

BOARD MEETING

Date: Wednesday 30 October 2019

Time: 1:30pm

Venue: Te Waiora Room, DHB Administration Building,

Corner Omahu Road and McLeod Street, Hastings

Members: Kevin Atkinson (Chair)

Ngahiwi Tomoana Dan Druzianic Barbara Arnott Peter Dunkerley

Dr Helen Francis (via teleconferencing)

Diana Kirton Heather Skipworth

Ana Apatu Jacoby Poulain Hine Flood

Apologies:

In Attendance: Craig Climo, Interim Chief Executive Officer

Executive Leadership Team members

Robin Whyman and Jules Arthur, Co-Chairs of Clinical Council

Rachel Ritchie, Chair HB Health Consumer Council

Members of the public and media

Minute Taker: Jacqui Sanders-Jones, Board Administrator

Public Agenda

Item	Section 1: Routine	Ref#	Time (pm)
1.	Welcome and Apologies		1:30
2.	Interests Register		
3.	Minutes of Previous Meeting 25 September 2019		
4.	Matters Arising - Review of Actions		
5.	Board Workplan		
6.	Chair's Report (verbal)		

Chief Executive Officer's Report		
Financial Performance Report — Carriann Hall, ED Financial Services		
- Quarterly report to the MoH		
Board Health & Safety Champion's Update (verbal) - Board Safety Champion		2.00
Section 2: Governance / Committee Reports		
Pasifika Health Leadership Group report		2:05
Māori Relationship Board report – Chair, Heather Skipworth		2:10
HB Clinical Council report— Co-Chairs, Julie Arthur & Dr Robin Whyman		2:20
12.1 HB Clinical Council new appointment		
HB Health Consumer Council report— Chair, Rachel Ritchie		2:30
Te Pitau Health Alliance HB report – Deputy Chair, Hine Flood		2.40
Section 3: For Decision		
		2.50
		3.00
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		3.15
		3.30
		3.35
Te Ara Whakawaiora – Adult Health indicators – Bernard Te Paa		3.40
Section 5: Recommendation to Exclude the Public Under Clause 32, New Zealand Public Health & Disability Act 2000		
Under Clause 32, New Zealand Public Health & Disability Act 2000	Ref#	Time (pm)
Under Clause 32, New Zealand Public Health & Disability Act 2000 uded Agenda	Ref#	l
Under Clause 32, New Zealand Public Health & Disability Act 2000 uded Agenda Section 6: Routine	Ref#	(pm)
Under Clause 32, New Zealand Public Health & Disability Act 2000 uded Agenda Section 6: Routine Minutes of Previous Meeting 28 August 2019 (public excluded)	Ref#	(pm)
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	Financial Performance Report — Carriann Hall, ED Financial Services - Quarterly report to the MoH Board Health & Safety Champion's Update (verbal) - Board Safety Champion Section 2: Governance / Committee Reports Pasifika Health Leadership Group report Māori Relationship Board report— Chair, Heather Skipworth HB Clinical Council report— Co-Chairs, Julie Arthur & Dr Robin Whyman 12.1 HB Clinical Council new appointment HB Health Consumer Council report— Chair, Rachel Ritchie Te Pitau Health Alliance HB report— Deputy Chair, Hine Flood	Financial Performance Report — Carriann Hall, ED Financial Services - Quarterly report to the MoH Board Health & Safety Champion's Update (verbal) - Board Safety Champion Section 2: Governance / Committee Reports Pasifika Health Leadership Group report Māori Relationship Board report— Chair, Heather Skipworth HB Clinical Council report— Co-Chairs, Julie Arthur & Dr Robin Whyman 12.1 HB Clinical Council new appointment HB Health Consumer Council report— Chair, Rachel Ritchie Te Pitau Health Alliance HB report— Deputy Chair, Hine Flood Section 3: For Decision Te Pitau Health Alliance— CEO 15.1 Te Pitau Health Alliance appendix 1 15.2 Te Pitau Health Alliance agreement Section 4: For Information & Discussion Planning & Funding report to Board— Chris Ash - 20/21 Planning Priorities Proposed Induction Package for New Board members— Ken Foote Shareholder represenatatives for Allied Laundry— Ken Foote

The next HBDHB Board Meeting will be held at 1.30pm on Wednesday 27 November 2019

Our shared values and behaviours





Welcoming

✓ Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles

Respectful

Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity Shows kindness, empathy and compassion for others

Kind

Helpful

Enhances peoples mana

Reliable, keeps their promises; advocates for others

✓ Attentive to people's needs, will go the extra mile

- x Is closed, cold, makes people feel a nuisance
- Ignore people, doesn't look up, rolls their eyes
- Lacks respect or discriminates against people
- Lacks privacy, gossips, talks behind other people's backs
- x Is rude, aggressive, shouts, snaps, intimidates, bullies
- Is abrupt, belittling, or creates stress and anxiety
- x Unhelpful, begrudging, lazy, 'not my job' attitude
- x Doesn't keep promises, unresponsive

AKINA IMPROVEMENT Continuous improvement in everything we do

Positive

Appreciative

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

RARANGA TE TIRA PARTNERSHIP Working together in partnership across the community

Listens

Involves

Connects

- ✓ Listens to people, hears and values their views Takes time to answer questions and to clarify
- Communicates

 Explains clearly in ways people can understand Shares information, is open, honest and transparent
 - ✓ Involves colleagues, partners, patients and whanau
 - Trusts people; helps people play an active part
 - Pro-actively joins up services, teams, communities
 - Builds understanding and teamwork

- x 'Tells', dictates to others and dismisses their views
- X Judgmental, assumes, ignores people's views
- Uses language / jargon people don't understand
- Leaves people in the dark
- Excludes people, withholds info, micromanages
- Makes people feel excluded or isolated
- x Promotes or maintains silo-working
- 'Us and them' attitude, shows favouritism

Professional

TAUWHIRO CARE Delivering high quality care to patients and consumers

- Calm, patient, reassuring, makes people feel safe
- Has high standards, takes responsibility, is accountable

Safe

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



Board "Interest Register" - as at 4 August 2019

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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non- Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non- Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	RENEW Counselling Services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Wharariki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The	on this topic, and will not take part in any decisions / or financial discussions relating	The Chair	8.08.18
Hine Flood	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.	on the specific provision of services in	The Chair	14.02.17

MINUTES OF THE BOARD MEETING HELD ON WEDNESDAY 25 SEPTEMBER 2019, IN THE TE WAIORA ROOM, DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS AT 1.37PM

PUBLIC

Members: Kevin Atkinson (Chair)

Ngahiwi Tomoana (Deputy Chair)

Dan Druzianic
Dr Helen Francis
Peter Dunkerley
Diana Kirton
Barbara Arnott
Heather Skipworth
Jacoby Poulain
Ana Apatu
Hine Flood

Apology Ngahiwi Tomoana (Deputy Chair), Barbara Arnott

Absent Jacoby Poulain

In Attendance: Craig Climo (Interim Chief Executive Officer)

Members of the Executive Management Team

Julie Arthur & Dr Robin Whyman (as co-Chairs, HB Clinical Council)

Rachel Ritchie (Chair, HB Health Consumer Council)

Members of the public and media

Jacqui Sanders-Jones, Board Administrator

1. APOLOGY

Apologies received from Ngahiwi Tomoana (Deputy Chair) and Barbara Arnott

Jacoby Poulain noted as absent

Chair thanked Barbara Arnott for chairing August board meeting and thanked Ngahiwi Tomoana for responding on Chair's behalf to media queries last week.

2. INTEREST REGISTER

No changes to the interests register were advised

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

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 28 August 2019, were confirmed as a correct record of the meeting.

Moved: Peter Dunkerley Seconded: Dan Druzianic

Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES

- Item 1: Person & Whanau Centred Care October workplan
- Item 2: He Ngakau Aotea CEO updated members that this would be addressed at October meeting
- Item 3: Mental Health Zero seclusion Agenda item. Complete
- Item 4: Annual Plan 20/21 CEO to identify timeframes for Workshop between Board & Management CEO explained the initial intention was that this discussion would take place prior to the new board in place and in order to consider proposals for funding. CEO has been working with ELT as to timeframes of planning for next year and will bring this item to board next month CEO Action/Workplan

It was discussed and noted that once new board members are known there is an opportunity to invite them into these planning discussions. A wider meeting is tentatively scheduled for early March on 20/21 Planning.

This led to further discussion and agreement to put *Board Induction* on Workplan in October so as to determine what the induction should like and gain feedback from current board members.

ACTION: New item to workplan - local Board induction

Heather Skipworth suggested reviewing the date of new board powhiri, so as to ensure alignment with the induction dates.

5. BOARD WORK PLAN

The Board Work Plan was noted

6. CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Phillipa Poelina-Hunter	Registered Nurse	Surgical Services	28	9 August 2019

7. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report with comments noted in addition, including the following key points:

- Planning process has begun for the next financial year with more information on this coming to October board meeting. CEO feels *flow* is the focal delivery point for the hospital with Mental Health and Wairoa also a top focus.
- Already off plan with our financial results and a troublesome forecast ahead, with a current \$2.5m unfavourable variance against plan (noting plan is unapproved as yet by the Minister). However, there are opportunities for management to reduce expenditure and have been encouraged to 'get on' and do so. Some matters may come through to Board for approval.
- Hospital over capacity is a focus, with thrice daily reports coming through Integrated Operations Centre.
 Seasonal issues bring pressure on hospital beds with knock on effect to the emergency department.

There is a lack of short-term levers to affect the flow pressures, however the management team are determined to address this with good results. It is important to note that clinical staff need to be fully engaged to positively affect any changes applied.

- Need to address planning processes and utilising the tools we already have in place. Chris Ash, Executive
 Director of Primary Care now has a Planning and Funding peer view over the whole organisations (rather
 than just Primary Care). Actively rationalising the work being done with a plan to discuss and agree what
 the focus of management should be. Board will be informed of this planning next month. There is a
 desire to streamline the governance process in order to expedite opportunities.
- Level of strike activity and industrial relations feels 'grim'. Strikes underway are through APEX union (Psychologists, radiographers, laboratory staff).
 - Radiographer strike will impact significantly as it is staggered over six half days, with consequential difficulties in getting back to business as usual with non-acute work. Life Preserving Services are in place but recognise there is heightened risk to patients. Our job is to mitigate this risk to patients.
 - Our DHB has received over 30 separate strike notices over a range of groups this past year.
- Nature of reporting coming to board From October 2019, there will be summarised reports from CEO,
 CFO, COO and GM Planning & Funding as these are high activity areas.
 - Chair clarified that these reports will be summaries brought through from the FRAC reports received.

Co-Chair of MRB emphasised the importance of MRB being involved with items coming to Board in order to capture MRB feedback and ensure inclusion and an equity lens. MRB are currently reviewing their own reporting process, and this should then feed into the desire to move items through more swiftly to Board.

Member raised concern that we need to ensure we capture community reporting (Primary Care) as the reporting proposed is quite operational and 'hospital' focused.

RECOMMENDATION

That the HBDHB Board:

1. Note the contents of this report.

Adopted

8. FINANCIAL PERFORMANCE REPORT

Carriann Hall (Executive Director of Financial Services) spoke to the Financial Report for August 2019, which showed a \$0.5m unfavourable variance to plan. Comments noted in addition to the report included:

- Plan has been adjusted to \$12.9million deficit, however this is unapproved by MoH as yet
- Drivers include a combination of seasonal and specific issues (net spend on medical and locum personnel, and specific blood products)
- First forecast suggesting \$2.5m adverse to plan. Clear risks include:
 Unpresented level of activity in hospital (provider) through mid-August/September, which will probably continue through October, and cost consequence of industrial action.
- Utilising our overdraft facility, with \$18m into overdraft (this is within statutory limit)

Chair commented on the significant challenges ahead to bring forecast back to plan.

RECOMMENDATION

That the HBDHB Board:

• Note the contents of this report

Adopted

9. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Board Health & Safety Champion Heather Skipworth recently visited Medical Records and provided a verbal report on observations. Report has been sent through to Safety & Wellbeing team to further investigate and pick up any action points.

REPORT FROM COMMITTEE CHAIRS

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

Hine Flood as Deputy Chair of the Health Alliance spoke on matters discussed at their meeting held 11 September 2019.

Rangatahi Redesign was a prominent presentation which impressed as a good example of whanau voice for change.

There was feeling that the Rangatahi needed to be recognised for their work and time into this redesign project and requested that the HBDHB Renumeration policy be reviewed in order to address this.

Chair of Consumer Council highlighted that there is current policy on recognising Consumer Engagement.

Mental Health & Addictions (MH&A) redesign was noted to involve engagement of services from Devante consultancy group. Te Pitau Health Alliance have requested that management consider using Diane Kopua with co-design of community NGO MH&A contract. ACTION

Chair suggested that management work with Te Pitau Health Alliance for solutions to issues mentioned above.

Recommendation

That the HBDHB Board:

- 1. Note the contents of this report
- **2. Request that management review** HBDHB's Remuneration Policy in relation to current non-financial recognition of time and valuable contributions and expertise being received from Rangatahi stakeholder groups (ACTION)

Adopted

11. MĀORI RELATIONSHIP BOARD (MRB)

Heather Skipworth as Chair of MRB spoke to the meeting held 11 August 2019, noting the following points:

- MRB members were impressed by Rangatahi redesign presentation; fully supporting their mahi.
- Mahi A Atua wananga for this Maori based psychology and specific approach to Mental Health issues
 is to be set up for a cross section of stakeholders. This an action point from MRB for Maori Health/Health
 Improvement and Equity team.

RECOMMENDATION That the HBDHB Board: Note the contents of this report

12. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Adopted

Rachel Ritchie, Chair of Consumer Council advised the outcomes of their meeting held on 12 September 2019:

- 1737 service Council continuing to support addressing the issue with this service by developing a letter sent jointly from Hastings District Youth Council and HB Health Consumer Council
- Finalised planning for next year with eight resulting objectives and a new plan of how to address each one.

RECOMMENDATION	
That the HBDHB Board:	
Note the contents of this report	
Adopted	

13. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair Jules Arthur spoke to the report from the Council's meeting held on 11 September 2019, noting that the majority of the meeting was spent in Public Excluded time with the Annual meeting agenda.

RECOMMENDATION	
That the HBDHB Board:	
Note the contents of this report	
Adopted	

FOR INFORMATION

14. HAWKE'S BAY FOUNDATION HEALTH FUND

Ken Foote, Company Secretary, introduced Hawke's Bay Foundation representatives to the meeting, for the signing of the agreement between HB Foundation and HBDHB to establish a Hawke's Bay (HB) Health Fund.

Giles Pearson and team from HB Foundation gave an overview of the new HB Health Fund and options available within this fund when a donation is received. HBDHB staff can actively promote this health fund as there is no conflict of interest. Community donations are well established as charitable options for those wanting to donate/bequest and the HB Foundation are working together with other health providers across Hawke's Bay to promote the fund. Donations can be 'tagged' for specific causes.

This is an exciting opportunity for people of Hawke's bay to contribute and 'Live Here, Give Here'.

Ken Foote, Company Secretary was thanked for the notable amount of time he has put into building relationships and working towards finalising this agreement.

Agreement executed through signing by both parties.

15. MATARIKI HB REGIONAL ECONOMIC DEVELOPMENT AND SOCIAL INCLUSION STRATEGY

Report from Health Improvement and Equity team provided to update board on the progress of Matariki Development Strategies and the HBDHB contribution towards these. Report accepted with no further comment.

RECOMMENDATION

That the **HBDHB Board**:

• Notes the contents of this report.

Adopted

16. MENTAL HEALTH & ADDICTION SERVICE: SECLUSION & STAFF ASSAULT UPDATE REPORT

John Burns, Executive Director of Provider Services presented the report indicating overall improved results, and noting the contribution to these improvements through good leadership. There was no further comment.

RECOMMENDATION

That the **HBDHB Board**:

• Notes the contents of this report.

Adopted

GENERAL BUSINESS

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

17. RECOMMENDATION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

- 18. Confirmation of previous minutes 31 July 2019 Public Excluded
- 19. Matters Arising (public excluded)
- 20. Board Approval of Actions exceeding limits delegated by CEO
- 21. Chair's Update
- 22. CEO report to Board (Public excluded)
- 23. Patient Air Transfer (fixed wing) CEO
- 24. HB Clinical Council report to Board (public excluded)
- 25. HB Health Consumer Council report to Board (public excluded)
- 26. NZ Health Partnerships
- 27. Finance Risk and Audit Committee

Moved: Peter Dunkerley Seconded: Heather Skipworth

Carried

The public section of the Board Meeting closed 3.05pm

Signed: -		
o.g., cu.	Chair	
Date:		

BOARD MEETING - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	26/06/19	Person & Whanau Centred Care Review the report and proposed new 2 x FTE roles as to how they can be developed to more widely link with He Ngakau Aotea. Report on progress	Kate Coley	October 2019	Further meeting with Chairs of Consumer Council and MRB held. Draft framework presented and discussion around options and approaches to ensuring this piece of work is prioritised. Short document to be socialised with Consumer Councils and MRB in November and December and report to be provided by Chairs of both governance groups in December Board report.
2	26/06/19	Consider how these recommendations will be actioned and resourced Regular updates requested as to costs and progress	Bernard Te Paa	October 2019	Update report provided as appendix to Matters Arising. Workplan for March 2020
3	28/08/19	Annual Plan 20/21 CEO to identify timeframes for Workshop between Board & management - CEO has been working with ELT as to timeframes of planning for next year and will bring this item to board next month	CEO	October 2019	Agenda item within Planning & Funding report to Board
4	25/09/19	Board Induction Discussion item for next meeting to be added to workplan	Ken Foote	October 2019	Agenda item

Action	Date Entered	Action to be Taken	By Whom	Month	Status
5	25/09/19	Te Pitau Health Alliance Actions:	Chris Ash	Oct	Response provided below.
		a) Request that management consider using Diane Kopua with co-design of community NGO MH&A contract b) Request that management review HBDHB's Remuneration Policy in relation to current non-financial recognition of time and valuable contributions and expertise being received from Rangatahi stakeholder groups			

Action 5a: Request that management consider using Diane Kopua with co-design of community NGO MH&A contract

When need for co-design support was identified for the Mental Health redesign, extensive input was sought to identify qualified parties that would be able to satisfy the brief. This included liaison with our Māori Health team to both identify potential partners, and to ensure the preferred proposals were culturally competent. When work is contracted with external parties HBDHB is bound by the Government Procurement Rules and, even where these do not apply, adheres to the Principles of Government Procurement. Final decisions around appointment of contractors are an issue for management, working within these frameworks.

Action 5b: Request that management review HBDHB's Remuneration Policy in relation to current non-financial recognition of time and valuable contributions and expertise being received from Rangatahi stakeholder groups

HBDHB policies to financially recognise the input of members of the public to pieces of work such as this has been reviewed recently. Our policies ensure maximum flexibility within the law and the IRD taxation obligations. Where longer term input is required, the DHB has the option to bring people onto its payroll, although this can give rise to negative financial implications for the individuals involved (e.g. taxation or benefits entitlement). The issue of the capacity to make such payments is an issue for budget setting, and needs to be considered in the wider context of the DHB approach to co-design and whānau voice. In the case of the rangatahi redesign, no budget was established to remunerate more extensive input from those currently participating in the mahi.

	He Ngakau Aotea
HAWKE'S BAY District Health Board	For the attention of:
Whakawāteatia	Hawke's Bay District Health Board
Document Owner:	Bernard Te Paa, Executive Director of Health Improvement & Equity
Month:	October 2019
Consideration:	For noting

RECOMMENDATION

That the HBDHB Board

1. **Notes** the content of this report

Since presentation of the He Ngakau Aotea paper in June 2019, authored by the Chief Executive of Ngāti Kahungunu Iwi Inc. (NKII), Chrissie Hape, the Iwi have been driving the development of the approach with an internal focus, whereby the development of positive relationships across the social services sector has been the aim. To this end, the following actions have occurred, led by the Iwi:

- Workshop held October 3rd to discuss how the strategy might be operationalised on the ground.
 This hui was attended by representatives of the DHB Health Improvement and Equity Directorate, PHO, Māori provider representative and the Ministry for Social Development.
 Key discussion points included how a new approach to equity might be achieved, changes in investment in social wellbeing and how the Iwi might foster local Maori leadership.
 This workshop has further informed our internal thinking, with the Iwi looking to develop their approach further before coming back to the Board to update fully.
- The iwi are leading a delegation to the South Central Foundation in Alaska for ten days to enable a range of participants to engage directly with those responsible for development and implementation of the NUKA system, which is what the Iwi have been basing their He Ngakau Aotea work on. Attendees from the sector include Oranga Tamariki and NZ Police, alongside members of Te Taiwhenua o Heretaunga. The Ministry for Social Development is looking to attend South Central Foundation at a later date.
- NKII are continuing to build their position paper to bring to the DHB Board and various committees, which includes clear actions and possible resource requirements.
 This will not be available until early 2020.

		GOVERNANCE WO	RKPLAN PAPERS						
26-Oct-21									
BOARD MEETING 30 OCTOBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Sept)		Carriann Hall	Chris	15-Oct-19				30-Oct-19	30-Oct-19
Shareholder representatives for Allied Laundry and TAS meetings each year		Ken Foote		15-Oct-19					30-Oct-19
Te Ara Whakawaiora - Access Rates 45 -64 years (local indicators) ADULT HEALTH		Chris Ash	Kate Rawstron	1-Oct-19	10-Oct-19				30-Oct-19
Quarterly Report to the Minister of Health (July 19-Sept 19) October 19 Board		Carriann Hall							30-Oct-19
Management Workplan		Craig Climo							30-Oct-19
Induction Package for New Board members		Ken Foote							30-Oct-19
2020/21 Planning Process & Timetable		Craig Climo							30-Oct-19
Cost Savings		Craig Climo							30-Oct-19
BOARD MEETING 27 NOVEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	FRACMeeting date	BOARD Meeting date
Finance Report (Oct)		Carriann Hall	Chris	19-Nov-19				27-Nov-19	27-Nov-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) last one in cycle	Е	Wayne Woolrich	Jill Garrett						30-Oct-19
HBDHB Non-Financial Performance Framework Dashboard Q1 - ЕМТ/Воагd	Е	Chris Ash	Peter MacKenzie	19-Nov-19					27-Nov-19
HBDHB Performance Framework Exceptions Q1 Feb19 /May/Aug/Nov (Just in time for MRB Mtg then to EMT)	Е	Chris Ash	Peter McKenzie	12-Nov-19					27-Nov-19
People Safety & Wellbeing report	E	Kate Coley						27-Nov-19	27-Nov-19
BOARD MEETING 18 DECEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Nov)		Carriann Hall	Chris	10-Dec-19				18-Dec-19	18-Dec-19
VIP/Family Harm report		Bernard Te Paa	Patrick le Geyt	3-Dec-19	11-Dec-19				18-Dec-19
Electives - Status to public & referers		Craig Climo							18-Dec-19
Laboratory Negotiations update		Chris Ash	Di Vicary						18-Dec-19
BOARD MEETING 26 FEBRUARY 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) Feb - Aug		Bernard TePaa	Rachel Eyre	28-Jan-20	12-Feb-20	12-Feb-20	13-Feb-20		26-Feb-20
Finance Report (Dec)		Carriann Hall	Chris	18-Feb-20				26-Feb-20	26-Feb-20
HBDHB Non-Financial Performance Framework Dashboard Q2 - EMT/Board	E	Chris Ash	Peter MacKenzie	18-Feb-20					26-Feb-20
HBDHB Performance Framework Exceptions Q2 Nov 18 Feb 19 /May/Aug 19 (just in time for MRB mtg then to EMT)	E	Chris Ash	Peter McKenzie	11-Feb-20					26-Feb-20
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 20 (annual update)		John Burns	Russell / Bernice Gabriel	24-Mar-20	8-Apr-20	8-Apr-20	9-Apr-20		26-Feb-20
People Safety & Wellbeing report	E	Kate Coley		18-Feb-20				26-Feb-20	26-Feb-20
Quarterly Report to the Minister of Health (Oct 19-Dec 19) Feb 20 Board		Carriann Hall							26-Feb-20



CHAIR'S REPORT

Verbal

	Chief Executive Officer's Report - Public
HAWKE'S BAY District Health Board Whakawateatia	For the attention of: HBDHB Board
Document Owner:	Craig Climo, Interim Chief Executive Officer
Month as at	22 October 2019
Consideration:	For Information

RECOMMENDATION

That the Board

1. Note the contents of this report.

FINANCIAL PERFORMANCE TO DATE

Key points are:

- 1. Year to date (YTD) 30 September (3 months) is \$860k U.
- 2. September was \$258k U. Excluding one-offs it was \$293k U.

Within the result the provider-arm was materially on budget for the month.

The big variances were in Pharmaceutical Cancer Treatment (PCT) and Aged Residential Care (ARC), both of which are in the funder-arm. PCTs are not in the provider-arm because nationally they are treated the same as community prescribing, and in our case much of the prescribing is done by other DHBs. Pharmac rebate assumptions have not been increased in line with the extra spend.

The two areas, PCT and ARC, could have a multi-million dollar adverse impact on our results. Spending has definitely increased and we are trying to ascertain why, the utility of the spending, and how it might be managed.

3. Forecast is \$2.45M U to the \$12.9M planned deficit.

The year-end forecast is about a \$5.6M gap on the \$8M deficit planned for 2020/21. The difference is that \$1.8M for the extra day in this leap year has been backed out of 2020/21. No other flow throughs are included, however, a forecast for 2020/21 is being developed that will be progressively adjusted for unbudgeted expenditure and cost reductions in 2019/20. Later this year planning assumptions re revenue increases and cost inflation for next financial year will also be included.

EMPHASIS ON 2020/21

The reason for the emphasis on 2020/21 is that with just eight months until it starts, and the big planned reduction on this current year's deficit, that it need be focused on. We have to achieve the \$12.9M this year, but it's a milestone on the way to the \$8M deficit next year.

PROVIDER-ARM AND FUNDER-ARM REPORTS

A provider-arm report is in the agenda and will be standard each month, as will the funder-arm report. Both areas are of such a size and dynamism that reporting to each Board meeting is desirable. Other services can report less often but should still report on a planned basis. Major issues and decision papers will come to the Board as they arise.

Provider-arm

The good news is that Hawke's Bay Hospital is invariably better now - in the three times daily status reports - than "code red", however the radiographer strikes in particular are disruptive and preventing normal services for much of the period they encompass.

The seasonal pressure - which we appear to have emerged from – that had manifested itself around bed availability in particular, will lead to another attempt to address the bed issue prior to next winter. This is touched on again under the "project re-orientation" heading.

A decision point is near as to how the Christmas/New Year period will be planned. We are behind on planned surgery and it is possible that we may seek to maintain elective surgery during the non-public holiday days. Other services may reduce to acute.

The provider-arm report in this agenda is the report in the FRAC agenda.

Funder report

The first funder report is a new standing agenda item. It is work in progress and will be refined to meet Board preferences.

PROJECT RE-ORIENTATION

A key item for this agenda is management's proposed re-orientation of the major projects to be undertaken in the balance of this financial year. Chris Ash, Executive Director Planning & Funding, will present, but in summary:

We propose to change what we do in the remainder of this year and how we do it.

The main project will be "bed availability." This has been pared down from "flow and right place" to reduce the scope to its bare essence in order to launch and implement within six months. In that time we need to recruit/backfill, identify opportunities, get buy-in, and implement.

The change in "how" we do it is two-fold. Firstly, that it's clinically, not management led. We are discussing with senior doctors that they run the project together with nursing, and that management and other resources will support them. Without senior doctor buy-in it will not succeed.

Secondly, that we will try to have just enough project methodology to succeed; in that Planning & Funding will provide the monitoring, reporting, and post evaluation; and that Anne Speden's Business Intelligence and Service Improvement teams will provide the information and process improvement expertise. Anne's team is well regarded by senior doctors.

The bed availability project will naturally spin off numerous other projects to look at the best care settings and flow for patients. These projects will be captured and prioritised for 2020/21 and beyond.

It is fair to ask where addressing the big picture fits in this. The big picture being:

- 1. Create a healthier community including addressing inequity.
- 2. Services in the right place, at the right time, by the right people.

My response is that:

- 1. The projects listed are not all the work being done, business as usual and self-contained projects will carryon.
- 2. It is only eight months until the end of the year and the emergence of next winter.
- 3. The bed availability project will identify issues of settings and flow; and
- 4. It is also about trying to remove something that gets in the way of the broader conversation, as well achieving a win.

Other significant projects in 2019/20 are:

- Integrated laboratory
- Wairoa in terms of the services that can be safely and sustainably provided in Wairoa.

And the building works of:

- Radiotherapy
- Surgical expansion
- Radiology

PLANNING 2020/21 - MILESTONES AND TIMEFRAME

Another key agenda item this month is that Chris Ash (ED P&F) will present for discussion the draft outline activities and timeframe for planning for 2020/21. The milestones and timeline do not of themselves give a feel for the nature and quality of the planning process. We are keen to see:

- An annual plan that is an action plan, that is, the focus being on the "how we are going to get there" part, rather than the "where are we" and "where do we want to be" parts, for which fulsome descriptions and plans already exist
- A process that is top down and bottom up. Planning guidelines are top down, and all parts of the DHB –
 units, departments, wards are asked to think about their priorities for the year ahead and identify the
 few things they want to act on. A plan at this level may be three or four things posted on the department
 wall.
- That no unit, or SMO, is able to say they didn't have the opportunity to input to the process, noting that planning includes operational and capital expenditure.

ANNUAL PLAN 2019/20

We have had no contact from the Ministry of Health since the September Board meeting regarding the sign-off status of our 2019/20 annual plan.

This includes the radiology funding.

INDUSTRIAL RELATIONS

Since the last Board meeting the APEX union – Deborah Powell – carried out or continued national strike action across radiographers, psychologists, and laboratory workers.

A central issue is that more than one union represents workers in these areas and their claims have already been settled. APEX is seeking superior terms. For obvious reasons the DHBs will not agree to superior pay and conditions for APEX members. It should also be noted that the Ministry of Health has to approve all offers from DHBs.

Radiographers (Medical Imaging Technologists - MIT)

I forwarded an email to members on 21 October containing information that back-grounded the situation and advised what the latest offer will be.

To date we have had, or have notice of, 10 days of strike action, with one being withdrawn. We have had four days of full strikes and have notices for two more plus three partial strikes. Individually DHBs are now seeing different dates and types of action being taken. The action is either full withdrawal of labour, or more recently here no MIT service for orthopaedic outpatients.

The full withdrawals have been quite disruptive. Due to the spacing between the strikes – day about – it had been impossible to resume normal services.

In fairness to our MITs, they and all other staff have worked hard on the non-strike affected days to get as many patients through as possible.

Life Preserving Services (LPS) have worked satisfactorily and we are unaware of any direct patient harm. However, scan waiting times for cancer patients has gone from 10 to 20 days and routine scanning for other patients has gone from 3-4 weeks to 6-8 weeks. We are out-sourcing to the private radiology service in Hawke's Bay but they cannot perform complex scans.

We are the only DHB that has sought LPS for the orthopaedic clinic. LPS covers risk to life or limb. It has been refused by the union and has gone to adjudication.

Psychologists

There is no change from my report last month. The strike action is restricting patient face-to-face time to two hours per day. This one month strike ends 1 November.

Laboratory workers

Full withdrawal by union members occurred on 11 October. The impact was minimal with non-union members working; the hospital doctors helping by reducing demand – blood sample requests were about 60 percent of usual levels – and the private laboratory SCL processing all privately originated tests.

CLOSURE OF WAIROA GP PRACTICE

The DHB owned GP practice in Wairoa is closing and its patient register will transfer to the other practice in Wairoa. Closure will occur on 1 December 2019.

The DHB established the practice in 2012 to try to maintain GP services in Wairoa. DHB ownership was intended to be interim until the DHB could step out of owning and providing the service.

It was appropriate for the DHB as a last resort to set up a service to sustain an essential service. Equally it's not a business that the DHB should remain in if there are other options.

Closing will lend to more integrated services.

The business was not successful. Closing it will save the DHB \$106K per annum. The gross saving is \$210k but the balance will be reinvested in additional SMO cover in the health centre. Also, during our ownership, enrolments declined from about 3,300 to about 2,950 and nearby ED attendances increased 21 percent.

In establishing the practice, the DHB purchased the assets of two other practices for a total of \$78k, of which \$32k were debtors and subsequently realised. The rest was for vehicles, plant and equipment, some of which were sold. The current book value of fixed assets is \$12k. These will be sold or re-used.

Unfortunately there are staff affected who, if not re-deployed, will incur redundancy costs of \$71k.

Legal advice is that there is little risk under the Commerce Act given that we have made the decision independently and are simply closing the practice, not selling it.

Announcements have been made to staff and public.

	Financial Performance Report September 2019
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: HBDHB Board
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Chris Comber, Head of Finance
Reviewed by	Executive Leadership Team
Month/Year	October, 2019
Purpose	For Information

RECOMMENDATION:

That the HBDHB Board:

Note the contents of this report

Resolve that the Board approve the representation to the Minister of Health that cost increases between Q1 2018/19 and 2019/20 financial years, have only been approved where unavoidable (refer Section 14)

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

The result for the month of September is \$0.3m unfavourable to the revised plan of \$12.9m deficit for the financial year, taking the year-to-date (YTD) result to \$0.9m unfavourable to plan, as we continue to experience high levels of activity and the impact of seasonal factors that are not built into the plan.

Our forecast is \$15.3m deficit, which is \$2.4m adverse to plan.

		Septe	mber			Year to	o Date		Year	
									End	Refer
\$'000	Actual	Budget	Variance		Actual	Budget	Varia	nce	Forecast	Appendix
Income	52,044	50,948	1,096	2.2%	154,265	153,032	1,232	0.8%	614,548	1
Less:										
Providing Health Services	24,529	24,290	(239)	-1.0%	75,783	74,510	(1,274)	-1.7%	303,639	2
Funding Other Providers	23,135	21,765	(1,371)	-6.3%	66,664	65,552	(1,112)	-1.7%	266,188	3
Corporate Services	4,785	4,861	76	1.6%	14,781	14,986	204	1.4%	59,369	4
Reserves	(28)	153	180	118.1%	338	426	88	20.7%	701	5
	(378)	(120)	(258)	-214.6%	(3,301)	(2,441)	(860)	-35.2%	(15,348)	

Key Drivers (YTD)

The detail of the variances are covered in the appendices to the report. The main areas for discussion are:

Income

1. Ministry of Health (MoH) revenue - \$636k favourable, largely due to pay equity which partly offsets adverse expense in Funding Other Providers

- Other Income and ACC are also favourable YTD and largely relate to Providing Health Services, partly offsetting the adverse expense variance. These are expected to continue to overperform as we focus on ensuring revenue is maxmised
- 3. Note that the YTD position assumes the full amount of planned care revenue will be received from MoH. There are some risks to this which are further discussed in activity section

Providing Health Services

- 1. Net Locum / Medical Personnel costs \$408k adverse YTD, although the net position improved marginally in September. Detailed work has been completed to plan locum usage for the remainder of the year for known absences such as sabbatical and leave. As a result, we expect a decrease in locum usage in the second of half of the financial year (H2). There continues to be risk of unplanned usage, particularly around long-term sick leave, which is one of the reasons for the adverse position YTD. Guidelines around efficient and cost effective use of locums is being provided to Service Directors and utilisation is being closely monitored by the Executive Director Provider Services (EDPS).
- 2. Clinical Supplies \$958k adverse YTD with material contributors being Intragam blood product and Patient Transport largely as a result of flight. A review of flight is underway and recommendations expected to be in place during H2.

Funding Other Providers

- 1. Pharmaceuticals \$425k adverse YTD. As highlighted in previous reports, detailed work has been underway to validate pharmaceutical expenditure. As a result, we restated Quarter 1 (Q1) spend in month, driving a \$419k adverse result in month. The main driver of overspend is Pharmaceutical Cancer Treatments (PCTs). HBDHB has a higher level of spend per head of population than the national average, although it is broadly in line with comparable DHBs. Factors influencing the use of PCTs include lack of private provision and cancer prevalence. We are undertaking further work to ensure this expenditure is appropriate. Please note, this position assumes PHARMAC rebates achieve plan, there could be a material upside or downside risk.
- 2. Health of Older Persons \$503k adverse YTD. Whilst this is partly offset by a favourable variance in revenue, there has been a step change in cost in Q1 compared to 2018/19 and further work to understand the drivers, the potential levers to control cost and the impact for the remainder of the year will be completed this month. We anticipate a combination of factors including actions to reduce winter pressures in the hospital, the interplay of pay equity and in-between travel and the level of service / volume of patients compared to plan are all contributing.

Other Performance Measures

		Septe	mber			Year to	o Date		Year	
									End	Refer
	Actual	Budget	Varia	nce	Actual	Budget	Varia	nce	Forecast	Appendix
	\$'000	\$'000	\$'000	%	\$'000	\$'000	\$'000	%	\$'000	
Capital spend	1,446	1,769	(323)	-18.3%	2,280	5,307	(3,027)	-57.0%	21,695	12
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Empl oyees	2,504	2,515	11	0.4%	2,458	2,495	37	1.5%	2,502	2 & 4
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,756	2,679	77	2.9%	7,581	7,840	(259)	-3.3%	29,239	2

Capital spend (Appendix 12)

We have ongoing slippage against the phased capital budget, this will be covered in more detail in the Capital Plan. A rephase of the budget will be undertaken.

• Cash (Appendices 11 & 13)

We continue to utilise our credit facility at the end of the month, with the cash low point in September being \$21.3m overdrawn, against a forecast of \$15.9m. Receipt of \$3m from Mid Central DHB for oncology clinics was forecast for September, but actually landed in October. Together with \$6m of the elective surgery wash up funding expected in October, our forecast cash overdraft for the end of October is substantially reduced to a low point of \$6.7m overdrawn. This is subject to timely receipt of further washup payments from MoH. Our statutory limit is \$29m and we expect to stay within this for normal operations

The Holidays Act review and remediation will likely have further impact on cash, which is not built into our forecast. We have received a Letter of Comfort from the joint Ministers of Health and Finance in respect of this, which has been provided to FRAC as part of the Annual Report 2018/19 agenda item.

• Employees (Appendices 2 & 4)

Employee numbers are favourable reflecting vacancies in medical and allied staff partly offset by higher than budgeted use of medical locums, nursing resources and support personnel – security and patient watches.

Activity (Appendix 2)

This has been an area of focus, particularly given the issues around delivery of elective volumes, detailed in the EDPS report. There is a risk that MoH revenue is impacted if elective Case Weight Discharges (CWDs) do not achieve the levels agreed with MoH. The timing of reporting of activity causes some complexity, but MoH information at 3 October indicates a shortfall of 94 CWD on elective activity for YTD August 2019. This translates to a potential reduction in revenue of \$489k. We expect that September activity will also be adverse to plan.

We have not recognised the income loss in our YTD results, on the basis that we have time to recover the volumes. The EDPS report gives further detail on the actions being taken to ensure that we meet the CWD target by the end of the year, including ongoing maximisation of available resources and ensuring our clinical notes and coding are timely and of good quality.

Forecast

The forecast indicates a \$2.4m adverse result at the end of June 2020. Further detail on the forecast expenditure by month is provided over the page. This is still work in progress, but adjusting for known issues, our September result was broadly in line with our forecast expectation.

The forecast aims to take a balanced view of the position. There continues to be risk in achieving the savings required and managing unanticipated cost pressures in year.

