



BOARD MEETING

Date: Wednesday, 31 August 2016

Time: 1.00pm

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

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

Apologies: -

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

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Routine	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report - verbal	-	
8.	Chief Executive Officer's Report	84	
9.	Financial Performance Report	85	
10.	Consumer Story (Kate Coley)	-	

Board Meeting 31 August 2016 - Agenda

	Section 2: Reports from Committee Chairs		
11.	HB Clinical Council (Chris McKenna & Dr Mark Peterson)	86	1.50
12.	HB Health Consumer Council (Chair, Graeme Norton) - Endorsement of appointment of Replacement Council Member (Ken Foote)	87	
13.	Māori Relationship Board (Deputy Chair, Heather Skipworth)	88	
	Section 3: Decision		
14.	Health Partnerships – Shareholder Approval Request (Ken Foote) NZ Health Partnerships Annual Plan 2016-17 NZ Health Partnerships SOI and SOP Expectations for 2016-17 Heads of Agreement	89	2.15
15.	Community Based Pharmacy Services in HB (Tim Evans & Billy Allan)	90	2.20
	Section 4: Presentation and Discussion		
16.	Travel Plan (Sharon Mason & Andrea Beattie)	91	2.30
	Section 5: Monitoring		
17.	Transform and Sustain Strategic Dashboard Q4 Apr-Jun 16 (Tim Evans)	92	2.40
18.	HBDHB Performance Framework Exceptions Report Q4 Apr-Jun 16 (Tim Evans) - HBDHB Performance Monitoring Dashboard Q3 2015/16 provided by MoH	93	2.45
19.	Annual Māori Plan Q4 Apr-Jun 2016 Non-Financial Exceptions (Tracee TeHuia) - Annual Māori Plan Q4 2015/16 Dashboard (Tracee TeHuia)	94	2.55
20.	Te Ara Whakawaiaora / Culturally Competent Workforce (Paul Davies. HR)	95	3.05
21.	Te Ara Whakawaiaora / Mental Health (Sharon Mason & Allison Stevenson)	96	3.15
22.	HR KPIs Q4 Apr-June 2016 (Jim Scott, HR)	97	3.25
	Section 6: General Business		
	Section 7: Recommendation to Exclude		
23.	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 8: Agenda Items	Ref #	Time (pm)
24.	Minutes of Previous Meeting		3.35
25.	Matters Arising – Review of Actions (nil)		
26.	Board Approval of Actions exceeding limits delegated by CEO NIL	-	
27.	Chair's Report (verbal)		
	Section 9: Reports from Committee Chair		
28.	Finance Risk & Audit Committee (Dan Druzianic)	98	3.40
29.	HB Clinical Council (Chris McKenna & Dr Mark Peterson)	99	3.55

Next Meeting: 1.00 pm, Wednesday 28 September 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Board "Interest Register" - 4 August 2016

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

Board Meeting 31 August 2016 - Interests Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair	7.12.10
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Andrew Blair	Active	Owner of Andrew Blair Consulting Limited	Engaged from time to time to provide consultancy and advisory services to healthcare and other organisations.	Will not take part in decision relating to organisations to which he provide consultancy and advisory services.	The Chair	04.12.13
	Active	Advisor to Trustees and Management of Chelsea Hospital Trust	Engaged to provide advisory services to the Trust who own and operate the private hospital in Gisborne.	Will not take part in decisions relating to services HBDHB may from time to time engage.	The Chair	24.07.14
	Active	Advisor to Hawke's Bay Orthopaedic Group Ltd	Engaged to provide advisory services to the Group	Will not provide advice in relation to contracting, employment or relationship matters between the HBOG and HBDHB. Will not participate in any decisions made by HBDHB regarding orthopaedic services.	The Chair	19.09.15
	Active	Chair of Southern Partnership Group	Southern Partnership is to progress the facilities redevelopment of Dunedin Hospital.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	19.09.15
	Active	Director, Breastscreen Auckland Limited	Breast screening facility.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.15
	Active	Director, St Marks Womans Health (Remuera) Limited	Womans Health facility in Auckland	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.15
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 covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumataua - 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	Will not take part in any discussions or decisions relating to the Contract with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14

**MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 27 JULY 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM**

Present:	Kevin Atkinson (Chair) Dan Druzianic Andrew Blair Peter Dunkerley Diana Kirton Barbara Arnott Helen Francis Heather Skipworth Jacoby Poulain Denise Eaglesome
Apology	Ngahiwi Tomoana
In Attendance:	Kevin Snee (Chief Executive Officer) Members of the Executive Management Team Dr John Gommans for HB Clinical Council Graeme Norton (Chair, HB Health Consumer Council) Members of the public and media
Minutes	Brenda Crene

KARAKIA

Heather Skipworth opened the meeting with a Karakia.

APOLOGY

Noted above from Ngahiwi Tomoana who was in talks with Ministers around the Regional Economic Strategy.

INTEREST REGISTER

No changes to the interests register were advised and no board member advised of any interest in the items on the Agenda.

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 29 June 2016, were confirmed as a correct record of the meeting.

Moved: Dan Druzianic
Seconded: Peter Dunkerley
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

- Item 1: Te Ara Whakawaiaora/Breastfeeding: Will be included in the CEO's report in September. Action remains.
- Item 2: Discussion with NKII to be held in September. Remove action.
- Item 3: MRB Recommendations: Nick Jones to respond.

Those raised in June had been addressed by HR under action item 4 and also under item 5.

- Item 4: Maori Staff Employed – paper provided to FRAC 27 July for consideration entitled “TAW / Culturally Competent Workforce” will be provided to the Board in August. Remove action.
- Item 5: Actioned
- Item 6: Ensure board agenda remains consistent (removing peaks and troughs). Noted, remove action.
- Item 7: Unnecessary to note interests for member Denise Eaglesome - remove action.

BOARD WORK PLAN

The Board Work Plan was noted and would be updated at least to calendar year end.

The papers in italics have been deferred.

31 Aug	Consumer Story Draft Quality Accounts Travel Plan update – verbal <i>Annual Organisational Development Plan/Programme now Nov</i> Community Based Pharmacy Services in HB - Strategic Direction <i>HB Integrated Palliative Care (Draft) now Sept</i> <i>Final HBDHB Annual Plan 16/17 SOI (on Diligent & Website)</i> Monitoring HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 16 Annual Maori Health Plan Q4 Apr-Jun 2016 Transform and Sustain Strategic Dashboard Q4 Apr-Jun 16 Human Resource KPIs Q4 Te Ara Whakawaiaora: Culturally Competent Workforce includes Maori Staffing Te Ara Whakawaiaora: Mental Health and Alcohol & Other Drugs	Kate Coley Kate Coley Sharon Mason <i>John McKeefry</i> Billy Allan Mary Wills Tim Evans Tracee TeHuia Tim Evans John McKeefry John McKeefry Allison Stevenson

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
Forbes Bennett	Intensivist	Acute & Medical	38	20-Jun-16
Pamela Walker	Medical Typist	Facilities & Operational Support	14	30-Jun-16

- John McKeefry's GM Human Resources resignation was acknowledged (effective end of August 2016). The Board thanked John sincerely for his contribution over the past seven years and wished him well for the future.
- Liz Stockley GM Primary Care and CEO of Health HB, had tendered her resignation earlier in July, effective at the end of October 2016.
- Congratulations were extended to Jacoby Poulain on the birth of her son during the month.
- During the month the Minister of Health advised the free flu vaccine would be extended for a further month.

- The Minister had endorsed the Central Region's Regional Service Plan for 2016/17, advising he planned to strengthen the role of RSPs in future.
- The National Health IT Board were disbanded and the MoH have replaced them with a new "Digital Advisory Board".

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report which included the end of year performance targets and advised the financial unaudited result was better than planned. At this stage HBDHB were a standout financially, on a population basis.

The Regional Economic Strategy had been launched that morning with ministers in attendance. There had been a number of announcements regarding investments to support infrastructure. The detail will be brought to the Board in August, noting we have an important part to play going forward.

Presently in the process of securing consultation on the social inclusion strategy.

FINANCIAL PERFORMANCE REPORT

The Financial Report for June 2016, showed a favourable variance of \$266 thousand for the month, with a year end result of \$376 thousand favourable with all contingencies used. This was a provisional, unaudited figure.

Technical adjustments (also made by the rest of the region's DHBs) included: reducing RHIP costs to capital operating costs by \$687 thousand; anticipating raised capital definition to \$2m which resulted in a number of assets being fully depreciated, and increased operating costs by \$448 thousand. The savings programme came in at 85% \$8.7m of the \$10.2m target. IDFs remain work in progress, with Capital spend behind plan by \$4.2m.

The Board expressed thanks to the team and staff for achieving the financial result to date.

NATIONAL PATIENT EXPERIENCE SURVEY RESULTS 2015-16

Kate Coley provided an overview of the presentation provided.

In summary:

Only a 21% response rate was received with a slight increase in Maori respondents (50 people, 15% - compared to 38 people, 11% last year) and youth 15–24 years (7.6%) (last year 4.8%).

We scored positively across all four domains (communication, coordination, partnership and physical and emotional needs). In several areas we tracked higher than the NZ average. During the survey we captured 503 positive words and 140 negative.

The plan now is to undertake a "local experience survey" and develop a "quarterly quality dashboard" to enable us to identify themes, trends and improvements made.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Council supported the following at their 13 July Meeting:

- The purpose and principles paper and business case for the establishment of Health & Social Care networks.
- The implementation plan for Clinical Governance Committees Structure
- The development of a position statement on reducing alcohol related harm.
- Ongoing work of the last days of life care planning
- The principles of the Transform & Sustain refresh and next steps.

Dr John Gommans attended on behalf of the co-chairs and specifically mentioned Health and Social Care Networks and Council's support for Executive Management Team's recommendation to move forward with Wairoa and Central HB in the first instance.

John advised he was now on leave for several months which included Council's AGM being held in August.

Hawke's Bay Health Consumer Council

Council supported the following at their 14 July 2016 meeting:

- The purpose and principles paper and business case for the establishment of Health & Social Care networks. Come such a long way and he felt consumers had been heard.
- The development of a position statement on reducing alcohol related harm.
- The principles of the Transform & Sustain Refresh but with some strong recommendations around integration of the 6 priorities.

In summary the Consumer Chair noted:

- Consumer members on steering groups still sense and experience siloed behaviours. The need to ensure a joint approach will ensure the goal of an integrated whole is achieved.
- Feel it is important to focus on what else is occurring out there (locally and nationally) and not try to reinvent the wheel.
- Suggested the Health Awards be "alcohol free" in support of Iwi who have made similar decisions around their functions and gatherings.

Māori Relationship Board (MRB)

Heather Skipworth (Acting Chair) provided an overview of their meeting held on 13 July 2016:

MRB wish to understand fluoridation prior to legislation being passed.

The workforce target: MRB are taking a leading role and solutions are being worked through that can make significant improvements.

Heat Tool is not applied across all papers provided to MRB. Presently the tool is being piloted and will come to MRB for endorsement shortly.

The Chair sought feedback from board members at the table who were part of MRB.

Board members responded positively about the value of MRB and that they felt much better informed and aware of Maori health issues, as a result of participating in discussions of MRB.

FOR DISCUSSION / DECISION

TRANSFORM & SUSTAIN REFRESH

Tim Evans (GM PIF) spoke to the report provided.

We are presently half way through a five year programme and need to ensure we have the capacity and focus on the right areas. The priorities list had been reaffirmed as well as focus on prior lessons learned. Kate Rawstron the new Project Office Manager had provided advice and guidance which had been taken on board.

PRESENTATION

UNDER 19 MENTAL HEALTH WAIT TARGET (0 to 19 year olds)

Allison Stevenson (Service Director) and Dr Simon Shaw spoke to the presentation they provided.

The paper related to target PP8 – The percentage of 0-19 year olds referred for non-urgent mental health or addiction services seen within 3 weeks (by a mental health service provider), 0 to 19 years.

This target had not been achieved (trending at around 60% of the 80% target). This resulted in a review of the service and within a three week period, the target had lifted to 96% of the 80% target.

Action: Several board members felt there may be unidentified and unmet mental health needs within the community for those under 19 years of age. Denise and Heather to provide Allison.stevenson@hbdhb.govt.nz with detail.

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

17. Confirmation of Minutes of Board Meeting
- Public Excluded
18. Matters Arising from the Minutes of Board Meeting - nil
- Public Excluded
19. Board Approval of Actions exceeding limits delegated by CEO - nil
20. Chair's Report

Reports and Recommendations from Committee Chairs

21. Finance Risk and Audit Committee Report
22. HB Clinical Council

Moved: Helen Francis

Seconded: Diana Kirton

Carried

The public section of the Board Meeting closed 2.30 pm

Signed:

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Chair

Date:

BOARD MEETING - MATTERS ARISING (Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	30/3/16	Te Ara Whakawaiaora / Breastfeeding: The Board wish to understand what other DHBs are doing and also to see where HB is benchmarked (including reasons and relative demographics).	Caroline McElroy / Nick Jones	Sept	This will be included in the CEO's September report.
2	25/5/16 29/6/16	MRB Recommendations: A response to items raised within the MRB's May Board Report to be prepared and provided to MRB. The linkages between the three strategies have been covered off in a report in June and are also represented in the Regional Economic Development Strategy.	Nick Jones for Caroline	Aug	Actioned
3	27/7/16	Under 19 Mental health Wait Target: Unidentified and unmet mental health needs in the community. Several board members (Denise and Heather) advised they would provide feedback on this directly to Allison.Stevenson@hbdhb.govt.nz	Sharon Mason	Aug	

HAWKE'S BAY DISTRICT HEALTH BOARD WORKPLAN

Meetings 2016	Papers and Topics	Lead(s)
28 Sept	Consumer Story Draft Developing a Person Whanau Centred Culture Final Quality Accounts Family Violence – Strategy Effectivess Orthopaedic Review Closure of phase one FROM AUGUST NKII MoU Relationship Review Mental Health Consolidation / Benefits Realisation Annual Report (interim) HB Integrated Palliative Care (Draft) – FROM JULY Health and Social Care Networks update (6 monthly Sept-Mar17) Pacifika Health Leadership Group Qtly Update Final HBDHB Annual Plan 16/17 SOI (on Diligent & Website) Regional Economic Development Strategy (REDS) Monitoring Te Ara Whakawaiaora / Obesity (National Indicator) Breastfeeding Indicator update (board Action)	Kate Coley Kate Coley Kate Coley Nick Jones Andy Phillips Ken Foote Sharon/Allison Stevenson Tim Evans Tim Evans / Mary Wills Liz Stockley Nick Jones Tim Evans / Carina Kevin Snee Nick Jones Nick Jones/Katie Kennedy
8 Oct	Election Day	
26 Oct	Consumer Story New Patient Safety and Experience Dashboard Alcohol Renal Stage 4 Final HB Integrated Palliative Care FROM SEPTEMBER Annual Report (Final) Final External Audit Report on agenda (P/excl) External Audit Engagement Arrangements Urgent Care Service Change Proposal	Kate Coley Kate Coley Caroline / Rachel Ayre Sharon Mason Tim Evans / Mary Wills Tim Evans Tim Evans Tim Evans Liz Stockley

2017	Papers and Topics	Lead(s)
24 Nov	HB Health Awards presentation evening	
30 Nov	Consumer Story Final Developing a Person Whanau Centred Culture Travel Plan (quarterly update) – verbal Tobacco – Annual Update on progress against Plan HB Integrated Palliative Care Annual Organisational Development Plan/Programme Endoscopy Project Build Update Monitoring Te Ara Whakawaiaora / Smoking (national Indicator) HBDHB Non-Financial Exceptions Report Q1 Jul-Sept 16 plus MoH dashboard Annual Maori Health Plan Q1 Jul-Sept 16 Transform and Sustain Strategic Dashboard Q1 Jul-Sept 16 Human Resource KPIs Q1 Staff Engagement Survey – any corrective actions	Kate Coley Kate Coley Sharon Mason / Andrea Caroline /Penny Tim Evans / Mary Wills HR Sharon Mason / Trent Caroline McElnay Tim Evans Tim Evans / Tracee Tim Evans HR Manager HR Manager
14 Dec	Consumer Story HB Workforce Plan – Discussion Document (Dec 16 – final March 17) Annual Organisational Development Plan/Programme - draft Orthopaedic Review – Phase 2 draft FROM SEPTEMBER Pasifika Health Leadership Group	Kate Coley HR Manager HR Manager Andy Phillips Caroline McElnay
2017	Papers and Topics	Lead(s)
22 Feb	Consumer Story Orthopaedic Review – phase 3 Draft Pasifika Health Leadership Group Qtly Monitoring HBDHB Non-Financial Exceptions Report Q2 Oct-Dec16 plus MoH dashboard Annual Maori Health Plan Q2 Oct-Dec16 Transform and Sustain Strategic Dashboard Q2 Oct-Dec16 Human Resource KPIs Q2 Te Ara Whakawaiaora / Access (local indicator) Te Ara Whakawaiaora / Cardiology (national indicator)	Kate Coley Andy Phillips Caroline McElnay Tim Evans Tim Evans Tim Evans HR Manager Mark Peterson John Gommans
29 Mar	Consumer Story Pasifika Health Leadership Group HBDHB Workforce Plan – Final Travel Plan Update Te Ara Whakawaiaora / Breastfeeding (national indicator) Health and Social Care Networks (6 monthly update)	Kate Coley Caroline McElnay HR Manager Sharon Mason Caroline McElnay Belinda Sleight



CHAIR'S REPORT

Verbal

 HAWKE'S BAY District Health Board Whakawāteatia	Chief Executive Officer's Report	84
	For the attention of: HBDHB Board	
Document Owner:	Dr Kevin Snee, Chief Executive Officer	
Reviewed by:	Not applicable	
Month: As at	24 August 2016	
Consideration:	For Information	

Recommendations

That the Board

1. Note the contents of this report.

INTRODUCTION

This month we have a full agenda with quarterly reporting, community based pharmacy strategy, an update on the transport strategy and Te Ara Whakawaiaora looking at mental health and cultural competence. We also have the performance against government health targets which underline the key issues of under-performance in the ED six hour target, Faster Cancer Treatment and smoking cessation in primary care.

The key issue that we have all been dealing with since 12 August is the largest common source outbreak of infectious disease in New Zealand's history as a consequence of a waterborne campylobacter organism. This has been an enormous challenge for the local community and the health system. Current estimates suggest that there have been in excess of 4000 cases in Havelock North alone. At its peak, as a consequence of diarrheal illnesses, there were 22 patients in hospital, 27 patients presenting to the emergency department (ED), 131 patients sick in Aged Residential Care Homes and 231 patients presenting to General Practice in one day.

It has been impressive how the health system has responded. In the community General Practice working with District and Specialist Nursing, Aged residential Care, Pharmacy and St John's Ambulance have worked extremely well together and put in place plans that have managed large numbers of sick people in their home – without this the hospital would have been under very significant pressure, particularly with high levels of sickness from those staff who live in Havelock North.

The DHB led the incident response and over a 10 day period delivered an effective CIMS structure to manage the outbreak. We are now in the recovery phase and the Public Health Unit is managing our ongoing incident response. I have also asked Kate Coley to oversee our internal investigation of the incident response so that we can learn any lessons.

PERFORMANCE

Measure / Indicator		Target	Month of July	Qtr to end July	Trend For Qtr
Shorter stays in ED		≥95%	91.7	91.7%	▼
Improved access to Elective Surgery (2016/17YTD)		100%	107.7%	-	-
	<i>Waiting list</i>	<i>Less than 3 months</i>	<i>3-4 months</i>	<i>4+ months</i>	
	<i>First Specialist Assessments (ESPI-2)</i>	2,758	370	11	
	<i>Patients given commitment to treat, but not yet treated (ESPI-5)</i>	1,007	101	36	
Faster cancer treatment*		≥85%	60.7% (June 2016)	63.2% (6m to June 2016)	▼
Increased immunisation at 8 months (3 months to July)		≥95%	---	94.9%	▼
Better help for smokers to quit – Primary Care		≥90%	81.3% (Quarter 4, 2015/16)	---	▲
Better help for smokers to quit – Maternity		≥90%	89.0% (Quarter 4, 2015/16)	---	▲
Raising healthy kids (New health target with results being published from Q1)		≥95%	-	---	
More heart diabetes checks (This indicator is no longer a Health Target)		≥90%	88.5% (Quarter 4, 2015/16)	---	▼
Financial – month (in thousands of dollars)		\$1,236	\$1,441	---	---
Financial – year to date (in thousands of dollars)		\$1,236	\$1,441	---	---

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

<i>Faster Cancer Treatment Expected Volumes v Actual</i>	<i>Target</i>	<i>Month Actual / Expected</i>	<i>Rolling 6m Actual / Expected</i>
	100%	28/19 = 147%	87/114 = 76.3%

Performance this month shows us continuing to struggle in ED6 and Faster Cancer Treatment. The result for July is a favourable variance of \$204 thousand.

CONSUMER STORY

This month we share a story about one mother's experience of previous encounters with the health system which stopped her from attending appointments with her daughter. We share that experience and the reasons she was prompted to return to the clinic with her daughter.

NZ HEALTH PARTNERSHIPS LTD – SHAREHOLDER APPROVAL

In accordance with the Shareholders Agreement, NZ Health Partnerships Ltd (NZHP) has distributed a number of documents for approval by DHB shareholders:

- NZHP Annual Plan 2016-17
- NZHP Statement of Intent 2016 – 2020 and Statement of Performance Expectations 2016-17
- Revised Head Agreement between NZHP and DHBs for the Delivery of Shared Services to DHBs

It is recommended that the Board approve these documents.

COMMUNITY BASED PHARMACY SERVICES IN HAWKE'S BAY – STRATEGIC DIRECTION 2016-2020

The Board and Clinical Council requested that a strategy for Community Pharmacy Services in Hawke's Bay be established. The 'Community Based Pharmacy Services in Hawke's Bay - Strategic Direction 2016-2020' on this meeting's agenda has been developed with stakeholder input and aligns with national strategies such as the 'New Zealand Health Strategy' and the 'Pharmacy Action Plan 2016-2010'. The Community Pharmacy services contract will be a key enabler to give effect to the local strategy.

GO WELL

The early stages of Go Well have been about preparing foundation work for the implementation of the travel plan. Much work has gone into structuring the project, researching initiatives, drafting communications, developing content for the webpages and policies and procedure development as well as engaging with stakeholders, local councils and other community organisations.

The Go Well working group consisting of staff, Consumer Council, Health Hawke's Bay and local council representation are now meeting regularly and will be working on the parking layout review, promoting new bus services and assisting in developing rules around parking and parking charge exemptions.

It has been a busy time till now, but the coming months will be even busier. In September we expect to have a dedicated and focussed resource on-board to drive Go Well's implementation. New bus services will also commence, and in the few months following you will start to see physical changes on the hospital site including parking layout changes, consistent signage, improved cycling facilities and installation of the parking management controls.

TRANSFORM AND SUSTAIN STRATEGIC DASHBOARD QUARTER FOUR

The three high level "vital signs" indicators are all now green with year-end figures confirmed for resource sustainability, and our first figures for the difference between Maori and Non-Maori deaths under 50 years of age. The life expectancy indicator is an annual figure, which has just been reported for the 2015 calendar (baseline 2014). This shows a reduction in the gap from 16.3 percent to just over 8 percent. We will need to undertake further analysis to understand why the improvement has occurred. Finally, we are working through "supporting dimensions" with red ratings, and report the FRAC discussion and consequent actions on Faster Cancer Treatment in the Board paper.

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS REPORT QUARTER FOUR

We continue to struggle to achieve 95% for under six hour waits in our emergency department. Performance dropped slightly in quarter four to 92.5%. Our Heart and Diabetes checks dropped below 90 percent to 89 percent for the first time since 2014. For Faster Cancer Treatment we are now flagging enough patients for fast track monitoring but, at 63.2 percent, are not yet treating enough of them within 62 days of referral.

On the up side we delivered five percent more elective surgery than required by the Ministry, hit the immunisation target for Maori, Pacific, and total populations, and achieved Mental Health utilisation targets across all age ranges.

ANNUAL MĀORI PLAN EXCEPTIONS REPORT QUARTER FOUR / DASHBOARD

The DHB's quarter four report of the Annual Māori Health Plan 2015-2016 demonstrates steady and continued improvements in the areas of immunisation; ambulatory sensitive hospitalisations (ASH); quick access to angiograms; and cervical screening. Staff cultural training has made good progress from 64 percent in quarter one to 77.5 percent in quarter four, with the medical staff specifically having shown the largest increase from 14 percent in quarter one to 39.6 percent in quarter four. This progress is attributed to the growing push from the Executive Management Team coupled with closer monitoring by Managers and Heads of Departments. While specific measures are being put in place to progress the areas of slow improvement, the report specifically notes the need for more attention in the reduction of the numbers of Māori under Mental Health Act Compulsory Treatment Orders and increase in the number of Māori recruitment in the workforce.

TE ARA WHAKAWAIORA / CULTURALLY COMPETENT WORKFORCE

The Te Whakawaiaora report sets out a new target for increasing Maori staff representation by 30 June 2017 and a series of organisational wide actions to lift Maori staff retention and recruitment. In addition to these actions, the Executive Management team will work to develop targeted actions to increase Maori staff representation for the various workforce groups including Nursing and Allied. The targets for the years beyond 2017 will also be developed.

TE ARA WHAKAWAIORA / MENTAL HEALTH

The Te Ara Whakawaiaora: Mental Health and AOD document shows the concern raised about Maori people being on a Community Treatment Order (CTO) more so than any other ethnicity. This factor has encouraged Maori Health and Mental Health to get together and arrange a hui with other agencies to look at the factors that contribute to this growing trend.

Child, Adolescent and Family services (CAFS) are now doing well, with a 100 percent compliance for waiting times of three and eight weeks for children aged between 0 and 19 years of age. A lot of work has been accomplished to achieve this outcome and one they wish to sustain.

HUMAN RESOURCES KPIS

Maori staff representation in the workforce has improved slightly in the last quarter and the gap to our 2015/16 target sits at 54 at 30 June 2016. To address this ongoing gap we are deepening our focus in Nursing staff and extending our focus to include Allied Health staff. There are no concerns with Sick Leave, Staff Turnover or Occupational Health & Safety KPI results. Contracted FTE figures are higher than last year which is also reflected in the Accrued FTE figures discussed briefly in the HR KPI report and more fully in the Financial report. Annual Leave (2+ years) at 146 is slightly higher than this time last year (143). The total liability has, however, decreased by \$350k since June 2015. This is made up of \$634k favourable driven by a decrease in total leave hours owing and \$284k unfavourable driven by an increase in the average rates.

We are the third best performing mid-sized DHB and the seventh best of the 20 DHBs for this measure.

SUMMARY

In summary, in July our performance has continued to be problematic in the areas we have had difficulty with for some time. We have, however, managed an outbreak on a massive scale which has not overwhelmed our services and given us considerable food for thought on how we can take some of the lessons from this incident into normal working practice

 HAWKE'S BAY District Health Board Whakawāteatia	Financial Performance Report, July 2016	85
	For the attention of: HBDHB Board and the Finance Risk and Audit Committee (FRAC)	
Document Owner:	Tim Evans, GM Planning, Informatics & Finance	
Document Author(s):	Finance Team	
Reviewed by:	Executive Management Team	
Month:	August 2016	
Consideration:	For Information	

RECOMMENDATION

That the Board and FRAC
 Note the contents of this report

1. GM Planning Informatics & Finance comments

Financial performance

The result for July is a favourable variance of \$204 thousand. The elective surgery health target is 7.7% ahead of plan spread equally between on-site and outsourced provision.

2. Resource Overview

	July				Year End Forecast	Refer Section
	Actual	Budget	Variance			
	\$'000	\$'000	\$'000	%		
					\$'000	
Net Result - surplus/(deficit)	1,441	1,236	204	16.5%	5,000	3
Contingency utilised	-	250	250	100.0%	3,000	8
Capital spend	484	1,753	(1,269)	-72.4%	22,042	16
	FTE	FTE	FTE	%	FTE	
Employees	2,210	2,139	(71)	-3.3%	2,198	5 & 7

The favourable variance for July comprises: additional MOH income; the reversal of a provision for unpaid allowances; and delays in implementing some transform and sustain and new investment projects.

No contingency was utilised in July.

Quality and Financial Improvement (QFI) programme savings will be included from next month when savings plans are finalised and approved.

Capital spend is behind plan. A number of projects have not started at the estimated times projected in the capital plan, and later than planned purchase of some large clinical equipment items going through the trial process has also impacted timing.

The FTE variance year to date reflects high patient volume in some areas, efficiencies not yet achieved, unbudgeted leave cover including long term sick leave, and cover for employees undergoing training.

Case weighted discharges have not been included this month. The price volume schedule (payments between the funder and provider arms) is being changed, and the change affects the availability of case weighted discharge volumes. Volumes are expected to be available from next month.

3. Financial Performance Summary

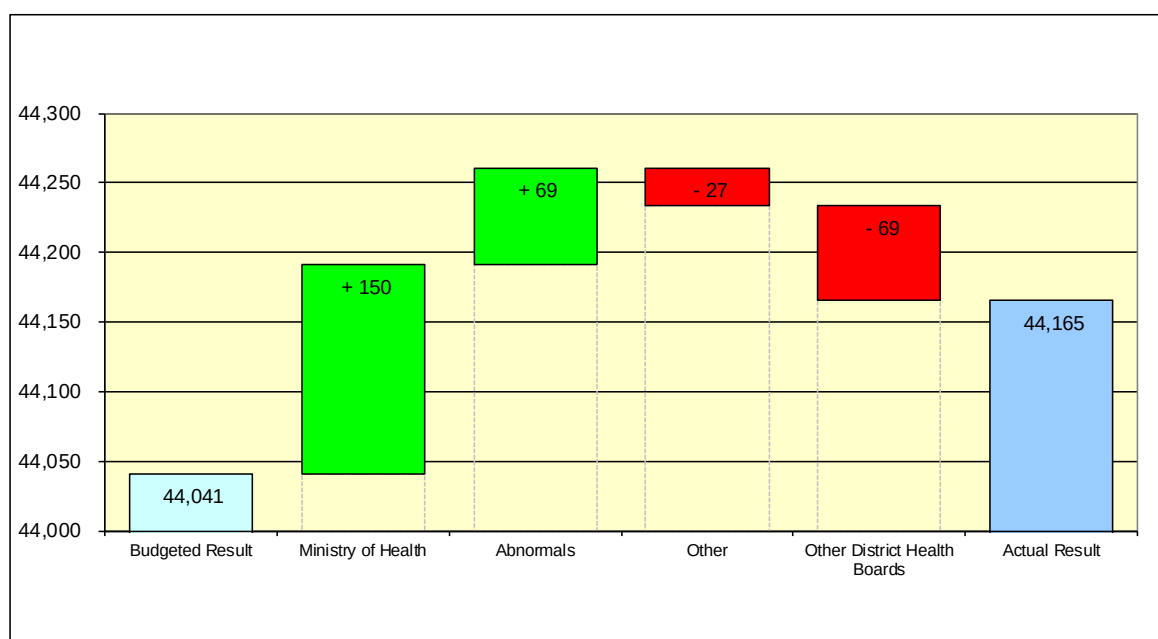
\$'000	July				Year End	Refer Section
	Actual	Budget	Variance		Forecast	
Income	44,166	44,041	125	0.3%	532,562	4
Less:						
Providing Health Services	18,789	18,861	71	0.4%	242,581	5
Funding Other Providers	19,156	19,042	(114)	-0.6%	228,318	6
Corporate Services	4,457	4,444	(13)	-0.3%	48,372	7
Reserves	322	457	135	29.4%	8,290	8
	1,441	1,236	204	16.5%	5,000	

Additional MOH income and delayed transform and sustain/new investment expenditure drives the favourable result.

4. Income

\$'000	July				Year End Forecast
	Actual	Budget	Variance		
Ministry of Health	42,123	41,973	150	0.4%	507,960
Inter District Flows	629	629	(0)	0.0%	7,545
Other District Health Boards	265	334	(69)	-20.5%	4,004
Financing	23	81	(58)	-71.8%	885
ACC	525	493	33	6.6%	5,980
Other Government	67	68	(1)	-1.8%	414
Patient and Consumer Sourced	104	120	(15)	-12.9%	1,447
Other Income	360	344	16	4.5%	4,260
Abnormals	70	0	69	37172.3%	67
	44,166	44,041	125	0.3%	532,562

July Income



Note the scale does not begin at zero

Ministry of Health (favourable)

Additional funding for first contact services and child development.

Abnormals (favourable)

National patient flow funding.

Other District Health Boards (unfavourable)

Lower sales of cancer treatment pharmaceuticals to Tairāwhiti DHB.

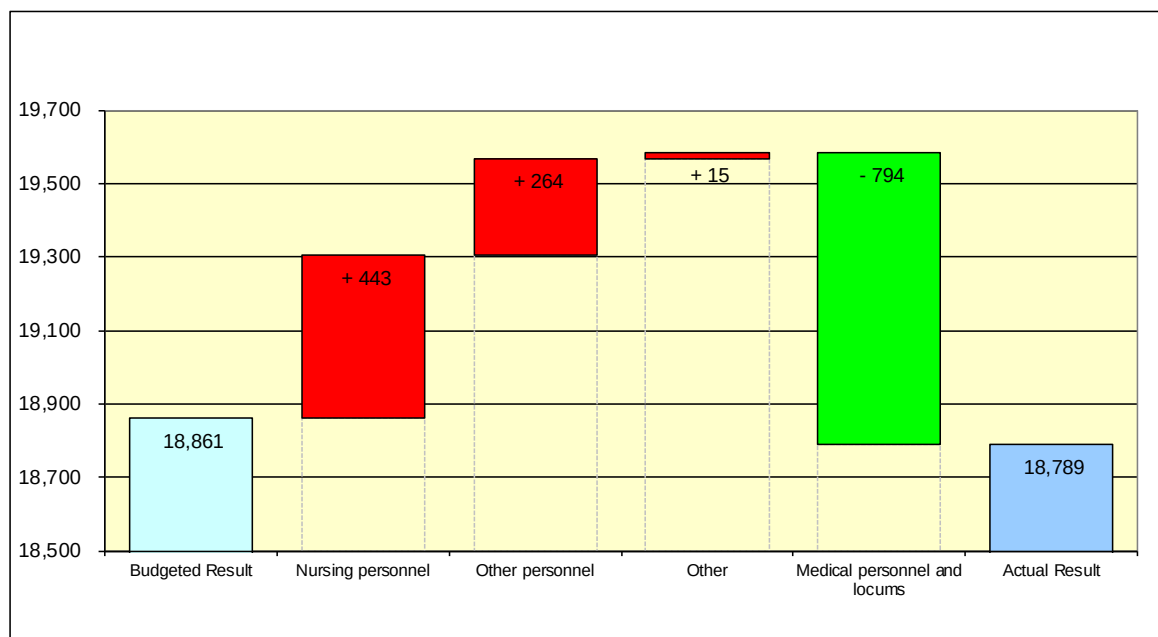
5. Providing Health Services

	July				Year End Forecast
	Actual	Budget	Variance		
	Expenditure by type \$'000				
Medical personnel and locums	3,524	4,319	794	18.4%	57,422
Nursing personnel	5,737	5,293	(443)	-8.4%	72,967
Allied health personnel	2,484	2,570	86	3.3%	32,981
Other personnel	1,884	1,620	(264)	-16.3%	20,938
Outsourced services	522	567	45	7.9%	6,982
Clinical supplies	3,028	2,888	(140)	-4.9%	32,187
Infrastructure and non clinical	1,609	1,604	(6)	-0.4%	19,106
	18,789	18,861	71	0.4%	242,581
Expenditure by directorate \$'000					
Acute and Medical	5,013	4,855	(157)	-3.2%	65,061
Surgical Services	4,176	3,982	(194)	-4.9%	52,510
Women Children and Youth	1,611	1,494	(118)	-7.9%	19,708
Older Persons & Mental Health	2,482	2,551	69	2.7%	33,467
Rural, Oral and Community	1,793	1,718	(75)	-4.4%	21,840
Other	3,714	4,261	547	12.8%	49,995
	18,789	18,861	71	0.4%	242,581
Full Time Equivalents					
Medical personnel	301.7	300.6	(1)	-0.3%	308.3
Nursing personnel	897.1	849.4	(48)	-5.6%	893.4
Allied health personnel	434.0	445.9	12	2.7%	448.0
Support personnel	137.5	124.6	(13)	-10.4%	127.9
Management and administration	268.5	243.3	(25)	-10.4%	244.3
	2,038.8	1,963.8	(75)	-3.8%	2,021.9

Directorates

- Women, Children and Youth – High patient numbers in maternity and paediatrics. Some seasonal factors are likely to reverse later in the year.
- Other – Reversal of 2015/16 provisions for unbudgeted allowances.

July Expenditure



Note the scale does not begin at zero

Nursing personnel (unfavourable)

High volumes of patients, efficiencies not yet achieved, and leave provisioning (expected to reverse in future months).

Other personnel (unfavourable)

Payments to retiring staff, efficiencies not yet achieved, and higher staffing in reception and health records.

Medical personnel and locums (favourable)

Includes release of a provision for allowance payments, and the reversal of continuing medical education provisions due to the retirement of a number of senior medical officers.

Full time equivalents (FTE)

FTEs are 75 unfavourable in July, including:

Nursing personnel (48 FTE / 5.6% unfavourable)

- Partly driven by efficiencies not yet achieved (savings have been budgeted from the beginning of July, however the actual realisation of savings may be more gradual). High workloads in certain areas including: ED, A1 and B2 medical wards, maternity, the surgical overflow ward (unbudgeted), and SCBU.

Management and administration personnel (25 FTE / 10.4% unfavourable)

- High workloads in reception, health records and secretarial services. Hours related retirement payments.

Support personnel (13 FTE / 10.4% unfavourable)

- Leave cover, long term sick leave, and training, mainly impacting on orderlies, security and kitchen assistants.

MONTHLY ELECTIVE HEALTH TARGET REPORT

July 2017



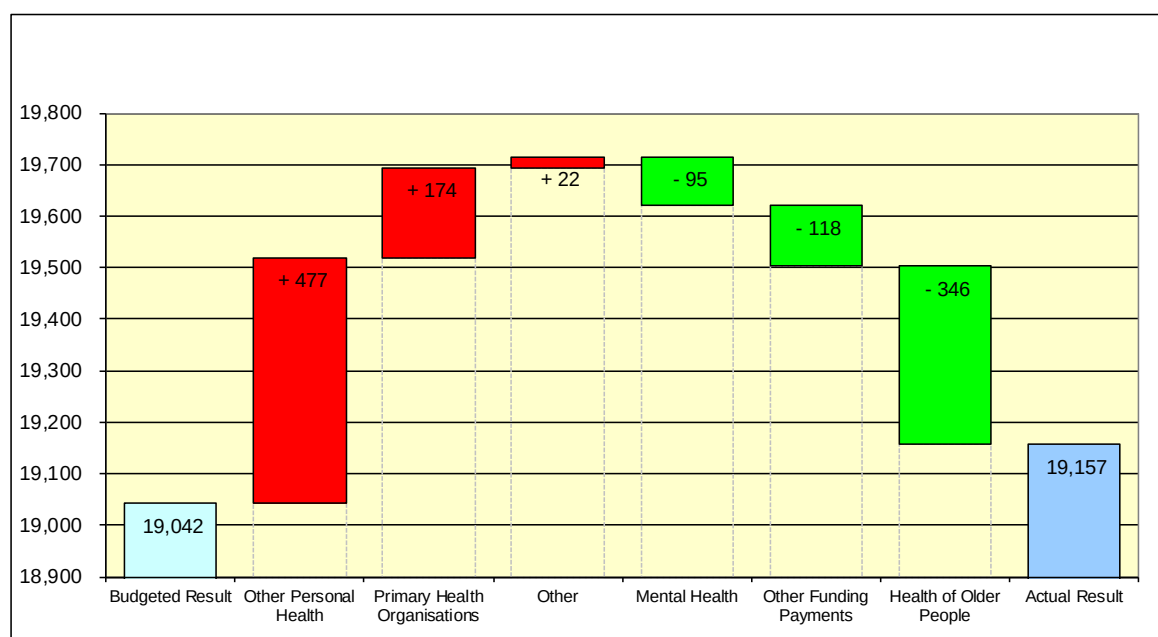
Discharge Type	Group	Actual	Plan	Variance	Variance %
On-Site	Avastins	19	14	5	35.7%
	ENT	32	45	-13	-28.9%
	General Surgery	61	71	-10	-14.1%
	Gynaecology	54	38	16	42.1%
	Maxillo-Facial	14	15	-1	-6.7%
	Ophthalmology	84	75	9	12.0%
	Orthopaedics	102	68	34	50.0%
	Skin Lesions	9	12	-3	-25.0%
	Urology	37	34	3	8.8%
	Vascular	16	10	6	60.0%
	Surgical - Arranged	46	48	-2	-4.2%
	Non Surgical - Elective	3	13	-10	-76.9%
	Non Surgical - Arranged	1	6	-5	-83.3%
On-Site	Total	478	449	29	6.5%
Outsourced	Cardiothoracic	0	1	-1	-100.0%
	ENT	9	3	6	200.0%
	General Surgery	14	8	6	75.0%
	Gynaecology	5	0	5	
	Maxillo-Facial	1	0	1	
	Neurosurgery	0	0	0	
	Orthopaedics	0	0	0	
	Paediatric Surgery	0	0	0	
	Urology	10	1	9	900.0%
	Vascular	4	2	2	100.0%
	Surgical - Arranged	0	0	0	
	Non Surgical - Elective	0	0	0	
	Non Surgical - Arranged	0	0	0	
Outsourced	Total	43	15	28	186.7%
IDF Outflow	Cardiothoracic	5	7	-2	-28.6%
	ENT	2	3	-1	-33.3%
	General Surgery	1	3	-2	-66.7%
	Gynaecology	2	0	2	
	Maxillo-Facial	8	17	-9	-52.9%
	Neurosurgery	4	4	0	0.0%
	Ophthalmology	0	2	-2	-100.0%
	Orthopaedics	3	0	3	
	Paediatric Surgery	3	4	-1	-25.0%
	Skin Lesions	3	5	-2	-40.0%
	Urology	2	0	2	
	Vascular	1	1	0	0.0%
	Surgical - Arranged	8	20	-12	-60.0%
	Non Surgical - Elective	7	0	7	
	Non Surgical - Arranged	1	0	1	
IDF Outflow	Total	50	66	-16	-24.2%
TOTAL		571	530	41	7.7%

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

6. Funding Other Providers

\$'000	July				Year End
	Actual	Budget	Variance		Forecast
Payments to Other Providers					
Pharmaceuticals	3,755	3,753	(2)	-0.1%	43,351
Primary Health Organisations	3,019	2,845	(174)	-6.1%	35,401
Inter District Flows	3,796	3,776	(19)	-0.5%	45,317
Other Personal Health	2,396	1,919	(477)	-24.9%	23,187
Mental Health	1,036	1,131	95	8.4%	13,574
Health of Older People	4,813	5,159	346	6.7%	61,928
Other Funding Payments	341	459	118	25.7%	5,560
	19,156	19,042	(114)	-0.6%	228,318
Payments by Portfolio					
Strategic Services					
Secondary Care	4,236	3,898	(338)	-8.7%	46,778
Primary Care	8,129	7,974	(156)	-2.0%	95,054
Mental Health	1,036	1,131	95	8.4%	13,574
Health of Older People	4,894	5,198	304	5.8%	62,395
Other Health Funding	98	89	(10)	-10.8%	1,063
Maori Health	464	529	65	12.4%	6,403
Population Health					
Women, Child and Youth	196	113	(83)	-74.0%	1,765
Population Health	104	112	8	7.3%	1,286
	19,156	19,042	(114)	-0.6%	228,318

July Expenditure



Note the scale does not begin at zero

Other Personal Health (unfavourable)

Includes costs relating to a high cost patient, and additional costs for health of young people.

Primary Health Organisations (unfavourable)

Higher than budgeted costs relating to low cost access.

Mental Health (favourable)

Lower community residential and home based support costs.

Other Funding Payments (favourable)

Lower costs in Maori primary health, Say Ahh services and screening programmes.

Health of Older People (favourable)

Lower residential care costs partly offset by higher home support.

7. Corporate Services

\$'000	July				Year End Forecast
	Actual	Budget	Variance		
Operating Expenditure					
Personnel	1,289	1,218	(71)	-5.8%	15,136
Outsourced services	92	94	2	2.2%	1,092
Clinical supplies	14	9	(4)	-47.5%	114
Infrastructure and non clinical	1,755	1,820	65	3.6%	8,906
	3,150	3,142	(9)	-0.3%	25,248
Capital servicing					
Depreciation and amortisation	1,141	1,137	(4)	-0.4%	13,887
Financing	165	165	-	0.0%	2,052
	1,307	1,303	(4)	-0.3%	23,125
	4,457	4,444	(13)	-0.3%	48,372
Full Time Equivalents					
Medical personnel	0.3	0.3	(0)	-4.4%	0.3
Nursing personnel	10.2	15.2	5	33.3%	15.5
Allied health personnel	0.4	4.4	4	89.9%	4.4
Support personnel	9.9	9.4	(1)	-6.0%	9.4
Management and administration	150.8	145.9	(5)	-3.3%	146.0
	171.6	175.2	4	2.0%	175.6

Personnel costs include staff costs for clinical trials (unbudgeted), the talent management programme, high study and sick leave. Lower time taken for the postgraduate nursing programme explains the favourable nursing FTEs.

8. Reserves

\$'000	July				Year End Forecast
	Actual	Budget	Variance		
Expenditure					
Contingency	250	250	-	0.0%	6,700
Transform and Sustain resource	36	61	25	41.0%	593
Other	37	146	110	75.0%	997
	322	457	135	29.4%	8,290

No contingency has been released. Some transform and sustain projects are starting later than budgeted. Delays implementing new investment projects are behind the "Other" category variance.

9. Financial Performance by MOH Classification

\$'000	July			End of Year		
	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding						
Income	42,171	42,044	128 F	511,803	511,803	-
Less:						
Payments to Internal Providers	22,964	22,964	-	278,485	278,485	-
Payments to Other Providers	19,156	19,042	(114) U	228,318	228,318	-
Contribution	51	37	14 F	5,000	5,000	-
Governance and Funding Admin.						
Funding	266	266	-	3,197	3,197	-
Other Income	3	3	-	30	30	-
Less:						
Expenditure	243	269	26 F	3,227	3,227	-
Contribution	26	0	26 F	0	0	-
Health Provision						
Funding	22,698	22,698	-	275,288	275,288	-
Other Income	1,992	1,995	(3) U	20,729	20,729	-
Less:						
Expenditure	23,326	23,493	168 F	296,017	296,017	-
Contribution	1,364	1,199	165 F	0	0	-
Net Result	1,441	1,236	204 F	5,000	5,000	-

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

10. Management Budget Movements

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

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2016/17 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

\$'000	July			End of Year		
	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding						
Income	42,044	41,901	143 F	511,803	511,803	-
Less:						
Payments to Internal Providers	22,964	22,712	(252) U	278,485	275,461	(3,023) U
Payments to Other Providers	19,042	19,295	253 F	228,318	231,341	3,023 F
Contribution	37	(106)	144 F	5,000	5,000	(0) U
Governance and Funding Admin.						
Funding	266	268	(2) U	3,197	3,220	(23) U
Other Income	3	3	-	30	30	-
Less:						
Expenditure	269	271	2 F	3,227	3,250	23 F
Contribution	0	-	0 F	0	-	0 F
Health Provision						
Funding	22,698	22,444	254 F	275,288	272,241	3,046 F
Other Income	1,995	1,965	30 F	20,729	20,366	363 F
Less:						
Expenditure	23,493	23,066	(428) U	296,017	292,608	(3,409) U
Contribution	1,199	1,343	(144) U	0	(0)	0 F
Net Result	1,236	1,236	-	5,000	5,000	-

11. Quality and Financial Improvement Programme

The savings plan for 2016/17 is being finalised and will be included from next month.

12. Financial Position

30 June		July				Annual
2016	\$'000	Actual	Budget	Variance from budget	Movement from 30 June 2016	Budget
	Equity					
102,608	Crown equity and reserves	102,608	105,733	3,125	-	105,376
(10,973)	Accumulated deficit	(9,532)	(15,032)	(5,499)	1,441	(11,268)
91,635		93,076	90,701	(2,374)	1,441	94,108
	Represented by:					
	<u>Current Assets</u>					
15,552	Bank	15,988	5,876	(10,112)	436	8,523
1,724	Bank deposits > 90 days	1,732	1,741	9	8	1,741
22,433	Prepayments and receivables	17,499	18,267	768	(4,934)	18,618
4,293	Inventory	4,255	3,968	(287)	(38)	4,044
1,220	Non current assets held for sale	1,220	1,220	-	-	-
45,222		40,694	31,073	(9,622)	(4,528)	32,927
	<u>Non Current Assets</u>					
151,944	Property, plant and equipment	151,329	158,620	7,291	(614)	166,159
2,037	Intangible assets	1,994	1,171	(823)	(43)	665
9,777	Investments	10,071	8,350	(1,720)	293	9,476
163,758		163,394	168,142	4,747	(364)	176,299
208,980	Total Assets	204,088	199,214	(4,874)	(4,892)	209,226
	Liabilities					
	<u>Current Liabilities</u>					
-	Bank overdraft	-	-	-	-	-
38,137	Payables	31,959	30,468	(1,491)	(6,179)	30,697
34,070	Employee entitlements	33,916	33,167	(749)	(154)	34,484
-	Current portion of borrowings	-	-	-	-	6,000
72,208		65,875	63,635	(2,240)	(6,332)	71,180
	<u>Non Current Liabilities</u>					
2,638	Employee entitlements	2,638	2,377	(260)	-	2,438
42,500	Term borrowing	42,500	42,500	-	-	41,500
45,138		45,138	44,877	(260)	-	43,938
117,345	Total Liabilities	111,013	108,513	(2,500)	(6,332)	115,118
91,635	Net Assets	93,076	90,701	(2,374)	1,441	94,108

The variance from budget for:

- Bank reflects lower capital spend and the higher payables and employee entitlement balances;
- Property, plant and equipment relates to slower than planned expenditure on capital projects;
- Employee entitlements – see below

13. Employee Entitlements

30 June		July				Annual
2016	\$'000	Actual	Budget	Variance from budget	Movement from 30 June 2016	Budget
7,466	Salaries & wages accrued	7,902	6,559	(1,343)	436	6,559
482	ACC levy provisions	405	1,027	622	(77)	851
5,348	Continuing medical education	5,010	4,798	(212)	(338)	5,131
19,149	Accrued leave	18,981	19,132	152	(168)	20,249
4,263	Long service leave & retirement grat.	4,256	4,028	(227)	(7)	4,131
36,708	Total Employee Entitlements	36,554	35,545	(1,009)	(154)	36,922

14. Treasury

Liquidity management

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

Debt management

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

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

Foreign exchange risk management

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

15. Capital Expenditure

2017 Annual Plan		Year to Date		
		Actual \$'000	Budget \$'000	Variance \$'000
	Source of Funds			
	Operating Sources			
14,440	Depreciation	1,141	1,137	(4)
5,000	Surplus/(Deficit)	1,441	1,236	(204)
(3,479)	Working Capital	(2,103)	(621)	1,482
15,961		479	1,753	1,274
	Other Sources			
-	Special funds and clinical trials	5	-	(5)
1,220	Sale of assets	-	-	-
5,000	Borrowings	-	-	-
6,220		5	-	(5)
22,181	Total funds sourced	484	1,753	1,269
	Application of Funds:			
	Block Allocations			
3,183	Facilities	(45)	265	310
3,125	Information Services	(10)	260	270
5,464	Clinical Plant & Equipment	356	455	99
11,772		302	981	679
	Local Strategic			
2,460	MRI	-	205	205
500	Renal Centralised Development	18	42	24
3,000	New Stand-alone Endoscopy Unit	35	250	215
710	New Mental Health Inpatient Unit Development	24	59	35
100	Maternity Services	54	8	(46)
400	Upgrade old MHIU	-	33	33
400	Travel Plan	-	33	33
400	Histology Upgrade	-	33	33
1,100	Fluoroscopy Unit	-	92	92
200	Education Centre Upgrade	-	17	17
9,270		131	772	641
	Other			
-	Special funds and clinical trials	5	-	(5)
-	Other	46	-	(46)
-		52	-	(52)
21,042	Capital Spend	484	1,753	1,269
	Regional Strategic			
1,139	RHIP (formerly CRISP)	-	-	-
1,139		-	-	-
22,181	Total funds applied	484	1,753	1,269

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

Board Meeting 31 August 2016 - Financial Performance Report

16. Rolling Cash Flow

	Actual	July Forecast	Variance	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	47,927	43,353	4,574	41,955	54,137	43,354	41,955	41,739	43,293	45,475	41,720	42,995	41,954	48,574	43,495
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	4,200	-
Cash receipts from donations, bequests and clinical trials	99	-	99	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	(343)	396	(739)	445	437	502	443	449	438	459	465	457	465	461	426
Cash paid to suppliers	(31,788)	(26,988)	(4,800)	(25,338)	(28,206)	(25,266)	(25,429)	(25,613)	(24,910)	(21,997)	(25,623)	(25,316)	(24,554)	(29,441)	(27,430)
Cash paid to employees	(14,696)	(14,132)	(564)	(19,525)	(15,035)	(15,061)	(17,705)	(14,362)	(16,588)	(14,388)	(19,431)	(15,175)	(17,769)	(15,470)	(13,909)
Cash generated from operations	1,199	2,628	(1,429)	(2,463)	11,333	3,528	(737)	2,213	2,233	9,549	(2,868)	2,961	97	8,325	2,582
Interest received	23	81	(58)	80	67	66	80	72	75	68	75	73	75	73	81
Interest paid	-	(330)	330	(330)	(95)	(41)	(69)	(160)	(359)	(325)	(139)	(60)	(14)	(150)	(330)
Capital charge paid	-	-	-	-	-	-	-	(3,665)	-	-	-	-	-	(3,996)	-
Net cash inflow/(outflow) from operating activities	1,222	2,378	(1,157)	(2,713)	11,304	3,553	(726)	(1,540)	1,948	9,292	(2,931)	2,974	158	4,252	2,332
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	-	0	(0)	0	0	0	0	1,220	0	0	0	0	0	0	0
Acquisition of property, plant and equipment	(484)	(3,003)	2,519	(3,003)	(3,003)	(3,003)	(3,003)	(4,003)	(2,028)	(2,028)	(2,028)	(2,028)	(2,028)	(2,032)	(2,028)
Acquisition of intangible assets	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Acquisition of investments	(293)	-	(293)	-	(285)	-	-	(285)	-	-	(285)	-	-	(284)	-
Net cash inflow/(outflow) from investing activities	(777)	(3,003)	2,226	(3,003)	(3,288)	(3,003)	(3,003)	(3,068)	(2,028)	(2,028)	(2,313)	(2,028)	(2,028)	(2,316)	(2,028)
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	5,000	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	-	-	-	-	(357)	-
Net cash inflow/(outflow) from financing activities	-	-	-	-	-	-	5,000	-	-	-	-	-	-	(357)	-
Net increase/(decrease) in cash or cash equivalents	444	(625)	1,069	(5,716)	8,016	550	1,271	(4,608)	(80)	7,264	(5,245)	946	(1,870)	1,578	304
Add: Opening cash	17,276	14,972	2,304	17,720	12,004	20,020	20,570	21,841	17,233	17,153	24,417	19,172	20,118	18,248	19,826
Cash and cash equivalents at end of year	17,720	14,347	3,373	12,004	20,020	20,570	21,841	17,233	17,153	24,417	19,172	20,118	18,248	19,826	20,130
Cash and cash equivalents															
Cash	4	7	(3)	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	14,733	11,245	3,488	8,902	16,918	17,468	18,739	14,130	14,050	21,315	16,070	17,016	15,146	16,724	17,028
Short term investments (special funds/clinical trials)	3,018	3,095	(77)	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	(35)	(0)	(35)	-	-	-	-	-	-	-	-	-	-	-	-
Cash and cash equivalents at end of year	17,720	14,347	3,373	12,004	20,020	20,570	21,841	17,232	17,152	24,417	19,172	20,118	18,248	19,826	20,130



CONSUMER STORY

Verbal Presentation

	Hawke's Bay Clinical Council	86
	For the attention of: HBDHB Board	
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs	
Reviewed by:	Not applicable	
Month:	August, 2016	
Consideration:	For Information	

RECOMMENDATION

That the Board

Review the contents of this report; and support the recommendation outlined in the Board papers for "Community Based Pharmacy Services in HB – Strategic Direction 2016-2020"

Note that Clinical Council:

- **Supported** the Travel Plan Update and progress made.
- **Supported** the work being done around Operation Productivity which is being presented to the FRAC in August.
- **Supported** the actions identified in the "Governing for Quality" paper which is for review by the FRAC in August.
- **Note** the following papers were received:
  - Annual Māori Plan Q4 Non-Financial Exceptions Report
  - Annual Māori Plan Q4 Dashboard
  - Te Ara Whakawaiaora / Culturally Competent Workforce
  - Te Ara Whakawaiaora / Mental Health

Council met on 11 August 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

The following (included on the Board agenda) were discussed by Council and summarised as follows:

- ***Community Based Pharmacy Services in HB – Strategic Direction 2015-2020 (Board)***

Clinical Council requested that a strategy for Community Pharmacy Services development in Hawke's Bay (2014-2020) be established. This arose from a HBDHB Board (December 2013) request for an updated long term strategy for Hawke's Bay.

