# BOARD MEETING

| | |
|---|---|
| **Date:** | Wednesday 26 September 2018 |
| **Time:** | 1:30pm |
| **Venue:** | Te Waiora Room, DHB Administration Building,<br>Corner Omahu Road and McLeod Street, Hastings |
| **Members:** | Kevin Atkinson<br>Ngahiwi Tomoana (Chair)<br>Dan Druzianic<br>Barbara Arnott<br>Peter Dunkerley<br>Dr Helen Francis<br>Diana Kirton<br>Jacoby Poulain<br>Heather Skipworth<br>Ana Apatu<br>Hine Flood |
| **Apologies:** | Hine Flood and Ngahiwi Tomoana |
| **In Attendance:** | Dr Kevin Snee, Chief Executive Officer<br>Executive Management Team members<br>Rachel Ritchie, Chair HB Health Consumer Council<br>Jill Garrett, Strategic Services Manager – Primary<br>Shari Tidswell, Intersectoral Development Manager<br>Dr David Rodgers, GP, Member of Clinical Council and HHB Advisor<br>Members of the public and media |
| **Mintute Taker:** | Brenda Crene |

**Public Agenda**

| Item | Section 1: Routine | Ref # | Time (pm) |
|---|---|---|---|
| 1. | Karakia | | 1:30 |
| 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 – Kevin Snee | 128 | |
| 9. | Financial Performance Report – Carriann Hall | 129 | |
| 10. | Board Health & Safety Champion's Update – Board Safety Champion | 130 | |
| | **Section 2: Reports from Committee Chairs** | | |
| 11. | HB Clinical Council – Co-Chairs, John Gommans / Andy Phillips | 131 | 2:10 |
| 12. | HB Health Consumer Council – Chair, Rachel Ritchie | 132 | |
| 13. | Māori Relationship Board – Chair, Heather Skipworth | 133 | |
| | **Section 3: For Discussion / Information** | | |
| 14. | After-Hours Urgent Care Update – Wayne Woolrich and David Rodgers | 134 | 2:30 |
| 15. | Clinical Services Plan update – Ken Foote | 135 | 2:40 |
| 16. | Matariki Regional Development Strategy and Social Inclusion Strategy Update – Shari Tidswell | 136 | 2:45 |
| 17. | Annual Plan 2018/19 Update (no presenter) | 137 | 2:55 |
| | **Section 4: General Business** | | |
| 18. | **Section 5: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000 | | |

**Public Excluded Agenda**

| Item | Section 6: Routine | Ref # | Time (pm) |
|---|---|---|---|
| 19. | Minutes of Previous Meeting (public excluded) | | |
| 20. | Matters Arising – Review of Actions (nil) | | |
| 21. | Board Approval of Actions exceeding limits delegated by CEO | 138 | 3:00 |
| 22. | Chair's Update (verbal) | | |
| | **Section 7: Reports from Committee Chairs** | | |
| 23. | Finance Risk and Audit Committee – Chair, Dan Druzianic | 139 | 3:05 |
| | **Meeting concludes** | | |

**The next HBDHB Board Meeting will be held at 1.30pm on Wednesday 31 October 2018**

## Board "Interest Register" - 8 August 2018

| Board Member Name | Current Status | Conflict of Interest | Nature of Conflict | Mitigation / Resolution Actions | Mitigation / Resolution Actions Approved by | Date Conflict Declared |
|---|---|---|---|---|---|---|
| Kevin Atkinson (Chair) | Active | Trustee of Te Matau a Maui Health Trust | The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders. | Will not take part in any decisions or discussion in relation to the Trust | The Chair of FRAC | Mar-11 |
| | Active | Board Member of NZ Health Partnership Limited, *effective from 20 March 2017* | Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services. | Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified. | The Chair of FRAC | 22.02.17 |
| | Active | Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited. | Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines. | Will not take part in any decisions or discussions in relation to HBDHB electricity contracts.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair of FRAC | 26.10.17 |
| Ngahiwi Tomoana (Deputy Chair) | Active | Chair, Ngati Kahungunu Iwi Incorporated (NKII) | Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB:<br>(i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department.<br>(ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department. | Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB. | The Chair | 01.05.08 |
| | Active | Uncle of Tiwai Tomoana | Perceived Conflict of Interest. Non-Pecuniary interest.<br>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.<br>Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital. | Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital. | The Chair | 01.05.08 |
| | Active | Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government | Requested that this be noted on the Interest Register | Unlikely to be any conflict of Interest. | The Chair | 28.03.18 |
| Barbara Arnott | Active | 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 |
| | 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.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair | 26.10.17 |
| Dr Helen Francis | Active | Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited. | Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines. | Will not take part in any decisions or discussions in relation to HBDHB electricity contracts.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair | 03.10.11 |
| | Active | HB Medical Research Foundation | Trustee | Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on. | The Chair | 20.08.14 |
| | Active | Independent Consultant | To a variety of health organisations. | Will declare at the beginning of meeting(s) if there are any projects that have anything to do with items on the agenda and will not be involved in those discussions | The Chair | 26.02.18 |

| Board Member Name | Current Status | Conflict of Interest | Nature of Conflict | Mitigation / Resolution Actions | Mitigation / Resolution Actions Approved by | Date Conflict Declared |
|---|---|---|---|---|---|---|
| Diana Kirton | Active | Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB. | Perceived Conflict of Interest. Non-Pecuniary interest. | Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO | The Chair | 18.02.09 |
| | Active | Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014 | Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers. | Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on. | The Chair | 16.01.14 |
| | Active | Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited. | Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines. | Will not take part in any decisions or discussions in relation to HBDHB electricity contracts.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair | 03.10.14 |
| | Active | Member, Hawke's Bay Law Society Standards Committee | Law Society | No conflict perceived | The Chair | 20.06.17 |
| | Active | RENEW Counselling Services | Counsellor | No conflict perceived | The Chair | 17.07.17 |
| Dan Druzianic | Active | Director of Markhams Hawke's Bay Limited | Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB | Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter. | The Chair | 7.12.10 |
| Jacoby Poulain | Active | Board Member of Eastern Institute of Technology (EIT) | Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations. | Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT | The Chair | 14.1.14 |
| | Active | Councillor Hastings District Council | Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay | Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action. | The Chair | 14.1.14 |
| Heather Skipworth | Active | Daughter of Tanira Te Au | Kaumatua - Kaupapa Maori HBDHB | All employment matters are the responsibility of the CEO | The Chair | 04.02.14 |
| | Active | Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited) | The Trust has contracts with HBDHB including the<br>Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal) | Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited. | The Chair | 04.02.14<br><br>25.03.15<br>29.03.17 |
| | Active | Director of Kahungunu Asset Holding Company Ltd | The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest. | Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair. | The Chair | 26.10.16 |
| Peter Dunkerley | Active | Trustee of Hawke's Bay Helicopter Rescue Trust | Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB | Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB | The Chair | 15.05.14 |
| | Active | Shareholder Need a Nerd | IT support for home or business | No conflict perceived | The Chair | 13.12.17 |
| | Active | Shareholder of NZ Technologies | Technology and innovative support for businesses to grow | No conflict perceived | The Chair | 13.12.17 |
| Ana Apatu | Active | CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)<br>The U-Turn Trust renamed / rebranded "Wharariki Trust" (advised 30-8-17) | Relationship and and may be contractural from time to time | No conflict | The Chair | 5.12.16 |
| | Active | Whakaraki Trust "HB Tamariki Health Housing fund" | Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau. | Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement. | The Chair | 8.08.18 |
| Hine Flood | Active | Member, Health Hawkes Bay Priority Population Committee | Pecuniary interest - Oversight and advise on service delivery to HBH priority populations. | Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB | The Chair | 14.02.17 |
| | Active | Councillor for the Wairoa District Council | Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region. | Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action. | The Chair | 14.02.17 |

**MINUTES OF THE BOARD MEETING**
**HELD ON WEDNESDAY 29 AUGUST 2018, IN THE TE WAIORA ROOM,**
**DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS**
**AT 1.30PM**

**PUBLIC**

**Present**: Ngahiwi Tomoana (Chair)
Dan Druzianic
Peter Dunkerley
Diana Kirton
Barbara Arnott
Heather Skipworth
Jacoby Poulain
Ana Apatu
Hine Flood

**Apology** Kevin Atkinson and Helen Francis

**In Attendance**: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Drs Gommans and Phillips (as co-Chairs, HB Clinical Council)
Rachel Ritchie (Chair, HB Health Consumer Council)
Members of the public and media
Brenda Crene

**APOLOGIES**

Noted above had been received from Kevin Atkinson and Helen Francis

Chair Ngahiwi Tomoana opened the meeting.

**3. INTEREST REGISTER**

No changes to the interests register were advised

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

**4. CONFIRMATION OF PREVIOUS MINUTES**

The minutes of the Board meeting held on 25 July 2018, were confirmed as a correct record of the meeting.

**Moved: Peter Dunkerley**
**Seconded: Hine Flood**
**Carried**

**5. MATTERS ARISING FROM PREVIOUS MINUTES**

Item 1: **HR KPIs workforce detail –** this will be provided via CEO's report monthly, action to be removed.

Item 2: **Addiction Services update** – ongoing

Item 3: **IS Topics –** separate sessions for the board to be advised by Anne Speden. Action to be removed.

Item 4: **He Ngakau Aotea –** Moved to later in the year and included on the workplan, action to be removed.

Item 5: **H&S matters noted within Pharmacy –** Understanding on approaches available in the medium / long term to achieve a better solution. Included on workplan as an action, for Kate Coley to respond to.

Item 6: **Maternal Well-Being Programme Update –** Included on workplan (likely October) action removed.

## 6. BOARD WORK PLAN

The Board Work Plan was noted as being buy in October.

## 7. CHAIR'S REPORT

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

| Name | Role | Service | Years of Service | Retired |
|---|---|---|---|---|
| Elizabeth Crosland | Kitchen Assistant | Operations Directorate | 13 | 31-Aug-18 |

- Nothing further to report.

## 8. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report, commenting on the following:

- Noted the nurses pay settlement was welcome which will bring further investment into nursing positons which is helpful.
- July was another difficult month in ED and August no better. A lot of pressure has been due to winter and now influenza is affecting both patients and staff.
- Elective surgery: we do have a backlog in patients waiting for outpatient treatment and elective surgery and will come back to the Board and talk about a range of areas where work is being undertaken to address this. Follow-up gaps have been recognised nationally and there is work progressing to address this according to clinical need.
- Faster Cancer Treatment has been improving; Immunisation has dropped slightly; the smoking target is lower but in the process of being changed to a better measure. A lot of work is being done centrally to look at health targets to have them more relevant. However the bad news is, there will be more of them.
- The Financial positon is marginally ahead of plan for the first month of the financial year.
- The health system continues to be under pressure.
- The Capital Plan is being worked through and rationalised due to our forecasted deficit. In 2018/19 we will no longer be able to fund capital programmes to the extent we have. If we look at where we were in 2009, with a $5m deficit and carry that forward then all of the new facilities which have been built, could not have been afforded. Capital funding afforded by HBDHB equates to around $70m.

## 9. FINANCIAL PERFORMANCE REPORT

Carriann Hall, newly appointed Executive Director of Financial Services spoke to the Financial Report for July 2018, which showed $12,000 favourable to plan, with no contingency released.

Comments noted in addition to the report included:

- $8.6m adverse against plan for 2017/18. Undergoing audit process at the moment. A final draft of the Annual Report 2017/18 will be brought to FRAC and the Board, however timing will require delegated authority to be obtained for signing.
- Confirmed that a deficit of $5m had been agreed for the 2018/19 year
- 2018/19 will be seen as a transition year with a targeted focus to get the DHB back on to a sustainable footing.
- There has been a need to review the Capital Plan due to the forecasted deficit this financial year.

### 10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

The Board Safety Champion, Ana Apatu advised she had visited the Tower Block A2 & B2 and found the staff were doing a very good job.

The B2 ward contained various multidisciplinary areas. Ana raised in particular the 'discharge lounge' which has a lot of traffic, and was certainly not fit for purpose. Those being discharged were seated very close to each other, there was no privacy when doctors visited to discuss cases with patients being discharged. It was suggested a discharge lounge may be best closer to the main entrance.

The A2 ward, the home to neurology and stroke patients was viewed also. The lack of handrails in the corridors was noted. They were struggling with oxygen cylinders (trolleys were needed and understood difficult to get).

With summer coming on, the heat in the tower block will again be extremely challenging, especially on the west side of the building. This will now be further heightened by the lack of airflow due to the new Endoscopy Unit build on the east side. This was of real concern for both patients and staff.

IT was noted that the cleaners should be complemented, as the wards were spotless.

Prioritising risks is crucial when working with minimal funds! Several options were mentioned by the CEO and the Facilities Manager. Matrix's are used when prioritising, and in a quiet month it was suggested take FRAC through the process for assessing capital works. **Action**
It was advised that an engineer is being utilised to look at varying options to cool the tower block.

## SECTION 2: PRESENTATION

### 11. HBDHB ENVIRONMENTAL SUSTAINABLE HEALTH CARE - MoH Expectations

Lisa Malde (Sustainability Officer) and Gavin Carey-Smith (Facilities Manager) were in attendance for this presentation. Nick Jones and team also instrumental in this work.

The presentation provided covered: **Climate Change Mitigation / Sustainability in DHBs** and what other DHBs currently have in place;

**Focus areas:** Energy and Carbon Management; Sustainable Waste Management (reduce waste and increase recycling); Sustainable Water Management; Sustainable and Efficient Buildings and Site Design; Sustainable Transportation and Travel Management.

**Impact of Climate Change on Human Health** include severe weather / extreme heat, air pollution, increasing allergens, food and water supply impacts.

Advised they had been working within facilities for some time around sustainably and are now looking to ramp up activities in this area.

An overview of HBDHB's **current status and Next Steps** was provided. A Business Case will be brought forward covering requirements needed to reach targets to attain MoH Sustainable Health Care.

In summary:

- Gathering data stage: waste, vehicles, staff travel, huge assessment and once the process is complete an inventory report will be prepared and compared with other DHBs.

- Then have a reduction and management plan – over three years. The vehicle to attain certification is CEMARS, gold standard and the only certified programme in NZ (with benchmark ability) which HBDHB are currently working towards achieving.
- Interdepartmental collaboration will follow, driving and advocating regional environmental sustainability.
- We need to ensure we get the equity outcomes.
- Our role with water and waste quality – we are working with stakeholders on a range of areas.

The presentation was well received by the Board.

## SECTION 3: REPORT FROM COMMITTEE CHAIRS

*This additional item was included onto the Board agenda after papers had been issued:*

**PRIMARY CARE DEVELOPMENT PARTNERSHIP – GOVERNANCE GROUP REPORT**

The inaugural meeting of the Primary Care Development Partnership Governance Group (PCDP) had been held on 22nd August 2018. This and future reports will be provided to the boards of HBDHB and Health HB. The makeup of the group includes: 3 HBDHB Board members, 3 Health HB Board members; 1 representative from each of MRB, Clinical and Consumer Councils.

There is such a sense of good will with everyone involved feeling really optimistic around this critical piece of work. Noted that the earlier Health Alliance had been in existence for some time ie, an historical partnership not meeting regularly. We need to show this new relationship, with a different name will be courageous and progressive. The bar has been set high.

There will be a formal Powhiri launch held in September 2018.

### 12. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair Andy Phillips spoke to the report from the Council's meeting held on 8 August 2018:

He mentioned, in particular, the Violence Intervention Programme presentation received by Council and in particular the leadership and commitment of Claire Caddie, Russell Wills and Cheryl Newman.

Cheryl and team have done a lot of really good work and noted also there had been missed opportunities to make a difference. Council recognised the importance and need to greatly improve outcomes in this area - one being an opportunity for early detection factored in to clinical pathways (noted by clinicians they/or their staff were not consistent in asking the right questions); DHB and primary care support for staff resilience, and the Intersectoral areas working together.

Council also:

- Received the presentation on the Annual Plan for 2018/19
- Received verbal updates on the People & Quality Dashboard and Clinical Services Plan
- Discussed preparation for the AGM
- Noted the update from the Clinical Advisory & Governance Group
- Noted reports received for information being the. Te Ara Whakapiri Next Steps (Last Days of Life); and Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs

### 13. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised she was looking forward to working as a member of the Primary Care Development Partnership Governance Group and will be able to keep her members updated on a number of matters going forward.

Again she noted the need for a more whanau centred care focus throughout HBDHB!

Within the Consumer Council some good work is being done by deputy Consumer Council Chair, Dr Diane Mara who has been working with Pasifika Health noting the need for Pasifika needs to be

visible as a specific group; and also on the development of a Disability Strategy which has come from within Consumer Council.

Council also:

- Received an Annual Plan 2018/19 presentation
- Received an update on the Primary Care Service Development Plan, with particular interest and discussion around access to primary care, measuring equity improvements, how wrap around services should be provided and relationships with other agencies. Huge interface for consumers.
- Progress updates on these papers were noted: Te Ara Whakapiri Next Steps (Last Days of Life); and Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs

## 14. MĀORI RELATIONSHIP BOARD (MRB)

Heather Skipworth as Chair of MRB spoke to the report for the meeting held on 8 August 2018.

It was advised that 'He Nakau Aotea' was being presented to the community prior to coming back to Board.

A number of those who had travelled to view the South Central Foundation's 'Nuka Model' had gathered to discuss what had been learnt, with further meetings planned. Commented that they would like to see a similar (Nuka) model implemented through the Clinical Services Plan but wish to discuss with the community first.

Graduate nurses who commence their nurse entry to practice NEtP had five Māori nurses on the programme, with four having pulled out. Several months ago Ngaira Harker (Māori Nurse Director) had submitted a report around strengthening support for these nurses. We have a great track record bringing nurses on to the programme but have difficulty sustaining commitment. A range of interventions is being looked at.

MRB also:

- Received the HBDHB Annual Plan 2018/19 presentation.
- Received HBDHB Performance Framework Exceptions Report Q4, requesting further detail
- Received an update on progress with the Clinical Services Plan
- Noted and discussed the Te Ara Whakawaiora Access rates 0-4 / 45-64 years Q4 report. Endorsed the actions being taken; Supported recommendations made by EMT including future quarterly updates. Noted there are limited formal systems in place that address "equity", with a need to focus more on this area.

## 15. PASIFIKA HEALTH LEADERSHIP GROUP (PHLG)

Barbara Arnott (Chair of CPHAC) who oversees the PHLG provided an overview of the meeting held 13 August 2018. Andy Phillips and Emma Foster had attended the meeting along with Ken Foote (who explained their governance role).