When we reduced our planned deficit from \$15m to \$12.9m and committed to deliver \$8m deficit in 2020/21, we based this on back ending savings into the latter half of the year and reducing our recurrent run-rate. There are opportunities being worked through which have not been included in the forecast. We are looking for recurrent savings which will reduce our run-rate to deliver the \$8m planned deficit in 2020/21.

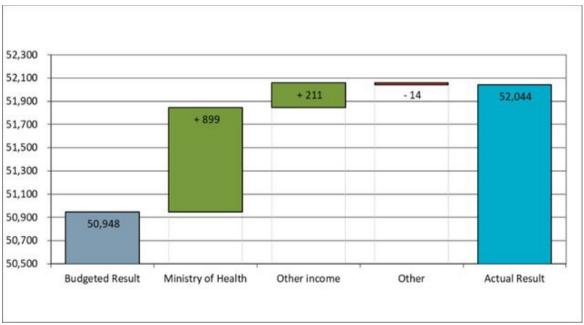
\$'000)	/ear-to-date	•					ı	Monthly Act	ual/Forecast						Year	Full
				Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	End	Year
	Actual	Budget	Variance	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Budget
Income																	
Ministry of Health	147,313	146,677	636	49,397	48,278	49,638	49,094	49,248	48,789	49,048	48,852	48,947	49,080	48,902	49,132	588,407	587,184
Inter District Flows	2,044	2,122	(79)	831	541	673	707	707	707	707	707	707	707	707	707	8,411	8,489
Other District Health Boards	1,176	1,046	130	497	358	322	377	364	363	370	367	375	393	367	373	4,524	4,184
Financing	22	21	1	25	1	(4)	-	-	-	-	-	-	-	-	-	22	84
ACC	1,419	1,258	161	400	407	612	396	396	488	415	415	488	415	415	489	5,337	4,952
Other Government	112	168	(57)	79	5	28	65	27	62	23	23	23	62	23	24	445	673
Abnormals	1		1	-	1	-			-			-				1	
Patient and Consumer Sourced	353	311	42	113	152	89	104	104	104	104	104	104	104	104	104	1,286	1,244
Other Income	1,826	1,429	397	562	577	687	476	476	481	474	476	476	476	476	476	6,115	5,718
	154,265	153,032	1,232	51,902	50,319	52,044	51,221	51,323	50,994	51,141	50,945	51,121	51,237	50,995	51,305	614,548	612,528
Less:																	
Providing Health Services																	
Medical personnel and locums	17,918	17,510	(408)	6,372	5,945	5,601	6,184	5,898	5,971	9,063	5,379	5,957	6,011	5,856	6,136	74,373	72,770
Nursing personnel	22,986	23,007	20	7,697	7,690	7,600	8,311	7,560	7,434	8,935	7,204	7,766	8,335	7,608	8,149	94,287	94,232
Allied health personnel	9,514	10,084	570	3,284	3,150	3,079	3,411	3,275	3,287	3,391	3,095	3,431	3,470	3,328	3,498	39,700	40,335
Other personnel	6,632	6,458	(174)	2,224	2,250	2,158	2,213	2,117	2,121	2,178	1,950	2,173	2,212	2,113	2,261	25,970	25,925
Outsourced services	2,494	2,648	155	873	874	746	894	895	794	793	904	906	907	907	900	10,394	9,854
Clinical supplies	11,376	10,418	(958)	3,818	3,744	3,813	3,574	3,289	3,282	3,346	3,240	3,202	3,385	3,122	3,168	40,984	40,651
Infrastructure and non-clinical	4,864	4,384	(480)	1,793	1,538	1,532	1,464	1,441	1,486	1,440	1,444	1,445	1,445	1,449	1,452	17,931	17,151
	75,783	74,510	(1,274)	26,062	25,192	24,529	26,050	24,475	24,375	29,145	23,216	24,881	25,766	24,383	25,564	303,639	300,918
Funding Other Providers																	
Pharmaceuticals	11,407	10,983	(425)	3,365	3,962	4,080	3,677	3,677	3,677	3,677	3,677	3,677	3,677	3,677	3,695	44,520	43,948
Primary Health Organisations	11,213	10,916	(297)	3,817	3,371	4,024	3,593	4,083	3,617	3,593	3,593	3,862	3,593	3,593	3,634	44,375	43,681
Inter District Flows	14,688	15,128	440	5,043	5,033	4,613	4,993	4,993	4,943	4,943	4,943	4,943	4,943	4,993	4,993	59,373	60,513
Other Personal Health	6,068	5,922	(146)	2,108	1,981	1,980	1,958	2,046	2,063	1,941	2,041	1,976	2,261	2,289	2,121	24,764	24,618
Mental Health	3,520	3,172	(348)	1,057	1,457	1,006	1,057	1,057	1,057	1,057	1,057	1,057	1,057	1,057	1,063	13,042	12,695
Health of Older People	18,902	18,400	(503)	6,323	5,469	7,110	6,360	6,360	6,360	6,360	6,360	6,360	6,360	6,360	6,392	76,178	73,609
Other Funding Payments	865	1,031	167	232	310	322	344	344	344	340	340	340	340	340	341	3,936	4,102
	66,664	65,552	(1,112)	21,946	21,583	23,135	21,983	22,561	22,061	21,912	22,011	22,215	22,232	22,310	22,239	266,188	263,165
Corporate Services																	
Personnel	4,819	5,142	324	1,771	1,478	1,570	1,761	1,663	1,684	1,736	1,541	1,719	1,715	1,660	1,750	20,048	20,372
Outsourced services	396	229	(166)	118	164	114	77	76	76	77	76	76	76	76	76	1,083	916
Clinical supplies	120	165	45	29	51	40	55	55	54	54	57	57	56	56	56	623	668
Infrastructure and non-clinical	4,268	4,053	(215)	1,411	1,499	1,358	1,317	1,328	1,277	1,239	1,331	1,377	1,359	1,528	1,353	16,378	16,163
Depreciation and amortisation	3,318	3,559	242	1,112	1,122	1,084	1,204	1,118	1,163	1,171	1,064	1,195	1,161	1,210	1,174	13,778	14,465
Financing	24	-	(24)	14	3	7	8	8	8	11	11	11	11	11	11	113	17
Capital charge	1,837	1,837	-	612	612	612	612	612	612	612	612	612	612	612	612	7,346	7,346
	14,781	14,986	204	5,067	4,929	4,785	5,033	4,861	4,876	4,900	4,692	5,048	4,991	5,154	5,033	59,369	59,947
Reserves																	
Contingency	_	422	422	_	167	(167)	_	_	_	_	_	_	_	_		_	2,034
Other	338	4	(334)	70	129	139	66	66	3,266	(3,134)	66	66	(11)	(11)	(11)	701	(636)
	338	426	88	70	296	(28)	66	66	3,266	(3,134)	66	66	(11)	(11)	(11)	701	1,398
Surplus/(Deficit)	(3,301)	(2,441)	(860)	(1,243)	(1,680)	(378)	(1,912)	(640)	(3,584)	(1,682)	960	(1,089)	(1,740)	(842)	(1,519)	(15,348)	(12,899)
	(-,-32)	(-,: 12)	(-50)														(,3)
Budgeted Surplus/(Deficit)				(1,134)	(1,188)	(120)	(1,506)	(385)	(3,529)	(1,277)	1,207	(874)	(1,552)	(1,010)	(1,532)	(12,900)	
Variance				(109)	(493)	(258)	(406)	(255)	(55)	(405)	(247)	(215)	(188)	168	13	(2,448)	

APPENDICES

1. INCOME

		Septe	mber			Year to	Date .		Year	
\$'000	Actual	Budget	Variance		Actual Budget		Varia	nce	End Forecast	
Ministry of Health	49,638	48,739	899	1.8%	147,313	146,677	636	0.4%	588,407	
Inter District Flows	673	707	(35)	-4.9%	2,044	2,122	(79)	-3.7%	8,411	
Other District Health Boards	322	349	(27)	-7.7%	1,176	1,046	130	12.5%	4,524	
Financing	(4)	7	(11)	-163.4%	22	21	1	3.9%	22	
ACC	650	523	127	24.2%	1,457	1,258	198	15.8%	5,375	
Other Government	28	43	(16)	-36.4%	112	168	(57)	-33.7%	445	
Patient and Consumer Sourced	89	104	(15)	-14.2%	353	311	42	13.5%	1,286	
Other Income	687	476	211	44.3%	1,826	1,429	397	27.8%	6,115	
Abnormals	(37)	-	(37)	0.0%	(37)	-	(37)	0.0%	(37)	
	52,044	50,948	1,096	2.2%	154,265	153,032	1,232	0.8%	614,548	

September



Note the scale does not begin at zero

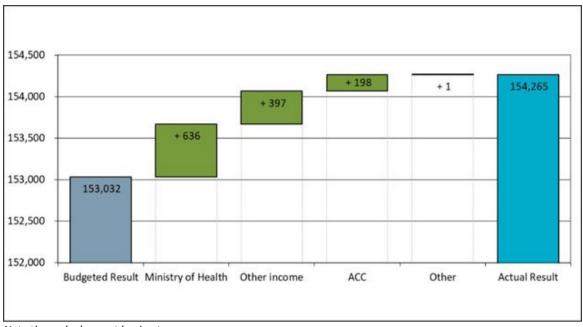
Ministry of Health (favourable)

Pay equity and In-Between-Travel funding, further work on this underway.

Other income (favourable)

GP Health Care and Pharmacy.

Year-to-date



Note the scale does not begin at zero

Ministry of Health (favourable)

Pay equity and In-Between-Travel funding reduced to reflect costs, partly offset by clinical training income from Health Workforce NZ to reimburse costs incurred.

Other income (favourable)

Donations and clinical trial revenue, GP Health Care, Pharmacy, Ngatahi income and patient transport recoveries.

ACC (favourable)

Some one offs in month due to surgical activity and ongoing favourable variances relating to radiology volumes.

2. PROVIDING HEALTH SERVICES

		Septe	ember			Year to	o Date		Year
									End
	Actual	Budget	Varian	псе	Actual	Budget	Varia	nce	Forecast
Expenditure by type \$'000									
Medical personnel and locums	5,601	5,634	33	0.6%	17,918	17,510	(408)	-2.3%	74,373
Nursing personnel	7,600	7,470	(129)	-1.7%	22,986	23,007	20	0.1%	94,287
Allied health personnel	3,079	3,249	169	5.2%	9,514	10,084	570	5.7%	39,700
Other personnel	2,158	2,107	(51)	-2.4%	6,632	6,459	(173)	-2.7%	25,970
Outsourced services	746	878	132	15.0%	2,494	2,648	155	5.8%	10,394
Clinical supplies	3,813	3,478	(335)	-9.6%	11,376	10,418	(958)	-9.2%	40,984
Infrastructure and non clinical	1,532	1,474	(59)	-4.0%	4,864	4,384	(480)	-10.9%	17,931
	24,529	24,290	(239)	-1.0%	75,783	74,510	(1,274)	-1.7%	303,639
Expenditure by directorate \$'000			4 >				4		
Medical	6,766	6,727	(40)	-0.6%	20,717	20,581	(137)	-0.7%	84,837
Surgical	5,496	5,624	128	2.3%	17,128	17,064	(64)	-0.4%	70,175
Community, Women and Children	4,016	4,037	20	0.5%	12,354	12,368	14	0.1%	50,510
Mental Health and Addiction	1,863	1,701	(162)	-9.5%	5,687	5,277	(411)	-7.8%	23,029
Older Persons, NASC HB, and Allied H	,	1,601	180	11.3%	4,198	4,730	531	11.2%	17,334
Operations	3,962	3,627	(335)	-9.2%	12,074	11,104	(970)	-8.7%	47,299
Other	1,004	973	(31)	-3.2%	3,624	3,386	(238)	-7.0%	10,454
	24,529	24,290	(239)	-1.0%	75,783	74,510	(1,274)	-1.7%	303,639
Full Time Equivalents									
Medical personnel	368.8	370.2	1	0.4%	341	368	28	7.5%	374.7
Nursing personnel	1,042.2	1,029.8	(12)	-1.2%	1,033	1,020	(13)	-1.3%	1,025.3
Allied health personnel	482.3	496.1	14	2.8%	476	498	22	4.4%	493.6
Support personnel	124.4	114.7	(10)	-8.4%	123	114	(9)	-7.9%	114.9
Management and administration	281.3	281.8	1	0.2%	276	274	(1)	-0.4%	273.3
	2,299.0	2,292.7	(6)	-0.3%	2,248	2,274	26	1.2%	2,281.9
	,	, -	V-7		, -	,			,
Case Weighted Discharges									
Acute	1,989	1,833	156	8.5%	5,470	5,445	26	0.5%	19,957
Elective	538	639	(101)	-15.8%	1,548	1,761	(213)	-12.1%	6,850
Maternity	175	169	6	3.4%	459	525	(66)	-12.5%	2,000
IDF Inflows	54	38	16	42.7%	104	110	(6)	-5.2%	432
	2,756	2,679	77	2.9%	7,581	7,840	(259)	-3.3%	29,239

Directorates YTD

- Mental Health and Addiction locum psychiatrist costs for vacancy and sick leave cover
- Older Persons et al vacancies, especially allied health
- Operations—blood products, patient transport.
- Other SMO leave cover. Maori workforce scholarships, offset in income.

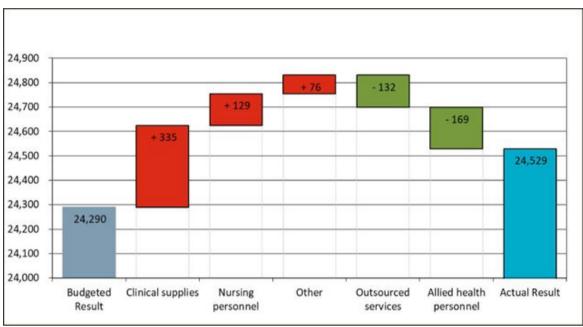
Case Weighted Discharges

Case weighted discharges (CWD) have fallen behind plan in orthopaedic surgery, maternity, general surgery, internal medicine and ophthalmic elective surgery, partly offset by high acute neonatal and general medicine, as well as elective gynaecology volumes. Note that whilst the Elective CWD is an indicator of performance on the Planned Care target, timing and impact of elective IDF outflows means this is not the definitive result.

The Monthly Elective Surgical Discharges Report is not available this month. The way the Ministry measures elective activity has changed to a new planned care approach, to ensure activity such as outpatient

procedures are also recognised. The targets for 2019/20 have not been approved by MOH. As a result of these changes, we are considering how we better report the Planned Care target performance. MoH information at 3 October indicates a shortfall of 94 CWD on elective activity for YTD August 2019. This translates to a potential reduction in revenue of \$489k. We expect that September activity will also be adverse to plan.

September



Note the scale does not begin at zero

Clinical supplies (unfavourable)

Patient transport costs, blood products (mainly Intragam), disposable instruments, diagnostic supplies, partially offset by pharmaceuticals.

Nursing personnel (unfavourable)

The unprecendented activity towards the end of the August, which was in September has been reflected in September's result. In addition use of nursing resources to support allied health activity has been a factor.

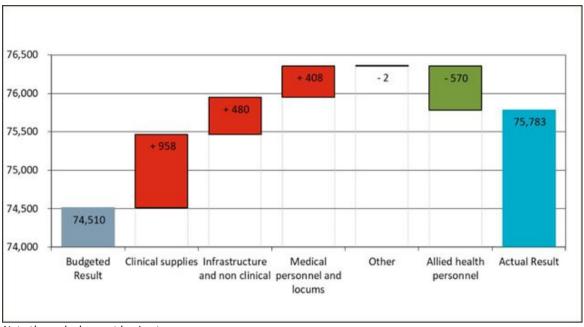
Outsourced services (favourable)

Medical vacancy cover. Higher than budgeted orderlies, security, sterile supply staff and operations staff, partly driven by seasonal variation in activity.

Allied health personnel (favourable)

Vacancies mainly in social workers, laboratory technicians, psychologists and occupational therapists.

Year-to-date



Note the scale does not begin at zero

Clinical supplies (unfavourable)

Patient transport costs, blood products (mainly Intragam), surgical implants, diagnostic supplies and disposable instruments, partly offset by pharmaceuticals and renal fluids.

Infrastructure and non clinical (unfavourable)

Maori workforce scholarships (offset in income), food and laundry costs, security and maintenance.

Medical personnel and locums (unfavourable)

Difficulty filling medical positions has high cost locum cover significantly offsetting reduced personnel costs.

Allied health personnel (favourable)

Vacancies mainly in social workers, laboratory technicians, occupational therapists, medical radiation technologists (MRTs), cultural workers, and psychologists.

Full Time Equivalents (FTE)

FTE numbers are volatile reflecting the human resource needs of the DHB and the availability of staff, factors that change significantly from month to month. Consequently FTEs are reported on a year-to-date (YTD) basis to improve understanding of underlying trends. However, in the first few months of the year, the dampening effect of YTD reporting is limited.

FTEs are 26 (1.2%) favourable including:

Medical personnel (17.5 FTE / 4.75% favourable)

Vacancies across emergency medicine, radiologists, house surgeons and obstetricians. Small
favourable variances across a number of specialties, partly offset by unfavourable variances in
anaesthetics.

Nursing personnel (-11.4 FTE / -1.1% unfavourable)

• Pressure mainly on the relief team and staff bureau, coronary care and the medical wards.

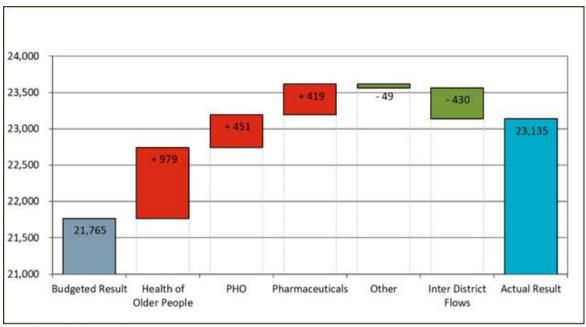
Allied health personnel (22.2 FTE / 4.45% favourable)

• Ongoing vacancies in social workers, laboratory technicians, psychologists, and occupational therapists.

3. FUNDING OTHER PROVIDERS

	September				Year to Date				Year
									End
\$'000	Actual	Budget	Variance		Actual	Budget	Variance		Forecast
Down and the Other Dural days									
Payments to Other Providers			(440)	44.500			(****)		
Pharmaceuticals	4,080	3,661	(419)	-11.5%	11,407	10,983	(425)	-3.9%	44,520
Primary Health Organisations	4,024	3,574	(451)	-12.6%	11,213	10,916	(297)	-2.7%	44,375
Inter District Flows	4,613	5,043	430	8.5%	14,688	15,128	440	2.9%	59,373
Other Personal Health	1,980	1,955	(25)	-1.3%	6,068	5,922	(146)	-2.5%	24,764
Mental Health	1,006	1,057	52	4.9%	3,520	3,172	(348)	-11.0%	13,042
Health of Older People	7,110	6,131	(979)	-16.0%	18,902	18,400	(503)	-2.7%	76,178
Other Funding Payments	322	344	21	6.2%	865	1,031	167	16.2%	3,936
	23,135	21,765	(1,371)	-6.3%	66,664	65,552	(1,112)	-1.7%	266,188
Payments by Portfolio									
Strategic Services									
Secondary Care	4,226	4,633	407	8.8%	13,525	13,910	385	2.8%	54,554
Primary Care	9,300	8,439	(861)	-10.2%	26,188	25,560	(628)	-2.5%	104,401
Mental Health	1,496	1,386	(109)	-7.9%	4,512	4,159	(352)	-8.5%	16,996
Health of Older People	7,405	6,665	(740)	-11.1%	20,503	20,001	(503)	-2.5%	82,588
Maori Health	576	512	(64)	-12.4%	1,568	1,535	(33)	-2.1%	6,119
Population Health	133	129	(4)	-2.9%	368	387	19	4.9%	1,530
	23,135	21,765	(1,371)	-6.3%	66,664	65,552	(1,112)	-1.7%	266,188

September



Note the scale does not begin at zero

Health of Older People (unfavourable)

Changes in mix of care to higher cost packages, pay equity and In-Between-Travel costs.

Primary Health Organisation (unfavourable)

Capitation costs, offset in income

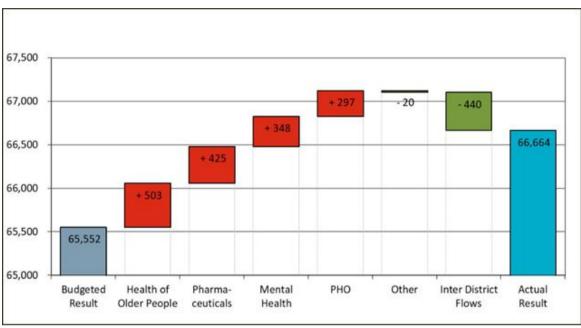
Pharmaceuticals (unfavourable)

Rebasing of pharmaceutical costs for the quarter as a result of recent deep dive, impacted in month.

Inter District Flows (favourable)

IDF outflow costs better than plan, although some volatility and risk in this.

Year-to-date



Note the scale does not begin at zero

Health of Older People (unfavourable)

Changes in mix of care to higher cost packages, pay equity and In-Between-Travel costs.

Pharmaceuticals (unfavourable)

Pharmaceutical Cancer Treatment costs a particular driver of adverse variance.

Mental Health (unfavourable)

Prior year adjustment as a result of washup impacting YTD result.

Primary Health Organisation (unfavourable)

Capitation costs, offset in income

Inter District Flows (favourable)

 $\ensuremath{\mathsf{IDF}}$ outflow costs better than plan, although some volatility and risk in this.

4. CORPORATE SERVICES

		Septe	mber			Year to	Date -		Year
\$'000	Actual	Budget	Variar	псе	Actual	Budget	Varia	nce	End Forecast
Operating Expenditure									
Personnel	1,570	1,645	74	4.5%	4,819	5,142	324	6.3%	20,048
Outsourced services	114	76	(38)	-49.3%	396	229	(166)	-72.6%	1,083
Clinical supplies	40	71	31	43.7%	120	165	45	27.3%	623
Infrastructure and non clinical	1,358	1,297	(61)	-4.7%	4,268	4,053	(215)	-5.3%	16,378
	3,082	3,089	7	0.2%	9,603	9,590	(13)	-0.1%	38,131
Capital servicing	,	,			,	,	` ,		,
Depreciation and amortisation	1,084	1,160	76	6.6%	3,318	3,559	242	6.8%	13,778
Financing	7	-	(7)	0.0%	24	-	(24)	0.0%	113
Capital charge	612	612	-	0.0%	1,837	1,837	-	0.0%	7,346
	1,703	1,772	69	3.9%	5,179	5,396	217	4.0%	21,238
	4,785	4,861	76	1.6%	14,781	14,986	204	1.4%	59,369
Full Time Equivalents									
Medical personnel	0.4	0.3	(0)	-40.3%	0	0	(0)	-5.4%	0.3
Nursing personnel	19.2	17.0	(2)	-12.7%	15	17	2	10.3%	16.8
Allied health personnel	-	0.4	0	100.0%	0	0	0	94.2%	0.4
Support personnel	30.1	30.4	0	0.9%	30	30	(0)	-0.2%	30.0
Management and administration	155.1	173.8	19	10.7%	165	173	8	4.9%	172.2
	204.8	221.9	17	7.7%	210	221	10	4.7%	219.7

Personnel is mainly executive staff partly offset in outsourced services, and information services staff whose time has been capitalised to capital projects.

Infrastructure includes deferred maintenance (which has some adverse timing variance), software charges and affiliation fees relating to the Health Round Table and TAS. The adverse deferred maintenance result is timing and is likely to be offset later in the year.

Depreciation and amortisation reflects the extention of building lives assumed in the 30 June 2019 revaluation of land and buildings and slower than planned capital expenditure.

5. RESERVES

		Septe	ember		Year t	o Date	Year
							End
\$'000	Actual	Budget	Variance	Actual	Budget	Variance	Forecast
Expenditure							
Contingency	(167)	147	314 213.4%	-	422	422 100.0%	-
Efficiencies	-	-	- 0.0%	-	-	- 0.0%	-
Other	139	6	(134) -2393.3%	338	4	(334) -8771.9%	701
	(28)	153	180 118.1%	338	426	88 20.7%	701

The contingency budget reduces when ELT approves use of reserves, which have been largely allocated against specific initiatives expected to drive improvements in patient outcome and access. The YTD favourable variance shows the release of contingency into the position.

The "Other" category includes prior year adjustments and loss on disposal of clinical equipment.

6. 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	49,123	48,308	815	145,668	145,203	465	582,564	581,833	731
Less:									
Payments to Internal Providers	29,888	29,888	-	88,531	88,531	-	338,307	338,307	-
Payments to Other Providers	22,390	21,143	(1,247)	64,128	63,687	(440)	256,037	258,081	2,044
Contribution	(3,154)	(2,723)	(432)	(6,990)	(7,014)	24	(11,779)	(14,554)	2,775
Governance and Funding Admin.									
Funding	308	308	-	925	925	-	3,603	3,603	-
Other Income	3	3	-	7	8	(1)	29	30	(1)
Less:									
Expenditure	271	287	16	899	874	(24)	3,623	3,633	10
Contribution	40	24	16	33	58	(25)	9	0	9
Health Provision									
Funding	29,579	29,579	-	87,606	87,606	-	334,704	334,704	-
Other Income	2,820	2,541	278	8,294	7,533	761	30,794	29,551	1,243
Less:									
Expenditure	29,663	29,543	(120)	92,244	90,624	(1,620)	369,076	362,601	(6,476)
Contribution	2,736	2,578	158	3,656	4,514	(859)	(3,578)	1,654	(5,233)
Net Result	(378)	(120)	(258)	(3,301)	(2,442)	(859)	(15,348)	(12,900)	(2,448)

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

7. MANAGEMENT BUDGET MOVEMENTS

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

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

		September			Year to Date			End of Year	
	Mgmt			Mgmt			Mgmt		
\$'000	Budget	Annual Plan	Movement	Budget	Annual Plan	Movement	Budget	Annual Plan	Movement
Funding						4			
Income	48,308	48,348	(40)	145,203	145,323	(119)	581,350	581,833	(484)
Less:									
Payments to Internal Providers	29,888	29,888	-	88,531	88,531	-	338,307	338,307	-
Payments to Other Providers	21,143	21,346	203	63,687	64,288	601	255,702	258,081	2,378
Contribution	(2,723)	(2,886)	164	(7,014)	(7,496)	481	(12,660)	(14,554)	1,895
Governance and Funding Admin.									
Funding	308	308	-	925	925	-	3,603	3,603	-
Other Income	3	3	-	8	8	-	30	30	-
Less:									
Expenditure	287	290	3	874	883	9	3,598	3,633	34
Contribution	24	21	3	58	50	9	34	0	34
Health Provision									
Funding	29,579	29,579	_	87,606	87.606	_	334.704	334,704	-
Other Income	2,541	2,442	99	7,533	7,401	132	29,995	29,551	444
Less:	,-	,		,	, -		.,	,,,,,	
Expenditure	29,543	29,277	(266)	90,624	90,002	(622)	364,974	362,601	(2,373)
Contribution	2,578	2,745	(167)	4,514	5,004	(490)	(275)	1,654	(1,929)
Net Result	(120)	(120)	(0)	(2,442)	(2,442)	(0)	(12,900)	(12,900)	0

8. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Planned savings, including a vacancy factor, have been incorporated into operational budgets and will be managed as part of the normal operational performance reviews in 2019/20. Our focus will be on sustainable changes that generate qualitative improvements that positively impact patient outcomes. It is anticipated that in many cases these will also impact the drivers of cost, such as length of stay and therefore will have a positive impact on the financial position.

9. FINANCIAL POSITION

			Septe	ember		
30 June 2019	\$'000	Actual	Budget	Variance from budget	Movement from 30 June 2019	Annual Budget
	Equity					
188,048	Crown equity and reserves	188,742	164,706	24,037	695	174,339
(44,407)	Accumulated deficit	(47,708)	(18,813)	,		(29,271)
143,641		141,034	145,892	(4,858)	(2,607)	145,068
	Represented by: Current Assets					
759	Bank	732	840	(108)		840
1,881	Bank deposits > 90 days	1,889	1,855	34	8	1,855
29,342	Prepayments and receivables	33,830	26,113	7,716	4,487	26,488
4,023	Inventory	4,000	3,866	135	(22)	3,933
-	Investment in NZHP	-	2,638	(2,638)	-	2,638
36,005		40,451	35,312	5,140	4,446	35,754
	Non Current Assets					
190,552	Property, plant and equipment	189,218	181,539	7,679	(1,334)	188,324
13,790	Intangible assets	14,068	2,450	11,618	278	3,412
1,189	Investments	1,189	9,002	(7,812)	=	9,002
205,532		204,475	192,990	11,485	(1,056)	200,737
241,537	Total Assets	244,927	228,302	16,625	3,390	236,491
	Liabilities Current Liabilities					
10,208	Bank overdraft	16,684	6,684	(10,000)	(6,476)	1,828
31,318	Payables	31,982	35,934	3,952	(664)	47,228
53,370	Employee entitlements	52,226	37,066	(15,160)		39,576
94,895	, .,	100,892	79,684	(21,207)		88,633
34,833	Non Current Liabilities	100,832	73,084	(21,207)	(3,337)	88,033
3,001	Employee entitlements	3,001	2,725	(276)	_	2,790
3,001	, ,	3,001	2,725	(276)	_	2,790
97,896	Total Liabilities	103,893	82,409	(21,484)	(5,997)	91,423
37,390	Total Eddinities	103,033	02, 4 03	(21,404)	(3,331)	31,423
143,641	Net Assets	141,034	145,892	(4,858)	(2,607)	145,068

Crown equity and reserves variance from budget includes changes in the 2018/19 result subsequent to the preparation of the 2019/20 budget including land and building revaluations, the equity injection for cash flow purposes and Holidays Act remediation provisioning.

The current assets variance reflects differences between estimated and actual receipt of wash-up funding such as elective surgery, partly offset by the write-off of the investment in New Zealand Health Partnerships (NZHP) at the end of last year.

Higher than budgeted non-current assets results from the revaluation of land and buildings at 30 June 2019.

The movement in current liabilities mainly reflects Holidays Act remediation provisioning.

10. EMPLOYEE ENTITLEMENTS

			Septe <u>mber</u>					
30 June 2019	\$'000	Actual	Budget	Variance from budget	Movement from 30 June 2019	Annual	Budget	
7,755	Salaries & wages accrued	7,145	7,325	180	610		9,483	
1,027	ACC levy provisions	1,088	964	(124)	(61)		1,174	
5,530	Continuing medical education	4,947	4,921	(27)	583		5,656	
37,303	Accrued leave	37,190	21,898	(15,293)	113		21,255	
4,755	Long service leave & retirement grat.	4,856	4,684	(172)	(101)		4,798	
56,371	Total Employee Entitlements	55,227	39,791	(15,436)	1,143		42,366	

Accrued leave includes provisioning for the remediation of Holiday's Act non-compliance, in accordance with the memorandum of understanding with health sector employee representatives and the Ministry of Business, Innovation and Employment (MBIE).

11. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by NZHP under a sweep arrangement facilitated by BNZ. The DHB provides forecast cash flow information to NZHP to allow it to invest the funds at the most advantageous rates and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due. The cash balance at the end of September was a \$16.9m overdraft.

The cash low point for each month is generally incurred immediately prior to receipt of MoH funding on the 4th of the month. September's low point was an \$18.4m overdraft on 3 September. October's low point is likely to be the \$6.7m overdrawn on 3 October, subject to timely receipt of cash from MoH. Our statutory overdraft limit is \$29m.

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

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

12. CAPITAL EXPENDITURE

Capital spend is lower than plan as a number of projects will not progress until equity funding for the radiology extension is confirmed. The plan phasing will be reviewed once confirmation on the radiology business case is received. If the equity funding is declined, the capital plan will be reviewed and options presented to FRAC and Board.

See table on the next page.

2020			Year to Date	
Plan		Actual	Budget	Variance
		\$'000	\$'000	\$'000
	Source of Funds			
	Operating Sources			
14,465	Depreciation	3,318	3,559	242
7,230	Equity Injection not approved	(1,794)	1,747	2,153
21,695		1,523	5,307	2,394
	Other Sources			
-	Special Funds and Clinical Trials	62	-	(62)
-	Funded Programmes	-	-	-
-	Sale of Assets	-	-	-
-	Equity Injection approved	695	-	695
-		756	-	633
21,695	Total funds sourced	2,280	5,307	3,027
	Application of Funds:			
	Block Allocations			
3,075	Facilities	1,021	749	(271)
3,027	Information Services	335	756	421
3,525	Clinical Plant & Equipment	563	900	337
9,627		1,919	2,406	487
	Local Strategic			
500	Replacement Generators	-	125	125
-	Endoscopy Building	(3)	-	3
2,550	Radiology Extension	123	637	514
700	High Voltage Electrical Supply	18	60	42
1,450	Seismic AAU Stage 2 and 3	10	362	352
1,500	Seismic Surgical Theatre HA37	43	375	332
200	Seismic Radiology HA27	-	50	50
1,195	MC2D Proc Rm3 Endoscopy HA57	-	299	299
3,300	Surgical Expansion	106	825	719
11,395		297	2,733	2,436
	Other			
-	Special Funds and Clinical Trials	62	-	(62)
-	Funded Programmes	-	-	-
-	Other	(81)	-	81
-		(19)	-	19
	Regional Strategic			
673	Regional Digital Health Services (formerly RHIP)	84	168	85
673		84	168	85
21,695	Capital Spend	2,280	5,307	3,027

13. ROLLING CASH FLOW

The cash flow is based on the September forecast result. The DHB does not anticipate breaching its statutory overdraft limit of \$29m in year on normal operations.

The cash flow assumes wash-up revenue from MOH volume-based funding will be received quarterly. However, both the volume provided and timing of receipt are uncertain and the impact on cash inflow can be significant.

The approved equity injections for seismic remediation have been included, although the timing is uncertain. Unapproved equity injections for the radiology expansion have also been included to match the associated expenditure. No allowance has been made for Holidays Act remediation costs nor any associated equity support from MoH.

It should be noted that the recent changes to the capital charge regime means that HBDHB will receive revenue to offset capital charges arising from the investment related equity injections.

A \$3m receivable for oncology clinics (Mid Central Health) was paid in early October rather than September as forecast last month, and is the main reason for the variance in the cash balance at the end of September.

		September		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Actual	Forecast	Variance	Forecast											
Cash flows from operating activities															
Cash receipts from Crown agencies	47,070	48,848	(1,778)	56,415	54,674	48,912	52,817	48,868	49,044	53,714	48,917	49,228	52,938	48,724	48,864
Cash receipts from donations, bequests and clinical trials	(32)	40,040	(32)	30,413	34,074	40,312	52,617	40,000	43,044	33,714	40,317	49,228	32,938	40,724	48,804
Cash receipts from other sources	3,146	3,209	(63)	3,460	211	216	208	211	211	210	211	211	211	211	211
Cash paid to suppliers	(29,696)	(29,608)	(88)	(29,320)	(29,777)	(29,710)	(28,349)	(26,288)	(29,328)	(29,408)	(28,751)	(29,643)	(29,647)	(29,110)	(29,333)
Cash paid to employees	(20,239)	(18,999)	(1,241)	(21,763)	(19,134)	(18,126)	(25,914)	(18,694)	(18,782)	(23,030)	(19,366)	(19,813)	(23,678)	(18,751)	(18,653)
Cash generated from operations	249	3,450	(3,201)	8,792	5,974	1,292	(1,239)	4,096	1,145	1,487	1,012	(18)	(177)	1,074	1,088
Interest received	(4)	7	(11)	7	7	7	7	7	7	7	7	7	7	7	7
Interest received	(7)	(28)	21	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
Capital charge paid	(612)	(0)	(612)	(0)	(0)	(4,264)	(0)	(0)	(0)	(0)	(0)	(4,264)	(0)	(0)	(0)
Capital Charge pard	(012)	(0)	(012)	(0)	(0)	(4,204)	(0)	(0)	(0)	(0)	(0)	(4,204)	(0)	(0)	(0)
Net cash inflow/(outflow) from operating activities	(375)	3,429	(3,804)	8,796	5,978	(2,968)	(1,235)	4,100	1,149	1,490	1,015	(4,278)	(173)	1,077	1,092
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	-	(1)	1	0	0	0	0	0	0	0	0	0	(0)	(0)	0
Acquisition of property, plant and equipment	(1,164)	(926)	(238)	(914)	(2,112)	(1,564)	(1,722)	(1,948)	(1,708)	(1,421)	(1,401)	(1,738)	(1,899)	(1,899)	(1,899)
Acquisition of intangible assets	(289)	(173)	(116)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)
Acquisition of investments	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Net cash inflow/(outflow) from investing activities	(1,453)	(1,100)	(353)	(1,087)	(2,285)	(1,737)	(1,895)	(2,121)	(1,881)	(1,594)	(1,574)	(1,911)	(2,073)	(2,073)	(2,072)
Cash flows from financing activities															
Proceeds from equity injection	_	_	_	_		_	5,700	_	_	_		_	_	_	
Repayment of finance leases	_	_	_	_	_	_	580	_	_	_	_	_	_	_	_
Equity repayment to the Crown	-	-	-	-	-	_	-	-	-	-	-	(357)	-	-	
Net cash inflow/(outflow) from financing activities	-	-	-	-	-	-	6,280	-	-		-	(357)	-	-	
Net increase/(decrease) in cash or cash equivalents	(1,827)	2,329	(4,156)	7,708	3,693	(4,705)	3,150	1,979	(732)	(104)	(559)	(6,546)	(2,246)	(995)	(980)
Add:Opening cash	(12,235)	(12,235)	-	(14,063)	(6,355)	(2,662)	(7,367)	(4,217)	(2,238)	(2,971)	(3,074)	(3,633)	(10,180)	(12,425)	(13,421)
Cash and cash equivalents at end of period	(14,063)	(9,907)	(4,156)	(6,355)	(2,662)	(7,367)	(4,217)	(2,238)	(2,971)	(3,074)	(3,633)	(10,180)	(12,425)	(13,421)	(14,401)
Cash and cash equivalents															
Cash	4	-	4	-	-	-	_	-	-	-	-	-	4	4	4
Short term investments (excl. special funds/clinical trials)	(16,884)	(12,205)	(4,679)	(6,514)	(3,056)	(8,086)	(5,304)	(3,803)	(4,882)	(5,258)	(5,993)	(12,698)	(15,120)	(15,980)	(16,851)
Short term investments (special funds/clinical trials)	2,617	47	2,570	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	(19)	2,690	2,690	2,690
Bank overdraft	200	2,251	(2,051)	178	413	738	1,106	1,584	1,930	2,203	2,378	2,537	-	(136)	(245)
	(14,063)	(9,906)	(4,156)	(6,355)	(2,661)	(7,367)	(4,217)	(2,238)	(2,970)	(3,074)	(3,634)	(10,180)	(12,425)	(13,421)	(14,401)
Cash Low Point (before the 4th of the following month)	(21,313)	(15,918)	(5,395)	(6,694)	(3,526)	(8,086)	(5,664)	(5,385)	(8,544)	(5,538)	(12,198)	(22,592)	(15,430)	(26,033)	(20,554)

14. CASH SUPPORT - CONDITIONS

Financial delegations

The Minister of Health expects the Board to assure itself that any increases to HBDHB's cost base are only approved where unavoidable. To that end he expects the Board will limit its delegations of financial authorities to ensure that potential increases to the major elements of the DHB's cost base are approved directly by the Chief Executive. This expectation is in respect of:

- Recruitment to new positions:
- · Increases in contracts for community providers; and
- · Approval of capital expenditure plans.

