CANTERBURY DHB BOARD

Thursday, 15 March 2018
9:00am

Board Room
Level 1
32 Oxford Terrace
Christchurch

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 15 March 2018 commencing at 9:00am

ADMINISTRATION			**9.00am**
	Apologies		
1.	**Conflict of Interest Register** *Update Board Conflict of Interest Register and Declaration of Interest on items to be covered during the meeting*		
2.	**Confirmation of the Minutes of Previous Meetings** *Public Meeting 15 February 2018*		
3.	**Carried Forward/Action List Items**		
4.	**Patient Story**		
REPORTS			**9.10am**
5.	**Chair's Update (Oral)**	Dr John Wood *Chair, CDHB*	9.10-9.20am
6.	**Chief Executive's Update**	David Meates *Chief Executive*	9.20-9.45am
7.	**Finance Report**	David Green *Financial Controller*	9.45-10.00am
8.	**QFARC – 2018 Meeting Schedule**	Barry Bragg *Chair, QFARC*	10.00-10.10am
9.	**FAC - 2018 Meeting Schedule**	Ta Mark Solomon *Chair, Facilities Committee*	10.10-10.20am
10.	**CPHAC/DSAC 2018 Meeting Schedule**	Tracey Chambers *Chair, DSAC* Dr Anna Crighton *Chair, CPHAC*	10.20-10.30am
MORNING TEA			**10.30-10.45am**
11.	**Mental Health Update - Presentation**	Toni Gutschlag *General Manager, Specialist Mental Health Services*	10.45-11.15am
12.	**Maori & Pacific Health Progress Report**	Hector Matthews *Executive Director, Maori & Pacific Health*	11.15-11.30am
13.	**Advice to Board** • **CPHAC – Draft Minutes** *1 Mar 2018* • **DSAC – Draft Minutes** *1 Mar 2018*	Dr Anna Crighton *Chair, CPHAC* Tracey Chambers *Chair, DSAC*	11.30-11.40am
14.	**Resolution to Exclude the Public**	Anna Craw *Board Secretariat*	11.40am

INFORMATION ITEMS

- NZ Health Partnerships – Annual Report 2016/17
- NZ Health Partnerships – Quarter Two Report 2017/18

ESTIMATED FINISH TIME – PUBLIC OPEN MEETING **11.40am**

NEXT MEETING: Thursday, 19 April 2018 at 9.00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

Dr John Wood (Chair)
Ta Mark Solomon (Deputy Chair)
Barry Bragg
Sally Buck
Tracey Chambers
Dr Anna Crighton
Andrew Dickerson
Jo Kane
Aaron Keown
Chris Mene
David Morrell

Executive Support

David Meates *(Chief Executive)*
Mary Gordon *(Executive Director of Nursing)*
Sue Nightingale (*Chief Medical Officer)*
Stella Ward *(Executive Director – Allied Health Scientific & Technical)*
Carolyn Gullery (*General Manager – Planning & Funding)*
Hector Matthews *(Executive Director -Maori & Pacific Health)*
Michael Frampton (*General Manager – People & Capability)*
Justine White *(General Manager – Finance & Corporate Services)*
Kay Jenkins *(Executive Assistant - Governance Support)*
Anna Craw *(Board Secretariat)*

CANTERBURY DISTRICT HEALTH BOARD MEMBERS' CONFLICTS OF INTERESTS REGISTER

Canterbury District Health Board
Te Poari Hauora ō Waitaha

(As disclosed on appointment to the Board and updated from time-to-time, as necessary)

DR JOHN WOOD (CHAIR)

Advisory Board NZ/US Council – Member
Chief Crown Treaty Negotiator for Ngai Tuhoe
Chief Crown Treaty Negotiator for Ngati Rangi
Chief Crown Treaty Negotiator, Tongariro National Park
Chief Crown Treaty Negotiator for the Whanganui River
College of Arts – External Advisory Committee Member
Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA) – Member
Kaikoura Business Recovery Grants Programme Independent Panel – Member
Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice – Ex-officio (as Chief Crown Treaty of Waitangi Negotiator) – Ex-officio member.
School of Social and Political Sciences – Adjunct Professor
Te Urewera Governance Board – Inaugural Member
University of Canterbury - Chancellor
University of Canterbury Foundation – Ex-officio Trustee
Universities New Zealand – Chair, Chancellors' Group

TA MARK SOLOMON (DEPUTY CHAIR)

Te Waka o Maui – Independent Representative
Oaro M Incorporation - Member
Ngāti Ruanui Holdings - Director
Pure Advantage - Trustee
He Toki ki te Rika / ki te Mahi - Patron
Te Ohu Kai Moana - Director
Deep South NSC Governance Board - Member
Sustainable Seas NSC Governance Board - Member
Canterbury Recovery Learning & Legacy Sponsors Group - Member
Liquid Media Operations Limited - Shareholder
Greater Christchurch Partnership Committee - Member
Police Commissioners Māori Focus Forum - Member
Post Settlement Advisory Group – Member
Royal NZ Police College – Patron of Wing 312
SEED NZ Charitable Trust – Chair and Trustee

BARRY BRAGG

Ngai Tahu Property Limited – Chairman
Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.

Canterbury West Coast Air Rescue Trust – Trustee
The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.

New Zealand Flying Doctor Service Trust – Chairman
The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.

CRL Energy Limited – Managing Director
CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.

SALLY BUCK

Christchurch City Council (*CCC*) – Community Board Member
Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC.

Registered Resource Management Act Commissioner
From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time.

TRACEY CHAMBERS

Chambers Limited - Director
Arohanui Trust - Trustee
Rata Foundation - Trustee

Chambers Limited has clients and former clients that may mean a conflict or potential conflict arises. These will be discussed at the appropriate time if they arise.

DR ANNA CRIGHTON

Christchurch Heritage Trust – Chair - Governance of Christchurch Heritage
Christchurch Heritage Limited - Chair - Governance of Christchurch Heritage
Heritage New Zealand – Honorary Life Member

ANDREW DICKERSON

Accuro (Health Service Welfare Society) - Director (from 9 December 2016)
Is a not-for-profit, member owned co-operative society providing health insurance services to employees in the health sector and (more recently) members of the public. Accuro has many members who are employees of the CDHB.

Maia Health Foundation - Trustee
Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital.

Canterbury Health Care of the Elderly Education Trust - Chair
Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB.

Canterbury Medical Research Foundation - Member
Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB.

Heritage NZ - Member
Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings.

No Conflicts of Interest are envisaged for the following interest, but should a conflict arise this will be discussed at the time.

NZ Association of Gerontology - Member
Professional association that promotes the interests of older people and an understanding of ageing.

JO KANE

Latimer Community Housing Trust – Project Manager
Delivers social housing in Christchurch for the vulnerable and elderly in the community.

NZ Royal Humane Society – Director
Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.

HurriKane Consulting – Project Management Partner/Consultant
A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised.

AARON KEOWN

Christchurch City Council – Councillor and Community Board Member
Elected member and of the Fendalton/Waimairi/Harewood Community Board.

Grouse Entertainment Ltd – Director and Shareholder
Grouse Films Ltd – Director
O3 Productions – Writer/Director
Road Accident Trauma Trust – Deputy Chair

No conflicts of interest are anticipated from these roles but will be discussed at the appropriate time should they arise.

CHRIS MENE

Canterbury Clinical Network – Child & Youth Workstream Member

Core Education – Director
Has an interest in the interface between education and health.

Wayne Francis Charitable Trust - Board Member
The Wayne Francis Charitable Trust is a philanthropic family organisation committed to making a positive and lasting contribution to the community. The Youth focussed Trust funds cancer research which embodies some of the Trust's fundamental objectives – prevention, long-term change, and actions that strive to benefit the lives of many.

Regenerate Christchurch – General Manager, Partnerships and Engagement
Regenerate Christchurch (*RC*) - established to lead regeneration activities across Christchurch. RC will work with strategic partners, including the Canterbury DHB, the community, iwi and other stakeholders to plan and drive development in key areas of the city.

DAVID MORRELL

British Honorary Consul
Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time.

Nurses Memorial Chapel Trust –Chair
(CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.

Heritage NZ – Subscribing Member
Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance.

Canon Emeritus - Christchurch Cathedral
The Cathedral congregation runs a food programme in association with CDHB staff.

Great Christchurch Buildings Trust – Trustee
The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing.

Hospital Lady Visitors Association - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time.

Friends of the Chapel - Member

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held at 32 Oxford Terrace, Christchurch
on Thursday 15 February 2018 commencing at 9.00am

BOARD MEMBERS

Dr John Wood (Chair); Ta Mark Solomon (Deputy Chair); Barry Bragg; Sally Buck; Tracey Chambers; Dr Anna Crighton; Andrew Dickerson; Jo Kane; Aaron Keown; and David Morrell.

APOLOGIES

An apology for absence was received and accepted from Chris Mene.
Apologies for lateness were received and accepted from Jo Kane (9.05am); and Dr Anna Crighton (9.05am).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Carolyn Gullery (General Manager, Planning & Funding and Decision Support); Michael Frampton (General Manager, People & Capability); Mary Gordon (Executive Director of Nursing); Hector Matthews (Executive Director, Maori & Pacific Health); Sue Nightingale (Chief Medical Officer); Karalyn van Deursen (Strategic Communications Manager); Justine White (General Manager, Finance & Corporate Services); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions or alterations to the Interest Register.

Declarations of Interest for Items on Today's Agenda
Barry Bragg declared an interest in Item 10 and will not take part in any discussions on this item.
Aaron Keown and Sally Buck declared interests in Item 11 and will not take part in any discussions on this item.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING

Resolution (1/18)
(Moved: Aaron Keown/seconded: Ta Mark Solomn – carried)

"That the minutes of the meeting of the Canterbury District Health Board held at 32 Oxford Terrace on 14 December 2017 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward items were noted.

4. PATIENT STORY

The Patient Story was viewed.

5. CHAIR'S UPDATE

Dr Wood welcomed everyone to the first meeting for 2018 and commented that there will be a lot of business for the Board over the next few months.

He advised that there has been good contact with the Government since the last Board meeting. He and the Chief Executive had met with Megan Woods on 20 December 2017. They have agreed on a contact plan with her, as well as agreed meetings with her and the Minister of Health. One meeting has already taken place in the New Year around mental health in schools, which was followed up by a workshop requested by the Ministers.

It was noted that today is the first reading of the State Sector and Crown Entities Reform Bill in Parliament. This will be circulated to Board members.

The Chair advised that at the upcoming National Chairs meeting on 8 March 2018, there is to be a Mini Annual General Meeting to appoint/re-appoint Directors to New Zealand Health Partnerships Limited (*NZHPL*), and he would require the Board's authority to vote.

Resolution (2/18)
(Moved: Ta Mark Solomon/seconded: Sally Buck – carried)

"That the Board give the Chair authority to vote on their behalf on the appointment/re-appointment of Directors to the NZHPL Board."

A Board member advised that submissions on the End of Life Choice Bill closed in a few days and that there were some things in this that the Board should stay in touch with. The Chief Executive commented that the DHB is responsible for enacting the decision of Parliament and agreed that it is important for us to understand the consequences.

The Chair's update was noted.

6. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, took his report as read and highlighted the following:

- Again, the Canterbury Health System remains under pressure. Influenza planning is underway and we are very conscious that we have had very light influenza seasons over the last few years. A whole of system approach is being taken around this planning.
- The DHB is managing through and undertaking some of the largest commissioning of buildings in the country with HREF; ASB; Outpatients and also Grey Hospital. In addition to buildings, this also includes workforce changes and the introduction of IT systems.
- In Mental Health there are the ongoing pressures on Child and Adult Services. A lot more graduate nurses are choosing to work in the mental health area.
- As we continue to shape different services, there is ongoing migration to Burwood and also Stage 2 of Rangiora, which will commence in 2019.

Discussion took place regarding sleep overs and the amount of patients leaving DHB premises for this purpose. Discussion also took place regarding the work being undertaken around a system at capacity and the ability to deal with additional work. It was noted that the risk of sustaining services is getting higher and the focus is on trying to mitigate this risk.

In regard to Master Planning, it was noted that it is important not to look at things in isolation as we need to ensure we do not fragment this out of the wider picture.

Resolution (3/18)
(Moved: Ta Mark Solomon/seconded: David Morrell – carried)

"That the Board:

i. notes the Chief Executive's Update."

7. FINANCE REPORT

Justine White, General Manager, Finance & Corporate Services, presented the Finance Report which was taken as read. The consolidated Canterbury DHB financial result for the month of December 2017 was a deficit of $5.950M, which was $0.008M unfavourable against the draft annual plan deficit of $5.942M. The year to date position is $0.238M unfavourable to the draft annual plan.

It was noted that there are some unknowns around MECA settlements.

A query was made regarding the position around the 2016/17 Annual Plan. It was noted that this is with the Ministers for signing.

A query was also made regarding deficit funding and it was noted that this currently sits with the Ministry. We have been told to expect advice around this in February.

Resolution (4/18)
(Moved: David Morrell/seconded: Aaron Keown – carried)

"That the Board:

i. notes the financial result and related matters for the period ended 31 December 2017."

8. SPECIAL PURPOSE AUDIT REVIEW

Justine White, General Manager, Finance & Corporate Services, presented this report which was taken as read. Ms White advised that this was a pro-active audit which was applied to the Executive Management Team and extended to the Board.

It was noted that a couple of process issues were found, but there was nothing in the audit to indicate any fraudulent claiming.

Resolution (5/18)
(Moved: Ta Mark Solomon/seconded: Barry Bragg – carried)

"That the Board, as recommended by the Quality, Finance, Audit and Risk Committee, notes the completion of the following reviews:

i. Audit of Expense Reimbursement Claims for EMT; and
ii. Audit of Expense Reimbursement Claims for Board."

The meeting moved to Item 10.

10. DISPOSAL OF CDHB LAND AT 16 AMURI AVENUE, HANMER SPRINGS

(Board member Barry Bragg took no part in this item due to a conflict of interest).

Justine White, General Manager, Finance and Corporate Services, presented this report which was taken as read. Ms White advised that this had been discussed by the Facilities Committee.

It was noted that consultation has been completed and no submissions had been received.

Resolution (6/18)
(Moved: David Morrell/seconded: Ta Mark Solomon – carried)
(Abstained: Barry Bragg)

"That the Board:

i. declares 16 Amuri Avenue surplus to DHB requirements and, subject to Ministerial approval, disposes of it in accordance with the New Zealand Public Health and Disability Act."

11. DISPOSAL OF CDHB LAND FRONTING HILLMORTON HOPSITAL

(Board members Aaron Keown and Sally Buck took no part in this item due to conflicts of interest).

Justine White General Manager, Finance and Corporate Services, presented this report which was taken as read. Ms White advised that this paper was regarding disposal to Christchurch City Council for Road Reserve.

There was no discussion on the item, which had been considered by the Facilities Committee.

Resolution (7/18)
(Moved: Andrew Dickerson/seconded: Ta Mark Solomon – carried)
(Abstained: Aaron Keown and Sally Buck)

"That the Board:

i. declares the parcels surplus to DHB requirements and, subject to Ministerial approval, disposes of them to the Christchurch City Council for the purpose of road reserve."

12. AMENDING THE NAME OF BRACKENRIDGE ESTATE LIMITED

Justine White, General Manager, Finance and Corporate Services, presented this report which was taken as read.

There was no discussion on the paper.

Resolution (8/18)
(Moved: Andrew Dickerson/seconded: Ta Mark Solomon – carried)

"That the Board, as recommended by the Quality, Finance, Audit and Risk Committee:

i. notes that Brackenridge Estate Limited has been renamed Brackenridge Services Limited."

13. ADVICE TO BOARD

Hospital Advisory Committee

Andrew Dickerson, Chair, Hospital Advisory Committee, took the draft minutes from the meeting as read.

Resolution (9/18)

(Moved: Andrew Dickerson/seconded: Ta Mark Solomon – carried)

"That the Board:

i. notes the draft minutes from the Hospital Advisory Committee meeting held on 1 February 2018."

It was agreed that the Board move into the Public Excluded part of the meeting and move back into Public at 10.45am for the scheduled Alpine Fault Presentation.

14. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (10/18)

(Moved: Aaron Keown/Seconded: Chris Mene – carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and the information items contained in the report;

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting of 14 December 2017	For the reasons set out in the previous Board agenda.	
2.	Chair & Chief Executive's Update on Emerging Issues – Verbal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	People Report - Presentation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	AT&R Risk Assessment Review	Protect the privacy of natural persons.	S9(2)(a)
5.	QFARC Meetings 2018	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Joint Venture With Precision Driven Health	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	NZ Health Innovation Hub – Update and Future Direction	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Replacement CT Purchase	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Home Dialysis Service Relocation from Diabetes Building	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Laboratory Services Strategy & Facilities	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	Investor Confidence Rating Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	S9(2)(a) s9(2)(j) s9(2)(h)
13.	Advice to Board: • Facilities Committee Draft Minutes *30 Jan 2018* • HAC PX Draft Minutes *1 Feb 2018* • QFARC Draft Minutes *30 Jan 2018*	For the reasons set out in the previous Committee agendas.	

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the 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."

The Public meeting adjourned at 10.00am.
The Public meeting reconvened at 10.45am.

9. ALPINE FAULT PRESENTATION

Tracey Chambers left the meeting at 10.48am.

Dr Caroline Orchiston, Science Lead, Project AF8 (the *Project*), University of Otago, provided the Board with a presentation regarding the work of the Project, the Alpine Fault, and planning for the next big event. The Project has stimulated a lot of discussion and collaborative work. A "Safer Plan" is expected to result from the work of the Project.

The Chair thanked Dr Orchiston for the presentation.

There being no further business, the Public meeting concluded at 11.26am.

Dr John Wood, Chairman Date

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 15 MARCH 2018

DATE	ISSUE	REFERRED TO	STATUS
16 Nov 17	Organ Transplant/Donation Programme – Update Presentation		To 17 May 2018 meeting.
15 Feb 18	Mental Health - Update Presentation	Toni Gutschlag	Today's agenda – Item 11.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Chief Executive**

DATE: **15 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and progress from the Chief Executive to the Board of the Canterbury DHB.

2. RECOMMENDATION

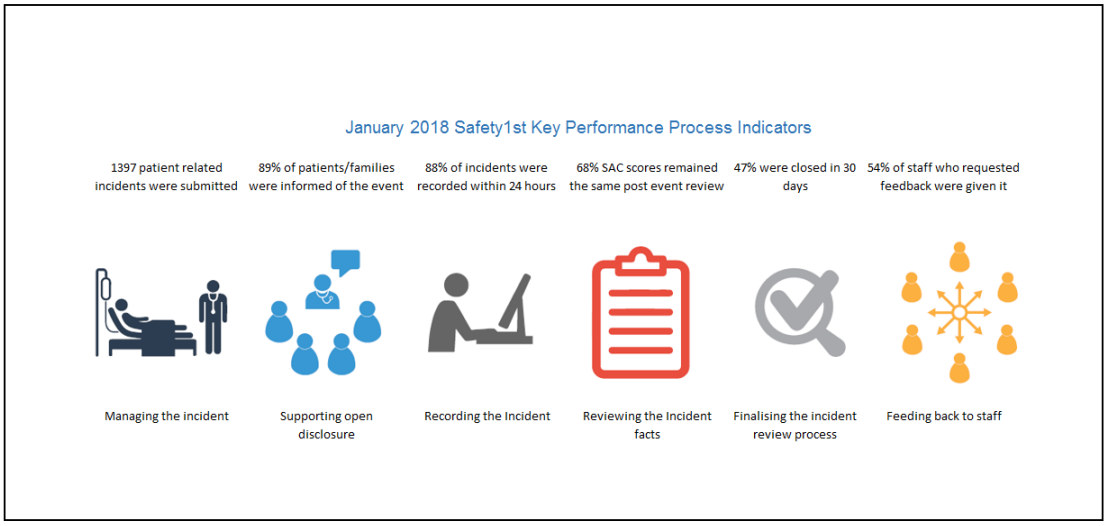
That the Board:

i. notes the Chief Executive's update.

PUTTING THE PATIENT FIRST – PATIENT SAFETY

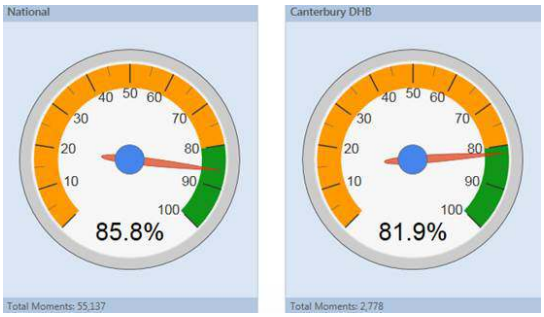
Patient Safety

- **Certification Audit:** Preparation is underway for the MOH audit against the Health and Disability Service Standards 2008 which is planned to commence in the week of the 18 June 2018.
- **Hospital Acquired Complications:** The Quality Team is working with Lightfoot to make it easier for clinical staff to review trends in hospital acquired complications (e.g. urinary tract infections) via SfN. This is in a 'test' system at present.
- **Incident Management:** Gains in open disclosure have been maintained.

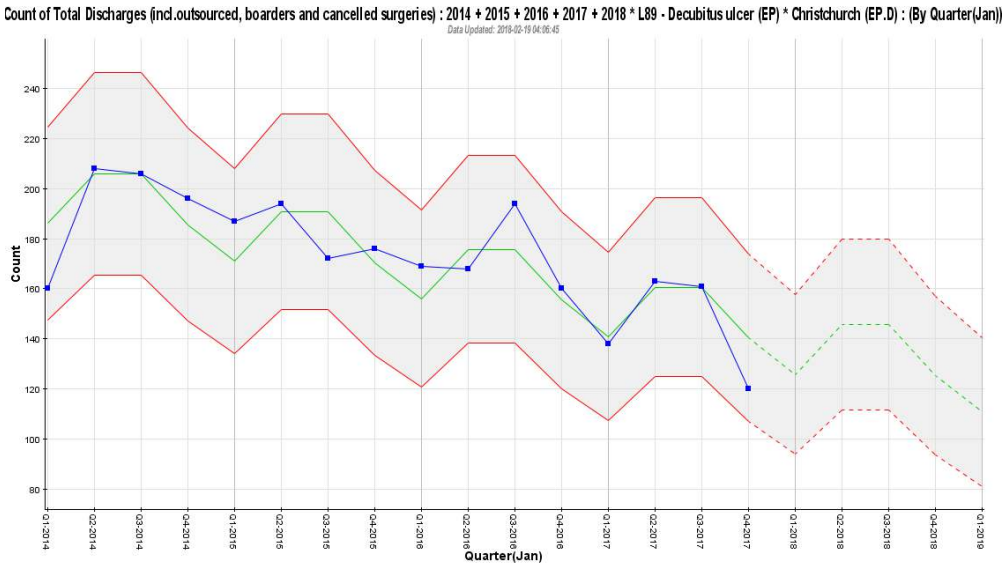


Note: *KPI's are reported one month after months end to allow to allow for complete data set*

- **Hand Hygiene:**



- As per 27 February 2018, the interim result is 81.9% with the required minimum number of moments collected for audit period ending 31 March 2018. Auditing continues to ensure all areas have completed allocated audits. Services that are performing under the 80% target have an improvement action plan in place.
- **Falls:** Planning is underway for the local April Falls Awareness campaign.
- **Releasing Time to Care (RT2C):** Maternity and the Primary Birthing Units have introduced patient bedside boards and spot audits show that they are being used. Discussion with women and their families tell us they like them. For example, a woman whose baby was in NICU used the boards to tell staff which room her baby was in (and the extension number) and asked that staff phone her when her medications were due (cell phone number written on the board). Saves time, makes sure medications are given on time, improves communication, and reduces walking up and down between floors.
- On the 28 February, 60 nursing, medical and allied health staff from OPH&R held a Medication Safety workshop at Burwood Hospital. The focus was on medication safety at all stages of the administration process and staff were presented with data about medication incidents, staff survey and patient engagement results. These results informed the future actions with the overarching aim that patient outcomes will be improved by safe and more reliable medication practice and processes. Maternity and Neonatal services have committed to a similar workshop in May 2018.
- **The system's focus on reducing pressure injuries:** Pressure injuries cause pain, disability, extended hospitalisation and sometimes death for those that are affected by them. The best approach to minimising the harm caused is to prevent them before they occur. Between 2011 and 2015 a series of prevalence studies was carried out in a selection of wards across Canterbury's hospitals. Initial studies found a prevalence of 39% of pressure injuries in those areas. This was significantly higher than international standards which sit between 4 and 21%. By the end of the four year period prevalence was reduced to 14.5%.
- Early work included providing feedback to clinical teams about rates of pressure injury in their areas, replacing the worst of our mattresses with high density foam mattresses and implementation of a screening and process audit on prevention of pressure injury. The Intensive Care Unit, whose patients are at especially high risk of pressure injury, now has full pressure relieving mattresses as its standard. These are used except when the patient condition means they cannot be used.
- The number of cases coded as having pressure injuries on discharge from Christchurch Hospital shows that rates have continued to reduce since 2015. Based on this information there were around 100 less cases in 2017 than in 2016.

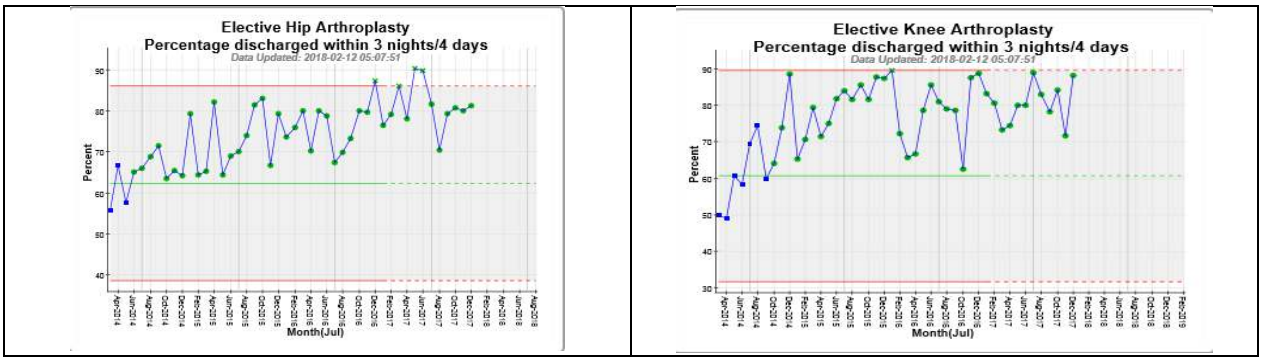


- Over the past four years there has been a significant increase in awareness of the importance of pressure injury prevention. Senior clinical nurses Pam Mitchell, Rachael White and Jude Matheson continue to promote work in this area across Christchurch, Burwood and Ashburton Hospitals but note that while they might champion this area of practice, success requires the whole system to be working.
- The Canterbury Pressure Injury Group leads work in this area and involves Nurses, Medical Staff, Corporate Quality, District Nursing Organisations and Occupational Therapists from the hospital and community
- In around 2015 focus was placed on pressure injury prevention nationally with the involvement of the Accident Compensation Corporation, Health Quality and Safety Commission and Ministry of Health. Data indicates that many more people are admitted to hospitals in Canterbury already experiencing pressure injuries than develop them while in Hospital and so Canterbury District Health Board will be working with the Accident Compensation Corporation on the Pressure Injury Prevention Community of Practice to work on primary care prevention and raise awareness of the risk factors and management strategies to prevent pressure injuries in the community and Aged Residential care and hospital facilities.
- **Hyperbaric chamber upgrade:** The hyperbaric chamber at Christchurch Hospital is the only one in the South Island, it is part of a national service providing services to people South of Taupo. The other chamber is in Auckland. Its clinical uses include treating divers for decompression sickness (the bends), assisting with wound healing, and the treatment of carbon monoxide poisoning and arterial gas embolism. The chamber and its control panel have been upgraded bringing the facility in line with Australasian quality standards for hyperbaric medicine:
    - Lighting inside the chamber has been improved, providing 50% more light inside the chamber allowing better observation of cyanosis, which is an important clinical sign;
    - The ceiling tiles inside the chamber have been replaced, providing sound reduction and better acoustics. This will improve the patient experience. Our patients spend many hours sitting inside the chamber and some previously found the soundscape disconcerting;
    - The fire extinguishing deluge system has been improved;
    - Flooring within the chamber has been updated to provide a safer environment, it is antistatic, antibacterial, antiskid and easy to clean. Along with this newly designed floor plates have eliminated a trip hazard;

- The video surveillance of the internal chamber has been updated, increasing patient safety and supporting communication;
- The gas analysis system has been updated, once again ensuring patient safety;
- A new console has been fitted, replacing one that had been in operation since 1996. The new console has a touch screen for chamber control and another for chamber services. This system allows precise control and memory of treatment profiles. Gas services are alarm monitored for treatment safety.

IMPROVING FLOW IN OUR HOSPITALS

- Enhanced Recovery After Surgery (ERAS) – Overall trend for both Elective Hips and Knees seeing improvement in the percentage of patients discharged within the target. Still some variation however variation on the positive line of improvement.



- Outpatient clinic activity moving from CHCH Campus to Burwood is continuing. Confirmed services include:
  - Christchurch Women's Obstetrics - "Preparing to Breastfeed" Group Education– commenced 18/01/2018 Monthly sessions alternating between Thursdays and Saturdays utilising Education Room space
  - Canterbury Eye Service - Diabetic Retinal Screening –commenced 08/02/2018, 2 full days weekly on Wednesday and Friday utilising 2 clinic rooms per session (this is a high volume group)
  - Christchurch Women's Outpatients Department – Gestational Diabetes Education to commence on 5/03/2018, weekly session on Monday pm utilising 2 meeting rooms 1.3 & 1.5.
- We are currently exploring how we support the following services to Burwood
  - Eye outpatients (Avastin & Paeds)
  - Bacillus Calmette–Guérin (BCG) Immunisation Clinics (This is a vaccine primarily used against tuberculosis with paediatrics which is new provision of cover by Burwood Hospital)
- We continue to see the impacts of an increased orthopaedic acute workload. In January, 32 acute operations transferred to Burwood importantly none of these led to elective lists being dropped. The acute case mix included:
  - MaxioFacial = 3
  - Plastic acute = 1
  - Orthopaedic = 25

- **Clinical Pharmacology contributes to patient flow in Canterbury and around New Zealand:** An effective service is the production of patient information leaflets that help patients understand what a medicine does, how it should be taken, whether it can be taken with other medicines and what side effects might be experienced. This information is available to patients and clinicians in an online format or is able to be printed out if required. Providing people with this information helps them to make proper use of their medicine, giving them the best chance of returning home from hospital sooner and remaining healthy in the community.
    - Work is underway with Te Pou NZ to consider costs and timeframes of providing medicine sheets that are relevant to Mental Health requirements.
    - Work is complete for Haematology drugs which are complex. The Haematology pharmacist fed back that in 2017 she was able to complete a patient counselling session with all the required sheets available.
    - Work is completed on provision of sheets for HIV and hepatitis related drugs.
- While this work has been developed and sustained in Canterbury it benefits patients throughout New Zealand, it is partially funded by the New Zealand Formulary.
- Another arm of the service is the drug information service which provides drug information to health professionals to assist with the management of patients, focussing on responding to questions that relate to the care of specific patients rather than general questions. This service is clearly directed at hospital and community based clinicians in Canterbury. Most enquiries do come from within this district with close to 300 out of a total of 2000 enquiries coming from outside of Canterbury. The majority (512) were from community doctors (general practitioners or private consultants); followed by community pharmacists (435); hospital pharmacists (390), hospital consultants (210) and other health professionals (360).
- The Therapeutic Drug Monitoring Service provides clinical interpretation and oversight of drug concentration testing for CDHB, working closely with Canterbury Health Laboratories which provides the greatest range of therapeutic drug assays in New Zealand. This service provides clinical advice that assists with the fine tuning and use of specific drugs for patients. This advice enables patients' drug concentrations to reach optimal point as quickly as is safely possible.
- A future focus for the service is on making use of prescribing data from e-medicines (electronic prescribing) to assist, among other things, in the development and maintenance of standard approaches to therapy within services. It will also allow analysis down to the level of specific clinician detail, which will enable peer review of practice. This will require an initial commitment of clinical resource so that an analytical system can be constructed in a way to enable fast responses to specific enquiries.
- **Pharmacist in the emergency Department continues to provide benefits to patients:** As reported previously a pharmacist is stationed in the Emergency Department to provide a range of services directly to patients. Foremost amongst these is ensuring that an accurate medication history is provided, especially for patients on complex or high risk medication regimes who are being admitted to hospital.
- The following case stories illustrate the benefits.
    - An elderly patient presented to ED following a seizure. His weekly blister pack indicated he was only taking the morning dose of his epilepsy drug and missing the larger evening dose of 1g. During conversation the patient expressed frustration that it was inconvenient for him to take his medicine labelled as "dinner time" in the middle of the day as he is always busy at that time. He considered that dinner time related to midday, and tea time to the evening meal. He and his whanau agreed that there should be no problem for him to take the medication with evening meal or at night. The community pharmacy was

contacted and asked to change the "dinner time" dose to "bed time" when the patient would remember to take his medication. It was also suggested to the GP to change the larger dose to the morning when medication compliance was more reliable.

