BOARD MEETING

Date: Wednesday, 27 April 2016

Time: 1.00pm

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

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

Apologies:

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

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Agenda Items	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report (verbal)		
8.	Chief Executive Officer's Report	29	
9.	Financial Performance Report	30	
10.	Consumer Story (Jeanette Rendle)		

	Section 2: Reports from Committee Chairs		**Time (pm)**
11.	HB Clinical Council (Dr Mark Peterson and Chris McKenna)	31	1.50
12.	HB Health Consumer Council (Graeme Norton)	32	
13.	Māori Relationship Board (Ngahiwi Tomoana)	33	
	Section 3: For Information and Discussion		
14.	Transform and Sustain Refresh Draft (Tim Evans)	34	2.20
15.	DHB Elections 2016 (Ken Foote)	35	2.35
16.	Electronic Papers – Post Implementation Review (Ken Foote)	36	2.40
	Section 4: Presentation		
17.	Vision / Values and Behaviours (John McKeefry)		2.50
	Section 5: Recommendation to Exclude		
18.	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	**Section 6: Agenda Items**	Ref #	**Time (pm)**
19.	Minutes of Previous Meeting		3.30
20.	Matters Arising – Review of Actions		
21.	Board Approval of Actions exceeding limits delegated by CEO	37	
22.	Chair's Report (verbal)		
	Section 7: Reports from Committee Chair		
23.	Finance Risk & Audit Committee (Dan Druzianic)	38	3.40
24.	HB Clinical Council (Dr Mark Peterson and Chris McKenna)	39	
	Section 8: General Business		

Next Meeting: 1.00 pm, Wednesday 25 May 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Board "Interest Register" - 30 March 2016

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

Board Meeting 27 April 2016 - Interests Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Daughter-in-law, Eve Fifield, Paediatric Registrar with HBDHB	Non-pecuniary interest: Will not take part in discussions regarding paediatric registrars	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair	7.12.10
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Andrew Blair	Active	Owner of Andrew Blair Consulting Limited	Engaged from time to time to provide consultancy and advisory services to healthcare and other organisations.	Will not take part in decision relating to organistions to which he provide consultancy and advisory services.	The Chair	04.12.13
	Active	Advisor to Trustees and Management of Chelsea Hospital Trust	Engaged to provide advisory services to the Trust who own and operate the private hospital in Gisborne.	Will not take part in decisions relating to services HBDHB may from time to time engage.	The Chair	24.07.14
	Active	Advisor to Hawke's Bay Orthopaedic Group Ltd	Engaged to provide advisory services to the Group	Will not provide advice in relation to contracting, employment or relationship matters between the HBOG and HBDHB. Will not participate in any decisions made by HBDHB regarding orthopaedic services.	The Chair	19.09.15
	Active	Chair of Southern Partnership Group	Southern Partnership is to progress the facilities redevelopment of Dunedin Hospital.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	19.09.15
	Active	Director, Breastscreen Auckland Limited	Breast screening facility.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.2015
	Active	Director, St Marks Womans Health (Remuera) Limited	Womans Health facility in Auckland	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.2015
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust	The Trust has a lifestyle Contract with HBDHB signed 31 January 2015 Awarded a Green Prescription Contract with HBDHB 11 February 2015	Will not take part in any discussions or decisions relating to the Contract.	The Chair	04.02.14
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 30 MARCH 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

Present: Kevin Atkinson (Chair)
Peter Dunkerley
Diana Kirton
Barbara Arnott
Jacoby Poulain
Denise Eaglesome
Dan Druzianic

Apologies Ngahiwi Tomoana, Andrew Blair, Heather Skipworth and Helen Francis

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

Minutes Brenda Crene

KARAKIA

Denise Eaglesome opened the meeting with a Karakia.

APOLOGIES

Apologies were noted from Ngahiwi Tomoana, Heather Skipworth, Andrew Blair and Helen Francis

INTEREST REGISTER

Action Diana Kirton asked that Eve be removed as an Interest on the Register as her placement had been brief.

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

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 24 February 2016, were confirmed as a correct record of the meeting.

Moved: Peter Dunkerley
Seconded: Barbara Arnott
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: Health & Social Care Networks: Timelines had been included on the workplan. Remove action.

Item 2: Human Resources – Maori Staff representation in the workforce: the points noted in the action status had been provided by HR Manager. Remove action.

Item 3: Te Ara Whakawaiora / Access: In considering aspects of the report provided, Jacoby Poulain received a response to her query regarding information to those in the home, which was mainly through public health nurses. Remove action

BOARD WORK PLAN

The Board Work Plan was noted.

The Surgical Wait List Flow noted on the workplan was to be moved out month as data was being sought. **Action**

A Refresh of Transform and Sustain had been drafted and would receive wide consultation. This will be a topic for discussion at the HB Health Sector Leadership Forum on 17 May. It was noted that Clinical and Consumer Council as well as MRB were to consider the draft in April.

CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retires
Tony McKee	Facilities Manager	Facilities & Operational Support	14	31-Mar-16
Jenny O'Sullivan	Midwife	Women Children & Youth	21	31-Mar-16
Dr Rob Armstrong	Respiratory Physician	Acute & Medical	26	1-Apr-16
Noeline Paenga	Medical Secretary	Facilities & Operational Support	21	1-Apr-16

- Kate Coley (Director QIPS) had been instrumental in preparing a response to the "privacy assessment" ie, a maturity assessment based on criteria and expectations established and rated across nine key principles. The Board were advised HBDHB generally sat in the middle of the defined area. An action plan will be developed from this assessment.

  The Board Chair and CEO signed off the assessment document during the meeting which was provided to Kate.

  The privacy assessment and audit process take place again in early 2017.

- The Chair referred to a Health Quality and Safety Commission (HQSC) book entitled "Governing for Quality" which focused on governance, quality and safety and included a section on how board members should go about assessing quality and safety.

  Kate Coley and Ken Foote advised of their intention to bring a report to the Board in July 2016 entitled "Governing for Quality".

  The Board indicated their interest to have a two hour Quality Workshop also. This would be investigated and timeline(s) advised as part of the Governing for Quality piece of work.

- MoH funding for the DHB in the 2016/17 year had increased 3.96% (based on the population). The largest increase in funding went to Northland.
- A health workforce review was referred to by the Chair. A key point noted by the Board was the aging workforce (with 45.4% of nurses being over 50 years of age).
- Board members were pleased to see there had been an increase in the number of qualified support workers.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO's report was taken as read and is summarised as follows:

- An overview of the performance targets was provided.
- Improvements in ED should enable HBDHB to be better placed heading into winter. From June onwards, initiatives will be in place which will result in further improvements.

- Smoking cessation in primary care had seen a small improvement and will likely to be close to target by the end of the next quarter. Liz Stockley provided some detail around the work occurring.
- The MoH Q2 results were appended to the CEO's report which showed problems in ED and the smoking target.
- The financial result for February was positive.

Following the CEO's report a new 8 minute Induction and Recruitment video was played to board members. The two minute version will be included on the website.

FINANCIAL PERFORMANCE REPORT

The Financial report for February 2016, was reviewed with the month yielding a favourable variance of $55 thousand, with the year-to-date result at $136 thousand favourable (for month nine).

The forecast for the 30 June 2016 year remains at the $3.990 million budgeted surplus. It was noted that 0.99m was MoH funding provided but not to be spent.

- Only the year to date part of the $1.0 million transferred to Surgical Services and the $90 thousand contributed to the corporate 3% savings plan, had been released from contingency.
- Elective surgery was 5.5% above plan after adjusting for prior period entries, and 1.5% ahead of the health target year to date, with 81% provided in-house in comparison to the planned 75%.
- Capital spend was close to the budget with employee numbers lower than planned.
- Case weighted discharges were well placed and were a good indicator.
- There is room for error with the need to continue to work hard to achieve the anticipated budget.
- The CFO advised a Budget update around the effect of spends by category would follow the prioritisation process, with Clinical Council in May.

  Action: Ensure this is included on the board agenda for May.

CONSUMER STORY

Difficulties experienced by a well-known leader in the community (as he prepared for surgery) highlighted challenges which will hopefully be alleviated as a new orthopaedic pathway is developed.

HBDHB Customer Service Manager, Jeanette Rendle sought out and was put in touch with Henare O'Keefe. She was wanting to know how consumers felt about orthopaedic services. Henare has since volunteered to become involved (with system changes) from a consumer perspective because of his experiences.

The co-design of service(s) will focus on consumer outcomes. These outcomes may not be exactly what consumers want (due to financial constraints) but outcomes must be communicated in a way that shows respect and ensures everyone is valued.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Dr Mark Peterson spoke to the Council report to the Board which included the Davanti IS review. He noted clinicians were impatient in this area and have been for some time. Council were generally supportive but had an element of scepticism as IS were not proactive and existing systems were seen as barriers not enablers.

The mobility action plan had been reviewed with the aim to support people with musculoskeletal conditions to fulfil their health potential and increase independence, through improved access to

high quality advice, assessment, diagnosis and treatment. Ministry funding was available and would be applied for to assist with costs in this area.

Urgent Care Alliance – expressions of interest had closed and there was now enough interest to be able to put together a request for proposal. The goal being to establish a model in primary care that would reduce pressure within the hospital (specifically ED). A behavioural/culture change in this area would not happen quickly.

Action: Clinical Council were asked how far advanced was the Hepatitis C Clinical Pathway as this would likely be a priority for the Ministry? This should be kept on the radar and an update provided to the board.

Hawke's Bay Health Consumer Council

Graeme Norton reiterated the wishes of Council to focus on where they can make a difference with their goal to see the consumer voice included in every aspect of the health system.

- Obesity and Youth received focus during their meeting earlier in the month.
- Council were now working with the population health team and strengthening confidence that what was being done would work.
- The Chair emphasised how the Consumer Relationship Manager's role was now starting to link through and supporting consumer focus in a more managed way.

Māori Relationship Board (MRB)

Denise Eaglesome spoke to the report in the absence of Ngahiwi Tomoana and Heather Skipworth.

She advised some MRB members appeared to be frustrated with progress and the lack of focus on equity. There was mention MRB were adamant that if staff wanted to report or present to MRB they must first use the HEAT tool to identify how their work was going to reduce inequity. MRB highlighted the important of DHB needing a formal process for this to occur across all governance groups as it is one of the overall priorities.

Board members felt this was more about communications coming through in the reporting provided.

Was there a need to review the MRB structure?

It appears MRB want to know how they can deliver their role more effectively, with some confusion surrounding their role within the DHB. The DHB (in 2013) removed DSAC, CPHAC and HAC from their meeting structure but MRB remained.

Since the restructure it was noted:

- MRB now has five HBDHB board members, previously two.
- MRB have always had strong advocacy at the HBDHB Board table.
- MRB members may not realise it but there is a lot of Maori input elsewhere in the health system (across the sector). This may not always be visible in the reporting they receive.

It appears MRB may be advocating for what is not visible. They may feel a lack of response to comments raised.

The CEO advised from where he was sitting HBDHB were doing better than anywhere else in NZ for Maori health. The Trendly data is what is generating other DHBs to look at what we are doing here in HB. The CEO stated that he has asked the GM Maori Health to provide a report to MRB on where DHB is doing well in Maori Health. This will be provided to the April meeting.

It must be remembered that most of the levers for improvement(s), sit outside the health system, hence there is such a high focus on multiagency (Intersectoral) work which will ultimately make the biggest impact.

The author of the HB Health Equity report advised this was presently being reviewed as part of its yearly cycle.

Action: Kevin Snee will meet with MRB members in April to discuss issues.

Whanau Ora was raised as something the DHB needed to better define. P LeGeyt is developing this further following the workshop in March.

Pasifika Health Leadership Group (PHLG)

As an introduction, Barbara Arnott advised this followed on from discussions in December 2015. PHLG feel the need to have more navigators within the health system, to help the growing population of Pasifika in HB. These people come from many different islands, speak various languages, and have different cultures and values.

Collectively the six members of Pasifika Health Leadership Group believe the navigators are the best option to reduce inequity and enhance communication.

Barbara introduced Tim Hutchins of Pasifika Navigation Service who provided a snapshot of consumer stories relating to his work with Pacific families.

- A variety of situations have occurred which have needed to be dealt with in very different ways because of the wide ranging cultures and languages of the Pasifika people. Their needs have often been overwhelming.
- The Navigator role has also been utilised in the ED setting also, focusing on reducing ED visits by pasifika people who have used it as a GP service. The main issues have been communication (language barriers) and the fact that health services mostly run during normal working hours making it difficult for those working to attend.
- Tim advised he has had a heavy workload and had worked with 950 families. His original contract was for Rheumatic Fever.

Another navigator has since been employed at Totara Health.

It was suggested a more holistic approach is required with a review of navigators (for Maori and Pasifika people). Look at what exists now and include nurses/district nurses into the equation as they are, in a sense, navigators also. Services need to be utilised in a more coordinated and cost effective manner.

A funding bid had been prepared for consideration.

The Board thanked those in attendance and wished them luck with their bid.

FOR DECISION

NZ Health Partnerships Ltd

NZ Health Partnerships Ltd was incorporated in 2015 to take over many of the functions and activities previously undertaken by Health Benefits Ltd. NZ Health Partnerships is a multi-parent Crown subsidiary that is led, supported and owned by New Zealand's 20 DHBs and has been established to enable DHBs to collectively maximise shared service opportunities for the national good. On consideration the Board approved the following Resolution.

RESOLUTION

That as a shareholder of NZ Health Partnerships Ltd, the Hawke's Bay District Health Board approved the Company's:

- Statement of Intent – 1 July 2015 to 30 June 2019
- Statement of Performance Expectations – 1 July 2015 to 30 June 2016; and
- Annual Plan 2015/16

Moved Dan Druzianic
Seconded Peter Dunkerley
Carried

Action: Ken Foote to provide the response to NZ Health Partnerships.

FOR INFORMATION

Draft HBDHB Annual Plan and SOI 2016/17 - Draft v1.1

Changes to the Annual Plan since 2015/16 were outlined noting the Minister was seeking a refreshed Statement of Intent (SOI) in this year's Annual Plan. The refresh is focused on incorporating the NZ Health Strategy themes and how we measure the implementation and impact of Transform and Sustain.

The areas of increased Focus; less Focus and local Maori Priorities were relayed to members.

Any feedback on the plan would be provided directly to Carina.Burgess@hbdhb.govt.nz

- The draft has been through the various Committees and through various other stakeholder groups
- It was noted the final draft was due in May 2016
- A query from the Chair related to page 59 of the plan. It was felt that HBDHBs position on food services and laundry services should be better defined. Carina noted this point at the meeting.
- Advanced Care planning was now included in the Plan (although not in the version provided)

Thanks were conveyed to Carina for a job well done.

Draft Central Region Regional Service Plan

The draft document provided outlined the Central Region's Plan developed collaboratively by the six DHBs in the Central Region reflecting strong focus on co-design principles across regional work. In 2016/17 the focus across the region would be on improving health outcomes and reducing disparities for Maori as well as working on the implementation of the five themes within the NZ health strategy through integration, regional collaboration and reducing silos.

MONITORING REPORTS

Te Ara Whakawaiora / Breastfeeding

Caroline McElnay introduced Nicky Skerman and Katie Kennedy (as Authors of the report).

It was acknowledged that Hawke's Bay had yet to meet the Ministry's target for breastfeeding across age bands and ethnicities, with breastfeeding rates for Māori being consistently lower than other ethnicities. A review of how best to improve breastfeeding rates by supporting mothers/whānau more intensively, starting specifically in the first at six weeks of a child's life, is underway.

An active discussion followed, resulting in the following action.

Action: **The Board wish to understand what other DHBs are doing and also to see where HB is benchmarked (including reasons and relative demographics).**

This will be included in the CEO's report when the information is available.

Annual Maori Plan Dashboard for Q2 (October to December 2015)

The Trendly tool has enabled better management ie., best practice where HB can learn from.

It was heartening to see the achievements made and the board were advised where results were not as good (ie., the challenging areas) had been incorporated into the Annual plan.

Areas of progress noted were more heart and diabetes checks and breast screening.

The challenging areas were Breastfeeding rates; Post natal Maori women smoke free; Immunisation rates; Maori under the Mental Health Act; and the Maori Workforce (with 2% below target of the 14.3% target).

Not yielding results as fast as would like in some areas but the focus is working with the person, not the disease, and see how we can reach the whole family at one time in a more co-ordinated way.

There being no general business the Board moved to the public excluded section of the meeting.

