicity, level of deprivation and where a person lives.

In this context, TAS was asked to facilitate the Central Region Cardiac System of Care Strategic Plan to achieve a long term vision for equitable access to cardiac services across the region. The Central Region Cardiac Network was heavily involved in development of the plan. The Network includes managerial, clinical and Māori health representation from across the Central Region DHBs - Nelson Marlborough, Capital & Coast, Hutt Valley, Wairarapa, Whanganui, MidCentral and Hawke's Bay – as well as members of the Heart Foundation and the National Cardiac Network.

Currently access to services for patients is variable and inconsistent across the region. For example, if a patient has a heart disease in Palmerston North or Hawke's Bay the local hospitals can do angiography, an x-ray of the heart to see where the blockage exists but they can't do an angioplasty that enables them to unblock the artery. Therefore, the patient is flown to Wellington Hospital to have the procedure to unblock the artery. This means patients endure two operations.

Palmerston North is making progress towards developing a business case for an interventional service.

Dr Nick Fisher, head and founder of the cardiology department for Nelson Marlborough DHB, holds the role of Clinical Director on the Central Region Network. "We realised that for equity to be achievable we all had to 'play by the same rules'. Therefore we developed the NZ recommendations for referral and access to secondary care which all DHBs have signed up to."

"Based on this nationally accepted document it was readily apparent that there were major inequities" he says. "Timely access to care

is critical otherwise you can have higher mortality rates."

"Access to echocardiography and time critical treatment for ischaemic heart disease are the two fundamental pillars of cardiac investigation and treatment. These have been long standing challenges in the Central Region, and we have decided that these are the main focus moving forward," Dr Fisher continues. The Central Region is also focusing on improving access to primary care for Māori.

The Cardiac Network was tasked with formulating a deep understanding of existing services and models of care and recommending options to build a sustainable approach with more equitable access and better outcomes for the future.

Taking a whole of system viewpoint meant looking across home, primary, secondary and tertiary settings, working collaboratively with key groups across the system and using health informatics to inform the approach.

Informatics depicting population data by ethnicity, deprivation and locality were analysed. Other analysis included the prevalence and incidence of six heart disease categories in the Central Region population to determine unmet need. The data analysis showed that there is inconsistent access to primary care, cardiovascular risk assessments and triple therapy. For Māori there are significant inequalities as they are less likely to access primary care for treatment and are more likely to die from ischaemic heart disease.

The consumer perspective was also taken into account to ensure patients were kept at the heart of service design.

Greg Edmunds held the role of consumer representative on the Central Region Cardiac Network. "My role was to ensure that, where indicated, the experience of the consumer remained the focal point of any discussion." Greg's overarching hope is that regardless of where you live or your ethnicity, you have equity of access to appropriate care.

The Network identified that it was important to have a thorough engagement process. During the three consultation workshops that were carried out recommendations were formed to address the short and long term challenges for cardiac services in the region.

Debbie Chin, CE of Capital & Coast District Health Board and Lead CE for the Central Region Cardiac Network, says "one of the successes of the Network is the excellent collaboration amongst clinicians across the region. They also had a shared commitment to improve equity and co-ordinate quality of care. This sets an example for other networks to follow."

The options to improve outcomes in the cardiac health system of care require a focus on:

- Improving access to primary care for Māori
- Supporting the agreed clinical pathways and the NZ recommendations for referral and access to secondary care
- Supporting the focus on prevention, treatment and management of atrial fibrillation and heart failure including access to echocardiography and urgent angioplasty/percutaneous coronary intervention (PCI) across the Central Region
- Recalibrating sub-regional networks to improve access to specialist cardiac health workforce including echocardiography and specialists.

Now the project moves into an implementation phase over the next five years as it rolls out the recommendations across the region.

BUSINESS PROCESS

STRATEGIC OBJECTIVE

Innovating smart business processes

Continuous improvement of the efficiency and effectiveness of our services is an important part of ensuring our value to customers.

A key area for development was across business intelligence reporting and analysis. TAS has developed an Information Services Strategy to centralise our data management and take an enterprise approach to delivering analysis and reporting to customers. It emphasises teams working together to manage processes, solve problems and deliver better value for customers. This strategy has now moved into the implementation phase and will be rolled out over the course of the following year.

We also introduced several new digital tools to improve some of our common business processes. An online people performance review system was implemented making it easier for people leaders and staff to efficiently and effectively work through their performance process. It also enables the leadership team to more easily monitor growth activities, such as ensuring learning and development plans are in place for all staff.

We introduced an online expense management system, streamlining the financial processes for low value transactions.

We also implemented an online recruitment tool to support our approach to sourcing and managing employee candidates. This has enabled us to shift from utilising an external recruitment agency for all roles to running this process ourselves. This has delivered significant cost savings and also enabled more input and greater visibility for hiring managers.

TAS has an active health and safety committee of employee representatives who meet monthly. The committee has taken a leadership role with the move to our new premises in Wellington. All desks are now equipped with disaster safety packs and water to help us get through a civil disaster. Our new building is refurbished to a high quality, earthquake strengthened state to ensure safety.

Average cost to recruit reduced to $1,600 vs $8,000 per role in 2015/16

LEARNING & GROWTH

STRATEGIC OBJECTIVE

Growing our people

Continually building the capability of our people to lift our performance is an important aspect of our business. Our key focus has been on developing leadership across the organisation and improving internal communications to build our people's engagement with TAS and the outcomes we are striving to achieve.

Learning and Development

Two successful TAS Days were held, giving all staff the opportunity to come together, focus on personal development, and work 'on' the business rather than 'in' it. This chance to briefly step away from day to day operations has helped to enhance collaboration and enabled our staff to input into and understand the future direction of TAS.

Our senior leaders have continued in their leadership development journey through regular workshops and coaching. This has now been extended to all people leaders and Tier 3 staff, with renewed vigour for monthly peer meetings and quarterly professional development workshops, which have focused on leadership basics.

Staff Engagement

TAS annually undertakes the 'IBM New Zealand Workplaces Survey' to formally monitor and gather feedback from our people. For the 2016/17 year 90% of staff responded to the survey which showed an overall improvement of 3% staff engagement on the previous year. Our engagement index of 68.4% also rates higher than the state services benchmark of 62.5%.*

This is a result of changes we made in response to the previous years' survey. These included improving understanding of our strategic direction through workshops, better communication and embedding our organisation goals into our performance review system. We also created more opportunities for staff wellbeing, professional development and celebrating success.

80% of all staff from across the country attended our two TAS days

68.4% staff engagement performance index vs 62.5% state sector*

* State sector benchmark performance index 2015

CASE STUDY

Photo: Supplied by Plunket

Supporting our youngest Kiwis

Well Child Tamariki Ora (WCTO) is a programme of health assessments and support services for all New Zealand children and their families from birth to five years, funded by the Ministry of Health. As a vital gateway to primary and specialist health care, education and social services, Well Child supports parents and caregivers to care for their child's health so our youngest Kiwis can reach their potential.

Midwifery care during pregnancy and care during the early weeks of a baby's life is transitioned to the WCTO provider. The WCTO schedule is delivered with families by a range of health professionals including WCTO trained nurses and health workers. These practitioners may be employed by Plunket, a Māori or Pacific WCTO provider, a General Practice team or a Public Health service.

