BOARD MEETING

Date:	Wednesday, 26 April 2017
Time:	1.00pm
Venue:	Te Waiora Room, DHB Administration Building, Corner Omahu Road and McLeod Street, Hastings
Members:	Kevin Atkinson (Chair) Ngahiwi Tomoana Dan Druzianic Barbara Arnott Peter Dunkerley Helen Francis Diana Kirton Jacoby Poulain Heather Skipworth Ana Apatu Hine Flood
Apology:	-
In Attendance:	Dr Kevin Snee, Chief Executive Officer Members of Executive Management Team Members of the public and media
Board Administrator:	Brenda Crene

Public Agenda

Item	Section 1 : Routine	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report – verbal		
8.	Chief Executive Officer's Report	35	
9.	Financial Performance Report	36	
10.	Board Health & Safety Champion's Update – Helen Francis		
11.	Board Health & Safety Responsibilities – Kate Coley	37	
12.	Consumer Story (verbal) - Kate Coley		
	Section 2: Reports from Committee Chairs		
13.	HB Clinical Council – Co-Chair Chris McKenna	38	2.00
14.	Maori Relationship Board – Chair, Ngahiwi Tomoana	39	2.10
15.	HB Health Consumer Council - no meeting held due to the weather		
	Section 3: Discussion / Information		
16.	Establishing Health and Social Care Localities in HB – Tracee TeHuia and Jill Garrett	40	2.20
17.	Benefits from Investment in Mental Health Services Redesign *presentation* – Allison Stevenson	41	2.35
	Section 4: Monitoring		
18.	Te Ara Whakawaiora / Cardiology	42	2.50
	Section 5: General Business		
19.	**Section 6: Recommendation to Exclude the Public**		2.55
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Agenda Items	Ref #	Time (pm)
20.	Minutes of Previous Meeting		
21.	Matters Arising – Review of Actions		
22.	Board Approval of Actions exceeding limits delegated by CEO	43	
23.	Chair's Update		
24.	Cranford Hospice	44	
25.	Finance Risk & Audit Committee – Chair Dan Druzianic - Banking Supplier Recommendation	45	3.00

1.00pm, Wednesday 31 May 2017

Board "Interest Register" - 29 March 2017

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of Unison Networks Limited	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB. Unison leases 3 generators which are located at Hawke's Bay Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	Chair of FRAC	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair of FRAC	
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited	The Chair of FRAC	22.02.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
Barbara Arnott	Active	Trustee of the Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
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
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship and and may be contractural from time to time	No conflict	The Chair	5.12.16
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	5.12.16
	Active	Chair, Health Promotion Forum	Relationship	No conflict	The Chair	5.12.16
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 29 MARCH 2017, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.10PM

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

Apology Ngahiwi Tomoana

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Chris McKenna and Dr Mark Peterson (as co-Chairs, HB Clinical Council)
Graeme Norton (Chair, HB Health Consumer Council)
Members of the public and media
Brenda Crene

KARAKIA

Hine Flood opened the meeting with a Karakia.

APOLOGY

As noted above, an apology was received from Ngahiwi Tomoana.

INTEREST REGISTER

Several changes were advised to the Interest Register for Diana Skipworth and Heather Skipworth.

Jacoby Poulain, during the course of discussions noted her role as a Hastings District Councillor when several items were discussed.

CONFIRMATION OF PREVIOUS MINUTES

The minutes board meeting held on 22 February March 2017 were confirmed as a correct record of the meeting, following a correction at the bottom of page 6/9 of the minutes with the word “Waiting” changed to “Weighting”. With that change noted the minutes were approved.

Moved: Barbara Arnott
Seconded: Dan Druzianic

Carried

The minutes of the Special Board meeting held on 15 March 2017 at the Cheval Lounge, were the meeting.

Moved: Ana Apatu
Seconded: Dan Druzianic
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Interest Register –** complete, action removed

Item 2: **Draft HB Health Sector Leadership Forum** – complete, action removed

Item 3: **Board Workplan updates** – Renal Services Review (June) and Vulnerable Children Project (April) were included on the workplan – completed and action removed.

Item 4: **Submission re Joint Induction Day** – the submissions was provided - action removed.

Item 5: **Te Ara Whakawaiora / Access** – 0-4 year olds report was included with March board papers; detail around 45-64 years will be provided to the April board meeting – action removed.

Item 6: **Orthopaedic Review – Phase 2** – a response around waiting list assessment criteria was provided by the COO – action removed.

Item 7: **Annual Maori Health Plan non-financial exceptions report Q2** – a response around future comparisons was provided, action removed.

BOARD WORK PLAN

The Board Work Plan was noted with changes advised as follows: the Telephony Business Case would be available in June; and Social Inclusion would move to May. The workplan changed accordingly. **Action**

CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Lynda Van Kooten	Medical Typist	Operations Directorate	12	24-Feb-17
Margaret McGuire	Kaitakawaenga	Communities Women & Children	21	28-Feb-17
Dolly Toombs	Clinical Nurse Specialist - Diabetes	Communities Women & Children	16	17-Mar-17
Rhona Lincoln	Health Records Associate	Operations Directorate	21	24-Mar-17
Jennifer Taylor	Cook	Operations Directorate	29	31-Mar-17

- A letter had been received from the HB Cancer Society advising the sale of their building in Nelson Street in Hastings, and their intent to construct a new building on Little Elms site (near the hospital). A letter of support was requested from the Society, to assist with their funding applications. Timing for completion of their new facility is the end of 2018.
  The board felt the location was excellent and this move could create more opportunities around cancer services in HB.
- The MoH had noted the benefit for the people of Hawke's Bay with the new muscular skeletal services within the HB community. Because of this different pathway, an unintended negative consequence is the reduction in epidurals undertaken which although good for consumers, has impacted by reducing HBDHBs surgical discharge counts. The MoH recognise the different pathway being taken.
- A letter had been received from NZ Health Partnerships Limited advising they had agreed a new procurement operating model. This relates to PHARMAC's wider purchasing abilities, a shift away from the Health Alliance Service model.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report with comments noted in addition to the report including:

- For most measures, we are holding our own, or where problematic we are showing signs of improvement
- Financial performance is now a major issue with the projected surplus likely to fall short of budget.
- Placed in context however, this financial year should be the 7th year of surplus – unique within DHBs.

FINANCIAL PERFORMANCE REPORT

The Financial report for February 2017, showed an adverse variance of $1.2m year to date, with capacity significantly affected by the RMO strikes and the Gastroenteritis outbreak in Havelock north, eroding the expected gains forecasted.

Comments noted in addition to the report included:

- The MoH had been approached to assist with costs of Gastroenteritis Outbreak with costs in excess of $1m.
- The RMO strike cost us also as ED needed to be staffed by GPs.
- Now sitting with around $100k contingency for each of the remaining four months of the financial year.
- Nursing costs – it was noted we got phasing assumptions wrong which has impacted variances at this time.
- By year end we project $500 adverse cf today at $1.2m if we are successful in obtaining funding assistance for the one off Gastroenteritis outbreak from the MoH.
- It will be very difficult to hold budgets through to June 2017 and also hit MoH activity targets.

HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Helen Francis, the board health and safety champion (following discussions with staff) suggested bi monthly reports to the Board meeting with alternate months covered by FRAC through the Health and Safety Updates.

In response, the Chair acknowledged the input to date but advised he was now keen to see board members share this role to better ensure the Board as a whole, were meeting their due diligence obligations. He requested that this be considered in the paper scheduled to be provided to the April board meeting. **Action**

CONSUMER EXPERIENCE FEEDBACK PRESENTATION

Kate Coley provided the quarterly results of the Consumer Experience Survey for Quarter 4 (Oct-Dec 2016). Overall it was noted that the value from this survey comes through the commentary provided by consumers and identifying the themes.

Most DHBs are in a similar range. On average, Hawke's By receive more compliments (>25%) than complaints.

Through the GoWell (travel) initiative, we expect to see reduction in complaints around the lack of car parking

The next steps were summarised as follows:

- Inpatient Experience Survey Response Rates
- Working with Maori Health to develop local experience survey
- Reporting Calendar
- Organisational wide quality initiatives
  - ✓ Discharge planning (FLOW)

  - ✓ Medication safety (HQSC – Patient Safety Week)
  - ✓ GoWell (Paid carparking)
- Service specific quality initiatives
- Upgrade of Consumer Feedback system – allow better reporting

In discussion around upgrading the Consumer Feedback System, several points were raised, some for potential **action**:

- **The method by which the feedback** can be obtained will likely expand in line with other DHBs who are receiving higher percentages of feedback.
- **A suggestion for a badge to be worn by staff who speak TeReo** (which had been implemented elsewhere). Maybe this could be considered in Hawkes Bay?
- **Were children or would children be asked to provide feedback?** Kate would enquire and respond to the next meeting.
- **Maori health gather detail and feedback from consumers** however as an organisation, we are not good utilising this information.
- Dr Gommans advised that **professional bodies (medical practitioners) were now requiring 360 degree feedback** from patients as part of certification requirements. DHBs are required to have mechanisms in place to receive this feedback. We also need to factor in clinicians needs and the time is right to explore these options.

  Kate advised testing was currently occurring in the Paediatrics area.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Chris McKenna spoke to the report from the Council's meeting held on 8 February 2017:

Council noted their support for the Strategy on "Palliative Care in Hawke's Bay" (noting the need to further discuss outcome measures); also discussed further was the new Clinical Committees Structure (which remains work in progress) and the draft Annual Plan 2017/18 (first draft).

Other areas discussed by Council included the Travel Plan update (with parking newly implemented on the hospital site and at Corporate Office). Clinicians fully supportive and appreciative of the travel plan / parking implementation given the benefits for patients/consumers

Other reports received included Te Ara Whakawaiora / breastfeeding; Maternity Clinical Governance Group update Tracking well with no concerns and the Falls Minimisation Committee update – set of national indicators around strengthening programs.

Dr Gommans advised the new Clinical Committees structure was progressing but it was a slow process. Currently 5 new committees, under which sit 24 advisory groups. This structure covers across the health sector, with ToRs being developed and provisional chairs in place.

Hawke's Bay Health Consumer Council

Graeme Norton had conveyed his apology as he was unable to make the meeting due to fog cancelling flights in Wellington.

The outcomes of the Council meeting held on 9 March were conveyed within his report, noting support for the HB Palliative Care Strategy and draft Annual Plan 2017/18 (first draft); with discussion included the Consumer Engagement draft Strategy and the Tenure of a number of Consumer Council members which comes up in June 2017.

The Board Chair advised that Graeme had indicated his intention to stand down from the role as

Chair of Consumer Council in the next few months, and a process for the appointment/reappointment of consumer members would follow in due course.

Graeme was applauded for his work with HB Health Consumer Council since their inception in 2013.

FOR DECISION

Palliative Care in Hawke's Bay

Chris McKenna introduced the topic and the leadership team responsible for coordinating the development of the strategy:

Dr Martyn Horsfall, Medical Director Cranford Hospice
Sarah Nichol RN, Quality Facilitator Cranford Hospice
Mary Wills, Social Services General Manager, PSEC (until recently Head of Strategic Services HBDHB)
Emma Merry, SMO Palliative Medicine HBDHB
Paul Malan, Acting Head of Strategic Services, HBDHB

- An apology had been received from Janice Byford-Jones – CEO of Cranford Hospice

Mary Wills presented the strategy, noting it was now titled **"Live Well, Stay Well, Die Well".** The strategy had taken time to develop given the wide and engaging consultation processes and the drafting/reviewing of various versions prior to finalisation. This final version had only minor updates and alterations to that reviewed by the board last month.

Comments noted during discussions included:

- Two business cases would be drafted for consideration in due course: one for Primary Care the other for the Medical Workforce
- More input was needed from Wairoa
- There was difficulty in capturing unmet need and services to Maori/Pasifika, due to lack of information.
- The inpatient bed data had been drawn from recently completed Ministry of Health review of palliative care.

In summary, the Board congratulated the team on the engagement and consultation processes undertaken, and the production of an excellent strategy.

RESOLUTION

That the HBDHB Board:

1. Note amendments to the plan following workshops with primary care, palliative care stakeholders, consumers and in rural areas
2. Approve the plan.

Moved: **Dan Druzianic**
Seconded: **Barbara Arnott**

Carried

Draft HBDHB Annual Plan 2017/18

Tracee TeHuia spoke to the plan presented which was due to be sent to the MoH on Friday 31st March. This version had been viewed and supported by MRB, Clinical and Consumer Councils. An overview of the many strategies and plans that have been viewed and incorporated into this much reduced version was relayed.

All DHBs are to reduce their plans to 36 pages. We are checking what is required to monitor what we report against. In addition there are many areas over and above the MoH requirements HBDHB focus on.

Advised board member that this reduction in document size was good practice and linking up the various plans has been a great challenge.

RECOMMENDATION

That HBDHB Board

- Note the draft contents, timeline and process for the Hawke's Bay DHB Annual Plan 2017/18.
- Approve the Draft Annual Plan being submitted to MoH by 31 March subject to any changes.

Carried

FOR DISCUSSION / INFORMATION

Chaplaincy Presentation

The Chair welcomed Reverend Barbara Walker (Chaplain) and Colleen Kay Chair of the local support committee (to speak to the financial situation).

A "Chaplaincy" video was provided to the Board to view in their own time.

The service is part of the Interchurch Council for Hospital Chaplaincy (ICHC), based in Wellington who employ the chaplains and provide funding. Funding for the service was also obtained from the HBDHB, local churches, various people in the community as well as trusts. The service also fundraises directly.

The role of the service is to offer spiritual and emotional care and support in your community hospital, improving healthcare outcomes by bringing comfort, hope, and meaning to patients' lives. This extends out to the community on request.

What has affected funding? The main issue is around the denominational funding (churches) funding has been dropping for some time. Also the fixed amount funded by ICHC had also dropped due to difficulties being experienced.

Following Rev. Barbara Walker's heartfelt presentation the Chair summarised by acknowledging it was clearly evident his was an invaluable service, and we must explore ways to have this service continue 24/7. Information shared with all the board members indicated a $60k shortfall to have the service working 24/7, on a sustainable basis.

Currently 1.6 FTEs covering 24/7 service was noted as extremely challenging and that Barbara personally had provided an extraordinary service to the wider community.

Mayor of HDC, Lawrence Yule had earlier indicated that Councils have some responsibility within the community. Following discussion the board members unanimously felt an approach to HB Councils for shared funding of the Chaplaincy shortfall would be a good option.

Jacoby Poulain declared a conflict as a Hastings District Councillor.

In preparation we need to consider:

- How to provide a sustainable service 24/7.
- Think about succession planning as Rev. Walker indicated she would likely retire in several years.
- Have safe car parking on the hospital grounds
- Personal safety on the hospital grounds at any time of night.

Actions:

1. **Chair/CEO to facilitate an opportunity for Rev Barbara Walker to speak to the HB Mayoral Forum.**
2. **Executive Director Corporate Services to develop funding options for contributions to the $60k shortfall.**

Travel Plan Report

Andrea Beattie, author of the report provided a PowerPoint presentation which touched briefly on: bus services; cycling; the provision of bike sheds and various maps that were available; the guaranteed ride home scheme for difficult circumstances; car-pooling and the need to expand car parks in this area due to interest;; parking controls/management; parking back end processes; and parking fee exemptions.

In addition, consideration had been given to ensuring staff were supported in the dark and wet (through security escort) or a fleet vehicle to deliver people to their cars.

Advised one complaint had been received from a local resident around parking near their residential propertys and this was being worked through.

It was noted that council representatives from Hasting District Council and HB Regional Council were on the Steering Committee and working together in partnership.

A good result following the launch with thank conveyed from the Board

MONITORING PAPERS

Te Ara Whakawaiora / Access 0-4 (local indicator)

Patrick LeGeyte and Nicky Skerman were in attendance. It was noted the original report submitted to the Board in February was incomplete and had been resubmitted in March covering 0-4 years, with the 45-64 years to be provided to the Board in April.