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION	
22.	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 Report
25.	Information Services Function Review
	Reports and Recommendations from Committee Chairs
26.	Finance Risk and Audit Committee
27.	HB Clinical Council
Moved:	**Dan Druzianic**
Seconded:	**Diana Arnott**
Carried	

The public section of the Board Meeting closed 3.25pm

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	30/3/16	**Agenda item for May – budget update,** around the effect of spends by category would follow the prioritisation process (with Clinical Council)	Tim Evans	May	
2	30/3/16	Clinical Council requested to enquire about **timing for the Clinical Pathway for Hepatitis C.**	Mark Peterson	May	
3	30/3/16	Kevin Snee will meet with MRB members in April to discuss issues.	Kevin Snee	April	
4	30/3/16	**NZ Health Partnerships approved recommendations advised**	Ken Foote	March	Actioned
5	30/3/16	**Te Ara Whakawaiora / Breastfeeding:** The Board wish to understand what other DHBs are doing and also to see where HB is benchmarked (including reasons and relative demographics). This will be included in the CEO's report when the information is available.	Caroline McElnay	Sept	

HAWKE'S BAY DISTRICT HEALTH BOARD

WORKPLAN

Meetings 2016	Papers and Topics	Lead(s)
17 May	**HB Health Sector Leadership Forum – Waipatu Marae, Karamu Road North, Hastings**	
25 May	Consumer Story	Kate Coley
	Travel Plan update	Sharon Mason
	Orthopaedic Review Closure of phase 1	Andy Phillips
	Best Start Heathy Eating Plan (Final)	Caroline McElnay
	Health Equity Update	Caroline McElnay
	Transform and Sustain Refreshed (Final)	Tim Evans
	Final Regional Services Plan	Tim Evans / Carina
	HB Integrated Palliative Care (Draft)	Tim Evans / Mary Wills
	Surgical Waitlist Flow (p/excl)	Sharon Mason
	Investment/Disinvestment Prioritisation	Tim Evans
	Monitoring	
	Te Ara Whakawaiora / Cardiovascular	John Gommans (on leave)
	HBDHB Non-Financial Exceptions Report Q3 Jan-Mar16	Tim Evans
	Annual Maori Health Plan Q3 Jan-Mar 2016	Tim Evans
	Transform and Sustain Strategic Dashboard Q3 Jan-Mar16	Tim Evans
	Human Resource KPIs Q3	John McKeefry
	HBDHB Quarterly Performance Monitoring Dashboard Q2 Oct-Dec 15 – provided by MoH	
29 June	Consumer Story	Kate Coley
	Suicide Prevention Plan Update	Caroline McElnay
	Youth Health Strategy	Caroline McElnay
	Food Services Review	Sharon Mason
	Health and Social Care Networks update	Liz Stockley
	IS Review/Restructure	Tim Evans
	Final Annual Plan and SOI	Tim Evans / Carina
	Monitoring	
	Te Ara Whakawaiora / Oral Health	Sharon Mason
27 July	Consumer Story	Kate Coley
	Developing a Person Whanau Centred Culture (draft)	Kate Coley
	Staff Engagement Survey – any corrective actions	John McKeefry
	Annual Organisational Development Plan/Programme	John McKeefry
	HB Intersectoral Group (priority plan) final	Kevin Snee/Caroline

Meetings 2016	Papers and Topics	Lead(s)
31 Aug	Consumer Story	Kate Coley
	Draft Quality Accounts	Kate Coley
	Travel Plan update	Sharon Mason
	Community Pharmacy Strategy (board action 16/12/15)	Tim Evans/Billy Allan
	Monitoring	
	HBDHB Non-Financial Exceptions Report Q3 Jan-Mar16	Tim Evans
	Annual Maori Health Plan Q3 Jan-Mar 2016	Tim Evans
	Transform and Sustain Strategic Dashboard Q3 Jan-Mar16	Tim Evans
	Human Resource KPIs Q3	John McKeefry
	HBDHB Quarterly Performance Monitoring Dashboard Q2 Oct-Dec 15 – provided by MoH	
7 Sept	**HB Health Sector Leadership Forum**	
28 Sept	Orthopaedic Review – Phase 2 draft	Andy Phillips
	Family Violence – Strategy Effectivess – for noting	Caroline McElnay
	Final Developing a Person Whanau Centred Culture	Kate Coley
	Final Quality Accounts	Kate Coley
	NKII MoU Relationship Review	Ken Foote
	Mental Health Consolidation / Benefits Realisation	Sharon Mason / Allison
	Final HB Integrated Palliative Care	Tim Evans / Mary Wills
	IS Review / Restructure Report	Tim Evans
	Long Term Investment Plan (Asset Management Plan)	Tim Evans / Peter K
	Annual Report (interim)	Tim Evans

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 29
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month: As at	18 April 2016
Consideration:	For Information

8

Recommendations

That the Board

1) Note the contents of this report.

In relation to RHIP:

2) **That the Chairs and CEs** reconfirm the commitment of the RHIP Programme vision as per their commitment on 15 October 2015.
3) **Agree** to Deploy (build implement and operate), the RIS, Clinical Portal (Core and Enhanced), Healthcare Practitioner Index, Regional WAN and Infrastructure to all 6DHBs.
4) **Agree** that the Programme of deployment to other DHBs, following Whanganui's deployment, will be subject to:
   a) The successful implementation and go live of the current planned phase of the Programme (recommendation 2 above) within the current allocated Programme budget.
   b) That there is a Post Implementation review of the Clinical Portal Implementation to ensure it is a sound base upon which to build the Enhanced Portal
   c) That there is a review of the proposed Enhanced Portal design and functionality against the existing Portal functionality as a reference to ensure it will provide additional value
   d) That there is continued independent review of the Programme.
5) **Agree** to deploy the Interim Regional Operating Model as agreed to support the Whanganui deployment as above.
6) **Note** that the Interim Service Model will need to be developed to meet the regional needs as other DHBs come onto the regional solution.
7) **Agree** to have WebPAS build and available for local implementation / uptake, initially by first Whanganui in 2016, followed by MidCentral / Wairarapa and then the remaining DHBs (timing and sequence to be advised).
8) **Agree** to the commitment of funding of up to $8.3M (in addition to the $56.2M already committed) to support the above recommendations, noting that any additional funds to be invested will be accompanied by a revised cash flow, accommodating where possible each DHB's funding availability and constraint
9) **Note** that some Chairs and CEs will need to seek Board approval for this additional funding and will do so before 30 April 2016.

INTRODUCTION

In this month's Board report I will comment on our performance. The key problems in March were:

- Smoking cessation in primary care
- Faster cancer treatment

This month we will revisit a number of the previous consumer stories shared at Board meetings to provide an update on the improvements and developments that have been implemented as a result of sharing those stories. We will also discuss how we will refresh our five year strategy, Transform and Sustain, as we near its mid-point and as we receive the new National Health Strategy whose launch is imminent. We will also discuss the approach to Board elections in October and the post-implementation review of our move to electronic papers at governance and executive level.

The are two further issues that I wish to comment on that have been discussed many times at Board level: Regional Health Information Programme (RHIP) and Fluoridation.

RHIP

We have reached the point where MidCentral and Whanganui DHBs are gearing up to go live with the base clinical portal (Concerto) and the Radiology Information System soon after. This is intended to commence in mid-May. Obviously neither DHB will proceed without certainty that the remaining four DHBs will follow. In order to provide this certainty, the Regional Governance Group and CEOs met and agreed a set of recommendations which are detailed above.

We need to be clear in committing to some additional funding to complete this programme that the benefits of doing so outweigh the likely cost to this DHB. Whilst financial details are still being refined, our Population Based Funding Formula share of an additional $8.3 million to complete RHIP would be of the order of $1.7 million.

Against this level of cost, the adverse consequences of withdrawing from CRISP, or of failing to commit to completion of core systems (including an enhanced Clinical Portal), would be significant both financially and functionally. There would also be consequences in terms of our reputation as a regional partner as MidCentral and Whanganui DHBs would be unable to proceed with completing their build work on the Regional WebPas and Clinical Portal. This DHB currently has $5.2 million on the balance sheet as work in progress, which we would need to write off. We would be unable to deliver an acceptably functional Clinical Portal within the next two years, which is the most tangible CRISP product for our clinicians.

I am asking the Board to support the recommendations which allow the programme to proceed.

FLUORIDATION

I welcome the recent announcement by the Minister of Health making clear the government's intention to ask DHBs to take responsibility for making this decision rather than local government. It has been very clear that local government is ill-equipped to deal with this issue and as a consequence many local residents miss out on the health benefits which are clear and scientifically proven. A recent report by Sapere indicated that for people living in areas with fluoridated drinking-water there is a:

- 40 percent lower lifetime incidence of tooth decay among children and adolescents
- 48 percent reduction in hospital admissions for the treatment of tooth decay among children aged 0 to 4 years
- 21 percent reduction in tooth decay among adults aged 18 to 44 years
- 30 per cent reduction in tooth decay among adults aged 45 years and over.

In addition to the savings in dental costs for both the health system and the public, there will be an overall positive impact on people's general health, fewer days lost at school or work and reduced pain and suffering.

I welcome this change and look forward to reviewing our position locally. Any proposal will be considered within national guidelines about process and will be considered against any other proposed investment in health services.

PERFORMANCE

Measure / Indicator	Target	Month of March	Qtr to end March	Trend For Qtr
Shorter stays in ED	≥95%	94.2%	93.9%	▲
Improved access to Elective Surgery (2015/16YTD)	100%	101.8%	-	▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	*2,645*	*410*	*6*
Patients given commitment to treat, but not yet treated (ESPI-5)	*1,051*	*116*	*8*

Faster Cancer Treatment*	≥85%	42.9% (Feb 2016)	64.7% (rolling 6m to Jan 2016)	▼
Increased immunisation at 8 months (3 months to March)	≥90%	---	95.8%	▲
Better help for smokers to quit – Hospital	≥95%	96.8%	97.8%	▼
Better help for smokers to quit – Primary Care *there was a change in definition at the start of 2015/16 which has an impact on the results	≥90%	75% (Quarter 2, 2015/16)	---	▼
More heart and diabetes checks	≥90%	90.3% (Quarter 2, 2015/16)	---	▬
Financial – month (in thousands of dollars)	$1,186	$1,238	---	---
Financial – year to date (in thousands of dollars)	($4,299)	($4,111)	---	---

***Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 76 people a year (11.4 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%	*7/11 = 61%*	*51/68 = 74.6%*

Performance this month has seen a further improvement in shorter stays in the Emergency Department (ED). Our position for the quarter will be reported as 94 percent, up from 93 percent in Q2 and 92 percent in Q1, so there is steady progress, and for the first two weeks of April we are at 95 percent. In elective surgery we have returned to within contractual tolerances for waiting times and we remain above plan for activity. This year the activity in individual specialties is closer to plan than in previous years and in orthopaedics the output in relation major joints has significantly improved.

Immunisation has continued to improve as anticipated and is now above target.

Our performance for the Faster Cancer Treatment (FCT) health target has declined in the last four months. Quarterly results (for six months to February 2016) were 64.7 percent against the expected 85 percent compliance for the 62 day health target. February 2016 results for the 31 day indicator were 90.3 percent. The Medical and Surgical Directorate leadership teams are focusing on ensuring Consultants prioritise referrals and identify patients with high suspicion of cancer and the need to be seen within two weeks. This alone will improve compliance for the 62 day target. Access to diagnostics is highlighted as a key focus area, specifically Endoscopic Biopsy under Ultrasound (EBUS) which is currently provided via an external contract and resulting in delays to diagnose (specifically for lung tumour stream). The directorate team is exploring options to bring the service in house.

Access to CT and reporting turnaround is proving problematic, and proposals are being developed to address this. A detailed update will be prepared for the May board.

The financial result for February is a favourable variance of $52 thousand, making the year-to-date result $188 thousand favourable. With only three months of the financial year to go, this is a strong position particularly when compared with other DHBs nationally. In February we were one of only six who are meeting financial targets and we are delivering the largest surplus as a percentage of budget. Of course there remain risks to be addressed and we are very focussed on developing a sustainable position for next year.

TRANSFORM AND SUSTAIN REFRESH

We are now about half way through the plan horizon for our Transform & Sustain strategy. The direction of our strategy is still relevant, but the underpinning suite of projects where we aim to achieve change is due for a refresh. This paper updates the Board on how that refresh process has begun, and seeks agreement to the proposed approach and milestone timetable for expanding involvement in the refresh.

DHB ELECTIONS

DHB elections are scheduled for 8 October 2016. A paper providing notice of the elections, with key dates, is included on the agenda. The paper also includes information and recommendations on a number of pre-election issues for consideration by the Board.

ELECTRONIC PAPERS – POST IMPLEMENTATION REVIEW

Electronic Board papers were introduced in July 2015 through the use of Diligent Boards application on Surface Pro devices. Given the number of issues that have arisen, a post implementation review was initiated and recently completed by Jeff Petrie. Jeff's report on the review, with the Steering Group's comments included against each recommendation, is included on the agenda for discussion and comment.

VALUES AND BEHAVIOURS

Our Values have been in place for some years now. In order to become a Values led organisation and health sector we need to fully embed our Values (and behaviours) into everything we do. Our Values need to be visible in our everyday behaviours, from front line staff to EMT and the Board, across the sector and in every interaction with consumers and between staff.

John McKeefry, General Manager Human Resources, will give a presentation on the new behaviours we have developed that describe each of our Values and how we are going to fully embed our Values into everything we do.

STRATEGIC RELATIONSHIPS

In April 2015, the Board was presented with a report on "Strategic Relationships – Central Region DHBs". This report set out a range of issues impacting on such relationships at the time, along with a number of deductions arising from an EMT workshop on these issues. The Board endorsed the EMT conclusion "that at senior management and Board level, such relationships be maintained and enhanced through continued proactive and constructive engagement". The Board further requested a review of progress in six months and at six monthly intervals until further notice.

Good positive relationships now exist within the leadership of the Central region DHBs which is enhancing proactive and constructive engagement.

SUMMARY

In summary, the local health system coped well in March and we have continued good progress with our DHB partners in building a better health system across the Central Region.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, March 2016** 30
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, GM Planning, Informatics & Finance Finance Team
Reviewed by:	Executive Management Team
Month:	April 2016
Consideration:	For Information

RECOMMENDATION

That the Board and FRAC
Note the contents of this report

1. GM Planning Informatics & Finance comments

Financial performance

The result for March is a favourable variance of $52 thousand, making the year to date result $187 thousand favourable. Slower than planned implementation of new investments offset the cost of elective surgery outsourced to Royston.

Only the year to date part of the $1.0 million transferred to Surgical Services and the $90 thousand contributed to the corporate 3% savings plan, have been released from contingency.

Forecast result

The forecast for the 30 June 2016 year remains at the $3.990 million budgeted surplus. Cover for medical vacancies and sick leave, likely costs to avoid ESPI breaches, and claw-back by MOH of PHARMAC hospital pharmacy price savings, will together be much higher than the remaining contingency. However, one off savings are expected to offset the additional costs for this year. The savings relate to:

- Intermediate care beds for health of older people
- lower than expected growth in primary health care strategy costs and pharmacy payments, delayed under 13 access implementation, and unlikely expenditure of the primary mental health risk wash-up budget.

Efficiencies not achieved in the sustain programme, are expected to be offset by savings achieved elsewhere and delays in implementing new investments.

Note that the IDF and elective services wash-ups contribute uncertainty to the forecast.

Strategic Resource Redeployment (Quarter 3)

The Board approved a budget that meets the strategic requirement to shift resource from Hospital to Community, Primary, and Population health settings. The first quarter saw a significant change in the surgical directorate budget to reflect elective surgical activity expectations at a speciality level and reduced the shift out of the Hospital health setting from 0.19% to 0.07%.

The second quarter table indicated the shift in the first half of the year has been into rather than out of the Hospital health setting by 0.33%. This reflected faster cost growth in hospital services due to service improvement initiatives and unusually high locum cover requirements, and the lower level of aged community bed utilisation and timing of the engAGE programme.

The shift in the first half has continued into the third quarter (see table below). The same factors are driving the shift, and have been exacerbated by outsourcing of some elective surgery to Royston to help ESPI compliance and major joint targets, and slower than planned implementation of new investments in the out of hospital setting.

The forecast indicates the shift will continue through to the end of June, and is likely to be greater than 1%.

	2014-15		2015-16		Change	2015-16		Change
	[1] Outturn $'000	Split %	[2] Adj Budget $'000	Split %	Split %	[3] YTD Actual $'000	Split %	Split %
Population Health	7,524	1.67%	8,201	1.77%	0.10%	5,352	1.53%	-0.14%
Primary Care	94,565	21.01%	97,065	20.94%	-0.07%	72,748	20.79%	-0.22%
Community Care	125,272	27.83%	129,189	27.87%	0.04%	95,484	27.29%	-0.54%
Out of Hospital sub-total	227,362	50.52%	234,456	50.58%	0.07%	173,584	49.61%	-0.91%
Local Hospital	173,207	38.48%	178,211	38.45%	-0.04%	137,742	39.37%	0.88%
Out of District	49,500	11.00%	50,840	10.97%	-0.03%	38,564	11.02%	0.02%
Hospital sub-total	222,707	49.48%	229,051	49.42%	-0.07%	176,307	50.39%	0.91%
	450,068	100%	463,507	100%		349,891	100%	
Corporate	39,525		41,751			31,279		
Total Expenditure	**489,593**		**505,258**			**381,170**		

1. Forecast outturn as presented to Board
2. 2015/16 adjusted budget as present to October 2015
3. Actual expenditure YTD July to March 2016

2. Resource Overview

	March				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)	1,238	1,186	52	4.4%	(4,111)	(4,299)	187	4.4%	4,382	3
Contingency utilised	91	250	159	63.7%	818	2,250	1,433	63.7%	3,000	8
Quality and financial improvement	579	741	(162)	-21.9%	5,873	6,734	(861)	-12.8%	10,200	11
Capital spend	795	2,428	(1,633)	-67.2%	13,863	15,682	(1,819)	-11.6%	21,358	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,175	2,225	50	2.2%	2,129	2,175	46	2.1%	2,188	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,215	2,288	(73)	-3.2%	20,967	20,353	614	3.0%	27,009	5

The result for March is a favourable variance of $52 thousand, with $818 thousand of the contingency utilised ($750 thousand transferred to surgical, and $68 thousand contributed to the corporate 3% savings plan year to date).