"TAS' role is to support and project manage the quality improvement cycles across the lower North Island Well Child programmes," explains Craig Moore, Project Adviser – Quality Improvement at TAS, the organisation charged with helping to facilitate the programme for the Central Region District Health Boards. "Our key focus is to support the innovators and improvers to quickly test their good ideas using proven quality improvement methods to improve access to and the services provided by the Well Child Tamariki Ora system," he says. "For example, we recently helped Plunket partner with the 'Bee Healthy' Dental Service in the Hutt Valley by bringing the dental therapist to the Plunket clinic for toddlers and their parents to visit for check-ups. This meant parents only had to bring their child to one appointment rather than two. The day was a real success," Craig says. Similar days are planned for the future.

Recently, Craig and his colleague, Stephanie Calder, have helped three District Health Boards develop and test their services for new breastfeeding mums. Breast milk provides the best start to life and helps protect babies from developing things like eczema and allergies later in life. "We used a quality improvement tool, called a driver diagram, to help consumers, midwives, lactation consultants and Well Child nurses to identify all the parts of the system. We then helped test their ideas: what flyers, bookmarks and information resources they use and trying different ways of training nurses in general breastfeeding support."

"One of the benefits of TAS' role in the programme is that we have staff who understand the Well Child contract inside out, we have developed collaborative relationships with DHBs and we have the know-how on running change programmes," Craig explains. "We are now spreading this knowledge amongst others in TAS and the Well Child sector by facilitating the NHS' School for Change Agents using Skype."

Wendy Allen, a Plunket Clinical Leader in Hawke's Bay, works closely with Craig and agrees with these sentiments. She says "having Craig as an independent and objective facilitator with a good understanding of the WCTO schedule and with a quality focus has supported effective collaboration across agencies. Craig's unbiased approach broke down barriers that had historically inhibited change and growth in improving child health outcomes through a collaborative approach in this geographical area."

FACTS & STATISTICS

- There are 16 WCTO contract holders in the Central Region
- 8,709 babies in the Central Region are enrolled in a WCTO provider
- Around 95% of babies receive a WCTO service
- Each year, Central Region Well Child Providers deliver almost 53,000 core contacts. That's 203 children between Wairoa, Raetihi and Wellington every work day!

Looking Ahead

'TAS 2020: Our Future Focus' outlines a refined vision and new sense of direction for TAS over the coming three years.

The strategic framework and road map outlined in this plan builds on where the organisation is today, reflects what we know are the needs of our sector and where our capabilities lie for the future.

Photo: 'Transforming'

Delivering four key areas of value to the sector. Whole of system analysis of health performance will play a significant role, informing our customers to make better policy, operational and investment decisions.

AREAS OF FOCUS

Greater health system analysis and insights	Improved service efficiency and effectiveness
Growth in sector people capability	Foster partnerships and collaboration

Building a closer connection with stakeholders and customers and expanding our network of relationships to better deliver on their needs.

AREAS OF FOCUS

Strengthen our relationship networks	Broaden stakeholder reach and channels for engagement

Building enterprise wide approaches and consistent standards is key to ensuring a high quality service and achieving our vision.

AREAS OF FOCUS

Transform the data analytics infrastructure	Innovate enterprise wide business processes
Develop strategic partnerships to support service delivery	

Continually building the capability of our people to lift our performance and achieve our 2020 goals.

AREAS OF FOCUS

Develop internal and external leadership capabilities	Evolve our professional services culture
Invest in expertise	

CASE STUDY

Getting on the Front foot

Front+ Centre

When TAS moved to newly built office premises in central Wellington in April, we also opened a purpose built meeting and collaboration space called Front+Centre.

Blending top-notch service in a relaxed environment the venue features seven different rooms with capacity ranging from eight to 85 people. Break out areas, hot desks and drop in offices are combined with fast Wi-Fi and state of the art video and audio conferencing facilities.

"Designed specifically to meet the needs of our health sector stakeholders, we're proud of our unique meeting and collaboration venue where people can come together to shape the ideas and projects that will bring them to the forefront of their fields. By encouraging the collaboration of multiple health sector agencies we believe we can support their delivery of quality, sustainable and effective services to the New Zealand population," explains Graham Smith, TAS Chief Executive.

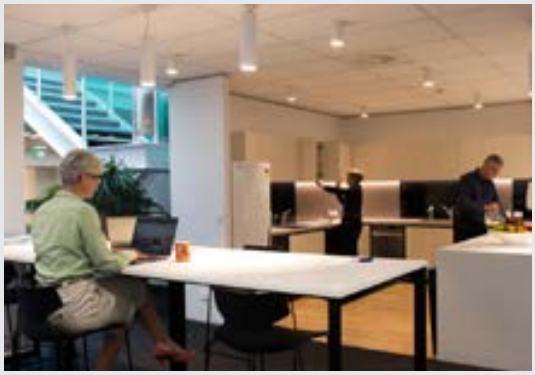
It was important to distinguish Front+Centre from other TAS services which is why a separate identity was established for the venue. The brand was developed specifically to provide a subtle connection to the TAS brand, while being strong enough in its own right to stand alone in the broader Wellington meeting venue market. The name plays on the venue's purpose and location as the venue is situated in the heart of Wellington – right in the middle of the action.

"The venue is available for our staff, DHBs and our health sector stakeholders, as well as the wider Wellington professionals' market, who are looking for a meeting venue." As there are currently no other purpose built health sector specific collaboration spaces in Wellington this is Front+Centre's key point of difference. This health sector focus means customers can network with other health professionals and use the hot desk and drop in office facilities when attending meetings in Wellington. "We want Front+Centre to feel like an office away from home where our stakeholders can base themselves when in Wellington and network with other professionals" says Graham.

A frequent user of the new venue, Chief Executive of the Hutt Valley DHB Dr Ashley Bloomfield, says "the new Front+Centre venue is a great facility for our regular regional and national meetings. The meeting rooms are well set up and the common area has plenty of places to sit and catch up on work."

"The onsite parking is a bonus on the days when public transport or biking are not an option! And, being Wellington, there are plenty of choices for great coffee nearby," Ashley says.

TAS has received a great deal of positive feedback so far, and hopes the momentum of Front+Centre will continue to build as the venue gains traction within the health sector and the wider professional market.



FINANCIAL STATEMENTS

Statement of comprehensive revenue and expense for the year ended 30 June 2017

	Notes	2017 $000	2016 $000
Revenue			
DHB revenue		25,876	28,464
Interest revenue		19	107
Other revenue	2	8,716	8,194
Total revenue		**34,611**	**36,765**
Expenditure			
Personnel costs	3	20,570	20,818
Depreciation and amortisation expense		284	244
Other expenses	4	12,598	15,450
Total expenditure		**33,452**	**36,512**
Net surplus		**1,159**	**253**
Other comprehensive revenue		-	-
Total comprehensive revenue		**1,159**	**253**

Statement of changes in equity for the year ended 30 June 2017

	2017 $000	2016 $000
Balance at 1 July	**1,768**	**1,515**
Total comprehensive income and expense for the year	1,159	253
Balance at 30 June	**2,927**	**1,768**