Talalelei Taufale the Pacific Health Development Manager was also in attendance at the Board meeting.

An overview of the 'Le Va Engaging with Pasifika Training' provided to EMT, general practice, HR, and Hohepa had been well-attended, which highlighted the building of relationships and specific Pacific targeted interventions as being fundamental to the improvement of Pacific health.

The PHLG will work with the Pasifika Health team to develop community engagement opportunities for; bowel screening, Clinical Services Plan, Ministry of Health refresh of the Ministry's 4 year plan for Ala Mo'ui (pathways to Pacific health and wellbeing 2014-18), and Pacific youth research.

Talk about health being in the community, about Cook Island Leaders – connecting and building relationships and looking innovatively vs standard way.

The Equity Report being developed will include Pasifika.

PHLG also wish to explore opportunities to work closer with Pasifika members on the Consumer Council. The Chair of Consumer Council Rachel Ritchie advised that would be welcomed. **Noted**

Advised they are looking at targeted interventions – not just the people we work with, it is the service providers also – full wrap around.

Need to make a real difference in the population about what commissioning means. This is about pushing greater levels of discretion and autonomy about delivery. It is about targeted interventions/solutions being put in place that may look very different to that put in place in other areas of the community eg., Māori.

## SECTION 4: FOR INFORMATION

### 16. TE ARA WHAKAPIRI NEXT STEPS (last days of life)

The paper was received by the Board for information only.

It was noted that MRB had provided a favourable response and embraced this Framework as an approach (back in April), and identified that the Plan was perfect in relation to effectively engaging with Māori whānau. It was suggested this be circulated to the Councils and Board for their information.

Former DHB employee Leigh White had worked with Maori Health to develop this. The assessment tools that evolved from the process were high level and clearly was a transferable tool.

### 17. TE ARA WHAKAWAIORA – ACCESS RATES 0-4 45-64 YEARS (local indicator)

Chris Ash (Executive Director, Primary Care) presented this paper.

Following several years of progress with 0-4 years, there appears to be some elements of reversal. For 56-64 years it appears that we are not getting the traction.

Dental has kept the equity gap manageable, and narrowing. Had focussed on conditions that mattered to Maori and Pasifika, now there is a shift to wrap around care, not condition specific.

Patrick LeGeyt advised that the beauty of Te Ara Whakawaiora reporting is not about holding people to account but more about what is the meaning for inputs. When we have a collaborative effort, we see results. Where we see no actions, we see slippage.

There was some discussion around oral health treatment and the perception that it had left primary schools. This was not the case. There are mobile services taken into schools and rural communities. There is a comprehensive project on oral health (a collaborative project) with a whole range of activities happening. This is all about a whanau approach, rather than siloed approach with 20 cars up the driveway. It is about a community based model and the community looking after their own health care.

**RECOMMENDATION:**

That the HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the actions being taken.
3. **Support** recommendations made by EMT (31 July 2018)

   Provide quarterly updates against activities that:

   - contribute to the Te Ara Whakawaiora indicators;
   - are reported against as part of the System Level Measures Improvement Plan
     - Keeping Children out of Hospital and Using Health Resources Effectively.

**Moved Dan Druzianic**
**Seconded Heather Skipworth**

**Carried**

## 18. PERFORMANCE REPORTS

### 18. 1 HBDHB Non-Financial Performance Framework Dashboard Q4 April-June 18

Jacoby queried a programme 12 week LMCs system issue, advising fragmentation and a systemic issue. This would be discussed with Jacoby outside of the meeting. **Action**

### 18. 2 HBDHB Non-Financial Performance Exceptions Report Q4 April-June 2018

The report was received and noted with no further discussion.

### 18. 3 HBDHB Quarterly Performance Monitoring Dashboard Q3 (provided by MoH)

The report was received and noted with no further discussion

## 19. CLINICAL SERVICES PLAN UPDATE

Ken Foote provided an update of progress made since the previous Board Meeting in July, advising that a full and comprehensive CSP consultation programme was commencing with the HB community the following week (from 3 September 2018).

Anna Kirk, Communication Manager showed the CSP video prepared as part of the consultation process. In addition, pamphlets will be issued and distributed widely.

## SECTION 5: GENERAL BUSINESS

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

## 20. RESOLUTION TO EXCLUDE THE PUBLIC

The Chair moved that the public be excluded from the following parts of the meeting:

21. Confirmation of Minutes of Board Meeting - Public Excluded
22. Matters Arising from the Minutes of Board Meeting - Public Excluded
23. Board Approval of Actions exceeding limits delegated by CEO
24. Chair's Update
25. HB Clinical Council
26. Finance Risk and Audit Committee
27. Whole of Board Appraisal

**Moved:** **Hine Flood**
**Seconded:** **Dan Druzianic**
**Carried**

There being no further business, the public section of the meeting closed at 3.04pm

**Signed:** ______________________________
**Chair**

**Date:** ______________________________

# BOARD MEETING - MATTERS ARISING (Public)

5

| Action | Date Entered | Action to be Taken | By Whom | Month | Status |
|---|---|---|---|---|---|
| 1 | 30/5/18<br><br><br>25/7/18 | **Human Resource (HR) KPIs – Maori Workforce**<br>Detail sought by Ngahiwi Tomoana in June 2018.<br>Monthly updates on Maori Workforce to be provided via CEO's Report.<br><br>*Update:*<br>HR KPI report for Q4 and Māori workforce data for CEOs report (monthly), to be provided in October. | Kate Coley | Sept 18<br><br>Oct 18 | Māori workforce data provision delayed (due to Analyst on leave) |
| 2 | 27/6/18<br><br><br>25/7/18 | **Addiction Services**<br>Raised by Diana Kirton in June advising this does not appear on the workplan currently.<br>To be determined<br>A number of teams in primary care are working up a scoping report. | Colin Hutchison<br>Chris Ash | | Ongoing |
| 3 | 25/7/18 | **Health and Safety matters**<br>**Pharmacy:** to be reviewed (refer to Board H&S Champion's report in July. Useful to gain an understanding on the approaches available in the medium to long term to achieve a better situation. | Kate Coley<br>Anne McLeod & Colin Hutchison | Sept 18 | FRAC agenda |
| 4 | 31/8/18 | **Capital Expenditure -** Matrix Presentation, explaining the prioritisation of risks when working with minimal funds. Gavin Carey-Smith suggested to provide this to FRAC in a quiet month. | Admin | TBD | To be transferred to FRAC actions. |

6

## BOARD WORKPLAN

**As at 20 Sept 2018**

| **31-Oct-18** | **EMT Member** | **MRB Meeting Date** | **Clinical Council Meeting Date** | **Consumer Council Meeting Date** | **BOARD Meeting date** |
|---|---|---|---|---|---|
| Radiology Facility Development Business Case | Colin Hutchison | | 10-Oct-18 | | 31-Oct-18 |
| Cardiology Review and plan of action | Colin Hutchison | | 10-Oct-18 | | 31-Oct-18 |
| Te Ara Whakawaiora - Improving Access Indicator | Colin Hutchison | 10-Oct-18 | 10-Oct-18 | 11-Oct-18 | 31-Oct-18 |
| Te Ara Whakawaiora - Cardiovascular (National Indicator) | John Gommans | 10-Oct-18 | 10-Oct-18 | 11-Oct-18 | 31-Oct-18 |
| Clinical Services Plan Monthly Update (aug, sep, oct) | Ken Foote | 10-Oct-18 | 10-Oct-18 | 11-Oct-18 | 31-Oct-18 |
| Annual Plan 2018/19 final | Chris Ash | 10-Oct-18 | 10-Oct-18 | 11-Oct-18 | 31-Oct-18 |
| Technical Advisory Services (TAS) Annual Plan | Ken Foote | | | | 31-Oct-18 |
| He Ngakau Aotea (following consultation with Iwi) | Patrick LeGeyt | | | | 31-Oct-18 |
| Finance Report (Sept) | Carriann Hall | | | | 31-Oct-18 |

| **28-Nov-18** | **EMT Member** | **MRB Meeting Date** | **Clinical Council Meeting Date** | **Consumer Council Meeting Date** | **BOARD Meeting date** |
|---|---|---|---|---|---|
| Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) Quarterly (Info only) | Chris Ash | 14-Nov-18 | 14-Nov-18 | 15-Nov-18 | 28-Nov-18 |
| Te Ara Whakawaiora "Smokefree update" (6 monthly May- **Nov**) each year Board action Nov 17 | Andy Phillips | 14-Nov-18 | 14-Nov-18 | 15-Nov-18 | 28-Nov-18 |
| Health Equity Report | Andy Phillips | 14-Nov-18 | 14-Nov-18 | 15-Nov-18 | 28-Nov-18 |
| Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-**Nov18**) | Andy Phillips | | 14-Nov-18 | 15-Nov-18 | 28-Nov-18 |
| Alcohol Harm Reduction Strategy (6 monthly update) **Nov**-May-Nov-May | Andy Phillips | 14-Nov-18 | 14-Nov-18 | 15-Nov-18 | 28-Nov-18 |
| Consumer Engagement Strategy Implementation Plan and presentation. | Kate Coley | | | 15-Nov-18 | 28-Nov-18 |
| HR - KPIs **Q1** Jul-Sept 18 t + Māori Workforce detail via CEOs report | Kate Coley | | | | 28-Nov-18 |
| Wairoa Service Integration Workshop with the Board | Chris Ash / Emma Foster | | | | 28-Nov-18 |
| National Bowel Screening Programme, Indicative Equity Outcomes in Māori and Pasifika | Chris Ash | 14-Nov-18 | 14-Nov-18 | 15-Nov-18 | 28-Nov-18 |
| HBDHB Performance Framework Exceptions Q1 **Nov 18** Feb 19 /May/Aug 19 (jit) | Chris Ash | 14-Nov-18 | | | 28-Nov-18 |
| HBDHB Quarterly Performance Monitoring Dashboard Q4 (produced by MoH) EMT/ Board | Chris Ash | | | | 28-Nov-18 |
| HBDHB Non-Financial Performance Framework Dashboard Q1 - EMT/Board | Chris Ash | | | | 28-Nov-18 |
| Finance Report (Oct) | Carriann Hall | | | | 28-Nov-18 |
| Clinical Services Plan - Final | Ken Foote | 14-Nov-18 | 14-Nov-18 | 15-Nov-18 | 28-Nov-18 |

| **19-Dec-18** | **EMT Member** | **MRB Meeting Date** | **Clinical Council Meeting Date** | **Consumer Council Meeting Date** | **BOARD Meeting date** |
|---|---|---|---|---|---|
| People Plan (6 monthly - **Dec**, Jun) | Kate Coley | 5-Dec-18 | 5-Dec-18 | 6-Dec-18 | 19-Dec-18 |
| Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators) | Andy Phillips | 5-Dec-18 | 5-Dec-18 | 6-Dec-18 | 19-Dec-18 |
| Mobility action plan implementation - progress update on the phases | Andy Phillips | 5-Dec-18 | 5-Dec-18 | 6-Dec-18 | 19-Dec-18 |
| Maternal Wellbeing Programme Update (Board action 25/7) | Patrick LeGeyt | 5-Dec-18 | 5-Dec-18 | 6-Dec-18 | 19-Dec-18 |
| Finance Report (Nov) | Carriann Hall | | | | 19-Dec-18 |

| **27-Feb-19** | **EMT Member** | **MRB Meeting Date** | **Clinical Council Meeting Date** | **Consumer Council Meeting Date** | **BOARD Meeting date** |
|---|---|---|---|---|---|
| Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 19** | Colin Hutchison | 13-Feb-19 | 13-Feb-19 | 14-Feb-19 | 27-Feb-19 |
| Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov- **Feb**-May | Chris Ash | 13-Feb-19 | 13-Feb-19 | 14-Feb-19 | 27-Feb-19 |
| HR - KPIs Q2 Oct-Dec 18 (Nov-Feb-May-Aug) | Kate Coley | | | | 27-Feb-19 |
| HBDHB Performance Framework Exceptions Q2 Nov 18 **Feb 19** /May/Aug 19 (jit) | Chris Ash | 13-Feb-19 | | | 27-Feb-19 |
| HBDHB Quarterly Performance Monitoring Dashboard Q1 (produced by MoH) EMT/ Board | Chris Ash | | | | 27-Feb-19 |
| HBDHB Non-Financial Performance Framework Dashboard Q2 - EMT/Board | Chris Ash | | | | 27-Feb-19 |
| Finance Report (Jan) | Carriann Hall | | | | 27-Feb-19 |

| **27-Mar-19** | **EMT Member** | **MRB Meeting Date** | **Clinical Council Meeting Date** | **Consumer Council Meeting Date** | **BOARD Meeting date** |
|---|---|---|---|---|---|
| After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) | Wayne Woolrich | 13-Mar-19 | 13-Mar-19 | 13-Mar-19 | 27-Mar-19 |
| Te Ara Whakawaiora - Breastfeeding (National Indicator) | Chris McKenna | 13-Mar-19 | 13-Mar-19 | 14-Mar-19 | 27-Mar-19 |
| Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept- **Mar** | Andy Phillips | 13-Mar-19 | 13-Mar-19 | 14-Mar-19 | 27-Mar-19 |
| Finance Report (Feb) | Carriann Hall | | | | 27-Mar-19 |

| **24-Apr-19** | **EMT Member** | **MRB Meeting Date** | **Clinical Council Meeting Date** | **Consumer Council Meeting Date** | **BOARD Meeting date** |
|---|---|---|---|---|---|
| Hawke's Bay Health Awards Event - review Alcohol at this event annually | Kevin Snee | | | | 24-Apr-19 |
| Finance Report (Mar) | Carriann Hall | | | | 24-Apr-19 |

# CHAIR'S REPORT

Verbal

| | |
|---|---|
| | **Chief Executive Officer's Report** 128 |
| | For the attention of:<br>**HBDHB Board** |
| Document Owner: | Kevin Snee, Chief Executive Officer |
| Reviewed by: | Not applicable |
| Month as at | 20 September 2018 |
| Consideration: | For Information |

8

**RECOMMENDATION**

**That the Board**

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

**INTRODUCTION**

In August we can see the hospital remains under significant pressure with emergency department (ED) performance poor and elective activity below plan. This is not untypical of the rest of the sector nationally.

On today's agenda there are a number of important strategic issues to be addressed; firstly the progress we are making in after-hours care, creating consistency across Napier and Hastings; secondly the Clinical Services Plan highlighting our direction of travel for clinical services for the next 10 – 15 years and a key building block for our five year strategic plan; and thirdly our Regional Development Strategy, Matariki.

**PERFORMANCE**

| Measure / Indicator | Target | Month of August | Qtr to end August | Trend For Qtr |
|---|---|---|---|---|
| Shorter stays in ED | ≥95% | 85.9% | 86.8% | ▼ |
| Improved access to Elective Surgery * (2018/19YTD) | 100% | - | 88% | - |

| Waiting list | Less than 3 months | 3-4 months | 4+ months |
|---|---|---|---|
| First Specialist Assessments (ESPI-2) | 3,324 | 693 | 147 |
| Patients given commitment to treat, but not yet treated (ESPI-5) | 1,154 | 202 | 345 |

| Measure / Indicator | Target | Month of August | Qtr to end August | Trend For Qtr |
|---|---|---|---|---|
| Faster cancer treatment** *(Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).* | ≥90% | 55.6% (July 2018) | 85.3% (6m to July 2018) | ▼ |
| Increased immunisation at 8 months | ≥95% | --- | 92% (3m to August) | ▼ |
| Better help for smokers to quit – Primary Care | ≥90% | -- | 85.5% (15m to August) | ▼ |
| Better help for smokers to quit – Maternity **The number of events is likely to be lower than the number of births recorded in any one quarter; however until the National Maternity Record is fully operational (approx. 2020) then reporting on this indicator will be from data collected from MMPO and DHB employed midwifes and remains developmental.* | ≥90% | --- | 75% | |
| Raising healthy kids (New) | ≥95% | --- | 99% (6m to August) | ▬ |
| Financial – month (in thousands of dollars) | (1,574) | (1,537) | --- | --- |
| Financial – year to date (in thousands of dollars) | (1,286) | (1,237) | --- | --- |

** The profile is not yet agreed with the MoH this is our estimate of what our position will be when it is agreed.*
*** Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.*

| *Faster Cancer Treatment Expected Volumes v Actual* | *Target* | *Month Actual / Expected* | *Rolling 6m Actual / Expected* |
|---|---|---|---|
| | *100%* | *17/19 = 89%* | *112/114 = 98%* |

The year-to-date (August 2018) elective health target is not yet on track and our plan and trajectory is not yet agreed with the Ministry of Health (MoH). I expect this position to improve over the coming months.

This month's result was behind because of:
- Delay in Inter District Flows (IDFs) being counted
- SMO leave in some groups
- Outsourcing was less than it will be in the remainder of the year
- Recent cancellations from the nursing strike and winter bed constraints

The surgical team is looking at a range of options to improve our position including extra weekend shifts and the use of wet theatres (privately owned theatres staffed by HBDHB employees) in the Bay.

In addition to the issues with elective activity, our performance remains below target in relation to shorter stays in emergency departments (ED6). This is as a consequence of the volume and acuity of patients attending the hospital acutely which has, in turn, had an impact on elective activity – I was clear last month that this was unlikely to improve until quarter two.

Our Faster Cancer Treatment target remains slightly below target for the six months to July. July's performance was partly because of the impact the nurses strike had, both on our local services and on our tertiary providers. There has been a return to good performance in August.

We remain just below target on immunisation and are exceeding the healthy weight target.

The financial result for August is $37 thousand favourable for the month which is a $49 thousand favourable for the year, so we are on plan for the year.

**AFTER HOURS URGENT CARE SERVICE**

Post the six-month review of the redesigned Urgent Care After Hours model (effective 1 December 2017), it is acknowledged that there are still challenges to overcome, but that the model represents a step forward in consistency of service for Napier and Hastings. Further collaboration to improve and enhance the urgent care model (in partnership with patients, consumers and their whānau) will be identified pre the annual review that should result in further refinements to this service model.

**CLINICAL SERVICES PLAN (CSP)**

The engagement activity is well underway, with some media pick up, posters, brochures and frequently asked questions (FAQ) widely distributed and the CSP itself (with supporting material) readily available on both Our Hub and www.ourhealthhb.nz. Leaders all have access to resources and are utilising appropriate opportunities within networks to engage. There has been limited feedback to date, but what has been received has generally been very positive.