Quality and Financial Improvement (QFI) programme savings continue below plan reflecting the progressive realisation of savings. Efficiency budgets are being transferred to areas that have favourable variances. The implementation and monitoring of the remaining savings plans is ongoing. Realisation of IDF savings will not be known until the 2015/16 IDF wash-up process is complete.

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

The FTE variance year to date reflects vacancies relating to new programmes or changes in the model of care.

Case weighted discharges are marginally below plan in March, and are 3% ahead of plan year to date. High acute general surgery, and gastroenterology volumes drive the year to date variance partly offset by lower than planned maternity case weights.

3. Financial Performance Summary

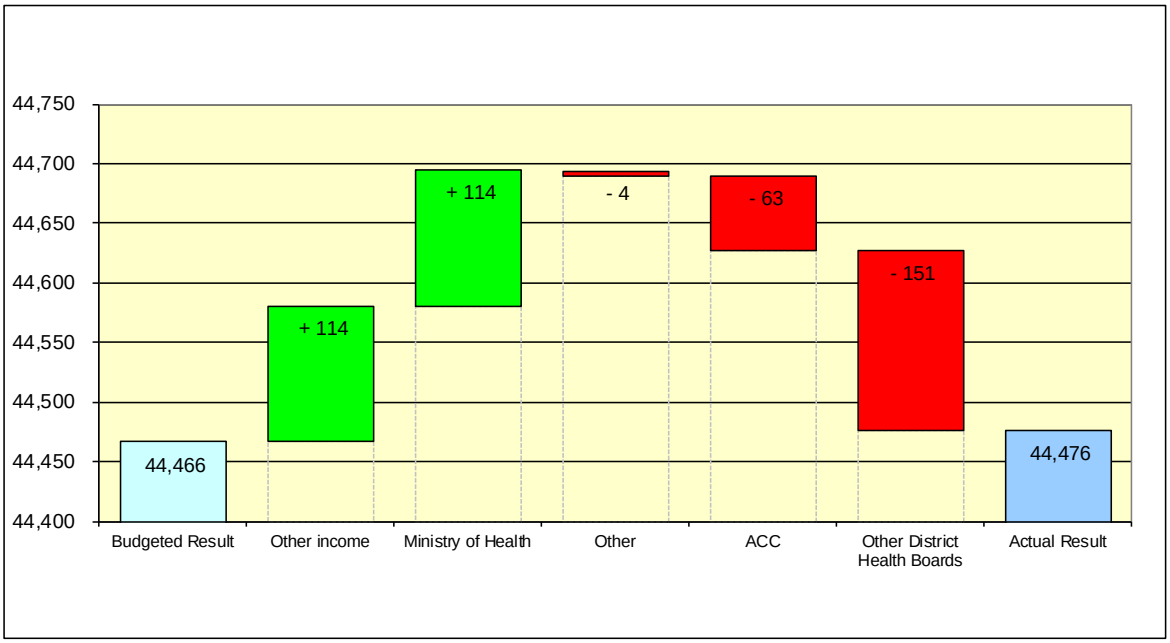
	March				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	44,475	44,466	9	0.0%	377,058	377,742	(683)	0.2%	512,291	4
Less:										
Providing Health Services	21,280	20,499	(781)	-3.8%	179,552	178,182	(1,370)	-0.8%	240,699	5
Funding Other Providers	18,183	19,001	819	4.3%	167,209	169,054	1,845	1.1%	221,307	6
Corporate Services	3,531	3,535	4	0.1%	31,467	32,029	562	1.8%	43,815	7
Reserves	244	244	1	0.3%	2,942	2,776	(165)	-6.0%	2,480	8
	1,238	**1,186**	52	4.4%	**(4,111)**	**(4,299)**	187	-4.4%	**3,990**	

Reduced income from ACC (resources reprioritised to elective surgery), and other DHBs (mostly offset by reduced costs), is partly offset by interest income. Vacancy and leave cover for medical staff and outsourcing to Royston, are more than offset by slower than planned implementation of new investment expenditure in the funding arm, and lower depreciation and amortisation costs.

4. Income

$'000	March				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	42,425	42,311	114	0.3%	358,947	358,866	81	0.0%	488,332
Inter District Flows	624	624	0	0.0%	5,616	5,612	4	0.1%	7,487
Other District Health Boards	288	440	(151)	-34.4%	2,664	3,286	(622)	-18.9%	3,572
Financing	86	86	(0)	-0.5%	1,078	755	323	42.8%	1,329
ACC	443	506	(63)	-12.4%	3,865	4,643	(778)	-16.8%	5,183
Other Government	35	35	1	2.7%	264	311	(46)	-14.9%	368
Patient and Consumer Sourced	117	123	(5)	-4.3%	893	1,149	(257)	-22.3%	1,249
Other Income	457	342	114	33.4%	3,659	3,120	540	17.3%	4,712
Abnormals	(0)	-	(0)	0.0%	72	-	72	0.0%	58
	44,475	**44,466**	9	0.0%	**377,058**	**377,742**	(683)	-0.2%	**512,291**

March Income



Note the scale does not begin at zero

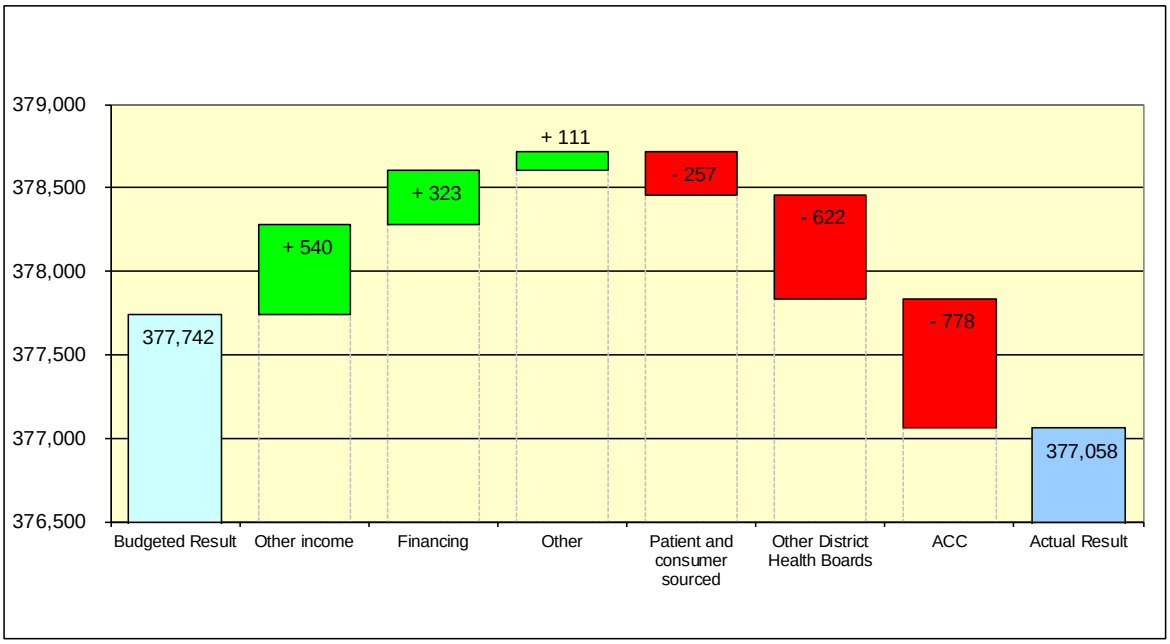
Other income (favourable)
Includes clinical trial income and donations (unbudgeted).

Ministry of Health (favourable)
Clinical training (offset by expenditure).

ACC (unfavourable**)**
Prioritisation of elective surgery over ACC volumes.

Other District Health Boards (unfavourable)
Lower sales of cancer drugs to Tairawhiti DHB, mostly offset by lower expenditure. Lower oncology income from Mid Central DHB.

Year to date Income



Note the scale does not begin at zero

Other income (favourable)
Includes clinical trial income and donations (unbudgeted).

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

Patient and consumer sourced (unfavourable**)**
Lower non-resident charges and patient co-payments (audiology and mental health – both offset by reduced costs).

Other District Health Boards (unfavourable**)**
Lower sales of cancer drugs to Tairawhiti DHB, partly offset by higher oncology clinic charges to Mid Central DHB. Both offset in expenditure.

ACC (unfavourable)
Prioritisation of elective surgery over ACC volumes.

5. Providing Health Services

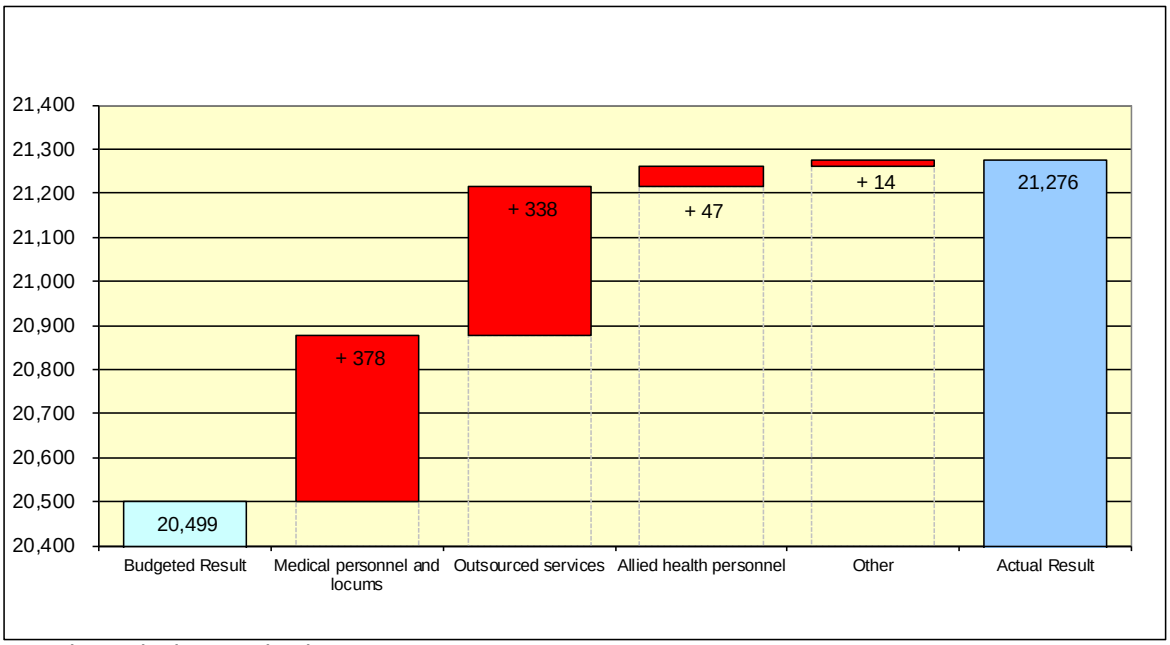
	March				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,052	4,674	(378)	-8.1%	43,693	41,879	(1,815)	-4.3%	58,106
Nursing personnel	6,040	6,043	3	0.0%	52,277	52,566	289	0.6%	69,971
Allied health personnel	3,005	2,958	(47)	-1.6%	22,865	24,211	1,346	5.6%	30,693
Other personnel	1,778	1,763	(15)	-0.8%	15,176	15,174	(1)	0.0%	20,242
Outsourced services	807	465	(342)	-73.5%	4,384	3,891	(492)	-12.7%	5,622
Clinical supplies	3,072	3,058	(14)	-0.5%	27,346	26,567	(779)	-2.9%	37,293
Infrastructure and non clinical	1,526	1,538	12	0.8%	13,811	13,893	82	0.6%	18,769
	21,280	**20,499**	(781)	-3.8%	**179,552**	**178,182**	(1,370)	-0.8%	**240,696**
Expenditure by directorate $'000									
Acute and Medical	5,584	5,452	(132)	-2.4%	49,183	47,984	(1,199)	-2.5%	65,705
Surgical Services	5,049	4,315	(734)	-17.0%	40,418	38,493	(1,925)	-5.0%	53,682
Women Children and Youth	1,758	1,692	(66)	-3.9%	14,695	14,685	(10)	-0.1%	19,612
Older Persons & Mental Health	2,885	2,912	27	0.9%	24,591	25,177	586	2.3%	32,695
Rural, Oral and Communlty	1,962	2,021	59	2.9%	16,194	16,546	352	2.1%	21,671
Other	4,042	4,108	66	1.6%	34,472	35,297	825	2.3%	47,331
	21,280	**20,499**	(781)	-3.8%	**179,552**	**178,182**	(1,370)	-0.8%	**240,696**
Full Time Equivalents									
Medical personnel	301.3	305.4	4	1.4%	305	304	(2)	-0.6%	303.8
Nursing personnel	897.0	913.5	17	1.8%	877	886	9	1.1%	893.7
Allied health personnel	437.9	454.5	17	3.7%	415	443	28	6.3%	445.6
Support personnel	129.0	131.8	3	2.1%	130	129	(2)	-1.4%	129.4
Management and administration	246.7	246.5	(0)	-0.1%	247	246	(1)	-0.3%	247.2
	2,011.8	**2,051.7**	40	1.9%	**1,974**	**2,007**	33	1.6%	**2,019.6**
Case Weighted Discharges									
Acute	1,621	1,524	97	6.4%	14,819	13,902	918	6.6%	18,426
Elective	528	560	(31)	-5.6%	4,772	4,643	128	2.8%	6,195
Maternity	47	174	(126)	-72.7%	1,061	1,542	(481)	-31.2%	2,035
IDF Inflows	19	31	(13)	-40.1%	314	266	48	18.2%	353
	2,215	**2,288**	(73)	-3.2%	**20,967**	**20,353**	614	3.0%	**27,009**

Directorates

The unfavourable result for March relates to:

- Surgical Services – major joint elective surgery outsourced to Royston, and vacancy and leave cover (medical personnel).
- Acute and Medical – Vacancy and leave cover (medical personnel).

March Expenditure



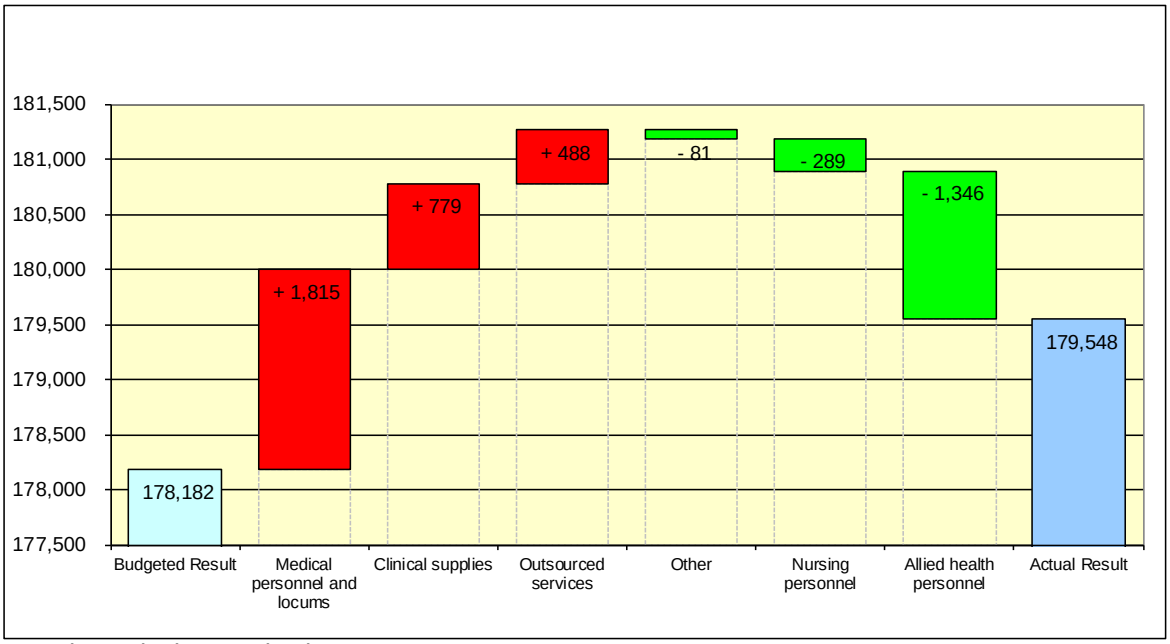
Note the scale does not begin at zero

Medical personnel and locums (unfavourable)
Vacancy and leave cover.

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

Allied health personnel (unfavourable)
Restructuring of home-based support services towards a restorative model of care, partly offset by vacancies in therapies.

Year to date Expenditure



Note the scale does not begin at zero

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

Clinical supplies (unfavourable)
Savings targets not achieved (offset elsewhere).