Statement of financial position as at 30 June 2017

	Notes	2017 $000	2016 $000
Current Assets			
Cash and cash equivalents	5	8,131	9,258
Receivables	6	4,846	2,972
Prepayments		-	146
GST receivable		-	143
Total current assets		**12,977**	**12,519**
Non-current assets			
Property, plant & equipment		823	324
Intangible assets		276	329
Total non-current assets		**1,099**	**653**
Total assets		**14,076**	**13,172**
Current liabilities			
Payables	7	3,499	3,779
Funds received in advance		5,713	6,017
GST Payable		150	-
Employee entitlements	8	1,072	893
Total current liabilities		**10,434**	**10,689**
Non-current liabilities			
Working capital reserve		715	715
Total non-current liabilities		**715**	**715**
Total liabilities		**11,149**	**11,404**
Net assets		**2,927**	**1,768**
Equity			
Share capital		-	-
General funds		2,927	1,768
Total equity		**2,927**	**1,768**

Statement of cash flows for the year ended 30 June 2017

	Notes	2017 $000	2016 $000
Operating Activities			
Receipts from customers		32,414	42,027
Interest received		19	107
Payments to employees		(20,277)	(20,741)
Payments to suppliers		(12,839)	(18,273)
Goods and services tax (net)		293	139
Net Cash Flow from Operating Activities	**9**	**(389)**	**3,259**
Investing Activities			
Purchase of property, plant, equipment		(738)	(482)
Net Cash from Investing Activities		**(738)**	**(482)**
Net (decrease)/increase in cash and cash equivalents		**(1,127)**	**2,777**
Cash and cash equivalents at the beginning of the year		9,258	6,481
Cash and cash equivalents at the end of the year		**8,131**	**9,258**
Represented by:			
Short-term deposits		-	-
Cash and cash equivalents		**8,131**	**9,258**

For and on behalf of the Board:

Dr Jan White
Chair
27 September 2017

Murray Bain
Director
27 September 2017

Central Region's Technical Advisory Services Limited

Notes to the Financial Statements

1. Statement of accounting policies

REPORTING ENTITY

Central Region's Technical Advisory Services Limited (TAS) is owned by the six central region DHBs, which are Crown entities as defined by the Crown Entities Act 2004. The relevant legislation governing TAS operations is the Crown Entities Act 2004. TAS' ultimate parent is the Crown.

TAS' primary objective is to provide professional services to the New Zealand health sector. TAS does not operate to make a financial return.

TAS has designated itself as a public benefit entity (PBE) for financial reporting purposes. The financial statements for TAS are for the year ended 30 June 2017, and were approved by the Board on 27 September 2017.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis. All accounting policies have been applied consistently throughout the period.

Statement of compliance

The financial statements of TAS have been prepared in accordance with Tier 1 PBE accounting standards. These financial statements comply with the PBE accounting standards.

Measurement base

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

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

15.3

Standards issued and not yet effective and not early adopted

There are no new, revised or amended standards that have been issued but are not yet effective that would have a significant impact on the company's financial statements.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue

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

DHB funding

TAS is funded by the National and Regional DHBs. DHB revenue is recognised as revenue when it becomes receivable unless there is an obligation in substance to return the funds if conditions of the National or Regional Work Plans are not met. If there is such an obligation, the funding is initially recorded as revenue in advance and recognised as revenue when conditions of the work plans are met.

Ministry of Health funding

TAS receives funding from the Ministry of Health (MoH) for a number of different initiatives, the most significant being interRAI. MoH revenue is recognised as revenue when it becomes receivable unless there is an obligation in substance to return the funds. If there is such an obligation, the funding is recorded as revenue in advance.

Interest revenue

Interest revenue is recognised by accruing on a time proportion basis the interest due for the investment.

Leases

Operating leases

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

Cash and cash equivalents

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

Receivables

Receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that TAS will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Payables

Short-term payables are recorded at their face value.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service, are measured on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date and annual leave earned but not yet taken at balance date.

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

Presentation of employee entitlements

Annual leave is classified as a current liability.

Equity

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Critical judgements in applying accounting policies

TAS must exercise judgement when recognising DHB and MOH revenue to determine when contractual obligations have been satisfied. Judgement is exercised per contract, excess funds received on contracts with pay back clauses are recognised as funds in advance. If a contract period is across year end the revenue will be allocated based on percentage of completion of the contract, if milestones are not obvious in the contract expenses incurred to date will be used as a guide for the percentage of completion.

Comparatives

Certain amounts in the comparative information have been reclassified to ensure consistency with the current year's presentation.

2. Other revenue

	2017 $000	2016 $000
MOH revenue	8,255	7,669
Other revenue	461	525
Total other revenue	**8,716**	**8,194**

3. Personnel costs

	2017 $000	2016 $000
Salaries and wages	20,134	20,549
Defined contribution plan employer contributions	374	329
Increase/(decrease) in employee entitlements	62	(60)
Total personnel costs	**20,570**	**20,818**

Employer contributions to KiwiSaver are accounted for as defined contribution superannuation schemes and are expensed in the surplus or deficit as incurred.

15.3

4. Other expenses

	2017 $000	2016 $000
Fees to auditor		
- Fees to KPMG for audit of financial statements	40	40
Office lease	568	419
Travel and transport	1,300	1,361
Consultancy	2,763	3,269
Information Communications Technology - RHIP*	2,575	4,660
Information Communications Technology - Non-RHIP	3,586	3,643
Legal Fees	424	530
Facility Reimbursements	-	246
Other	1,342	1,282
Total expenses	**12,598**	**15,450**

* RHIP – Regional Health Informatics Programme

5. Cash and cash equivalents

	2017 $000	2016 $000
Cash at bank and on hand	8,131	9,258
Total cash and cash equivalents	**8,131**	**9,258**

6. Receivables

	2017 $000	2016 $000
Receivables (gross)	4,731	2,539
Accrued debtors	115	438
Less: provision for impairment	-	(5)
Total receivables	**4,846**	**2,972**
Total receivables comprises:		
Receivables from exchange transactions	4,846	2,972
Receivables from non-exchange transactions	-	-

The ageing profile of receivables at year end is detailed below:

	2017 $000	2016 $000
Not past due	2,512	1,897
Past due 31 - 60 days	493	257
Past due over 60 days	1,841	818
Total	**4,846**	**2,972**

All receivables greater than 30 days in age are considered to be past due.

There is a $nil impairment provision for receivables (2016: $5k).

7. Payables

	2017 $000	2016 $000
Creditors	**2,226**	**1,929**
Accrued expenses	1,273	1,850
Total payables	**3,499**	**3,779**
Total payables comprises:		
Payables from exchange transactions	3,299	3,645
Payables from non-exchange transactions	200	134

8. Employee entitlements

	2017 $000	2016 $000
Current portion		
Accrued salaries	269	172
Annual leave	667	604
Other short term benefits	136	117
Total employment entitlements	**1,072**	**893**

9. Reconciliation of net surplus/deficit with net cash flow from operating activities

	2017 $000	2016 $000
Net surplus	**1,159**	**253**
Add back non-cash items		
Depreciation and amortisation expense	301	232
Total non-cash items	**301**	**232**
Add/(less) movements in statement of financial position items		
Decrease/(increase) in receivables	(1,874)	3,003
(Increase)/decrease in prepayments	146	(60)
(Decrease)/increase in payables	13	(2,751)
Increase/(decrease) in employee entitlements	179	77
(Decrease)/increase in funds received in advance	(304)	2,505
(Increase)/decrease in WIP	(9)	-
Net movements in working capital items	**(1,849)**	**2,774**
Net cash flow from operating activities	**(389)**	**3,259**

10. Commitments

Capital Commitments

	2017 $000	2016 $000
Within 12 months	-	391
Greater than 12 months	-	-
Total Capital Commitments	**-**	**391**

The 2016 capital commitments related to leasehold improvements to the new premises in Tory Street which TAS occupied in April 2017.