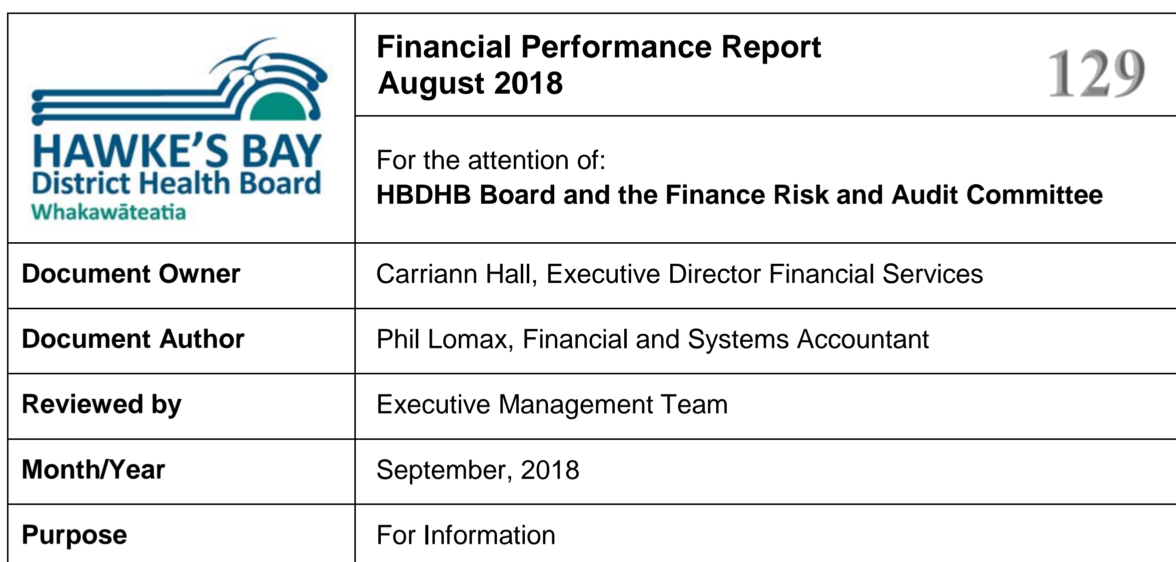
**MATARIKI HAWKE'S BAY REGIONAL ECONOMIC DEVELOPMENT STRATEGY AND SOCIAL INCLUSION STRATEGY**

Hawke's Bay District Health Board is committed to the work under Matariki that is included in our Annual Plan. Primarily the actions in: "Ready for Work" with links to the CSP, support for Community Investment Panels, and our role as partners in Project 1,000 (supporting youth into employment).

We also continue to provide in-kind support for the Social Inclusion Working Group. With the establishment of a governance structure and new operational roles advertised, we look forward to increased progress over the following 12 months.

**CONCLUSION**

August has continued much the same as July with the hospital under pressure, but financially the organisation is on plan. I expect the pressure on the health system to abate in quarter two as a consequence of the actions we are taking.



| HAWKE'S BAY District Health Board Whakawāteatia | **Financial Performance Report August 2018** 129 |
|---|---|
| | For the attention of: **HBDHB Board and the Finance Risk and Audit Committee** |
| **Document Owner** | Carriann Hall, Executive Director Financial Services |
| **Document Author** | Phil Lomax, Financial and Systems Accountant |
| **Reviewed by** | Executive Management Team |
| **Month/Year** | September, 2018 |
| **Purpose** | For Information |

9

**RECOMMENDATION:**

It is recommended that the HBDHB Board and Finance Risk and Audit Committee:

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

## 1. EXECUTIVE DIRECTOR CORPORATE SERVICES' COMMENTS

### *Financial Performance*

The year-to-date result is $49 thousand favourable to plan. The result for the month of August is $37 thousand favourable.

Underlying the year-to-date result is:

- Release of accruals relating to 2017/18 community pharmaceutical expenditure;
- Additional income from Mid Central DHB for oncology clinics, higher Accident Compensation Corporation (ACC) revenue for rehabilitation services partly offset by lower ACC elective surgery, and adjustments to Ministry Of Health (MOH) funding;
- Lower than planned outsourcing of elective surgery this point in the year;
- TAS costs for the Regional Health Informatics Programme lower than projected;

Offset by:

- Undelivered savings with plans in the identification stage;
- Known cost pressures, particularly around pharmaceuticals (largely biologics);
- Locum cover for medical staff and pressure on nursing resources more than offsetting medical and allied health vacancies.

There is uncertainty over when strategic savings will be achieved (section 11) and when the contingency will be utilised (section 8). Consequently both items are being accrued to budget so they do not obscure the underlying operating result.

There are minor prior period adjustments made to the classification of some revenue and expenditure in July to comply with MOH reporting requirements.

## 2. RESOURCE OVERVIEW

| | August | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| | $'000 | $'000 | $'000 | % | $'000 | $'000 | $'000 | % | $'000 | |
| Net Result - surplus/(deficit) | (1,537) | (1,574) | 37 | 2.4% | (1,237) | (1,286) | 49 | 3.8% | (5,000) | 3 |
| Contingency utilised | - | 550 | 550 | 100.0% | - | 550 | 550 | 100.0% | 2,982 | 8 |
| Quality and financial improvement | 111 | 1,179 | (1,068) | -90.6% | 111 | 2,359 | (2,248) | -95.3% | 14,152 | 11 |
| Capital spend | 2,247 | 1,847 | 400 | 21.7% | 3,609 | 3,693 | (85) | -2.3% | 22,168 | 16 |
| | FTE | FTE | FTE | % | FTE | FTE | FTE | % | FTE | |
| Employees | 2,370 | 2,477 | 107 | 4.3% | 2,372 | 2,409 | 36 | 1.5% | 2,424 | 5 & 7 |

No contingency was released in August. The mechanism for use of the contingency has been modified this year (see section 8).

Savings plans have been identified for 50% of the $14.2 million needed. Of the identified savings $922 thousand has been removed from operational budgets (section 11).

Capital spend is close to budget and was mostly on building projects including endoscopy, the surgical expansion and the histology and education centre upgrade.

Employee numbers are favourable reflecting vacancies in medical and allied health positions.

## 3. FINANCIAL PERFORMANCE SUMMARY

| | August | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| $'000 | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| Income | 48,134 | 47,196 | 938 | 2.0% | 95,793 | 95,087 | 705 | 0.7% | 569,462 | 4 |
| *Less:* | | | | | | | | | | |
| Providing Health Services | 25,483 | 24,348 | (1,135) | -4.7% | 48,362 | 47,027 | (1,336) | -2.8% | 280,702 | 5 |
| Funding Other Providers | 20,225 | 20,146 | (79) | -0.4% | 39,705 | 40,288 | 583 | 1.4% | 242,521 | 6 |
| Corporate Services | 4,364 | 4,191 | (173) | -4.1% | 8,687 | 8,637 | (50) | -0.6% | 48,205 | 7 |
| Reserves | (401) | 85 | 486 | 570.2% | 276 | 423 | 147 | 34.7% | 3,034 | 8 |
| | **(1,537)** | **(1,574)** | 37 | 2.4% | **(1,237)** | **(1,286)** | 49 | 3.8% | **(5,000)** | |

### *Income*
Reimbursement by regional cancer services funder Mid Central DHB for oncology clinics provided in Hawke's Bay. ACC rehabilitation revenue more than offsetting the cessation of ACC elective surgery. The increased level of ACC rehabilitation revenue is likely to continue.

### *Providing Health Services*
High activity and acuity in August have been a significant driver of costs over plan, particularly provision of medical and nursing capacity. This has been exacerbated by high levels of staff absence due to illness. Management of cost pressures such as pharmaceuticals (biologics) and savings has been challenging, offset by vacancies where there are recruitment issues.We are looking at ways to address nursing capacity, supported by the additional funding from MoH for nursing.

### *Funding Other Providers*
Lower pharmaceutical expenditure than forecast.

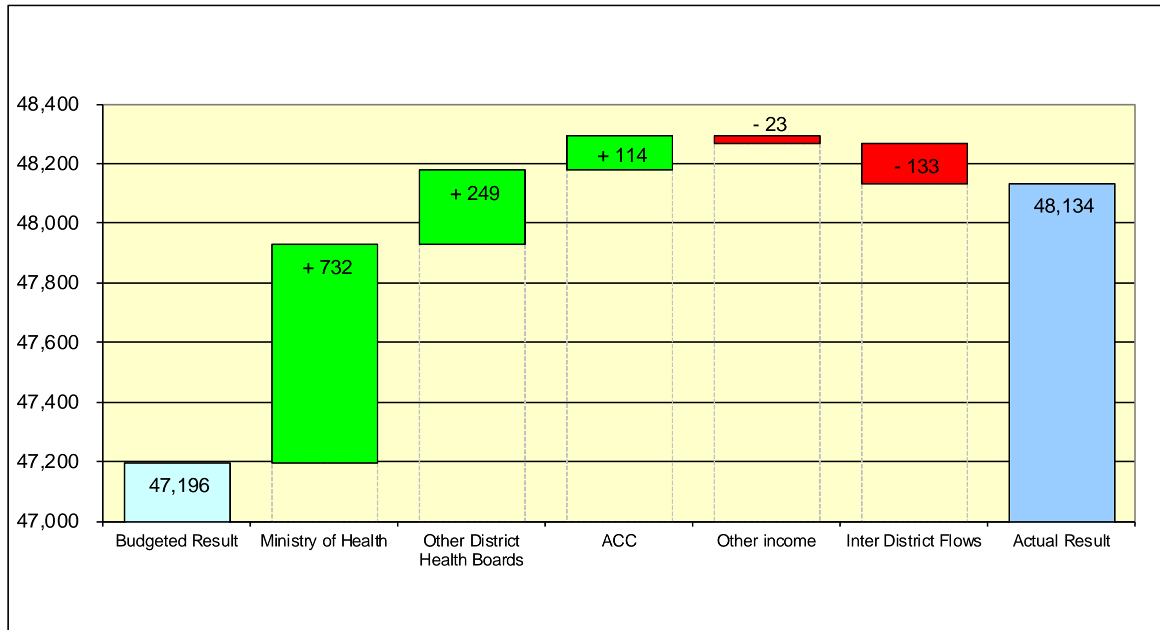
### *Reserves*
Prior year adjustments, non recurrent benefit.

9

## 4. INCOME

| $'000 | August | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| Ministry of Health | 45,696 | 44,964 | 732 | 1.6% | 91,172 | 90,619 | 553 | 0.6% | 542,364 |
| Inter District Flows | 629 | 762 | (133) | -17.5% | 1,400 | 1,524 | (124) | -8.1% | 9,146 |
| Other District Health Boards | 609 | 360 | 249 | 69.1% | 970 | 693 | 277 | 39.9% | 4,159 |
| Financing | 39 | 64 | (25) | -38.6% | 89 | 127 | (38) | -30.0% | 765 |
| ACC | 527 | 413 | 114 | 27.6% | 994 | 827 | 168 | 20.3% | 5,249 |
| Other Government | 32 | 43 | (11) | -26.4% | 31 | 125 | (94) | -75.0% | 673 |
| Patient and Consumer Sourced | 95 | 112 | (17) | -15.4% | 188 | 225 | (37) | -16.5% | 1,360 |
| Other Income | 507 | 477 | 30 | 6.3% | 949 | 947 | 1 | 0.1% | 5,747 |
| Abnormals | - | - | - | 0.0% | - | - | - | 0.0% | - |
| | 48,134 | 47,196 | 938 | 2.0% | 95,793 | 95,087 | 705 | 0.7% | 569,462 |

### *Month of August*




*Note the scale does not begin at zero*

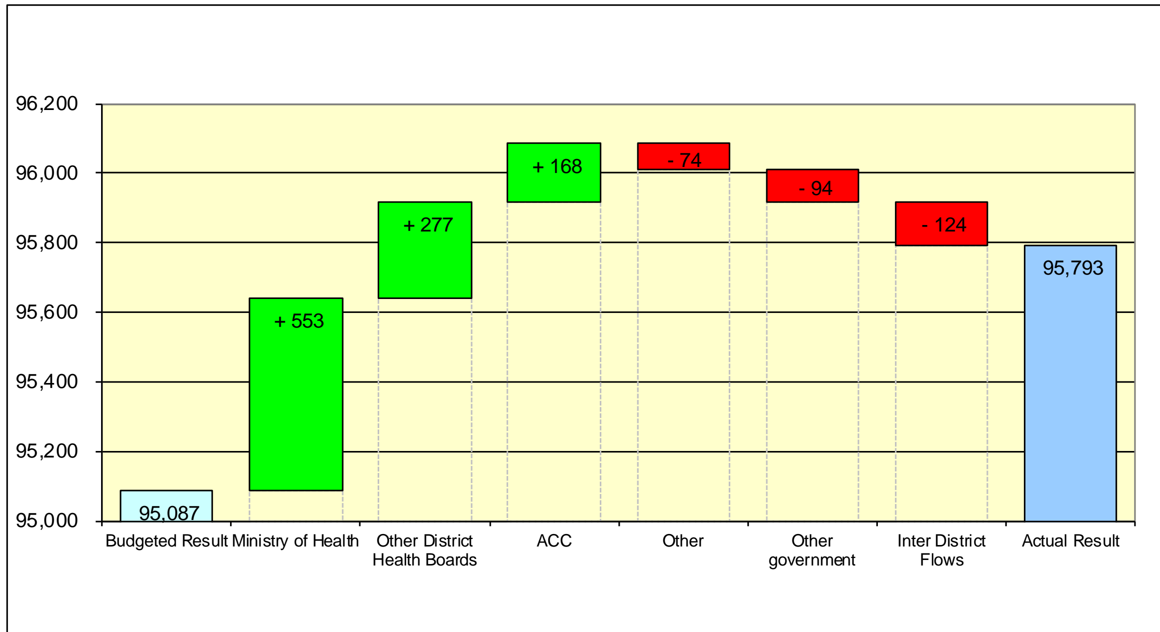
**Ministry of Health** (favourable)
Pay equity offset in section 6 Funding Other Providers.

**Other District Health Boards** (favourable)
Mid Central DHB oncology income.

**ACC** (favourable)
Income for rehabilitation services, partly offset by low elective surgery.

**Inter District Flows** (unfavourable)
Provision for reduced IDF revenue relating to mental health service changes with Hutt Valley DHB.

***Year to Date***




*Note the scale does not begin at zero*

**Ministry of Health** (favourable)
Pay equity offset in section 6 Funding Other Providers.

**Other District Health Boards** (favourable)
Mid Central DHB oncology income mainly in August.

**ACC** (favourable)
Income for rehabilitation services, partly offset by low elective surgery.

**Other government** (unfavourable)
One-off effect of the change in accounting treatment for early childhood education funding made in July.

**Inter District Flows** (unfavourable)
Provision for reduced IDF revenue.

9

# 5. PROVIDING HEALTH SERVICES

| | August | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| **Expenditure by type** $'000 | | | | | | | | | |
| Medical personnel and locums | 6,037 | 5,760 | (278) | -4.8% | 11,353 | 11,093 | (259) | -2.3% | 67,510 |
| Nursing personnel | 7,237 | 7,165 | (71) | -1.0% | 13,833 | 13,526 | (307) | -2.3% | 81,326 |
| Allied health personnel | 3,122 | 3,498 | 376 | 10.7% | 6,103 | 6,698 | 595 | 8.9% | 38,747 |
| Other personnel | 2,196 | 2,187 | (9) | -0.4% | 4,314 | 4,271 | (43) | -1.0% | 24,841 |
| Outsourced services | 881 | 999 | 119 | 11.9% | 1,488 | 2,002 | 514 | 25.7% | 12,057 |
| Clinical supplies | 3,964 | 2,900 | (1,063) | -36.7% | 7,424 | 5,768 | (1,657) | -28.7% | 34,049 |
| Infrastructure and non clinical | 2,046 | 1,838 | (208) | -11.3% | 3,847 | 3,667 | (180) | -4.9% | 22,172 |
| | **25,483** | **24,348** | **(1,135)** | **-4.7%** | **48,362** | **47,027** | **(1,336)** | **-2.8%** | **280,702** |
| **Expenditure by directorate** $'000 | | | | | | | | | |
| Medical | 7,046 | 6,317 | (730) | -11.6% | 13,282 | 12,169 | (1,113) | -9.1% | 73,177 |
| Surgical | 5,356 | 5,360 | 4 | 0.1% | 10,186 | 10,382 | 196 | 1.9% | 62,684 |
| Community, Women and Children | 3,937 | 3,855 | (82) | -2.1% | 7,665 | 7,433 | (232) | -3.1% | 44,244 |
| Older Persons, Options HB, Menta | 3,141 | 3,132 | (9) | -0.3% | 5,990 | 6,013 | 23 | 0.4% | 35,521 |
| Operations | 3,573 | 3,443 | (130) | -3.8% | 6,825 | 6,700 | (125) | -1.9% | 39,399 |
| Other | 2,399 | 2,210 | (189) | -8.5% | 4,361 | 4,270 | (91) | -2.1% | 25,341 |
| | **25,453** | **24,317** | **(1,136)** | **-4.7%** | **48,308** | **46,967** | **(1,341)** | **-2.9%** | **280,366** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 338.2 | 371.5 | 33 | 9.0% | 342 | 363 | 21 | 5.7% | 365.5 |
| Nursing personnel | 996.1 | 988.7 | (7) | -0.7% | 982 | 946 | (36) | -3.8% | 965.7 |
| Allied health personnel | 464.9 | 512.2 | 47 | 9.2% | 469 | 503 | 34 | 6.7% | 500.4 |
| Support personnel | 139.7 | 141.7 | 2 | 1.4% | 141 | 138 | (3) | -2.1% | 138.6 |
| Management and administration | 262.8 | 278.3 | 15 | 5.5% | 270 | 277 | 7 | 2.5% | 275.4 |
| | **2,201.7** | **2,292.3** | **91** | **4.0%** | **2,205** | **2,228** | **22** | **1.0%** | **2,245.6** |

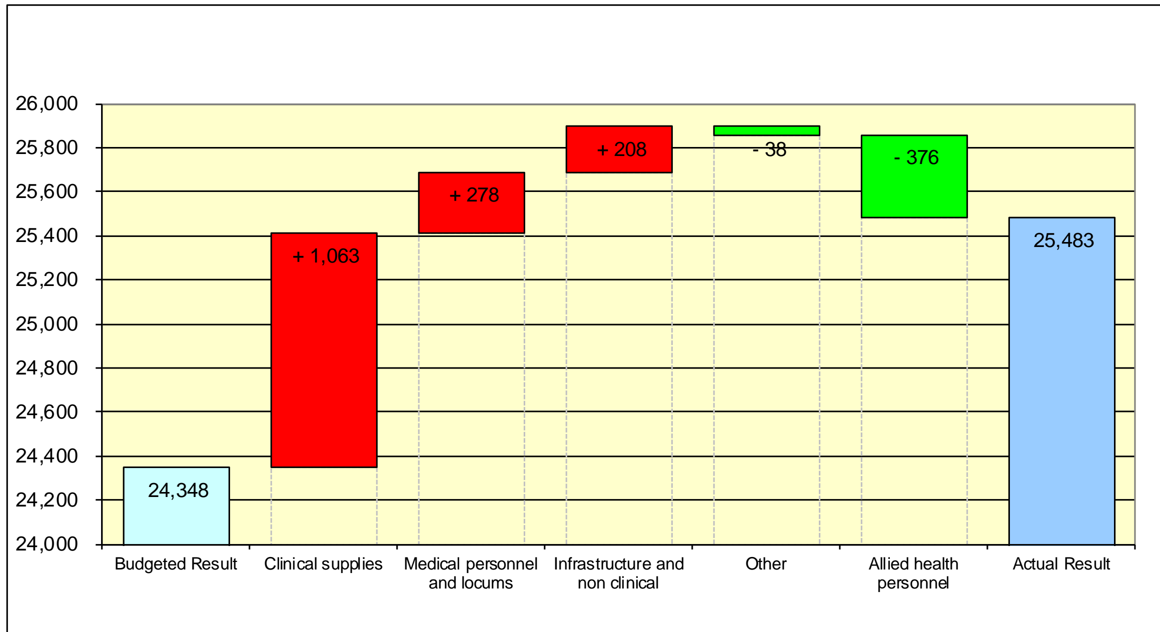
### *Directorates*

- Medical – medical staff vacancy cover, planned efficiencies not yet achieved, pharmaceutical costs (mainly biologics), and radiology reads (radiologist vacancies).
- Other – catch up on sabbatical cover costs and costs for campylobacter research project

### *Case Weighted Discharges*

Not reported this month due to issues with the data. Expected to be resolved by next month.