- Another gentleman was suffering pain from a fractured neck of humerus, and had been taking dangerously high doses of paracetamol and codeine. As increasing doses of codeine were not working he sought help from ED. When looking through his medication history it was discovered the patient had been taking fluoxetine – which inhibits the enzyme responsible for converting codeine to morphine. The pain improved with a dose of morphine the patient was discharged home with a prescription for morphine with laxatives and advice on safe doses of paracetamol.

- A patient presented to ED following a second episode of anaphylaxis from sulphite food allergy. She had been prescribed an Epipen® however didn't use it as she was unfamiliar with how to operate it. This had led to her requiring high doses of injected and nebulised adrenaline in the ambulance on her way to hospital and had put her at high risk. While she was in the Emergency Department she was provided with further education and the opportunity to practice using an Epipen® placebo device. She was discharged with a further prescription for an Epipen® and the confidence to use it should the need arise.

REDUCING THE TIME PEOPLE SPEND WAITING

Medical & Surgical and Women's & Children's Services

- **Key Outcomes - Faster Cancer Treatment Targets:** For the period November, December and January 18 our compliance against the **62 days** target was 92%. The target set by the Ministry of Health is 90% so Canterbury District Health Board met the target for another quarter. It is not possible to compare our performance against the same time period last year as the criteria for inclusion changed in July.

- For the same period our compliance against the **31 days measure** was 89% which exceeds the Ministry of Health requirement of 85%.

- **Elective Services Performance Indicator Target Outcomes:** Latest preliminary reporting from the Ministry of Health shows that Canterbury District Health Board achieved a yellow result for elective services performance indicator two (covering first specialist assessment) at the end of January. 18 of the 26 services that contribute to this measure had no patients waiting longer than 120 days, seven services had three or fewer and one service had seven patients waiting longer than that time.

- The same report shows that Canterbury DHB achieved a red result for elective services performance indicator five (covering waiting time for surgery) for the fifth month in a row. Data issues associated with the transition of data between patient management systems is one cause for this ongoing apparent failure to make target. The Ministry of Health has provided Canterbury District Health Board with dispensation for Elective Services Performance Indicator achievement related to data issues until the end of June, agreeing that we will use a notional buffer of 35 people failing to meet target time to define transition from yellow to red, and report against this manually. Reports distributed to District Health Boards will continue to be published using the usual methodology with manual reporting used to inform discussions about improvements required.

- In addition to this the number of operations provided at Christchurch Hospital was reduced throughout January and February because work to form a link between the Parkside and Acute Services Buildings required that two theatres were closed down. This closure lasted much longer

than originally estimated. Accordingly the Ministry of Health has provided a dispensation in relation to the delay caused by this work that covers January and February, requiring that we will once again exit red status before the end of June. This will allow four months for a recovery plan to eliminate the backlog.

- **Glaucoma backlog improvement:** People with glaucoma require regular follow-up to check whether the treatment provided continues to be appropriate. If the condition changes and treatment is not altered there is a risk of irreversible vision loss. Early in 2017 Canterbury and other District Health Boards were experiencing challenges in providing timely follow up of people with glaucoma. At the end of May 2017, of the 1,508 people being followed up for treatment of glaucoma 166 were overdue by more than 50% of the intended time. As an example, a patient who was due to come back in six months and is still waiting at nine months is considered to be overdue by more than 50%.

- A number of changes have been put in place including running additional clinics at nights and weekends along with more effectively backfilling clinics freed up when specialists are on leave. Files have been reviewed to ensure that patients are correctly categorised and appropriately included in specific follow up lists, this has included a clinical review of files to identify patients who should be discharged from specialist care.

- Other improvements have been put in place that will have an ongoing impact on our ability to reliably provide high quality follow up to people with glaucoma. These include:

    - Acceptance criteria and triage processes have bene clarified;

    - An updated model of care has been developed that includes follow-up by in-house optometrists or technical staff working within defined parameters. This will create increased follow up capacity, with specialist ophthalmologists being involved on a regular but less frequent basis, unless clinically required;

    - Pathways used by general practitioners are being clarified to ensure optometrists are used where appropriate. These also provided clearer information for community optometrists to ensure that only people requiring specialist investigation or care are referred to the department;

    - Physical space has been made available for new specialist clinics by shifting diabetes retinal screening clinics to Burwood Hospital;

    - Improved administrative processes ensure that we have clear information

- These changes will ensure that people are not waiting unnecessarily for the care they require, that care is provided in a community setting to those for whom this is appropriate and that specialist resources are used for tasks that only they can safely provide.

- Alongside these changes a new specialist Ophthalmologist has been recruited and will begin work in August 2018. Until she arrives we will continue purchasing additional capacity from clinicians already in Christchurch.

- These changes have been successful as while the total number of people receiving treatment for glaucoma in Canterbury District Health Board at the end of January 2018 has increased to 1,585 there is now only one person waiting for > 50% longer than stipulated. This focus has created an improvement for the people we care for. It has required that we utilised extra resources (staff, equipment and space) and has required that we further tighten our triage criteria. Future capacity issues are looming and we are working towards ensuring these are covered with the staff, facilities and equipment required.

- A structured approach to operational management is being put in place to ensure that we sustainably manage the eye care required by the people of Canterbury with a focus on the long

term care required by many eye conditions. This includes embedding systems for reliable data collection, ensuring we continue to use models of care that utilise a range of professional groups appropriately and development of a production planning system that enables us to project the human resources, space and equipment required in the future as well as working effectively on a day to day basis.

- **Use of telehealth reducing travelling time for rural patients:** Patients living in rural areas often travel long distances to see health professionals at Christchurch Hospital. In many cases the service being provided can be effectively provided using TeleHealth. Recently the practice manager at Hanmer Springs Health Centre has been working with Canterbury District Health Board's Telehealth Service to ensure that people living in Hanmer take advantage of this technology when it is clinically appropriate.

- In one recent example, arrangements were made for a child with two siblings to be seen by a dietitian via video conference. This significantly reduced the travel time for the mother and children as they only had to make their way to the Health Centre, avoiding driving for more than 250 kilometres. The mother reported being really happy with both the reduced travel and the way the session went. Following this the dietitian has identified three other patients that they plan to see using TeleHealth early in 2018.

- Having a practice manager at Hanmer who is dedicated to encouraging appropriate use of this technology is proving to be effective at helping patients cared for by that centre, and will assist specialist services to work through the changes in workflow that are required to deliver services to other rural patients in a safe, effective and efficient manner.

- **Linwood Medical Centre and the Diabetes Centre working together to improve care:** Linwood Medical Centre and the Diabetes Centre have together become one of six successful teams who submitted innovation projects to the Health Quality and Safety Commission Whakakotahi 2018, Primary Care Quality Improvement challenge. This grant is designed to support the release of staff from primary care practices to attend workshops, work closely with a specialist team, gain collaborative insight from the other involved national teams and learn valuable improvement techniques.

- The aim of the Canterbury project will be to improve the way that the system supports a cohort of people who have especially poor glucose control and currently receive a lot of support from the specialist service that could be better provided through their general practice. Success will be shown by an improvement in glucose control along with an increase in retinal screening rates. The first step in the project is formation of a practice consumer group to help direct our activity. The project is expected to take a range of approaches to improving the way that patient self-management is supported and extending the clinic's confidence and practice with people who have diabetes. These approaches are likely to include building confidence and trust through joint case conferences, introduction of new tools to support self-management, patient co-design to improve the way that we work so that it suits patients better, the fostering of other partnerships across the health system. Updates will be provided as results become available.

- **Work with Christchurch Men's Prison to simplify care for people with Hepatitis C:** People with Hepatitis C require ongoing monitoring to ensure that changes to their liver are recognised early and that appropriate treatment is provided. This care includes provision of a specialised liver scan (fibroscan), and supporting corrections staff to treat and monitor this vulnerable group. Eradicating the virus has the significant benefit of halting any further progression of scarring in the liver which could ultimately result in liver failure or liver cancer, and also decreases the prevalence and subsequent transmission of the virus in the wider population. Clinical Nurse Specialists from Gastroenterology and Infectious Diseases departments have worked closely with the Department of Corrections health teams to provide regular clinics at Christchurch Men's Prison and Christchurch Women's and to Rolleston Men's

as required. Additional resources such as a portable fibroscan, have allowed us to provide an enhanced service on site. This enables care to be provided to up to ten prisoners per visit. Clinics are fully utilised and make effective use of the Nurses' time. Running these clinics at the prison ensures that the required care is provided in a timely manner without the need for increased resource demands on the Department of Corrections.

- This collaboration has already shown additional benefits for prisoners, The Department of Corrections, and Christchurch Hospital staff. It is our observation that the prisoners are more engaged, and we do not have prisoners electing not to attend, which decreases the non-attendance rates at Hagley Outpatient Clinics. This model is a significant improvement on the way things were previously done, which involved prisoners being required to attend outpatient appointments at Christchurch Hospital to receive care. Each of these visits required the Corrections Department to provide transport and at least two corrections officers. This model aligns with the Ministry of Health (MOH) plan for an integrated approach to the delivery of Hepatitis C services for groups considered to be at increased risk of infection. This initiative saves both time and costly resources, while having a positive impact on all involved.

- **An 0800 number has been launched for Gynaecology Outpatients:** Women who have been sent appointment letters for Gynaecology Outpatients' regularly need to contact the department to ask about details of the appointment, seek rescheduling or for other reasons. There has previously been confusion about how best to contact the department, also reliance on mobile phones without sufficient credit to make calls has served as an obstacle to many people successfully contacting the department.

- Provision of a 0800 number that is publicised in the appointment letter gives a single point of contact for these patients and removes cost as a barrier to communication. This is just one part of our efforts to ensure that we're working to make it easier for the people we care for to use our services, and to reduce "did not attend" events.

- **Newborn hearing screening programme – here's the numbers:** Over the past six months two brief accounts have been provided about aspects of the work done by the Universal Newborn Hearing Screening and Early Intervention Programme at Canterbury District Health Board. Neither of these have discussed the number of children whose lives have been improved as a result. A review has recently been published covering the programme's first seven years of operation – from January 2010 to December 2016. Each year, up to 180 infants are born in New Zealand with hearing loss. The first six months of a baby's life is a critical period for language development. Early detection and intervention significantly improves long-term outcomes for children with hearing loss and promotes normal development of communication.

- New Zealand's National Screening unit has set three relevant high level objectives. These are that:

    - Babies are to be screened by 1 month of age;

    - Audiology assessment to be completed by 3 months of age for children who do not pass screening;

    - Initiation of appropriate medical, audiological and early intervention education services by 6 months of age for children identified with hearing loss.

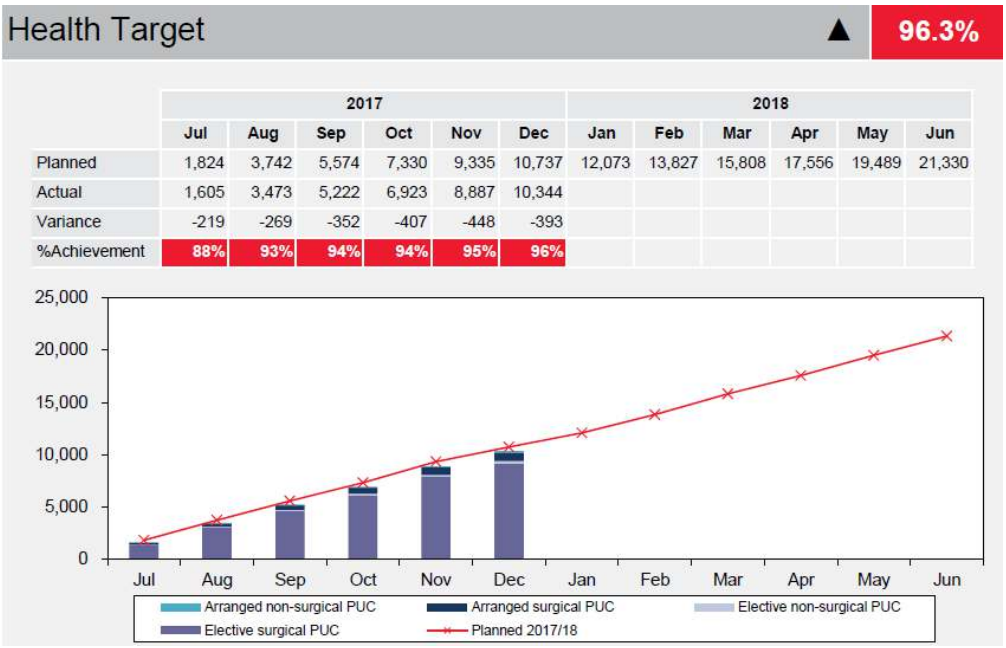
- In order to achieve this the service, made up of 10 part time screeners and a coordinator, work seven days a week and in a range of contexts including Christchurch Women's Hospital, birthing centres and community clinics to make it easier for mothers to have their baby's hearing screened. If need be, home visits are arranged. There is regular interaction with midwives both in the hospitals and Lead Maternity Carers and General Practitioners. A strength of the programme which has been commended by the National Screening Unit, is that there is a

combined Canterbury District Health Board and the West Coast District Health Board clinical advisory group for both which has promoted close interdisciplinary relationships.

- The members include:
  - The coordinator of the newborn hearing screening programme from Christchurch and Greymouth
  - audiology services and the surgeons who specialise in otology and cochlear implants
  - Neonatologists and developmental paediatricians
  - Advisors on Deaf Children, who provide advice and direct support to families of deaf children to the age of 18,
  - the van Asch Deaf Education Centre
  - Triton Hearing Aid Service paediatric audiologists as the fitting of hearing aids for babies has been contracted to this private business
  - The Southern Cochlear Implant Programme Audiologist
  - Consumer representation
- This committee ensures regular case reviews so that the service continues to refine its practices and services provided. Inter-disciplinary information is shared as Canterbury have developed an integrated data management system that uploads automatically to Health Connect South which supports clinicians working with babies with hearing loss throughout their journey as there is yet to be a national data base. The recent report describes the service's engagement with 43,712 babies born between January 2010, when the service was introduced, and December 2016. Since introduction almost all parents have been offered screening with 99.7% or 99.8% receiving an offer over each of the last three years reported on. One of the National Screening Unit's goals is that 95% of babies will receive screening by one month of age. This has been consistently achieved in Canterbury, with achievement improving further to 97% and 98% over 2015 and 2016.
- It is expected that less than two percent of babies will require referral to audiology, with the exception of 2010 this has been the case in Canterbury. Of those that are referred to audiology 16.8% (128 babies) were diagnosed with permanent hearing loss. Less than half of this group had known risk factors for hearing loss. 75% of the babies with hearing loss had a completed diagnosis before three months of age – often within the six to eight week period so that interventions can begin. Babies diagnosed with bilateral hearing loss are contacted within two days by a specialised advisor who becomes the family's key contact. They work with family members to help them understand the implications of their child's hearing loss and talk with parents about how deaf children learn to communicate and understand. Support provided includes accompanying families to appointments and visiting them at home, preschools and schools. Advisors follow an 'Informed Choice' approach ensuring that families and whanau are fully informed and have a good understanding of all communication pathways including New Zealand Sign Language. They help families identify their priorities and goals for their child and ways to achieve these. 23 infants have received at least one cochlear implant. Two babies that were not suitable have travelled to Germany to receive a brain stem implant.
- This programme is a great success story, working as part of a wider system to identify and support children with hearing loss to achieve different outcomes throughout their lives than would otherwise be possible. The final word on this success is provided below Dr Philip Bird and Dr Melanie Souter: CDHB Ear, Nose and Throat Specialists and Southern cochlear implant surgeons.

- *"Prior to the introduction of Neonatal hearing screening, often severely deaf children weren't diagnosed until 18m-5yrs which is traumatic for the family let alone the developmental impacts for the child. The Newborn Hearing Screening Program has been a major milestone for paediatric hearing loss. Early diagnosis and early intervention not only makes a huge difference for early speech and language development, but has a massive impact for the rest of their life. This is a clear example where screening makes an astronomical difference to individual outcomes and is highly cost effective to society. With the ability to screen babies by one month, we can have babies implanted with bilateral cochlear implants by 6 months of age or in some cases sooner. With the continuing advances of technology and research the role of cochlear implantation for single sided deafness is emerging. The availability of other implantable and non-implantable hearing devices means that early stimulation of auditory pathways to achieve binaural hearing is our goal. This can only be achieved with a reliable Neonatal Hearing Screening Program".*

- **Elective Health Target Delivery:** Ministry of Health reporting for 2017/18 showed that following December 2017 Canterbury was running behind planned delivery by close to 400 discharges.



- Internal reporting shows that in house delivery is sitting at planned levels with the deficit entirely explained by a current under-run of outsourced volumes. We are confident that this will be corrected prior to the end of June 2018 meaning that Canterbury District Health Board is on track to achieve the Elective Health Target volumes. Note however that there is a mismatch between target and delivery in the various sub-categories (i.e. arranged versus elective and between specialties). Canterbury District Health Board is working through this with the Ministry of Health.

- **Preparing the administration team for success:** The coming year will see Christchurch Hospital teams transition from our established Patient Management System to the South Island Patient Information Care System. Along with this a number of teams will be shifting to the new Outpatient Services Building. This marks a change in setting, functions carried out and tools used for many administrators and it is important that we prepare these people so that they will experience a successful transition and continue to perform at the high level the system requires. As a part of this a number of courses and activities are continuing or being put in place.

  - A series of "Destination Outpatients – Better Together" workshops are being delivered. Topics discussed at these include how we'll work together and with patients in the new building, how logistics will be arranged, the need to streamline our work areas and practices

now so that we are moving less junk and fewer inefficient processes into the new environment. The fifth and final workshop is to be held on Thursday 22 February and the focus is 'Well Organised Workplace'. The engagement through the workshops and subsequent workstreams remains high with a high level of commitment to get it right.

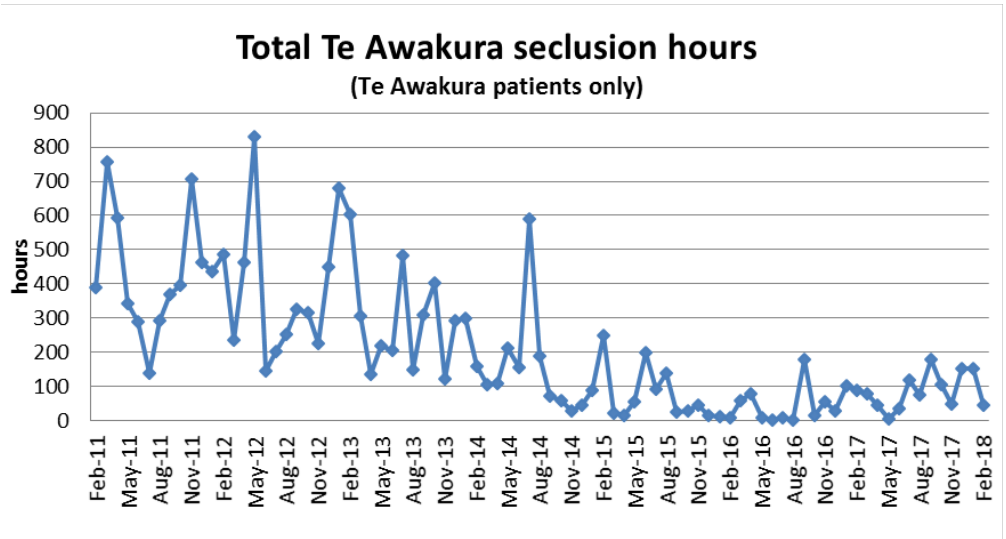
- Excel training with a focus on the functions required of users of the South Island Patient Information Care System is being planned. This will be delivered immediately prior training for the new system so that administrators are equipped to provide reporting and other functions.
- Administration team leaders will be provided with the opportunity to attend sessions on leading and managing change.

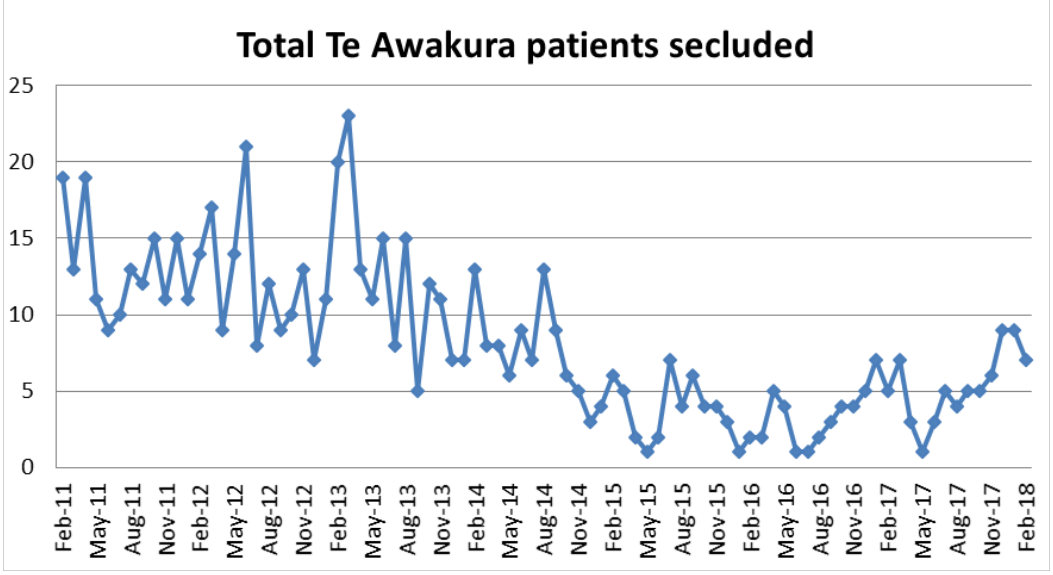
Specialist Mental Health Services (SMHS)

- **Demand for Specialist Mental Health Services**: The Specialist Mental Health Services divisional leadership team and Planning & Funding continue to closely monitor demand for Mental Health Services. Demand for both adult general services is continuing to grow. Our staff work exceptionally hard, to provide the best care possible in some very challenging circumstances and we are continuously looking for ways to make the environment as safe as possible for consumers and staff. A range of initiatives are contributing to ongoing improvements. These include:
  - Plans are underway for a building modification designed to contain a high care area (HCA) to assist with addressing significant health and safety concerns that exist in the AT&R unit. This is the inpatient service for people with intellectual disability and challenging behaviour. An interim environmental modification has seen a significant improvement in seclusion reduction and improved safety for patients and staff.
  - Nurse Coaches were established within Te Awakura (the adult acute inpatient service) in late 2017. These roles were established to support practice for both registered and enrolled nurses in their first year of Mental Health practice. A formal 3-stage evaluation of the impact of the role is underway. Stage 1 has been completed with uniformally positive feedback.
  - There are currently several AT&R staff on ACC due to serious work related injuries. Strategies have been put in place to maintain staffing levels for the unit through using pool staff familiar with the area and a short term staff secondment to assist in continuity of care. Maintaining this level of staffing is an ongoing challenge.
- We acknowledge the great work of inpatient staff is being complemented by the new entry to specialist practice (NESP) groups. The recent commencement of forty five nurses and fourteen allied health new graduates add much to the work that we do.
- The nursing vacancy rate at end January 2018 is 12 FTE. We have a volunteer system across SMHS where staff can elect to work extra shifts, which is having a positive impact.
- Occupancy of the **adult acute inpatient service** has been high at 96% in February 2018. Such high occupancy is unsustainable and does not allow for increased demand over time. Planning and Funding are leading the development of community services that will provide an alternative to an acute inpatient admission.
- **Demand for Crisis Resolution** increased slightly over the summer period. There were 190 new crisis case starts in February 2018. New crisis case starts require an assessment and response within a day of referral. The service is exceeding national targets with respect to wait times for adult Specialist Mental Health Services. The wait time targets are 80% of people seen within 21 days and 95% within 56 days. In February 2018, 96.4% of people referred to the Adult

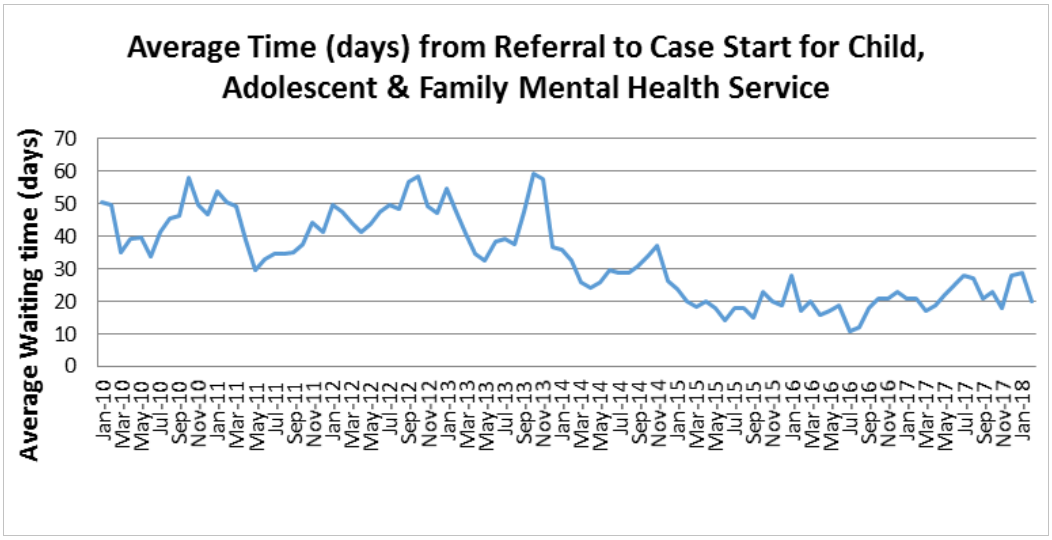
Community Service were seen within 21 days and 99.3% were seen within 56 days. The percentages for February 2018 were 90.8% and 97.1% respectively when other adult services i.e. Specialty, Rehabilitation and Forensic were included.

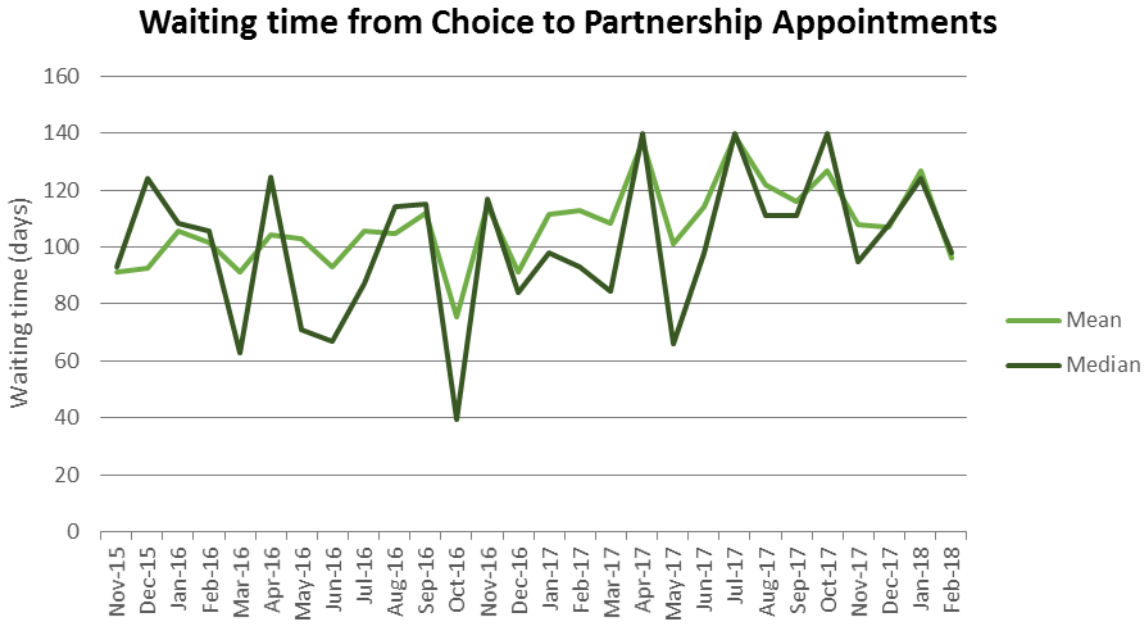
- Our focus on **least restrictive practice** continues to result in reduced seclusion. Within Te Awakura there were seven seclusion events for February 2018 for a total of 45.7 hours. The monthly average for the previous 12 months is currently 86.4 hours.





- **Child, Adolescent and Family (CAF):** Reducing wait times for Child, Adolescent and Family services remains a concern. National targets require 80% of young people to be seen within 21 days and 95% within 56 days. Our results for February 2018 show that 76.7% of children and adolescents were seen within 21 days and 89.5% within 56 days. Child, Adolescent and Family Services had 209 new case starts in February 2018.





- The average waiting time between Choice and Partnership appointments is calculated retrospectively and has decreased slightly over the past month.
- **Schools based Mental Health Team** has continued to provide regular workshops and support to over 150 schools across Canterbury. New workshops have been developed including on attachment; how teachers can foster greater security for their students, and sensory modulation; helping young people to self-regulate. The team is currently planning a School Counsellor Forum for term two. This forum is an education and networking forum led by members of the team
- The team have recently allocated a liaison clinician for each Communities of Learning | Kāhui Ako – these are groups of education and training providers that form around children and young people's learning pathways.