The delegations have had minor amendments to accommodate these expectations.

Approval of capital expenditure plans are reserved to the Board.

Quarterly Report to the Minister of Health

The Minister also expects the Board to provide him, on a quarterly basis, with representation that cost increases have only been approved where unavoidable. The representation is to be accompanied by supporting reports which include the detail of, and explanation for, any increases in expenditure from the corresponding quarter of the previous year, including:

- Full Time equivalents (FTE), personnel and outsourced personnel expenditure;
- Total provider arm expenditure;
- Expenditure on community provider contracts; and
- Actual capital expenditure.

The Minister received the first representation and the supporting report for Quarter Four of 2018/19 in early August following the July Board meeting. We received no feedback from this.

Because the report is a comparison between quarters in different financial years, it will have differences that arise from year-to-date adjustments and changes in accounting practice that are unrelated to financial performance. The main difference relating to accounting treatment of pharmaceutical spend, has been adjusted in the table and explained below it. Others have been referred to in the commentary.

The September 2019 representation and supporting report which compares Quarter 1 ended September 2018 to Quarter 1 ended September 2019.

Quarterly Report to the Minister of Health

Quarter Ended 30 September 2019

• increases in additional sessions (SMO)

Description	This Year	Last Year	Variance	Var %			
FTEs	2,488	2,399	-89	-3.7%			
	\$'millions	\$'millions	\$'millions	%			
Personnel Costs	58.8	54.1	-4.7	-8.7%			
Outsourced Personnel	3.3	2.0	-1.2	-60.2%			
Provider Arm Expenditure	92.2	84.0	-8.2	-9.8%			
Expenditure on Community Provider Contracts	64.1	59.9	-4.3	-7.1%			
Actual Capital Expenditure	2.3	5.2	2.9	56.0%			
FTEs (89 increase)							
Includes:					FTE		
 Increase in Medical Personnel driven by RMO run-rate review and other recruitment; 							
 additional nursing resources relating to patient demand and acuity across most clinical areas, largely as a result of CCDM and NZNO settlement; 							
 net increase in actual allied health, a number of approved positions va 		ificant diffic	ulty recruiti	ing and	3		
 increase in Operations as a resu clinical staff, additional hours wo meals), orderlies and security (pati 	orked by kitc	hen assist			12		
 other increases including 6 additional as a result of investment in Informational Primary Care. There was a net zero 	mation Syste	ms and str	uctural cha		17		
Personnel Costs (\$4.7m increase)							
Includes:					\$'m		
increases in employee pay rates from M	ECA settleme	ents, partia	lly MoH fur	nded;	2.8		
 additional staffing (see FTEs). 					1.9		
Outsourced Personnel (\$1.2m increase)							
Includes:					\$'m		
increases in vacancy and leave cover;							

0.2

Provider Arm Expenditure (\$8.2m increase)

Includes the \$4.7m of personnel costs and the \$1.2m of outsourced personnel noted above. Also includes:	\$'m
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 increases in regional health information systems costs; 	0.6
 increases in patient transport costs; 	0.6
 increases in blood product usage; 	0.3
increases in maintenance costs;	0.3
increases in outsourced cleaning costs.	0.2
Expenditure on Community Provider Contracts (\$4.3m increase)	
Includes:	\$'m
increases in residential care and home support;	1.6
 increases in community pharmaceutical costs; 	1.2
increases in PHO payments for health promotion and service improvement	1.2
increases in capitated primary practice payments	0.3

Actual Capital Expenditure (\$2.9m decrease)

Last years figure reflects expenditure on the self funded Endoscopy project, completed in October 2018.

The Board and management of Hawke's Bay District Health Board confirm, to the best of our knowledge and belief, that cost increases between Quarter 1 of the 2018/19 and Quarter 1 2019/20 financial year, have only been approved where unavoidable.



BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	Pasifika Health Leadership Group – Chairs Report For the attention of: HBDHB Board
Document Owner:	Barbara Arnott, Chair of CPHAC
Reviewed by:	Traci Tuimaseve, Chair of PHLG Bernard Te Paa, Executive Director, Health Improvement & Equity Directorate
Month:	October 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

1. Note the contents of this report.

The Pasifika Health Leadership Group (PHLG) met on 7 October 2019. An overview of the issues discussed and/or agreed at the meeting is provided below.

HEALTH EQUITY FRAMEWORK

The Health Equity Framework was presented.

PHLG discussion included:

- Little change for Pasifika over the Health Equity Report lifecycle and that further work is required to implement what we know works well
- Higher rates of immunisation and screening is reflective of the services being delivered in the community
- Co-design e.g. whānau voice surveys are not far reaching enough into the community with little or no feedback provided
- The representation of Pasifika within the Matariki programme
- Their support for resourcing to be available that will achieve actions within the Pacific Health Action Plan and have less risk aversion to doing things differently
- Opportunities that can inform the PHLG Workplan

HB PASIFIKA YOUTH PROJECT

Dr Diane Mara (Pacific Researcher) and Amataga Iuli (Pacific Health Promoter) provided an overview of their initial findings.

The key project questions set out to identify:

- 1. What are the perspectives of HB Pacific Youth of their own health and wellbeing and access to services?
- 2. What are the aspects of Pacific Youth health needs that will inform the provision of appropriate responsive youth health needs by HBDHB and PHO services?

3. What resilience factors and sources of support do Pacific Youth access in ensuring their health and well-being needs are being met now and into the future?

The survey was wrapped around four main themes; relationships, education, identity and health and wellbeing. Approximately 400 out of 600 Pacific students from 12 schools in the Hawke's Bay region participated in the survey. Principals, teachers and DHB Pacific staff were engaged throughout the process. Youth valued the face to face engagement during the process.

A report outlining the results and recommendations will be presented to Committees and Board early 2020.

PHLG WORKPLAN

The Workplan was ratified by PHLG. Recommendation noted under Priority 1 – Engaged Pacific Communities:

- The DHB leads out on intersectoral conversations building on the current actions developed through the Pasifika Health Youth Survey
- A continuity plan be adopted for the HB Pasifika Youth Survey
- The findings from the Ministry of Health community fono be used as community engagement to develop the Pasifika Health Action Plan Strategy
- The PHLG Workplan will provide the basis to monitor DHB performance.

NOTED:

- 1) The Equity Framework has revealed little change and the work needs to go into implementating what is currently working.
- 2) PHLG Workplan is complete and provides the basis to monitoring DHB performance for Pacific and will be our focus
- 3) The DHB leads out on the intersectoral conversations building on the current actions developed through the Pasifika Health Youth Survey.

GENERAL BUSINESS

- The PHLG acknowledged Barbara Arnott's contribution as Chair of CPHAC at PHLG since its inception
 in December 2013. Barbara has provided enormous support, contribution and has been a passionate
 champion on the issues that face Pasifika. PHLG recognise Barbara's commitment as a member of
 this group noting it has been an honour having Barbara represent PHLG at Board. We wish her the
 best going forward.
- PHLG members felt strongly that there needs to be Pasifika representation at Board level.

HAWKE'S BAY District Health Board Whakawāteatia	Māori Relationship Board (MRB) For the attention of: HBDHB Board
Document Owner:	Patrick Le Geyt (on behalf of MRB Chair)
Month:	October 2019
Consideration:	For Information
Reccomendation	•
That HBDHB Board:	
Note the content of this report	

MRB met on 9 October 2019. An overview of issues discussed and recommendations at the meeting are provided below.

TE ARA WHAKAWAIORA (TAW) - (ADULT HEALTH INDICATORS)

This report focused on an amalgamation of ASH rate for 44 – 65 year olds, cardiovascular and smoking rates. These are all areas that contribute to premature mortality for Maori and are all preventable conditions.

MRB were very disappointed with the lack of any action and very little progress against Māori ASH rates 45-64 years. They were very concerned that these rates were getting worse over the last two years and that there had been very little attention and focused interventions. The members felt that the next steps needed greater attention and more work and whilst the recommendations remain clinically based, any whanau wellbeing approaches were not considered, which could be a missed opportunity toward prevention of Long Term Conditions.

It was agreed that all targets need to have greater accountability in terms of actions and consequences for not delivering to target. Representation of accountabilities for each specific intervention should be considered with consequences identified, to ensure results against indicators.

RECOMMENDATION

It is recommended that the ${\bf M\grave{a}ori}$ ${\bf Relationship}$ ${\bf Board}:$

- 1. Note the contents of the Te Ara Whakawaiora (Adult Health) report
- 2. **Recommend** the TAW Champion (ASH Rates 45-64 years) provide an improved comprehensive plan on addressing the inequities for Māori to the Board.
- 3. **Endorse** the next steps and recommendations of the remaining TAW Adult Health report (cardiovascular and smoking).

Adopted

TO WAHA

Charrissa Keenan, Programme Manager for Maori Health presented some whānau interview videos following the To Waha oral health initiative, which provided valuable consumer insight into 'whānau voice', 'whānau led' and 'whānau centred service approaches'.

This was well received by MRB members and Charrissa and the team were commeneded for their work on this project.

SOUTH CENTRAL FOUNDATION VISIT (NUKA)

Discussion took place in regards to the next NUKA trip, but confirmed no HBDHB representatives attending this next contingent to South Central Foundation. With He Ngākau Aotea and iwi relationships being of such high importance, it was felt by some members that this is an essential part of forming an understanding of the whole concept of Person & Whanau Centred Care.

Response discussions included evidence of tangible actions resulting from those who have already been part of the NUKA experience and addressing implementation of the Strategic Plan (Clinical Services plan). There are already many NUKA aligned initiatives running within the DHB.

OURHEALTH HAWKE'S BAY Whakawateatia	Hawke's Bay Clinical Council For the attention of: HBDHB Board
Document Owners:	Robin Whyman & Jules Arthur (Co-Chairs)
Month:	October 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

1. Notes the contents of this report

HB Clinical Council met on 9 October 2019. A summary of matters discussed is provided below:

ANNUAL OBJECTIVES

Council members discussed and confirmed a limited number of objectives for 2019/20:

- 1. Provide a clinical perspective on the Implementation Plan for Whanau Ora Hapori Ora (the new 5 Year Strategic Plan for the HB health sector) and the Annual Plan for 2020/21 by 31 March 2020
- 2. Co-design with Consumer Council and support the initial implementation of a detailed plan for Person and Whanau Centred Care in HB by 30 Jun 2020
- 3. Ensure the Clinical Governance Structure is fully implemented and integrated, with appropriate reporting, management and administration processes in place, by 31 March 2020
- 4. Ensure the development and implemention of a sector wide process for monitoring, reporting and effectively managing clinical risk, clinical quality and patient safety by 30 Jun 2020
- 5. Ensure the development of a HB Clinical Workforce Plan to support Whanau Ora Hapori Ora (the new 5 Year Strategic Plan), by 30 Jun 2020

It was agreed that the initial focus needs to be on Objective 4, and ensuring that effective systems and reporting is in place for Clinical Council to meet it's clinical governance responsibilities to FRAC and the Board.

The role of Clinical Council in supporting the work of the Te Pitau Health Alliance Governance Group was discussed, and the requirement for this relationship to be clarified was agreed.

WORKPLAN 2019/20

A monthly workplan for Council was discussed and agreed. This plan provides for a combination of:

- Discussion/progress on the above objectives
- Presentations on clinical issues direct from Directorates & Primary Care
- Receive/monitor clinical governance structure reports
- Clinical quality, patient safety and risk reports, workshops and performance management
- HBDHB Governance Workplan issues requiring Clinical Council input
- Review/confirm appropriate reports to FRAC/Board

COMMUNICATIONS & CLINICAL COUNCIL VISIBILITY

Agreement reached on updating the Clinical Council web page and implementing other communications to enhance the level of knowledge and understanding about Council's role.

GENERAL ISSUES

Other issues discussed and/or agreed included:

- Improving communications between prescribers and pharmacists
- · Processes around minimising/managing mis-directed lab results
- Appointments of replacement Chairs to some Clinical Governance Committees
- Amending the membership provisions of the Terms of reference for the Consumer Experience Committee, from four to three members from each Council
- Clinical/patient impacts of recent strikes

OURHEALTH HAWKE'S BAY Whakawateatia	Hawke's Bay Clinical Council - Appointment of New member For the attention of: HBDHB Board
Document Owner:	Ken Foote, Company Secretary
Approved by:	Craig Climo, Chief Executive
Month:	October 2019
Consideration:	For Endorsement

RECOMMENDATION

That the HBDHB Board:

1. Endorses the appointment of Dr Umang Patel to Clinical Council

The Chief Executive has received and approved a recommendation to appoint Dr Umang Patel to the vacant General Practitioner appointment on Clinical Council.

Dr Patel is the Medical Director of City Medical in Napier. He is a Fellow of the College of Urgent Care rather than General Practice and also has a background in emergency medicine. He works sometimes in the Emergency Department at Hawkes Bay Fallen Soldiers Memorial Hospital.

It is recommended that the Board endorse this appointment.

OURHEALTH HAWKE'S BAY Whakawateatia	Hawke's Bay Health Consumer Council
	For the attention of: HBDHB Board
Document Owner:	Rachel Ritchie (Chair)
Month:	October 2019
Consideration:	For Information

RECOMMENDATION

That the **HBDHB Board**:

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

Council met on Thursday 10 October 2019. An overview of matters discussed is provided below:

2019/2020 ANNUAL PLAN

The eight draft Council objectives for 2019/20 discussed last month, were confirmed:

- Actively promote and participate in co-design processes for Mental Health & Youth
- Actively promote and participate in co-design processes for Primary Care and Urgent Care
- Actively participate in agreeing and implementing priority actions from the Strategic Plan (Whānau Ora Hāpori Ora)
- Monitor and assist initiatives that make health easy to understand within the health sector and community
- Facilitate and promote the implementation of a 'person and whanau centered care' approach and culture to the delivery of health services in partnership with other group where appropriate
- Monitor all 'Consumer Experience' performance measures/indicators/feedback etc., to ensure 'changes on the ground' are visible to the Council and that consumer experience and health outcomes are improving.
- Support and monitor the implementation of the Consumer Collaboration (previously Engagement)
 Strategy and principles in Hawke's Bay
- Raise awareness of the work of Consumer Council

A small group of Council members was assigned to each objective and it was agreed that over the next six months, each Council meeting will progressively address each of these objectives, with the relevant small group presenting and facilitating a discussion at each meeting on:

- What's been achieved so far?
- What's currently available/in place?
- What's needed to achieve the objective?
- How do we know we are on track? (monitoring)

REPORTS RECEIVED & DISCUSSED

• Consumer Experience Committee:

Consumer Council agreed to amend the membership provisions of the Terms of reference for the Consumer Experience Committee, from four to three members from each Council

• Consumer Experience Facilitators

Report noted the opportunity to be involved in a review of the National Experience Survey – a subgroup of Council members was set up to do this.

Also noted was a schedule of Consumer Council members representation on 18 current projects/working groups/committees, with 4 more about to commence

Pharmacy Services Advisory Group

Having previously noted that consumer knowledge of eligblity for the prescription subsidy was poorly understood, Council were pleased to learn that the Interim Chief Pharmacist has agreed to further promote and enhance the level of advertising around this.

• Disability Implementation Group

Council representatives on this Group reported that the MoH are bringing out a new Disability Action Plan with the aim to make the health system more responsive.

MoH want to develop a fully responsive policy by seeking community voices and have requested feedback on this plan, which is a positive move to hearing more community voice. As part of this, feedback has been given that the MoH should better monitor the vast number of providers. Consumers simply aren't aware of what they are entitled to and there is confusion for users of the services.

- Te Pitau Health Alliance Governance Group
- Matariki HB Regional Development Strategy & Social Inclusion Strategy Update

IS UPDATE/PRESENTATION

Council received a presentation from the IS Team on 'A Year of Delivery' which summarised the more significant developments over the past 12 months.

A number of queries and comments were made in regards to the initiatives as follows:

- Self-Serve kiosks at Napier Health Centre
 - Disability friendly?
 - Are they wheelchair user height?
 - How is privacy ensured for the user?
- Emergency Q at ED as a triage system
 - Is this voucher system free for everyone?
 - Does it consider those with community service cards?

The IS Team undertook to respond to these queries.

CHAIRS REPORT

Issues discussed/agreed during the Chair's report included:

- The heavy demand on the hospital and the stress, fatigue, and impact on staff was being noted by consumers
- Similar stresses on primary care were also noted, with particual concern expressed around access/waiting times to see a GP
- The potential introduction of Health Coaches and/or Health Improvement Practitioners within primary care was welcomed and fully supported by Council members
- Governance workplan:

During a brief discussion on the current governance processes/workplan, members considered that input from stakeholder groups is key to the initial planning/ideas/draft of any proposals going to board. The benefits of input at an earlier stage to encourage engagement and feedback was discussed. Having the relevant stakeholder groups was an issues that the Consumer Council had faced over the last 18 months and the leadership group have worked to ensure a better balance. It

TE PITAU HEALTH ALLIANCE	Te Pītau Health Alliance (Hawke's Bay) Governance Group
	For the attention of: HBDHB and Health Hawke's Bay Ltd Boards
Document Owner:	Bayden Barber, Chair
Author:	Chris Ash, Executive Director Primary Care
Month:	October, 2019
Consideration:	For Information

Recommendation

That the Boards:

Note the contents of this report.

The Te Pītau Health Alliance (Hawke's Bay) Governance Group met on Wednesday 9 October 2019.

Significant issues discussed and agreed (including resolutions) are noted below.

Te Pītau Health Alliance (Hawke's Bay) Agreement

Ken Foote (Company Secretary) referred to the Te Pītau Health Alliance (Hawke's Bay) Agreement, and reaffirmed to members Te Pītau's scope and purpose, with HBDHB/PHO Board delegated authority, to improve health outcomes for the Hawke's Bay population through transforming, evolving and integrating primary and community healthcare. The effectiveness of operating arrangements to enable this will be considered in a review of the Te Pītau Health Alliance, which will take place in December.

The technical considerations associated with remunerating members of the public for involvement in redesign, including tax implications, were relayed by Ken. The issue will be considered further by management as part of the implementation plan for the Health Strategy.

Ken reminded members that Clinical Council and Consumer Council stakeholder groups are available to Te Pītau Health Alliance for support and advice.

Communications Plan

A Communications strategy, presented by Wayne Woolrich (CEO, Health Hawke's Bay) in the absence of Anna Kirk (Communications Manager), was noted by members.

Anna is to undertake a workshop with the Te Pītau Governance Group to coincide with the December review of Alliance arrangements.

Page 1 of 2

Mental Health & Addiction (MH&A) Redesign Update

Resolution

The Te Pītau Health Alliance (Hawke's Bay) Governance Group:

 Accepted the co-design and co-decision-making frameworks and approach as depicted in report appendices.

Janine Jensen (Senior Commissioning Manager) and Shirley Lammas (Planning & Commissioning Manager) provided a formal summary on project progress since November 2018, which covered framework (co-design/co-decision-making), design (consultation) and approach (six stages).

Following consultation with local Māori, the MH&A redesign project is to be known as Oranga Hinengaro: Well-Being of the Mind. A communications plan is being compiled.

The Government's other primary care interventions were noted, e.g. MH&A Request For Proposal (RFP), Alcohol and Other Drug (AOD) and, Crisis work (not funded within the redesign budget).

Noting the sheer volume of work in the MH&A field at present, it is important to ensure that project progression does not become frustrated by an unclear or moving scope. It was agreed that the Chair would discuss with Chris Ash and Wayne Woolrich how to resolve concerns about workload feasibility in this important area.

System Level Measure (SLM) Reporting Requirements

Resolution

The Te Pītau Health Alliance (Hawke's Bay) Governance Group:

1. Acknowledged the draft template for the SLM dashboard (noting potential amendments over 2019/20), and agreed to provide feedback on any changes.

Kate Rawstron (Head of Planning & Strategic Projects) and Louise Pattison (Project Manager) provided explanation on the SLM 2019/20 Quarter 3 Dashboard (example only), and the six listed MoH SLM milestones.

Suggested measurement of 'wait time to see GP' and 'improved access to primary care' were noted as future potential SLM milestones. A quarterly monitoring return was raised.

For example only purposes, Dr Peter Culham will present the Dashboard via Clinical Council.

HAWKE'S BAY	Te Pītau Health Alliance "Te Pītau" For the attention of:
HAWKE'S BAY District Health Board Whakawāteatia	HBDHB Board
Document Owner:	Craig Climo, Interim Chief Executive Officer
Document Author:	Craig Climo, Interim Chief Executive Officer
Month:	October 2019
Consideration:	For decision

RECOMMENDATION

That the HBDHB Board:

- 1. **Receives** this report; and
- Agrees that the Te Pītau Health Alliance Governance Group be disestablished, and replaced by the
 current support group with additional management and clinical leader membership as indicated in this
 report.

I undertook to come back to the Board regarding streamlining structure and process to improve progress.

In 2013 New Zealand moved to implement a governance model across the entire country, aimed at integration of health services by requiring an "Alliance" between each DHB and corresponding PHOs. This provided a method of bringing health professionals together from different parts of the health system into an integrated care governance model and motivating them to work collaboratively on what services should look like from a patient, community and clinical perspective.

It is a requirement of the PHO Services Agreement between DHBs and PHOs that they have an Alliance Agreement in place and an Alliance Leadership Team established. The Alliance Agreement between HBDHB and Health Hawke's Bay (PHO) was signed in December 2018 and is known as the Te Pītau Health Alliance "Te Pītau". Ideally, Alliance members would include clinicians, consumer representatives and importantly those who command resources, such as the chief executives of the DHB and respective PHO(s). This facilitates decisions around how best to integrate the various services for a particular patient group, and how the service can be clinically-driven and resourced by the respective providers conterminously.

The parties to the Alliance appoint Alliance Leadership Team members.

Te Pītau is made up of predominantly governance focussed with three representatives from HBDHB, three from Health Hawke's Bay PHO and one representative from Hawke's Bay District Health Board (HBDHB) Māori Relationship Board NKII, one from Hawke's Bay Consumer Council and one from Hawke's Bay Clinical Council. Te Pītau has Service Level Alliances (SLA) including:

- Rangatahi service re-design aimed at youth not accessing services
- End of Life services in implementation of the palliative care plan
- Mental Health Primary Care
- System Level Measures (SLM)

The SLM group is required to develop an annual plan around the nationally agreed SLMs to enable SLM funding to flow and, to date, appears to be the only output from the Alliance.

At the time Alliancing was introduced into the PHO Services Agreement in 2013, the environment was less mature and it was common for there to be more than one PHO in any one DHB district which created inter PHO relationship issues.

I spoke recently about the requirement to have an Alliance in place with the relevant Deputy Director-General. The advice was that technically for DHBs to receive SLM improvement funding (nationally \$23M) an Alliance is to be in place. However, the form of the Alliance is entirely open and the Ministry of Health (MoH) simply wants to know that there is effective collaboration. DHBs and PHOs are free to do their own thing, but it was noted that the more effective Alliances across New Zealand are operationally-focussed Alliances that have management and clinical leaders as part of their membership. This has also been my experience. The effective Alliance groups have the relevant executive managers who have the necessary delegated authority and clinical leaders who can advise and lead their clinical colleagues along on the journey.

The reason given for the current structure of the Te Pītau Alliance is due to a poor relationship between the DHB and PHO. The poor relationship between the DHB and PHO stemmed from an event of which I think we can say is consigned to history.

I see the relationship with PHO management as friendly, open, and transparent. While we are actively in discussion with the PHO regarding scope, results, and funding, it is being conducted amicably. DHB management also want to have a broader and closer relationship with primary care.

The foregoing aside, the main argument for an Alliance governance group or not is conceptual, not one of actual performance, however I might be expected to comment on progress of the Alliance governance group to date. I understand that it's been in place about 18 months, and perhaps fully functional for about 12 months, in which time relatively little appears to have been achieved, although it may be accelerating. A self-review of performance may be planned for December. In any event, attribution of success or failure would not be clear as to where it belongs — which is another challenge in our structures. The incremental operating costs of Te Pītau are small. It may be about $1/8^{th}$ of administrative support and \$250 meeting fee for the MRB and Consumer Council members.

The opportunity cost – what members and in particular management and others would otherwise be doing – is of more concern.

There is currently an alliance "Support Group" that consists of:

- Wayne Woolrich (Chief Executive, PHO)
- Chris Ash (Executive Director, Planning & Funding)
- Patrick Le Geyt (General Manager, Maori Health)

I suggest that this continues as the core of the Alliance group with the addition of clinical leaders. Others, such as the Executive Director of Provider Services, can come and go as indicated by what is planned. For example, if it were proposed that a group of DHB staff be deployed in the community. An independent chair is only necessary where there are warring factions, in the absence of which the election of a chair on a rotating basis from within the membership is the best option.

These changes would simplify and speed up activity.

Recommendation

That the Board receives this report and agrees that the Te Pītau Health Alliance Governance Group be disestablished, and replaced by the current support group with additional management and clinical leader membership as indicated in this report.

ATTACHMENTS

Appendix One: Te Pītau membership Appendix Two: Te Pītau Alliance Agreement

15.

APPENDIX ONE

TE PĪTAU HEALTH ALLIANCE GOVERNANCE GROUP MEMBERSHIP

Hawke's Bay District Health Board

- Anna Apatu
- Hine Flood (Deputy Chair)
- Heather Skipworth

Health Hawke's Bay

- Bayden Barber (Chair)
- Jeremy Harker
- Jason Ward

Ngati Kahungunu Iwi Incorporated

• Bev Te Huia

Consumer Council

• Rachel Ritchie

Clinical Council

Dr Peter Culham

APPENDIX TWO

TE PITAU Health Alliance (Hawke's Bay) AGREEMENT

BETWEEN

HAWKE'S BAY DISTRICT HEALTH BOARD

AND

HEALTH HAWKE'S BAY LIMITED - TE ORANGA HAWKE'S BAY

DECEMBER 2018

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HEALTHY HAWKE'S BAY TE HAUORA O TE MATAU-A-MAUI

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

Our values

Tauwhiro-delivering high quality care to patients and consumers

Raranga te tira - working together in partnership across the community

He kauanuanu - showing respect for each other, our staff, patients and consumers

Akina-continuously improving everything we do

TE PITAU HEALTH ALLIANCE (HAWKE'S BAY) AGREEMENT

DATE: 19 DECEMBER 2018

1 THE PARTIES (each a Party) are:

Hawke's Bay District Health Board (DHB)

Health Hawke's Bay Limited - Te Oranga Hawke's Bay (PHO)

2 KEYINFORMATION

1. Commencement Date: 1 July 2018

2. Te Pitau Governance Group Members:

Core members will be:

· Three Directors of Health Hawke's Bay Ltd

Bayden Barber - Chair

Jeremy Harker

Jason Ward

• Three Members of Hawke's Bay District Health Board

Ana Apatu

Hine Flood

Helen Francis - Deputy Chair

• HBDHB Maori Relationship Board NKII representative

Beverly Te Huia

Hawke's Bay Clinical Council representative

David Rodgers

Hawke's Bay Health Consumer Council representative

Rachel Ritchie

As the Scope of our alliance activities expands to cover them, representatives from other parts of the Hawke's Bay health sector may be added, eg:

- Community Pharmacy
- Aged Care
- NGOs

3 OUR AGREEMENT

In consideration of the mutual promises given and received by each of us in this Agreement, we agree that we will be bound by and perform this alliance Agreement.

We agree that our alliance shall be known as 'Te Pitau'

Our Agreement comprises the following parts:

Part A: Our Commitment - is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles and commitment to success. We agree that the remainder of this Agreement will be interpreted in accordance with the statements made in Part A.

Part B: How We Will Succeed – is a statement of how we will work together, in particular, to achieve success by completing our alliance activities and meeting and exceeding our objectives.

Part C: How We Will Work Together - details the processes that we have agreed to apply to how we will work together.

Part D: Term of Te Pitau - details how long we expect to work together for and, if or when necessary, how we will wind up our alliance.

Schedule 1-includes the scope and annual activities of Te Pitau

PART A: OUR COMMITMENT

Part A of this Agreement is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles, values and commitment to success.

1. Scope of Te PTtau

- 1.1 Who We Are: We, the Parties to Te Pitau, are the DHB and PHO for the Hawke's Bay district.
- 1.2 Our Leaders: We are led by our Te PTtau Governance Group, made up of those governance, management and clinical leaders and other key stakeholders, who can successfully lead Te Pitau to complete our alliance activities and achieve our objectives.
- 1.3 Our Purpose: We have formed Te Pitau to improve health outcomes for our populations, through:
 - 1.3.1 transforming, developing, evolving and integrating primary and community healthcare services, consistent with commitments made within the 2018 Clinical Services Plan, i.e.:
 - · achieve equity with a particular focus on those with unmet needs
 - · create a culture that is person and whanau centred
 - co-design and prioritise services to meet the needs of populations with the poorest health and social outcomes
 - · make health easy to understand
 - 1.3.2 eliminating inequities in primary care access and health care delivery
 - 1.3.3 making (and assisting the DHB to make) strategic health care decisions on a "whole-of-system" basis;
 - 1.3.4 providing direction and building relationships within our primary and community health system;
 - 1.3.5 assessing the primary and community health care needs of our populations;
 - 1.3.6 planning health care delivery in our District that is amenable to primary and community settings, to make the best use of_health_resources;
 - 1.3.7 balancing a focus on the highest priority needs areas in our communities, while ensuring appropriate care across all our populations;
 - 1.3.8 determining models to be commissioned from delegated funding pools
 - 1.3.9 establishing Service Level Alliances to advise on the development, delivery and monitoring of primary and community health services within the scope of our alliance;
 - 1.3.10 monitoring the effectiveness and health outcomes of groups of services that fall within the scope of our alliance; and
 - 1.3.11 informing our populations and other stakeholders of our performance in achieving our objectives.

1.4 Te Pitau Activities:

- 1.4.1 Our alliance activities are defined in the scope of Te Pitau. It is anticipated that this scope will be initially restricted to specific service areas, but will expand over time. Te Pitau, in carrying out its activities, may not be involved in all healthcare services in our District.
- 1.4.2 The scope and activities of Te Pitau (including objectives) are set out in Schedule 1.
- 1.5 Our Conduct: We will conduct our activities and achieve our objectives, by acting consistently with our Te Pitau Principles.

1.6 What We Are Not:

- 1.6.1 Te PTtau does not directly provide healthcare services although we will make decisions and recommendations on what services should be funded by the Parties.
- 1.6.2 Te PTtau does not have any authority over, nor responsibility for, any services provided directly by any employees of the Parties.
- 1.6.3 We work collaboratively but are not collectively established as a legal entity.

2. Overview of Decision Making

- 2.1 Allocation of Decision Making: At the core of this Agreement is a decision-making process that makes clear which decisions remain with the DHB, the PHO and the Government, and which decisions are devolved to us, the Parties.
- 2.2 Clinician Input into Decision Making: We recognise that clinical input is essential in all levels of decision making. At the alliance level, this will be achieved by ensuring all major Te Pitau activity decisions will involve input and support from the Hawke's Bay Clinical Council. At all other levels, this input will be provided through proactive involvement of appropriate clinicians.
- 2.3 Maori Contribution to Decision Making: We acknowledge our responsibilities under Te Tiriti o Waitangi and our desire to work with local Maori to enable them to contribute to Te PTtau decision making. Given the Memorandum of Understanding between HBDHB and Ngati Kahungunu lwi Incorporated, this will be achieved through active engagement with HBDHB Maori Relationship Board (MRB) on all major Te Pitau decisions. At all other levels, we will ensure that a Maori perspective is present and/or represented in all decision making processes.
- 2.4 Consumer Input into Decision Making: We recognise that consumer input is essential in all levels of decision making. At the alliance level, this will be achieved by ensuring all major Te Pitau activity decisions will involve input and support from the Hawke's Bay Health Consumer Council. Consumer representatives will be involved in all co-design and decision making processes at all other levels.
- 2.5 Other Input into Decision Making: Where appropriate, we will work together with a wide range of different cultures, disadvantaged groups and communities to design the health services they need and engage them in our decision making processes.
- 2.6 Decisions Made by Government: The balancing side of the decision-making process is that it remains the role of the Government to determine the gross allocation of public funding, so as to achieve the best balance of outcomes for the population. Wherever possible this will involve discussion with clinicians, providers and/or the community through Te PTtau but we recognise that in some cases these decisions may be taken centrally.
- 2.7 Decisions Made by the DHB: We recognise that the DHB has two roles:
 - 2.7.1 as a Party within Te PTtau, and
 - 2.7.2 as the Government's agent, as the funder of health services in the District.

- 2.8 Te Pitau is intended, in part, to assist the DHB to fulfil its statutory objectives and functions as a funder of health services. The DHB will work within Te Pitau to fulfil those obligations where it is appropriate and practicable to do so.
- 2.9 However, we acknowledge that the DHB's statutory and other obligations will require it to make some decisions, which may affect Te PTtau, outside of this Agreement. Without limiting its ability to make those decisions, the DHB undertakes to make those decisions, insofar as is reasonably practicable, in good faith and having regard to Te Pitau's Principles. We agree that nothing in this Agreement limits the DHB's rights, powers, obligations or liabilities under any Law or other agreement.
- 2.10 Decisions Made by the PHO: Equally, we recognise that the PHO is subject to its own governance obligations. We also agree that nothing in this Agreement limits the PHO's rights or obligations, necessary to comply with its governance obligations under any Law or other agreement.

3. Te Pitau Principles

- 3.1 We will conduct ourselves and undertake our alliance activities in a manner consistent with the Hawke's Bay Health Sector Vision and Values, and our Te PTtau Principles and will take all reasonable steps to ensure that our employees, contractors and agents do likewise.
- 3.2 We agree that every part of this Agreement must be read in such a way as to be consistent with, and ensure the integrity of, our commitments to Te PTtau Principles.
- 3.3 **Te Pitau Principles**: Te Pitau is founded on the following principles:
 - 3.3.1 we will adopt a person and whanau centred, integrated, whole-of-system approach, and make decisions on a 'Best for System' basis;
 - 3.3.2 we will seek to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes and equity for our populations;
 - 3.3.3 we will apply the principles of Te Tiriti o Waitangi and incorporate kaupapa Maori practice and whanau ora approaches within our alliance activities;
 - 3.3.4 we will conduct ourselves with honesty and integrity, and develop a high degree of trust;
 - 3.3.5 we will support clinical leadership and, in particular, clinically informed service development;
 - 3.3.6 we will promote an environment of high quality, performance and accountability, and low bureaucracy;
 - 3.3.7 we will strive to resolve disagreements co-operatively and, wherever possible, achieve consensus:
 - 3.3.8 we will adopt and foster an open and transparent approach to sharing information, subject only to statutory privacy principles;
 - 3.3.9 we will monitor and report on our achievements, including public reporting;
 - 3.3.10 we will be collectively responsible for all decisions and outcomes;
 - 3.3.11 we will operate as a unified team providing mutual support, appreciation and encouragement;
 - 3.3.12 we will conduct ourselves in accordance with best practice;
 - 3.3.13 we will support professional behaviour and leadership;

- 3.3.14 we will remain flexible and responsive to support an evolving health environment;
- 3.3.15 we will develop, encourage and reward innovation and challenge our status quo;
- 3.3.16 we will actively support and build on our successes; and
- 3.3.17 we commit to fully exploring the collective sharing and management of the risks and benefits arising from our alliance activities. Where we cannot manage risk collectively, our principle is to allocate responsibility for each risk to those of us who can best manage it.
- 3.3.18 we will each accept our own costs of all participation in Te PTtau activities, and we agree that any third party costs directly incurred by Te Pitau, shall be shared equally.

PART B: HOW WE WILL SUCCEED

Part B of this Agreement is a statement of how we will work together, in particular, to achieve success by completing our alliance activities and meeting and exceeding our objectives.

4. Commitments

4.1 Shared Decision Making:

- 4.1.1 Each of us is fully committed to Te PTtau and carrying out our alliance activities to achieve our objectives. We acknowledge that this commitment is fundamental to Te PTtau's success.
- 4.1.2 We will work as one team, in a transparent, innovative and collaborative manner, to produce outstanding results.

4.2 Shared Responsibility:

- 4.2.1 We both take responsibility for Te Pitau's success and ourfailures.
- 4.2.2 We both take responsibility for achieving consensus decisions within Te Pitau.
- 4.2.3 We both take responsibility for addressing all potential disputes within Te Pitau.
- 4.2.4 We will establish and maintain an environment within Te PTtau that encourages open, honest and timely sharing of information.
- 4.3 Shared Accountability: We are both responsible collectively for identifying, managing and mitigating all risks associated with our alliance activities.
- 4.4 Commitment to Good Faith: We will, at all times:
 - 4.4.1 act in good faith and be fair, honest and ethical in our dealings with each other;
 - 4.4.2 make all decisions on a Best for System basis and when making such decisions, will give predominate weight to the interests of Te PTtau over our own self-interest;
 - 4.4.3 do everything that is reasonably necessary to enable each of us to undertake our alliance activities and perform our obligations under this Agreement;
 - 4.4.4 not act in a manner that impedes or restricts each other's performance of our alliance activities and the performance of our obligations under this Agreement; and
 - do all things that are, or may reasonably be, expected of us so as to give effect to the spirit and intent of this Agreement and Te Pitau.
- 4.5 **Commitment to Consultation:** We recognise that both of us may, in the course of undertaking our alliance activities and otherwise meeting our commitments under this Agreement, be required to consult with others who do not form part of Te PTtau. We will provide a reasonable opportunity to do so in a prudent and timely manner.

Service Level Alliances & Working Groups

- 5.1 Service Development: Where Te PTtau identifies a service within its scope that requires transformational change, we may establish a Service Level Alliance (SLA) to:
 - 5.1.1 Collaboratively co-design and recommend how the service should be delivered within the scope of Te PTtau;
 - 5.1.2 Monitor and report on the performance of a service within the scope of Te Pitau.
- 5.2 Working Groups: Clause 5.1 does not limit Te Pitau's ability to establish any other Working Groups that it considers necessary to advise it on any aspect of our alliance activities.
- 5.3 Scope and Conditions: A SLA or other Working Group will operate according to any directions, conditions or restrictions established by us. This will include the lines of accountability to the appropriate body within Te PTtau structures, and may include a direction to work collaboratively with others.

6. Services Planning

- 6.1 We will work together to decide how Te PTtau will carry out service planning for those services within its scope, which may include delegating decision making authority to our Te Pitau Governance Group.
- 6.2 Our Te Pitau Governance Group may, as a result of service model decisions or recommendations made, recommend to the DHB and/or PHO the method and form of contracting for the delivery of the service on a Best Practice basis.
- 6.3 The DHB and/or PHO will implement our Te PTtau Governance Group's decisions and recommendations, subject only to the provisions of clauses 2.9 and 2.10 respectively
- 6.4 In implementing our Te Pitau Governance Group's decisions or recommendation, the DHB and/or PHO (as appropriate) may:
 - 6.4.1 undertake a procurement process based on the specification for the activity, work or service recommended by Te Pitau;
 - 6.4.2 enter into agreements/contracts with relevant providers, which may include Parties and/or others; and/or
 - 6.4.3 select from the Parties and other service providers those capable of providing the activity, work or service in accordance with the specification for the activity, work or service recommended by Te Pitau.

PART C: HOW WE WILL WORK TOGETHER

Part C of this Agreement details the structures and processes that apply to how we will work together.