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

Nursing personnel (favourable)
Slower than planned incurrence of GP/DN alignment costs, and vacancies in rural services.

Allied health personnel (favourable)
Vacancies mainly in mental health, but also across most other services.

Full time equivalents (FTE)

FTEs are 40 favourable year to date, including:

Allied health personnel (28 FTE / 6.3% favourable)

- Vacancies. Recruitment to positions for new models of care, low supply of applicants, delays in staged recruitment of pharmacy facilitators, and difficulty recruiting laboratory vacancies.

Nursing personnel (9 FTE / 1.1% favourable)

- Management of low volumes in Ata Rangi, and vacancies in rural services.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To January 2016

Plan for 2015/16	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	70	0	0	**70**
Non Surgical - Elective	187	0	0	**187**
Surgical - Arranged	382	0	370	**752**
Surgical - Elective	4,682	768	650	**6,100**
TOTAL	**5,321**	**768**	**1,020**	**7,109**

		YTD March 2016						March 2016			
		Actual	Plan	Var.	%Var.			Actual	Plan	Var.	%Var.
On-Site	Avastins	144	147	-3	-2.0%	On-Site	Avastins	1	17	-16	-94.1%
	ENT	359	316	43	13.6%		ENT	37	37	0	0.0%
	General Surgery	742	790	-48	-6.1%		General Surgery	90	93	-3	-3.2%
	Gynaecology	438	414	24	5.8%		Gynaecology	49	49	0	0.0%
	Maxillo-Facial	112	92	20	21.7%		Maxillo-Facial	10	11	-1	-9.1%
	Ophthalmology	825	508	317	62.4%		Ophthalmology	120	60	60	100.0%
	Orthopaedics	673	702	-29	-4.1%		Orthopaedics	72	83	-11	-13.3%
	Skin Lesions	127	133	-6	-4.5%		Skin Lesions	8	16	-8	-50.0%
	Urology	331	339	-8	-2.4%		Urology	60	40	20	50.0%
	Vascular	115	85	30	35.3%		Vascular	16	10	6	60.0%
	Surgical - Arranged	420	288	132	45.8%		Surgical - Arranged	74	34	40	117.6%
	Non Surgical - Elective	41	141	-100	-70.9%		Non Surgical - Elective	2	17	-15	-88.2%
	Non Surgical - Arranged	26	53	-27	-50.9%		Non Surgical - Arranged	0	7	-7	-100.0%
On-Site	**Total**	**4353**	**4008**	**345**	**8.6%**	**On-Site**	**Total**	**539**	**474**	**65**	**13.7%**
Outsourced	Cardiothoracic	0	0	0	0.0%	Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	114	263	-149	-56.7%		ENT	36	37	-1	-2.7%
	General Surgery	144	130	14	10.8%		General Surgery	26	19	7	36.8%
	Gynaecology	6	42	-36	-85.7%		Gynaecology	6	6	0	0.0%
	Maxillo-Facial	41	81	-40	-49.4%		Maxillo-Facial	1	11	-10	-90.9%
	Neurosurgery	0	0	0	0.0%		Neurosurgery	0	0	0	0.0%
	Ophthalmology	47	0	47	0.0%		Ophthalmology	19	0	19	0.0%
	Orthopaedics	1	18	-17	-94.4%		Orthopaedics	1	2	-1	-50.0%
	Paediatric Surgery	0	0	0	0.0%		Paediatric Surgery	0	0	0	0.0%
	Urology	30	19	11	57.9%		Urology	5	3	2	66.7%
	Vascular	6	0	6	0.0%		Vascular	2	0	2	0.0%
	Surgical - Arranged	0	0	0	0.0%		Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%		Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%		Non Surgical - Arranged	0	0	0	0.0%
Outsourced	**Total**	**389**	**553**	**-164**	**-29.7%**	**Outsourced**	**Total**	**96**	**78**	**18**	**23.1%**
IDF Outflow	Cardiothoracic	52	64	-12	-18.8%	IDF Outflow	Cardiothoracic	4	7	-3	-42.9%
	ENT	30	32	-2	-6.3%		ENT	1	4	-3	-75.0%
	General Surgery	29	41	-12	-29.3%		General Surgery	0	4	-4	-100.0%
	Gynaecology	23	27	-4	-14.8%		Gynaecology	1	3	-2	-66.7%
	Maxillo-Facial	138	114	24	21.1%		Maxillo-Facial	3	12	-9	-75.0%
	Neurosurgery	39	32	7	21.9%		Neurosurgery	3	4	-1	-25.0%
	Ophthalmology	24	19	5	26.3%		Ophthalmology	2	2	0	0.0%
	Orthopaedics	11	24	-13	-54.2%		Orthopaedics	1	2	-1	-50.0%
	Paediatric Surgery	29	35	-6	-17.1%		Paediatric Surgery	3	3	0	0.0%
	Skin Lesions	53	48	5	10.4%		Skin Lesions	0	5	-5	-100.0%
	Urology	2	3	-1	-33.3%		Urology	0	1	-1	-100.0%
	Vascular	12	46	-34	-73.9%		Vascular	1	5	-4	-80.0%
	Surgical - Arranged	113	276	-163	-59.1%		Surgical - Arranged	4	31	-27	-87.1%
	Non Surgical - Elective	98	0	98	0.0%		Non Surgical - Elective	7	0	7	0.0%
	Non Surgical - Arranged	25	0	25	0.0%		Non Surgical - Arranged	0	0	0	0.0%
IDF Outflow	**Total**	**678**	**761**	**-83**	**-10.9%**	**IDF Outflow**	**Total**	**30**	**83**	**-53**	**-63.9%**
GRAND TOTAL		**5420**	**5322**	**98**	**1.8%**	**GRAND TOTAL**		**665**	**635**	**30**	**4.7%**

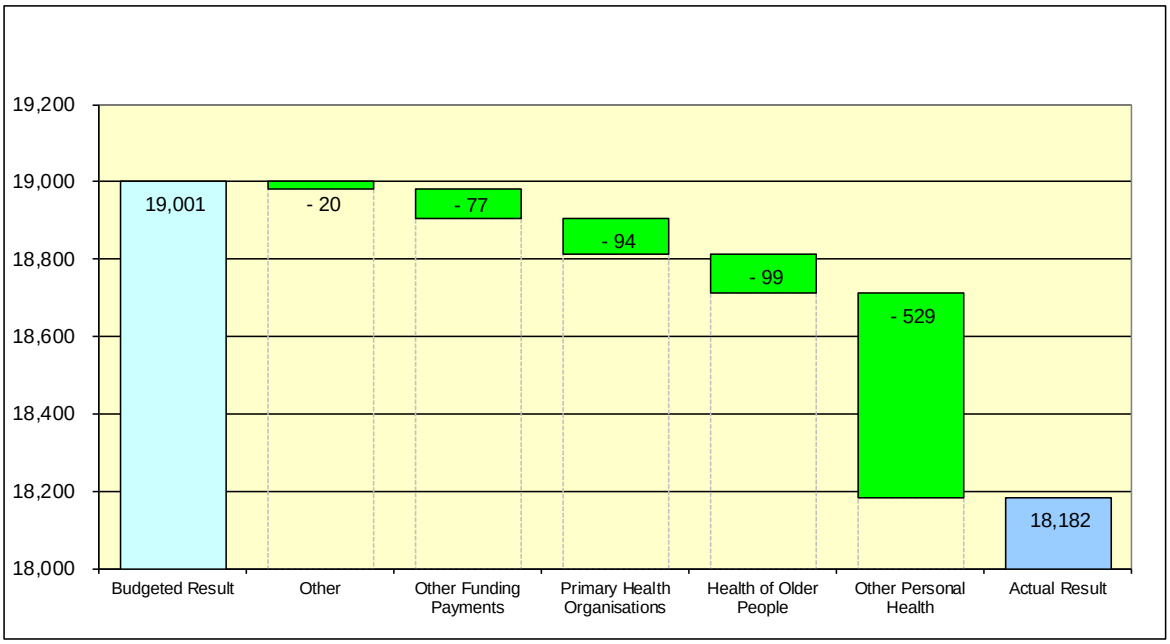
Please Note: The data displayed is as at 7 April 2016. IDF events not yet captured in NMDS will not be reported above.

Please Note: The data displayed is as at 7TH April 2016. IDF Events not yet captured in NMDS will not be reported above.

6. Funding Other Providers

$'000	March Actual	March Budget	March Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,391	3,416	25	0.7%	31,714	31,885	171	0.5%	42,043
Primary Health Organisations	2,965	3,059	94	3.1%	25,330	25,829	499	1.9%	33,994
Inter District Flows	3,919	3,899	(21)	-0.5%	35,172	35,088	(84)	-0.2%	46,868
Other Personal Health	1,580	2,110	**529**	**25.1%**	17,174	17,732	557	3.1%	20,913
Mental Health	1,100	1,116	15	1.4%	10,078	10,041	(37)	-0.4%	13,350
Health of Older People	4,850	4,949	99	2.0%	44,308	44,540	232	0.5%	59,278
Other Funding Payments	377	454	**77**	**17.0%**	3,432	3,940	**508**	**12.9%**	4,861
	18,183	19,001	819	4.3%	**167,209**	**169,054**	1,845	1.1%	221,307
Payments by Portfolio									
Strategic Services									
Secondary Care	4,006	4,122	116	2.8%	37,102	37,389	287	0.8%	47,563
Primary Care	7,609	7,757	148	1.9%	65,785	66,629	844	1.3%	87,825
Chronic Disease Management	315	345	29	8.5%	2,930	3,124	**194**	**6.2%**	3,949
Mental Health	1,100	1,112	11	1.0%	10,074	10,006	(68)	-0.7%	13,335
Health of Older People	4,570	5,035	**464**	**9.2%**	44,956	45,311	355	0.8%	59,892
Other Health Funding	-	(17)	(17)	-100.0%	(48)	(150)	**(102)**	**-68.1%**	(123)
Maori Health	494	526	32	6.1%	4,608	4,737	129	2.7%	6,240
Population Health									
Women, Child and Youth	100	114	14	12.5%	979	964	(15)	-1.5%	1,339
Population Health	(13)	7	20	275.5%	822	1,043	221	21.2%	1,286
	18,183	19,001	819	4.3%	**167,209**	**169,054**	1,845	1.1%	221,307

March Expenditure



Note the scale does not begin at zero

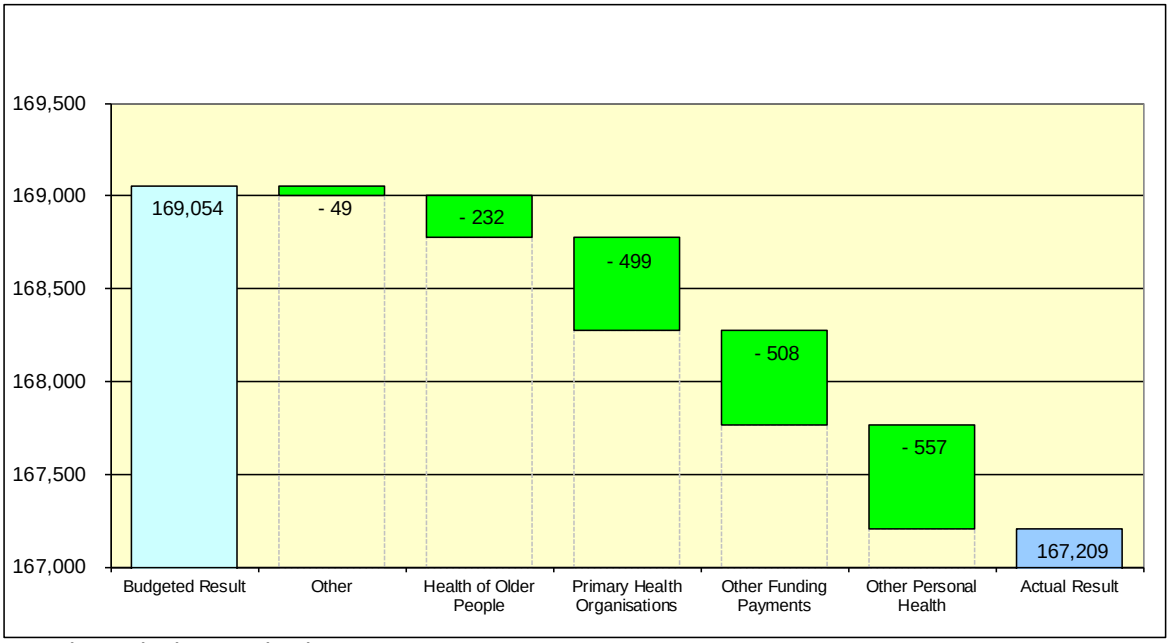
Other Funding Payments (favourable)
Later than planned new investment expenditure.

Primary Health Organisations (favourable)
Delayed implementation of lower cost access services and skin lesion removals.

Health of Older People (favourable)
Lower community support costs (demand driven).

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

Year to date Expenditure



Note the scale does not begin at zero

Health of Older People (favourable)
Home care partially offset by increased community health services and support.

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

Other Funding Payments (favourable)
Later than planned implementation of new investments, and delay of the Whanau Manaaki programme.

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

7. Corporate Services

$'000	March Actual	March Budget	March Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,337	1,378	41	3.0%	10,993	11,139	147	1.3%	14,679
Outsourced services	93	86	(6)	-7.3%	876	778	**(97)**	**-12.5%**	1,159
Clinical supplies	32	0	(32)	-6686.7%	119	4	**(115)**	**-2664.8%**	148
Infrastructure and non clinical	759	707	**(52)**	**-7.4%**	6,154	6,319	165	2.6%	8,562
	2,221	2,172	(49)	-2.3%	18,141	18,241	100	0.5%	24,548
Capital servicing									
Depreciation and amortisation	1,145	1,198	52	4.4%	9,873	10,247	374	3.6%	13,498
Financing	165	166	1	0.3%	1,466	1,470	4	0.3%	1,952
Capital charge	-	-	-	0.0%	1,987	2,071	84	4.1%	3,816
	1,311	1,363	53	3.9%	13,326	13,788	462	3.4%	19,267
	3,531	**3,535**	4	0.1%	**31,467**	**32,029**	562	1.8%	**43,815**
Full Time Equivalents									
Medical personnel	-	-	-	0.0%	0	-	(0)	0.0%	-
Nursing personnel	11.5	16.6	**5**	**30.8%**	12	16	5	29.4%	16.5
Allied health personnel	-	-	-	0.0%	0	-	(0)	0.0%	-
Support personnel	10.4	9.6	(1)	-8.7%	9	9	(0)	-0.4%	9.4
Management and administration	141.6	147.1	5	3.7%	133	142	**9**	**6.2%**	142.8
	163.5	**173.2**	**10**	**5.6%**	**155**	**168**	**13**	**7.8%**	**168.7**

Outsourced services includes administrative support for the Doctor's unit and diagnostic coding, and the DHB's contribution to the HB Intersectorial Advisor position. Clinical supplies including planned savings and health promotion costs, are offset by savings achieved elsewhere. Depreciation and amortisation costs reflects the later than budgeted opening of the new mental health inpatient unit.

8. Reserves

$'000	March Actual	March Budget	March Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Royston surgery contract	-	-	-	0.0%	-	-	-	0.0%	-
Contingency	159	159	(0)	0.0%	1,433	1,433	-	0.0%	92
Transform and Sustain resource	47	44	(3)	-6.9%	370	354	(16)	-4.6%	862
System improvement opportunities	-	-	-	0.0%	-	-	-	0.0%	-
Other	38	42	4	9.2%	1,139	990	**(149)**	**-15.1%**	1,525
	244	**244**	1	0.3%	**2,942**	**2,776**	**(165)**	**-6.0%**	**2,480**

The Other category includes loss on disposal of assets and TAS audits relating to 2014/15.