Following an in-depth discussion around falling through the gaps accessing Well Child and Tamariki Ora and varying experiences, it was decided this discussion would continue outside the meeting. Feedback would be provided to the board when available.

A further report will be provided in April on the 45 to 64 year group.

Te Ara Whakawaiora / Breast Feeding (national indicator)

There was some discussion around the fragmented information given to mothers on breastfeeding. Pair support should be considered for those breastfeeding (ie, a buddy support system). Early engagement from birth to Lead Maternity Carer (LMC) handover seen as crucial.

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

21. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

23. Board Approval of Actions exceeding limits delegated by CEO
24. Chair's Update
25. Havelock North Gastroenteritis Outbreak August 2016
26. Cranford Hospice
27. Finance Risk and Audit Committee Report
    - Audit NZ – Final Management Report on the Audit of HBDHB for y/e June 2016
    - Audit NZ Engagement / Arrangement Letter
28. Hawke's Bay Clinical Council

Moved: **Peter Dunkerley**
Seconded: **Ana Apatu**
Carried

The public section of the Board Meeting closed 3.40pm

Signed: _____
Chair

Date: _____

5

BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	Apr	Status
1	29 Mar 17	Interest register changes were noted for Diana Kirton and Heather Skipworth.	Admin	Mar	Actioned
2	29 Mar 17	Health & Safety Board's role (six monthly review): the paper due to the Board in April, to encompass the option of all board members sharing the due diligence obligations required of them.	Kate Coley	Apr	Scheduled
3	29 Mar 17	Consumer feedback system – options and some actions for consideration include: • **The method by which the feedback** can be obtained will likely expand in line with other DHBs who are receiving higher percentages of feedback. • **A suggestion for a badge to be worn by staff who speak TeReo**. • **Were children or would children be asked to provide feedback?** Kate would enquire and respond to the next meeting. • **Maori health gather detail and feedback from consumers** however as an organisation, we are not good utilising this information. • Dr Gommans advised that **professional bodies (medical practitioners) were now requiring 360 degree feedback** from patients as part of certification requirements. Kate advised testing was currently occurring in the Paediatrics area.	Kate Coley		All actions have been noted and will be considered for the future.
4	29 Mar 17	**Chaplaincy Services:** 1. Facilitate an opportunity for Rev Barbara Walker to speak to the HB Mayoral Forum. 2. Develop funding options for contributions to the $60k shortfall within the Chaplaincy service	Board Chair & Kevin Snee Tim Evans		

HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
26 Apr	Benefits from Investment in Mental Health Services Redesign (pres) Board Health and Safety responsibilities Establishing Health and Social Care Localities in HB Banking Supplier Recommendation ***Monitoring*** Te Ara Whakawaiora / Cardiology	Allison Stephenson Kate Coley Tracee TeHuia Tim Evans Paula Jones
31 May	Health Literacy update Clinical Services Plan presentation Briefing GP services Wairoa Community Pharmacy Service Agreement Best Start Healthy Eating Plan (yearly review) Social Inclusion Final Draft Annual Plan 2017 ***Monitoring*** HBDHB Non-Financial Exceptions Report Q3 Jan-Mar 17 + MoH dashboard Q2 Annual Maori Health Plan Q4 - Dashboard HR KPIs Q3 Te Ara Whakawaiora / Access *revised from Feb Report 45-65 years*	Kate Coley Tracee TeHuia / Carina Sharon Mason Tim Evans Tracee TeHuia Tracee TeHuia Carina Burgess Tracee TeHuia Tracee TeHuia Kate Coley Mark Peterson
29 June	Consumer Experience Results Qtly People Strategy (2016-2021 first draft (p/excl) Youth Health Strategy update for Information Renal Services Review Pasifika Health Leadership Group incl Dashboard (6mthly) ***Monitoring*** Te Ara Whakawaiora / Oral Health (national indicator)	Kate Coley Kate Coley Tracee / Paul Malan Sharon Mason Sharon Mason / Robin W
26 July	Quality Accounts draft Histology Laboratory and completion of the Education Centre (final approval of tender)	Kate Coley Sharon Mason / Trent
30 Aug	People Strategy (2016-17) final Ngātahi Vulnerable Children Project (Board action Feb 17) Transform & Sustain Strategic Dashboard ***Monitoring*** Te Ara Whakawaiora / Culturally Competent Workforce (local ind) Te Ara Whakawaiora / Mental Health and AOD (national / local) HR KPIs quarterly Annual Maori Health Plan Q4 – Dashboard HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 17 + MoH	Kate Coley Tracee TeHuia Tracee TeHuia Kate Coley Sharon Mason / Paul M Kate Coley Tracee TeHuia Tracee TeHuia

Mtg Date	Papers and Topics	Lead(s)
6 Sept	**HB Health Sector Leadership Forum – East Pier, Napier**	
27 Sept	Orthopaedic Review – phase 3 draft	Andy Phillips
	Quality Accounts final	Kate Coley
	Patient Experience Results Qtly	Kate Coley
	Final Annual Plan 2017	Carina Burgess
	Interim Annual Report	Tim Evans
	Monitoring	
	Te Ara Whakawaiora – Healthy Weight Strategy (national Indicator)	Tracee TeHuia
25 Oct	People Strategy Quarterly Report	Kate Coley
	Establishing Health and Social Care Localities Update	Tracee TeHuia
	Annual Report 2017 (Board and FRAC)	Tim Evans
	Travel Plan Update Report	Sharon Mason
29 Nov	***Monitoring***	
	Te Ara Whakawaiora – smoking (national Indicator)	Tracee TeHuia / Johanna
	HR KPIs quarterly	Kate Coley
	Maori Annual Plan Q1 Dashboard	Tracee TeHuia
	HBDHB Non-Financial Exceptions Report Q1 Jul-Oct 17 + MoH dashboard Q4	Tracee TeHuia
13 Dec	Audit NZ Final Management Report on the audit of HBDHB for y/e June 2017	Tim Evans
	Consumer Experience Review –annual review since inception	Kate Coley

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 35
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	18 April 2017
Consideration:	For Information

8

Recommendations

That the Board

1. Note the contents of this report.

INTRODUCTION

This month our major concern is the emerging financial strain for the DHB.

PERFORMANCE

PERFORMANCEMeasure / Indicator	Target	Month of March	Qtr to end March	Trend For Qtr
Shorter stays in ED	≥95%	95.7%	93.8%	▲
Improved access to Elective Surgery	100%	-	98.6%	▼

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,789	360	0
Patients given commitment to treat, but not yet treated (ESPI-5)	1,035	113	23

Faster cancer treatment*	≥85%	73.7% (February)	65.3% (6m to February)	▼
Increased immunisation at 8 months (3 months to end of January)	≥95%	---	94.2%	▼
Better help for smokers to quit – Primary Care	≥90%	86.4%	---	---
Better help for smokers to quit – Maternity	≥90%	---	88.5% (Quarter 2,)	---
Raising healthy kids (New)	≥95% (by June 2017)	---	72% (6m to January)	---
Financial – month (in thousands of dollars)	$(1,483)	$(2,086)	---	▼
Financial – year to date (in thousands of dollars)	$2,064	$286	---	▼

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

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*19/19 = 100%*	*118/114 = 103.5%*

Ministerial Targets

Performance in this month shows an improvement in our Shorter Stays in Emergency Departments (ED 6) so that the 95 percent target was exceeded; this has continued and improved in April further. Elective activity remains below plan, however we remain confident that the plan will delivered and that the further plan for additional joints and general surgery will be delivered. It is now unlikely that the additional activity in orthopaedics will be delivered, this is partly because a change in clinical practice through the development of alternative pathways for back pain have led to fewer patients requiring treatment for back pain by epidural. Faster Cancer Treatment has reduced in February to 73.7 percent for the month; it will take a number of months before the six month average significantly improves, but the underlying performance is improving as can be seen from the table below. You will also notice that the months of December and January have reduced slightly from the most recent data because of changes in the cases that have been included in the analysis.

	FASTER CANCER TREATMENTS – CHANGING SIX MONTHLY POSITON JANUARY TO FEBRUARY					
	6 Months to January			**6 Months to February**		
	Total number of cases	**No. seen within 62 days**	**Percentage of cases seen within 62 days**	**Total number of cases**	**No. seen within 62 days**	**Percentage of Cases seen Within 62 days**
Aug-16	26	19	73.1%	-	-	
Sep-16	19	10	52.6%	19	10	52.6%
Oct-16	22	13	59.1%	22	13	59.1%
Nov-16	19	14	73.7%	19	14	73.7%
Dec-16	19	11	57.9%	18	10	55.6%
Jan-17	20	16	80.0%	21	16	76.2%
Feb-17	-	-		19	14	73.7%
	125	83	66.4%	118	77	65.3%

There is no new data at the time of writing for 'Raising Healthy Kids'. Immunisation is slightly below target for the month. Smoking cessation in primary care has seen no significant change in February.

Financial Performance

The adverse variance for the DHB increased from $1.2 million to $1.8 million in the month of March. This is not an acceptable performance for this DHB. Despite the analysis in February that much of that month's pressure was one-off, it is now clear that underlying pressures will drive further adverse results unless exceptional and firm actions are taken.

We have planned for a $5 million surplus this financial year, but that expectation is already looking unlikely. We need to minimise any shortfall against the target to preserve planned future investment into our services and infrastructure.

In particular, the detailed analysis in the Financial Performance report shows an accelerating overspend in our Health Services provider is putting unsustainable pressure on bottom line performance.

Health Services overspent by 7 percent in February, rising to 11 percent in March, to be 4 percent cumulatively adverse by at the end of March. Their cumulative adverse balance stands at $7.5 million. This is clearly offset by reserves and other underspending to give the overall balance of $1.8 million adverse.

There are less dramatic problems in other areas.

The Corporate budget is in balance overall.

The Funder arm is 0.7 percent adverse, driven by $1.8 million Inter District Flow overspend and $0.9 million spend on one high cost patient (though the latter was mostly funded by MoH and is offset by favourable revenue).

As a consequence the Executive Management Team has moved to override normal budgetary controls and has implemented a number of immediate measures to relieve the overspending pressure, and stop the escalating trend on Health Services. For example, all staff appointments will be required to have a 1 July start date, unless approval is given by the CEO for an earlier start.

Performance meetings have been held with the Directorates reporting recovery and loss reduction plans to me. These are now being actioned.

Corporate and Funder functions, including Māori Health and Population Health, have been asked to hold back all elective spend regardless of their budgetary position.

Looking forward to the 2017-18 it is clear we need to make additional effort over and above normal to return successfully to our preferred mode of operation. That is normal budgetary control. Despite not having a funding envelope from the Ministry of Health, we are instigating a detailed savings plan to be based on clearly allocated targets at a range of savings levels.

HEALTH AND SAFETY RESPONSIBILITIES REVIEW

Within the papers a progress report has been provided on the role of the Health and Safety Board Champion. The paper outlines the need to continue with this role ensuring that the Board's due diligence obligations under the new Health and Safety Act are met. It has been identified that the Board could gain more benefit by rotating this role among more Board Members over the term of the Board, rather than having just the one member fulfil the role for three years. Rotating the role will expose more Board members to health and safety issues at an operational level within the DHB and significantly enhance their level of understanding and provide the level of assurance required to meet their due diligence obligations.

CONSUMER STORY

Recently a consumer shared their experience and gratitude through the anonymous quarterly patient experience survey. This feedback highlights how delivering care and treatment in a patient and whānau centred way positively impacts the consumer experience.

ESTABLISHING HEALTH AND SOCIAL CARE LOCALITIES IN HAWKE'S BAY

The work in both localities is progressing well, and each is well placed to embed the initiatives that are currently underway. The change leadership roles are proving effective in growing the locality stakeholder membership, trust in the processes that are being followed and building effective relationships across the sector providers, both in health and the wider social sector.

Each locality has worked within a co-design, consumer driven approach. Projects have begun that address priority areas identified within health needs assessment, equity reporting and consumer consultation findings.

The range of initiatives are diverse within each of the localities. Where appropriate, direct links are made to existing DHB initiatives. The locality work provides us with the opportunity to work differently and more innovatively with our partner agencies.

MENTAL HEALTH BENEFITS MAP

In 2011, Mental Health Services completed the benefits mapping process to improve Acute Mental Health Services in Hawke's Bay and place a measure against those improvements. The benefit was put into three domains looking at safe therapeutic environment; improved patient care and outcomes; and improved value from investment.

The new facility was opened in January 2016. Mental Health Services will present the benefits map outcomes and the ongoing work to deliver the targeted measure.

TE ARA WHAKAWAIORA / CARDIOLOGY

Acute coronary syndromes (ACS) are an important cause of mortality and morbidity in patients admitted to hospital, which can be modified by appropriate intervention including urgent angiography (within three days) for those identified as at high risk.

Hawke's Bay has maintained satisfactory performance against the national data collection indicator, consistently meeting the >95 percent target for both Māori and the total population for the last year. However, we have struggled to consistently meet the access to angiograms target. Many of these interventions (about two-thirds) are delivered by specialist services based at Wellington Hospital with associated delays regarding transport and access to regional beds for Hawke's Bay patients. To help address this we now have an additional local angiography list (three times per week), regular communication between Capita and Coast DHB and HBDHB to support timely transfers of patients, and management representatives have been added to the Regional Cardiology Network to aid regional planning focus on improving compliance.

For a longer term solution, the Regional Cardiology Network has recommended that consideration be given to provision of Interventional Angiography Services on site in Hawke's Bay within 3-4 years. Local provision of this service would remove the current delays awaiting transport to or beds in Wellington. The Clinical Services Plan being developed later this year will consider this possibility.

CONCLUSION

We have seen the continuation of the relatively poor financial performance continuing into March. This is the most critical issue we are dealing with and will remain a key focus for the remainder of the year. We cannot allow it to undermine the positive gains we have seen in recent years because we have had money to invest in services and infrastructure. I am confident, with the team we have in place, that this will come under control. We will obviously keep our position under review and report to the Board how we intend to improve our position in 2017/18 when DHB budgets for next year have been clarified.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, March 2017** 36
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, Executive Director Corporate Director Phil Lomax, Financial Accountant
Reviewed by:	Executive Management Team
Month:	April 2017
Consideration:	For Information

RECOMMENDATION

That the Finance Risk and Audit Committee and HBDHB Board

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

1. Executive Director Corporate Services' comments

Financial performance

The result for the month of March is an unfavourable variance of $0.6 million making a year to date adverse variance of $1.8 million.

Efficiencies not achieved ($505 thousand), additional outsourced surgery ($541 thousand), and leave and vacancy cover for medical personnel ($503 thousand) provided unfavourable results in March. Offsetting these were favourable ACC and clinical training income and the release of provisions for Maori primary care, new investment, pharmaceuticals, and transform expenditure.

Elective Health Target

Elective discharges deteriorated from on-plan (adjusted) in February to 1.7% under target year to date in March.

Forecast year end result

The forecast has not been changed and remains as a $4.5 million surplus for the 2016-17 year. That target will be difficult to achieve and will require: MOH to agree to cover the costs of the Havelock North gastroenteritis outbreak; achievement of the efficiency targets; fulfilment of the surgical health target activity within existing resources; and a close financial watch to remain within budget over the last quarter. As part of the financial watch a number of corrective action meetings have been held with lead managers in Corporate, Funder, and Health Services. The Chief Executive has agreed corrective actions supported by management accounting forecasts.