7. Leadership Structure

- 7.1 General Structure:
 - 7.1.1 Te Pitau will be directed and lead by our Te Pitau Governance Group.
 - 7.1.2 The day-to-day affairs of Te Pitau will be co-ordinated by our Te Pitau Support Team (made up of relevant members of the management and clinical leadership teams of the DHB and PHO) and supported by the Clinical and Consumer Councils, and the MRB.
 - 7.1.3 Our Te Pitau Support Team will be led by the HBDHB Executive Director Primary Care
- 7.2 Service Developments: Our SLAs will be led and directed by a Service Level Alliance Leadership Team, acting within a scope of authority, agreed by the Parties.

8. Te P tau Governance Group Terms of Reference

- 8.1 Te Pitau Governance Group: We agree that we will have a Te Pitau Governance Group whose primary function will be to lead us with respect to our alliance activities and Te PTtau, in accordance with this Agreement.
- 8.2 Duties of our Te Pitau Governance Group: The duties of our Te Pitau Governance Group include:
 - 8.2.1 promoting and supporting the vision, values and direction of Te Pitau;
 - 8.2.2 facilitating development and implementation of commitments and service changes set out in the 2018 Clinical Services Plan, as they apply to primary and community care
 - 8.2.3 role modelling Te Pitau Principles and setting challenging objectives;
 - 8.2.4 facilitating, empowering and enabling the achievement of Te Pitau objectives/outcomes;
 - 8.2.5 maintaining a coherent set of policies and procedures as necessary to undertake its duties;
 - 8.2.6 agreeing with the DHB and PHO, in accordance with clause 6:
 - (a) our alliance activities and objectives, including the systems and key performance indicators for assessing achievement of these;
 - (b) the work, activity and services to be provided to meet our Te PTtau objectives;
 - 8.2.7 establishing and/or supporting Service Level Alliances and other Working Groups as necessary to oversee the development and delivery of services that fall within the scope of Te PTtau;
 - 8.2.8 providing high level support and stakeholder interface;
 - 8.2.9 monitoring and encouraging inter-Party relationships and stakeholder engagement;
 - 8.2.10 agreeing and adopting transparent governance and accountability structures for Te PTtau; and

- 8.2.11 mentoring and championing Te Pitau and its Parties as reasonably required.
- 8.2.12 approving the allocation of delegated/devolved funding pools
- 8.2.13 approving system and district level measures and related allocation of incentives , in conjunction with the Clinical Council.
- 8.3 Membership of Te Pitau Governance Group:
 - 8.3.1 At the date of this Agreement the appointed core members of our Te Pitau Governance Group are set out in the Key Information on page 5 of our Agreement.
 - 8.3.2 Alternates for appointed core members from the Maori Relationship Board, Clinical Council and Health Consumer Council shall also be appointed
 - 8.3.3 Membership of our Te PTtau Governance Group shall be reviewed annually by an Appointments Panel made up of the Chair's and CEO's of the DHB and PHO, who shall consider the level of interest in membership, the benefits of some rotation balanced with retaining some experience, and the need to maintain a good mix of perspectives, skills and experience.
 - 8.3.4 The Appointments Panel shall make recommendations to the DHB and PHO Boards.
 - 8.3.5 The appointment of all core members (and alternates) requires the formal approval of both the DHB and PHO Boards.
 - 8.3.6 Our Te PTtau Governance Group may, by agreement, add representatives from other parts of the Hawke's Bay health sector as members at any time, and may remove such members as necessary.

8.4 Involvement:

- 8.4.1 We agree that the members' regular involvement in and attendance at our Te PTtau Governance Group meetings is critical to Te Pitau's success.
- 8.4.2 Should any core member from either the DHB or PHO be unable to attend a Te Pitau Governance Group meeting, they may nominate another member to act by proxy in relation to any decision to be made by the Governance Group.
- 8.4.3 Should any core member from the Maori Relationship Board, Clinical Council or Health Consumer Council be unable to attend a Te Pitau Governance Group meeting, they may request that their appointed alternate attend in
- 8.5 Chair: The Chair of our Te Pitau Governance Group shall be the Chair of the PHO.
- 8.6 Deputy Chair: The DHB shall appoint one of the three DHB Board members to be the Deputy Chair
- 8.7 Decision Making: When making a decision, determination or resolution, our Te PTtau Governance Group (together and individually) must:
 - 8.7.1 have regard to its duties, specified at clause 8.2 of this Agreement;
 - 8.7.2 have regard to the intent of Agreement;
 - 8.7.3 consider the matter before them in good faith and use their best endeavours to facilitate a consensus decision;
 - 8.7.4 not prevent a consensus decision being made for trivial or frivolous reasons;
 - 8.7.5 use all relevant information in a timely fashion;
 - 8.7.6 actively seek and facilitate a consensus decision, determination or resolution; and

- 8.7.7 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.
- 8.8 **Reporting:** Our Te PTtau Governance Group will provide a report to the Parties following each Te PTtau Governance Group meeting, and an Annual Report about its performance.
- 8.9 **Implementing Decisions:** We will implement all decisions and directions of our Te Pitau Governance Group concerning our alliance and this Agreement.

9. Service Level Alliance (SLA) Leadership Team

- 9.1 **SLA Leadership Team:** We agree that our Te PTtau Support Team may appoint a leadership team (SLA **Leadership Team),** whose primary function will be to direct and lead a SLA and provide guidance and leadership to us with respect to those of our alliance activities that are within the scope of that SLA
- 9.2 **Duties of** a SLA **Leadership Team**: The duties of a SLA Leadership Team may include:
 - 9.2.1 providing a vision, strategic leadership and direction;
 - 9.2.2 providing operational/project leadership and relationship management;
 - 9.2.3 recommending the model via which services should be delivered in the District; and
 - 9.2.4 monitoring and reporting on the performance of the service against its agreed outcomes;
- 9.3 **Consensus Decision-Making:** When making a decision, determination or resolution, a SLA Leadership Team (together and individually) must:
 - 9.3.1 actively seek and facilitate a consensus decision, determination or resolution; and
 - 9.3.2 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.

PART D: TERM OF TE P TAU

Part D of this Agreement details how long we expect to work together for and, if or when necessary, how we will wind up Te PTtau.

10. Term

This Agreement commences upon the Commencement Date specified in the Key Information and continues in effect until:

- 10.1 30 June 2028
- 10.2 The Parties may agree to renew this Agreement from this date, after following an agreed process having been initiated at least twelve months before this date.

11. Suspending Te P tau Activities

- 11.1 Suspension by our Te Pitau Governance Group: Our Te Pitau Governance Group may suspend some or all of our alliance activities at any time.
- 11.2 Suspension by the DHB or PHO: The DHB or PHO may suspend some or all of our alliance activities, if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).
- 11.3 Recommencement: We will recommence the performance of our alliance activities only when directed to do so by our Te PTtau Governance Group.

12. Terminating Te Pitau

- 12.1 Termination by the DHB or PHO: We agree that the DHB or PHO may, in exceptional circumstances, terminate this Agreement if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).
- 12.2 Termination by either Party: We agree that either Party may terminate this Agreement due to ongoing Wilful Default by the other Party.
- Termination by Agreement: We agree that this Agreement may be terminated by mutual agreement between the Parties.

Executed for Health Hawke's Bay Limited by: in the presence of Director/Authorised Signatory Address Executed for Hawke's Bay District Health Board by: in the presence of Director/Authorised Signatory Director/Authorised Signatory Director/Authorised Signatory

Occupation \overline{I}

Address

Schedule 1 - Scope of Te Pitau

- The ultimate scope of Te Pitau may include any/all those publically funded primary and community healthcare services and activities, within the Hawke's Bay Health Sector that are amenable to delivery in a primary and community healthcare setting.
- On an ongoing basis, the scope of Te PTtau will generally be determined by agreement to establish specific Service Level Alliances or Working Groups. General issues may be included within the scope as agreed from time to time.
- The initial scope of Te Pitau and our alliance activities for 2018/19 shall include the following:

Area of Focus	SLA	Whole	Description	De	elegation Notes	Te Pitau Involvement
		Model				2018/19
Community Mental Health & Addictions	Yes	Yes	Multi-stage redesign and reprocurement of community based mental health and addictions services ahead of July 2020 go-live	•	Total indicative operating envelope <\$20m per annum (including DHB contracts and Primary Care directorate PVS transfers into provider arm) PHO Mental Health packages of care (c\$1m) inscope Will be informed by national Mental Health & Addictions	Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with Te Pitau Principles. Approve the work of the SLA as design authority, in order to progress proposed model of care into the procurement phase.
					Inquiry	

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pitau Involvement 2018/19
End of Life	Yes	Yes	Review of existing services supporting patients at the end of life, and redesign within existing resource envelope	Operating envelope to be confirmed, but will include DHB contracts (most notably hospice services) and PHO discretionary funding Likely to also include internal DHB provider PVS relating to hospital palliative care services	Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with TeP1tau Principles Approve the work of the SLA as design authority; in order to progress proposed model of care into the procurement phase
Community Pharmacy	Yes	No	Development, review and prioritisation of developmental schemes within Schedule 3b of the new Integrated Community Pharmacy agreement	N/A	Receive regular SLA updates for discussion and incorporation into the wider strategic approach
Integrated Care Teams (ICT)	Yes	No	Phased programme of work to test, refine and implement the model for extended integrated care teams operating seamlessly around the enrolled patient list	Year one activity likely to include District Nursing services (Primary Care directorate PVS transfers into provider arm)	Receive regular SLA updates on progress of service design pilots and provide governance oversight of the process in line with Te P1tau Principles Review recommendations and guide the prioritisation of work to further iterate ICT design

Area of Focus	SLA	Whole .	Description	Delegation Notes	Te Pi'tau Involvement
.,		Model Redesign	·	•	2018/19
Youth Services	TBC	Yes	Potential fast- follower SLA, reviewing design and effectiveness of primary health and wellbeing services targeted at young people	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA
Urgent and On-Day Primary Care Access	TBC	Yes	Potential fast- follower SLA, reviewing design and effectiveness of primary care services meeting urgent and on- day healthcare needs	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA
Health of Older People	ТВС	Yes	Potential fast- follower SLA, reviewing design and effectiveness of services to keep older people well and independent. Will build on internal strategic programme within HBDHB	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA
Rural Localities Model	No	No	Develop a framework for the development of sustainable rural services	N/A	Review intelligence relating to the development of rural services in line with the stated priorities of rural communities Commission focus work on underlying
				İ	themes relating to sustainability (e.g. workforce, technology, clinical governance) Oversee development of a framework approach to the development of sustainable rural
1				i	services

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pitau Involvement 2018/19
Primary Care Innovation & Development	No	No	Develop the framework for the evolution of primary healthcare in line with the Hawke's Bay CSP	N/A	Review intelligence relating to existing innovation and development of enrolment-based primary care, including structural considerations that impact the pace of change Review recommendations and guide the prioritisation of work to further iterate primary care innovation and development
System Level Measures	No	No	Ownership of the Hawke's Bay System Level Measures framework	N/A	Review and critically evaluate progress against the System Level Measures for Hawke's Bay Provide commentary to the Boards of HBDHB and HHB concerning delivery against these priorities Review recommendations and prioritise the development of measures within future iterations of the framework

Area of Focus	SLA	Whole	Description	Delegation Notes	Te P1tau Involvement
		Model			2018/19
		Redesign			
Primary	No	No	Development and	N/A	Review
Healthcare			ownership of a		recommendations
KPI			set of key		and prioritise the
framework			performance		selection of
			indicators by		measures for the
			which to assess		framework
			the quality of		
			primary healthcare in		Critically evaluate reported progress
			Hawke's Bay		and plans to mitigate
					adverse variances
				l	against the agreed KPIs
Information	TBC	 NI=	Drive and	NI/A	Descive reguler
	IBC	No	Primary	N/A	Receive regular
Systems			healthcare		updates on progress
			governance input to the		against the IS Strategy.
			development of		Strategy.
			the Information		Review
			Systems strategy		recommendations
			for Hawke's Bay		and prioritise the
					development of
					primary healthcare
			ł. I		priorities within the
					Strategy
					Strategy

HAWKE'S BAY District Health Board Whakawāteatia	PLANNING & FUNDING MONTHLY REPORT For the attention of: HBDHB Board
Document Owner:	Chris Ash, Executive Director of Planning & Funding
Document Author:	Chris Ash, Executive Director of Planning & Funding
Month:	October 2019
Consideration:	For Noting

RECOMMENDATION

That the HBDHB Board

. Note the contents of the report

[1] Executive Summary

This is the first report from the Executive Director of Planning & Funding (formerly Executive Director of Primary Care) to the Board. The report will focus on the service commissioning activities of the directorate.

The project and portfolio management functions of the directorate will be reported through alternate means, as detailed below.

As a first report, this document sets a significant amount of context. While adhering to the structure of this document, future reports (based around exception reporting) will be in shorter form.

In October, the following headlines should be noted:

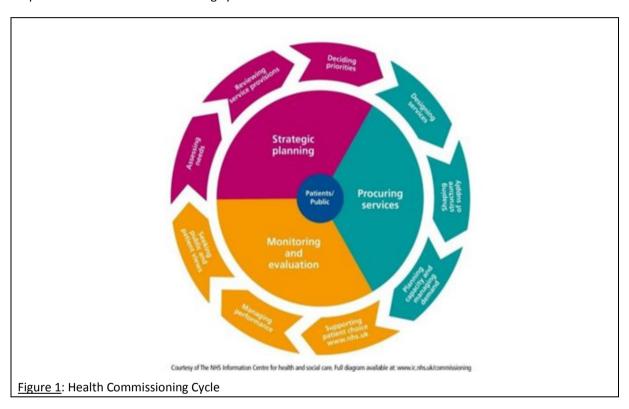
- Planning & Funding is moving to a whole system model in Hawke's Bay. The full scope of the new commissioning portfolios (Annexe 1) will be developed and reported as these arrangements come into place over the coming months.
- Primary care service changes in Wairoa have established a strong platform to progress the
 development of integrated healthcare. The Wairoa Community Partnership Group ('CPG') will
 play a key governance role in shaping the future model.
- Negotiations are ongoing with a provider in Napier to help address under-supply in the enrolment-based primary healthcare market. This development may enable a series of related service changes and improvements.
- The approach to community laboratories procurement is currently being finalised with the Interim CEO.
- The commissioning team has brokered an agreement between DHB Provider Services and NGOs
 to secure a financially sustainable future for Alcohol and Other Drug ('AoD') services at
 Springhill.
- Planning & Funding is forecasting a full-year \$2.9m adverse position to budget. This is underwritten by two clear issues in Aged Residential Care volumes and Pharmaceuticals.

[2] Developments & Innovation

To help implement our Strategy, the DHB will move to a singular planning & funding model

The Interim CEO is reorienting the Planning & Funding (Commissioning) model to align with the remainder of New Zealand. This will extend the Primary Care directorate remit to all services purchased or provided by the DHB. The directorate will be re-named Planning & Funding. All new commissioning portfolio groupings will include both primary and secondary care - important to supporting the future health system ambitions set out in Whānau Ora, Hāpori Ora.

Commissioning is defined as 'the process of assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes'. High quality outcomes will be equitable, safe, person and whanau centred, timely, clinically effective, and efficient. Figure 1 (below) provides a graphical representation of the commissioning cycle.



While work takes place to build the systems, knowledge and processes required to fulfil the wider scope, a joint Commissioning Leadership Group ('CLG') between Planning & Funding, Health Improvement & Equity and Financial Services is providing management-level governance of the change.

More detailed updates on progress will be provided in coming months.

We have re-evaluated how we put corporate resource and focus on the biggest priorities

The Executive Leadership Team has recently re-assessed activity in the 2019/20 plan to ensure adequate corporate resourcing of major priorities, in line with learning from the FRAC review of the Transform & Sustain programme and the 'Planning Alignment' internal audit recommendations.

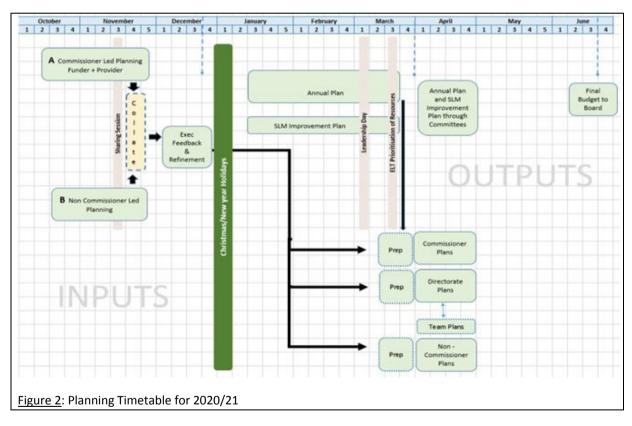
This has resulted in the rationalisation of formal projects and the identification of a number of interdependent priorities for service improvement and/or redesign that will receive a high level of structured support. These are:

- Bed Availability The first year focus in a multi-year piece of work focused on easing pressure and getting the right care, in the right place, at the right time.
- Mental Health & Addictions A project to co-design and re-procure community-based services.
- <u>Cardiology</u> A project to ensure high quality secondary cardiology services (including interventional cardiology) that deliver equitable outcomes for the population of Hawke's Bay.
- <u>Wairoa Integrated Health System</u> A project aiming to ensure a safe, responsive and sustainable
 health system across both primary and secondary care, aligned to what Wairoa whānau have told us is
 important to them
- <u>Integrated Laboratory Solution</u> A project to secure the projected benefits of an integrated laboratory solution for Hawke's Bay.

Corporate resources are now being identified and allocated to ensure they are sufficient to deliver the stated objectives of each work area. The Corporate Portfolio Management Office (CPMO) will keep FRAC appraised of progress on these projects, and other 'registered' activity (including agreed capital projects), via separate regular reporting. The first new-style report will come to FRAC in December 2019.

We are making progress towards joined up planning, and the process to identify 2020/21 priorities has begun

Activities to develop the health system plan for 2020/21 commenced in October and are set out in Figure 2 (below). The new planning and funding arrangements described above will enable far stronger joint planning.



With the *Whānau Ora, Hāpori Ora* strategy signed off in August 2019, the process to plan for 2020/21 will occur at the same time as partnership with Iwi and communities to co-design the multi-year Implementation Plan. The two streams of organisational planning will come together at a Heath Sector Leadership Forum Planning Workshop on the 4th March (date subject to confirmation). By this time we expect to have a first outline of the multi-year strategic roadmap, a full list of priorities (mirrored by MOH Annual Plan actions) for 2020/21, an initial cut of resource and capacity allocation.

The DHB is engaged with a number of external providers to support them in managing challenging workforce positions

In recent weeks, a small number of providers have separately approached the DHB to signal labour market issues, directly or indirectly linked to the salaries they are able to pay in the market. Commissioners have engaged directly with each of these providers to understand and verify the issues, enabling a clear dialogue around options available to resolve or mitigate.

In respect of Age Related Residential Care, should any such issues raised have a potential impact on quality of care the DHB operates to a clear process under the ownership of the Chief Nursing & Midwifery Officer to determine actions.

Recent developments have strengthened the foundation for integrated care in Wairoa

Work is continuing apace to move towards a single, integrated operating model for primary healthcare in Wairoa. Following the acquisition of Wairoa Medical Centre by Queen Street Practice earlier this year, all general practice services will move to operate from a single location (on the Wairoa Hospital site) by Christmas 2019.

The DHB Provider Arm has also decided to exit its role as a general practice provider at Healthcare Centre and will formally close its doors on 1st December 2019. The closure will not impact continuity of care, as Health Hawke's Bay will support the enrolment of registered patients to transfer to the local primary care provider (Queen Street Practice).

This decision was based on how to secure clinically, culturally, and financially sustainable outcomes for the population. It enables the DHB to focus, in partnership with all local providers, on developing a single integrated health and wellbeing model between primary and secondary care. A number of community hui have already taken place, supported by both Planning & Funding and Health Improvement & Equity. Commissioning teams will continue to work with Community Partnership Group (CPG) members to develop an even better understanding of whānau voice and aspirations.

To enable action on the back of what we hear from local people, work is ongoing to review the current operating model for all services at Wairoa Hospital in the context of care quality and patient experiences of care.

The DHB is now firmly focused on access issues in Central Hawke's Bay (CHB) and Napier

Both areas lack choice for whānau in access to primary care enrolment, and potential under-serving of enrolled populations (in terms of timely care) is an issue that we are looking more closely at with Health Hawke's Bay.

In CHB, issues include limited practice capacity (including some of the highest patient to GP ratios in the district), minimal clinical support to services in rural areas such as Takapau, and DHB services (such as those delivered from Cook Street Medical Centre in Waipukurau) that are not yet enabled to make a full contribution to driving highly integrated primary healthcare. As part of the DHB response, Emma Foster (Deputy Director of Planning & Funding) is working directly with local community stakeholders on development of an overarching plan.

In Napier, the DHB is working alongside Health Hawke's Bay to actively support development of a proposal to create an additional enrolling primary care provider, located in the Napier Health Centre at Wellesley Road. This would provide much needed additional capacity and choice for whānau. At present, negotiations are ongoing around DHB incentivisation to encourage the new provider to shape its offer around identified priority population needs.

Co-location of an enrolling practice with our existing Urgent Care offer in Napier (City Medical) opens the potential for significant clinical innovation and integration, and for the development of Wellesley Road as a high function clinical hub over an extended day.

Commissioning Portfolios - Exception Reports

Primary Care (Health Hawke's Bay Back to Back Agreement)

Health Hawke's Bay is actively considering its future organisational purpose and operating model as
part of its Ka Hikitia review. Access, and particularly equitable access, to primary care continues to be
a major risk factor in Hawke's Bay. The DHB is working with the PHO to more closely manage their
performance against contract, influence development of strategic direction, and secure greater
assurance that their stated objectives of delivering clinical model change and equity for the population
can be delivered as a result of the Ka Hikitia process.

Child, Youth & Dental

Rangatahi Redesign (Te Pītau) - Marie Beattie (Planning & Commissioning Manager) continues to
actively support the Te Pītau Service Level Alliance (SLA) rangatahi services redesign. The financial
envelope for redesign will be appraised in line with both final SLA proposals and a review of the
effectiveness of the existing investment.

Pharmacy, Radiology & Laboratories (Referred Services)

- Community Laboratories Negotiations are due to commence ahead of contract end in June 2020.
- <u>Community Pharmacy</u> Di Vicary (Planning & Commissioning Manager) has worked with stakeholders
 to develop a Contract Policy & Quality Framework, which was signed off by CLG in September.
 Implementation during October will lift the moratorium the DHB has had in place on new community
 pharmacy contracts. We are currently looking at how this model may be applied to other sectors.

Frail & Older People

- End of Life SLA (Te Pītau) The SLA is in place and has met a number of times. It includes representation from across the community and from the established Palliative Care Governance Group. Current focus is on understanding how existing services are serving the whole target population. To ensure positive stakeholder management and a robust design proposal, a recommendation has been made to extend the delivery date for the redesign process. The existing Palliative Care Strategy is also being used as a foundation document for the work of the group.
- <u>Home Based Support (Household Management)</u> The criteria for standalone household management support (levels 2a and 2b) have been tightened following consultation, allowing available care hours to be focused on highest risk clients. The new criteria are now subject to a communication process to ensure eligible clients receive the right level of care.

Mental Health & Addictions

- Mental Health Community Redesign SLA (Te Pītau) Investment logic planning workshops conclude at
 the end of October, allowing clear articulation of the benefits required from the new community
 mental health model. The process to confirm SLA membership will be undertaken in November, with
 Devanti consulting engaged to support a wide reaching process of co-design for the procurement.
- <u>Springhill</u> Shirley Lammas (Planning & Commissioning Manager) has secured agreement between
 DHB Provider Services and NGO partners to implement the Central Region AoD model of care. The
 model includes respite, step-up and step-down services. The partners have restructured funding and
 delivery responsibilities to ensure the sustainability of the Springhill Treatment Facility. Work is
 ongoing with Central Region to build on the base that has been created through this collaboration.
- <u>Primary Mental Health RFP</u> The DHB submitted a tender on 24th October. While the DHB will be the lead contract holder, the model is a collaboration that we have brokered between Health Hawke's Bay, GP Practices, Mental Health & Addiction NGOs, and DHB Mental Health services. If successful, the tender will deliver a significant expansion of primary mental health services available to people with

low to moderate needs. While services will be based out of general practices, partners are committed to a highly integrated model of care that proactively reaches those in highest need of this support.

Planned Care & Long-Term Conditions

<u>Clinical Pathways</u> – Work has commenced in partnership with Health Hawke's Bay and Information
Services to create a business case to reintroduce a clinical pathways tool. Following the withdrawal of
Map of Medicine, Hawke's Bay is now the only DHB in New Zealand without a pathways tool.
However, work will ensure the required value is understood before a decision is made and that the
process is supported by clinically led implementation.

Urgent and Acute Care

No exceptions to report in October.

Financial Performance

The directorate finished Month 3 \$723k adverse, and \$954k adverse Year to Date. While the in-month position was a significant deterioration to M2 reporting, analysis to inform forecasting demonstrates that the underlying run rate is in line with the Year to Date (Q1) position.

The two most significant drivers of the overspend are:

- Age Related Residential Care Current utilisation is running 34 bed days above budget. It is important
 the trend is understood in the wider context of Health of Older Persons activity. A 'tiger team', led by
 Janine Jensen (Planning & Commissioning Manager) and including Finance and Provider Services
 representation, is being put in place to provide direct assurance to respective Executive Directors.
- <u>Pharmacy</u> While drug spend is increasing across the board, the most notable costs relate to Primary Cancer Treatments. Di Vicary, Planning & Commissioning Manager, has undertaken detailed analysis of the position, including benchmarking of Hawke's Bay against comparable DHBs.

Risk Management

This report details the actions in train to mitigate commissioning-related risk. The risks identified by the Planning & Funding directorate with a previous month score >12 or an overall rating of 'Extreme' are as follows:

	Previous Score	Current Score	Change	Reporting
External provider viability linked to nationally agreed terms & conditions	16	16	⇒	
Prioritisation and management of change	16	12	\Rightarrow	Remove from report
Planning	16	9		Remove from report
Urgent and after hours primary care model	15	15	⇒	
Age Related Residential Care (ARRC) bed capacity	15	15	ѝ	
Implementation of national priorities	16	16	⇒	
Primary care demand and capacity	20	20	⇒	

<u>Annexe 1</u>: Commissioning Team Portfolios

Portfolio	Planning & Commissioning Manager	Principal DHB Provider Directorate
Deputy Director of Planning & Funding (Head of Commissioning)	Emma Foster	Holds Health Hawke's Bay contract
Mental Health & Addictions	Shirley Lammas	Mental Health & Addictions
Health of Older People	Janine Jensen	Health of Older People
Pharmacy, Radiology & Laboratories	Di Vicary	Operations
Child, Youth & Oral Health	Marie Beattie	Community, Women & Children
Planned Care & Long Term Conditions	Penny Rongotoa	Surgical
Acute & Urgent Care	Jill Garrett	Medical

	Board Member Induction 2019 – Discussion Document
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: HBDHB Board
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Chief Executive
Month:	October 2019
Consideration:	For Discussion/Decision

RECOMMENDATION

That the Board:

- Provide feedback/direction on the proposals and options presented for local induction of new Board members; and/or
- Agree a process for finalising issues currently unable to be decided

PURPOSE

The purpose of this discussion document is to:

- Outline proposed DHB Board induction resources and activities to be delivered by the Ministry of Health:
- Present proposals and options for a local induction process for new HBDHB Board Members, coming into office on 9 December 2019; and
- Receive feedback/direction from current (and newly elected) HBDHB Board Members.

The overall objective is to ensure the process will be of real value and achieve it's intended purpose.

PROPOSED MoH INDUCTION RESOURCES AND ACTIVITIES

Attached as **Appendix 1** is an early presentation from the Ministry of Health setting out proposed:

- Board Induction Context
- Objectives for 2019 Board Induction
- Proposed Resources and Activity
- Proposed Targetting of Resources and Activity

Also attached (as **Appendix 2**) is a Draft Table of Contents for a 'Welcome on Board' summary document to be prepared by the Ministry.

Following some negative feedback from the induction process conducted in 2016, the MoH have this time engaged with DHB Chairs on the development of this material.

National induction for DHB Chairs will take place on 11/12 December 2019.

A regional induction day for new and returning Board members in the Central Region will be held on Thursday 5 March from 10.00am to 3.30pm in Wellington. This meeting will be jointly run to support Board members understanding their role and the expectations the Crown and Chairs will have of them, and to support regional collaboration. The first half of the day is for the Crown, and Central Region matters the second half. It is expected that the Minister of Health will be present in the morning.

No details have been given on timings for the release of the above proposed resources, but the expectation is that they wil be available early November.

LOCAL INDUCTION

A number of schedules have been drafted for discussion, to guide the development and delivery of a local induction process for new (and potentially returning) Board members. These include:

Board Induction Process (Appendix 3)

Sets out a potential programme for a range of activities:

- Powhiri
- Welcome & Introductions
- Presentations
- Administration
- Site Tours

Feedback is requested on these potential activities; are they all required? are there any key issues missing? the timings for each of them and the potential length of time to be allocated to each one? It is not suggested that all these take place on the same day.

Board Induction Pack (Appendix 4)

Suggested schedule of documentation to be made available.

Feedback requested here on the proposed contents and also on how this should be made available; electronic (Diligent Resources) and/or hard copy?

Board Induction Administration (Appendix 5)

Sets out the various administrative matters to be completed for new Board members. Key issues here are the set up and training required to get Board members using Diligent, as the clear intent is to completely cease printing hard copies of Board papers.

Although more than an administrative process, also included in here are the proposed new Board member one to one sessions with the Chair. It may be appropriate for returning members to also have these sessions, particularly if a new Chair is appointed.

Feedback on the issues included (or not included) and potential timings/format for the various activities would be appreciated.

Board Induction Site Visits (Appendix 6)

A schedule of potential sites to be visited, noting the potential time required to visit Wairoa and Central Hawkes Bay in particular.

Feedback here would be appreciated on the requirement/desire to visit these sites (and others not included) and some indication on prioritisation and timings.

Governance Manual Table of Contents (Appendix 7)

This is provided more for information and completeness. This full Manual is currently being updated and made available as part of the Induction Pack referenced above.

It is noted that there may be some duplication between this and the proposed MoH 'Welcome on Board' document. As the Governance Manual is written in a Hawkes Bay context and the MoH document is not yet available however, no attempt will be made at this stage to remove these potential duplications.

TIMINGS

Apart from feedback on the content and format of the various components identified above, the key issue to be discussed and agreed is around timings:

'When should each of the induction components take place?'

Unfortunately a number of factors relating to timing are not yet known, not least of which is when the Minister will announce the four Board members to be appointed to HBDHB, as well as the Chair and Deputy Chair.

We know the new board takes office on 9 December 2019 and the first scheduled Board meeting is 18 December 2019, so the expectation is that these appointments will be announced late November/early December at the latest. We also know that to cover all the issues/activities described above would take several days to do well, so they could be spread over a period of time, extending well into the new year. We need to remember also, that we do not usually schedule activities in January due to the 'holiday' period, and the planned regional Board member induction activity is not likely to be held until February/March 2020.

One option could be:

Early November 2019 - MoH 'Welcome On Board' information pack available

Monday 9 December 2019 – Powhiri and Board Induction Presentations & Administration (Board Induction Pack distributed on this day as well)

Tuesday 10 December to Tuesday 17 December 2019 - I:I sessions with the Chair

Wednesday 18 December 2019 – Board meeting

Thursday 5 March 2020, 10.00am – 3.30pm – Central Region Induction Day

February to June 2020 - Scheduled site visits.

Comments and suggestions on this and other options would be appreciated.

UNKNOWNS/UNCERTAINTIES

Given the number of 'unknowns' and/or 'uncertainties' at this stage, should a firm decision on any issue not be appropriate at this time, it would be useful to agree a process for providing certainty so that relevant planning and preparation can be completed.



Board Induction:Providing the context and setting expectations

Context

- The Minister is responsible for ensuring new board members understand their role and any expectations the Crown might have of them.
- The Chair is responsible to brief new board members on the particular environment within which the board operates.
- Being a DHB Board member is complex and multi layered and induction needs to take multiple forms and layers and be relevant to the skills and knowledge of the incoming member
- The Ministry is supporting the Minister and DHB Chairs with this responsibility

Objectives for 2019 DHB Board Induction



Crown / Central	REGIONAL	LOCAL
BOARD CHAIRS		
To provide new Chairs with information and advice to support their understanding of: their role & additional responsibilities as a Chair the legislative and accountability parameters they must work within the roles of the Minister(s), select committees, Ministry and other important players Treaty of Waitangi obligations being part of politically neutral state sector, and what that means for them applying a no surprises principle & approach and a mechanism to build relationship(s) with the Minister key crown and central stakeholders	To provide new Chairs with information, advice to support their understanding of: the region their DHB is part of the role of Regions and regional service plans the collaborative nature of regions the additional responsibilities as a Regional Chair and a mechanism to build a relationship with members from the other Regional Boards members from other Regional Executives key regional stakeholders local lwi	To provide new Chairs with information, advice to support their understanding of: - the environment the DHB is operating within - the composition of the board and its committees and advisory bodies - core operating Documents (e.g. SOI, Annual Plan etc) and a mechanism to build a relationship with - the Chief Executive - the DHB Executive and management - local lwi
BOARD MEMBERS		
To provide new Board members with information and advice to support their understanding of: their roles and responsibilities the legislative and accountability parameters they must work within the roles of the Minister(s), select committees, Ministry and other important players Treaty of Waitangi obligations being are part of politically neutral state sector, and what that means for them applying a no surprises principle & approach	To provide new Board members with information and advice to support their understanding of: the region their DHB is part of the role of Regions and regional service plans the collaborative nature of regions local Iwi members from the other Regional Boards members from other Regional Executives	To provide new Board members with information and advice to support their understanding of: the environment the DHB is operating within the composition of the board and its committees and advisory bodies core operating Documents (e.g. SOI, Annual Plan etc) and a mechanism to build a relationship with the DHB Executive and management local lwi



Proposed Resources and Activity

	Resources	Meetings / Activity
Centrally Developed	 Welcome on Board – 2019 A summary document that provides context, background, legislative framework etc Being a DHB Chair – 2019 Summary of specific responsibilities, "useful things to know", insights etc Board Member Needs Assessment Pack Information and tools to support Boards members training and development needs Board Continuous Improvement Pack Information and tools to support Boards self-evaluation and quality improvement 	 One on one with Minister (Chairs only) To individually meet and discuss specific expectations and priorities One on one with DG (Chairs only) To individually meet and discuss roles and responsibilities All Chairs Induction day (Chairs only) To collectively meet and discuss with the Minister the role of Chairs, Govt expectations and priorities Welcome to Health - 2019 (Chairs only) To provide new Chairs who are new to the sector with relevant targeted information and support Regional Induction Day A jointly run day to support Board members understanding their role and the expectations the Crown and Chairs will have of them, and to support regional collaboration.
Locally Developed	 Regional Introduction Pack <i>Documents and material associated to the region.</i> Local Introduction Pack <i>Documents and material associated to the governance, accountability and performance of the DBH, including Local Board Governance Manual – 2019</i> 	 Local Induction Programme To facilitate relevant local introductions and relationship building and to support understanding of the DHB. Needs assessment Discussion Initial Board member needs assessment and development options



Proposed Targeting of Resources and Activity

Who	Resources	Meetings / Activity
New Chair and new to Board / Sector	Welcome on Board – 2019 Being a DHB Chair - 2019 Board Member Needs Assessment Pack Board Continuous Improvement Pack Regional Introduction Pack Local Introduction Pack	One on one with Minister One on one with DG All Chairs Induction day Welcome to Health - 2019 Regional Induction Day Local Induction Programme
New Chair but returning Board member	Being a DHB Chair Board Member Needs Assessment Kit Board Continuous Improvement Pack Local Board Governance Manual – 2019	One on one with Minister One on one with DG All Chairs Induction day Regional Induction Day
Returning Board Chair	Being a DHB Chair Board Member Needs Assessment Kit Board Continuous Improvement Pack	One on one with Minister One on one with DG All Chairs Induction day Regional Induction Day
New Board members	Welcome on Board – 2019 Regional Introduction Pack Local Introduction Pack	One on one with Chair DHB CEO and Executive Local Induction Activity Regional Induction Day
Returning Board Member new Chair		One on one with Chair Regional Induction Day
Returning Board Members same Chair		Regional Induction Day

Draft Tables of Content

Welcome on Board - 2019 (Developed by the Ministry)

A summary document (web and print based) that provides context, background, legislative framework, and generally material to provide new Board member with information to support their understanding of their role, responsibilities and accountabilities.

- Background & context to NZ Health system
- Today's health system and how it compares
- The legislative framework
- The Ministry of Health Role etc.
- Treaty of Waitangi Obligations
- Health and Safety
- Briefings from health Crown entities
- Briefings from national health agencies
- How boards work
- Governance in the public sector
- Objectives, functions and powers of DHBs
- Board meetings
- Being a DHB Board member
 - What questions might I ask / What documents might I expect to see
- Board committees
- The accountability cycle
- Duties and expectations of members
- Role of the Chair, Deputy Chair and Crown monitors
- Conflicts of interest
- Ministerial portfolios
- Common abbreviations
- Bibliography
- Links to relevant material e.g. Summary of Information to new Members of Crown Entity Boards (SSC)

Being a DHB Chair - 2019

A summary document of the specific responsibilities of Chairs, information on "useful things to know", insights etc.

- Role of Chair and specific responsibilities
 - Board member training and development
 - Board Evaluation
- Statutory Crown Entities It Takes Three: Operating Expectations (SSC) and link to full doc
- Useful things to know
- Who's Who for Chairs

2019 HBDHB BOARD INDUCTION PROCESS

POWHIRI (Te Awa o Te Hauora Marae)

CHAIRS WELCOME / INTRODUCTIONS (HBDHB Board Room)

HEALTH & SAFETY / ADMIN BRIEF

OVERVIEW OF INDUCTION PROCESS

'WALK THROUGH' INDUCTION PACK (refer attached)

- Areas of Focus
 - Governance Structures / Manual
 - Strategic Planning
 - 19/20 and 20/21 Annual Planning
 - Clinical Risk
 - Finance

CEO PRESENTATION

- Overview
- Introduction Executive Directors, Clinical Leaders and other key staff
- Brief Descriptions of roles, priorities and governance related issues

STRATEGIC PRIORITIES UPDATES

- Equity
- Community Ownership / Consumer Engagement / Person & Whanau Centred Care
- Clinical Quality & Patient Safety
- People Plan / Workforce
- Operational / Financial Performance
- Digital Enablement

HHB LTD CHAIR / CEO PRESENTATION

ADMINISTRATION (refer attached)

SITE TOURS (refer attached)

2019 HBDHB BOARD INDUCTION PACK

OVERVIEW

- Vision, Mission, Values
- Our Shared Values & Behaviours
- History of HBDHB
- 2018/19 Annual Report
- Websites / Facebook
- Acronyms

HBDHB GOVERNANCE

- Governance Structures
- Key Relationships/Alliances
- Governance Manual (refer separate folder)
- Finance Risk & Audit Committee ToR
- Maori Relationship Board ToR / MoU with NKII
- Pacifika Health Leadership Group ToR & Annual Plan
- Clinical Council ToR, Annual Plan & Clinical Governance Structure
- Consumer Council ToR and Annual Plan
- Te Pitau Health Alliance Agreement
- Meeting Schedule

PLANNING

- Whanau Ora Hapori Ora (5 Year Strategic Plan)
- Clinical Services Plan
- Equity Report
- People Plan
- 2019/20 Annual Plan / Operating Plan
- 2020/21 Annual Planning Process

STAFF

- Staff Structure
- Key Roles & Responsibilities
 - Management
 - Clinical Leadership

HEALTH HAWKES BAY LTD

- Strategic Priorities
- Governance / Staff Structures

RISK MANAGEMENT

- Strategic Risks
- Clinical Risks
- Operational Risks
- Health & Safety (Board Health & Safety Champion)

FINANCE

- Capital Plan
- Operating Budget / Performance

2019 HBDHB BOARD INDUCTION

ADMINISTRATION

PERSONAL

- Payroll Documentation
- Contact Details
- Interests / Conflicts

ID CARDS / ACCESS

- Photos
- Issue of Cards

GENERAL INFORMATION / BRIEFINGS

- Site maps / Layouts
- Amenities & Parking
- Evacuation Procedures
- Health & Safety (individual responsibilities)

BOARD PAPERS / RESOURCES

- Provision / Use / Security of Devices HBDHB Policy
- Issue & Set Up of IPad (if required)
- Load Diligent App on Own Device (if preferred)
- Diligent Training
 - Access to Board papers
 - Access to Resources
 - Help

INTERVIEW WITH BOARD CHAIR

- 1:1
- Expectations
- Committee / Role Preferences
- Development / Training Requirements

06 Administration

2019 HBDHB BOARD INDUCTION SITE VISITS

- Hawkes Bay Fallen Soldiers Memorial Hospital
- HBDHB / HHB Corporate Office
- Napier Health Centre
 - City Medical
- Wairoa Hospital & Health Centre
- Central Hawkes Bay Health Centre
- Community
 - Hastings Health Centre
 - Te Taiwhenua o Heretaunga



GOVERNANCE MANUAL

for

Hawke's Bay District Health Board

November 2016

Introduction

All statutory Crown entities, including District Health Boards (DHBs) are expected to have a board governance manual that reflects good practice standards and the range of legislation that applies to them.