9. Financial Performance by MOH Classification

	March			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	42,743	42,745	(2) U	361,430	361,564	(134) U	491,566	491,789	(223) U
Less:									
Payments to Internal Providers	22,502	22,502	0 F	197,477	197,477	(0) U	262,934	263,091	157 F
Payments to Other Providers	18,183	19,001	819 F	167,209	169,054	1,845 F	221,307	224,184	2,877 F
Contribution	**2,059**	**1,241**	**817 F**	**(3,256)**	**(4,967)**	**1,710 F**	**7,325**	**4,514**	**2,811 F**
Governance and Funding Admin.									
Funding	262	262	-	2,354	2,354	-	3,140	3,140	-
Other Income	3	3	-	33	23	10 F	40	30	10 F
Less:									
Expenditure	296	260	(36) U	1,999	2,287	288 F	2,737	3,049	311 F
Contribution	**(32)**	**4**	**(36) U**	**388**	**90**	**298 F**	**443**	**121**	**321 F**
Health Provision									
Funding	22,240	22,241	(0) U	195,123	195,123	0 F	259,794	259,951	(157) U
Other Income	1,730	1,719	11 F	15,596	16,155	(559) U	20,684	21,479	(794) U
Less:									
Expenditure	24,759	24,018	(740) U	211,962	210,700	(1,262) U	284,256	282,076	(2,181) U
Contribution	**(788)**	**(59)**	**(730) U**	**(1,243)**	**578**	**(1,821) U**	**(3,778)**	**(646)**	**(3,132) U**
Net Result	**1,238**	**1,186**	**52 F**	**(4,111)**	**(4,299)**	**187 F**	**3,990**	**3,990**	**-**

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

10. Management Budget Movements

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

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2015/16 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

	March			Year to Date			End of Year		
$'000	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	42,745	42,548	197 F	361,564	359,861	1,703 F	491,789	489,518	2,271 F
Less:									
Payments to Internal Providers	22,502	22,322	(180) U	197,477	197,799	322 F	263,091	263,334	243 F
Payments to Other Providers	19,001	18,994	(7) U	169,054	167,542	(1,512) U	224,184	222,194	(1,990) U
Contribution	**1,241**	**1,232**	**9 F**	**(4,967)**	**(5,480)**	**513 F**	**4,514**	**3,990**	**524 F**
Governance and Funding Admin.									
Funding	262	262	-	2,354	2,354	-	3,140	3,140	-
Other Income	3	3	-	23	23	-	30	30	-
Less:									
Expenditure	260	271	11 F	2,287	2,378	91 F	3,049	3,170	121 F
Contribution	**4**	**(7)**	**11 F**	**90**	**(1)**	**91 F**	**121**	**(0)**	**121 F**
Health Provision									
Funding	22,241	22,061	180 F	195,123	195,445	(322) U	259,951	260,194	(243) U
Other Income	1,719	1,602	117 F	16,155	15,610	545 F	21,479	20,865	613 F
Less:									
Expenditure	24,018	23,701	(318) U	210,700	209,873	(827) U	282,076	281,060	(1,016) U
Contribution	**(59)**	**(39)**	**(20) U**	**578**	**1,183**	**(604) U**	**(646)**	**0**	**(646) U**
Net Result	**1,186**	**1,186**	**-**	**(4,299)**	**(4,299)**	**(0) U**	**3,990**	**3,990**	**(0) U**

11. Quality and Financial Improvement Programme

Row Labels	Sum of Planned Savings	Count of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	Sum of monthly savings
CORPORATE	**1,360**	**14**	**1020**	**1020**	**113**
Green	1,360	14	1020	1020	113
Health Services	**7,000**	**69**	**5051**	**4536**	**594**
Amber	1,022	4	766	503	54
Green	5,733	61	4100	4033	540
Red	246	4	184	0	0
Maori Health	**82**	**1**	**62**	**62**	**7**
Green	82	1	62	62	7
POPULATION HEALTH	**70**	**2**	**52**	**52**	**6**
Green	70	2	52	52	6
STRATEGIC SERV	**1,688**	**2**	**549**	**549**	**61**
Green	1,688	2	549	549	61
Grand Total	**10,200**	**88**	**6734**	**6219**	**781**

We are $515 thousand behind in our savings plans year to date. This is all in Health Services where we have achieved 90% of our year to date savings plan target. The gap in the savings plan for Health Services has largely been covered by additional savings made in other programs not on the original savings plan. These include delayed staff appointments and intense management of all discretionary spend e.g travel.

Health Services

The below table shows the amber and red savings plan by Service

Amber					
Acute & Medical	758	2	568	399	10
COO	159	1	119	40	40
SURGICAL	105	1	79	64	4
Red					
Acute & Medical	176	2	132	0	0
COO	70	2	53	0	0

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

- Radiology duplicate testing ($45 thousand);
- Share of the additional $1million savings in Acute Medical ($131 thousand)
- Reduction in harm from falls ($50 thousand);
- Reduction in pressure sores ($20 thousand);

There are four amber programmes

Acute and Medical (2 projects): Savings of $399 thousand against a $568 thousand ytd target 70% attained.

COO (1 projects): Savings of $40 thousand against a $119 thousand target ytd 33% achieved.

Surgical (1 project). Savings of $64 thousand against a target of $79 thousand 81% achieved

Corporate, Maori Health, Population Health and Strategic Services

All green

12. Financial Position

30 June 2015	$'000	March Actual	March Budget	Variance from budget	Movement from 30 June 2015	Annual Budget
	Equity					
120,014	Crown equity and reserves	102,965	108,540	5,574	(17,048)	108,183
(32,388)	Accumulated deficit	(19,451)	(24,709)	(5,258)	12,937	(16,420)
87,626		83,515	83,831	316	(4,111)	91,763
	Represented by:					
	Current Assets					
14,970	Bank	17,397	-	(17,397)	2,427	8,756
1,703	Bank deposits > 90 days	1,741	1,564	(178)	39	1,564
17,862	Prepayments and receivables	11,018	18,056	7,038	(6,844)	18,146
3,881	Inventory	3,870	3,796	(74)	(11)	3,845
1,220	Non current assets held for sale	1,220	-	(1,220)	-	-
39,635		35,246	23,416	(11,830)	(4,389)	32,310
	Non Current Assets					
148,434	Property, plant and equipment	152,571	164,285	11,714	4,138	166,016
2,298	Intangible assets	2,011	1,887	(124)	(287)	2,217
7,301	Investments	8,932	9,003	71	1,630	9,351
158,033		163,514	175,175	11,661	5,481	177,583
197,668	**Total Assets**	**198,760**	**198,591**	**(169)**	**1,092**	**209,894**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	2,425	2,425	-	-
29,960	Payables	36,501	35,749	(752)	6,541	35,540
35,239	Employee entitlements	33,902	31,673	(2,229)	(1,337)	32,660
65,199		70,403	69,847	(556)	5,204	68,200
	Non Current Liabilities					
2,342	Employee entitlements	2,342	2,413	71	-	2,431
42,500	Term borrowing	42,500	42,500	-	-	47,500
44,842		44,842	44,913	71	-	49,931
110,042	**Total Liabilities**	**115,245**	**114,760**	**(485)**	**5,204**	**118,131**
87,626	**Net Assets**	**83,515**	**83,831**	**316**	**(4,111)**	**91,763**

The variance from budget for:

- Crown equity and reserves relates to the reversal of revaluation reserves for assets disposed of prior to 30 June 2015, to comply with Audit NZ's recommendations, and to a lower valuation of land and buildings than estimated at 30 June 2015;
- Bank reflects lower capital spend and the receipt of wash-ups
- Prepayments and receivables reflect the accrual for wash-ups. This amount will continue to increase until wash-ups are received sometime after 30 June 2016.
- Property, plant and equipment relates to the revaluation and later payments for the MHIU over the project life;
- Employee entitlements – see below

13. Employee Entitlements

30 June		*March*				*Annual*
2015	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2015*	*Budget*
7,916	Salaries & wages accrued	6,449	4,429	(2,020)	(1,467)	5,482
1,370	ACC levy provisions	1,688	1,005	(682)	318	1,176
4,951	Continuing medical education	5,881	5,468	(412)	930	4,860
19,383	Accrued leave	18,169	19,288	1,118	(1,213)	19,649
3,962	Long service leave & retirement grat.	4,057	3,896	(161)	95	3,925
37,582	**Total Employee Entitlements**	36,244	34,086	(2,158)	(1,337)	35,091

14. Treasury

Liquidity management

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

Debt management

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

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

Foreign exchange risk management

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

15. Capital Expenditure

2016 Annual Plan		Actual $'000	Year to Date Budget $'000	Variance $'000
	Source of Funds			
	Operating Sources			
13,872	Depreciation	9,873	10,247	374
3,990	Surplus/(Deficit)	(4,111)	(4,299)	(187)
(113)	Working Capital	9,635	10,777	1,142
17,749		15,397	16,725	1,328
	Other Sources			
-	Special funds and clinical trials	96	-	(96)
5,000	Borrowings	-	-	-
5,000		96	-	(96)
22,749	**Total funds sourced**	**15,493**	**16,725**	**1,232**
	Application of Funds:			
	Block Allocations			
3,856	Facilities	2,119	2,755	636
3,000	Information Services	712	2,100	1,388
5,200	Clinical Plant & Equipment	2,066	3,928	1,862
-	Minor Capital	26	27	1
12,056		4,923	8,810	3,887
	Local Strategic			
665	Renal Centralised Development	62	499	437
848	New Stand-alone Endoscopy Unit	154	447	294
5,654	New Mental Health Inpatient Unit Development	6,670	4,241	(2,429)
2,035	Maternity Services	1,874	1,598	(276)
100	Upgrade old MHIU	-	75	75
9,302		8,759	6,859	(1,900)
	Other			
-	Special funds and clinical trials	96	-	(96)
-	Transform and Sustain	3	-	(3)
-	Other	82	12	(70)
-		181	12	(168)
21,358	***Capital Spend***	***13,863***	***15,682***	***1,819***
	Regional Strategic			
1,391	RHIP (formerly CRISP)	1,630	1,043	(587)
1,391		1,630	1,043	(587)
22,749	**Total funds applied**	**15,493**	**16,725**	**1,232**

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

Monthly Project Board Report
Mar 2016

HAWKE'S BAY District Health Board

New Mental Health Unit Development

Project Director: G Carey-Smith

Overall Project Progress	Overall Status	Time Status	Financial Status
93%	G	G	G

Phase: Service & Facility Implementation

Formal approval of the Business Case was received in April 2013 from the Minister of Health for a replacement mental health facility. The project will provide four key deliverables:
1). Service redesign of acute mental health services to align with the HBDHB 2012 Mental Health Model of Care. Includes for investment in alternatives to inpatient care, with an increased focus on care provided in the community.
2). A replacement mental health inpatient unit on the Hawke's Bay Regional Hospital site.
3). A replacement mental health sub-acute facility, co-located with the inpatient unit.
4). A replacement of the Recovery Centres to move to a Day programme (co-located with the inpatient unit) and some services within the community.
The project programme spans over a 30 month period and occur in 2 phases. The first phase including service & transition planning, facility design & tendering was completed on time with the main construction contract approved at the 25 June 2014 Board Meeting. Phase 2 is now underway and includes the main build construction contract together with the implementation of transition management to the new service delivery model.

Project Budget Status

Total Approved Project Budget	**$ 18,300,000**	Total 15/16 Total Forecast Spend	$ 7,272,000
Total Project Spend to Date	$ 16,989,984	Total 15/16 Spend to Date	$ 6,670,000
Percentage of Total Spend vs Budget	93%	Percentage 15/16 Spend vs Forecast	92%

The tender process was completed and project approval at a total cost of $19.8M received on the 25 June 2014 Board Meeting. Continued value engineering and management during the porject has resulted in an overall saving of $1.5M resulting in the total project budget being reduced to $18.3M. The new figures are reflected in the graph below. The 2015/16 Total Forecast Spend against 15/16 Spend to Date is consistent with plan.

Deliverable Dates

Phase 2 Facilities: Design & Tendering Stage	Jul-14	√	Phase 2 / Stage 2 of Service Transition begins	Apr-15	√
Site Works	Sep-14	√	HBT, unplanned respite implemented & embedded	Jul-15	√
Main Construction	Oct-15	√	Design and IT decisions made re CMHT	Oct-15	√
Commissioning & Building Fit-out	Nov-15	√	Revised policies, process, performance indicators	Nov-15	√
Decant Relocate Staff	Dec-15	√	Acute Unit "Goes Live"	Jan-16	√
Project Handed over for 'Go Live'	Jan-16	√	IT solutions, reporting in place	Jun-16	
Property Disposal	(Settlement Dependant)		TOR Phase 3 commences	Mar-16	

Key Achievements this period

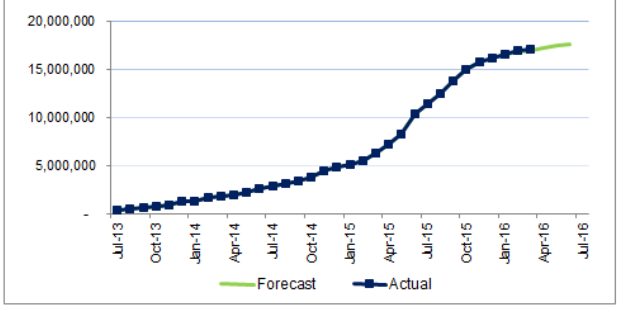
Planning for Phase 3 underway.
Ongoing development and implementation work for IDP and SPoE. Continue to work with vendor to confirm the feasibility for IS developments needed to support the new model of care and implement SPoE.
Continue to work with vendor to confirm the feasibility for IS developments needed to support the new model of care. IS systems necessary to support operations.
Focus continues on integration across services, embedding Vision & Behaviour statement and strengthening community mental health.
Review of Transition to Nga Rau Rakau commenced.

Planned Activities next period

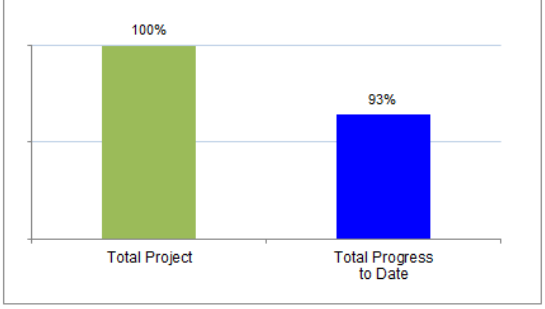
Embedding, integration & review of changes implemented; includes reporting, procedures, Vision & Behaviour statement, patient journey
SPoE - progressing towards implementation
IDP - Working group meeting weekly. Recruitment of lead priority.
Implementation of 1 Assessment: 1 Plan
Strengthen Community Mental Health; recruitment of Manager, Case Load management, Key worker role, Review of meeting framework.
Any building defects are managed as required over the next 12 months. Final external landscaping, parking and other works are to be finalised.

Risks & Issues of Note	Mitigation & Resolutions
Ensure project costs remain safely within budget parameters	Regular assessments and tight control of project costs and contingency spend
Service delivery model not fully "owned" by service providers	Ongoing development and implementation of MoC. Staying true to MoC as founding document.
Timely alignment of any Community Contracts	Service Re-design & Transition Management completed in timely manner
Engagement with wider consumers	Partnership Advisory Group ongoing.
Ability to secure adequate resources in timely manner	Dependent on availability within current market as well as freeing up capacity and capability internally.
Potential Inability of IS to deliver IT requirements & adequate resourcing to support implementation of Model of Care	Ongoing engagement with IS resource and potential provider to establish timeline & any funding requirements

Forecast vs Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	March Forecast	Variance	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget	Feb Budget	Mar Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	44,747	43,886	861	41,105	40,798	42,702	43,876	42,407	51,446	43,734	42,407	42,407	43,864	42,517	42,439
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	44	-	44	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	(2,417)	428	(2,845)	440	444	465	394	412	404	472	409	417	406	428	430
Cash paid to suppliers	(22,750)	(25,520)	2,770	(25,129)	(23,623)	(25,948)	(26,292)	(24,414)	(26,168)	(24,630)	(24,571)	(25,146)	(24,302)	(21,385)	(24,973)
Cash paid to employees	(18,895)	(18,262)	(633)	(15,272)	(14,722)	(16,248)	(14,102)	(19,758)	(15,245)	(15,190)	(17,856)	(14,469)	(16,742)	(14,481)	(19,568)
Cash generated from operations	**729**	**531**	**198**	**1,144**	**2,897**	**970**	**3,876**	**(1,352)**	**10,437**	**4,386**	**390**	**3,210**	**3,227**	**7,079**	**(1,671)**
Interest received	86	88	(2)	84	86	82	81	80	67	66	80	72	75	68	75
Interest paid	(211)	(98)	(114)	(419)	(261)	(190)	(0)	(0)	(98)	(420)	(271)	(213)	(14)	(94)	(180)
Capital charge paid	-	-	-	-	-	(3,910)	-	-	-	-	-	(4,142)	-	-	-
Net cash inflow/(outflow) from operating activities	**603**	**522**	**81**	**809**	**2,721**	**(3,048)**	**3,957**	**(1,273)**	**10,405**	**4,032**	**198**	**(1,073)**	**3,288**	**7,053**	**(1,776)**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	0	-	0	-	-	0	0	0	0	0	0	1,220	0	0	0
Acquisition of property, plant and equipment	(795)	(1,665)	870	(2,015)	(1,861)	(3,799)	(3,078)	(3,078)	(3,078)	(3,078)	(1,753)	(2,753)	(1,753)	(1,753)	(1,753)
Acquisition of intangible assets	-	(65)	65	(50)	(20)	(20)	(375)	(375)	(375)	(375)	-	-	-	-	-
Acquisition of investments	-	(479)	479	0	0	(348)	-	-	(285)	-	-	(285)	-	-	(285)
Net cash inflow/(outflow) from investing activities	**(795)**	**(2,209)**	**1,414**	**(2,065)**	**(1,881)**	**(4,167)**	**(3,453)**	**(3,453)**	**(3,738)**	**(3,453)**	**(1,753)**	**(1,818)**	**(1,753)**	**(1,753)**	**(2,038)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	5,000	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	(357)	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**5,000**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	(192)	(1,687)	1,495	(1,256)	840	(7,573)	503	(4,726)	6,667	579	3,445	(2,891)	1,535	5,299	(3,814)
Add:Opening cash	19,331	19,331	-	19,139	17,882	18,722	11,149	11,653	6,927	13,594	14,173	17,618	14,728	16,263	21,562
Cash and cash equivalents at end of year	**19,139**	**17,643**	**1,495**	**17,882**	**18,722**	**11,149**	**11,653**	**6,927**	**13,594**	**14,173**	**17,618**	**14,728**	**16,263**	**21,562**	**17,748**
Cash and cash equivalents															
Cash	7	7	-	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	16,036	14,538	1,498	14,780	15,619	8,047	8,551	3,825	10,492	11,071	14,516	11,626	13,160	18,460	14,645
Short term investments (special funds/clinical trials)	3,093	3,098	(5)	3,093	3,093	3,093	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	2	-	2	2	2	2	-	-	-	-	-	-	-	-	-
	19,139	**17,643**	**1,495**	**17,883**	**18,722**	**11,150**	**11,653**	**6,927**	**13,594**	**14,173**	**17,618**	**14,728**	**16,262**	**21,562**	**17,747**

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

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 31
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs
Reviewed by:	Not applicable
Month:	April, 2016
Consideration:	For Information

RECOMMENDATION

That the Board

Note the contents of this report

11

Council met on 13 April 2016, an overview of issues discussed/agreed at the meeting is provided below.