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)	(2,086)	(1,483)	**(603)**	**-40.7%**	286	2,064	**(1,778)**	**-86.1%**	4,500	3
Contingency utilised	100	250	**150**	**60.0%**	2,700	2,250	**(450)**	**-20.0%**	3,000	8
Quality and financial improvement	578	1,083	**(505)**	**-46.6%**	6,954	9,750	**(2,796)**	**-28.7%**	13,000	11
Capital spend	1,726	1,753	(27)	-1.6%	7,973	16,776	**(8,803)**	**-52.5%**	22,042	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,243	2,236	(8)	-0.3%	2,211	2,192	(20)	-0.9%	2,204	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,826	2,407	**419**	**17.4%**	22,728	20,915	**1,813**	**8.7%**	27,609	5

One month's share of the remaining contingency was released in March leaving $300 thousand in the reserve. The contingency released year to date includes cover for the cost of the gastroenterology outbreak in Havelock North.

The Quality and Financial Improvement (QFI) programme has achieved 71% of planned savings year-to-date.

Capital continues behind plan. A number of projects have not started at the estimated times projected in the capital plan, and the major radiology equipment purchases have been delayed into future years.

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

Case weighted discharges (CWD) reflect continuing high acute volumes into March. Year-to-date, the main specialties driving the result are gastroenterology, general internal medicine, general surgery, paediatrics, vascular surgery, and partly offset by lower orthopaedic surgery.

3. Financial Performance Summary

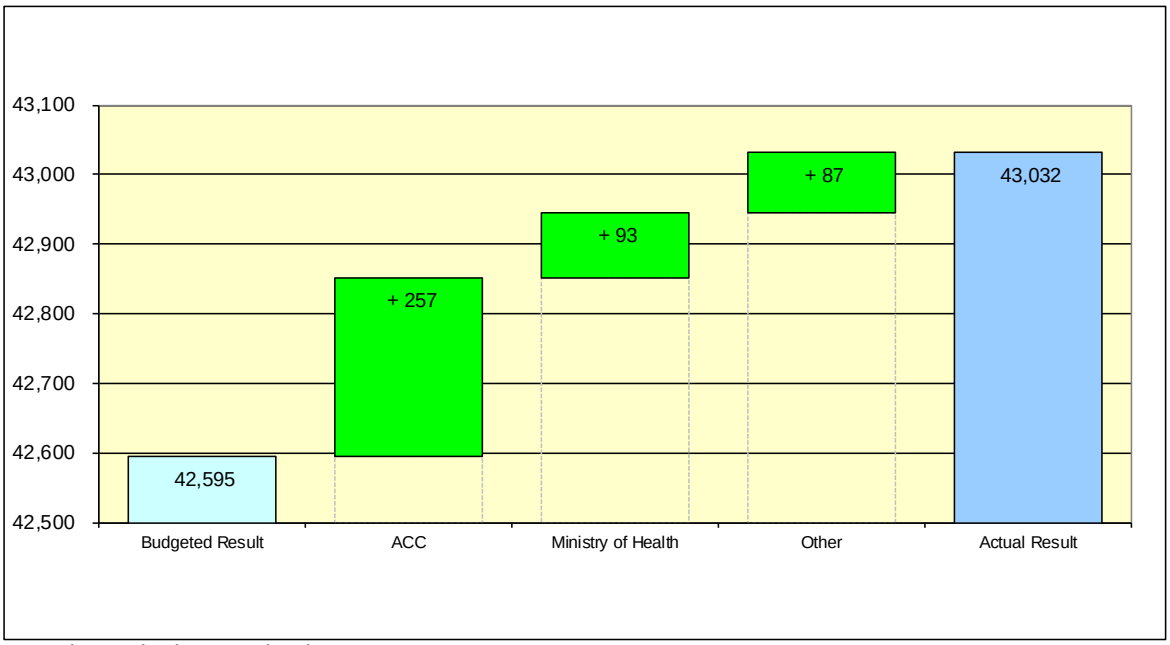
	March				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	43,032	42,595	438	1.0%	394,393	392,417	1,976	-0.5%	533,989	4
Less:										
Providing Health Services	23,741	21,319	**(2,422)**	**-11.4%**	191,699	184,174	(7,525)	-4.1%	253,912	5
Funding Other Providers	18,214	19,305	**1,091**	**5.6%**	170,669	170,511	(158)	-0.1%	227,104	6
Corporate Services	3,731	3,406	**(324)**	**-9.5%**	34,597	34,635	38	0.1%	47,833	7
Reserves	(568)	47	**615**	**1316.2%**	(2,858)	1,033	**3,892**	**376.6%**	640	8
	(2,086)	**(1,483)**	(603)	40.7%	**286**	**2,064**	**(1,778)**	**-86.1%**	**4,500**	

Favourable results came from ACC and clinical training income and the release of provisions for Maori primary care, new investment, pharmaceuticals, and transform expenditure. However they were more than offset by efficiencies not achieved, additional outsourced surgery, leave and vacancy cover provided by locums, and contract payments for cleaning and maintenance.

4. Income

$'000	March				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	40,626	40,533	93	0.2%	376,335	374,047	2,288	0.6%	509,864
Inter District Flows	630	629	2	0.3%	5,840	5,659	181	3.2%	7,726
Other District Health Boards	367	334	33	10.0%	2,848	3,002	**(153)**	**-5.1%**	3,835
Financing	89	75	14	18.0%	652	664	(12)	-1.8%	873
ACC	782	525	**257**	**49.0%**	4,137	4,499	**(362)**	**-8.1%**	5,541
Other Government	18	18	0	1.3%	263	326	**(62)**	**-19.1%**	414
Patient and Consumer Sourced	175	123	**53**	**42.9%**	941	1,084	**(143)**	**-13.2%**	1,290
Other Income	345	359	(14)	-3.9%	3,380	3,070	**311**	**10.1%**	4,449
Abnormals	-	0	(0)	-100.0%	(4)	67	**(71)**	**-106.0%**	(3)
	43,032	**42,595**	**438**	**1.0%**	**394,393**	**392,417**	**1,976**	**0.5%**	**533,989**

March Income

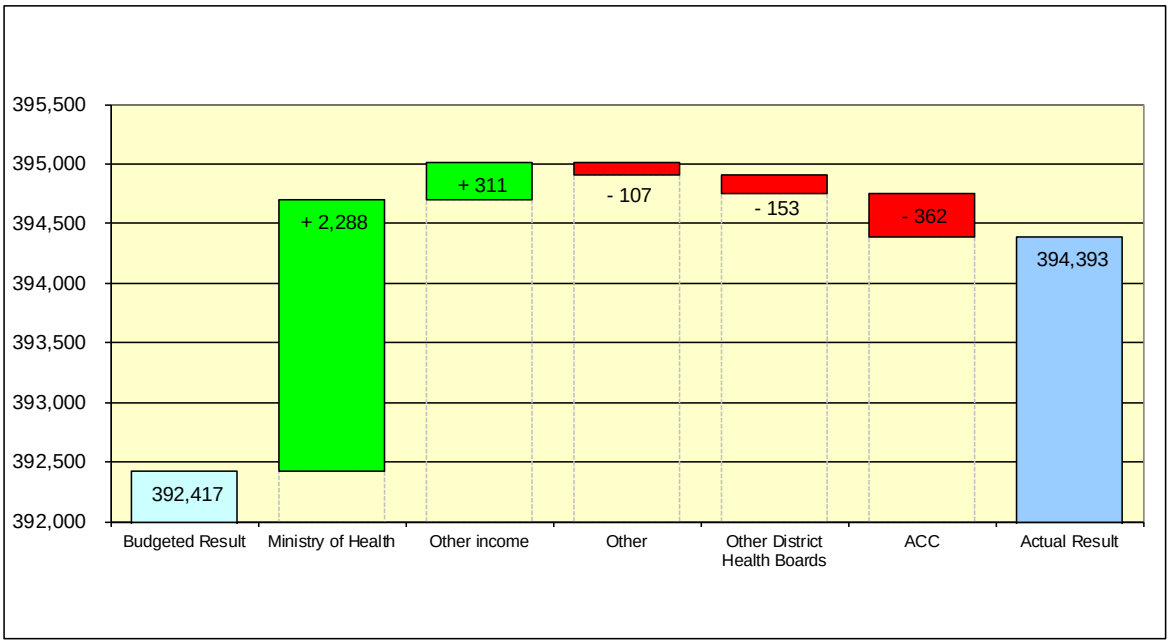


Note the scale does not begin at zero

ACC (favourable)
Higher income from ACC elective surgery during the month, and associated additional ACC income for rehabilitation services.

Ministry of Health (favourable)
Additional income for clinical training and NASC management.

Year to Date Income



Ministry Of Health (favourable)
Mainly high cost patient treatment income, child development and in-between-travel funding.

Other income (favourable)
Unbudgeted donations and clinical trial income, and a wide variety of sundry income.

Other District Health Boards (unfavourable)
Lower than budgeted cancer drug sales to Tairawhiti DHB, marginally offset by patient transport recoveries from a number of DHBs.

ACC (unfavourable)
Lower ACC rehabilitation income due to lower demand. Lower ACC elective volumes due to capacity constraints.

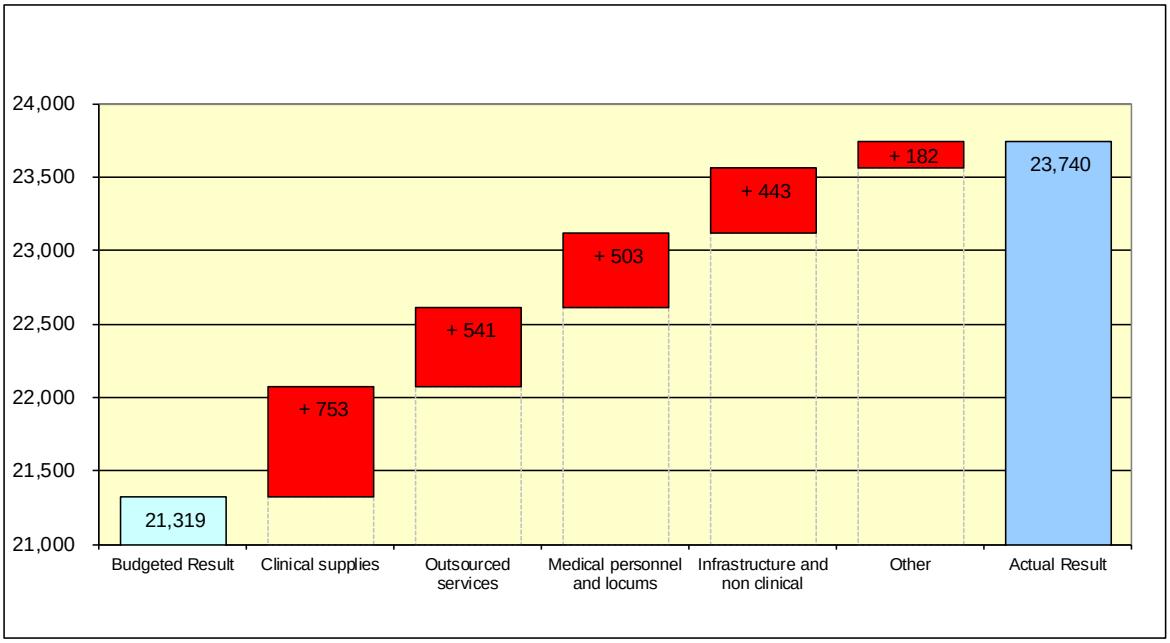
5. Providing Health Services

	March				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,519	5,016	(503)	-10.0%	45,686	44,693	(993)	-2.2%	60,386
Nursing personnel	6,397	6,036	(361)	-6.0%	55,100	53,788	(1,312)	-2.4%	73,987
Allied health personnel	2,948	3,089	142	4.6%	23,921	24,944	1,023	4.1%	32,100
Other personnel	1,884	1,921	38	2.0%	16,278	15,645	(633)	-4.0%	21,775
Outsourced services	1,225	684	(541)	-79.0%	7,373	6,185	(1,188)	-19.2%	10,389
Clinical supplies	3,732	2,979	(753)	-25.3%	28,279	24,472	(3,807)	-15.6%	35,004
Infrastructure and non clinical	2,036	1,593	(443)	-27.8%	15,061	14,447	(614)	-4.3%	20,268
	23,740	**21,319**	**(2,420)**	**-11.4%**	**191,697**	**184,174**	**(7,523)**	**-4.1%**	**253,911**
Expenditure by directorate $'000									
Medical	6,097	5,503	(594)	-10.8%	51,409	48,802	(2,607)	-5.3%	67,813
Surgical	5,791	4,715	(1,076)	-22.8%	43,700	40,613	(3,087)	-7.6%	57,282
Community, Women and Children	3,792	3,581	(210)	-5.9%	32,406	31,459	(947)	-3.0%	42,863
Older Persons, Options HB, Menta	3,049	2,919	(131)	-4.5%	25,193	24,986	(207)	-0.8%	33,536
Operations	3,211	3,161	(50)	-1.6%	27,603	27,228	(375)	-1.4%	36,914
Other	1,801	1,441	(360)	-25.0%	11,386	11,085	(301)	-2.7%	15,502
	23,740	**21,319**	**(2,420)**	**-11.4%**	**191,697**	**184,174**	**(7,523)**	**-4.1%**	**253,911**
Full Time Equivalents									
Medical personnel	326.9	320.5	(6)	-2.0%	316	316	(1)	-0.3%	315.5
Nursing personnel	928.7	884.0	(45)	-5.1%	910	882	(28)	-3.2%	890.2
Allied health personnel	437.6	472.5	35	7.4%	433	452	20	4.3%	453.7
Support personnel	131.1	129.2	(2)	-1.5%	133	127	(6)	-4.9%	127.5
Management and administration	253.9	261.5	8	2.9%	256	248	(8)	-3.3%	249.4
	2,078.1	**2,067.6**	**(10)**	**-0.5%**	**2,049**	**2,024**	**(24)**	**-1.2%**	**2,036.2**
Case Weighted Discharges									
Acute	1,905	1,552	353	22.7%	15,634	14,132	1,502	10.6%	18,713
Elective	628	645	(18)	-2.7%	4,829	4,938	(109)	-2.2%	6,451
Maternity	189	171	19	10.9%	1,614	1,515	99	6.5%	2,000
IDF Inflows	105	40	65	162.7%	652	330	322	97.4%	445
	2,826	**2,407**	**419**	**17.4%**	**22,728**	**20,915**	**1,813**	**8.7%**	**27,609**

Directorates

- Surgical includes efficiencies not achieved, locum vacancy and leave cover, and fee for service payments for additional surgery sessions.
- Medical includes vacancy and leave cover for medical staff, efficiencies not achieved yet, gastrointestinal pharmaceuticals and biologics.
- Community, Women and Children is mostly efficiencies not achieved, increased paediatric and maternity volumes, additional junior medical staff, and locums for sabbatical leave cover.