This manual has been compiled to provide HBDHB Board members with guidance and information they may require to assist them meet their governance responsibilities. DHB governance not only includes the generic processes by which organisations are directed, controlled and held to account, but has added obligations and complexities derived from the ethos of public service, health legislation and the impact DHBs have on individuals, businesses and communities in New Zealand.

This is the fourth edition of HBDHB Governance Manual and replaces the third edition published in 2013. This edition is significantly based on a document "Resource for Preparation of District Health Board Governance Manuals" prepared by the State Services Commission in 2010 in conjunction with the Ministry of Health. All documents in the schedules have been brought forward from the third edition and updated where appropriate.

Whilst this document contains links to relevant websites and other documents, HBDHB does not necessarily endorse any of the material in these links, not does it guarantee that such links and documents will remain current.

Further updates and/or new editions of this manual will be produced as necessary.

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	Allied Laundry Services Ltd Annual General Meeting
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: HBDHB Board
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Chief Executive
Month:	October 2019
Consideration:	For Decision

RECOMMENDATION

That the Board

- 1. **Note** the Annual Report and Financial Statements for Allied Laundry Services Ltd (which have been reviewed but not yet signed off by the auditors) for the year ended 30 June 2019.
- 2. **Appoint** Ken Foote as the HBDHB Shareholder representative to attend the Allied Laundry Services Ltd Annual General Meeting to be held on Tuesday 26 November 2019, with Carriann Hall appointed as his Alternate.

FINANCIAL STATEMENTS & ANNUAL REPORT

Attached are copies of:

- Notification of the Annual General Meeing
- Minutes of last years Annual General Meeting
- Chair and Chief Executives Report
- Financial Statements

The Allied Laundry Board has declared the 'interest on capital dividend' of \$0.06 per share to shareholders for the 2018/19 financial year, as required by the Shareholders Agreement. Given this requirement, the dividend is treated as a monthly 'expense' within the management accounts of the company, therefore leaving a 'small' annual surplus of \$148,774 (1.36% of revenue).

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 Carriann Hall be appointed as his Alternate.



Annual General Meeting

Tuesday 26th November 2019

Cover Page (Shareholders)

Please find attached;

- Notification of Annual General Meeting; 26th November 2019 to be held at 10am at Allied Laundry.
- Minutes of the 27th November 2018 Allied Laundry Services Limited Annual General Meeting.
- Letter accounts.
- Draft Financial Accounts for year 2018/19 (Reviewed by Deloitte and Allied Laundry Board of Directors).
- Allied Laundry Services Limited Chairman's Report for the Year ended 30 June 2019.
- 6. Letter requesting appointment of Shareholder Representative.

Mark Mabbett

CEO

Allied Laundry Services Limited.



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 26th November 2019 at 10am.

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 27 November 2018.

Recommendation: That the minutes of the Annual Meeting held on 27 November 2018 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 2019 together with the auditor's report thereon.

Recommendation: That the annual report of the company for the year ended 30th June 2019 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 2019 is received.

That the letter of representation for the year ended 30th June 2019 be signed by 1 Director and the CEO.

Hospital Gate 12, Ruahine Street, Palmerston North, 4410 • Phone: 0800 LAUNDRY (528 637) • www.alliedlaundry.co.nz

5 Chairs Report.

To receive and accept the annual Chairs report.

That the Chairpersons report for the year ended 30th June 2019 is received.

6 Payment of Dividend.

To note; the intention of the board is that a dividend of \$0.06 per share from 1 July 2018 to 30 June 2019 is to be paid to the six shareholding District Health Boards.

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 16 October 2019 Ken Foote

Chair



ANNUAL GENERAL MEETING

Minutes

27 November 2018

Venue: Meeting Room, Allied Laundry, Palmerston North

Present:

Shareholder representatives: Ken Foote, Simon Barrett, Brian Walden, Judith Parkinson, Gina Lomax, Neil Wanden
Mark Mabbett, Kathy O'Neill, Denise Climo

1. Apologies

TeAroha Hohaia for Taranaki DHB

2. Share Holders Representatives

Letters of Appointment from the DHB shareholding for representatives have been received from Taranaki District Health Board for TeAroha Hohaia, Simon Barrett as alternate, Whanganui District Health Board for Brian Walden, Hawkes Bay District Health Board for Ken Foote, MidCentral District Health Board for Neil Wanden, Capital & Coast District Health Board for Gina Lomax and Hutt District Health Board for Judith Parkinson.

The Shareholder Representatives to the Allied Laundry Board are Simon Barrett, Brian Walden, Ken Foote, Gina Lomax and Judith Parkinson, Neil Wanden

3. Minutes

Minutes of the Annual General Meeting of 28th November 2017 have been received and approved.

Moved:

Gina Lomax

Second:

Judith Parkinson

Carried

Matters Arising From the Minutes:

Note; the recommendation to retain the surplus funds should have been undertaken prior to the 2017/18 financial year end but if all Board members approve will recommend the retention of the surplus funds at this AGM.

4. Financial Statements and Reports

CEO apologised – just noticed last 4 pages of financials were missing from packs – copies available at meeting. Directors had previously seen the financials.

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In the Letter of Representation, no mention had been made of the Lease commitment to Mid Central DHB – it is an ongoing Lease, renewal every 3 years. It should be included next year.

The Audit Report – Assessment of internal controls recommendation for Vice Chair to approve Chair expenses, not the CEO. As there is no Vice Chair recommend these expenses are approved by the Chair of the FRAC Committee.

A discussion was held around the declaration of Dividends and how they are treated in the accounts. The Shareholders Agreement is clear that the Shareholders will receive a return on the capital investment dividend, but the Constitution is not clear on who declares the dividend. It was agreed to move the Declaration of Dividends to be made by the Directors at a Board meeting prior to the end of that financial year. The retention of surplus funds should also be undertaken prior. Further discussions were held for the next item on the Agenda

Recommendation: That the Annual Report for the year ended 30th June 2018 is adopted

Moved:

Simon Barrett

Second:

Brian Walden

Carried

Recommendation: That the letter of Representation for the year ended 30 June 2018 be signed by 1 Director, namely the Chair, and the CEO of Allied Laundry

Moved:

Simon Barrett

Second:

Brian Walden

Carried

Recommendation: That the surplus for the year be retained and that future decisions on the retention of surpluses are made by the Board prior to the finalisation of the Annual Report

Moved:

Simon Barrett

Second:

Brian Walden

Carried

5. Chairs Report

This year it is a combined Chair and CEO report. Seemed appropriate as it is more about operations now.

Recommendation: The Chair and CEO report be adopted

Moved:

Ken Foote

Second:

Simon Barrett

Carried

Chair took the opportunity to thank the CEO personally and acknowledge his efforts over the year, getting us through a consolidation year and tidying up a few loose ends after the massive changes. Now we can settle down and get on with the new way of business.

6. Dividend

Rewind to previous discussions. It was added to the Board Agenda to declare the Dividend

Recommendation; That Shareholders recommend to the Board that a Dividend payment of 6 cents per Share for the 2017/18 financial year be declared

Moved:

Neil Wanden

Second:

Brian Walden

Carried

7. Appointment of Auditors

It is a requirement for Allied Laundry to be audited as it is 100% owned by DHB's.

Recommendation; That the Board reappoint Deloitte as Auditors for Allied Laundry

Moved:

Simon Barrett

Second:

Gina Lomax

Carried

8. General Business

No General Business

Meeting closed at 10.35am

Signed:

_____ Date: _____

Ken Foote (Chair)



Wednesday 16th October 2019

Chair of the Boards and CEO's Allied Laundry Shareholders.

MidCentral District Health Board Taranaki District Health Board Whanganui District Heath Board Hawkes Bay District Health Board Capital & Coast District Health Board Hutt Valley District Health Board.

Dear Sir or Madam,

Regarding Allied Laundry financial accounts for the 2018/19 financial year.

Please find attached the final accounts for Allied Laundry Services for the 2018/19 financial year. The Accounts have been reviewed by Deloitte. Final stamped and signed accounts will be made available once completed.

The accounts show a small profit for Allied Laundry for the 2018/19 financial year.

The Allied Laundry Board will declare a dividend of \$0.06 per share to the shareholders for the 2018/19 financial year.

The Allied Laundry Board of Directors have received and reviewed the accounts.

Due to the timing of the notifications for AGM being sent out and the need for a second Partner from Deloitte to review the Going Concern qualification these accounts are not final.

Yours sincerely Mark Mabbett

CEO

Allied Laundry Services Limited

Financial Statements For the Year ended 30 June 2019

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Directory

As at 30 June 2019

Nature of Business

During the year the company has continued to provide a laundry and linen services to Taranaki, Whanganui, Hawkes Bay, MidCentral, Hutt Valley, Capital & Coast and Wairarapa District Health Boards and

commercial customers.

Registered Office

Palmerston North Hospital, Ruahine Street

Palmerston North

Directors

Simon Barrett

Brian Walden (resigned 30 September 2019)

Ken Foote (Chair) Judith Parkinson Neil Wanden

Delwyn Hunter (resigned 20 August 2019)

Shareholders

MidCentral District Health Board

1,150,000 Ordinary Shares 1,150,000 Ordinary Shares

Whanganui District Health Board Taranaki District Health Board Hawkes Bay District Health Board Capital & Coast District Health Board Hutt Valley District Health Board

1,150,000 Ordinary Shares 1,150,000 Ordinary Shares 1,150,000 Ordinary Shares 1,150,000 Ordinary Shares

Accountants

Naylor Lawrence & Associates Limited

Chartered Accountants 196 Broadway Avenue Palmerston North

Bankers

BNZ Bank

Palmerston North

Solicitors

Buddle Findlay

Wellington

Company Number

877063

Annual Report

For the Year Ended 30 June 2019

For and on behalf of the Board

The board of directors submit their annual report including the financial statements for Allied Laundry Services Ltd for the year ended 30 June 2019, and the auditors report.

The shareholders of Allied Laundry Services Ltd have exercised their right under section 211(3) of the Companies Act 1993 and unanimously agreed that this annual report need not comply with any of paragraphs (a) and (e) - (j) of section 211(1).

Auditor

Neil Wanden

The Auditor-General is the auditor of Allied Laundry Services Ltd. The Auditor-General has appointed Melissa Youngson for Deloitte Limited to carry out the audit of the financial statements of the Company on his behalf.

Director

Date

Statement of Comprehensive Income

For the Year Ended 30 June 2019

	Note	2019	2018
		\$	\$
Operating Revenue			
Revenue - Capital & Coast DHB		3,200,786	3,066,385
Revenue - Wairarapa DHB		384,139	371,714
Revenue - External		615,505	632,744
Revenue - Rag Sales		17,192	5,140
Revenue - MidCentral DHB		2,078,281	2,109,836
Revenue - Taranaki DHB		1,127,886	1,088,289
Revenue - Whanganui DHB		697,464	664,270
Revenue - Hawkes Bay DHB		1,761,374	1,656,595
Revenue - Hutt Valley DHB		1,041,228	995,333
Total Sales		10,923,855	10,590,306
Gross Income		10,923,855	10,590,306
Less Expenses			
Operating Expenses			
Assembly Supplies		155,755	157,082
Chemicals & Detergents		246,206	239,837
Delivery - Transport		1,331,221	1,286,724
Freight		21,506	16,476
Steam & Electricity		402,174	399,959
Maintenance plant		409,979	400,957
Protective Clothing/Uniforms		12,593	8,922
Health & Safety		38,024	44,780
Travel Expenses		9,730	12,630
Wages/Labour costs		4,249,410	3,930,257
Water & Waste		71,457	69,812
	es.	6,948,055	6,567,436

Statement of Comprehensive Income (continued)

E	or	tho	Voor	Ended	30	luno	2010
г	· OI	uie	Tear	Ellago	Ju	June	2019

	Note	2019	2018
		\$	\$
Administration Expenses			
Audit fees		48,708	41,802
Bad Debts Written Off		1	3
Bank Charges		2,474	3,621
Cleaning		63,570	64,101
Communication expenses		11,334	12,467
Directors fees		105,000	101,250
Fringe Benefit Tax		6,002	7,976
General expenses		47,660	47,626
Motor Vehicle expenses		4,505	4,653
Office Supplies		94,848	82,368
Professional Fees		68,603	66,025
Superannuation Contributions		91,848	90,941
	-	544,553	522,833
Interest Rent and Lease			
Interest Paid - Loans		27,986	42,683
Rent		325,831	324,317
		353,817	367,000
Rates and Insurance			
ACC Levies		11,407	74,648
Insurance		58,048	47,770
	_	69,455	122,418
Non Cash Expenses			
Depreciation		2,441,853	2,467,722
Total Expenses		10,357,733	10,047,409
Operating Surplus before Other Income	-	566,122	542,897
Other Income			
Interest Received		239	82
Profit/(Loss) on Sale of Fixed Assets		(8,093)	(4)
Total Other Income	- T	(7,854)	78
Net Surplus	-	558,268	542,975

Statement of Movements in Equity

For the Year Ended 30 June 2019

	Paid Capital	Retained Earnings	Total
Opening balances at 1 Jul 2018	6,600,000	236,012	6,836,012
Total comprehensive income for the year, net of tax			
Profit for the period		558,268	558,268
Total comprehensive income for the year, net of tax		558,268	558,268
Transactions with owners, recorded directly in equity			
Share Capital	300,000		300,000
Dividend Payable		(409,494)	(409,494)
Balance at the End of Year	6,900,000	384,786	7,284,786
Opening balances at 1 Jul 2017	6,300,000	84,537	6,384,537
Total comprehensive income for the year, net of tax			
Profit for the period		542,975	542,975
Total comprehensive income for the year, net of tax	**************************************	542,975	542,975
Transactions with owners, recorded directly in equity			
Share Capital	300,000		300,000
Dividend Payable		(391,500)	(391,500)
Balance at the End of Year	6,600,000	236,012	6,836,012

Statement of Financial Position

As at 30 June 2019			
	Note	2019	2018
		\$	\$
Equity			
Paid up Share Capital	2	6,900,000	6,600,000
Retained Earnings	3	384,786	236,012
Total Equity	-	7,284,786	6,836,012
Represented by:			
Current Assets			
BNZ Bank		257,331	46,188
Accounts Receivable	4	1,030,442	1,029,820
Inventories	<u></u>	63,086	51,039
Total Current Assets	(0)	1,350,859	1,127,047
Non Current Assets			
Property, Plant & Equipment	5	7,772,021	8,091,342
Goodwill	6	795,427	795,427
Total Non Current Assets		8,567,448	8,886,769
Total Assets	_	9,918,307	10,013,816
Current Liabilities			
Trade Creditors		571,297	505,630
Accruals - General		257,421	295,251
Accruals - Dividends & Rebates		801,000	1,198,759
Holiday Pay Liability		494,703	472,785
Current Portion of Term Loans	8	286,990	243,890
GST Payable Provision for Gratuity	7	52,129	30,244
Total Current Liabilities	_	2,463,540	13,123 2,759,682
Non Current Liabilities		2,403,340	2,739,002
Term Loans	8	169,981	418,122
Total Non Current Liabilities	-	169,981	418,122
Total Liabilities	-	2,633,521	3,177,804
Net Assets		7,284,786	6,836,012
not noote	-	7,204,700	0,000,012

Statement of Financial Position (continued)

s at 30 June 2019			
Simon Barrett	Director	Date	
Ken Foote (Chair)	Director	Date	
Judith Parkinson	Director	Date	
Neil Wanden	Director	Date	

Statement of Cash Flows

For the Year Ended 30 June 2019			
	Note	2019	2018
		\$	\$
Cash Flows from Operating Activities			
Cash was provided from:			
Receipts from Customers		10,923,234	10,688,241
Interest Received Goods and Services Tax Received		239 21,885	82
Sadd and Solffed Tax Notified	-	10,945,358	10,688,323
Cash was disbursed to:			
Payments to Suppliers and Employees		7,858,561	7,863,045
Goods and Services Tax Paid			18,812
Interest Paid	<u>===</u>	27,986 7,886,547	42,683
Net Cash Flows from Operating Activities	-		7,924,540 2,763,783
Net Cash Flows from Operating Activities		3,058,811	2,103,103
Cash Flows from Investing Activities			
Cash was provided from:			
Asset Sales	_	(8,093)	
		(8,093)	-
Cash was disbursed to:			
Purchase of Fixed Assets	_	2,122,534	2,032,013
	_	2,122,534	2,032,013
Net Cash Flows from Investing Activities		(2,130,627)	(2,032,013)
Cash Flows from Financing Activities			
Cash was provided from:			
Issue of Share Capital	_	300,000	300,000
	-	300,000	300,000
Cash was disbursed to:			
Repayment of Term Loans		205,041	751,037
Dividends Paid	-	812,000	240,000
Not Cook Flows from Financing Activities	_	1,017,041	991,037
Net Cash Flows from Financing Activities		(717,041)	(691,037)
Net Increase in Cash Held		211,143	40,733
Cash at the Beginning of the Year	_	46,188	5,455
Cash at the End of the Year	_	257,331	46,188

Notes to and forming part of the Financial Statements

For the Year Ended 30 June 2019

1 Statement of Accounting Policies

Reporting Entity

The financial statements and notes are for Allied Laundry Services Limited (the Company). It is a profit oriented entity incorporated and domiciled in New Zealand and is a company registered under the Companies Act 1993.

The address of its registered office is 196 Broadway Avenue, Palmerston North, New Zealand. Its principal place of business is 12/50 Ruahine Street, Roslyn, Palmerston North, New Zealand.

The principal activities of the Company during the financial period were the provision of laundry and linen services to Taranaki, Whanganui, Hawkes Bay, MidCentral, Hutt Valley, Capital & Coast and Wairarapa District Health Boards and commercial customers.

Statement of Compliance and Basis of Preparation

The Company has adopted the New Zealand equivalents to International Financial Reporting Standards - Reduced Disclosure Regime ("NZ IFRS - RDR") as set out in the External Reporting Board's "Accounting Standards Framework".

The financial statements are general purpose financial statements that have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand ("NZ GAAP). They comply with New Zealand equivalents to NZ IFRS - RDR. The Company has elected to report under NZ IFRS - RDR as the Company is a for-profit Tier 2 entity for financial reporting purposes on the basis that it does not have public accountability and is not a large for-profit public sector entity. The financial statements have been prepared in accordance with the requirements of the Companies Act 1993. All reporting concessions have been taken.

The financial statements were approved and authorised for issue by the Board of Directors

The accounting principles recognised as appropriate for the measurement and reporting of the Statement of Comprehensive Income and Statement of Financial Position on the accounting principles recognised as appropriate for the measurement and reporting of the Statement of Comprehensive Income and Statement of Financial Position on a historical cost basis are followed by the company, unless otherwise stated in the Specific Accounting Policies. The information is presented in New Zealand dollars. All values are rounded to the nearest \$.

Adoption of new and revised standards

NZ IFRS 9 Financial Instruments

In the current financial year, the company has applied NZ IFRS 9 Financial Instruments that was effective for an annual period that begins on or after 1 January 2018. NZ IFRS 9 replaces the provisions of NZ IAS 39 that relates to the recognition, classification and meaurement of financial assets and financial liabilities, derecognition of financial instruments, impairment of financial assets and hedge accounting.

NZ IFRS 15 Revenue from Contracts with Customers

In the current financial year, the company has applied NZ IFRS 15 Revenue from Contracts with Customers which is effective for an annual period that begins on or after 1 January 2018. NZ IFRS 15 introduced a 5-step approach to revenue recognition. The application of NZ IFRS 15 has not had a significant impact on the financial position and/or financial performance of the company. Policy wording has been updated to reflect terminology of NZ IFRS 15.

Specific Accounting Policies

The following specific accounting policies which materially affect the measurement of the Statement of Comprehensive Income and Statement of Financial Position have been applied:

(a) Revenue

The company provides laundry and linen services to DHB's and commercial customers and then dispatches it to these customers. Revenue is recognised when control of the products has transferred, being when the products are dispatched and delivered to the customer. Delivery occurs when the products have been shipped to the specific location and either the customer has accepted the products in accordance with the sales contract or the company has objective evidence that all criteria for acceptance have been satisfied.

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

Revenue is measured based on the consideration to which the company expects to be entitled in a contract with a customer and excludes payment collected on behalf of third parties. No element of financing is deemed present as the sales are made with a credit term of 30 days, which is consistent with market practice. A receivable is recognised when the goods are delivered as this is the point in time that the consideration is unconditional because only the passage of time is required before the payment is due. There were no critical judgements made relating to revenue recognition.

(b) Expenses

Operating expenses are recognised in profit or loss upon utilisation of the service or at the date of their origin.

(c) Inventory

Inventories are stated at the lower of cost and net realisable value. Cost includes all expenses directly attributable to the manufacturing process as well as suitable portions of related production overheads, based on normal operating capacity. Costs of ordinarily interchangeable items are assigned using the first in, first out cost formula. Net realisable value is the estimated selling price in the ordinary course of business less any applicable selling expenses.

(d) Trade Receivables

Trade Receivables are recognised at fair value, then amortised cost, making allowances for doubtful debts.

(e) Property, Plant & Equipment

The cost of purchased assets is the value of consideration given to acquire the assets and the value of other directly attributable costs which have been incurred in bringing the assets to the location and condition necessary for their intended service. Costs include financing costs that are directly attributable to the purchase of those assets.

Depreciation is calculated at the following rates:

Buildings 2-8.3% Straight Line Leasehold 5-20% Straight Line Textiles & Linen 33% Straight Line Plant 10-40% Straight Line Office Equipment 18.6% Straight Line Motor Vehicles 20% Straight Line

Work in progress is not depreciated. The total cost of a project is transferred to property and/or plant and equipment on its completion and then depreciated.

The internal controls over the identification and existence of Textiles & Linen stock movements are limited. This therefore has a direct impact on the final value of Textiles & Linen stock as well as the Textiles & Linen depreciation balances.

(f) Operating Leases

Operating lease payments, where the lessors effectively retain substantially all of the risks and benefits of ownership of the leased items, are recognised in the determination of the operating surplus in equal instalments over the lease term.

(g) Income Tax

The company is exempt from income tax under Section CW 38 (2) of the Income Tax Act 2007.

(h) Goodwill

Goodwill represents the excess of the purchase consideration over the fair value of the net tangible asset and intangible assets, acquired at the time of acquisition of a business or an equity interest in a subsidiary or associate company. Goodwill is tested annually for impairment. Brand names are recognised at cost. They are regarded as having indefinite useful lives because there is no foreseeable limit to the period over which they are expected to be useful. They are therefore not amortised. Instead, they are tested annually for impairment.

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

(i) Financial Instruments

The company classifies all of its financial assets as at amortised cost. This is because the assets are held within a business model whose objective is to collect the contractual cash flows and the contractual terms give rise to cash flows that are solely payments of principal and interest.

Trade receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, less loss allowance. Trade receivables are amounts due from customers for goods sold or services performed in the ordinary course of business. They are generally due for settlement within 30 days and therefore are all classified as current. The company applies the NZ IFRS 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for all trade receivables and contract assets. There was no allowance for credit losses for the year (2018; None).

Financial assets are assessed for indicators of impairment at the end of each reporting period. Financial assets are considered to be impaired when there is objective evidence that, as a result of one or more events that occurred after the initial recognition of the financial asset, the estimated future cash flows of the asset have been affected.

Financial Liabilities consist of trade and other payables, accruals and term loans. They are recognised initially at their fair value and subsquently measured at amortised cost using the effective interest method. The Company derecognises financial liabilities when, and only when, the Company's obligations are discharged, cancelled or have expired. The difference between the carrying amount of the financial liability derecognised and the consideration paid and payable is recognised in profit or loss.

(j) Foreign currencies

The financial statements are presented in New Zealand Dollars (NZD), which is also the functional currency of the Company.

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions (spot exchange rate). Foreign exchange gains and losses resulting from the settlement of such transactions and from the re-measurement of monetary items at year end exchange rates are recognised in profit or loss.

(k) Goods and Services Taxation (GST)

Revenues and expenses have been recognised in the financial statements exclusive of GST except that irrecoverable GST input tax has been recognised in association with the expense to which it relates. All items in the Statement of Financial Position are stated exclusive of GST except for receivables and payables which are stated inclusive of GST.

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

(I) Impairment

For impairment assessment purposes, assets are grouped at the lowest levels for which there are largely independent cash inflows (cash-generating units). As a result, some assets are tested individually for impairment and some are tested at cash-generating unit level. Goodwill is allocated to those cash-generating units that are expected to benefit from synergies of the related business combination and represent the lowest level within the Company at which management monitors goodwill.

Cash-generating units to which goodwill has been allocated are tested for impairment at least annually. All other individual assets or cash-generating units are tested for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable.

An impairment loss is recognised for the amount by which the asset's or cash-generating unit's carrying amount exceeds its recoverable amount, which is the higher of fair value less costs to sell and value-in-use. To determine the value-in-use, management estimates expected future cash flows from each cash-generating unit and determines a suitable interest rate in order to calculate the present value of those cash flows.

Impairment losses for cash-generating units reduce first the carrying amount of goodwill allocated to that cash-generating unit. Any remaining impairment loss is charged pro rata to the other assets in the cash-generating unit. With the exception of goodwill, all assets are subsequently reassessed for indications that an impairment loss previously recognised may no longer exist. An impairment charge is reversed if the cash-generating unit's recoverable amount exceeds its carrying amount.

(m) Cash and Cash Equivalents

Cash and cash equivalents comprise cash on hand and demand deposits, together with other short-term, highly liquid investments that are readily convertible into known amounts of cash and which are subject to an insignificant risk of changes in value.

(n) Employee Benefits

(1) Short-term employee benefits

Short-term employee benefits are benefits, other than termination benefits, that are expected to be settled wholly within 12 months after the end of the reporting period in which the employees render the related service. Examples of such benefits include wages and salaries and non-monetary benefits. Short-term employee benefits are measured at the undiscounted amounts expected to be paid when the liabilities are settled.

(2) Other long-term employee benefits

The Company's liability for annual and long service leave are included in other long term benefits as they are not expected to be settled wholly within 12 months after the end of the period in which the employees render the related service. They are measured at the present value of the expected future payments to be made to employees. The expected future payments incorporate anticipated future wage and salary levels, experience of employee departures and periods of service, and are discounted at rates determined by reference to market yields at the end of the reporting period on government bonds that have maturity dates that approximate the timing of the estimated future cash outflows. Any re-measurement arising from experience adjustments and changes in assumptions are recognised in profit or loss in the periods in which the changes occur.

The Company presents employee benefit obligations as current liabilities in the statement of financial position if the Company does not have an unconditional right to defer settlement for at least twelve months after the reporting period, irrespective of when the actual settlement is expected to take place.

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

(o) Equity, Reserves and Dividend Payments

Share capital represents the fair value of shares that have been issued. Any transaction costs associated with the issuing of shares are deducted from share capital.

Retained earnings include all current and prior period retained profits.

Dividend distributions payable to equity shareholders are included in other liabilities when the dividends have been approved prior to the reporting date.

Dividends are paid by the company after reviewing the financial position and impact of the dividend on the solvency of the company. All dividends are approved by the Board before payment.

(p) Business Combinations

The Company applies the acquisition method in accounting for business combinations. The consideration transferred by the Company to obtain control of a subsidiary is calculated as the sum of the acquisition-date fair values of assets transferred, liabilities incurred and the equity interests issued by the Company, which includes the fair value of any asset or liability arising from a contingent consideration arrangement. Acquisition costs are expensed as incurred.

The Company recognises identifiable assets acquired and liabilities assumed in a business combination regardless of whether they have been previously recognised in the acquired's financial statements prior to the acquisition. Assets acquired and liabilities assumed are generally measured at their acquisition-date fair values.

Goodwill is stated after separate recognition of identifiable intangible assets. It is calculated as the excesss of the sum of: (a) fair value of consideration transferred; (b) the recognised amount of any non-controlling interest in the acquiree; and (c) acquisition-date fair value of any existing equity interest in the acquiree, over the acquisition-date fair values of identifiable net assets. If the fair value of identifiable net assets exceed the sum calculated above, the excess amount (i.e. gain on bargain purchase) is recognised in profit or loss immediately.

(q) Provisions and Contingent Liabilities

Provisions are recognised when the Company has a present obligation or constructive obligation as a result of a past event, it is probable that an outflow of economic resources will be required from the Company and amounts can be estimated reliably. Timing or amount of the outflow may still be uncertain.

Provisions are measured at the estimated expenditure required to settle the present obligation, based on the most reliable evidence available at the reporting date, including the risks and uncertainties associated with the present obligation. Where there are a number of similar obligations, the likelihood that an outflow will be required in settlement is determined by considering the class of obligation as a whole. Provisions are discounted to their present values, where the time value of money is material.

No liability is recognised in an outflow of economic resources as a result of present obligation that is not probable. Such instances are disclosed as contingent liabilities, unless the outflow of resources is remote in which case no liability is recognised.

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

(r) Statement of Cash Flows

The Statement of Cash Flows is prepared exclusive of GST, which is consistent with the method used in the Statement of Financial Performance.

The following are definitions of the terms used in the Statement of Cash Flows:

- (a) Cash is considered to be cash on hand, current accounts in banks, and other highly liquid investments in which the entity invests as part of its day to day cash management. Cash includes borrowings from financial institutions such as bank overdrafts, where such borrowings are on call and are used as part of the day to day cash management.
- (b) Investing activities are those activities relating to the aquisition, holding and disposal of fixed assets and of investments. Investments can include securities not falling within the definition of cash.
- (c) Financing activities are those activities which result in changes in the size and composition of the capital structure of the group. This includes both equity and debt not falling within the definition of cash. Dividends paid in relation to the capital structure are included in financing activities.
- (d) Operating activities includes all transactions and other events that are not financing or investing activities.

(s) Significant Management Judgement in applying Accounting Policies and Estimation Uncertainty

When preparing the financial statements, management undertakes a number of judgements, estimates and assumptions about the recognition and measurement of assets, liabilities, income and expenses.

Information about estimates and assumptions that have the most significant effect on recognition and measurement of assets, liabilities, income and expenses is provided below. Actual results may be substantially different.

Impairment

In assessing impairment, management estimates the recoverable amount of each asset or cash-generating unit based on expected future cash flows and uses an interest rate to discount them. Estimation uncertainty relates to assumptions about future operating results and the determination of a suitable discount rate.

Useful life of depreciable assets

Management reviews its estimate of the useful life of depreciable assets at each reporting date, based on the expected utility of the assets. Uncertainties in these estimates relate to technical obsolescence that may change the utility of certain software and IT equipment.

Furthermore, the useful life for linen stocks is based on an assumption that linen stocks last for 36 months (3 years). The policy is based on the life of the total pool of circulating linen stocks and reflects linen life, linen ragging and unidentified stock losses.

Changes in Accounting Estimates

There have been no changes in accounting estimates during the reporting period.

(t) Changes in Accounting Policies

There have been no changes in accounting policies. All policies have been applied on a basis consistent with those from previous financial statements.

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

2	Share Capital	2019	2018
		\$	\$
	Paid in Capital		
	Opening Balance	6,600,000	6,300,000
	Movements	300,000	300,000
	Closing Balance	6,900,000	6,600,000
	Total Share Capital	6,900,000	6,600,000

The share capital of the Company consists only of fully paid ordinary shares; the shares do not have a par value. All shares are equally eligible to receive dividends and the repayment of capital and represents one vote at the shareholders' meeting.

The shareholding as at the end of the reporting period is set out below. Shares are worth \$1 each.

		Number of	Cost of
			\$
	MidCentral District Health Board	1,150,000	1,150,000
	Wanganui District Health Board	1,150,000	1,150,000
	Taranaki District Health Board	1,150,000	1,150,000
	Hawkes Bay District Health Board	1,150,000	1,150,000
	Capital & Coast District Health Board	1,150,000	1,150,000
	Hutt Valley District Health Board	1,150,000	1,150,000
		6,900,000	6,900,000
3	Retained Earnings	2019	2018
		\$	\$
	Opening Balance	236,012	84,537
	Plus:		
	Net Surplus	558,268	542,975
	Less:		
	Dividend Payable	409,494	391,500
	Retained Earnings Closing Balance	384,786	236,012

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

4	Current Receivables	2019	2018
		\$	\$
	Accounts Receivable		
	Trade Debtors	1,030,442	1,029,820
	Total Current Receivables	1,030,442	1,029,820

All amounts are short-term. The net carrying value of trade receivables is considered a reasonable approximation of fair value.

All of the Company's trade and other receivables have been reviewed for indicators of impairment, and no evidence of impairment has been identified.

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

5 Property, Plant & Equipment

a contract of the contract of the contract of								
	Leasehold - At cost	Textiles & Linen - At cost	Buildings - At cost	Capital Work in Progress	Plant	Motor Vehicles	Office Equipment	Total
Gross carrying amount	-							0.0000000000000000000000000000000000000
Balance 1 July 2018	47,456	6,673,307	438,957	89,985	9,747,257	33,466	240,787	17,271,215
Additions		1,840,436	•	290,191		*		2,130,627
Transfers				(381,870)	350,696		11,174	
Disposals		(761,779)			(49,261)			(811,040)
Balance 30 June 2019	47,456	7,751,964	438,957	18,306	10,048,692	33,466	251,961	18,590,802
Depreciation and impairment								
Balance 1 July 2018	39,613	4,003,175	31,123	10000	4,968,544	10,597	126.821	9,179,873
Impairment				8,094		-		8,094
Disposals		(761,775)			(49,261)			(811,036)
Depreciation	1,719	1,835,017	18,239		532,886	6,693	47,296	2,441,850
Balance 30 June 2019	41,332	5,076,417	49,352	8,094	5,452,169	17,290	174,117	10,818,781
Carrying amount as at 30 June 2019	6,124	2,675,547	389,595	10,212	4,596,523	16,176	77,844	7,772,021
Carrying amount as at 30 June 2018	7,843	2,670,132	407,834	89,985	4,778,713	22,869	113,966	8,091,342

These financial statements are to be need in conjunction with the accompanying Note

Page 1

Naylor Lawrence & Associates Limited

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

6 Goodwill	2019	2018
	\$	\$
Goodwill	795,427	795,427
Total Goodwill	795,427	795,427

The recoverable amount of the Cash Generating Unit (CGU), consisting of Textiles & Linen and Plant, was estimated based on the present value of the future cash flows expected to be derived from the CGU (value in use), using a discount rate of 6% and a terminal value growth rate of 1.5% in Revenue and 2.5% in Expenditure from 2020. The recoverable amount of the CGU was estimated to be higher than its carrying amount and no impairment was required.

7	Provisions	2019	2018
		\$	\$
	Provision for Gratuity		
	Opening Balance	13,123	12,446
	Movement for period	(13,123)	677
	Closing Balance		13,123
	Total Provisions		13,123
8	Term Loans	2019	2018
		\$	\$
	Allied Laundry Services Limited has a BNZ overdraft facility of \$664,460 (2018: \$664,460) \$42,998 was drawn as at 30 June 2019 (2018: Nil).		
	BNZ holds perfected security in all present and after acquired property of Allied Laundry Services Limited, as well as certain other significant assets.		
	The carrying amount of the term loans is considered to be a reasonable approximation of the fair value.		
	The BNZ Term Loan carries interest at 5.71% per annum (2018: 5.71%). The BNZ Credit Plus facility carries interest at 5.05% per annum (2018: 5.05%).		
	The Energy Efficiency and Conservation Authority (EECA) facility is interest free. The facility totalled \$220,000.		
	Non-current portion		
	Term Loan - BNZ	147,981	352,122
	Term Loan - EECA	22,000	66,000
	Total Non-current portion	169,981	418,122
	Current Portion		
	Term Loan - BNZ	199,992	199,992
	Term Loan - EECA	44,000	44,000
		243,992	243,992
	BNZ - Credit Plus Facility	42,998	(102)
	Total Current portion	286,990	243,890
	Total Term Loans	456,971	662,012

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

9 Financial Instruments

(a) Categories of Financial Assets and Financial Liabilities

The carrying amount of financial assets and financial liabilities in each category are as follows:

Financial Assets - At amortised cost	2019	2018
	\$	\$
Accounts Receivable	1,030,442	1,029,820
BNZ Bank	257,331	46,188
	1,287,773	1,076,008
Financial Liabilities - At amortised cost	2019	2018
	\$	\$
Trade Creditors	571,297	505,630
Accruals - Dividends & Rebates	801,000	1,198,759
Accruals - General	257,421	295,251
Term Loans	456,971	662,012
	2,086,689	2,661,652

10 Events Occurring After Balance Date

No significant adjusting or non-adjusting events have occurred between the reporting date and the date of authorisation.

Allied Laundry Services Ltd

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

11	Transactions with Key Management Personnel	2019	2018
		\$	\$
	Director Fees		
	Whanganui DHB	15,000	15,000
	MidCentral DHB	15,000	15,000
	Hawkes Bay DHB	30,000	30,000
	Capital & Coast DHB	15,000	11,250
	Hutt Valley DHB	15,000	15,000
	Taranaki DHB	15,000	15,000
	Total Director Fees	105,000	101,250
	Executive Management remuneration	184,232	180,796
	Total Transactions with Key Management Personnel	289,232	282,046

Key Management Personnel of the Company are members of the Board of Directors and members of the Executive Management team. Key Management Personnel remuneration includes the expenses listed above. There have been no other transactions with Key Management Personnel.

Allied Laundry Services Ltd

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

12 Related Party Transactions

Allied Laundry Services Limited has provided laundry services to the MidCentral, Whanganui, Hawkes Bay, Hutt Valley, Wairarapa, Capital & Coast and Taranaki DHB's. These entities are related to Allied Laundry Services Limited by common ownership. MidCentral DHB leases a building and charges electricity, steam and gas costs to Allied Laundry Services Limited. These transactions are entered into on a commercial basis and during the year totalled \$485,982. Outstanding amounts will be settled in cash when due. Dividends will be settled in cash in line with repayment plan disclosed in Note 14. The revenue from the shareholders is disclosed in the Statement of Comprehensive Income.