***Month of August***




*Note the scale does not begin at zero*

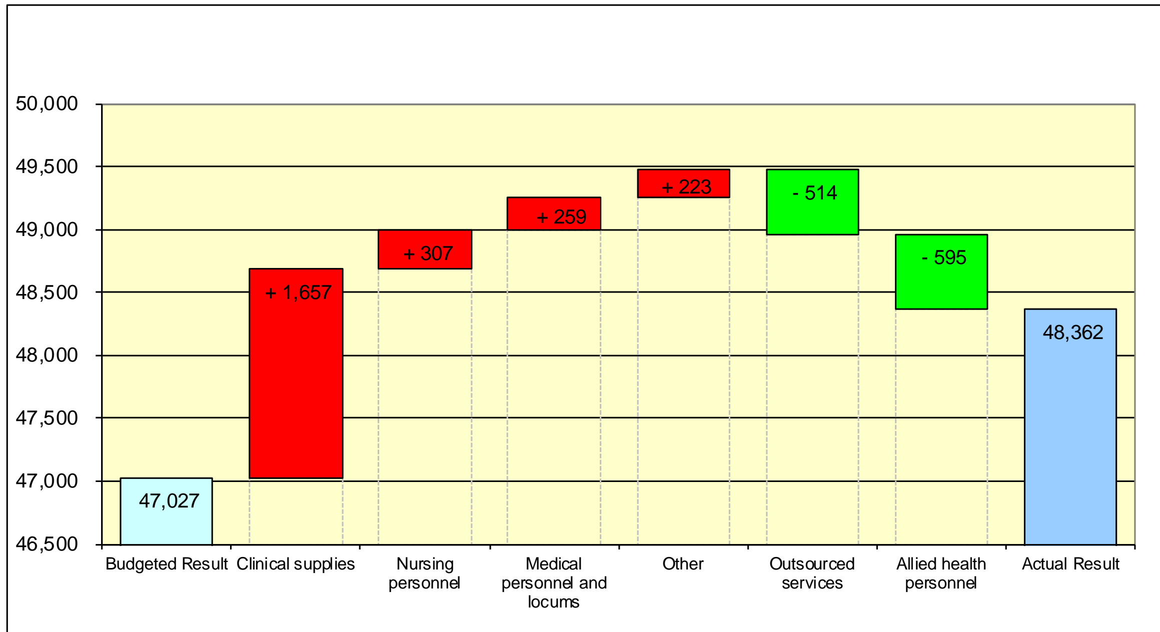
**Clinical supplies** (unfavourable)
We are looking at ways to address a long standing budgetary challenge around pharmaceutical costs (mainly biologics) and continence products. Actual costs are in line with consumption in prior years.

**Medical personnel and locums** (unfavourable)
Vacancy, sabbatical and sick leave cover.

**Infrastructure and non clinical** (unfavourable)
Maori workforce development, postage, and lower clinical engineering recoveries.

**Allied health personnel** (favourable)
Challenges in recruitment/retention, as being experienced nationally

***Year to Date***




*Note the scale does not begin at zero*

**Clinical supplies** (unfavourable)
We are looking at ways to address a long standing budgetary challenge around pharmaceutical costs (mainly biologics) and continence products. Actual costs are in line with consumption in prior years.

**Nursing personnel** (unfavourable)
High patient volumes and acuity impacting surgical wards, ED and ICU. This has been exarcebated by high levels of leave absence, due to illness.

**Medical personnel and locums** (unfavourable)
Vacancy, sabbatical and sick leave cover.

**Outsourced services** (favourable)
Actual cost of outsourced activity (mainly to Royston) at similar levels to 2017/18 at this point. It is expected that the variance will reduce in future months as actions underway to manage activity volumes start to impact.

**Allied health personnel** (favourable)
Challenges in recruitment/retention, as being experienced nationally.

***Full Time Equivalents (FTE)***

FTEs are 22 (1.0%) favourable year-to-date including:

**Medical personnel** (21 FTE / 5.7% favourable)
- Vacancies in ED and radiology.

**Nursing personnel** (-36 FTE / -3.8% unfavourable)
- Impact of high patient volumes and acuity in ED, ICU and the wards.

**Allied health personnel** (34 FTE / 6.7% favourable)

- Vacancies including MRTs, occupational therapists, laboratory technicians, social workers, and community support workers.

## MONTHLY ELECTIVE HEALTH TARGET REPORT
## YTD To June 2018

| | August 2018 | | | | YTD August 2018 | | | |
|---|---|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | % | Actual | Plan | Variance | % |
| Cardiothoracic | 6 | 9 | -3 | -33.3% | **20** | **19** | **1** | **6.7%** |
| Avastins | 16 | 17 | -1 | -5.9% | **34** | **34** | **0** | **0.0%** |
| ENT | 39 | 63 | -24 | -38.1% | **86** | **126** | **-40** | **-63.5%** |
| General Surgery | 113 | 111 | 2 | 1.8% | **211** | **222** | **-11** | **-9.9%** |
| Gynaecology | 68 | 59 | 9 | 15.3% | **122** | **119** | **3** | **5.3%** |
| Maxillo-Facial | 31 | 43 | -12 | -27.9% | **50** | **86** | **-36** | **-83.7%** |
| Neurosurgery | 6 | 7 | -1 | -14.3% | **16** | **15** | **1** | **10.7%** |
| Ophthalmology | 113 | 113 | 0 | 0.0% | **209** | **224** | **-15** | **-13.5%** |
| Orthopaedics | 118 | 96 | 22 | 22.9% | **216** | **192** | **24** | **25.0%** |
| Paediatric Surgery | 3 | 7 | -4 | -57.1% | **7** | **14** | **-7** | **-100.0%** |
| Skin Lesions | 14 | 21 | -7 | -33.3% | **24** | **42** | **-18** | **-85.7%** |
| Urology | 32 | 52 | -20 | -38.5% | **71** | **104** | **-33** | **-63.5%** |
| Vascular | 17 | 28 | -11 | -39.3% | **31** | **57** | **-26** | **-91.0%** |
| Non Surgical - Arranged | 12 | 11 | 1 | 9.1% | **16** | **24** | **-8** | **-60.1%** |
| Non Surgical - Elective | 6 | 16 | -10 | -62.5% | **19** | **30** | **-11** | **-69.6%** |
| **TOTAL** | **594** | **653** | **-59** | **-9.0%** | **1132** | **1308** | **-176** | **-26.9%** |

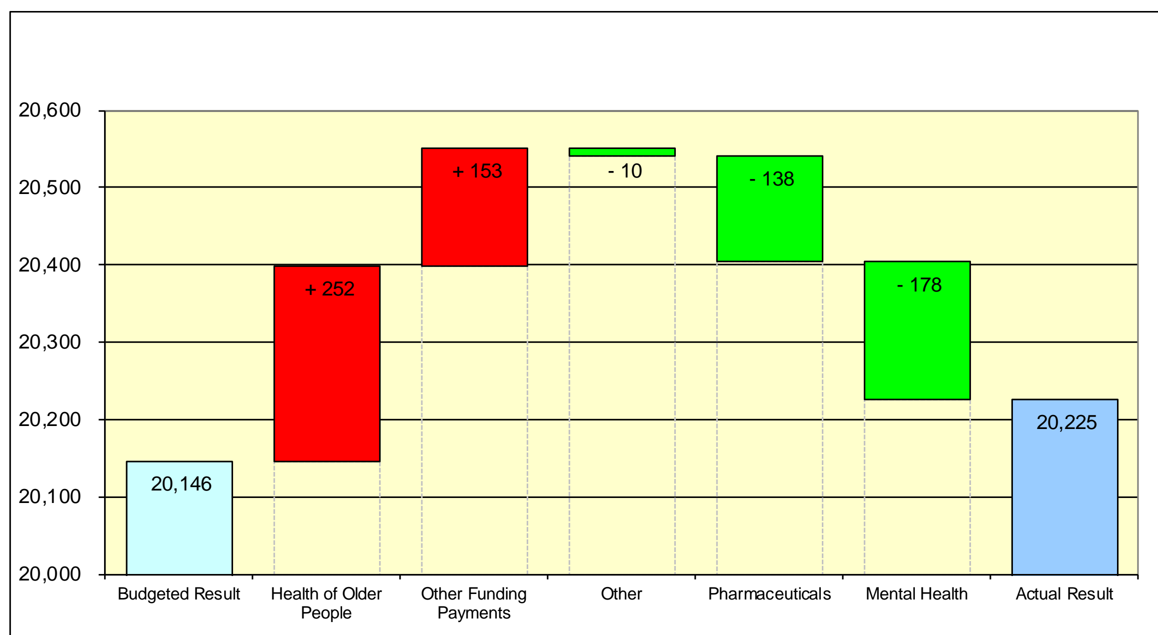
Please Note:This report was run on 11th September 2018.
The volumes by specialty now include both Elective and Arranged discharges rolled into one.
Data is subject to change.

9

## 6. FUNDING OTHER PROVIDERS

| $'000 | *August* | | | | *Year to Date* | | | | *Year End Forecast* |
|---|---|---|---|---|---|---|---|---|---|
| | *Actual* | *Budget* | *Variance* | | *Actual* | *Budget* | *Variance* | | |
| **Payments to Other Providers** | | | | | | | | | |
| Pharmaceuticals | 3,549 | 3,687 | 138 | 3.7% | 6,925 | 7,374 | 449 | 6.1% | 44,261 |
| Primary Health Organisations | 3,019 | 3,037 | 18 | 0.6% | 6,274 | 6,293 | 19 | 0.3% | 37,528 |
| Inter District Flows | 4,788 | 4,797 | 9 | 0.2% | 9,675 | 9,594 | (81) | -0.8% | 57,564 |
| Other Personal Health | 1,644 | 1,627 | (17) | -1.0% | 2,927 | 2,988 | 61 | 2.0% | 18,869 |
| Mental Health | 889 | 1,067 | 178 | 16.7% | 1,862 | 2,135 | 273 | 12.8% | 12,813 |
| Health of Older People | 5,870 | 5,618 | (252) | -4.5% | 11,245 | 11,243 | (2) | 0.0% | 67,451 |
| Other Funding Payments | 465 | 312 | (153) | -49.0% | 796 | 661 | (135) | -20.4% | 4,034 |
| | 20,225 | 20,146 | (79) | -0.4% | **39,705** | **40,288** | 583 | 1.4% | 242,521 |
| **Payments by Portfolio** | | | | | | | | | |
| Strategic Services | | | | | | | | | |
| Secondary Care | 4,535 | 4,472 | (63) | -1.4% | 8,711 | 8,488 | (222) | -2.6% | 50,928 |
| Primary Care | 7,413 | 7,763 | 350 | 4.5% | 15,271 | 15,933 | 662 | 4.2% | 96,371 |
| Mental Health | 1,074 | 1,298 | 224 | 17.3% | 2,346 | 2,596 | 250 | 9.6% | 15,581 |
| Health of Older People | 6,304 | 5,868 | (437) | -7.4% | 11,849 | 11,742 | (108) | -0.9% | 70,454 |
| Other Health Funding | 267 | 133 | (133) | -100.0% | 267 | 267 | - | 0.0% | 1,600 |
| Maori Health | 503 | 501 | (2) | -0.3% | 998 | 1,017 | 19 | 1.9% | 6,024 |
| Population Health | 130 | 111 | (19) | -17.1% | 263 | 245 | (18) | -7.4% | 1,563 |
| | 20,225 | 20,146 | (79) | -0.4% | **39,705** | **40,288** | 583 | 1.4% | 242,521 |

### *Month of August*




*Note the scale does not begin at zero*

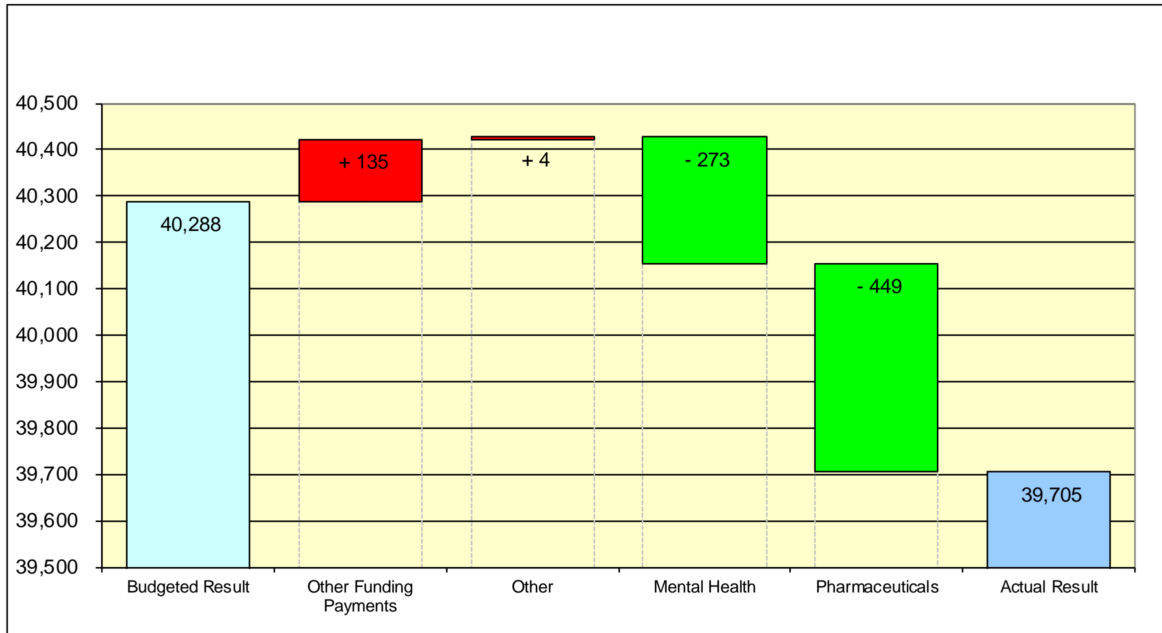
**Health of Older People** (unfavourable)
Lower than projected pay equity costs offset in income.

**Other Funding Payments** (unfavourable)
Addiitional funding to support dementia beds.

**Pharmaceuticals** (favourable)
Reduction in 2017/18 PHARMAC expected wash up to 99% of forecast, in line with previous years.

**Mental Health** (favourable)
Delay in transfer of Te Taiwhenua O Heretaunga (TTOH) mental health flexi fund contract from Hutt Valley DHB to Hawke's Bay DHB.

***Year to Date***




**Other Funding Payments** (unfavourable)
Addiitional funding to support dementia beds.

**Mental Health** (favourable)
Delay in transfer of TTOH mental health flexi fund contract from Hutt Valley DHB to Hawke's Bay DHB.

**Pharmaceuticals** (favourable)
Reduction in 2017/18 PHARMAC expected wash up to 99% of forecast, in line with previous years.