March Expenditure



Note the scale does not begin at zero

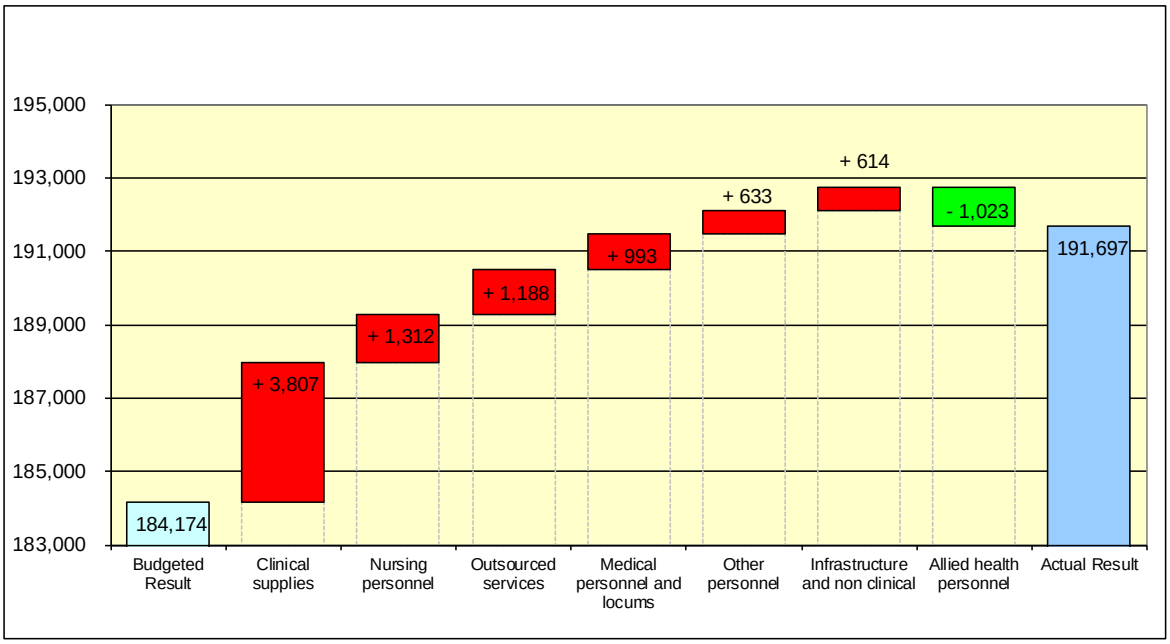
Clinical supplies (unfavourable)
Efficiencies not yet achieved or achieved elsewhere, oncology drugs, and health promotion costs.

Outsourced services (unfavourable)
Dermatology services, surgical procedures, and sub-acute mental health care.

Medical personnel and locums (unfavourable)
Locums for vacancy and leave cover, leave not taken, additional sessions to meet targets and some additional RMO positions.

Infrastructure and non-clinical (unfavourable)
Cleaning contract catch-up, maintenance contracts, legal fees relating to the gastroenteritis outbreak.

Year to Date Expenditure



Clinical supplies (unfavourable)
Mainly efficiencies not yet achieved or achieved elsewhere. Also includes patient transport costs.

Nursing personnel (unfavourable)
Nursing staff taking leave at different times to that budged. Also includes some additional staffing, overtime, and termination payments.

Outsourced services (unfavourable)
Outsourced elective surgery to meet discharge targets, higher use of outsourced mental health beds, the acute flow management refresh, and CT teleradiology reads.

Medical personnel and locums (unfavourable)
Locums for vacancy and leave cover, leave not taken, additional sessions to meet targets and some additional RMO positions.

Other personnel (unfavourable)
Maori Health vacancies, management restructuring costs, and additional administration staffing to provide cover.

Infrastructure and non-clinical (unfavourable)
Efficiencies not yet achieved, and outsourced maintenance costs.

Allied Health personnel (favourable)
Mainly mental health vacancies including psychologists, therapies and community support staff. Also includes vacancies in laboratory technicians, health promotion officers and pharmacists.

Full time equivalents (FTE)

FTEs are 24 unfavourable year to date including:

Nursing personnel (28 FTE / 3.2% unfavourable)

- Higher than budgeted staffing in certain areas including ED and the medical wards. Some planned efficiencies have not been achieved or have been achieved elsewhere.

Management and administration personnel (8 FTE 3.3% unfavourable)

- Minimal leave cover not coping with high workloads and long term sick leave. Hours related retirement payments earlier in the year.

Support personnel (6 FTE / 4.9% unfavourable)

- Cover for leave, long term sick leave, and training, mainly impacting on orderlies and kitchen assistants.

partly offset by:

Allied Health Personnel (20 FTE / 4.3% favourable)

- Vacancies mainly in technicians, health promotion, social workers, community support workers and occupational therapy.

Medical FTEs are close to budget. Usually medical FTEs will be favourable because vacancy and leave cover is often provided by locums who do not generate an FTE. However year to date reductions caused by vacancies and staff on leave have been offset by leave not taken and new positions.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To March 2017

Plan for 2016/17	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	70		0	**70**
Non Surgical - Elective	187		0	**187**
Surgical - Arranged	390		307	**697**
Surgical - Elective	5,003	788	629	**6,420**
TOTAL	**5,650**	**788**	**936**	**7,374**

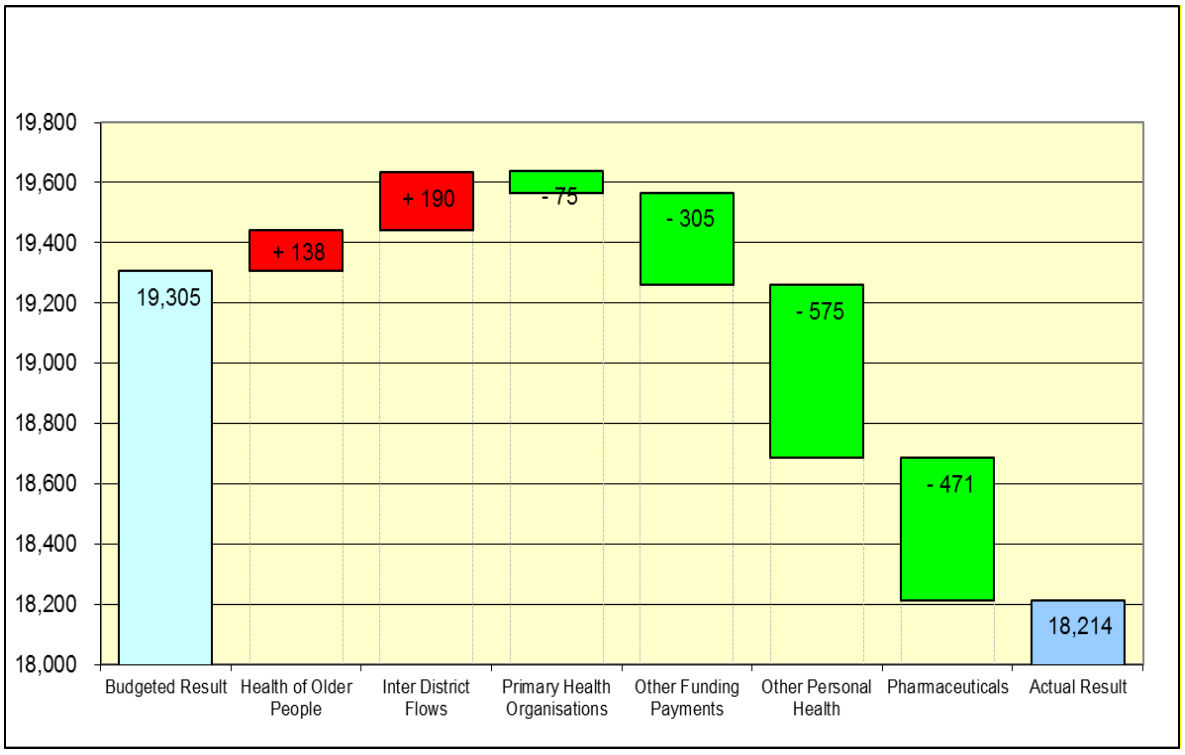
		YTD March-17						Mar-17			
		Actual	Plan	Var.	%Var.			Actual	Plan	Var.	%Var.
On-Site	Avastins	150	150	0	0.0%	On-Site	Avastins	19	19	0	0.0%
	ENT	397	426	-29	-6.8%		ENT	47	55	-8	-14.5%
	General Surgery	624	667	-43	-6.4%		General Surgery	85	85	0	0.0%
	Gynaecology	423	375	48	12.8%		Gynaecology	53	48	5	10.4%
	Maxillo-Facial	122	137	-15	-10.9%		Maxillo-Facial	10	18	-8	-44.4%
	Ophthalmology	739	812	-73	-9.0%		Ophthalmology	79	109	-30	-27.5%
	Orthopaedics	604	687	-83	-12.1%		Orthopaedics	88	96	-8	-8.3%
	Skin Lesions	131	131	0	0.0%		Skin Lesions	18	18	0	0.0%
	Urology	367	322	45	14.0%		Urology	58	41	17	41.5%
	Vascular	131	103	28	27.2%		Vascular	20	13	7	53.8%
	Surgical - Arranged	417	324	93	28.7%		Surgical - Arranged	72	46	26	56.5%
	Non Surgical - Elective	57	142	-85	-59.9%		Non Surgical - Elective	5	19	-14	-73.7%
	Non Surgical - Arranged	22	52	-30	-57.7%		Non Surgical - Arranged	1	7	-6	-85.7%
On-Site	**Total**	**4184**	**4328**	**-144**	**-3.3%**	**On-Site**	**Total**	**555**	**574**	**-19**	**-3.3%**
Outsourced	Cardiothoracic	0	33	-33	-100.0%	Outsourced	Cardiothoracic	0	5	-5	-100.0%
	ENT	112	109	3	2.8%		ENT	4	15	-11	-73.3%
	General Surgery	224	202	22	10.9%		General Surgery	19	29	-10	-34.5%
	Gynaecology	11	29	-18	-62.1%		Gynaecology	0	5	-5	-100.0%
	Maxillo-Facial	33	53	-20	-37.7%		Maxillo-Facial	2	8	-6	-75.0%
	Neurosurgery	0	14	-14	-100.0%		Neurosurgery	0	2	-2	-100.0%
	Ophthalmology	98	18	80	444.4%		Ophthalmology	4	0	4	0.0%
	Orthopaedics	60	51	9	17.6%		Orthopaedics	8	1	7	0.0%
	Paediatric Surgery	0	2	-2	-100.0%		Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	3	0	0	0.0%		Skin Lesions	0	0	0	100.0%
	Urology	49	61	-12	-19.7%		Urology	1	9	-8	-88.9%
	Vascular	19	32	-13	-40.6%		Vascular	3	4	-1	-25.0%
	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**	**609**	**604**	**5**	**0.8%**	**Outsourced**	**Total**	**41**	**78**	**-37**	**-47.4%**
IDF Outflow	Avastins	2	0	2	0.0%	IDF Outflow	Avastins	0	0	0	0.0%
	Cardiothoracic	51	58	-7	-12.1%		Cardiothoracic	2	7	-5	-71.4%
	ENT	25	36	-11	-30.6%		ENT	3	5	-2	-40.0%
	General Surgery	39	36	3	8.3%		General Surgery	5	4	1	25.0%
	Gynaecology	28	18	10	55.6%		Gynaecology	1	2	-1	-50.0%
	Maxillo-Facial	110	144	-34	-23.6%		Maxillo-Facial	4	18	-14	-77.8%
	Neurosurgery	58	32	26	81.3%		Neurosurgery	3	3	0	0.0%
	Ophthalmology	24	24	0	0.0%		Ophthalmology	2	3	-1	-33.3%
	Orthopaedics	25	15	10	66.7%		Orthopaedics	2	2	0	0.0%
	Paediatric Surgery	59	39	20	51.3%		Paediatric Surgery	8	5	3	60.0%
	Skin Lesions	45	57	-12	-21.1%		Skin Lesions	2	7	-5	-71.4%
	Urology	16	5	11	220.0%		Urology	0	1	-1	0.0%
	Vascular	11	12	-1	-8.3%		Vascular	0	2	-2	-100.0%
	Surgical - Arranged	119	228	-109	-47.8%		Surgical - Arranged	8	28	-20	-71.4%
	Non Surgical - Elective	92	0	92	0.0%		Non Surgical - Elective	11	0	11	0.0%
	Non Surgical - Arranged	42	0	42	0.0%		Non Surgical - Arranged	4	0	4	0.0%
IDF Outflow	**Total**	**746**	**704**	**42**	**6.0%**	**IDF Outflow**	**Total**	**55**	**87**	**-32**	**-36.8%**
TOTAL		**5539**	**5636**	**-97**	**-1.7%**	**TOTAL**		**651**	**739**	**-88**	**-11.9%**

Please Note:This report was run on 7th April 2017. Skin Lesions and Avastins have been adjusted to plan.
Data is subject to change.

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	3,025	3,496	471	13.5%	32,250	32,673	423	1.3%	42,785
Primary Health Organisations	3,055	3,129	75	2.4%	26,315	26,500	185	0.7%	35,216
Inter District Flows	3,889	3,699	(190)	-0.5%	35,476	33,291	(2,185)	-1.1%	45,698
Other Personal Health	1,642	2,216	575	18.9%	16,981	17,096	115	-10.3%	24,352
Mental Health	1,155	1,148	(7)	-0.6%	10,114	10,313	199	1.9%	13,565
Health of Older People	5,297	5,159	(138)	-2.7%	46,005	46,429	424	0.9%	61,015
Other Funding Payments	153	457	305	66.6%	3,528	4,209	681	16.2%	4,967
	18,214	19,305	1,091	5.6%	**170,669**	**170,511**	(158)	-0.1%	227,598
Payments by Portfolio									
Strategic Services									
Secondary Care	4,268	3,898	(370)	-9.5%	37,635	35,082	(2,553)	-7.3%	49,472
Primary Care	7,544	8,262	718	8.7%	70,366	70,974	609	0.9%	94,217
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,155	1,267	112	8.8%	10,249	10,313	64	0.6%	13,700
Health of Older People	5,317	5,079	(238)	-4.7%	46,425	46,778	353	0.8%	61,544
Other Health Funding	(516)	68	584	864.4%	110	629	519	82.5%	216
Maori Health	259	528	268	50.8%	4,065	4,673	608	13.0%	5,808
Population Health									
Women, Child and Youth	101	105	3	3.1%	1,008	1,147	139	12.1%	1,530
Population Health	87	100	13	13.1%	810	914	104	11.4%	1,111
	18,214	19,305	1,091	5.6%	**170,669**	**170,511**	(158)	-0.1%	227,598

March Expenditure



Note the scale does not begin at zero

Health of Older persons (unfavourable)
Timing difference

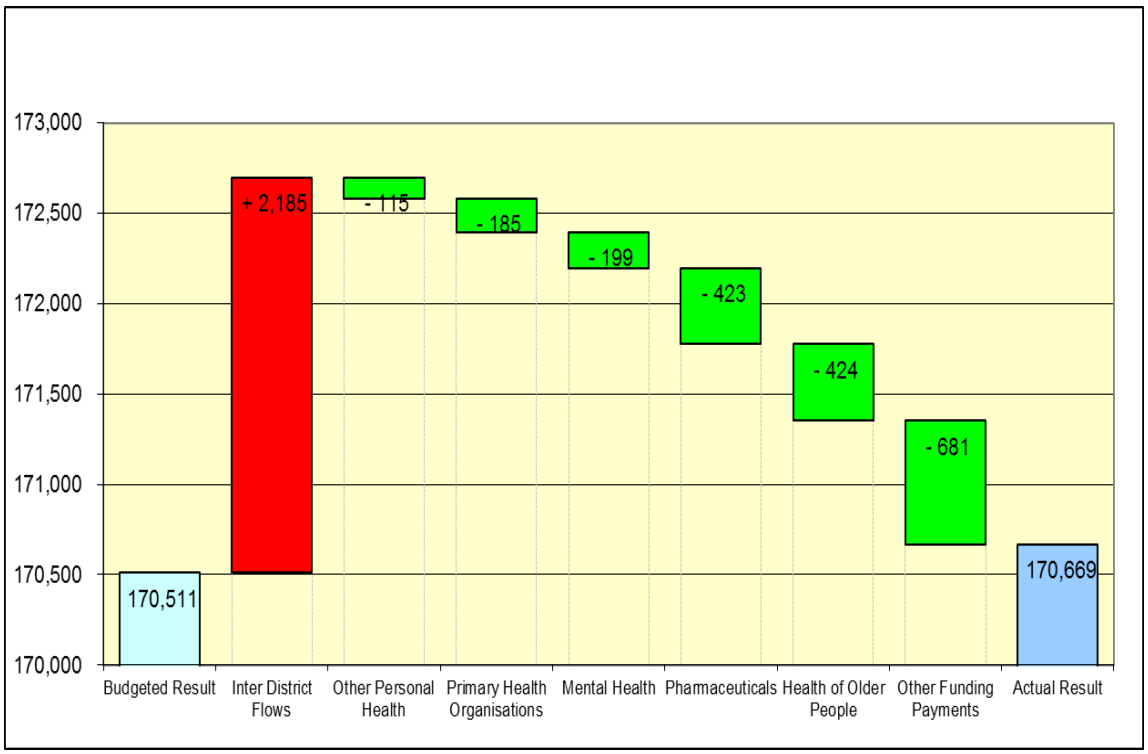
Inter district flows
Overspend largely in Cardiothoracic and Cardiology cases

Other funding payments (favourable)
Further release of Maori primary health accruals from 2015/16.