	2019	2018
	\$	\$
Allied Laundry Services Limited paid rent to		
MidCentral DHB	311,041	308,263
Taranaki DHB		1,264
Whanganui DHB	5,190	5,190
Capital & Coast DHB	4,800	4,800
Hutt Valley DHB	4,800	4,800
192	325,831	324,317
Accounts Receivable		
MidCentral DHB	193,969	194,870
Taranaki DHB	102,581	104,936
Whanganui DHB	64,271	62,503
Hawkes Bay DHB	166,292	167,620
Capital & Coast DHB	307,828	300,535
Wairarapa DHB	34,247	
Hutt Valley DHB	96,542	94,257
	965,730	924,721
Accounts Payable		
MidCentral DHB	102,270	78,072
Taranaki DHB	1,456	1,443
Whanganui DHB	2,103	2,101
Hawkes Bay DHB	2,875	2,875
Capital & Coast DHB	9,118	7,681
Hutt Valley DHB	1,898	460
	119,719	92,632
Accruals - Dividend payments owing by Allied Laundry Services Limited		
MidCentral DHB	138,000	230,415
Taranaki DHB	138,000	230,415
Whanganui DHB	138,000	230,415
Hawkes Bay DHB	138,000	230,415
Capital & Coast DHB	138,000	194,015
Hutt Valley DHB	111,000	83,084
	801,000	1,198,756

These financial statements are to be read in conjunction with the accompanying Notes.

Allied Laundry Services Ltd

Notes to and forming part of the Financial Statements (continued)

For the Year Ended 30 June 2019

13 Board Representatives Attendance at Meetings

Ken Foote Simon Barrett Brian Walden Neil Wanden Judith Parkinson Gina Lomax Delwyn Hunter

July	August	September	October	November	December	January	February	March	April	May	June
Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting
Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting	No	No meeting
Yes	No meeting	No	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting
Yes	No meeting	Yes	No meeting	Yes	No meeting	No	No meeting	Yes	No meeting	Yes	No meeting
Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting	Yes	No meeting
No	No meeting	Yes	No meeting	Yes	No meeting	No	No meeting	N/A	No meeting	N/A	No meeting
N/A	No meeting	N/A	No meeting	N/A	No meeting	N/A	No meeting	Yes	No meeting	Yes	No meeting

14 Going Concern

These financial statements have been prepared using the going concern assumption. As at 30 June 2019, Allied Laundry Services Limited recorded an accounting profit of \$558,268.

As at 30 June 2019, the entity's current liabilities exceeded its current assets by \$1,112,681 (2018: \$1,632,635). It should be noted however that \$801,000 (2018: \$1,198,759) of the total current liabilities relates to accrued dividends and rebates to the shareholders.

Assets of the entity are recorded at cost.

The considered view of the Directors of Allied Laundry Services Limited is that, after making due enquiry, there is a reasonable expectation that the entity has adequate resources and pre-approved borrowing facilities to continue operations and manage perceived outgoings as they fall due during the next twelve months from the date of signing the 30 June 2019 financial statements.

Having regard to the circumstances which it considers likely to affect the entity during the period of one year from the date these financial statements are signed, and to circumstances which it believes will occur after that date, the Directors believe the going concern assumption is a valid basis on which to prepare these financial statements.

Dividend Repayment Plan

The approved dividend payment plan is as follows:

- 2017/18 Dividend \$391,500 to be paid 1 July 2019 (paid)
- 2018/19 Dividend \$409,500 to be paid January 2020

These financial statements do not include any adjustments relating to the recoverability and classification of recorded asset amounts or to the amounts and classifications of liabilities that may be necessary should the entity be unable to continue as a going concern.

15 Contingent Liabilities

The Company has no contingent liabilities as at 30 June 2019, (2018 Nil).

16 Capital Commitments

The Company has no capital commitments as at 30 June 2019, (2018 Nil).

These financial statements are to be read in conjunction with the accompanying Notes



CHAIR & CHIEF EXECUTIVE'S REPORT FOR THE YEAR ENDED 30 JUNE 2019

OVERVIEW

The last year has been the first full year of expanded 'business as usual' for Allied Laundry. The company has continued to deliver high-quality products and services to the regional DHB's, whilst at the same time improving operational performance and developing the business. Financially the year end result came out just on budget after a challenging start and we are improving our financial position. Further tranches of deferred dividends were paid in January and August 2019, the EECA loan is almost paid off and the BNZ loans are being reduced. We have continued with our commitments to staff development and welfare, with the Renew Empower Allied Laundry (REAL) literacy, numeracy and communication programme dovetailing with an NZQA level two Manufacturing qualification for some, and significant enhancements and full staff involvement in Wellness Health and Safety improvements.

PRODUCTION

The reduced throughput at the start of last financial year reversed to a considerable over budget throughput (and therefore revenue) into June of 2019. June did see the highest weekly production in the company's history (93,562 kg) with the highest monthly production of 415,838 in July 2019. The unprecedented demand from the DHB's put the plant under some operational pressure which was met with changes in the plant operations, which also lifted the percentage pack-out from around 97% to 99.9%.

STRATEGIC DEVELOPMENTS

Strategically we are looking at a number of developments:

- The most exciting development is the potential purchase of the Distribution Agreement to be the exclusive New Zealand supplier of the Standard Textiles range of Compel branded reusable barrier theatre linen. The purchase of the distribution rights will pass savings into the purchase price of reusable barrier linen and create economies with the sale of products to other laundries. Linking in to one of the largest global linen suppliers, with 24 manufacturing plants globally and 4,000 employees, means Allied Laundry has an enviable access to innovation and products in the linen industry.
- The continuing relationship with New South Wales Healthshare has meant Allied
 Laundry has partnered on a project to analyse the possible issue of micro-plastics in

Hospital Gate 12, Ruahine Street, Palmerston North, 4410 • Phone: 0800 LAUNDRY (528 637) • www.alliedlaundry.co.nz

the wastewater stream and the potential for a solution. Micro-plastics are being recognised as a considerable pollutant and have been seen as a greater threat to the planet than climate change. All washing, including domestic, puts micro-plastics into the wastewater stream. Allied Laundry is investigating technology to remove the particulates from the waste stream and lead the industry in New Zealand in this development.

- This relationship has also created the opportunity to be a party to ongoing research
 and development into RFID and other technologies that will assist laundries such as
 ours, to better track and manage significant linen stock.
- The proposed investment in a garment processing system to process the 7,500 scrubs and gowns per day has been placed on hold until early 2020, to allow for all deferred dividends to be been paid first. A full garment finishing / sorting / folding system will require an investment of around \$1m plus another \$200k to expand the plant footprint. Robotics have surged in laundry processing systems and we will be continuing to stay up to date with these changes to scope future investment.

STAFF DEVELOPMENT

As discussed above the Board and management have focussed on developing our staff during the year. The REAL programme has been a success with twelve staff receiving certificates for completing the REAL initiative as well as receiving level two NZQA qualifications in manufacturing. The second tranche of twelve staff are three quarters of the way through the programme and we are looking to continue the programme next year. The literacy, numeracy and communication components of these programme, along with enhanced involvement and commitment to wellness, health and safety issues, have resulted in positive work and personal changes in the staff and an improvement in plant culture. We sincerely congratulate and thank all staff who have contributed to these outcomes.

The move to the living wage in January 2019 has lifted the staff wages and created a positive effect through the plant and the community. Allied Laundry is regarded as a very good employer with agency staff expressing a preference to work at Allied Laundry. This is also reflected in a relatively low staff turnover rate of around 8%.

ACKNOWLEDGEMENTS

We would like to sincerely thank all the staff, directors and shareholders for their ongoing support of Allied Laundry, for the results achieved and for the belief in the cooperative spirit that has shown what DHB's can do when they choose to work together to create regional solutions. Allied Laundry, New Zealand's leading DHB joint venture, continues to offer the regional DHB's a low cost, high quality and customer focussed laundry service that we can all be proud of.

Ken Foote Chair Mark Mabbett Chief Executive



Wednesday 16th October 2019

To Chairs; Boards of District Health Boards; Allied Laundry Services Limited Shareholders.

Regarding; appointment of Shareholding District Health Board Annual General Meeting Representatives.

The Allied Laundry Annual General Meeting is being held on Tuesday 26th November 2019 at Allied Laundry Services Ltd. Palmerston North.

The Shareholders' Agreement for Allied Laundry Services Limited requires each shareholder to appoint a representative for the Annual General Meeting.

Could the shareholding DHB's nomination for representative to the Allied Laundry AGM please be forwarded as soon as possible to Denise Climo (dclimo@alliedlaundry.co.nz) at Allied Laundry.

Regards

Mark Mabbett

CEO

Allied Laundry Services Limited.

	Central Regions Technical Advisory Services Ltd Annual General Meeting
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: HBDHB Board
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Chief Executive
Month:	October, 2019
Consideration:	For Decision

RECOMMENDATION

That the Board

- Note the Annual Report for TAS for the year ended 30 June 2019.
- Appoint Kevin Atkinson as the HBDHB representative to attend the TAS Annual General Meeting to be held Wednesday 4 December 2019, with Craig Climo appointed as his Alternate.

ATTACHMENTS

- A Notice of Meeting
- B Minutes of 2018 AGM
- C Annual Report 2018/19

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 4 December 2019.

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 Craig Climo be appointed as his Alternate.



14 October 2019

Kevin Atkinson Chair Hawke's Bay District Health Board c/o -Admin Building Private Bag 9014 HASTINGS

Dear Kevin

I am pleased to enclose the formal notice of TAS' AGM, draft minutes from last year's meeting, together with an electronic version of TAS' 2018/19 Annual Report, for noting. The report includes the approved financial statements, along with the signed Independent Auditor's Report.

Please let me know if you would like to receive hard copies of the report.

I would be grateful if you would let me know, who has been nominated to represent your Board at the TAS AGM.

Kind regards

Graham Smith TAS Chief Executive



Minutes

Name of Meeting: TAS AGM 2018

Date:	5 December 2018			
Start Time:	2.00pm	Finish Time:	2.15pm	
Method:	Face to Face			

Present: Directors: Murray Bain (Chair), Deryck Shaw, Wendy McPhail, Catherine Waugh, Sir

Paul Collins

Shareholders: Andrew Blair, (Capital and Coast District DHB and Hutt Valley DHB) Dot

McKinnon (MidCentral and Wanganui DHBs), Kevin Snee (Hawkes Bay DHB)

In Attendance: Graham Smith (TAS Chief Executive), Jane Doherty (Secretariat)

Apologies: Kath Cook

1 Welcome

The Chair opened the meeting at 2.00pm and welcomed everyone.

2 Confirmation of Minutes

2.1 Confirmation of Minutes

Resolved: That the minutes of the Annual General Meeting held on 6 December 2017 be accepted as a true and accurate record of that meeting.

Carried: all

3 Financial Statements and Reports

3.1 The Chair made a presentation on the TAS Annual Report and Financial Statements for 2018.

Resolved: That the Company's financial statements for the year ending 30 June 2018, together with the Auditor's report and the Directors' Annual Report, be received and adopted.

Carried: all

4 Auditors

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

Carried: all

General Business

5.1 There was no general business.

There was a vote of thanks to the Directors and CE of TAS for the significant and important work undertaken by TAS during the year.

The meeting concluded at 2.15 pm.



Notice of TAS Annual General Meeting

2:00pm, Wednesday 4 December 2019 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 4 December at 2.00pm.

Agenda

- 1. Apologies
- 2. Minutes

To review and accept the minutes of the AGM held 5 December 2018.

- 3. Directors' Report on the year ended 30 June 2019
 - 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 2019, along with the Independent Auditor's Report.

- 5. Auditors
 - To record the continuance of KPMG as the Company's auditors for the 2019/20 financial year.
- 6. General

Any other business.





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Our Annual Report photos

The photos in this year's Annual Report depict one of our TAS areas of value add to the sector: that of partnership and collaboration. We are proud to showcase imagery representing the dynamic meetings and events that have taken place over the past year.





LEVERAGING OUR EXPERTISE

Working across the breadth of the health system gives us a unique perspective. We're leveraging our collective expertise in the areas we know we can have the greatest impact. These areas include:

- · Growing sector collaboration
- · Data analysis, insights and strategy
- · Efficient, effective programme management
- · Building capability through education and training
- · Trusted, independent advice.



DELIVERING OUR STRATEGIC OBJECTIVES

Through our expertise, we can deliver our strategic objectives:

- Delivering value to the sector
- · Getting closer to our customers
- Ensuring our processes deliver a high quality, consistent customer experience
- Continually building the capability of our TAS people.





WHO WE WORK WITH

The six Central Region District Health Boards (DHBs) are our shareholders. Through our work we partner with New Zealand's 20 DHBs, the Ministry of Health (MoH) and a wide range of stakeholders across the health and social care sectors including:

- · Aged residential care providers
- · Primary health organisations (PHOs)
- Unions
- Professional associations and clinical groups
- · Government organisations
- · Sector bodies and representatives
- lwi
- · Non-government organisations (NGOs)
- · Health workforce and service providers.



HIGHLIGHTS OF OUR WORK

20 DHB CE commitment to taking tangible actions to increase Māori participation in the health workforce, underpinned by the position statement developed by Te Tumu Whakarae on Māori workforce.

Wellbeing project partnership now includes the Ministry of Health's (MoH) Clinical Cluster to ensure a multi-professional approach, and the Health Sector Relationship Agreement (HSRA). Development of a regional equity framework for Central Region DHBs.

Delivery of the new evergreen Integrated Community
Pharmacy Services Agreement (ICPSA) on 1 October
2018, which includes greater ability for DHBs to commission
local services to meet population need, address equity and
support delivery of the Government's Pharmacy Action Plan.
Includes over 1000 community pharmacies, accounting for
around \$472 million annually.

Management of the Aged Residential Care (ARC) Funding Model Review sponsored by DHBs and MoH, undertaken by Ernst & Young.

Establishment of the pay equity unit and development of a process to respond to claims covering 87% of the health workforce.

Regional launch of the New Zealand Out of Hospital ST elevation myocardial infarction (STEMI) pathway in March 2019. Set up of the Regional Digital Health Service (RDHS), formerly called Regional Health Informatics Programme (RHIP).

Centre of Excellence

(people, processes and technology capability) set up to take advantage of advances in data and analytics. Enhances the value of health insights we provide to the sector. Data analysis and a research report produced by TAS and championed by the Health System Performance-Insights programme (HSP-I) for DHBs to better understand the pressures caused by acute demand (unplanned hospital admissions). Report provided performance insights to help DHBs pinpoint opportunities to improve their acute demand flow.

TAS is committed to enhancing value for our customers to enable them to deliver the best healthcare for all New Zealanders. The following highlights profile TAS' role as a key strategic partner and

ORGANISATION PERFORMANCE

enabler to the sector achieving its goals.

Our key performance results in 2018/19 reflect our continuing work to build a sustainable and high performing organisation.

	2018/19	2017/18		
New investment	\$5M	\$3M		
(\$) ₩	Funding increases or investment for new work programmes or projects			
Customer Satisfaction	76.2%	79%		
	Respondents who rated overall sati services 7+/10	sfaction with TAS		
Customer Advocacy	56%	58%		
\bigcirc	Respondents who are likely to recommend TAS services 8+/10			
People Engagement	87%	80%		
33	Participation rate 55% Engagement score	Participation rate		

Board Meeting 30 October 2019 - Shareholder Representatives for TAS meetings



Our conference and meeting venue has enabled these partnerships to thrive. Leaders, clinicians and health professionals regularly come together at Front+Centre to shape ideas that collectively help us progress our country's health priorities.

TAS has forged a new direction over the last year, including forming a Services Group and Insights and Analytics Group to optimise how we work across the business.

We've created a Centre of Excellence with increased capability across our people, technology and processes – to more effectively take advantage of evolving data analytics. By harnessing our data resources, we have enhanced the value of health insights we provide across our customer base. This puts us in the best position to offer expert advice and services that benefit health and social care in New Zealand.

Perceptions of quality outcomes, customer advocacy, customer satisfaction and the value that TAS provides are fundamental to our reputation and success as an organisation – nationally and globally.

Perceptions of quality outcomes, customer advocacy, customer satisfaction and the value that TAS provides are fundamental to our reputation and success as an organisation – nationally and globally.

TAS ANNUAL REPORT 2018/19 7

In the last year we enjoyed hosting overseas visitors who had heard about TAS' work with our health partners and wanted to gain knowledge about our service model and expertise.

One group included Singaporean health authorities who visited during March to learn about how we use the interRAI assessment tool in the healthcare of older people. These visits have expanded the exchange of ideas between TAS and our neighbouring counterparts and are the type of collaboration we aim to continue over the coming year.

TAS has forged a new direction over the last year, including forming a Services Group and Insights and Analytics Group to optimise how we work across the business.

.......

To conclude, I'd like to welcome two exceptional new Board members to the table. Sir Paul Collins and

Catherine Law are already bringing their wealth of experience to the fore. I'd also like to thank my fellow Board members, Chief Executive Graham Smith, Board Secretary Jane Doherty, the TAS management team and staff for their support over what has been a significant twelve months for TAS.



11/1900

Board Meeting 30 October 2019 - Shareholder Representatives for TAS meetings



A key part of this was embarking on a 2020 programme to invest in our people and culture. We set defined change aims that resulted in a new TAS people strategy, culture strategy, and a refreshed IT security model, architecture and framework.

This past year we have achieved some meaningful results alongside our health sector partners on national and regional work programmes. This includes the delivery of the new evergreen Integrated Community Pharmacy Services Agreement (ICPSA), management of the Aged Residential Care (ARC) Funding Model Review, development of a regional equity framework for Central Region DHBs, and the implementation of a Stroke Clot Retrieval Service, among many other positive initiatives. The case studies throughout this Annual Report show these programmes are creating lasting impact.

As a reflection of our past programme successes, we are pleased the DHB CEs and DHB Executive Governance Group have endorsed our 2019/20 National and Regional Work Plans, enabling our progress for the next 12 months.

Earlier this year, we were honoured to receive double accreditation by Joint Accreditation System of Australia and New Zealand (JASANZ) and Accreditation Audit by International Health Accreditation Organisation (ISQua). ISQua assessed our TAS Certification Audit Programme as exceptional for its processes and systems, noting the strategy and vision are deeply implemented throughout TAS.

TAS ANNUAL REPORT 2018/19

This past year we have achieved some meaningful results alongside our health sector partners on national and regional work programmes.

In April 2019, we also celebrated two years of Front+Centre, our meeting venue that provides a space for health sector stakeholders and external customers to hold important discussions and shape ideas.

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In looking forward, I am excited for the many initiatives we have underway at TAS to cement our strong organisational values of Integrity, Professionalism, Courage and Aspiration. To that end, we are evolving our cultural competencies through the establishment of a Māori Strategy Steering Group in partnership with our Māori staff group (Te Roopu Māori o TAS) to develop our Tikanga and Te Reo Māori.

I'd like to thank Murray Bain, our Board Chair, and our dedicated Board members and staff for their commitment to helping our partners deliver the best healthcare for all New Zealanders, now and in future.



Graham Smith | Chief Executive

TAS ANNUAL REPORT 2018/19 TAS ANNUAL REPORT 2018/19 1

Board of Directors

1 July 2018 - 30 June 2019

MURRAY BAIN (CHAIR)



Murray is an experienced company director who is currently Chair of the Open Polytechnic, Deputy Chair of TSB Bank and a director of NorthTec. In the past, Murray has held Chief Executive roles in the Foundation for Research Science and Technology and the Ministry of Science and Innovation. Prior to that, he held senior management positions in IT, finance and banking in the Trust Bank Group, and roles as Chief Operating Officer at the Accident Compensation Corporation (ACC) and Assistant Governor at the Reserve Bank of New Zealand.

DERYCK SHAW



Deryck is Chair of Lakes District Health Board and Deputy Chair of New Zealand Māori Arts and Crafts Institute/Te Puia. He is a former member of the Waikato District Health Board and NZ Health Partnerships Board, former Chair of Waiariki Institute of Technology and Board Member of Institutes of Technology Polytechnics New Zealand and a former President of NZ Football.

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.

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.

SIR PAUL COLLINS



Sir Paul is currently the chairman of the Wairarapa District Health Board and private investment company, Active Equity Holdings Limited, and a director of the Hurricanes Limited, Ecopoint Limited and Shott Beverages Limited.

He has served on the Board of more than 50 listed companies in New Zealand, Australia, Hong Kong and London. He was the chairman of Sport New Zealand and High Performance Sport New Zealand Limited from 2009 to 2018 and of the Wellington Regional Stadium Trust from 2000 to 2012.

CATHERINE LAW



Catherine is a Partner in Deloitte's Risk Advisory team and has over 25 years practitioner and advisory experience in the financial services, retail and government sectors both in New Zealand and in the United Kingdom. Catherine's experience includes providing risk management advice, information security and technology advisory services for organisations in the public and financial services sectors.

Interest Register

As at June 2019

Nome	Poord/Organization
Name	Board/Organisation
Murray Bain (Chair)	Deputy Chair, TSB Bank Chair, Open Polytech NZ Shareholder and Director, Oryx Technologies Ltd Shareholder and Director, M I Bain & Associates Ltd Director NorthTec Director, ESA Publications Ltd Director, Optimum Ltd
Deryck Shaw	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 Partner, Shaw Property Partnership Chair NZ Walking Association Inc Director, Great Value Accommodation Ltd Director Waimangu Ltd Director, Te Puia Ltd
Wendy McPhail	Advisory Board Member to The Marketing Company Principal Consultant and Director, Wendy McPhail Consulting Limited Director, Great Sleep Company
Kathryn Cook	Chief Executive, MidCentral District Health Board Chair of the National CEOs Director Health Round Table Ltd
Sir Paul Collins	Chair, Wairarapa DHB Director, Active Equity Holdings Limited (Chair) Director, Hurricanes GP Limited Director, Ides Limited Director and shareholder, AEL Managers Limited Director, Shott Beverages Limited Director and shareholder, Beverage Holding Limited Director and shareholder, Ecopoint Limited Director and shareholder, Cohiba Traders Limited Member Shareholder Review Group – New Zealand Health Partnerships Ltd
Catherine Law	Directorship of Deloitte





SHAPING THE STRATEGY

To develop the strategy, TAS on behalf of DHBs held a number of consultation workshops nationally, with each workshop engaging the voices of both clinical and non-clinical employees, and union representatives. The workshops focused on the overarching objective that future employment arrangements need to deliver across the health sector and the challenges facing the sector in New Zealand.

Stephen Cummings, Victoria University of Wellington's Professor of Strategy and Innovation was brought in as an expert advisor to support the workshops, and team, to develop the strategy.

TAS is proud to have partnered with some extraordinary strategic minds and received well considered contributions to help build the 20 DHBs Employment Relations Strategy 2019-2024.

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Stephen focused on using the 'Growth Options Heatmap' to help sort and prioritise feedback from the workshops. The heatmap is a unique approach to the use and interpretation of the traditional SWOT analysis and enabled the identification of five key strategic intents. Stephen's book, Strategy Builder (Wiley, 2015) was a relevant source of information on the most effective way to develop and visualise a strategy.

The Balanced Scorecard approach was then used to develop operational strategies, goals and measures, across innovation and learning, customer, financial and internal business perspectives.

THE ENVIRONMENTAL CHALLENGES

Any ER strategy needs to enable future proofed employment arrangements to address our workforce and health operating environment challenges.

Examples of these changes and challenges include:

- the increasing complexity and expectations of the medical treatments available to diagnose and treat each patient
- the use of artificial intelligence, robotics, automation and advanced digital and cognitive technologies disrupting health care delivery models
- the increased use of trans disciplinary teams in the delivery of patient care
- the continuing pressure on the funding available for health care.

"We enjoyed a high level of enthusiastic engagement with unions and health sector practitioners who all provided a realistic picture of the challenges facing DHBs and their views on strengths in the sector."

.....

PETER BROWN | TAS DIRECTOR OF EMPLOYMENT RELATIONS

ALIGNMENT OF WORKFORCE PRINCIPLES AND ER STRATEGIC INTENTIONS

It was important that the ER Strategy Development team closely engaged with the Ministry of Health Workforce Strategy Group, in order to align the strategy, goals and measures across both strategies.

The more than 70,000 employees across our 20 DHBs account for the majority of the health expense budget. It was important to develop a pragmatic ER Strategy that recognised this and enabled achievement of our overall workforce objectives and created long-term benefits for our health operations and workforce.

THE ROAD AHEAD

The Employment Relations Strategy 2019-2024 has been signed off by all 20 DHBs. This signals their commitment to:



Develop employment arrangements across the sector which will **enable effective teams** to do their best work to **deliver Pae Ora** for our communities.

In practice, this means DHBs will:

- Seek to think and act as one managing and delivering services, thinking and acting as one organisation and one system.
- Tackle pay disparity lessen the gap between low and high paid staff and address pay
 equity.
- Support our staff to do meaningful work leaders within DHBs commit to developing our people and ensuring the work environment supports our people to thrive.
- Support mutual agility and innovation employment arrangements support our people to be agile and innovative in how they deliver services.
- Be financially sustainable recognise our agreements need to be financially sustainable.

"We are confident the commitment of the DHBs to the implementation of this strategy will enable employment arrangements across DHBs, which support continuously improving healthcare for all New Zealanders."

PETER BROWN | TAS DIRECTOR OF EMPLOYMENT RELATIONS





Over the last year we've been providing value to our customers through four key areas:



Deliveringgreater health system analysis

and insights

Growing
sector people
capability
via our
workforce team

Improving
le service
efficiency
and
effectiveness



Fostering partnerships and collaboration

We've developed our operating model to set TAS up to deliver on our future aspirations to grow the value we deliver, and to build a resilient, agile organisation that's a great place to work.

In a move to drive better consistency and bring our collective expertise together, we formed the Services Group and Insights and Analytics Group. With our services aligned, we shifted our focus to work smarter, so we can provide more for our customers.

Harnessing the strategic value of our data, we've enhanced our reporting capability to provide information that supports health system performance, strategy and policy development.

"With our customers at the forefront of our work, we're not only optimising how we work now but we're looking to the future; growing new business and developing new services to have greater impact and add benefit back to the health sector."

GRAHAM SMITH | TAS CHIEF EXECUTIVE

TAS' core services are focused on facilitating key national and regional work programmes on behalf of New Zealand DHBs and the MoH. In 2018/19, we worked with our DHB and MoH partners and broader sector stakeholders to deliver key achievements across the following programmes of work.



EMPLOYMENT RELATIONS

- Established the pay equity unit and developed process to respond to claims covering 87% of the health workforce.
- Led the DHBs' response to the MBIE Labour Inspectorate Holidays Act compliance requirements and pay equity claims, in partnership with NZ Council of Trade Unions (CTU) and other health unions.
- Partnered with E tū to investigate, design and implement a new multiemployer collective agreement (MECA), which met the Government's expectations for low paid workers and the DHBs' expectation of linking qualifications to remuneration structures to build a skilled workforce.
- Positive engagement with the 20 DHBs, including development of employment relations (ER) capacity and capability within DHBs through inclusion of ER/HR DHB staff in national MECA bargaining.
- Coordination of national contingency planning process during periods of national industrial action.
- Over 100 attendees at the national employment relations conference 'The Changing Landscape', designed and managed by TAS.





WORKFORCE PLANNING AND DEVELOPMENT

- 20 DHB CE commitment to taking tangible actions to increase Māori
 participation in the health workforce, underpinned by the position statement
 developed by Te Tumu Whakarae on Māori workforce.
- Developed nursing graduate costing model to quantify the costs for DHBs of employing additional nursing graduates as part of the Nursing Accord.
- Wellbeing project partnership now includes the Ministry of Health's (MoH) Clinical Cluster to ensure a multi-professional approach to wellbeing, along with the Health Sector Relationship Agreement (HSRA).
- Established partnership approach with MoH's new Workforce
 Directorate on the identification and development of workforce strategic
 priorities.
- Completed a workforce assessment process on the Anaesthetic Assistant workforce that will guide a multi-disciplinary approach to the development of this workforce.



SAFE STAFFING HEALTHY WORKPLACES (SSHW)

- The CCDM software was constantly improved to enable DHBs to achieve greater traction with their full-time equivalent (FTE) calculations. The development of a roster testing tool provided DHBs with a rigorous method for managing rosters.
- Operationalised core data set (CDS) with great examples from at least two DHBs on how they have operationalised the CDS. One DHB hosted webinars with the developer (Qlik) for the sector, to share their CDS journey and key Care Capacity Demand Management (CCDM) learnings.
- Actively supported workforces beyond nursing, namely allied health and midwifery with additional dedicated programme consultant resource.
 These specific roles enable increased support to DHBs to progress CCDM implementation for allied health and midwifery.



COMMUNITY PHARMACY

- Delivered the new evergreen Integrated Community Pharmacy
 Services Agreement (ICPSA) on 1 October 2018, which includes greater
 ability for DHBs to commission local services to meet population need,
 address equity and support delivery of the Government's Pharmacy Action
 Plan. Includes over 1000 community pharmacies, accounting for around \$472
 million annually.
- Established the National Annual Agreement Review process, which aligns with the Primary Care and Age-Related Residential Care annual review processes.

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HEALTH OF OLDER PEOPLE

- Managed the Aged Residential Care (ARC) Funding Model Review sponsored by DHBs and MoH, undertaken by Ernst & Young.
- Managed and allocated the transitional support fund for ARC providers who required temporary support to deal with the negative effects of the allocation methodology used in ARC for the Care and Support Workers' Pay Equity Settlement.
- Managed the annual review of the Age-Related Residential Care Agreements and associated work plan.
- Supported DHBs in their engagement with the Home and Community Support sector and MoH about consistent approaches to pricing, devolution of pay equity into contracts, in-between travel and guaranteed hours.
- Provided technical advice to DHBs about the flow-on impact of the DHB NZNO MECA on other community sectors and managed the process for providing additional funding to ARC providers to help mitigate the impact.
- Worked with NZ Aged Care Association and MoH to model the cost impacts on the ARC sector for 2019/20. The first initiative of this kind in the sector and applauded by the Association.
- Worked with primary care, ARC and MoH representatives as part of a Joint Primary Care ARC Working Group considering how to ensure equitable access to primary care for residents living in aged residential care.



AIR AMBULANCE

 Established the DHB Air Ambulance Steering Group and project to support DHBs and MoH to roll out new contractual arrangements to implement interhospital transfers by Air Ambulance.



ELECTRONIC ORAL HEALTH RECORD

• Completed the planning phase and commenced implementation.





ORAL HEALTH

- Used design thinking to prototype an oral health analytics dashboard with DHB portfolio managers, clinicians, provider and adolescent oral health coordinators. This work is completed with biannual analysis and reporting for the stakeholder to be able to make informed decisions on oral health for adolescent services.
- Analysed the triannual New Zealand Dental Association fees survey to help DHB customers put forward a successful price increase for 2019/20.
- Coordinated a review of the Combined Dental Agreement (CDA).
 This included running a consultation process between the New Zealand
 Dental Association and DHB Adolescent Oral Health Coordinators, Approving
 Dental Officers and Portfolio Managers.
- Organised National Oral Health Group meetings, tracked actions through to completion and made recommendations to sponsor.



MENTAL HEALTH AND ADDICTION

- Facilitated the establishment of a Partnership Group focused on six key issues impacting mental health and addiction Non-Government Organisation (NGO) providers with a national focus.
- Established a training support fund for support workers in mental health and addiction with a view to having 80% of support workers at level 4 NZQA or equivalent within a two-year timeframe.



REGIONAL SERVICES PLAN (RSP)

- Development of a regional equity framework for the region.
- Developed and agreed a single system of care operating model for the region for cancer services.
- Regional launch of the New Zealand Out of Hospital ST elevation myocardial infarction (STEMI) pathway in March 2019.
- Implementation of a regional clot retrieval service.
- Influenced and collaborated regionally to improve outcomes for carers of those with dementia, those with young onset dementia and intellectual disability – through supporting the New Zealand Dementia Framework Collaboration and the initiation of new pathways of care for people and their whānau.





PRIMARY CARE

- Supported Lead DHB Negotiators with advice on policy, funding, contracting, negotiation and implementation to introduce new subsidies for Community Services Card holders and 13-year olds from 1 December 2018. Held a forum for all DHB Portfolio Managers to support the implementation. Over 90% of general practices are now providing the new subsidies.
- National DHB CEs approved the extension of the scope of the Primary Care Programme to include Public Health. This has provided an immediate mandate to engage MoH on negotiating the next three-year agreement for public health services.
- Began development of action-orientated Strategic Priorities for the DHBs' collective primary care work programme over the next three-to-five years.



interRAI

- 93% of Registered Nurses in aged residential care are competent to undertake interRAI assessments.
- 100% of Home Care assessors are interRAI competent.
- Programme of education and support updated with new ways of training delivery through accreditation model and tertiary providers.
- Online training introduced for health professionals who read assessments.
- Quality indicator reports launched for aged residential care providers and DHBs showing patterns of service delivery.
- All recommendations from the review of the introduction of interRAI in aged residential care implemented and final report issued.
- Record number of 120 data requests shows growing interest in interRAI
- Six studies using interRAI data were published.
- Visit from Singapore delegates to learn how interRAI Services supports the interRAI assessment tool in New Zealand.





REGIONAL DIGITAL HEALTH SERVICES

- Set up the Regional Digital Health Service (RDHS), formerly called Regional Health Informatics Programme (RHIP) as a standalone service.
- RDHS team and its Service Delivery Partner (previously located at Capital & Coast DHB) now based under one roof at the TAS office on Cambridge Terrace and renamed to Regional Support Team (RST).
- Preparing for the onboarding of Hawkes Bay and Capital & Coast **DHBs** in 2019.
- Implemented enhancements and streamlined operating processes.
- Restructured operating model and reduced resource expenditure on contractors.
- · Initiated regional webPAS upgrade project.
- Completed regional RIS upgrade into production.
- Established a Regional RIS Service Delivery Manager role to lead the ongoing enhancements and support of the regional instance, providing a single point of contact between DHBs, radiology departments and the region.
- Significant improvements in regional infrastructure and support costs, achieved through continued consolidation of infrastructure and application environments, and targeted services improvement.
- Established a Regional Commercial Manager role to improve vendor engagements and contract management.



HEALTH SYSTEM PERFORMANCE INSIGHTS

Data analysis and research report produced by TAS and championed by the Health System Performance-Insights programme (HSP-I) for DHBs to better understand the pressures caused by acute demand (unplanned hospital admissions). Report provided performance insights to help DHBs pinpoint opportunities to improve their acute demand flow.

"Managing acute demand is a significant issue for health systems in Aotearoa New Zealand and across the world. The HSP-I Governance Group worked closely with experts at TAS to understand the questions that need to be answered and to develop insights from the data."

> DR ANDY PHILLIPS I CHAIR OF HEALTH SYSTEM PERFORMANCE INSIGHTS PROGRAMME GOVERNANCE GROUP, HAWKES BAY DHB



AUDIT AND ASSURANCE

- The equivalent of **65 audits** completed within the Central Region.
- Double accreditation by Joint Accreditation System of Australia and New Zealand (JASANZ) and Accreditation Audit by International Health Accreditation Organisation (ISQua). ISQua assessed TAS Certification Audit Programme as exceptional for its processes and systems, noting the strategy and vision are deeply implemented throughout TAS.
- Extension of audit service scope to enable TAS to award certification.
- Reviews undertaken within the Central Region DHBs covering but were not limited to:
- HISF (Health Information Security Framework)
- · Business Continuity
- · Delegated Authorities
- · Children's Hospital Procurement
- Sector Operations Payment Process
- Māori Pro Equity
- External Penetration Tests
- · Phishing Attacks
- · Medicine Reconciliation

- · Health and Safety
- Control Environment
- · Event Reporting
- · Doctors Rostering
- · Suspicious Transaction Analysis
- · Asset Management

· Project Management

Minder Utilisation

Risk Management

· Clinical Governance

· Electives and ESPI Performance

"The Certification Audit Programme integrates well into the overall business structure as the TAS organisation provides shared services to the Programme."

ISQUA AUDIT REPORT







TAS interviewed a range of DHB leaders to determine their perspectives on acute demand and the impact it has on the health system. These interviews raised several themes which TAS subsequently explored in data.

In June 2019, TAS produced the report *Addressing Acute Demand Pressures*, championed by the Health System Performance-Insights (HSP-I) programme, to provide a collective narrative for acute demand. The data insights in the report aim to provide a better understanding of the factors affecting acute demand pressures on the public health system.

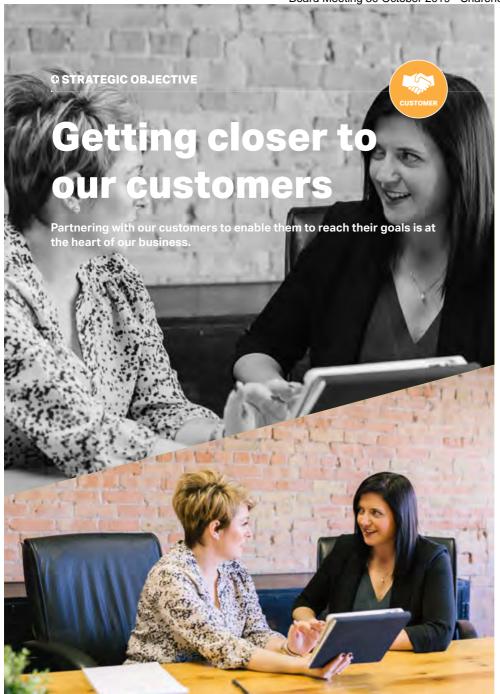
DHBs reported in their interviews with TAS the increasing Emergency Department volumes and increasing pressure on resources. These reported challenges were reinforced by TAS data analysis, which proved that the numbers of acute admissions to hospital are growing faster than the rate of population growth.

Due to the different characteristics of each DHB, they are faced with different pressures and opportunities to address acute demand. TAS identified how DHBs are currently responding and the opportunities to improve management of acutely unwell people. TAS' insights show that almost one in three of all hospital admissions is considered potentially avoidable by delivering more planned care in the community.

The health insights gained from the report will benefit all DHBs, despite their differences. With increased clarity and understanding, the DHBs are better positioned to work together, and from a new perspective, to overcome these challenges and ultimately affect positive change in our communities.

"High quality relationships led to a trusted partnership that has produced some actionable insights for individual health systems and across NZ. I am confident that this baseline work will be used to derive further insights from the comprehensive data set that TAS has access to. I am delighted with the quality of work that we were able to deliver together."

DR ANDY PHILLIPS I CHAIR OF HEALTH SYSTEM PERFORMANCE, INSIGHTS PROGRAMME GOVERNANCE GROUP, HAWKE'S BAY DHB



CUSTOMER SATISFACTION

Strong partnerships and collaboration with our customers are the cornerstone of our business, enabling us to help them deliver the best healthcare for all New Zealanders.

Every year we formally measure how well we are delivering against customer expectations through our annual customer satisfaction survey. This year's survey examined four key areas: perceptions of TAS, customer satisfaction, customer advocacy and our value proposition.

Survey respondents covered District Health Boards, primary care and other health sector organisations in a variety of roles from chief executive and board members to portfolio managers, and operational and clinical staff.

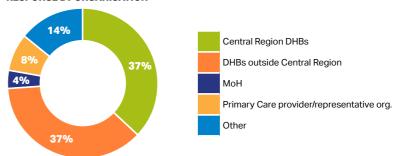
Overall the survey findings were positive, with most key indicators yielding similar results to last year. Areas for organisational development were also identified.

Strong partnerships and collaboration with customers is the cornerstone of our business.