Since 2012 the National Community Pharmacy Agreement (CPSA) had been developing a new model with the sector that would develop clinical pharmacist services in the community.

A new model of care has now been developed nationally for a new model of pharmacy care; with a phased implementation approach. Clinical Council were pleased with the work done saying our clinical pharmacists are currently underutilised and undervalued, and therefore a waste of potential in terms of access for high risk patient care. This proposal can only benefit communities

and should be applauded. Clinical Council provided their full support and ask the Board to support the recommendation also.

- ***Travel Plan Update (Board)***

A presentation was received by Council who noted that very good progress is being made. This is a fantastic opportunity for co-benefits in health sustainability, climate change issues and opportunities for health benefits from this type of initiative.

The Board will be advised of the detail relayed to the Councils and MRB.

- ***Operation Productivity (FRAC)***

A presentation was received around the project, including background, the driving forces behind the initiative, and the critical success factors.

The next step is to move the project initiated in 2014 to “business as usual” under the name “Operation Producton Planning” with the goal being to continuously improve operations with a longer term focus on future planning, anticipating demand and clarifying inhouse capability.

Questions raised and discussed centred around the impact on RMO workloads; would capacity be increased in-house; planning around types of weekend procedures and how that impacts on weekend staffing etc.

Clinical Council were support of the work being undertaken.

- ***Governing for Quality (FRAC)***

The paper provided was in response to the HQSC’s publication “Governing for Quality” which looks at overall quality and safety systems operating within the DHB. The Board has ultimate responsibility for this and delegated this to Clinical Council who primarily provide clinical advice. It is a matter of providing an assessment to the Board as to where we are regarding quality and Safety systems. This is work in progress with Council endorsing the actions identified in the paper which will be incorporated into the overarching Quality Annual Plan.

The following monitoring papers (also included on the Board agenda) were received with no issues discussed:

- *Annual Māori Plan Q4 Non-Financial Exceptions Report*
- *Annual Māori Plan Q4 Dashboard*
- *Te Ara Whakawaiaora / Culturally Competent Workforce*
- *Te Ara Whakawaiaora / Mental Health*

Reports of a clinical nature (not on the Board agenda) are summarised below:

- ***Collaborative Clinical Pathways***

The focus will be on ensuring the clinical pathways developed now are implemented well. Several matters raised included IT interfaces (MedTech and Map of Medicine); the need to work closer with GPs; the need to promote the developed pathways but first ensure consumer focus is applied. Moving forward we need to see pathways improve health outcomes for patients.

- ***Draft Quality Accounts***

Favourable feedback on the draft provided. The Quality Accounts in final form will be provided to the Board in October for endorsement.

- ***ICU Learnings Update***

Advised an ongoing action plan is in place as a result of the ICU review.

- **Complementary Therapies Policy**

On review, members agreed to the policy (in principle) however more was required before it could be finalised. The draft policy focused on health modalities and complementary therapies that may work in DHB leased/owned facilities which arose following a query about an alternative practitioner in the Napier Health Centre.

- **Primary Care Smoke Free**

A verbal update was provided by Drs Peterson and Rodgers, advising a lot of work had been done to improve the primary result for HB around the number of patients recorded as being smokers and providing them with Smokefree advice. This was at 83.1% compared to the target of 90%. It was advised this target would remain for a further 12 months, after which it will be changed to "Infants in Smokefree homes at 6 weeks".

11

Clinical Council's Annual General Meeting:

Following the ordinary meeting, the 6th Annual General Meeting of Clinical Council was held.

In Summary:

- It was confirmed co-chairs Dr Mark Peterson and Chris McKenna would continue in their roles.
- A review of topics/areas considered by Council from September 2015 to August 2016 was provided.
- A Planning Workshop was held to review the following:
  - } **Clinical Council's Terms of Reference**
  - } **The Quality Improvement & Patient Safety Annual Plan**
  - } **The Clinical Governance Committee Structure; and**
  - } **Review of Council's Annual Workplan (past) to develop the future Workplan for 2016/17**

With limited time, members were asked to suggest other priority areas/actions for focus in 2017; these centred around:

- } Meeting agendas
- } Advisory & Assurance Functions
- } Engagement with Consumer Council
- } Workforce Development
- } Health Literacy
- } Prioritisation Process
- } Being proactive and innovative.

With the information provided, a sub-group would work together to update and prepare a draft Clinical Council Annual Workplan for 2016/17 for discussion in September. At that time further discussions will be required as memberships and TORs are developed for the new committee structures.

	HB Health Consumer Council 87
	For the attention of: HBDHB Board
Document Owner:	Graeme Norton, Chair
Reviewed by:	Not applicable
Month:	August 2016
Consideration:	For Information

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Consumer Council:

- **Supported** the work being done by Dr Andy Phillips in the development of a Complementary Therapies Policy. Whilst it originally came as a “decision” paper it was recognised that there was still more work to be done before endorsement.

Council met on 11 August 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- ***Complementary Therapies Policy***

The development of this policy comes from the Clinical Council having concerns that there may be practices or therapies that were being delivered on DHB premises or associated with DHB premises and that they were seen as being ratified by the DHB.

The intent of the policy is to set up some principles to ensure complementary therapies that are valued by the public could be provided on DHB owned or leased premises. This policy is not about whether they have an evidence base or that the therapies are valid or not. There is already a separate policy around complementary and alternative medicines so that is not included in this policy.

Following a precis of suggested changes from HB Clinical Council the previous day, members were highly engaged on this topic, recognising that this was a challenging subject given the many and varied views and also that, for many, these therapies were a valid part of what matters to them.

- ***Quality Accounts Draft***

Some members of Council have been actively involved throughout the development process. On the whole the feedback was this is a step up from last year and a number of suggestions for improvement were made. The suggestion was made, and supported, that future plans focus on the

themes of Transform & Sustain rather than service by service commentary (which perpetuates a siloed feel when we are strongly aiming for integrated response around the needs of people.

Others reports provided for information and discussion included:

- ***QIPS Annual Plan (Draft)***

It was decided to discuss this in September as part of Consumer Council's own planning for the year ahead. This will include our own priorities along with those aspects which will come to us from others.

- ***Te Ara Whakawaiaora / Mental Health***

Whilst this paper was for information it was clear that members were wanting to discuss mental health issues, especially focus on youth services but in the context of family/whānau and not in isolation. We propose to have this on our agenda for October.

	Appointment to HB Health Consumer Council XX
	For the attention of: HBDHB Board and Health Hawke's Bay Ltd Board
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Not applicable
Month:	August 2016
Consideration:	For Endorsement

RECOMMENDATION

That the Board endorse the CEO's approval to appoint Samitioata (Sami) McIntosh to fill a current vacancy on Consumer Council, with a term expiring in June 2018.

The attached memo to the Chief Executives of HBDHB and Health Hawke's Bay Ltd has been prepared and submitted and approved in accordance with the Terms of Reference of the Hawke's Bay Health Consumer Council. The memo provides some background to the recommendation.

It is now recommended that both Board endorses this appointment.

12.1



MEMO

To: Kevin Snee, Chief Executive HBDHB
Liz Stockley, Chief Executive, Health Hawke's Bay Ltd

From: Ken Foote, Company Secretary HBDHB

Subject: **APPOINTMENT TO HAWKE'S BAY HEALTH CONSUMER COUNCIL**

Date: 8 August, 2016

A selection panel chaired by Graeme Norton has recommended that Samitioata (Sami) McIntosh be appointed to fill a current vacancy on Consumer Council.

Comments from the panel include:

Sami is a mother to three and heavily vested in Hauora Maori and Pasifika as she has a foot in both worlds. She recognises the disparity in terms of health status between those of Maori and Pacific Island decent and all other New Zealanders, and is keen to contribute to improving health gains especially here in Heretaunga.

Sami is currently a student nurse (in her first year at EIT) having previously studied Science at Waikato University and worked for a number of years.

When she is not studying, working, raising three children, Sami is involved in Waka Ama and Kapa Haka. She is involved in her children's schooling through Kura kaupapa and Kohanga reo. She is in touch with issues and struggles affecting Maori and Pacific women through all of her daily interactions.

Sami presents as someone who can clearly see where the real issue lies and how they affect people. Her passion, networks and collaborative style will serve her well as a member of Council and a participant in other forums supporting the consumer voice being heard across the sector.

RECOMMENDATION

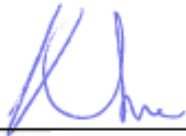
It is therefore recommended that Samitioata McIntosh be appointed to Consumer Council.

New Appointment to HB Health Consumer Council

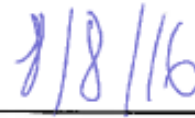
8 August, 2016

APPROVAL

We approve the recommendation



Kevin Snee, CEO HBDHB



Date



Liz Stockley, CEO Health Hawke's Bay



Date

Following your approval, these appointments will be forwarded to the Boards of HBDHB and Health Hawke's Bay Ltd for endorsement.

12.1

 HAWKE'S BAY District Health Board Whakawāteatia	Māori Relationship Board (MRB)	88
	For the attention of: HBDHB Board	
Document Owner:	Heather Skipworth (Deputy Chair)	
Reviewed by:	Not applicable	
Month:	August, 2016	
Consideration:	For Information	

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that the Māori Relationship Board:

- **Supported** the use of HEAT in new investment proposals and service redesign
- **Supported** the responsibility of Te Ara Whakawaiaora: Culturally Competent Workforce Key Performance Indicator (KPI) to move to Sharon Mason (Chief Operating Officer)
- **Supported** a wānanga with Mental Health Services with a specific focus on this matter, and to include external providers, consumers and their whānau to gain more perspective across the whole continuum.

MRB met on 10 August 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- ***Te Ara Whakawaiaora: Culturally Competent Workforce***

John McKeefry (General Manager Human Resources) and Andrew Phillips (Chief Officer Allied Health) presented the paper highlighting the challenges the organisation has faced to increase the Māori workforce. Issues such as attracting Māori to seek employment with the HBDHB and staff turnovers especially in the area of nursing. Plus the problems with recruitment and retention, and the recruitment process itself.

MRB provided the following comments and advice:

1. MRB are not happy with the progress to date and want real change in real time. Not having the full support of all staff to achieve this target is a significant issue and increased effort needs to be put into shifting behaviours with greater accountability for the results.
2. The number of Māori in positions of seniority is a matter for concern in terms of influencing and driving cultural competency.
3. MRB like the idea of an Indigenous Recruitment Strategy. We need to understand why Māori consumers respond or engage well with Māori practitioners and/or professionals and incorporate the learnings not only within recruitment but also within professional development.

4. There has to be a willingness to enact and fully understand principles of Māori culture by the organisation as well as interview panels and interviewees. Māori consumer and staff representation on interview panels needs greater consideration.
5. There should be greater support systems in place for Māori applicants as well as unsuccessful applicants. Greater cultural support for existing staff within the organisation should be part of a retention strategy.

MRB acknowledged John and thanked him for his contribution over the past year. Further acknowledgement was given for John's leadership and commitment to increasing the development and recruitment strategy for Māori nursing. Kevin Snee (Chief Executive Officer HBDHB) considered the most appropriate person to take responsibility for this KPI is Sharon Mason (Chief Operating Officer). MRB supported the COO being responsible for the KPI.

- ***Te Ara Whakawaiaora: Mental Health***

Allison Stevenson (Service Director) and Dr Simon Shaw (Clinical Director & DAMHS) presented the report and the three indicators monitored by the Mental Health Services as follows:

- Rate of Section 29 Compulsory Treatment Orders (CTO)
- Percentage of clients discharged from Children Adolescent and Family Service (CAFS) with a Transition or Discharge Plan
- Wait time for non-urgent Mental Health & Addictions; 3-week; 8-week; 0 to 19 years of age.

Dr Shaw provided a brief explanation of a CTO and the compliance criteria that is determined by law and ultimately by a judge. There is no difference in the way in which the criteria is applied. CTO rates for Māori and non-Māori differ by DHB and the factors remain unclear.

An analysis of 50 people currently on long term treatment orders was conducted. The analysis identified some differences in factors for Māori and non-Māori that may require a national study to fully understand and explore these factors. Allison talked about the Random Consumer Files placed on the CTO and offered to provide MRB and ethnicity breakdown for better understanding. A brief synopsis of this sample included:

- Māori having fewer physical health problems than non-Māori (further research required to understand why).
- Māori have more criminal justice history than non-Māori
- Māori are more likely to have relatives with severe mental illness
- Unemployment and substance abuse appeared equal across Māori and non-Māori
- Māori appeared to have no fixed address as opposed to non-Māori
- More Māori diagnosed with Schizoaffective Disorder than non-Māori.

A greater sample is required for better analysis. If specific reasons are found as to why more Māori are placed under long term treatment orders, the question must be asked whether or not the Mental Health Service is the appropriate service to ameliorate those reasons or conditions. These factors include housing; employment; upbringing and amongst others.

There was a robust discussion and MRB offered the following feedback:

- MRB want Mental Health Services to gain more in-depth understanding around the underlying causes for the inequity between Māori and non-Māori CTO rates.
- MRB acknowledge the determinants of mental health and that mental health services are not always the appropriate intervention in addressing the underlying causes. MRB suggest Mental Health Services develop a cross sector approach involving agencies such as Housing NZ, WINZ, Justice, Police etc.

- MRB offered to support Mental Health Services and to wānanga with a specific focus on this matter, and to include external providers, consumers and their whānau to gain more perspective across the whole continuum.

- **Annual Māori Health Plan Quarter 4 (April-June 2016)**

Tracee Te Huia (General Manager Māori Health) and Justin Nguma (Senior Health and Social Policy Advisor Māori Health) briefly talked to the plan covering the highlights. While a number of targets have not been achieved, the information highlights the challenges for the organisation (equity) and the progress that has occurred to date. Justin reiterated the requirement of the various services within the organisation to provide quantitative and qualitative data for greater understanding regarding what is actually happening in the organisation, where there is need for improvement and how MRB can be most effective in terms of guidance and support.

Others reports provided for information and discussion included:

- **Health Equity Assessment Tool (HEAT) Implementation**

Mary Wills (Head of Strategic Services) and Nicholas Jones (Acting Director, Population Health) provided a presentation. The purpose of the presentation was to discuss how to apply the HEAT and to get MRBs feedback as follows:

- Data received is not always conducive to what is actually happening in real time. The data may not also be helpful in terms of what is trying to be achieved
- Equity must always be the focus in relation to the application of the HEAT. Therefore, the application of the tool should be outcomes based no matter the proposal
- In terms of addressing equity across the organisation, every decision should be subject to the HEAT, no matter the service agreement or service investment, or if the decision has already been made
- Real change in real time to have greater effect in removing inequity
- Consider other mechanisms for assessment and application. The HEAT is one tool for consideration. There are others that may be more applicable e.g. Te Pae Mahutonga
- Ensure all groups are being considered including Māori when applying the HEAT - unintentional marginalisation
- Clinical and cultural competency must be considered as being of equal value across the organisation
- Collective ownership, including with intersectoral agencies and external providers. Remove the silo behaviours and practices
- For the sake of further confusion, rather than continue to develop the HEAT, perhaps leave as it is and where there are other tools that may be more applicable, apply it within that context and in accordance with the demand.

Heather Skipworth, Acting MRB Chair acknowledged the presenters for their openness and willingness to share information. In addition, the good use and pronunciation of Te Reo Māori (Māori Language).

Nicola Ehau (Acting CEO Health Hawke's Bay PHO) acknowledged the DHB for their work currently undertaken and the leadership provided to Health Hawke's Bay PHO (HHB PHO) in the use of the HEAT which has been of great benefit. This has added value to the pieces of work HHB PHO has found challenging such as supporting general practices to move forward. Furthermore, the HEAT is being used to review current HHB PHO programmes, before and after, as well as with the formation of new programmes. It provides a framework that forces one to focus on outcomes and objective of the programmes.

- **Go Well - Travel Plan Update Verbal Presentation**

Andrea Beattie (Property and Service Contracts Manager) provided a verbal update of the Go Well – Travel Plan following on from her earlier presentation to MRB back in May 2016. The number of updates since May was noted. MRB provided the following feedback:

- Is there an opportunity for collaboration with anyone else in the region that has or is currently undertaking a similar plan that we can take direction and learnings from?
- Concern that 'aspiration and inspiration' has been lost sight of, acute factors in the promotion and backing of the initial plan. Andrea to keep this in mind with regard to progressing the Go Well Plan and for future reporting or presentations to MRB
- More focus should be on what we are doing to look after our staff rather than just focussing on the travel plan
- Promote members of the Executive Management Team who have taken up biking or walking to inspire other members or groups of staff
- Are there other incentives other than the obvious benefits that may be explored in terms of inspiring or making the plan aspirational to staff? For example, Te Taiwhenua o Heretaunga Wellness Point Plan
- Ensure that messaging also caters for staff who are not able to make a complete change due to busy lifestyles or working split shifts/two jobs etc. Encourage staff to make a different choice(s) when they can.
- Provide other options and or messaging for other things staff can be doing to improve their overall health. Employ these and other factors in an overall health improvement strategy for staff.

A copy of the HEAT assessment baseline plan was requested. MRB stressed the importance of receiving a copy of the presentation prior to the meeting to ensure members are fully briefed and prepared for the meeting.

- **Draft Quality Accounts**

Jeanette Rendle (Consumer Engagement Manager) and Adam McDonald (Health Literacy Advisor) gave a presentation on the Draft Quality Accounts.

The following was discussed:

- Cultural competency across the organisation and the use or current state of language and terminology with regard to communicating both with our community and staff was discussed.
- It was agreed MRB should feature in the Quality Accounts as this is a vital vessel for MRB to connect with Māori communities, provide understanding of the function and role of the MRB to the wider community and the differing groups of staff across the organisation.
- MRB is part of the governance structure as opposed to the management structure. Any change will require a change in structure and reporting. This matter will be included for an agenda item when the MRB meet with Adele White (CEO Ngāti Kahungunu Inc.) on the 24 August 2016.

MRB provided additional feedback:

- The use and definition of Māori kupu was considered to be an excellent way to bring the whole community on board and broaden their understanding of Te Reo Māori, while also demonstrating what is going on in the organisation
- Core objective of the DHB is **removing** inequity which needs to be reflected in the wording of Draft Quality Accounts

- Acknowledged Jeanette for highlighting areas of concern regarding wording and terminology for MRBs feedback.
- Concern raised regarding the use of negative language such as Māori doing badly and the obligation of everyone within the organisation to transform the culture and attitude. We need to breakdown the silo mentality
- MRB supported the notion of the translation of the services with the use of Te Reo Māori.

Others discussions included:

- ***Fluoridation***

There was a discussion about Dr Robin Whyman, Te Ara Whakawaia Ora Oral Health Champion's presentation in November 2016, specifically neurotoxins and the requirement for the most up to date information concerning this issue to be made available and discussed with MRB. MRB request that Dr Whyman traverse neurotoxins during his presentation and if possible, have a neurologist available to present this information in conjunction with Dr Whyman.

- ***Health and Social Care Networks; Purpose and Principles – Phase Two***

Emphasis was given to the idea of establishing a local leadership group in Wairoa to have their own reference group to drive the kaupapa forward rather than having to keep referring back to MRB. This included the initiation of this group being led by the Wairoa community rather than MRB. MRB also considered it paramount that the balance of this leadership group be less clinical in its membership, with the impetus being community (whānau) influenced, both in its outlook and development of networks and services for Wairoa.

 HAWKE'S BAY District Health Board Whakawāteatia	NZ Health Partnerships – Shareholder Approval Request	89
	For the attention of: HBDHB Board	
Document Owner:	Ken Foote, HBDHB Company Secretary	
Reviewed by:	Kevin Snee, Chief Executive Officer	
Month:	August 2016	
Consideration:	For Approval	

RECOMMENDATION**That the Board approve:**

1. NZ Health Partnerships Annual Plan 2016/17
2. NZ Health Partnerships Combined Statement of Intent 2016-20 and Statement of Performance Expectations 2016/17
3. NZ Health Partnerships Head Agreement.

HBDHB, along with the 19 other DHBs are shareholders in NZ Health Partnerships Ltd. In accordance with the Shareholders Agreement, shareholders must unanimously approve the Company's Annual Plan, Statement of Intent and Statement of Performance Expectations. An updated Heads of Agreement between NZ Health Partnerships Ltd and the District Health Boards for the delivery of shared services to DHBs has also been distributed for approval by all DHBs.

These documents have been under development for some time in consultation with DHBs, and whilst they have not been formally endorsed nationally, discussions and the work programme are proceeding well with the Company.

Find the documents attached.

Please note that page 37 of the Annual Plan is missing the heading / title: "Management Services".



Annual Plan 2016/17

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Confidential

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Who we are

Our Purpose

NZ Health Partnerships is a multi-parent Crown-entity subsidiary that is supported and owned by New Zealand's 20 District Health Boards (DHBs).

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

What we do

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

With an aging population, increasing cost of new clinical equipment, and rising public demand, our initiatives are focused on creating financial efficiencies for DHBs.

By thinking, acting and investing collaboratively DHBs are able to achieve greater benefits than they would by operating independently.

However, what we do is about more than cost reduction. While the company's primary focus is on administrative, support and procurement activities, most of our work has direct or indirect clinical implications.

We are key contributors to the government's goals of having an effective, integrated and innovative Health and Disability Sector that enables New Zealanders to live well, stay well and get well. Ultimately, patient outcomes are at the heart of the company and our operations.

NZ Health Partnerships is part of the New Zealand Health and Disability Sector.

We contribute to the wider health sector strategies:

- People-powered
- Closer to home
- Value and high performance
- One team
- Smart system.

Ensuring solutions are fit for purpose and best serve the needs of DHBs is paramount.

NZ Health Partnerships and DHBs are collaborating on programmes and services that have already started to deliver benefits to the Sector.

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Our Values

Our values underpin how we work together and engage with our stakeholders. They are central to our collective culture and as individuals we strive to live these values everyday in the decisions we make, our planning and processes and our behaviours.

- Accountability
- Commitment
- Respect
- Transparency.

Governance and Accountability

NZ Health Partnerships works in a commercial manner within a public sector environment. The company operates under a Board, programme and service governance structures with strong DHB representation. The Board comprises four regional DHB Chairs and three independent Directors. The Board is chaired by an independent Director.

New Zealand Health Partnerships Board:

- Peter Anderson (Chair)
- Murray Cleverley
- Jo Hogan
- Dr. Lee Mathias
- Terry McLaughlin
- Deryck Shaw
- Phil Sunderland

Within the parameters of the Annual Plan, the Board is responsible for the delivery of its portfolio of initiatives, core budget and performance of programmes and services.

Programme and service governance groups are chaired by a DHB Chief Executive Sponsor. The Sponsors drive the vision of the overall programme through strong stakeholder management engagement with DHB leaders and other stakeholders.

Our first year

NZ Health Partnerships became operational on 1 July 2015, taking over key areas of work from Health Benefits Limited which was ceased operations on 30 June 2015.

In our Annual Plan 2015/16 NZ Health Partnerships stated in our first year of operation we would focus on three strategic themes:

- Theme One: Develop and deliver shared services initiatives to our shareholders
- Theme Two: Planning and portfolio optimisation
- Theme Three: Building joint capability in the sector.

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Theme One: Develop and deliver shared services initiatives to our shareholders

To ensure we developed and delivered shared services to our shareholders we aimed to complete four objectives:

1. continue to develop and implement our current programmes
2. implement best practice programme methodology
3. support DHBs for local implementation
4. manage the services and contracts for the business cases we have implemented.

Continue to develop and implement our current our current programmes

At 1 July 2015 NZ Health Partnerships had four programmes under development; Linen and Laundry, Food Services, the National Oracle Solution and the National Infrastructure Platform.

During 2015/16 Linen and Laundry ceased being a national programme and Food Services transitioned to a service.

The National Oracle Solution programme is tracking within budget and project timelines. It successfully met all criteria applied at its November 2015 Stage Gate and the report has been presented to its governance groups and other key stakeholders including all 20 DHB Chief Financial Officers.

The programme is completing the build of the core solution, finalising the Infrastructure as a Service (IaaS) contract with Datacom, and preparing to conduct Solution Acceptance Testing from July 2016.

The National Infrastructure Platform programme has experienced a series of significant delivery delays. During the second half of the year the programme has been subject to commercial and technical reviews in order to determine the best way forward for DHBs given those delays.

Implement best practice programme methodology

We recognise that project management is a strategic capability we must have to successfully develop, build and transition programmes into services for our shareholders. To strengthen our programme governance we have implemented and embedded Prince2, a best practice programme management methodology.

Support DHBs for local implementation

Supporting DHBs with change and implementation is another strategic capability we offer. We have worked alongside Compass Group and the Auckland, Waitemata, Counties Manukau, Hauora Tairāwhiti and Southern DHBs to successfully implement the Food Services Agreement. We are currently supporting implementation with Nelson Marlborough DHB.

Manage the services and contracts for the business cases we have implemented

Contract negotiation and vendor management are key strategic capabilities. We have invested in this area to ensure DHBs realise maximum benefits. We have established a Commercial Services team responsible for providing these services for Procurement, Food, Banking and Insurance.

Theme Two: Planning and portfolio optimisation

To ensure we developed and delivered shared services that meet our shareholders' needs we set two objectives:

1. refocus our current programmes and services to align with our operating model and shareholders' expectations
2. develop a centralised approach to managing vendor performance and a detailed services catalogue.

Refocus our current programmes and services to align with our operating model and shareholders' expectations.

In its first 90 days NZ Health Partnerships worked with its DHB Shareholders to review all Programmes and Services and establish priorities for the 2015/16 financial year. It was agreed that greater flexibility should be applied to Programmes to maximise benefits by optimising DHB participation. This shift in focus recognises that many differences exist between DHBs and that one-size-fits-all is not necessarily the best approach for individual DHBs or the collective.

An example of this is the Linen and Laundry programme. Through ongoing collaboration it became clear that achieving buy-in from all 20 DHBs on the initial proposal would prove difficult as some DHBs have existing arrangements they would rather leverage and similar savings could be achieved through regional initiatives.

Develop a centralised approach to managing vendor performance and a detailed services catalogue

NZ Health Partnerships has established a Commercial Services team with a dedicated manager for each service we manage on behalf of the DHBs. The Commercial Services team is responsible for managing the vendor's performance (including healthAlliance (FPSC)).

A service catalogue has been developed and is currently being tested with key stakeholders.

Theme Three: Building joint capability in the sector

NZ Health Partnerships is committed to working collaboratively with DHBs to utilise their expertise and experience to develop and deliver shared services. Our people benefit from working side-by-side with DHB subject matter experts, clinicians and management across the portfolio. There is strong DHB representation on our programme and service advisory and governance groups and where possible we second DHB experts into NZ Health Partnerships to work with us on specific projects.

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

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Our future

Currently Health makes up 22 percent of Government spending. The Treasury estimates that, if nothing were to change in the way services are funded and delivered, Government health spending would increase from about 7 percent of GDP now, to about 11 percent of GDP in 2060¹. The challenge for the sector is to continue to improve clinical outcomes while ensuring it is financially sustainable.

In April 2016, the Ministry of Health released the '*New Zealand Health Strategy — Future direction*' which outlines its refreshed 10-year vision for the health system to address the pressures and significant demands on its services and on the health budget.

The Ministry's shared future direction for health, to deliver a fit for the future system, has five strategic themes; being:

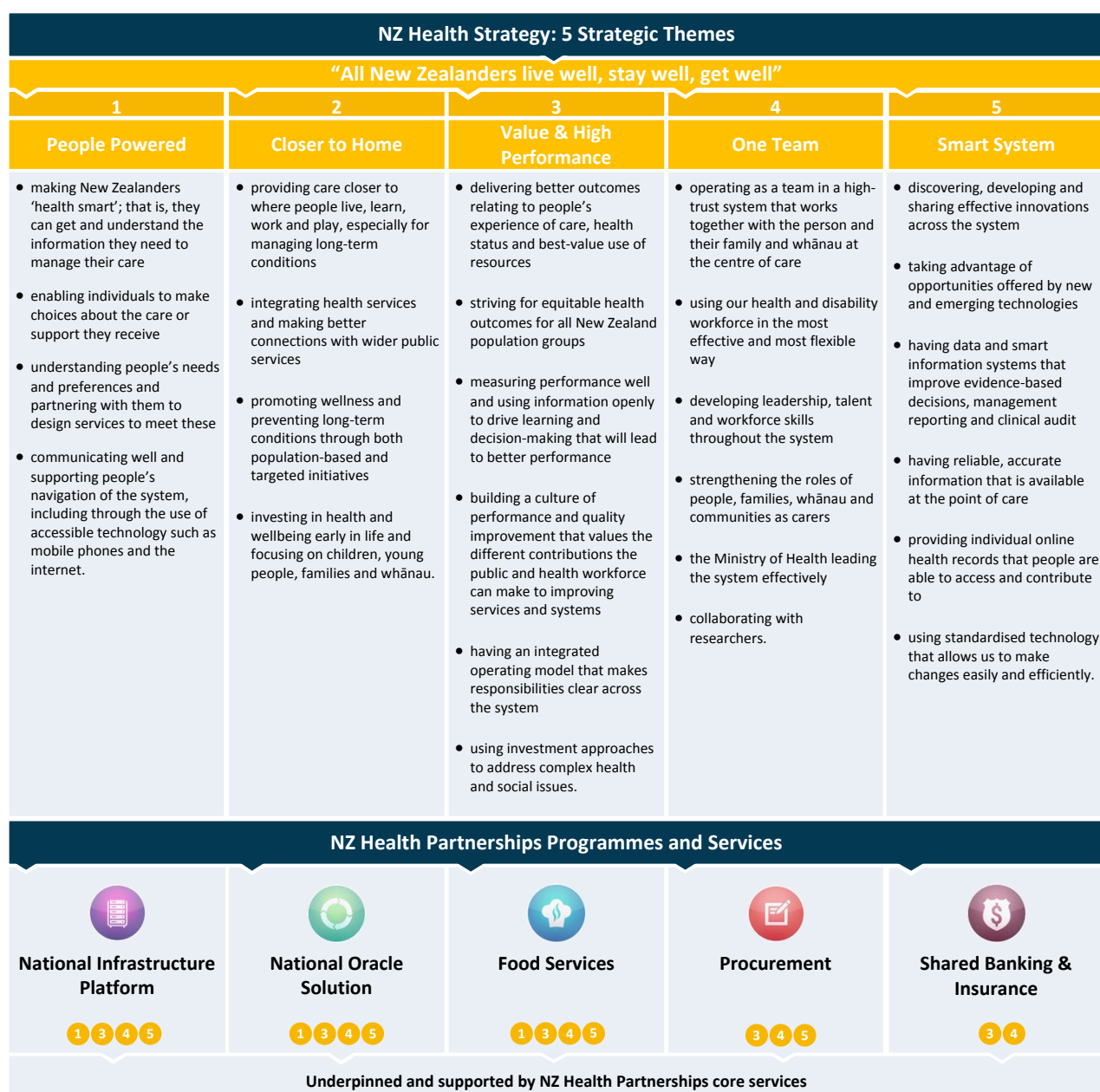
1. People-powered
2. Closer to home
3. Value and high performance
4. One team
5. Smart System

NZ Health Partnerships helps the DHBs achieve the shared future direction of health services by providing cost effective shared services. Our current programmes and services align to one or more of the five strategic themes, as shown in figure 1 on the next page.

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¹ Ministry of Health. 2016. *New Zealand Health Strategy — Future direction*. Wellington: Ministry of Health.

Figure 1: NZ Health Partnerships contribute to the wider Health Sector strategies



Examples of how our programmes and services are helping DHBs achieve the shared future direction today are outlined below.

People-powered

“In the future it is important people are provided with the information they need to fully understand issues to do with health and wellness, are able to access health services and manage their own health care”. *Source: ‘New Zealand Health Strategy — Future direction’.*

The **National Infrastructure Platform** will rationalise the number of data centres, infrastructure systems, and increase security, reliability, service levels and reduce waste.

The **National Oracle Solution** will assist DHBs to analyse in greater detail the processes and associated cost of providing services. This information will enable DHBs in the future to work alongside people and communities to design services to meet their needs and preferences.

As our population is becoming more ethnically diverse our needs and expectations are changing. The **Food Service** provides patients with greater selection and choice, reflecting the changing nature of New Zealand’s population.

Closer to home

Good health begins at home and in communities, so it makes sense to support people’s health through services located close to these places where possible. *Source: ‘New Zealand Health Strategy — Future direction’.*

By working collaboratively in **procurement** we can use the sector’s purchasing data to more effectively understand and respond to the needs of individuals and communities.

Value and high performance

It is important to get the best value we can from services, so that New Zealanders receive high-quality services that are affordable and sustainable. *Source: ‘New Zealand Health Strategy — Future direction’.*

The **National Infrastructure** Programme will rationalise the number of data centres, and infrastructure systems, reducing duplication and waste.

The **National Oracle Solution** will enable procurement to deliver better purchasing outcomes, improving the system, enable procurement performance to be better measured to drive better performance.

Food Services provide patient meals, meals-on-wheels, and cafeteria services, ward supplies and optional services for vendor machines and catering. The introduction of common food guidelines will improve food quality and consistency of food service across the sector.

Having a collective agreement for **Shared Banking** and **Insurance** services enables the DHBs to obtain terms and conditions more favourable than they would achieve if they negotiated independently.

One team

“To reach the goal of a high-performing system we need to reduce the fragmentation of services and care in our health system”. *Source: ‘New Zealand Health Strategy — Future direction’.*

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We are working collectively with the DHBs to deliver national solutions, such as the **National Infrastructure Platform, National Oracle Solution, Procurement, Shared Banking, Insurance** and **Food Services**. By working collaboratively we have assisted the DHBs to improve the quality of service, improve timeliness of access and reduce duplication of resources by standardising data, rationalising support services and infrastructure.

Smart System

“Our system needs to become a learning system, by seeking improvements and innovations, monitoring and evaluating what we are doing, and sharing and standardising better ways of doing things when appropriate. Key tools to help make this shift are data and technology”. *Source: ‘New Zealand Health Strategy — Future direction’.*

As previously stated the **National Infrastructure Platform** will provide capability to enable future national IT development and standardise the data centres and underlying ICT infrastructure of our DHBs.

The **National Oracle Solution** will assist DHBs to analyse in greater detail the processes and cost of providing services. The National Oracle Solution will enable procurement performance to be better measured, driving better performance to deliver better purchasing outcomes.

Food Services will provide patient meals, and meals-on-wheels based on common food guidelines and people individual dietary requirements. Data will be used to improve the efficiency, quality and satisfaction of the service.

New opportunities

An aging population, increasing clinical costs and a rise in demand for healthcare are putting pressure on our health system. To address these issues we believe there are other national, regional or individual DHB led initiatives that can provide additional benefits to our shareholders. The challenge is how, as a collective, we identify and co-develop opportunities to obtain the greatest benefits and enable DHBs to maximise the health dollar.

The 20 DHBs are responsible for providing health services that improve, promote and protect the health of people and communities. To meet their responsibilities each DHB seeks the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs.

We propose engaging with the sector in an inclusive and collaborative manner, similar to the method used in developing the DHB Procurement Strategy. In late 2016 we recommend organising a national hui for all DHB Chairs, Chief Executives, Chief Financial Officers and senior clinicians, along with representatives from other sector organisations such as PHARMAC. Together we would discuss and prioritise areas of opportunity for investigation.

New Zealand Health Partnerships manages a portfolio of work on behalf of the DHBs.

Opportunities requiring qualification, design and prioritisation

Programmes to build and deliver new shared services ranging from simple to transformational

Services catalogue requiring contract management and performance monitoring (and delivery)

The ideation and qualification of opportunities could lead to new programmes being approved for build and implementation to support a number of shared services. Once implemented, New Zealand Health Partnerships manages the services delivery via contracts with third parties, or provides them directly.

Our programmes and services

The DHBs, as our shareholders, invest in the programmes we develop. Our programme teams work with the DHBs as shareholders, co-creators and customers to develop and build shared services. Once a shared service is built, it transitions to our Commercial Services team for delivery to our DHB customers.

14.2



NATIONAL ORACLE SOLUTION

The National Oracle Solution (NOS) emerged from the re-planning of the Finance, Procurement and Supply Chain (FPSC) programme. Significant progress has been made within the programme since the replanning process. The Solution Validation process was completed and the November Stage Gate Report presented to its governance groups. The report outlined that the solution can be delivered, ready for a DHB implementation, within the parameters set out by the Business Change Case.

Since the November Stage Gate, the programme has been deploying the new infrastructure, finalising the Infrastructure as a Service (IaaS) contract with Datacom, configuring and deploying the modifications in preparation to conduct Solution Acceptance Testing scheduled to occur in July 2016.

The programme represents a significant investment for the sector and is a critical foundation to the National Procurement Strategy.

Objective

The NOS will design and build a single financial management information system ready for DHB implementation.

Initiatives

During 2016/17 NOS will transition from a programme to a service. This is an exciting and challenging new phase for the programme. Prior to implementation the focus for the programme is to successfully complete Solution Acceptance Testing.

The implementation plan is phased with multiple waves; with Bay of Plenty, Canterbury, Waikato and West Coast being the first DHBs to implement. The DHBs will lead the implementation. While some DHBs may be in a position to manage their own change and support the change of others, NZ Health Partnerships will provide support where requested.

A change programme of this magnitude is challenging. NZ Health Partnerships will capture lessons learned and incorporate into the implementation plans of future waves. The second wave of DHB implementation is scheduled for July 2017.

To support the programme transition from a project to an operational service the NOS Transition and Support Team will be established within NZ Health Partnerships to manage and govern the Oracle environment.

Performance

The National Oracle Solution programme performance measures and targets for 2016/17 are outlined in table 2 below.

Table 1: NOS performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
1	Ensure readiness of Oracle Administration Model	Key positions filled and capability in place	Quality	30 September 2016
2	Complete Technology Build	Solution acceptance testing successfully completed	Quality Timeliness	30 September 2016
3	Complete Solution Readiness	User acceptance testing successfully completed	Quality Timeliness	30 November 2016
4	Confirm DHB implementation Waves 2 & 3	Wave 2 & 3 High Level Implementation Plans completed	Quality	30 September 2016
5	Support First Wave DHB Implementation	Implementation completed on schedule, within budget, with no open action items	Timeliness Financial Quality	31 March 2017



NATIONAL INFRASTRUCTURE PLATFORM

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

The National Infrastructure Platform programme has experienced a series of significant delivery delays. During the second half of the year the programme has been subject to commercial and technical reviews in order to determine the best way forward for DHBs given those delays.

14.2

Objective

The National Infrastructure Platform programme will rationalise the infrastructure facilities into an integrated platform to deliver efficiency gains to the sector, while also creating the capability to enable future national IT development in the health sector is aligned with the IT Health Plan and Government's ICT Strategy.

Initiative

During 2016/17 the National Infrastructure Platform programme will implement series of activities to enable the programme recovers from the significant delivery delays by vendor so the original business case objectives can be realised during 2016/17. The recommendations from the commercial and technical reviews during the second half of 2015/16 will heavily inform the detail of the 2016/17 work program in consultation with the sector.

Performance

The National Infrastructure Platform programme performance measures and targets for 2016/17 are outlined in table 1 below.

Table 2: NIP performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
6	Implement agreed recommendations from the commercial, technical and delivery review	Programme, governance and processes aligned to the agreed recommendations from the commercial, technical and delivery review	Quality	30 June 2017
7	Deliver NIP Solution	Final Solution built and delivered on time, within scope, and within budget	Timeliness Quality Financial	15 April 2017



SHARED BANKING and INSURANCE

Shared Banking

Banking and Treasury Services was one of the first areas identified where collective savings could be delivered to DHBs through a national arrangement. Since 2011, Westpac Bank has provided banking and treasury services for all DHBs, HealthShare, healthAlliance and healthAlliance (FPSC). On any given day NZ Health Partnerships manages on behalf of the sector a cash balance of between \$300 million to \$1.4 billion through the Shared Banking and Treasury Services ("The Sweep") functions.

Objective

NZ Health Partnerships invests funds held in a restricted range of low risk investments to optimise the return on funds, while ensuring sufficient cash is available to meet all DHB needs.

Initiative

Shared Banking will work with the DHBs to improve cash forecasting capabilities within the sector.

NZ Health Partnerships will identify underlying drivers to inaccurate forecasting, and facilitate discussions to raise the forecasting capabilities within the sector.

In 2016/17 we will go to market to tender the Banking and Treasury Services to ensure we continue to provide the sector with the best possible banking and treasury arrangements.

Table 3: Shared Banking initiatives 2016/17

#	Initiative	Target	Type	When
1	Assist the sector improve their cash forecasting capabilities	Actual cash balance variance to forecast does not exceed 10% during the month	Quality	30 June 2017
2	Continue to monitor benefit baseline calculation	Complete a review of the benefit calculation annually and after a change to the OCR	Quality	30 June 2017

Performance

NZ Health Partnerships provides the Shared Banking activities. Unlike the other services where we act as a vendor manager, NZ Health Partnerships delivers the service and is responsible for achieving the following service performance targets.

Table 4: Shared Banking performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
8	Maximum number of issues raised in the Independent Audit Report rated as 'significant' or higher	Nil	Quality	30 Jun 2017
9	Minimum average sweep interest rate on funds placed on term deposit is at least 0.15% above the sweep on-call rate	0.15%	Financial	30 June 2017
10	Minimum non budgetary financial benefits delivered to DHBs during 2016/17 financial year			
	Minimum percentage of DHBs agree to the benefits for 2016/17	100%	Financial	31 December 2016
	Minimum Benefits realised	\$925,000	Financial	30 June 2017
11	Minimum percentage of DHBs and other participants are satisfied with the Banking Services service	80%	Quality	30 June 2017

Insurance

Collectively DHBs have assets valued around \$15 billion. Since 2010 the insurance needs of the sector has been managed under the Collective Insurance programme. The service is responsible for managing the insurance requirements for all 20 DHBs, and various joint ventures and subsidiaries that have elected to join the Collective Insurance Service. For the 2016/17 financial year the expected realised benefit from the Collective Insurance programme is \$5 million.

Objective

The objective of the service is to obtain insurance for the 20 DHBs and other participants that represents value for money, taking into account the terms and conditions, market dynamics and the strategic intentions of the DHBs.

Initiatives

The Collective Insurance programme has been able to realise benefits by working closely with DHBs and the insurance brokers to determine the appropriate insurance cover and the assets included in that cover. NZ Health Partnerships will continue to work alongside DHBs to provide appropriate information for the insurance broker to market the sectors insurance needs to insurers in New Zealand and internationally.

The sector continually needs to review its insurance coverage to ensure it remains fit for purpose and responds to emerging insurance risks. NZ Health Partnerships will work alongside DHBs to review the sectors insurance needs for emerging insurance risks such as Professional Indemnity, Environmental, Cyber and Extortion.

Table 5: Collective Insurance initiatives 2016/17

#	Initiative	Target	Type	When
3	Develop and agree refinements to the Insurance Service with the DHBs	Assessment of DHB Collective Insurance requirements in Professional Indemnity, Environmental, Cyber and Extortion, along with any other refinements completed	Quality	31 March 2017
4	Complete documentation of appropriate information for Insurance Broker to market DHB risk to insurers	Documented insurance underwriters' reports completed	Quality	30 June 2017

Performance

As the contract and vendor manager, NZ Health Partnerships has the relationship with the Broker and is responsible for ensuring the following performance targets are achieved.

Table 6: Collective Insurance performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
12	Minimum percentage of DHBs and Joint Ventures that have agreed insurance coverage for material damage business disruption, liability, travel and motor vehicle	100%	Quality Timeliness	30 June 2017
13	Minimum non budgetary financial benefits Collective Insurance delivered to DHBs and Joint Ventures during 2016/17 financial year	\$5 million	Financial	30 June 2017
14	Minimum percentage of DHBs and Joint Ventures are satisfied with the General Insurance service	80%	Quality	30 June 2017
15	New Collective Insurance agreement negotiated and selected Broker is ready to commence 2017/18 renewal by 01 October 2016.	Achieved	Timeliness	30 September 2016



DHB PROCUREMENT SERVICE

DHB Procurement includes both the DHB Procurement Strategy implementation work as well as the oversight of the National Procurement Service provided by healthAlliance (FPSC) Ltd.

In 2015 NZ Health Partnerships and DHB Shareholders identified a clear need for a nationally agreed DHB wide Procurement Strategy to ensure the best value for money. The DHB Procurement Strategy, published in May 2016, is the result of a collaborative development process between DHBs, NZ Health Partnerships, PHARMAC and MBIE. The strategy was endorsed by all 20 DHB CEOs on 14 April 2016, followed by NZ Health Partnerships Board approval on 28 April 2016.

The strategy is based on eight core principles that guide how DHBs work together, both collaboratively with each other and alongside PHARMAC and MBIE. It also determines that healthAlliance (FPSC) will transition out of medical device procurement as PHARMAC scales up. A collaborative approach to planning, engagement and a focus on both the enablers for good procurement and making the most of PHARMAC and MBIE opportunities are strategic priorities for 2016/17.

Initiatives

The focus in 2016/17 will be the implementation of the DHB Procurement Strategy against the agreed transition plan and ongoing contract management of the National Procurement Service delivered by healthAlliance (FPSC) Ltd.

Performance

The DHB Procurement performance measures and targets for 2016/17 are outlined in table 7.

14.2

Table 7: DHB Procurement performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
16	Establish the foundations for the DHB Procurement Strategy Implementation	Agreed leadership and advisory groups established and operating.	Quality	Q1 FY16/17
		Agreed frameworks and mechanisms in place to deliver the key activities outlined in the strategy.	Quality Timeliness	Q1 FY16/17
		Agreed implementation approach and supporting plan for the strategy with specific targets and measures.	Quality Timeliness	Q1 FY16/17
17	Commence the transition of Medical Devices from the scope of hA (FPSC)	Agreed transition group in place to manage the transition process	Quality	Q1 FY16/17
		Agreed implementation plan outlining the transition with specific targets and measures and DHB oversight	Quality Timeliness	31 July 2016
18	Provide management oversight of the delivery of the National Procurement Service by healthAlliance (FPSC)	Service Catalogues is delivered according to agreed 2016/17 scope	Quality Timeliness	Q1 FY16/17
		A highly effective and transparent customer supplier relationship facilitated by NZ Health Partnerships which delivers value to all parties is achieved	Quality	30th June 2017
		Commercial arrangements in place are improved	Quality	Q1 FY16/17



FOOD SERVICES

The Food Services Agreement was signed in 2014. Under the agreement Compass Group is contracted to provide patient meals, meals-on-wheels, and cafeteria services, ward supplies and optional services for vendor machines and catering.

The first DHBs to join the agreement were Auckland, Waitemata and Counties Manukau. Since then Southern, Hauora Tairāwhiti, and Nelson Marlborough have joined.

Objective

Food Services seek to implement a comprehensive food solution to DHBs. The solution will deliver common nutritional guidelines; a centralised electronic menu management system and improved visibility of food services spend across the sector.

14.2

Initiatives

Food Services will complete a number of initiatives in 2016/17 designed to expand the number of DHBs participating in the agreement to ensure the long term benefits of the service is delivered to the sector, while strengthening the governance of the service.

At present Compass Group provides around 60 percent of all patient meals served in New Zealand, as well as other services such as Meals on Wheels.

NZ Health Partnerships will provide the contract and vendor management of the Food Services Agreement on behalf of the participating DHBs.

Performance

The Food Service performance measures and targets for 2016/17 are outlined in table 8.

Table 8: Food Services performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
19	Participate in NFSP (National Food Services Programme)	All existing contracts executed in a timely manner and to the satisfaction of the stakeholder parties	Timeliness Quality	30 June 2017
		The contractual uplift percentage, triggered by non-participation, is minimised	Financial	30 June 2017
20	Promote alignment of National Nutritional specification	All participating DHBs accept the requirement for alignment with national contract specification (nutritional, performance management)	Quality	30 June 2017
21	Facilitate the adoption of the Ministry of Health's Healthy Food & Drinks Guidelines	NZHP to provide appropriate assistance and guidance to DHBs adopting the Ministry of Health's Healthy Food & Drinks Guidelines	Quality	30 June 2017
22	Lead/Facilitate Programme Level Implementation	Implementations are completed and delivered to plan (agreed contractual schedule), and within cost (budget) for all the participating DHBs	Quality Timeliness Financial	30 June 2017
23	Collaborate with the sector (including service providers) to establish agreement and implement a sector wide national nutritional performance matrix	There is clear evidence of sector collaboration i.e. that reporting framework is established and multi-provider data is able to be presented including an agreed review process in place	Quality	30 June 2017
24	Embed Benefits Realisation/CIP	Delivered according to agreed specification and trends are clear and concise	Timeliness Financial Quality	Q2 2016/17
25	Assist with the development of a mature National Programme Level Governance Framework	All participating DHB's have an established, operating governance model in place	Quality	30 June 2017

Benefits

In 2016/17, NZ Health Partnerships will work alongside DHBs, healthAlliance, PHARMAC and MBIE to strengthen the current benefits reporting process, establish a Benefits Community, and embed the National Procurement Strategy.

Benefit tracking is essential to assess relative success of our programmes and services, and to determine whether or not the DHBs investment in the programmes and services is delivering the benefits outlined in the business cases.

NZ Health Partnerships is responsible for coordinating the aggregated sector benefit and performance reporting based on information provided by NZ Health Partnerships programmes, DHB identified and realised benefits and other third party benefit providers such as healthAlliance and MBIE. The benefits reported by NZ Health Partnerships are owned by the DHBs.

To date it is fair to say benefit tracking has been a challenge across the sector. The current benefit tracking process was designed as a temporary measure until the National Oracle Solution programme was rolled out across the all the DHBs. However due to delays in the programme the sector will have to continue to use this benefits measurement process until the end of 2017 at the earliest.

Initiatives

During 2016/17 NZ Health Partnerships will work with the newly appointed CE Sponsor for Benefits and DHBs to develop a more sophisticated model for assessing, monitoring and reporting benefits in a range of criteria, including financial, in line with the concept of the National Good.

Key Benefits Definitions

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

BUDGETARY BENEFITS

Budgetary is defined as the incremental annual change, primarily cash, and includes any depreciation impact. These benefits result in a budget line reduction, compared with the prior year.

NON-BUDGETARY BENEFITS

Non-Budgetary benefits are defined as those that form part of the business case that do not meet the definition of Budgetary. There are three general components:

- **Cash Avoidance:** Cash that would have been spent is now totally avoided or reallocated as a result of the business case.
- **Cumulative benefits:** are those that are carried forward from previous years, whether they are budgetary or non-budgetary in nature.
- **Qualitative benefits:** accrue from associated activity as a result of a business case and need to be reported in some way. These may be able to be quantified but this may prove to be too difficult to do reliably.

14.2

Benefits Estimates

Table 9: Estimated Total Gross Benefits for Output Class 1 & 2, for FY2016/17.

	Estimated 2016/17 \$000
OUTPUT CLASS 1: PROGRAMMES	
National Oracle Solution	
Budgetary	0
Non-Budgetary	0
National Infrastructure Platform	
Budgetary	0
Non-Budgetary	0
<i>Total Annual Gross Benefits</i>	
Budgetary	0
Non-Budgetary	0
OUTPUT CLASS 2: SERVICES	
National Procurement Service	
Budgetary	27,300
Non-Budgetary	27,300
Food Services	
Budgetary	4,110
Non-Budgetary	1,960
Shared Banking	
Budgetary	0
Non-Budgetary	925
Insurance	
Budgetary	0
Non-Budgetary	2,527
Other Procurement	
Budgetary	4,228
Non-Budgetary	6,341
<i>Total Annual Gross Benefits</i>	
Budgetary	35,638
Non-Budgetary	39,035
TOTAL GROSS ANNUAL BENEFITS	74,691

Supporting our programmes and services

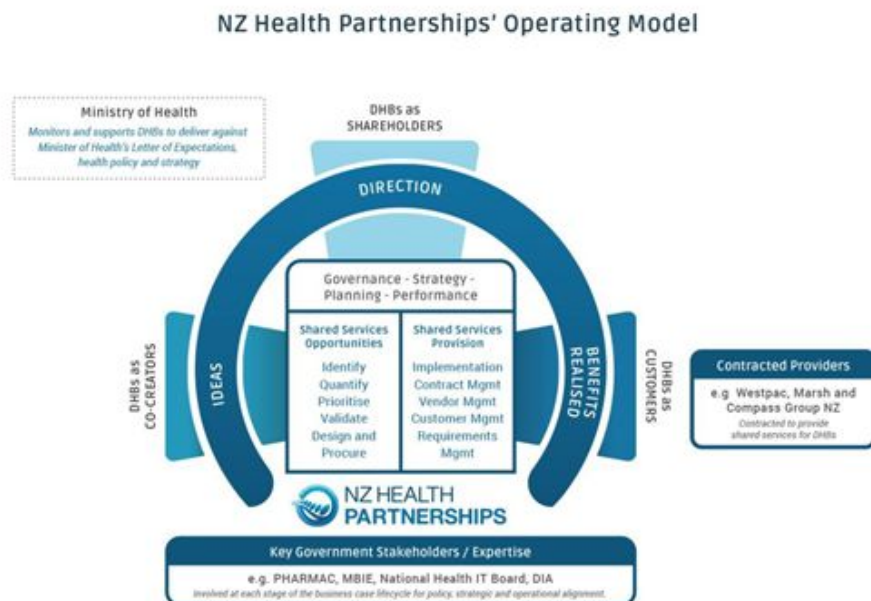
14.2

NZ Health Partnerships' has three strategic capabilities:

- Project management
- Contract, Vendor and Customer management
- Implementation and change management

These are embedded into our functions and activities illustrated in our Operating Model below.

Figure 2: NZ Health Partnerships Operating Model



Our strategic capability in project management is provided by our Programme Teams and is responsible for the Shared Services Opportunities function. Our Commercial Services Team provides our strategic capability in Contract, Vendor and Customer management, and is responsible for our Shared Services Provision function. The remaining function - Partnerships Governance, Strategy, Planning and Performance – consists of two teams:

- Communications and Engagement
- Corporate Services.



Governance, Strategy, Planning and Performance

NZ Health Partnerships Governance, Strategy, Planning and Performance is our internal function responsible for change management, strategy, finance, stakeholder communication and engagement, and our people.

Communication and Engagement

Our Communication and Engagement team is responsible for delivering our third strategic capability of change management, as well as provides stakeholder communication and engagement services.