Older Persons Health & Rehabilitation (OPH&R)

- **Orthopaedic Flow:** From 2009 to 2017, the overall number of patients admitted into Christchurch Public Hospital orthopaedics has increased by approximately 28% (growth rate per year of 2.8%) and in the over 65 year group by 36% (growth rate per year 3.5%) (Fig 1 & 2)

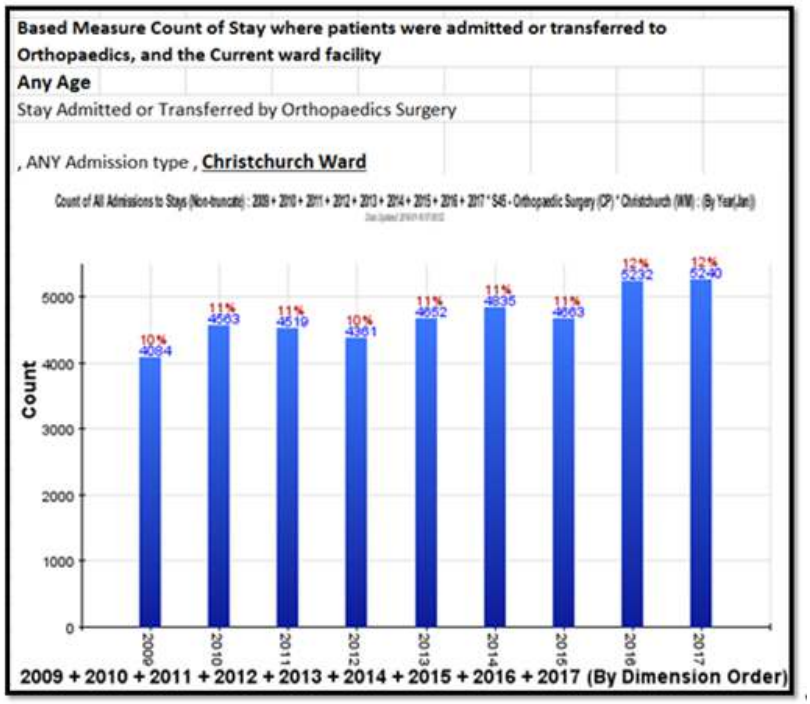


Fig 1

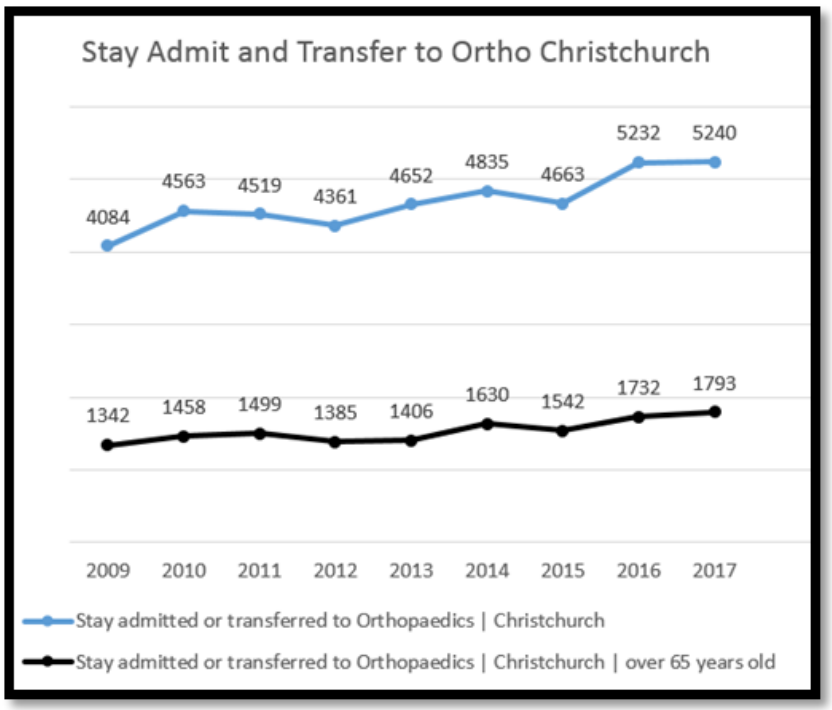


Fig 2

- However, overall admissions to ORU (D1) in Burwood have remained stable at a little under 500 patients per year (Fig 3)

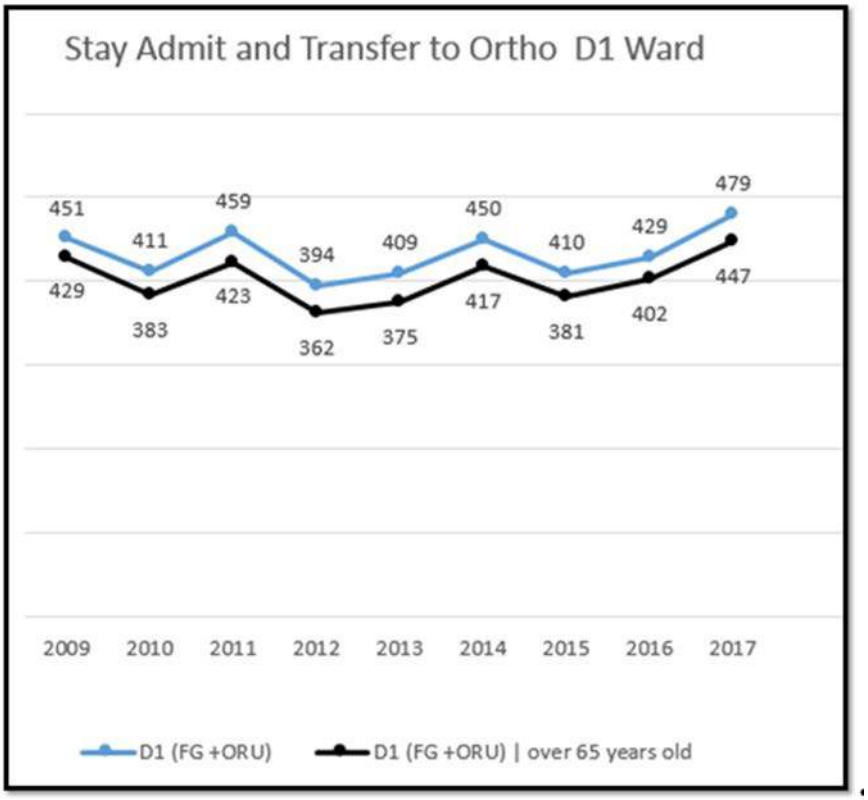
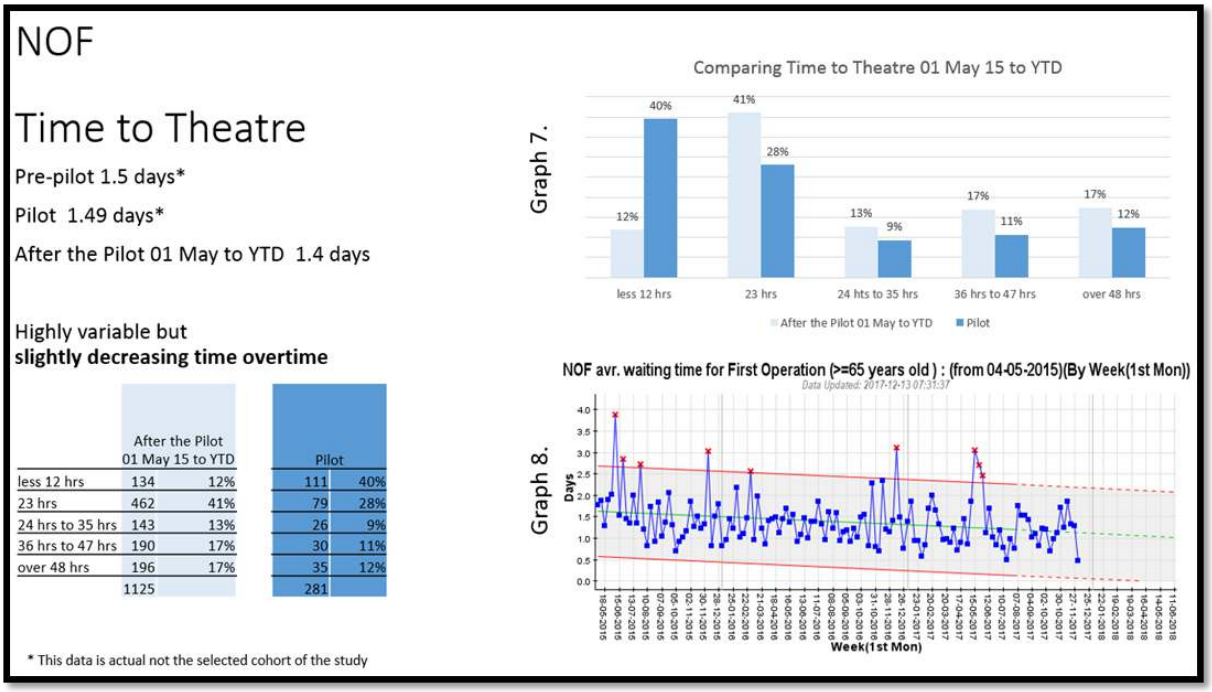


Fig 3



	After the Pilot 01 May 15 to YTD		Pilot	
less 12 hrs	134	12%	111	40%
23 hrs	462	41%	79	28%
24 hrs to 35 hrs	143	13%	26	9%
36 hrs to 47 hrs	190	17%	30	11%
over 48 hrs	196	17%	35	12%
	1125		281	

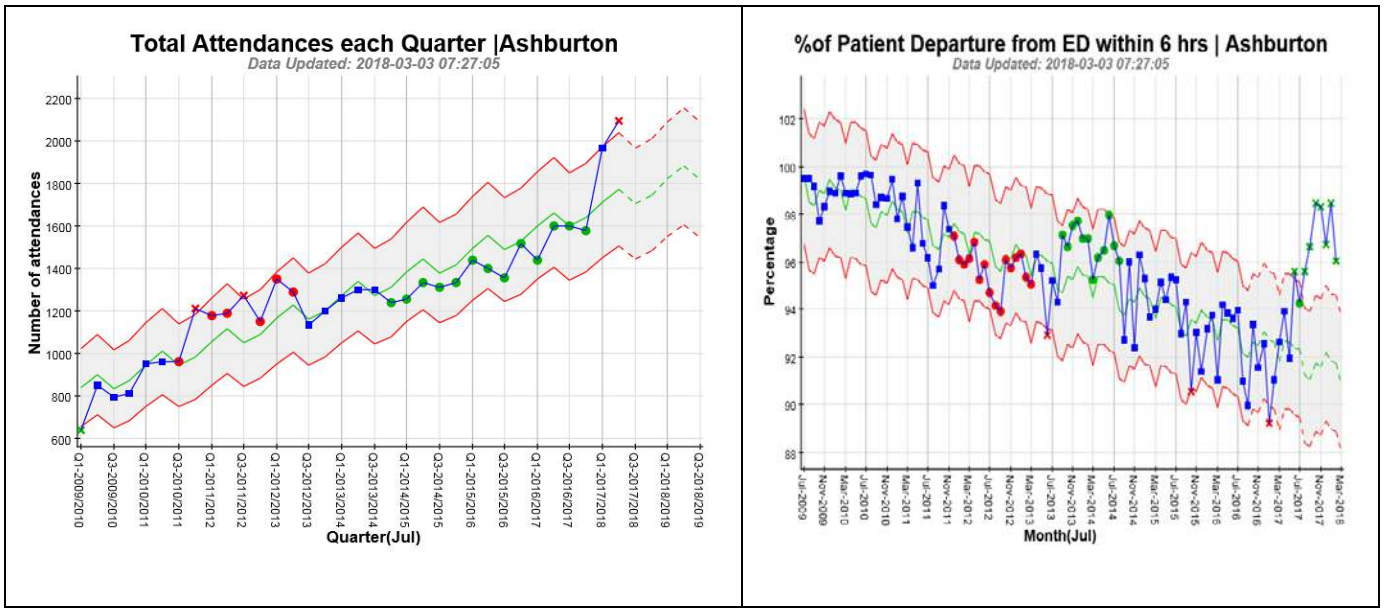
Fig 4

- While the wait for theatre in light of increasing overall numbers of orthopaedic patients has gone down from 1.47 hours to 1.42 hours (Fig 4). Our Enhanced Recovery After Surgery (ERAS) continues to be a focus and a revisiting of the markers used to identify patients is taking place to ensure timely access to theatre, and/or referral for Older Persons Health.
- **Burwood Theatres:** After Hours Equipment requests have increased significantly over the last twelve months. We plan to have appropriate nursing staff on an 'on-call' roster after hours to

cover these demands in a more sustainable manner with the right staff available to ensure that the right equipment is available in a timely manner for acute cases.

- **Community Dental Service:** Recruitment for the new model of Clinical leadership underway recruiting for five team leaders and a clinical managers. Plan to confirm appointments by early march 2018. The logistics co-ordinator position was filled and commenced in mid January 2018. Due to the success of opening additional Clinics over the Christmas period the service is seeking expressions of interest from staff to provide this in the April School Holidays. This enabled more access for our families than previously and supports our transformation of opening hours and accessibility to service.
- *Eighteen Month Recall Project.* A small trial is being undertaken in the Lincoln clinic to understand the possibility of increasing low needs Children to 18 months recall rather than the current 12 months. The project includes Dentist review of X-rays moving to a peer review self and peer audit tool.
- The Community Dental Call Centre exploring evening outbound calling. Many appointment calls are made during the day with low success rate – taking three to four calls to successfully make contact and book the appointment. The call centre presently works 8am-5pm and we are tracking trends and peak demands times. We plan to trial a volunteer to work 5pm-7pm making these calls and a trial offering these appointments by text. At the end of the trial data will be reviewed required changes worked through.

Ashburton Health Services



- The trend of increased presentation into the Acute Assessment Unit (AAU) continues. Through the Ashburton Service Level Alliance (ASLA), a recent meeting was held with local general practices to discuss the current status and investigate mitigations in light of coming winter demand. It was called as part of the Access to Acute Care co-design process which seeking to achieve a consistent patient experience.
- Planning and Funding opened the discussion by providing a snap shot of utilisation of the Acute Assessment unit and changes experienced over the past year. Some of the key points noted through this presentation included:

- Ashburton AAU experienced an increase in demand from December 2016 (when 8 to 8 was first introduced) but this significant increased from July 2017.
- In the last 365 days 5685 people attended AAU, this is a 50% growth from 2011 (in the context of a 10% population growth)
- On a daily basis this converts to an increase from Nov 2016 of an average of 18 attendances per day to 25 per day
- Ashburton attendances are greater for Paediatric presentations and 75 years old and over, when comparing the distribution with Christchurch ED
- Ashburton AAU attends more people between Mon to Fri 8am to 6pm compared to Christchurch (38% Christchurch, 43% Ashburton)
- 44% of all attendances are people 75 years old and over. 50% of these presentations occur between Mon to Friday
- In comparing the Triage 5 presentations in AAU versus Christchurch Emergency Department over the past 371 days (as at 22 Jan 2018), 17% of the AAU presentations were Triage 5, compared to 4% Christchurch.

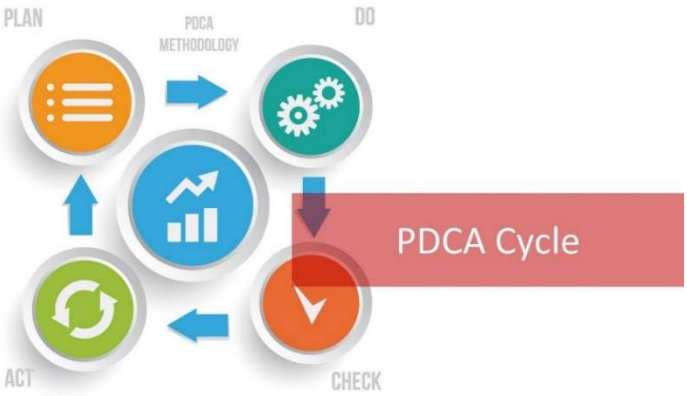
- Reporting from AAU collated for Ashburton Clinical Governance however indicates an increasing presentation of Triage 2 and Triage 3 patients. The table below is an extract for the month of January, demonstrating the total attendances by day of week and triage cohort. The reporting indicates an increase in hours worked and overtime by nursing staff, we continue to explore models of service delivery and improvements that will enable us to manage the flow within our constraints. Staff are encouraged to provide feedback on these issues and solutions in the monthly staff meeting.

ATTENDANCES BY TRIAGE

Attend Date	Attends	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
Monday	137		10	56	47	24
Tuesday	114		9	52	37	16
Wednesday	131	1	10	50	47	23
Thursday	87		3	47	26	11
Friday	94	2	10	29	39	14
Saturday	95	1	19	33	30	12
Sunday	89	1	6	40	27	15
Total	**747**	**5**	**67**	**307**	**253**	**115**

- Clinical governance reporting is now in place from all service areas. The information collates information from Safety First, along with reporting from extracted from the patient management system (PMS) and provide the opportunity for the Charge Nurse Managers and Service Co-ordinators to highlight quality initiatives and service improvement opportunities.

- In February we welcomed Amy Jukes, our Service Improvement Co-ordinator to the team in Ashburton. Amy has a nursing background and worked in multitude of clinical settings and environments including Starship and Gisborne Hospital. Amy has recently completed her Masters in Health Leadership majoring in Health Management. This study focused on improving the experiences of patients, the health of communities and the operation of health services. Our local focus is to explore innovative thinking, to manage the complexities and to provide a different approach to reoccurring problems. Our Service Improvement Co-ordinator role is newly developed (re purposing a vacant administration role), the main priority will be improving hospital processes and trying to provide care in a more efficient and streamlined way. Amy's first focus is consolidating our Winter Planning preparation and alignment with the work underway in Christchurch and Burwood Hospitals.



- The Allied Health Team based at Ashburton Hospital took part in the **Calderdale Framework** Foundation Training. Ann Buckley, Angela Kennedy and Vicki Prout facilitated the session and helped the team to look at ways to apply LEAN thinking to task delegation and sharing. It proved to be a lively discussion with Occupational Therapists, Physiotherapists, Social Workers, Dietitians, Student Occupational Therapist and assistants all exploring the possibilities of using the framework to identify areas of work that can be systematically reviewed to support safe redesign of patient centred care. The next stage is to develop capacity locally and participate in the Facilitators training at the end of March 2018. This will lead into integrating this work with our District Nursing and Clinical Nurse Specialist staff.

- The Administration team under the guidance our Administration Manager Philippa Waters are actively preparing the Ashburton and Rural delivery for SIPICS. In readiness the team are auditing and cleansing existing data, local champions have been identified, training is well in progress and local 'test sites' set up to socialise with the wider teams what SIPICS will look and operate like when implemented. Philippa is connected with the Christchurch Campus administration leadership to align preparation, it is intended that administration representation from the Ashburton site join the Christchurch campus role out, enabling us to share in the learnings as the work goes live in preparation for Ashburton go live.

Laboratory Services

- **Testing:** New quantitative BCR/ABL test went live in early February – this will bring about a reduced turnaround time and less labour required overall. The majority of labour can be carried out by a technician, freeing up scientists to better utilise their skills and experience in other areas.
- Investigation is continuing into the circulating mumps genotype.

- Trialling a replacement analyser (QTOF) for the 3200 Liquid chromatography–mass spectrometry (LCMS) which was able to identify the presence of the Tutin toxin from the Tutu berry in samples from a patient in ICU, queried as having ingested them (the old instrument was unable to measure this).
- Mass spectrometry (MS) strategy and planning underway, with ongoing discussions to develop CHL wide plan to maximise capacity, test development opportunities, increase standardisation and choosing the most appropriate new technology.
- **Phlebotomy workload project:** The Phlebotomy team at Canterbury Health Laboratories collect specimens for laboratory analysis from both inpatient and outpatients across various sites. A five week project has been undertaken by our process improvement team to make visible the service demand requirements for both patient populations, enabling the development of optimal staffing levels across the day. This visibility is now informing our current recruitment process to ensure the best utilisation of FTE to meet service requirements and engagement with staff and unions is being undertaken.
- **Winter Planning:** Planning continues in the Microbiology service at Canterbury Health Laboratories, with a focus on rapid diagnosis options for respiratory viruses, to support the triage of patients for hospitals. Review of winter workload planning review underway in collaboration with the wider winter planning group across the CDHB.
- **Coronial Services:** Negotiations for delivery of Coronial Support Services are progressing well with the Ministry of Justice.
- **High Volume Automation:** A draft concept brief for the Core Laboratory, Ashburton and West Coast is underway in readiness to approach the market for potential solutions.
- **Facilities:** Work continues around developing the facilities plan in line with Treasury's Better Business Case model.

INTEGRATING THE CANTERBURY HEALTH SYSTEM

Acute Demand Management

- The Acute Demand Management Service received 7,908 referrals in the October to December quarter of 2017/18. The Acute Community nursing team continues to support heart failure people to return to their own homes.
- The Urgent Care SLA recently met with a focus on winter planning for 2018, our services will be very constrained as we attempt to manage expected volumes before transitioning to the Acute Services Building in 2019. The recent increase in ED attendances of both accident and medical numbers is of concern with high weekly volumes into February. The re-invigoration of care around the clock will be a key strategy over this time.

SUPPORTING OUR VULNERABLE POPULATIONS

Older Persons' Health

- **Dementia:** The South Island Alliance produced a shared model of care for South Island Dementia Services: Dementia is Everybody's Business. This provides a shared vision for consistent, integrated, comprehensive, person-centred services. The Canterbury Dementia Stakeholders group will start by clarifying the navigation of dementia services throughout the region. Canterbury DHB's 'HealthPathways' and the work of NGOs in the sector have meant

that dementia services in Canterbury already have clear referral pathways. The challenge is to make sure that these pathways are visible and accessible to people with dementia, their carers, and whānau.

- **Pay Equity:** The Ministry of Health has indicated Pay Equity revenue will remain separate for 2018/19 and then be incorporated into population based funding formulas in 2019/20. A working group has been established to integrate pay equity into Home Based Support Services and Aged Related Residential Care contracts.
- **Carer Stress:** We are continuing to investigate better options for supporting informal carers of people in their own homes. Informal carers are a major support for our health system – without them, our system could not function. InterRAI research shows weak social supports (and carer stress) are drivers for entry into Aged Residential Care.
- We can support this informal carer workforce by providing opportunities to take a break from an often-onerous job. Carer Support funding via the Ministry of Health may be used to fund this, but there are perceived difficulties in purchasing services using this limited funding (which must be claimed retrospectively), including that funding cannot be used to provide care if the carer is working.
- Work in this area includes finding criteria and methods by which to provide respite at home, and also promoting our expectation that carers will need support right from the beginning of their journey (in order to de-stigmatise this necessary part of the care process and avoid carer stress).
- **Smoking Cessation:** Te Hā – Waitaha referrals increased from 735 in quarter one to 1,264 in quarter two. A reporting error in the number of referrals enrolled has been identified, meaning that in the percentage being converted from referral to enrolment has decreased to 37%. Te Hā – Waitaha has established education sessions for clinical staff to ensure that people have sufficient motivation to quit before being referred to the service.
- The number of people enrolled with the service and attempting to quit fell due to lower referral rates for the month of December. However monitoring of enrolment numbers for the beginning of quarter three indicate that these have already picked up. New Year's resolutions and annual excise tax increases have resulted in more motivated people.

Mental Health

- **Psychosocial Recovery in Kaikoura and North Canterbury:** The opening of the roads and the breaking of the drought have had major positive impact on the psychosocial wellbeing on people in Kaikoura and North Canterbury. The Multi-agency Steering group continues to oversee and monitor the Psychosocial Recovery plan for North Canterbury and Kaikoura. Agencies are well into planning their future service deliveries with their new 'business as usual' services to be inclusive of ongoing psychosocial needs.

Primary Care

- **Delivering on the Pharmacy Action Plan:** The Pharmacy Action Plan 2016-2020 sees pharmacist services as a critical part of an integrated model of care, delivered in innovative ways so all New Zealanders have access to medicine and health care services. DHBs aim to strengthen patient safety by supporting pharmacists to work as expert medicine managers in a team of skilled health professionals.
- DHBs are seeking the views of pharmacy owners, pharmacists, health professionals and the public on how to deliver on the strategic direction in the Pharmacy Action Plan. DHBs have proposed a draft Integrated Pharmacist Services in the Community Agreement (IPSCA) to support the Pharmacy Action Plan, to begin on 1 July 2018, and a one-year extension of

current service agreements for those wishing to take more time to consider the IPSCA. Consultation on this proposal is open until 10 April.

- **Ashburton General Practice Engagement Meeting:** Consumers and general practice teams will have a workshop on 28 February on how to deliver consistent patient experience for people needing urgent care after hours. The meeting will be facilitated by the Rakaia GP and was one of the strategies identified by the co-design process, which took place in 2017.

Integrated Family Health Services and Community Health Hubs

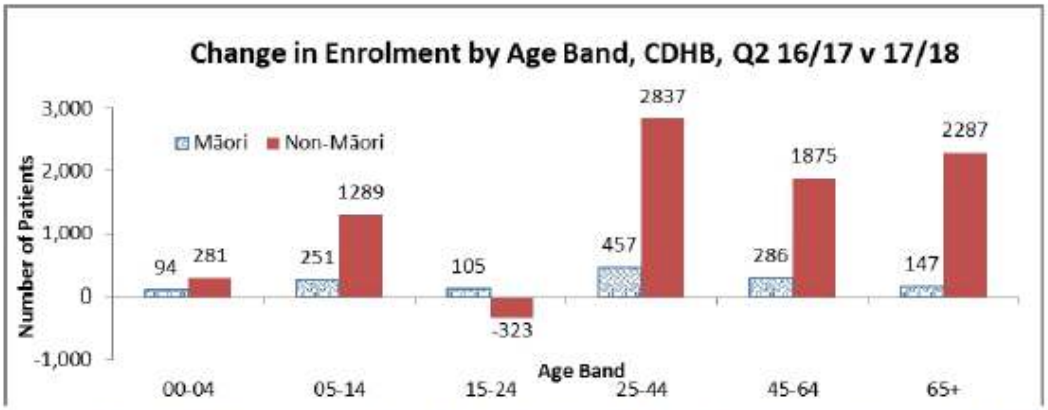
- Closer integration of health services is being pursued in several rural areas including Hurunui, Oxford and Akaroa.
- **Akaroa**: In early March the tender for building Akaroa Health Centre will have been granted along with the appointment of a GM. The site was blessed with Canterbury DHB Board, MPs, health providers, local Māori and community present on 24 February. The community have already raised over a $1 million towards the build.

Maori and Pacific Health

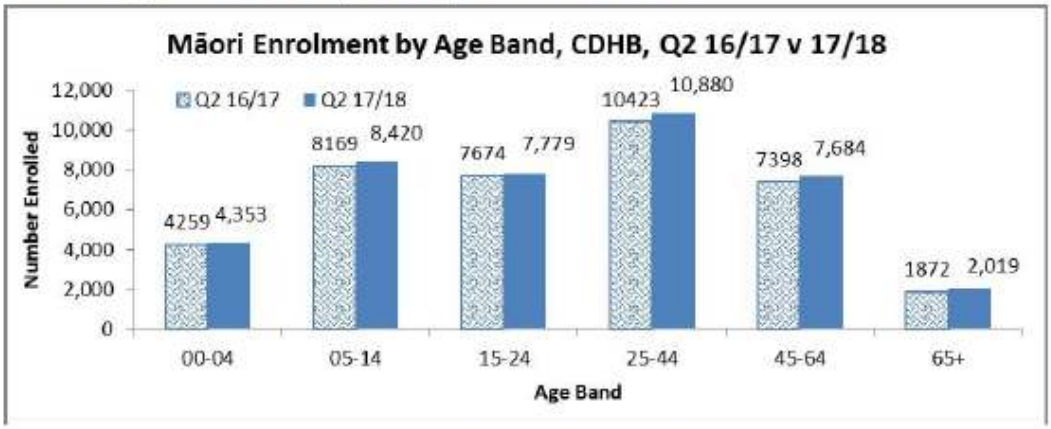
- **Pūrongorongo Hauwhā – Primary Care Quarterly Report Q2 Oct – Dec 2017**
- **Tirohanga Whānui - Overview:** Pūrongorongo hauwhā is a quarterly update from data and information from the PHOs on three key operational areas:
    - Raraunga whakauru – Enrolment data
    - Arai mate – Immunisation
    - Tamariki ora e waru – B4 School Checks
- **Raraunga whakauru1 Enrolment Data:** Patient enrolment data held within each PHO is instrumental in monitoring the Māori population in Canterbury. Trends across the PHOs and between Māori and non-Māori can be charted each quarter.
- Another positive increase in Māori enrolment (+0.9%) within the DHB this quarter, along with relative increases in enrolments of non-Māori (+0.4%). The graphs that follow compare the changes in enrolment by age band from Q2 2016/17 to Q2 2017/18 between Māori and non-Māori.

Pegasus Health			
	Previous Quarter Jul – Sep 2017	Current Quarter Oct – Dec 2017	Variance
Māori	**33,278**	**33,627**	**+ 349**
Non-Māori	383,350	385,105	+ 1,755
Total Pop	416,628	418,732	+ 2,104
Rural Canterbury PHO			
	Previous Quarter Jul – Sep 2017	Current Quarter Oct – Dec 2017	Variance
Māori	**4,785**	**4,868**	**+ 83**
Non-Māori	56,550	56,682	+132
Total Pop	61,335	61,550	+215
Christchurch PHO			
	Previous Quarter Jul – Sep 2017	Current Quarter Oct – Dec 2017	Variance
Māori	**2,706**	**2,640**	**- 66**
Non-Māori	32,723	32,519	- 204
Total Pop	35,429	35,159	-270
TOTAL MĀORI	**40,769**	**41,135**	**+ 366**

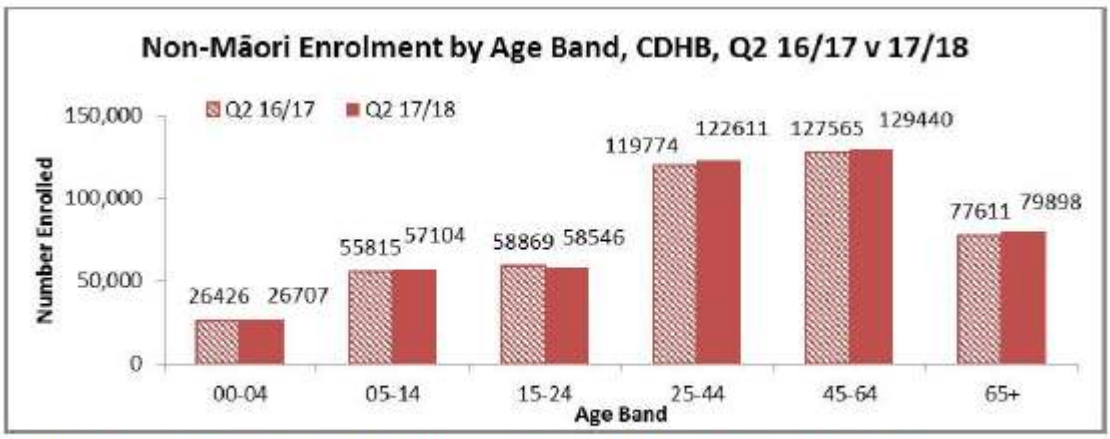
[1] MOH 2017 PHO Enrolment Demographics 2017 Q2 – Oct – Dec 2017



GRAPH 1: Māori enrolments have risen in all age bands, whilst the non-Māori population has seen another small fall in 15 to 24. Overall, Māori enrolment is up 3.4% compared to +1.8% in non-Māori.



GRAPH 2: The highest increase for Māori enrolments in absolute numbers is again the 25 to 44 age band (+457) whilst the biggest % change is again the 65+ age band (+7.9%) whilst the lowest % increase is in the 15-24 age band (+1.4%)



GRAPH 3: Non-Māori enrolments show slight losses in only the 15-24 age band (-323). The highest % growth is in the 65yrs+ group (+2.9%), but the biggest increase in absolute numbers is the 25-44 age band (+2,837).

- **Arai mate – Immunisations:** The immunisations for this report include the National Childhood Schedule, Human Papilloma Virus (HPV) and the influenza vaccine for over 65 years and people with long term conditions. The 8 month fully immunised coverage has increased this quarter to 92%. While it is not back to target rates, it is a positive increase. Coverage at 2 year old exclude target while coverage at 5 years old – remains at 93% consistent with the total population.
- On reviewing the recent HPV coverage, there appears to be drop in coverage. This is linked to the number of girls coded as Maori on the NIR vs the eligible population. This raises a concern around the ethnicity coding, as coverage should not drop during the year – it should increase as more girls are vaccinated. The NIR team, will look at this data and see if the ethnicity issues can be resolved. The HPV school-based programme shows an increase for the quarter.

Influenza coverage is not reported on this quarter.

Measure	12 months to 31 Dec 2017	Previous Quarter (Jul –Sep 2017)	Quarter: Oct – Dec 2017		Target Coverage (Māori)
	Coverage (Māori)	Coverage (Māori)	Coverage (Māori)	Coverage (Total)	
8 months fully immunised children	91%	91%	92%	95%	95%
2 years fully immunised children	95%	93%	95%	96%	95%
5 years	92%	92%	93%	93%	95%
11 years	64% *	n/a	64%	64%	
HPV total (Dose1) Cohort 2004		66%	59%	69%	75%
HPV total (Dose2) Cohort 2004		55%	50%	63%	75%
Influenza (>65 & LTC)	n/a	n/a	n/a	n/a	75%

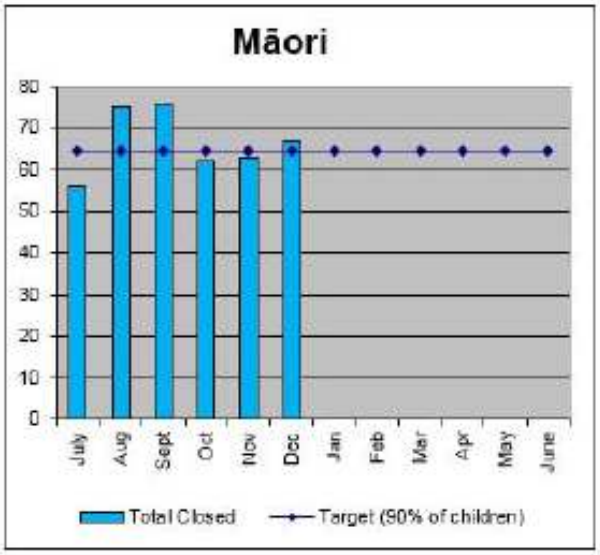
* this is new data shown in the datamart report and the parameters around this are not yet known.