9

## 7. CORPORATE SERVICES

| $'000 | *August* | | | | *Year to Date* | | | | *Year End Forecast* |
|---|---|---|---|---|---|---|---|---|---|
| | *Actual* | *Budget* | *Variance* | | *Actual* | *Budget* | *Variance* | | |
| **Operating Expenditure** | | | | | | | | | |
| Personnel | 1,565 | 1,556 | (9) | -0.5% | 2,919 | 2,971 | 52 | 1.7% | 16,813 |
| Outsourced services | 192 | 71 | **(121)** | **-169.2%** | 226 | 142 | **(83)** | **-58.5%** | 855 |
| Clinical supplies | 9 | (116) | **(125)** | **-107.8%** | 21 | (188) | **(209)** | **-111.0%** | (1,128) |
| Infrastructure and non clinical | 868 | 902 | 34 | 3.8% | 2,064 | 2,158 | 94 | 4.4% | 9,418 |
| | 2,633 | 2,413 | **(220)** | **-9.1%** | 5,230 | 5,084 | (146) | -2.9% | 25,959 |
| **Capital servicing** | | | | | | | | | |
| Depreciation and amortisation | 1,076 | 1,062 | (14) | -1.3% | 2,147 | 2,120 | (26) | -1.2% | 13,652 |
| Financing | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Capital charge | 655 | 716 | **61** | **8.5%** | 1,310 | 1,432 | **122** | **8.5%** | 8,595 |
| | 1,731 | 1,778 | 47 | 2.7% | 3,457 | 3,553 | 96 | 2.7% | 22,246 |
| | **4,364** | **4,191** | **(173)** | **-4.1%** | **8,687** | **8,637** | **(50)** | **-0.6%** | **48,205** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 0.2 | 0.3 | 0.1 | 46.6% | 0.3 | 0.3 | 0.0 | 9.4% | 0.3 |
| Nursing personnel | 11.1 | 13.8 | 2.8 | 20.0% | 11.1 | 13.5 | 2.4 | 17.7% | 13.6 |
| Allied health personnel | 0.8 | 0.4 | (0.3) | -83.5% | 0.5 | 0.4 | (0.1) | -25.0% | 0.4 |
| Support personnel | 9.4 | 8.4 | (1.1) | -12.6% | 9.6 | 8.3 | (1.3) | -16.1% | 8.1 |
| Management and administration | 147.0 | 162.2 | **15.2** | **9.4%** | 145.7 | 158.7 | **13.0** | **8.2%** | 155.9 |
| | **168.4** | **185.1** | **16.7** | **9.0%** | **167.1** | **181.1** | **14.0** | **7.7%** | **178.3** |

The clinical supplies unfavourable variance relates to the current year savings programme currently in development. The lower than budgeted accrual for capital charge reflects the lower equity level for 2017/18 than projected in the plan.

## 8. RESERVES

| $'000 | *August* | | | | *Year to Date* | | | | *Year End Forecast* |
|---|---|---|---|---|---|---|---|---|---|
| | *Actual* | *Budget* | *Variance* | | *Actual* | *Budget* | *Variance* | | |
| **Expenditure** | | | | | | | | | |
| Contingency | 550 | 550 | (0) | 0.0% | 550 | 550 | (0) | 0.0% | 2,982 |
| Other | (951) | (465) | **486** | **104.7%** | (274) | (127) | **147** | **115.7%** | 52 |
| | **(401)** | **85** | **486** | **570.2%** | **276** | **423** | **147** | **34.7%** | **3,034** |

The mechanism for managing the contingency has been modified this year. Executive mnanagement approval of unfunded expenditure (i.e. where no source of funding has been identified) will result in the transfer of budget from the contingency, to the operating budget where the expenditure will be incurred. As in previous years, contingency can still be released for unusual or unexpected events up to the remaining balance of the contingency.

Transfers out of the original $4 million contingency year-to-date include:

- New nursing initiatives $718 thousand, that will increase to $1 million in September; and
- Executive Director Provider Services contingency $300 thousand.

The remaining contingency has been accrued to budget, and will be released as the need arises. The “Other” category comprises the net impact of an ongoing review of accruals relating to the prior year. If the variance remains favourable it will be a one-off benefit.

## 9. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

| $'000 | August | | | Year to Date | | | End of Year | | |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Annual Plan | Variance | Actual | Annual Plan | Variance | Forecast | Annual Plan | Variance |
| **Funding** | | | | | | | | | |
| Income | 44,984 | 44,589 | 395 | 89,930 | 89,671 | 259 | 537,477 | 537,477 | - |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 27,930 | 27,938 | 8 | 53,673 | 53,690 | 17 | 309,025 | 309,025 | - |
| Payments to Other Providers | 19,356 | 19,524 | 168 | 38,058 | 39,044 | 986 | 235,058 | 235,058 | - |
| Contribution | **(2,301)** | **(2,873)** | **572** | **(1,802)** | **(3,064)** | **1,262** | **(6,607)** | **(6,607)** | **-** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 290 | 290 | - | 580 | 580 | - | 3,383 | 3,383 | - |
| Other Income | 3 | 3 | - | (2) | 5 | (7) | 30 | 30 | - |
| *Less:* | | | | | | | | | |
| Expenditure | 347 | 301 | (46) | 526 | 584 | 59 | 3,410 | 3,410 | - |
| Contribution | **(55)** | **(8)** | **(46)** | **53** | **1** | **52** | **3** | **3** | **-** |
| **Health Provision** | | | | | | | | | |
| Funding | 27,639 | 27,639 | - | 53,093 | 53,093 | - | 305,542 | 305,542 | - |
| Other Income | 3,054 | 2,517 | 537 | 5,677 | 5,236 | 441 | 30,902 | 30,902 | - |
| *Less:* | | | | | | | | | |
| Expenditure | 29,874 | 28,849 | (1,025) | 58,259 | 56,554 | (1,705) | 334,840 | 334,840 | - |
| Contribution | **819** | **1,307** | **(488)** | **512** | **1,776** | **(1,264)** | **1,604** | **1,604** | **-** |
| **Net Result** | **(1,537)** | **(1,574)** | **38** | **(1,237)** | **(1,287)** | **50** | **(5,000)** | **(5,000)** | **-** |

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

## 10. MANAGEMENT BUDGET MOVEMENTS

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

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

| $'000 | August | | | Year to Date | | | End of Year | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Mgmt Budget* | *Annual Plan* | *Movement* | *Mgmt Budget* | *Annual Plan* | *Movement* | *Mgmt Budget* | *Annual Plan* | *Movement* |
| **Funding** | | | | | | | | | |
| Income | 44,589 | 44,589 | - | 89,671 | 89,671 | - | 537,477 | 537,477 | - |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 27,938 | 27,938 | - | 53,690 | 53,690 | - | 309,025 | 309,025 | - |
| Payments to Other Providers | 19,524 | 19,271 | (253) | 39,044 | 38,792 | (253) | 235,058 | 233,452 | (1,607) |
| Contribution | **(2,873)** | **(2,620)** | **(253)** | **(3,064)** | **(2,811)** | **(253)** | **(6,607)** | **(5,000)** | **(1,607)** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 290 | 290 | - | 580 | 580 | - | 3,383 | 3,383 | - |
| Other Income | 3 | 3 | - | 5 | 5 | - | 30 | 30 | - |
| *Less:* | | | | | | | | | |
| Expenditure | 301 | 301 | 1 | 584 | 585 | 1 | 3,410 | 3,413 | 3 |
| Contribution | **(8)** | **(9)** | **1** | **1** | **1** | **1** | **3** | **-** | **3** |
| **Health Provision** | | | | | | | | | |
| Funding | 27,639 | 27,639 | - | 53,093 | 53,093 | - | 305,542 | 305,542 | - |
| Other Income | 2,517 | 2,427 | 90 | 5,236 | 5,146 | 90 | 30,902 | 30,594 | 308 |
| *Less:* | | | | | | | | | |
| Expenditure | 28,849 | 29,011 | 162 | 56,554 | 56,716 | 162 | 334,840 | 336,136 | 1,296 |
| Contribution | **1,307** | **1,055** | **252** | **1,776** | **1,523** | **252** | **1,604** | **-** | **1,604** |
| **Net Result** | **(1,574)** | **(1,574)** | **0** | **(1,287)** | **(1,287)** | **0** | **(5,000)** | **(5,000)** | **(0)** |

## 11. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Savings plans are transferred to operational budgets as they are agreed. Living within budget will indicate that directorates are achieving their savings targets.

The table below shows $7.0 million of savings targets have been identified. Of this amount $922 thousand had been removed from operational budgets at the time this report was prepared. We are working to have all identified savings moved to operational budgets by the end of Quarter 1.

The $3 million of strategic savings targets have been redistributed across all directorates.

Savings targets have been budgeted evenly through the year at directorate level. However, the savings are more likely to grow incrementally as schemes are identified and implemented. The mismatch between budget and likely achievement obscures the underlying operational performance of the DHB, and savings are being accrued at a consolidated level to overcome this. The amount accrued year-to-date August was $809 thousand.

| | Target | Current Year Identification | | | | | Savings Delivered / Forecast | | | | Recurrency | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Division** | **2018/19 Savings Target $'000** | **2018/19 Identified Saving $'000** | **%** | **2018/19 Budget Adjusted** | **2018/19 Savings WIP** | **2018/19 Un-identified Savings** | **YTD Actual** | **YTD Plan** | **Var** | **2018/19 Forecast** | **2019/20 Identified Saving $'000** | **%** |
| Strategic | - | - | - % | - | - | - | - | - | - | - | - | - % |
| Primary Care | 4,673 | 1,973 | 42 % | - | 1,973 | 2,700 | - | 779 | (779) | 1,675 | 1,919 | 41 % |
| Provider Services | 6,544 | 2,790 | 43 % | 515 | 2,275 | 3,754 | 70 | 1,091 | (1,021) | 2,528 | 2,866 | 44 % |
| HI&E | 402 | 407 | 101 % | 407 | - | (5) | 41 | 67 | (26) | 350 | 184 | 46 % |
| People & Quality | 105 | 103 | 98 % | - | 103 | 2 | - | 18 | (18) | 87 | 63 | 60 % |
| Information Services | 254 | 200 | 79 % | - | 200 | 54 | - | 42 | (42) | 182 | 200 | 79 % |
| Financial Services | 1,430 | 1,056 | 74 % | - | 1,056 | 374 | - | 238 | (238) | 954 | 1,056 | 74 % |
| Executive | 112 | - | - % | - | - | 112 | - | 19 | (19) | - | - | - % |
| Capital Servicing | 632 | 498 | 79 % | - | 498 | 134 | - | 105 | (105) | 415 | 490 | 77 % |
| Timing Adjustments | - | - | - % | - | - | - | - | (809) | 809 | - | - | - % |
| **Totals** | **14,152** | **7,026** | **50 %** | **922** | **6,104** | **7,126** | **111** | **1,550** | **(1,439)** | **6,192** | **6,778** | **48 %** |

## 12. FINANCIAL POSITION

| 30 June 2018 | $'000 | August Actual | August Budget | Variance from budget | Movement from 30 June 2018 | Annual Budget |
|---|---|---|---|---|---|---|
| | **Equity** | | | | | |
| 168,706 | Crown equity and reserves | 168,706 | 175,069 | (6,363) | - | 174,711 |
| (15,982) | Accumulated deficit | (17,219) | (12,260) | (4,959) | (1,237) | (15,973) |
| 152,723 | | 151,486 | 162,809 | (11,322) | (1,237) | 158,738 |
| | **Represented by:** | | | | | |
| | Current Assets | | | | | |
| 7,444 | Bank | 1,046 | 10,078 | (9,032) | (6,398) | 2,313 |
| 1,885 | Bank deposits > 90 days | 1,862 | 1,901 | (39) | (23) | 1,901 |
| 25,474 | Prepayments and receivables | 20,206 | 24,684 | (4,478) | (5,268) | 25,045 |
| 3,907 | Inventory | 3,820 | 4,451 | (631) | (88) | 4,520 |
| 2,293 | Non current assets held for sale | 2,293 | 625 | 1,668 | - | 625 |
| 41,003 | | 29,226 | 41,739 | (12,513) | (11,777) | 34,404 |
| | Non Current Assets | | | | | |
| 179,460 | Property, plant and equipment | 180,880 | 179,141 | 1,739 | 1,420 | 185,018 |
| 1,479 | Intangible assets | 1,446 | 3,082 | (1,636) | (33) | 4,147 |
| 9,280 | Investments | 9,309 | 11,684 | (2,375) | 29 | 11,798 |
| 190,220 | | 191,635 | 193,907 | (2,272) | 1,416 | 200,963 |
| **231,223** | **Total Assets** | **220,861** | **235,646** | **(14,785)** | **(10,361)** | **235,368** |
| | **Liabilities** | | | | | |
| | Current Liabilities | | | | | |
| - | Bank overdraft | - | - | - | - | - |
| 35,817 | Payables | 27,201 | 35,442 | 8,241 | (8,615) | 36,249 |
| 40,064 | Employee entitlements | 39,555 | 34,684 | (4,871) | (509) | 37,579 |
| 75,881 | | 66,756 | 70,126 | 3,370 | (9,124) | 73,828 |
| | Non Current Liabilities | | | | | |
| 2,619 | Employee entitlements | 2,619 | 2,712 | 93 | - | 2,802 |
| 2,619 | | 2,619 | 2,712 | 93 | - | 2,802 |
| **78,500** | **Total Liabilities** | **69,375** | **72,838** | **3,462** | **(9,124)** | **76,629** |
| **152,723** | **Net Assets** | **151,486** | **162,809** | **(11,322)** | **(1,237)** | **158,738** |

*Note: The sign in the variance column has been reversed from this month so that reductions in equity and assets have negative (adverse) variances, and reductions in liabilities have positive variances.*

Crown equity and reserves includes changes in the 2017/18 result subsequent to the preparation of the 2018/19 budget. The decline in cash holdings reflects a reduction in the amounts owing to non health board providers and the greater than planned deficit for 2017/18.

## 13. EMPLOYEE ENTITLEMENTS

| 30 June 2018 | $'000 | August Actual | August Budget | Variance from budget | Movement from 30 June 2018 | Annual Budget |
|---|---|---|---|---|---|---|
| 10,004 | Salaries & wages accrued | 10,089 | 6,716 | (3,373) | 85 | 7,756 |
| 1,157 | ACC levy provisions | 1,133 | 301 | (832) | (24) | 532 |
| 5,945 | Continuing medical education | 5,552 | 5,545 | (7) | (393) | 6,456 |
| 21,348 | Accrued leave | 21,198 | 20,527 | (671) | (150) | 21,199 |
| 4,230 | Long service leave & retirement grat. | 4,203 | 4,307 | 104 | (27) | 4,438 |
| 42,683 | **Total Employee Entitlements** | 42,174 | 37,396 | (4,778) | (509) | 40,380 |

Salaries and wages accrued includes additional provisions for settlements that were not allowed for in the budget, partly recognised in last year's result.

## 14. TREASURY

***Liquidity Management***

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



Cash low point for August was $152 thousand and forecast low by the end of the financial year is $4.601 million overdraft, which is within our statutory limit of $27 million.

***Debt Management***

The DHB has no interest rate exposure relating to debt.

***Foreign Exchange Risk Management***

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

## 15. CAPITAL EXPENDITURE

Overall capital spend for the month is close to budget. The June budget assumed even phasing across the year, hence the large variances to actual expenditure on individual lines. Note that budget is that approved by the Board in June. Given cash constraints, a revised Capital Plan was presented in August, but the Finance Risk and Audit Committee (FRAC) requested further information, which will be presented to the FRAC at its September meeting.

Strategic project performance against plan is discussed in the Transform and Sustain Monthly Programme Overview presented to FRAC.

See table on the next page.

| 2018 Annual Plan | | ------------------ Actual $'000 | Year to Date Budget $'000 | ------------------ Variance $'000 |
|---|---|---|---|---|
| | Source of Funds | | | |
| | **Operating Sources** | | | |
| 13,652 | Depreciation | 2,147 | 2,120 | (26) |
| (5,000) | Surplus/(Deficit) | (1,339) | (1,287) | 52 |
| 13,646 | Working Capital | 2,902 | 2,860 | (42) |
| 22,297 | | 3,710 | 3,693 | (16) |
| | **Other Sources** | | | |
| - | Special Funds and Clinical Trials | (3) | - | 3 |
| - | | (3) | - | 3 |
| **22,297** | **Total funds sourced** | **3,707** | **3,693** | **(13)** |
| | Application of Funds: | | | |
| | **Block Allocations** | | | |
| 3,430 | Facilities | 102 | 717 | 615 |
| 3,200 | Information Services | 306 | 533 | 227 |
| 3,225 | Clinical Plant & Equipment | 106 | 392 | 286 |
| 9,855 | | 515 | 1,642 | 1,127 |
| | **Local Strategic** | | | |
| 600 | Replacement Generators | - | 100 | 100 |
| 280 | Renal Centralised Development | - | 47 | 47 |
| 2,046 | New Stand-alone Endoscopy Unit | 1,670 | 341 | (1,329) |
| 500 | Upgrade old MHIU | - | 83 | 83 |
| 350 | Travel Plan | - | 58 | 58 |
| 1,187 | Histology and Education Centre Upgrade | 678 | 198 | (480) |
| 850 | Radiology Extension | - | 142 | 142 |
| 950 | Fit out Corporate Building | - | 158 | 158 |
| 550 | High Voltage Electrical Supply | - | 92 | 92 |
| 5,000 | Surgical Expansion | 649 | 833 | 184 |
| 12,313 | | 2,997 | 2,051 | (945) |
| | **Other** | | | |
| - | Special Funds and Clinical Trials | (3) | - | 3 |
| - | Other | 101 | - | (101) |
| - | | 98 | - | (98) |
| ***22,168*** | ***Capital Spend*** | ***3,609*** | ***3,693*** | ***85*** |
| | **Regional Strategic** | | | |
| 129 | RHIP (formerly CRISP) | 98 | - | (98) |
| 129 | | 98 | - | (98) |
| **22,297** | **Total funds applied** | **3,707** | **3,693** | **(13)** |