Clinical Council Business Cases for Investment 2015/16

A number of proposals were put forward for endorsement from Clinical Council. These business cases related to already approved funding from Clinical Council for the 2015/16 year.

Palliative Care
Registrar Trainee; Clinical Nurse Specialist cover and Villa 6 RN posts were all discussed. The investment bids would provide better cover for the palliative care services and provide opportunities for us to extend the palliative service to Napier Health Centre. Work is also currently underway to develop a more integrated model and strategy for a continuous palliative care service for Hawkes Bay.

Cardiac – Clinical Nurse Specialist
This bid related to a Clinical Nurse Specialist responsible for patients with pacemakers and implantable cardiac defibrillators. Currently our patients are transferred to Wellington or Auckland for their regular check-ups and in implementing this role we will be able to provide this service in house.

Patient at Risk Nurse Led Service
A further proposal was discussed by Clinical Council which had been approved in principle as part of the investment bids for 2015/16 - this was part of transform and sustain out of hours inpatient mortality of care piece of work. A lot of work is going on nationally, with the Health Quality Safety Commission (HQSC) making this a specific work stream. This service has been piloted with good results from a patients perspective and in establishing these positions it was hoped that this would enable improved patient outcomes by boosting the identification of people who are at risk and ensuring they have plans in place to stop them deteriorating. In the hospital we have a rapid response system so when people do deteriorate we have a more sophisticated response for rescuing them, however this service is about getting to them before they deteriorate and have well developed plans in place. The Clinical Council discussed the language used "patient at risk" and "deteriorating patient" – it was agreed that this is the international language which is currently being used and that we should align ourselves to that.

All three business cases were endorsed by Clinical Council.

BEST START HEALTHY EATING (DRAFT)

This draft strategy had been under development for a number of months and feedback had been gathered from our governance groups, communities and schools as to our best approach for tackling this issue. The strategy and plan had been built around four key objectives:

1. Increase healthy eating environments
2. Develop and deliver prevention programmes via food literacy, maternal nutrition, physical activity and implementing policy
3. Intervention – support people to have healthy weight
4. Provide leadership in healthy eating

General discussion held and feedback from Clinical Council was as follows:

- Excellent document and captures a lot of the complex research
- Key component of the strategy relates to the environment and is there an opportunity for us to influence supermarkets. Food labelling will also support individuals making better decisions
- Need to design programmes e.g. My food Bag concept will be another key strategy, however we would need to develop those with the community
- Discussion around sugar and is there room for specific interventions around sugar
- Need to improve "food literacy"
- Consider aligning our strategy with the World Health Organisation (WHO) recommendations and six domains
- Need to educate our health providers around food so that they are able to provide better advice
- The document name - should it be healthy lifestyle rather than solely healthy eating

Clinical Council endorsed the direction of travel and looked forward to reviewing the final document in the future.

Committee Reports

The Clinical Council received reports on the following areas:

Urgent Care Alliance – update provided in regards to the process of the RFP

Radiology Service Committee – discussion in regards to education programme for primary care around rational use of ultrasound

Laboratory Service Committee – brief discussion around progress of IANZ corrective actions

Clinical Advisory Governance Group – reports taken as read

Clinical Pathways Committee Update – report taken as read

Aim 24/7 Quarterly Update – progress was noted and key work streams discussed

Transform & Sustain Refresh – priorities we discussed and endorsed

Prioritisation Process

Clinical Council received a presentation around the process for prioritisation of investment bids which would be discussed in detail at next month's meeting. There were a number of cases that would need to be reviewed against the Triple Aim methodology by each individual member and the results of that analysis would be the foundation for the discussions at next month's meeting.

OURHEALTH HAWKE'S BAY Whakawateatia	**HB Health Consumer Council**	32
	For the attention of: **HBDHB Board**	
Document Owner:	Graeme Norton, Chair	
Reviewed by:	Not applicable	
Month:	April 2016	
Consideration:	For Information	

12

RECOMMENDATION

That the Board

Note the contents of this report

Consumer Council met on 14 April 2016, an overview of issues discussed/agreed at the meeting is provided below.

OLDER PERSONS PANEL

A self selected sub-group of Consumer Council members is now working with the Service Director of Mental Health, Older Persons & Options Directorate to establish a working panel that the directorate can use for ongoing consumer engagement on various aspects of service development and delivery. The form that this takes will evolve over time.

HEALTH & SOCIAL CARE NETWORKS

A sub-group of Consumer Council members will work with GM Primary Care to ensure robust engagement of consumers in network development.

BEST START HEALTHY EATING (Obesity Strategy)

The draft strategy was robustly discussed and further refined in a workshop format. The challenge of making a worthwhile contribution to changing behaviour in a social environment where temptation for unhealthy eating is pervasive is well understood by members. We think that this strategy has good community engagement in design; the challenge will be to ensure the actions are owned in the community.

CONSUMER ENGAGEMENT PRINCIPLES & FRAMEWORK

QIPS directorate and Consumer Council are working on a toolkit and guidance for health sector teams on both Person & Whānau Centred Care and consumer engagement. We robustly discussed a draft developed by the QIPS director and made some progress. We will use our work to date as a basis for conversation with Clinical Council.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB) Special Meeting** 33
	For the attention of: **HBDHB Board**
Document Owner:	Ngahiwi Tomoana (Chair)
Reviewed by:	Not applicable
Month:	April, 2016
Consideration:	For Information

13

RECOMMENDATION

That the Board

Note the content of this report:

PURPOSE

The purpose of this report is to provide an overview of the MRB Special Meeting held on the 13 April 2016. A specific workshop was facilitated by Adele White (CEO, Ngāti Kahugnunu Iwi Inc) to identify ways in which the DHB could operate that would substantially improve health outcomes for Māori. MRB acknowledged there has been a lot of improvement acheived to date, however this has not been well communicated. Therefore, it leaves an impression that the Māori populations health is declining and not improving.

MRB acknowledged the efforts of the Executive Management Team and the drive to date to reduce inequity in Hawke's Bay. Todays workshop was to support the DHB in identifying more effective was to help significantly achieve health equity for Māori. Members engaged in constructive robust discusssion where a number of issues were identified then narrowed down to priority areas. The following priority problems and solutions were identfied:

Creating a system that is 'Whānau" inclusive

Enable the system to better meet the needs of whānau through developing services that do not silo out patients but includes whole whānau. Relate the concepts of 'whānau to delivery of services'. This will empower both the clinician and the whānau to deliver an effective service that provides for better outcomes.

Transforming Relationships

The transformation from a 'quasi' relationship to a real and authentic relationship. MRB sectioned this issue into three components:

1. Review the form and function of MRB

We are currently providing advice on papers that come to MRB at a governance level. However, when the implemenation of our advice occurs it seems to misconstrue our initial advice. We want to see a more crystalised and effective action for our people. The question was raised about how we get a real partnership between MRB and the Board.

2. Māori leadership and capability development including governance and operations

Invest into capability, training and development opportunities to elevate Māori leadership across the health sector. Identify gaps which may not necessarily mean a position but targeting where Māori influence is required within the organisation. Strengthen the analytical, clinical, and policy function of the Māori Heath Service. MRB needs to be inclusive of succession planning to the DHB Board election process and profiling Māori board members through Ngāti Kahungunu Iwi Inc. Sharing of leadership roles between the Iwi, HBDHB and Post Settlement Groups Entities (PSGEs) could be an option to improve health outcomes.

3. Communication

The DHB could strengthen the way it communicates with the different communities. The community at large have no idea on what difference is being made for the health of Māori in Hawke's Bay. Yet there is lots of improvement that could be highlighted. This would help change the perception on what the DHB is doing to reduce inequity and improve trust and relationships. We should celebrate more.

Improving the health system to accelerate Māori health

Consult and engage with the whānau and community. Empower the Māori community through ownership and invovlement in co-design. Target resources to high needs groups better. Shift contracts to a more whānau based service with less contraints and reporting requirements. Have the DHB writers of plans, proposals and investment papers apply the HEAT tool to all documents to ensure we are clear on how we are going to reduce inequities. Strengthen the Māori Health Services to provide more clinical and analytical advice to assist the system both secondary and primary on how it needs to better respond to customers and their whānau.

Change the prevelance of unconcious systemic bias that does a dis-service to all

1. Behavioural change

Raise awareness of the impact of unconcious systemic bais through education and health literacy. All staff complete the Treaty of Waitangi online and Engaging Effectively with Māori training as its mandatory training. Being courageous and calling it out when unconscious systemic bia ses occur. Engaging more Māori staff and valuing more non-clinical input. Hold Wānanga to empower communities to take ownership of their health.

2. Systemic change

Improve the current funding model so that it is more whānau based, less dictative and restrictive and more trusting. Pilot a funding model using a ready made strategy that has already gone through the process, such as the Obesity Stragegy.

There were a number of actions that have been allocated to the following members:

ACTIONS:

1. **Communication** - *Ana Kirk (Commuications Manager) and NKII Communication staff*
   Share stories and promote successes.

2. **Review form and function of MRB -** *Adele White (CEO NKII) and Tracee Te Huia (GM Māori Health HBDHB)*
   MRB to be invovled in discussions.

3. **Māori leadership and capability development** - *Tracee Te Huia (GM Māori Health HBDHB) and Adele White (CEO NKII)*

4. **Change the sytem to accelerate Māori Health**

a) Tell the stories – good and bad, to value the customer voice

b) Shift contracts to more of a whānau focus with less contraints
c) HEAT tool for all strategic papers to all governance groups
d) Reduce financial cost barriers to primary care for whānau. A paper on Primary Care developments *Mary Wills (Head of Strategic Services) and Nicola Ehau (Head of Health Services HB PHO)*.

5. **Change the prevelance of unconcious systemic bias that does a dis-service to all** *Nicola Ehau, G Mackey, D Ratima and Graeme Norton*
Tease the pilot funding model out further to get more detail of how this could be rolled-out before testing the pilot on a strategy.

The following was discussed in General Business:

MRB Representation on Clinical Council

Clinical Council approved inclusion of a MRB representative to attend Clinical Council Meetings. The MRB representative will be an observer in the same capacity as the Chair Consumer Council that is committee participation but no voting rights. MRB will confirm its representative for the next Clinical Council meeting in May.

HAWKE'S BAY District Health Board Whakawāteatia	**Transform & Sustain Refresh (draft)** 34
	For the attention of: **HBDHB Board**
Document Owner:	Tim Evans
Reviewed by:	Executive Management Team, Clinical Council, Consumer Council and Maori Relationship Board (MRB)
Month:	April, 2016
Consideration:	For Information and decision.

14

RECOMMENDATION

That the Board:

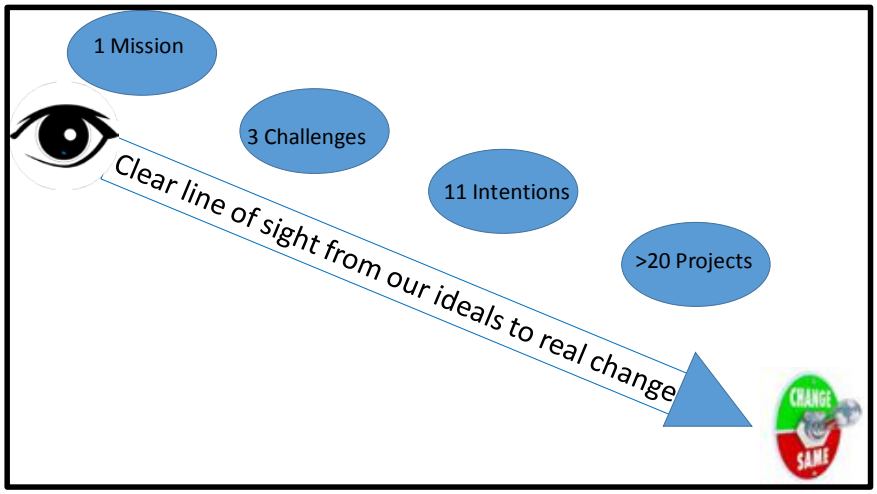
- Note the reasoning and process thus far in refreshing the implementation programme underpinning the Strategy
- Agree the proposed approach and timetable for widening the discussion and project design.

OVERVIEW

The Transform & Sustain Strategy, a 5 year strategy published in December 2013, is now half way through its planning horizon. The Strategy is not therefore due for replacement, but the underpinning programme projects which achieve the intentions of the Strategy are due a refresh. This paper updates the District Health Board on out how that refresh has begun, and seeks agreement to the proposed milestoned timetable to complete.

BACKGROUND

The Transform and Sustain Strategy was designed to ensure that we moved from a clear statement our strategic mission in a clear and direct line to projects which make real change happen:



In developing the Strategy we agreed that it would be "emergent". That is to say that the high level Mission and Challenges would not change, (at least in our 5 year timescale), but the translation into action through intentions and projects would need to be adaptive. While there has been a healthy programme of live projects with over 20 live in the programme at any given time over the past two and a half years, we have a diminishing number of projects planned in future years.

The aim of the refresh is therefore to:

- check if we have been achieving the outcomes set out in Transform & Sustain;
- to generate new Projects and (if necessary) Intentions to progress those outcomes;
- to engage stakeholders in the refresh and new project specification

PROCESS TO DATE

The Project management Office made a list of all of the 24 "outcome" descriptions given in the Transform & Sustain document. Executive Management Team scored these for achievement to date separately and individually.

In a Team day on 15 November 2015 the aggregated and individual scores were played back in to an EMT. These were discussed and moderated to get an EMT consensus idea of where we were not yet achieving desired outcomes.

In the afternoon of that team day the Health Services Leadership made their assessment in syndicate groups of the 8 areas of best progress and 8 areas of least progress. This was then played back and compared against the EMT aggregate scoring. The degree of match remarkable. There was then some generation of ideas to progress in the areas that we need to improve.

The agreed areas for further work were distilled from the November workshop and presented to EMT on 1 March. EMT amended these further to arrive at 6 agreed areas for future focus:

⇒ Person and Whanau Centred Care (people as partners in their healthcare)

⇒ Health and Social Care Networks (creating strong primary and community care clusters)

⇒ Whole of Public Sector delivery (delivering effectively with public sector partners)

⇒ Information System connectivity (and improved outpatient process)

⇒ Financial Flows and models (incentivising and funding the right behaviours)

⇒ Investing in Staff and changing culture (equipping our staff for a changing world)

The need to address health inequity was a repeated theme to be woven into all of these focus areas. The team day then concentrated on identifying what work streams and projects we have in progress, or about to begin to deliver benefit in these focus areas.

The Executive Team members finally generated proposed new projects and work streams to deliver outcomes in the 6 focus areas.

It was generally agreed that each of the focus areas and consequent work would fit comfortably into our current framework of 11 intentions.

FUTURE DEVELOPMENT

The work thus far has been generated by the DHB and Health Services executive leadership. That does involve a lot of clinical input, managerial expertise, health sector, and some cultural perspective, but lacks consumer, wider sector, and broader cultural input. These areas of focus need to be discussed with and endorsed and/or amended by wider stakeholder groups.

We also need to brain storm our whole community of interest to generate ideas, work streams and projects to progress in the future focus areas (if indeed they are endorsed or more if added).

Finally we need to find ways to engage widely in co-designing the precise nature of our future crop of projects so they deliver the right change effectively and efficiently.