* = girls born in 2003

- **Tamariki ora e waru – Before School Check:** The Canterbury Before School Check (B4SC) programme comprises two parts; the nurse component, carried out by B4SC trained nurses in general practice and Public Health and the vision & hearing testing component by the CDHB. A good result for Māori this quarter. 99% of the target population had the full (Nurse and VHT) B4SC, which gives a total of 103% of the target population checked this financial year to date.

Canterbury DHB Completed Checks (VHT & Nurse Component)

Month	No Children	Target (90% of children)	Total Closed
July	72	64	56
Aug	72	64	75
Sept	72	64	76
Oct	72	64	62
Nov	72	64	63
Dec	72	64	67
Jan	72	64	
Feb	72	64	
Mar	72	64	
Apr	72	64	
May	72	64	
June	72	64	
2017/18	659	773	399



Nurse component Completed Checks by Provider Q2

Pegasus Health (Charitable) Ltd		
Month	Target (90% of children)	Nurse Closed
Oct	42	41
Nov	42	46
Dec	42	17

Rural Canterbury PHO		
Month	Target (90% of children)	Nurse Closed
Oct	6	9
Nov	6	14
Dec	6	4

Christchurch PHO		
Month	Target (90% of children)	Nurse Closed
Oct	2	2
Nov	2	1
Dec	2	0

Public Health Nursing Service		
Month	Target (90% of children)	Nurse Closed
Oct	14	16
Nov	14	14
Dec	14	9

Promotion of Healthy Environments & Lifestyles

- ***All Right?* social marketing campaign update:** Kaikoura/Hurunui - Opinions Market Research Ltd has been contracted to evaluate the work of *All Right?* in the Kaikoura and Hurunui districts. *All Right?* received some funding from the Lotteries Commission Earthquake fund for health promotion work in both districts. A representative sample of people aged 15 and over living in both districts will be invited to participate in the research and eight key informants will be interviewed. The objectives of the research are to assess the awareness and impact of the campaign as well as attitudes towards it.

- Māori Resilience - Ihi Research and Development have carried out an investigation into Māori resilience with the final report now being edited. It will be available through the *All Right?* website on completion. The research, which took a strengths-based approach, was informed by kaupapa Māori theory and research principles. The research had two main aims, firstly, to investigate how Māori in Christchurch identified resources and processes which enabled individual and community recovery after the earthquakes. Secondly, to understand whether a connection to Māori cultural values played a part in how whānau responded to the earthquakes. Overall the research findings demonstrate that core cultural values related to being Māori were significant to Māori participant's earthquake recovery and resilience.

- Compliments 2.0 - This pre-Christmas campaign attracted 3,481 visits to the GIF advent calendar in December. The compliments cards proved popular with Cantabrians with 3,499

being distributed before Christmas. The compliments cards are now part of the core collection of resources as they are relevant for any occasion.

- **Greater Christchurch Psychosocial Committee – an update:** The greater Christchurch Psychosocial Committee plans, coordinates, promotes, and monitors the psychosocial recovery and wellbeing of the population of greater Christchurch. An update to the Shared Programme of Action activity tables was released in January. The Shared Programme of Action is a practical tool for the Psychosocial Committee. As well as demonstrating the Committee's collective knowledge about its work and the context of that work, the Shared Programme of Action provides the Committee with clarity regarding the activities the partners are involved with that are contributing to the Committee's shared vision and priorities.

- At its December meeting, the Governance Group accepted the final proposal resulting from the review of the Canterbury Wellbeing Index. The new tool will collate and curate high quality information about our region's wellbeing status and factors influencing wellbeing (determinants), with a focus on strengths-based measures and analysis of equity.

- The review of the Index was requested in mid-2017 to ensure the format and content of the Index were relevant and valuable in emerging 'post-recovery' contexts, while remaining within resource constraints. The need for a tool like the Index was identified in early engagement, particularly need for a trusted, reliable, high-calibre wellbeing monitoring tool. With insights from New Zealand and international best practice, and the input of a wide range of local stakeholders, the redesigned tool will meet this need. It will also be a useful tool in a region where earthquake recovery is an aspect of wellbeing, and where wellbeing is also monitored broadly. The Psychosocial Committee and Governance Group will meet quarterly in 2018.

- **Measles cases:** For the last month Community and Public Health's communicable disease team have been busy with measles cases following an imported case which was notified at the end of January. The team have followed up 14 notified cases of which 4 have been confirmed following testing. The last confirmed case was notified on the 19th February (the case was still infectious and quarantined). The investigations have been resource intensive involving staff in following up hundreds of contacts, quarantining susceptible persons and also running a special vaccination clinic. The last two cases are from the same family and the team anticipate that the steps taken will have prevented further spread into the community. Several follow up actions have included encouraging GP teams to update and maintain accurate immunisation registers, ensuring that all data is entered into the National Immunisation Register (NIR). Childhood centres and primary schools have also been encouraged to maintain accurate immunisation registers.

- **HSNO (Hazardous Substances and New Organisms) Forum established:** The North Canterbury HSNO forum has now been established. Community and Public Health has been asked to present a HSNO scenario at the upcoming May forum demonstrating the value of our involvement, as a health agency in this forum. During the most recent meeting held in February 2017 NZ Fire and Emergency notified all agencies involved that the HSMAT (term referring to hazardous materials or resources used in managing hazardous material incidents) Co-ordination Committee will begin meeting again on a regular basis and explicitly noted that representation from Health will be required. Having representation on both these groups is of great benefit as CPH seeks to plan for, and respond to, HSNO events of public health concern.

- **Broadly Speaking about health and its determinants:** The Broadly Speaking programme has been developed by Community and Public Health to help develop a greater understanding of the many factors, beyond the health sector, that impact on the health of populations. Highlighted on the CDHB's Learning and Development Calendar the course is available to those within and beyond the health sector. The Broadly Speaking Programme leads participants through a series of workshop-based discussions and activities. Working with others from across

the DHB and wider health sector participants unpack the complexities of ill-health in our population. Designed to encourage collaborative action, through inspiring participants to broaden the role they play in advocating for improved population outcomes, the course highlights the DHB's mandate to prevent disease and to protect and promote good health.

- The course is facilitated by Community and Public Health over two half-day sessions. Course dates for 2018 are as follows:
  - 9 May and 23 May (8.30 – 12.30 on each day), or
  - 8 August and 22 August (8.30 – 12.30 on each day)
- Board members are welcome to attend the course. To register your interest and enrol in the Broadly Speaking Programme please contact Nicola Laurie (Nicola.Laurie@cdhb.health.nz).

SUPPORTING OUR TRANSFORMATION

Effective Information Systems

- **Acute Services Building**
  - Final marked up hardware plans are now in progress
  - Procurement activities are on track.
  - Risks remain around multiple facilities projects having a similar timeframe and competing for resources.
  - The budget is tracking well at this stage and is continuously tracked to ensure scope is adhered to, with a process to manage any escalations.
- **Amadeus (new patient data repository)**
  - Discussions ongoing with Orion on using Amazon Web Services for hosting the data
  - Privacy requirements with MOH are being worked through before we can start to receive data.
- **Christchurch Outpatients**
  - Marked up plans detailing hardware and IT details are in production and a formal sign of process and template has been agreed.
  - The budget is on track and is regularly monitored to ensure compliance
  - The programme team are working to ensure robust communication from the operational working groups to ensure effective planning.
  - Meeting arranged with the migration planning team next month to understand the approach to migration and ISG operational impacts.
- **Cardiac Test Repository**
  - Vendor Contract (FujiFilm) and Financial Plan process completed.
  - Regional delivery framework and Governance agreed and in place between all participating DHB's.
  - Network design, device audit and test plan development in progress.
  - Engagement started with other regional DHB's
- **Electronic Medicines**
  - Meetings are ongoing with the vendor, DXC, to work through what is required to upgrade the MedChart software.

- A business case has been progressed for a larger software upgrade in 2018.

- **Health Connect South**
  - Independent report into service improvements completed, and a plan to implement recommendations is being prepared.
  - A release to bring in new functionality was completed this month.

- **South Island Patient Information Care System (SIPICS)**
  - Preparations continue for the rollout of the software into the main Christchurch Hospital.
  - Work flows are being documented for each service that provide assistant for detailed planning.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Communications and Engagement

- The Communications team is supporting a pilot programme at Burwood Hospital to improve hand hygiene compliance called "Going for Gold". Essentially it has brought together Hand Hygiene Gold Auditors and Charge Nurse Managers to agree how they might allow the Gold Auditors to increase their presence and achieve more challenging targets for their auditing, thereby improving hand hygiene performance and contributing to patient safety.

- We are working to an action plan that will promote the national April Falls initiative, linking it to work within the Restorative Care Programme. The two work-streams overlap to ensure people retain muscle conditioning during a hospital stay by moving more, while ensuring that increased movement can be done safely and without increasing the risk of falling.

- Communications is also working with the Antibiotic Stewardship Group on how we can inform and support people to make better decisions on the use of antibiotics. This will be timed to coincide with the increase in colds, coughs and flu as we approach winter and the associated increased demand for antibiotics that won't do any good and may cause harm, as well as hastening the spread of antibiotic resistant microbes. It will build on last year's promotion work with General Practice during Antibiotic Awareness Week.

- **Care Starts Here:** Communications work in the past month included developing case studies of the Care Starts Here behaviours in action (Doing the Right Thing, Being and Staying Well and Valuing Everyone). The first case study focused on medical students spending a "day in the life" of a nurse. Work also included promoting a survey to help inform new and strengthened People and Capability policies with over 230 responses in week one and ongoing social media activity.

- **Influenza season/winter planning:** Plans are progressing for our seasonal influenza campaign, which will involve the creation of a website to house down-loadable resources for a range of audiences. The campaign will include immunisation promotion as well as messages about hand hygiene, covering coughs and sneezes, staying home if you're sick and we'll be refreshing our information on 'caring for someone with influenza at home'.

Media

- Media enquiries for February 2018 included many resulting from the issuing of media releases by the Communications team; such as the measles outbreak, an influx of presentations to Christchurch Hospital's Emergency Department as a result of MDMA (Ecstasy)and encouraging people to complete promoting the Census. A story in the CEO Update on two orderlies who assisted a woman to give birth just inside the main hospital entrance was picked

up by national and international media. The story of another woman who birthed in a car outside the entrance to Christchurch Women's Hospital also attracted media attention.

- Canterbury DHB worked on national communications for an issue with Heater-Cooler Units used in operating theatres. This included coordinating media interviews with Dr Josh Freeman, clinical microbiologist with Canterbury Health Labs on the issue of the risks of Mycobacterium chimera affecting patients who have had open heart surgery and had a valve implanted in Christchurch or St Georges Hospital in the past 5 years. We produced a video to explain what had happened and to reinforce that the risk to patients was low, with a 1:5000 chance of developing an infection. There has been on-going engagement with patients following the announcement. A web was produced to provide more information for patients and hosts our video: http://www.cdhb.health.nz/Your-Health/Pages/Important-information-for-open-heart-surgery-patients.aspx
- Other media enquiries included:
  - Canterbury DHB Board and Executive expenses review
  - Midwife shortage
  - Cancelled physicians exam (nationwide) affecting RMOs
  - Impact of ongoing road works near Christchurch Hospital
- Seven Sharp (TVNZ) featured the work of MRI Technologist Peter Dooley in developing a virtual reality programme to assist children undergoing MRI scans which has resulted in more scans being completed, fewer children needing a general anaesthetic and a massive drop in waiting times.
- We issued media releases detailing the second and third cases of measles detected in Christchurch. Dr Alistair Humphrey fronted several media opportunities to explain preventative measures.
- The Canterbury-based transalpine communications team were part of the response to Ex-Cyclones Fehi and Gita. Our involvement included providing the public information management function for public health, media, internal and external communications for the Community & Public Health and West Coast DHB Emergency Operations Centres.
- Internal and External messaging was shared to encourage people to complete the Census. This include creating a series of videos featuring Canterbury DHB staff, sharing and boosting on social media, adverts in The Press, along with internal emails, media interviews, articles and sharing information with networks and colleagues in other government departments to encourage their staff and clients to participate.
- Media releases were issued for health warnings at Lake Forsyth, Lake Pegasus and the Rakahuri/Ashley River due to the discovery of toxic algal bloom, and on the health risks of swimming in rivers after heavy rainfall.
- Live radio interviews – Canterbury Mornings with Chris Lynch – included Dr Alistair Humphrey on measles, Maia Health's Michael Flatman on the 13 Minutes fundraising campaign, and Ngaire Button, Planning and Funding, on the Census push.
- **Facilities Redevelopment:** our regular communications channels have been kept up to date.
- Ongoing work communicating site activity related to the Acute Services and Outpatients builds, mostly via the daily global and weekly CEO updates.
- Current roadworks in the vicinity of the hospital have been communicated extensively to staff, working with Downers and Otakaro communications advisors.

- **Acute Services building:** Attending initial meeting with the Acute Services building migration manager.
- **Outpatients building:** Staff communications to summarise Workshop 5 (February 22) at the Design Lab, including reminders of Dump the Junk/dealing with waste and other move preparations.
- **HREF (Health Research Education Facility) building:** We have worked closely with the Ara communications team this month on a joint communications plan for the HREF building.
- **Akaroa Health Centre:** A blessing/sod-turning ceremony was held on Saturday February 24. Communications team planning involved organisation of the event and a community meeting, sending out invitations, and preparing advertisements and editorial in the local press.
- **New public websites:** Work is progressing our two new websites for Canterbury and West Coast District Health Boards. We are working towards a June 'go live' date for both sites.

CEO Update stories:

- A record number of 50 registered nurses (RNs) began the New Entry to Specialty Practice (NESP) programme in Canterbury DHB's Specialist Mental Health Service on February 5. The NESP programme, which combines theory, supported clinical experience, clinical preceptorship and supervision, celebrated its 20 year anniversary in 2017. Programme participant numbers have risen yearly as interest in mental health nursing increases and the support of the programme becomes widely known.
- Former All Blacks Logistics Manager and Canterbury earthquake rescue hero Kevin "Chalky" Carr passed away in January after a brave battle with pancreatic cancer. He was 45. The Chalky Carr Trust which he set up to raise money for `people bound together by cancer' is fundraising to buy 15 specialist medical oncology treatment chairs for Christchurch Hospital. 'Chalky's Chairs' have been dubbed the "First XV" in reference to Chalky's background in rugby. The chairs enable frail patients to make subtle adjustments to remove the pressure when sitting for long periods.
- The much admired and respected Dermatology secretary, Shirley McTaggart, retired after a 48 year career in health. When she started work at Christchurch Hospital in 1969 she worked for six surgeons, six ophthalmologists as well as the Emergency Department and Clinical Records.
- Alan Pithie was recognised at his last Internal Medicine Cluster meeting as Chief of Medicine with a gift from his colleagues. Alan will continue as a physician in Infectious Diseases and General Medicine. Former Clinical Director Cardiology, David Smyth, is the new Chief of Medicine for the Christchurch Campus.
- On Tuesday 9 January leading Christchurch Obstetrician Harry Bashford passed away peacefully after a long illness surrounded by his family. Harry had a long career and was an exceptional servant to women's health in Christchurch from 1979 until his retirement in 2007. His unrelenting cheerfulness and willingness to help will be remembered and he will be greatly missed.
- The Radiation Oncology team has set up a modified Air New Zealand style quiz in the department's waiting room. The initiative is one of the Five Ways to Wellbeing (Keep Learning) which the team have embraced to improve their own and their patients' mental wellbeing.
- Canterbury DHB congratulated one of its Specialist Mental Health Service (SMHS) staff on his appointment as a member of the Mental Health Inquiry Review team. Dean Rangihuna, a Maori Consumer Advisor (Pukenga Atawhai) of Ngati Porou and Ngāti Hei descent, has a lot of experience in national leadership around seclusion reduction in mental health. He is a passionate advocate for consumers being able to help shape improved care and outcomes for people using

mental health services and has held key Māori mental health positions both nationally and with Canterbury DHB. The inquiry team is led by former health and disability Commissioner Ron Paterson and will have a particular focus on equity of access to quality service.

- Canterbury Community & Public Health (C&PH) staff have contributed to a book of case studies on Health in All Policies (HiaP) after a request from the World Health Organization. The book, 'Progressing the Sustainable Development Goals through Health in All Policies: Case studies from around the world', arose out of an international HiaP conference held in Adelaide last year. The chapter, "Applying a Health in All Policies approach to the Greater Christchurch Urban Development Strategy: the experience to date in Canterbury", is by Public Health Physician, Anna Stevenson and C&PH Team Leader, Sandy Brinsdon. Their chapter is the only one written from a regional organisation perspective, rather than a national one, and the only one that describes a district health board approach. This reflects Canterbury's' approach of a partnership model with sectors that work outside the district health board, the others are top down, Anna says.

- Canterbury DHB has lost a nursing taonga – treasure – when Nanette Ainge retired from her role on March 2, 50 years after she began nursing. Over the five decades Nanette has worked tirelessly, using her skills to facilitate change for nursing as a profession and for individual nurses. Much of her life's work has been in the Canterbury Health System, effecting, guiding and influencing changes in nursing education.

- Specialist Mental Health Services Librarian at Hillmorton Hospital, Julie Milne, departed Bluff in the first week of February on a six week long ride around New Zealand to raise awareness of the positive improvements that can occur after stroke. Julie suffered two debilitating strokes at the age of six. She says that fifty-four years later she is still seeing improvements in her condition and wants others to know they can too.

- **Te Panui Runaka (TPR)**

- The Te Panui Runaka column for February was on mindfulness. Focusing on breathing is a very helpful and basic practice for becoming more mindful. To make it easy for whānau to practice mindful breathing, the team at *All Right?* worked with Rāwiri Hindle (Muriwhenua) to develop Hikitia te Hā. This is a simple breathing exercise that can help people to become more mindful and relaxed. By helping people become more aware of te hā (the breath), Hikitia te Hā allows them to be more present in the moment, reducing stress and anxiety.

FACILITIES REPAIR AND REDEVELOPMENT

General Earthquake repairs within Christchurch campus

- Parkside Panels: Detailed planning is continuing for disconnecting the Chemo Day Ward for Parkside. This may require partial decanting of the ward. Still awaiting pricing from ASB Link contractor for this work. Design work for replacing confined corner panels is proceeding well now that a number of technical fire and durability issues have been resolved.

- Clinical Service Block roof strengthening above Nuclear Medicine: The business case has been approved. Current delivery dates for the equipment are forecast for the end of May 2018. The programme for construction is reliant on this date. Design consultants have been engaged. Detailed design has started and programme will be updated shortly.

- Design and planning underway for Labs Stair 3 (south-west corner). Business case for remaining work to Stair 3 and panels has been approved. Exemption from Building Consent has been granted and work is underway. Lab Stair 4 initial/scoping work to begin. Some work

to the plant room will need to be undertaken before the completion of Lab Stair 3 and when the Eye Department are still in the Portacoms.

- Concept Design for strengthening of Parkside link to CSB is complete and has been priced by the Quantity Surveyor. A decision will be required on whether to proceed with these works.

Christchurch Women's Hospital

- Stair 2: Awaiting review from fire engineer to enable planning as part of the overall Women's Risk analysis.
- Level 4: Crack injection around core to be undertaken. Parent room, kitchen and toilet areas complete. Difficulties gaining access to area due to patient levels.
- Level 5: Small amount of work to corridor unable to commence due to operational constraints (NICU). Working with teams to identify a suitable time.
- Level 3: All areas complete except reception, which is to be done at same time as stair strengthening to minimise disruption.
- Inspection of the flooring structure (Ribs) has been completed and no structural remediation is required.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering**
  - Database designs complete and in use by Site Redevelopment on current passive work.
  - Test rig complete and installer testing has commenced. RFP for materials is currently active on GETs and due to close mid Feb.
  - Currently working with ISG/Developers for options to transfer database to a cloud base system complete with E form and onsite inspection capability via IPad/ Android phone apps. Draft Policy and Guidelines issued to M&E and Senior Management. SRU continue to upgrade on project to project basis until comment/ advice received.
  - Continue to identify more non-compliant areas as other projects open walls/ ceilings.
- **Christchurch Hospital Campus Energy Centre**: This is managed by the Ministry of Health (*MoH*)
  - Service Tunnel: Services being commissioned. Expect steam from coal boilers 16 Feb.
  - Energy Centre: Concept report including cost plan received by CDHB and commented. Awaiting preliminary start.
- **235 Antigua St and Boiler House (Demolition).** No work to be undertaken until boiler requirements have been resolved for the new energy centre.
- **Parkside renovation project to accommodate clinical services, post ASB (managed by MoH):** Health planners appointed and planning underway. This project is being managed by the MoH with close stakeholder involvement from the CDHB. Still waiting on advice from MoH as to outcome of master planning process. The SRDU team are having regular meetings with the MoH project managers (Projex) to assist in their information gaps.
- **Back up VIE tank:** Work on developing a target strength for the VIE enclosure is underway. Balancing operational and post-disaster requirements against cost and build ability is a key focus for this work.
- **New Outpatient project (managed by MoH**): Façade 80% complete. Architectural/ services fit out on all floors well underway. Rev 5.0 programme issued to MoH/JSL: with SP1 date 29 June. SP2 4 August.

- **Avon Generator Switch Gear and Transformer Relocation**. Design work underway. Due to the small size and engineering component this is now being managed by M&E.
- **Otakaro/CCC Coordination.** Otakaro have issued revised contractor programme. Oxford Terrace complete Sep 2018, Antigua St (OPD/HREF) Apr 2018, Oxford Gap Apr 2018 to Sep 2018. Tuam St/Bus Super Stops has no dates. Land swap discussion still with LINZ.
- **Parkside Canopies:** Temporary repairs to plastic wrap have been made. Planning underway to replace the wrap at the main entry.

Burwood Hospital Campus

- **Burwood New Build**: Defects are being addressed as they come to hand.
- **Burwood Admin old main entrance block:** Feasibility study complete and work to commence on repurposing building to accommodate community teams for TPMH. Concept work also to commence on purpose built structure for the Mini Health Precinct.
- **Drainage repairs**: Work complete. In final stages of As Built review.
- **Spinal Unit:** Design and user group process continues. ROI for main contractors on GETS. Closes 14 February.
- **Burwood Birthing/Brain Injury Demolition**: Methodology to be agreed. External project managers commissioned to undertake work. Programme from commencement of demolition could take up to 12 months to complete due to the complex nature of asbestos removal and the proximity of other clinical facilities. Existing switch board servicing other parts of the campus will need to be relocated and or re-routed to allow demolition to commence. Price for switchboard works received from market and orders are about to be placed. Consultant agreements complete and with legal for sign off with design work planned to commence in early February. ROI on GETS for main contractor to demolish building. The work will be carried out under separable portions.
- **Burwood Tunnel Repairs:** Work has been scoped and priced. Expected start is March 2018.
- **2nd MRI Installation:** Design work and planning continues. MRI scanner temporarily relocated from Merivale to storage at Print Place. Faraday cage installation is being repriced by another provider. A new MRI has now been sourced with the original Merivale MRI traded in as part of the procurement process. Scope of works being finalised and costed with Siemens.
- **Decision making frame work**: Workshops to be run by Planning and Funding are scheduled for 5 March and 11 April.

Hillmorton Hospital Campus

- **Earthquake Works:** No earthquake works currently taking place. This will be reviewed once the outcome of the TPMH mental health business case has been advised.
- **Food Services Building**. On hold at present. Currently undertaking a structural review to determine options for repairs concurrently with full or partial occupation.
- **Cotter Trust** on-going occupation being resolved as part of overall site plan requirements.
- **Mental Health Services:** Review of all Forensic services including PSAID, AT&R, and Roko being completed, including refurbishment verses rebuild cost and logistic process. Awaiting results of clinical review. Concept design for AT&R built at Design Lab has been reviewed by staff. All Design Lab work complete. Designs returned from Architect. Currently with Clinical team for clinical leaders group sign off prior to business case being prepared. RFP for full design currently in development stage and due to be issued mid to late Feb 2018.

- **Decision making frame work**: Workshops, to be run by Planning and Funding, are scheduled for 22 Feb and 9 April.

The Princess Margaret Hospital Campus

- **Older Persons Health (*OPH*) Community Team Relocation:** The feasibility study is now complete and work is to commence shortly on repurposing the old Burwood Administration building to accommodate community teams
- **Mental Health Services Relocation:** Indicative Business case approved by Ministers in Sept 2017. The next step is the development of Detailed Business Case which is planned for July 2018 for submission.

Ashburton Hospital & Rural Campus

- Stage 1 and 2 works are both complete. Final claims have been agreed with the contractor. Final defects resolution and retention release expected by June 2018.
- **Tuarangi Plant Room**: Upgrade of access and egress systems. Options have been provided by the Architect and Safety consultant. Next meeting is on site at Tuarangi to confirm which option should go through to concept design for pricing and signoff.
- **New Boiler and Boiler House**: Project process commenced. This is being managed by M&E.

Other Sites/Work

- **Decision Making Frame Work:** This work is now being led by Planning and Funding. Workshops have been scheduled to occur Feb to April 2018 for both the Burwood and Hillmorton campuses. Resilient Organisation Ltd have been contracted by Planning and Funding to assist with this process. SRDU will continue to be heavily involved to ensure a streamlined process is achieved.
- **Akaroa Health Hub**. Both Resource Consent and Building Consent have been received. Evaluation of main contractor tenders is complete. Contract award and start of site works is expected shortly.
- **Kaikoura Integrated Family Health Centre**: Code compliance received. Scoping of cosmetic damage due to November's earthquake is complete. Estimates provided to Corporate Finance. Final design works for remedial to adjoining neighbours drives have now started. These had been stalled due to EQ issues in the area.
- **Rangiora Health Hub**: Design complete. Building consent application lodged with Waimakariri District Council mid-January. Main contractor tender documents signed off by Corporate. RFP will be placed on GETS 19 February. Current MoH date for the Hagley Outpatients building to be available is 29 June.
- **Former Christchurch Women's Site**: Order issued for bi annual grass cutting and weed treatment following requests from neighbouring owners.
- **Home Dialysis**. Business case has been presented to 30 January 2018 Facilities Committee meeting, recommended to 15 February 2018 Board for approval. Approval of consultants to proceed.
- **SRDU**. Project Management Office manuals re-write and systems overview. Approximately 55% complete. Aligning with P3M3 process and documentation where appropriate.
- **Seismic Monitoring**: Business Case approved. RFP documentation being developed.
- **Laundry Building**: Currently under review for options to fix based on a change of use possibly for CDHB store/warehouse and other facilities. Feasibility study underway.

- **New Laundry:** SRU continuing to assist CLS with procurement of construction advice for the new design/build/lease laundry facility.
- **HREF:** SRU continues to be involved in providing construction and contract administration/interpretation advice to the HREF project.
- **Annual Damage reviews:** Planning is underway for the 2018 repeat damage assessment of the DHB's building stock.

Project Programme Key Issues

- The recent notification of Fletcher Construction closing down their building and interiors division will have effects on current work programmes and pricing. SRDU are currently working through outstanding work and projects to identify the risks and issues for delivery of these projects.
- The lack of a detailed Master Plan for the Hillmorton campus is still affecting our ability to provide a comprehensive EQ decision making assessment. This requirement has been forwarded onto Planning and Funding for review and action.
- Additional peer reviews of Parkside and Riverside structural assessments, being undertaken by the MoH, are now complete. Clarity on the direction of the Master Planning process is required to plan the next stage of the POW. This is also having an effect on the sizing and future proofing of energy supply from the proposed boiler house.
- Delays to the POW continue to add risk outside the current agreed Board time frames. Key high risk areas of Panel replacement are starting, as instructed by the Facilities Committee and CDHB Board.
- Identifying a new cladding system for Parkside has been delayed by uncertainty around the compliance status and acceptability of a number of products and systems. Understanding of the Christchurch City Council's position in relation to passive fire, the tests that are to be applied and which elements are to be subjected to assessment can best be described as emerging. Systems and products that have been used in the past or in projects already under construction have not been deemed compliant for this project, and this has made it difficult for the CDHB's designers to provide advice with any degree of confidence. After several months of research and assessment, the CDHB's fire engineers, façade engineers, and architect have identified a system that the Council has indicated will be accepted as compliant.
- Access to NICU to undertake EQ repairs to floors continues to be pushed out due to access constraints. The urgent works undertaken to facilitate the MoH run link corridor works has further affected this. Restricted access has been given to one area.
- Passive fire wall repairs continue to be identified. Repairs to these items are being completed before the areas are being closed up, but the budget for this has not been formalised. On-going repairs of these items, while essential, continue to put pressure on limited budgets and completion time frames.
- Passive fire issues are now being raised in the Labs building. Work completed and in final review and potential passive fire issues around comm floor 80 and use of all proof collars at outpatients, ASB and Burwood are currently under review.
- Uncertainty of delivery of MoH projects is severely affecting our ability to programme projects and allocate resources efficiently. Rangiora is one such example. A firm date from the MoH is still not able to be provided with any level of confidence.

- Proposed ASB Western Link – a number of constraints and issues have been identified by CDHB and these are being worked through with assistance from SRU. The requirements of additional decant space, the responsibility for undertaking the work and payment of costs is still to be addressed by the MoH as they are an ASB related project work face. Additional passive fire noncompliance has been found in areas of the proposed new links during opening works. Site Redevelopment have provided support and design details to mitigate risks to service provision for the theatres. Due to the limited timeframe certain noncompliance areas will be temporary filled, photographed and recorded for future repair.
- Burwood 2nd MRI. Delays to the procurement of the faraday cage installation contractor and the change of procurement strategies continue to push this project out. This is currently being managed by procurement. The use of an alternative contractor will create additional budget pressure due to existing agreements.
- Impact of changes to the Building Act and Seismic assessment methodology continue to be assessed in relation to DHB buildings. Some buildings will be assessed at a higher % NBS than previously, but it is likely that more buildings will be deemed to be EQ prone than is currently the case. There are significant cost implications arising from these changes as strengthening schemes are likely to cost more and existing engineering reports are no longer valid as a basis for consentable strengthening work.
- Work is about to commence on reconciling CDHB buildings that have been placed on the National EQ prone buildings register with those that we understand to be EQ prone. There appears to be a discrepancy between the information CERA has provided to CCC and our own records.