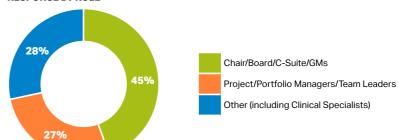
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OVERALL SURVEY DEMOGRAPHICS

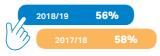
RESPONSE BY ORGANISATION



RESPONSE BY ROLE



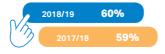
How likely is it that you would recommend TAS to a colleague or to another organisation?



Overall high advocacy (8+/10) has remained similar for 2018/19.

CUSTOMER SATISFACTION

Overall how satisfied are you with the services you receive from TAS?



69% of respondents from DHBs outside Central Region rated satisfaction as high (8+) compared with 64% in 2017/18.

PERCEPTIONS

Perceptions of TAS remain positive (the trend shows customers agree/strongly agree with positive perception statements).

The highest rated areas are related to professionalism of relationships and quality services/ advice.

VALUE ATTRIBUTES

This year our survey explored key areas of value that TAS provides to customers. We tested how important these areas of value were to customers and asked them to rate our performance.

RESPONDENTS RATE THESE AREAS OF VALUE AS TAS' STRENGTHS:











Effective access to expertise

There is a continued strong correlation between importance and performance. This indicates that the areas where TAS is performing the best are also areas which are most important to our customers.

REFRESHED WEBSITE DESIGNED FOR CUSTOMERS

In February 2019, we launched a refreshed website designed to reflect our TAS 2020 direction and be a more effective communication hub for our customers.

To see where the opportunities lay for making improvements, we interviewed a range of stakeholders at different levels from DHBs, the Ministry of Health, crown agencies, sector groups and TAS staff to understand how customers were using our site and their reasons for visiting.



OUR REFRESHED WEBSITE OFFERS

- a clear user experience with better navigation and information easily accessible
- · a new section for news and media
- · handy quick links to topical information
- · new sections, including Insights, Analytics and Strategy.

Visit us at tas.health.nz



FRONT+CENTRE TEAM CELEBRATING SECOND BIRTHDAY MILESTONE

A key part of our work at TAS is supporting and enhancing partnership and collaboration across the sector.

Our meeting and collaboration space, Front+Centre, has transformed the way we achieve this. In April 2019, we celebrated two years of providing a bespoke and neutral space for our health sector stakeholders to join together, hold important discussions and shape ideas. With our high-tech video conferencing, our out of town customers can successfully link into meetings without the need to travel.

"We especially like the fresh modern look and feel of the rooms; they provide a great environment for learning and discussion."

BLUE CIRCLE CONSULTING

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Over the last year we've continued to build awareness in the Wellington venue market (and beyond) by:

- Growing our customer base beyond the health sector on average we hold around four meetings per week from external organisations.
- Identifying training providers as a new market Blue Circle Consulting are among other consulting companies who have been complimentary of our space and facilities.
- Hosting conferences and overseas delegations the 20 DHBs Employment Relations conference and Singaporean delegation were both successful events and received great feedback.
- Connecting with some inspiring groups we hosted a Chamber of Commerce business breakfast with Lucy Revill (Wellington blogger), welcomed PACE, an EA network for an after-hours tour, and hosted the Public Relations Institute of New Zealand (PRINZ).

HIGHLIGHTS



- · The team has expanded to four permanent staff.
- We launched a real time online booking system 'Get a room' improving customer experience (users can now view actual availability and receive immediate confirmation of their bookings).
- We have continued to receive highly positive feedback on our venue and service from our health sector stakeholders and external clients.





Three auditors from Australia, France and Malaysia visited the TAS Wellington Office to assess our Audit processes along with our overall governance, IT, Finance, HR, Risk Management, Quality Management and strategic planning processes. We were assessed against eight organisational standards and received positive feedback particularly on our processes and systems.

The auditors also commented that our strategy and vision are deeply implemented throughout the organisation and were obvious during conversations with a range of people interviewed, including students, employees, the CE, Board Chair and external contractors.

The ISQua accreditation is a testament not only to the hard work of our certification audit team in their preparation for the audit, but also to their efforts to further demonstrate our credibility, and position TAS as trusted advisors in the sector.

The accreditation shows the integrity and quality of our services, ensuring our customers always have faith that we are delivering value in everything we do.

"I have been a surveyor (auditor) for ISQua for 7 years and I have never seen a company that performed so exceptionally well and was so well prepared as TAS was, which is even more remarkable given that this was the first time ISQua have audited TAS and the standards were unknown to TAS."

LEAD AUDITOR

"The strategic planning process which the organisation embarked upon was an exceptional example of co design with all parties who have a relationship with TAS. The forming of a specific 2020 Project Implementation Team working on designing the framework on how the 2020 Vision is to be

delivered and managed is very innovative thinking."

AUDITOR FEEDBACK





TRANSFORMING OUR BUSINESS AND THE WAY WE WORK

Over the last year, TAS has been developing its operating model to help us achieve our future aspirations to grow the value we deliver to the sector, and to build a resilient, agile organisation that's a great place to work.

We started by forming the Services Group and Insights and Analytics Group to optimise how we work across service lines to deliver greater impact where it matters most. Integrating our teams and leveraging areas of shared capability, we shifted our focus and way of working.

With robust and future proofed systems and processes, we're supporting and enabling the specialisation we need to succeed and become a high-performing organisation – with our customers at the heart of everything we do.

MIGRATION TO WINDOWS 10

In March 2019, we transitioned our IT environment from Revera to Microsoft Azure, with a major component being the transition of our laptops and desktops to use Windows 10. The pilot was successful in identifying a number of unknown issues which our team were able to resolve ahead of the move. Before the migration, employees who were familiar with Windows 10 were encouraged to be Windows 10 champions to support colleagues during and after the transition.



This was a complex project for our IT team whose detailed planning and preparation paid off. They put in a huge amount of effort, despite the short timeframe, to minimise disruption and ensure all staff were supported during the process. The successful migration was a big step towards an IT infrastructure that is more robust, secure and fit for purpose. It will not only improve the way we manage and access our data, but is also a smarter environment, allowing greater opportunity for collaboration, more capability and better functionality. Ultimately this environment will make it easier to do our work alongside our customers.

"Our IT infrastructure being on the Azure Public Cloud platform affords us a more secure environment for our data and opens up new functionality for how we work together."

GRAHAM SMITH | TAS CHIEF EXECUTIVE



As part of the Regional Services Plan, we've built strong and collaborative relationships with programme partners across diverse areas like cardiac care, sudden unexplained death in infants (SUDI), and stroke intervention.

We're also proud to have worked alongside the Central Region Service Planning Forum (CRSPF) on an Equity Framework, designed to achieve health equity for all New Zealanders.

"The Central DHBs' regional programmes reach all pockets of our communities, from caregivers and babies through to those needing lifesaving therapy," said Tricia Sloan, General Manager, TAS Services Group.

"By taking a whole of system approach to eliminating inequities and improving quality, safety and experiences of care across the region, the benefits are far-reaching."

SUDI PREVENTION - MAKING SUDDEN UNEXPECTED DEATH IN INFANCY HISTORY

Preventing SUDI through safe sleeping practices and smokefree whānau is a key regional priority and one close to people's hearts.

TAS Child Wellness, Planning and Improvement Managers Jessica Sandbrook and Katie Kennedy have been leading collaboration with the Central Region DHBs on developing and implementing local SUDI prevention plans that empower whānau to protect their pepi from SUDI, and meet Ministry of Health requirements.

"The two key modifiable risk factors that impact on SUDI are smoking during pregnancy and bedsharing."

JESSICA SANDBROOK | TAS CHILD WELLNESS, PLANNING AND IMPROVEMENT MANAGER

The year's achievements have included support for DHB portfolio managers and local safe sleep coordinators

on programme initiation and development. Regional connections have been strengthened through monthly online hui for DHB safe sleep coordinators. Katie and Jessica have collaborated with Hapai te Hauora on National Safe Sleep guidelines and SUDI prevention needs assessments.

TAS has supported DHBs who have existing SUDI prevention programmes, and also worked alongside Hutt Valley DHB to set up and outwork their new safe sleep device service, Moe Ora. This service is directly connected to the hapu mama stop smoking service – a clever approach to support whānau to protect pepi from SUDI.

A highlight for TAS was the regional SUDI prevention wānanga hosted at Napier's Pukemokimoki Marae to support workforce development for kaimahi.

"The two key modifiable risk factors that impact on SUDI are smoking during pregnancy and bedsharing," says Jessica Sandbrook.

"The goal of the SUDI prevention programme is to address these factors in a mana enhancing way, utilising a safe sleep solution designed by Māori for Māori. The respect and

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value given to a wahakura woven from harakeke is valuable for the pepi that will sleep safely in one tonight, and for their wider whānau who see the DHB's value and investment in a kaupapa Māori solution."

"The hui was designed to support collaboration with health workers across the region and identify ways to support whānau to act on the knowledge that separate sleep surfaces are safest for baby and 'smoke-free' is best for pregnant women, babies and whānau."

The hui was grounded in a Māori worldview, provided as a wānanga, and held on Pukemokimoki Marae. Participants learned about the history of wahakura – New Zealand's first indigenous response to reduce the inequity of SUDI for Māori whānau – from its creator Dr David Tipene-Leach.

"The National SUDI Prevention Coordination Service (NSPCS) were pleased to attend this well organised and facilitated hui. It offered the team an opportunity to meet face to face with and hear directly from those at the coal-face and to answer their concerns and queries directly," said Fay Selby Law, National SUDI Prevention Programme General Manager.

"Those in attendance were personnel from a wide range of health and community organisations within the Central Region, who each have a stake in providing SUDI prevention messaging through their specific work programme. There were opportunities to hear from well-known SUDI prevention advocates and workshops to discuss and learn from one another."

FAY SELBY LAW I NATIONAL SUDI PREVENTION PROGRAMME GENERAL MANAGER



STEMI – NEW INITIATIVE ENABLING QUICKER ACCESS TO LIFE SAVING TREATMENT

Every day in New Zealand, five people will suffer the most life-threatening form of heart attack (myocardial infarction), and approximately 20% will die.

To minimise these statistics, TAS was proud to facilitate conversations between clinical leads on introducing a new out-of-hospital treatment pathway for cardiac patients in the Central Region.

Known as STEMI (ST elevation myocardial infarction), this new pathway enables paramedics to give a clot busting drug to patients in the community and then transport those patients directly to the most appropriate hospital.

"TAS has organised the work programme and managed most of the project streams within the work programme."

CRAIG JOHNSTON | MIDCENTRAL
DHB GENERAL MANAGER
STRATEGY, PLANNING AND
PERFORMANCE

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The pathway was launched initially by DHBs in the Central Region and is a collaborative treatment method developed by St John, the Ministry of Health and the Cardiac Network. TAS managed the complexities of in-depth discussions between partners, enabling the pathway to move forward.

"The result is a crucial reduction in the time it takes to receive lifesaving treatment. A quicker journey to hospital means the loss of heart muscle is minimised, enabling patients to potentially go back to work two weeks later, rather than months after their heart attack," says Jeanine Corke, TAS Planning and Improvement Manager.

Craig Johnston said the ability to have STEMI patients assessed in the community by St John paramedics will "decrease transfer waiting times to Wellington Hospital, preserve cardiac function and improve outcomes for patients across the region".

Any initiative involving emergency healthcare relies on the expertise, composure and care of the paramedics, nurses and doctors delivering this lifesaving treatment around the clock. The impact on clinical teams is significant and Capital Coast DHB and St John's role in providing this 24/7 service has been fundamental to its success.

Around 350 patients each year could benefit from the pathway, resulting in improved long-term survival and the delivery of equitable healthcare to all New Zealanders, particularly those living in rural and remote areas.

"This is a crucial step in achieving regional equity which is one of the fundamental goals of the Cardiac Network and represents a lot of hard work from all involved. We still have more work to do. The current pathway only benefits those patients who call 111 and we will be looking to extend the pathway for those patients who attend emergency departments of non-PCI capable hospitals this year," said Nick Fisher, Clinical Lead Central Cardiac Network and Head of Department Cardiology, Nelson Marlborough DHB.

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CENTRAL REGION EQUITY FRAMEWORK - ESTABLISHING EQUITY FOR ALL

Over the past year, TAS has supported Central Region DHBs to strengthen the equity focus in the Regional Services Plan. A major piece of that work has been the development of a Central Region Equity Framework. The Framework, informed by the Ministry of Health's 'Equity of Health Care for Māori' has been designed to provide guidance to the Central Region Service Planning Forum on strengthening their commissioning role to achieve equity.

Central Region DHB Chief Executives have agreed that the implementation approach for the Framework includes regional activity focused on strengthening equity in the Regional Services Plan, local activity building the capacity and capability of staff in each DHB, as well as local activities that would be captured in the DHBs' Annual Plans.

People who are poor, have chronic conditions/disease, live with disabilities, live rurally and are of different ethnicities will have poorer health, greater exposure to health risks and poorer access to health services. In New Zealand, the differences between Māori and non-Māori are the most persistent and compelling equity issues in health. Achieving equity for Māori is a priority, as health gaps across the life-course is significant for Māori.

While the Equity Framework takes a very broad approach, the companion Treaty of Waitangi DHB obligations document under development will provide guidance to the Central Region DHBs on what they need to do meet their Treaty of Waitangi obligations, as well as achieve equity for Māori.



STROKE CLOT RETRIEVAL SERVICE – REDUCING THE LONG-TERM IMPACT OF STROKE ON PATIENTS

Stroke is the second most common cause of death and adult disability in New Zealand and worldwide. Nationally, around 8,500 people had a stroke in 2015/16 and about 50,000 lived with the consequences of stroke.

Launched in the Central Region in April 2019, the Regional Stroke Clot Retrieval Service is a highly specialised treatment, involving removal of a blood clot in the brain when 'clot-busting' drugs cannot dissolve the clot.

"It has a high success rate, significantly improving the likelihood of a patient walking out of hospital the next day versus a long process of rehabilitation and recovery or potential permanent disability," said Stephanie Calder, TAS Director, Regional Services Programme.

To get the Regional Stroke Clot Retrieval Service over the line, TAS helped support the introduction of the Service within the six Central Region DHBs, along with bordering DHBs in Nelson-Marlborough and Taranaki.

Early intervention with endovascular clot retrieval (ECR) is the most effective treatment available to reduce the debilitating impact of strokes, and improve survival rates.

"The implementation of a regional ECR service will help to reduce current inequities in achieving best patient outcomes, reducing overall post-stroke disability."

The service applies to patients presenting to one of the participating emergency departments (Hastings, Hutt, Masterton, Nelson, Taranaki Base, Wairau, Wellington, or Whanganui hospitals).

There is strong evidence that clot retrieval, as a procedure, directly prevents avoidable costs in acute medical care, neurosurgical procedures, rehabilitation for stroke patients, as well as aged residential care.

"The implementation of a regional ECR service will help to reduce current inequities in achieving best patient outcomes, reducing overall post-stroke disability."

STEPHANIE CALDER I TAS DIRECTOR, REGIONAL SERVICES PROGRAMME



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BUILDING OUR CULTURE

2018 – 2019 has been an important year for growing TAS people and culture. We built on the earlier role-modelling we'd done of our TAS values (aspiration, integrity, courage and professionalism) and moved into how we approach our work. We then embarked on a 2020 programme to invest in our people and personal growth.

TAS' current and future success is hugely reliant on having highly talented, committed and capable people with well-honed skills, who can build relationships and do great work.

We acted on the opportunity to amplify our efforts in the people space, by improving our employee value proposition and actively managing our talent. Key to this was building a great culture, great people development and opportunities to thrive.

OUR CHANGE AIMS WERE:



- New leadership framework and ways of working
- · Leadership for our Services Group
- Operating model for Data and Analytics service
- Learning Management System
- IT roadmap
- · Capability mapping
- · People and culture strategies
- · Quick win initiatives.

WHAT WE ACHIEVED:



- TAS People Strategy developed
- TAS Culture Strategy developed
- New leadership framework and ways of working developed
- IT Security model, architecture and framework refreshed
- New purpose, direction and operating model for Services Group and Data and Analytics service developed and teams set up
- IT roadmap finalised
- · Data management framework built
- Cross functional collaboration a feature of leadership
- · Capability mapping in place
- Framework for capturing all Line of Business opportunities across the Services Group
- Learning Management System (LMS) identified.

Board Meeting 30 October 2019 - Shareholder Representatives for TAS meetings

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TAS DAY

We ran a very successful TAS Day in December 2018 to connect our strategy with personal action and impact. This involved our staff exploring key elements of our future culture, to support the Culture work stream.

HEALTH, SAFETY AND WELLNESS

Our health, safety and wellness (HSW) committee, made up of representatives from each business unit, meet regularly to foster and monitor positive health and safety practices in the organisation.

A monthly report on HSW activities, issues and incidents is presented to the TAS Board so that it can ensure TAS is meeting its obligations under the Health and Safety at Work Act.

KEY ACHIEVEMENTS OVER THE PAST YEAR INCLUDED:



- New HSW intranet hub to host information on upcoming initiatives, wellbeing, fire safety, workstation assessments, EAP, the HSW Committee and First Aid/Floor Warden representatives.
- Launch of monthly 'Wellness Wednesday' initiative kicking off with fresh fruit for three months, followed by subsidised chair massage to reduce stress and boost energy.
- . First Aid course run on site for staff.
- Proactive health initiatives such as free flu vaccinations.
- Ergonomic workstation set ups and assessments.
- Events organised to encourage staff engagement and collaboration

 such as Move it March (10,000 step challenge) and Pink Shirt Day
 anti-bullying quiz and staff morning tea.







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New Zealand's aged residential care sector has transformed since the government's funding model for residential care was put in place over 20 years ago.

While the aged population is growing steadily, the characteristics of people going into aged residential care have changed. People are going into care much later, at an average age of 85, and a high number have complex needs involving long-term conditions and disability-related dependencies, requiring specialist or around the clock 24/7 care.

"The funding model for aged residential care must be fit for purpose and financially sustainable long-term to cope with the changing nature of the sector, so facilities can continue to provide effective, quality services," said Chris Fleming, lead District Health Board Chief Executive for the Health of Older People, and Chief Executive of Southern District Health Board.

SIGNIFICANT ENGAGEMENT AND ANALYSIS OVER EIGHTEEN MONTHS

On behalf of the 20 DHBs and the Ministry of Health, TAS commissioned Ernst & Young to undertake a comprehensive review of the funding model, to see if it was keeping pace with the changes in the sector and would support future requirements. The focus was purely on the funding model – the amount of funding was not considered in the Review.

Advice as the Review progressed was provided by a cross-sector steering group including representatives of aged care providers, consumers and unions as well as DHBs and the Ministry of Health. The steering group was co-chaired by Chris Fleming, and Keriana Brooking, Deputy-Director General, Health System Improvement and Innovation, Ministry of Health.

"At TAS, we were privileged to manage the Review, working closely with Ernst & Young and the cross-sector steering group," said Jon Shapleski, TAS Programme Director, Health of Older People.

"The Review was a great example of partnership and collaboration across the entire aged care sector. It took eighteen months and involved extensive engagement with a wide range of people – from providers to residents to consumers."

JON SHAPLESKI | TAS PROGRAMME DIRECTOR, HEALTH OF OLDER PEOPLE

Board Meeting 30 October 2019 - Shareholder Representatives for TAS meetings

"TAS' role was key to

landing on an agreed

final report with solid

recommendations for

CHRIS FLEMING | LEAD DHB CHIEF EXECUTIVE FOR THE HEALTH OF

OLDER PEOPLE

the future."

TAS ANNUAL REPORT 2018/19

The Review involved interviews, workshops, surveys and forums with older people and their families, funders, providers, health professionals and regulators.

Funding models in other countries were studied, particularly those of Australia and Canada due to their similarities to New Zealand. The review analysed data about older people's needs, use of aged residential care, trends in aged residential care capacity and costs of service provision.

"The result was a comprehensive and insightful report which provides a wealth of information about how the current funding model is working today and the opportunities that exist for improvement," said Chris Fleming.

"The Review makes seven primary recommendations, including use of a new funding model based on the interRAI clinical assessment approach, that is more directly linked to individual needs.

"TAS' role was key to landing on an agreed final report with solid recommendations for the future," he said.

NEXT STEPS

The Ministry of Health, the DHBs and the cross-sector steering group have accepted that all recommendations have merit and warrant further consideration. Considerable work is now needed to fully understand the feasibility of adopting the recommendations, including health system and cost implications and any legislative changes that may be required.

"We will continue to work closely with the Ministry, the DHBs and the aged care sector as work progresses to build on this landmark Review, and consider the full implications of the report's recommendations."

.....

JON SHAPLESKI I TAS PROGRAMME DIRECTOR, HEALTH OF OLDER PEOPLE



Statement of comprehensive revenue and expense for the year ended 30 June 2019

Total comprehensive revenue		332	1,740
Net surplus		332	1,740
Total expenditure		39,730	36,445
Other expenses	4	15,807	13,213
Depreciation and amortisation expense		458	327
Personnel costs	3	23,465	22,905
Expenditure			
Total revenue		40,062	38,185
Other revenue	2	9,440	8,253
Interest revenue		211	165
DHB revenue		30,411	29,767
Revenue			
	Notes	2019 \$000	2018 \$000

Statement of changes in equity for the year ended 30 June 2019

Balance at 30 June	4,999	4,667
Total comprehensive income and expense for the year	332	1,740
Balance at 1 July	4,667	2,927
	2019 \$000	2018 \$000

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Statement of financial position as at 30 June 2019

Notes	s 2019 \$000	2018 \$000
Current Assets	\$000	φ000
Cash and cash equivalents 5	12,043	11,028
Short term investments	12,043	550
Receivables 6	3,669	
		6,189
Prepayments	530	
Total current assets	16,242	17,767
Non-current assets		
Property, plant & equipment 7	923	776
Intangible assets 7	949	199
Work in progress	8	
Total non-current assets	1,880	975
Total assets	18,122	18,742
Current liabilities		
Payables 8	8,398	9,967
Funds received in advance	2,804	2,249
GST payable	94	74
Employee entitlements 9	1,112	1,070
Total current liabilities	12,408	13,360
Non-current liabilities		
Working capital reserve	715	715
Total non-current liabilities	715	715
Total liabilities	13,123	14,075
Net assets	4,999	4,667
Equity		
Share capital	-	-
General funds	4,999	4,667
Total equity	4,999	4,667

For and on behalf of the Board:

Murray Bain Chair

25 September 2019

Catherine Law Director

25 September 2019

Statement of cash flows for the year ended 30 June 2019

Not		2018
	\$000	\$000
Operating Activities		
Receipts from customers	42,925	33,213
Interest received	211	165
Payments to employees	(23,423)	(22,907)
Payments to suppliers	(17,905)	(6,724)
GST (net)	20	(76)
Net Cash Flow from Operating Activities 10	1,828	3,671
Investing Activities		
Purchase of property, plant, equipment	(432)	(224)
Purchase of intangibles	(931)	-
Purchase of short term investments	550	(550)
Net Cash from Investing Activities	(813)	(774)
Net Cash from Financing Activities	-	-
Net increase in cash and cash equivalents	1,015	2,897
Cash and cash equivalents at the beginning of the year	11,028	8,131
Cash and cash equivalents at the end of the year	12,043	11,028

TAS ANNUAL REPORT 2018/10

Central Region's Technical Advisory Services Limited

1. Statement of accounting policies

Notes to the Financial Statements

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. Relevant legislation governing TAS's operations as a Crown entity subsidiary, is the Crown Entities Act 2004, and as a company, the Companies Act 1993. TAS's ultimate parent is the Crown.

TAS's 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 2019 and were approved by the Board on 25 September 2019.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the 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.

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 ANNUAL REPORT 2018/10

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 fair 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.

Property, plant and equipment

Property, plant and equipment consists of leasehold improvements, information technology and furniture and office equipment. Items of property, plant and equipment are stated at cost, less accumulated depreciation. The cost of property, plant and equipment is the purchase cost together with any incidental costs for integration or acquisition.

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Depreciation

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

Leasehold improvements 2-10 years
 Information technology 3-5 years
 Furniture and office equipment 3-10 years

Intangible assets

Intangible assets are capitalised on the basis of the costs incurred to acquire and bring into use the specific software. Items of intangibles are stated at cost, less accumulated amortisation. Costs associated with maintenance are recognised as an expense when incurred.

Amortisation

Intangible assets have finite lives and are amortised on a straight-line basis over their useful lives as follows:

• Software 3-5 years

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

· Accumulated surplus/(deficit)

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.

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2. Other revenue

Total other revenue	9,440	8,253
Other revenue	811	640
Ministry of Health revenue	8,629	7,613
	2019 \$000	2018 \$000

3. Personnel costs

Total personnel costs	23,465	22,905
Increase in employee entitlements	76	36
Defined contribution plan employer contributions	446	400
Salaries and wages	22,943	22,469
	2019 \$000	2018 \$000

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

4. Other expenses

Total expenses	15,807	13,213
Other	1,285	1,148
Legal fees	776	905
Information Communications Technology-Non-RDHS*	3,640	3,344
Information Communications Technology-RDHS*	3,415	2,665
Consultancy	3,820	2,766
Travel and transport	1,767	1,478
Office lease	1,057	867
Fees to auditor - to KPMG for audit of financial statements	47	40
	2019 \$000	2018 \$000

^{*} RDHS - Regional Digital Health Services

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5. Cash and cash equivalents

	2019 \$000	2018 \$000
Cash at bank and on hand	7,043	3,228
Term deposits with maturities less than 3 months	5,000	7,800
Total cash and cash equivalents	12,043	11,028
6. Receivables		
	2019 \$000	2018 \$000
Receivables (gross)	2,983	5,656
Accrued debtors	686	533
Total receivables	3,669	6,189
Total receivables comprises:		
Receivables from exchange transactions	3,669	6,189
The aging profile of receivables at year end is detailed below:		
Not past due	3,281	2,914
Past due 31 - 60 days	202	1,563
Past due over 60 days	186	1,712
Total	3,669	6,189

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

There is a \$nil impairment provision for receivables (2018: \$nil)

7. Property, Plant and Equipment and Intangibles

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Total payables

Total payables comprises:

Payables from exchange transactions

	Leasehold improvements	Furniture & office equipment	Information technology	Intangible Assets	Total
	\$000	\$000	\$000	\$000	\$000
Cost					
Balance at 01 July 2017	429	320	644	480	1,873
Additions	34	8	122	47	211
Balance 30 June 2018	463	328	766	527	2,084
Balance at 01 July 2018	463	328	766	527	2,084
Additions	107	125	198	925	1,355
Balance 30 June 2019	570	453	964	1,452	3,439
Accumulated depreciation and impairment losses					
Balance at 01 July 2017	12	115	435	204	766
Depreciation expense	49	31	138	125	343
Balance 30 June 2018	61	146	573	329	1,109
Balance at 01 July 2018	61	146	573	329	1,109
Depreciation expense	85	42	157	174	458
Balance 30 June 2019	146	188	730	503	1,567
Carrying amounts					
As at 30 June 2018	402	182	192	199	975
As at 30 June 2019	424	265	234	949	1,872
8. Payables					
				2019 \$000	2018 \$000
Creditors				7,314	7,732
Accrued expenses				1,084	2,235

8,398

8,398

9,967

9,967

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9. Employee entitlements

	2019 \$000	2018 \$000
Current liability portion		
Accrued salaries	330	258
Annual leave	782	702
Other short term benefits	-	110
Total employment entitlements	1,112	1,070

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

Net movements in working capital items	1,037	1,604
(Decrease)/increase in funds received in advance	554	(3,464)
Increase/(decrease) in employee entitlements	42	(2)
(Decrease)/increase in payables	(1,549)	6,413
(Increase)/decrease in prepayments	(530)	-
Decrease/(increase) in receivables	2,520	(1,343)
Add/(less) movements in statement of financial position items		
Depreciation and amortisation expense	459	327
Add back non-cash items		
Net surplus	332	1,740

11. Commitments

Capital Commitments

TAS has no capital commitments (2018: Nil).

Operating Leases as Lessee

The future aggregated minimum lease payments to be paid under non-cancellable operating leases are as shown in the table below.

Later than five years Total non-cancellable operating leases	1,867 6.501	2,690 7.395
Later than one year and not later than five years	3,674	3,636
Not later than one year	960	946
	2019 \$000	2018 \$000

TAS leases office space in Wellington, Christchurch and Auckland. There are two Wellington leases-Tory Street Building including rights of renewal, expires in 15 years from the commencement date of 18 April 2017, and the Cambridge Terrace Building, including rights of renewal, expires 3 years from the commencement date of 17 November 2018. The Christchurch lease, including rights of renewal, expires in nine years from the commencement date of 01 February 2017. The Auckland lease, including rights of renewal, expires in 12 years from the commencement date of 01 December 2016.

12. Contingencies

TAS has no contingent liabilities or contingent assets (2018: Nil).

13. 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.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. TAS's exposure to fair value 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 fair value interest rate risk.

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 ris

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

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.

	Carrying amount \$000	Contractual cash flows \$000	Less than 6 months \$000
2018			
Payables (excluding funds received in advance and taxes payable)	9,967	9,967	9,967
Total	9,967	9,967	9,967
2019			
Payables (excluding funds received in advance and taxes payable)	8,398	8,398	8,398
Total	8,398	8,398	8,398

14. 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 party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, Government departments and Crown entities) 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.

The following table provides the total amount of transactions that have been entered into with related parties for the relevant financial year.

	Rever	nue	Expe	Expenses		Balance Receivable/ (Payable)		
	Year to June 2019	Year to June 2018	Year to June 2019	Year to June 2018	As at 30 June 2019	As at 30 June 2018		
Capital & Coast DHB	6,445	3,112	1,830	1,339	194	(209)		
Hawke's Bay DHB	3,974	2,221	117	5	428	210		
Hutt Valley DHB	3,271	1,863	3	4	138	1,137		
MidCentral DHB	6,093	3,795	-	32	315	860		
Wairarapa DHB	1,351	1,432	-	-	93	920		
Whanganui DHB	2,556	1,825	-	19	329	255		

Transactions with Key Management Personnel

TAS classifies its key management personnel into the following categories:

- Directors
- Leadership Team

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The table below depicts the aggregate remuneration of key management personnel and the number of individuals on a full-time equivalent basis receiving remuneration within the category.

	2019		2018	
	Remuneration \$000	Number	Remuneration \$000	Number
Directors	85	5.0	75	4.0
Leadership Team	2,150	9.7	1,892	8.3
Total	2,235	14.7	1,967	12.3

Compensation of key management personnel includes salaries and non-cash benefits

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

TAS has provided a deed of indemnity to Directors for certain activities undertaken in the performance of TAS's 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's capital is its equity, which comprises accumulated funds. Equity is represented by net assets.

TAS as a company, is subject to the financial management and accountability provisions of the Companies Act 1993.

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 balance date.



Independent Auditor's Report

To the shareholders of Central Region's Technical Advisory Services Limited

Report on the audit of the financial statements

Opinion

In our opinion, the accompanying financial statements of Central Region's Technical Advisory Services Limited (the 'company') on pages 53 to 65:

- present fairly in all material respects the company's financial position as at 30 June 2019 and its financial performance and cash flows for the year ended on that date; and
- comply with Public Benefit Entity Standards (Public Sector).

We have audited the accompanying financial statements which comprise

- the statement of financial position as at 30
- 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.

Our firm has also provided other services to the company in relation to technical assistance with supplier selection. Subject to certain restrictions, partners and employees of our firm may also deal with the company on normal terms within the ordinary course of trading activities of the business of the company. These matters have not impaired our independence as auditor of the company. The firm has no other relationship with, or interest 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 independent auditor's 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 independent auditor's report, or any of the opinions we have formed.



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 (Public Sector));
- 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:

http://www.xrb.govt.nz/standards-for-assurance-practitioners/auditors-responsibilities/audit-report-8/

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



Wellington

25 September 2019



Employment Relations conference—the changing landscape

Over 100 human resources and employment relations practitioners joined TAS staff in April 2019 for the '20 DHBs Employment Relations Conference' to examine the changing landscape of employment and industrial relations.

Minister of Health, Hon Dr David Clark addressed the conference alongside a line-up of employment relations specialists.

"As significant employers in New Zealand, by their very nature District Health Boards (DHBs) manage complex employment and legal matters relating to safer staffing, pay equity and industrial claims," said Peter Brown TAS Director of Employment Relations.

New Zealand has a highly skilled and dedicated health workforce. By continuing to learn about the significance of employment and industrial relations in our country, practitioners can lead the way in supporting a productive and innovative health workforce.

How likely is it that you would recommend this conference to a colleague?

91% highly likely

How likely are you to attend another ER conference, say in a year's time?

81% highly likely

Delegates commended the great networking opportunities, strong content and excellent organisation





www.tas.health.nz

69 Tory Street, Wellington 6011

	Te Ara Whakawaiora – Adult Health						
HAWKE'S BAY District Health Board Whakawateatia	For the attention of: HBDHB Board						
Document Owner	Patrick Le Geyt, General Manager, Maori Health, Te Puni Matawhānui						
	Access – Chris Ash, Executive Director of Provider Services						
Champions	Cardiovascular – Dr Andy Phillips, Hospital Commissioner						
Champions	Smoking – Bernard Te Paa, Executive Director for Health Improvement & Equity						
	Jill Garrett						
Document Author(s)	Andy Phillips						
	Johanna Wilson						
Reviewed by	Charrissa Keenan, Programme Manager, Māori Health						
Month/Year	October 2019						
Purpose	To provide the Executive Management Team (EMT) and governance groups with highlights on the implementation progress of the following Adult Health indicators in the past 6 months:						
	 i) Access to services for 45-64 year olds - heart disease, skin infections, respiratory infections and diabetes checks ii) Cardiovascular services 						
	i) 90% of eligible 35-55 year olds that have received a heart and diabetes check.						
	ii) 70% of all ACS patients that will have an angiogram within 3 days of admission.						
	iii) 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS AND Cath/PCI registry data collection within 30 days						
	iii) Smokefree - Percentage of pregnant Māori women that are smokefree at 2-weeks postnatal						
Previous Consideration Discussions	Reported annual.						
Summary	 Access There has been no significant shift in these indicators for Māori that would indicate that current activity is having a direct impact on equitable health outcomes. The national picture looks very similar as does results for DHBs with comparable demographic. We can continue to do what we have been doing – with no 						
	significant result, or we can decide to change our approach. iii) It is encouraging to note that our approach for Pasifika is showing impact.						

iv) It is recommended that in the next 6 months, a working group made up of population health, primary care, leads within the medical directorate, and lead by Māori health get together to inform the activities and measures that will inform activities and indicators within the Annual Plans of both Primary and Secondary Services, the SLM and TAW plan for the 2020-21 cycle

Cardiovascular

- Avoidable hospital stays for Māori and Pacific adults aged 45-64 years are increasing due to heart attacks, chronic lung disease and skin infection.
- ii) HBDHBs performance for angiogram within three days was 46% 49% Maori and 48% European/other which fell below the 70%
- iii) DHB continues not to meet this target due to limited dedicated cardiac catheter laboratory sessions (angiograms) and cardiologist availability to perform the tests at the HBDHB.
- iv) Compared to Pasifika (100%) and Other (98%) only 93% of Māori patients presenting with ACS who had coronary angiography were able to complete their ANZACS data within 30 days. This was below the 95% target.
- v) HBDHB has the longest wait times for coronary angiography and PCI in the Central Region.
- vi) DHB continue failing to meet minimum standards for echocardiography, including surveillance scanning for known disease conditions.

Smokefree

- i) In June 2018 the HBDHB and Te Haa Matea (HB Stop Smoking Services) in consultations with pregnant women, new mums as well as wider whānau members, key stakeholders and practitioners reviewed the Increasing Smokefree Pregnancies Programme (ISPP) with recommendations to accelerate stop smoking behavior among Wahine Hapu and their whānau.
- ii) The changes made to ISPP led to an increase in referrals, enrolments and guit rates for both Wahine Hapu and Whānau.
- iii) Following a successful pilot project on the use of midwives in screening for Carbon Monoxide (CO) on home visits with Wahine Hapu and Whānau the HBDHB Smokefree Service:
 - a) Purchased and distributed fifteen carbon monoxide monitors to Independent Midwives (LMCs) working predominately with Māori and Pacific Wahine in the Hastings, CHB and Napier areas
 - b) Provided Smokefree education and training to the midwives to encourage them to have the Smokefree conversations, explain the benefits of being smokefree and to demonstrate how much carbon monoxide the mum and her baby are exposed to from smoking during pregnancy.
- iv) The use of midwives contributed to an increase in referrals to ISPP in Wairoa as the midwives routinely screen for CO at each home visit.
- v) The HBDHB Smokefree Service team established a 0.6FTE Maternal & Child Health Coordinator role for a practicing midwife with Te Atarangi Maternity services which has been

	instrumental in working closely with community and hospital based midwives to support Wahine Hapu and whānau become smokefree
Contribution to Goals and Strategic Implications	i) Use of Whānau voices in improving intervention strategies and programmes to enhance equity
	ii) Use of continuous programme monitoring data to highlight areas of health inequities to inform better programming and service delivery.
Impact on Reducing Inequities/Disparities	The core objective of the Hawke's Bay Health Strategy 2019-2029 is to increase healthy life expectancy for all and halve the life expectancy gap between Maori and non-Maori as a step towards health equity. This can happen by raising awareness among the whanau in recognizing health risky behaviours and supporting them in adopting preventive behaviours including seeking prompt treatment. Successful implementation of activities under the 3 adult indicators in this paper are envisioned to make this happen consequently impacting on reducing inequalities between Māori and Other and enhancing health equity.
Consumer Engagement	Included where appropriate in responsive planning and development of relevant activities under each indicator
Other Consultation /Involvement	Not applicable
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that the HBDHB Board:

- 1. **Note** the contents of the report
- 2. **Endorse** the next steps and recommendations.



ADULT HEALTH – Access Services

Author/s:	Jill Garrett – Senior Commissioning Manager – Primary Care Portfolio: Long Term Conditions
Contributors	Andrea Rooderkerk – Clinical Nurse Manager Diabetes - DHB Ian Elson – Deputy Service Director Medical – DHB Trish Freer – Program Delivery Lead – PHO
Date:	Sept 2019

MĀORI HEALTH PLAN INDICATOR: ADULT HEALTH

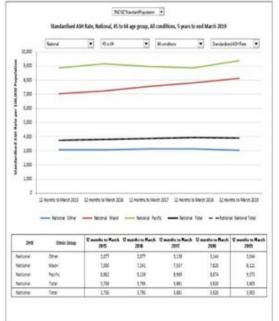
This report provides an update the following indicators for Adult Health:

Access	45-64 year olds - heart disease, skin infections,	Chris Ash	Jill Garrett	OCT 2019	
Local Indicator	respiratory conditions and diabetes				
Baseline -138%	March 2018	115%	2,935		
	March 2019	125%	3,175		
Note: The Standardised rates are now represented in numbers, so as to show local improvement					
versus previous comparisons in relation to the national rates. (BI Analyst – Peter McKenzie)					

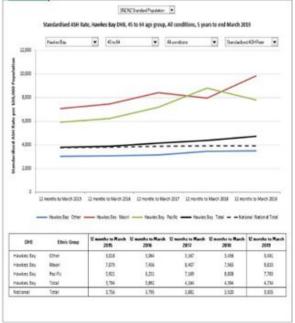
OVERVIEW

In summary there has been no significant shift in these indicators for Māori that would indicate that current activity is having a direct impact on equitable health outcomes. The national picture looks very similar as does results for DHBs with comparable demographic. We can continue to do what we have been doing – with no significant result, or we can decide to change our approach. What is encouraging is our approach for Pasifika is showing impact. That approach includes targeting specific conditions and specific target groups.