Operating Leases as Lessee

The future aggregated minimum lease payments to be paid under non-cancellable operating leases are as follows:

	2017 $000	2016 $000
Not later than one year	924	578
Later than one year and not later than five years	3,696	3,282
Later than five years	3,679	3,864
Total non-cancellable operating leases	**8,299**	**7,724**

TAS has signed a leases for a new premises in Wellington, Christchurch and Auckland. The Wellington and Christchurch leases, including rights of renewal, expire in nine years from commencement. The Auckland lease, including rights of renewal will expire in 12 years from commencement.

11. Contingencies

TAS has no contingent liabilities or contingent assets (2016: Nil).

12. Financial instruments

TAS is risk averse and seeks to minimise exposure arising from its treasury activity. TAS does not enter into any transaction that is speculative in nature.

TAS has a series of policies providing risk management for interest and currency rates and the concentration of credit.

Interest Rate Risk

Interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. TAS' exposure to interest rate risk is limited to its bank deposits which are held at fixed rates of interest. TAS does not actively manage its exposure to interest rate risk.

15.3

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. TAS has no exposure to currency risk.

Credit risk

Credit risk is the risk that a third party will default on its obligation to TAS causing it to incur a loss.

Due to the timing of cash inflows and outflows, TAS invests surplus cash with registered banks.

In the normal course of business, TAS is exposed to credit risk from cash and term deposits with banks and receivables. For each of these, the maximum credit exposure is best represented by the carrying amount in the statement of financial position.

TAS holds no collateral or other credit enhancements for financial instruments that give rise to credit risk.

Liquidity Risk

Management of liquidity risk

Liquidity risk is the risk that TAS will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash.

TAS mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements.

Contractual maturity analysis of financial liabilities

The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows.

	Carrying amount $000	Contractual cash flows $000	Less than 6 months $000	6-12 months $000	Later than 1 year $000
2016					
Payables*	3,621	3,621	3,621	-	-
Total	**3,621**	**3,621**	**3,621**	**-**	**-**
2017					
Payables*	3,299	3,299	3,299	-	-
Total	**3,299**	**3,299**	**3,299**	**-**	**-**

* Excluding funds received in advance and taxes payable

13. Related Party Transactions

TAS is a multi-parent subsidiary of a group of Central Region DHBs.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and conditions no more or less favourable than those that it is reasonable to expect TAS would have adopted in dealing with the part at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entitles) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

15.3

The following transactions are not at arm's length:

	Revenue		Accounts Receivable		Expenses		Accounts Payable	
	Year to June 2017 $000	Year to June 2016 $000	As at June 2017 $000	As at June 2016 $000	Year to June 2017 $000	Year to June 2016 $000	As at June 2017 $000	As at June 2016 $000
Auckland DHB	31	-	36	-	98	75	-	-
Bay of Plenty DHB	621	632	59	-	32	84	-	29
Canterbury DHB	1,254	1,347	-	123	395	501	3	-
Capital & Coast DHB	3,406	5,192	1,019	823	161	262	27	17
Counties Manukau DHB	42	-	47	-	107	77	-	15
Hawke's Bay DHB	2,500	3,780	148	30	24	79	-	10
Hutt Valley DHB	1,985	3,189	640	159	88	143	1	26
Lakes DHB	324	289	51	-	40	10	2	-
MidCentral DHB	4,088	4,490	1,038	125	23	53	-	10
Nelson Marlborough DHB	513	451	-	48	23	53	-	10
Northern Regional Alliance*	4,140	5,031	-	-	304	236	4	3
Northland DHB	109	-	56	-	3	53	-	10
Tairawhiti DHB	144	147	-	-	-	24	-	14
Taranaki DHB	355	314	-	30	566	672	-	5
South Canterbury DHB	164	177	-	-	10	24	-	-
South Island Alliance Programme Office**	576	-	-	-	-	-	-	-
Southern DHB	962	988	-	-	65	150	-	86
Waikato DHB	1,018	1,006	-	-	33	75	-	86
Wairarapa DHB	1,315	1,925	316	29	10	24	-	5
Waitemata DHB	65	-	4	-	33	75	-	15
West Coast DHB	161	111	11	-	-	-	-	-
Whanganui DHB	2,090	2,450	402	216	10	24	-	5

*Revenue is billed to Northern Regional Alliance on behalf of Auckland DHB, Counties Manukau DHB, Northland DHB and Waitemata DHB.

**Revenue is billed to South Island Alliance Programme Office on behalf of Canterbury DHB, South Canterbury DHB, Nelson Marlborough DHB and Southern DHB and West Coast DHB.

Key management personnel compensation

	2017 $000	2016 $000
Leadership team		
Remuneration	$1,727	$1,655
Full-time equivalent members	**8.0**	**8.0**

14. Board member remuneration

The total value of remuneration paid or payable to each Board member during the year ended 30 June 2017 was:

	2017 $000	2016 $000
Dr Jan White (Chairperson)	30	30
Murray Bain	15	15
Deryck Shaw	15	15
Murray Georgel	-	15
Wendy McPhail	15	15
Total Board member remuneration	**75**	**90**

Kathryn Cook is the fifth board member and does not receive any remuneration as she is the representative of the A Class shareholders and is a paid employee of MidCentral DHB.

There have been no payments made to committee members appointed by the Board who are not Board members during the financial year.

TAS has provided a deed of indemnity to Directors for certain activities undertaken in the performance of TAS' functions.

TAS has taken out Directors and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

15. Capital management

TAS' capital is its equity, which comprises accumulated funds. Equity is represented by net assets.

TAS is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

TAS manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments and general financial dealings to ensure TAS effectively achieves its objectives and purpose, whilst remaining a going concern.

16. Events after Balance date

There were no significant events after the balance date.

INDEPENDENT AUDITOR'S REPORT

15.3

To the shareholders of Central Region's Technical Advisory Services

Report on the financial statements

Opinion

In our opinion, the accompanying financial statements of Central Region's Technical Advisory Services (the company) on pages 30 to 38:

i. present fairly in all material respects the company's financial position as at 30 June 2017 and its financial performance and cash flows for the year ended on that date; and

ii. comply with Public Benefit Entity Standards (Not For Profit).

We have audited the accompanying financial statements which comprise:

- the statement of financial position as at 30 June 2017;
- the statements of comprehensive revenue and expense, changes in equity and cash flows for the year then ended; and
- notes, including a summary of significant accounting policies and other explanatory information.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (New Zealand) ('ISAs (NZ)'). We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the company in accordance with Professional and Ethical Standard 1 (Revised) Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board and the International Ethics Standards Board for Accountants' Code of Ethics for Professional Accountants (IESBA Code), and we have fulfilled our other ethical responsibilities in accordance with these requirements and the IESBA Code.

Our responsibilities under ISAs (NZ) are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

Other than in our capacity as auditor we have no relationship with, or interests in, the company.