LIVING WITHIN OUR FINANCIAL MEANS

Live Within our Financial Means

- The consolidated Canterbury DHB financial result for the month of January 2018 was a deficit of $2.579M, which was $0.674M unfavourable against the draft annual plan deficit of $1.905M. The year to date position is $0.912M unfavourable to the draft annual plan. The table below provides the breakdown of the January result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	(0.000)	-	**(0.000)**	(0.968)	-	(0.968)
Funder	(1.057)	0.123	**(1.180)**	(11.995)	(12.863)	0.868
DHB Provider	(1.522)	(2.028)	**0.506**	(12.683)	(11.871)	(0.812)
Canterbury DHB Group Result	**(2.579)**	**(1.905)**	**(0.674)**	**(25.646)**	**(24.734)**	**(0.912)**

Report prepared by: David Meates, Chief Executive

DELIVERING AGAINST THE NATIONAL HEALTH TARGETS – PRELIMINARY RESULTS		Q1	Q2	Q3	Q4	Target	Status
 **Shorter Stays in ED** Patients admitted, discharged or transferred from an ED within 6 hours	Canterbury DHB met the health target in quarter two with 95% of patients admitted, discharged or transferred from ED within 6 hours The Acute Demand Management Service continues to play a critical role in keeping people well in the community and avoiding unnecessary presentations to ED. More than 7,809 acute demand packages of care were provided in quarter 2.	94%	95%			95%	✓
 **Improved Access to Elective Surgery** Canterbury's volume of elective surgery	Canterbury DHB did not achieve the health target in quarter 2, delivering 10,344 elective surgeries against the year to date target of 10,737. We delivered 96% of planned discharges this quarter. Performance was adversely affected by a large number of coding delays. The delayed codes are being worked through and future reporting will more accurately reflect the DHB's position.	4,989 (90%)	10,344 (96%)			21,330	✗
 **Increased Immunisation** Eight-month-olds fully immunised	Canterbury DHB achieved the health target with 95% of eligible children fully vaccinated at eight months. Only 1.3% (21 children) were not immunised on time (excluding declines and opt-offs of). Coverage was high across all population groups, meeting the health target for most ethnicities (98% Asian, 97% Pacific, and 96% New Zealand European).	95%	95%			95%	✓
 **Better Help for Smokers to Quit** Smokers enrolled in primary care receiving help and advice to quit	Canterbury DHB achieved the health target in quarter one with 90% of smokers enrolled with a PHO offered advice and help to quit smoking against the 90% target. This is a 1% reduction in performance on the previous quarter. Performance remains above the national average of 88%. Canterbury DHB's cessation support indicator is again the highest in the country at 56%. This indicator shows the percentage of current smokers who have taken the next step from brief advice and accepted an offer of cessation support services in the last 15 months.	91%	90%			90%	✓
 **Faster Cancer Treatment** Patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer	Canterbury DHB achieved the target in quarter 2 with 94% of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer. This is the second quarter under the new target and definition.	95%	94%			90%	✓
 **Raising Healthy Kids** Percent of obese children identified at B4SC will be offered a referral for clinical assessment and healthy lifestyle intervention	Canterbury DHB achieved the health target in quarter two with 96% of four-year-olds identified as above the 98th centile for their BMI (height and weight measurement) referred for clinical assessment and healthy lifestyle intervention. This is a 3% increase on the previous quarter. 'Referrals declined' increased slightly from quarter one (21% to 30%) however, there was no inequity between ethnicities. The Ministry commended Canterbury for equity across all ethnicities with 93% of Pacific children (previously 88%) and 94% of Māori children (previously 90%) referred and acknowledged this quarter.	93%	96%			95%	✓

FINANCE REPORT – AS AT 31 JANUARY 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Finance**

DATE: **15 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This is a regular report and standing agenda item providing an update on the latest financial results and other relevant financial matters to the Board of the Canterbury DHB. A more detailed report is presented to and reviewed by the Quality, Finance, Audit and Risk Committee monthly, prior to this report being prepared.

2. RECOMMENDATION

That the Board:

i. notes the financial result for the period ended 31 January 2018.

3. DISCUSSION

Overview of January 2018 Financial Result

The consolidated Canterbury DHB financial result for the month of January 2018 was a deficit of $2.579M, which was $0.674M unfavourable against the draft annual plan deficit of $1.905M. The year to date position is $0.912M unfavourable to the draft annual plan. The table below provides the breakdown of the January result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	(1.530)	(1.933)	**0.404**	(12.420)	(11.765)	(0.655)
Community & Public Health	(0.007)	(0.023)	**0.016**	(0.327)	(0.115)	(0.212)
Total In-House Provider excl Subsidiaries	**(1.536)**	**(1.956)**	**0.420**	**(12.746)**	**(11.880)**	**(0.867)**
Add: Funder & Governance						
Funder Revenue	131.936	132.402	(0.466)	923.883	926.694	(2.811)
External Provider Expense	(55.667)	(55.048)	(0.619)	(394.654)	(398.939)	4.286
Internal Provider Expense	(77.325)	(77.230)	(0.095)	(541.224)	(540.617)	(0.607)
Total Funder	**(1.057)**	**0.123**	**(1.180)**	**(11.995)**	**(12.863)**	**0.868**
Governance & Funder Admin	(0.000)	-	(0.000)	(0.968)	-	(0.968)
Total Canterbury DHB (Parent)	**(2.593)**	**(1.833)**	**(0.760)**	**(25.710)**	**(24.743)**	**(0.967)**
Add: Subsidiaries						
Brackenridge Estate Ltd	0.003	0.007	**(0.004)**	(0.012)	(0.025)	0.013
Canterbury Linen Services Ltd	0.011	(0.079)	**0.090**	0.075	0.033	0.042
Canterbury DHB Group Surplus / (Deficit)	**(2.579)**	**(1.905)**	**(0.674)**	**(25.646)**	**(24.734)**	**(0.912)**

4. APPENDICES

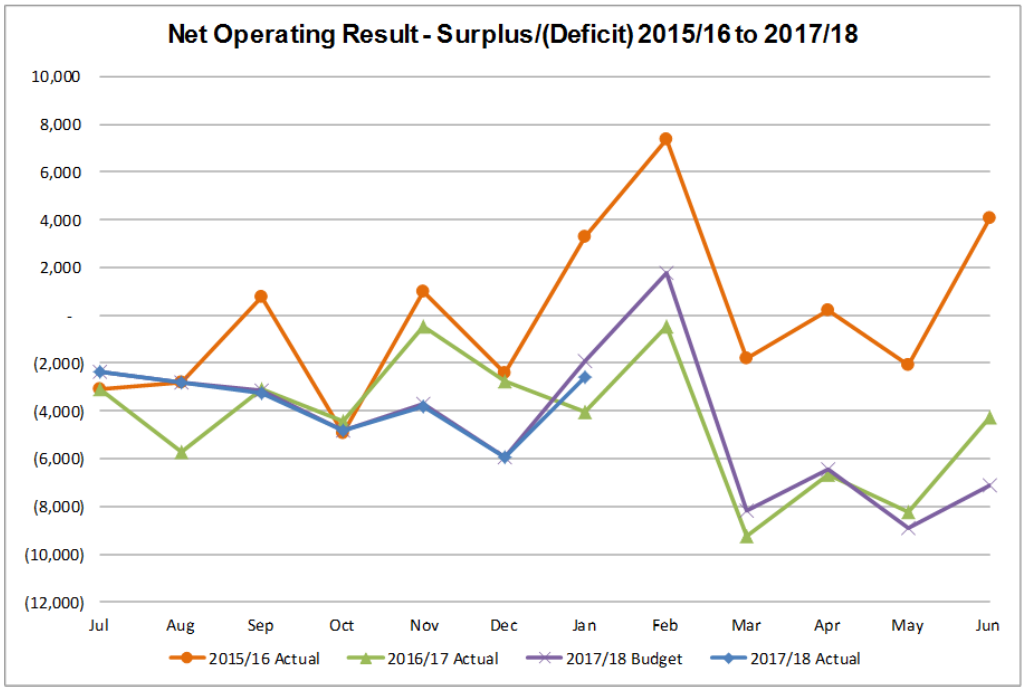
Appendix 1: Financial Result
Appendix 2: Statement of Comprehensive Revenue & Expense
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow

Report prepared by: Justine White, General Manager Finance & Corporate Services

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – YTD JANUARY 2018

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Surplus/(Deficit)	(2,579)	(1,905)	(674)	35%	×	(25,646)	(24,734)	(912)	4%	×



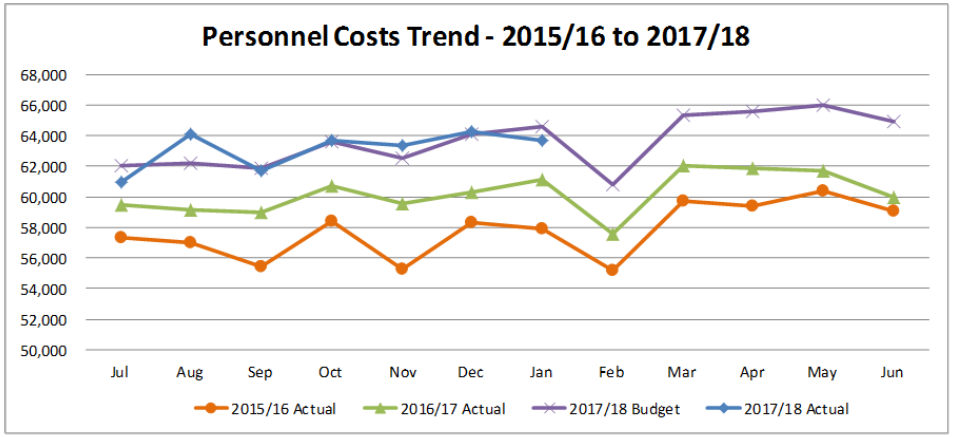
Our 2017/18 Annual Plan was submitted with a deficit of $53.644M - this is still going through the MoH approval process.

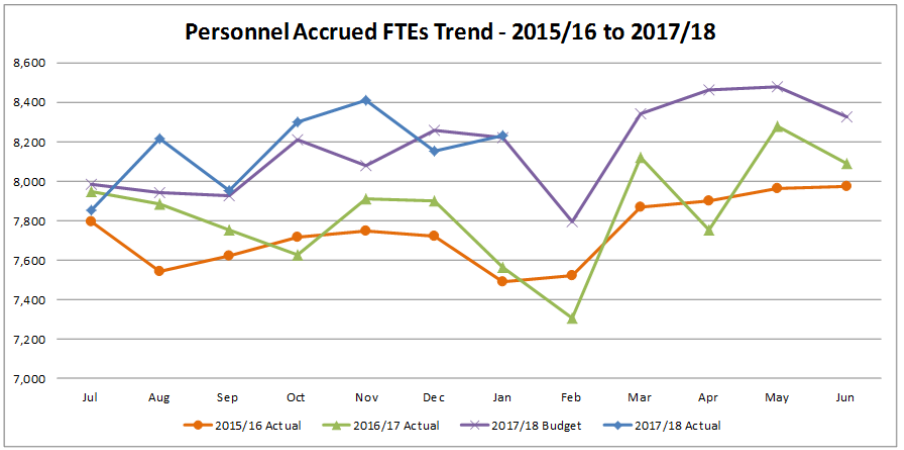
The year to date earthquake related costs (excluding the Kaikoura earthquake costs) are estimated at $8.521M, offset by insurance revenue drawdown from the MoH of $2.014M.

KEY RISKS AND ISSUES

We expect to continue to incur earthquake related repair and maintenance expenditure and the depreciation impacts of quake related capital spend for a significant number of years into the future. There will be variability between the expected and actual timing of these costs. MECA settlements over and above our planned amount will impact on our results.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

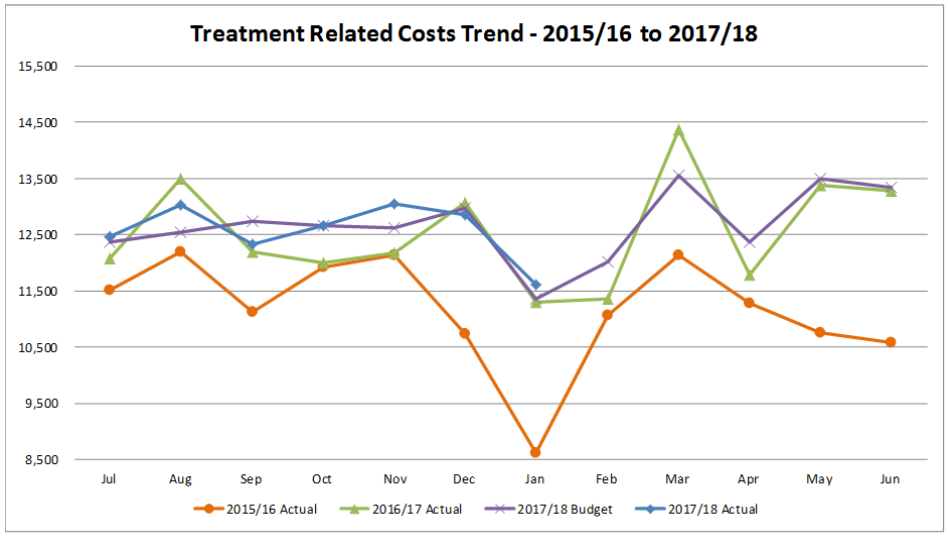


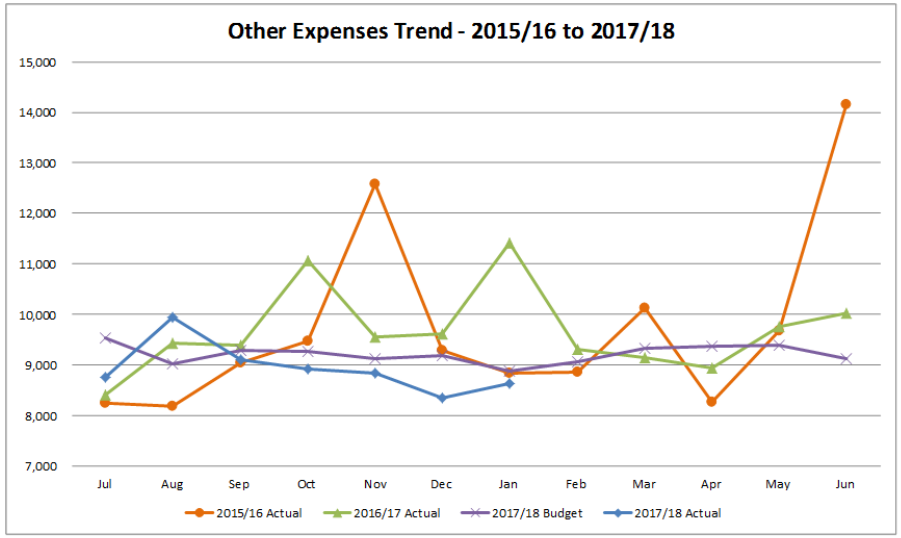


KEY RISKS AND ISSUES

Pressure will continue on personnel costs into the foreseeable future, as a result of settlements as well as additional resource required for the new ASB redevelopment.

TREATMENT & OTHER EXPENSES RELATED COSTS





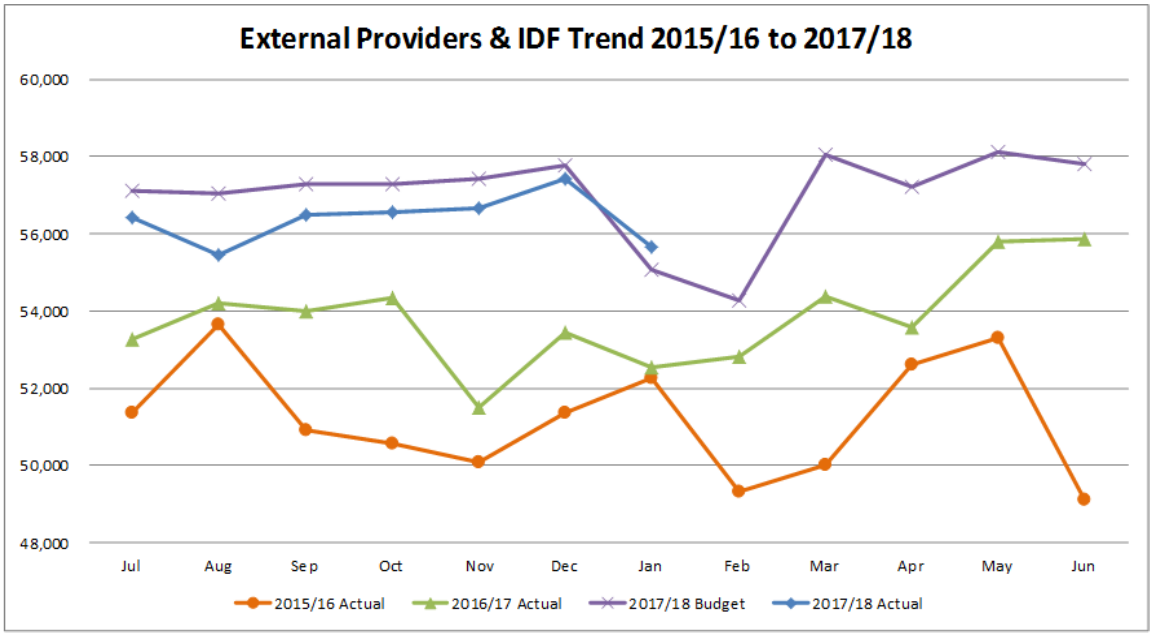
KEY RISKS AND ISSUES

Treatment related costs are influenced by activity volume, as well as complexity of patients.

Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital campus. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site.

EXTERNAL PROVIDER COSTS

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
External Provider Costs excl Pay Equity	54,409	52,908	(1,501)	-3%	✗	382,756	384,027	1,271	0%	✓



Community pharmaceutical spend continues to be favourable ($4.043M YTD), but is expected to drop to approximately $2.3M favourable at year end – we are starting to see an increase in claims submitted.

Community aged residential care expenditure is favourable $0.189M YTD. However, the rest home expenditure component is $2.473M unfavourable YTD, and is predicted to be $3M unfavourable at year end, and is one of the main drivers of this month's result. The budget anticipated a decreasing expenditure trend, but actual expenditure has been stable, rather than declining.

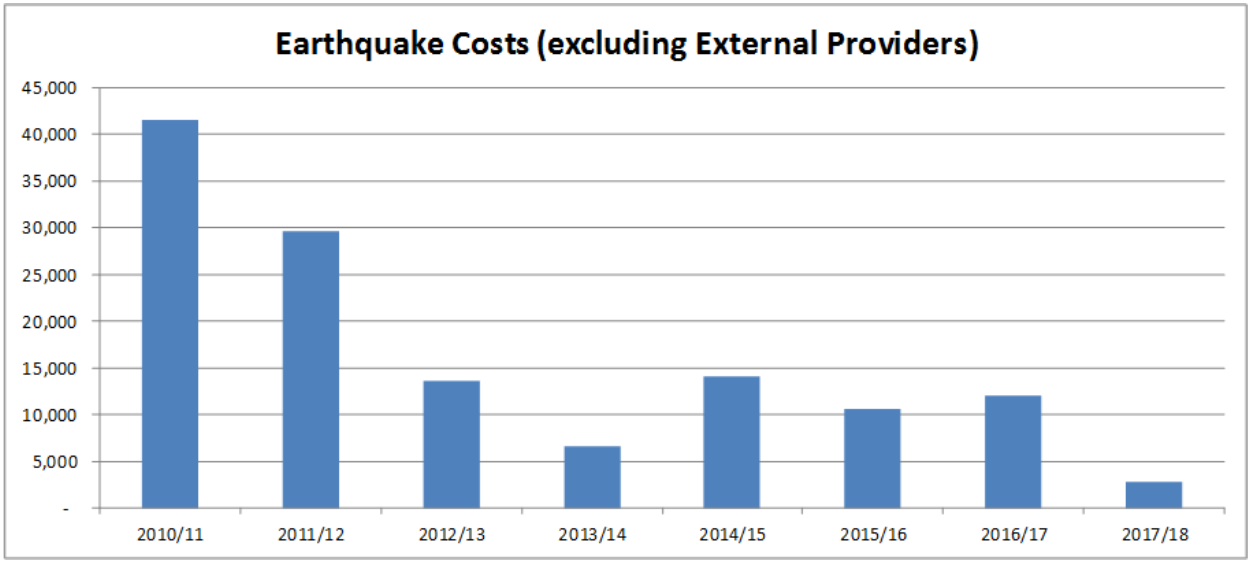
Our elective surgery procedures have been impacted by the delays in the turnover of 2 theatres involved in the MoH led ASB Link project, resulting in additional outsourcing requirements as well as postponement of surgeries, for which we are still assessing the impact. We would expect the financial impact to flow through into our February / March results. Our forecast year end result does not take into account any financial impact of additional outsourcing nor any elective funding that may need derecognising at this point in time.

KEY RISKS AND ISSUES

Our current consolidated YTD result is largely on target, with the external providers underspend offsetting unfavourable MoH revenue. Any catchup on external provider spend will need to be offset with favourable variances in other areas.

EARTHQUAKE

Data in this table excludes the Kaikoura earthquakes	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Total Earthquake Revenue (Draw Down)	171	442	(271)	100%	✗	2,014	4,194	(2,180)	100%	✗
Earthquake Costs - Repairs	273	442	169	100%	✓	2,063	4,194	2,131	100%	✓
Earthquake Costs - External Provider	808	808	-	100%	✓	5,661	5,661	-	100%	✓
Earthquake Costs - Non Repairs	128	114	(14)	100%	✗	797	617	(180)	100%	✗
Total Earthquake Costs	**1,209**	**1,364**	**155**	**100%**	✓	**8,521**	**10,472**	**1,952**	**100%**	✓



Earthquake (EQ) operating costs include EQ repair works and other non-repair related costs such as additional security and building leases.

EQ repair (integral part of the DHB EQ Programme of Works) costs are offset by an equivalent amount of insurance revenue that will be progressively drawn down to minimise the impact of EQ repair costs on the net result. The insurance revenue relates to the portion of earthquake insurance settlement amount that was repaid to the Crown in 2013/14 for future draw down by the DHB as and when appropriate to fund the earthquake repairs and programme of works.

Note: 'Quake' costs associated with additional funder activity such as increased outsourced surgery are captured under external provider costs.

KEY RISKS AND ISSUES

The variability and uncertainty of these costs will continue to put pressure on meeting our monthly budgets in future periods.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		
Equity	501,445	503,101	(1,656)	0%	✗
Cash	(17,028)	(30,235)	13,207	-44%	✓

The sweep account was overdrawn at the end of January with a balance of $18.009M. Our closing forecast for June 2018 is for an overdrawn position, but is still based on receiving $52.833M 16/17 deficit support before the end of March 2018. If 16/17 deficit support is not received, we would expect an overdraft position of around $60M, rising to over $100M by calendar year end. This is over the maximum facility that we have available to us under the OPF. As with any forecast, there is expected to be variability, including unexpected expenditure, so a small but reasonable buffer needs to be maintained.

Canterbury DHB is relying on deficit funding for future cash flows. This will be critical towards the end of the current financial year. A formal application to the MoH is still under review, and it is understood that we are unlikely to know whether deficit funding will be available, and the amount that may be available, until February / March 2018. This will leave little scope for unplanned costs, and if full deficit funding of 2016/17 is not provided, the DHB will have serious cash capacity issues for future operational needs.

(Note that the cash favourable variance is timing of payments only, such as payroll, PAYE, and GST, and is offset with an unfavourable variance in payables. We continue to ensure our liabilities are paid on time at this point.)

KEY RISKS AND ISSUES

16/17 deficit funding will be dependent on our cash requirements over the 17/18 year, and our application for deficit funding may not be fully approved – we are awaiting confirmation of the level that will be funded. Our cash forecast will be impacted should the full amount of deficit funding not be received. Additionally, earthquake costs continue to be difficult to predict with certainty.

APPENDIX 2: CANTERBURY DHB GROUP STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The Group financial results include Canterbury DHB and its subsidiaries, Canterbury Linen Services Ltd and Brackenridge Estate Ltd
For the 7 Months Ended 31 January 2018

Month					Year to Date				Annual
17/18 Actual	17/18 Budget	16/17 Actual	Variance to Budget		17/18 Actual	17/18 Budget	16/17 Actual	Variance to Budget	17/18 Budget
136,915	137,787	133,096	(873) ✗	MoH Revenue	958,985	964,511	915,951	(5,526) ✗	1,653,435
3,688	3,830	2,949	(142) ✗	Patient Related Revenue	27,929	26,610	23,695	1,319 ✓	45,765
2,524	2,883	3,174	(359) ✗	Other Revenue	19,764	21,128	25,828	(1,364) ✗	36,947
143,127	**144,501**	**139,220**	**(1,374)**	**Total Operating Revenue**	**1,006,678**	**1,012,249**	**965,474**	**(5,571)**	**1,736,147**
63,694	64,479	61,158	786 ✓	Personnel Costs	441,744	440,851	419,397	(893) ✗	763,497
11,605	11,348	10,779	(257) ✗	Treatment Related Costs	87,946	87,234	84,772	(713) ✗	151,996
55,667	55,048	55,048	(619) ✗	External Service Providers	394,654	398,939	373,239	4,286 ✓	684,378
8,643	8,829	9,413	186 ✓	Other Expenses	62,542	64,240	70,392	1,699 ✓	110,657
139,609	**139,705**	**136,399**	**96** ✓	**Total Operating Expenditure**	**986,886**	**991,264**	**947,800**	**4,378** ✓	**1,710,528**
3,518	**4,796**	**2,821**	**(1,277)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**19,793**	**20,985**	**17,674**	**(1,192)** ✗	**25,619**
611	611	450	- ✓	Capital Charge Funding for Revaluation & Rate Change	4,279	4,279	2,700	- ✓	7,332
269	75	168	194 ✓	Interest	1,042	773	1,245	269 ✓	1,579
249	138	24	111 ✓	Donations	709	1,166	534	(457) ✗	1,860
-	-	(1)	- ✓	Profit / (Loss) on Sale of Assets	(24)	-	719	(24) ✗	-
1,130	**824**	**640**	**306** ✓	**Total Indirect Revenue**	**6,005**	**6,218**	**5,198**	**(213)** ✗	**10,771**
2,470	2,487	1,823	17 ✓	Capital Charge	17,849	17,895	8,623	46 ✓	30,330
4,747	4,988	5,047	241 ✓	Depreciation	33,538	33,892	33,429	354 ✓	59,704
10	50	617	40 ✓	Interest Expense	58	150	3,776	92 ✓	-
7,227	**7,525**	**7,488**	**298** ✓	**Total Indirect Expenses**	**51,444**	**51,937**	**45,828**	**493** ✓	**90,034**
(2,579)	**(1,905)**	**(4,027)**	**(674)** ✗	**Total Surplus / (Deficit)**	**(25,646)**	**(24,734)**	**(22,956)**	**(912)** ✗	**(53,644)**

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

As at 31 January 2018

Audited 30-Jun-17 $'000		Group Actual 31-Jan-18 $'000	YTD Group Budget 31-Jan-18 $'000	Annual Group Budget 30-Jun-18 $'000
199,933	Opening Equity	517,833	517,833	517,833
372,224	Net Equity Injections / (Repayments) During Year	9,258	10,000	114,618
(1,491)	Reserve Movement for Year	-	-	-
(52,833)	Operating Results for the Period	(25,646)	(24,734)	(53,644)
517,833	**TOTAL PUBLIC EQUITY**	501,445	503,099	578,807
	Represented By:			
	Current Assets			
1,985	Cash & Cash Equivalents	981	-	-
1,350	Short Term Investments	842	1,350	1,350
63,240	Trade and Other Receivables	63,972	63,238	116,882
9,629	Prepayments	8,851	9,411	9,411
9,119	Inventories	11,399	9,119	9,119
11,815	Restricted Assets	10,793	11,815	11,815
97,138	**Total Current Assets**	96,838	94,933	148,577
	Less Current Liabilities			
16,505	Overdraft	18,009	30,235	2,250
107,154	Trade and Other Payables	109,528	96,426	93,937
12,111	Restricted Funds	10,810	12,110	12,110
156,703	Employee Benefits	154,146	156,700	156,700
292,473	**Total Current Liabilities**	292,493	295,471	264,997
(195,335)	**Working Capital**	(195,656)	(200,538)	(116,420)
	Non Current Assets			
296	Restricted Funds	16	296	296
5,936	Investment in NZHPL	5,936	5,936	5,936
713,091	Fixed Assets	697,264	703,560	695,150
719,323	**Term Assets**	703,215	709,792	701,382
	Non Current Liablilties			
6,155	Employee Benefits	6,114	6,155	6,155
6,155	**Term Liabilities**	6,114	6,155	6,155
517,833	**NET ASSETS**	501,445	503,099	578,807

APPENDIX 4: CASHFLOW

Audited 30-Jun-17 $'000		Actual 31-Dec-17 $'000	YTD Budget 31-Dec-17 $'000	Budget 30-Jun-18 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
15,897	**Net Cash from Operating Activities**	8,585	(1,355)	(6,940)
	CASHFLOW FROM INVESTING ACTIVITIES			
(55,202)	**Net Cash from Investing Activities**	(20,351)	(24,360)	(41,762)
	CASHFLOW FROM FINANCING ACTIVITIES			
11,239	**Net Cash from Financing Activities**	9,258	10,000	60,972
(28,066)	Overall Increase/(Decrease) in Cash Held	(2,508)	(15,715)	12,270
13,546	Add Opening Cash Balance	(14,520)	(14,520)	(14,520)
(14,520)	**Closing Cash Balance**	(17,028)	(30,235)	(2,250)

QFARC – 2018 MEETING SCHEDULE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Chair, QFARC**

DATE: **15 March 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to propose changes to the format and workplan of the Quality, Finance, Audit and Risk Committee (*QFARC*) for a 12 month duration. These changes to the workplan are in response to a request from the Board Chair to review the workplan of committees in the coming 6-12 months to ensure that we are best placed to succeed in the ongoing key focus areas of the CDHB in the 2018 calendar year.

2. RECOMMENDATION

That the Board, as recommended by the Quality, Finance, Audit and Risk Committee:

i. notes and endorses the revised QFARC meeting schedule for the 2018 calendar year.

3. DISCUSSION

The CDHB Board Chair signalled in early January, a need to review committee workplans for the coming 6-12 months to assist to reduce workloads and pressures on the organisation, as we step through some critical issues that are fundamental to the success of the DHB and the broader Canterbury Health System.

Based on this premise, and following discussions and feedback from both QFARC and the Board, the current QFARC workplan has been reviewed and a number of changes proposed in order to maintain appropriate oversight, whilst allowing for streamlined involvement of management. The proposed changes recognise the need to:

- fully utilise external QFARC membership to support the CDHB Board;
- declutter agendas to focus on what matters most; and
- continue monthly engagement with CDHB senior management (outside of Board Meetings) to govern/monitor high consequential risks.

QFARC agendas for the past six months have been reviewed in order to better fit items into the proposed 2018 workplan. Whilst it is not proposed to change any of the scheduled meeting dates, a change to the format of the meetings is proposed as follows:

a. Bi monthly conference call to review standard monthly monitoring items.
27 Mar, 29 May, 31 July, 2 Oct, and 27 Nov meetings.

b. Bi monthly full meeting agenda.
1 May, 3 July, 28 Aug, and 30 Oct meetings.

In addition to the formal meetings and monthly provision of information, it is anticipated that there may be a number of special purpose meetings that will be arranged as necessary. An example of this

may be a special meeting to agree the Annual Plan, or to endorse the Christchurch Campus Business Case. It is also proposed that QFARC members be available as required to support other initiatives, such as the 10 year capital and operating plan/funding components of the Truth & Reconciliation Process.

Report prepared by: Barry Bragg, Chair, QFARC

FACILITIES COMMITTEE – 2018 MEETING SCHEDULE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Chair, Facilities Committee**

DATE: **15 March 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to propose changes to dates for the Facilities Committee meetings to better align with Hospital Redevelopment Partnership Group (*HRPG*) meeting dates.

2. RECOMMENDATION

That the Board

i. notes and endorses the revised Facilities Committee meeting schedule for the 2018 calendar year;
ii. notes that where Facilities Committee meetings are scheduled on CDHB Board meeting dates, Board meetings will start at the later time of 11.00am.

3. DISCUSSION

At its meeting on 27 February, the Facilities Committee discussed a revised meeting schedule for the remainder of 2018. The primary purpose of this revision is to better align CDHB's Facilities Committee meetings with HRPG meetings. The proposed change will allow the Facilities Committee to consider and discuss HRPG papers immediately prior to HRPG meetings, ensuring any issues or concerns raised can be taken to the HRPG meeting for addressing. This will also ensure the Facilities Committee will have greater oversite of HRPG issues going forward.

In order for the Facilities Committee to consider HRPG papers prior to the HRPG meetings, it is proposed that it will meet, generally, one day prior to the scheduled HRPG meeting date. In several instances this will require the Facilities Committee to meet the morning of scheduled CDHB Board meetings. On these occasions, it is proposed that the Board meeting will commence at the later time of 11.00am. In all other cases, Board meetings will remain at the current 9.00am start time.

The revised schedule was approved in principle by the Committee, subject to approval by the Board.