Other personal health (favourable)
Release of new investment budgets that are unlikely to be spent this year.

Pharmaceuticals (favourable)
Re-estimation of drug use accruals.

Year to Date Expenditure



Inter district flows
Overspend largely in acute activity related to Cardiothoracic, Cardiology, General medicine, Haematology, Oncology and Plastics.

Other Personal Health (favourable)
IDF wash-up provisions (included under other personnel health to allow MOH to consolidate inter DHB transactions), and high cost patient expenditure, partly offset by lower GMS payments, and the release of new investment budgets that are unlikely to be spent this year.

Pharmaceuticals (favourable)
Reducing volume.

Health of Older People (favourable)
Lower residential care costs partly offset by higher home support.

Other Funding Payments (favourable)
Release of Maori primary health accruals from 2015/16.

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	1,494	1,324	(170)	-12.8%	12,214	11,293	(922)	-8.2%	15,953
Outsourced services	135	92	(44)	-47.5%	991	863	(128)	-14.8%	1,291
Clinical supplies	24	9	(15)	-153.4%	104	85	(19)	-22.6%	64
Infrastructure and non clinical	629	630	1	0.1%	6,840	7,404	564	7.6%	8,837
	2,283	2,056	(227)	-11.1%	20,150	19,645	(505)	-2.6%	26,145
Capital servicing									
Depreciation and amortisation	1,158	1,171	13	1.1%	10,197	10,328	131	1.3%	13,771
Financing	-	180	180	100.0%	777	1,524	747	49.0%	1,305
Capital charge	283	-	(283)	0.0%	3,467	3,138	(329)	-10.5%	6,605
	1,441	1,351	(90)	-6.7%	14,441	14,990	549	3.7%	21,681
	3,724	**3,406**	(318)	-9.3%	**34,590**	**34,635**	44	0.1%	**47,826**
Full Time Equivalents									
Medical personnel	0.3	0.3	(0)	-13.0%	0	0	(0)	-36.0%	0.3
Nursing personnel	12.2	14.8	3	17.2%	13	14	2	13.0%	14.5
Allied health personnel	0.9	0.4	(0)	-112.8%	0	0	(0)	-23.2%	0.4
Support personnel	9.4	9.6	0	2.4%	9	9	0	0.1%	9.4
Management and administration	142.2	142.9	1	0.4%	140	143	3	2.0%	142.9
	165.0	**168.0**	3	1.7%	**163**	**167**	5	2.7%	**167.5**

Personnel includes restructuring costs including recruitment. Financing and capital charges reflect the debt to equity swap. The swap is cost neutral with the variance from budget offset in income (see section 4).

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									
Contingency	(617)	(36)	582	1634.6%	(3,137)	45	3,182	7056.4%	639
Transform and Sustain resource	1	43	42	98.5%	130	481	350	72.9%	227
Other	48	39	(9)	-23.2%	148	508	359	70.8%	(226)
	(568)	**47**	615	1316.2%	**(2,858)**	**1,033**	3,892	376.6%	**640**

Contingency usage year to date includes:

- $1.4 million to offset IDF provisioning
- $1.0 million for costs relating to the gastroenteritis outbreak
- $0.3 million for costs relating to the RMO strike.

Contingency budgets transferred to operational costs reconcile as follows:

	$'000
Original contingency budget	3,000
Plus:	
Revenue banking	4,200
Less:	
Additional surplus agreed with MOH	-500
Feasibility studies	-600
Elective surgery delivery costs	-1,942

Melanoma and oncology treatments	-295
Additional resource for payroll and health records	-61
Remaining contingency budget ($3.0 million of general contingency, and $0.8 million T&S)	3,802

NB. All of the contingency has been released for the forecast.

9. Financial Performance by MOH Classification

$'000	March Actual	March Annual Plan	March Variance	Year to Date Actual	Year to Date Annual Plan	Year to Date Variance	End of Year Forecast	End of Year Annual Plan	End of Year Variance
Funding									
Income	40,944	40,978	(34) U	379,161	376,930	2,231 F	513,650	511,184	2,466 F
Less:									
Payments to Internal Providers	23,688	23,641	(47) U	207,807	207,289	(518) U	279,847	279,328	(518) U
Payments to Other Providers	18,214	19,305	1,091 F	170,669	170,511	(158) U	227,104	227,630	526 F
Contribution	**(958)**	**(1,968)**	**1,010 F**	**684**	**(870)**	**1,554 F**	**6,699**	**4,226**	**2,473 F**
Governance and Funding Admin.									
Funding	266	266	-	2,397	2,397	-	3,197	3,197	-
Other Income	3	3	-	22	23	(1) U	29	30	(1) U
Less:									
Expenditure	384	301	(83) U	2,363	2,672	309 F	3,393	3,573	180 F
Contribution	**(115)**	**(32)**	**(83) U**	**55**	**(253)**	**308 F**	**(167)**	**(346)**	**179 F**
Health Provision									
Funding	23,422	23,375	47 F	205,410	204,892	518 F	276,650	276,131	518 F
Other Income	2,086	1,614	471 F	15,211	15,465	(254) U	20,310	20,638	(329) U
Less:									
Expenditure	26,520	24,472	(2,048) U	221,074	217,170	(3,904) U	298,992	295,650	(3,342) U
Contribution	**(1,013)**	**517**	**(1,530) U**	**(453)**	**3,187**	**(3,640) U**	**(2,032)**	**1,120**	**(3,152) U**
Net Result	**(2,086)**	**(1,483)**	**(603)** U	**286**	**2,064**	**(1,778)** U	**4,500**	**5,000**	**(500)** U

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

10. Management Budget Movements

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

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

$'000	March Mgmt Budget	March Annual Plan	March Movement	Year to Date Mgmt Budget	Year to Date Annual Plan	Year to Date Movement	End of Year Mgmt Budget	End of Year Annual Plan	End of Year Movement
Funding									
Income	40,978	40,806	172 F	376,930	377,375	(445) U	511,184	511,803	(619) U
Less:									
Payments to Internal Providers	23,641	23,021	(620) U	207,289	203,897	(3,392) U	279,328	275,461	(3,867) U
Payments to Other Providers	19,305	19,620	315 F	170,511	173,293	2,781 F	227,630	231,341	3,711 F
Contribution	**(1,968)**	**(1,835)**	**(133) U**	**(870)**	**185**	**(1,055) U**	**4,226**	**5,000**	**(774) U**
Governance and Funding Admin.									
Funding	266	268	(2) U	2,397	2,414	(17) U	3,197	3,220	(23) U
Other Income	3	3	-	23	23	-	30	30	-
Less:									
Expenditure	301	271	(30) U	2,672	2,436	(236) U	3,573	3,250	(323) U
Contribution	**(32)**	**-**	**(32) U**	**(253)**	**-**	**(253) U**	**(346)**	**-**	**(346) U**
Health Provision									
Funding	23,375	22,753	622 F	204,892	201,483	3,409 F	276,131	272,241	3,890 F
Other Income	1,614	1,594	20 F	15,465	15,268	197 F	20,638	20,366	272 F
Less:									
Expenditure	24,472	23,994	(477) U	217,170	214,872	(2,298) U	295,650	292,608	(3,042) U
Contribution	**517**	**353**	**164 F**	**3,187**	**1,879**	**1,308 F**	**1,120**	**(0)**	**1,120 F**
Net Result	**(1,483)**	**(1,483)**	**0** F	**2,064**	**2,064**	**0** F	**5,000**	**5,000**	**0** F

11. Quality and Financial Improvement Programme

The purpose of this report is to give Finance, Risk and Audit Committee (FRAC) a monthly update on the identified quality and financial improvement savings (QFI) and progress year-to-date.

At the end of March we have achieved 75% of our year-to-date savings target (up from 74% at end of January).

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Corporate	1,526,792	1,145,094	1,086,704	95%
Health Services	8,292,287	6,219,216	4,550,734	73%
Population Health	26,166	19,625	19,625	100%
Maori	148,195	111,146	111,146	100%
Health Funding	3,006,808	2,255,106	1,558,500	69%
Grand Total	**13,000,248**	**9,750,186**	**7,326,708**	**75%**

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings
AMBER	**4,779,206**	**3,584,404**	**2,621,243**
Acute Medical	2,407,523	1,805,642	1,249,149
Business Intelligence	9,012	6,759	-
CEO	145,930	109,448	109,448
Depreciation	517,008	387,756	387,756
DON	10,587	7,940	-
FAC	22,652	16,989	7,596
Information Services	326,304	244,728	204,862
OPE	283,469	212,602	51,279
Surgical	676,082	507,062	425,394
WCY	380,638	285,479	185,760
RED	**2,121,625**	**1,591,219**	**263,725**
Human Resources	123,967	92,975	92,975
OPE	78,975	59,231	-
Strategic Services	1,153,808	865,356	168,750
Surgical	764,875	573,656	2,000
Grand Total	**6,900,830**	**5,175,623**	**2,884,968**

12. Financial Position

30 June		*March*				
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Annual Budget*
	Equity					
102,608	Crown equity and reserves	150,108	105,733	(44,375)	47,500	105,376
(10,973)	Accumulated deficit	(10,687)	(14,204)	(3,517)	286	(11,268)
91,635		139,421	91,529	(47,892)	47,786	94,108
	Represented by:					
	Current Assets					
15,552	Bank	26,550	6,799	(19,751)	10,998	8,523
1,724	Bank deposits > 90 days	1,755	1,741	(14)	31	1,741
22,433	Prepayments and receivables	16,353	18,522	2,169	(6,080)	18,618
4,293	Inventory	4,292	4,023	(269)	(1)	4,044
1,220	Non current assets held for sale	625	-	(625)	(595)	-
45,222		49,575	31,085	(18,490)	4,353	32,927
	Non Current Assets					
151,944	Property, plant and equipment	150,490	164,445	13,955	(1,454)	166,159
2,037	Intangible assets	1,731	813	(919)	(306)	665
9,777	Investments	10,430	9,192	(1,238)	653	9,476
163,758		162,652	174,450	11,798	(1,106)	176,299
208,980	**Total Assets**	**212,227**	**205,535**	**(6,692)**	**3,247**	**209,226**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
38,137	Payables	33,545	30,732	(2,813)	(4,592)	30,697
34,070	Employee entitlements	36,623	33,353	(3,270)	2,553	34,484
-	Current portion of borrowings	-	6,000	6,000	-	6,000
72,208		70,168	70,085	(84)	(2,039)	71,180
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,421	(216)	-	2,438
42,500	Term borrowing	-	41,500	41,500	(42,500)	41,500
45,138		2,638	43,921	41,284	(42,500)	43,938
117,345	**Total Liabilities**	**72,806**	**114,006**	**41,200**	**(44,539)**	**115,118**
91,635	**Net Assets**	**139,421**	**91,529**	**(47,892)**	**47,786**	**94,108**

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2015/16 result and the variance in the 2016/17 result year-to-date, the swap of the DHB's debt into equity on 15 February, and the $5 million equity injection for the mental health build;
- Bank and property, plant and equipment mainly reflect the lower capital spend;
- Non-current assets held for sale was adjusted for the reclassification of 307 Omahu Road to property, plant and equipment in November;
- Borrowing, both term and current, reflect the debt to equity swap.
- Employee entitlements – see below

13. Employee Entitlements

30 June		*March*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
7,466	Salaries & wages accrued	9,520	5,513	(4,007)	2,054	6,559
482	ACC levy provisions	1,380	744	(636)	898	851
5,348	Continuing medical education	5,909	5,855	(53)	561	5,131
19,149	Accrued leave	18,472	19,559	1,088	(677)	20,249
4,263	Long service leave & retirement grat.	3,981	4,103	122	(282)	4,131
36,708	**Total Employee Entitlements**	39,261	35,774	(3,486)	2,553	36,922

14. Treasury

Liquidity management

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

Debt management

The $42.5 million term debt facility with MOH was swapped into equity on 15 February 2017. The $5 million equity injection for the mental health build, was received in March. The DHB now has no interest rate exposure relating to debt.

Foreign exchange risk management

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

15. Capital Expenditure

See next page.

2017 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
14,440	Depreciation	10,197	10,328	131
5,000	Surplus/(Deficit)	286	2,064	1,778
(2,479)	Working Capital	40,310	(981)	56,149
16,961		50,793	11,411	58,058
	Other Sources			
-	Special funds and clinical trials	40	-	(40)
1,220	Sale of assets	-	1,220	(1,220)
5,000	Borrowings	(42,500)	5,000	(47,500)
6,220		(42,460)	6,220	(48,760)
23,181	**Total funds sourced**	**8,333**	**17,631**	**9,298**
	Application of Funds:			
	Block Allocations			
3,183	Facilities	1,698	2,437	739
3,125	Information Services	477	2,344	1,866
5,464	Clinical Plant & Equipment	1,966	4,045	2,079
11,772		4,141	8,826	4,685
	Local Strategic			
2,460	MRI	-	1,844	1,844
500	Renal Centralised Development	699	375	(324)
3,000	New Stand-alone Endoscopy Unit	1,047	2,249	1,202
710	New Mental Health Inpatient Unit Development	381	532	151
100	Maternity Services	131	75	(56)
400	Upgrade old MHIU	1,300	619	(681)
400	Travel Plan	167	300	133
400	Histology and Education Centre Upgrade	37	181	144
1,100	Fluoroscopy Unit	-	825	825
200	Education Centre Upgrade	-	(50)	(50)
9,270		3,763	6,950	3,187
	Other			
-	Special funds and clinical trials	40	-	(40)
1,000	New Technologies/Investments	-	1,000	1,000
-	Other	30	-	(30)
1,000		70	1,000	930
22,042	***Capital Spend***	***7,973***	***16,776***	***8,803***
	Regional Strategic			
1,139	RHIP (formerly CRISP)	360	855	495
1,139		360	855	495
23,181	**Total funds applied**	**8,333**	**17,631**	**9,298**