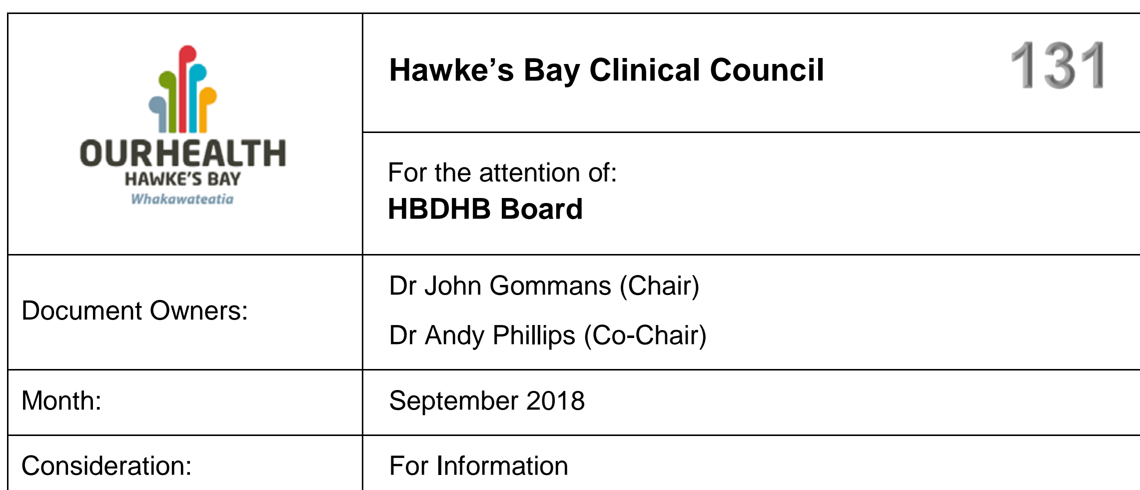
## 16. ROLLING CASH FLOW

| | Actual | August Forecast | Variance | Sep Forecast | Oct Forecast | Nov Forecast | Dec Forecast | Jan Forecast | Feb Forecast | Mar Forecast | Apr Forecast | May Forecast | Jun Forecast | Jul Forecast | Aug Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cash flows from operating activities** | | | | | | | | | | | | | | | |
| Cash receipts from Crown agencies | 47,232 | 46,005 | 1,228 | 46,159 | 51,766 | 46,561 | 46,243 | 46,355 | 46,109 | 46,363 | 46,444 | 46,109 | 46,469 | 46,791 | 46,090 |
| Cash receipts from donations, bequests and clinical trials | 53 | - | 53 | - | - | - | - | - | - | - | - | - | - | - | - |
| Cash receipts from other sources | 5,775 | 497 | 5,278 | 495 | 3,094 | 2,066 | 495 | 498 | 504 | 498 | 498 | 504 | 498 | 495 | 501 |
| Cash paid to suppliers | (33,887) | (26,388) | (7,500) | (27,178) | (27,102) | (27,568) | (35,144) | (19,102) | (24,335) | (27,472) | (27,435) | (25,985) | (28,308) | (28,715) | (27,176) |
| Cash paid to employees | (22,083) | (22,664) | 581 | (16,918) | (20,120) | (17,352) | (16,857) | (22,751) | (17,643) | (17,152) | (17,779) | (20,469) | (17,372) | (16,802) | (22,611) |
| **Cash generated from operations** | **(2,910)** | **(2,551)** | **(359)** | **2,559** | **7,638** | **3,707** | **(5,263)** | **5,001** | **4,635** | **2,237** | **1,729** | **159** | **1,287** | **1,769** | **(3,196)** |
| Interest received | 39 | 64 | (25) | 54 | 49 | 44 | 39 | 34 | 29 | 24 | 19 | 14 | 9 | 4 | (0) |
| Interest paid | - | - | - | - | - | - | - | - | (5) | (7) | (10) | (13) | (15) | (17) | (20) |
| Capital charge paid | (655) | (0) | (655) | (0) | (0) | (0) | (4,350) | (0) | (0) | (0) | (0) | (0) | (4,670) | (0) | (0) |
| **Net cash inflow/(outflow) from operating activities** | **(3,526)** | **(2,487)** | **(1,039)** | **2,612** | **7,687** | **3,750** | **(9,574)** | **5,034** | **4,659** | **2,254** | **1,737** | **160** | **(3,390)** | **1,755** | **(3,216)** |
| **Cash flows from investing activities** | | | | | | | | | | | | | | | |
| Proceeds from sale of property, plant and equipment | 0 | - | 0 | - | (0) | 0 | 0 | (0) | - | - | 0 | 0 | 0 | 0 | - |
| Acquisition of property, plant and equipment | (2,185) | (1,323) | (862) | (1,728) | (1,728) | (1,263) | (1,263) | (1,263) | (1,263) | (1,263) | (1,263) | (1,263) | (1,263) | (1,263) | (1,269) |
| Acquisition of intangible assets | (61) | (133) | 72 | (115) | (115) | (115) | (115) | (115) | (115) | (115) | (115) | (115) | (115) | (115) | (115) |
| Acquisition of investments | (98) | (167) | 69 | - | - | - | - | (129) | - | - | - | - | - | - | - |
| **Net cash inflow/(outflow) from investing activities** | **(2,344)** | **(1,623)** | **(721)** | **(1,843)** | **(1,843)** | **(1,378)** | **(1,378)** | **(1,508)** | **(1,378)** | **(1,378)** | **(1,378)** | **(1,378)** | **(1,378)** | **(1,378)** | **(1,384)** |
| **Cash flows from financing activities** | | | | | | | | | | | | | | | |
| Equity repayment to the Crown | - | - | - | - | - | - | - | - | - | - | - | - | (357) | - | - |
| **Net cash inflow/(outflow) from financing activities** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **(357)** | **-** | **-** |
| Net increase/(decrease) in cash or cash equivalents | (5,870) | (4,111) | (1,760) | 769 | 5,843 | 2,372 | (10,953) | 3,526 | 3,281 | 875 | 359 | (1,219) | (5,125) | 377 | (4,601) |
| Add:Opening cash | 8,779 | 8,779 | - | 2,908 | 3,677 | 9,520 | 11,892 | 940 | 4,466 | 7,746 | 8,622 | 8,981 | 7,762 | 2,637 | 3,014 |
| **Cash and cash equivalents at end of period** | **2,908** | **4,668** | **(1,760)** | **3,677** | **9,520** | **11,892** | **940** | **4,466** | **7,746** | **8,622** | **8,981** | **7,762** | **2,637** | **3,014** | **(1,587)** |
| **Cash and cash equivalents** | | | | | | | | | | | | | | | |
| Cash | 4 | 4 | - | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Short term investments (excl. special funds/clinical trials) | 152 | 1,786 | (1,634) | 796 | 6,639 | 9,011 | (1,942) | 1,584 | 4,865 | 5,740 | 6,099 | 4,881 | (245) | 132 | (4,469) |
| Short term investments (special funds/clinical trials) | 2,701 | 2,877 | (176) | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 | 2,877 |
| Bank overdraft | 51 | - | 51 | - | - | - | - | - | - | - | - | - | - | - | - |
| | **2,908** | **4,667** | **(1,759)** | **3,677** | **9,520** | **11,892** | **939** | **4,465** | **7,746** | **8,621** | **8,980** | **7,762** | **2,636** | **3,013** | **(1,588)** |

Changes have been made to the phasing of some major cash-flows based on best estimates of when they will occur e.g. elective services revenue, IDF wash-up and the rest home worker's pay equity settlement.

# BOARD HEALTH & SAFETY CHAMPION’S UPDATE

Verbal



| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Clinical Council** 131 |
|---|---|
| | For the attention of:<br>**HBDHB Board** |
| Document Owners: | Dr John Gommans (Chair)<br>Dr Andy Phillips (Co-Chair) |
| Month: | September 2018 |
| Consideration: | For Information |

11

**RECOMMENDATION**

**That the Board**

Review the contents of this report; and

**Note that Clinical Council:**

- **Discussed** the report on After Hours Urgent Care
- **Discussed** the HB Health Awards shortlisting process
- **Note** the Annual General Meeting
- **Note** reports for information only

Council met on 12 September 2018. An overview of matters discussed is provided below:

## AFTER HOURS URGENT CARE

The high level six-month review of the Urgent Care After Hours Service was discussed. Council noted that a comprehensive 12-month review will be completed where recommendations will be made to improve how care is provided in the community.

General discussion noted: growth of attendences to ED from some practices with proximity to ED being a factor; financial factors that influence patient decisions; options available for care overnight; next day GP appointments being available;; having triage overnight in City Medical and an overnight emergency service (ED) in Hastings; need for a clear set of KPIs and being clear on what we want to achieve; investment required to make the desired changes; and the St Johns Service being underutilised.

The Chair congratulated David Rodgers noting that the urgent care plan was put together quickly under challenging circumstances. The primary aim was to get people currently using urgent care re-connected with their primary care provider and improve access to their GP. Options for further development include re-prioritising the current urgent care money, looking at more next day appointments and whether CHB can join the model. Council looked forward to receiving the full 12 month report.

## HB HEALTH AWARDS

Anna Kirk, Communication Manager attended the meeting to discuss Clinical Council's involvement in the shortlisting process for this year. General discussion took place regarding the judging process, how to encourage/assist people from across the health sector to put in entries and whether the Consumer Council should be involved next year.

Following the discussion Council members were allocated to each of the categories (volunteers at meeting plus allocations by chairs).

## ANNUAL GENERAL MEETING

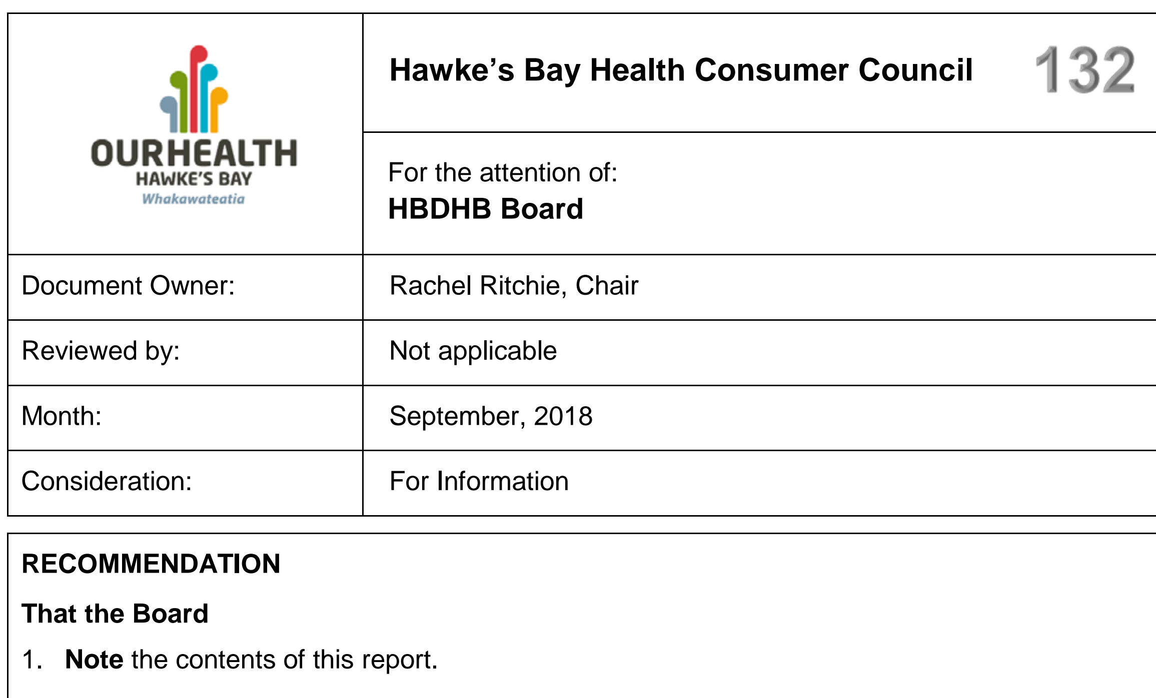
Council held its delayed AGM with extensive discussion around its role and performance including:

- Review of member attendance and tenure
- Clinical Services Plan
- Person and Whanau Centred Care – The Consumer Council chair joined us for this
- Quality Indicators and Dashboard
- Clinical Risk Management
- Clinical Governance – a draft clinical governance manual was reviewed
- Allocation of Council members to its Committees and Advisory Groups
- Review of Clinical Council's ToR and Workplan 2018/19

Council is in a period of transition with some members in acting roles that influence their eligibility for membership of Council. Andy Phillips indicated that due to his role of Acting Executive Director of Health Improvement and Equity he would be stepping down from his co-chair position. The election of a Chair/Co-Chairs has been deferred for two months to allow for provision of information regarding the work and time required and a more formal Expression of Interest process.

## REPORTS FOR INFORMATION were noted from the following:

- Matariki Regional Development Strategy and Social Inclusion (6-Month update)
- Clinical Advisory & Governance Group (CAG) Report



| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Health Consumer Council** 132 |
|---|---|
| | For the attention of: **HBDHB Board** |
| Document Owner: | Rachel Ritchie, Chair |
| Reviewed by: | Not applicable |
| Month: | September, 2018 |
| Consideration: | For Information |



**RECOMMENDATION**

**That the Board**

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

Consumer Council met on 13 September 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

**CONSUMER EXPERIENCE FACILITATORS**

The Facilitators have been appointed to start shortly. This role has been vacant since January so the council is looking forward to having these two roles moving the consumer voice forward again.

**AFTER HOURS URGENT CARE RE-DESIGN UPDATE**

David Rodgers, GP and Clinical Council member, and advisor to the PHO, spoke to the update report. David explained the new model was put together at short notice to meet contractual arrangements. Consumer Council's feedback was that while they understood there was consumer input into the steering group, prior to the new model being put together at short notice, there was no consumer engagement in the model, no consumer engagement in this six month review and no ongoing consumer engagement focus to capture the feedback around the system put in place. Feedback from members of Council was that the model:

- was too expensive – which very negatively affects access and equity;
- the change to involve a mobile paramedic is not an option that consumers can quickly assimilate and decide on as an option when they call in. The paramedic option has not been well optimised.

**MATARIKI**

Council understands this piece of work is taking some time to come to fruition. As last time the comments were that it is positive to see cross sector work under way.

**CONSUMER COUNCIL ANNUAL WORKPLAN 2018/19 including portfolio areas**

These were finalised and formerly approved by Council in September.
(Annual plan 'actions' were provided at the prior meeting)

**YOUTH CONSUMER COUNCIL**

The review of the YCC has been undertaken and the proposal to connect with other youth groups and encourage wider membership, re-set the age brand bracket in the terms of reference and provide a greater level of in-house support to the Council, was endorsed.

**UPDATES AND TOPICS OF INTEREST:**

**Disability Strategy**
This initiative is currently progressing well.

**Feedback on papers to Consumer Council**
Members who had been on the Council for some time and have seen a number of the papers coming through, expressed concern that while they made comment and gave feedback there was not a process for assessing what changes were effected in the paper(s) before they went through the other governance committees. Alongside this concern, that while the feedback is given at Council level, when Council members go back out into their work places they are not seeing any 'change on the ground'. Council will be talking to the paper authors more on this point in the future but would also like to bring this issue to the fore. Council would like to see a 'consumer lens' through the papers, and how that manifests in change on the ground.

| HAWKE'S BAY District Health Board Whakawāteatia | **Māori Relationship Board** 133 |
|---|---|
| | For the attention of: **HBDHB Board** |
| Document Owner: | Heather Skipworth, Chair |
| Reviewed by: | Not applicable |
| Month: | September, 2018 |
| Consideration: | For Information |

13

**RECOMMENDATION**

**That the HBDHB Board**

- **Review** the contents of this report.

**MRB recommend that the HBDHB Board:**

1. **Agree** that Equity is the driving value for the HBDHB
2. **Agree** that annual plans, work plans, services plans and clinical plans will be equity driven
3. **Agree** that all KPIs reflect equity measures and actions at all levels.

*In addition:*

4. **Agree** that Cultural competencies and equity measures be developed within expertise and be implemented by the CEO with both included as KPI measures.

The Māori Relationship Board met on 12 September 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

MRB received a report from the GM Māori Health covering Māori Health Services which included: Te Wahānga Hauroa Māori role changes (within Maori Health Services); the NZ NUKA System of Care Conference–He Ngākau Aotea; Children's health; Māori Health Workforce Action Plan; HBDHB Research Committee; Maori Nursing, including NEtP graduation and Māori retention; the Tu Kaha Conference 2018; Wai 2575 Treaty Claim Targets Alcohol amongst Māori.

## NUKA CONFERENCE

An update had been provided that this was being held in Hawke's Bay on 23 & 24 October with around 350 (60%) of available places dedicated to Hawke's Bay attendees. It was suggested that MRB members who had not attended NUKA visits (to Anchorage) should attend the Conference.

## KAUPAPA MĀORI TERMINOLOGY

There was some discussion on the cultural sensitivity of using the term Kaupapa Māori. This resulted in Management being asked to take care when using the term in programme development as it is culturally sensitive and should be used appropriately.

**BOWEL CANCER SCREENING**

Following lobbying by a number of DHBs for the MoH to lower the bowel screening age for Māori and Pasifika people to 50 years, their review had recently been received. The outcome was the MoH did not support lowering the age of eligibility to below 60 years. MRB members highlighted the importance of understanding the impact of this policy for our local population and of developing counter measures to address an increased level of inequity.

**EMPLOYMENT OF MĀORI FTEs**

Employment of Māori FTEs compared with the Central Region CEO's report issued included App 7 statistics. There is a large gap between Māori FTEs today but in 4 years' time the gap will still be the same (around 219).

Currently, Māori form 25% of Hawke's Bays population base. Focus in this area is important, as in the near future this base will be represented by approximately 40% Māori, relating to a much higher percentage of Māori working within the health workforce.

Bullying is a problem and the recipients are hesitant to speak up for fear of retribution. Suggested there is a need for non-Māori champions to support curbing this type of behaviour.

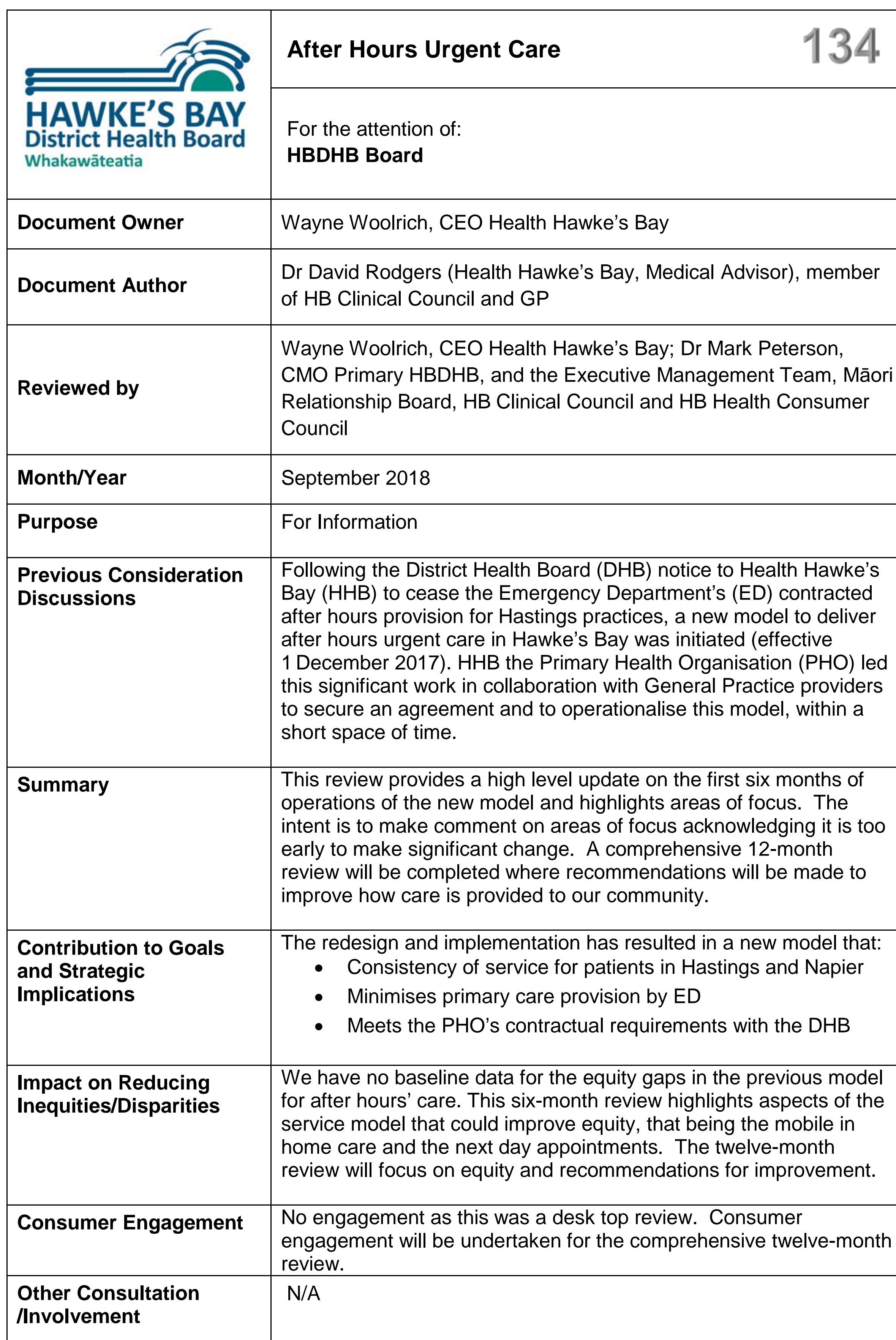
Leadership pathways and mentoring for Māori was raised to build competent leaders for the future. We need a nurturing workforce environment with staff having expectations that they can learn and be helped to grow.