Other information

The Directors, on behalf of the company, are responsible for the other information included in the entity's Annual Report. Our opinion on the financial statements does not cover any other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Use of this independent auditor's report

This report is made solely to the shareholders as a body. Our audit work has been undertaken so that we might state to the shareholders those matters we are required to state to them in the independent auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the shareholders as a body for our audit work, this report, or any of the opinions we have formed.

KPMG

Responsibilities of the Directors for the financial statements

The Directors, on behalf of the company, are responsible for:

- the preparation and fair presentation of the financial statements in accordance with generally accepted accounting practice in New Zealand (being Public Benefit Entity Standards (Not For Profit));
- implementing necessary internal control to enable the preparation of a set of financial statements that is fairly presented and free from material misstatement, whether due to fraud or error; and
- assessing the ability to continue as a going concern. This includes disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they either intend to liquidate or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objective is:

- to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error; and
- to issue an independent auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs NZ will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error. They are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of these financial statements is located at the External Reporting Board (XRB) website at:

https://www.xrb.govt.nz/Site/Auditing_Assurance_Standards/Current_Standards/Page8.aspx.

This description forms part of our independent auditor's report.

KPMG

KPMG
Wellington

27 September 2017

69 Tory Street, Wellington 6011
info@tas.health.nz, www.tas.health.nz


www.tas.health.nz

HAWKE'S BAY District Health Board Whakawāteatia	**Allied Laundry Services Ltd Annual General Meeting** 124
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Chief Executive
Month:	October 2017
Consideration:	For Decision

RECOMMENDATION

That the Board

- Note the Financial Statements for Allied Laundry Services Ltd will be made available once signed off by the Auditors.
- Appoint Ken Foote as the HBDHB Shareholder representative to attend the Allied Laundry Services Ltd Annual General Meeting to be held on Tuesday 28 November 2016, with Tim Evans appointed as his Alternate.

16

ATTACHMENTS

Notice of AGM
Chair's Report

FINANCIAL STATEMENTS & ANNUAL REPORT

A copy of the Financial Statements will be forwarded once they have been signed off by the Auditors.

Draft reports and financial statements currently indicate a very successful year of consolidation following the significant expansion of the business in March 2016 and with Capital and Coast and Hutt Valley DHBs joining Allied. The company is currently reporting an operating surplus of $559k prior to the proposed Interest on Capital Dividends of $407k.

AGM REPRESENTATIVE

The Shareholders Agreement requires each shareholder to appoint a representative for the AGM.

As the HBDHB appointed Director on the Board of Allied (and the current Chair) it would be appropriate for Ken Foote to be appointed as the HBDHB shareholder representative to attend and vote at the AGM. If for some reason Ken is unable to attend, it is recommended that Tim Evans be appointed as his Alternate.

ALLIED LAUNDRY
BY HEALTH • FOR HEALTH

Allied Laundry Services Limited
Notification of Annual General Meeting.

Notice is hereby given that the Annual Meeting of shareholders of Allied Laundry Services Limited will be held:

At **Allied Laundry Services Limited; Palmerston North.**

On Tuesday 28th November 2017

BUSINESS

1 Apologies

2 Shareholders Representatives

To clarify who is attending the meeting and has voting rights as the representative of a shareholder.

3. Minutes

To review and accept the minutes of the Annual Meeting held on 29 November 2016.

Recommendation: That the minutes of the Annual Meeting held on 29 November 2016 be accepted as a true and accurate record of that meeting.

4 Financial Statements and Reports

To receive, consider and adopt the company's financial statements for the year ended 30 June 2017 together with the auditor's report thereon and the Chairperson's Annual Report.

Recommendation: That the annual report of the company for the year ended 30th June 201/ be required to include only the signed financial statements for the accounting period completed and an auditors report.

That the annual report for the year ended 30th June 2017 is received.

That the Chairpersons report for the year ended 30th June 2017 is received.

That the letter of representation for the year ended 30th June 2017 be signed by 2 Directors.

5 Chairs Report.

To receive and accept the annual Chairs report.

6 Payment of Dividend.

To declare a dividend of $0.07 per share from 1 July 2016 to 31 December 2016 and $0.06 per share from 1 January 2017 to 30 June 2017 to the six shareholding District Health Boards.

Recommendation: That a dividend payment of $0.07 per share from 1 July 2016 to 31 December 2016 and $0.06 per share from 1 January 2017 to 30 June 2017 is declared to each shareholding District Health Board.

7 Appointment of Auditors

To record the continuance of Deloitte as auditors on behalf of the Office of the Auditor General for Allied Laundry Services Limited.

Recommendation: That the continuance of Deloitte as auditors on behalf of the Office of the Auditor-General be recorded.

8 General

To deal with any other business that may be properly brought before the meeting.

By Order of the Board

27 September 2017

Ken Foote

Chair

CHAIR'S REPORT FOR THE YEAR ENDED 30 JUNE 2017

The strategic theme adopted by the Company for the year was 'consolidation'. This required us to continually enhance, refine, develop and maximise the benefits of the significant changes implemented during 2015/16, ie:

- Over $6.0m spent on fixed assets including expanding and updating the linen processing equipment, associated energy savings additions, and doubling the value of linen stock.
- Full service provision taken over the CCDHB and HVDHB from March 2016, and integrated into Allied business processes.
- 10% price reductions implemented form 1 March 2016, to recognise benefits anticipated in original Contingency Scenario.
- Strategic alliances entered into with New South Wales Healthshare, Canterbury Linen Services and other (non Spotless) DHB laundries.
- Planning completed for introduction of new linen and financial managerial system.

16.1

I am very pleased to report that despite the challenges and increased complexity created by these changes, significant progress has been made on consolidating them and incorporating them into our expanded business operations.

Key achievements in particular have included:

- Enhanced plant operation, efficiency and productivity
- High levels of customer service maintained and acknowledged
- Linen stocks stabilised, 'national' catalogue agreed and specification developed for 'national' tender
- Enhanced focus on health and safety in all localities.
- Successful implementation of MYOB (financial) and Bundle (linen management) systems.
- Construction and operation of new steam generator.
- Further strengthening of strategic alliances with New South Wales Healthshare and Canterbury Linen Services.
- Achievement of a $559k operating surplus, leaving a net surplus of $152k after providing for Interest on Capital Dividend to shareholders ($407k).
- Efficient management of cash flow (despite the deliberate Board decision to minimise long term borrowings to fund the recent capital expansion) allowing for the implementation of a payment plan for outstanding rebates and dividends, commencing November 2017.

With further work still required on some of these, the focus will gradually shift from consolidation to continuous improvement. Two specific issues of note have already been identified that will require some shareholder involvement (as customers). The most strategically significant of these is the current debate on the relative merits of reusable and disposable theatre linen. The other is our concern over the ongoing significant "losses" of scrubs. Whilst Allied will both support reviews and implement shareholder/customer decisions on these issues, each has the potential to have some operational and/or financial impact on the Company.

Chairman's Report for year ended 30 June 2017

I would like to record my thanks and appreciation to all those involved in the above achievements and in the general development of the Company into the very successful shared service cooperative it has become. Particularly I would like to thank:

- The CEO (Mark Mabbett) and all the Allied staff for working through the challenges of change and producing such positive results
- My fellow Board Members for their ongoing commitment and achievements. I would particularly like to acknowledge the contribution of Ashley Bloomfield who resigned as a Director in June 2017, and welcome Judith Parkinson as his replacement.
- Our DHB shareholders for their ongoing support to grow the Company, and in particular for their agreement to defer receipt of recent years rebates and dividends to support our cash flows.