It is proposed that for the remainder of 2018, the Facilities Committee will meet from 8.30 to 10.30am on the following dates:

Facilities Committee Proposed 2018 Dates 8.30-10.30am	CDHB Board Meeting 11.00am start
12 April	
17 May	17 May
21 June	21 June
23 July	
16 August	16 August
20 September	20 September
18 October	18 October
21 November	
11 December	

Report prepared by: Ta Mark Solomon, Chair, Facilities Committee

CPHAC/DSAC – 2018 MEETING SCHEDULE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Chairs, DSAC and CPHAC**

DATE: **15 March 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to propose merging into one the Community and Public Health Advisory Committee (*CPHAC*) and Disability Support Advisory Committee (*DSAC*) meetings for the remainder of 2018. This change is in response to a request from the Board Chair to review the workplan of committees in the coming 6-12 months to ensure that we are best placed to succeed in the ongoing key focus areas of the CDHB in the 2018 calendar year.

2. RECOMMENDATION

That the Board:

i. endorses the merging of CPHAC and DSAC meetings for the remainder of the 2018 calendar year.

3. DISCUSSION

The CDHB Board Chair signalled in early January, a need to review committee workplans for the coming 6-12 months to assist to reduce workloads and pressures on the organisation, as we step through some critical issues that are fundamental to the success of the DHB and the broader Canterbury Health System.

Based on this premise, and following discussions at recent meetings and workshops, it is proposed that CPHAC and DSAC meetings merge for the remainder of 2018. There will be a clear distinction on meeting agendas identifying DSAC specific items, with this portion of the meeting being Chaired by Tracey Chambers, Chair, DSAC. The remainder of the meeting will be Chaired by Dr Anna Crighton, Chair, CPHAC.

CPHAC/DSAC meetings will commence at 9.00am, and membership of both committees shall remain unchanged.

Report prepared by: Tracey Chambers, Chair, DSAC
Dr Anna Crighton, Chair, CPHAC

MĀORI AND PACIFIC HEALTH PROGRESS REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Executive Director, Māori and Pacific Health**

DATE: **15 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report provides an update on progress and activities pertaining to Māori and Pacific Health.

2. RECOMMENDATION

That the Board, as recommended by the Community and Public Health Advisory Committee:

i. notes the Māori and Pacific Health Progress Report.

3. DISCUSSION

Canterbury Māori Health Action Plan Dashboard Report
Attached (Appendix 1) to this report is the latest Canterbury Māori Health Action Plan Dashboard Report against targets from the 2017/18 Māori Health Action Plan. The Māori Health Action Plan is primarily a monitoring document and we measure our performance across a range of targets, although it represents a small part of the actual targeted activity for our Māori population in Canterbury.

The Canterbury DHB Māori Health Action Plan focuses on priority areas that show how the system is working towards Pae Ora.

We seek to reduce and eliminate the health inequities that have long persisted in the Māori population as a step towards pae ora for Māori in our community.

Please note the table below the dashboard which describes the measure, data source and period of latest results for each indicator. There is a lag time between some of the data being received and the Ministry of Health (*MoH*) publishing the data. This dashboard represents the latest data.

National Māori Health Indicators Dashboard Report
Also attached (Appendix 2) to this report is the latest National Māori Health Indicators Report, which enables us to compare performance by ethnicity (Māori vs non-Māori), and by DHB.

The target field is blank where there is no target, or the indicator assigned by the MoH is a specific target tailored for each DHB. Rheumatic fever is not displayed in the dashboard table because the MoH reports total population and South Island data is aggregated.

The report demonstrates that although Canterbury is one of the better performing DHBs for our Māori population, there are still stark differences between Māori and non-Māori across all DHBs, but we are making progress towards improving. Such comparisons provide compelling data as to why we should be targeting Māori to reduce inequity in our system.

Canterbury Pacific Health Dashboard

Similar to our Māori population, our analyst staff in Planning and Funding have been hard at work developing a Pacific Health Dashboard (Appendix 3). The dashboard should be read in conjunction with the notes on the second page.

As with the Māori dashboard, there are some areas that our Pacific population are doing well and indeed very well in, but others that need much more progress. For example, Pacific children are tracking very well in breastfeeding and immunisation (8 months), but as with Māori children the oral health target results are poor.

The adult and child ASH rates are very poor and again, similar to Māori, the cancer screening rates need improving.

4. APPENDICES

Appendix 1: Canterbury Māori Health Action Plan Dashboard Report, January 2018.
Appendix 2: National Māori Health Indicators Dashboard Report, February 2018.
Appendix 3: Canterbury Pacific Health Dashboard Report, December 2017.

Report prepared by: Hector Matthews, Executive Director, Māori and Pacific Health

Canterbury DHB Māori Health Action Dashboard Report

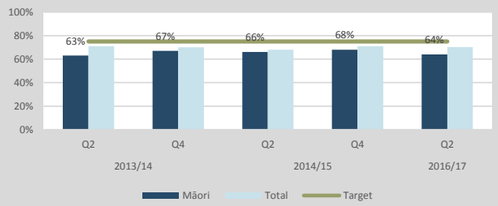
January 2018

Kia whakakotahi te hoe o te waka
WE PADDLE OUR WAKA AS ONE

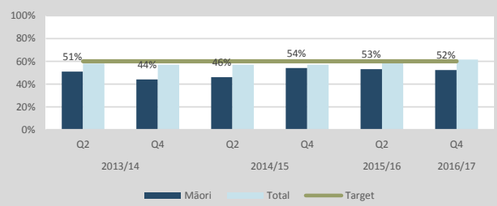
- The difference between Māori and non Māori is less than 5% or the target is met
- The difference between Māori and non Māori is between 5% and 10%
- The difference between Māori and non Māori is grater than 10%

Tamariki Health and Wellbeing

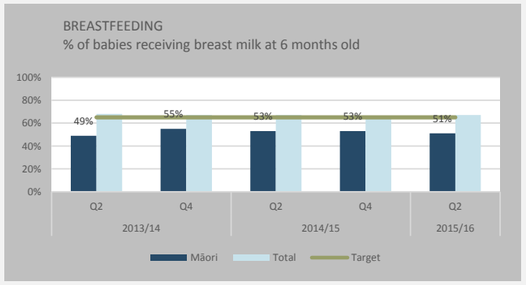
BREASTFEEDING
% of babies exclusive/fully breastfed at LMC discharge



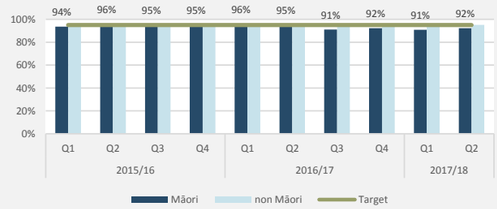
BREASTFEEDING
% of babies exclusive/fully breastfed at 3 months old



BREASTFEEDING
% of babies receiving breast milk at 6 months old

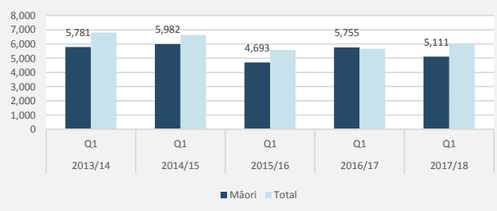


IMMUNISATION
% of 8 month old children fully vaccinated

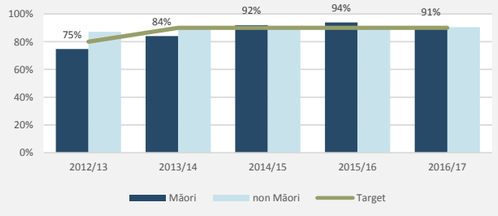


ORAL HEALTH
% of pre-school children (aged 0-4 years) enrolled with school and community dental services

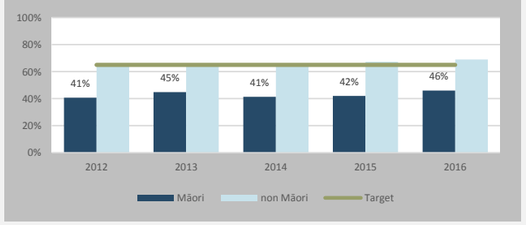
EARLY INTERVENTION
ASH rate per 100 000 people - Children 0-4 years old



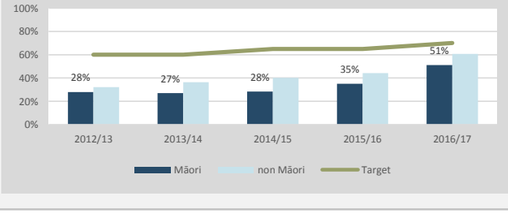
B4SCHOOL CHECK
Percentage of children receiving a B4SC by age 4 years



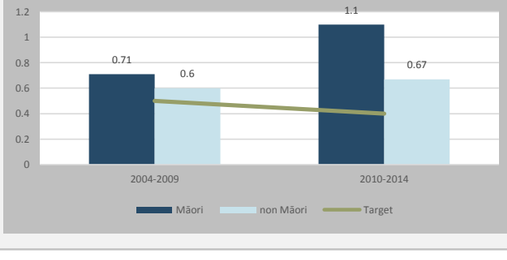
ORAL HEALTH
% of childrent caries free at age 5 years



IMMUNISATION - HPV
Percentage of eligible girls receiving the final dose of the HPV immunisation

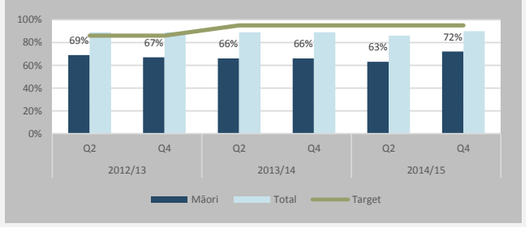


Rate of SUDI per 1,000 live births

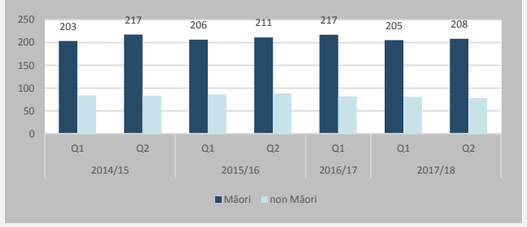


Adult Health and Wellbeing

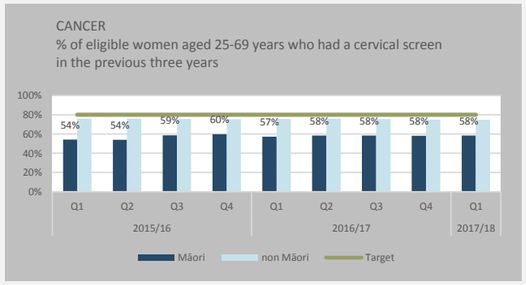
SMOKING
% of women smokefree at two weeks postnatal



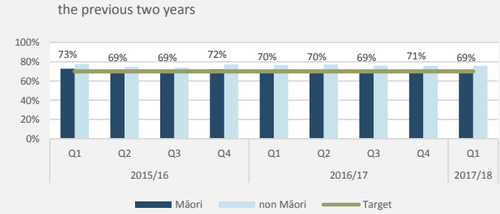
MENTAL HEALTH
Community Treatment Orders Rate per 100 000 people



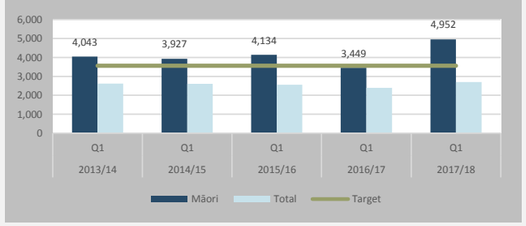
CANCER
% of eligible women aged 25-69 years who had a cervical screen in the previous three years



CANCER
% of eligible women aged 50-69 years who had a breast screen in the previous two years



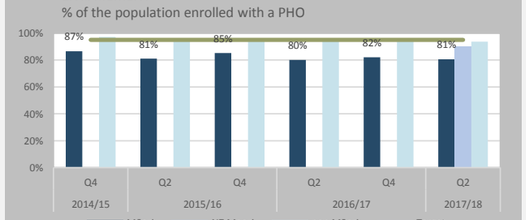
EARLY INTERVENTION
ASH rate per 100 000 people - Adults 45-64 years old



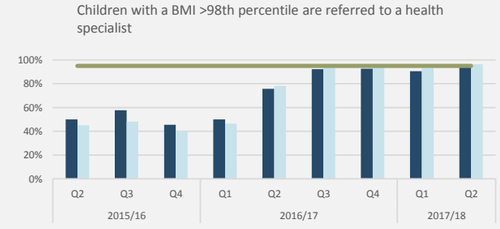
IMMUNISATION - INFLUENZA
% of population (65+years) who have had a seasonal influenza vaccination

Enablers to support Improved Health and Wellbeing

ENGAGEMENT
% of the population enrolled with a PHO



B4 SCHOOL CHECK
Children with a BMI >98th percentile are referred to a health specialist



Indicator Full Name	Data Source	Reporting Period	Data Release Date	Notes
Infants are exclusively or fully breastfed at discharge from LMC	National Maternity Collection (MAT)	Oct - Dec 2016	Oct 2017	Data is incomplete, excludes 43% of data where records have no status
Infants are exclusively or fully breastfed at three months	Well Child Tamariki Ora (WCTO) National Dataset	Apr - Jun 2017	Oct 2017	Data is inconsistent with previous years - the number of records analysed is approximately 15%-20% fewer than previous reporting periods
Percentage of babies receiving breast milk at six months	Plunket Operational National Database	Oct - Dec 2015	Mar 2016	Due to the time it takes for Plunket to gather information, data is available 2-3 months following the end of the year.
Percentage of Infants fully vaccinated at eight months	National Immunisation Register	Jul - Sep 2017	Sep 2017	
Children aged 0-4 years are enrolled with the Community Oral Health Service	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2016	Oct 2017	Results are provided annually in line with the school year. The next release is expected in March 2018
ASH rates per 100,000 Children 0-4 years old	National Minimum Dataset (NMDS)	Sep 2013 - Sep 2017	Sep 2017	
B4SCs are started before children are 4½ years	B4 School Check	Jul 2016 - Jun 2017	Oct 2017	
Percentage of children caries-free for 5 years	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2016	Oct 2017	Results are provided annually in line with the school year. The next release is expected in March 2018
Percentage of eligible girls receiving dose 3 of the HPV immunisation	National Immunisation Register	Jul 2016 - Jun 2017	Jun 2017	
Rate of SUDI per 100,00 live births	The Mortality Collection (MORT)	Jan 2010 - Dec 2014	Jan 2017	Due to small numbers, SUDI data is release every five years. Release of next series is expected in 2019
Percentage of Women Smokefree at two weeks postnatal	National Maternity Collection (MAT)	Apr - Jun 2015	Mar 2016	MAT data can take up to two years to show all events which may explain deviation between reports
Population under Mental Health Act: section 29 Community Treatment Orders, rate per 100 000 population	Project for the Integration of Mental Health Data (PRIMHD)	Apr 2016 - Mar 2017	Jul 2017	Data is provided 3 months in arrears for each reporting quarter
Women aged 25-69, who have had a cervical smear once in the last three years	National Screening Unit	Jul - Sep 2017	Sep 2017	
Women aged 50-69, who have had a breast screen once in the last two years	National Screening Unit	Jul - Sep 2017	Sep 2017	
ASH rates per 100,000 Children 45-64 years old	National Minimum Dataset (NMDS)	Sep 2013 - Sep 2017	Sep 2017	
Percentage of population (65+years) who have had a seasonal influenza vaccination	National Immunisation Register	Mar - Sep 2017	Sep 2017	This meausre has changed from using PHO enrolled populaiton data to census population data. The reporting dates have changed from 2016, the reporting period now covers Mar- Sep where previously this was Jan-Dec. Results are not directly comparible between 2017 and previous years.
Percentage of the population enrolled with a PHO	Canterbury DHB data Q2 onwards PHO Enrolment Collection	Apr - Jun 2017	Jun 2017	
Children with a BMI >98th percentile are referred to a health specialist	B4 School Check	Oct - Dec 2017	Jan 2018	

National Health Indicators Dashboard - Māori - Feb 18

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Reached Target
PHO Enrolment	Jan-Mar 2018	90%	76.0%	96.0%	81.0%	85.0%	92.0%	97.0%	89.0%	100.0%	86.0%	86.0%	99.0%	78.0%	83.0%	100.0%	86.0%	93.0%	97.0%	81.0%	85.0%	97.0%	9
ASH (0-4 yrs)	Yr to Mar 2017	-	6624	8223	5305	6415	6529	5150	9231	8861	6340	4393	8712	2787	5331	7661	7188	8015	10000	5960	5227	8196	0
ASH (45-64 yrs)	Yr to Mar 2017	-	5988	6719	4032	5487	8837	6334	7386	8387	6228	4872	8022	5383	3665	5231	7903	8029	5252	7324	5275	9125	0
Breastfeeding (6 wks)	Jan-Jun 2016	75%	61.5%	64.0%	62.8%	53.1%	46.0%	59.3%	49.7%	51.7%	52.7%	54.8%	67.5%	51.4%	58.4%	59.7%	49.6%	56.3%	57.4%	58.2%	75.0%	56.3%	1
Breastfeeding (3 mths)	Jan-Jun 2016	60%	53.4%	44.5%	52.6%	42.6%	34.4%	38.8%	39.2%	41.4%	38.3%	43.2%	54.2%	41.3%	43.3%	38.2%	41.3%	41.4%	60.0%	50.2%	62.5%	42.8%	2
Breastfeeding (6 mths)	Jan-Jun 2016	65%	57.6%	53.6%	53.8%	54.9%	48.8%	50.2%	44.4%	57.7%	44.3%	62.3%	61.7%	37.5%	48.2%	55.4%	46.8%	49.1%	56.1%	61.5%	64.7%	57.1%	0
Breast Screening (50-69 yrs)	2018 Q1	70%	57.2%	59.3%	69.6%	67.1%	64.0%	67.5%	68.7%	64.0%	65.1%	76.5%	70.3%	70.2%	67.4%	68.1%	61.4%	57.7%	70.2%	62.7%	66.1%	69.4%	4
Cervical Screening (25-69 yrs)	Oct-Dec 2017	80%	54.4%	70.3%	57.7%	61.2%	65.0%	74.4%	66.1%	72.3%	62.4%	68.5%	68.0%	61.6%	64.2%	70.8%	75.8%	67.3%	70.2%	59.4%	65.9%	70.0%	0
Immunisation (8 mths)	Oct-Dec 2017	95%	78.3%	83.4%	92.2%	94.0%	85.7%	93.4%	90.7%	91.1%	93.0%	90.1%	90.3%	100.0%	93.8%	86.8%	85.7%	86.2%	93.5%	89.5%	83.3%	86.0%	1
Immunisation (Influenza)	Mar-Aug 2017	75%	33.1%	53.8%	41.9%	45.5%	40.0%	55.8%	46.4%	32.0%	47.9%	50.6%	50.2%	41.7%	43.9%	53.8%	42.1%	47.4%	50.9%	32.9%	48.9%	64.6%	0
Mental Health	Year to Sep 2017	-	521	178	208	478	387	384	228	406	217	148	433	159	255	329	199	439	308	304	203	187	0
Oral Health	Jan-Dec 2016	95%	65.3%	67.3%	43.7%	70.2%	73.5%	72.7%	81.1%	88.1%	94.6%	64.2%	70.5%	41.7%	65.4%	95.7%	81.4%	72.0%	67.7%	71.3%	88.1%	102.1%	2
SUDI	2012-2016 combined	-	0.73	0.61	0.92	1.92	2.15	1.54	1.36	1.18	1.49	-	1.03	-	1.96	2.37	1.55	1.75	-	-	-	2.97	0

Target attained	Within 10% of target
10-20% away from target	More than 20% away from target

- Target field is blank where there is either no target for the indicator assigned by the Ministry of Health, or where there are specific targets tailored to each DHB.
- Rheumatic fever is not displayed on this table as the Ministry of Health reports Total Population data, and data for South Island DHBs is aggregated.

National Health Indicators Dashboard - non-Māori - Feb 18

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Reached Target
PHO Enrolment	Jan-Mar 2018	90%	81.0%	100.0%	93.0%	94.0%	92.0%	98.0%	100.0%	97.0%	95.0%	99.0%	101.0%	98.0%	93.0%	98.0%	96.0%	95.0%	102.0%	92.0%	94.0%	101.0%	19
ASH (0-4 yrs)	Yr to Mar 2017	-	5473	6606	5940	5441	4720	4333	8176	7847	5663	3746	5819	4577	5498	7034	6697	6422	4913	4555	4156	6200	-
ASH (45-64 yrs)	Yr to Mar 2017	-	2393	3011	2410	2597	2828	2446	3485	3708	3978	2394	3151	3634	2838	2931	3918	3163	3147	3426	2333	4750	-
Breastfeeding (6 wks)	Jan-Jun 2016	75%	75.2%	77.1%	65.1%	72.6%	65.8%	70.5%	65.2%	66.2%	60.3%	70.3%	73.6%	71.1%	68.0%	77.8%	66.7%	69.3%	70.6%	71.3%	80.4%	70.6%	4
Breastfeeding (3 mths)	Jan-Jun 2016	60%	67.1%	67.4%	58.9%	68.0%	57.2%	60.9%	56.7%	57.9%	51.4%	63.2%	73.4%	58.9%	58.1%	57.4%	59.2%	61.5%	60.4%	66.4%	55.2%	60.0%	10
Breastfeeding (6 mths)	Jan-Jun 2016	65%	78.8%	72.4%	67.2%	78.9%	66.3%	68.4%	69.5%	62.5%	58.3%	72.3%	77.1%	63.3%	64.9%	69.5%	68.0%	67.3%	72.1%	73.9%	62.0%	52.2%	14
Breast Screening (50-69 yrs)	2018 Q1	70%	78.3%	73.1%	77.9%	81.5%	107.2%	77.8%	83.9%	75.7%	80.9%	81.4%	74.7%	77.5%	76.7%	76.8%	77.8%	73.6%	76.6%	74.6%	77.8%	82.2%	20
Cervical Screening (25-69 yrs)	Oct-Dec 2017	80%	68.0%	83.3%	74.8%	79.1%	74.0%	78.0%	77.0%	78.8%	77.5%	82.2%	78.2%	78.5%	79.4%	81.6%	82.8%	78.9%	78.9%	74.9%	76.6%	78.7%	4
Immunisation (8 mths)	Oct-Dec 2017	95%	95.0%	89.5%	95.8%	94.5%	93.2%	92.7%	97.8%	92.9%	94.8%	91.0%	86.1%	90.7%	95.5%	86.1%	91.7%	92.1%	90.8%	92.1%	98.1%	89.0%	5
Immunisation (Influenza)	Mar-Aug 2017	75%	50.9%	58.2%	61.6%	57.3%	46.0%	59.0%	51.3%	37.5%	59.8%	60.5%	51.6%	59.9%	51.5%	53.4%	52.7%	52.7%	62.1%	45.7%	55.6%	55.5%	0
Mental Health	Year to Sep 2017	-	130	49	78	140	96	124	92	96	96	78	140	105	97	114	83	111	88	102	105	109	-
Oral Health	Jan-Dec 2016	95%	88.2%	114.6%	66.6%	106.9%	89.5%	107.0%	107.7%	127.3%	95.9%	88.4%	74.7%	95.4%	84.9%	113.2%	101.0%	72.1%	92.3%	99.6%	100.3%	106.4%	12
SUDI	2012-2016 combined	-	-	-	0.63	-	-	-	0.51	-	-	-	-	-	0.3	-	0.6	0.46	-	0.11	-	-	-

Target attained	Within 10% of target
10-20% away from target	More than 20% away from target

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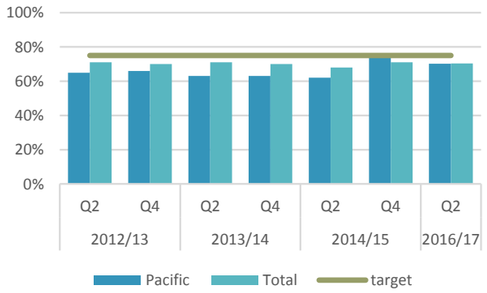
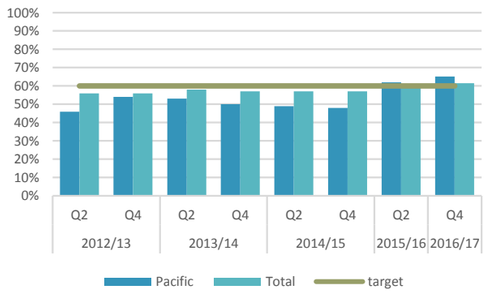
- Rheumatic fever is not displayed on this table as the Ministry of Health reports Total Population data, and data for South Island DHBs is aggregated.

Pacific Health Dashboard
December 2017

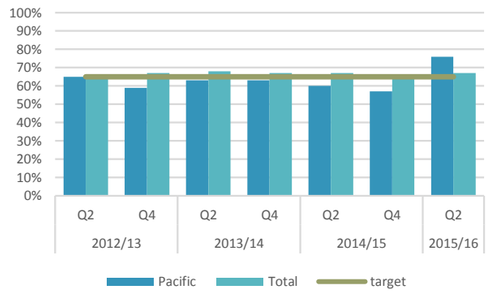
Babies exclusively and fully breastfed at LMC discharge



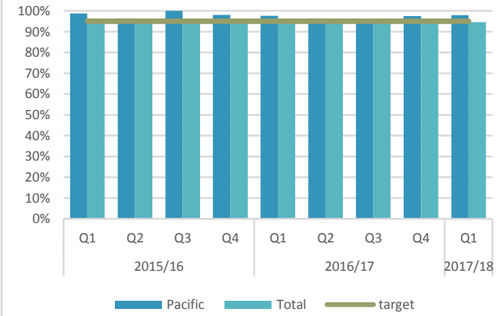
Babies exclusively and fully breastfed at 3 months (WCTO)



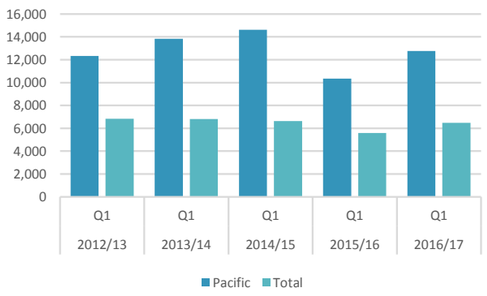
Babies receiving breast milk at 6 months (WCTO)



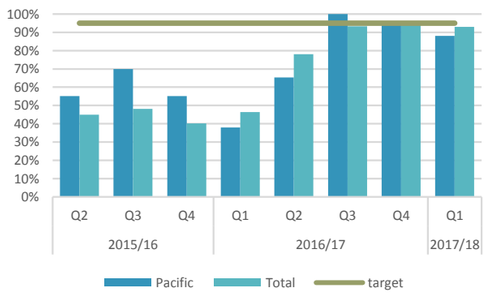
Infants fully immunised by eight months of age



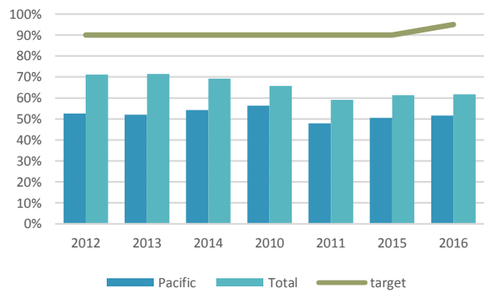
ASH rate for children 0-4 years old, per 100,000 population



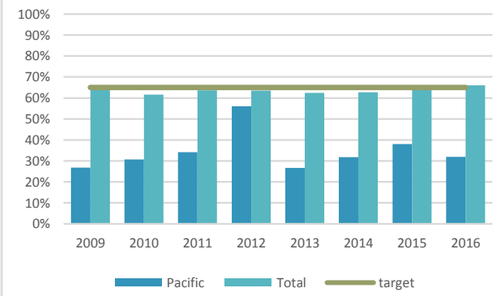
Children with a BMI >98th percentile are referred to a health specialist



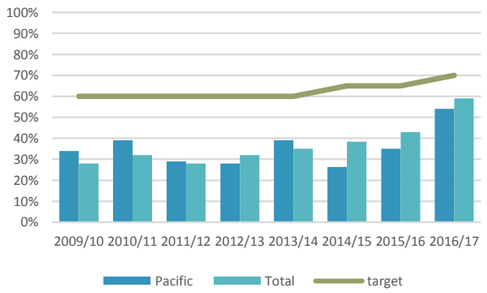
Children aged under 5 enrolled in DHB community oral health service



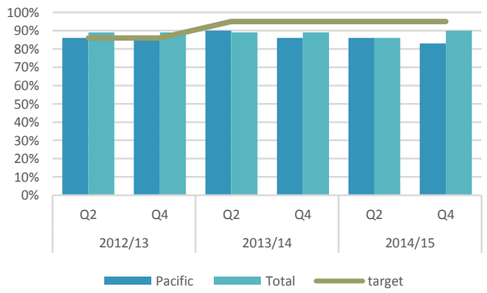
Children carries-free (no holes or fillings) at age 5



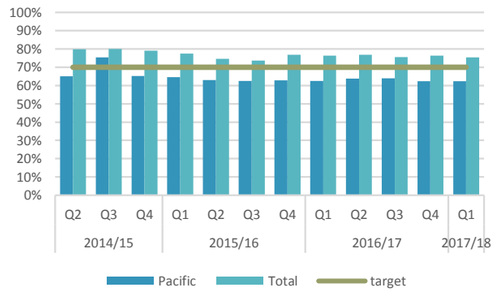
Eligible girls receiving final dose of the HPV vaccination



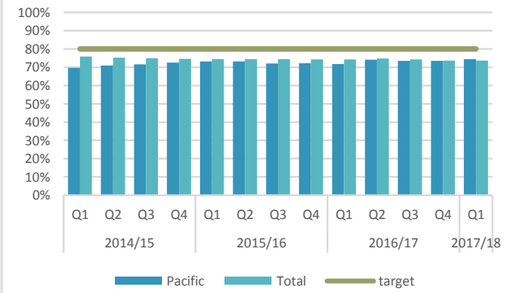
Women who are smokefree at two weeks postnatal



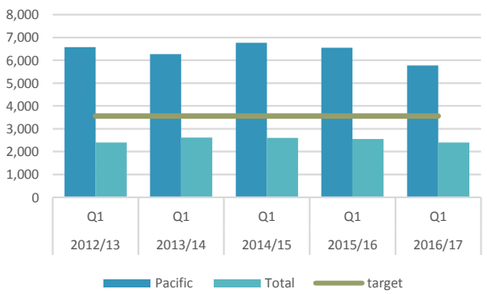
Women aged 50-69, who have had a breastscreen once in the last two years



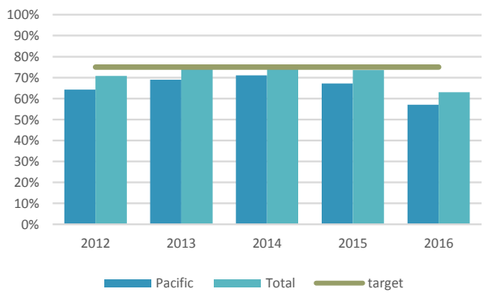
Women aged 25-69, who have had a cervical smear once in the last three years



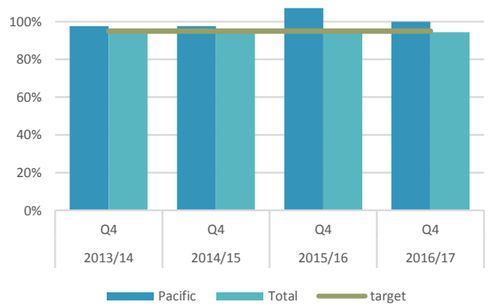
ASH rate for adults 45-64 years old, Standardised per 100,000 population



Eligible population (aged 65y+) who have had a seasonal influenza vaccination



Population enrolled with a PHO



Indicator Full Name	Data Source	Reporting Period	Data Release Date	Notes
Infants are exclusively or fully breastfed at discharge from LMC	National Maternity Collection (MAT)	Oct - Dec 2016	Oct 2017	Data is incomplete, excludes 43% of data where records have no status
Infants are exclusively or fully breastfed at three months	Well Child Tamariki Ora (WCTO) National Dataset	Apr - Jun 2017	Oct 2017	Data is inconsistent with previous years - the number of records analysed is approximately 15%-20% fewer than previous reporting periods
ASH rates per 100,000 Children 0-4 years old	National Minimum Dataset (NMDS)	Jul - Sep 2016	Sep 2017	
Children with a BMI >98th percentile are referred to a health specialist	B4 School Check	Jul - Sep 2017	Sep 2017	
Percentage of eligible girls receiving final dose of the HPV immunisation	National Immunisation Register	Jul 2016 - Jun 2017	Jun 2017	
Percentage of Women Smokefree at two weeks postnatal	National Maternity Collection (MAT)	Apr - Jun 2015	Mar 2016	MAT data can take up to two years to show all events which may explain deviation between reports
ASH rates per 100,000 Children 45-64 years old	National Minimum Dataset (NMDS)	Jul - Sep 2016	Sep 2017	
Percentage of population (65+years) who have had a seasonal influenza vaccination	National Immunisation Register	Jan - Dec 2016	Dec 2016	This meausre has changed from using PHO enrolled populaiton data to census population data. As such the results are not directly comparible between 2016 and previous years.
Percentage of babies receiving breast milk at six months	Plunket Operational National Database	Oct - Dec 2015	Mar 2016	Due to the time it takes for Plunket to gather information, data is available 2-3 months following the end of the year.
Percentage of Infants fully vaccinated at eight months	National Immunisation Register	Jul - Sep 2017	Sep 2017	
Children aged 0-4 years are enrolled with the Community Oral Health Service	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2016	Oct 2017	Results are provided annually in line with the school year. The next release is expected in March 2018
Percentage of children caries-free for 5 years	Canterbury DHB Community Oral Health Service database "Titanium"	Jan - Dec 2016	Oct 2017	Results are provided annually in line with the school year. The next release is expected in March 2018
B4SCs are started before children are 4½ years	B4 School Check	Jul 2016 - Jun 2017	Oct 2017	
Women aged 50-69, who have had a breast screen once in the last two years	National Screening Unit	Jul - Sep 2017	Sep 2017	
Women aged 25-69, who have had a cervical smear once in the last three years	National Screening Unit	Jul - Sep 2017	Sep 2017	
Percentage of the population enrolled with a PHO	Canterbury DHB data	Apr - Jun 2017	Jun 2017	

CPHAC – 1 MARCH 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Community and Public Health Advisory Committee**

DATE: **15 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Community and Public Health Advisory Committee's (*CPHAC*) meeting held on 1 March 2018.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from CPHAC's meeting on 1 March 2018 (Appendix 1).