**EQUITY AND CULTURAL COMPETENCY**

An active discussion around the topic of equity and cultural competency took place. This resulted in the recommendation for the Board's consideration.

**OTHER REPORTS REVIEWED/DISCUSSED INCLUDED**

- Matariki Regional Development Strategy and Social Inclusion Update
- After Hours Urgent Care Update



| HAWKE'S BAY District Health Board Whakawāteatia | **After Hours Urgent Care** 134 |
|---|---|
| | For the attention of:<br>**HBDHB Board** |
| **Document Owner** | Wayne Woolrich, CEO Health Hawke's Bay |
| **Document Author** | Dr David Rodgers (Health Hawke's Bay, Medical Advisor), member of HB Clinical Council and GP |
| **Reviewed by** | Wayne Woolrich, CEO Health Hawke's Bay; Dr Mark Peterson, CMO Primary HBDHB, and the Executive Management Team, Māori Relationship Board, HB Clinical Council and HB Health Consumer Council |
| **Month/Year** | September 2018 |
| **Purpose** | For Information |
| **Previous Consideration Discussions** | Following the District Health Board (DHB) notice to Health Hawke's Bay (HHB) to cease the Emergency Department's (ED) contracted after hours provision for Hastings practices, a new model to deliver after hours urgent care in Hawke's Bay was initiated (effective 1 December 2017). HHB the Primary Health Organisation (PHO) led this significant work in collaboration with General Practice providers to secure an agreement and to operationalise this model, within a short space of time. |
| **Summary** | This review provides a high level update on the first six months of operations of the new model and highlights areas of focus. The intent is to make comment on areas of focus acknowledging it is too early to make significant change. A comprehensive 12-month review will be completed where recommendations will be made to improve how care is provided to our community. |
| **Contribution to Goals and Strategic Implications** | The redesign and implementation has resulted in a new model that:<br>• Consistency of service for patients in Hastings and Napier<br>• Minimises primary care provision by ED<br>• Meets the PHO's contractual requirements with the DHB |
| **Impact on Reducing Inequities/Disparities** | We have no baseline data for the equity gaps in the previous model for after hours' care. This six-month review highlights aspects of the service model that could improve equity, that being the mobile in home care and the next day appointments. The twelve-month review will focus on equity and recommendations for improvement. |
| **Consumer Engagement** | No engagement as this was a desk top review. Consumer engagement will be undertaken for the comprehensive twelve-month review. |
| **Other Consultation /Involvement** | N/A |

| | |
|---|---|
| **Financial/Budget Impact** | The business case provided for an operating deficit of $76k in year one, to be underwritten equally by the DHB and HHB. At the time of the review the model is forecasted to operate in line with the business case projection.<br><br>A major financial concern was the low utilisation rates of the overnight paramedic. This service was projected to make a budget contribution of up to $70K p.a. but has to date only realised less than $1K in revenue (identified early on as a significant risk).<br><br>HHB worked with St John with both parties agreeing (in good faith) to a renegotiated and rationalised service level agreement, with similar service specifications now being delivered to a smaller number of clients for a lower cost than originally agreed. This variation has significantly reduced the financial risk to the model. |
| **Timing Issues** | N/A |
| **Announcements/ Communications** | N/A |

**RECOMMENDATION:**

That the HBDHB Board:

1. **Note** the six month review of the After Hours Urgent Care service.

| To | Health Hawke's Bay Board of Directors | From | Dr David Rodgers |
| --- | --- | --- | --- |
| Title | After Hours Urgent Care | Date | August 2018 |

FOR INFORMATION

## Purpose

To provide Health Hawke's Bay Board of Directors and Hawke's Bay District Health Board with a six-month review of the Urgent Care After Hours service.

### Context



Following the District Health Board (DHB) notice to Health Hawke's Bay (HHB) to cease the Emergency Department's (ED) contracted after hours provision for Hastings practices, a new model to deliver after hours urgent care in Hawke's Bay was initiated (effective 1 December 2017). HHB the Primary Health Organisation (PHO) led this significant work in collaboration with General Practice providers to secure an agreement and to operationalise this model, within a short space of time. The redesign represents a step forward in consistency of service, and is understood by all parties to be an early step in a wider process that will see further collaboration to improve and enhance the urgent care model (in partnership with patients, consumers and their whānau).

The redesign and implementation has resulted in a new model that:

- Provides an appropriate level of care for all patients
- Greater use of multidisciplinary skills
- Consistency of service for patients in Hastings and Napier
- Minimises primary care provision by ED
- Sustainability within available financial resources
- Meets the PHO's contractual requirements with the DHB
- Provides a firm foundation for the further development of integrated primary care solutions to ensure that the patient remains connected with their own GP

### PRIOR TO THE NEW MODEL

In Hastings, general practice provided primary care from 8.00am to 8.00pm seven days a week (as agreed with the DHB) utilising the health line phone triage service and ED for those patients who needed be seen.

In Napier, general practice had an after hours roster, whereby most GPs serviced their afterhours via City Medical.
This model was problematic due to:

- Recruitment challenges as Napier practices required GP's to work on the afterhours roster
- Widespread concern that servicing the onerous afterhours roster was impacting on quality of care in hours
- Accessing care overnight was expensive for some patients
- Perception that the Hastings model was encouraging inappropriate use of ED

**REVIEW OF MODEL**

Aspects of the Napier model (noted below) were extended in the redesign, to provide benefits to all within Napier and Hastings.

- Accident and Medical centres and co located pharmacies in both Napier and Hastings to remain open until 9.00pm
- Nurse triage and treatment (free of charge) from 9.00pm to 8.00am at City Medical (Napier)
- The Urgent Care nurse service (based in Napier) extended its scope to provide phone support and walk-in triage for all Napier and Hastings patients (between the hours of 9.00pm and 8.00am), with the ability to utilise the provider portal enabling direct access to GP notes
- Professional development support provided for the overnight nurses who work in City Medical
- Service model includes access to telephone support from an on-call GP until 3.00am
- Mobile paramedic offering an advanced face to face service at patients' own homes (available across Napier and Hastings 9.00pm to 3.00am
- Ability for GPs to ring fence next-day urgent care appointments with the patient's own GP
- ED contracted to provide face-to-face support for a small number of patients requiring urgent primary care need between the hours of 3.00am and 8.00am

Challenges

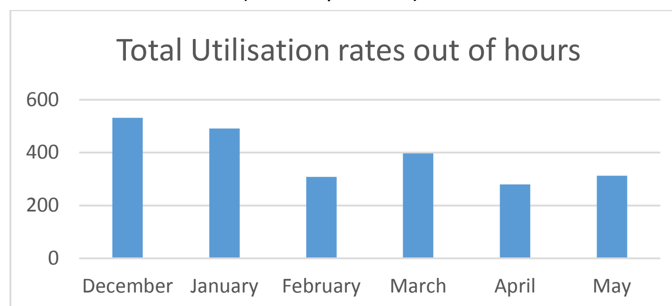
The redesigned service was a new contractual arrangement between multiple providers and required a significant investment of time to contract and establish the service. This resulted in a lack of focus on the need to communicate the changes to consumers. To remedy this, a fairly generic (and expensive) PR campaign shared the message that 'calling your usual GP number out of hours would connect you to an urgent care service' but communicating the detail of the plan remained challenging. A social media campaign communicating the service and personalising the urgent care paramedic helped to clarify the services available, but it is still unclear how well consumers understand the changes.

In the first few months it became evident that the utilisation rates for the urgent care paramedic were below those that were expected (and despite PR activities) the urgent care paramedic service remained underutilised. This presented an immediate financial and workforce concern. The PHO and St John worked together to review and agree a new model, whereby the urgent care paramedic skill set would be deployed across the ambulance fleet overnight rather than one paramedic dedicated to the service being on call.

The Shared Electronic Health Record has been difficult and utilisation has been slow, due to operational issues with the software vendor and logistical issues training staff to use the software (this has now been remedied).

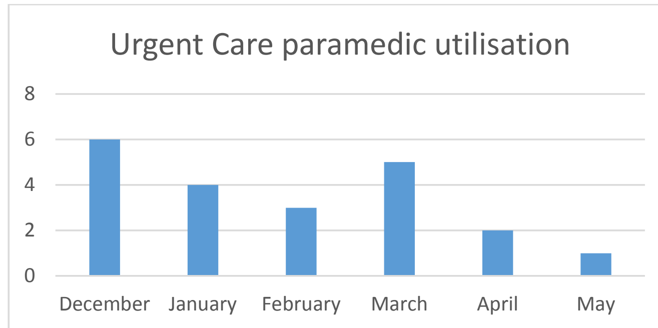
Utilisation rates and audit of subset of cases

*Total utilisation rates across the new service (all components):*



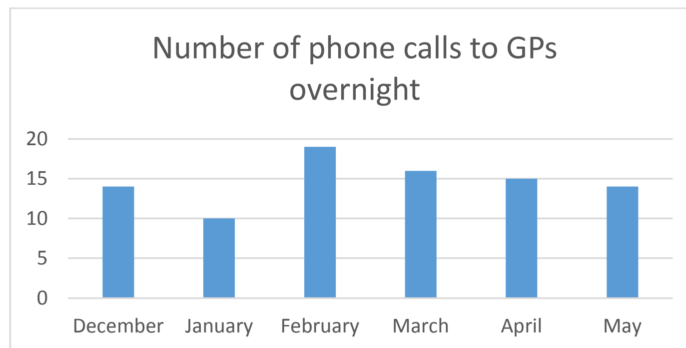
Total service utilisation across Hastings and Napier which includes presentations at City Medical (Napier), phone calls out of hours and paramedic call outs. December and January were months of high utilisation across the health sector in the province as our local economy is heavily tourist dependent. The drop in February is also likely related to the fact it's a shorter month. Overall though there is a definite decline in overall utilisation, this is also apparent at an individual service level.

*Paramedic utilisation rates:*



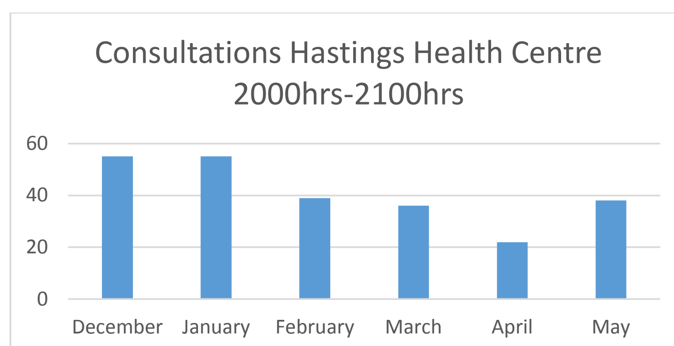

Urgent care paramedic visit rates per month started at a low point, which has continued to decline. The redesigned service allowed for three urgent care paramedic visits per night not being realised. The Paramedic utilisation rate is an area that requires additional focus.

*GP phone support utilisation rates*




The number of phone calls to GPs overnight has remained fairly static. A positive contributor to a manageable call level has been implementing more effective standing orders at the start of the redesign and available to the nurses who work overnight at City Medical.

*Hastings Health Centre utilisation rates*



Utilisation rates for Hastings Health centre have remained low with an average of 1.35 presentations per hour between 2000hrs and 2100hrs. With no change over the past six months this is an area that requires additional focus.

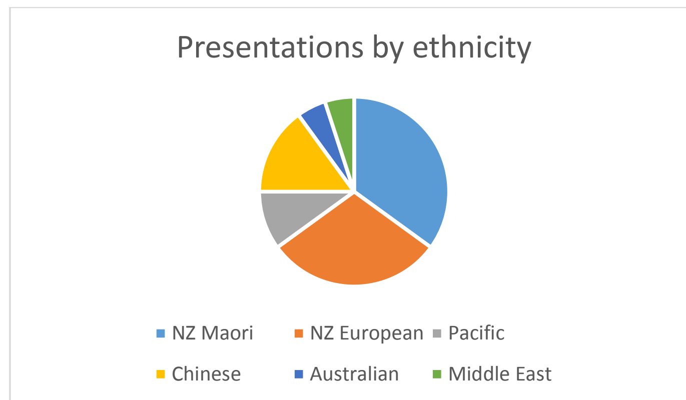
*Next day GP appointments*

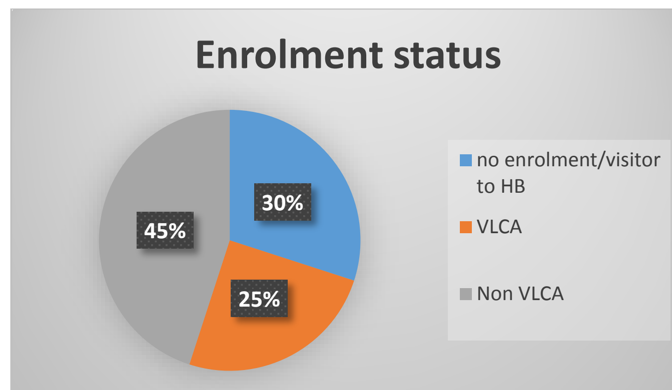
The next day GP appointments were only formally (recorded from April) ash resulted in thirty seven next day requests made in eighty four nights of on call duty. As some of these nights are weekends, this equates to thirty seven next day appointments across seventy working days, representing one appointment per workday across Napier and Hastings. At this point in time there is no way to determine whether these next day GP review appointments actually took place. This is an area to focus on to understand whether barriers such as cost or transport were relevant to non-attendance.

Patient Case Audit

Twenty random cases (across the six months from the contact records kept by the overnight City Medical nursing team) were used as a sample for the audit.

*Ethnicity and Enrolment status*




*Points to highlight:*

- The majority were NZ Māori (35%), followed by NZ European (30%)
- A significant minority were not enrolled in a practice locally, although this may be confounded by overseas visitors

- There was poor correlation between VLCA enrolment and ethnicity – less than half of NZ Māori consumers and none of the Pasifika consumers (identified in the audit) were enrolled at a VLCA practice

*Clinical disposition:*

- No one utilised the urgent care paramedic service. This isn't surprising as the total number of paramedic visits across six months was twenty one. While the total number of consumer contacts with the after hours model was two thousand, three hundred and twenty, twenty one urgent care paramedic patient contacts represents less than 1% of total patient contacts. The audit identified one clinical case appropriate for the paramedic service as it fit within their scope of practice and it was for a patient for whom transport was an issue. In this case the patient couldn't afford the paramedic service ($65 fee), so the paramedic was not dispatched.
- One of the twenty contacts resulted in transfer to ED. On review of the clinical notes this appears entirely appropriate, and a case that would almost certainly have been transferred to ED under the previous model
- Nine of the twenty contacts were treated using standing orders by the City Medical based nurse
- Ten of the twenty contacts were referred to next day GP services
- Seventeen of the twenty contacts were attendances onsite to the nurse at City Medical



<u>Intangible benefits not captured in audit/utilisation analysis</u>

The working relationship between HHB and St John (both regionally and nationally) has been immeasurably strengthened through the development of this new service model. This was highlighted by being able to negotiate an entire new service level agreement and renegotiate the contract quickly as the model developed throughout the months of implementation. This changed the service from one dedicated paramedic on shift waiting for calls for six hours per night, to using the paramedics that were already on duty in ambulances to deliver the same scope of practice as the dedicated urgent care paramedic. This significantly reduced the financial risk to those parties funding the model.

One of the benefits of training a larger cohort of paramedics (in the urgent care skill set) is that these skills are then deployed across their rosters and the St John network in Hawke's Bay. As one paramedic put it, "Once you've learnt this stuff you can't really unlearn it." This means patients are being treated in their homes by St John using the urgent care skill set and equipment which then prevents hospitalisation or GP review. Anecdotally this is happening several times per day, and is apparent in Central Hawke's Bay (CHB). CHB was outside the remit of this model, so it's great that some benefit is being felt in what remains a difficult to service part of Hawke's Bay.

General Practice has benefited from the alignment and consistency of Napier and Hastings resulting in reduced recruitment barriers. As one GP stated "you are fresher in your day job because you haven't been up the night before. Even if you're not called out, when you're on call you don't really sleep well."

While the shared health electronic record is still not being fully utilised, we have been able to hit a major milestone and significant step forward whereby GPs are comfortable with sharing information by engaging in a Hawke's Bay wide model. It has been identified that approaching general practice early on to ask for better information sharing was a key to success. General practice had a good understanding of what the information would be used for and how it would be accessed. The ability to have all general practice agree to this demonstrates the continued strength of the growing relationship of trust between general practice and Health Hawke's Bay.

Financial Analysis
The business case provided for an operating deficit of $76k in year one, to be underwritten equally by the DHB and HHB. At the time of the review the model is forecasted to operate in line with the business case projection.