Change management

We employ a joint delivery model for the implementation of services with DHBs taking the lead and NZ Health Partnerships playing a supporting change management role if requested. The range of services we could offer include:

- detailed role based impact assessments
- training needs assessment
- development of training collateral
- online training delivery
- business readiness assessments.

In 2016/17 NZ Health Partnerships will establish common change standards and a framework to support programmes throughout their life cycle from business case development through to service establishment, continuous improvement, measurement and reporting.

Our primary change management focus for the year will be supporting the implementation of the DHB Procurement Strategy.

Table 10: Change Management and Implementation Services initiatives 2016/17

#	Initiative	Target	Type	When
5	Support DHB-led change management	Change Management framework approved	Quality	30 September 2016
6	Assist DHBs with programme and service-related change management where required	Change management strategy for DHB Procurement Strategy approved; and other plans developed and implemented as requested	Quality	On-going

Stakeholder communication and engagement

Ensuring our stakeholders are well informed and actively engaged at both strategic and operational levels is critical to NZ Health Partnerships' collaborative operating model. We will continue to enhance our transparency and introduce stakeholder engagement and customer focus plans internally.

14.2

Table 11: Communications initiatives 2016/17

#	Initiative	Target	Type	When
7	Embed Communications customer focus as a way of working	Stakeholder engagement plan completed	Quality	On-going
		Customer Focus plan completed	Quality	On-going
		Stakeholder survey completed	Quality	On-going
8	Improve communication transparency with stakeholders	Communication plans documented and approved by Programme and Service governance fora	Quality	On-going
		Communications metric in the stakeholder survey improved	Quality	On-going
9	Inform all stakeholders of developments on a no surprise basis	Timely communication of information to all stakeholders improved by:	Quality	On-going
		• Communications risks and issues framework is developed and embedded	Quality	On-going
		• 100% of Official Information Act requests answered within the statutory requirement	Quality Timeliness	On-going
		• 100% of Parliamentary Question answered within two days	Quality Timeliness	On-going
10	Participate in NZ Health Partnerships Continuous Improvement Programme	Formal review process to ensure processes and practices are efficient and fit for purpose developed and embedded	Timeliness Quality	30 June 2017

Corporate Services

Corporate Services provides finance, accounting and legal services to NZ Health Partnerships. Two of its core activities are benefits reporting and contract negotiation and management.

Benefits Reporting

NZ Health Partnerships coordinates the reporting of all benefits generated across the sector. This includes reporting benefits achieved by NZ Health Partnerships' initiatives, All of Government, and local and collaborative DHB procurement. In 2016/17 NZ Health Partnerships will improve the current process and will proactively assist DHBs to resolve issues with benefits reporting, re-establish benefits reporting to the Board and shareholders, establish a Benefits Community as a forum share expertise across the sector, and embed the National Procurement Strategy.

Contract Negotiation and Management

NZ Health Partnerships, subject to DHB approval, will enter into negotiations with Preferred Respondents to negotiate commercially astute programme and service Agreements. Agreements are drafted for DHB consideration and approval. Once Agreements have been signed, we manage contracts, performance and relationship of the vendors and suppliers on behalf of the DHBs. During 2016/17 we will re-negotiate NZ Health Partnerships lease of our Central Park premises.

Table 12: Corporate Services initiatives 2016/17

#	Initiative	Target	Type	When
11	Improved financial reporting to the Executive and Board	Improved financial reporting template for Executive and Board level reporting is developed and embedded	Quality	30 September 2016
12	Implement a Benefits Reporting Process	Benefits reported to the Board monthly	Quality	30 September 2016
13	Renegotiate lease of Central Park premises	New lease negotiated and agreed	Financial	30 August 2016
14	Enhance Debt Management	Debt management governance processes enhanced with target of money owed to NZ Health Partnerships is less than \$1.5m by the end of the financial year achieved.	Financial	30 June 2017
15	Develop and embed new Planning and Performance function across the NZ Health Partnerships portfolio	Annual Planning and Performance Framework developed and embedded	Quality	01 July 2016
16	Develop Budgeting & Planning processes, and address areas identified as requires improvement	Budgeting and Planning Process map completed	Quality	30 September 2016
		Improvement areas identified and action plan developed	Quality	30 September 2016
17	Delivery on time all accountability documents	Key accountability documents delivered and approved	Timeliness Quality	30 June 2017
18	Participate in NZ Health Partnerships Continuous Improvement Programme	Formal review process to ensure processes and practices are efficient and fit for purpose developed and embedded	Timeliness Quality	30 June 2017

14.2

Our People

Critical to the success of any organisation are the people it employs. NZ Health Partnerships must continue to retain, attract and develop skilled and experienced people to ensure successful programme and service delivery for its customers.

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

Having confident, motivated and capable people will empower the organisation to perform at its best, continually lifting organisational health to meet the expectations of the DHBs.

Building our people capability

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

- optimising workforce capacity to deliver results
- ensuring our people are customer focused and are working on what matters most to the DHBs
- identifying and developing capable leaders who will provide a strong force for promoting internal organisational change
- integrating our shareholders' workforce more effectively and efficiently, encouraging understanding about a 'common toolkit' of skills, and improving the sector's ability to shift staff into national, regional and local levels of strategic implementation.

Good Employer

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

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

Table 13: Our People initiatives 2016/17

#	Initiative	Target	Type	When
19	Develop a HR Strategy	Comprehensive HR Strategy completed	Quality	30 September 2016
		Workforce Planning toolset developed and approved	Quality	31 December 2016
20	Deliver integrated Employee Performance and Development Framework	A comprehensive Annual Planning and Performance framework for employees developed and embedded	Quality Financial	31 October 2016
21	Develop Remuneration Framework	A comprehensive Remuneration Framework is developed and embedded.	Quality Financial	30 November 2016
		Integration of remuneration plans with HR strategy and Performance and Development framework is completed	Quality	30 November 2016
22	Implement Human Resources Strategy	5 - 10% increase in aggregated staff engagement is achieved	Quality	30 September 2016
		Internal communications processes developed and embedded	Quality Timeliness	30 September 2016
23	Embed customer focus as a way of working including unpacking core values and implementing internal culture initiatives	Minimum 5% increase of stakeholders rating NZ Health Partnerships' customer focus as satisfactory or above	Quality	30 June 2017
		5 - 10% increase in staff believing we are focussed on our customers' needs	Quality	30 June 2017

14.2

Risk management

NZ Health Partnerships recognises that risk and issue management is essential for the delivery of its programmes and services. NZ Health Partnerships is committed to working closely with its stakeholders to ensure we maintain an effective system able to define and determine acceptable levels of risk within each programme and service.

The aims of our risk and issues management processes are to improve the quality of decision making to minimise and manage adverse impacts.

Initiatives

NZ Health Partnerships will complete a number of initiatives in 2016/17 designed to strengthen governance of its programmes and services.

Table 14: Risk Management initiatives 2016/17

#	Initiative	Target	Type	When
24	Ensure Quality Assurance in place across NZ Health Partnerships Portfolio	100% of programmes & services have engaged an Independent Quality Assurance provider	Quality	30 Sep 2016
25	Participate in NZ Health Partnerships Continuous Improvement Programme	Formal review process to ensure processes and practices are efficient and fit for purpose developed and embedded	Timeliness Quality	30 June 2017
26	Develop Legislative Compliance checklist	Development of a Legislative Compliance Checklist completed	Quality	31 December 2016
27	Complete Benefits Quality Assurance	Benefits Quality Assurance to support year-end audit completed	Quality	30 June 2017
28	Ensure a Health & Safety structure in place to support new legislation	Health & Safety structure to ensure NZ Health Partnerships comply with new legislation completed and embedded	Quality	30 June 2017

Our performance

The success of NZ Health Partnerships will be measured by its ability to deliver fit for purpose programmes and services that meet our shareholders' expectations and enable them to realise benefits.

Assessing our performance

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

14.2

Table 15: Performance assessment ratings

	Performance Rating	Description
	Achieved	The measure has been achieved within its target date.
	Partially Achieved	The activities and inputs have been completed; however, the measure was not achieved within the target date.
	Not Achieved	The measure has not been completed.

The perspectives that underpin our assessment of performance are quality, financial and timeliness.

Table 16: Performance categories

Perspective	Description
Quality	This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement.
Financial	This will report performance against the projected costs and benefits for financial measures.
Timeliness	The programmes and services will have progress measured against agreed milestones to determine if they are delivery on schedule.

Financial Statements

1.1 PROSPECTIVE STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

For the year ended 30 June 2017

	Budget \$000's
Revenue:	
Revenue from DHBs	22,696
Interest revenue - NZ Health Partnerships	120
Shared banking	24,000
Other revenue	-
Total revenue	46,816
Expenditure:	
Personnel costs	4,201
Depreciation and amortisation expense	132
Finance costs - NZ Health Partnerships	-
Shared banking	24,000
Other expenses	18,483
Total Expenditure	46,816
Surplus/ (Deficit)	0
Other Comprehensive revenue and expense	0
Total Other Comprehensive Revenue and Expense	0
TOTAL COMPREHENSIVE REVENUE AND EXPENSE	0

	Budget FY 2016/17 \$000's
Expenditure:	
Employees Costs	
Salary & Wages	2,948
Course fess, Conference & Memberships	100
Recruitment	20
Total	3,069
Outsourced Services	
Contractors	0
Finance & Payroll Bureau- hANZ	96
Information Technology-hANZ	90
Total	186
Other Expenditure	
Rents, Utilities, Cleaning etc.	317
Staff Travel Flights, Accommodation, Meals - Domestic	80
Staff Accommodation and Meals	15
Software leases & rentals	97
Telecommunications	83
Bank Charges	2
Audit & Legal Fees	305
Assurance Fees & Consultants	393
Insurance	65
Stationery and Supplies	31
Reception and Catering	15
Information Technology Depreciation	132
Sundry Expenses	25
Board Members Fees & Expenses	275
Total	1,835
Total Expenditure	5,090

14.2



Combined

Statement of Intent

1 July 2016 to 30 June 2020

Statement of Performance Expectations

1 July 2016 to 30 June 2017

Confidential.
Statement of Intent 2016-2020 and Statement of Performance Expectations 2016/17

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PART ONE

14.3

STATEMENT OF INTENT

Chairs' foreword

As a new organisation we focused on establishing strong foundations. We recruited new experienced people, including Chief Executive, Megan Main, who have the capabilities to meet our shareholders' expectations. Governance structures were refreshed, including the introduction of CEO Sponsors to our services and programs. Programs were re-scoped and improved vendor performance management processes were introduced.

While work continues on the foundations, NZ Health Partnerships is focused on supporting District Health Boards (DHBs) as we enter a period of significant but positive change.

The implementation of the National Oracle Solution, a programme in gestation for several years, will get underway in early 2017 and continue for up to three years.

In 2016/17 the sector will implement its first ever aligned Annual Procurement Plan. This collective commitment to delivering well governed, well planned and co-ordinated procurement across the sector has the potential to be transformative - driving down costs, and improving health outcomes. In the process, this work will help catalyse collaboration and co-operation in the health sector.

Our role is to help facilitate that collaboration across a range of programmes and commercial services. We are an enabler and we exist to help DHBs deliver better health outcomes. That means we have to deliver value today by continuing to enhance our customer centric approach to developing and delivering services.

We will also establish a new Benefits Management Framework to improve transparency and accountability.

Internally, we will continue to build our organisational health and the capabilities of our people, while leveraging the knowledge and skills in the sector.

While our priority is to provide our DHB shareholders with a strong return on investment today we need to keep an eye on tomorrow. The recently refreshed NZ Health Strategy outlines the challenges facing health and a 10-year vision for the future.

NZ Health Partnerships will discuss with its shareholders how we best work together to meet these challenges, to align with the direction set by the Ministry of Health and to identify new, smarter, people-focussed initiatives that maximise DHBs' health dollar and allow New Zealanders to live well, stay well, get well.



Peter Anderson
Chair

Statement of responsibility

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

The Statement of Intent sets out our strategic intentions of NZ Health Partnerships for the four year period from 1 July 2016 to 30 June 2020.

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

14.3

Signed on behalf of the Board



Peter Anderson
Chair

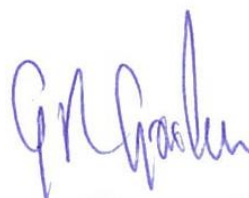


Terry McLaughlin
Chair of Finance, Risk, Audit and
Compliance Committee

Countersigned



Megan Main
Chief Executive



Geoff Goodwin
General Manager Corporate Services



SECTION ONE

OUR OPERATING ENVIRONMENT

Who we are

NZ Health Partnerships is part of the New Zealand Health and Disability Sector.

Our Purpose

NZ Health Partnerships is a multi-parent Crown-entity subsidiary that is supported and owned by New Zealand's 20 District Health Boards (DHBs).

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

What we do

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

With an aging population, increasing cost of new clinical equipment, and rising public demand, our initiatives are focused on creating financial efficiencies for DHBs.

By thinking, acting and investing collaboratively DHBs are able to achieve greater benefits than they would by operating independently.

However, what we do is about more than cost reduction. While the company's primary focus is on administrative, support and procurement activities, most of our work has direct or indirect clinical implications.

We are key contributors to the government's goals of having an effective, integrated and innovative Health and Disability Sector that enables New Zealanders to live well, stay well and get well. Ultimately, patient outcomes are at the heart of the company and our operations.

14.3

We contribute to the wider health sector strategies

Figure 1: NZ Health Strategy: 5 Strategic Themes

NZ Health Strategy: 5 Strategic Themes				
1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

Our operating environment

Working with DHBs to improve shared services

We work collaboratively with DHBs and other participants in the NZ Health Sector to develop and deliver the innovative and effective share services the DHBs require.

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

Shareholders: DHBs will be the shareholders of the NZ Health Partnerships and own and govern the entity by way of an Independent Board.

Co-creators: DHBs will work with NZ Health Partnerships to identify, prioritise and develop shared services opportunities.

Customers: DHBs will receive services provided by NZ Health Partnerships under separate business case implementation agreements.

Strategic Partnerships

NZ Health Partnerships operate in a multi-tiered relationship environment that requires active stakeholder management to foster

stronger strategic relationships with our stakeholders. These include:

healthAlliance NZ Ltd

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

healthAlliance (FPSC) Ltd

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

Existing DHB Shared Services Agencies NZ Health Partnerships will work with DHB shared service organisations such as Central TAS, DHB Shared Services, HealthShare and the South Island Alliance to leverage existing knowledge and expertise on working with the DHBs. This will allow greater alignment across the sector.

Ministry of Health

The Ministry will monitor and support the DHBs to deliver against the Minister of Health's Letter of

Expectations, health policy and strategy. Through the DHBs, the Ministry will enable NZ Health Partnerships to implement regional and national shared services.

National Health IT Board

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

PHARMAC

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

Ministry of Business, Innovation and Employment (MBIE)

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

Commercial Organisations

Support from commercial partners is integral to the delivery of shared services for all our programmes and on-going services. These contractual

relationships will be managed and monitored by NZ Health Partnerships on behalf of the sector.

Reduce our administration costs

Operating within our baseline will be a challenge as our costs increase each year. We are reducing our administration costs through better management practices and targeted improvement initiatives. At the same time, we are improving our services and developing innovative solutions for DHBs shared services. We need to do this while managing risks associated with carrying out our core business, while maintaining the trust and confidence of the DHBs and wider NZ Health Sector.

Respond to the challenges of an increasing digital world

We need to keep pace with rapid technology changes, the expectations of our customers, their increasing digital needs.

Statutory and Compliance Requirements

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

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

14.3



SECTION TWO

OUR STRATEGIC INTENTIONS

Our first year

NZ Health Partnerships became operational on 1 July 2015, taking over key areas of work from Health Benefits Limited which ceased operations on 30 June 2015.

On 1 July 2015 NZ Health Partnerships was managing on behalf of the DHBs for programmes and three services.

Programmes:

- National Oracle Solution
- National Infrastructure Platform
- Food Services
- Linen and Laundry

Services:

- National Procurement Service
- Shared Banking
- Collective Insurance

In our first year of operation NZ Health Partnerships focused on three strategic themes:

- Theme One: Develop and deliver shared services initiatives to our shareholders
- Theme Two: Planning and portfolio optimisation
- Theme Three: Building joint capability in the sector.

Theme One: Develop and deliver shared services initiatives to our shareholders

To ensure we developed and delivered shared services to our shareholders we aimed to complete four objectives:

1. continue to develop and implement our current programmes
2. implement best practice programme methodology
3. support DHBs for local implementation
4. manage the services and contracts for the business cases we have implemented.

Continue to develop and implement our current programmes

At 1 July 2015 NZ Health Partnerships had two programmes under development; the National Oracle Solution and the National Infrastructure Platform.

The National Oracle Solution programme is tracking within budget and project timelines. It successfully met all criteria applied at its November 2015 Stage Gate and the report has been presented to its governance groups and other key stakeholders including all 20 DHB Chief Financial Officers.

The programme is completing the build of the core solution, finalising the Infrastructure as a Service (IaaS) contract with Datacom, and preparing to conduct Solution Acceptance Testing from July 2016.

The National Infrastructure Platform has experienced technical delays and NZ Health Partnerships is working to resolve these.

14.3

Implement best practice programme methodology

We recognise that project management is a strategic capability we must have to successfully develop, build and transition programmes into services for our shareholders. To strengthen our programme governance we have implemented and embedded Prince2, a best practice programme management methodology.

Support DHBs for local implementation

Supporting DHBs with change and implementation is another strategic capability we offer. We have worked alongside Compass Group and the Auckland, Waitemata, Counties Manukau, Hauora Tairāwhiti and Southern DHBs to successfully implement the Food Services Agreement. We are currently supporting implementation with Nelson Marlborough DHB.

Manage the services and contracts for the business cases we have implemented

Contract negotiation and vendor management are key strategic capabilities. We have invested in this area to ensure DHBs realise maximum benefits. We have established a Commercial Services team responsible for providing these services for Procurement, Food, Banking and Insurance.

Theme Two: Planning and portfolio optimisation

To ensure we developed and delivered shared services that meet our

shareholders' needs we set two objectives:

1. refocus our current programmes and services to align with our operating model and shareholders' expectations
2. develop a centralised approach to managing vendor performance and a detailed services catalogue.

Refocus our current programmes and services to align with our operating model and shareholders' expectations.

In its first 90 days NZ Health Partnerships worked with its DHB Shareholders to review all Programmes and Services and establish priorities for the 2015/16 financial year. It was agreed that greater flexibility should be applied to Programmes to maximise benefits by optimising DHB participation. This shift in focus recognises that many differences exist between DHBs and that one-size-fits-all is not necessarily the best approach for individual DHBs or the collective.

An example of this is the Linen and Laundry programme. Through ongoing collaboration it became clear that achieving buy-in from all 20 DHBs on the initial proposal would prove difficult as some DHBs have existing arrangements they would rather leverage and similar savings could be achieved through regional initiatives.

Develop a centralised approach to managing vendor performance and a detailed services catalogue

NZ Health Partnerships has established a Commercial Services team with a dedicated manager for

each service we manage on behalf of the DHBs. The Commercial Services team is responsible for managing the vendor's performance (including healthAlliance (FPSC)).

A service catalogue has been developed and is currently being tested with key stakeholders.

Theme Three: Building joint capability in the sector

NZ Health Partnerships is committed to working collaboratively with DHBs to utilise their expertise and experience to develop and deliver shared services. Our people benefit from working side-by-side with DHB subject matter experts, clinicians and management across the portfolio.

There is strong DHB representation on our programme and service advisory and governance groups and where possible we second DHB experts into NZ Health Partnerships to work with us on specific projects.

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

14.3

Our future direction

NZ Health Partnerships' long-term strategies are designed to respond to our challenges and guide us towards the organisation our shareholders need us to be.

NZ Health Partnerships will focus on three main themes:

- continue to develop and implement our current programmes
- deliver and improve our services, including enhancing our customer centric approach to developing and delivering our services
- contribute to identifying future shared services opportunities with our shareholders

We will work in these three linked areas concurrently, balancing our need to deliver today and innovate for tomorrow.

NZ Health Partnerships programmes and services are aligned to helping DHBs achieve the shared future direction outlined by the Ministry of Health.

In April 2016, the Ministry of Health released the '*New Zealand Health Strategy — Future direction*' which outlines its refreshed 10-year vision for the health system to address the pressures and significant demands on its services and on the health budget.

The Ministry's shared future direction for health, to deliver a fit for the future system, has five strategic themes; being:

Figure 2: NZ Health Strategy: 5 Strategic Themes

NZ Health Strategy: 5 Strategic Themes				
1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

Currently Health makes up 22 percent of Government spending. The Treasury estimates that, if nothing were to change in the way services are funded and delivered, Government health spending would increase from about 7 percent of GDP now, to about 11 percent of GDP in 2060¹. The challenge for the sector is to continue to improve clinical outcomes while ensuring it is financially sustainable.

NZ Health Partnerships helps the DHBs achieve the shared future direction of health services by providing cost effective shared services. Our current programmes and services align to one or more of the five strategic themes.

Table 1: NZ Health Strategy: 5 Strategic Themes

NZ Health Strategy: 5 Strategic Themes				
"All New Zealanders live well, stay well, get well"				
1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System
- making New Zealanders 'health smart'; that is, they can get and understand the information they need to manage their care - enabling individuals to make choices about the care or support they receive - understanding people's needs and preferences and partnering with them to design services to meet these - communicating well and supporting people's navigation of the system, including through the use of accessible technology such as mobile phones and the internet.	- providing care closer to where people live, learn, work and play, especially for managing long-term conditions - integrating health services and making better connections with wider public services - promoting wellness and preventing long-term conditions through both population-based and targeted initiatives - investing in health and wellbeing early in life and focusing on children, young people, families and whānau.	- delivering better outcomes relating to people's experience of care, health status and best-value use of resources - striving for equitable health outcomes for all New Zealand population groups - measuring performance well and using information openly to drive learning and decision-making that will lead to better performance - building a culture of performance and quality improvement that values the different contributions the public and health workforce can make to improving services and systems - having an integrated operating model that makes responsibilities clear across the system - using investment approaches to address complex health and social issues.	- operating as a team in a high-trust system that works together with the person and their family and whānau at the centre of care - using our health and disability workforce in the most effective and most flexible way - developing leadership, talent and workforce skills throughout the system - strengthening the roles of people, families, whānau and communities as carers - the Ministry of Health leading the system effectively - collaborating with researchers.	- discovering, developing and sharing effective innovations across the system - taking advantage of opportunities offered by new and emerging technologies - having data and smart information systems that improve evidence-based decisions, management reporting and clinical audit - having reliable, accurate information that is available at the point of care - providing individual online health records that people are able to access and contribute to - using standardised technology that allows us to make changes easily and efficiently.
NZ Health Partnerships Programmes and Services				
 National Infrastructure Platform 1 3 4 5	 National Oracle Solution 1 3 4 5	 Food Services 1 3 4 5	 Procurement 3 4 5	 Shared Banking & Insurance 3 4
Underpinned and supported by NZ Health Partnerships core services				

Examples of how our programmes and services are helping DHBs achieve the shared future direction today are outlined below.

People-powered

“In the future it is important people are provided with the information they need to fully understand issues to do with health and wellness, are able to access health services and manage their own health care”. *Source: ‘New Zealand Health Strategy — Future direction’.*

The **National Infrastructure Platform** will rationalise the number of data centres, infrastructure systems, and increase security, reliability, service levels and reduce waste.

The **National Oracle Solution** will assist DHBs to analyse in greater detail the processes and associated cost of providing services. This information will enable DHBs in the future to work alongside people and communities to design services to meet their needs and preferences.

As our population is becoming more ethnically diverse our needs and expectations are changing. The **Food Service** provides patients with greater selection and choice, reflecting the changing nature of New Zealand’s population.

Closer to home

Good health begins at home and in communities, so it makes sense to support people’s health through services located close to these places where possible. *Source: ‘New Zealand Health Strategy — Future direction’.*

By working collaboratively in **procurement** we can use the sector’s purchasing data to more effectively understand and respond to the needs of individuals and communities.

Value and high performance

It is important to get the best value we can from services, so that New Zealanders receive high-quality services that are affordable and sustainable. *Source: ‘New Zealand Health Strategy — Future direction’.*

The **National Infrastructure Platform** will rationalise the number of data centres, and infrastructure systems, reducing duplication and waste.

The **National Oracle Solution** will enable procurement to deliver better purchasing outcomes, improving the system, enable procurement performance to be better measured to drive better performance.

Food Services provide patient meals, meals-on-wheels, and cafeteria services, ward supplies and optional services for vendor machines and catering. The introduction of common food guidelines will improve food quality and consistency of food service across the sector.

Having a collective agreement for **Shared Banking and Insurance** services enables the DHBs to obtain terms and conditions more favourable than they would achieve if they negotiated independently.

One team

“To reach the goal of a high-performing system we need to reduce the fragmentation of services and care in our health system”. Source: ‘New Zealand Health Strategy — Future direction’.

We are working collectively with the DHBs to deliver national solutions, such as the **National Infrastructure Platform, National Oracle Solution, Procurement, Shared Banking, Insurance and Food Services**. By working collaboratively we have assisted the DHBs to improve the quality of service, improve timeliness of access and reduce duplication of resources by standardising data, rationalising support services and infrastructure.

Smart System

“Our system needs to become a learning system, by seeking improvements and innovations, monitoring and evaluating what we are doing, and sharing and standardising better ways of doing things when appropriate. Key tools to help make this shift are data and technology”. Source: ‘New Zealand Health Strategy — Future direction’.

As previously stated the **National Infrastructure Platform** will provide capability to enable future national IT development and standardise the data centres and underlying ICT infrastructure of our DHBs.

The **National Oracle Solution** will assist DHBs to analyse in greater detail the processes and cost of providing services. The National Oracle Solution will enable procurement performance to be better measured, driving better performance to deliver better purchasing outcomes.

Food Services will provide patient meals, and meals-on-wheels based on common food guidelines and people individual dietary requirements. Data will be used to improve the efficiency, quality and satisfaction of the service.

Delivering our programmes

The DHBs, as our shareholders, invest in the programmes we develop. Our programme teams work with the DHBs as shareholders, co-creators and customers to develop and build shared services.

On 1 July 2015, four programmes were transferred to NZ Health Partnerships:

- National Oracle Solution
- National Infrastructure Platform
- Food Services
- Linen and Laundry

During 2015/16 Food Services transitioned from a programme to a service.

Linen and Laundry is no longer a national programme. Through ongoing collaboration it became clear that achieving buy-in from all 20 DHBs on the initial proposal would prove difficult as some DHBs have existing arrangements they would rather leverage and similar savings could be achieved through regional initiatives.



NATIONAL ORACLE SOLUTION

In late 2012, DHBs agreed to take a national approach to this purchasing through a programme now known as National Oracle Solution.

Every year, DHBs spend about \$1.3 billion buying goods and services, including everything from cotton wool

buds through to hospital beds.

Traditionally the purchasing of these goods and services by DHBs – including how they get ordered, stored, delivered and paid for – has been done in a variety of ways across the 20 DHBs, with no single register or process for handling the transactions.

Benefits of a co-operative approach include improved service levels, increased visibility and transparency of information, elimination of inefficiencies, better management of medical stock levels and less wastage, improved distribution of medical stock between DHBs, and emergency stock will be better managed. There will also be significant financial savings and a wide range of direct and indirect clinical benefits

During 2016/17 NOS will transition from a programme to a service. This is an exciting and challenging new phase for the programme.

The implementation plan is phased with multiple waves; with Bay of Plenty, Canterbury, Waikato and West Coast being the first DHBs to implement. The DHBs will lead the

implementation. While some DHBs may be in a position to manage their own change and support the change of others, NZ Health Partnerships will provide support where requested.

A change programme of this magnitude is challenging. NZ Health Partnerships will capture lessons learned and incorporate into the implementation plans of future waves. The second wave of DHB implementation is scheduled for July 2017.

To support the programme transition from a project to an operational service the NOS Transition and Support Team will be established within NZ Health Partnerships to manage and govern the Oracle environment.

14.3



NATIONAL INFRASTRUCTURE PLATFORM

The National Infrastructure Platform programme aims to achieve qualitative, clinical and financial benefits for DHBs through a national approach to IS infrastructure consumption.

During the second half of the 2015/16 financial year the programme has been subject to commercial, technical, and delivery reviews in order to determine the best way forward for DHBs.

During 2016/17 the National Infrastructure Platform programme will implement series of activities to enable the programme original business case objectives to be realised. The recommendations from the commercial, technical, and delivery reviews during the second half of 2015/16 will heavily inform the detail of the 2016/17 work program in consultation with the sector.

Providing our services

Once a shared service programme is built, it transitions to our Commercial Services team for delivery to our DHB customers.

On 1 July 2015, three services were transferred to NZ Health Partnerships:

- Shared Banking
- Collective Insurance
- DHB Procurement

During the 2015/16 financial year, Food Services transitioned from a programme to a service.



SHARED BANKING and INSURANCE

Shared Banking

Banking and Treasury Services was one of the first areas identified where collective savings could be delivered to DHBs through a national arrangement. Since 2011, Westpac Bank has provided banking and treasury services for all DHBs, HealthShare, healthAlliance and healthAlliance (FPSC). On any given day NZ Health Partnerships manages on behalf of the sector a cash balance of between \$300 million to \$1.4 billion through the Shared Banking and Treasury Services ("The Sweep") functions.

Unlike the other services where we act as a vendor manager, NZ Health Partnerships delivers the service. The objective of the Shared Banking is for NZ Health Partnerships to invest funds held in a restricted range of low risk investments to optimise the return on funds, while ensuring sufficient cash is available to meet all DHB needs.

Our intentions are to improve the effectiveness of the service by working with the DHBs to improve cash forecasting capabilities within the sector.

Collective Insurance

Collectively DHBs have assets valued around \$15 billion. Since 2010 the insurance needs of the sector has been managed under the Collective Insurance programme. The service is responsible for managing the insurance requirements for all 20 DHBs, and various joint ventures and subsidiaries that have elected to join the Collective Insurance Service. For the 2016/17 financial year the expected realised benefit from the Collective Insurance programme is \$5 million.

The objective of the service is to obtain insurance for the 20 DHBs and other participants that represents value for money, taking into account the terms and conditions, market dynamics and the strategic intentions of the DHBs.

The Collective Insurance programme has been able to realise benefits by working closely with DHBs and the insurance brokers to determine the appropriate insurance cover and the assets included in that cover.

NZ Health Partnerships will continue to work alongside DHBs to provide appropriate information for the insurance broker to market the sectors insurance needs to insurers in New Zealand and internationally.

The sector continually needs to review its insurance coverage to ensure it remains fit for purpose and responds to emerging insurance risks. NZ Health Partnerships will work alongside DHBs to review the sectors insurance needs for emerging insurance risks such as Professional Indemnity, Environmental, Cyber and Extortion.



DHB PROCUREMENT SERVICE

DHB Procurement includes both the DHB Procurement Strategy implementation work as well as the oversight of the National Procurement Service provided by healthAlliance (FPSC) Ltd.

In 2015 NZ Health Partnerships and DHB Shareholders identified a clear need for a nationally agreed DHB wide Procurement Strategy to ensure the best value for money. The DHB Procurement Strategy, published in May 2016, is the result of a

collaborative development process between DHBs, NZ Health Partnerships, PHARMAC and MBIE. The strategy was endorsed by all 20 DHB CEOs on 14 April 2016, followed by NZ Health Partnerships Board approval on 28 April 2016.

The strategy is based on eight core principles that guide how DHBs work together, both collaboratively with each other and alongside PHARMAC and MBIE. It also determines that healthAlliance (FPSC) will transition

out of medical device procurement as PHARMAC scales up. A collaborative approach to planning, engagement and a focus on both the enablers for good procurement and making the most of PHARMAC and MBIE opportunities are strategic priorities for 2016/17 onwards.

Our focus in 2016/17 will be the implementation of the DHB Procurement Strategy against the agreed transition plan and ongoing contract management of the National Procurement Service delivered by healthAlliance (FPSC) Ltd.



FOOD SERVICES

The Food Services Agreement was signed in 2014. Under the agreement Compass Group is contracted to provide patient meals, meals-on-wheels, and cafeteria services, ward supplies and optional services for vendor machines and catering.

The first DHBs to join the agreement were Auckland, Waitemata and Counties Manukau. Since then Southern, Hauora Tairāwhiti, and Nelson Marlborough have joined and up to nine additional DHBs are considering joining.

The objective of Food Services is to implement a comprehensive food solution to DHBs. The solution, will for the first time, deliver common nutritional guidelines; a centralised electronic menu management system

and improved visibility of food services spend across the sector.

The focus of Food Services in 2016/17 onwards is to re-baseline financials to help inform DHB participation decisions and work with Compass to refine and improve the contract, as well as strengthening governance of the service.

At present Compass Group provides around 60 percent of all patient meals served in New Zealand, as well as other services such as Meals on Wheels.

NZ Health Partnerships will provide the contract and vendor management of the Food Services Agreement on behalf of the participating DHBs.

Future opportunities

New Zealand Health Partnerships manages a portfolio of work on behalf of the DHBs.

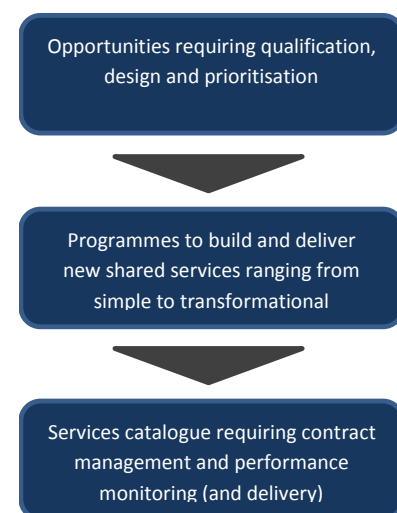
The 20 DHBs are responsible for providing health services that improve, promote and protect the health of people and communities. To meet their responsibilities each DHB seeks the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs.

New Zealand's aging population; increasing clinical costs and a rise in demand for healthcare are putting pressure on our health system. To address these issues we believe there are other national, regional or individual DHB led initiatives that can provide additional benefits to our shareholders. The challenge is how, as a collective, we identify and co-develop opportunities to obtain the greatest benefits and enable DHBs to maximise the health dollar.

NZ Health Partnerships engage with the sector in an inclusive and collaborative manner, to identify and discuss and prioritise areas of opportunity for investigation.

The ideation and qualification of opportunities could lead to new programmes being approved for build and implementation to support a number of shared services.

Figure 3: NZ Health Partnerships portfolio life cycle



14.3



SECTION THREE

ORGANISATIONAL HEALTH

Managing our functions and operations

14.3

To meet our strategic intentions we manage our functions and operations through the following teams:

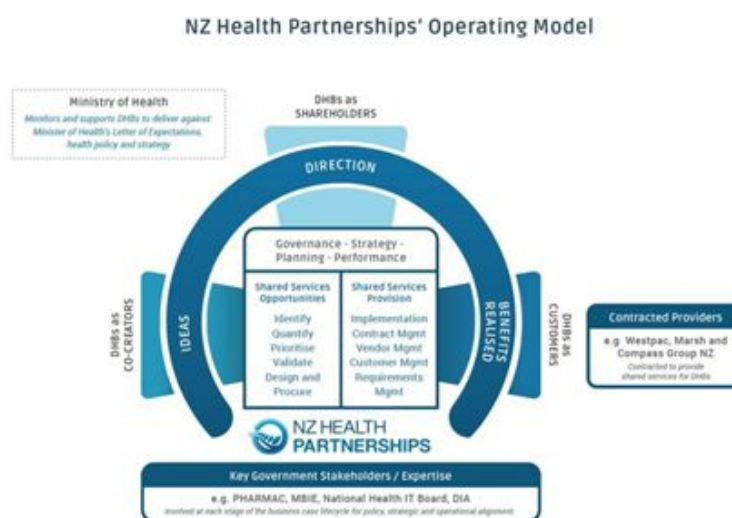
- Programmes—develop and build our programmes.
- Commercial Services—provides contract, vendor and customer management services for Procurement, Food, Banking and Insurance.
- Communications and Engagement — manages corporate and customer information, internal and external communication, and change management.
- Corporate Services —provides corporate support and service functions, including governance, legal, risk, assurance, procurement, human resources services, financial and planning services and manages our facilities.

To achieve our strategic intentions NZ Health Partnerships' has three strategic capabilities:

- Project management
- Contract, Vendor and Customer management
- Implementation and change management

These are embedded into our functions and activities illustrated in our Operating Model.

Figure 4: NZ Health Partnerships operating model



Our strategic capability in project management is provided by our Programme Teams and is responsible for the Shared Services Opportunities function. Our Commercial Services Team provides our strategic capability in Contract, Vendor and Customer management, and is responsible for our Shared Services Provision function. The remaining function - Partnerships Governance, Strategy, Planning and Performance – consists of two teams:

- Communications and Engagement
- Corporate Services.

Our Values

Our values underpin how we work together and engage with our stakeholders. They are central to our collective culture and as individuals we strive to live these values everyday in the decisions we make, our planning and processes and our behaviours.

- Accountability
- Commitment
- Respect
- Transparency



Governance, Strategy, Planning and Performance

NZ Health Partnerships Governance, Strategy, Planning and Performance is our internal function responsible for change management, strategy, finance, stakeholder communication and engagement, and our people.

Communication and Engagement

Our Communication and Engagement team is responsible for delivering our third strategic capability of change management, as well as provides stakeholder communication and engagement services.

Change management

We employ a joint delivery model for the implementation of services with DHBs taking the lead and NZ Health Partnerships playing a supporting change management role if requested. The range of services we could offer include:

- detailed role based impact assessments
- training needs assessment
- development of training collateral
- online training delivery
- business readiness assessments.

In 2016/17 NZ Health Partnerships will establish common change standards and a framework to support programmes throughout their life cycle from business case development through to service establishment, continuous improvement, measurement and reporting.

Our primary change management focus will be supporting the DHBs implementation of the National Oracle Solutions and DHB Procurement Strategy.

Stakeholder communication and engagement

Ensuring our stakeholders are well informed and actively engaged at both strategic and operational levels is critical to NZ Health Partnerships' collaborative operating model. We will continue to enhance our transparency and introduce stakeholder engagement and customer focus plans internally.

Corporate Services

Corporate Services provides finance, accounting and legal services to NZ Health Partnerships. Two of its core activities are benefits reporting and contract negotiation and management.

Benefits Reporting

NZ Health Partnerships coordinates the reporting of all benefits generated across the sector. This includes reporting benefits achieved by NZ Health Partnerships' initiatives, All of Government, and local and collaborative DHB procurement. In 2016/17 NZ Health Partnerships will improve the current process and will proactively assist DHBs to resolve issues with benefits reporting, re-establish benefits reporting to the Board and shareholders, establish a Benefits Community as a forum share expertise across the sector, and embed the National Procurement Strategy.

Contract Negotiation and Management

NZ Health Partnerships, subject to DHB approval, will enter into negotiations with Preferred Respondents to negotiate commercially astute programme and service Agreements. Agreements are drafted for DHB consideration and approval. Once Agreements have been signed, we manage contracts, performance and relationship of the vendors and suppliers on behalf of the DHBs. During 2016/17 we will re-negotiate NZ Health Partnerships lease of our Central Park premises.

14.3

Organisational health and capability

Our People

Critical to the success of any organisation are the people it employs. NZ Health Partnerships must continue to retain, attract and develop skilled and experienced people to ensure successful programme and service delivery for its customers.

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

Having confident, motivated and capable people will empower the organisation to perform at its best, continually lifting organisational health to meet the expectations of the DHBs.

Building our people capability

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

- optimising workforce capacity to deliver results
- ensuring our people are customer focused and are working on what matters most to the DHBs
- identifying and developing capable leaders who will provide a strong force for promoting internal organisational change
- integrating our shareholders' workforce more effectively and efficiently, encouraging understanding about a 'common toolkit' of skills, and improving the sector's ability to shift staff into national, regional and local levels of strategic implementation.

Good Employer

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

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

Governance and Accountability

NZ Health Partnerships works in a commercial manner within a public sector environment. The company operates under a Board, programme and service governance structures with strong DHB representation. The Board comprises four regional DHB Chairs and three independent Directors. The Board is chaired by an independent Director.

New Zealand Health Partnerships Board:

- Peter Anderson (Chair)
- Murray Cleverley
- Jo Hogan
- Dr. Lee Mathias
- Terry McLaughlin
- Deryck Shaw
- Phil Sunderland

Programme and service governance groups are chaired by a DHB Chief Executive Sponsor. The Sponsors drive the vision of the overall programme through strong stakeholder management, engagement with DHB leaders and specialist stakeholders.

IT Strategy

Policies and procedures for NZ Health Partnerships have been developed in relation to our Information

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

Dividend policy

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

Process in relation to acquisitions

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

14.3

Risk management

NZ Health Partnerships recognises that risk and issue management is essential for the delivery of its programmes and services. NZ Health Partnerships is committed to working closely with its stakeholders to ensure we maintain an effective system able to define and determine acceptable levels of risk within each programme and service.

The aims of our risk and issues management processes are to improve the quality of decision making to minimise and manage adverse impacts.

NZ Health Partnerships' strategic risks include:

Table 2: NZ Health Partnerships strategic risks

NZ Health Partnerships: Strategic Risks			
1	2	3	4
Scale and complexity of activities	Multiple delivery partners	Resource pressure	Shareholder constraints
Our programmes and services are being, and have been, implemented nationally. These national programmes are services touch all parts of the NZ health system. NZ Health Partnerships will work closely with the DHBs, their subsidiaries and the service providers to put in place proactive and detailed changed plans to mitigate risks during design and implementation.	Our programmes and services have many delivery partners spanning both the public and private sector. Best practice methodology and the development of centralised vendor performance management framework will ensure alignment and effective integration.	NZ Health Partnerships will effectively engage with the sector to build collaborative programme teams, including seconding and embedding DHB subject matter experts in our work. This enables NZ Health Partnerships to avoid the risk of not delivering the programmes within agreed budgets and quality criteria. This approach also helps build capability in the sector.	The DHBs are facing many challenges such as an aging New Zealand population, rising cost of technology and growing demand for health services, all of which lead to tightening fiscal constraints. DHBs are also managing a large number of complex change programmes at any one time. Aligning and integrating our resource planning cycle with DHBs will help alleviate resource pressures and improve financial forecasting.

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PART TWO

14.3

STATEMENT OF PERFORMANCE EXPECTATIONS

Statement of responsibility

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

The Statement of Performance Expectations sets out our performance measures and targets of NZ Health Partnerships for the period from 1 July 2016 to 30 June 2017.

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

Signed on behalf of the Board



Peter Anderson
Chair

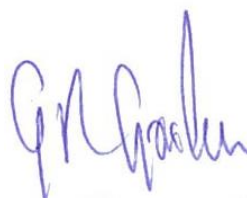


Terry McLaughlin
Chair of Finance, Risk, Audit and
Compliance Committee

Countersigned



Megan Main
Chief Executive



Geoff Goodwin
General Manager Corporate Services



SECTION FOUR

14.3

OUR PERFORMANCE

Measuring our performance

The success of NZ Health Partnerships will be measured by its ability to deliver fit for purpose programmes and services that meet our shareholders' expectations and enable them to realise benefits.

NZ Health Partnerships' achieves its purpose of enabling DHBs to collectively maximise shared services opportunities for the national good by managing on behalf of the DHBs a portfolio of work through 2 output classes:

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

Figure 5: NZ Health Partnerships performance framework



Output Class 1

programmes

The DHBs, as our shareholders, invest in the programmes we develop. Our programme teams work with the DHBs as shareholders, co-creators and customers to develop and build shared services. Once a shared service is built, it transitions to our Commercial Services team for delivery to our DHB customers.

14.3



NATIONAL ORACLE SOLUTION

Objective

The National Oracle Solution will design and build a single financial management information system ready for DHB implementation.

The programme represents a significant investment for the sector and is a critical enabler to the National Procurement Service.

Contributes to New Zealand Health Strategy strategic themes

1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

Progress to date

The National Oracle Solution (NOS) emerged from the re-planning of the Finance, Procurement and Supply Chain (FPSC) programme. Significant progress has been made within the programme since the replanning process. The Solution Validation process was completed and the November Stage Gate Report presented to its governance groups. The report outlined that the solution can be delivered, ready for a DHB implementation, within the parameters set out by the Business Change Case.

Since the November Stage Gate, the programme has been deploying the new infrastructure, finalising the Infrastructure as a Service (IaaS) contract with Datacom,

configuring and deploying the modifications in preparation to conduct Solution Acceptance Testing scheduled to occur in July 2016.

Focus for 2016/17

During 2016/17 NOS will transition from a programme to a service. This is an exciting and challenging new phase for the programme. Prior to implementation the focus for the programme is to successfully complete Solution Acceptance Testing.

The implementation plan is phased with multiple waves; with Bay of Plenty, Canterbury, Waikato and West Coast being the first DHBs to implement. The DHBs will lead the implementation. While some DHBs may be in a position to manage their own change and support the change of others, NZ Health Partnerships will provide support where requested.

A change programme of this magnitude is challenging. NZ Health Partnerships will capture lessons learned and incorporate into the implementation plans of future waves. The second wave of DHB implementation is scheduled for July 2017.

To support the programme transition from a project to an operational service the NOS Transition and Support Team will be established within NZ Health Partnerships to manage and govern the Oracle environment.

Performance

The National Oracle Solution programme performance measures and targets for 2016/17 are outlined in table 3.

Table 3: NOS performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
1	Ensure readiness of Oracle Administration Model	Key positions filled and capability in place	Quality	30 September 2016
2	Complete Technology Build	Solution acceptance testing successfully completed	Quality Timeliness	30 September 2016
3	Complete Solution Readiness	User acceptance testing successfully completed	Quality Timeliness	30 November 2016
4	Support First Wave DHB Implementation	Implementation completed on schedule, within budget, with no open action items	Timeliness Financial Quality	31 March 2017



NATIONAL INFRASTRUCTURE PLATFORM

Objective

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

Contributes to New Zealand Health Strategy strategic themes

1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

14.3

Progress to date

In the later months of 2015/16 a commercial, technical, and delivery review of the National Infrastructure Platform programme commenced.

Focus for 2016/17

During 2016/17 the programme will complete a number of activities to deliver the NIP solution agreed from the commercial, technical, and delivery review.

Performance

The National Infrastructure Platform programme performance measures and targets for 2016/17 are outlined in table 4.

Table 4: NIP performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
5	Implement agreed recommendations from the commercial, technical and delivery review	Programme, governance and processes aligned to the agreed recommendations from the commercial, technical and delivery review.	Quality	30 June 2017
6	Deliver NIP Solution	Final Solution built and delivered on time, within scope, and within budget	Timeliness Quality Financial	15 April 2017

Output Class 1: Financial Perspective

Table 5: Output Class 1 – financial budget for 2016/17

	2016/17 Budget \$000's
Revenue:	
National Oracle Solution	4,875
National Infrastructure Platform	
<i>Total revenue</i>	4,875
Expenditure:	
National Oracle Solution	4,875
National Infrastructure Platform	
<i>Total Expenditure</i>	4,875
Surplus/ (Deficit)	0

Output Class 2

services

This output class comprises the services delivered to DHBs by NZ Health Partnerships; Shared Banking, Collective Insurance, Food Services, DHB Procurement Service, and Management Services. The purpose of this output class is to provide DHBs with high performing services that deliver qualitative and quantitative benefits.

14.3



SHARED BANKING and COLLECTIVE INSURANCE

Shared Banking

Objective

Banking and Treasury Services invests funds held in a restricted range of low risk investments to optimise the return on funds, while ensuring sufficient cash is available to meet all DHB needs.

On any given day NZ Health Partnerships manages on behalf of the sector a cash balance of between \$300 million to \$1.4 billion through the Shared Banking and Treasury Services ("The Sweep") functions.

Contributes to New Zealand Health Strategy strategic themes

1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

Focus of 2016/17

Since 2011, Westpac Bank has provided banking and treasury services for all DHBs. In 2016/17 the contract will be tendered to ensure the service remains fit for purpose and meet the needs of DHBs.

Performance

NZ Health Partnerships provides the Shared Banking activities. Unlike the other services where we act as a vendor manager, NZ Health Partnerships delivers the service and is responsible for achieving the following service performance targets.

Table 6: Shared Banking performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
7	Minimum average sweep interest rate on funds placed on term deposit is at least 0.15% above the sweep on-call rate	0.15%	Financial	30 June 2017
8	Minimum non budgetary financial benefits delivered to DHBs during 2016/17 financial year			
	Minimum percentage of DHBs agree to the benefits for 2016/17	100%	Financial	31 December 2016
	Minimum Benefits realised	\$925,000	Financial	30 June 2017
9	Minimum percentage of DHBs and other participants are satisfied with the Banking Services service	80%	Quality	30 June 2017

Collective Insurance

Objective

The objective of the service is to obtain insurance for the 20 DHBs and other participants that represents value for money, taking into account the terms and conditions, market dynamics and the strategic intentions of the DHBs.

Collectively DHBs have assets valued around \$15 billion. The Collective Insurance programme is responsible for managing the insurance requirements for all 20 DHBs, and various joint ventures and subsidiaries that have elected to join the Collective Insurance Service.

Contributes to New Zealand Health Strategy strategic themes

1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

14.3

Focus for 2016/17

In 2016/17 the contract will be tendered to ensure the service remains fit for purpose and meet the needs of DHBs.

Performance

As the contract and vendor manager, NZ Health Partnerships has the relationship with the Broker and is responsible for ensuring the following performance targets are achieved.

Table 7: Collective Insurance performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
10	Minimum percentage of DHBs and Joint Ventures that have agreed insurance coverage for material damage business disruption, liability, travel and motor vehicle	100%	Quality Timeliness	30 June 2017
11	Minimum non budgetary financial benefits Collective Insurance delivered to DHBs and Joint Ventures during 2016/17 financial year	\$5 million	Financial	30 June 2017
12	Minimum percentage of DHBs and Joint Ventures are satisfied with the General Insurance service	80%	Quality	30 June 2017



DHB PROCUREMENT SERVICE

Objective

The DHB Procurement Service is provided to all 20 DHBs. In 2015/16 the DHB National Procurement strategy was developed for the DHBs, by the DHBs. The strategy was endorsed by the CE Forum on 14 April 2016, and approved by NZ Health Partnerships Board on 28 April 2016.

Contributes to New Zealand Health Strategy strategic themes

1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

Focus for 2016/17

The core focus for 2016/17 will be ensuring that DHBs achieved increased value from collective procurement through the implementation of the DHB Procurement Strategy including contract management of the National Procurement service delivered by healthAlliance (FPSC) Ltd.

Performance

The DHB Procurement Service performance measures and targets for 2016/17 are outlined in table 8.

Table 8: DHB Procurement performance measures and targets 2016/17

#	Performance Measure	Target	Type	When
13	Establish the foundations for the DHB Procurement Strategy Implementation	Agreed frameworks and mechanisms in place to deliver the key activities outlined in the strategy. Agreed implementation approach and supporting plan for the strategy with specific targets and measures.	Quality Timeliness	Q1 FY16/17
14	Commence the transition of Medical Devices from the scope of hA (FPSC)	Agreed transition group in place to manage the transition process Agreed implementation plan outlining the transition with specific targets and measures and DHB oversight	Quality Timeliness	Q1 FY16/17 31 July 2016
15	Provide management oversight of the delivery of the National Procurement Service by healthAlliance (FPSC)	Service Catalogues is delivered according to agreed 2016/17 scope A highly effective and transparent customer supplier relationship facilitated by NZ Health Partnerships which delivers value to all parties is achieved	Quality Timeliness Quality	Q1 FY16/17 30th June 2017

14.3



FOOD SERVICES

Objective

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

NZ Health Partnerships will provide the contract and vendor management of the Food Services Agreement on behalf of the participating DHBs. The DHBs to join the agreement: Auckland, Waitemata, Counties Manukau, Southern, Hauora Tairāwhiti, and Nelson Marlborough.

Contributes to New Zealand Health Strategy strategic themes

1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

Focus for 2016/17

Food Services focus in 2016/17 is to designed to expand the number of DHBs participating in the agreement to ensure the long term benefits of the service is delivered to the sector, while strengthening the governance of the service. To aid in this, NZ Health Partnerships is re-baselining financials to help inform DHB participation decisions and working with Compass to refine and improve the contract.

At present Compass Group provides around 60 percent of all patient meals served in New Zealand, as well as other services such as Meals on Wheels. NZ Health Partnerships is in discussions with nine DHBs regarding the possibility of them joining the Food Services agreement.

Performance

The Food Service performance measures and targets for 2016/17 are outlined in table 9.

Table 9: Food Services performance measures and targets 2016/17

#	Initiative	Target	Type	When
16	Participate in NFSP (National Food Services Programme)	All existing contracts executed in a timely manner and to the satisfaction of the stakeholder parties	Timeliness Quality	30 June 2017
17	Lead/Facilitate Programme Level Implementation	Implementations are completed and delivered to plan (agreed contractual schedule), and within cost (budget) for all the participating DHBs	Quality Timeliness Financial	30 June 2017
18	Embed Benefits Realisation/CIP	Delivered according to agreed specification and trends are clear and concise	Timeliness Financial Quality	Q2 2016/17
19	Assist with the development of a mature National Programme Level Governance Framework	All participating DHB's have an established, operating governance model in place	Quality	30 June 2017



MANAGEMENT SERVICES

Objective

Management Services are the central functions within NZ Health Partnerships that deliver organisational change, cultural alignment, strategy, stakeholder communication, engagement, and programme and service management services.

Contributes to New Zealand Health Strategy strategic themes

1	2	3	4	5
People Powered	Closer to Home	Value & High Performance	One Team	Smart System

Focus for 2016/17

The focus for 2016/17 for Management Services is to provide support to the programmes as they are implemented by DHBs and transition to a service, while continuing to provide support to our services NZ Health Partnerships provide to DHBs.

Performance

The Food Service performance measures and targets for 2016/17 are outlined in table 10.

Table 10: Management Services performance measures and targets 2016/17

#	Initiative	Target	Type	When
20	Assist DHBs with programme and service-related change management where required	Change management strategy for DHB Procurement Strategy approved; and other plans developed and implemented as requested	Quality	On-going
21	Implement a Benefits Reporting Process	Benefits reported to the Board monthly	Quality	30 September 2016
22	Embed customer focus as a way of working including unpacking core values and implementing internal culture initiatives	Minimum 5% increase of stakeholders rating NZ Health Partnerships' customer focus as satisfactory or above	Quality	30 June 2017
		5 - 10% increase in staff believing we are focussed on our customers' needs	Quality	30 June 2017

Output Class 2: Financial Perspective

Table 11: Output Class 2 – financial budget for 2016/17

	2016/17
	Budget
	\$000's
Revenue:	
Shared Banking and Collective Insurance	24,000
Interest Revenue from Shared Banking Facility	
Shared Banking and Insurance Operations	603
Food Services	350
Management Services	5,090
National Infrastructure Platform	550
National Procurement Service	11,227
NZ Health Partnership Interest	120
Total Revenue	41,740
Expenditure:	
Shared Banking and Collective Insurance	
Interest Revenue from Shared Banking Facility	24,000
Shared Banking Operations	603
Food Services	350
Management Services	5,090
National Infrastructure Platform	550
National Procurement Service	10,927
Integrator	300
Total Expenditure	41,740

14.3

Benefits

Benefits management is at the very heart of NZ Health Partnerships' purpose. In conjunction with our shareholders programmes are identified, assessed, prioritised, developed and implemented with the singular purpose of delivering benefits (value) to DHBs.

A benefit is defined as a clear financial or performance improvement. This may include building organisational capabilities, delivering efficiencies or effectiveness, including clinical improvements. Whether financial or performance-based all benefits ultimately contribute to better health outcomes.

Effectively defining, measuring, tracking and reporting these benefits determine the success of our programmes and the operational performance of our live commercial services. In short, benefits management determines DHBs' return on investment from NZ Health Partnerships' activities. More broadly it ensures taxpayers' money is being well spent.

To advance the sector's work in this area, NZ Health Partnerships has developed a Benefits Management Framework. At a high level the Framework considers the tools, methodologies and support required to track, measure and report the benefits outlined in business cases.