3. APPENDICES

Appendix 1: CPHAC Draft Minutes – 1 March 2018.

Report prepared by: Anna Craw, Board Secretary

Report approved by: Anna Crighton, Chair, Community and Public Health Advisory Committee

DRAFT
MINUTES OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 1 March 2018 commencing at 9.00am

PRESENT

Dr Anna Crighton (Chair); David Morrell (Deputy Chair); Sally Buck; Tracey Chambers; Jo Kane; Chris Mene; Wendy Dallas-Katoa; Rochelle Faimalo; Dr Susan Foster-Cohen; Yvonne Palmer; Dr John Wood (ex-officio); and Sir Mark Solomon (ex-officio).

APOLOGIES

Apologies for lateness were received and accepted from Dr John Wood (9.07am); Tracey Chambers (9.08am); Jo Kane (9.09am); David Morrell (9.15am); and Rochelle Faimalo (9.17am).

IN ATTENDANCE

David Meates (Chief Executive); Dr Greg Hamilton (Team Leader Service Transition, Planning & Funding); Kerry Marshall (Public Health Manager, Community and Public Health); Tanya McCall (Public Health Manager, Community and Public Health); Kay Jenkins (Executive Assistant, Governance Support); Anna Craw (Board Secretariat); and Charlotte Evers (Assistant Board Secretariat).

ITEM 6

Dr Matthew Reid, Public Health Physician, Planning & Funding.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Wendy Dallas-Katoa is to advise of changes to her interests.

There were no other alterations or additions to the Interest Register.

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

Resolution (01/18)
(Moved: Dr Anna Crighton/Seconded: Wendy Dallas-Katoa - carried)

"That the minutes of the meeting of the Community and Public Health Advisory Committee held on 2 November 2017 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS/POSITION STATEMENTS

There was a query around material requested from Wayne Turp's presentation to the Committee at its meeting on 2 November 2017. Material will be recirculated to Committee members.

The Committee noted the carried forward list.

4. COMMUNITY & PUBLIC HEALTH UPDATE REPORT

Tanya McCall and Kerry Marshall, Public Health Managers from Community and Public Health presented the report.

Dr John Wood joined the meeting at 9.07 am.
Tracey Chambers joined the meeting at 9.08am.
Jo Kane joined the meeting at 9.09am.

Ms McCall spoke to the following items in the report:

- Christchurch City Council (*CCC*) Local Alcohol Policy (LAP).
- Havelock North Report.
- The temporary chlorination of Christchurch city's water supply.

In addition, Ms McCall advised that a measles outbreak had been notified earlier this month. Four cases were identified following the initial notification. Assuming no further cases are identified prior to 16 March 2018, the outbreak will be confirmed over.

Discussion took place on the following:

- CCC LAP and the need for this to be progressed given the impact intoxication has on health services, and from a community and public health perspective generally. There was discussion on what the DHB could do to actively encourage CCC to get the LAP in place. It was suggested that Ms Currie, General Manager, Community and Public Health, take this to EMT for progressing. Dr Anna Crighton, Chair, requested a further update in the May report to the Committee, as well as advising that this could be discussed further with City Councillors at the next Board/Council quarterly meeting.
- All Right? Social Marketing Campaign and whether there had been any engagement with the Chamber of Commerce with regards to this campaign. Ms Marshall advised that meetings have been held with the Chamber of Commerce, but not specifically in relation to this. There was a request that consideration be given to this.
- Prison based course for Maori men and whether there is a focus on linking these men with primary care providers and encouraging them to enrol in a GP practice. The Committee was advised that this was a trial programme, and that future programmes will certainly be addressing this issue.
- Congratulations on establishing the Hurunui presence for the All Right? Campaign.
- Water supply compliance and the request for a list to the next meeting, detailing by territorial local authority, the current status of compliance levels.

Resolution (02/18)
(Moved: Tracey Chambers/Seconded: David Morrell - carried)

"That the Committee:

i. notes the Community and Public Health Update Report."

David Morrell joined the meeting at 9.15am.
Rochelle Faimalo joined the meeting at 9.17am.

5. PLANNING & FUNDING UPDATE REPORT

Dr Greg Hamilton, Team Leader Service Transition, Planning & Funding, presented the report which was taken as read. Dr Hamilton highlighted the following:

- A workshop was held at the beginning of the month to consider how best to support schoolchildren and their families, build resilience, and engage positively in learning. Partners from government and non-government organisations participated in the workshop, which focused on how to deliver services to improve outcomes for primary and intermediate schoolchildren to meet the Government's election promise.

  Following the workshop, Prime Minister Jacinda Ardern, announced better mental health support for Canterbury children, advising of the first stage of the Government's plan to deliver dedicated mental health support to primary and intermediate schools in the region. It is expected that the programme will be rolled out rapidly over the next three years.

  A Service Level Alliance under the Canterbury Clinical Network (*CCN*) is to be established.

- Risks sitting around diagnostics. For example, whilst delivery of urgent colonoscopy work is being met, non-urgent colonoscopy results fell from 90% in September to 59% in December, and surveillance colonoscopy results continued their downward trend from 64% in September to 50% in December. Radiology is another area under pressure.

The Committee discussed further the recent developments with the School Based Mental Health Service and the initiative launched by the Government. This was seen as extremely positive.

Dr John Wood, Chair CDHB, advised that from informal discussions with the Prime Minister at the launch of the initiative, the Government saw this as a pilot programme to assess needs in this space and whether the programme could be taken wider.

Resolution (03/18)
(Moved: Jo Kane/Seconded: Yvonne Palmer - carried)

"That the Committee:

i. notes the Planning & Funding Update Report."

6. MAORI AND PACIFIC HEALTH PROGRESS REPORT

In the absence of Hector Matthews, Executive Director Maori & Pacific Health, Dr Matthew Reid, Public Health Physician, Planning & Funding, presented the report which was taken as read.

Discussion took place around the "ASH 0-4 year old" rates on the Pacific dashboard. It was noted that work is underway to better understand factors contributing to the results. These results are not Canterbury specific, with similar rates evident across the country.

There was discussion around HPV Immunisation and the need for a "catch-up reminder" to ensure all three doses are received and full immunisation achieved. It was also noted that a degree of stigmatisation still exists in some areas with regards to the immunisation programme. A continued focus on messaging was stressed.

The Committee noted the pleasing results with the B4School Check programme. There was a query around the follow through with those children who have issues identified. It was noted that the B4School Governance Group monitors and receives reports on this.

There was a query around the decline in influenza immunization rates over the past couple of years. It was noted that a degree of complacency has crept in as a result of light flu seasons, but it was anticipated that, in light of the current northern hemisphere season, uptake for 2018 will be higher.

There was a query as to why the B4School Check features on the Maori dashboard, but not the Pacific dashboard. This was an error by omission and will be corrected in future dashboard reporting.

Resolution (04/18)
(Moved: Ta Mark Solomon/Seconded: Sally Buck - carried)

"The Committee recommends that the Board:

i. notes the Maori and Pacific Health Progress Report."

7. KEY PERFORMANCE AREAS AND 2018 WORKPLAN

Dr Anna Crighton, Chair, addressed the Committee on the year ahead and challenges faced by the DHB. In order to ensure critical work and timeframes are met, prioritisation of reporting over the next six to nine months is required.

There was discussion around ensuring the Committee's Terms of Reference continue to be met, as well as ensuring that management/governance relationships continue to be strong.

The following items were requested to be added to the workplan:

- Emerging Issues – Chair/CEO – Oral Update – every meeting.
- Terms of Reference Review – 1 November 2018.

8. NATIONAL ISSUES UPDATE - PRESENTATION

Tracey Chambers left the meeting at 10.29am.

Dr Greg Hamilton, Team Leader Service Transition, Planning and Funding, provided an update presentation on the following issues:

- Mental Health – including pay equity issues and broader work.
- Primary Care – the Government's new initiatives and changes required.
- Community Pharmacy Services – today and tomorrow.

Tracey Chambers rejoined the meeting at 10.46am.

INFORMATION ITEMS

- Taxing of Sugary Drinks - Update
- Healthy Eating in Schools – Nutritional Advisory Guidelines – Update
- Review of Winter Plan 2017 (ex Hospital Advisory Committee - 1 Feb 18)
  - *Copy of Healthy Homes Investing in Outcomes Report is to be circulated to Committee members.*
- CCN Q1 2017/18
- Community & Public Health Six Month Report to Ministry of Health – Collated Highlights
- Community & Public Health Six Month Report to Ministry of Health
- 2018 Workplan

There being no further business the meeting concluded at 10.58am.

Confirmed as a true and correct record:

_____ _____

Dr Anna Crighton Date
Chair

DSAC – 1 MARCH 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Disability Support Advisory Committee**

DATE: **15 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Disability Support Advisory Committee's (*DSAC*) meeting held on 1 March 2018.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from DSAC's meeting on 1 March 2018 (Appendix 1).

3. APPENDICES

Appendix 1: DSAC Draft Minutes – 1 March 2018.

Report prepared by: Anna Craw, Board Secretary

Report approved by: Tracey Chambers, Chair, Disability Support Advisory Committee

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 1 March 2018 commencing at 1.00pm

PRESENT

Tracey Chambers (Chair); Chris Mene (Deputy Chair); Sally Buck; Dr Anna Crighton; Tom Callanan; Dr Olive Webb; Sir Mark Solomon (ex-officio); and Dr John Wood (ex-officio).

APOLOGIES

Apologies were received and accepted from Hans Wouter.
Apologies for lateness were received and accepted from Dr Olive Webb (1.07pm); and Dr John Wood (1.53pm).

IN ATTENDANCE

Stella Ward (Executive Director Allied Health); Kathy O'Neill (Team Leader, Planning and Funding); Kay Jenkins (Executive Assistant, Governance Support); Anna Craw (Board Secretariat); and Charlotte Evers (Assistant Board Secretariat).

Item 5

Jane Cartwright, Chair, Brackenridge Services Limited (*BSL*).
Pip Stewart, Chief Executive, BSL.
Nick Scott, General Manager, Service Delivery, BSL.

Item 6

Ross Denton, Manager, Organisational Development Unit.

Item 7

Allison Nichols-Dunsmuir, Health In All Policies Advisor, Community and Public Health.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no alterations or additions to the Interest Register.

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

Dr Olive Webb joined the meeting at 1.07pm.

2. MINUTES OF THE PREVIOUS MEETING

Resolution (01/18)
(Moved: Chris Mene/Seconded: Ta Mark Solomon – carried)

"That the minutes of the meeting of the Disability Support Advisory Committee held on 2 November 2017 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward action list was noted.

4. OUR PEOPLE

The "Our People" story was viewed.

5. BRACKENRIDGE SERVICES LIMITED (*BSL*) – PRESENTATION

Jane Cartwright, Chair; Pip Stewart, Chief Executive; and Nick Scott, General Manager Service Delivery, presented an update on BSL. The presentation included the following:

- Established in 1999 following the closure of the Templeton Centre.
- Support is provided to 185 people with a range of disabilities including autism, mental health conditions and those with complex social circumstances or health conditions.
- 137 people are supported in 36 residential homes throughout Canterbury. 66 people are living at 150 Maddisons Road. The remainder are living in the community.
- In addition, 48 people are supported through respite services; 43 people are supported through Vocational Community Choices Day Services; and 12 people are supported under the Enabling Good Lives (*EGL*) Flexible Disability Support Contract.
- Undergone evolving change since 1999, with the focus now on supporting individuals and their needs, one person at a time. Vision is "My Life My Way – Being, Belonging, Becoming".
- Telling a story around the changing disability services model, particularly in regards to the age, need and types of disabilities individuals are presenting with.
- Examples presented of the types of individuals BSL currently support. There is a particular focus on those with high complex needs.
- Focus is now on consolidating, regrouping, revitalising and improving sustainability.

There was a query as to whether BSL needs to remain a subsidiary of the Board. Ms Stewart advised that at this time, yes, BSL should remain a subsidiary of CDHB.

Tracey Chambers, Chair, commended BSL for its leading position in the transformation of disability services.

The Chair made a request for the final slide of BSL's presentation be used at the next Board meeting.

The Chair thanked BSL staff for the presentation and their attendance.

Dr John Wood joined the meeting at 1.53pm.

6. CDHB WORKFORCE UPDATE

Ross Denton, Manager, Organisational Development Unit, presented the report which was taken as read.

Discussion was held around the development of the People Strategy. Some highlights to date include the Care Starts Here Facebook group, and the Big Shout Out held in December 2017. Focus groups will be held in March 2018, leading to the development of policies around April/May 2018.

It was noted that People and Capability have a strong relationship with BSL.

There was a query about how qualitative issues will be measured. The Committee was advised that the next Wellbeing and Engagement Survey, scheduled for later in 2018, should address this.

There was a query relating to how many people with disabilities are employed by the Canterbury DHB. The Committee was advised that no-one in the state sector measures figures for disabled staff, as there is no agreement on how this should be measured. The Committee requested that consideration be given as to how CDHB could measure and record this data to reflect CDHB's position. It was suggested that the measurement be based on how many people the DHB employs that an "accommodation" is made for.

Resolution (02/18)
(Moved: Chris Mene/Seconded: Sally Buck – carried)

That the Committee:

i. notes the CDHB Workforce Update report.

7. CANTERBURY ACCESSIBILITY CHARTER

Allison Nichols-Dunsmuir, HIAP Advisor, presented the report, which was taken as read.

Stella Ward, Executive Director of Allied Health, acknowledged that the signing of the Accessibility Charter (the *Charter*) is the beginning of the accessibility journey. She advised that an action plan is now required, which will be developed and reported through to the Committee in due course. A meeting for the signatories of the Charter will be held in April and engagement with CDHB staff has commenced.

The Chair recognised the work of Committee members in ensuring the Charter was agreed upon and signed.

Ta Mark Solomon questioned the spelling of Aratiki in the report – this is incorrect. The correct spelling is Arataki.

Resolution (03/18)
(Moved: Tracey Chambers/Seconded: Chris Mene – carried)

That the Committee:

i. notes the report.

INFORMATION ITEMS

- PHAS Contract Update
- Disability Steering Group Minutes: 15 Dec 17 / 27 Oct 17 / 15 Sep 17
- Sector Transformation Forum
- 2018 Workplan

There being no further business the meeting concluded at 2.23pm.

Confirmed as a true and correct record:

_____ _____

Tracey Chambers Date
Chair

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Corporate Services**

DATE: **15 March 2018**

Report Status – For: **Decision** ☑ **Noting** ☐ **Information** ☐

1. ORIGIN OF THE REPORT

The following agenda items for the meeting are to be held with the public excluded. This section contains items for discussion that require the public to be excluded for the reasons set out below. The New Zealand Public Health and Disability Act 2000 (the *Act*), Schedule 3, Clauses 32 and 33, and the Canterbury DHB Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7 and the information items contained in the report;

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting of 15 February 2018	For the reasons set out in the previous Board agenda.	
2.	Chair & Chief Executive's Update on Emerging Issues – Oral Reports	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	S9(2)(a) s9(2)(j) s9(2)(h)
4.	People Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Strategic Assessment: Canterbury Health Laboratories	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Health Research Education Facility (*HREF*)	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Advice to Board: • Facilities Committee Draft Minutes *27 Feb 2018* • QFARC Draft Minutes *27 Feb 2018*	For the reasons set out in the previous Committee agendas.	

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the 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.

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

"A Board may by resolution exclude the public from the whole or any part of any meeting of the Board on the grounds that:

(a) the public conduct of the whole or the 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.

In addition Clauses (b) (c) (d) and (e) of Clause 32 provide further grounds on which a Board may exclude members of the public from a meeting, which are not considered relevant in this instance.

Clause 33 of the Act also further provides:

(1) Every resolution to exclude the public from any meeting of a Board must state:

(a) the general subject of each matter to be considered while the public is excluded; and

(b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on Clause 32(a) the particular interest or interests protected by section 6 or 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and

(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32)

(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution must be available to any member of the public who is present and form part of the minutes of the Board.

Approved for release by: Justine White, GM Finance & Corporate Services

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NZ Health Partnerships

Annual Report 2016/17

Ehara taku toa, he takitahi, he toa takitini

My success should not be bestowed on me alone, as it was not individual success but success of a collective

- Whakataukī, Maori Proverb

From the Chair

Peter Anderson

NZ Health Partnerships' second year of operation was one of change and growing maturity as an organisation.

Our operating model tilted from being heavily programme oriented, to having greater focus on the provision of operational services to District Health Boards (DHBs). This shift positions us well to directly deliver greater value and more immediate financial benefits to our shareholders.

The most significant change in the past year was the establishment of the National Procurement Service at NZ Health Partnerships in May 2017. While in 2017/18 we have modest savings targets, much of our focus going forward will be on increasing returns on DHB investment in procurement.

Late in the financial year, all 20 DHBs approved the appointment of the Bank of New Zealand (BNZ) as the sector's new banking services provider, a change that will increase financial and service benefits to DHBs from this point forward. Delivering a successful banking services provider transition and implementation is a priority for 2017/18.

In what was a busy end of the financial year, the National Oracle Solution (NOS) programme commenced a re-set process. This was disappointing, but the process has led to a top to bottom refresh of programme governance and management. This has NOS strongly positioned for delivery in the new financial year.

At Board level, two new directors were appointed during the year - Kevin Atkinson and Rabin Rabindran, Chair of Hawke's Bay DHB and Deputy Chair of Counties Manukau DHB respectively. Kevin and Rabin bring significant IT and legal experience which have already provided strong direction to the NOS programme.
I would like to acknowledge the outstanding contributions of Lee Mathias, Murray Cleverley and Phil Sunderland all of whom had been directors since NZ Health Partnerships' inception in July 2015. Phil sadly passed away last year.

Looking ahead to 2017/18, NOS, the National Procurement Service and a successful transition to the BNZ are our three key areas of focus. From a strategic perspective we are also working to develop a more holistic value framework and to streamline decision making, both of which were discussed at our shareholders' meeting in March this year.

Put simply, 2017/18 is the year for us to deliver and to engage well while we do so. Together, delivery and engagement is the key to NZ Health Partnerships building trust and confidence amongst our shareholders. Once our three priorities are completed or substantially progressed, we will continue the conversation with DHBs around how we can best leverage our combined scale and strength to unlock greater value for the sector.

Thank you to our shareholders and other stakeholders for their continued guidance and support of NZ Health Partnerships. Thank you to Megan Main and the rest of the NZ Health Partnerships team for their ongoing hard work and commitment in supporting DHBs.

> Our operating model tilted from being heavily programme orientated to having greater focus on the provision of operational services to DHBs.

Contents

From the Chief Executive

Megan Main

Last year was challenging for NZ Health Partnerships and its shareholders, the DHBs, as we focused on the re-set of the NOS programme and worked through contractual and vendor performance issues in Food Services. These challenges have however provided valuable lessons which are being applied to our current work.

Challenges aside, 2016/17 was also transformative as our business mix and internal structures evolved to support the transition of the National Procurement Service back in-house. Establishing the national service at NZ Health Partnerships, which is owned by all 20 DHBs, better aligns to the DHB Procurement Strategy and the new cross-sector governance model led by the Joint Procurement Authority (JPA).

NZ Health Partnerships is working directly with Pharmaceutical Management Agency (PHARMAC) to manage the transition of medical device procurement over the next two years. We are also working with DHBs to transition local and collaborative procurement back to individual DHBs or clusters of DHBs. The move to this operating model has seen DHBs retain close to $5.5m in procurement budget compared to the previous year.

This layered operating model, encapsulates how NZ Health Partnerships' unique national ownership structure can best provide value to its shareholders. DHBs are charged with providing the best possible care to their local communities. NZ Health Partnerships' focus is bringing all DHBs together to look at the national picture which is complementary to and supportive of local and regional initiatives.

The national Shared Banking service is also in the process of change, with DHBs approving the appointment of the BNZ as the sector's new banking services provider. The change in providers will see DHBs realise around 35% greater financial benefits going forward than in previous years.

With respect to our other services, we are working with the Banking & Insurance Service Performance Group to ensure the sector's insurance brokerage needs are met, while we have embedded the new Food Services governance model.

DHBs are our customers as well as shareholders. To deliver quality commercial services to DHBs we are focused on establishing a strong customer service culture at NZ Health Partnerships. We initiated customer service mind set training in April 2017 and more than two-thirds of our people have been through this to date. Further customer-focused training is planned on a rolling basis.

Our National Procurement Service leadership team have visited all DHBs to help them understand local perspectives and discuss first hand local procurement needs. Having a good number of our procurement workforce spread throughout DHBs also allows us to keep our ears closer to the ground.

We learned plenty in 2016/17. The NOS build was not completed by 30 June as planned due to a range of technical issues with the supporting IT infrastructure. Late in the financial year we started realigning the programme's governance and management structures, and at 30 June were finalising a Change Control Report (CCR) for the DHBs' approval.

Last year also saw the completion of the re-scoped National Infrastructure Platform (NIP) programme on schedule. This followed NZ Health Partnerships' successful negotiation of a variation to the contract with a third-party provider in late-2016.

> Our focus is bringing all DHBs together to look at the national picture which is complementary to, and supportive of, local and regional initiatives.

Sector strategy creates fresh Operating Model

Two years ago, our DHB shareholders identified the need for a nationally-agreed strategy for health sector procurement to ensure the best value for money. After considerable consultation, the health sector's first ever aligned DHB Procurement Strategy was endorsed by all DHB Chief Executives in April 2016.

The strategy focuses on reducing complexity through consolidation and standardisation, and leveraging the existing procurement capability of DHBs, PHARMAC and the Ministry of Business, Innovation and Employment (MBIE).

The strategy has three strategic goals:

- driving health outcomes by focusing on clinical imperatives such as quality, safety, standardisation and sustainability
- reducing overall procurement costs and increasing real return on DHB investment
- catalysing collaboration and cooperation in the health sector, by working as one team for the national good.

In March 2017, the sector introduced a new Procurement Operating Model under the guidance of the sector's first-ever collective governance model. On 1 May 2017, the National Procurement Service was established at NZ Health Partnerships - the first step in implementing the Procurement Operating Model.

Other procurement initiatives that commenced planning in 2016/17 include:

- establishing strategic category management which will see a systematic approach applied to each category type to identify savings potential and value generation above and beyond a regular sourcing approach
- building a National Catalogue of goods and services progressively, as DHBs migrate onto the National Oracle Solution
- delivering Clinical Engagement and Supplier Relationship Management frameworks
- working collaboratively to transition medical device management to PHARMAC.

Internally, the composition of the Executive Leadership Team has been strengthened over the last 12 months. New to the team are Carriann Hall, GM Corporate and Finance, and Paul Knight, GM Programmes. Also it was pleasing to confirm Waikato DHB Supply Chain Director, Angela Morley, as the NOS Programme Director in late 2016/17.

Looking ahead, we are very focused on what we now call the "Big Three", namely, delivering NOS, generating greater value through National Procurement Service, and maximising Banking and Insurance service value.

We are also placing more emphasis on key strategic enablers that will support delivery of the "Big Three". These enablers include the development of our formal organisational plan to ensure we remain focused on our commitments in the NZ Health Partnerships accountability documents, and consulting with DHBs on two key frameworks covering value, and decision making.

Thank you to our people and our shareholders for their ongoing commitment as we rapidly evolve into an organisation that is providing greater, direct and tangible value to the health sector.

Lastly and importantly, thank you to the DHB people who have worked directly with us in a range of ways over the past year. You have been extremely generous with your time, leadership and expertise. The level of collaboration continues to strengthen, which underlines that all of our work is by the DHBs, for the DHBs.

Looking ahead, we are very focused on what we are now calling the "Big Three", namely: delivering NOS, generating greater value through Procurement and maximising Banking and Insurance service value.

Part one:

About NZ Health Partnerships

Who we are and what we do

NZ Health Partnerships was established on 1 July 2015 as a multi-parent Crown-entity subsidiary owned by the country's 20 DHBs. We operate as a cooperative, which is responsible for collectively maximising shared service opportunities for the national good.

Put another way, we exist to support DHBs to meet the needs of the communities they serve. We do this by bringing DHBs together to collaborate at a national level, thereby leveraging their combined strength and collective best practice.

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

There are increasing demands being placed on the health system, from an ageing population and the cost of new technologies to the challenges of long term conditions such as mental health issues and obesity related illnesses.

Treasury estimates that, if nothing were to change in the way we fund and deliver services, government health spending would rise from 6.9 per cent of GDP in 2011, to around 11 per cent of GDP in 2060[1].

One way we can help mitigate rising costs is by facilitating greater collaboration amongst our shareholders. By thinking, acting and investing collaboratively DHBs can achieve greater savings than they would by operating independently.

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

We are aligned to the Government's goals of reducing inequalities and delivering a modern health system. Ultimately, we harness the power of working together to deliver better health outcomes for all New Zealanders.

How we work

Strong DHB leadership and representation

NZ Health Partnerships works in a commercial manner within a public sector environment. We are overseen by a Board of Directors as well as programme and service governance structures with strong DHB leadership and representation.

Alongside the NZ Health Partnerships Chief Executive, each programme and service has a DHB Chief Executive Sponsor. These Sponsors help drive strategic delivery and support performance through strong stakeholder engagement.

Strategic partnerships

NZ Health Partnerships actively works to foster strategic relationships across the sector. Organisations with which we work closely include the Ministry of Health, PHARMAC, MBIE, New Zealand Treasury, Department of Internal Affairs, commercial organisations and other health sector shared services organisations.

OUR VALUES: ACCOUNTABILITY | COMMITMENT | RESPECT | TRANSPARENCY

1 The Treasury, 2012, Health Projections and Policy Options for the 2013 Long-term Fiscal Statement, p 18.

Our focus

Our Strategic Business Plan recognises that we need to continue our journey toward becoming a high-performance company. By doing so we will be better placed to support existing programmes and services, and build shareholder confidence in our ability to deliver.

We are doing this through the five key workstreams in our business strategy.

In 2017/18 the middle work stream - Delivery - is largely focused on our "Big Three": delivering NOS, generating value through National Procurement Service and maximising Banking and Insurance service value. The other work streams and the key frameworks contained within them are strategic enablers that support delivery.

NZ Health Partnerships will optimise its organisational performance and alignment with shareholders to deliver maximum value for the cooperative as a whole

- NZ Health Partnerships, Statement of Intent 1 July 2016 to 30 June 2020

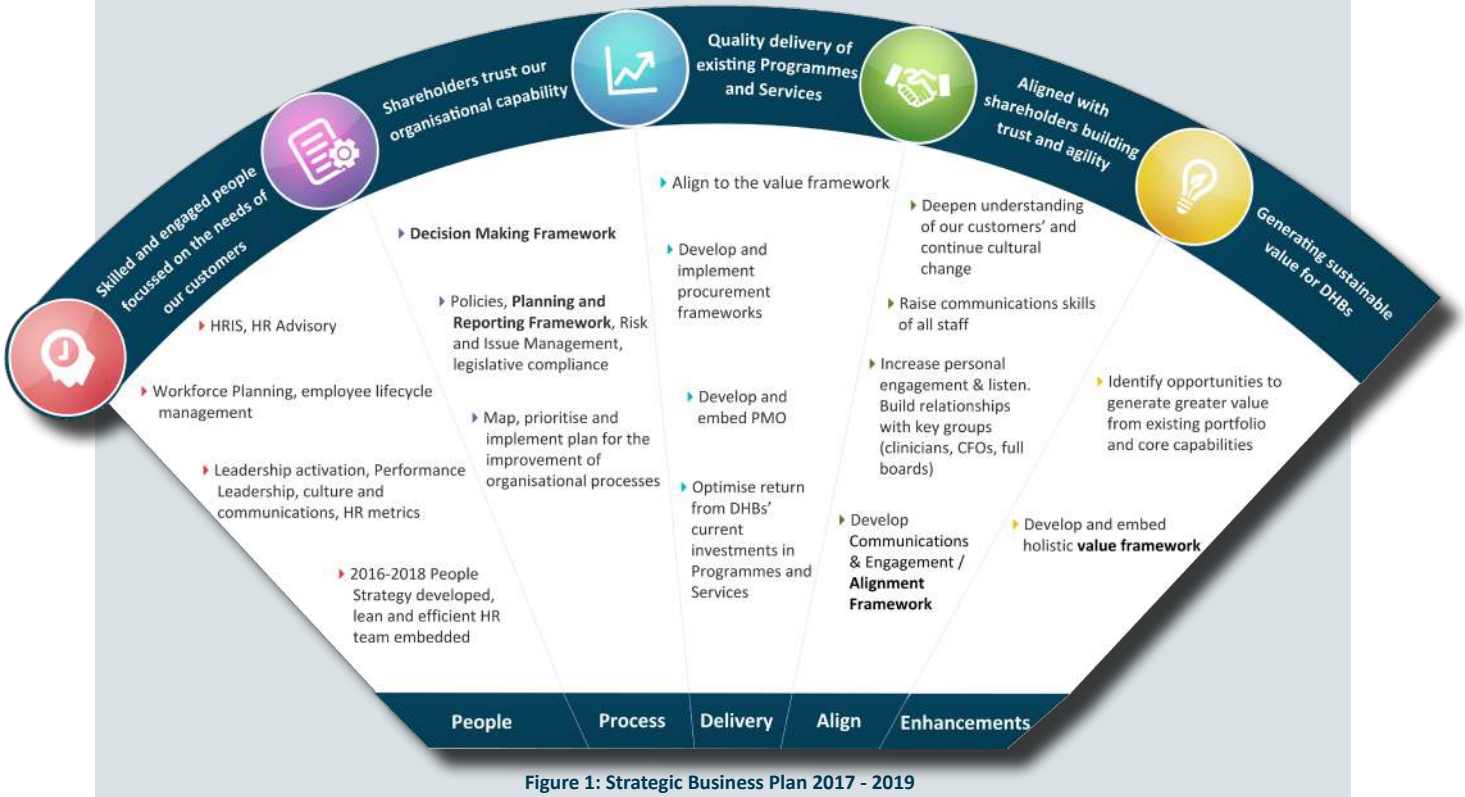

Figure 1: Strategic Business Plan 2017 - 2019

FIVE KEY WORKSTREAMS: PEOPLE | PROCESS | DELIVERY | ALIGN | ENHANCEMENTS

Statutory and compliance environment

As a Crown-entity, NZ Health Partnerships is required to comply with a variety of legislation including:

- Companies Act 1993
- New Zealand Public Health and Disability Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989
- Official Information Act 1982
- Health and Safety at Work Act 2015

Good employer

To ensure the company meets its Good Employer obligations prescribed in the Crown Entities Act Part 3 section 119, NZ Health Partnerships provides equal employment opportunities to:

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

Risk management

NZ Health Partnerships recognises that risk and issue management is essential for effective delivery of programmes and services. We are committed to working closely with our stakeholders to ensure we maintain an effective system that defines and determines acceptable levels of risk within each programme and service.