A major financial concern was the low utilisation rates of the overnight paramedic. This service was projected to make a budget contribution of up to $70K p.a. but has to date only realised less than $1K in revenue (identified early on as a significant risk). HHB worked with St John with both parties agreeing (in good faith) to a renegotiated and rationalised service level agreement, with similar service specifications now being delivered to a smaller number of clients for a lower cost than originally agreed. This variation has significantly reduced the financial risk to the model.

There are other parts of the model which also have significant costs, with very low utilisation rates. While it was reasonable to underwrite these costs during the initial phase of the model, given that there has been no increase in utilisation across six (6) months it is timely to look at these costs.

Other areas of focus is the provision of the extra hour of care at Hastings Health Centre. The total cost for this service is $144K p.a. comprising of $93K p.a. for GP services and $51K p.a. for Community Pharmacy services. The utilisation rates for the extra hour of Community Pharmacy are not available, but it reasonable to infer it will be similar to the GP utilisation rate. The investment equates to $395 per hour to keep the Hastings GP and pharmacy service open. At the current utilisation rates this equates to approximately $294 per consumer which is difficult to justify long term if utilisation does not increase.

ED is contracted for $30k p.a. to see consumers between 0300 and 0800. This is an area of focus to explore as to whether this investment could be better used elsewhere to improve consumer care options.

Equity Assessment
We have no baseline data for the equity gaps in the previous model for after hours care. Anecdotally, utilisation of the after hours service overnight at City Medical has tended to include significant numbers of high needs consumers. This has been supported in the results shown in this audit.

The numbers utilising the new elements of the service (the urgent care paramedic and the Hastings Health Centre 8.00pm – 9.00pm) have been so low that there is limited scope for an adequate equity assessment of utilisation.

It is worth noting (that in the audit of a small subset of clinical cases) the one case that would have been really appropriate for the urgent care paramedic could not afford the service.

Two aspects of this model have significant potential to have an impact on equity. These are mobile treatment in a consumer's own home and next day general practice review. Each of these has potential to improve consumer's ability to access care, but each have cost implications which has likely impacted their use for those who most need them. This will be an area of focus for the twelve month review.

## Potential Changes to the Model

There is scope to make several changes to the model, either individually or as a suite of changes to try to make it more cost efficient and have impact on the equity gap in provision of primary and urgent care in Hawke's Bay.

Areas identified:

*Efficiencies*

- Pulling back from the extended service in Hastings, this the between 8.00pm and 9.00pm. This would represent considerable financial savings with little impact in terms of clinical risk. The service is underutilised and is a poor use of both financial resource, and more importantly, of clinical resources (GP, practice nurse and pharmacist).
- Reduce the level of contracted support from ED services for the care of patients between 0300hrs and 0800 hrs.
- Reduce the level of GP phone support service. Whilst not used very often, the City Medical overnight nurses feel it is a valuable support service for their clinical safety and their confidence. The nurses have expressed a preference for this service to be extended throughout the night i.e. extending past the 0300hrs current cut off time.
- Professional development fund for the overnight nurses is currently under-utilised. However, it is an area that is important to ensure the nurses providing overnight care feel supported and have access further education or professional development. This not an area we would consider reducing.

*Investments from efficiencies*

- Used to offset the current projected service deficit
- Extend the GP phone support service to cover 0300hrs to 0800hrs. There is appetite from the City Medical nurses who work overnight to extend the GP call support.
- Extend the hours of urgent care paramedic service. The model has moved from one dedicated paramedic, to using the network of paramedics. This service could be extended to cover 0300hrs to 0800hrs.
- Reduce / remove the co-payment for the St John's service. The utilisation rates are low and there is capacity to increase consumer care utilisation. On review, it seems that there aren't many clinically relevant cases, and where there are, cost can be a barrier. Reducing the co-payment to the consumer would address one of these problems
- Reduce / remove the co-payment for next day GP review that impacts consumers not being able to see their GP the next day because they cannot afford to. The recommended next day appointment is not only good for the consumer, it provides the overnight nurse a degree of safety in discharging someone overnight.

With the service being operational for six months, there has not been the operational time to justify making recommendations for material change. The twelve-month review will present an opportunity to consider redesigning the service model to improve its equity impact and to address its current deficit. If certain aspects of the current model were to be withdrawn from, funding could be repurposed to improve access for those who most need.

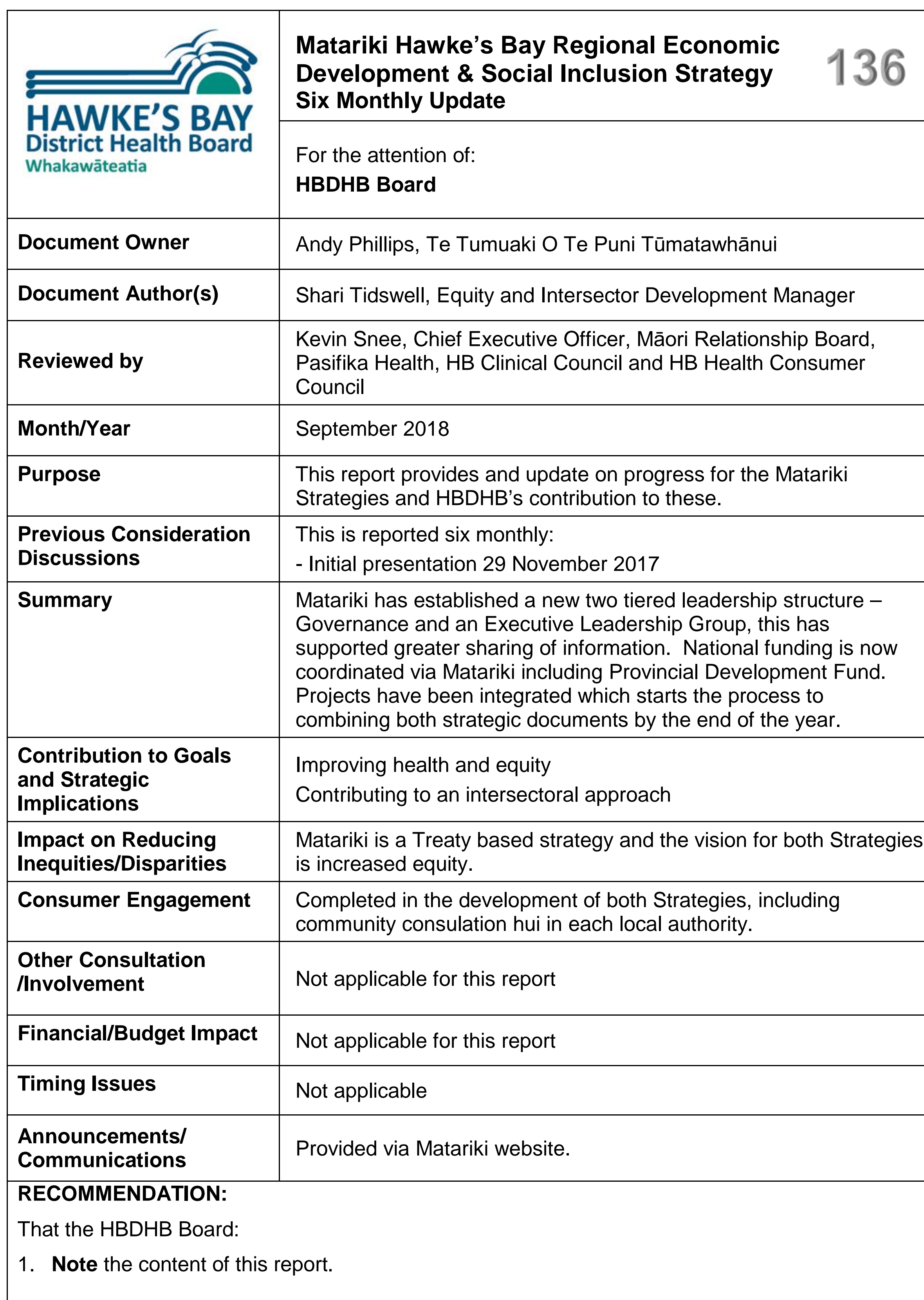
A future focus identified during the review is whether Central Hawkes Bay (CHB) could join this service model. This would require engagement with local model stakeholders, CHB stakeholders and St John. This would require a further piece of work from HHB to investigate the practicalities and appetite for this in CHB.

**Conclusion and Next Steps**

This review provides a high level update on the first six months of operations of the new model and highlights areas of focus. The intent is to make comment on areas of focus acknowledging it is too early to make significant change. A comprehensive 12-month review will be completed where recommendations will be made to improve how care is provided to our community.

# CLINICAL SERVICES PLAN

Verbal Update



| HAWKE'S BAY District Health Board Whakawāteatia | **Matariki Hawke's Bay Regional Economic Development & Social Inclusion Strategy Six Monthly Update** 136<br>For the attention of:<br>**HBDHB Board** |
|---|---|
| **Document Owner** | Andy Phillips, Te Tumuaki O Te Puni Tūmatawhānui |
| **Document Author(s)** | Shari Tidswell, Equity and Intersector Development Manager |
| **Reviewed by** | Kevin Snee, Chief Executive Officer, Māori Relationship Board, Pasifika Health, HB Clinical Council and HB Health Consumer Council |
| **Month/Year** | September 2018 |
| **Purpose** | This report provides and update on progress for the Matariki Strategies and HBDHB's contribution to these. |
| **Previous Consideration Discussions** | This is reported six monthly:<br>- Initial presentation 29 November 2017 |
| **Summary** | Matariki has established a new two tiered leadership structure – Governance and an Executive Leadership Group, this has supported greater sharing of information. National funding is now coordinated via Matariki including Provincial Development Fund. Projects have been integrated which starts the process to combining both strategic documents by the end of the year. |
| **Contribution to Goals and Strategic Implications** | Improving health and equity<br>Contributing to an intersectoral approach |
| **Impact on Reducing Inequities/Disparities** | Matariki is a Treaty based strategy and the vision for both Strategies is increased equity. |
| **Consumer Engagement** | Completed in the development of both Strategies, including community consulation hui in each local authority. |
| **Other Consultation /Involvement** | Not applicable for this report |
| **Financial/Budget Impact** | Not applicable for this report |
| **Timing Issues** | Not applicable |
| **Announcements/ Communications** | Provided via Matariki website. |

**RECOMMENDATION:**

That the HBDHB Board:

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

16

# Board Six Monthly Update: Matariki Hawke's Bay Regional Economic Development and Social Inclusion Strategy

| **Author(s):** | Shari Tidswell, Equity and Intersector Development Manager |
|---|---|
| **Date:** | **September 2018** |

**OVERVIEW**
Matariki includes two regional strategies designed to achieve regional development via economic development and social inclusion. Through the delivery of actions, these complementary strategies will support the Regional Economic vision:

> *"Every household and every whānau is actively engaged in, contributing to and benefiting from a thriving Hawke's Bay economy."*

and Social Inclusion vision:

> *"Hawke's Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has the opportunities that result in equity of outcomes."*

Underpinning this is the understanding that regional economic growth and equitable opportunities for individuals, whānau and community go hand in hand.

An intersectoral approach is being used to deliver actions and support the strategies. Intersectoral partners include community, Iwi, hapū, business, local government and government partners.

**PROGRESS ON ACTIONS LED OR CONTRIBUTED TO BY HBDHB**
Progress on the governance structure has been achieved with the adoption of a two tiered model. This group includes; five Councils (Mayors and a Chair), five Maori leadership representatives and five business leaders. The Governance Group provides leadership and overall direction for Matariki.

The Executive Leadership Group comprises of CEOs (senior officials and managers) from all stakeholder groups including government agencies, this includes the HBDHB CEO Kevin Snee and/or his delegate. This group provides operational and direct project support including monitoring the progress of the Strategy's actions. Administrative support is to be provided via the Business Hawke's Bay.

The Regional Growth Fund now has criteria and a process for applications. The Executive Leadership Group will review funding applications for endorsement – this will require proposals to illustrate how they will contribute to Matariki actions. Most funding to date is focused on youth employment.

The HBDHB continues to provide in-kind support for the Social Inclusion Working Group with the following recently completed:

- A communications plan for Social Inclusion
- An integrated actions table for both Strategies
- A joining statement to link the Strategies
- Supporting documents for the activity leads to deliver their roles

The HBDHB's current activity has potential to link with Matariki in the following actions:

- "Investigating whānau centric places, connected to local communities, where people access a wide range of support services…" HBDHB localities, community hubs and whānau centric programmes link to this work.
- The HBDHB's Clinical Services Plan being a good example of "Develop a new sustainable operating system for government agencies and NGOs delivering social support services".
- Supporting the development of community investment panels in Wairoa and Central Hawke's Bay. These "Establish representative groups in locations across Hawke's Bay to enable community and whānau voice and leadership in social and economic development".

HBDHB are contributing to Matariki actions as follows:

- Partnering with MSD, TPK and EIT to deliver "Project 1,000 linking 1,000 local people on benefits with new jobs". Our role includes membership on the Rangatahi Kia Eke advisory group. This project has placed 25 youth previously on health and disability benefits, into work experience placements. Have also contributed to design of the evaluation which is a collaboration with EIT.
- "Support the employment of people with challenges that may impact on their capacity to obtain or retain employment" - the DHB Annual Plan has included this work under "Work Ready" action. This is a Transform and Sustain project and a full project plan is under development. Initial activity will address barriers to employment including supporting youth to pass employer drug tests and access to support for driver licensing.



**CHALLENGES**

Some challenges had earlier hindered progress, notably:

- Changes in key staff, the project support role changed twice in eight months
- Delay in establishing the Governance and Executive Leadership structures which impacted the monitoring of projects to deliver actions
- Resourcing uncertainties via the change in Government and establishment of a new fund

These issues have been addressed over the previous two months. The project is now back on track with actions being accelerated and funding opportunities available to support new projects.

**CONCLUSION**

The work linked to Matariki is included in the HBDHB's Annual Plan, primarily under the actions in "Ready for Work". As stated above, there are also links with other key areas of work.

HBDHB benefits from cross-sector relationships developed via the membership of Matariki and these relationships will continue to offer opportunities. An example of this was the opportunity to use the Executive Leadership Group meeting to engage these key stakeholders in the Clinical Service Plan process.

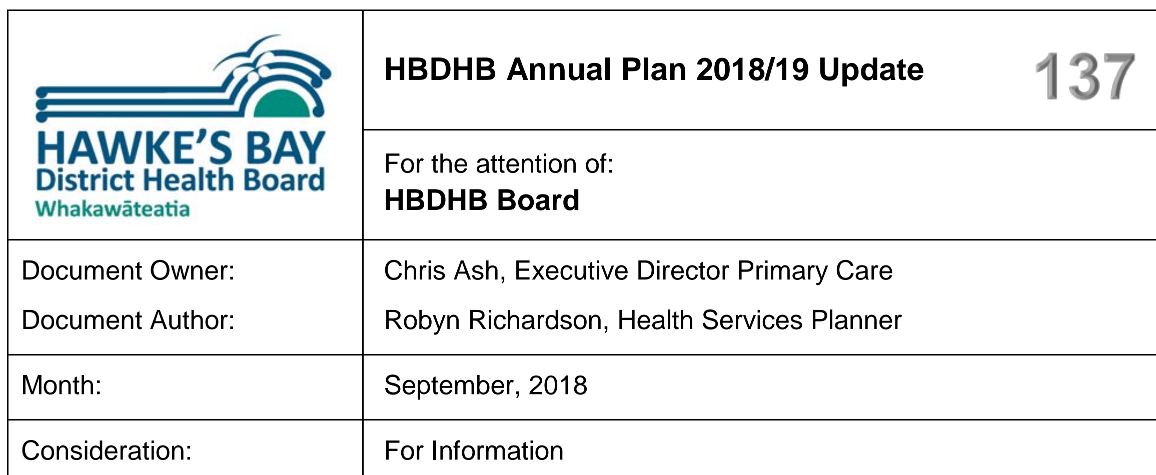
**RECOMMENDATIONS**

| Key Recommendation | Description | Responsible | Timeframe |
|---|---|---|---|
| HBDHB continues to contribute to Executive Leadership Group | • Attend monthly meetings and contribute to actions | Kevin Snee/ Andrew Phillips | Ongoing |
| Continue to support actions areas with in-kind support | • Support the ready for work actions<br>• Contribute to the work delivering whānau centric approaches<br>• Complete the housing actions via Housing Coalition | Shari Tidswell | 1 July 2019 |

**RECOMMENDATION:**

That the HBDHB Board:

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



| HAWKE'S BAY District Health Board Whakawāteatia | **HBDHB Annual Plan 2018/19 Update** 137 |
|---|---|
| | For the attention of:<br>**HBDHB Board** |
| Document Owner:<br>Document Author: | Chris Ash, Executive Director Primary Care<br>Robyn Richardson, Health Services Planner |
| Month: | September, 2018 |
| Consideration: | For Information |

**RECOMMENDATION**

**That HBDHB Board**

1. Note this update on the Annual Plan 2018/19

17

**OVERVIEW**

The first draft of the HBDHB Annual Plan for 2018/19 was submitted in July 2018.

**PROCESS**

Provisional feedback was received from the Ministry of Health on 10th September.

Formal, high-level feedback is to be sent to CEs and Chairs after the CEs and Chairs meetings on 13 September.

Fourteen of our Priority Areas are green (approved) with nine amber (requiring some technical clarification) and no red.

The Ministry has also requested further technical clarification on workforce and IT.

The 13 July 2018 update to the planning guidance included the below requirement:

"*It is expected that the DHB will include a summary of the key areas of focus, covered in the DHBs 2018/19 strategic discussions held with the Ministry of Health, along with confirmation of the DHBs resulting high level planning intentions. Please note, the key areas of focus are those from the notes provided back to the DHB following the meeting.*

*The Ministry will request quarterly progress updates on the delivery of confirmed planning intentions as part of routine quarterly reporting processes."*

We are awaiting guidance on how we should reflect this in our plans.

As in previous years, we will submit revised excerpts of our plan progressively as they are ready, however the Ministry has not asked for a full final draft plan to be submitted by a certain date.

We understand that this may change so are awaiting further guidance on this as well.

# 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:

19. Confirmation of Minutes of Board Meeting - Public Excluded
20. Matters Arising from the Minutes of Board Meeting - Public Excluded
21. Board Approval of Actions exceeding limits delegated by CEO
22. Chair's Update
23. Finance Risk and Audit Committee

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).