During 2016/17 NZ Health Partnerships will work with the newly appointed CEO Sponsor for Benefits and DHBs to operationalise the Benefits Management Framework including supporting any DHB-led change management to embed new processes.

NZ Health Partnerships is responsible for reporting benefits at an aggregated level.

Key Benefits Definitions

Benefits management refers to the identification, definition, tracking, realisation and optimisation of benefits. Benefits can be made up of two parts: Budgetary and Non-Budgetary.

BUDGETARY BENEFITS

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

NON-BUDGETARY BENEFITS

Non-Budgetary benefits are defined as those that form part of the business case that do not meet the definition of Budgetary. There are three general components:

- **Cash Avoidance:** Cash that would have been spent is now totally avoided or reallocated as a result of the business case.
- **Cumulative benefits:** are those that are carried forward from previous years, whether they are budgetary or non-budgetary in nature.
- **Qualitative benefits:** accrue from associated activity as a result of a business case and need to be reported in some way.

Benefits Estimates

Table 12: Estimated Total Gross Benefits for Output Class 1 & 2, for FY2016/17.

	Estimated 2016/17 \$000
OUTPUT CLASS 2: SERVICES	
National Procurement Service	
Budgetary	27,300
Non-Budgetary	27,300
Shared Banking	
Budgetary	0
Non-Budgetary	925
Insurance	
Budgetary	0
Non-Budgetary	2,527
Food Services	
Budgetary	4,110
Non-Budgetary	1,960
Other Procurement	
Budgetary	4,228
Non-Budgetary	6,341
<i>Total Annual Gross Benefits</i>	
Budgetary	35,638
Non-Budgetary	39,053
TOTAL GROSS ANNUAL BENEFITS	<u>74,691</u>

14.3

Note: the figures above are indicative estimates to be confirmed with individual DHBs and Programme and Service governance groups. Programmes in of themselves do not generate benefits. Benefit generation is achieved when programmes are completed and the build phase moves to service delivery phase. As such NZ Health Partnerships Programmes do not deliver any benefits until they become services.

Assessing performance

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

Table 13: Performance assessment ratings

	Performance Rating	Description
	Achieved	The target has been achieved by the stated date.
	Partially Achieved	The activities and outputs have been completed; however, they were not completed by the stated date.
	Not Achieved	The target has not been achieved.
	Discontinued	Programme or service has been discontinued, and the targets are no longer applicable.

The perspectives that underpin our assessment of performance are quality, financial and timeliness.

Table 14: Performance categories

Perspective	Description
Quality	This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement.
Financial	This will report performance against the projected costs and benefits for financial measures.
Timeliness	The programmes and services will have progress measured against agreed milestones to determine if they are delivery on schedule.

Reporting performance

The performance of output classes will be reported in NZ Health Partnerships Annual Report, and Quarterly to our Shareholders.



SECTION FIVE

14.3

FINANCIAL STATEMENTS

Financial statements

1.1 PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE BY OUTPUT CLASS

For the year ended 30 June 2017

	2015/16 Forecast \$000's	2016/17 Budget \$000's
Revenue:		
Output Class 1: Programmes	10,914	4,875
Output Class 2: Services	41,129	41,740
Total Revenue by Output Class	52,043	46,816
Expenditure:		
Output Class 1: Programmes	10,914	4,875
Output Class 2: Services	40,971	41,740
Total Expenditure by Output Class	51,885	46,816
Surplus/ (Deficit)	158	0

1.2 PROSPECTIVE STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE**For the year ended 30 June 2017**

	2015/16 Forecast \$000's	2016/17 Budget \$000's
Revenue:		
Revenue from DHBs	22,505	22,696
Interest revenue - NZ Health Partnerships	200	120
Shared banking	24,000	24,000
Other revenue	5,338	-
Total revenue	52,043	46,816
Expenditure:		
Personnel costs	4,095	4,201
Depreciation and amortisation expense	2,112	132
Finance costs - NZ Health Partnerships	-	-
Shared banking	24,000	24,000
Other expenses	21,678	18,483
Total Expenditure	51,885	46,816
Surplus/ (Deficit)	158	0
Other Comprehensive revenue and expense	0	0
Total Other Comprehensive Revenue and Expense	0	0
TOTAL COMPREHENSIVE REVENUE AND EXPENSE	158	0

14.3

1.3 PROSPECTIVE STATEMENT OF FINANCIAL POSITION**As at 30 June 2017**

	2015/16 Forecast \$'000's	2016/17 Budget \$'000's
ASSETS		
Current Assets:		
Cash and cash equivalents	192,750	5,339
Receivables	6,955	11,533
Investments – shared banking	90,000	139,822
Total Current Assets	289,755	156,694
Non-Current Assets:		
Property, plant, and equipment	1,720	796
Intangible assets	61,730	57,768
Total Non-Current Assets	63,450	58,564
Total Assets	353,205	215,258
LIABILITIES		
Current Liabilities:		
Payables	6,888	9,959
DHB Shared Banking Facility	281,028	139,822
Employee entitlements	215	334
Total Current Liabilities	288,131	150,115
Non-Current Liabilities:		
Employee entitlements	0	0
Total Non-Current Liabilities	0	0
Total Liabilities	288,131	150,115
Net Assets	65,074	65,143
EQUITY		
Contributed Capital	64,916	68,633
Accumulated surplus / (deficit)	158	(3,490)
Total Equity	65,074	65,143

1.4 PROSPECTIVE STATEMENT OF CHANGES IN EQUITY**For the year ended 30 June 2017**

	2015/16	2016/17
	Forecast	Budget
Notes	\$000's	\$000's
Balance at 1 July 2016	64,916	68,633
Total Comprehensive Revenue and Expense for the year	158	(3,490)
Owner Transactions		
Issue of B class shares	0	0
BALANCE AT 30 June 2017	65,074	65,143

14.3

1.5 PROSPECTIVE STATEMENT OF CASH FLOWS**For the year ended 30 June 2017**

	2015/16 Forecast \$000's	2016/17 Budget \$000's
Cash flows from Operating Activities:		
Receipts from DHBs	24,485	22,680
Receipts from other revenue	3,358	0
Interest received	24,000	124,000
Payments to suppliers	(21,728)	(4,256)
Payments to employees	(4,095)	(15,441)
Interest paid	(24,000)	(124,000)
Goods and services tax (net)	50	52
Net Cash Flow from Operating Activities	2,070	3,035
Cash flows from Investing Activities:		
Funds from Deposit	90,798	0
Purchase of property, plant, and equipment	20	0
Purchase of intangible assets	(9,216)	(2,970)
Funds to Deposit	(139,000)	0
Net Cash Flow from Investing Activities	(57,398)	(2,970)
Cash flows from Financing Activities:		
B class shares	0	0
Proceeds from borrowings	0	0
Repayment Interest	0	0
Net Cash Flow from Financing Activities	0	0
Net (decrease)/increase in cash and cash equivalents	(55,328)	65
Cash and cash equivalents at the beginning of the year	248,078	5,274
Cash and cash equivalents at the end of the year	192,750	5,339

Notes to the Prospective Financial Statements

The prospective financial statements are based on policies and approvals in place as at 1st July 2016. The prospective financial statements set out NZ Health Partnerships activities and planned performance. The use of this information for other purposes may not be appropriate. These prospective financial statements have been prepared on the basis of assumptions of future events that NZ Health Partnerships reasonably expects to occur and associated actions that NZ Health Partnerships reasonably expects to take at the date that this information was prepared.

Statement of Accounting Policies

REPORTING ENTITY

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

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

BASIS OF PREPARATION

Statement of compliance

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

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

The prospective financial statements have been prepared for the special purpose of the Statement of Performance Expectations 2016/17 of NZ Health Partnerships for its shareholders. They have not been prepared for any other purpose and should not be relied upon for any other purpose.

These statements will be used in our Annual Report as the budgeted figures. The Statement of Performance Expectations narrative informs the prospective financial statements and the document should be read as a whole.

The preparation of prospective financial statements in conformity with PBE FRS 42 requires the Board and management to make good judgements, estimates, and assumptions that affect the application of policies and reported amounts of assets and liabilities, income, and expenses. The prospective financial statements were approved on 29 June 2016. The Board is responsible

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

Measurement base

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

Presentation currency and rounding

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

Summary of Significant Accounting Policies

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

REVENUE

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

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

Interest Revenue

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

LEASES

Operating leases

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

BORROWING COSTS

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

CASH AND CASH EQUIVALENTS

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

Receivables

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

Investments

Bank term deposits

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

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

Property, plant and equipment

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

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

Additions

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

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

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

Disposals

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

Subsequent costs

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

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

Depreciation

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

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

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

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

Intangible assets

Software acquisition and development

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

Staff training costs are recognised as an expense when incurred.

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

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

Amortisation

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

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

Intangible Asset Type	Useful Life	Rate
Acquired computer software	2.5 – 3 years	33% - 40%
FPSC system intangible assets	5 - 15 years	6.67% - 20%

Impairment of property, plant, and equipment and intangible assets

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

Non-cash generating assets

Property, plant and equipment and intangible assets held at cost that have a finite useful life

are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

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

Payables

Short-term payables are recorded at their face value.

Employee entitlements

Short-term employee entitlements

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

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

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

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

Long-term employee entitlements

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

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

Superannuation schemes

Defined contribution schemes

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

Borrowings

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

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

Equity

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

FPSC rights

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

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

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

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

Financial Instrument Risks

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

Critical Accounting Judgements and Estimates

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

General Assumption – cost levels

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

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

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

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

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

DHB Shared Banking Facility

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

14.3

Critical judgements in applying accounting policies

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

Leases classification

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

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

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

Capitalisation of FPSC costs

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

Through the development of the FPSC programme, the assets that are created by the FPSC programme will be held in Work in Progress (WIP). The construction is expected to last around 18 months and during this period there will be progressive deployments of functionality leading to a gradual realisation of benefits. The FPSC programme is not a single asset, but a bundle of assets that are both tangible such as IT hardware and intangible, such as software, policy manuals, process documentation, process maps, standard operating procedures, reference materials and intellectual property. The costs that are directly associated with the development of the FPSC programme will be recognised as tangible or intangible assets when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. Direct costs include project development employees, contractors, consultants and apportionment of the relevant overheads.

Indirect costs are recognised as expenses when incurred and include travel, training and recruitment costs.

Amortisation

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



14.4

HEAD AGREEMENT

between

NZ HEALTH PARTNERSHIPS LTD

and

DISTRICT HEALTH BOARDS

for the delivery of Shared Services to District Health Boards

EXECUTION VERSION

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THIS HEAD AGREEMENT commenced on 1 July 2014 and is varied and restated on 1 September 2016.

PARTIES

- (1) **DISTRICT HEALTH BOARDS** listed in Annexure 2, each being a district health board under the New Zealand Public Health and Disability Act 2000 (each a "**DHB**" and together the "**DHBs**")
- (2) **NZ HEALTH PARTNERSHIPS LIMITED** (company number 5729811) ("**NZ Health Partnerships**")

BACKGROUND

- A. This Head Agreement was made between the DHBs and Health Benefits Ltd (**HBL**), a Crown owned company listed in Schedule 4A of the Public Finance Act 1989.
- B. Under the Health Sector Transfers (NZ Health Partnerships Limited) Order 2015, the assets and liabilities of HBL were transferred to NZ Health Partnerships on 1 July 2015.
- C. The Parties agree to vary and restate this Head Agreement to reflect the role of NZ Health Partnerships.
- D. NZ Health Partnerships is a company registered under the Companies Act 1993 and a Crown entity under section 7(1) of the Crown Entities Act 2004 (being a multi-parent subsidiary of two or more Crown entities). It was established, and is operated, as a co-operative undertaking, with the purpose of enabling DHBs to collectively maximise shared services opportunities for the National Good. DHBs are the shareholders, the co-creators, and the customers, of NZ Health Partnerships. NZ Health Partnerships works with the DHBs to, in accordance with the Governance Charter, identify, prioritise, develop, and implement Shared Services, initiatives for the Health Sector's benefit and, ultimately, for all New Zealanders.
- E. The Parties accordingly wish to work together on shared services initiatives within the framework set up by this Head Agreement. NZ Health Partnerships agrees to ensure the delivery of Shared Services on the terms set out in this Head Agreement.

THE PARTIES AGREE:

1. SHARED SERVICES

- 1.1 **Shared Services:** The Parties may agree from time to time to provide and receive services on a shared basis between them. As at the Commencement Date, the Parties have agreed on certain procurement Shared Services set out in Schedules A to D. As at the Variation Date, NZ Health Partnerships and certain DHBs have agreed in the National Infrastructure Platform Programme Shared Services Schedule ("NIP Schedule").
- 1.2 **Variation Date:** This Head Agreement, as varied and restated will commence on the later of:
  - (a) 1 September 2016; and
  - (b) the date on which the last DHB signs this varied and restated Head Agreement.
- 1.3 **Effect of Variation:** From the Variation Date:
  - (a) all Parties will be bound by this Head Agreement, as varied and restated, including Schedules A to D relating to procurement, but excluding the NIP Schedule;
  - (b) NZ Health Partnerships and the DHBs which have signed the NIP Schedule prior to the Variation Date will continue to be bound by that Schedule; and

- (c) a DHB which signs the NIP Schedule after the Variation Date will be bound by that Schedule from the date of signature.

1.4 Additional Shared Services: The Parties agree that any Shared Services added after the Variation Date:

- (a) will be governed by the principles set out in the Governance Charter;
- (b) must be consistent with the Shared Services Principles;
- (c) must be agreed by all Parties providing or receiving the benefit of the additional Shared Services;
- (d) will be set out in a schedule, substantially in the form of the existing Schedules, which will bind each DHB from the date it signs the schedule;
- (e) will be deemed to be incorporated into and form part of this Head Agreement.

2. PRINCIPLES

2.1 Overarching Principles: The Parties will at all times act in accordance with the principles set out in the Governance Charter.

2.2 Shared Services Principles: The Parties acknowledge and agree that all Shared Services under this Head Agreement are to be agreed, implemented, and delivered, in accordance with these mutually agreed objectives, which are to:

- (a) reduce costs and be fit-for-purpose;
- (b) be driven by customer defined business needs with appropriate technology as an enabler (where appropriate);
- (c) be scalable to include additional services and customers over time;
- (d) be based on achieving the optimal outcome for the Health Sector;
- (e) offer a seamless and timely customer and supplier experience, regardless of location;
- (f) standardise the provision of services and processes based on leading practice, innovation and continuous improvement, with clear processes to validate any service variation;
- (g) establish clear end-to-end process ownership and accountability;
- (h) leverage existing material and expertise wherever possible;
- (i) have a transparent and well-understood governance and accountability structure;
- (j) enable and facilitate effective partnerships between customers and suppliers, and across the Shared Service functions;
- (k) build and retain capability by offering compelling opportunities;
- (l) ensure that patient safety will not be compromised; and
- (m) ensure the design delivers the benefits.

3. ROLE OF NZ HEALTH PARTNERSHIPS

3.1 Primary role: NZ Health Partnerships is a DHB-led, supported, and owned, vehicle enabling DHBs to collectively maximise shared services opportunities for the National Good. NZ Health Partnerships will work with DHBs in accordance with the Governance Charter, to fulfil a strategic role in developing and establishing Shared Services and providing service governance and

monitoring of Shared Services, to ensure that benefits are realised and delivered as planned for the National Good.

3.2 Accountabilities: NZ Health Partnerships is accountable to:

- (a) DHBs as its shareholders – for delivery of the portfolio of initiatives approved in the Annual Plan and meeting all other obligations to DHBs as shareholders; and
- (b) DHBs as its customers – for all Shared Services in accordance with the terms of this Head Agreement (including applicable Service Levels and KPIs).

3.3 Scope of role: The Parties agree that the Shared Services may be performed by NZ Health Partnerships itself or by Service Partners in accordance with Service Partner Agreements. Where a Shared Service is performed by a Service Partner, NZ Health Partnerships will not carry out the operational delivery of the Shared Service but, on a day-to-day and operational level:

- (a) the Service Partner and DHBs will have a direct relationship; and
- (b) NZ Health Partnerships, will perform an oversight and monitoring role.

3.4 Performance management: In meeting its accountabilities set out in clause 3.2, NZ Health Partnerships will:

- (a) develop a performance scorecard reporting tool to measure its performance, as described in the Governance Charter ("**Performance Scorecard**");
- (b) ensure that Service Levels and KPIs in this Head Agreement and in Service Partner Agreements align with and feed into the Performance Scorecard approach;
- (c) provide the appropriate Governance Group with a monthly Shared Service performance report which will compare actual performance to the Annual Plan. In the event that an issue arises that could result in missing a benefits target, NZ Health Partnerships will escalate the issue to the appropriate Governance Group, including full details of proposals and mitigation plans; and
- (d) ensure continuous improvement opportunities are identified and implemented.

4. GENERAL OBLIGATIONS

4.1 Mutual obligations: Each Party must comply with all:

- (a) Reference Documents;
- (b) Service Levels and KPIs, as applicable; and
- (c) applicable Laws and industry codes of practice, and obtain, maintain and comply with all Consents as applicable to providing or receiving (or both) the Shared Services.

4.2 Governance Charter: Each Party must carry out its obligations under this Head Agreement in a manner that is consistent with the Governance Charter, including by undertaking the governance roles specified in the Governance Charter.

4.3 NZ Health Partnerships' obligations: NZ Health Partnerships must:

- (a) meet the accountabilities set out in clause 3.2;
- (b) without limiting any general obligations set out in a Schedule, act with reasonable care, skill and diligence when performing its obligations under this Head Agreement; and
- (c) promptly respond to any reasonable requests for information made by DHBs in relation to Shared Services.

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4.4 DHB obligations: In respect of each Shared Service, each DHB must:

- (a) ensure that its own policies, processes, and procedures that interface with the Shared Services:
  - (i) align to this Head Agreement, including all relevant Reference Documents; and
  - (ii) include appropriate internal controls and delegations in relation to the requisition of Shared Services;
- (b) co-operate with NZ Health Partnerships and Service Partners in relation to the Shared Services;
- (c) actively participate (including ensuring appropriate representation) in Shared Services governance as relevant and as described in the Governance Charter and Schedules;
- (d) promptly provide such access to the DHB's personnel, premises and data, and such facilities, as reasonably requested by NZ Health Partnerships or Service Partners to enable the Shared Services to be delivered;
- (e) comply with all relevant requirements under any applicable health and safety Law to ensure the safety of Personnel while at work on DHB premises;
- (f) ensure payment of all NZ Health Partnerships, Service Partner, and Supplier, invoices relating to the Shared Services, in accordance with the relevant payment terms;
- (g) be severally liable for their obligations under this Head Agreement including payment of any invoices issued in accordance with clause 9;
- (h) promptly respond to any reasonable requests for information made by NZ Health Partnerships or any Service Partner as applicable in relation to Shared Services; and
- (i) drive a continuous improvement philosophy within their organisation to identify and implement opportunities to improve the end-to-end processes.

4.5 Risk management: Each Party must:

- (a) manage Shared Services risks in accordance with its own risk management policy;
- (b) report and escalate risks in accordance with the Governance Charter and relevant Schedules; and
- (c) DHBs will ensure that all issues that cause or may cause adverse public or Health Sector publicity are notified to NZ Health Partnerships together with details of how to mitigate that risk.

5. GOVERNANCE

- 5.1 **Governance overview:** The Parties reconfirm their commitment to the principles described in clause 2 in all dealings. The Parties agree that all Shared Services will be provided in accordance with the governance framework described in the Governance Charter.
- 5.2 **Terms of reference:** The terms of reference for each of the Governance Groups are set out in the Governance Charter (including in each case, for example, the purpose, membership, and meeting frequency).
- 5.3 **Decision making:** The decision-making responsibility of each Governance Group is set out in the Governance Charter. Without limiting the Governance Charter, the Parties acknowledge and agree that operational decisions must be exercised in a manner that is consistent with this Head Agreement and the Annual Plan.

6. REFERENCE DOCUMENTS

- 6.1 **Approach:** The Parties agree that the performance of this Head Agreement and the delivery of Shared Services will be assisted by the adoption of appropriate policies and other documents in relation to aspects of the Shared Services. **Reference Documents**, in relation to the Shared Services, will be designed to provide (without limitation) relevant policies, processes, and procedures, and ensure consistency in relevant areas across the Health Sector. Current Reference Documents will be listed in Annexure 4 and amended by NZ Health Partnerships from time to time as necessary.
- 6.2 **New and amended Reference Documents:** Reference Documents may be amended, or removed from Annexure 4, and new Reference Documents may be added to Annexure 4, by NZ Health Partnerships, following consultation with the relevant Governance Group (if any). NZ Health Partnerships will provide the DHBs with written notice of any such change.
- 6.3 **Incorporation:** For the avoidance of doubt, all Reference Documents (including any new or amended Reference Document) listed in Annexure 4 are deemed to be included in, and form part of, this Head Agreement. Reference Documents removed from Annexure 4 cease to be part of the Head Agreement.

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7. ANNUAL PLAN AND BUDGETS

7.1 Annual Plan:

- (a) NZ Health Partnerships will prepare an annual plan (including budget) that will include all Shared Services for each financial year ("**Annual Plan**").
- (b) Each Annual Plan will be prepared in accordance with the Governance Charter and must be submitted to the Annual Shareholders' Meeting for DHBs' approval.

7.2 Content: Each Annual Plan must:

- (a) include the forecasted costs of:
  - (i) NZ Health Partnerships' services under this Head Agreement; and
  - (ii) each Service Partners' services under relevant Service Partner Agreements; and
- (b) reflect the requirements of the Performance Scorecard approach (for example, the anticipated benefits, and planned process and continuous improvement initiatives).

7.3 Budget:

- (a) As part of the Annual Plan process, NZ Health Partnerships will prepare a budget setting out the forecasted costs of the Shared Services for the next financial year ("**Shared Services Budget**"). The Shared Services Budget will be incorporated into the Annual Plan.
- (b) NZ Health Partnerships will align the budgeting process to the DHB planning cycles and inform the DHBs of the details of the Shared Services Budget for the following year, in time for DHBs' respective annual planning processes.
- (c) NZ Health Partnerships is accountable to the DHBs for the delivery of Shared Services to budget, subject to the terms of this Head Agreement. NZ Health Partnerships will use all reasonable endeavours to:
  - (i) prepare all Shared Services Budgets in good faith and on a reasonable basis; and
  - (ii) operate within all Shared Services Budgets.
- (d) NZ Health Partnerships will provide the DHBs with quarterly reports of actual and forecast costs against the Shared Services Budget.

- 7.4 **Service Partner budgets:** NZ Health Partnerships will procure each Service Partner to prepare a budget for Shared Services that the Service Partner provides under this Head Agreement ("**Service Partner Budgets**"). Service Partner Budgets will be fixed once approved by NZ Health Partnerships, and may only be changed after proposed changes are endorsed by the appropriate Governance Group (if any), and approved by the NZHP Board. The Parties agree that, in considering any changes to a Service Partner Budget, the Governance Group will consider other options such as amending the Service Partner Budget, or changing the Shared Services or relevant Service Levels, to keep within the Service Partner Budget.
- 7.5 **Service Partner obligations:** NZ Health Partnerships will procure each Service Partner to:
- (a) use all reasonable endeavours to:
    - (i) prepare its Service Partner Budget in good faith and on a reasonable basis;
    - (ii) comply with all its agreed Service Partner Budget; and
    - (iii) notify NZ Health Partnerships as soon as possible if its Service Partner Budget is, or is likely to be, exceeded;
  - (b) report any forecasted variance to its Service Partner Budget and provide NZ Health Partnerships with relevant commentary and analysis to explain the forecasted variance;
  - (c) in the event of any forecast or actual variance to its Service Partner Budget, require the Service Partner to provide NZ Health Partnerships with an action plan to contain costs within the Service Partner Budget, which may include a potential dilution of Shared Services if agreed by the Parties; and
  - (d) provide monthly reports to NZ Health Partnerships within five Business Days of the end of each month, of the Service Partner's actual performance against its Service Partner Budget (in a form agreed between the Parties from time to time).

8. COST RECOVERY PRINCIPLES

- 8.1 **Cost recovery principles:** The Parties acknowledge and agree that:
- (a) NZ Health Partnerships' performance of its obligations under this Head Agreement is on a cost recovery basis as set out in this clause 8;
  - (b) the DHBs will reimburse NZ Health Partnerships for all costs and expenses incurred by NZ Health Partnerships arising out of or in connection in any way with this Head Agreement and any Service Partner Agreement ("**Cost Recovery Amount**"), including:
    - (i) any costs, losses, expenses, or damages, arising out of, or in connection with, performing its obligations under this Head Agreement; and
    - (ii) any costs, losses, expenses, or damages, arising out of, or in connection with, any Claim in performing its obligations under this Head Agreement.
- 8.2 **Recovery:** The Cost Recovery Amount will be recovered by NZ Health Partnerships issuing each DHB invoices for Service Fees in accordance with clause 9.2 (Service Fees) and clause 9.6 (True-ups).

9. FEES AND PAYMENT

- 9.1 **Scope:**
- (a) This clause 9 applies to fees for Shared Services provided by NZ Health Partnerships under this Head Agreement ("**Service Fees**").

- (b) This clause does not apply to Supplier invoices (for example, for goods and services supplied directly to a DHB) which will be governed by and paid in accordance with the applicable Schedule and Supplier Agreement.
- 9.2 **Service Fees:** The Service Fees for each DHB will be determined by NZ Health Partnerships and will cover:
- (a) that DHB's share of the Shared Services Budget as set out in the Annual Plan;
  - (b) the costs of any other specific services (not Shared Services) provided to that DHB, as agreed by NZ Health Partnerships and that DHB ("**Discretionary Services**");
  - (c) costs incurred by NZ Health Partnerships in dealing with issues affecting only that particular DHB or a group of DHBs including that DHB (other than costs in relation to any Claims); and
  - (d) that DHB's share of NZ Health Partnerships' costs relating to any Claim or other costs which cannot be attributed to one or more DHBs.
- 9.3 **Tax:** The Service Fees are inclusive of all Taxation except GST.
- 9.4 **Invoices:** NZ Health Partnerships will issue DHBs with monthly valid tax invoices for the Service Fees by the 20th of each month for the Service Fees payable for the following month.
- 9.5 **Payment:** Each DHB shall pay NZ Health Partnerships the amount payable in respect of each invoice issued under clause 9.4, on the day after the DHB receives its monthly funding from the Ministry of Health.
- 9.6 **True-Ups:** Each quarter (or more frequently if considered appropriate by NZ Health Partnerships) NZ Health Partnerships will undertake a reconciliation of budgeted versus actual expense (including any Cost Recovery Amount adjustment) and will either invoice DHBs or issue a credit note as appropriate.
- 9.7 **Disputed invoices:** If a DHB disputes any amount in any invoice issued under this clause 9, that DHB must:
- (a) pay the full amount of the relevant invoice by the due date; and
  - (b) notify NZ Health Partnerships as soon as reasonably practicable, identifying the amount in dispute, and the reasons for the dispute.

If the dispute is not resolved within 10 Business Days of the dispute being notified to NZ Health Partnerships in accordance with clause 9.7(b), the DHB and NZ Health Partnerships must engage in the dispute resolution process described at clause 21.

10. SERVICE PARTNERS

- 10.1 **Engagement of Service Partners:** NZ Health Partnerships may engage Service Partners via Service Partner Agreements, to perform Shared Services.
- 10.2 **Service Partner Agreements:** NZ Health Partnerships will ensure that all Service Partner Agreements:
- (a) align and are consistent with the applicable Schedule (including the Service Levels and KPIs) and the relevant terms of this Head Agreement;
  - (b) require the Service Partner to:
    - (i) act with reasonable care, skill and diligence and, where appropriate, in accordance with Good Industry Practice;
    - (ii) where relevant, meet or exceed that Service Partner's agreed service levels and key performance indicators, as applicable;

- (iii) provide all personnel, processes, and resources, required to provide the Shared Services in accordance with this Head Agreement;
- (iv) adopt or comply with (or both) any Reference Documents as may be applicable to the Shared Services that the Service Partner provides;
- (v) comply with all applicable Laws and industry codes of practice, and obtain, maintain, and comply with, all Consents;
- (vi) comply with each DHB's reasonable health, safety, and security, policies and procedures (where relevant to a DHB site and the performance of Shared Services) notified to the Service Partner from time to time, and promptly notify the relevant DHB of any health and safety hazards or issues which arise in relation to the Shared Services;
- (vii) promptly respond to any reasonable requests for information made by NZ Health Partnerships or any DHB, in relation to the Shared Services; and
- (viii) drive a continuous improvement philosophy within their organisation to identify and implement opportunities to improve the end-to-end processes;
- (c) allow NZ Health Partnerships, and any auditors of or other advisers to NZ Health Partnerships, to access any of the relevant Service Partner's or other Subcontractor's premises, personnel, and relevant records, as may be reasonably required to verify that they are complying with their obligations under the relevant agreement;
- (d) require the Service Partner to maintain appropriate insurance (including professional indemnity insurance and public liability insurance) on appropriate terms and for appropriate coverage levels and amounts with reputable insurers throughout the relevant term; and
- (e) require the Service Partner to have business continuity and disaster recovery plans (including testing obligations) which:
  - (i) are appropriate for the scope of the Shared Services being provided;
  - (ii) meet the requirements of any applicable Reference Document; and
  - (iii) are flexible and allow change as necessary or appropriate, as reasonably required by NZ Health Partnerships (in consultation with the appropriate Governance Group if any).

11. DATA

11.1 Data ownership and access:

- (a) NZ Health Partnerships acknowledges and agrees that DHB Data, in whatever form and on whatever media, remains the property of the relevant DHBs or their licensors. The DHBs acknowledge that NZ Health Partnerships may require access to DHB Data to fulfil its obligations under this Head Agreement. The DHBs agree:
  - (i) to promptly (and within the timeframes specified by NZ Health Partnerships) provide NZ Health Partnerships with access to DHB Data for the purposes of this Head Agreement when reasonably requested to do so by NZ Health Partnerships; and
  - (ii) that NZ Health Partnerships may store, disclose, and use, information obtained by NZ Health Partnerships under this Head Agreement (including DHB Data) as required for the purposes of performing the Shared Services or otherwise as required under this Head Agreement.
- (b) Each DHB acknowledges and agrees that the Shared Services Data, in whatever form and on whatever media, remains the property of NZ Health Partnerships.

- (c) NZ Health Partnerships may share Shared Services Data or DHB Data (or both) with the Ministry of Health, PHARMAC, MBIE, Service Partners, and DHBs ("**Recipient**").
  - (d) NZ Health Partnerships will provide, to appropriate personnel at each DHB, access to that DHB's DHB Data and Shared Services Data (where required under this Head Agreement).
- 11.2 **DHB Data Security:** Whenever the DHBs provide DHB Data to NZ Health Partnerships, and whenever NZ Health Partnerships provides DHB Data to a Recipient, NZ Health Partnerships must and shall procure that any Recipient must:
- (a) if it is a Service Partner, use and disclose the DHB Data only to the extent necessary to provide the relevant Shared Services, and process such DHB Data in accordance with any applicable data protection Laws;
  - (b) keep the DHB Data secure, and prevent the loss of, unauthorised access to, and any other misuse relating to, that DHB Data;
  - (c) keep the DHB Data confidential and not disclose it to any other agency or person; and
  - (d) dispose of the DHB Data once it is no longer required for the purposes of the provision of the Shared Services or otherwise.

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12. NOMINATED PARTIES

- 12.1 A DHB may, on giving Notice to NZ Health Partnerships, and subject to NZ Health Partnerships' consent in accordance with clause 12.2, nominate related parties (including subsidiaries, Health Sector joint ventures and affiliated Health Sector entities) to receive Shared Services under this Head Agreement ("Nominated Party"). If the Nominated Party is owned by or affiliated to more than one DHB, the relevant DHBs must determine which of them will nominate and be responsible for that Nominated Party under this Head Agreement.
- 12.2 On receipt of Notice under clause 12.1, NZ Health Partnerships will consult with the relevant Service Partner(s) and, within 10 Business Days, notify the DHB whether it consents or objects to the Nominated Party receiving Shared Services. If NZ Health Partnerships consents, it will engage (and will procure the relevant Service Partners to engage) with the DHB and the relevant Nominated Parties, where applicable, to agree appropriate lead-in times, transition and any other relevant requirements in order for the Nominated Party to receive Shared Services.
- 12.3 Each DHB is responsible for all obligations of all Nominated Parties nominated by that DHB and must ensure that all Nominated Parties comply with applicable terms of this Head Agreement (including clause 4 and all Service Levels) as if they were a Party to this Head Agreement.

13. RECORDS

- 13.1 NZ Health Partnerships shall (and shall procure any Service Partner and other Subcontractors to):
- (a) keep full, accurate and up-to-date records relating to the performance of the Shared Services (including supporting documentation for all amounts payable by the DHBs and documentation measuring its performance as against the Service Levels); and
  - (b) retain such records for a minimum of seven years (or such longer time as may be required by Law) from the expiry or termination of this Head Agreement or the relevant Service Partner Agreement, as applicable.

14. CHANGES

- 14.1 **Shared Services changes:** The Parties agree that:

- (a) any changes to clauses 1 to 23, and the Annexures (except Annexure 4), of this Head Agreement, must be agreed in writing by all the Parties; and
- (b) any changes to Reference Documents or Annexure 4 (or both) must be made in accordance with clause 6.2; and
- (c) any changes to a Schedule must be agreed in writing by all Parties to that Schedule, unless expressly provided otherwise in that Schedule.

14.2 **Amendments required by Law:** If there is a change in any Law or any direction of the Crown made in accordance with Law, for example, under the New Zealand Public Health and Disability Act 2000 or the Crown Entities Act 2004, affecting the operation of this Head Agreement then:

- (a) the appropriate Governance Group (if any) will, at a special meeting called for the purpose if required, consider any amendments required to the Head Agreement and shall make appropriate recommendations to all Parties to vary this Head Agreement in accordance with clause 14.1(a) ("**Amendment**");
- (b) NZ Health Partnerships will use its best endeavours to negotiate and agree any consequential amendments to Service Partner Agreements; and
- (c) NZ Health Partnerships may revise the Service Fees to reasonably reflect the extent to which such Amendments impact upon the cost to NZ Health Partnerships (including via applicable Service Partner Agreements) of delivering the relevant Shared Services.

15. INTELLECTUAL PROPERTY RIGHTS

15.1 **Ownership:** Unless specified otherwise in this Head Agreement, or otherwise agreed in writing between the Parties, NZ Health Partnerships shall not use any of the DHBs' Intellectual Property Rights, and the following ownership arrangements for Intellectual Property Rights will apply:

- (a) all Intellectual Property Rights of a Party or any of its licensors that are not developed, commissioned or created under or in connection with this Head Agreement ("**Existing Intellectual Property Rights**"), but are used for the purposes of this Agreement, will be owned by that Party or the relevant licensor; and
- (b) all new Intellectual Property Rights that are developed, commissioned or created under or in connection with this Head Agreement, including all Intellectual Property Rights in modifications, adaptations and additions to the Existing Intellectual Property Rights of a Party that are developed, commissioned or created under or in connection with this Head Agreement, will be owned by the Party or Parties as agreed in the applicable Schedule and if no provision is made in the applicable Schedule, by NZ Health Partnerships.

15.2 **Licence to use:** The DHBs grant to NZ Health Partnerships:

- (a) a royalty free, non-exclusive licence (for the Term) to use the DHBs' Intellectual Property Rights solely to the extent necessary to perform the Shared Services in accordance with this Head Agreement ("**Licence**"); and
- (b) the right to sub-license the Licence to any Service Partner solely to the extent necessary to enable the Service Partner to perform the relevant Shared Services in accordance with Service Partner Agreement.

16. CONFIDENTIALITY

16.1 **Restrictions:** Except as permitted by this clause 16 or otherwise expressly permitted in this Head Agreement, each Party shall keep the other Party's Confidential Information confidential. In

fulfilling its obligations under this clause 16.1, each Party shall, as a minimum standard, use the same degree of care to avoid disclosure as it uses to protect its own Confidential Information.

16.2 **Exceptions:** Notwithstanding clause 16.1, either Party may disclose any Confidential Information:

- (a) to:
  - (i) its directors, employees or contractors who need to know such information for the purpose of this Head Agreement; or
  - (ii) its professional advisers, auditors or bankers for a proper purpose;

provided that the Party ensures that each such person to whom it discloses Confidential Information complies with the restrictions in this clause as if such person were a Party to this Head Agreement;
- (b) if and to the extent disclosure is required by Law (including the Official Information Act 1982), or any Governmental Agency, minister of the Crown or parliamentary officer or body, provided that Party gives the other Party Notice of the requirement, and consults with the other Party, as soon as practicable before such disclosure is made (other than where it is prohibited from doing so as a matter of Law); or
- (c) if and to the extent the information:
  - (i) was known to the receiving Party before the information was disclosed to it;
  - (ii) is disclosed to the receiving Party on a non-confidential basis by a third party who has the right to make such disclosure; or
  - (iii) is generally available to the public through no fault of the receiving Party.

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17. TERM AND TERMINATION

17.1 **Term:** This Head Agreement commenced on the Commencement Date and continues for an initial term of 15 years, unless earlier terminated in accordance with this Head Agreement ("Initial Term").

17.2 **Renewal by agreement:** At least twelve months prior to the expiry of the Initial Term, the Parties shall meet to discuss the possibility of renewing this Head Agreement upon the expiry of the Initial Term. Any such renewal shall be on the same terms and conditions as this Head Agreement, except as otherwise agreed in writing.

17.3 **Termination:** This Head Agreement or any Schedule may only be terminated:

- (a) by agreement between the DHBs and NZ Health Partnerships; and
- (b) following consultation with the relevant Service Partner.

The date on which termination takes effect must be 12 months after the agreement to terminate or any such other period which the Parties agree is necessary to allow sufficient time for all DHBs to transition the relevant Shared Services to alternative providers or in-house.

17.4 **Consequences of termination:** On and following termination or expiry of a Schedule or this Head Agreement for any reason:

- (a) the termination or expiry shall be without prejudice to either Party's rights and remedies in respect of any breach of this Head Agreement by either Party, where the breach occurred before the termination or expiry of this Head Agreement; and
- (b) the provisions of clause 18 apply.

18. POST TERMINATION SERVICES

- 18.1 **Post Termination Services:** Upon termination or expiry of all or any part of this Head Agreement or any Schedule for any reason, NZ Health Partnerships shall, at the request of the DHBs, assist, and procure the assistance of Service Partners where appropriate, in the orderly transition of the terminated Shared Services to the DHBs or their nominated alternative service provider (whether to an alternative organisation performing substantively the same role as NZ Health Partnerships or directly to the relevant Service Partner, if applicable) in accordance with this clause 18 (the "**Post Termination Services**").
- 18.2 **Term of Post Termination Services:** NZ Health Partnerships shall provide Post Termination Services for up to six months after the date of termination or expiry of this Head Agreement or any Schedule (or any longer period as agreed), as required by the DHBs.
- 18.3 **Included services:** The DHBs shall notify NZ Health Partnerships of the Post Termination Services required. At the DHBs' option, the Post Termination Services may include any or all of the following:
- (a) continued performance of the relevant Shared Services to the extent required by the DHBs;
  - (b) promptly assisting the DHBs to prepare a transition plan specifying the tasks to be performed by each Party to enable the orderly transition of the provision of the relevant Shared Services and the timeframes for the performance of such tasks;
  - (c) co-operating with the DHBs or an alternative service provider as necessary for an orderly transition; and
  - (d) providing reasonable assistance for the DHBs to acquire rights to access and use third party software, facilities, equipment, documentation and other resources used by NZ Health Partnerships to provide the Shared Services.
- 18.4 **Fee:**
- (a) The DHBs shall pay NZ Health Partnerships for Post Termination Services at rates to be agreed in writing between the Parties based on the Service Fees.
  - (b) If the Parties cannot reach agreement on such fees within a reasonable time, the dispute will be resolved under clause 21. If required by the DHBs, NZ Health Partnerships shall provide Post Termination Services pending resolution of the dispute.

19. FORCE MAJEURE

- 19.1 **No breach:** A Party (the "**Affected Party**") shall not be liable for any failure or delay in performance of any obligations under this Head Agreement to the extent such failure or delay is due to a Force Majeure Event, provided that the Affected Party:
- (a) promptly notifies the other Party ("**Non-affected Party**") of the nature and extent of the Force Majeure Event and keeps the Non-affected Party reasonably informed of the steps the Affected Party is taking to mitigate and remedy the Force Majeure Event;
  - (b) uses reasonable endeavours to mitigate the effect of the Force Majeure Event and to carry out its obligations under this Head Agreement to the extent reasonably practicable; and
  - (c) resumes full performance as soon as reasonably practicable.
- 19.2 **Corresponding obligations:** The Non-affected Party shall be relieved of its corresponding obligations to the same extent the Affected Party is relieved of its obligations due to this clause 19.

- 19.3 **No requirement to settle:** Nothing in this clause 19 shall be construed to require any Party to settle a lock-out, strike or other industrial dispute by acceding against its judgement to demands made to it.

20. DEFAULT EVENTS

- 20.1 **Notification:** A DHB must promptly give Notice to NZ Health Partnerships of any Default Event (a "Default Notice").
- 20.2 **Further information and requirement to remedy:** Where a Default Notice is given, or if NZ Health Partnerships becomes aware of a Default Event, NZ Health Partnerships may, by further Notice, require the DHB to:
- (a) supply such information reasonably required by NZ Health Partnerships in order to fully assess the nature of the Default Event; and
  - (b) remedy (if it is capable of remedy) the Default Event within 20 Business Days (the "**Remedy Period**") of the date of receipt (in terms of clause 23.3) of that further Notice.
- 20.3 **Failure to remedy:** If the DHB fails to remedy the Default Event within the Remedy Period, or if the Default Event (as the case may be) is not capable of remedy, NZ Health Partnerships may by Notice to the DHB:
- (a) charge default interest, payable to NZ Health Partnerships, on any amounts owed by the DHB to NZ Health Partnerships at a rate of the Bank Bill Bid Rate appearing on the first Business Day of each month during which default interest is charged, plus 3 percent per annum, calculated daily and capitalised monthly; or
  - (b) suspend the provision of the Shared Services to that DHB; or
  - (c) both (a) and (b);
- in each case until such time as the Default Event is remedied.

14.4

21. DISPUTES BETWEEN THE PARTIES

- 21.1 **Negotiations:** The Parties agree to meet and negotiate in good faith to resolve any and all disputes relating to an alleged or actual breach of this Head Agreement. Where a dispute arises, any Party to the dispute may give Notice to the other Party or Parties to the dispute (a "**Dispute Notice**"), providing the relevant details of the dispute.
- 21.2 **Mediation:** If the relevant Parties cannot resolve a dispute by negotiations within 20 Business Days of the issue of the Dispute Notice, any Party may by further Notice to the other Party or Parties, require that the dispute be dealt with by mediation (a "**Mediation Notice**") under the following terms:
- (a) the mediation shall be conducted in terms of the Resolution Institute (formerly known as LEADR) standard mediation agreement; and
  - (b) the mediation shall be conducted by a mediator and at a fee agreed by the Parties. Failing agreement between the Parties within 10 Business Days of the issue of the Mediation Notice, the mediator will be selected, and his or her fee determined, by the Chief Executive for the time being of the Resolution Institute (or his or her nominee).
- 21.3 **No proceedings:** Subject to clause 21.4, no Party may initiate or commence court or arbitration proceedings relating to the dispute unless that Party has complied with clauses 21.1 and 21.2 above.

- 21.4 **Interlocutory relief:** Nothing in this clause 21 will prevent a Party from seeking urgent interlocutory relief.
- 21.5 **Continued performance:** Regardless of any dispute, each Party shall continue to perform this Head Agreement to the extent practicable, but without prejudice to their respective rights and remedies.

22. SERVICE PARTNER AND SUPPLIER DISPUTES

- 22.1 **Process:** Service Partner and Supplier disputes will be:
- (a) resolved in accordance with the relevant Service Partner Agreement or Supplier Agreement; and
  - (b) managed, as between NZ Health Partnerships, the relevant Service Partner, and the relevant DHBs, in accordance with the Litigation Framework.
- 22.2 **Cooperation:** NZ Health Partnerships and each DHB (and, where relevant to the dispute, NZ Health Partnerships will procure that the relevant Service Partner) will cooperate fully with each other including by providing all necessary documents and information, and making staff and contractors available for witness or other dispute resolution purposes.

23. NOTICES

- 23.1 **Writing:** Each notice under this Head Agreement (each a "**Notice**") shall be in writing and delivered personally or sent by post or email.
- 23.2 **Addresses:** Each Notice shall be sent to the address of the relevant Party advised for that purpose from time to time.
- 23.3 **Receipt:** A Notice under this Head Agreement is deemed to be received if:
- (a) **Delivery:** delivered personally, when delivered;
  - (b) **Post:** posted, via registered post, three Business Days after the date of posting; and
  - (c) **Email:** sent by email, at the time on the Business Day it actually comes to the recipient's attention in readable form,
- provided that any Notice deemed received after 5pm on a Business Day or on a non-Business Day shall be deemed to have been received on the next Business Day.

24. GENERAL

- 24.1 **Effect of subcontracting:** The entry by NZ Health Partnerships into a subcontract with a Service Partner (or any other Subcontractor) will not relieve NZ Health Partnerships from liability for the performance of any obligations under this Head Agreement. NZ Health Partnerships is liable to the DHBs for the acts and omissions of each of its Subcontractors as if they were NZ Health Partnerships' own acts or omissions.
- 24.2 **Assignment and novation:**
- (a) A Party may not assign, transfer, or novate, any of its rights or obligations under this Head Agreement without the prior written consent of the other Parties (such consent not to be unreasonably withheld).
  - (b) Clause 24.2(a) does not apply to any assignment, transfer, or novation, of all or any rights or obligations under this Head Agreement by NZ Health Partnerships to an alternative organisation performing substantively the same role as NZ Health Partnerships. In such

circumstances, NZ Health Partnerships will give Notice to the DHBs of the intended assignment, transfer, or novation, and the DHBs must, at their own expense, promptly sign and deliver any documents, and do all things that are reasonably required by NZ Health Partnerships to give full effect to such assignment, transfer or novation.

- 24.3 **Privity:** A person who is not a Party shall not have any rights under or in connection with this Head Agreement by virtue of the Contracts (Privity) Act 1982.
- 24.4 **Further assurances:** Each Party shall, at its own expense, promptly sign and deliver any documents, and do all things, which are reasonably required to give full effect to the provisions of this Head Agreement.
- 24.5 **Relationship of Parties:** Each Party, in relation to each other Party, is an independent contractor. Nothing in this Head Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party the agent (unless expressly stated otherwise in a Schedule) or employee of the other Party, nor authorise any Party to make or enter into any commitments for or on behalf of any other Party.
- 24.6 **Survival:** Following expiry or termination of this Head Agreement, clauses 8 (*Cost Recovery Principles*), 15 (*Intellectual Property Rights*), 16 (*Confidentiality*), 17 (*Term and Termination*), 18 (*Post Termination Services*) and 21 (*Disputes*), together with other provisions that are by their nature intended to survive, will remain in effect.
- 24.7 **Governing Law and jurisdiction:** This Head Agreement is governed by New Zealand Law and the Parties irrevocably submit to the non-exclusive jurisdiction of the New Zealand courts in any proceedings relating to it.
- 24.8 **Counterparts:** This Head Agreement may be executed in any number of counterparts (including any scanned PDF counterpart), each of which shall be deemed an original, but all of which together shall constitute the same instrument. No counterpart shall be effective until each Party has executed a counterpart.

EXECUTED as an agreement

SIGNED for and on behalf of	)	
NZ HEALTH PARTNERSHIPS LIMITED by	)	
	)	
	)	Signature
	)	
	)	
_____	)	
Print Name	)	Position

Date:

14.4



SIGNED for and on behalf of)
AUCKLAND DISTRICT HEALTH BOARD by)
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) Signature
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Print Name) Position

Date:

SIGNED for and on behalf of)
BAY OF PLENTY DISTRICT HEALTH)
BOARD by)
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) Signature
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Print Name) Position

Date:

SIGNED for and on behalf of)
CANTERBURY DISTRICT HEALTH BOARD)
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Print Name) Position

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SIGNED for and on behalf of)
CAPITAL & COAST DISTRICT HEALTH)
BOARD by)
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Print Name) Position

Date:



SIGNED for and on behalf of)
COUNTIES MANUKAU DISTRICT HEALTH)
BOARD by)
) Signature
) _____
) _____
Print Name) Position

Date:

SIGNED for and on behalf of)
HAWKE'S BAY DISTRICT HEALTH BOARD)
by)
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Print Name) Position

Date:

SIGNED for and on behalf of)
HUTT VALLEY DISTRICT HEALTH BOARD)
by)
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Print Name) Position

Date:

SIGNED for and on behalf of)
LAKES DISTRICT HEALTH BOARD by)
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Print Name) Position

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SIGNED for and on behalf of	)	
MIDCENTRAL DISTRICT HEALTH BOARD	)	
by	)	
	)	Signature
	)	
	)	
Print Name	)	Position

Date:

SIGNED for and on behalf of	)	
NELSON MARLBOROUGH DISTRICT	)	
HEALTH BOARD by	)	
	)	Signature
	)	
	)	
Print Name	)	Position

Date:

SIGNED for and on behalf of	)	
NORTHLAND DISTRICT HEALTH BOARD	)	
by	)	
	)	Signature
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	)	
Print Name	)	Position

Date:

SIGNED for and on behalf of)
SOUTH CANTERBURY DISTRICT HEALTH)
BOARD by)
) Signature
) _____
) _____
Print Name) Position

Date:



SIGNED for and on behalf of)
SOUTHERN DISTRICT HEALTH BOARD by)
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Print Name) Position

Date:

SIGNED for and on behalf of)
TAIRAWHITI DISTRICT HEALTH BOARD)
by)
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Print Name) Position

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SIGNED for and on behalf of)
TARANAKI DISTRICT HEALTH BOARD by)
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Print Name) Position

Date:

SIGNED for and on behalf of)
WAIKATO DISTRICT HEALTH BOARD by)
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Print Name) Position

Date:

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SIGNED for and on behalf of	)	
WAIRARAPA DISTRICT HEALTH BOARD	)	
by	)	
	)	Signature
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Print Name	)	Position

Date:

SIGNED for and on behalf of	)	
WAITEMATA DISTRICT HEALTH BOARD	)	
by	)	
	)	Signature
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	)	
Print Name	)	Position

Date:

SIGNED for and on behalf of	)	
WEST COAST DISTRICT HEALTH BOARD	)	
by	)	
	)	Signature
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	)	
Print Name	)	Position

Date:

SIGNED for and on behalf of	)	
WHANGANUI DISTRICT HEALTH BOARD	)	
by	)	
	)	Signature
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	)	
Print Name	)	Position

Date:

ANNEXURES

14.4

ANNEXURE 1 – DEFINITIONS & INTERPRETATION

1. Definitions

In this Head Agreement, unless the context requires otherwise:

WORDS	DEFINITIONS
Affected Party and Non-affected Party	have the meanings given in clause 19.1.
Annexure	means an annexure to this Head Agreement.
Annual Plan	means the annual plan developed by NZ Health Partnerships and its DHB shareholders in accordance with the Governance Charter.
Annual Shareholders' Meeting	means an annual meeting of NZ Health Partnerships' DHB shareholders, as described in the Governance Charter.
Appendix	means an appendix to a Schedule.
Bank Bill Bid Rate	means the average New Zealand dollar 90 day bank bill bid rate (rounded up to the nearest second decimal place) as appearing at 11.00 am or as soon as practicable thereafter on the relevant day on page BKBM of the Reuters screen (or its successor or equivalent page).
Business Day	means any day other than a Saturday, a Sunday, a public holiday (as defined in the Holidays Act 2003) (and to avoid doubt, Business Day excludes any provincial anniversary holiday).
Claim	means any claim or proceeding brought, in connection with a Shared Service, against: - a third party by NZ Health Partnerships or a Service Partner; - NZ Health Partnerships by a Service Partner or vice versa; or - NZ Health Partnerships or a Service Partner by a DHB or any group of DHBs, or by a third party (for example, a Supplier).
Commencement Date	means 1 July 2014.
Confidential Information	means the provisions of this Head Agreement, all information obtained as a result of the negotiations relating to this Head Agreement, and all information obtained as a result of entering into or performing this Head Agreement which relates to the subject matter of this Head Agreement or the other Party (including DHB Data).
Consents	means all permissions, consents, approvals, certificates, permits, licences (including, to avoid doubt, licences of intellectual property), agreements and authorities (whether statutory, regulatory, contractual or otherwise) necessary for the provision and receipt of the Shared Services.
Control	means, in relation to a person (the "first person"), the ability of a person (the "second person") to ensure that the activities and business of the first person are conducted in accordance with the wishes of the second person, whether through ownership of voting shares, contract or otherwise. Without limitation, the direct or indirect beneficial ownership of more than 50% of the voting shares of a person is deemed to constitute Control.
Cost Recovery Amount	has the meaning set out in clause 8.1(b).
Crown	has the meaning set out in the Public Finance Act 1989.
Default Event	means, in respect of a DHB, any of the following: - the DHB failing to meet its financial obligations under the Head Agreement; - the DHB committing a material breach of its obligations under the Head Agreement; or - the DHB becoming bankrupt or insolvent.
Default Notice	Has the meaning set out in clause 20.1.