A draft timetable follows:

Key Steps	**Proposed Timeframes**
1. Pre-discussion re how we optimally use the Leadership Meeting scheduled for the 17th May 2016. • Graeme Norton; Chris McKenna; Kevin Atkinson; Mark Peterson; Ken Foote	March / April
2. Run sessions to discuss "have we got it right / what have we missed", information sharing etc.	
• Finance	April and early May
• Quality and Safety	
• IS and Business Intelligence	
• Human Resources	
• Strategic Services and Planning	
• HS Leadership and Service Directorships	
• T&S Union Engagement Forum	
• Clinical Council and Primary Care (possibly CAG)	
3. Run various workshops to ask "What would we be doing (how would we be working) with your people if we are doing it right? (Vulnerable Families; Co-Design and Engagement etc.)	
• Consumer Council	Early to mid-May April to mid-May 17 May 2016
• MRB	
• Leadership Forum	
4. Final Presentation Process	
• EMT	31 May
• Clinical Council	8 June
• Consumer Council	9 June
• DHB Board (FRAC)/ PHO Board	29 June/tba
5. Business As Usual protocol for project co-design documented and agreed	30 June

HAWKE'S BAY District Health Board Whakawāteatia	**DHB Elections 2016** 35
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Month:	April 2016
Consideration:	For Consideration and Decision

RECOMMENDATION

That the Board

- Appoints Warwick Lampp from Electionz.com as the HBDHB Electoral Officer
- Resolves that the names of candidates on the voting documents be arranged in alphabetic order of surname
- Requests the DHB elections communications programme includes the promotion of nominations as well as encouragement to vote.
- Advertise and conducts "information evenings" for potential candidates (in Hastings and Napier) prior to nominations being opened.

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PRE-ELECTION BOARD RESOLUTIONS

Local Government (including District Health Board) triennial elections are coming up later this year.

Key dates relating to the elections include:

13 July	First Public Notice of Election
15 July	Nominations Open / Roll Open for Inspection
12 August	Nominations Close / Electoral Roll Closes
19 August	Public Notice of Candidates
16 September	Delivery of Voting Documents
8 October	Election Day / Voting Closes at Noon
13 October	Official Result Declaration
5 December	New Board comes into office

The purpose of this report is to provide notice of the forthcoming election, and for the Board to consider and decide on a number of pre-election issues and resolutions.

ELECTORAL OFFICER

Clause 9B of Schedule 2 of the NZPHD Act 2000 states:

"The person appointed by a District Health Board under section 12 of the Local Electoral Act 2001 must be a person who is also the electoral officer of a territorial authority in whose district the District Health Board is wholly or partly situated"

Over more recent years. HBDHB has appointed the electoral officer of the Hastings District Council (HDC) as its own electoral officer. For various reasons however, the HDC have advised that the in-house electoral officer would not be able to fulfil this role for this year's HBDHB elections.

Napier City Council (NCC), like many Councils around New Zealand,have contracted out their electoral officer functions to companies established to provide such services.

NCC have contracted electionz.com, who also provide electoral officer services to twenty four other Territorial Local Authorities (including Central Hawke's Bay District Council) and five District Health Boards. NCC's named electoral officer from electionz.com is Warwick Lampp.

Given the above notice from HDC and arrangements with NCC, a meeting and discussions with Warwick Lampp were entered into, and "reference checks" undertaken with NCC and Waikato District Health Board (one of the five DHBs Warwick provides electoral officer services to). A contract with electionz.com (with Warwick Lampp as the named electoral officer) has subsequently been agreed, subject to Board approval.

It is recommended therefore that the Board formally appoint Warwick Lampp as the HBDHB Electoral Officer.

ORDER OF CANDIDATES NAMES ON VOTING DOCUMENTS

Regulation 31 (2) of the Local Electoral Act permits each DHB to decide the order in which the names of candidates are arranged on voting documents. In the absence of any board resolution approving another arrangement, candidates' names must be arranged in alphabetic order of surname.

The options available include:

- Alphabetic by surname
- Pseudo random – where names are drawn randomly once and then printed on all voting forms in that same order.
- Random – where every voting form is printed with names in a different random order.

Arrangement in alphabetic order of surname is recommended due to:

- Has been the consistently adopted option by HBDHB over recent elections,
- Is the order previously used and most likely choice of all Hawke's Bay TLAs and the Regional Council for this year's election.
- Is the order in which the candidate profile book (accompanying the voting forms) is printed.
- Printing voting forms in random order is very expensive.

Alphabetic order therefore provides simplicity and consistency which should encourage more electors to vote.

STRATEGIC RISK – GOVERNANCE

In November 2012, FRAC considered a report on HBDHB governance risks. One of the risks identified in the report was:

- Governance Talent Stands for HBDHB
  - Sufficient people with the required skills and attributes do not get elected.

The mitigation strategies approved to address this risk were:

"Actively promote nominations prior to elections"

"Conduct Seminars for potential candidates"

ELECTIONS COMMUNICATIONS

Three years ago the Board noted that much of the Ministry of Health promotional material related to encouraging people to vote. A resolution was adopted to ensure that there was also adequate promotion of nominations.

A similar recommendation is therefore included above, on the assumption that the Board would wish to see this happen again, as part of the above risk mitigation strategy.

INFORMATION EVENINGS

Prior to the last election, the Board held two information evenings/seminars for potential candidates, one in Napier and one in Hastings. Despite the very low attendance at these sessions three years ago, given that they are only one of the two mitigation strategies identified for the above risk, and they have very low resource requirements, it is recommended that two more sessions be conducted this year – dates, times and places can be agreed at a later date.

HAWKE'S BAY District Health Board Whakawāteatia	**Electronic Papers Post Implementation Report** 36
	HBDHB Board
Document Owner: Document Author(s):	Ken Foote, Company Secretary Jeff Petrie, Assistant to CEO Health Hawke's Bay
Reviewed by:	Executive Management Team
Month:	April, 2016
Consideration:	Discussion / Comment

RECOMMENDATION

That the Board

Note the contents, recommendations and comments contained within the attached report.

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OVERVIEW

Electronic Board papers were introduced in July 2015 through the use of Diligent Boards application on Surface Pro devices.

Given the number of issues that have arisen, a post implementation review was initiated and recently completed by Jeff Petrie. Jeff's report is attached.

Following receipt of the report the Steering Group consisting of Ken Foote, Gina McEwen and Brenda Crene, considered the contents with Steering Group comments now included against the recommendations on page 14 – 17 of this report.

ATTACHMENTS

Electronic Papers – Post Implementation Review
Appendix A: Recommendations
Appendix B: Print Volumes

Electronic Papers - Post Implementation Review

Hawke's Bay District Health Board

This report presents the findings and recommendations from a review of the introduction of electronic papers for Hawke's Bay District Health Board, Committees and Executive Management Team meetings in 2015.

April 2016

Table of Contents

1. Introduction

In October 2013 Hawke's Bay District Health Board (HBDHB) approved a business case for the delivery of electronic Board, Executive Management Team (EMT) and committee papers for all meetings. Between late-2013 and July 2015 further planning, set up, training and subsequent roll out of Diligent Electronic Board papers occurred. Electronic papers are now embedded into the administration process, delivery and reviewing of reports, papers and communications for all meetings.

HBDHB requested a review of the project to evaluate whether the objectives of the project had been met, to establish how effective the project was implemented, to learn lessons for the future and to ensure HBDHB has achieved the best possible value from the project. The scope of the review included the following parameters:

- Analysis of documentation to determine how closely the project results compared to original objectives
- To establish whether project implementation goals were achieved
- To determine user satisfaction
- To identify areas for development
- To identify lessons learned

This report describes the process taken in conducting the review, the current state, and where relevant, future recommendations.

The post implementation review was overseen by a working group consisting of Ken Foote (review sponsor), Brenda Crene (Board Administrator), Gina McEwen (IS) and Jeff Petrie (review lead). This report has been prepared by Jeff Petrie.

2. Methodology

The following methodology was used:

- Review of existing documentation in relation to the implementation of electronic papers
- Informal interviews with Board and EMT administrators
- Informal interviews with Information Services Team (IS) members
- Online survey of users (Board and EMT members)

This report summarises findings, includes anecdotal comments from the interviews and survey results, summary of survey data and a summary of observations and/or recommendations where relevant.

Interactions for information gathering:

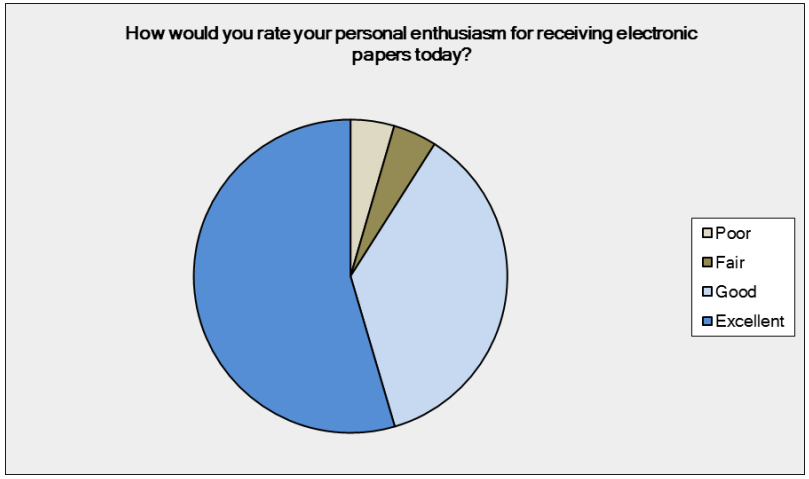
- 23 Board Directors and EMT members participated in the online survey.
- Two Administrators were interviewed.
- Four members of the Information Services with direct contact to the project were interviewed.

3. Current State and Summary

3.1 Summary

Although there were initial issues with the project, which resulted in a number of negative implications (discussed further in report), the current enthusiasm for users to receive electronic papers is positive and there is consensus that this method should continue. The administration team report improved administration processes in preparing and distributing papers. Time savings, ability to update papers, speed of delivery, archiving, and a reduction in the number of staff involved in preparing paper meeting packs have been identified as the major improvements made since moving to a paperless environment. The review has highlighted serious concerns with the set-up of the current IS supported device (Surface Pro) which is used to access the Diligent Board Books application.

91% of the survey respondents rate their current enthusiasm for receiving electronic papers as being good or excellent.



Answer Options	Response Percent	Response Count
Poor	4.5%	1
Fair	4.5%	1
Good	36.4%	8
Excellent	54.5%	12
answered question		22
skipped question		1

The IS Team continue to experience an increased workload due to ongoing problems with the Diligent application on Surface Pro devices, post implementation. The IS Team report experiencing pressure from both users and administration team to fix issues, often with tight turnarounds and little warning. IS report receiving an average of two issue notifications a week – 70% problems with Diligent and 30% device related issues.

3.2 Diligent Board Papers Application

Both administrators and users report good functionality of the application with key benefits being; ease of navigation, ability to annotate papers, ability to review old papers and speed of delivery. The administrators noted not all application functions have been explored and acknowledge there could be further exploration of the tools available.

3.3 IS recommended and supported device – Surface Pro

Administrators, users and IS all report major issues with the Surface Pro device including:

- High frequency of password changes and required upgrades
- Poor battery life
- Less functionality than what was anticipated
- Diligent application uninstalling
- User loss of confidence

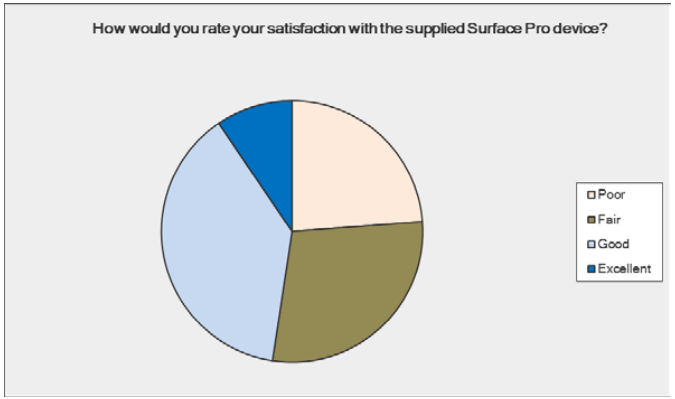
Issues with Diligent uninstalling itself from a number of HBDHB Surface Pro devices without warning has resulted in frustrations from within IS and widespread user dissatisfaction. Although no extensive testing has occurred or definitive reason is available for why this is occurring, IS speculate it is due to users letting the Surface Pro devices battery life rundown without charging. It is important to note a user who has purchased a Surface Pro independent to the project is not experiencing problems with Diligent. It is suggested the setup of the Surface Pro devices may have been overcomplicated.

Observations made during the review indicate initial set up of the Surface Pro devices, where security had priority over functionality, has impacted on how the device is used and restricted what the device can be used for (limits on functionality). The result of which has seen:

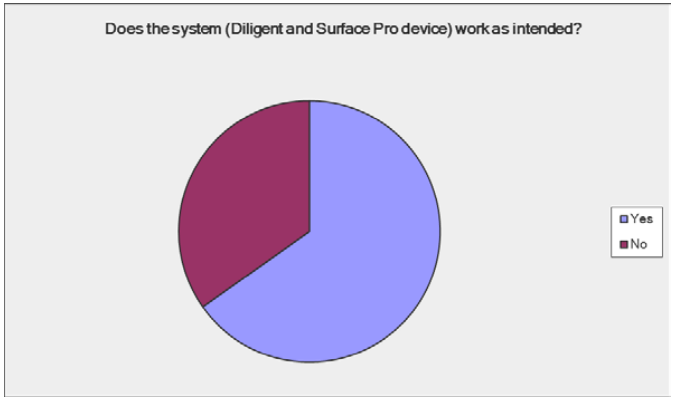
- A number of users only accessing the device when it is time to read papers – loss in familiarity with device, device not charged, passwords expired or forgotten, updates required
- Five of the 26 users have returned their Surface Pro and are now accessing Diligent on personal devices.
- Users not being able to access all functions the device offers (including: camera for videoconferencing, video, PowerPoint, USB access).

It is important to note, there are examples of users within the HBDHB who are mostly satisfied with the device and are using it in place of their primary desktop computer (through docking station).

53% of survey respondents rate their satisfaction with the Surface Pro device as being fair or poor (38% good, 9% excellent). Comments made by the users indicate this may be due to the frequently changing passwords, limited functionality and Diligent issues on HBDHB Surface Pros rather than the actual device itself. 65% of respondents believe the system (Surface Pro and Diligent) is working as intended.



Answer Options	Response Percent	Response Count
Poor	23.8%	5
Fair	28.6%	6
Good	38.1%	8
Excellent	9.5%	2
answered question		21
skipped question		2



Answer Options	Response Percent	Response Count
Yes	65.2%	15
No	34.8%	8
Please comment		15
answered question		23
skipped question		0

3.4 Summary of recommendations

The recommendations made in this report address areas that require attention to ensure best value from the project can continue to be achieved. The recommendations are categorised as:

1. Device and functionality
2. Training
3. Relationship building
4. Further exploration of Diligent Board application and expansion

See appendix A for recommendations in full.

4. Project delivery

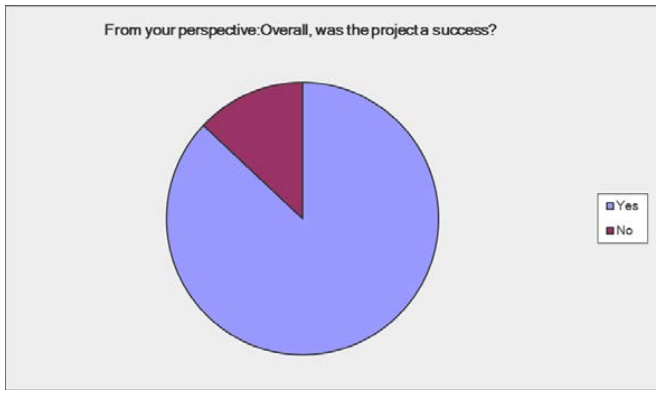
4.1 Summary

Following Board approval to implement the delivery of electronic papers through Diligent in October 2013, there were a number of issues raised by IS that contributed to a long-term delay for the roll-out:

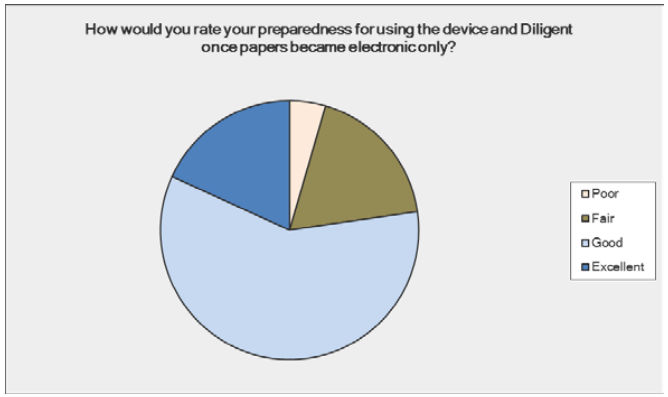
- Lack of staff resource due to commitment to project DANE (no dedicated staff member available)
- HBDHB's move to a windows 8.1 environment
- Waiting for Diligent 8.1 application to be released

All stakeholders noted that project delivery was mostly successful once a new timeline was established in September 2015 (and driven) and there was commitment from all parties. 86.96% of survey respondents felt the overall project was a success.

Following the setup and distribution of devices and after the diligent training, 77.3% of survey respondents rated their preparedness for using the device and Diligent as being good or excellent.