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	41,365	42,272	(908)	43,294	41,777	48,684	43,210	41,712	45,478	52,018	41,846	41,601	43,315	45,259	42,038
Cash receipts from revenue banking	-	4,200	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	5	-	5	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	7,612	489	7,123	443	450	446	426	425	427	492	432	439	428	448	455
Cash paid to suppliers	(28,066)	(27,439)	(627)	(26,783)	(24,181)	(29,820)	(27,144)	(25,118)	(27,069)	(24,932)	(25,223)	(25,825)	(24,761)	(21,644)	(25,812)
Cash paid to employees	(17,837)	(19,540)	1,703	(15,342)	(17,944)	(15,635)	(13,909)	(19,483)	(15,098)	(15,100)	(17,792)	(14,458)	(16,750)	(14,515)	(19,549)
Cash generated from operations	**3,078**	**(18)**	**7,296**	**1,611**	**102**	**3,675**	**2,582**	**(2,463)**	**3,738**	**12,478**	**(737)**	**1,758**	**2,233**	**9,549**	**(2,868)**
Interest received	89	75	14	73	75	73	81	80	67	66	80	72	75	68	75
Interest paid	-	0	(0)	(0)	(0)	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0	0
Capital charge paid	(283)	-	(283)	-	-	(5,403)	-	-	-	-	-	(5,421)	-	-	-
Net cash inflow/(outflow) from operating activities	**2,884**	**58**	**7,027**	**1,684**	**177**	**(1,655)**	**2,662**	**(2,383)**	**3,804**	**12,544**	**(657)**	**(3,591)**	**2,307**	**9,617**	**(2,792)**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	0	0	0	0	0	0	0	0	0	0	0	1,220	0	0	0
Acquisition of property, plant and equipment	(1,693)	(1,897)	204	(2,266)	(2,191)	(3,134)	(2,981)	(2,881)	(2,881)	(2,881)	(2,881)	(3,881)	(2,881)	(2,881)	(2,881)
Acquisition of intangible assets	(32)	(20)	(12)	(20)	(20)	-	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)
Acquisition of investments	-	(1,075)	1,075	(245)	-	(245)	-	-	(285)	-	-	(285)	-	-	(285)
Net cash inflow/(outflow) from investing activities	**(1,726)**	**(2,992)**	**1,267**	**(2,531)**	**(2,211)**	**(3,379)**	**(3,066)**	**(2,966)**	**(3,251)**	**(2,966)**	**(2,966)**	**(3,031)**	**(2,966)**	**(2,966)**	**(3,251)**
Cash flows from financing activities															
Proceeds from equity injection	5,000	-	5,000	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	(357)	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**5,000**	**-**	**5,000**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	6,159	(2,935)	9,093	(847)	(2,034)	(5,392)	(404)	(5,349)	553	9,578	(3,623)	(6,622)	(659)	6,651	(6,044)
Add:Opening cash	22,146	22,149	(3)	28,305	27,457	25,423	20,032	19,628	14,278	14,832	24,410	20,787	14,164	13,505	20,156
Cash and cash equivalents at end of year	**28,305**	**19,214**	**9,090**	**27,457**	**25,423**	**20,032**	**19,628**	**14,278**	**14,832**	**24,410**	**20,787**	**14,164**	**13,505**	**20,156**	**14,113**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	25,266	16,169	9,097	24,419	22,385	16,993	16,526	11,176	11,729	21,308	17,684	11,062	10,403	17,054	11,011
Short term investments (special funds/clinical trials)	3,033	3,042	(9)	3,033	3,033	3,033	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	1	(1)	2	1	1	1	-	-	-	-	-	-	-	-	-
	28,305	**19,215**	**9,090**	**27,458**	**25,424**	**20,032**	**19,628**	**14,278**	**14,831**	**24,410**	**20,786**	**14,164**	**13,505**	**20,156**	**14,113**

17. Outstanding Audit Recommendations Update

Outstanding audit recommendations are being attributed to EMT member and lead manager and status updated. Progress on recommendations will be reported into FRAC as separate agenda item monthly from May 2017. The aim will be to report until all items are closed.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Board Health & Safety Responsibilities** 37
	For the attention of: **HBDHB Board**
Document Owner:	Kate Coley, Executive Director Quality & People
Contributions from and reviewed by:	Ken Foote (Company Secretary); Gayle Harris (Health & Safety Advisor); and Helen Francis (Board H&S Champion)
Month:	April 2017
Consideration:	For Noting & Endorsement

11

RECOMMENDATION

That the Board:

- **Endorse** the recommendation to rotate the H&S Board Champion role across interested Board members
- **Note** the key pieces of work to be undertaken in the next 6 – 12 months

BACKGROUND

The role of the Board Health and Safety Champion was first established in April 2016 with the appointment of Helen Francis. The role was established following a review of the Board's responsibilities for Health and Safety with the new legislation and the resultant acknowledgement of Board member due diligence duties as Officers of the DHB. This requires members to have a good understanding of the hazards and risks existing within the business, and also to ensure that the DHB has appropriate resources and processes to monitor, manage, eliminate or minimise these risks.

The role generally provided for a Board Member to gain a more detailed understanding of relevant HBDHB health and safety issues, resources, processes and reports, and then provide an "independent" assessment of the accuracy and adequacy of these (as presented by management) and also liaise with appropriate managers on any issues of concern to the Board. This general role description was expanded in October 2016, when Helen tabled a document entitled "Communicating Health and Safety to the Board". This document (attached as Appendix 1) outlined the role of the Board Health and Safety Champion, as suggested by WorkSafe NZ.

REVIEW

As part of this six month review of Board health and safety responsibilities, it has been identified that the Board would be better placed to discharge their director responsibilities by rotating this role among more Board Members over the term of the Board, rather than having just the one Member fulfil the role for three years. By rotating the role this will expose more board members to health and safety issues at an operational level within the DHB and therefore significantly enhance their level of understanding and also provide the level of assurance required to meet their due diligence obligations. Depending on the number of Board members who could make themselves available for a rotational appointment into this role, each term would ideally be for a period of 6 months (dependent on interested parties) with a handover period (up to two months) to ensure continuity and the passing on of learnings and experience.

This review has also identified the potential for the Board Health and Safety Champion to express more personal observations and assessments when reporting back to the Board. The monthly standing agenda item also provides the opportunity for the health and safety champion to engage the whole Board in a way that will assist them generally with meeting their responsibilities and keeping health and safety issues to the fore, as a priority issue.

DIRECTORS GAP ANALYSIS

Under the Health & Safety Act the requirements of Directors of organisations are clearly defined and outlined. In light of this the DHB has undertaken an assessment of where the DHB is against those requirements utilising a tool called Safe365 and considering the WorkSafe & IOD Good Governance Guidance for Directors. The Safe365 Self-Assessment has been completed by Ken Foote, Gayle Harris and Kate Coley.

Safe365, allows the DHB to understand our capability and any gaps against best practice and the Health & Safety Act/Regulations. Safe365 has been developed by certified and experienced risk managers and aligns to best practices from a health and safety perspective. It is a cloud-based health & safety web application that quickly helps us to assess our health & safety status and provides practical solutions that enable us as an organisation to manage our health & safety responsibilities.

Safe365 generates a customised continuous improvement programme for the DHB, ensuring that we are healthy, safe and compliant, providing us with the ability to prioritise the health & safety programme of work, alongside the management and resolution of identified health & safety risks/hazards. It provides a safety index and innovative dashboard with a visual picture of where our strengths are and where we might potentially be exposed. The tool also provides over 300 resources such as videos, templates, resources and examples of how we can enhance our health and safety environment.

Within Safe365, Director Knowledge is a core module with a number of subsections as outlined in Appendix 2. Appendix 2 outlines those subsections, the DHBs current self-assessment and provides more detail around the actions to be undertaken.

In summary the core activities that will be undertaken in the next 6 – 12 months are as follows:

- Development of a formal Board orientation / induction programme
- Review of Health & Safety Policy & Charter
- Develop Board briefing documents e.g. industry specific requirements, incident reporting methodology
- Embed the role of H&S Board Champion
- Undertake internal audit of H&S System and 365 Self-Assessment
- Update all position profile templates to include H&S requirements
- Update all Executive Director position profiles to include relevant requirements

Appendix 1 – H&S Board Champion & H&S Advisor Roles

ROLE OF A NON-EXECUTIVE WORKER	ROLE OF THE BOARD HEALTH & SAFETY CHAMPION
Prepare or co-ordinate the preparation of relevant health and safety information to be submitted to the board.	Ensure that a copy of the information has been received prior to the board meeting and has been included in the 'pack' of information for the board.
Present routine reports to include: • Data on all incidents, including near misses, work related ill-health, compliance with health monitoring programmes and injury claims • Data on absence rates due to sickness as this can be an indicator of stress/fatigue • Data on trends, including routine exposure to risks that are potentially harmful to health e.g. high noise levels, chemicals, bullying etc • Progress towards implementing formal improvement plans and meeting policy goals – including the number of actions closed out on time • Actions in place aimed at preventing harm, such as training and maintenance programs • The health and safety performance and actions of contractors • Reports on internal and external audits and system reviews • Data on pro-active safety visits such as safety tours and workplace inspections.	Post-presentation of the data. Discuss with board members. Take back to non-executive any concerns, where more data is required or general feedback from the board (as appropriate). Advise any change to structure of the provision of the information. Prepare correspondence to Executive Managers where the board has any concerns with the results of the data presented. Monitor any actions plans as a result.
Present any actions plans in relation to improving safety 'culture' or safety 'performance'.	Monitor these action plans for completion. Identify any concerns with compliance.
Provide any other data as requested by the board.	Ensure information being presented addresses all of the board's requests.

Appendix 2 – Full Assessment of HBDHB against Director Knowledge Module (Safe365)

Area	Description	Current Status – Internal Self-Assessment	Actions & Activities
Induction	Inductions are a formal process of bringing directors up to speed with the organisation's health & safety environment. All directors must have a working knowledge of the organisation's health & safety environment.	*Some – informal Only* There are some examples of H&S inductions for directors, but the process is not necessarily documented or applied consistently	Develop a formal orientation and induction programme & information pack for Board Directors
Risk Expertise	Risk management expertise is invaluable as directors with an increased knowledge & understanding of this discipline will be able to contribute more effectively to the organisation's risk management planning	*Some – Trained* One or more directors has gained some risk management expertise through participation in a short course / seminar	Ensure confirmation and documentation available for external audit Consider opportunity for refresher training when new Board members join the organisation as part of induction
Meeting Agenda	A permanent agenda item is an item that occurs at every meeting. Reports may include health & safety reporting such as data on all incidents, changes to existing risk controls, reports on internal & external audits.	*Consistent Updated Report* There is a permanent agenda item for health & safety at each director meeting. The discussion is minuted & any action items recorded & communicated to the person responsible for implementing such actions. Supported by a consistent report of key health & safety data (such as near-miss incidents, minor incidents, and major incidents).	Maintain reporting structure to FRAC and ensure H&S Board Champion reports their observations through Board meetings.
Advice	It is important that directors consider taking independent advice on the quality of the health & safety programme to ensure the integrity of their health & safety environment & gain assurance that the organisation is meeting legislation, regulations, standards & codes that may apply.	*Some Advice – Undocumented (at times)* There are some examples of the directors taking independent advice on the quality of the health & safety environment. The advice was provided by someone with a health & safety and/or risk certification, but the advice was not necessarily consistently documented.	Continue to seek independent advice as and when necessary. Undertake an audit of the DHBs self-assessment at year end. Ensure H&S reviews are part of the Internal Audit plan. Continue to undertake ACCPP audits and Certification Audits.

Legislation Expertise	All directors have an understanding of their due-diligence requirements so they can ensure they meet their duties in practice.	*All – Some Understanding* All directors have some level of understanding of their duties under the legislation.	Provide a briefing document as a reminder to Directors on a regular basis
Industry Expertise	In addition to legislation, different industries often have specific health & safety requirements such as a regulation and/or code of practice. Directors need to have a good understanding of these industry-specific requirements.	*All – Some understanding* All directors have some level of knowledge of any relevant industry-specific health & safety requirements for our organisation.	Provide some guidance / briefing to Board on any specific health industry health and safety requirements.
Director Engagement	Directors must maintain a strong understanding of the operations of the PCBU & the impact of those operations on health & safety. The level of direct director involvement will vary depending on the size, scope & structure of your organisation.	*Some involvement, Ad hoc* There are examples of one or more directors taking practical steps to understand health & safety, such as a site visit, but this is on an ad-hoc basis.	H&S Board champion role – recommendation to rotate the role H&S Board Champion to attend H&S Committee Ensuring that all Board members are involved in reviewing H&S policy and organisational risk registers. Ensuring that all board members are provided with information and reports and actively contributing to the shaping of those to achieve a level of confidence that health and safety requirements are being fulfilled Board H&S Champion to observe and monitor the culture of the organisation in relation to worker engagement in health and safety and report those observations back to the Board

CONSUMER STORY

12

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 38
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs
Reviewed by:	Not applicable
Month:	April, 2017
Consideration:	For Information

13

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Endorsed** the next phase with the implementation of a Clinical Council Governance Structure and the development through those committees and their relevant advisory groups of a new clinical council dashboard.

- **Noted** the following reports & papers:
  - Health & Social Care Localities update
  - Rheumatic Fever update
  - Te Ara Whakawaiora – acute cardiovascular national indicator report
  - HB Radiology Service Committee Report
  - Laboratory Services Committee Report

Council met on 10 April 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following reports were tabled and discussed:

Implementation of the HB Clinical Governance Committee structure

Clinical Council considered the paper outlining the proposed advisory group structure, proposed Chairs and the next steps. A significant amount of work had been undertaken to get to this stage, however implementation now needs to occur within a short period of time. It was reinforced that this is a clinical governance structure and there are many other structures within the organisation and wider health sector that have management/operational responsibility that do not fit the definition of clinical governance. There is a risk trying to bring everything into this one structure and over time some of the advisory groups may not be appropriate to remain under this structure, when their terms of reference (TOR) are reviewed against the definition of clinical governance. (Definition: "*the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks and fostering an environment of excellence in care for consumers, patients, community*").

As part of the implementation it was agreed that the Clinical Committees with their relevant advisory groups would identify their KPIs and targets in relation to patient safety and quality of care and that these would inform an overarching clinical council quality dashboard which would be finalised in July and thereafter reported to Clinical Council and FRAC on a quarterly basis.

Clinical Council endorsed the next phase with the implementation of a Clinical Council Governance Structure and the development through those committees and advisory groups of a new clinical council dashboard

Establishing health & social care localities in Hawkes Bay

Paper was presented summarising the work that is underway in the seed localities (Wairoa and Central Hawke's Bay). Strong foundations are being built for the work to come in the networks around relationship building and trust between providers. Challenges noted include where authority is placed, connection between the district wide strategic plans and the locality based plans, models of change being responsive to the diverse approach while getting commonalities and recognising skills that may or may not exist and how the "back bone functions" (planning, contracting, analysis and reporting) will be supported.

The report was noted and the Clinical Council is happy with the work completed to date and the approach being taken.

Te Ara Whakawaiora / Cardiology (national indicator)

This report is on access to urgent cardiograms. The issues with data collection have been sorted out however there is an ongoing challenge with access to urgent angiograms within three days. Part of the challenge is that the bulk of these are done in Wellington with issues relating to transport delays and costs, and access to beds in Wellington. Regarding angiograms done locally, there are only two regular angiography sessions per week and it is expensive to use locums and other resources to sustain a third session. The regional cardiology network has recommended to the regional CEOs that Hawke's Bay and Palmerston North should both look at potential for local provision of this service within the next 3-4 years. This will be investigated as part of the work around the clinical services plan and future model of care for acute cardiology.

Clinical Council noted this update.

Rheumatic Fever target 2016-17

An update was provided to Clinical Council advising that at this point HBDHB will not meet the target for 2016/17 due to small numbers of new cases that arose from areas outside the current targeted programme, which was working well. In addition the Ministry of Health funding for the programme will change from 30 June 2017 and the funding for the primary care "Say Ahh" throat swabbing programme will discontinue from December 2017. A brief discussion was held around importance of housing and how this affects wellness and noting the work being undertaken under the healthy housing coalition. The healthy homes strategy is being reviewed with a greater focus on housing supply, particularly rental housing in Hawke's Bay.

The Clinical Council noted the contents of the report.

HB Nursing Midwifery leadership council update and dashboard

David Warrington, Chair of the Hawke's Bay Nursing and Midwifery Leadership Council noted five key points:

- A full audit of members and tenure of the Leadership Council is to be undertaken as some members are over their 2-year tenure
- Inclusion in the report of the nursing and midwifery dashboard – work in progress and links to the nursing and midwifery strategic plans

- The NZNO employment survey results and the themes which came from that survey are an accurate reflection of what is happening in the DHB on how our nurses feel
- MECA negotiations – it was felt that it was imperative that as part of the MECA negotiations that there was strong engagement with the senior nurse workforce
- International Nurses and Midwives Day 2017 – to be moved to a bi-annual ceremony, but will still be celebrated at team/service level yearly.