National table* - 5 years to March 2019



Hawke's Bay table* – 5 years to March 2019`



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^{*}All ASH Conditions

^{*} All ASH Conditions

SUMMARY COMMENTS:

It is timely that the TAW access indicators be reviewed. Cardiac and Respiratory Conditions remain within the top 3 ranked conditions as does Cellulitis. While diabetes is of priority it is not ranked within the top 10 conditions contributing to ASH in HB.

Cardiac and respiratory disease and cellulitis for Māori adults are significant and should be monitored, more effectively for equity. We have proven through a lack in change of results over time that focusing on multiple areas at one time has not worked. We need to narrow and concentrate our focus primarily in the detection prevention and early intervention areas with specific emphasis on Maori and Pacific population groups.

The DHB within our annual plan, System Level Measures Improvement Plan and Organisational priorities where our focus and resources need to be. To date, however the coming together of all these planning and reporting mechanisms with the Te Ara Whakawaiora reporting framework has not been well connected or synchronised.

It is recommended that;

- In the next 6 months, a working group made up of population health, primary care, leads within the
 medical directorate, and lead by Māori health get together to inform the activities and measures that
 will inform activities and indicators within the Annual Plans of both Primary and Secondary Services, the
 SLM and TAW plan for the 2020-21 cycle. These will be based on agreed organisational priorities that are
 currently being finalised.
- Accept the recommendations as per table below as the areas that will be actively worked on to address
 equity in the next 12 months. They are areas of activity already identified within various plans as being a
 priority. The areas listed under detection and prevention are activities that are currently resourced. The
 areas listed under early intervention have been identified for potential resourcing. All areas have a
 specific focus on address equity for Māori.

NEXT STEPS AND RECOMMENDATIONS

	Description	Responsible	Timeframe
Detection	LTC Flag: Measure: Readmission rates LTC Flag developed through BI to identify patients with ≤ 1 LTCs. Improved coordination of care	DHB Jill Garrett Lisa Jones Nurse Directors	Quarter 2
	Screening: CVDRA Measure: Māori Male 35-44	PHO Mark Peterson	Quarterly monitoring and revision
Prevention	Access to primary care: Measure: Referral and engagement of priority population groups into programs that improve access to primary care - SIA funded MDT clinics within general practice - High need enrolment program - Whanau wellness program - Kia ora self-management program - Pipi program (pre diabetes) - Respiratory Program	PHO Peter Satterthwaite	Quarterly monitoring and revision
Early Intervention*	Clinical Pathways Measure: Update on pathways status COPD and CHF Community based clinical pathways re-established	PHO Karyn Bousfield	Quarter 3 end

Targeted	support on discharge	DHB			Quarterly	
(at risk of	f readmission):	Kate N	McCrea	/ lan	monitoring	and
Measure	: Readmission rates	Elson/		Andrea	revision	
Gen Med	icine / Diabetes	Rooderl	kerk			

^{*}Note - Tentative work programs not yet with confirmed resource

SUMMARY OF CURRENT ACTIVITY

The following information provides a summary of activity undertaken specific to the four indicators listed for this report under ASH (Adult) 45-65. All data represented as Standardised Rates taken from MoH March Reporting (latest available report)

1. Heart Disease:

Standardised ASH rate, 45-64 Age group

	Angina and Chest Pain						
Ash ranking*		1:10					
Year	2016 2017 2018 2019						
Māori - HB	1515	1619	1710	1833			
Other - HB	927	1064	1008	999			
Māori –National	1476	1505	1511	1618			
	My	ocardia	l Infarcti	on			
Ash ranking*		2:	10				
Year	2016	2017	2018	2019			
Māori HB	828	788	671	815			
Other HB	432	368	401	436			
Māori –National	497	522	499	558			
	Con	gestive I	leart Fai	lure			
Ash ranking*		7:	10				
Year	2016	2017	2018	2019			
Māori HB	626	685	508	661			
Other HB	51	90	144	99			
Māori –National	467						

^{*}HB ranking as per March 2019 MoH Data

Actions:

Targeted approaches to areas with high admission rates – cardiac (Māori)

A Nurse Practitioner intern was appointed to the CNS cardiac workforce with a primary care focus. Analysis of data showed areas of high readmission rates specifically related to Congestive Heart Failure. Practice with high readmission rates have been supported by this specialist workforce in the management of these patients.

Limitations: The project team working on developing the PCI initiative for HB has identified significant areas for improvement in relation to screening, management and follow up that need to be addressed before the project can proceed. The current CNS FTE for Cardiac is 1.0 FTE the department is applying to increase this to 2.0 FTE.

Note: CVDRA screening is reported against under an alternative report heading. Current rates for Māori Male in the 34-44 age band is 61% with a 5% decline rate. The PHO has employed additional resource and different approaches to screening in order to improve this result (the target is 90%)

2. Skin Infections - Cellulitis

	Skin – Cellulitis				
Ash ranking*	3:10				
Year	2016 2017 2018 20				
Māori - HB	680	679	857	1020	
Other - HB	230	241	273	292	
Māori –National	697	749	813	762	

Actions: Cellulitis management inclusive of IV therapy in primary care is still supported by clinical pathways and the coordinated primary options program. No additional work has been undertaken for this age band (45-65).

3. Respiratory

	COPD			
Ash ranking*		4:	10	
Year	2016	2017	2018	2019
Māori - HB	775	1106	894	1010
Other - HB	188	149	213	260
Māori –National	941	922	995	944
		Pneur	nonia	
Ash ranking*		5:	10	
Year	2016	2017	2018	2019
Māori - HB	433	503	650	743
Other - HB	166	194	195	173
Māori –National	560	546	625	579

Actions: The CNS workforce in coordination with primary care continue to provide ongoing specialist support to targeted populations (Māori and high needs) They work in primary care building capacity and capability within this workforce to manage from early diagnosis to management focusing on high need population groups.

To better provide an across the lifespan approach the respiratory program now includes direct work with an NGO who works directly with whanau post discharge. (The focus is on whanau of 0-4 yr olds)

In the year to date 613 people were seen through this service, 26% were Māori. This programme delivers across age bandings and has a key focus to confirm diagnosis, and provide patient education and early intervention. Contracts for these services now include greater emphasis on equity in the access and utilisation of services and in the health outcomes expected as a result.

4. Diabetes

	Diabetes				
Ash ranking*	Not w	Not within Top 10 conditions			
Year	2016	2017	2018	2019	
Māori - HB	433	503	650	743	
Other - HB	166	194	195	173	
Māori –National	560	546	625	579	

Actions:

Coordination of Care and Transitions of Care are the two focus areas chosen for the period 2018-20 as part of the implementation of the HBDHB LTC Framework. Quality improvement activities. These areas are essential to ensure timely access to care, and appropriate support for patients. Specific activities that have been enacted are listed below under secondary and primary service headings.

Secondary Services

- Improve identification of patients needing specialist diabetes services on initiation of an admission: the referral and entry criteria to the diabetes service was reviewed as part of a quality improvement activity. What has resulted is a standardised entry criteria, service activity mapping and then onward referral processes. Improvements in this process will ensure no one gets left behind.
- o Improve discharge planning: A workforce development programme has been delivered for inpatient staff with the objective to improve discharge planning.
- Development of a shared care model of care is being developed between renal and diabetes working
 with a cohort of patients from an identified high need practice. This is at its preliminary stage. The
 objective is improved coordination of care and the efficient utilisation of specialist workforce –
 supporting general practice and reducing demand on secondary services.

Primary Care

- Work continues in establishing a diabetes repository that will monitor all screening and management
 activity with the view to ensuring; risk is managed with appropriate and timely service, equity of
 services for Māori particularly those living in rural areas has been the driver.
- Contracting and reporting of renal and podiatry services has been reviewed to better reflect equity of
 access to services and aligned to risk management. This is being trialled by providers currently in
 preparation of procurement process for 2020.

5. Generic approaches to addressing ASH as part of the LTC Framework implementation

A LTC Flag identifier is being developed for the purpose of identifying the full clinical team (and potentially lead) who should be involved in a patients care; on admission and throughout an inpatient stay. Context: 15% of the adult population have one or more LTC over 40% are Māori. It is important that their care is managed holistically. Currently there is no system approach to identifying the LTCs of any one individual. Work has been completed in mapping ICD10 codes relating to; Diabetes, Mental Health, Renal, Cardiac and Respiratory Disease.



ADULT HEALTH - Cardiovascular

Author/s:	Andy Phillips – Hospital Commissioner
Contributors	Andy Phillips, Chris Ash
Date:	Sept 2019

MĀORI HEALTH PLAN INDICATOR: ADULT HEALTH

This report provides an update the following indicators for Adult Health:

Cardiovascular	1. 90% of eligible 35-55 year olds that have	≥90%	Mark	Andy Phillips	OCT 2019
National Indicator	received a heart and diabetes check.		Peterson		
	2. 70% of all ACS patients that will have an				
	angiogram within 3 days of admission.	≥70%			
	95% of patients presenting with ACS who undergo coronary angiography have				
	completion of ANZACS QI ACS AND Cath/PCI registry data collection within 30 days	≥95%			

CHAMPION'S REVIEW: ACTIVITY DELIVERED TO IMPROVE ACCESS FOR 45 - 64 YEAR OLDS

CONTEXT

A headline objective set out within the Hawke's Bay Health Strategy 2019-2029 is to increase healthy life expectancy for all and halve the life expectancy gap between Maori and non-Maori. In our Annual Plan we commit to early detection and trearment to maximise wellbeing. We have said that for people at risk of illness or injury we will undertake activities that raise awareness and recognition of risky behaiours. We have noted the importance of supporting our whanau to identify risk early and make behavioural changes and provide prompt treatment.

Maori get heart disease 10-15 years earlier than non- Māori, are 72% more likely to be hospitalised with cardiovascular disease and are 87% more likely to have an acute cardiac event. Maori are 330% more likely to be admitted with heart failure and 85% more likely to be re-admitted with heart failure in 30 days. Of the patients seen in the heart function (failure) clinic, 52% are Māori men of working age and three quarters of Māori seen in this clinic are between 20 and 65 years old.

Coronary heart disease is the biggest cause of avoidable death across all ethnic groups. For Māori nearly a quarter of all avoidable deaths can be prevented if we can improve heart health. For Māori, lung cancer is the second biggest, followed by suicide and road crashes. For Pacific people, coronary heart disease is followed by diabetes, suicide and stroke. For NZ European/Other, coronary heart and lung cancer are also top causes, alongside bowel and breast cancer. More likely to live rurally

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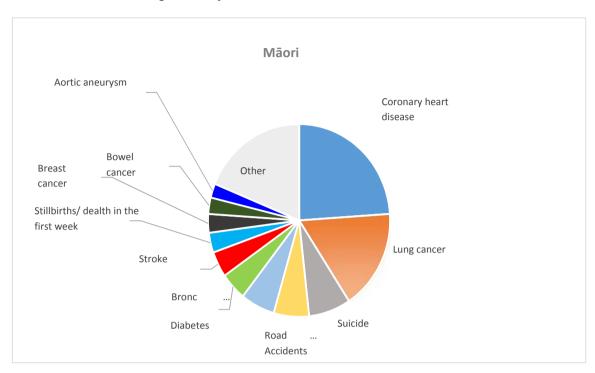
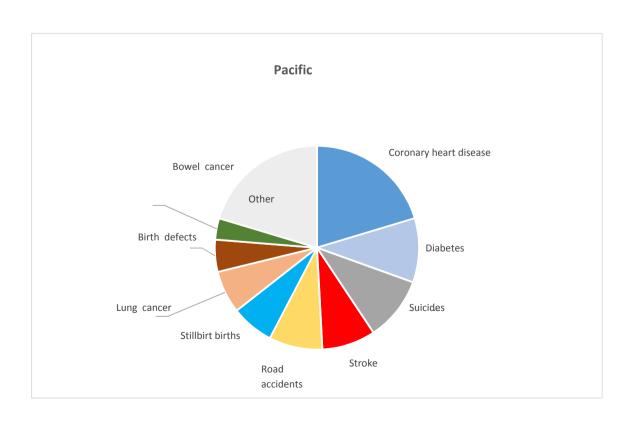


Figure 1: Major causes of Avoidable Deaths in New Zealand



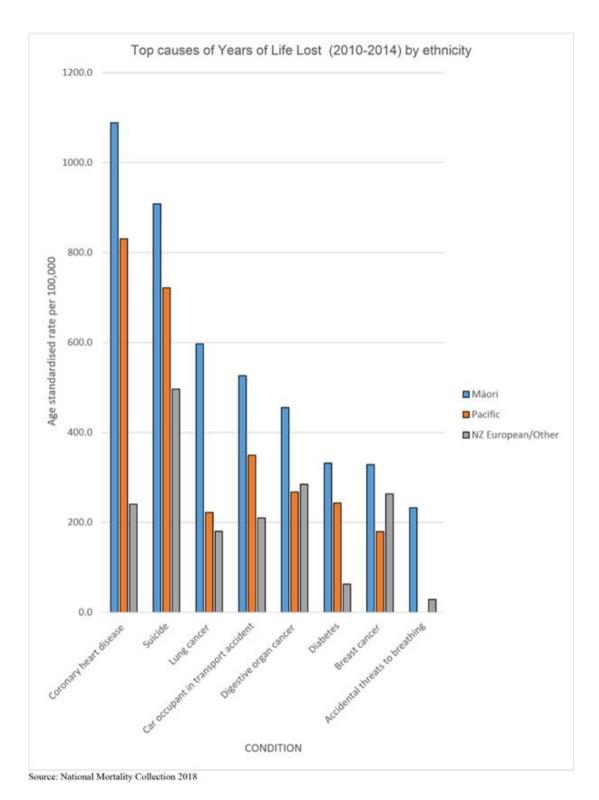
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Another way of looking at premature deaths as shown in Figure 2 is to calculate the average years a person would have lived if they had not died early. This method, known as Years of Life Lost (YLL), emphasises the importance of deaths which occur at earlier ages because there are more years of life lost. Top causes of Years of Life Lost for Māori are coronary heart disease, suicide, lung cancer and road traffic crashes.

Figure 2: TOP causes of Years of Life Lost (2010-2014) by Ethnicity

Other

Coronary heart diseases Diabetes Oesophagus cancer Other Birth Lung cancer defects Alcohol 이 Road Skin cancer Road traffic Bower.. injuries cancer Bronchitis ... Suicide Stroke Breast cancer...



Actions to avoid these early deaths of our whanau

Prevention

We need to support our whanau to stop smoking, eat more nutritious kai, engage in more physical activity and reduce alcohol intake. Methamphetamine and other drugs are known to harm heart health. Health behaviours are linked to underlying social conditions, emotional trauma early in life, inter-generational disadvantage and the effects of colonisation, feelings of empowerment (which are lower in more deprived communities) and the ease of healthy choices in the surrounding environment. An example of this is the

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higher density of fast food and alcohol outlets in low income communities, making the healthy choice much harder to make.

We know that socioeconomic factors are responsible for 42-46 percent of inequities so improving the income, housing, education and employment of our whanau would greatly reduce the equity gap in deaths over the long term.

Providing equitable and timely health care services

Māori are more likely to die early from a condition which was potentially avoidable through the effective and timely use of health services. Coronary heart disease is by far the largest of these causes of death.

Patient Story 1: Mr T presented to his GP Friday morning and a blood test showed evidence of a heart attack. He was admitted to the coronary care unit and discussed with CCDHB, for transfer next day. On Saturday he was made ready for transfer to CCDHB but the helicopter flight was cancelled due to wellingtonn weather. He was transferred Sunday, and received procedure Monday, 3 days after presentation. He was eventually discharged from HBDHB, but his heart attack was debilitating. He was 54 years old.

Māori and Pacific people not using the health services that will help them to live longer. We need to clearly understand what is preventing them from entering the system at the right time, and what is happening on their journey through the system. We need to redesign the health system to improve opening hours, resolve transport and cost, make the health system less complex and easier to navigate, improve cultural responsiveness of our services and eradicate subjective/ethnic bias within the system.

Patient Story 2: 70% of the patients we send to CCDHB are discharged from that hospital and have to find/arrange their own way back home from Wellington. Mrs B was told she was for discharge early afternoon. She had no family or support in town, and her husband did not drive. She was able to get a friend to come and get her. She was discharged late afternoon, her ride still on its way. She waited in the train station from 5pm until she was picked up. She was 76 years old

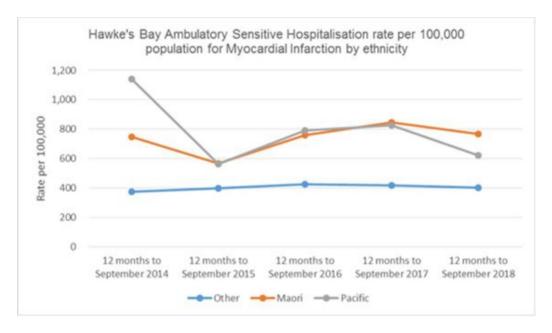
Some common themes in Hawke's Bay are :

- Rates of early and avoidable deaths for Māori and Pacific people have stopped declining while decline has continued for NZ European/Other. Reducing inequity will require focusing on heart disease, lung cancer, suicide and vehicle crashes for Māori and heart disease, diabetes, suicide and stroke for Pacific people.
- Similar patterns of inequity are also evident in hospital stays that can be avoided through better community care. For adults aged 45-64 years, inequity for Māori and Pacific people is increasing and the biggest inequities are in avoidable hospital stays for heart attacks, chronic lung disease and skin infections.
- There is more to health than hospital stays and dying and other measures of health service performance such as those linked to sexual health show persisting inequities reflecting the need for an increased focus on youth health services. This report also highlights the importance of mental health and family violence as key issues.

We noted current performance of cardiovasular risk assessment:

	Maori	Pasifika Other	Total	2019/20	Target
Five years to December 201884%	80%	87%	86%		> 90%
31/08/2019	78.3%	75.7%	83%	81.4%	> 90%

Avoidable hospital stays for Māori and Pacific adults aged 45-64 years are increasing. This is driven by increases in hospital stays for heart attacks, chronic lung disease and skin infection.

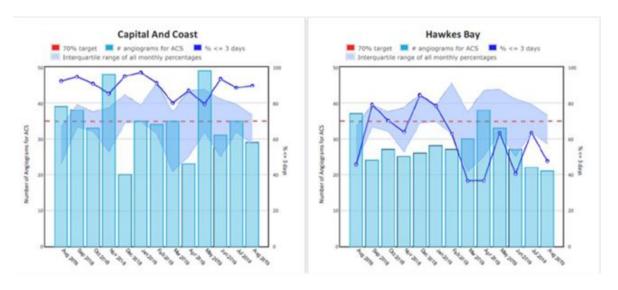


A further objective is to minimise complications of health conditions and slow down disease progression. Our commitment is to diagnose accurately and offer our whanau the most effective treatment as early as possible. We further commit to coordinating activities that support people to reduce the complications of disease so that they have better health and longer survival, are better able to participate in society and be more independent.

Angiogram within three days

Last quarter the HBDHBs performance for angiogram within three days was 46% - 49% Maori and 48% European/other. We continue not to meet this target due to limited dedicated cardiac catheter laboratory sessions (angiograms) at the HBDHB for diagnostic purposes only.

We relying heavily on other DHB's (mainly CCDHB), for cardiac angiography procedures including intervention, and continue to have delayed transfer times due limited bed availability and angiogram capacity at these hospitals. We have seen patients outsourced to other DHB's trying to manage this target including using Waikato and Nelson hospitals. This performance is similar to previous quarter's figures.



Current performance in terms of access to diagnostics :

	Maori	Pasifika Otl	her	Total 2019/20	Target
Accepted for					
Coronary angiography					
Completed <90 days	66%	50%	61%	60%	> 70%

We noted current performance for people with acute coronary syndrome for January to December 2018 as:

	Maori	Pasifika Other	Total 2019/	20 Target	
Coronary Angiogram DoorTo Cath within 3 Days	57%	50%	64%	61%	> 70%
Coronary Angiogram Pre-discharge LVEF	64%	75%	66%	66%	>85%
Secondary Prevention Medication	67%	80%	51%	55%	>85%
ANZACS data within 30 days	93%	100%	98%	97%	>95%
ANZACS data within 3/12	100%	100%	100%	100%	>99%

Treatment

HBDHB has the longest wait times for coronary angiography and PCI in the Central Region. We are failing to meet minimum standards for Heart Failure disease management. We are failing to meet minimum standards for echocardiography, including surveillance scanning for known disease conditions. Patients should be seen in the heart function (failure) clinic within 14 days and currently are 80-120 days. The backlog for echocardiography is 13 months overdue for routine echo tests, with at least 800 people on the list. We know that known valve disease patients must be scanned regularly as a lead up to surgery but there are multiple events where this has not happened.

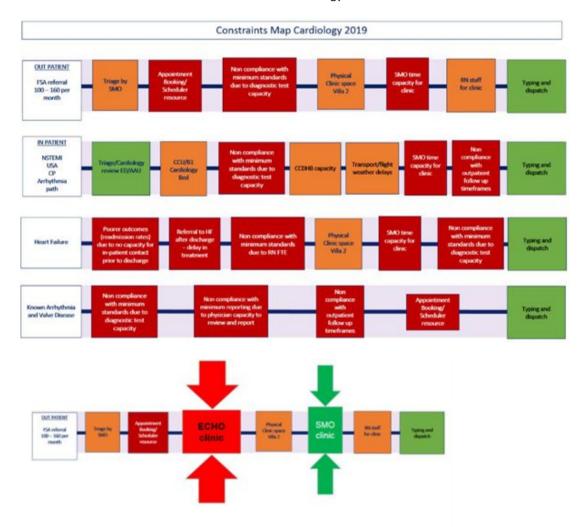
We are currently actively seeking to improve our non-interventional cardiology service where a number of patients have come to harm due to lack of capacity within the cardiology service. We need to increase the number of echocardiography technicians, Cardiologist FTE and clinical nurse specialists.

In terms of the quality of our interventional services in meeting National standards, zero patients within HB receive primary percutaneous coronary intervention (PCI) within 120 mins due to a need for these procedures to be performed in Wellington. Whilst the non-interventional cardiology service is being stabilised we will carry out a full business case analysis to investigate. We currently spend 1400 bed days per year for cardiology waiting with average over 4 days specifically for angio/PCI. Over three quarters of patients that were waiting for procedures we could do in Hawke's Bay. Of the beds in the cardiology unit, over half are occupied by patients waiting for procedures that could be carried out in Hawke's Bay

In terms of intervention including heart surgery, our intervention rates are very low as shown below:

	HB SIR	National Average	Ratio	Group
Cardiology	3.79	5.60	0.68	Significantly below
Cardiothoracic	3.67	4.38	0.84	No significant difference

There are workforce and facilities constraints for Cardiology that are shown below:



CHAMPION'S REPORT: ACTIVITY THAT WILL OCCUR TO INCREASE ACCESS FOR ADULTS AGED 45 – 64 YEARS IN THE NEXT 12 MONTHS

NEXT STEPS AND RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Cardiology Review	Complete Implementation of Action Plan	EDPS	1 July 2020
Stabilise Cardiology Service	2. Increase Echocardiographer FTE from 2 to 3	EDPS	1 July 2020
	3. Increase Cardiologist FTE by 1 FTE		
	4. Increase CNS FTE by 1 FTE		
PCI Service	Investigate Case for Primary PCI in HB	EDPS	1 July 2020



Smokefree: % of pregnant Māori women that are smoke free at 2 weeks postnatal

Author:	Johanna Wilson
Designation:	Smokefree Programme Manager
Date:	September 2019

MĀORI HEALTH PLAN INDICATOR: ADULT HEALTH

This report provides an update the following indicators for Adult Health:

Smoking	Percentage of pregnant Māori	≥90%	Bernard Te	Johanna	OCT 2019
National Indicator	women that are smokefree at 2-		Paa	Wilson	
	weeks postnatal				

PURPOSE

This is a sub-report of the inaugural Te Ara Whakawaiora joint report covering Adult Health Access for 45-64 year olds; Cardiovascular Health Services; and smokefree services for Pregnant Māori women (Table 1). The report highlights the implementation status of the smokefree activities delivered in the past six months to improve health outcomes for Māori women; the Champion's report of activities which will be implemented in the next six months to improve equity in health outcomes for Māori women who smoke; and key recommendations.

CONTEXT

According to the 2017/18 census data smoking trends in New Zealand appear to be going down. A growing proportion of young people in Hawke's Bay are choosing not to smoke. Smoking trends among 15– 17year-olds, for example, appear to have dropped from 16% in 2006/07 to 3.6% in 2017/18. Māori have the highest smoking rates and Māori women are three times more likely to smoke than non-Māori women. Thirty-three percent of Māori adults are reported as current smokers in the 2017/18 census data down from 42% in 2006/07 while data on their female counterpart appear to have dropped from 45% in 2006/07 to 37%. However, despite these encouraging trends, the smoking trends are not reflected across all populations, with Māori and Pacific peoples still smoking at high rates. In Hawke's Bay, for example, five adults still smoke daily compared with one in six nationally.

WHY IS THIS INDICATOR IMPORTANT?

Smoking during pregnancy is the leading cause of Sudden Unexpected Death in Infancy (SUDI) and accounts for 86% of SUDI cases between 2006 and 2010 (in comparison, if the mother is a non-smoker the rates of accounted SUDI is 14%)². Based on the Ministry of Health reports, about 13% of pregnant women are reported to be smokers.³ This is down from 16% in 2008. Pregnant women under 20 years-old (31%) and Māori (35%)

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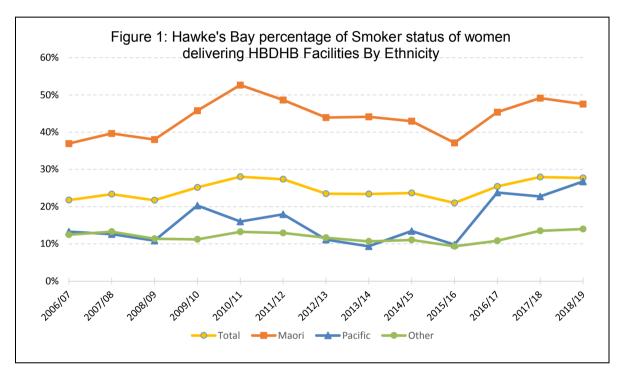
¹ Ministry of Health. (2018). Annual Update of Key Results 2017/18: New Zealand Health Survey. Wellington: Ministry of Health.

² Ministry of Health (2013). SUDI Statistics 2006-2010. Wellington: Ministry of Health

³ Ministry of Health. (2019). Report on maternity, 2017. Wellington: Ministry of Health

are more likely to be smokers. Pregnant women living in the poorer communities (24%) are more likely to be smokers than those living in the wealthiest communities (4%).

The 2018 Hawkes Bay District Health Equity Report expresses concerns on the slow trends in cutting down the number of maternal smoking rates since 2007. As shown in Figure 1 below, while smoking rates may have appered to be going down from 56.6% in 2010/11 to about 37.1% in 2015/16, the rates suddenly took an upward turn to 49.1% in 2017/18 and 47.5% in 2018/19 showing no sign of coming down as fast. This trend shows a continued growth in the levels of inequalities between Māori and Other from 27.1% in 2015/16 to 33.5% in 2018/19. Apparently maternal smoking among the the Pacific people appears to have also taken an upward trend from less than 10% in 2015/16 26.7% in 2018/19 widening the inequity level between Pacific and other by 12.8%. These statistics call for more comprehensive approaches to lower the smoking rates for both Māori and Pacifca women and their whanau.



Sources: HBDHB

CHAMPION'S REVIEW: ACTIVITY DELIVERED TO IMPROVE HEALTH OUTCOMES FOR MĀORI WOMEN WHO SMOKE

Increasing Smokefree Pregnancies Programme (ISPP)

In June 2018, HBDHB and Te Haa Matea (HB Stop Smoking Services) reviewed the ISPP and made several recommendations to accelerate stop smoking behavior among Wahine Hapu and their whānau. These included the following:

- Marketing the ISPP as a whānau opportunity to quit smoking for the new baby. By targeting smoking behaviours and norms within the wider whānau, the Wahine Hapu prospects of attempting to quit attempt and staying smokefree were increased
- Promoting the ISPP directly to Wahine Hapu and her whānau to increase self-referrals through
 the establishment of face-book page and the 0800 number to enhance access to Smokefree
 Service and support to Wahine Hapu and her whānau.

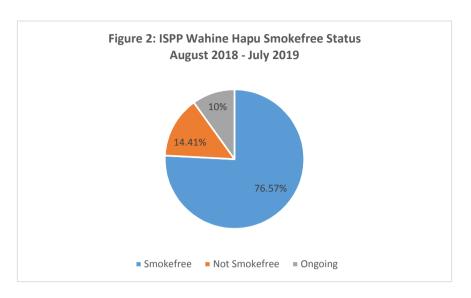
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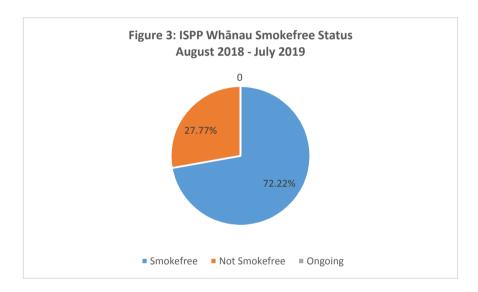


- Promoting ISPP more widely in the health and social sector through production and distribution
 of promotional materials among GPs, Tamariki Ora and Well Child providers, Te Haa Matea
 services, LMCs and Midwives, and workplaces including health promotion events in collaboration
 with other Hauora providers
- Enhancing incentive packages to include whānau members. Huggies Nappies which one of the core incentives in the programme appear to be cost-effective, appropriate and acceptable to our health professionals, key stakeholders, pregnant women and their whānau. Since July 2018 Huggies has been providing nappies to HBDHB towards ISPP programme at a cost of \$100 which are given free to Wahine Hapu per quit. These come in five sizes (Newborn, Infants, Crawlers, Toddlers and Walkers) of which, two sizes (Newborn and Infants). Other incentives packages now include grocery vouchers for both Wahine Hapu and whānau members who quit smoking.
- Improving the ease and speed of the referral process by modifying and reducing the amount of
 information required for referrals and enabling self-referrals via Te Haa Matea facebook page,
 text or email. The time lag between referral and follow up has also been reduced significantly.
- Increasing cessation support capacity in the communities. Te Haa Matea and the HBDHB Smokefree Service have been identifying and providing financial resources and capability training to other Stop Smoking Practitioners in the community including Kahungunu Executive, Plunket, Whatever It Takes Trust.
- Improving the quality if ISPP data and outcome analysis. ISPP spreadsheet was developed and shared with all Stop Smoking Practitioners to follow the pregnant women and their whānau on their smokefree journey, track CO monitor readings, track incentive distribution and quit rates. This data is collected monthly by all practitioners and sent to the HBDHB Smokefree Service for analysis.

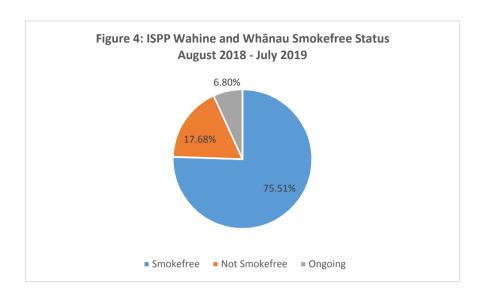
Following the changes made to ISPP we have seen an increase in referrals, enrolments and quit rates for both Wahine Hapu and Whānau. As shown in Figure 2, for example, of the 111 Wahine Hapu enrolled between August 2018 – July 2019, 76.6% were reported to be smokefree by the end of the 8 week programme while 10% are still on the programme. The rest (14.4%) are still not smokefree.



Similarly, of the group of 36 whanau enrolled during the same period (August 2018 - July 2019)(Figure 3), 72.2% were smokefree at the end of 8 weeks while 27.8% were reported not to be smokefree.



Apparently, of the 147 wahine hapu and whānau enrolled during the period, 75.5% were reported to be smokefree compared with 17.7% who continued to smoke during the 8 weeks programme. About 6.8% were still in the programme (Figure 4).



The changes made in the ISPP were a product of whanau voices in action. Through consultations with our pregnant women, new mums as well as wider whānau members, key stakeholders and practitioners we were able not only to learn the best ways to engage wahine hap and their whānau butalso on the importance of having more practitioners on the ground to carter for increasing demand for services. The quit rates observed here appear to be quite encouraging. The rates are likely to improve as more people in the communities become familiar with the new initiatives in the programme. We have developed a survey form which will enable us to make contact with all women and whānau at three months after completing the programme. We are also contacting those who did not complete the programme to re-engage with the programme as well as understanding how best we can attract new clients and supporting them to be smokefree.

"I am so happy to be smokefree. This programme was awesome. I chose this programme because of the incentives. My smoking practitioner was very supportive and had a lot of info to share with me ©." (Smokefree client).

The CO-free Homes project – Carbon Monoxide Screening in Pregnancy

Carbon Monoxide (CO) is a poisonous, invisible, tasteless gas that can kill people. It is present in exhaust fumes, faulty gas appliances, coal/wood fires and tobacco smoke. Exposure to CO during pregnancy causes serious harm to the health of the developing foetus.

In light of this knowledge, HBDHB and Te Haa Matea (HB Stop Smoking Services) launched a pilot project which provided midwives based at the Maternity Services and Wairoa Hospital with a CO Monitors (similar to breathalyser monitors) with the objective of enhancing smokefree conversations between the midwife and the Wahine hapu and her whānau under Wahine Hapu ISPP. The pilot project ran from 1 September to 30 November 2018 with evaluation findings shared with the midwife team in December 2018. While the pilot did not increase the number of referrals to ISPP the midwives valued the smokefree resources, cessation support and the CO monitor as it helped to build their confidence in having this difficult conversation with wahine hapu and Whānau

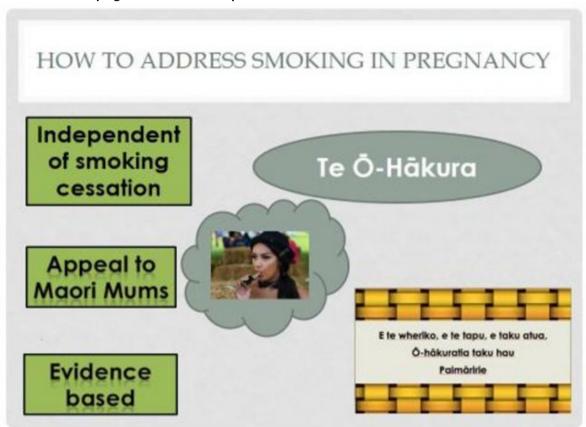
In June 2019, the HBDHB Smokefree Service purchased and distributed fifteen carbon monoxide monitors to Independent Midwives (LMCs) working predominately with Māori and Pacific Wahine in the Hastings, CHB and Napier areas. They received Smokefree education and training to encourage them to have the Smokefree conversations, explain the benefits of being smokefree and to demonstrate how much carbon monoxide the mum and her baby are exposed to from smoking during pregnancy. This has contributed to the increase in referrals to ISPP in Wairoa as the midwives routinely screen for CO at each home visit. The programme is now using LMCs to distribute the ISPP incentives rather than the Stop Smoking Practitioners. We are confident that, over time, this will happen in the rest of the Hawke's Bay region.

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The HBDHB Smokefree Service team includes a 0.6FTE Maternal & Child Health Coordinator who is a practicing midwife with Te Atarangi, Maternity services. This role is instrumental in working closely with community and hospital based midwives to support Wahine Hapu and whānau become smokefree. Engagement with community and hospital-based midwives, while slow, is positive and ongoing. Gift packs of smokefree car sunscreen shades, lip balm, pens, toothbrush and toothpaste are given to LMC's to share with their clients and whānau. A smokefree education day is in the planning process for March 2020 to bring together LMC's, midwives and stop smoking practitioners to hear about Vaping as a cessation aid and to brainstorm on how to work more effectively together with our clients. Our internal relationships are just as important as our external stakeholders if we are to make a difference to our Māori women and her whānau.

CHAMPION'S REPORT: ACTIVITY THAT WILL OCCUR TO INCREASE EQUITY IN HEALTH OUTCOMES FOR MĀORI WOMEN WHO SMOKE

Te Ö-Hākura a Vaping Pilot for Wahine Hapu



HBDHB and Te Haa Matea have been working with Dr David Tipene-Leach exploring smoking in pregnancy through the Wahakura Lens. Te \bar{O} -Hākura is encouraging pregnant women and their partner who chooses to Vape to learn how to use the device as a cessation tool and say a karakia to give them strength to be smokefree during and after pregnancy -

E te wheriko, e te tapu, e taku atua, Ō-hākuratia taku hau Paimārirei The purpose of Te Ō-Hākura is to empower women and her partner to provide a smokefree environment to the unborn pepi and whanau. This pilot will be implemented in November 2019, involves Vape training for all Hawke's Bay Stop Smoking Practitioners with access to 200 devices in the first year. The project will be evalutated within the 2019 / 2020 year.

HBDHB and Te Haa Matea strive to reach the Smokefree Aotearoa 2025 goal. Ongoing monitoring of this programme and witnessing the success of smokefree women and their whānau provides the rationale for continuing to invest in supporting our Māori whānau lead smokefree lives.

Tuai Kōpu programme

HBDHB propose to investigate a service redesign for Hawke's Bay wahine hapu to actively "reduce the number of cars up the driveway" and facilitate commitment to relationship centered practice. The redesign proposes to achieve the following outcomes: -

- Establishment of a coordinator role within the HBDHB Smokefree Service to design the **Tuai Kōpu programme**, coordinate delivery and engage partners
- Investigate establishing a centralized referral form / web accessible tool to increase visibility and access to Tuai Kopu supports, including help to find a midwife as early as possible in pregnancy and access to ISPP
- Align with other DHB non-clinical services.

The development of this programme will improve maternal health outcomes for Māori and Pacifica women, their pepi and wider whanau. Remove barriers to access to care for Māori and Pacifica women, and empower them to make informed decisions about their health and well-being. It is envisaged that the Tuai Kopu programme will also start in November 2019.

NEXT STEPS AND RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Wahine Hapu programme	Continue to review programme Update survey form to include vaping	Johanna Wilson / Smokefree Service	Q2, Q3 2019
Te Ō-Hākura	Development of Te Ō-Hākura project plan and reporting template with Te Haa Matea Governance and Operational groups Organise Vape training for Stop Smoking	Johanna Wilson	Commence Q2 2019
	Practitioners 3. Roll out Te Ō-Hākura with Wahine Hapu and her partner. 4. Evaluate Te Ō-Hākura		

Tuai Kōpu programme		Development of Tuai Kōpu service alignment pilot, reporting template and job description Commence recruitment	Johanna Wilson / Tracy Ashworth / Rawinia Edwards	Q2 2019
	3.	drive and interview Commence pilot		
CO-free Homes project	2.	Continue to support Midwives with Smokefree resources and education Investigate purchasing CO monitors for all LMC's based in the Hawke's Bay region	Johanna Wilson / Smokefree Service	Q4 2020



Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

- 22. Confirmation of previous minutes 25 September Public Excluded
- 23. Matters Arising (public excluded)
- 24. Board Approval of Actions exceeding limits delegated by CEO
- 25. Chair's Update
- 26. CEO report to Board (Public excluded)
- 27. HB Clinical Council report to Board (public excluded)
- 28. Chief Medical Officer verbal report
- 29. Planning & Funding report (public excluded)
- 30. Finance Risk and Audit Committee

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

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