We all have a collective right to be proud of what we have achieved, and the solid position and positive reputation we have developed.

Ken Foote
Chair

HAWKE'S BAY District Health Board Whakawāteatia	**Committee Structure and Meeting Schedule for 2018** 125
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Executive Management Team
Month:	October 2017
Consideration:	For Decision

RECOMMENDATION

That the Board

1. Confirm the current governance committee structures and processes
2. Approve the attached Meeting Schedule for 2018.

GOVERNANCE COMMITTEE STRUCTURES

It is appropriate to at least once a year review the governance committee structures operating within the DHB. These current structures are diagrammatically shown entitled "Governance Structures" on the following page.

Given that there appears to be general satisfaction with the existing structures, a review this year could be as simple as answering three key questions:

1. Is the current structure meeting the Board's needs?
2. If so, can the structures / processes be further improved?
3. If not, what needs to change?

It is acknowledged that there are some discussions going on with Ngati Kahungunu Iwi Inc about potentially enhancing the level and scope of HBDHB engagment with Maori. This could have a flow on impact on the role and function of MRB.

It is currently too early to anticipate this, so for planning purposes it has been assumed that MRB will continue to meet through 2018 under current arrangements. A similar assumption has been applied to all other committees on the basis that no changes will be made following the suggested review.

MEETING SCHEDULE 2018

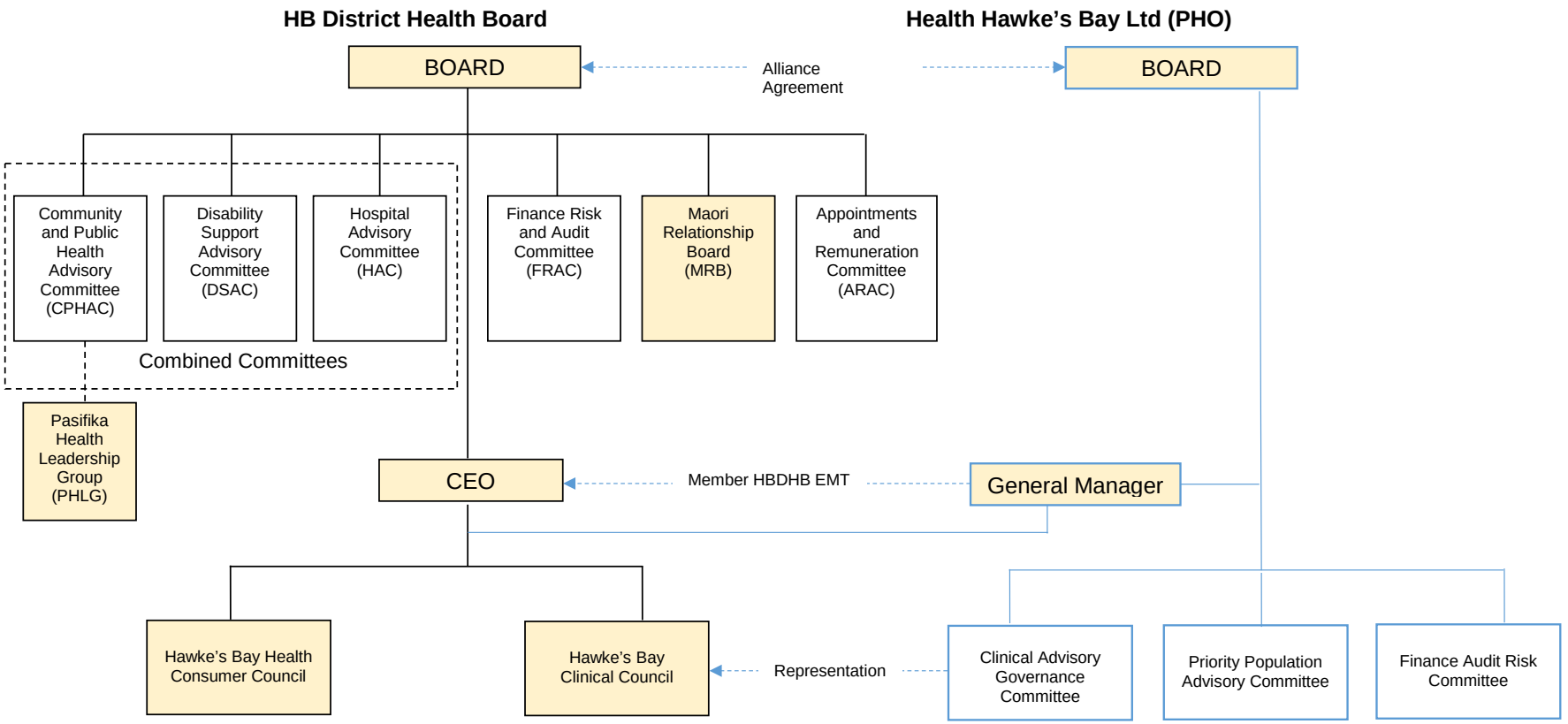
This schedule attached (in calendar and monthly meeting form) reflects the same meeting structure / processes as in 2017.

Of particular note in the draft schedule however are:

- Moving April FRAC and Board to Thursday 26 April due to ANZAC Day
- FRAC and Board December meeting scheduled for 12 December, but could be moved to 19 December.

Once approved, the intention will be to incorporate other regional and local health governance meetings into this schedule to provide a full overview, together with further formulation of indicative work plans.

HAWKE'S BAY HEALTH SECTOR
GOVERNANCE STRUCTURES



- Hawke's Bay Heatlh Sector Leadership Forum
- Representation on Alliance Leadership Team (other than Pasifika Health Leadership Group)