Others reports provided for information and discussion included:

- **Collaborative pathways**

Noted the contents of the report

- **HB Radiology Services Committee**

Noted the contents of the report.

- **Laboratory Services Committee**

Noted the contents of the report.

- **Falls Minimisation Committee Update**

Noted the contents of the report.

- **Consumer Experience Feedback Results – Q2 2016/17**

Noted the contents of the presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**	39
	For the attention of: **HBDHB Board**	
Document Owner:	Ngahiwi Tomoana (Chair)	
Reviewed by:	Not applicable	
Month:	April 2017	
Consideration:	For Information	

14

RECOMMENDATION

That the Board

Note the contents of this report.

MRB met on 12 April 2017, an overview of issues discussed and recommendations at the meeting are provided below.

The following reports and papers were discussed and considered:

MĀORI REPRESENTATION IN THE WORKFORCE

MRB discussed the local health target of Māori employed at HBDHB. The MRB were concerned with the low number of Māori employed and suggested the target of 13.75 percent has been set too low and the DHB should consider lifting the target. The MRB were informed that the DHB have a Māori workforce recruitment steering group, recruitment plan and related activities in place that the MRB can review and analyse.

To support oversight of Māori workforce representation, MRB requested they are provided, at either May or June meeting, with:

1. Statistics on percentages of all ethnicities being employed at the DHB;
2. a brief update of feedback from exit interview of Māori staff including the position/income level data;
3. the Māori workforce recruitment plan to review and analyse; and
4. the Māori workforce target be lifted to 25 percent over the next 5 years

HEALTH & SOCIAL CARE LOCALITIES UPDATE

MRB noted the contents of the report and discussed at length the possibility of sending a Wairoa representative to the NUKA training in Alaska later in 2017. Considering that Wairoa is somewhat isolated, having the ability to develop expertise further would be beneficial to the community. It is evident the DHB has trust within the community and taking a leadership role would strengthen that trust. However, it was confirmed by the GM Māori Health that all travel, including Alaska has been put on hold by the DHB given the current financial position. It was further confirmed that population health profiles have been developed for Wairoa and Central Hawke's Bay to ensure we are delivering what communities need and that the corporate office are currently thinking about enabling services to support these localities.

MRB requested further discussion take place, between GM Māori Health and Chrissie Hape (NKII), regarding the possibility of a Wairoa representative attending NUKA training and bring an update to the next MRB meeting in May 2017.

TE ARA WHAKAWAIORA: CARDIOVASCULAR (NATIONAL INDICATOR)
MRB noted the contents of the report and was supportive of the work being undertaken. The GM Māori advised and confirmed that the smaller variance in the graphs is due to the smaller numbers creating larger percentage variances.

It was proposed that the Angiograms indicator challenges remain due to the service provided in Wellington and not locally.

OURHEALTH HAWKE'S BAY Whakawateatia	**Update on Establishing Health and Social Care Localities in Hawke's Bay** 40
	For the attention of: **HBDHB Board**
Document Owner:	Tracee Te Huia (Executive Director of Strategy and Health Improvement)
Document Author:	Jill Garrett (Primary Care Strategic Services Manager)
Reviewed by:	Paul Malan (Acting General Strategic Services Manager); Te Pare Meihana (Change Leader Wairoa Locality), Executive Management Team, Māori Relationship Board and HB Clinical Council
Month:	April 2017
Consideration:	For Information

16

RECOMMENDATION

That the HBDHB Board

1. Note the contents of this report.

PROGRESS TO DATE ON LOCALITY DEVELOPMENT

Work is underway to establish Health and Social Care Localities in Central Hawke's Bay and Wairoa. The work in both localities is progressing well, and each are well placed to embed the initiatives that are currently underway and those being scoped. The Change Leadership roles are proving effective in growing the locality stakeholder membership, trust in the processes that are being followed and building effective relationships across the sector providers, both in health and the wider social sector.

Each locality has worked within a co-design, consumer driven approach. Projects have begun that address priority areas identified within health needs assessment, equity reporting and consumer consultation findings.

The range of initiatives are diverse within each of the localities. Where appropriate, direct links are made to contributing to existing DHB initiatives that are focused on rationalising the use of resources.

The benefits of attending the NUKA training in November last year is evident in the momentum that is growing within each of the localities. The confidence in where the process can lead and the autonomy of design is intrinsic to the NUKA model.

Strategic Leadership Established

In both Wairoa and Central Hawke's Bay, a DHB-sponsored Change Leader role has been established and they have the confidence of their multiple and diverse stakeholder groups.

The Change Leaders have worked within existing networks to establish and or strengthen provider networks, which have included both the health sector and wider social and local government agencies.

Confidence in their abilities in relationship management, project management and as change agents who can effectively manage the challenges that the locality work presents, is evident in the progress to date that has been made in each locality.

Activities and Progress in each Locality:

CENTRAL HAWKE'S BAY (CHB)

The Strategic Plan developed by the CHB Health Liaison Group (HLG) has provided a good foundation for prioritising ideas that present to the group on health reform for the area. The four areas aligns current work to the following mission statements of the locality:

- Reducing barriers to access
- Establishing and maintaining effective communication lines
- Facilitating a dynamic workforce
- Strengthening trust between providers

Locality strength continues to grow through the trust that is building amongst the local providers and HLG members. The HLG are working under a collective impact model (see Appendix 1 for an overview). Assessment against the model illustrates strength in Governance and Infrastructure. More work needs to be done in Community Involvement and Evaluation and Improvement before they can be confident in moving towards phase 2 – impact and action.

The HLG are working towards developing principles, similar to those of NUKA that reinforce the branding logo of "Living Well in CHB". The focus will be building an expectation of what wellness looks like at home, in the workplace, in the community and recovering and managing your own health in times of acute illness

CHB initiatives currently underway are:

- Contributions to 'Saving 4000 bed days'**:** the Change Leader is brokering the process by which transitioning of care to CHB is activated based on agreed levels of acuity. The model is proactive rather than only activated when Hastings Hospital is in crisis. Evidence is being gathered to monitor bed utilisation rates as well as looking ahead to readmission rates. The thinking behind this is patients managed closer to home will have:
    - increased confidence in self-management;
    - fewer acute episodes; and
    - lower readmission rates.

- CHB Workforce Wellness Package. This involves working with Silver Fern Farms, Workforce NZ, The DHB Health Promotion team and Central Health to design and implement a wellness package of care that would reinforce "Living Well in Central Hawke's Bay" brand. It would be informed by successful work place models currently in operation in other large employers in the wider Hawke's Bay district.

- Communication and signage using the DHB "Choose Well" branding. Currently the Change Leader is working through issues specific to the locality. Adequate signage has been a request of the community for some time in relation to access to urgent care and after hours care.

- Broadening the membership of the Health Liaison Group. Membership now includes representation from the GPs of Tukituki Medical. Pharmacy have also signaled interest in being part of the group. Current membership includes: Local Government – Deputy Mayor, Consumer Council, MRB, Māori Health Provider, CHB Health Centre Operations Manager, Mayoral leadership forum, Aged Residential Care, CHB Māori Iwi representative, Nursing leadership, PHO and DHB.

CHB initiatives currently being scoped;

- A whānau wellness model, focusing on 10 whānau to demonstrate how to improve health collaboration and connected care across providers (moving towards a whānau ora approach

and the eventual utilisation/support of shared care record)

- Using ideas from the NUKA model to improve consumer voice in the design and evaluation of current service provision, "Consumer Circles" are being set up to provide context on current issues brought to the attention of the HLG. The first was palliative care. The second will be access to primary care.

WAIROA

The Locality Leadership team is formed and has a wide membership representative of the community approach to this development. The structure of the locality framework includes information and design teams' in the following;

- Consumer/whanau – are involved as partners in co-design processes using a NUKA system approach. Wairoa stakeholders who attended the NUKA training agreed to the benefits adopting this system of change to support the development of the locality as the way forward to improving health and social outcomes for the community.
- Clinical Governance – responsible for developing and monitoring implementation of clinical pathways of care
- Whānau Oranga – responsible for establishing an integrated model for addressing social issues within whānau using the Tairawhiti children's team Director as an advisor to the process.
- Pakeke – responsible for ensuring any design processes include marae, hapū and iwi, provide tikanga oversight to the developments.
- Rangatahi – responsible for concept testing any design changes from a rangatahi perspective. Feed in to the developments and oversee decision making processes to ensure the rangatahi voice has been heard.
- Integration staffing forums – will be provided with regular communications and ability to support work streams and provide feedback to any developments as they are occurring.

Wairoa activities currently underway are:

- An initial co-design workshop to understand the collective journey towards improving community and whānau outcomes in Wairoa has been held. Outcomes of the day included a vision statement and set of values and a draft set of community outcomes linked to the health and social care aspects for the Wairoa community. Next steps to be confirmed.
- A proposal to create a single general practice is currently being considered by the DHB and if this is approved will provide a new beginning for primary care in Wairoa. A single practice provides a platform to address many of the challenges smaller practices currently face and the Model of Care will be further explored as a priority project of the locality work streams.
- The Change Leader is currently working with Kahungunu Executive on three main areas – integration opportunities internally and across its three business units, implementation of a single point of entry for Whānau Ora, organisational culture development and contracts and reporting review.
- Wairoa continues to build on local integration and collaborative activities as well as progress more strategic developments under the Health and Social Care framework.

The locality has progressed the following:

- The co-location of services on the Health Centre site. Including Māori healing services and other natural therapies.
- A close working relationship between the three general practices and the two year general practice alliance contract with Health Hawkes Bay.
- The inter-sectoral E Tu Wairoa Family Violence Network.
- Establishing professional roles that work across primary care and interface with secondary care

e.g. Rural Nurse Specialist, Clinical Pharmacy Facilitator and Social Worker

- Planning to align district nursing with primary care
- Integrated diabetes management between primary and community services
- Integrated Clinical Governance committee.

Wairoa initiatives currently being scoped:

- Links have been made with the asset mapping process undertaken by Victoria University for Ngati Pahauwera
- Review of the Health Needs Assessment Report and aligning its recommendations with the strategic plan of the locality
- A briefing paper and business model to be prepared for EMT/Board re scoping of the single general practice model that has been reworked.
- Relationships forged with Social Investment Initiatives - Tairawhiti Children's Team and MSD Leadership

EMERGING CHALLENGES

The work in both of the localities is progressing well, and each are well placed to embed the initiatives that are currently underway and those being scoped. Some emerging challenges include:

- Creating natural synergies between district wide and local strategies without compromising the principles and objectives of both. i.e formal mechanisms that link REDS[1] and SIS[2] with the Change Leaders in each locality.
- The role of the Change Leaders in intrinsically linking and influencing strategic plans and models at a district level without compromising individual strategies being developed at a local level.
- CHB have chosen Collective Impact (see Appendix 1) as its change methodology, however Wairoa will have different priorities. No one methodology should be used to drive the strategy of each locality. The selection and inclusion of what fits each will be key in maintaining local ownership of the process whilst achieving district wide outcomes.
- Building the confidence in the process requires dedicated resource. This is currently being identified as projects are developed. Formalising the process of resource allocation will be required in the future through new investment.
- "Back bone functions" (planning, contracting, analysis, reporting, etc.) are needed to support the work as it develops. Establishment of these functions will assist in avoiding duplication of resources, however a degree of autonomy is needed to create local ownership of outcomes.
- The quality assurance and research and development functions that will need to be in place to ensure best practice must be supported throughout the locality development and sustained over time.

[1] Regional Economic Development Strategy

[2] Social Inclusion Strategy

STRATEGIC DEVELOPMENT OF HAWKES BAY LOCALITIES:

In looking beyond CHB and Wairoa, three key questions have emerged that will require significant discussion and resolution before the wider strategy is developed and implemented further. These questions are:

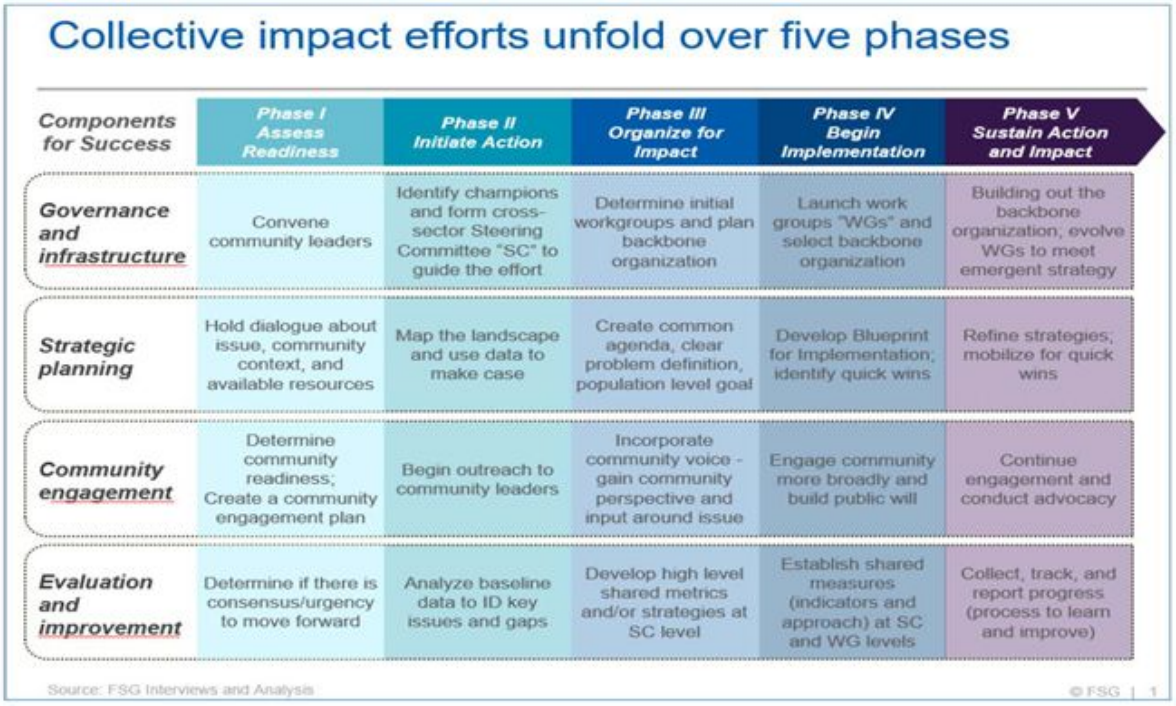
- Is health best placed to act as the lead agency in the development of health and social care localities?
- What are the mechanisms that will ensure the success of the locality work both district wide and locally?
- What form will research and development take and how will it be supported?

Answers to these questions will only be obtained through working with our community partners and other agencies in a collaborative way, and by identifying and implementing resources and processes that will enable the desired outcomes to be achieved. Answering them will also require a style of leadership that encourages bold thinking, tough conversations and experimentation. Evaluation and quality assurance will need to reflect this by looking for the planned and unplanned outcomes of the locality work. A balance therefore will need to be reached in identifying outcomes (success indicators) that both reassure and challenge the work that is being done in this space.

APPENDIX 1: THE COLLECTIVE IMPACT MODEL

The roles and responsibilities that fall out of a collective impact model – to support the work on the ground are outlined in diagram 1.0 below.

Diagram 1.0 – The Four Tiers of Collective Impact



At varying stages throughout both the locality development and the development of individual projects within each locality differing levels of input from a variety of roles will be required.

HAWKE'S BAY
District Health Board
Whakawāteatia

BENEFITS FROM INVESTMENT IN MENTAL HEALTH SERVICES REDESIGN

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Report from the Target Champion for Cardiovascular Disease** 42
	For the attention of: **HBDHB Board**
Document Owner:	John Gommans, Chief Medical Officer
Document Author(s):	Paula Jones (Service Director) and Gay Brown (CNM Cardiology Services)
Reviewed by:	Health Service Leadership Team & Executive Management Team, Māori Relationship Board and HB Clinical Council
Month:	April, 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

Note the contents of this report.