WORDS	DEFINITIONS
DHB Data	means DHB transactional data i.e. any data held or controlled by the DHBs relating to their business, including, for the avoidance of doubt, any Personal Data.
Discretionary Services	has the meaning set out in clause 9.2(b).
Force Majeure Event	means an event where the event itself and the consequences of the event are beyond the reasonable control of the affected Party, which may include: a. an act of God such as an earthquake, epidemic, fire, flood, riot, terrorism, war or volcanic activity; b. lock-outs, strikes or other industrial disputes which do not relate solely to that Party's workforce; c. an act or omission by a Governmental Agency; or d. any other extraordinary event or circumstance ("event") of a similar nature, that is beyond the reasonable control of the affected Party; but excludes: e. an event where the event, or the effect of the event on the affected Party, could have been avoided or overcome by the affected Party taking reasonable precautions; f. a lock out strike or other industrial dispute that relates solely to the affected Party's or its Related Companies' workforce; g. a lack of funds for any other reason; or h. the failure of a contractor or supplier, except to the extent that such failure is itself caused by the Force Majeure Event and the contractor or supplier would meet the requirements for relief under clause 19 if clause 19 applied.
Good Industry Practice	means, in relation to any activity or service, the practice or standard for that type of activity or service (in terms of quality, productivity, effectiveness and performance) adopted by service providers in the relevant industry in New Zealand.
Governance Charter	means the Reference Document entitled "NZ Health Partnerships Governance Charter", as updated and amended from time to time.
Governance Group	means a governance group described in Appendix 1 of the Governance Charter. References to the " <i>appropriate Governance Group</i> " refer to the Governance Group (or more than one) determined by NZ Health Partnerships (in its sole discretion) as being the appropriate Governance Group(s) in the circumstances.
Governmental Agency	includes any state or government and any governmental, local governmental, semi-governmental, judicial, statutory or regulatory entity, authority, body or agency or any person charged with the administration of any Law.
GST	means goods and services tax chargeable, or to which a person may be liable, under the GST Act.
GST Act	means the Goods and Services Tax Act 1985.
Head Agreement	means this agreement and includes the Annexures, Schedules, Appendices, and Reference Documents.
Health Sector	means the New Zealand public health and disability sector.
Initial Term	has the meaning given in clause 17.1
Insolvency Event	means, in relation to a Party, where that Party: a. ceases or threatens to cease to carry on all or substantially all of its business or operations; b. becomes or is presumed to be insolvent; c. has an encumbrancer, receiver, liquidator, administrator, statutory manager or any similar insolvency administrator appointed who takes possession of, or is appointed in respect of, the whole or a substantial part of the assets or undertaking of that Party; d. in the case of NZ Health Partnerships, is removed from the Register of Companies; e. an application is made or proceedings are issued for a court order and

WORDS	DEFINITIONS
	in either case not withdrawn, stayed or dismissed within 10 Business Days, or an order is made, or an effective resolution is passed, or any action of a similar nature is taken, for the dissolution or reorganisation of that Party, except for the purposes of a solvent reconstruction, merger or voluntary liquidation previously approved in writing by the other Party (such approval not reasonably withheld); or f. suffers any analogous event, which has substantially similar effects under the Law in respect of that Party.
Intellectual Property Rights	includes copyright, and all rights conferred under statute, common law or equity in relation to inventions (including patents), trademarks, designs, circuit layouts, domain names, rights in databases, confidential information, trade secrets, know-how, and all other proprietary rights, whether registered or unregistered, and all equivalent rights and forms of protection anywhere in the world, together with all right, interest or licence in or to any of the foregoing.
KPIs	means, for any Shared Services, the key performance indicators set out in the applicable Schedule.
Law	includes any rules of common law, statute, regulation, order in council, by-law, ordinance or other subordinate or secondary legislation in force from time to time.
Licence	has the meaning given in clause 15.2(a).
Litigation Framework	The Reference Document named as such and appended to [Procurement Schedule tbc], and which sets out the basis on which NZ Health Partnerships, DHBs, and relevant Service Partners will manage disputes and Claims.
MBIE	means the Ministry of Business, Innovation and Employment or any successor or alternative Ministry or government department with responsibility for managing the all-of-government procurement programme.
National Good	means, in relation to any activity, programme, or undertaking of NZ Health Partnerships, significant Health Sector-wide gains in any or all of the following areas: quality; scalability; cost effectiveness; capability; consistency; or anything required to enable future opportunities to deliver any or all of the above areas of gain.
Nominated Party	has the meaning given in clause 12.
Notice	has the meaning given in clause 23.1.
NZHP Board	means the NZ Health Partnerships board of directors.
Party	means a party to this Head Agreement including its personal representatives, successors and permitted assigns.
Performance Scorecard	has the meaning set out in clause 3.4(a).
Personal Data	means personal information about a patient or staff member of a DHB.
Personnel	means NZ Health Partnerships' and each Subcontractor's personnel (including employees and contractors) used to provide any Shared Services.
PHARMAC	means the Pharmaceutical Management Agency.
Post Termination Services	has the meaning given in clause 18.1.
Reference Document	has the meaning set out in clause 6, and are the documents listed in Annexure 4 (as amended from time to time).
Related Companies	has the meaning given in section 2(3) of the Companies Act 1993.
Remedy Period	Has the meaning given in clause 20.2(b).
Schedule	means a Shared Services schedule incorporated into this Head Agreement setting out the terms of an agreed Shared Service.
Service Fees	has the meaning given in clause 9.1.
Service Levels	means, for any Shared Services, the standards of service set out in the applicable Schedule.
Service Partner	means a third party engaged by NZ Health Partnerships to perform Shared Services under this Head Agreement.

WORDS	DEFINITIONS
Service Partner Agreement	means an agreement between NZ Health Partnerships and a Service Partner to perform Shared Services.
Shared Services	means the services set out in a Schedule.
Shared Services Budget	has the meaning set out in clause 7.3(a).
Shared Services Data	means data generated in the performance of any Shared Services as described in a Schedule.
Shared Services Principles	has the meaning set out in clause 2.2.
Subcontractor	means any person being a subcontractor of any tier engaged for the purpose of assisting NZ Health Partnerships to perform any of the Shared Services (including Service Partners).
Supplier	means a third party supplier of goods and services engaged by a Service Partner (or directly by the DHB) to supply goods or services or both directly to a DHB.
Supplier Agreement	means an agreement between a Supplier and a DHB, or a Supplier and a Service Partner, for the supply of goods or services or both, to a DHB.
Taxation or Tax	includes any present or future tax, levy, impost, duty, charge, fee, deduction or withholding of any nature (whether or not payable in money) and whatever called (including any interest, penalties, fines charges in respect of any such tax) imposed by any Governmental Agency, on whoever imposed, levied, collected, withheld or assessed.
Term	means the term specified in clause 17.1 and includes any renewed term under clause 17.2.
Variation Date	Means the date determined under clause 1.4.

14.4

2. Interpretation

In this Head Agreement, unless the context requires otherwise:

- 2.1 references to Reference Documents include any amended or replaced policy and includes any documents referred to within the policy, including terms of reference;
- 2.2 references to **clauses** and **schedules** are to clauses of and schedules to this Head Agreement;
- 2.3 **derivations** of any defined word or term shall have a corresponding meaning;
- 2.4 a **gender** includes each other gender;
- 2.5 the **headings** to clauses are inserted for convenience only and do not affect interpretation of this Head Agreement;
- 2.6 the word **including** and other similar words do not imply any limitation;
- 2.7 a **person** includes any individual, company, corporation, firm, club, partnership, joint venture, association of persons (incorporated or not), trust or Governmental Agency (in each case, whether or not having separate legal personality);
- 2.8 the **plural** includes the **singular** and vice versa;
- 2.9 a reference to a **statute** includes all regulations and other subordinate legislation made under that statute. A reference to a statute, regulation or other subordinate legislation, or to a provision of any statute, regulation or other subordinate legislation, includes that statute, regulation or other subordinate legislation or provision as amended, re-enacted or replaced from time to time;
- 2.10 all **amounts** payable under this Head Agreement are expressed exclusive of GST and in New Zealand dollars. If GST is payable on any amount it will be added to that amount and will be payable at the time the amount itself is payable;

- 2.11 a **document** (however described and including this Head Agreement) includes that document as amended or replaced from time to time; and
- 2.12 any **obligation falling due** for performance on or by a day other than a Business Day shall be performed on or by the Business Day immediately following that day.

3. Precedence

- 3.1 If there is any conflict between the body of this Head Agreement (clauses 1 to 23), Annexures, Schedules, Appendices, and Reference Documents, the following descending order of precedence will prevail:
  - a. the body of this Head Agreement;
  - b. Annexure 1 (Definitions and Interpretation);
  - c. Schedules (unless a Schedule expressly provides that it is to prevail over the Head Agreement);
  - d. Appendices;
  - e. Reference Documents; and
  - f. the remaining Annexures.

ANNEXURE 2 – DISTRICT HEALTH BOARDS

Auckland District Health Board
Bay of Plenty District Health Board
Canterbury District Health Board
Capital & Coast District Health Board
Counties Manukau District Health Board
Hawke's Bay District Health Board
Hutt Valley District Health Board
Lakes District Health Board
MidCentral District Health Board
Nelson Marlborough District Health Board
Northland District Health Board
South Canterbury District Health Board
Southern District Health Board
Tairāwhiti District Health Board
Taranaki District Health Board
Waikato District Health Board
Wairarapa District Health Board
Waitemata District Health Board
West Coast District Health Board
Whanganui District Health Board

14.4

ANNEXURE 3 – SHARED SERVICES

The following services are Shared Services for the purpose of this Head Agreement:

- Procurement Services
- National Infrastructure Platform Services

ANNEXURE 4 – REFERENCE DOCUMENTS

The following documents are Reference Documents for the purpose of this Head Agreement:

- Governance Charter
- DHB Procurement Strategy
- Category Ownership Schedule
- Litigation Framework

14.4

 HAWKE'S BAY District Health Board Whakawāteatia	Community Based Pharmacy Services in Hawke's Bay - strategic direction 2016-2020	90
	For the attention of: HBDHB Board	
Document Owner:	Tim Evans, GM Planning, Informatics and Finance	
Document Authors:	Billy Allan, Chief Pharmacist; and Mary Wills, Head of Strategic Services	
Reviewed by:	Executive Management Team and HB Clinical Council	
Month:	August 2016	
Consideration:	For Discussion and Endorsement	

RECOMMENDATION

That the Board:

1. **Note** the content of this report.
2. **Note** the phased approach to implementation.
3. **Note** the stakeholder feedback (Appendix 3).
4. **Note** that new pharmacy services will only be possible if adequately funded to ensure the viability and sustainability of the services.
5. **Endorse** the Community Based Pharmacy Services in Hawke's Bay - strategic direction 2016-2020.

THE VISION¹

People are at the centre of the Hawke's Bay health system. Pharmacy services, as an integrated component of a person, whānau and hapū-centred, collaborative model of care, will be delivered in innovative ways, across a broad range of settings, to ensure equitable access to medicines and healthcare services for all.

The unique and complementary skillset of pharmacists (and support staff), as medicines management experts, will be fully utilised in the Hawke's Bay healthcare team. The focus will be on the delivery of high quality care, supported by smart IT systems, that is responsive to the changing health needs of the people of Hawke's Bay and empowers them to manage their own health and well-being better, as part of a one-team approach that supports people to live longer, but also spend more of that life in good health.

There will be:

- New models of care – new ways of delivering pharmacist / pharmacy services, supporting advanced practice
- Larger pharmacies for scale and to maximise IT, technology and the availability of pharmacists for advanced practice
- A range of pharmacy models and sizes to support different ways of working to support local communities and priority populations

¹ Adapted from - Ministry of Health. Pharmacy Action Plan 2016-2020, Wellington, 2016.

- New contracting models supporting the delivery of advanced practice outside of the traditional 'bricks and mortar' pharmacies
- New models for utilising support staff (Pharmacy Technicians and Pharmacy Assistants) streamlining the way pharmacy works with everyone working higher in their scope of practice
- Pharmacies to support priority populations,² including in Central Hawke's Bay, Flaxmere, Maraenui and Wairoa
- Enhanced team work with primary care, supported by IT with a shared view of the patient's health record
- Under the Hawke's Bay 13-17 Year Old Primary Care Zero Rated Subsidy programme eligible patients will receive free subsidised medicines (no prescription charges).

Patients have told us that they want:

- Greater access to the Pharmacist
- To be able to easily identify the Pharmacist
- To not have to negotiate the retail side of community pharmacy to access the Pharmacist.

Patients want to be partners in their own care. Trust us to manage ourselves with your help. Empower people. (Consumer)

Pharmacists have told us that they want:

- An enhanced medicine management role. As the medicines management experts Pharmacists should be allowed to offer more medicine management roles to take greater advantage of their clinical pharmacy skills and accessibility to manage patients
- Increased face-to-face contact with patients
- A shared health record
- A financially viable and sustainable contracting model.

This strategy for Community Based Pharmacy Services in Hawke's Bay will ensure that:

1. Whilst recognising that pharmacists tend to be rule-bound and risk averse, we will push the boundaries from 'what is' to 'what could be'
2. Pharmacy will realise its potential to deliver medicines management services to the people of Hawke's Bay. We will develop pharmacists to do more. Pharmacists are qualified to do much more and are going to do much more as part of the health care team. We will develop a wider role for pharmacist in non-dispensing activities
3. Pharmacist will work with patients and the health care team to maximise the safe and effective use of medicines, contributing to the containment of the combined pharmaceutical budget
4. Opportunities for integration and changing professional relationships are dependent on inter-professional collaboration. This takes time³ and will have additional resource to accomplish alongside clinical work
5. Pharmacists will have an additional focus on brief interventions, self-care, medicines adherence, lifestyle modification and evidence based-based screening and intervention.
6. Community pharmacy services will be:
  - a. Patient centred
  - b. Safe
  - c. Of high quality
  - d. Efficient, utilising technology (e.g. robotics) and pharmacy technicians for the technical dispensing aspects of pharmacy services
  - e. Accessible

² Priority population groups = Māori, Pacifica and our most socioeconomic deprived people living in New Zealand Deprivation Index areas quintiles 4 and 5 (NZDep4&5).

³ Rosen R. Transforming general practice: what are the levers for change? Nuffield Trust. June 2015.

- f. Comprehensive
  - g. Coordinated
  - h. Integrated within the wider health care team.
7. Community Pharmacy Services will be a key component of health and social care networks, interfacing effectively with other services such as District Nursing and the engAGE teams within the Healthcare Home.

SITUATION

Clinical Council requested that a strategy for Community Pharmacy Services development in Hawke's Bay (2014-2020) be established. This arose from a HBDHB Board (December 2013) request for an updated long term strategy 'for pharmacies and licencing' for Hawke's Bay. There were concerns over the number of community pharmacies in the Hawke's Bay region and the potential HBDHB to restrict further community pharmacy services contracts. Since 2012 the National Community Pharmacy Agreement (CPSA) has been developing a new model with the sector that would develop clinical pharmacist services in the community. This paper describes a Hawke's Bay Community Pharmacy Strategy.

BACKGROUND

A prescribed medicine is the most frequent clinical intervention provided to patients. In the 2014/15 financial year 43.1 million prescription items were filled in New Zealand, with 3.5 million New Zealanders receiving funded medicines.⁴

Ensuring that medicines are used safely, that patients receive the maximum benefit from the correct medicines and that there is minimum wastage is more important than ever. This Community Pharmacy Strategy is committed to working in partnership across the health sector to ensure this vision is delivered for the people of Hawke's Bay.

This strategy will ensure that pharmacists develop their valuable role in meeting the everyday medicines health care needs of patients. This strategy will ensure that services offer better health access and health choice for patients by strengthening the contribution of pharmacists to the provision of high quality patient centred services.

Within this strategy, pharmacists will have 10 key roles:

1. Providing convenient access to prescription and other services
2. Advising patients and other health professionals on the safe and effective use of medicines
3. To be a point of first contact for health care services for people in the community
4. To provide medicines management services, especially for priority populations and for people with long term illnesses
5. To promote patient safety preventing, detecting and reporting adverse medicine reactions and medication errors
6. To contribute to seamless and safe medicines usage throughout the patient's journey
7. To support patients as partners in medicines taking
8. To prescribe medicines and monitor clinical outcomes
9. To be a public health resource and provide health promotion, health improvement and harm reduction services
10. To promote value for money in the safe use of medicines and reduce medicines wastage.

⁴ PHARMAC Annual Report 2014/15. Annual Report of Pharmaceutical Management Agency (PHARMAC) for the year ending 30 June 2015. E.59 Presented to the House of Representatives pursuant to Section 150(3) of the Crown Entities Act 2004

There is a great deal of activity at a national level that will impact on the strategic development of community pharmacy services in Hawke's Bay (see the Appendix 2 for detail on these programmes):

- The Partnership in Health 2020 Vision for Pharmacists and Doctors
- The recently updated NZ National Pharmacist Services Framework
- The Government's Implementing Medicines New Zealand 2015-2020 refresh
- New Zealand Health Strategy 2016-2026 review
  - o New Zealand Health Strategy: Future direction
  - o New Zealand Health Strategy: Roadmap of actions 2016
- The Pharmacy Action Plan 2016-2020.
- The ongoing national Community Pharmacy Service Agreement (CPSA) negotiations
- Alliancing (e.g. with the initiation of the Urgent Care SLAT)
- Health Hawke's Bay (HHB) 'alignment' with HB community pharmacy.

This developing strategy for Hawke's Bay aligns with these national initiatives and direction.

PRINCIPLES FOR THE DEVELOPING HAWKE'S BAY STRATEGY

In October 2003 HBDHB agreed seven foundation principles with local community pharmacists:

1. We see pharmacists as key members of the primary care team
2. Partnerships are the key to success
3. Information sharing will drive partnerships
4. Community pharmacy is a key access point into primary health care
5. The District Health Board, PHO and Community Pharmacy are committed to developing a vision for primary health care in Hawke's Bay
6. Funding mechanisms will need to be reviewed to align incentives towards medicine management
7. The pace of change must be in step with local capacity and capability.

These foundations principles are consistent with the ten national policies above.

Key enablers of the Hawke's Bay strategy include:

1. Information technology support – to support the sharing of information and better communication
  - Community pharmacist access to the Electronic Discharge Summaries (EDS) and laboratory results is being rolled out through Hawke's Bay
  - The New Zealand ePrescription Service (NZePS) is to be rolled out in Hawke's Bay in late 2016
  - The MediMap / Toniq 1Chart patient management systems being introduced into local residential care facilities. This links up the prescribing, dispensing and administration of medicines into pharmacy, general practice and residential care systems
  - The development of a medicines data repository (e.g. like those in MidCentral, CliniSafe; Northern Region, TestSafe; and Canterbury, HealthOne) as a source of patients' dispensed medicines history. In the next five years "My List of Medicines" will provide a single, accurate, shared and complete list of a patient's medicines including pharmacist-only medicines, plus diagnosis, adverse reaction and allergies information.

2. Funding mechanisms will be reviewed to align incentives away from a transactional product-centred model towards a health services orientated model (with recognition of patient centred care, medicines management and cognitive pharmacy services). Funding mechanisms will be developed that are financially and professionally sustainable, not dependent (propped up) by the provision of other pharmacy services (e.g. retail activities).

This work has commenced through the national CPSA process but needs to be refocused to maximise incentives and leverage.

It is recognised that it takes time for providers to learn new ways of working and to implement changes that will deliver efficiencies in the longer term. It is intended that financial risk will be introduced gradually to avoid organisational failure.⁵

3. **Workforce**

To provide advanced practice / enhanced pharmacist services pharmacists need to be freed up from technical responsibilities to more direct patient contact. To enable this pharmacy support staff (Pharmacy Technicians and Pharmacy Assistants) will need to be developed to work at 'top of their scope'. The recently introduced Pharmacy Accuracy Checking Technician (PACT) scheme is one approach to achieve this.

The DHB and PHO will support pharmacists' development, upskilling, leadership and culture change needed to give effect to the new ways of working and business models to provide more direct patient contact and enhanced pharmacist services.

ASSESSMENT

The national landscape and direction of travel will become clearer within the next 12 months. National activity will create an opportunity for a change in direction and focus.

The developing strategy for HBDHB will be consistent with national strategies that are already in place or are under development. The strategy for Community Pharmacy Services in Hawke's Bay will complement the CPSA-2017 (Community Pharmacy Services Agreement timetabled for implementation in July 2017) with local implementation of services if appropriate.

In developing the strategy for Community Pharmacy Services in Hawke's Bay we will deliver on the New Zealand triple aim:

- Improved health and equity for all populations
- Improved quality, safety and experience of care
- Best value for public health system resources

The strategy will be consistent with:

- National policy, including the principles of:
  - o Living well in healthy communities
  - o A great start for children and families
  - o Partnering with people
  - o Working together in a high-trust public system
  - o Building leaders and capability for the future
  - o Fostering and spreading innovation and quality improvement
  - o Best use of technology and information
- Hawke's Bay health sector's vision and values
- Hawke's Bay health sector's *Quality Improvement and Safety Framework*



⁵ Rosen R. Transforming general practice: what are the levers for change? Nuffield Trust. June 2015.

- Hawke's Bay health sector's development of local health networks.⁶ In particular the community pharmacy strategy must support the delivery of local community based services which reflect these principles:
  - o Equity based care, treating greatest need first - helping to eliminate health inequity from Hawke's Bay
  - o Do no harm
  - o Do no more than is necessary to achieve the desired outcomes
  - o Choose the most prudent care, openly together with the patient
  - o Consistently apply evidence based and knowledge based clinical practice
  - o Staff working to co-create health with the public, patients and partners
  - o Make services more accessible
  - o Make services more appropriate to the patient
  - o Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa
  - o Keep people out of hospital
  - o Support the development of advanced practice.

A series of enhanced patient-centric pharmacist services will be supported. This includes, but is not limited to, the following (See Appendix 1 for definitions):

- Triaging and funded Minor Ailments Scheme
- Health promotion and screening
- Immunisation by pharmacists
- Long Term Conditions (LTC)
- Medicines Use Review (MUR) e.g. in residential care facilities
- Community Pharmacy Anticoagulation Service (CPAMS) and similar services that optimise specific medicines where these medicines are targeted for optimisation, guided by defined testing/assessment criteria and standing orders as appropriate, e.g. the management of gout through the adjustment of allopurinol against point-of-care uric acid testing.
- Medicines Therapy Assessment (MTA)
- Comprehensive Medicines Management (CMM)
- Pharmacist prescribers

Whilst retaining traditional services

- Medicines supply & dispensing
- Medicines advice and counselling
- Over the counter medicines provision

These services are illustrated in Figures 1 as wrap-round services and Figure 2 as a hierarchy of pharmacist services provided with increasing complexity of care.

Some of these services will be directed at a person's need using eligibility criteria to ensure priority populations are targeted.

⁶ A Guide to Implementing the Hawke's Bay Primary and Community Strategic Framework 2015.

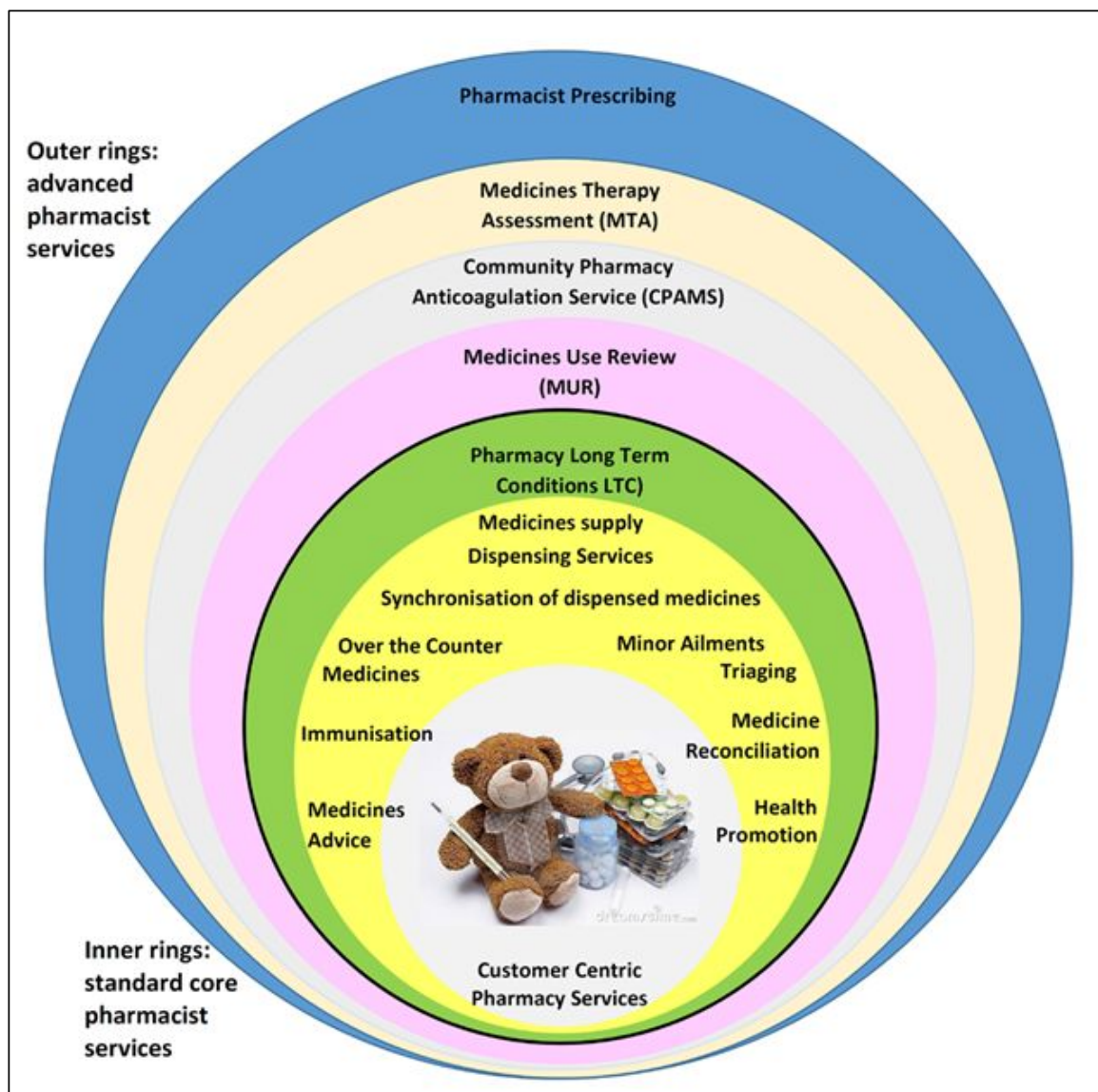


Figure 1. Pharmacists wrap-round services

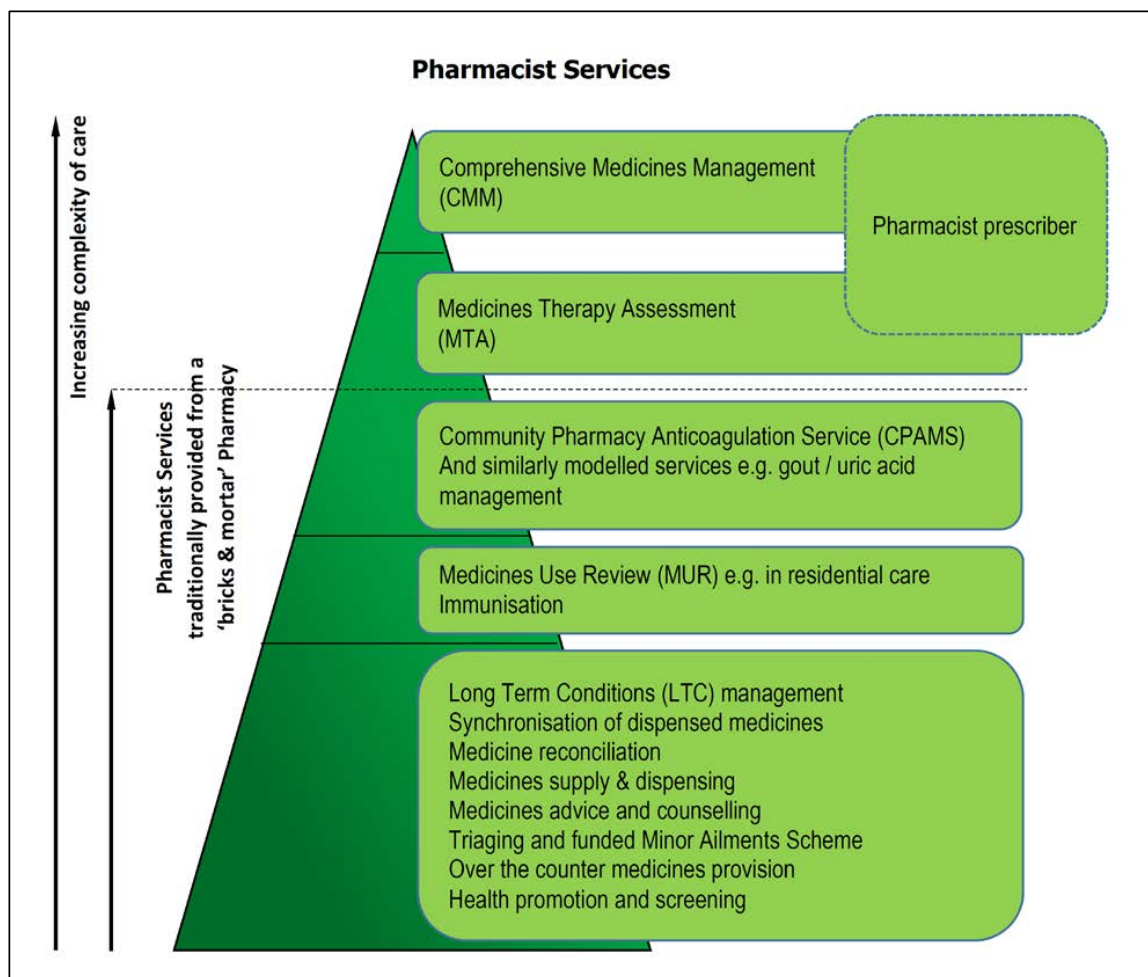


Figure 2. Hierarchy of pharmacist services with increasing complexity of care

These enhanced patient-centric pharmacist services will support the principles of the Hawke's Bay Primary and Community Strategic Framework as indicated below:

Principle	Indicative community pharmacy services to support the principle ⁷
Equity based care, treating greatest need first	
Do no harm	Core pharmacy service including • Managing and supporting the safe use of medicines • Assisting with patients' self-management of complex medicine regimens • Medicine reconciliation (establishing patients' actual treatment regimen at points of transfer of care) • Medicine interaction and allergy checking
Do no more than is necessary to achieve the desired outcomes	• Contributing to the containment of the HB combined pharmaceutical budget
Choose the most prudent care, openly together with the patient	• Health promotion and preventative services – advice on self-care, personal health and health promotion • Medicines Use Review (MUR) (assisting with adherence) • Medicines Therapy Assessment (MTA)
Consistently apply evidence based and knowledge based clinical practice	• Medicines Therapy Assessment (MTA) • Community Pharmacy Anticoagulation Management Service (CPAMS)
Staff working to co-create health with the public, patients and partners	• Participation in Alliancing • Local clinical pathway development
Make services more accessible	• Community Pharmacy Anticoagulation Management Service (CPAMS) • Vaccinations • Minor ailments service • Community Pharmacy Gout Management Service
Make services more appropriate to the patient	• Triaging and minor ailments service • Community Pharmacy Anticoagulation Management Service (CPAMS) • Community Pharmacy Gout Management Service • Immunisations
Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa	• Medicine reconciliation • Provision of patients' medicine history on admission to hospital (to facilitate in hospital medicine reconciliation)
Keep people out of hospital	• Medicines Adherence Services in Community Pharmacy • Minor ailments service • Medicines Use Review (MUR)

⁷ Pharmacist services are described in detail in the New Zealand National Pharmacist Services Framework 2014. Pharmaceutical Society of New Zealand.

Principle	Indicative community pharmacy services to support the principle ⁷
	- Medicines Therapy Assessment (MTA) - Comprehensive Medicine Management (CMM)
Support the development of advanced practice	- Community Pharmacy Anticoagulation Management Service (CPAMS) - Community Pharmacy Gout Management Service - Medicines Therapy Assessment (MTA) - Comprehensive Medicine Management (CMM) - Pharmacist prescribers

RECOMMENDATIONS

- To work with the national Community Pharmacy Services Agreement (CPSA) programme and the Pharmaceutical Society of New Zealand (PSNZ) to develop quality standards for community pharmacy services to ensure high quality care, value for money patient, whānau and hapū-centred services that respect culture and privacy.
- A phased approach is to be taken:

Phase One (2016-2017)

- Develop effective partnerships working with other key services such as District Nursing and engAGE
- Implement the New Zealand ePrescription Service (NZePS) across Hawke's Bay (Hawke's Bay is an early adopter site)
- Provide access to electronic discharge summaries and laboratory results to Hawke's Bay community pharmacists
- Introduce the MediMap / Tonic 1Chart patient management systems into Hawke's Bay residential facilities
- Further roll out Medicine Use Review (MUR) services
- Further roll out the Community Pharmacy Anticoagulation Management Service (CPAMS)
- Further roll out Clinical Pharmacist Facilitation across Hawke's Bay
- Closer working with Health Hawke's Bay PHO with governance and service development

Phase Two (2017-2019)

- Align Hawke's Bay's community pharmacy strategy with the Minister's Pharmacy Action Plan
- Integration of Community Pharmacy within health and social care networks
- Better partnerships and communication between pharmacists and doctors
- Community pharmacists are full partners at the Alliancing table
- The introduction of an electronic medicines data repository (e.g. CliniSafe)
- Introduction of a formalised triage of minor ailments with access to a funded minor ailments scheme or referral on to their GP / other, thus assisting with acute demand management and supporting self-care
- Development of advanced practice for community pharmacists, e.g. MUR, MTA
- More Pharmacist Prescribers
- To explore the appetite for restricting market entry by new community pharmacies into the Hawke's Bay region through minimum quality standards, to ensure high quality

community pharmacy services.⁸ To investigate the development of a quality framework to ensure safe, value for money, patient-centric service delivery. These standards could include having an appropriate number of pharmacists per pharmacy to encourage enhanced pharmacist services, and appropriate facilities considerations such as private consulting rooms, hearing aid induction loops or wheel chair access. Such quality standards would complement and enhance the existing Pharmacy Service Standards, Medicines Control Audits and Ministry of Health pharmacy licencing.

- Sustainable funding streams for community pharmacy, within the Community Pharmacy Services Agreement (CPSA) framework and local independent funding pathways

Phase Three (2019-2020)

- Working together in the broader healthcare team, One Team, across health and social care networks to ensure that there is no fragmentation of patient care
- Working with people as health navigators and helping to improve health literacy to support timely access to health services
- Further automation of pharmacies operation activities
- The introduction of ePrescribing into the hospital system to interface with the NZePS

Community based pharmacy services will add value to the Hawke's Bay health system providing a greater contribution to the vision of a Healthy Hawke's Bay – te hauora o te matau-ā-māui

⁸ DHBs are prohibited under the Commerce Act from using their market power as purchasers for an anti-competitive purpose. Hence, it would be illegal for a DHB to deny entry by a new pharmacy by withholding from it a community pharmacy services agreement (CPSA), for the purpose of protecting the competitive position of existing providers.

Appendix 1 - Glossary

CPAMS	Community Pharmacy Anti-Coagulation Management Service The CPAM Service manages patients on warfarin. Patients' INR (a measure of the degree of blood clotting) is measured using point-of-care testing by accredited community pharmacists. Following a finger prick sample of blood analysed in a machine to determine the INR result, the pharmacist adjusts the next dose of warfarin according to agreed Standing Orders and an approved on-line computer decision-support system which calculates the dose and date of the next test. The test result is available within minutes and the patient receives printed treatment advice immediately on the dose they should take. The GP is automatically informed of each test and the recommended dose. Reference: 1. Harper P, Harper J and Hill C. An audit of anticoagulant management to assess anticoagulant control using decision support software. BMJ Open 2014; 4: e005864. doi:10.1136/bmjopen-2014-005864.
CPSA	Community Pharmacy Services Agreement - the national contract for Community Pharmacy services. The CPSA is the contract between individual District Health Boards (DHB) and each individual pharmacy throughout New Zealand for the provision of pharmacy services. Introduced in July 2012, the CPSA reflected a shift to a patient centred pharmacy delivery model which encourages integration between health professionals has involved engagement and collaboration between community pharmacies, District Health Boards, PHARMAC and the wider health sector.
CMM¹⁴	Comprehensive Medicines Management A service to optimise the management of prescribed medications. An autonomous pharmacist integrated in the healthcare team providing support and advice on all matters related to the medication management of patients with complex clinical needs. May or may not include Pharmacist Prescriber Scope of Practice.
Gout management service	Where a patient's uric acid levels are measured using finger prick point-of-care testing, and in collaboration with the patients' general practitioners, under Standing Order, the pharmacist adjusts the patients' doses of allopurinol. This model is not yet proven; a proof of concept is being undertaken in Northland.
LTC⁹	Long Term Conditions Optimise supply and use of medications. The Community Pharmacy LTC Service is designed to support patients with identified medicine adherence issues (unintentional non-adherence, e.g. forgetfulness) become self-managing through the delivery of a pharmacist medicines management service. Patients must meet eligibility criteria to be registered in this service. Pharmacists assist in the focussed management of eligible patients to optimise the supply and use of prescribed medicines and to support adherence.

⁹ Pharmaceutical Society of New Zealand. New Zealand National Pharmacist Services Framework. Pharmaceutical Society of New Zealand, Wellington, 2014.

Minor ailments service

The provision of funded pharmaceuticals to treat a range of common 'minor' illnesses without a prescription (e.g. for the treatment of head lice, emergency hormonal contraception [EHC], smoking cessation, diarrhoea, constipation, acne). The service effectively supports the management of unscheduled care and helps keep patients out of hospital and general practice.

References:

1. Tranter B and Davis M. Maximising fresh opportunities through prudent pharmaceutical care. Welsh Government. 2015.
2. The Scottish Government. The New NHS Minor Ailment Service at Your Community Pharmacy. <http://www.gov.scot/Publications/2006/06/26102829/1>.

MUR¹⁴

Medicines Use Review

MUR is a comprehensive, systematic, evaluation of a patient's understanding of and adherence to prescribed medication treatment.

The Pharmacist aims to improve understanding of and adherence to medicines; identifying and addressing factors linked to non-adherence behaviours as well as minimising pharmaceutical waste.

MUR addresses intentional non-adherence. Interventions are longer and more complex than LTC addressing a person's values and beliefs in medicines and health literacy.

MTA¹⁴

Medicines Therapy Assessment

Used to optimise medication efficacy, MTA is a systematic, patient-centred clinical assessment of all medicines currently taken by a patient, identifying, resolving and preventing medication-related problems as well as optimising the effectiveness of medication treatment.

References:

1. Love T and Gullery C. Pharmacist Medicines Management Review Services. A case for Medicines Use Review (MUR) and Medicines Therapy Assessment. Pharmaceutical Society of New Zealand.
2. The Sapere Report. Love T and Wright C. Impact of Medicine Therapy Assessment. Pharmaceutical Society of New Zealand. 5 December 2013.

Appendix 2

National activity that informs the strategy for Community Based Pharmacy Services in Hawke's Bay 2016-2020

1. Vision 2020 - Partnership in Care - Pharmacists and Doctors Working Together

https://www.psnz.org.nz/Folder?Action=View%20File&Folder_id=86&File=PartnershipforCare2020PharmacistsandDoctorsWorkingTogether2014VisionPrinter.pdf

- An agreement between the NZ Medical Association (NZMA) and the Pharmaceutical Society of New Zealand (PSNZ).
- Provides a framework for better communication between the professional bodies and working together.
- Provides six vision areas for which the professions will identify five-year objectives and goals:
  1. The Patient's Healthcare Journey
  2. Health Professional Roles
  3. A Shared Working Environment
  4. Services
  5. Professional Competence and Ethics
  6. Payment Arrangements for Services
- The objectives and goals are to be agreed and implemented between 2015 and 2020.

2. The NZ National Pharmacist Services Framework

https://www.psnz.org.nz/Folder?Action=View%20File&Folder_id=86&File=PSNZPharmacistServicesFramework2014FINAL.pdf

- Initially developed in 2007 by District Health Boards NZ (DHBNZ) with review and ownership handed over to the Pharmaceutical Society of NZ (PSNZ).
- Provides detail on the structure and aims of the services available from pharmacists to improve patient care and outcomes; including medicines use review (MUR), Medicines Therapy Assessment (MTA), comprehensive medicines management (CMM), Community Pharmacy Anti-Coagulation Management (CPAM), a framework for new services and evidence based hospital pharmacist services.
- This document serves to describe the opportunities available for the profession to meet the objectives of the Medicines Strategy.

3. Implementing Medicines New Zealand 2015-2020

<http://www.health.govt.nz/publication/implementing-medicines-new-zealand-2015-2020>

- The third refresh of the action plan supports the New Zealand Medicines Strategy, *Medicines New Zealand* (December 2007).
- Shows what can and will be done to deliver *Medicines New Zealand* outcomes.
- The three core outcomes for the medicines system as set out in the Strategy are:
  - o access
  - o optimal use
  - o quality, safety and efficacy
- Implementing Medicines New Zealand is about the changes required to deliver on Medicines New Zealand. This action plan supports the achievement of the Strategy's outcomes by:
  - o making the most of every point of care
  - o enabling shared care through an integrated health care team
  - o optimal use of antimicrobials
  - o empowering individuals and families/whānau to manage their own medicines and health
  - o optimal medicines use in older people and those with long-term conditions

- o competent and responsive prescribers
- o removing barriers to access
- This will be done by harnessing the collective efforts of all health professionals, including those working in community organisations, primary health care, pharmacies, hospitals, rest homes and end-of-life care.

4. The Pharmacy Action Plan 2016-2020

<https://www.health.govt.nz/system/files/documents/publications/pharmacy-action-plan-2016-to-2020.pdf>

- The Pharmacy Action Plan was driven by the need to provide sustainable, high-quality pharmacist services in a complex and evolving environment. It emphasises the need for integration as well as coherence so that all are clear on the role they have to play in making this desired future a reality.
- The Pharmacy Action Plan is divided into four 'focus areas' and four 'enablers'.

Focus areas

1. Population and personal health has a people powered focus. Pharmacists will provide public health interventions that support people to manage and have the best health and wellbeing throughout their lives, and to easily access support close to their home. For example, pharmacists contributing to screening for and reduction of diabetes and obesity and improved population health literacy.
2. Medicines management services see pharmacists providing value and high performance: pharmacists will work collaboratively as part of an integrated team contributing to better health outcomes through the delivery of a comprehensive range of medicines management services. For example, mobile pharmacist services improving medicines adherence and pharmacists working in general practice teams to address polypharmacy.
3. Minor ailments and referral sees services being delivered closer to home: people will have equitable and timely access to self-care advice, treatment of minor ailments, acute demand triage and appropriate referral to enable early intervention and disease prevention. For example emergency department triage services and community based minor ailment services for priority populations.
4. Dispensing and supply services: more effective use of the pharmacist workforce and smart systems will see the reconfiguration of the dispensing process ensuring an accessible, sustainable and efficient medicines supply chain. Optimal use of smart systems will ensure timely and equitable access to these services for all New Zealanders wherever they live. For example, checking technicians making pharmacists more accessible to New Zealanders and greater use of electronic prescribing systems in aged care to reduce waste and provide more integrated services.

Key Enablers

1. Leadership is a key component of our one team vision: a cohesive team approach to leadership is needed within the pharmacy profession and across the health and disability sector. The way forward requires all to think and act differently, to clarify leadership roles and look to how interactions with others happen to focus efforts to improve the system. Active partnerships with people and communities are needed at all levels.
2. Smart systems: technology will be easy to access and contribute to improved health outcomes. The actions here are critical enablers, strongly align with the National IT strategy and see a high-performing system that people have confidence in.
3. Workforce: the capacity and skills of the existing pharmacist workforce will be fully utilised while growing future capability to deliver a wider range of integrated services in a wider range of settings. Culturally competent practice is key, in particular acknowledging the special relationship and commitment to partnership, protection and participation with Maori under the Treaty of Waitangi.

4. **Regulation:** a robust regulatory regime is a prerequisite for delivering high-quality integrated health services to people that are safe and effective. To achieve this vision the government is ensuring that the law enables rather than hinders this desired future direction.

5. New Zealand Health Strategy

New Zealand Health Strategy was refreshed in April 2016. The Strategy provides the overarching framework within which the Community Based Pharmacy Services in Hawke's Bay 2016-2020 strategy must function.

The Strategy has two parts.

- New Zealand Health Strategy: Future direction
http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-future-direction-apr16_1.pdf
- New Zealand Health Strategy: Roadmap of actions 2016
http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-roadmap-of-actions-2016-apr16_1.pdf

The Strategy has five themes:

- People powered – understanding people's needs and wants, partnering with them, improving their health literacy, supporting people to navigate the system and encouraging and empowering them to manage their own health and wellbeing.
- Closer to home – the right services, delivered closer to where people live, learn, work and play and a focus on wellness and prevention of long-term conditions.
- Value and high performance – focusing on improved performance and outcomes, transparent use of information, strong performance measurement, striving for equity of health outcomes, integrated operating models and the use of investment approaches to address complex health and social issues.
- One team – operating as a team in a high-trust system, making the best use of our workforce, leadership and talent development and strengthening the roles of people, families, whanau and communities.
- Smart system – information being reliable, data and smart information improving evidence based decisions, standardised technology allowing us to easily make efficient changes and being able to take advantage of opportunities that new and emerging technologies present.



6. Community Pharmacy Service Agreement (CPSA) Negotiations

- DHBs CPSA (contract) with individual community pharmacies for the provision of pharmaceutical services to the DHB population.
- The CPSA is a national agreement, implemented nationally.
- In 2012 there was a paradigm shift in the contract negotiations with a move away from fee for service, medicine supply to patient centric services (e.g. medicines adherence management).
- The contract has not yet achieved its end goal so further development is required. To allow this to occur the existing contract is to be rolled over for another 12 months, though a contract extension. It is a one-year extension with provision for an additional 'up to' 12 months should this be needed to accommodate time for the next CPSA to be ready, as we all recognise that more time is needed to develop this.

7. Alliancing (with the initiation of the Urgent Care SLAT)

- DHBs have made a commitment to community pharmacy to be included 'round the Alliancing table'.
- Hawke's Bay's Alliancing model does not fit the standard Ministry envisioned model.
- In Hawke's Bay pharmacy has been involved in 'alliancing (albeit to a limited extent) through Clinical Council (Chief Pharmacist), clinical pathway development and the Urgent Care Stakeholder Group (a Service Level Alliance Team [SLAT]).
- Further work is planned to include community pharmacy in local governance and service development.

8. Community Pharmacy's Relationship with Health Hawke's Bay PHO

- Health Hawke's Bay (HHB) has recently appointed a community pharmacist advisor to their Clinical Advisory and Governance Committee.
- This clinical governance role provides an opportunity for community pharmacy to work more closely with general practice through the PHO.

Appendix 3

Feedback Received

We appreciate all of the feedback that we received and acknowledge the time people took to respond. We received feedback through five submissions.

All feedback supports the general intention of the proposal. Submitters mentioned the gaps between the current state and the vision of the strategic direction. The following themes were raised in relation to this proposal:

Theme	Comment
Challenged the current CPSA contract as having cost control as the underlying principle. Also commented that current contract model has been a barrier to innovative change.	Hawke's Bay DHB acknowledges that funding model will need to change.
Community Pharmacist Facilitators are funded through community pharmacy budget.	Community Pharmacists Facilitators are not funded through CPSA budget. Hawke's Bay DHB invested new money for these services.
Pointed out the role and the benefits of having small size pharmacies. There were also views on having consolidated bigger pharmacies.	Hawke's Bay DHB notes that one size does not fit all and would support having flexible sizes of local pharmacies. To meet the needs of our population in the future there will be a need for pharmacists to have a greater role in community teams.
Commented on new and innovative community pharmacy services already offered by other DHBs.	Hawke's Bay DHB will review these new and innovative solutions that are already in place at other DHBs and implement these locally where possible.
Questioned whether Hawke's Bay would consider introducing the following services with adequate funding: • Minor ailments services, • Smoking cessation nicotine replacement therapy, • ECP, and • Gout management.	Currently, there are barriers to introducing number of these services. To ensure Hawke's Bay populations getting the required services Hawke's Bay DHB is committed to work towards eliminating these barriers.
Called attention to the limited relationship between the community pharmacies, DHB and the primary care organisations. There was a suggestion for community pharmacy engagement and representation on DHB/Alliance governance and service development groups.	Hawke's Bay DHB support community pharmacy working as one team in the health sector.
Criticised community pharmacies as disjointed and adversarial at present. There is no representative body for community pharmacy in Hawke's Bay.	Hawke's Bay DHB is supportive of having a local community pharmacy representative body.
Commended Phase Three of the recommendations which is light in detail and suggested wide consultation and discussion during this phase.	Noted. Hawke's Bay DHB acknowledges further work is needed and planning on working with the sector to further develop this phase.
Asked to consider adding strategies for how community based pharmacy services will focus on health outcomes and support the priority populations of Hawke's Bay DHB.	Noted and Hawke's Bay DHB will work with the sector to develop outcome based services with key focus in priority populations.



TRAVEL PLAN UPDATE

Presentation

 HAWKE'S BAY District Health Board Whakawāteatia	HBDHB Transform & Sustain Strategic Dashboard Q4 Apr-Jun 2016 92
	For the attention of: HBDHB Board
Document Owner:	Tim Evans, GM Planning Informatics and Finance
Document Author(s):	Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	August 2016
Consideration:	For Monitoring

Background

The Transform and Sustain Strategic dashboard has been developed to measure our Vision and Values and progress towards long term Transform and Sustain strategic objectives. In December FRAC and the Board endorsed the reorganisation of strategic non-financial reporting to better reflect the strategic roles between the two committees. It was agreed that the Transform and Sustain Dashboard would be presented to the Board quarterly.

Current results are colour coded to **Red** if significantly below target, **Amber** if below target but close to achieving target and **Green** if achieving target. There is also a trend line against each vital sign and dimension, this shows the trend over time and how each indicator is tracking to target. As this is the first issue of the dashboard not all indicators have a clear trend line but in future issues the trend line will start to become clearer and help to predict future trajectories.

Provided on the back of the dashboard are definitions of each measure.

Focus Areas

This quarter, for the first time, we have reported on the 'live healthier and longer lives' vital sign 'difference in Maori death rates (below 50 years of age)'. The 2015 calendar year result is 8.4% (target <14%) which is a significant improvement on the baseline 16.3% (2014 calendar year). In 2015 Maori deaths under the age of 50 years were 12% (20.5% in 2014), non-Maori deaths under the age of 50 years were 3.7% (4.2% in 2014). There are between 1,200 and 1,400 death per annum in the Hawkes Bay area. This result is very pleasing, further analysis will be done and included in next quarters report.

It has been agreed by FRAC this framework is to be used as a tool for Board (through FRAC discussion items) to focus on specific areas where the dashboard indicates poor performance or progress.

Items on future FRAC workplan that are actions linked to strategic dashboard indicators are:

- Case Weight per Health Service FTE – August
- Buildings Infrastructure Efficiency – September

Previous FRAC Discussion: Faster Cancer Treatment

In May 2016 Paula Jones (Service Director – Acute and Medical Services) and Mandy Robinson (Manager – Cancer Services) presented to FRAC. They tabled the following points.

- Issues and Key Focus Areas: Governance, Clinical Co-ordination, Monitoring, Access to Diagnostics
- Governance: FCT Governance Group, Tumour stream clinical leads/support staff
- Clinical Co-ordination: Whole of team approach with Tumour Stream Clinical Lead, Cancer Nurse Co-ordinators, Cancer Tracker and MDM coordinator, Clinical Nurse Specialists and Specialty Clinical Nurses, (neurology SCN to be recruited by July 2016).
- Monitoring: Daily Tracker report, Prospective monitoring to be strengthened, Retrospective analysis – audit/quality improvement.
- Access to Diagnostics: Radiology/Laboratory Guidelines, CT Capacity, Laboratory/Histology recruitment, Regional Collaboration for outsourced diagnostics.

It was noted that the indicator '85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016' (increases to 90% by June 2017).

Compliance statistics (January 2015 to April 2016) the key issues and key focus areas namely: governance (a focus on reorganising leadership); clinical coordination; monitoring; and, access to diagnostics were discussed. The COO advised on improved performance for April 2016 at 73% (Quarter 3). Quarter 4 data (January 2016 to July 2016) will be based on six month rolling data. A general national decline in the months of December and January was noted.

A Discussion was held regarding variation issues and the aim of increasing monthly volumes (19-25 cases), patient identification, correct patient process and alignment to NPF.

On access to radiology issues, the COO reported that the MoH is aware of DHBs' competing priorities. HBDHB's outsourcing for EBUS (Endobronchial Ultrasound) to Waikato DHB, and PET (Positron Emission Tomography) scans to Pacific Radiology, Wellington was noted.

Laboratory and Radiology guidelines are to be recommended (via the FCT Governance Group) to Clinical Council in the near future.

HEALTHY
HAWKE'S BAY

NZ TRIPLE AIM

TRANSFORM
& SUSTAIN

VITAL SIGNS

Responding to our population

Patient experience						Resource sustainability						Live healthier and longer lives					
		Baseline	Previous	Current	Target			Baseline	Previous	Current	Target			Baseline	Previous	Current	Target
Patient experience	Patient Experience Survey Score	8.5	8.7	8.7	≥ 8.5	Financial Surplus DHB \$'000		\$188		\$376	≥ \$0		Difference in Maori Death rates (Below 50 years of age)	16.3%	16.3%	8.4%	≤ 14%
						Breakeven PHO				On track							
		*Communication															
Better access to specialist outpatients	Did not attend (DNA) rate across first specialist assessments	6.10%	7.80%	7.40%	≤ 7.50%	Older people living independently	Over 85s Living Independently	78.4%	78.1%	78.4%	≥ 80.0%		Infant Mortality Rate	4.41	4.41	2.79	≤ 5
A safer hospital	Standardised Hospital Mortality Rate	101	108	103	≤ 100	Improved hospital workforce productivity	Case Weight per Health Service FTE	3.04	3.158	3.12	≥ 3.08		Maori All Cause Mortality Rate (less than 75 years and per 100,000 population)	469	469	-	≤ 310
More Very High Quality General Practices	General Practices with Cornerstone Accreditation	50.0%	86.0%	86.0%	≥ 80.0%	Better staff engagement	Staff Engagement Survey Satisfaction Rate	76.0%	76.0%	-	≥ 76.0%		Maori Children Obesity Rate	7.9%	9.3%	10.5%	≤ 8%
All General Practices are Demonstrably Good	General Practices that meet Foundation Standards	0.0%	64.0%	71.0%	≥ 100.0%	More Efficient Buildings	Buildings Infrastructure Efficiency	2.59%	2.59%	2.7%	≤ 2.41%		Diabetes and Cardiovascular Services Checks	88%	90%	89%	≥ 90%
Reduced readmissions	Hospital Standardised Readmission Rate	7.5%	7.7%	7.7%	≤ 7.4%	Better staff retention	Staff Turn-over	8.10%	9.11%	9.3%	Between 9.5% and 10.5%		Faster cancer treatment	62%	63%	63%	≥ 85%
A culturally responsive workforce	Percentage of DHB Staff Ethnicity who are Māori	11.6%	12.4%	12.5%	≥ 13.9%	Care close to home	Strategic Spending Shift	-0.3%	0.1%	0.4%	≥ 0.2%		Fewer women smoking in pregnancy	44%	44%	44%	≤ 22%
Emergency Department Waits	Patients waiting less than 6 hours in ED	91.5%	93.9%	92.5%	≥ 95.0%	More Treatments Out of Hospital	Ambulatory-sensitive Hospital Admissions	76.0%	73.0%	70.0%	≤ TBC		Reducing Rheumatic Fever	0.6	0.6	1.88	≤ 2

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Board Meeting 31 August 2016 - Transform & Sustain Strategic Dashboard Q4 April-June 2016

	Measure	Definition
Patient Experience	Communication	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
	Partnership	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
	Co-Ordination	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
	Physical and Emotional Needs	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
Better Access to Specialist Outpatients	Did not attend (DNA) rate across first specialist assessments	Patients who do not show up to an outpatient appointment without any prior notice
A Safer Hospital	Standardised Hospital Mortality Rate	Ratio of actual to expected hospital deaths
More Very Higher Quality General Practices	General Practises with Cornerstone Accreditation (Practices with Population >3,142)	GP's with Cornerstone accreditation (CORNERSTONE is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand) it allows GP's to measure themselves against a defined set of standards.
All General Practices are Demonstrably Good	General Practices that meet Foundation Standards	The Foundation Standard represents what is considered to be the minimum legal, professional, and regulatory requirements for general practice
Reduced Readmissions	Hospital Standardised Readmission Rate	Patients re-admitting to the hospital within 28 days of being discharged. MOH target.
A Culturally Responsive Workforce.	Percentage of DHB Staff Ethnicity who are Maori	The % of staff employed at the DHB that identify their ethnicity as Maori
Emergency Department Waits	Patients waiting less than 6h in ED	Health Target. Patients waiting less than 6 hours in the ED department

Resource Sustainability	Financial Surplus DHB Breakeven PHO	\$0 or + variance to budget Financial result = \$breakeven
Older People Living Independently	Over 85s Living Independently	The proportion of 85years who are not living in ARC
Improved Hospital Workforce Productivity	Case Weight per Health Service FTE	Numerator: Total caseweights. Denominator: Total Doctor and Nursing FTE. Improve productivity by either increasing case weights or decreasing
Better Staff Engagement	Staff Engagement Survey Satisfaction Rate	% engaged employees at HBDHB based on the Engagement questions in the staff engagement survey
More Efficient Buildings	Buildings Infrastructure Efficiency	Numerator : Total Infrastructure costs (everything to do with buildings & facility costs e.g. buildings, lease, maintenance, depreciation, rates . Denominator: Infrastructure costs weighted output e.g. service weights which is everything we do e.g. caseweights, contacts, face to face, tests, appointments
Better Staff Retention	Staff Turn-over	Turn-Over of HBDHB employees
Care Closer to Home	Strategic Spending Shift	To shift resources from hospital and IDFs to Primary and Community by 0.5% p.a.
More Treatment Out of Hospital	Ambulatory-sensitive hospitalisations	HBDHB ASH rate relative to the national Rate as a percentage. (the Ministry of health have recently updated the indicator and are currently collecting baseline data. A target will be set as part of the 2016/17 planning process).