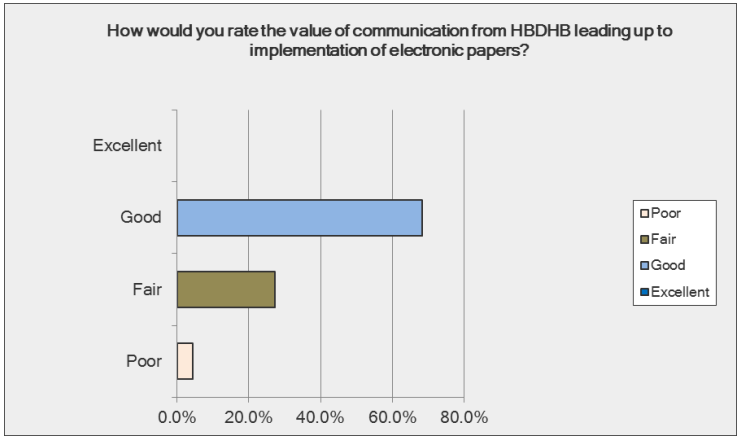
Answer Options	Response Percent	Response Count
Yes	87.0%	20
No	13.0%	3
answered question		23
skipped question		0



Answer Options	Response Percent	Response Count
Poor	4.5%	1
Fair	18.2%	4
Good	59.1%	13
Excellent	18.2%	4
answered question		22
skipped question		1

4.2 Communication

The survey results from users suggest communications from HBDHB leading up to the implementation were not always valuable. Comments made from a number of survey respondents noted that communications were not always clear or concise.



Observations made during the review indicate that an early breakdown in communication between the IS team and the project team contributed to the project running behind from day one. The following summary of comments made by IS, users and project team contributed to the communication issues:

- Misunderstanding of scope of project – pilot or full roll-out?
- Unclear lead, roles and responsibilities – IS or project team?
- IS feeling that concerns were not acknowledged – project team and management concerned IS delaying without warrant
- Each group felt the other was working against them
- Feeling that not all implications had been considered
- Loss of trust and respect

4.3 Training

The following comments were made in regards to the training opportunities:

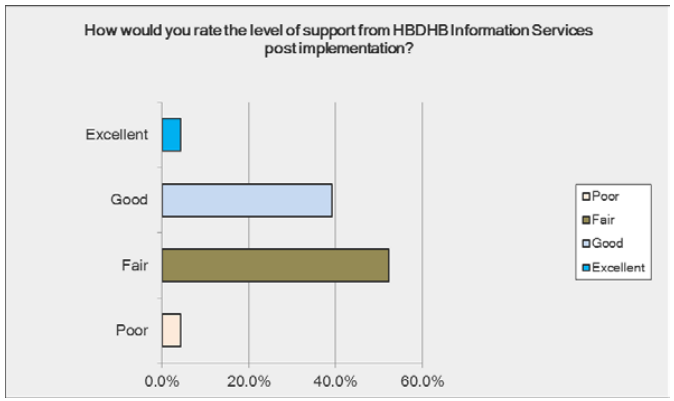
- Not all users had a device to train with
- Better organisation of training workshop required
- Separation between training for Surface Pro and Diligent would have been useful

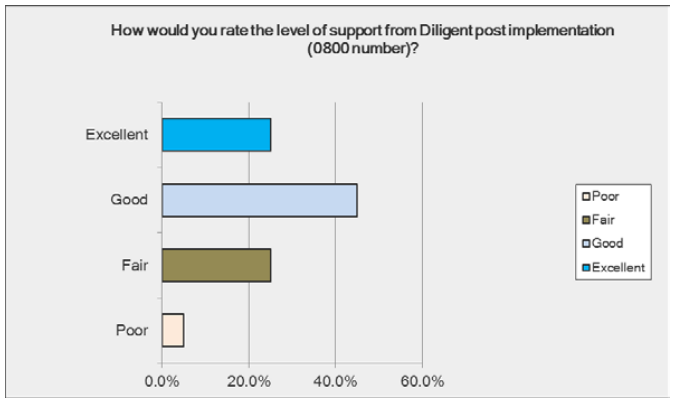
- More individual training or done in smaller groups
- Would have been good to have user champions – train the trainer sessions
- Greater visibility of IS team at first training workshop required

Answer Options	Response Percent	Response Count
Poor	9.1%	2
Fair	27.3%	6
Good	59.1%	13
Excellent	4.5%	1
answered question		22
skipped question		1

4.4 Ongoing support

Survey results rating the level of support received from IS and Diligent post implementation is summarised below:





5. Learnings

A summary of anecdotal responses from all stakeholders on aspects of the project that went well, not so well, and what could have been done better are included below:

5.1 What went well

- Achieved a near paperless environment in meetings
- Papers are now delivered on time
- Achieved an easy way to read and annotate papers. Diligent the right choice.
- Post implementation administrator support has been excellent
- Presentation of papers has improved
- Transition from paper to electronic was smooth
- Good level of support from IS at Board meetings post implementation (resolving most issues)

5.2 What went not so well

- How the devices were configured – limiting functionality
- Limited testing of devices prior to rollout (model brought for testing purposes was not used for this purpose)

- Implementation delays following decision
- Time pressures on IS
- Relationships between users, administrators and IS were strained at times
- Inflexible IS

5.3 What could have been done better

- More time taken on researching, testing and selecting the device
- Small user testing group to pilot the device and Diligent first
- Engagement with users about their needs - hardware had capability beyond what was required but didn't meet some of the users basic requirements
- Organisation of training workshops
- Giving users option to use personal device to access Diligent or make choice on what device to use

6. Achieving value

6.1 Summary of benefits achieved

Timely dissemination of information – with material being able to be published and accessible by users in real time Increased mobility of access – information (past and present) will be accessible from anywhere at any point in time. ie, through iPad, laptop or PC both on-line and off-line. Improved access to information – increased ability to navigate, filter and search for information required for individual needs easily Privacy and security – improved security over the access to information with a password required to access the portal and data encrypted at a page level protecting confidentiality, and Faster distribution of agenda papers to members.

83% of the survey respondents rated good or excellent in regards to how well they felt the benefits of the project were achieved, as outlined in the business case above. Those who rated poor or fair noted the following reasons for why they did not feel the benefits had been fully achieved:

- Benefits not realised due to poor performance of Surface Pro. Technology often doesn't work, so I've gone back to paper
- Difficult to use out of office
- Accessing and downloading can prove tricky and frustrating at times

- Most months there were issues re accessing papers with changing passwords, making it much more problematic than hard copies
- Difficulties in the beginnings with passwords and log in access problems that I found it far more difficult than receiving papers copies of agendas. I had to change and remember my password many times and then different ones for different screens and then come in when one or all of them didn't work. Accessing documents difficult at home.

The following benefits were noted from all stakeholders:

- Faster efficient reading when wanting to flick from one section to the next, tree saving
- Saving trees! Always having the up to date version. Always able to access papers across multiple platforms - not needing them with me
- Useful to have these accessed by PC. Surface Pro just causes frustration, so have reverted to paper after many visits to IT to fix
- We need to go this way. Savings in time and it is point of care technology that we should be using throughout the system
- Access to the papers without relying on the post or courier
- Easier to update papers
- Less paper. More timely access to current and past papers. Convenience
- Availability of archived documents
- Easy to make comments and record others comments
- Reduced cost in printing and mailing papers. Mobility of papers and having all the papers together and on hand consistently. Updated papers are easy to circulate
- Ease in reading, quick access to papers of interest, ability to make note and access it for next meeting (follow up on actions, issues discussed previously)
- Significant savings in printing costs (and removal of a printer) for comparison data please see appendix B.
- Reduction in the number of people involved in putting papers together (printing, binding, posting)
- Manual archiving now obsolete
- Ability to change papers and distribute electronically

Appendix A – Recommendations

Recommendation	Action	Benefit
1. Allow full functionality of device for users	i. HBDHB directors Either: Restore operating system of current Surface Pro devices to Microsoft standard to allow full functionality of device, with access to Diligent through application or web – Access to Wi-Fi and access to HBDHB network via Citrix (or similar) if relevant and necessary. Or: Allocation of annual allowance for purchase/use of personal device with access to Diligent through application – no device support from HBDHB IS.	- Remove issues with device passwords - User can use more than just for meetings - increase user familiarity with device - Users can choose a device that is suited to their preference – more likely to use as part of everyday life – device has purpose and may reduce battery being left to drain
	ii. HBDHB staff IS to meet with individual users to ascertain individual needs, requirements and user preferences, and address all outstanding issues. Supply docking stations where required to allow device to be used as primary desktop device. Consider device functionality as priority (camera, applications etc.). And/or Allow/promote use of personal devices in meetings and support access to Diligent via application.	- Increase user satisfaction and trust - Increased productivity - Less devices needed to be purchased and maintained by HBDHB - Increased familiarity with device
	iii. IS - Complete investigation of issues with Diligent uninstalling on Surface Pro (consider receiving external advice) and resolve. - If necessary, recommend a replacement device as part of the current HBDHB IS organisation wide review of devices – Consider supporting IPad use.	- User satisfaction - Reduce IS time dealing with issues

Steering Group Comment

1. *i* *HBDHB board members can choose to run own device and download access to Diligent themselves.*

   If using DHB purchased Surface Pro 3s then Information Services (IS) can return the Surface Pro devices to the Microsoft standard/vanilla, to allow full functionality of device to be available.

   Please note "vanilla" does not provide Microsoft Office capability but the user can install their own copy if required. Access to Diligent can be gained by downloading the application per Quick Reference Guide.

   Note this includes the need to create a Microsoft Account.

   Access to Wi-Fi when on site at DHB would be through Spark Hotspot.

   Support for Surface Pro's would be provided by IS for device faults.

   Any Diligent issues would be dealt with by Diligent Helpdesk on 0800 345 443.

   Upgrades to both the Surface pro and Diligent would be completed at home by HBDHB board members themselves.

   Responsibility to care, security and virus protection for the Surface Pro 3 would remain with HBDHB board members

   ii *HBDHB executive team members and others who may acquire surrendered devices, the set up will be the same as for any HBDHB device used on the network and will be established using the Core Image. This ensures consistency and ability to support device going forward.*

   The cost of expanding a Surface Pro 3 to a desktop device would be met by individual cost centres.

   iii *Agree, assuming issue with Diligent uninstalling can be resolved. Surface Pro users to be reminded that best performance can be achieved by keeping the device charged – do not let the battery go completely flat.*

2. Training	iv. Full training refresher on using Diligent. Immediate: Conduct a Diligent refresher training session – compulsory for all users Future: Diligent refresher training sessions offered to all users on an annual basis. v. Consider short workshop on using the Surface Pro device to its full potential – externally run or shared learnings from current users who are successfully using the device.	- Build on skills and knowledge - Achieve best value from investment - Increase productivity
Steering Group Comment *2. iv Prefer that all relevant users be encouraged to access the one-to-one training available from Diligent by ringing 0800 345 443 whilst having the device open in front of them.* *v An IS staff member is an experienced Surface Pro user capable of conducting Workshops in house, if required.*		
3. Strengthening of relationships	vi. Management consider creating a facilitated opportunity for administrators and key IS staff to meet to establish clear expectations, gain shared understanding, review processes and strengthen relationships	- Happier workforce - Focus on working together rather than against
Steering Group Comment *3. vi The process of conducting the review and sharing the outcomes has significantly enhanced understandings and relationships. Regular contact will be maintained.*		

4. Further exploration of Diligent Board application and expansion	vii. Administration team Review current use of the functions and tools the Diligent programme offers, and explore any missed opportunities to improve current administration processes. Consider further administrator training from Diligent if required. viii. Consider how Diligent use can be expanded to other HBDHB meetings including: - Department meetings - Project meetings - Steering groups	- Increased productivity - Reduce administration time further - Achieve best value from investment

Steering Group Comment

4. vii Agreed.

The number of trained administrators to also be increased.

New add-ons/offerings are relayed by Diligent from time to time and these are discussed between the administrators to ascertain their application and likely benefits to the organisation. These often have additional cost implications.

viii Agree that expanding the use of Diligent would have benefits, but additional costs would have to be justified.

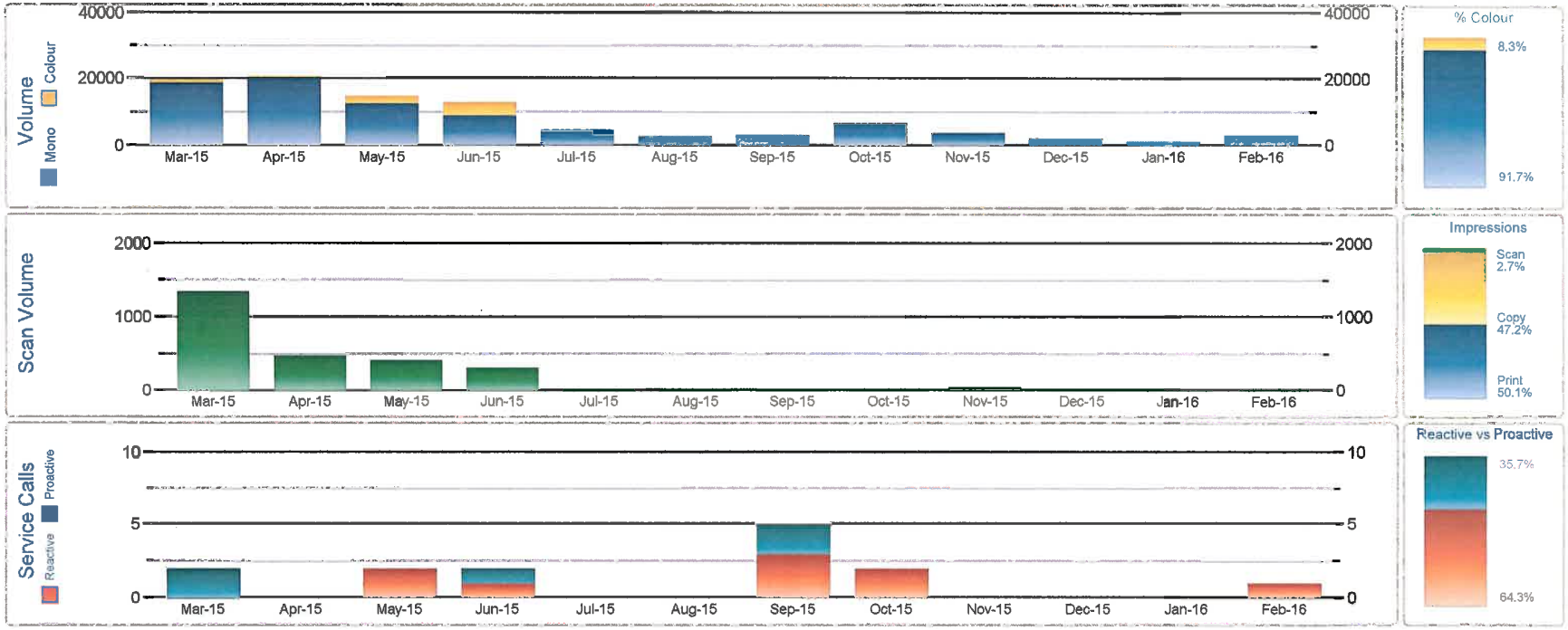
- *To set up another meeting in the Diligent system would cost an additional $60 per year, per meeting.*
- *To set up a new Diligent User in the system would cost an additional $500 per year, per user.*

KONICA MINOLTA

DEVICE DETAILS - HAWKES BAY DISTRICT HEALTH BRD

Model - C650 | No. of Machines - 1 | Speed - 65 ppm | Life Count - 3,500,000 | Min vol - 18,720 | Max vol - 43,680

Machine Type and Location		Average vol per month		Meter Readings		Impression Types		Service Calls	
Serial No	C65000124	Mono	7,240	Mono	1,133,445	% colour	8.3%	Avg calls per mnth	1.2
Model	C650	Colour	651	Colour	37,812	% A3	1.0%	Response Time h:mm	2:08
Location	TUTORIAL BUILDING	Total	7,891	Total	1,171,257	% duplex	89.0%	RTS Time h:mm	3:18
	OMAHU ROAD	Scan	220	Mnths to sol	295			Average % uptime	98.8%
	HASTINGS	Utilisation	1.3%						



KONICA MINOLTA

DEVICE DETAILS - HAWKES BAY DISTRICT HEALTH BRD

Model - C652 | No. of Machines - 1 | Speed - 65 ppm | Life Count - 3,500,000 | Min vol - 18,720 | Max vol - 43,680

Machine Type and Location		Average vol per month		Meter Readings		Impression Types		Service Calls	
Serial No	C65201524	Mono	8,300	Mono	879,211	% colour	42.6%	Avg calls per mnth	2.1
Model	C652	Colour	6,155	Colour	600,718	% A3	2.5%	Response Time h:mm	5:06
Location	CORPORATE OFFICE	Total	14,455	Total	1,479,929	% duplex	87.6%	RTS Time h:mm	5:48
	2ND FLOOR, MCLEOD STREET	Scan	380	Mnths to eol	140			Average % uptime	98.5%
	HASTINGS	Utilisation	2.3%						

CSG

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HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

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 Report

Reports and Recommendations from Committee Chairs

23. Finance Risk and Audit Committee

24. HB Clinical Council

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

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

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
ED	Emergency Department
ECA	Electronic Clinical Application

ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
EoIs	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Maori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Maori Health Service
MOPS	Maintenance of Professional Standards
MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding

MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RIS/PACS	Radiology Information System Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent

SUR	Service Utilisation Report
TAS	Technical Advisory Service
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date