Annual Calendar

vertex42

Hawke's Bay District Health Board 2018

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sun				1			1					
Mon	1 NEW YEARS DAY			2 EASTER MONDAY			2			1		
Tue	2 Day after New Year			3	1		3			2		
Wed	3			4	2		4	1		3		
Thu	4	1	1	5	3		5	2		4	1	
Fri	5	2	2	6	4	1	6	3		5	2	
Sat	6	3	3	7	5	2	7	4	1	6	3	1
Sun	7	4	4	8	6	3	8	5	2	7	4	2
Mon	8	5	5	9	7	4 QUEENS BIRTHDAY	9	6	3	8	5	3
Tue	9	6 WAITANGI DAY	6	10	8	5	10	7	4	9	6	4
Wed	10	7	7 Leadership Forum	11 MRB Clinical Council	9 MRB Clinical Council Consumer Council	6	11 MRB Clinical Council	8 MRB Annual Clinical Council	5 Leadership Forum	10 MRB Clinical Council	7	5 MRB Clinical Council
Thu	11	8	8	12 Consumer Council	10	7	12 Consumer Council	9 Consumer Council	6	11 Consumer Council	8	6 Consumer Council
Fri	12	9	9	13	11	8	13	10	7	12	9	7
Sat	13	10	10	14	12	9	14	11	8	13	10	8
Sun	14	11	11	15	13	10	15	12	9	14	11	9
Mon	15	12	12	16	14	11	16	13	10	15	12	10
Tue	16	13	13	17	15	12	17	14	11	16	13	11
Wed	17	14 MRB Clinical Council	14 MRB Clinical Council	18	16	13 MRB Clinical Council	18	15	12 MRB Clinical Council	17	14 MRB Clinical Council	12 FRAC BOARD
Thu	18	15 Consumer Council	15 Consumer Council	19	17	14 Consumer Council	19	16	13 Consumer Council	18	15 Consumer Council	13
Fri	19	16	16	20	18	15	20	17	14	19 HB ANNIVERSARY	16	14
Sat	20	17	17	21	19	16	21	18	15	20	17	15
Sun	21	18	18	22	20	17	22	19	16	21	18	16
Mon	22	19	19	23	21	18	23	20	17	22 LABOUR DAY	19	17
Tue	23	20	20	24	22	19	24	21	18	23	20	18
Wed	24	21	21	25 ANZAC DAY	23	20	25 FRAC BOARD	22	19	24	21	19
Thu	25	22	22	26 FRAC BOARD	24	21	26	23	20	25	22	20
Fri	26	23	23	27	25	22	27	24	21	26	23	21
Sat	27	24	24	28	26	23	28	25	22	27	24	22
Sun	28	25	25	29	27	24	29	26	23	28	25	23
Mon	29	26	26	30	28	25	30	27	24	29	26	24
Tue	30	27	27		29	26	31	28	25	30	27	25 XMAS DAY
Wed	31	28 FRAC BOARD	28 FRAC BOARD		30 FRAC BOARD	27 FRAC BOARD		29 FRAC BOARD	26 FRAC BOARD	31 FRAC BOARD	28 FRAC BOARD	26 BOXING DAY
Thu		29	29		31	28		30	27		29	27
Fri			30 GOOD FRIDAY			29		31	28		30	28
Sat			31			30			29			29
Sun									30			30
Mon												31
Tue												

17.1

HAWKE'S BAY District Health Board Whakawāteatia	**Update on Establishing Health and Social Care Localities in HB** 126
	For the attention of: **HBDHB Board**
Document Owner/Author:	Chris Ash, ED Primary Care
Document Author	Jill Garret (Change Leader Central HB) and Te Pare Meihana (Change Leader Wairoa)
Reviewed by:	Executive Management Team, Māori Relationship Board (MRB), HB Clinical Council, HB Health Consumer Council
Month:	October 2017
Consideration:	For Endorsement

RECOMMENDATION

That the Board

- Note the contents of this paper

18

PROGRESS TO DATE ON LOCALITY DEVELOPMENT

Commencement of Executive Director – Primary Care

Chris Ash has commenced in the Executive Director role and the management of the localities work has been transitioned across from Tracee Te Huia, Director of Strategy and Health Improvement.

Over the next 3 months, Chris will be reviewing the existing position of the Health & Social Care Localities programme, and defining a framework within which the DHB will structure and resource its partnership with local communities.

The goals of the revitalized programme will include supporting and enabling the development of new, integrated care and support service delivery arrangements that:

a) Better reflect local population identities, aspirations and health models (including structured support for the skills, expertise and potential already resident in those communities)
b) Improve access by delivering the right care (from the right professional), in the right place, at the right time
c) Target efforts to tackle inequities in health outcomes, particularly as they impact the local populations
d) Develop a wider set of skills and integrated working within multidisciplinary and intersectoral teams, with a focus on moving to strengths-based approaches and fostering greater personal responsibility for individual and whānau wellness

Matariki – Hawke's Bay Regional Social Inclusion Strategy (SIS) and Regional Economic Development Strategy (REDS)[1]

The Matariki steering group and wider stakeholder network has developed (in draft) 10 action points.

Figure 1.0 – Draft Action 2.1 relates directly to the work underway in localities.

Lead Organisation	Councils and Hapu	**Ref**	SI 2.1
Other Organisations	Iwi, HBDHB, MSD, Oranga Tamariki, Police, TPK, Corrections, Social Services Providers and Community Organisations		
RGP action	Establish representative groups in locations across Hawke's Bay to enable the local community and whānau to have a voice and leadership in social and economic development. The groups will represent key local stakeholders, who may not be directly connected to Matariki REDS/ILG and; have the capacity and authority to represent their community in communication with Matariki REDS/ILG. (Linked to 1 and 3)		

Introduction – *to tell decision makers what they will need to decide*
Communities across the region want to have a say in their economic and social development. An example is a recently established group is the Wairoa Community Partnership Group, created so that key local stakeholder groups can collaborate and have cohesion around responses to be developed in Wairoa. Similar groups can be established in other areas. The areas could be large e.g. Central Hawke's Bay or smaller clustered areas based on deprivation e.g. Flaxmere, Camberley, and Maraenui. This is consistent with the Social Inclusion Strategy identifying communities for targeted support and members of the community directly contributing to outcomes.

It is proposed that there is a merge of the two Matariki strategies but at this stage those discussions are in abeyance.

The change leaders of CHB and Wairoa localities have been intermittently included in the forum that oversee and contribute to the development of Matariki SIS. In their current capacity, they are finding themselves able to contribute positively to the development of locality governance structures, and to lead and influence the direction and pace of change. The change leaders involvement in all aspects of the social inclusion strategy and the wider REDs development is key to ensuring linkages are made between operational realities and strategic direction with the locality space. Ensuring continuity of their involvement and influence should be a priority of the DHB and will make a substantial contribution to future success.

Programme Governance CHB

Representation on the health liaison group, formed in July 2016, now includes a full complement of health providers within the rohe[2]; GP, Council, MRB, Consumer Council, Aged Care, Māori Health Provider, Nursing, Clinical Nurse Manager, Pharmacy and independent health providers.

The maturity of the group has developed over time from a focus on operational activities to one of influence and change at a governance level. Early conversations are now being had in relation to the value of this group merging with the wider social leadership group that is also functioning in CHB. The group's representation included senior management level from MoE, MSD[3], tertiary education providers, senior leaders within council and the wider social sector. As required justice, fire and police are also included.

[1] REDS – Regional Economic Development Strategy
[2] Rohe – Te Reo for designated area or region
[3] Ministry of Education, Ministry of Social Development

Both groups are requesting higher level data to inform priority areas whereas in the past it had been prioritised based on reactive responses to need.

The change leader is working towards the merger of these two groups in the next 8 months in readiness for the 2018-19 financial year and the development of a 3 year strategy for the locality.

With reference to the collective impact model and the five levels of relationships, the CHB locality is transitioning from cooperation to coordination, (level 3). It is anticipated by end of 2018/19 the locality will be operating at Level 4.

Figure 1.2 – Collective Impact – progressions to effective collaboration

The Five Levels of **Collaboration**

	1	2	3	4	5
	Networking	**Cooperation**	**Coordination**	**Coalition**	**Collaboration**
Relationship Characteristics	• Aware of organisation loosely defined roles. • Little communication. • All decisions are made independently.	• Provide information to each other. • Somewhat defined roles. • Formal communication. • All decisions are made independently.	• Share information and resources. • Defined roles. • Frequent communication. • Shared decision making.	• Share ideas. • Share resources. • Frequent and prioritised communication. • All members have a vote in decision making.	• Members belong to one system. • Frequent communication is characterised by mutual trust. • Consensus is reached on all decisions.