18

OVERVIEW

This report is from Dr John Gommans CMDO-Hospital and champion for the acute cardiovascular indicators. The report focuses on the two acute coronary syndrome (ACS) indicators, which were introduced as indicators of District Health Board (DHB) performance by the Ministry of Health in 2013/14 - high risk ACS patients accepted for angiogram within three days of admission and ACS patients who have completed data collection.

Priority	Indicator	Measure	Champion	Reporting Month
Cardiovascular	• Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. • Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	April 2016

There continues to be positive result with the HBDHB and all DHBs within the central region meeting these target indicators.

WHY IS THIS INDICATOR IMPORTANT?

Acute coronary syndromes are an important cause of mortality and morbidity in patients admitted to hospital, which can be modified by appropriate and prompt intervention including urgent angiography (within 3 days) for those identified as at high risk.

To provide a national consistent reporting framework, all regions are required to report measures of ACS risk stratification and time to appropriate intervention using ANZACS-QI system for data collection. HBDHB commenced using the ANZACS-QI system in September 2013. The DHBs actively monitor these two indicators of concern.

REGISTRY DATA COLLECTION INDICATOR

Regional Data – up to Quarter 2, 2016/17

% of all patients presenting with ACS who undergo coronary angiography and have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

Quarterly ANZACS QI KPI Detailed Report

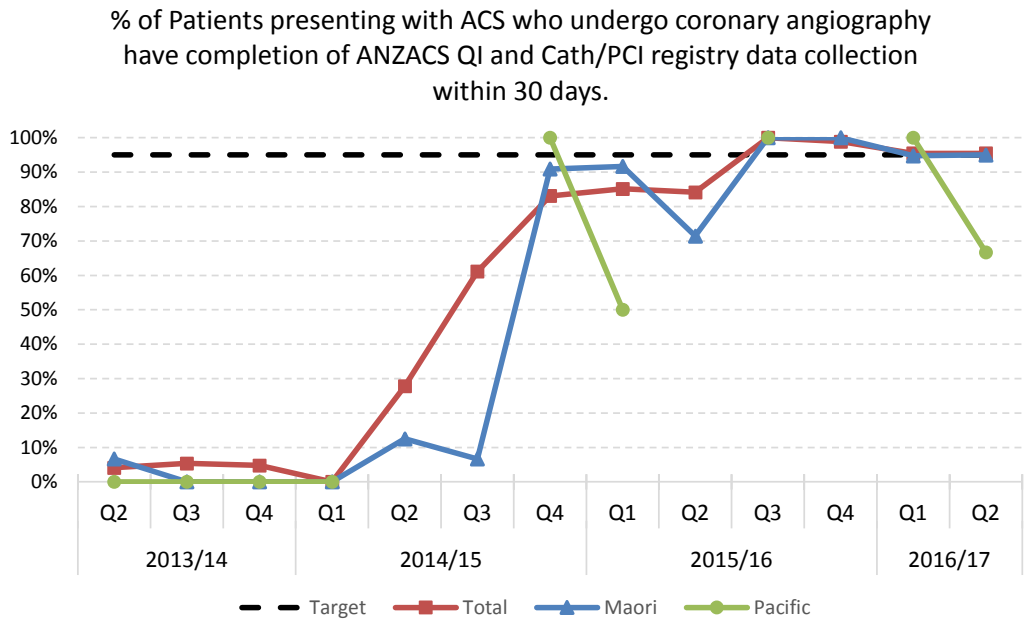
Registry Completion Quarterly Report - Jan 2017

Central Region DHBs

Period *	Central Region DHB Performance							Regional Performance				National Performance
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI	Northern	Midland	Central	Southern	
2015/2016 Q1 (Jun 2015 - Aug 2015)	68/68 (100.0%)	74/74 (100.0%)	47/47 (100.0%)	66/68 (97.1%)	64/66 (97.0%)	16/16 (100.0%)	21/21 (100.0%)	708/727 (97.4%)	407/414 (98.3%)	356/360 (98.9%)	497/542 (91.7%)	1968/2043 (96.3%)
2015/2016 Q2 (Sep 2015 - Nov 2015)	82/83 (98.8%)	83/83 (100.0%)	52/52 (100.0%)	52/53 (98.1%)	59/69 (85.5%)	16/16 (100.0%)	24/24 (100.0%)	691/712 (97.1%)	394/399 (98.7%)	368/380 (96.8%)	533/543 (98.2%)	1986/2034 (97.6%)
2015/2016 Q3 (Dec 2015 - Feb 2016)	75/75 (100.0%)	82/82 (100.0%)	43/43 (100.0%)	81/81 (100.0%)	66/66 (100.0%)	15/15 (100.0%)	33/33 (100.0%)	735/751 (97.9%)	427/436 (97.9%)	395/395 (100.0%)	495/500 (99.0%)	2052/2082 (98.6%)
2015/2016 Q4 (Mar 2016 - May 2016)	104/105 (99.0%)	88/89 (98.9%)	40/40 (100.0%)	61/61 (100.0%)	44/44 (100.0%)	23/23 (100.0%)	22/22 (100.0%)	703/732 (96.0%)	434/442 (98.2%)	382/384 (99.5%)	518/531 (97.6%)	2037/2089 (97.5%)
2016/2017 Q1 (Jun 2016 - Aug 2016)	82/82 (100.0%)	84/88 (95.5%)	52/53 (98.1%)	70/72 (97.2%)	60/65 (92.3%)	15/15 (100.0%)	32/33 (97.0%)	749/776 (96.5%)	475/492 (96.5%)	395/408 (96.8%)	471/483 (97.5%)	2090/2159 (96.8%)
2016/2017 Q2 (Sep 2016 - Nov 2016)	102/103 (99.0%)	84/88 (95.5%)	46/46 (100.0%)	78/78 (100.0%)	43/55 (78.2%)	22/22 (100.0%)	30/31 (96.8%)	603/719 (83.9%)	413/538 (76.8%)	405/423 (95.7%)	513/562 (91.3%)	1934/2242 (86.3%)

Quarter containing the date of admission signifying the start of each episode of care; Number (%) with both complete Cath Lab and ACS forms (Target is >95%); Denominator: Cath Lab patients with "STEMI<12h" or "other suspected/confirmed ACS" who have coronary angiogram.

Hawke's Bay Data – by ethnicity, up to Quarter 2, 2016/17



Hawke's Bay Data – by ethnicity, for Quarter 3 (Dec 2016 - Feb 2017)

% of all patients presenting with ACS who undergo coronary angiography and have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

	Maori	Pacific	Indian	Asian	Eur/Oth
Hawke's Bay	12/12 (100.0%)	2/2 (100.0%)	0/0 (100.0%)	0/0 (100.0%)	60/60 (100.0%)

Summary

There has been significant improvement since interventions to address this target were first put in place in 2015. Satisfactory performance against the indicator has been sustained for the last year with Hawke's Bay meeting the >95% target for Maori and the total population for five consecuitive quarters.

ACCESS TO ANGIOGRAMS INDICATOR

Regional Data – up to Quarter 2, 2016/17

% of all patients with high risk ACS Who Receive an Angiogram within 3 days of Admission (data upto Quarter 2 20016/17).

Quarterly ANZACS-QI KPI Detailed Report

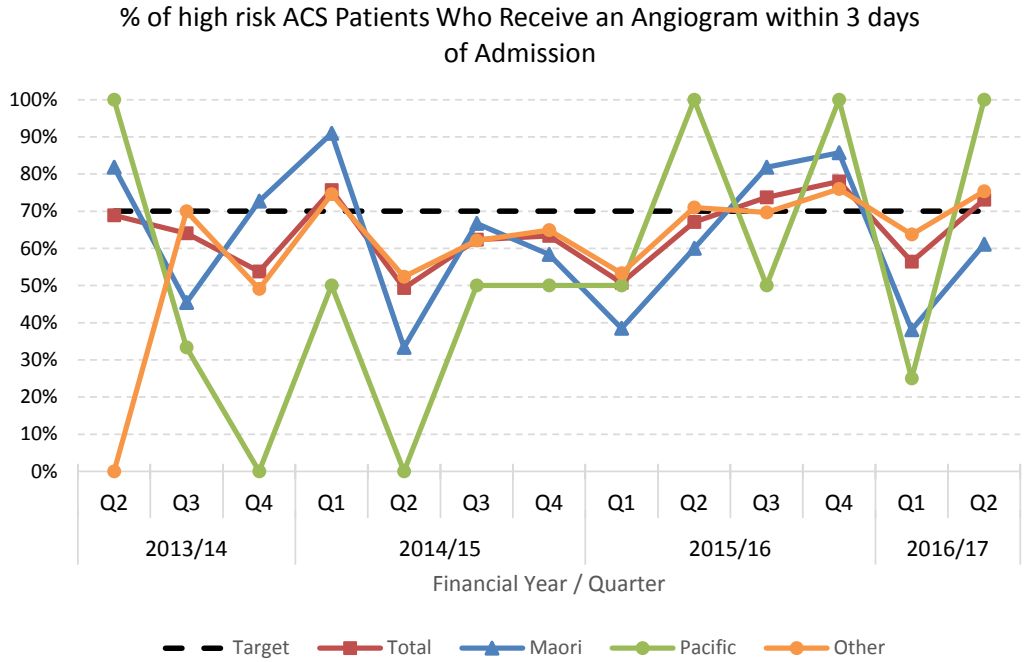
Door to Cath < 3-Days Quarterly KPI Report by DHB - Jan 2017

Central Region DHBs

Period	Central Region DHB Performance							Regional Performance				National Performance
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI	Northern	Midland	Central	Southern	
2015/2016 Q1 (Jul 2015 - Sep 2015)	65/73 (89.0%)	38/76 (50.0%)	41/51 (80.4%)	52/69 (75.4%)	59/67 (88.1%)	11/19 (57.9%)	13/21 (61.9%)	557/707 (78.8%)	272/408 (66.7%)	279/376 (74.2%)	472/557 (84.7%)	1580/2048 (77.1%)
2015/2016 Q2 (Oct 2015 - Dec 2015)	76/83 (91.6%)	57/85 (67.1%)	32/50 (64.0%)	46/58 (79.3%)	62/68 (91.2%)	11/13 (84.6%)	14/27 (51.9%)	628/767 (81.9%)	284/435 (65.3%)	298/384 (77.6%)	440/513 (85.8%)	1650/2099 (78.6%)
2015/2016 Q3 (Jan 2016 - Mar 2016)	78/86 (90.7%)	56/79 (70.9%)	41/43 (95.3%)	58/78 (74.4%)	54/58 (93.1%)	18/21 (85.7%)	23/32 (71.9%)	577/727 (79.4%)	324/457 (70.9%)	328/397 (82.6%)	451/530 (85.1%)	1680/2111 (79.6%)
2015/2016 Q4 (Apr 2016 - Jun 2016)	88/98 (89.8%)	71/91 (78.0%)	38/46 (82.6%)	49/59 (83.1%)	42/43 (97.7%)	16/21 (76.2%)	22/30 (73.3%)	560/725 (77.2%)	321/435 (73.8%)	326/388 (84.0%)	417/504 (82.7%)	1624/2052 (79.1%)
2016/2017 Q1 (Jul 2016 - Sep 2016)	82/87 (94.3%)	53/94 (56.4%)	33/46 (71.7%)	56/78 (71.8%)	72/73 (98.6%)	13/17 (76.5%)	16/28 (57.1%)	601/800 (75.1%)	385/497 (77.5%)	325/423 (76.8%)	456/526 (86.7%)	1767/2246 (78.7%)
2016/2017 Q2 (Oct 2016 - Dec 2016)	94/105 (89.5%)	68/93 (73.1%)	34/39 (87.2%)	59/80 (73.8%)	56/58 (96.6%)	18/23 (78.3%)	15/25 (60.0%)	551/701 (78.6%)	402/536 (75.0%)	344/423 (81.3%)	432/497 (86.9%)	1729/2157 (80.2%)

The dates are based on the dates of admission. Number (%) of all ACS patients where door to cath time is between -2 to 3 days. Target is 70%. Those with < -2 days are excluded from numerator but included in denominator.

Hawke's Bay Data – by ethnicity, up to Quarter 2, 2016/17



Hawke's Bay Data – by ethnicity, for Quarter 3 (Dec 2016 - Feb 2017)

% of patients with high risk ACS who receive an angiogram within 3 days of admission

Total	Maori	Pacific	Indian	Asian	Eur/Oth
68/93 (73%)	11/18 (61.1%)	2/2 (100%)	1/1 (100.0%)	0/0 (0.0%)	54/72 (75%)

Summary

While Hawke's Bay met the overall >70% target for the total population in the second and third quarters of 2016-2017, consistently maintaining compliance and across all ethnic groups is challenging as many of these interventions (about two thirds) are delivered by specialist services based at Wellington Hospital with associated delays for patients admitted to Hawke's Bay Hospital regarding transport and access to regional beds.

For Maori, in the 2016-2017 year, progress is being made with improvement from 40% in Quarter 1 to 61% in Quarter 3, which is still below the 70% target. Due to small numbers there is also wide variation in the results of the non-European ethnicity groups. For Maori in quarter 3, just two cases would have resulted in a >10% improvement in result and achievement of the target.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR?

Regarding the Registry Data Collection Indicator; Hawke's Bay has continued its satisfactory performance against this indicator for the last year, consistently meeting the >95% target for both Maori and the total population. The actions that were instituted two years ago will continue and ensure that we sustain this.

Regarding the Access to Angiograms Indicator; Hawke's Bay has struggled to consistently meet this target for both Maori and the total population. Many of these interventions (about two thirds) are delivered by specialist services based at Wellington Hospital with associated delays regarding transport and access to regional beds for Hawke's Bay patients.

Strategies already in place to improve local compliance include an additional local angiography list (now three times per week) and improved communication between CCDHB and HBDHB to support timely transfers of patients. In addition locum Cardiologists have been and will continue to be employed to complete additional angiography sessions.

In 2016 the Regional Cardiology Network membership was revised to include representation from Central Region DHB Service Managers to aid regional planning focus on improving compliance and reinforce the importance of Wellington supporting access from the provincial centres.

For the longer term solution, the Regional Cardiology Network has recommended to the regional CEOs that consideration be given to the implementation of an Interventional Angiography Service on site in Hawke's Bay within 3-4 years. Local provision of this service would remove the current delays awaiting transport to or beds in Wellington.

RECOMMENDATIONS FROM TARGET CHAMPION

The Medical Directorate leadership team in conjunction with the local and regional cardiology services will continue to monitor and review it's strategies to achieve and ensure sustained compliance with both cardiovascular indicators. The service will continue to participate in the regional cardiac network activities to align with regional and national strategies.

Key Recommendations	Description	Responsible	Timeframe
Access to specialist tertiary service angiography services will be actively monitored.	Delays with transport and/or access to Cardiology Services in Wellington will be actively monitored and escalated to senior management if/when impacting on patient care.	Gay Brown CNS Cardiology	Ongoing
A strategic assessment of options for provision of interventional cardiology services to people of Hawke's Bay be done.	That HBDHB under-takes a strategic assessment of options for provision of interventional cardiology services to the people of Hawke's Bay, including the possibility of implementing an on site service at Hawke's Bay Hospital within 3-4 years in line with the regional cardiac network's recommendation and the DHBs Clinical Services Plan to be developed in the coming year.	EMT	2019

CONCLUSION

There has been a positive and sustained result for the data collection indicator. Challenges remain in meeting the access to angiograms indicator that require ongoing local and regional actions in the short term pending a definitive long-term solution including possible local provision of this service within 3-4 years.

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

20. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

22. Board Approval of Actions exceeding limits delegated by CEO

23. Chair's Update

24. Cranford Hospice

25. Finance Risk and Audit Committee Report
    - Banking Supplier Recommendation

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).