Live Healthier and Longer Lives	Premature deaths under 50 years	The number of deaths under the age of 50 as a percentage of all deaths. Gap between Maori and Non-Maori.
Reduced Infant Mortality	Infant Mortality Rate	HB Children who die from any cause under the age of 1 / total number of live births in the year
Fewer Premature Deaths	Maori All Cause Mortality < 75	The age standardised rate of death for Maori people under the age of 75. per 100,000
Healthier Weight	Obesity Rate	Prevalence of Maori children having a B4shcool check who are obese according to the international obesity task force.
More Heart and Diabetes Checks	Better diabetes and cardiovascular services	Health Target. Enrolled people in the PHO who are eligible for a CVD risk assessment who have had a CVD risk recorded within the last 5 years.
Faster Cancer Treatment	Faster Cancer Treatment	62 Day FCT Health Target
Fewer women smoking in pregnancy	Maori Woman Smoking During Pregnancy	% All Maori Women who are recorded as smoking at the birth of their baby.
Reducing Rheumatic Fever	Rheumatic Fever Hospitalisation Rates	Rate per 100,000 TBC

 HAWKE'S BAY District Health Board Whakawāteatia	HBDHB Performance Framework Exceptions Quarter 4 2015/16	93
	HBDHB Quarterly Performance Monitoring Dashboard Quarter 3 2015/16 <i>provided by MoH</i>	
	For the attention of: HBDHB Board	
Document Owner:	Tim Evans, GM Planning Informatics and Finance	
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RECOMMENDATION**That the Board:**

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP). A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described on page 4) to represent this. Detailed information is included for all indicators where the variance to target was greater than 0.5% (indicated on the dashboard as a red cell with a 'U' symbol).

As this report ends June 2016, the results in some instances may vary to those presented in other reports.

BACKGROUND

The National Health Board (NHB) facilitates DHB performance planning and monitoring within the Ministry of Health. DHB non-financial monitoring arrangements operate within wider DHB accountability arrangements including legislative requirements, obligations formalised via Crown Funding Agreements and other contractual requirements, along with formal planning documents agreed with the Minister of Health/Minister of Finance.

ANNUAL PLAN (AP) 2015/2016

The AP is a statutory requirement that includes the key actions and outputs the DHB will deliver in order to meet Government priorities and Health targets. Through the AP, the DHB has formally agreed to deliver on the performance expectations associated with the measures in the NHB-mandated monitoring framework.

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2015/16

The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK

The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

- Achieving Government's priorities and targets (Policy priorities)
- Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)
- Providing quality services efficiently (Ownership/Provider Arm)
- Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

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Percentage of older patients assessed as risk of falling who received individualised care plan that addressed these risks	21

PERFORMANCE HIGHLIGHTS

Achievements

- Improved Access to Elective Surgery. At the end of the quarter the provisional result is 105%.
- Immunisation at 8 months. We have achieved target for Maori and Pacific as well as the total population at 95.2%.
- Secondary mental health service utilisation target was achieved for Total and Maori across all age groups (0-19, 20-64 and 65+)

Areas of Progress

- Shorter waits for non-urgent mental health and addiction services. For the Age group 0-19 we have improved this quarter of last quarter by 7.3% for the <3 week target and by 4.2% for the < 8 week target. (page 11)
- Cervical Screening. There has been a small increase for the total, Pacific and other populations. Maori has remained the same as the previous quarter (page 14).
- Percentage of older patients assessed as risk of falling who received individualised care plan that addressed these risks has increase from 86.3% in the previous quarter to 90.2%, this is still below the target of 98% (page 21)

Areas of Focus

We continue to focus our efforts in order to make gains with particular emphasis in the following areas:

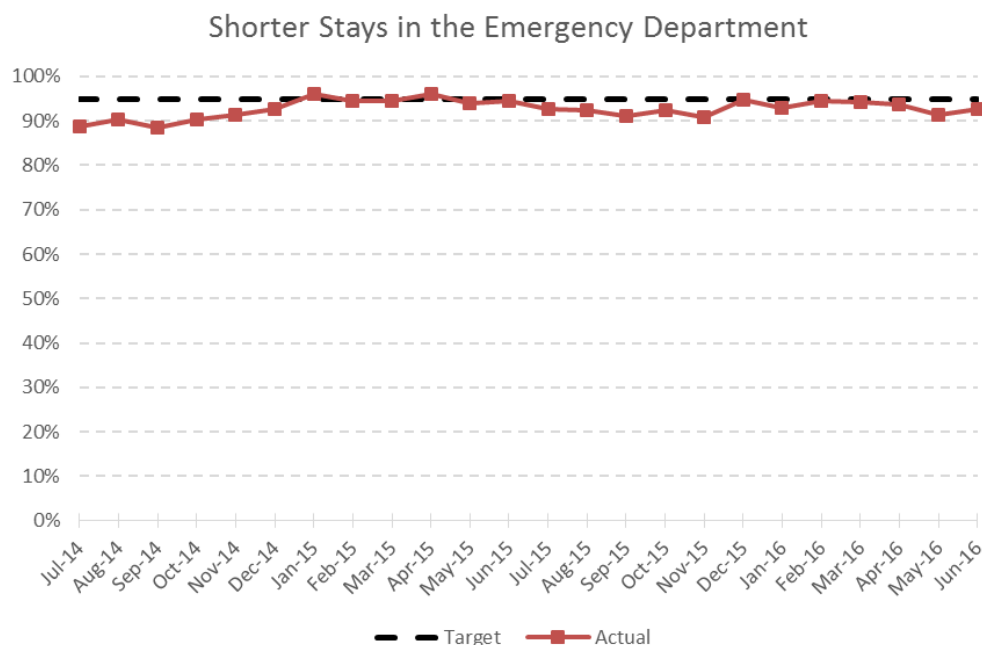
- Shorter Stays in ED. Patients waiting less than 6 hours in ED has decreased slightly from 93.9% to 92.5%, and remains below the target of 95% (page 5)
- More Heart and Diabetes checks. The provisional result provided by the Ministry is 89% which is below the target of 90%. This is the first time we have dropped below target since December 2014. (page 9)
- Diabetes Management. We are below target for 'Patients with a HbA1C score of less than or equal to 64 mmol/mol' for all ethnicities with Total 42.8% and Maori 39.8% against a target of 55% (page 13)
- Faster Cancer Treatment. Results have remained constant from the previous quarter to 63.2% and remain below the target of 85%. A program of work is underway to increase the number of patients identified with a high suspicion of cancer at referral. This will enable us to identify more patients with cancer and manage timeframes more effectively (page 6).

DIMENSION 1 – ACHIEVING GOVERNMENT PRIORITIES AND TARGETS**Health Target: Shorter stays in emergency departments**

95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Baseline ¹	Previous result ²	Actual to Date ³	Target 2015/16	Trend direction
91.5%	93.9% (U)	92.5% (U)	≥95%	▼

Please note: Data presented in the graph are monthly results, whilst the data in the result section above ('Previous result' and 'Actual to date') are for a 3 month period.

**Comments:**

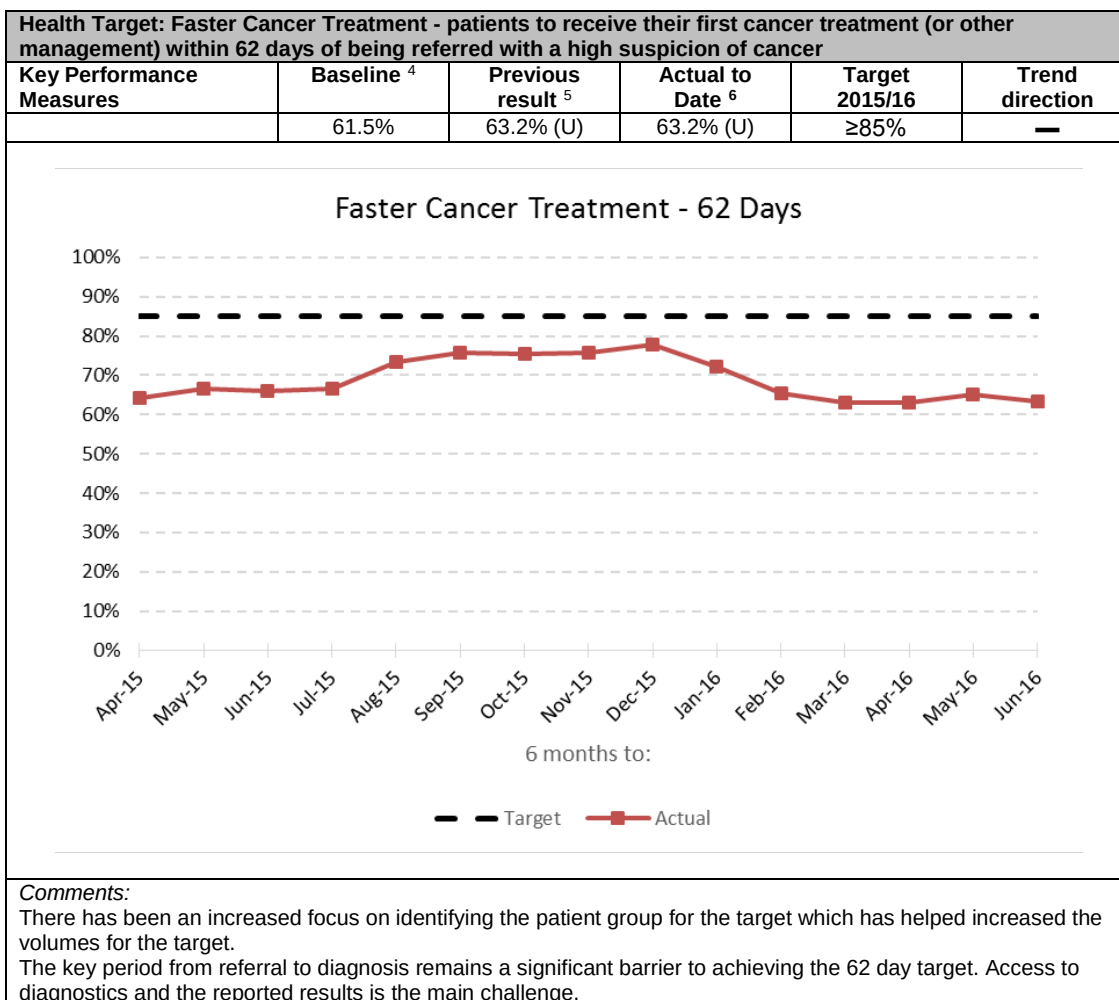
In order to understand breaches there have been Improvements in daily breach reporting systems to further explore reasons for breaches. There has been a reconfiguration of the ED front of house which is nearing completion, this will improve initiation of flow/care processes and assessment for people in the waiting room. Also the reconfiguration has resulted in additional treatment/assessment bays, next will come changing the model of care and nursing resource allocated to this area.

A pilot has commenced between ED and Primary Care to identify and case manage "frequent flyers" to ED through re-engagement with General Practice and the development of integrated care plans for the patient group. Hawkes Bay DHB has engaged the Francis Group and Dr Ian Sturgess to work with the ED, AAU and General Medicine to assist with optimising acute patient flow work stream.

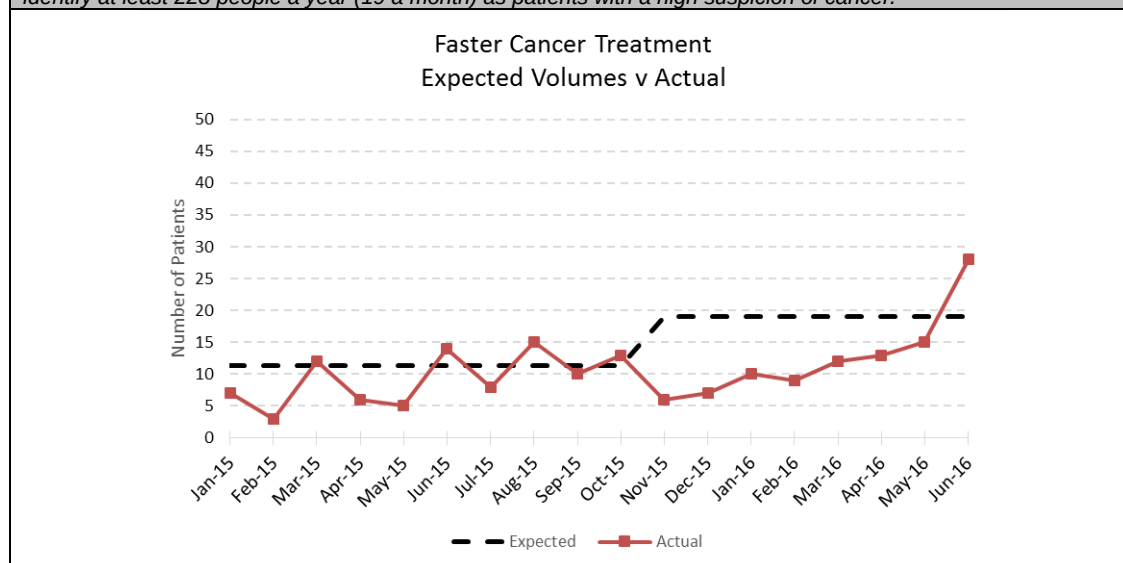
¹ October to December 2014

² January to March 2016

³ April to June 2016



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



⁴ 6 months to March 2015

⁵ 6 months to March 2016

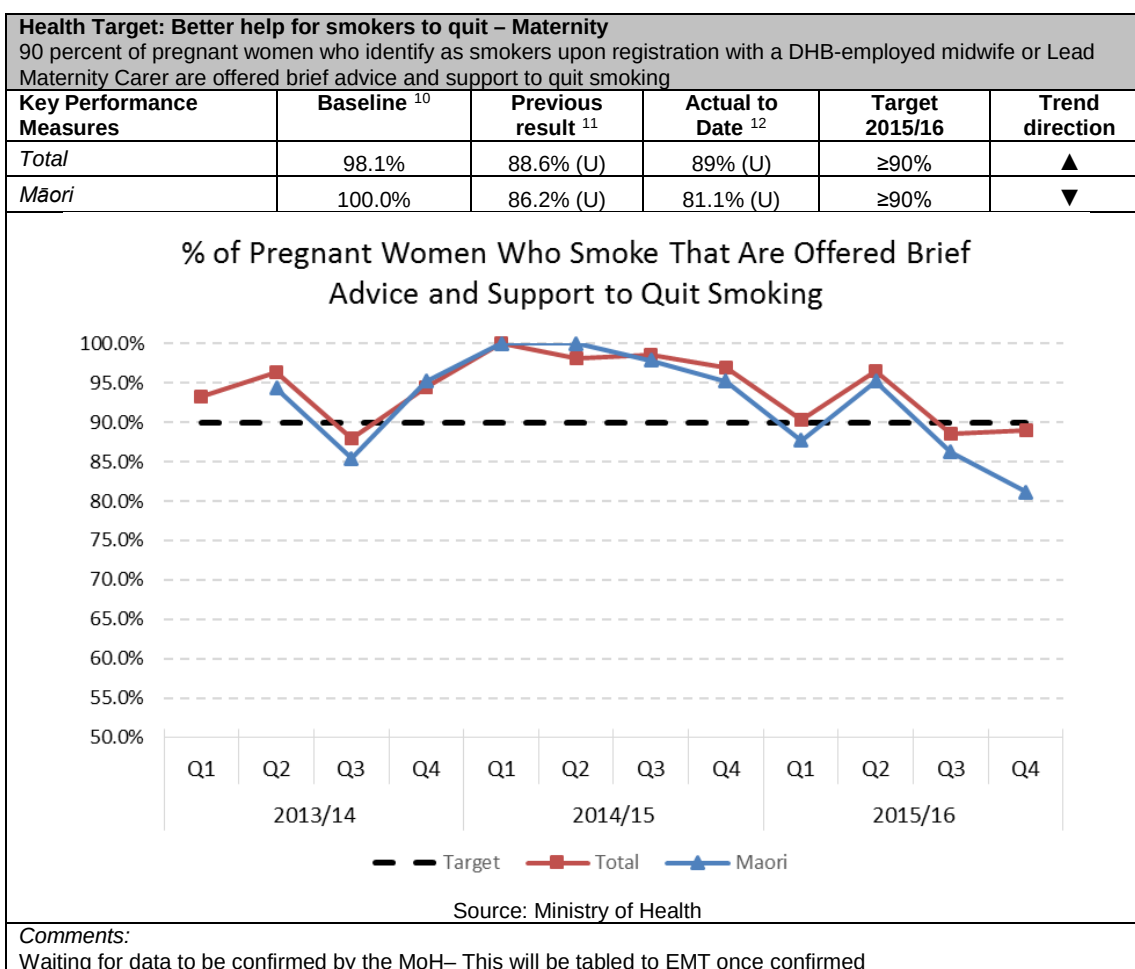
⁶ 6 months to June 2016

Health Target: Better help for smokers to quit – Primary Care 90% of patients who smoke are seen by a health practitioner in primary care are offered brief advice and support to quit smoking					
Key Performance Measures	Baseline ⁷	Previous result ⁸	Actual to Date ⁹	Target 2015/16	Trend direction
<i>Total</i>	96.1%	77.6% (U)	81.9% (U)	≥90%	▲
<i>Māori</i>	98.3%	74.5% (U)		≥90%	
<i>Pacific</i>	96.3%	70.7% (U)		≥90%	
<i>Other</i>	96.3%	75.8% (U)		≥90%	
Source: Ministry of Health					
Comments: Waiting for data to be confirmed by the MoH– This will be tabled to EMT once confirmed					

⁷ October to December 2013. Source: DHB Shared Services

⁸ January to March 2016. Source: DHB Shared Services

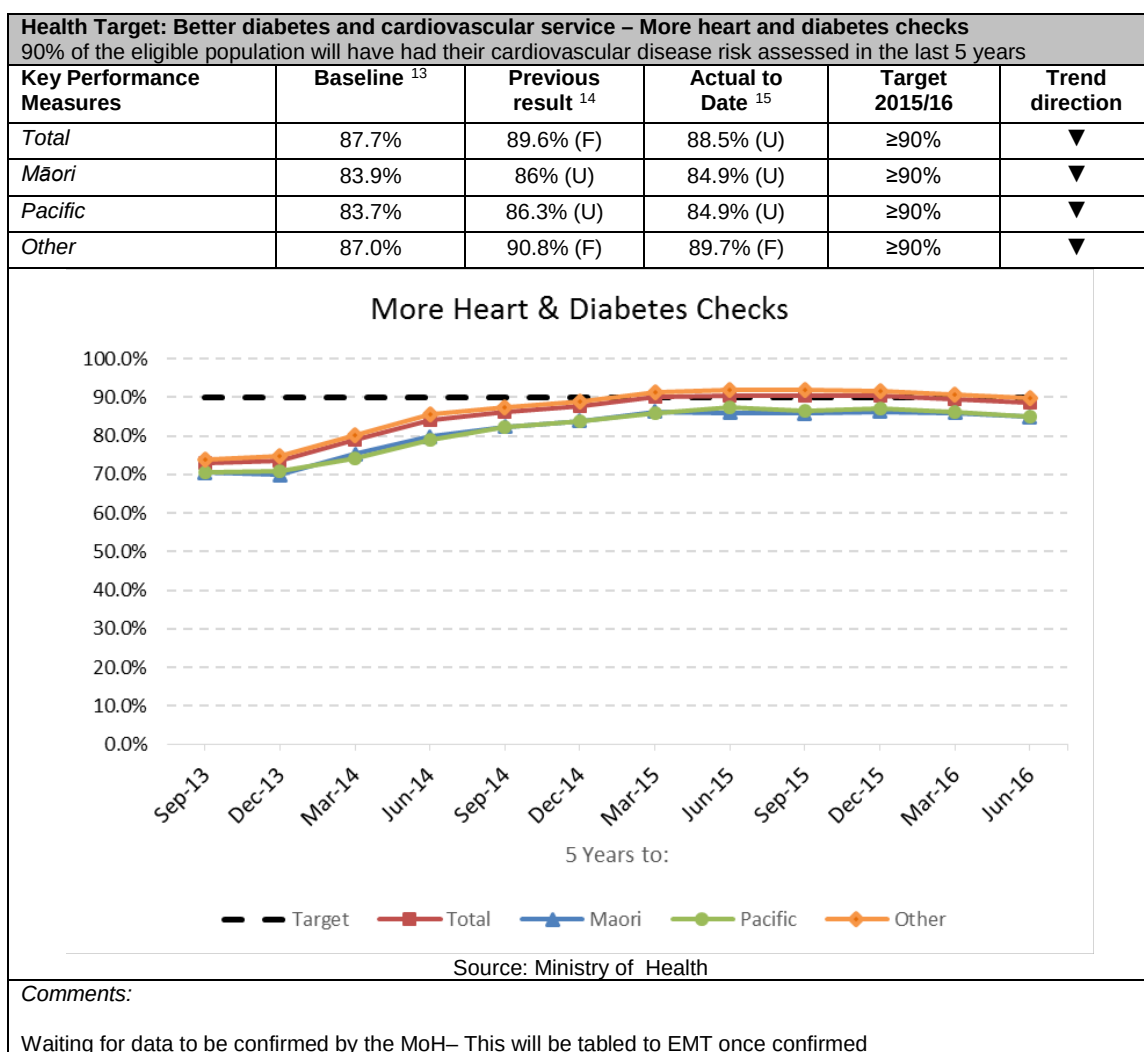
⁹ April to June 2016. Source: DHB Shared Services



¹⁰ October to December 2013. Source: DHB Shared Services

¹¹ January to March 2016. Source: DHB Shared Services

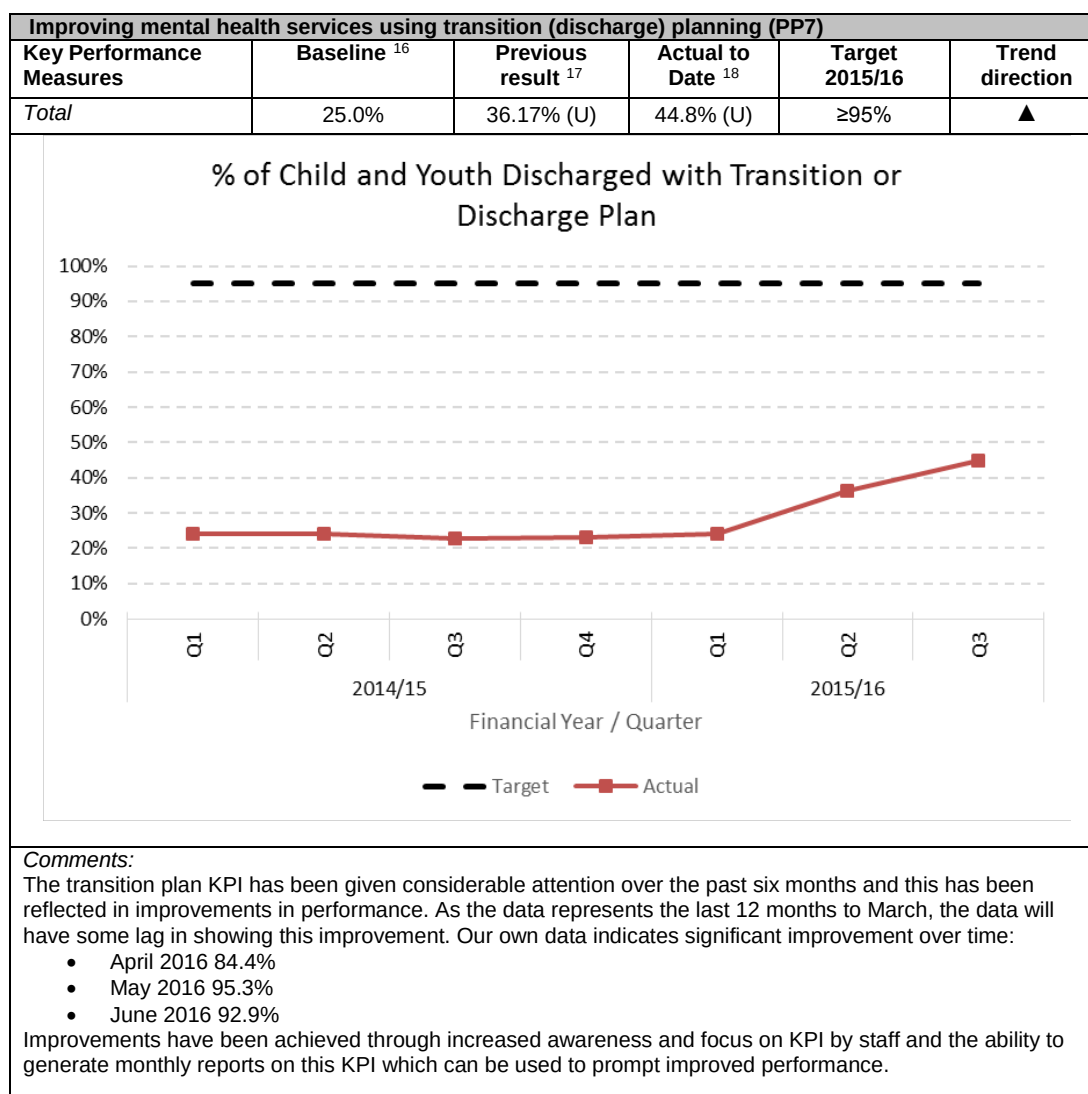
¹² April to June 2016. Source: DHB Shared Services



¹³ October to December 2013. Source: Ministry of Health

¹⁴ January to March 2016. Source: Ministry of Health

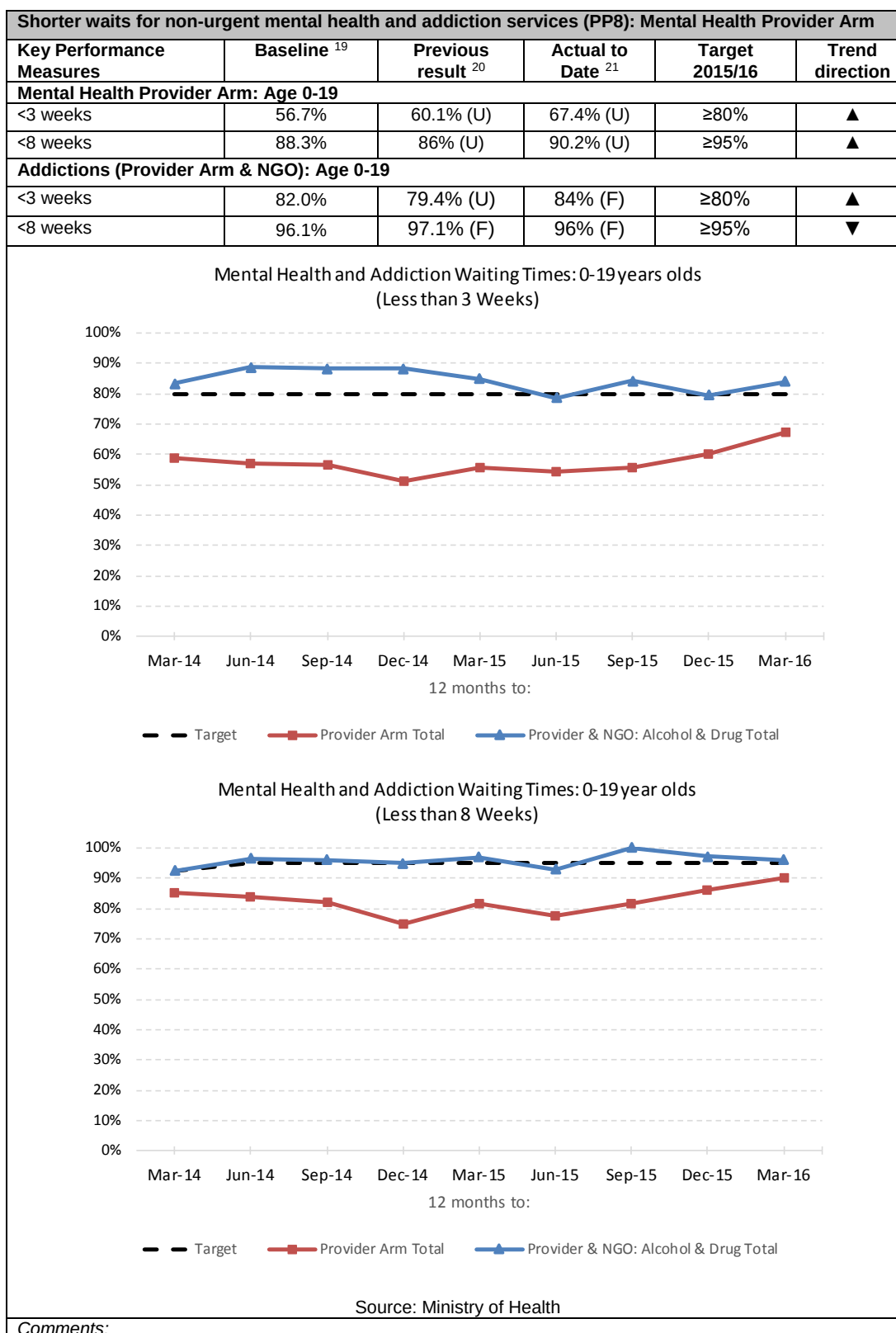
¹⁵ April to June 2016 . Source: Ministry of Health



¹⁶ October 2014 to September 2015.

¹⁷ January to December 2015.

¹⁸ April 2015 to March 2016..



¹⁹ 12 months to December 2014

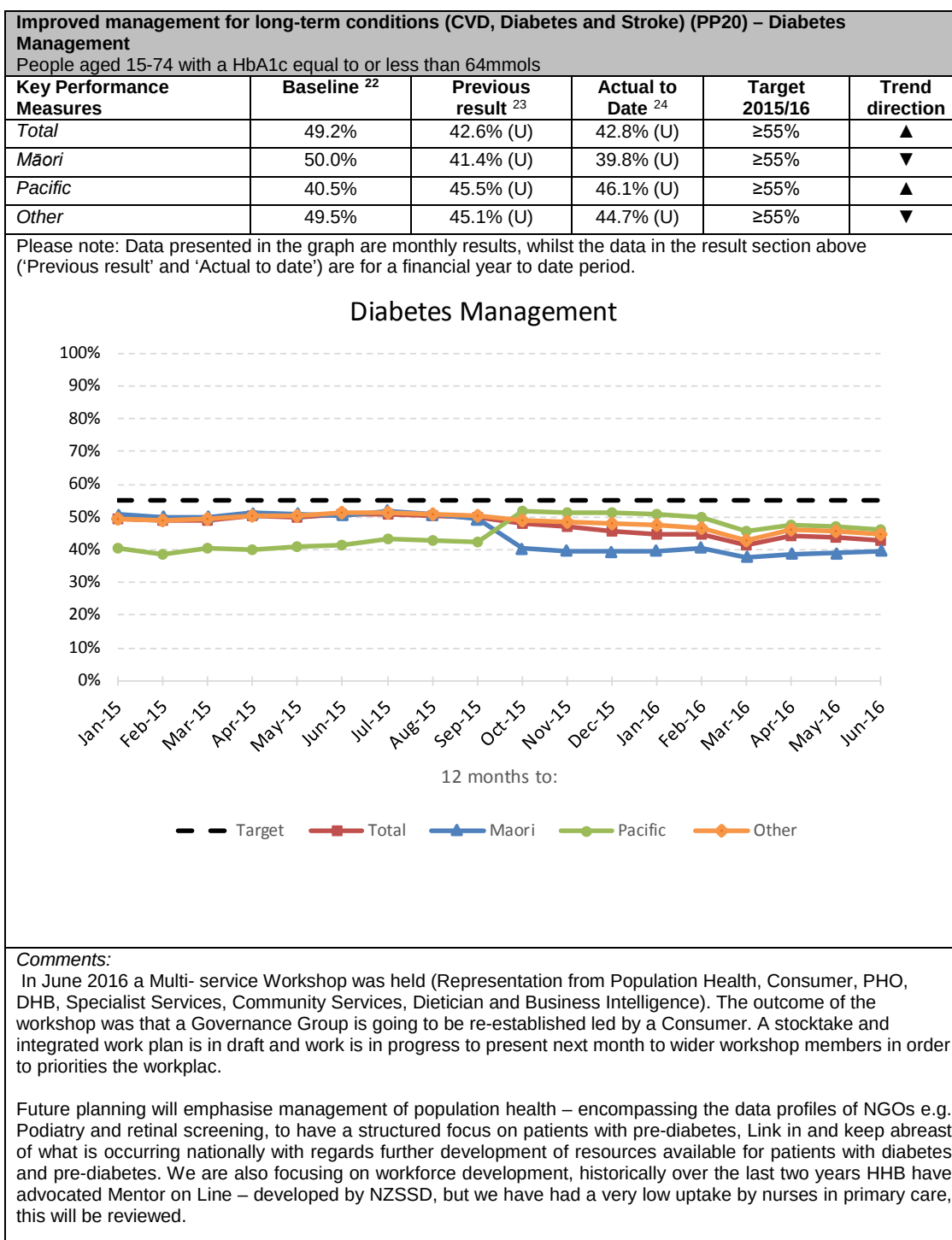
²⁰ 12 months to December 2015

²¹ 12 months to March 2016

The waiting times KPI has been given considerable attention over the past six months, and this has been reflected in improvements in performance. As the data represents the last 12 months to March, the data is will have some lag in showing this improvement. Our own data indicates significant improvement over time:

- April 2016 82% seen within three weeks, 96% within 8 weeks.
- May 2016 89% seen within three weeks, 100% within 8 weeks.
- June 2016 96% seen within three weeks, 100% within 8 weeks.

We anticipate that the 12 month data will begin to reflect the significant improvement over time.



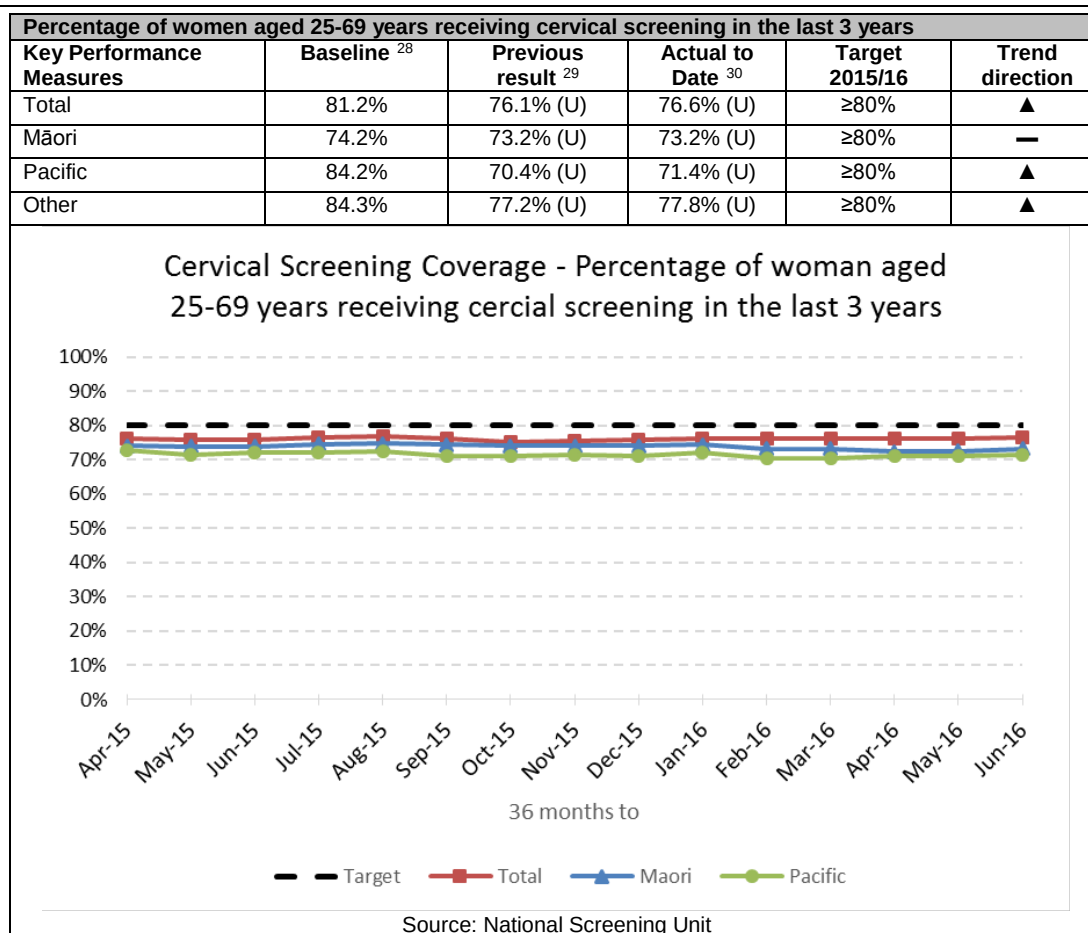
²² January to December 2014

²³ April 2015 to March 2016

²⁴ July 2015 to June 2016

Key Performance Measures	Baseline ²⁵	Previous result ²⁶	Actual to Date ²⁷	Target 2015/16	Trend direction
Improving waiting time for diagnostic services (PP29)					
Coronary Angiography	89.8%	75.6% (U)	0% (*)	≥95%	*
Computed Tomography (CT)	92.6%	93.2% (F)	94.6% (F)	≥90%	▲
Magnetic Resonance Imaging (MRI)	61.3%	46.5% (U)	44.7% (U)	≥80%	▼
Diagnostic Colonoscopy: Urgent	92.6%	91.3% (F)	93.5% (F)	≥75%	▲
Diagnostic Colonoscopy: Non-Urgent	39.7%	37.6% (U)	80.4% (F)	≥60%	▲
Surveillance Colonoscopy	50.7%	96.3% (F)	93.5% (F)	≥60%	▼
<i>Comments:</i> Waiting for data to be confirmed by the MoH– This will be tabled to EMT once confirmed					

DIMENSION 2 – SYSTEM INTEGRATION



²⁵ December 2015.

²⁶ March 2016.

²⁷ June 2016

²⁸ 36 months to 31 December 2014. Source: National Screening Unit

²⁹ 36 months to 31 March 2016. Source: National Screening Unit

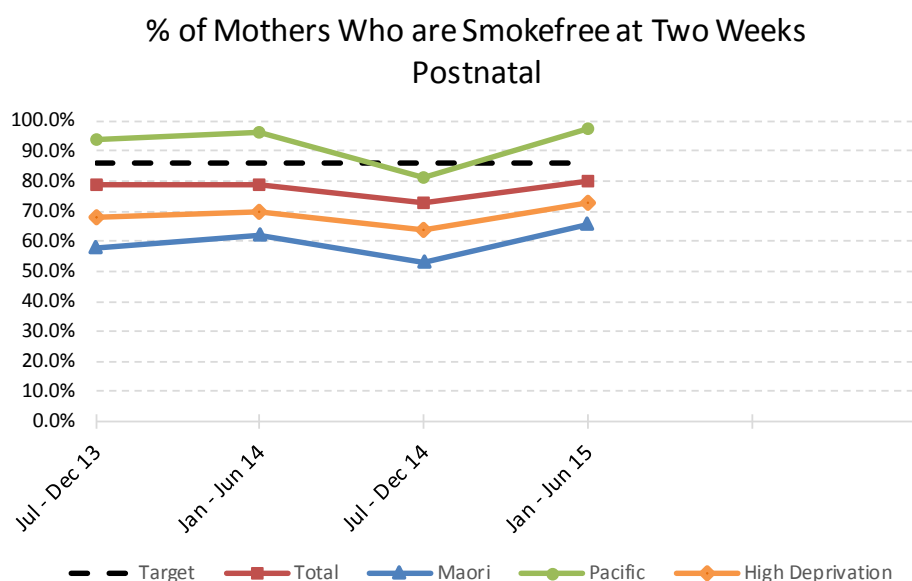
³⁰ 36 months to 31 June 2016. Source: National Screening Unit

Comments:

We are continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition we are contacting Maori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears, so far the uptake has been positive.

DIMENSION 4 – SERVICE PERFORMANCE**PREVENTION SERVICES****Percentage of Pregnant Māori woman that are Smokefree at 2 weeks postnatal**

Ethnicity	Baseline ³¹	Previous result ³²	Actual to Date ³³	Target 2015/16	Trend direction
Total	0.0%	73% (U)	79.9% (U)	≥86%	▲
Māori	58.0%	53% (U)	65.6% (U)	≥86%	▲
Pacific	0.0%	81% (U)	97.7% (F)	≥86%	▲

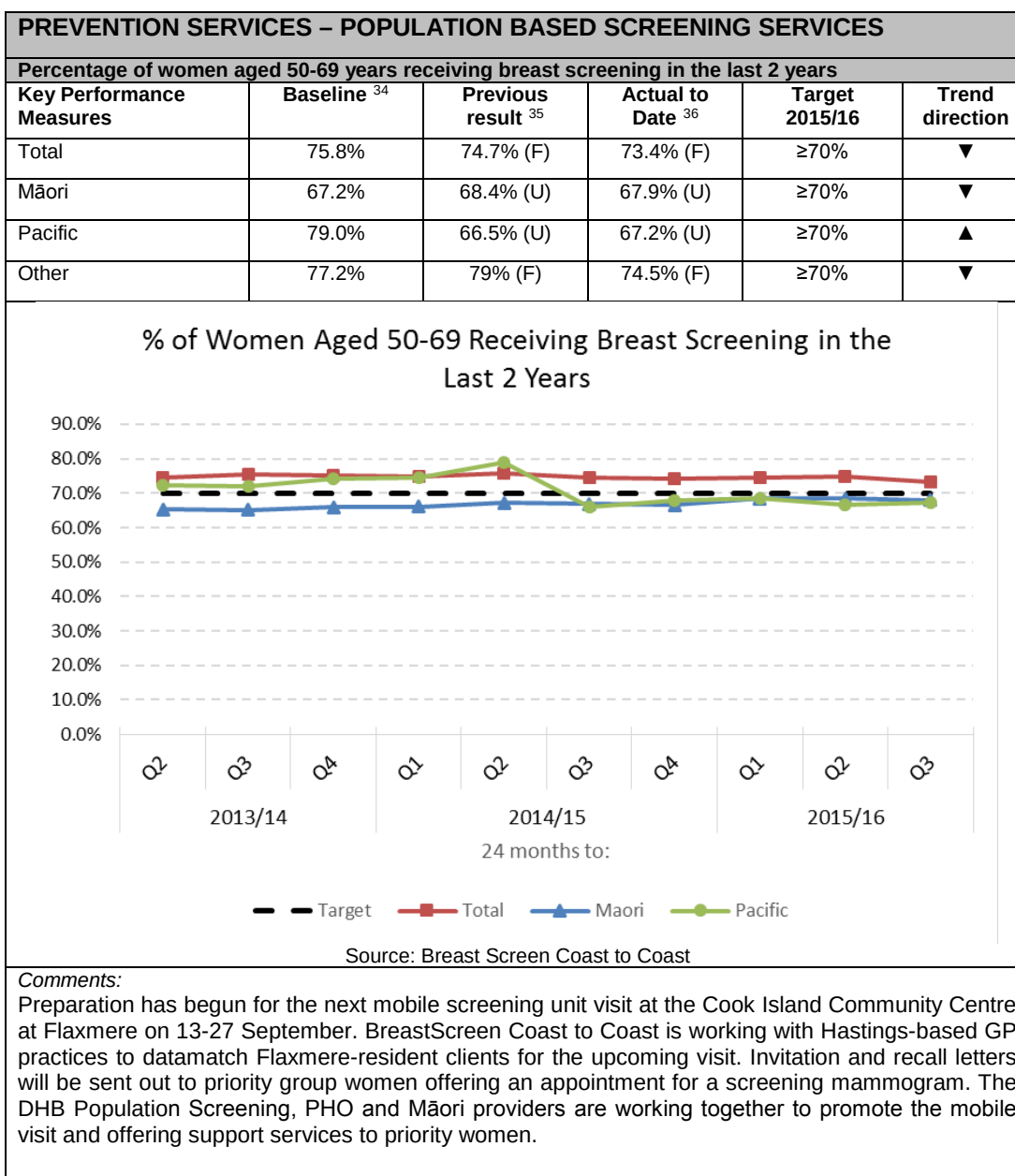
**Comments:**

HBDHB in collaboration with Choices Heretaunga have successfully implemented the Increasing Smokefree Pregnancy Programme (ISPP), HB midwives and LMCs refer pregnant mama who smoke to this programme. On post-partum up to six months of age woman who are still smoking can be referred to ISPP. ISPP supports pregnant and post-partum women to be smokefree at 1, 4, 8 and 12 weeks with a supply of nappies if they have a validated CO monitor reading which confirms they are not smoking. Since 1 July, the programme has expanded to support whānau members who live with pregnant woman, post-partum women and pepe to be smokefree at 1, 4, 8, 12 weeks with grocery vouchers, if they too have a validated CO monitor reading.

³¹ January to June 2014

³² July to December 2014

³³ January to June 2015



³⁴ 24 months to December 2014. Source: Breast Screen Coast to Coast

³⁵ 24 months to December 2015. Source: Breast Screen Coast to Coast

³⁶ 24 months to March 2016. Source: Breast Screen Coast to Coast

Breastfeeding Rates					
Key Performance Measures	Baseline ³⁷	Previous result ³⁸	Actual to Date ³⁹	Target 2015/16	Trend direction
Full or Exclusive At 6 Weeks					
Total	68.0%	68% (U)	73% (U)	≥75%	▲
Māori	68.0%	58% (U)	67% (U)	≥75%	▲
Pacific	68.0%	74% (U)	82% (F)	≥75%	▲
Full or Exclusive At 3 Months					
Total	54.0%	54% (U)	53% (U)	≥60%	▼
Māori	54.0%	46% (U)	39% (U)	≥60%	▼
Pacific	54.0%	62% (F)	63% (F)	≥60%	▲
Full, Exclusive or Partial At 6 Months					
Total	59.0%	56% (U)	58% (U)	≥65%	▲
Māori	59.0%	46% (U)	48% (F)	≥65%	▲
Pacific	59.0%	57% (U)	66% (F)	≥65%	▲
Source: Tamariki Ora Quality Improvement Framework					
<i>Comments:</i> With the combined Plunket and WCTO Breastfeeding data now being collected by the MOH more accurate breastfeeding data is becoming available, the new KPI card will over time show this new combined data as a trend line giving an improved picture of Breastfeeding performance for HB. The most recent Quarterly HB Breastfeeding data shows a 8% increase in Māori Breastfeeding rates at 6 weeks, with 3 month data showing a decline of 6% and 6 months remaining the same. Work continues on the development of a model of service provision that effectively supports Māori particularly, to sustain Breastfeeding, this is a joint approach between Māori Health and Women, Child and Youth.					

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³⁷ October to December 2013.

³⁸ April to June 2015.

³⁹ July to December 2015.

Proportion of the population enrolled in the PHO					
Key Performance Measures	Baseline ⁴⁰	Previous result ⁴¹	Actual to Date ⁴²	Target 2015/16	Trend direction
Total	97.3%	96.7% (F)	95.9% (U)	≥97%	▼
Māori	94.7%	97.8% (F)	95.6% (U)	≥97%	▼
Pacific	99.3%	89.4% (U)	88.4% (U)	≥97%	▼
Other	98.2%	96.7% (F)	96.5% (F)	≥97%	▼
Source: Ministry of Health					
Comments: The High Needs Enrolment Programme & New-Born Enrolment Programme are our priority programs in order to improve population enrolments within the PHO. <u>High Needs Enrolment Programme</u> This program provides a free 1 hour nurse consultation and a 15 Minute GP Consultation funded through SIA (Services to Improve Access) and therefore the person has to be either Maori, Pacific OR Quintile 5 <u>AND</u> not currently enrolled with a Health Hawkes Bay practice. This enables new people to the district to enrol with a practice, it enables people who haven't been seen for over three years and have dropped off the register to re-enrol, and those who have never been enrolled with a General Practice. We present to community organisations and DHB Services including ED to ask them to inform their patients about the programme and encourage them to enrol with a GP. There has been minimal referrals from DHB Services however, Work and Income regularly refer patients to the programme and promote enrolment with all of their clients. From May 2014 to March 2016 467 individuals have access the High Needs Enrolment Programme providing 317 GP Consults and 307 Nurse Consults. <u>New Born Enrolment Programme</u> Health Hawkes Bay and HBDHB Immunisation Team work together to ensure all new-born babies are enrolled with a GP within 2 weeks of birth and Health Hawkes Bay does regular practice audit. HBDHB works with maternity services to ensure all hospital discharge summaries are sent to general practice in a timely manner so they are aware of all new-born babies. Health Hawke's Bay has recently applied for direct access to the NIR data mart so we can start to use this information to identify babies (and families) who are not enrolled with a GP.					

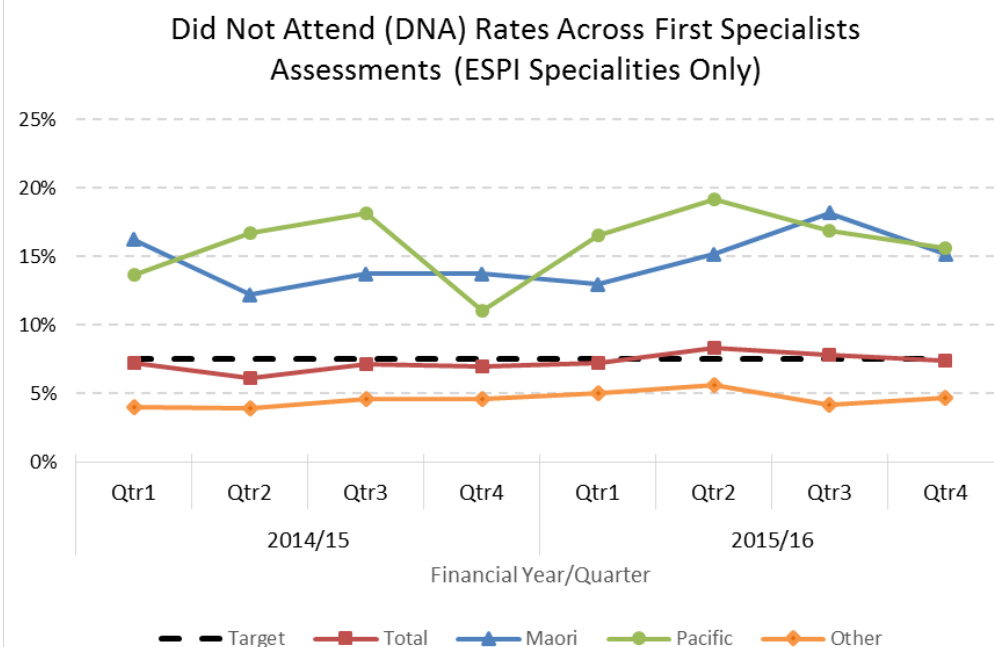
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⁴⁰ October to December 2014.

⁴¹ January to March 2016.

⁴² January to March 2016.

Did not attend (DNA) rate across first specialist assessments ⁴³					
Key Performance Measures	Baseline ⁴⁴	Previous result ⁴⁵	Actual to Date ⁴⁶	Target 2015/16	Trend direction
Total	7.2%	7.8% (F)	7.4% (F)	≤7.5%	▲
Māori	16.2%	18.2% (U)	15.2% (U)	≤7.5%	▲
Pacific	13.6%	16.9% (U)	15.6% (U)	≤7.5%	▲
Other	4.0%	4.1% (F)	4.7% (F)	≤7.5%	▼

**Comments:**

Although the overall DNA result is favourable against the target of 7.5% and although the gap has narrowed in the last quarter there remains persistent disparities for our Maori and Pacific populations. Through the Customer Focused Booking project recent changes have been made to the internal reporting of DNA. The new reports are user friendly and provide an "at a glance state of DNA" (including ethnicity breakdown) for the ESPI specialities, the project will use these reports to monitor and track DNA performance. The project recognises that a number of initiatives that are being developed have not yet translated to this key performance indicator. A new initiative focusing on the three specialities with the highest DNA rates for Maori has been instigated within the project.

Rate of Section 29 orders per 100,000					
Ethnicity	Baseline	Previous result ⁴⁷	Actual to Date ⁴⁸	Target 2015/16	Trend direction
Total	-	100.7 (U)	97.3 (U)	≤81.5	▲
Māori	-	212.7 (U)	201.6 (U)	≤81.5	▲
Other	-	100.7 (U)	97.3 (U)	≤81.5	▲

Comments:

We have put in place new services to provide early interventions for people with mental health problems and as alternatives to hospitalisation. These include; Home based Treatment; NGO provided recovery orientated short term day programmes; Resilience focussed community group programmes; and later this year the Harekeke acute day programme based in Nga Rau Rakau. We are also carrying out an audit of cases locally to see if any of these factors particularly stand out as contributing towards the inequity.

⁴³ ESPI specialities only⁴⁴ October to December 2014⁴⁵ January to March 2016⁴⁶ April to June 2016⁴⁷ January to March 2016⁴⁸ April to June 2016

Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital emergency department attendances (per 1,000)					
Age Band	Baseline ⁴⁹	Previous result ⁵⁰	Actual to Date ⁵¹	Target 2015/16	Trend direction
Age 75-79	139.5	144.4 (U)	153.3 (U)	≤139.5	▼
Age 80-84	183.1	218.5 (U)	211.1 (U)	≤183.1	▲
Age 85+	254	225 (F)	225 (F)	≤231	—
Comments: Analysis of overall attendances at ED (i.e. all triage levels) for people over 75 years of age in 2014/15 showed a growth rate slightly lower than population growth. These age-specific rates at the 5 year age group level show some variation within that analysis. The 80-84 age group are unfavourable to trend and declining compared to the previous period. We are unable to discern a trend at this stage or to identify any particular driver, but we will continue to monitor closely.					

Number of needs assessments completed (Disability Services)			
Key Performance Measures	Baseline ⁵²	Actual to Date ⁵³	Target 2015/16
	618	508 (U)	≥600
Comments: The DSS team currently has 1223 clients, with reassessments due every three years. This means, on average, Options would complete 408 assessments per year, with a number of additional reassessments driven by changing need. The DSS team is working within MoH timeframes for assessment and has a low number of overdue assessments (currently 1.1%). The unfavourable result is likely to be due to work conducted during 2013-2015 to ensure all assessments were up-to-date. This resulted in lower numbers of assessments being due in the 2015/16 financial year. The NASC information system is forecasting a further 120 assessments to be completed by the end of the financial year. Work is being conducted in the residential team to smooth assessment dates evenly throughout the year, to reduce spikes in assessment numbers. Monitoring of time frames and overdue tasks is continually occurring – with results being reported to the Ministry of health on a monthly basis as part of the Financial Reporting Suite.			