Source: Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. American Journal of Evaluation, 27, 3, 383-392

18

Locality Governance Wairoa

There has been significant progress made in Wairoa towards establishing an effective governance model that has the buy in from local leaders and government agencies. Initially the Change Leader brought together a Health and Social Care locality group that was a combination of agency leads and local individuals who had a passion for this development however further community discussions led to the Wairoa District Council introducing a community partnerships committee model that has provided the mechanism to develop a united leadership group that has assumed the responsibility to oversee and govern agreed priorities of health, social need, education and training, employment and housing.

This committee is now in place with an approved Terms of Reference and membership of local leaders and government agency decision makers. The committee is chaired by the Mayor.

It is intended that the health and social care locality plan will become one of the work streams of a wider program of action for Wairoa. The Change Leader has a lead role in supporting the Mayor and the committee to manage the community relationships and the development of the work programme.

This development is also being informed by the progress being made by Manaaki Tairawhiti – one of the three place based social investment initiatives that is underway. The Change Leader represents Wairoa at this forum and there are positive linkages, influence and learnings from the journey that Tairawhiti is undertaking towards becoming a Social Investment Board.

ACTIVITIES AND PROGRESS IN EACH LOCALITY

➢ CENTRAL HAWKE'S BAY (CHB)

The three areas within the strategic plan that are the current focus are;

- Reducing barriers to access
- Establishing and maintaining effective communication lines
- Strengthening trust between providers

Reducing barriers to access:

Through the influence of the Rural Alliance, uptake of funded programs offered by the PHO are now being accessed by the Tukituki Medical. The programs are aimed at the high need, high deprivation populations and include SIA funded programs, High Needs Enrolment, and Whānau Wellness.

The clinical nurse manager of CHB Health Center has created pathways for transitioning care from Hastings Hospital to the health center on identification of CHB inpatients with a level of acuity able to be managed. Evidence continues to be gathered to monitor; bed utilisation rates, average length of stay with metric analysis against readmission rates. This will contribute to the 'Saving 4000 bed days target and the System Level Measure – Using Health Resources Effectively.

Establishing and maintaining effective communication lines:

Signage and communication has been a priority for the health liaison group from inception. October 3rd is the launch date for the; distribution of magnets and flyers that outline for the consumer how to access urgent and emergency care relevant to CHB residents. In addition signage has been erected within Waipawa and Waipukurau. All of the material aligns to the DHB Choose Well Strategy.

This project has required significant coordination to achieve agreement and buy in of the health providers. It has served the purpose of illustrating the importance of establishing and maintaining effective communication and relationships between the extensive health network as the foundation for future and more significant work.

The Social Leadership forum of CHB is also using the launch for the material above to trial a survey that will be used to evaluate the responsiveness of social services within CHB. This is the beginnings of the work that is coming together for both groups as indicated above under strategic leadership.

Figure 1.0 – Magnets to be distributed to every household in CHB (n=5000)

Live Well in CHB is the brand that the Health Liaison group is using to identify the work that they are leading. In conjunction with the CHB District Council it was decided that this branding aligns with the council's strategy of "Thrive in CHB".

Strengthening trust between providers:

The increased membership- representation on the Health Liaison Group, the consistent attendance of meetings, the interest in new projects and the multi-agency involvement in those projects are all testament to the trust and confidence that is building between the providers within CHB (health and the wider social sector).

Projects currently being scoped:

- Extension of the engAGE program to include CHB – a meeting was held between the Health Liaison group and the engAGE team to discuss the work that needs to be done to replicate the program within CHB, utilising existing resources and services that are working well and augmentation of services that are currently not available.
- Creation of an LMC Hub in CHB – the Health Liaison group met with Jules Arthur to discuss the option of creating a hub serviced by local midwives and support workers for the benefit of the population of CHB.
- Both the Health Liaison group and the CHB Social Leadership forum are currently gathering data around the prevalence and influence of methamphetamine on the community of CHB. The intention is to scope a community based response supported by multi agencies.
- Population health and work place wellness – the population health team is working on a response to creating a 'large employer' workplace wellness strategy for CHB. Initial work is underway with Silver Fern Farms, in partnership with Worksafe NZ and ACC.
- Increased utilisation of Telehealth (VC- access to outpatient and specialist input) for the residents of CHB is being looked at by the DHB IT team for both CHB and Wairoa. The use of Telehealth and virtual clinics as a mechanism for outreach provision of GP services is being scoped as part innovation within the CHB Rural Alliance - annual plan.

- **WAIROA**

One of Wairoa's strongest assets is its people and the tikanga that underpins the fabric of Māori whānau and the community. The future success of any health and social transformation will need to include a strategy that encompasses the utilization of tikanga principles and values. In 2016 five Wairoa health leaders attended the NUKA training at the DHB. This group intends to utilize the learnings and experience taken from this indigenous development to support the shape and design of a tikanga based model of health care for Wairoa.

Integration activities

Ongoing activities are progressing across the General Practice Alliance network. February 2018 will see all three practices co-located on the Wairoa Health Centre site providing more opportunity for integration and consistency to occur.

Queen Street Practice, Kahungunu Executive and Te Whare Maire o Tapuwae are undertaking a "20 families" project to support the development of a one team approach to care. The cohort of patients will be those identified through general practice as pre-diabetic and a whānau led plan will be developed with each patient and their whānau, utilizing the clinical, health promotion and whānau ora skills and resources across the three providers. It is intended that the evaluation of this project will support further integrated practice across the wider health system.

A nursing review is in initial stages of planning as secondary, primary and community services are interested in further developing the rural health nursing model that enables strengthened nursing leadership in the pathways of care. This will provides further opportunity in the design of achieving a well-coordinated and one system of health care.

A co-design process is underway to develop a model for Health of Older Persons which will include introducing a variation of the Engage model into Wairoa. Key stakeholders in this process includes the Wairoa Health Centre, DHB strategic services, EngAGE, Glengarry BUPA, Aged Concern, Kahungunu Executive, Cranford Hospice and a local group of consumers and whānau.

Collaboration

The E Tu Wairoa (family violence intervention network) is making good headway with embedding the E Tu Whānau leadership model and values and have been chosen as one of the 3 communities to be involved in a national evaluation of our development and progress.

The integrated Clinical Governance committee is overseeing a major research study- He Korowai Manaaki – A Wrap Around Approach that is being undertaken by the Women's Health Research Centre University of Otago and continues to build its profile for clinical leadership in Wairoa and Hawkes Bay.

The Change Leader is working with Oranga Tamariki, Police and the DHB to establish a single triage system for referrals where there are family harm and care and protection issues. This is being modelled on a system that is already established in Tairawhiti with a view to utilizing the privacy framework and data sharing protocols.

Recommendations

The work in both of the localities is progressing well, each are well placed to embed the initiatives that are currently underway and those being scoped. It is timely that the following recommendations are addressed:

- Creating natural synergies between district and locality specific strategic direction.
- Creating formal mechanisms that link REDS[4] and SIS[5] with the locality work of the DHB through the roles of the change leaders
- Resourcing the coordination and administration of the work underway within each locality to free up the change leaders to operate strategically.

[4] Regional Economic Development Strategy
[5] Social Inclusion Strategy

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:

20. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

22. Board Approval of Actions exceeding limits delegated by CEO

23. Chair's Update

24. Hawke's Bay Clinical Council

25. Hawke's Bay Health Consumer Council

26. Finance Risk and Audit Committee Report

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).