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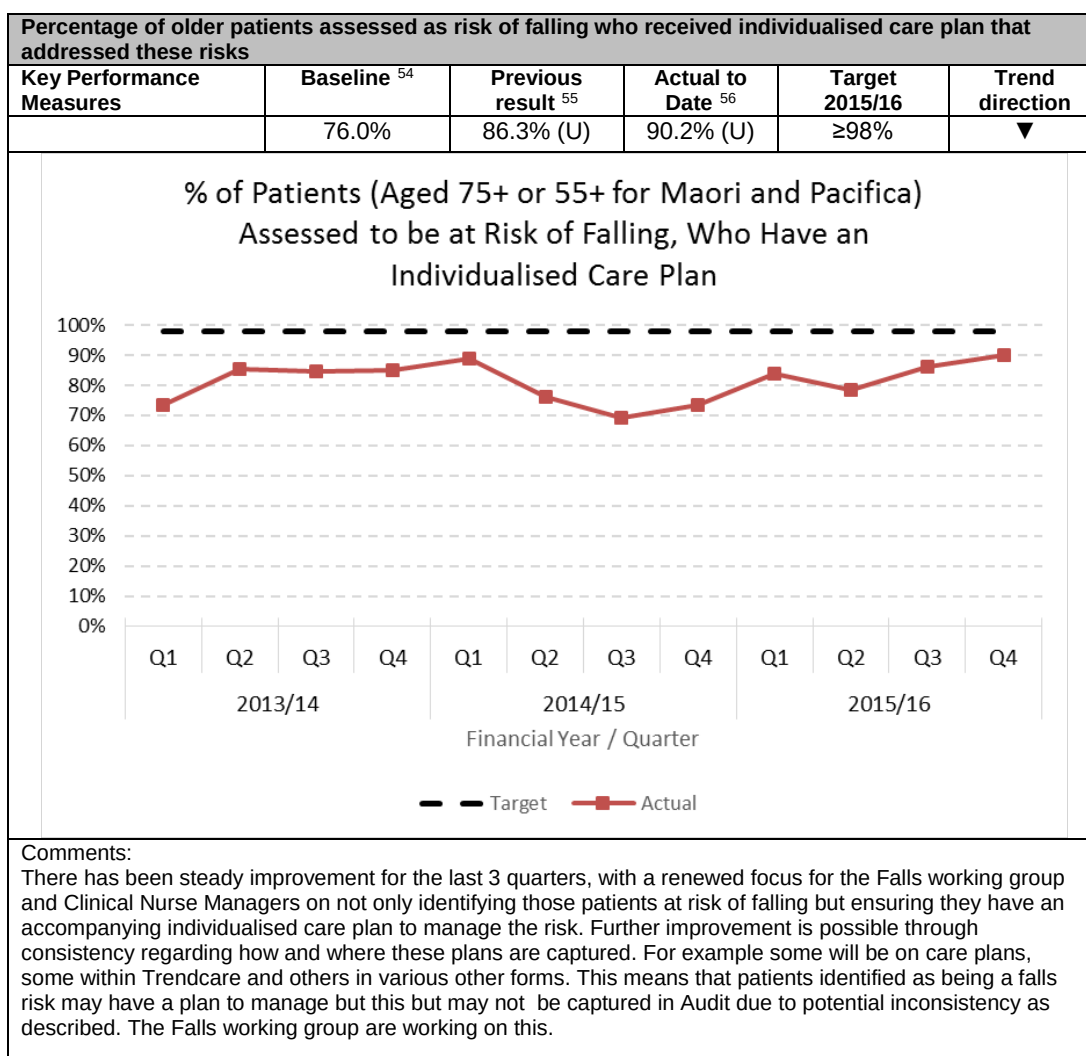
⁴⁹ October to December 2014

⁵⁰ January to March 2016

⁵¹ April to June 2016.

⁵² 2013/2014

⁵³ July 2015 to March 2016. Please note this is a 9 month progress update on a 12 month indicator.

⁵⁴ January to March 2016. .⁵⁵ January to March 2016.⁵⁶ April to June 2016.

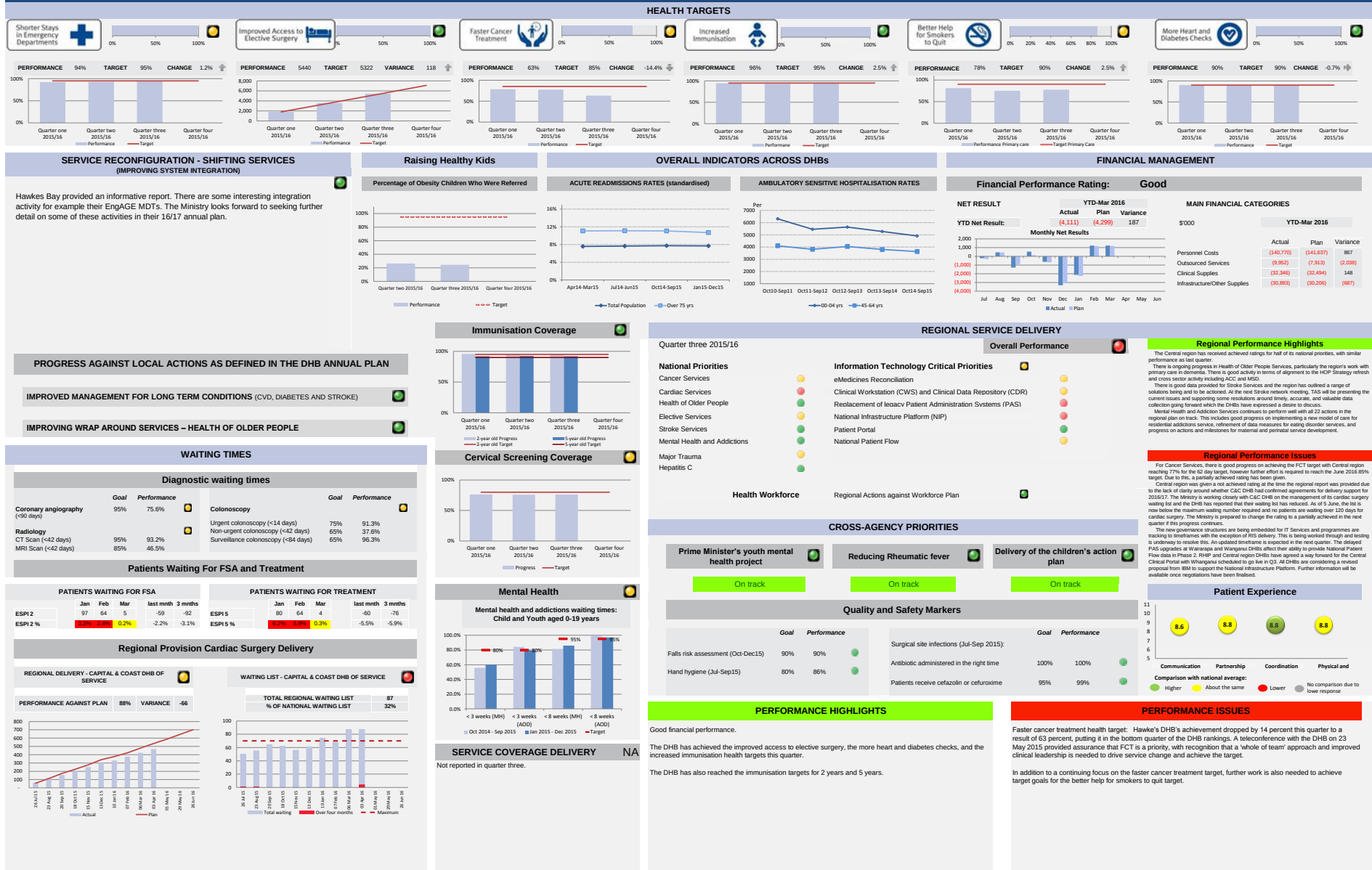
Board Meeting 31 August 2016 - HBDHB Performance Framework Exceptions Report Q4



Hawke's Bay DHB performance monitoring report quarter three 2015/16

Monitoring Status

Standard Monitoring



Board Meeting 31 August 2016 - HBDHB Performance Framework Exceptions Report Q4

How to read this dashboard

This dashboard shows a summary of most aspects of DHB performance. It combines indicators of DHB performance, as agreed in the 2015/16 Annual Plan, as well as complementary information such as financial net results, hospital indicators and other priorities. The structure has been designed to display DHB information using an 'at-a-glance' approach. It is not to be used for general publication. It groups information according to the following areas:

Health targets	Shows the progress made by the DHB against the health targets. The top bar chart show relative performance to target for each measure, while the time series charts absolute performance throughout the year.
Service Reconfiguration	This area displays information related to the progress DHBs are achieving in the implementation of the System Integration Programme.
Waiting Times	This area summarises an array of indicators that show DHB progress towards reducing waiting times.
Other Priorities	Emerging priorities such as the Prime Minister's youth mental health initiative.
Service coverage	Self-reported confirmation & exception report. DHBs must ensure service coverage expectations are met, or demonstrate resolution of service coverage gaps by providing an appropriate resolution plan, and adequate progress is being made against the resolution plan.
Financial Management	Overview of the financial performance of the DHB based on data provided by the DHBs in monthly financial templates.
Highlights and Lowlights	High level description of particular issues in which a DHB exceeded agreed performance expectations or has not met agreed performance expectation and does not have an appropriate resolution plan in place, or needs to progress further.

Each area includes one or more indicators. Definitions for those are as follow: (Definitions for health target indicators are shown in the health target summary table and therefore are not repeated here.)

Acute readmissions rates *	Acute readmission rates are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The rates are standardised by patient population characteristics, deprivation, rurality, patient health conditions, comorbidity and surgery, using national patient population as a 'standard'. Indirect standardisation using logistic regression method is applied to derive the rates.
Ambulatory sensitive hospitalisations (ASH) *	Ambulatory Sensitive Hospitalisations (ASH) result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. The ASH rates are derived by the total number of 12-month ASH for DHB patients aged 0-4 and 45-64 as the numerators and the same age population of the DHB as the denominators respectively.
Improved management for long term conditions	DHBs are expected to report on delivery of the actions and milestones as identified in the 2015/16 annual plans for long term conditions (LTC), diabetes care improvement packages (DCIP), acute coronary syndrome (ACS) services, and stroke services.
Improving wrap around services -Health of Older People	DHBs are expected to report on delivery of the actions and milestones as identified in the 2015/16 annual plans for health of older people services including home and community support services, InterRAI, dementia care pathways, HOP specialists and fracture liaison services.
Immunisation coverage	The percentage of children who have completed their age-appropriate immunisations by the age of 2 years and by the age of 5 years (shown separately in the graph). The rating - indicated by the traffic light colour - is based on performance for both the 2- and 5-year-old milestones.
Cervical screening coverage	The number of eligible women (aged 25-69 years) screened in the three years to end of quarter being reported as a proportion of the hysterectomy adjusted female population.
Regional delivery - cardiac	Regional cardiac provider delivery against plan. DHBs submit four-weekly reports.
Waiting list - cardiac	Regional cardiac provider total waiting list against the waiting list target including those waiting over four months. Proportion of regional to national waiting list. DHBs submit four-weekly reports.
Patients waiting for FSA (ESPI 2)	The total number on the waiting list waiting longer than four months for an FSA for the last three months, and the number waiting as a % of the total list.
Patients waiting for treatment (ESPI 5)	The total number on the waiting list waiting longer than four months for treatment for the last three months, and the number waiting as a % of the total list.
Alcohol and drugs waiting times: * Child and Youth aged 0-19 years	Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm.
Prime Minister youth mental health initiative	Reporting on service delivery and quality improvement in School Based Health Services, progress against local youth SLAT action plan to implement improvements in primary care responsiveness to youth, and youth primary mental health services (reported under PP26).
Reducing rheumatic fever *	A progress report against the DHB's rheumatic fever prevention plan (the regional plan for the South Island), plus hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 40% reduction from baseline (2009/10-2011/12).
Delivery of the children's action plan	Progress on delivery of the actions and milestones identified in DHB Annual Plans support the implementation of the Children's Action Plan and reduce child assaults.
Raising healthy kids	The percentage of children who were referred from the B4SC to a relevant service and acknowledged by the service provider or were already under care of service or the parent/caregiver declined the referral, among the total number of children who had a B4SC and were identified as obese (BMI>98th percentile).
Regional service delivery	A qualitative assessment of a progress report on behalf of the region agreed by all DHBs within that region. The report focuses on the actions agreed by each region as detailed in its RSP implementation plan.
Quality and Safety Markers	Progress toward the markers set by the Health Quality and Safety Commission. These include older patients receiving a falls assessment, compliance with good hand hygiene practice, and two surgical site infection measures: hip and knee replacement patients receiving 2g or more of cephazolin and antibiotic administered in the right time.
Patient Experience	Average rating out of 10 for inpatient experience across the four domains of communication, partnership, coordination of their care, and having physical and emotional needs met, based on results from the national patient experience survey.
Diagnostic waiting times	Performance against the waiting time indicators for Coronary Angiography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Colonoscopy.
Performance highlights	Brief analysis of areas where a DHB is performing above expectations by achieving/exceeding a performance expectation, making significant progress from their base position, or implementing/leading an innovation process that will lead to performance improvement.
Performance issues	Brief analysis of areas where a DHB is performing below expectations, and actions being taken to resolve the issue(s)

* Data for these measures covers a period prior to the current quarter to ensure complete coding of data.

Some indicators are for information only. Some, on the other hand, are accompanied by a traffic light colour.

This colour represents the perceived risk to a DHB achieving their target for the year.

The DHB is on track to achieve target	
Some aspects still need development / or the DHB is not tracking to target but has an appropriate resolution plan.	
The information available suggests the DHB is not on track to meet the target and does not have an appropriate resolution plan.	
To date, the DHB has provided no report.	NR
Not Applicable	NA

The Quality and Safety markers use a different traffic light scheme, to mimic that used by the Health Quality and Safety Commission.

Performance at or above the goal level	
Performance within 10/15% of the goal level (depending on the marker)	
Performance more than 10%/15% below the goal level (depending on the marker)	

	Annual Māori Health Plan Q4 (Apr-Jun 2016) Non-Financial Exceptions Report	94
	For the attention of: HBDHB Board	
Document Owners:	Tracee Te Huia, General Manager Māori Health	
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst	
Reviewed by:	Executive Management Team, Māori Relationship Board, HB Clinical Council and HB Health Consumer Council	
Month:	August 2016	
Consideration:	Monitoring	

RECOMMENDATION**That the HBDHB Board:**

Note the contents of this report.

19**OVERVIEW**

The purpose of this paper is to provide MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 4 on the implementation of Annual Māori Health plan. A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of Quarter 4 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indicators. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to show a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol 'U' (indicated on the dashboard in red) will be used to indicate unfavourable trend and 'F' for favourable trend (indicated on the dashboard in green colour) toward the annual target (see the table below).

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

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2015-2016 ANNUAL MĀORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. Cervical Screening for 25-69 year old Māori women (73.2%) for this quarter is slightly lower than the 74.4% in the first quarter but still puts HBDHB on the top list on Cervical Screening performance in New Zealand. This performance also narrows the disparity gap between Māori and European by 4%. The performance is attributed to the HBDHB integrated service approach where all service providers (i.e. HBDHB Population Health, Health HB PHO (HHB PHO), general practices and Hauora Providers etc.) across the screening pathways are joined up and working together towards a common goal of attaining the national target for Māori women and addressing inequity. Furthermore, Māori women have access to free cervical smear tests and support services across the district.

In an effort to further improve our services there has, over the years been a strong focus on continued service quality improvement e.g. improving systems and processes within primary care, improving National Cervical Screening Programme (NSCP) participant data quality on patient management systems (PMS) and the NCSP Register, compliance with NCSP policies and standards, offering client incentives, and improving access via clinical and outreach settings and support services.

2. Immunisation rates for 8 month old Māori have remained above or very near the target of $\geq 95\%$ throughout the year with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for 2 year old Māori remained above or very near the annual target of $\geq 95\%$ with 95.9% in Quarter 1 and 94.7% in Quarter 4. Immunisation results for 4 year olds remains above the expected target of $\geq 90\%$ with 94% immunised in Quarter 4.

This success is attributable to a number of factors. These range from having a champion in the executive management team; a committed, appropriate, experienced workforce; an action plan focused on bridging any gaps in service delivery; a very experienced NIR (National Immunisation Register) team; good collaboration across all immunisation providers and partners; a budget with a little leeway to try new initiatives; a service that can easily be delivered within the home; and a very effective outreach service team.

3. Ambulatory Sensitive Hospitalisation (ASH) rates overall declined from 82% in Quarter 1 to 79% in Quarter 4 following concerted work in the area of skin management through Public Holiday in early Childhood centres, Kōhanga reo and Primary Schools.. This Quarter has seen a continued focus on strengthening systems and relationships across Oral health services and providers. Resources to support self-care and management of skin have been translated in Te reo and English to support this work. To reduce DNA's at Community oral health clinics WCTO provider relationships with whānau will be strengthened coupled with funding to Tamariki ora and Plunket for advocacy and facilitation role in initiating oral health appointments and attendance. A joint analysis and review of currently contracted respiratory support services is being carried out to extend the Primary Care respiratory Pilot services to cover the 0-4 year age group.
4. Quick Access to Angiograms for Māori exceeded the expected target of $\geq 70\%$ with 84.6% in Quarter 4 up from 38.5% in Quarter 1. This success is attributed to Locum Cardiologist who completed full Friday angiogram sessions for the time he was here.

Areas of progress

1. Staff completed cultural training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4 (page 13). This progress is attributed to the growing push from EMT coupled with access to the electronic training reports by Managers and Heads of Service which enable them to keep track of their staff training.

2. Māori Breastfeeding rates at 6 weeks are 67% a 9% increase in comparison to the previous reporting period and Breastfeeding rates at 6 months shows a 2% increase.

Areas of focus

The above achievements notwithstanding, we are challenged to put more efforts in the following areas to gain traction towards targets:

1. Access to Care – Increase Patients Enrolment to the HHB PHO

The number of Māori enrolled in the HHB PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97% (page 5). These trends are attributed to the limited availability and capacity of GPs to enrol new patients. Only 5/28 practices are enrolling new patients; 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district etc.; and 9/28 practices are not enrolling new patients at all. Furthermore, some patients are using Emergency Department (ED) for General Practice (GP) services instead of enrolling with a general practice; limited access to affordable general practice services for low income patients; and some patients moving outside of HB.

HHB PHO has been working with GPs to consider models of care that include provision of services to walk in appointments. HHB PHO has also been looking into availability of High Need Enrolment Programme via NGOs, ED, DHB and GPs with initial GP and Nurse Consultations at no cost to patients. HHB PHO feels that efforts to address health inequalities may include: support to practices to recruit general practice clinicians and staff; continue to offer the High Need Enrolment Programme; and supporting general practice to consider and implement walk in appointments.

2. Child Health - Breastfeeding

Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. Multiple pieces of work are underway across Well Child and LMC/Midwife workforce to improve these rates. These include promotion of early engagement with services; consistent appropriate breastfeeding messages across sectors and the community; and the development of a responsive breastfeeding support service for Māori (a joint approach between the DHB Māori and Women, Child and Youth portfolios).

5. Oral Health

Pre-school oral health enrolments for Māori under 5 years of age increased from 65.3% in 2014 to 74.1% in 2015 (page 11). There is still some work to do to reach the expected target of ≥90%. We plan to update the data at the end of the calendar year.

8. Cancer Screening - Breast Screening

There has been a slight decrease from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of ≥70% (page 9). This can be attributed to a number of factors including a slight increase of 25 women on the Breast Screening Aotearoa (BSA) Māori population which forms the denominator for the coverage data; increased seasonal fluctuations; and access to appointments due to holidays and availability of seasonal work. Efforts will be made on identify unscreened and under- screened women along with other approaches tailored to improve access and encourage women to participate in the BSA programme.

9. Smokefree

Māori women who are smoke free at 2 weeks post natal increased from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected target of ≥ 86% (page 7). In an effort to up these rates, HBDHB is collaborating with Choices Heretaunga in the implementation of Increasing Smoke-free Pregnancy Programme (ISPP) which is currently being used by HB midwives and LMCs to refer pregnant mothers who smoke. Acknowledging the

importance of whānau support for mothers to be smoke-free the programme has expanded its support to whānau members to live with pregnant and post-partum women.

The report also noted that advice to quit smoking for Māori pregnant women at hospital setting declined from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of ≥90%. This is attributed to the high smoking rates among pregnant Māori women ages 20 to 29 years. We also know that most of these women either come from high deprivation areas or transient whānau so our efforts are focused on encouraging HB midwives and LMCs to refer pregnant women who smoke to ISPP, up to six months post-partum.

10. Mental Health

Māori under Mental Health Act Compulsory Treatment Orders has risen from 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population in Quarter 4. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1 (page 12). An audit has been carried out to better understand the issues around these rates and develop better strategies to lower them.

13. Workforce Development

Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3% (page 13). The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Since these are our two biggest workforce the impact of this trend is reflected across the overall performance figure for the period.

Following a significant rethink of our strategy to increase Māori staff representation we have identified actions that will make this happen. These include increasing the number of Māori applying for positions; number shortlisted and recruited for our roles and actions for better retention of our Māori staff.

An overarching Māori staff recruitment campaign is being developed with targeted actions by workforce grouping also. Focus groups discussions of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

1. Access to Care						
Outcome: Increase enrolment in the HHB PHO						
Key Performance Measures	Baseline ¹	Previous result ²	Actual to Date ³	Target 15-16	Trend direction	Time series
Māori	94.7%	94.5% (U)	95.6% (U)	≥97%	▲	% of Population Enrolled with a Health Hawke's Bay PHO Financial Year / Quarter — Target — Māori — Non Māori
Pacific	99.3%	86.5% (U)	88.4% (U)	≥97%	▲	
Other	98.2%	96.0% (U)	96.5% (F)	≥97%	▲	
Total	97.3%	95.2% (U)	95.9% (U)	≥97%	▲	
Comment:						
Limited availability and capacity of general practice to enrol new patients						
• 5/28 practices are enrolling new patients • 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district • 9/28 practices are not enrolling new patients - o Patients utilising ED for General Practice services instead of enrolling with a general practice - o Limited access to affordable general practice services for low income patients - o Patients moving outside of HB - o Plan to work with General Practices to consider and review models of care						

¹ October 2014 to December 2014

² October to December 2015

³ January to March 2016

2. Child Health

Outcome: Breastfeeding of pepi improved

Key Performance Measures	Baseline ⁴	Previous result	Actual to Date	Target 15-16	Trend direction	
Infants are exclusively or fully breastfed at 6 weeks						
Māori	-	58% (U)	67% (U) ⁵	≥75%	▲	Comments: With the combined Plunket and WCTO Breastfeeding data now being collected by the MOH more accurate breastfeeding data will be available, the new KPI card will over time show this new combined data as a trend line giving an improved picture of Breastfeeding performance for HB.
Pacific	-	74% (U)	82% (F)	≥75%	▲	
Total	-	68% (U)	73% (U)	≥75%	▲	
Infants are exclusively or fully breastfed at 3 months of age						
Māori	-	46% (U)	39% (U) ⁶	≥60%	▼	The most recent Quarterly HB Breastfeeding data shows a 5% increase in Māori Breastfeeding rates at 6 weeks, with 3 month data showing a decline of 6% and 6 months remaining the same.
Pacific	-	62% (F)	63% (F)	≥60%	▲	
Total	-	54% (U)	53% (U)	≥60%	▼	
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)						
Māori	-	46% (U)	48% (U) ⁷	≥65%	▲	Work continues on the development of a model of service provision that effectively supports Māori particularly, to sustain Breastfeeding, this is a joint approach between Māori Health and Women, Child and Youth (further details are included below)
Pacific	-	57% (U)	66% (F)	≥65%	▲	
Total	-	56% (U)	58.% (U)	≥65%	▼	

⁴ No baseline data available

⁵ 6 months to June 2015

⁶ 6 months to December 2015

⁷ 6 months to December 2015

5. Oral Health

Outcome: More pre-school enrolments in the community oral health service (COHS) - 90% children under 5 years of age enrolled in community oral health services

Key Performance Measures	Baseline ⁸	Previous result ⁹	Actual to Date ¹⁰	Target 15-16	Trend direction	Time series
Māori:	65.3%	74.1% (U)	-	≥90%	—	% of Pre-School Children Enrolled in DHB Funded Oral Health Service
Pacific:	71.7%	74.2% (U)	-	≥90%	—	
Other:	81.3%	99.8% (F)	-	≥90%	—	
Total	73.9%	87.1% (U)	-	≥90%	—	
Comments This is an annual indicator which is only reported in Q3 every financial year. Health Intelligence discussing with services about the capability of reporting more frequently.						

⁸ 2013 calendar year

⁹ 2014 calendar year

¹⁰

8. Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national target – 80% of 25-69 years

Key Performance Measures	Baseline ¹¹	Previous result ¹²	Actual to Date ¹³	Target 15-16	Trend direction	Time series
Māori	73.8%	73.2% (U)	73.2% (U)	≥80%	—	Cervical Screening Coverage - Percentage of woman aged 25-69 years receiving cervical screening in the last 3 years 36 months to — Target — Total — Maori — Pacific
Pacific	72.8%	70.4% (U)	71.4% (U)	≥80%	▲	
Other	78.0%	77.2% (U)	77.8% (U)	≥80%	▲	
Total	76.9%	76.1% (U)	76.6% (U)	≥80%	▲	
Comments: Continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive. Continuing to ensure accuracy of participant ethnicity data held on National Cervical Screening Programme Register. Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge to the sector.						Source: National Screening Unit

11 3 years to December 2014

12 3 years to December 2015

13 3 years to March 2016

Outcome: Achieve the National Breast Screen Aotearoa (BSA) national target – 70% of 50-69 years

Key Performance Measures	Baseline ¹⁴	Previous result ¹⁵	Actual to Date ¹⁶	Target 15-16	Trend direction	Time series
Māori	67.2%	68.4% (U)	67.9% (U)	≥70%	▼	% of Women Aged 50-69 Receiving Breast Screening in the Last 2 Years 24 months to: — Target — Total — Māori — Pacific
Pacific	79.0%	66.5% (U)	67.2% (U)	≥70%	▲	
Other	77.2%	79% (F)	74.5% (F)	≥70%	▼	
Total	75.8%	74.7% (F)	73.4% (F)	≥70%	▼	
Comments:						
Preparation has begun for the next mobile screening unit visit at the Cook Island Community Centre at Flaxmere on 13-27 September. BreastScreen Coast to Coast is working with Hastings-based GP practices to datamatch Flaxmere-resident clients for the upcoming visit. Invitation and recall letters will be sent out to priority group women offering an appointment for a screening mammogram. The DHB Population Screening, HHB PHO and Māori providers are working together to promote the mobile visit and offering support services to priority women. HHB PHO and TRG Imaging facilitated an education session for GPs focused on pathology, diagnostics and treatment for breast disease. Recent population projections released by the National Screening Unit show that in the next four years (2016-2020) Hawke's Bay's BSA eligible Māori population will increase by 8% and the Pacific population by 13%. This will be a challenge to the sector to achieve and maintain targets.						<i>Source: National Screening Unit</i>

14 24 months to December 2014

15 24 months to December 2015

16 24 months to March 2016

9. Smokefree

Outcome: 90% of pregnant women who identify as smokers upon registration with a DHB- employed midwife or Lead Maternity Carer (LMC) are offered brief advice & support to quit smoking

Key Performance Measures	Baseline ¹⁷	Previous result ¹⁸	Actual to Date ¹⁹	Target 15-16	Trend direction		
Māori	100.0%	95.2% (F)	86.2% (U)	≥90%	▼	Comments HBDHB in collaboration with Choices Heretaunga have successfully implemented the Increasing Smokefree Pregnancy Programme (ISPP). HB midwives and LMCs refer pregnant mama who smoke, to this programme. On post-partum up to six months of age, woman who are still smoking can be referred to ISPP. ISPP supports pregnant and post-partum women to be smokefree at 1, 4, 8 and 12 weeks with a supply of nappies, if they have a validated CO monitor reading. Since 1 July, the programme has expanded to support whānau members who live with pregnant mama and post-partum women and pepi to be smokefree at 1, 4, 8, 12 weeks with grocery vouchers, if they too have a validated CO monitor reading.	
Total	98.1%	96.5% (F)	88.6% (U)	≥90%	▼		

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¹⁷ October to December 2014

¹⁸ October to December 2015

¹⁹ January to March 2016

10. Mental Health

Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

Key Performance Measures	Baseline ²⁰	Previous result ²¹	Actual to Date ²²	Target 15-16	Trend direction	
Māori (per 100,000)	-	204.0 (U)	201.6 (U)	≤81.5	▲	Section 29 Orders per 100,000 Population
Other (per 100,000)	-	98.9 (U)	96.7 (U)	≤81.5	▲	
Total (per 100,000)	-	99.0 (U)	97.3 (U)	≤81.5	▲	
Comments We are still undertaking audits to understand the reason for the rate. First audit completed and further audit is now being undertaken.						

²⁰

²¹ January to March 2016

²² April to June 2016

13. Māori Workforce and Cultural Competency
Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 15/16 year 14.3%

Key Performance Measures	Baseline ²³	Previous result ²⁴	Actual to Date ²⁵	Target 15-16	Trend Direction	Time series																														
Medical	2.7%	3.2%	3.2%	-	—	Māori Employed by HBDHB <table><caption>Māori Employed by HBDHB Data</caption><thead><tr><th>Period</th><th>Target (%)</th><th>HBDHB (%)</th></tr></thead><tbody><tr><td>Q4 2013/14</td><td>11.6</td><td>10.1</td></tr><tr><td>Q1 2014/15</td><td>13.2</td><td>11.1</td></tr><tr><td>Q2 2014/15</td><td>13.2</td><td>11.6</td></tr><tr><td>Q3 2014/15</td><td>13.2</td><td>11.9</td></tr><tr><td>Q4 2014/15</td><td>13.2</td><td>12.2</td></tr><tr><td>Q1 2015/16</td><td>14.3</td><td>12.2</td></tr><tr><td>Q2 2015/16</td><td>14.3</td><td>12.2</td></tr><tr><td>Q3 2015/16</td><td>14.3</td><td>12.3</td></tr><tr><td>Q4 2015/16</td><td>14.3</td><td>12.5</td></tr></tbody></table>	Period	Target (%)	HBDHB (%)	Q4 2013/14	11.6	10.1	Q1 2014/15	13.2	11.1	Q2 2014/15	13.2	11.6	Q3 2014/15	13.2	11.9	Q4 2014/15	13.2	12.2	Q1 2015/16	14.3	12.2	Q2 2015/16	14.3	12.2	Q3 2015/16	14.3	12.3	Q4 2015/16	14.3	12.5
Period	Target (%)	HBDHB (%)																																		
Q4 2013/14	11.6	10.1																																		
Q1 2014/15	13.2	11.1																																		
Q2 2014/15	13.2	11.6																																		
Q3 2014/15	13.2	11.9																																		
Q4 2014/15	13.2	12.2																																		
Q1 2015/16	14.3	12.2																																		
Q2 2015/16	14.3	12.2																																		
Q3 2015/16	14.3	12.3																																		
Q4 2015/16	14.3	12.5																																		
Management & Administration	15.7%	16.1%	16.0%	-	▼																															
Nursing	10.1%	10.7%	10.8%	-	▲																															
Allied Health	11.9%	12.4%	13.2%	-	▲																															
Support Staff	26.7%	30.2%	29.3%	-	▼																															
HBDHB	11.6%	12.4% (U)	12.5% (U)	≥14.3%	▲																															
Comments: The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Because these are our two biggest workforce the impact is going to flow through to the overall figure. As a result of a significant rethink of our strategy for increasing Māori staff representation we have identified actions to increase the number of Māori applying, being shortlisted and recruited for our roles and actions for better retaining our Māori staff. An overarching Māori staff recruitment campaign is being developed and targeted actions by workforce grouping also. Focus groups of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.																																				

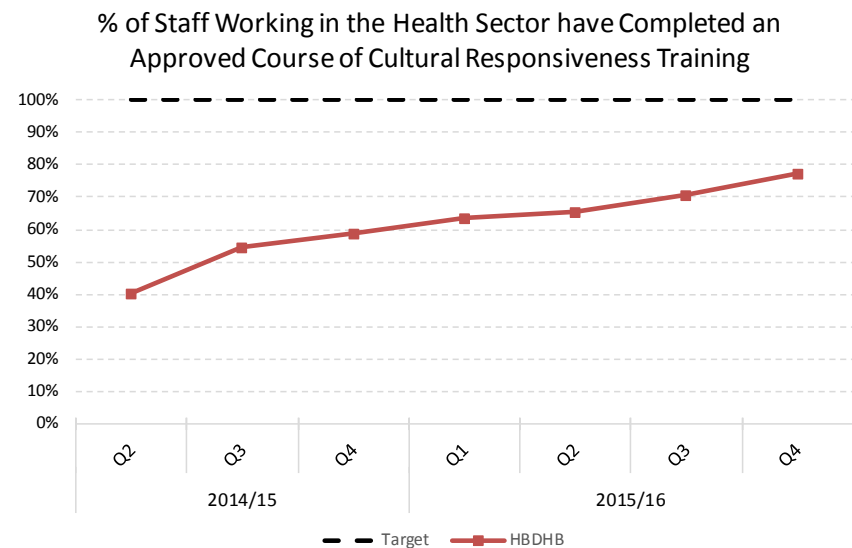
Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline ²⁶	Previous result ²⁷	Actual to Date ²⁸	Target 15-16	Trend direction	Time series

Medical	9.0%	32.4%	39.6%	-	▲
Management & Administration	43.0%	82.1%	85.6%	-	▲
Nursing	41.0%	74.7%	81.4%	-	▲
Allied Health	59.0%	80.4%	85.2%	-	▲
Support Staff	12.0%	38.6%	60.1%	-	▲
HBDHB	40.0%	70.6%	77.5% (U)	≥100%	▲

Comments:

- Current report shows DHB staff who have completed EEWM training or other cultural training.
- The Education & Development Forum are establishing a communication plan to include Primary Care in EEWM training.
- Managers now have access to reports within PAL\$ to monitor staff completion rates of EEWM and Treaty of Waitangi.
- The current Engaging Effectively with Māori (EEM) training sessions run to the beginning of September. There is a mandatory training report that all managers have access to and this now enables managers to follow-up on staff who have not attended EEM. This training has been rolled across the HHB PHO and NGOs.



 HAWKE'S BAY District Health Board Whakawāteatia	Annual Māori Health Plan Q4 (Apr-Jun 2016) Dashboard	96
	For the attention of: HBDHB Board	
Document Owners:	Tracee Te Huia, General Manager Māori Health	
Document Author(s):	Patrick LeGeyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst	
Reviewed by:	Executive Management Team, Māori Relationship Board, HB Clinical Council and HB Consumer Council	
Month:	August 2016	
Consideration:	Monitoring	

RECOMMENDATION**That HBDHB Board:**

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

- The Māori health indicators agreed as part of the development of 2015 /16 Annual Māori Health Plan.

A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 4) to represent this.

As this report is for the period ending June 2016, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 15-16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

2015-2016 ANNUAL MAORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (73.2%) and the lowest disparity gap between Māori and European (4% gap).
2. Immunisation rates for 8-month old Māori have remained above or very near the target of $\geq 95\%$ throughout 2015-2016 with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for Māori 2-year olds remained above or very near the target of $\geq 95\%$ throughout 2015-2016 with a 95.9% result in Quarter 1 and a 94.7% result in Quarter 4. Immunisation results for 4-year olds remains above the expected target of $\geq 90\%$ with 94% immunised in Quarter 4.
3. ASH Rates overall have declined from 82% in Quarter 1 to 79% in Quarter 4 and present a significant narrowing of disparity gap for 0-4 year old group between Māori and Other. Similarly, ASH Rates for 45-64 year old group have declined from 193% in Quarter 1 to 170% in Quarter 4 and present a significant narrowing of disparity gap between Māori and Other.
4. Quick Access to Angiograms for Māori exceeded the expected target of $\geq 70\%$ with 84.6% in Quarter 4 up from 38.5% in Quarter 1.

Areas of progress

1. Staff Completed Cultural Training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4.

Challenges

1. Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. All breastfeeding rates at 6 weeks (67%), 3 months (39%) and at 6 months (48%) for Maori fell below the target rates of 75%, 60% and 65% for the period.
2. Māori under Mental Health Act Compulsory Treatment Orders has risen 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1.
3. Māori women who are smokefree at 2-weeks post natal increased by 3.6% from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected performance target of $\geq 86\%$.
4. Advice to Māori smokers in hospital who are pregnant to quit declined by 7.5% from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of $\geq 90\%$.
5. Breast Screening has decreased slightly from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of $\geq 70\%$.
6. Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3%.
7. The number of Māori enrolled in the Health Hawke's Bay PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97%.
8. Pre-school Oral Health Enrolments for Māori under 5-years of age increased from 65.3% in 2014 to 74.1% in 2015. There is still some work to do to reach the expected target of $\geq 90\%$.

Please note:

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

19.1

ANNUAL MĀORI HEALTH PLAN, QUARTER 4 APRIL - JUNE 2016 DASHBOARD REPORT

Access to Care

PHO Enrolment and ASH rates

Indicator	Baseline	Prior period result	Actual to date Maori	Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment	94.7%	94.5%	95.6%	96.5%	≥ 97.0%	-595		↑
0-4 years (6m)	82.0%	82.0%	79.0%	70.0%	≤ -			↓
45-64 years (6m)	100.0%	172.0%	170.0%	94.0%	≤ -			↓

Child Health

Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	58.0%	67.0%	73.0%	≥ 75%	-		↑
At 3 months	54.0%	46.0%	39.0%	53.0%	≥ 60%	-		↑
At 6 months	59.0%	46.0%	48.0%	58.0%	≥ 65%	-		↑

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation (8 Months)	95.9%	97.7%	94.6%	95.4%	≥ 95%	-1		↑
Immunisation (2 years)	95.0%	94.8%	95.1%	94.9%	≥ 95%	0		↑
Immunisation (4 years)	-	93.2%	94.0%	92.1%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	56.5%	-	-	≥ 75%	-		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	4.3	2.48	7.33	1.87	≤ 2.0	-2		↓

Oral Health

Indicator	Baseline	Prior period result	Actual to date Maori	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate	65.3%	74.1%	-	-	≥ 90%	-771		↑

SUDI

Indicator	Baseline	Prior period result	Actual to date Maori	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Rate per 100,000	4.6	2.9	Update not available		≤ 0.5	-		↓

Indicator Legend

Target attained
Within 10% of target
10-20% away from target
Greater than 20% away from target

Time Series Key:

	Target
	Actual

Cardiovascular Disease

Indicator	Baseline	Prior period	Actual to date Maori	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Heart & diabetes checks	83.9%	86.3%	-	-	≥ 90%			↑
Quick access to angiograms	66.7%	81.8%	84.6%	77.6%	≥ 70%	1.9		↑
Completion of registry data	12.5%	100.0%	90.0%	96.6%	≥ 95%	-1		↑

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs)	73.8%	73.2%	73.2%	77.8%	≥ 80%	-614		↑
Breast screening (50-69 yrs)	67.2%	68.4%	67.9%	74.5%	≥ 70%	-74		↑

Smokefree

Indicator	Baseline	Prior period	Actual to date Maori	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal	58.0%	53.0%	65.6%	79.9%	≥ 86.0%	-		↑
Pregnant smokers Brief Advice to Quit	100.0%	86.2%	81.1%	89.0%	≥ 90.0%	-5		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000)	-	212.7	201.6	96.7	≤ 81.5	-46		↓

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.7%	3.2%	3.2%	-	≥ -			
Medical Management & Administration	15.7%	16.1%	16.0%	-	≥ -			
Nursing	10.1%	10.7%	10.8%	-	≥ -			
Allied Health	11.9%	12.4%	13.2%	-	≥ -			
Support Staff	26.7%	30.2%	29.3%	-	≥ -			
Maori staff - HBDHB	11.6%	12.4%	12.5%	-	≥ 14.3%	-54		↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9.0%	32.0%	39.6%	≥ -			
Medical Management & Administration	43%	82.1%	85.6%	≥ -			
Nursing	41%	74.7%	81.4%	≥ -			
Allied Health	59%	80.4%	85.2%	≥ -			
Support Staff	12%	38.6%	60.1%	≥ -			
HBDHB	40%	70.6%	77.5%	≥ 100%			↑

Te Ara Whakawaiora Priorities

Indicator	Baseline	Prior period result	Actual to date Maori	Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Obesity (BASC Healthy Weight for 4yrs)	75%	67.0%	61%	69%	≥ 75%	-62.75		↑
DNA's	16.2%	18.2%	15.20%	4.70%	≤ 7.50%	-98		↓
Oral Health (% Caries Free at 5yrs)	38.7%	36.0%	-	-	≥ 65%			↑
Bariatric Surgery	7.00	-	3.0	5.0	-	-		-

	Te Ara Whakawaiaora: Culturally Competent Workforce
Document Owner: Document Author(s):	95 For the attention of: HBDHB Board Chris McKenna, Chief Nursing Officer Andrew Phillips, Director of Allied Health John McKeefry, General Manager, Human Resources
Reviewed by:	Executive Management Team, Maori Relationship Board, HB Clinical Council, HB Health Consumer Council
Month:	August 2016
Consideration:	For Information

RECOMMENDATION:**That HBDHB Board**

Note the contents of this report.

OVERVIEW

The national General Managers Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators. In September 2013, the executive management team (EMT) considered a paper from Tumu Whakarae about an approach to accelerating Māori health plan indicator performance. As a result, individual EMT members agreed to provide a championship role for the Māori Health Plan across areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from John McKeefry, Chris McKenna and Andrew Phillips, Champions for the Culturally Competent Workforce Indicators.

THIS REPORT COVERS

Priority	Indicator	Champion	Reporting Month
Culturally Competent Workforce	▪ Increase % of HBDHB staff who are Māori ▪ 100% of HBDHB staff have completed Treaty on line training ▪ 100% of HBDHB staff have completed "Effective Engagement with Māori" (EEWM) training ▪ 100% of HBDHB staff have KPI's to accelerate the improvement of Māori health	John McKeefry, Chris McKenna, and Andrew Phillips	July 2016

MRB at its June 2016 meeting identified a number of actions for consideration by EMT as below. These were discussed with MRB at its meeting of 13 July 2016 and have been considered as part of the development of this report.

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

At the July 2016 MRB meeting, MRB also identified further actions for consideration as below.

- Would like to see the midwifery workforce as part of the strategy as Māori midwifery representation is less than 2% in DHBs. Action: The General Manager, Human Resources will look into this with the Chief Nursing Officer
- MRB raised almost two years ago the issues and the need for Māori nursing students to receive formal coaching, pastoral care and Tuakana/Teina support. While EIT are still working on these student services and the DHB are partnering with EIT to develop these services, MRB were somewhat disappointed that these issues have still not been addressed
- There seems to be a gap in the Hiring/ Selection process. Recruitment panels needs strengthening to ensure they understand the need to employ more Māori and why
- Introduction Relationship Based Management Skills training is being led by Andrew Phillips (Director Allied Health HBDHB). Suggest utilising a Māori to support the training to add more value because of their first-hand knowledge and experience
- There is a lot of comprehensive work around having Māori review recruitment processes to ensure Māori priorities and realities are implemented. We should be identifying what is **not** attractive about the DHB rather than trying to make the DHB look attractive. The recruitment process needs to be driven by Māori. Structural issues will impinge on Māori recruitment. The barriers of the recruitment process need to be identified through forensic audits.

MĀORI HEALTH PLAN INDICATOR: Culturally Competent Workforce**% of HBDHB Staff who are Māori****Current Performance**

At 30 June 2015 our Māori staff representation figure increased to 12.3% of our workforce from 8.7% in June 2012. This is off the back of increases from June 2012 (8.7%) to June 2013 (9.9%) to June 2014 (10.8%).

Unfortunately our performance has plateaued with our performance at 30 June 2016 sitting at 12.5% against a target of 14.3%. The position for all workforce groupings at 30 June 2016 is set out in Table A below. This shows for all workforce groupings the percentage of Māori staff has increased. Pleasingly there have been significant percentage increases of Māori staff representation from 2012 to 2016 in our two biggest workforces – Nursing 7.0% to 10.8% and Allied Health, 9.4% to 13.2%.
Note: Nursing workforce data is unable to be broken down into Midwifery workforce data.

Table A

Report as at 30 June last 5 years

	30-Jun-16					30-Jun-15					30-Jun-14				
	Staff	Target	Actual	Actual %	Gap	Staff	Target	Actual	Actual %	Gap	Staff	Target	Actual	Actual %	Gap
Medical - SMO	142	20	2	1.4%	18	140	18	3	2.1%	15	127	15	2	1.6%	13
Medical - RMO	138	20	7	5.1%	13	119	15	4	3.4%	11	123	14	2	1.6%	12
Nursing	1,504	215	162	10.8%	53	1,453	188	147	10.1%	41	1,386	163	129	9.3%	34
Allied Health	553	79	73	13.2%	6	528	68	69	13.1%	-1	525	62	55	10.5%	7
Support	188	27	55	29.3%	-28	181	23	50	27.6%	-27	174	20	49	28.2%	-29
Management & Admin	457	65	73	16.0%	-8	440	57	78	17.7%	-21	426	50	62	14.6%	-12
Total	2,982	426	372	12.5%	54	2,861	371	351	12.3%	20	2,761	325	299	10.8%	26

	30-Jun-13					30-Jun-12				
	Staff	Target	Actual	Actual %	Gap	Staff	Target	Actual	Actual %	Gap
Medical - SMO	132	14	1	0.8%	13	128	12	1	0.8%	11
Medical - RMO	122	13	4	3.3%	9	113	11	3	2.7%	8
Nursing	1,393	149	113	8.1%	36	1,313	128	92	7.0%	36
Allied Health	527	56	53	10.1%	3	521	51	49	9.4%	2
Support	182	19	49	26.9%	-30	186	18	46	24.7%	-28
Management & Admin	420	45	56	13.3%	-11	435	42	43	9.9%	-1
Total	2,776	297	276	9.9%	21	2,696	262	234	8.7%	28

When we look at Health Services where the majority of our staff work as can be seen in Table B below, the largest gaps are in Acute and Medical and Surgical Services.

Table B

Gap by Service	Nursing	Allied Health
Acute & Medical Services	30	7
Director of Nursing (Hospital)		
Surgical Services	20	3
Facilities & Operational Support	4	1
Laboratory		8
Older Persons & Mental Health	(5)	6
Oral Rural & Community		(6)
Woman Children & Youth Service	6	1
Subtotal Health Services	53	10

Māori candidates – application shortlisting, interview appointment**Proposed Target**

It is proposed by MRB that we increase the target to 25% by 2021 to mirror the population demographic for Hawke's Bay. This would see the percentage increases and gap for the next five years as below in Table C.

A 10% increase for each year would see gaps for each year through to 2021 also set out in Table C.

Table C

Increase year on year 11.82%							Increase year on year 10.00%						
Target	% Target	Emps	Target Maori	Actual	% Maori	Gap	Target	% Target	Emps	Target Maori	Actual	% Maori	Gap
2015/16	14.30%	2,970	425	366	12.32%	59	2015/16	14.30%	2,970	425	366	12.32%	59
2016/17	15.99%	2,970	475	366	12.32%	109	2016/17	15.73%	2,970	467	366	12.32%	101
2017/18	17.88%	2,970	531	366	12.32%	165	2017/18	17.30%	2,970	514	366	12.32%	148
2018/19	19.99%	2,970	594	366	12.32%	228	2018/19	19.03%	2,970	565	366	12.32%	199
2019/20	22.36%	2,970	664	366	12.32%	298	2019/20	20.94%	2,970	622	366	12.32%	256
2020/21	25.00%	2,970	742	366	12.32%	376	2020/21	23.03%	2,970	684	366	12.32%	318

This suggests that increasing the target to 25% by 30 June 2021 will be too high a target because of the sheer number of staff to be recruited and even increasing the target year on year by 10% each year will make the target harder and harder to achieve each year.

Table D

Table D below shows by workforce grouping the recruitment of Māori into the HBDHB, the turnover of Māori leaving the organisation and the total number and percent of Māori staff.

Report as at (or year end) 30 June 2016

	RECRUITMENT				TURNOVER		ACTUAL STAFFING 30 JUNE 2016				
	% Maori applied	% Maori Interviewed	% Maori Appointed	% Maori Appointed v Maori Interviewed	Maori	Total DHB	Staff	Target 14.3%	Actual	Actual %	Gap
Medical - SMO	0.0%	0.0%	0.0%	0.0%	0.0%	4.9%	142	20	2	1.4%	18
Medical - RMO	0.4%	2.0%	2.1%	100.0%	0.0%	0.0%	138	20	7	5.1%	13
Nursing	5.5%	12.3%	13.4%	58.6%	11.0%	9.2%	1,504	215	162	10.8%	53
Allied Health	11.7%	15.7%	13.8%	42.5%	5.3%	8.9%	553	79	73	13.2%	6
Support Management & Admin	29.3%	32.7%	24.0%	35.3%	12.2%	12.3%	188	27	55	29.3%	-28
	13.3%	17.0%	14.3%	29.5%	13.2%	10.2%	457	65	73	16.0%	-8
Total	9.3%	14.5%	12.8%	44.4%	10.4%	9.3%	2,982	426	372	12.5%	54

Table D shows that:

For nursing 5.5% of all applicants, 12.3% of interviewees and 13.4% of candidates appointed are Māori, 58.6% of Māori interviewed are appointed.

For Allied Health 11.7% of all applicants 15.7% of interviewees and 13.8% of candidates appointed are Māori. 42.5% of Māori interviewed are appointed.

For Support, 29.3% of all applicants, 32.7% of interviewees and 24% of appointees are Māori. 35.3% of Māori interviewed.

For Management and Administration 13.3% of applicants, 17 of interviewees and 14.3% of appointees are Māori. 29.5% of Māori interviewed and appointed.

This shows we need to increase the number of Māori applying and being interviewed for Nursing, Allied and Management and Administration roles and increase the number of Māori being interviewed and appointed for Support and Management and Administration roles.

As for turnover, Management and Administration and Nursing turnover is higher than the DHB turnover figure. This means we need to do better at reducing turnover in these areas particularly for Nursing as our biggest workforce.

Māori Staff Representation

The DHB wants to achieve Māori staff representation levels equal to the Hawke's Bay population Māori ethnicity of 25%. We want to do this to ensure we can better engage effectively with our communities and provide more jobs (and well paid jobs for Māori).

Overall we have increased Māori staff representation to 12.5% at June 2016. This has largely been achieved through our focus on increasing Māori staff representation in Nursing, increasing from 7.0% at June 2012 to 10.8% at June 2016. Increasing the target from 12.97% at June 2015 to 14.3% at June 2016 did not see a continued lift in performance. Performance at June 2015 was 12.3% only increasing to 12.5% at June 2016. We started the year with a gap of 59 closing to 54 at 30 June 2016. MRB have asked that the DHB commit to a target of 25% by 30 June 2021. This would require net increases of 109, 165, 228, 298 and 376 additional Māori staff through to 30 June 2021. Increasing the target by 10% each year through to 2021 would require net increases in Māori staff representation of 101, 148, 199, 256 and 318 each year to 30 June 2016.

EMT has considered each of these approaches at their meetings of 12 and 26 July 2016. EMT believes that it is better to commit to a realistic and achievable target for July 2017 and work with Medical, Nursing, Allied and other workforce leaders to confirm the targeted actions that need to be taken workforce grouping by workforce grouping to improve performance against the target. EMT believes a target of 30 June 2017 of 10% increase on the actual percentage achieved to 30 June 2016 of 12.5%. This would mean a new target by 30 June 2017 of 13.75%. A new target for the years' after June 2017 can be set once the targetted actions for each workforce grouping have been identified.

100% of HBDHB staff has completed Treaty on line training & 100% of HBDHB staff has completed the "Engaging Effectively with Māori" (EEWM) training.

Current Performance

We launched the newly developed package EEWM in August 2014 and it has been a success. Current training stats as at 30 June 2016 are attached as Appendix A.

To date 1925 current staff members (65.6%) have completed the EEWM training. A total of 86.3% managers have attended.

Feedback from staff attending has been positive and almost all staff feeding back through formal course feedback sheets state that they would recommend the course. We now automatically enrol all new staff onto the EEWM course and are following up with staff enrolled to make sure they attend.

This training is under review and will be modified for internal delivery from within Māori Health Services (MHS) from July 2016 onwards.

Programme Incubator

Our Programme Incubator has been running since 2007. In the 2016 uptake, 19 schools are participating with 352 year 12 and 13 total students of which 89 (28%) are Māori. Our Earn and Learn programme targets year 11, 12 and 13 students that may not have an academic interest but are still interested in working in health. However, once employed into the DHB roles such as Orderlies, Care Associates, Laboratory Technician etc., there is an opportunity to further their career pathway through workplace training to gain national qualifications. This programme has a total of 37 students participating of which 20 (54%) are Māori.

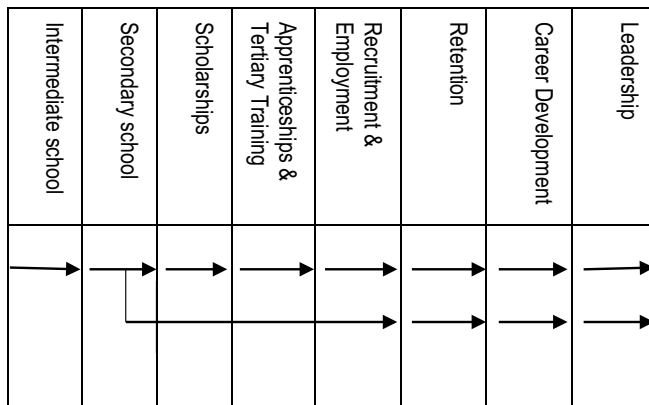
We run our annual Health Careers Expo targeting year 10 and 11 students to get these students interested in health careers and the sciences. Most recently run in June 2016, 492 students in total attended. Ethnicity is not recorded for this.

Turuki

For Turuki we offer Health Workforce New Zealand (HWNZ) funded and other scholarships which have had a total of 79 scholarships taken up over the last three years and promote health careers to Hastings Intermediate students.

Increasing Māori Staff representation

The pipeline for Māori staff out of intermediate and secondary school into employment in the HBDHB is described below:



Students can go from secondary schooling straight into employment or into employment via tertiary training and apprenticeships.

Recruitment and Employment

We need to move our hiring managers to taking on board the challenge of recruiting more Māori staff members from understanding it in their heads to taking it into their HeARTs. We propose to introduce a number of significant new interventions including:

1. Putting in place KPI targets for Māori staff representation into hiring managers' performance plans.
2. Train up all hiring managers to EEW and live our Values/behaviours.
3. Develop a community engagement campaign targeting local Māori through social media and events in conjunction with Communications.
4. Develop a recruitment campaign to map Māori health workers in New Zealand and Australia and target those workers to work in Hawke's Bay.
5. Understand how MHS is able to recruit high numbers of Māori and share learnings with other hiring managers.
6. Re-balance the membership of interview panels to include the hiring manager, professional lead, Māori staff member/consumer AND a community representative.

The current and proposed new actions for the tertiary training and apprenticeships and for the recruitment and employment parts of the pipeline are set out in Table E. Of the new actions identified some have been completed, others progressed and others only recently identified.

Table E

Intermediate school and secondary school student				Status
Current	<u>Turuki</u> – promoting health careers <u>Incubator</u> – promoting health careers in 19 secondary schools - targets year 12, 13 students <u>Earn and Learn</u> – targets 11, 12, 13 year students <u>Health Careers Expo</u> – targets year 10,11 students	New	Community engagement campaign to be developed including targeting Māori through social media and community events (local and national) held in Hawke's Bay).	Under development
		New	Promote new and innovative models of care that better meet community need /achieve equity e.g. EngAGE.	New
Current	<u>Turuki</u> – scholarships 79 Scholarships offered over last 3 years	New	KPI targets for Māori staff representation into hiring managers' performance plans.	New
Current	<u>Tertiary Training</u> Facebook contact with Incubator students	New	Campaign to promote HBDHB at Tertiary institutions Kanohi ki te Kanohi and on-line.	New

Recruitment and Employment				
Current	Focus on nursing with initial focus on Nurse Entry to Practice (NEtP) nursing and valuing locally trained and Māori applicants by weighting of two.	New	Work with Kia Ora Hauora to identify Māori candidates who are keen to work in the Hawke's Bay and develop ongoing relationships through their course of study.	Underway
Current	Using assessment centres to assess candidates demonstrate relationship management, EEWN skills.	New	Position profiles to be updated (key competencies and essential criteria) to include EEWM.	Completed
Current	Broadened focus to Allied Health and other roles systematically reviewing recruitment processes to audit where Māori applicants aren't recruited.	New	Update interview question template to ensure EEWM is Q2 or Q3 and also it is weighted two or higher for assessment.	Completed
Current	Job adverts include statements in Te Reo for some roles e.g. Community Health. Extend for all roles.	New	Ensure all HBDHB hiring managers complete EEWM course and can effectively assess for the competence EEWM	Ongoing (currently 86.3%)
		New	Ensure all members of an interview panel have completed EEWM and for this eventually to be a mandatory requirement before they can be involved in selection and assessment and complete Values and behaviours online training currently being developed.	Ongoing
		New	Include a Māori consumer or Iwi representative on interview panel in the interim utilise Māori staff members. For targeted areas re-balance the membership of interview panels to include the hiring manager, professional lead, a Māori staff member/consumer AND a community representative.	In place for Māori staff
		New	Develop "Day in the Life" video of current Māori staff.	First video developed, five more to come
		New	Briefing of CNMs, nurse leaders, allied health leaders, other hiring managers and Union bipartite forum to confirm focus on recruiting Māori staff.	All briefings held

		New	Understand what MHS are doing well to attract Māori staff to work for their teams, “bottle” it” and extend to other DHB hiring managers and teams. Then work with these teams to develop initiatives to improve Māori staff representation in their areas.	New
		New	Provide monthly reports to hiring managers (in addition to the Māori staff representation and advise KPI performance to date) - Total no. of Māori applicants / total applicants - Total no. of Māori shortlisted / total shortlisted - Total no. of Māori appointed / total shortlisted EMT to receive monthly report.	Requires system development. Almost complete.
		New	Include question in proposal to appoint to ask “Have you appointed a Māori applicant and if not why not.”	Requires system development. Almost complete.
		New	Identify unsuccessful Māori applicants and refer to other hiring managers and MHS for other potential opportunities.	Requires system development. To commence
		New	Systematic debriefing of unsuccessful Māori candidates	To commence
		New	Revise the Request to Recruit form to ask hiring managers to confirm that there is a Maori staff member or consumer on interview panels	Underway
		New	Develop a recruitment campaign to attract Māori staff to the Hawke’s Bay Health Sector. Focussed on: - Mapping the talent pool of Māori Health talent in New Zealand and Australia - Developing a talent and recruitment strategy to attract Māori Health talent to work in Hawke’s Bay. DHB recruitment team to provide proactive for NEtP candidates	Underway
		New	Improve EIT support for training and for application for nursing roles (tie into contract).	New
		New	Use assessment centres for other roles other than NEtP.	New
		New	Recruitment on Marae?	New
		New	Develop mid-career RN recruitment strategy	New
		New	Develop Allied Health recruitment strategy	New
		New	Work nationally to develop Allied Health career progression framework and remuneration to make Allied Health profession more attractive.	New

Retention

For retention Māori turnover has for the 12 months to 30 June 2016 been 10.4% versus the whole of DHB turnover figure of 9.3%. In previous years Māori staff turnover has been below or the same as DHB turnover.

Staff Turnover 12 months ended 30 June 2016 and reasons given by Māori staff for voluntary resignations for each workforce grouping are set out in Table F. Turnover for RMOs is 0% as all RMOs are fixed term and therefore not included in the calculation for voluntary turnover.

Table F

	DHB Turnover	Māori Staff Turnover	Number of Māori resignations	Reasons
Medical - SMO - RMO	4.9% 0.0%	0.0%	0	
Nursing	9.2%	11.0%	10	4 move to alternative position 3 not returning from maternity leave 1 retired 2 other reasons
Allied Health	8.9%	5.3%	3	1 move to alternative position 1 personal reasons 1 retired
Support	12.3%	12.2%	5	1 retired 1 relocating outside HB 1 not returning maternity leave 1 personal reasons 1 other reasons
Management & Admin	10.2%	13.2%	9	4 move to alternative position 2 relocating outside HB 1 retired 2 other reasons
Total	9.3%	10.4%	27	

Staff completion of exit interviews is low internationally and in New Zealand as staff feel it is too late and wonder what is the point. It is the same for the HBDHB with only a small percentage of all staff resigning for the 12 months to 30 June 2016 having completed an exit interview. Retention interviews with focus groups of Māori staff would work better and is proposed as a new retention initiative. For the HBDHB by holding focus groups with groups of Māori staff to understand what they like about working for the DHB, what they don't like and what needs to change. The feedback from these focus groups will be used to change practice within the DHB. Changing practice will lead to increased Māori staff retention.

In respect of additional retention initiatives addition we need to:

1. Revitalise the Tuakana / Teina groups in place and where this is not in place set these up by workforce grouping. This can be done post the focus groups.
2. In order to grow more Māori managers, identify aspirant Māori managers and leaders and enrol into the Basic Management and potentially Transformation Leadership programmes.
3. In rolling out our Values and behaviours team by team ensure our team leaders lead at out on our relationship based management and our Values and behaviours to ensure a supportive team environment is created.
4. Our managers to adopt flexible work practices that are family friendly and supportive and therefore better retain our Māori staff.
5. A new staff engagement survey has been selected (IBM Kenexa) and this provides an opportunity for Māori staff to feedback on a range of questions including questions based on each of our Values and new Behaviours. This survey will be run in October 2016.

Supply of Māori health workers

For each occupational group the 2016 supply of Māori Health Workforce is set out in Table G below: This shows that there will be a higher percentage of medical graduates who are Māori in five years' time but not in the interim. Nursing students across all years at 16.5% Māori which is slightly ahead of our 30 June 2016 target. For occupational therapy and physiotherapy indications are that the percentage of Māori students' graduates is low at 8% and 5%. Overall the supply of Māori health workers is not especially high and provides a challenge when wanting to increase the number of Māori applying for Nursing and Allied Health roles.

Table G

	Total Māori %
Medical	20% 2016 intake only
Nursing	16.35% for all students
Occupational Therapy	8% (estimated)
Physiotherapy	5% (estimated)

Appendix One

Cultural Training at 30 June 2016

By percentage

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	61	14
Medical - RMO	137	10	33
Nursing	1480	993	694
Allied Health	540	405	282
Support	187	96	65
Management & Admin	452	360	278
DHB Total - June 2016	2936	1925	1366

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	43.6%	10.0%
Medical - RMO	137	7.3%	24.1%
Nursing	1480	67.1%	46.9%
Allied Health	540	75.0%	52.2%
Support	187	51.3%	34.8%
Management & Admin	452	79.6%	61.5%
DHB Total - June 2016	2936	65.6%	46.5%

In addition to the specific recruitment initiatives above, add in the Māori staff representation KPI into all managers and team leaders performance plans and reviews.

 HAWKE'S BAY District Health Board Whakawāteatia	Te Ara Whakawaiaora – Mental Health	96
	For the attention of: HBDHB Board	
Document Owner: Document Author(s):	Sharon Mason – Chief Operating Office (Champion) Allison Stevenson, Service Director & Simon Shaw, Medical Director	
Reviewed by:	Paul Malan – Strategic Service Manager; Health Services Leadership Team; Executive Management Team, Māori Relationship Board, HB Clinical Council, HB Health Consumer Council	
Month:	August 2016	
Consideration:	For monitoring	

RECOMMENDATION**That HBDHB Board:**

Note the contents of this report.

OVERVIEW

Te Ara Whakawaiaora (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly with champions to oversee that monitoring and reporting.

Non-performing indicators are identified by the Māori Relationship Board which require special reporting through a channel of committees and then onto the HBDHB Board.

This report is from Sharon Mason, Champion of Mental Health Services Indicators. It focuses on key indicators to improve Mental Health Services for Māori.

UPCOMING REPORTS

The following are the indicators of concern; allocated Executive Management Team (EMT) Champion and reporting month in 2015 / 2016.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Mental Health	Rate of section 29 Compulsory Treatment Orders	81.5% (per 100,000)	Sharon Mason	Allison Stevenson	August 2016
	Percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan	95%	Sharon Mason	Allison Stevenson	August 2016
	PP8 mental health wait times for non-urgent mental health or addiction services seen within three weeks (mental health provider arm), 0 to 19 years	80%	Sharon Mason	Allison Stevenson	August 2016

WHY ARE THESE INDICATORS IMPORTANT?

Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need. Māori are over represented in these statistics, showing that just less than half the consumers on CTO are Māori.

Monitoring the percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan showing the discharge to primary care with a plan in place. Showing the partnership between primary and secondary services. Consumers must have had three face-to-face contacts for a discharge plan to be generated (MoH KPI). HBDHB count all consumers discharged from CAFS Service as having a discharge / transition plan in place.

Ministry of Health monitoring of mental health wait times for non-urgent Mental Health or Addiction Services seen within three weeks, (mental health provider arm), 0 to 19 years, showing people are receiving services within acceptable timeframes of referral to face-to-face appointment. Consumers are not waiting for appointments and the services have been timely and effective in their care.

Inequality in Outcomes in Mental Health Status for Māori

- Māori have a high rate of access to Mental Health Services than non-Māori.
- Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori on average.
- Estimated twelve month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%).
- Hospitalisation rate and readmission rate is higher for Māori (17%).

Rate of Section 29 Compulsory Treatment Orders

The Office of the Director of Mental Health reports annually on rates of Section 29 use by DHBs. The report comments that Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori on average.

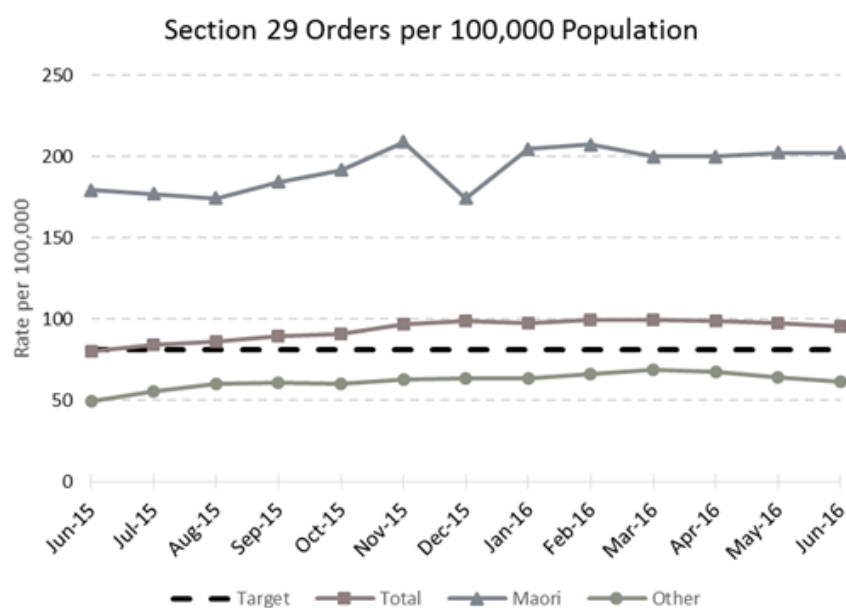
Compulsory Treatment Order (CTO) rates are symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need.

Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies including cultural and social agencies so as to provide a more holistic, integrated and comprehensive response.

No target was assigned to DHBs for this indicator through the “DHB Māori Health Plan Guidance”. However, the guidance document does mention that DHBs are to “reduce the rate of Māori on the Mental Health Act”. The guidance document goes on to state:

New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity. There are regional and local differences, not necessarily related to population mix, which DHBs need to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in Rising to the Challenge, and the Mental Health and Addiction Service Development Plan 2012-2017 including other actions in the plan that relate to addressing disparities or self-management.

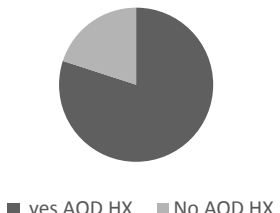
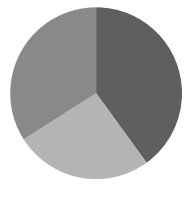
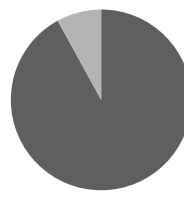
HBDHB Section 29 Orders – June 2015 to June 2016



		Target	Total	Māori	Other
2015/16	Q1	≤ 81.5	86.7	178.6	59.0
	Q2	≤ 81.5	95.6	191.7	62.2
	Q3	≤ 81.5	99.0	204.0	65.9
	Q4	≤ 81.5	97.3	201.6	64.5

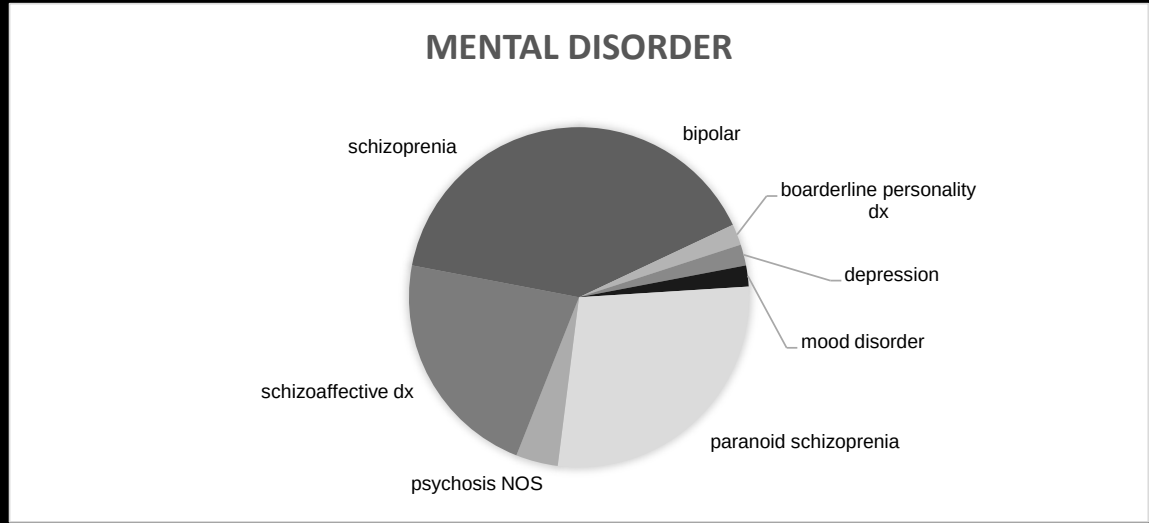
Audit of Fifty Random Consumer Files That Were Placed on the Community Treatment Order (CTO)

In the 2015 / 2016 Annual Plan, we signalled that we would undertake an audit of patients subject to CTO to determine factors associated with treatment under the Mental Health Act. The Mental Health Service completed the audit of fifty random files under the Mental Health Act over the past year showing the socioeconomic factors that are part of a person being place on a CTO. Some key factors examined were:

Addictions History Were addictions part of the person's history? 20% had no addictions history. 80% had an addictions history.	AOD History  ■ yes AOD HX ■ No AOD HX
Family History of Mental Illness Was there a history of mental illness within the family? 40% had a mental illness history. 26 % did not have a history of mental illness. 34 % were unknown.	Family History  ■ yes ■ no ■ unknown
Work Status Was the person employed at the time of the CTO? 92% of people on CTO were unemployed. 8% were is some type of employment.	Work Status  ■ Unemployed ■ Employed

What type of mental illness did people have who were placed under CTO?

People who were under CTO suffered from; schizophrenia 22%, bi-polar 18%, schizoaffective disorder 22% and paranoid schizophrenia 28%

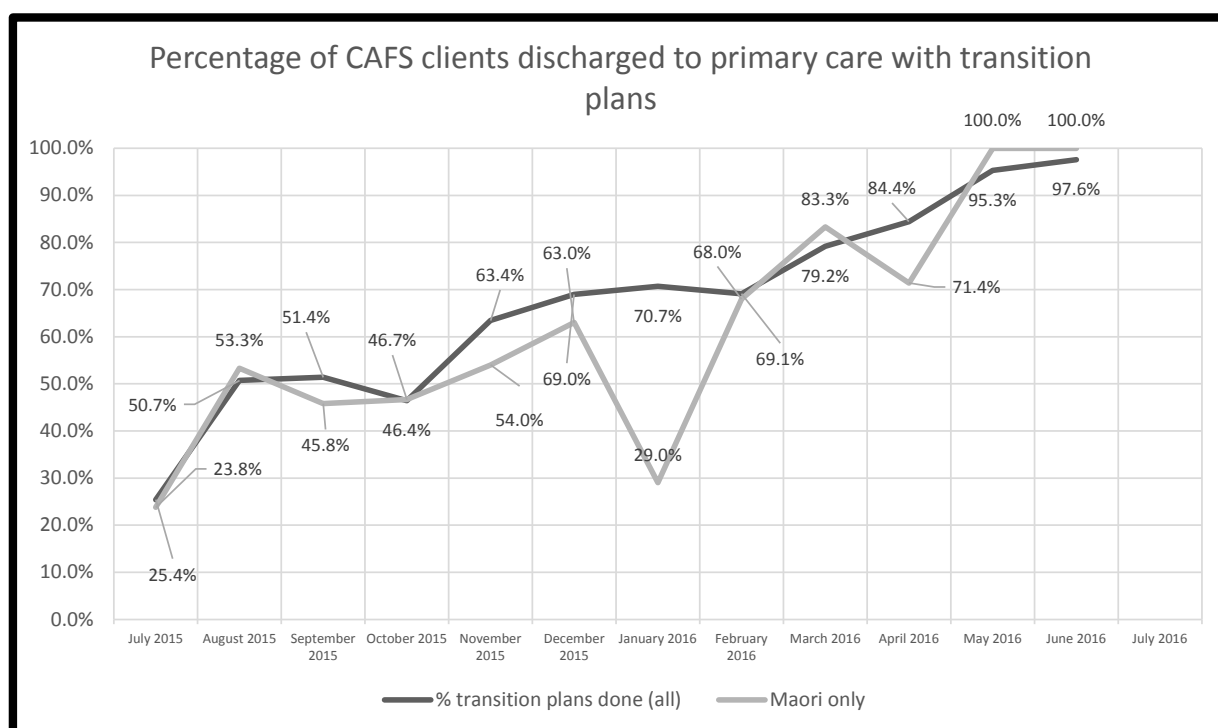


The audit shows that being placed under the CTO is not just about mental health but a complexity of social, family and health factors. In addition, differences in the population rates of these underlying factors may be a significant driver of compulsory treatment and is an important component of any attempt to reduce the rate. Currently we are analyzing the data for Māori vs non-Māori for the same content.

NUMBER 2 INDICATOR***Percentage of Clients Discharged from CAFS and Youth Alcohol and Other Drug (AOD) Services with a Transition (Discharge) Plan***

This ministry measurement is after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and referrer. HBDHB counts all children and family appointment regardless of how many face-to-face contacts have been held.

The below table shows that from July 2015 to July 2016 we have increased from 23.8% to 100%.



NUMBER 3 INDICATOR

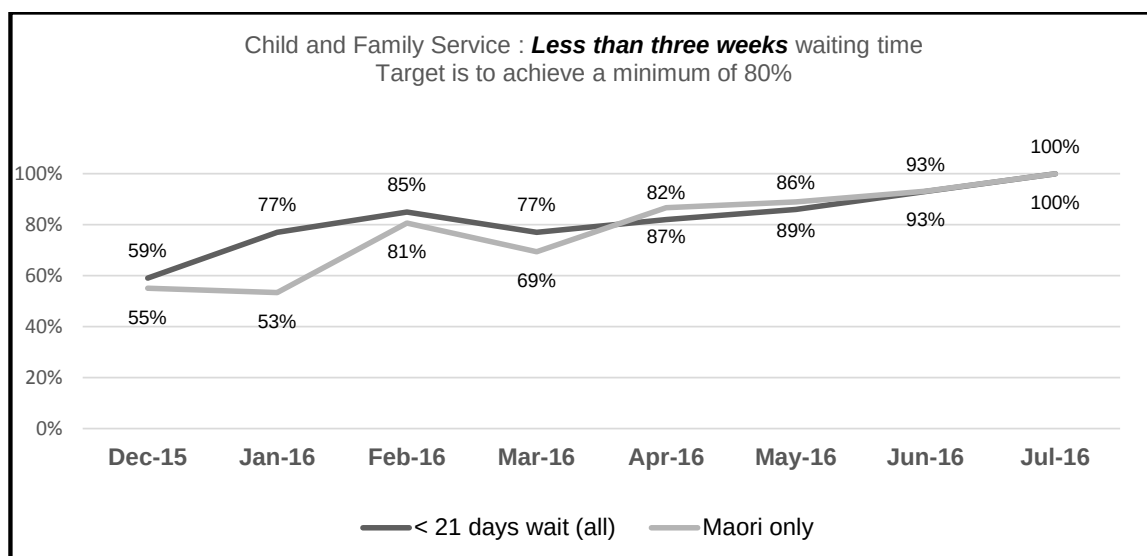
Mental Health Wait Times for Non-Urgent Mental Health or Addiction Services Seen within Three Weeks (provider arm) 0 – 19 years

This indicator shows from the time of receiving the referral from the referrer to the time the child / family are seen by a health practitioner. December 2015 at 59% to July 2016 100%.

Note: the table below is for quarter reporting and only is reported to March 2016.

Mental Health Provider Arm										
12 months to	<3 weeks					<8 weeks				
	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
Mar-16	80.0%	67.4%	66.4%	71.4%	68.0%	95.0%	90.2%	91.4%	95.2%	89.0%

During the first six months of 2016 (i.e. Q3 and Q4), the CAFS team completed extensive work to improve the waiting time between referral and appointment. A consistent improvement from January 2016 is shown in the graph below, and the service is achieving 100% within three weeks as of July 2016.



The second component of this measure is the proportion of CAFS clients seen within eight weeks, with a national target of 95%. In December 2015 we were at 90% and in March 2016, 91.4% for Māori children and adolescents.

As explained above, the CAFS team have completed extensive work on waiting times and we are now (July 2016) achieving 100% of referrals seen within three weeks. We have been achieving 100% for Māori since April 2016 but the eight week indicator has now become irrelevant as no one is waiting longer than three weeks.

CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR***Compulsory Treatment Orders***

In line with Annual Plan 2015 / 2016ⁱⁱⁱ, Mental Health and Addiction Services began an audit of CTO in quarter three. That audit has given us some baseline understanding of the population under CTO. Whilst there is still work to do on further investigation of those factors, the services we are already putting in place, are a new model of care for acute and community services. This includes a shift in focus to a recovery approach that builds resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment. These changes enhance access by integrating hospital and community services, strengthening collaboration with kaupapa services, and developing better primary care responses.

Transition and Discharge Planning

Over the last year we have developed a standard transition plan document / template that covers secondary mental health and addiction services. Every clinician who has primary responsibility for a case now completes the core transition document and we ensure that the primary care provider or primary referrer is prompted to make a follow-up appointment within three weeks. The completed transition plans are communicated to the primary referrer.

Reducing Waiting Times

The work that was planned to support this indicator was mostly procedural and administrative i.e. establishing prompts with appropriate policies and procedures to ensure proactive management of referrals. This was enhanced with good monitoring of results and attention to DNAs.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR

From the HBDHB Annual Plan 2016 / 2017^{iv}, the table below shows the activity that is planned to support the CTO indicator.

Short-term outcome	Activity	Monitoring and Reporting
Māori Health Priority Reduce the rate of Compulsory Treatment Orders	Home-based treatment team increases family involvement with planning and crisis intervention by Q4.	Rate of CTO in Māori and non-Māori 100% of intensive service staff trained by Q3 Number of referrals to specific services SI5: WHĀNAU ORA Key Indicator
	Ongoing daily step up step down with Ngā Rau Rākau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication.	
	Implement intensive day programme from Q1.	
	Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care.	
	Increase availability of treatment options across community mental health services.	
	Building networks within the community – increased use and referrals to NGOs within the community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes by Q2.	

From the HBDHB Annual Plan 2016 / 2017^v, the table below shows the activity that is planned to support transition planning:

Short-term outcome	Activity	Monitoring and Reporting
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) services	Formalise implementation of Transition Planning Checklist as standard practice in Q1.	PP7: 95% of clients discharged with have a transition (discharge) plan + exception reporting
	Amend discharge documentation to include standard prompt to primary referrer in Q2.	
	Introduce "error flag" in patient administration system to prompt completion in Q3.	
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy.	

From the HBDHB Annual Plan 2016 / 2017^{vi}, the table below shows the activity that is planned to support maintaining waiting times:

Short-term outcome	Activity	Monitoring and Reporting
Improve access to CAFS and Youth AOD Services	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful by Q1.	PP8: 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families by Q2.	
	DNA's and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary.	
	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	

PRIMARY AND SECONDARY SERVICES INEGRATION OF MENTAL HEALTH SERVICES

In March 2015, Primary Health Organisation (PHO) commissioned a review of primary mental health services and this was reviewed and completed with recommendations from the Chiplin group. The recommendations are clear about strengthening the relationships between secondary and primary care to improve and support access for clients. If availability of clinical pathways, provision of advice, joint consultations and case discussions were implemented this may reduce the increasing burden on secondary care and provide better outcomes for mental health clients in primary care.

RECOMMENDATIONS FROM TARGET CHAMPION

Activity to support these three indicators is well underway and should continue. The complexity around CTO will be better understood by further analysis of the audit results and, by sharing this information, the services will be better placed to ensure the most appropriate use of compulsory treatment. I support the intentions to increase family involvement, integrate services and service providers, and develop staff capability and to build networks.

Targets in respect of transition planning and waiting times are now all being met. This is commendable and must be maintained. The intentions in the Annual Plan will all help with ongoing

improvement but it is also recommended that the service ensure robust operational performance monitoring of these aspects of service quality in order to capture the gains.

I support the recommendations within the Chiplin report and encourage primary and secondary mental health services to implement mechanisms to allow for further integration.

CONCLUSION

Our changing models of care are designed to increase access to services, including earlier access for all people across the spectrum of need. Mental Health and Addiction Services have come a long way in the last year and it will be good to maintain that momentum and to keep improving on these and other markers of service quality.

REFERENCES

ⁱ Kake, Arnold and Ellis. Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. Aust NZ J Psychiatry. 2008 Nov; 42(11):941-9

ⁱⁱ <http://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance>

ⁱⁱⁱ Hawke's Bay District Health Board, Annual Plan 2015/16. HBDHB.

^{iv} Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.

^v Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.

^{vi} Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.

 HAWKE'S BAY District Health Board Whakawāteatia	Human Resource KPIs (Q4 Apr-Jun 2016)	97
	For the attention of: HBDHB Board	
Document Owner:	Acting GM Human Resources	
Document Author:	Jim Scott, Workforce Analyst	
Reviewed by:	Executive Management Team	
Month:	August 2016	
Consideration:	For Information	

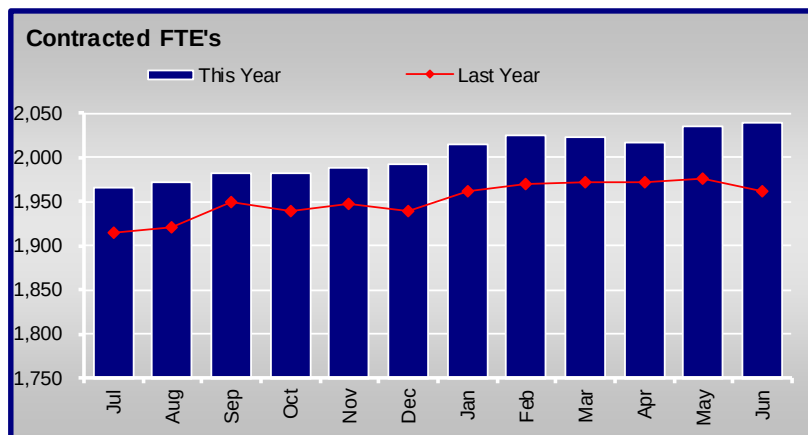
RECOMMENDATION:

That HBDHB Board

Note the contents of this report.

Headcount and positions

Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.



Contracted FTEs
 2038.6 at 30 Jun 2016
 1961.5 at 30 Jun 2015
 = 3.9% increase

Overall increases/ (decreases)

	FTE	
Medical	11.8	5.2%
Nursing	21.0	2.5%
Allied Health	26.1	6.4%
Support	3.0	2.5%
Mge. & Admin	15.2	4.0%
Total	77.1	3.9%

Accrued FTE:

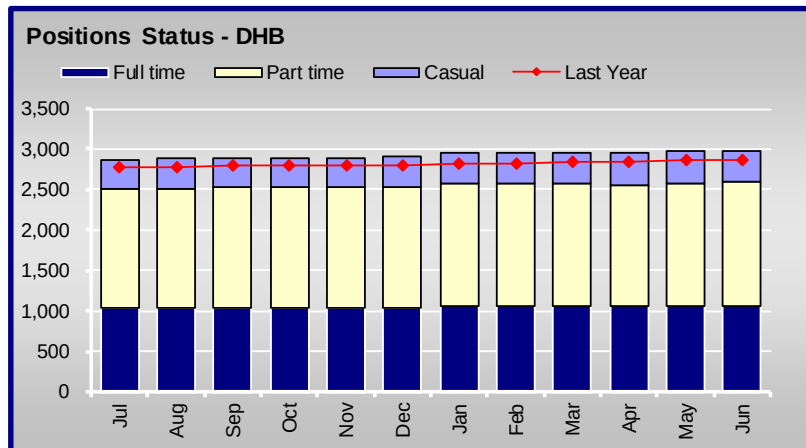
	Budget	Actual	Variance	% Variance
Month of June 2016	2253	2273	(20)	(0.9%)
Year to date to June 2016	2184	2164	20	0.9%

Accrued FTE has a year to date favourable variance to June of 20 or 0.9%. Details are in the Finance Report and include:

	FTE	Comments
Allied Health Personnel	23	Vacancies. Recruitment to positions for new models of care, low supply of applicants, delays in staged recruitment of pharmacy facilitators and difficulty recruiting laboratory vacancies.

New Position Requests to Recruit approved by EMT in April to June 2016 quarter:

Position	FTE
Specialty Clinical Nurse (Cardiac rhythm management)	1.0
Specialty Clinical Nurse (Neurology)	1.0
Kaiawhina	0.4
District Nurse	1.0
Public Health Nurse	0.5
Clinical Nurse Specialist (Fracture Liaison)	0.8
Specialist Otolaryngologist	1.0
Registered Nurse	5.0
Clinical Midwife Co-ordinator (Waioha)	2.8
Project Manager Facilities	0.5
Laboratory Scientist	1.0
Registered Health Practitioner (Emergency Mental Health)	1.0
Social Worker (Inpatient wards)	1.0
Medical Director Quality Improvement & Patient Safety	0.3
Care Associate (Maternity)	1.4
Clinical Nurse Specialist (Palliative Care)	0.5
Project Lead	0.2
Clinical Midwife Co-ordinator (Maternity services)	0.9
Clinical Midwife Co-ordinator (Maternity services)	0.9
District Nurse	1.0
Orderly	1.0
Orderly	0.75



Positions filled:
 2982 at 30 June 2016
 2861 at 30 June 2015
 = 4.2% increase (121 positions)

Of the 2948 positions (last year in brackets):
 36% are full-time (36%)
 51% are part-time (51%)
 13% are casual (13%)

Overall increases/ (decreases) – breakdown of 4.2% increase

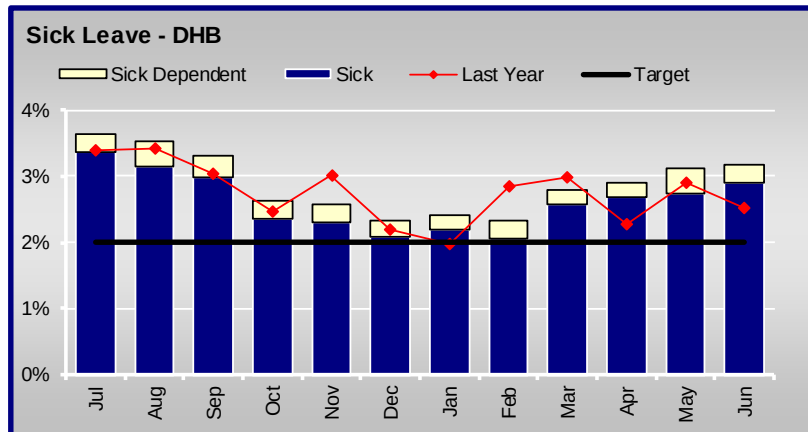
	Full time	Part time	Casual	Total	% change
Medical	4	11	6	21	8.1%
Nursing	(2)	30	23	51	3.5%
Allied Health	21	7	(3)	25	4.7%
Support	2	2	3	7	3.9%
Management & Admin	8	8	1	17	3.9%
Totals	33	58	30	121	4.2%

Sick Leave

The percentage of sick leave taken hours (paid and unpaid) to accrued FTE hours.

Note: as this KPI is reported early in the month, not all sick leave for the previous month has been recorded as yet. Figures and the graph will be adjusted in the following month.

Target is 2.00%



Jun 2016 = 3.18%
Jun 2015 = 2.50%

YTD Jun '16 = 2.90%
YTD Jun '15 = 2.74%

The sick leave taken for the month of June 2016 at 3.18% is above the 2.50% at June 2015. The June 2015 figure was low and at 3.18% for June 2016 is not worryingly high. The year to date figure of 2.90% is not a cause for concern

HBDHB is the second lowest of the mid-sized DHBs.

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 June 2016 – 8th lowest out of 20 DHBs (12 months ended June 2016 ranked 5th lowest)

31 June 2016 – 2nd lowest out of 6 mid-sized DHBs (12 months ended June 2016 ranked 2nd lowest)

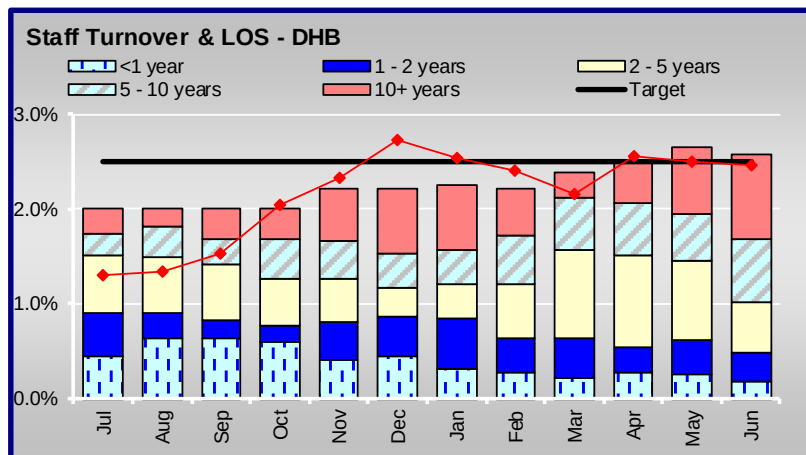
Staff Turnover

Incidence of staff resignations in an organisation. $\# \text{Voluntary resignations} \div \text{Total headcount at the beginning of the period}$. Period is a rolling 3 Months

Note: Junior Doctors (RMOs), Temporary (fixed term) employees and casual employees are excluded from this measure. Employment terminations due to redundancy, death, dismissal and medical grounds are excluded.

A new table has been included in the notes for each section to show total headcount at the beginning of the period, new starts, resignations, transfer and changes of status to reconcile to total headcount at the end of the quarter.

Target is 2.50% per quarter.



3 months ended Jun '16 = 2.58% which is slightly above the target of 2.50%

12 months to Jun '16 = 9.28% which is below the 10% annual target.

Support staff annual turnover is higher (at 12.34%) than the 10% annual target but present no concerns.

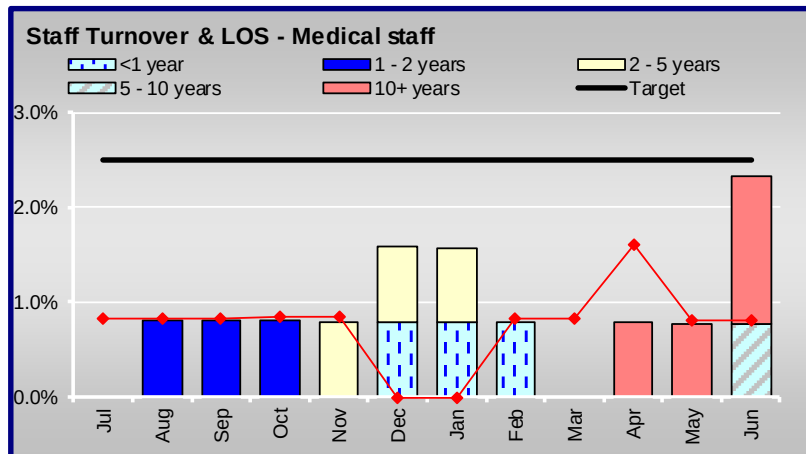
2251	Staff at 1 Apr '16
48	New Staff
(65)	Staff resignations
12	Change of status – mostly fixed term to permanent
2246	Staff at 30 Jun '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 June 2016 – 10th lowest out of 20 DHBs (12 months ended June 2016 ranked 8th lowest)

30 June 2016 – 5th lowest out of 6 mid-sized DHBs (12 months ended June 2016 ranked 5th lowest)

Staff Turnover – Medical Staff



3 months ended Jun '16 = 2.33% which is below the 2.50% target.

12 months to Jun '16 = 4.88% which is below the 10% annual target.

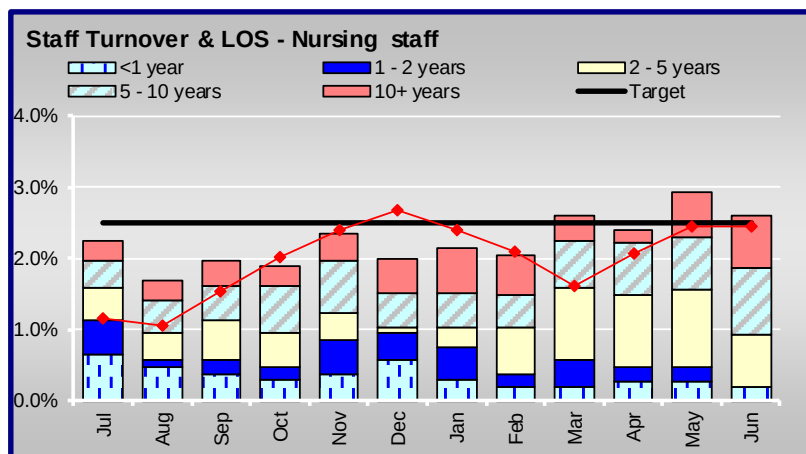
129	Staff at 1 Apr '16
3	New Staff
(3)	Staff resignations
0	Change of status –fixed term to permanent
129	Staff at 30 Jun '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 June 2016 – 16th lowest out of 20 DHBs (12 months ended June 2016 ranked 6th lowest)

30 June 2016 – 6th lowest out of 6 mid-sized DHBs (12 months ended June 2016 3rd the lowest)

Staff Turnover – Nursing Staff



3 months ended Jun '16 = 2.59% which is slightly above the target of 2.50%

12 months to Jun '16 = 9.21% which is below the 10% annual target.

No significant trends.

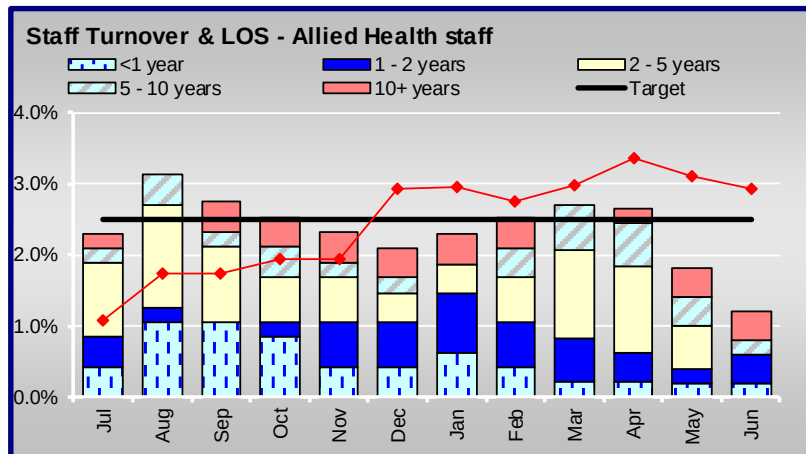
1080	Staff at 1 Apr '16
22	New Staff
(28)	Staff resignations
8	Change of status – mostly fixed term to permanent
(1)	Trf other staff group
1081	Staff at 30 Jun '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 June 2016 – 15th lowest out of 20 DHBs (12 months ended June 2016 ranked 9th lowest)

30 June 2016 – 6th lowest out of 6 mid-sized DHBs (12 months ended June 2016 ranked 5th lowest)

Staff Turnover – Allied Health Staff



3 months ended Jun '16 = 1.21% which is below the 2.50% target.

12 months to Jun '16 = 8.86% which is below the 10% annual target.

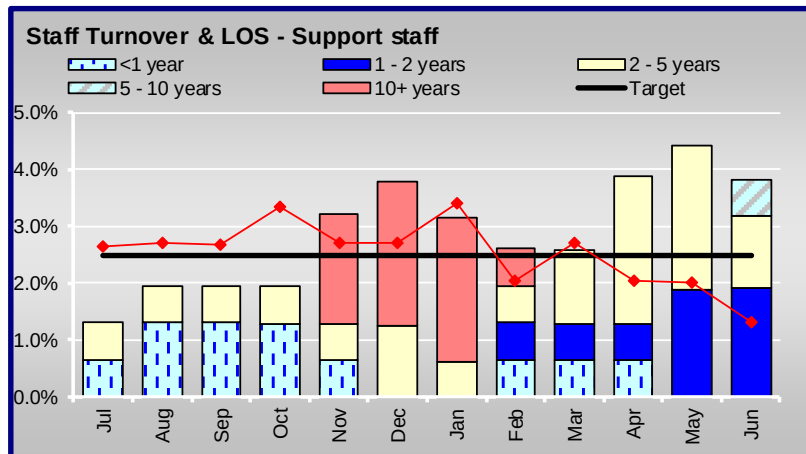
494	Staff at 1 Apr '16
10	New Staff
(14)	Staff resignations
(1)	Change of status – fixed term or casual to permanent
1	Trf other staff group
490	Staff at 30 Jun '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 June 2016 – the lowest out of 20 DHBs (12 months ended June 2016 ranked 3rd lowest)

30 June 2016 – the lowest out of 6 mid-sized DHBs (12 months ended June 2016 ranked the lowest)

Staff Turnover – Support Staff



3 months ended Jun '16 = 3.82% which is above the 2.50% target.

This 3.82% represents 6 resignations in the quarter:

- 2 relocating outside HB
- 1 further education
- 1 not returning maternity leave
- 1 personal reasons
- 1 other

12 months to Jun '16 = 12.34% which is above the 10% annual target.

This 12.34% represents 19 resignations in the year:

- 3 relocating outside HB
- 3 moving to position outside HBDHB
- 3 retired
- 2 further education
- 1 personal reasons
- 1 not returning maternity leave
- 2 other
- 4 unknown

157	Staff at 1 Apr '16
5	New Staff
(6)	Staff resignations
1	Change of status – casual to permanent
0	Trf. other staff group
157	Staff at 30 Jun '16

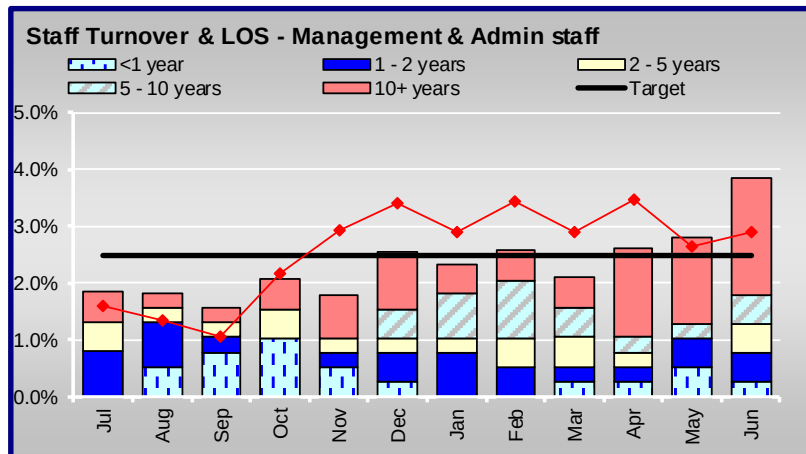
Compared to other DHBS, HBDHB has ranked as follows in the latest quarter.

30 June 2016 – 16th lowest out of 20 DHBS (12 months ended June 2016 ranked 14th lowest)

30 June 2016 – 5th lowest out of 6 mid-sized DHBS (12 months ended June 2016 ranked 4th lowest)

Note a number of other DHBS outsource much of their Support staff which can impact on their Turnover rate.

Staff Turnover – Management & Administration Staff



3 months ended Jun '16 = 3.84% which is above the 2.50% target.

This 3.84% represents 15 resignations in the quarter:

- 4 retired
- 3 relocating outside HB
- 1 moving to position outside HBDHB
- 1 personal reasons
- 1 other reason
- 5 unknown reasons

12 months to Jun '16 = 10.18% which is slightly above the 10% annual target.

This 10.18% represents 39 resignations in the year:

- 13 retired
- 6 relocating outside HB
- 6 moving to position outside HBDHB
- 3 family reasons
- 1 personal reasons
- 1 other reason
- 9 unknown reasons

391	Staff at 1 Apr '16
8	New Staff
(14)	Staff resignations
4	Change of status – mostly fixed term to permanent
0	Trf from staff groups
389	Staff at 30 Jun '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

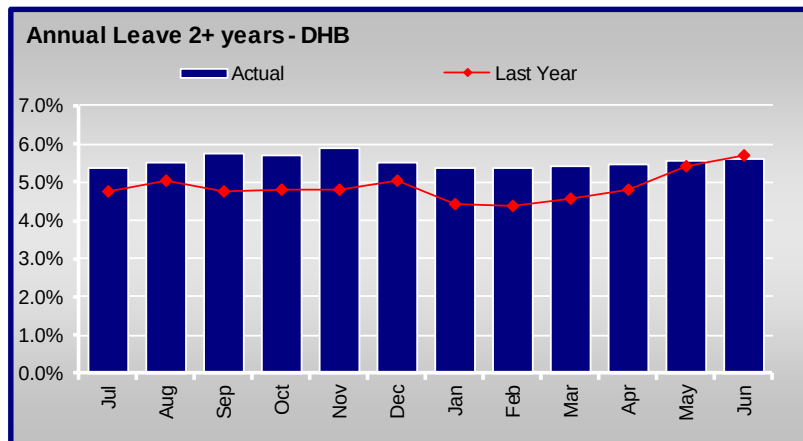
30 June 2016 – 13th lowest out of 20 DHBs (12 months ended June 2016 ranked 11th lowest)

30 June 2016 – 5th lowest out of 6 mid-sized DHBs (12 months ended June 2016 ranked 5th lowest)

Accrued Annual Leave (2+ years)

The percentage of employees where accrued annual leave balance is greater than 2 years annual leave entitlement.

Target is 0%.



Jun '15 = 5.69% (143 staff)
Jun '16 = 5.63% (146 staff)
Increased by 3 although the percentage of staff has decreased.

We are the third best performed mid-sized DHB for this KPI and the 7th best overall.

The total liability at 30 June 2016 was \$18.776m compares to \$19.125m at 30 June 2015. This \$350k improvement is made up of:

1. \$634k favourable driven by a decrease in the hours owing.
2. \$284k unfavourable driven by an increase in the average rates.

Note that the average AL balance has increased slightly over the last 5 years but that staff with 5 weeks (or more) annual entitlements increasing from 51.7% in March 2011 to 65.0% in March 2016.

	Average AL balance (hours)	% staff with an annual entitlement of 5 or more weeks Annual Leave
June 2016	121.53	64.3%
June 2011	119.72	52.8%

Note also that the total leave hours owed (includes statutory lieu leave etc.) is less than this time last year:

	Total Hours Owed	Employees with leave balance	Average Leave balance (hours)
June 2016	447,934	2597	172.48
June 2015	462,460	2520	183.52

We have implemented all the actions identified in the 31 December 2015 HR KPI report and continue to optimise leave taken.

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 June 2016 – 7th lowest out of 20 DHBs (June 2015 – 5th lowest)

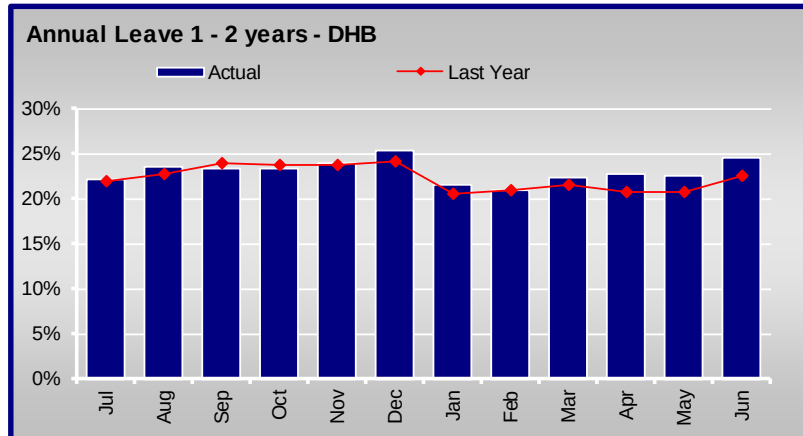
30 June 2016 – 3rd lowest out of 6 mid-sized DHBs (June 2015 – 2nd lowest)

30 June 2016 – 3rd lowest of the central Region DHBs (June 2015 – 3rd lowest)

Accrued Annual Leave (1 – 2 years)

The percentage of employees where accrued annual leave balance is between 1 and 2 years annual leave entitlement.

Target is 15%.



Jun '15 = 22.43% (564 staff)
Jun '16 = 24.43% (634 staff)
Increased by 70

An increase in the number and percentage of staff with 1 to 2 years of annual leave owing.

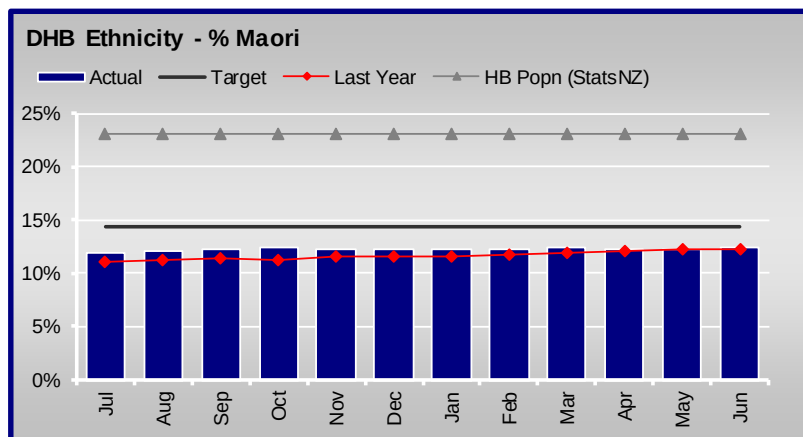
This is a cause for concern especially if the number of staff with 1 – 2 years accrued annual leave begin to spill over into the 2+. Services will need to continue to monitor annual leave balances closely and optimise opportunities to have annual leave taken.

Staff Ethnicity

Measure the number of positions at HBDHB where the incumbents identify themselves as Māori

Target is set at 10% improvement on previous year. 2015/16 target = 14.3%. The Māori population for HB is 23.1%

Note - We generally report on positions so we can break our numbers down for reporting purposes by Occupational Group, Service, and Department etc. Some employees have more than one position in more than one Department, Service or occupational group



Note – at 30 June 2011 the percentage of Māori staff was 8.9% compared to 12.5% at 30 June 2016.

Māori staff representation in the Workforce:

	People	Positions
Jun '16	12.95%	12.47%
Jun '15	12.56%	12.27%

June 2016 breakdown:

	Positions filled	% of Total
NZ & European	2248	75.39%
Maori	372	12.48%
Pacific Islands	35	1.17%
Other	255	8.55%
Not known	72	2.41%
Total	2982	

Support staff (29.26%) and Management & Admin staff (15.97%) exceed the DHB target.

Allied Health (13.20%) Medical (3.21%) and Nursing staff (10.77%) are below the target. Nursing has been the primary focus for recruitment and has increased from 10.1% to 10.8% in the last year.

The gap to our target sits at 54 at 30 June 2016.

365	Maori Staff - 1 Apr 2016
17	New Staff
(12)	Staff resignations
2	Changes to ethnicity
372	Maori Staff – 30 Jun 16

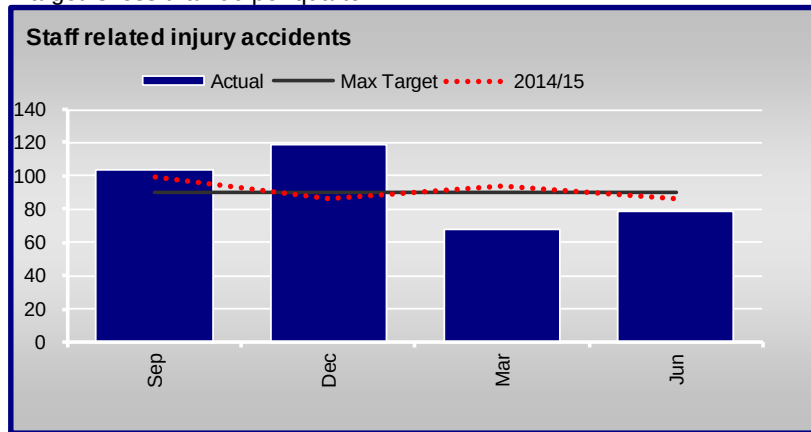
The Te Ara Whakawaiaora (Culturally Competent Workforce) report coming to the August Board identifies a series of actions to improve recruitment and retention of Maori staff.

Occupational Health & Safety KPIs

Staff related injury accidents reported

Workplace injuries reported.

Target is less than 90 per quarter



Total for the quarter = 79

April = 27

May = 21

June = 31

Percentage of total staff by quarter:

June '16	2.7%
Compared to: June '15	3.0%

The June 2016 quarter with 79 accidents was the second quarter in succession where accidents were less than the target of 90 and less than the two previous quarters.

The DHB is putting additional emphasis with the Worksafe Representatives in working with their teams in the identification of hazards and providing education to those teams. The DHB also initiated an online training tool to support greater awareness of health and safety in the organisation.

Of the 79 for the June quarter:

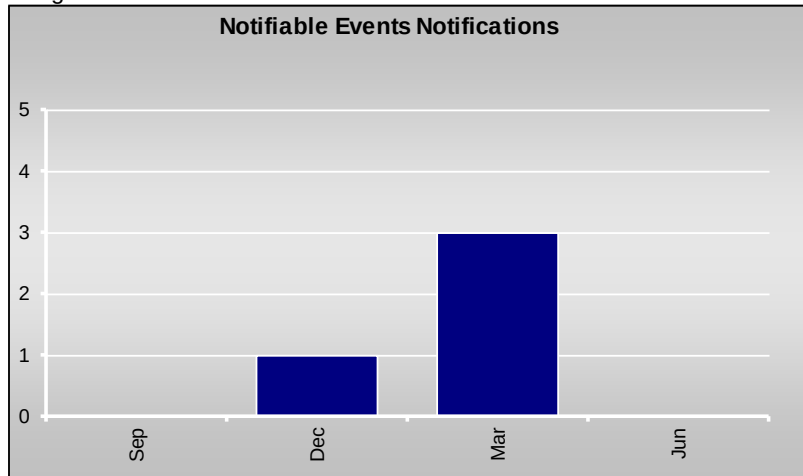
- 28 back injuries/ sprain/ strain
- 25 cuts/ bruises/ lacerations/ burns
- 9 needlestick injuries and exposure to blood and body fluids
- 17 remaining included fracture/ possible fracture, gradual onset discomfort, graze, abrasion.

None of the above were notified to Work Safe NZ as a notifiable event.

Notifiable Events

Accidents notified to the Ministry of Business Innovation and Employment (MoBIE) as soon as possible'. Measured against next working day.

Target is 100% notified on time



There were no notifiable events reported for the quarter.

This is the second quarter in the last 12 months where we have had no notifiable events for the quarter.



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:

- 24. Confirmation of Minutes of Board Meeting**
- Public Excluded
- 25. Matters Arising from the Minutes of Board Meeting**
- Public Excluded
- 26. Board Approval of Actions exceeding limits delegated by CEO**
- 27. Chair's Report**

Reports and Recommendations from Committee Chairs

- 28. Finance Risk and Audit Committee Report**
- 29. HB Clinical Council**

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

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