The Finance Risk and Audit Committee, and Board receive regular risk management reports allowing the oversight of risk management and assurance across our programmes and services.

Over the last 12 months, a series of internal audits have been carried out to provide independent and objective assurances that internal controls are in place to improve business practice and mitigate risk. Internal audits during the year covered benefits reporting, delegated financial authorities, health and safety, payroll, and shared banking.

A rolling multi-year internal audit plan will be developed from prioritised risk and management concerns to provide objective insight and assurance that our internal controls are appropriate and ensure our strategic goals are effectively and efficiently met.

Governance

Our Board

PETER ANDERSON: Chair and Independent Director

Appointed October 2015

NZ Health Partnerships Committees:

- NIP Subcommittee (Chair) until October 2016
- Remuneration Committee

TERRY MCLAUGHLIN

Independent Director

Appointed October 2015

NZ Health Partnerships Committee:

- Finance Risk and Audit Committee (Chair)

JOANNE HOGAN

Independent Director

Appointed April 2016

NZ Health Partnerships Committees:

- Remuneration Committee
- NIP Subcommittee (until October 2016)

RABIN RABINDRAN

DHB Director (Northern Region)

Appointed March 2017. Rabin is Deputy Chair of Counties Manukau DHB

NZ Health Partnerships Committees:

- Finance Risk and Audit Committee
- NOS Assurance Committee

DERYCK SHAW

DHB Director (Midlands Region)

Appointed June 2015. Deryck is Chair of Lakes DHB

NZ Health Partnerships Committee:

- Finance Risk and Audit Committee

KEVIN ATKINSON

DHB Director (Central Region)

Appointed March 2017. Kevin is Chair of Hawke's Bay DHB

NZ Health Partnerships Committees:

- NOS Assurance Committee (Chair)
- Remuneration Committee

RON LUXTON[2]

DHB Director (Southern Region)

Appointed July 2017. Ron is Chair of South Canterbury DHB

NZ Health Partnerships Committee:

- Finance Risk and Audit Committee

2 Ron Luxton was appointed post the end of the reporting period.

DHB shareholders and co-creators

Our programmes and services are run collaboratively with DHBs, who are our owners and customers. DHB leaders and other subject matter experts generously contribute both time and expertise to ensure our work meets the needs of the health sector.

Each of our programmes and services has its own governance and advisory structures. These include one DHB Chief Executive as Sponsor for each of our programmes and services.

Our various governance and advisory groups also include many other DHB leaders such as CFOs, CIOs, facilities managers, procurement and supply chain experts and clinicians.

These groups, where appropriate, also include senior representatives from other organisations such as the Ministry of Health, MBIE, Department of Internal Affairs and PHARMAC.

Our Chief Executive sponsors

Food Services
Jim Green
Chief Executive
Hauora Tairawhiti

National Oracle Solution (NOS)
David Meates
Chief Executive
Canterbury and West Coast DHBs

National Procurement Service
Dr Nigel Murray
Chief Executive
Waikato DHB

Shared Banking
Nigel Trainor
Chief Executive
South Canterbury DHB

Collective Insurance
Nigel Trainor
Chief Executive
South Canterbury DHB

National Infrastructure Platform (NIP)
Kathryn Cook
Chief Executive
MidCentral DHB
Note: Programme closed June 2017

Financial overview

As a shared services provider for our DHB shareholders, we operate on a cost recovery basis with the expectation that our net surplus for the year will be approximately $nil, subject to minor timing differences from year-to-year.

For 2016/17 our total revenue was $50.5m and total expenses $49.5m, resulting in a surplus of $1m - off-setting overspends in previous years and reducing our accumulated deficit to $3.1m.

The majority of our income is received from DHBs to fund the programmes and services we provide on their behalf. In addition, as the provider of the Shared Banking service, NZ Health Partnerships earned interest revenue of $20.6m in 2016/17, which was offset by a corresponding finance cost of $20.6m as the interest is passed onto DHBs.

Budgeted revenue and expenses were both $46.8m providing a budgeted surplus of $nil. However during this financial year, two significant activities required additional expenditure which was agreed and met by extra revenue from DHBs.

These were:

- Decision to exit the shared services agreement with healthAlliance (FPSC) Ltd and provide national procurement services internally,
- Negotiation of a contract variation with a third-party provider of Infrastructure as a Service (IaaS) to the NIP programme

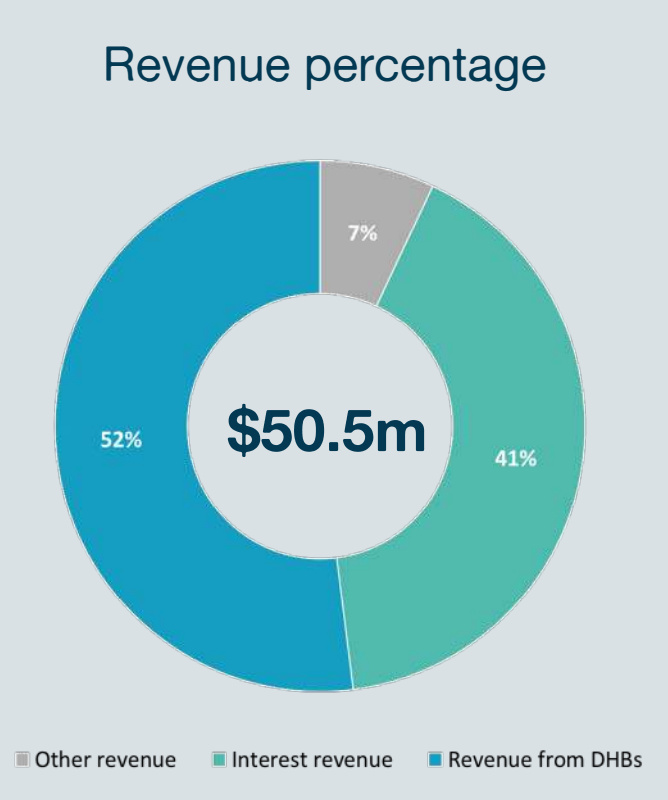

Figure 2: NZ Health Partnerships revenue sources 2016/17

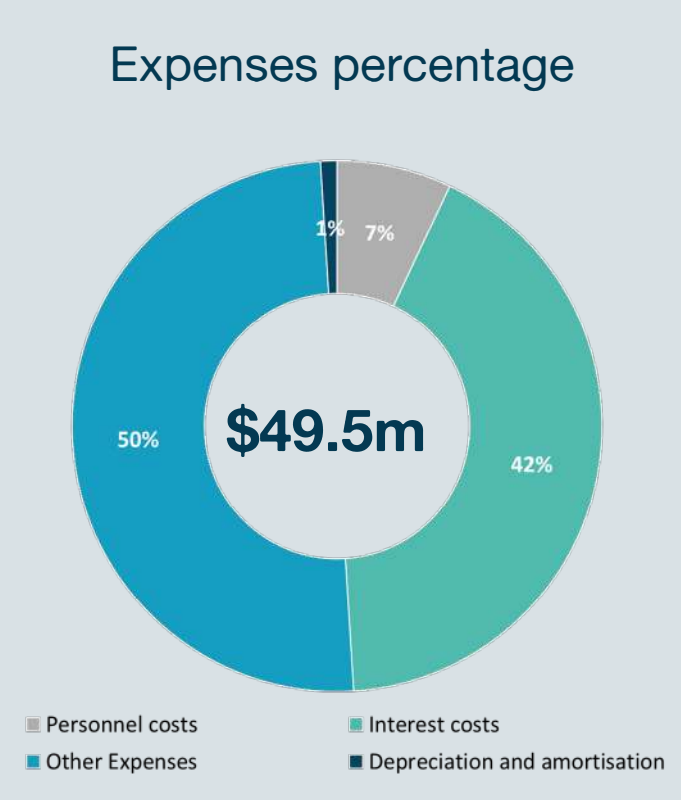

Figure 3: NZ Health Partnerships expenditure areas 2016/17

Highlights and challenges

Across the year

Targeted benefits for Shared Banking were exceeded with $3.4m delivered to the sector.

The plan to transition medical devices to PHARMAC agreed by NZ Health Partnerships and the JPA. It is expected that all medical device procurement will be in PHARMAC's remit by December 2019.

Achieved $2.5m in non-budgetary benefits with our Collective Insurance service broker, Marsh Limited.

Negotiated the Collective Insurance service cover for assets valued at over $15b for material damage business interruption, liability, motor vehicle, travel and personal accident.

2016/17 Challenges:

Ensuring Food Services met the participating DHBs' current and long-term needs. 2017/18 Focus: Transition to a focused governance and contract management group to improve oversight of service improvements.

Our shareholders agreed that the way decisions are made across our programmes and services needs work. Current approaches are impacting our agility and we can do better. 2017/18 Focus: Developing a revised Decision Making Framework.

Although much has been delivered with the core business solution 85% complete, the NOS programme was not ready to proceed to the implementation phase as planned. 2017/18 Focus: Continue improvements to governance, quality and management disciplines to support successful delivery.

August

Health's first ever cross-sector procurement governance model was established, led by the Joint Procurement Authority (JPA).

November

Successfully completed negotiations for a contract variation with a third-party provider, minimising cost impacts on DHBs.

February

Completed commercial negotiations with Datacom and Revera, achieving significant benefits for DHBs, including charge holidays, establishment of cost reductions and operational monthly savings per DHB region.

March

All 20 DHB Chief Executives approved the health sector's first ever sector-wide Procurement Operating Model.

Led the successful tender and negotiation process to select the sector's new Shared Banking services provider.

May

The National Procurement Service was established at NZ Health Partnerships.

June

The re-scoped NIP programme closed on schedule.

Our overall staff engagement score for 2016/17 was 80%, up 10 percentage points from one year earlier and up 25% over two years.

As at 30 June 2017, we had an almost 50% gender diversity in our workforce.

Stakeholder engagement

The Stakeholder Engagement 2017 Survey involved a range of stakeholders from all 20 DHBs, plus healthAlliance, Central Technical Advisory Services (TAS) and South Island Alliance. The DHB stakeholders included a mixture of Chairs, Chief Executives, Chief Financial Officers and others ie general managers, department heads and clinical managers. There were 26 in-depth interviews and 48 rapid interviews, from 42 and 82 identified stakeholders, respectively.

The survey showed that satisfaction with NZ Health Partnerships remains above average for 2017, with an overall score of 56 out of 100. While the score is above average it is lower than the previous survey. This shift was largely driven by the non-delivery of NOS.

Consequently, we are even more compelled and committed to meeting DHB shareholders and stakeholder expectations. We are very conscious that 2017/18 is the year to deliver, not only NOS, but on a well-managed banking services transition and generation of greater value from procurement.

Communications with our stakeholders remains a success factor. NZ Health Partnerships governance received strong support from the stakeholder groups and there is an appreciation that we are still in the emerging stages of organisational development. Stakeholders continue to believe that NZ Health Partnerships has been a change for the better.

Part two:

Statement of performance

Statement of responsibility

The NZ Health Partnerships Board is responsible for the preparation of NZ Health Partnerships' financial statements, Statement of Performance and for the judgements made in them.

The Board is also responsible for establishing and maintaining a system of internal controls designed to provide reasonable assurance about the integrity and reliability of financial reporting and non-financial service performance.

In the Board's opinion, these financial statements and Statement of Performance fairly reflect the financial position and operations of NZ Health Partnerships for the year ended 30 June 2017.

Signed on behalf of the Board

Peter Anderson

Chair

09 February 2018

Terry McLaughlin

Chair of Finance Risk and Audit Committee

09 February 2018

Performance snapshot

We report our performance against a number of programme and service measures which we manage collaboratively with DHBs. For this reason, we not only report against whether we have reached our measures and targets but also evidence of DHBs' sign-off of them.

For example, the target for the Shared Banking service measure for non-budgetary financial benefits delivered to DHBs is for 100% agreement and relies on all 20 DHBs to confirm their annual investment forecasts and individual banking benefit calculations. Three DHBs did not provide the required responses throughout the financial year, causing a negative outcome against the specific target, despite NZ Health Partnerships providing the Shared Banking service itself for all DHBs.

Overall performance

Our Statement of Performance Expectations (SPE) 1 July 2016 to 30 June 2017 has 22 performance measures, with 27 associated performance targets. Two of these targets were planned but determined to no longer be applicable. An additional performance target was identified and added during the year giving a total of 26 targets.

At the financial year-end, we achieved and partially achieved 58% of our performance targets.

Significant achievements include the:

- Collective Insurance service which maintained cover for all DHBs and provided a $2.5m non-budgetary benefit for DHBs
- successful conclusion of the new NIP Service Establishment programme provided certainty for the 12 DHBs and two regional entities involved, including delivery of all artefacts on schedule
- progress made implementing the DHB Procurement Strategy and Operating Model, including establishing the National Procurement Service at NZ Health Partnerships.

These successes are offset by challenges faced within the NOS programme and Food Services operation. The former in particular negatively impacted our Stakeholder Engagement Survey 2017 ratings. We have an organisational plan underway to help us deliver on our targets for 2017/18.

Our overall performance snapshot is summarised below.

Figure 4: NZ Health Partnerships Overall 2016/17 Year end Performance

Assessing our performance

As outlined in the SPE, we assess our performance as achieved, partially achieved or not achieved.

Table 1: NZ Health Partnerships performance assessment ratings

Performance Rating	Description
Achieved	The target has been achieved by the stated date.
Partially Achieved	The target has been completed, however, this was not completed by the stated date.
Not Achieved	The target has not been achieved.

Programmes

National Oracle Solution

CE Sponsor: David Meates, Canterbury and West Coast DHBs

The NOS programme is the sector-approved solution to replace DHBs' finance and supply chain systems, many of which are ageing and unsupported.

NOS will provide the data, processes and controls to support procurement which is the sector's biggest opportunity to reduce non-labour costs, and in doing so improve patient care and equity of access to technology.

Outside of National Procurement Service benefits, NOS will help drive product and process standardisation across DHBs which in turn helps to drive clinical outcomes. NOS will reduce administration effort across the sector, assist with policy and regulatory compliance, and minimise errors through improved controls and management features. It will also be more secure, more reliable and will mitigate the risks associated with current ageing financial systems.

Table 2: National Oracle Solution performance measures and targets 2016/17

1	**ENSURE READINESS OF ORACLE ADMINISTRATION MODEL**[3]		
	Target: Key positions filled and capability in place	Due: 30 September 2016	NOT ACHIEVED
2	**COMPLETE TECHNOLOGY BUILD**		
	Target: Solution acceptance testing successfully completed	Due: 30 September 2016	NOT ACHIEVED
3	**COMPLETE SOLUTION READINESS**		
	Target: User acceptance testing successfully completed	Due: 30 November 2016	NOT ACHIEVED
4	**SUPPORT FIRST WAVE DHB IMPLEMENTATION**		
	Target: Implementation completed on schedule, within budget, with no open action items	Due: 31 March 2017	NOT ACHIEVED

COMMENT

NOS did not go live for the four 'Wave 1' DHBs as planned in 2016/17. There were a range of issues which lead to the implementation date being missed.

During 2016/17 the programme encountered problems with the technology build of the infrastructure required to provide national capability. This included technical problems with the infrastructure provider and a design which was not fit for purpose. Focus on these problems resulted in the next phase going on hold.

Although the technical infrastructure required significant additional effort, the development team were able to progress to a point where it was estimated to be 85% complete at year-end. However, the additional effort required to complete the technology build led to the go-live date not being met. Instead, the decision was made to pause and re-set the programme.

3 Team to support the implementation and operation of the NOS.

Programmes of this size and scale, running across a number of relatively independent entities, are inherently challenging. It is not uncommon to underestimate the effort involved in driving architecture, development, implementation and change management activities in a complex environment like health.

A change in delivery approach and infrastructure provider saw the technology build being taken off the critical path. Governance and programme management improvements commenced in late 2016/17 including confirmation of Megan Main as NOS Senior Responsible Officer, and the appointment of an experienced Programme Director from the sector. These improvements also involved a change in our approach for managing key vendors.

The programme plans were re-cut from the bottom up to ensure the programme will be working to achievable and realistic timeframes and to a budget which is appropriate to meet the needs of the sector.

To give the NOS programme and its stakeholders comfort that the revised approach would achieve the desired outcomes, a review of the programme was undertaken by Independent Quality Assurance NZ (IQANZ). Their recommendations were in line with the activities underway by the programme team. IQANZ confirmed that once all the recommendations are implemented the chances of successful delivery of the NOS programme move from "in doubt" to "likely".

As at 30 June, the revised approach was documented and development of a Change Control Report (CCR) was underway for our Board approval in August, then consideration by DHBs. The CCR outlines the lessons learned, the importance of the NOS programme to the sector, and the approach going forward including timelines and expenditure costs. This revised NOS programme has 11 projects with delivery milestones scheduled through to July 2019.

Good progress is being made on DHB and Ministerial approval. All 20 DHBs have reaffirmed their commitment to the NOS programme and the funding required to complete the programme. Also, the amendment to Class B shares has been approved by all 20 DHBs.

The Wave 1 go-live date for the Bay of Plenty, Canterbury, Waikato and West Coast DHBs is set for July 2018.

National Infrastructure Platform

CE Sponsor: Kathryn Cook, MidCentral DHB

DHBs are moving to the All of Government (AoG) mandated IaaS enabling them to purchase their infrastructure on demand, as well as decreasing the need for and cost of maintaining their own IT hardware. IaaS will increase security, reliability, service levels and reduce the risk of critical outages.

The National Infrastructure Platform (NIP) programme had experienced substantial delays due to a lack of delivery by the Service Provider. Therefore toward the end of the previous financial year, NZ Health Partnerships initiated a series of commercial, technical and delivery reviews to determine the best way forward to remedy this situation. The updated NIP programme continued to assist the DHBs with a re-negotiated contract with the original third-party Service Provider plus the opportunity for DHBs to choose alternative IaaS providers, if desired.

Consequently this new NIP programme was re-scoped and DHBs led their own IaaS transitions. We supported these transitions with the development of 13 white-paper-style guides. Each guide focused on a key area of planning and transition pathways. There were 12 DHBs and two regional entities that participated in the updated NIP programme.

Table 3: National Infrastructure Platform performance measures and targets 2016/17

5	**IMPLEMENT AGREED RECOMMENDATIONS FROM THE COMMERCIAL, TECHNICAL AND DELIVERY REVIEWS**		
	Target: Programme, governance and processes aligned to the agreed recommendations from the commercial, technical and delivery review.	Due: 30 June 2017	ACHIEVED
6	**DELIVER NIP SOLUTION**		
	Target: Final Solution built and delivered on time, within scope, and within budget.	Due: 15 April 2017	NOT APPLICABLE
	NEW: SUPPORT FOR NIP SERVICE ESTABLISHMENT		
	Target: Participating DHBs are provided with supporting information to reduce cost and risks for service establishment.	Due: 30 June 2017	ACHIEVED

COMMENT

After successful negotiation of a contract variation with a third-party provider, the programme was re-scoped and NZ Health Partnerships role changed from delivering the NIP solution to supporting DHBs as they implement their own IaaS solution. Accordingly the original performance measure of “Deliver the NIP solution” was updated to “Support for NIP Service Establishment”.

The updated NIP Service Establishment programme was closed on 30 June 2017 after successful on-schedule delivery of all artefacts. The legacy of this programme’s success are the 13 white-paper-style guides that continue to support DHBs as they transition, as well as helping their IT project teams make decisions, solve problems and ensure all key IaaS solution areas have been considered and implemented.

Programmes: financial perspective

Table 4: Programme financials for 2016/17

	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
Revenue:			
National Oracle Solution	9,147	4,875	4,932
National Infrastructure Platform [1]	2,089	0	2,850
Food Services [2]	0	0	515
Total revenue	11,236	4,875	8,297
Expenditure:			
National Oracle Solution	7,656	4,875	8,972
National Infrastructure Platform [1]	3,273	0	3,196
Food Services [2]	0	0	515
Total expenditure	10,929	4,875	12,683
Surplus / (deficit)	**307**	**0**	**(4,386)**

Notes:

1 – When setting the 2016/17 budget for the National Infrastructure Platform (NIP) programme, it was anticipated this would transfer to a service for 2016/17. However following re-scoping, the updated NIP Service Establishment programme continued to be reported as a programme for 2016/17.

2 – Food Services was reported as a programme in 2015/16, however following implementation of the Food Services Agreement this transferred to a service for 2016/17.

Services: financial perspective

Table 5: Services financials for 2016/17

	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
Revenue:			
Shared Banking and Collective Insurance			
Interest Revenue from Shared Banking Facility	20,630	24,000	28,384
Shared Banking and Insurance Operations	603	603	360
National Procurement Service	12,561	11,228	10,926
Integrator	0	0	350
Food Services [2]	370	350	0
Management Services	5,094	5,090	5,709
NZ Health Partnerships Interest	48	120	0
National Infrastructure Platform [1]	0	550	0
Total revenue	39,306	41,941	45,729
Expenditure:			
Shared Banking and Collective Insurance			
Interest Expenses from Shared Banking Facility	20,579	24,000	28,363
Shared Banking and Insurance Operations	477	603	362
National Procurement Service	12,315	11,228	10,789
Integrator	0	0	374
Food Services [2]	478	350	0
Management Services	4,770	5,210	5,553
National Infrastructure Platform [1]	0	550	0
Total expenditure	38,619	41,941	45,441
Surplus / (deficit)	**687**	**0**	**288**

Notes:

1 – When setting the 2016/17 budget for the National Infrastructure Platform (NIP) programme, it was anticipated this would transfer to a service for 2016/17. However following re-scoping, the updated NIP Service Establishment programme continued to be reported as a programme for 2016/17.

2 – Food Services was reported as a programme in 2015/16, however following implementation of the Food Services Agreement this transferred to a service for 2016/17.

Services

Shared Banking

CE Sponsor: Nigel Trainor, South Canterbury DHB

NZ Health Partnerships manages shared banking and treasury services for DHBs and associated subsidiaries. DHBs benefit from streamlined transactional banking services, cash management and little or no working capital facility fees. On any given day, we manage a cash balance of between $0.3b and $1.4b on behalf of the sector.

As this is a mature service, we continually consider how we can add more value to the DHBs, whilst maintaining low levels of risk. In 2016/17 we led a process to review the provider of the sector's transactional banking service. As a result, this service is being moved from Westpac to BNZ in 2017/18.

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

7	**MINIMUM AVERAGE SWEEP INTEREST RATE ON FUNDS PLACED ON TERM DEPOSIT IS AT LEAST 0.15 PER CENT ABOVE THE SWEEP ON-CALL RATE**		
	Target: 0.15 per cent	Due: 30 June 2017	ACHIEVED
8	**MINIMUM NON-BUDGETARY FINANCIAL BENEFITS DELIVERED TO DHBS DURING 2016/17 FINANCIAL YEAR**		
	Target: 100 per cent - minimum percentage of DHBs agree to the benefits for 2016/17	Due: 31 December 2016	NOT ACHIEVED
	Target: $925,000 - Minimum benefits realised	Due: 30 June 2017	ACHIEVED
9	**MINIMUM PERCENTAGE OF DHBS AND OTHER PARTICIPANTS ARE SATISFIED WITH BANKING SERVICES SERVICE**		
	Target: 80 per cent	Due: 30 June 2017	NOT ACHIEVED

COMMENT

For 2016/17, the average margin achieved above the sweep on-call rate was well above target at 0.55 per cent, with a minimum of 0.39 per cent (October 2016).

The minimum benefit target was also exceeded, with non-budgetary benefits of $3.4m delivered.

17 DHBs (85 per cent) agreed the methodology to calculate their individual banking benefits for 2016/17. While the other three DHBs - Whanganui, Southern and Nelson Marlborough - participate in the Shared Banking service, they do so without formally agreeing to the benefit calculation methodology.

The Stakeholder Engagement 2017 Survey showed that the Chief Financial Officer (CFO) stakeholder group had mixed perceptions of the Shared Banking service. The 11 CFO stakeholders interviewed for this survey were asked to assess their DHBs' banking services. Although as a group they were happy with the service, they were unhappy with the engagement process for changing the banking services. This is reflected in the 36 per cent satisfied and 64 per cent not satisfied result from the 11 CFO stakeholders. The lessons learned about listening and interconnectivity between different shared services is being applied to our current work.

Collective Insurance

CE Sponsor: Nigel Trainor, South Canterbury DHB

Collectively DHBs own assets valued at over $15b. On behalf of DHBs and other associated entities, NZ Health Partnerships facilitates the process of collective insurance, we do this by working with DHBs, the DHB Banking and Insurance Services Performance Group, the insurance broker and other key stakeholders including MBIE, the Department of Internal Affairs and Fire and Emergency New Zealand, to secure the best insurance deal available on a collective basis.

By working together, the sector offers insurers a portfolio that is geographically spread with a high level of risk identification and management processes in place. Greater and more cost-effective cover is achieved as a result of a collective insurance package, than if each DHB were to insure on its own.

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

10	**MINIMUM PERCENTAGE OF DHBS AND JOINT VENTURES THAT HAVE AGREED INSURANCE**		
	Target: 100 per cent	Due: 30 June 2017	ACHIEVED
11	**MINIMUM NON-BUDGETARY FINANCIAL BENEFITS COLLECTIVE INSURANCE DELIVERED TO DHBS AND JOINT VENTURES DURING 2016/17 FINANCIAL YEAR**		
	Target: $2.5m[4] 2015/16 Target: $5.283m - Achieved	Due: 30 June 2017	ACHIEVED
12	**MINIMUM PERCENTAGE OF DHBS AND JOINT VENTURES ARE SATISFIED WITH THE GENERAL INSURANCE SERVICE**		
	Target: 80 per cent	Due: 30 June 2017	ACHIEVED

COMMENT

Collective Insurance cover for all 20 DHBs has been obtained for Material Damage and Business Interruption, Liability, Motor Vehicle, Travel, and Personal Accident. The coverage has been obtained from insurers in New Zealand, Australia, London, Singapore and China.

Savings achieved by DHBs through Collective Insurance were $2.5m in non-budgetary benefits in 2016/17, compared to $5.3m in 2015/16. The main reason for the reduction in benefits was a Supreme Court decision which has resulted in the fire service levy payable by DHBs increasing substantially in 2016/17.

Reported benefits for Collective Insurance are estimated by our insurance broker Marsh Limited, based on a comparison with the coverage that could reasonably be expected to be achieved by each DHB acting individually, versus what is achieved via the collective agreement. The assessment of what could be achieved by each DHB acting individually is necessarily subjective and is based on Marsh's knowledge and expertise.

The Stakeholder Engagement Survey 2017 showed that 89 per cent of DHB and stakeholder respondents were satisfied with the Collective Insurance service.

4 This performance measure is noted as $5m (NZ Health Partnerships Statement of Performance Expectations 2016/17, page 42) and $2.5m (NZ Health Partnerships Statement of Performance Expectations 2016/17, page 50). The correct amount is $2.5m.

National Procurement Service

CE Sponsor: Dr Nigel Murray, Waikato DHB

During 2016/17, NZ Health Partnerships continued to work with DHBs to operationalise the DHB Procurement Strategy which was approved in May 2016. This included establishing strong sector-wide governance via the Joint Procurement Authority (JPA) and the Procurement Operations Advisory Group (POAG), and by facilitating the development of a new Procurement Operating Model.

As part of this process it became clear that the existing National Procurement Service arrangements contracted to healthAlliance (FPSC) Ltd (hA(FPSC)) were not meeting the needs of all 20 DHBs and did not align well to the sector strategy nor PHARMAC's evolving role. As a result it was agreed with DHB Chief Executives that we would negotiate to exit the service agreement with hA(FPSC) and to take the national component of the new operating model in house at NZ Health Partnerships.

On 1 May 2017, we took on responsibility for providing a National Procurement Service for DHBs. This aligned with our other procurement services, annual procurement planning across the sector and role in information management to support decision making.

Establishing this national service within NZ Health Partnerships was a key step in implementing the full Procurement Operating Model across the sector. We are supporting implementation by facilitating the move of a number of procurement categories back to DHBs to manage locally or collaboratively.

We are also working with PHARMAC to manage the transition of medical device procurement over the coming two years.

Table 8: National Procurement Service performance measures and targets 2016/17

13	**ESTABLISH THE FOUNDATIONS FOR THE DHB PROCUREMENT STRATEGY IMPLEMENTATION**		
	Target: Agreed frameworks and mechanisms in place to deliver the key activities outlined in the strategy	Due: 30 September 2016	ACHIEVED
	Target: Agreed implementation approach and supporting plan for the strategy with specific targets and measures	Due: 30 September 2016	ACHIEVED
14	**COMMENCE THE TRANSITION OF MEDICAL DEVICES FROM THE SCOPE OF HEALTHALLIANCE**		
	Target: Agreed transition group in place to manage the transition process	Due: 30 September 2016	ACHIEVED
	Target: Agreed implementation plan outlining the transition with specific targets and measures and DHB oversight	Due: 31 July 2016	PARTIALLY ACHIEVED
15	**PROVIDE MANAGEMENT OVERSIGHT OF THE DELIVERY OF THE NATIONAL PROCUREMENT SERVICE BY HEALTHALLIANCE**		
	Target: Service catalogue is delivered according to agreed 2016/17 scope	Due: 30 September 2016	NOT ACHIEVED
	Target: A highly effective and transparent customer supplier relationship facilitated by NZ Health Partnerships which delivers value to all parties is achieved	Due: 30 June 2017	ACHIEVED

COMMENT

Key activities outlined in the DHB Procurement Strategy were the establishment of the overarching JPA governance group, and agreeing a new Memorandum of Understanding with PHARMAC. These were achieved in the first quarter of the year, as planned.

A three-phase implementation approach covering the Procurement Plan Operating Model 2016/17 was agreed and completed. However the PHARMAC transition plans for medical devices was not achieved by the target date of 31 July 2017. The NZ Health Partnerships - PHARMAC transition plan is being overseen by the JPA with advice on priorities, risks and issues from the POAG.

The Procurement Operating Model 2016/17 also saw the termination of the shared services arrangement between NZ Health Partnerships and hA(FPSC), and the new National Procurement Service function transitioned to NZ Health Partnerships on 1 May 2017. For the transition, hA(FPSC) handed-over 105 commenced projects, which were in various stages of progression. A total of 68 sourcing projects (equating to 55 per cent by number of activities) were incomplete and close to approximately 80 local and national contracts were expired, or near expiring, by 30 June. Prior to this national procurement transition, a transparent customer supplier relationship between NZ Health Partnerships and hA(FPSC) had been achieved.

Megan Main: Chief Executive, NZ Health Partnerships, Speaking at the Procurement Suppliers Briefing (March 2017)

Food Services

CE Sponsor: Jim Green, Hauora Tairawhiti

Under the Food Services Agreement (FSA), Compass Group New Zealand is contracted to provide patient meals, meals-on-wheels, cafeteria services, ward supplies and other optional services to DHBs.

NZ Health Partnerships provides the contract and vendor management of the FSA on behalf of the six participating DHBs being Auckland, Waitemata, Counties Manukau, Southern, Hauora Tairawhiti and Nelson Marlborough.

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

16	**PARTICIPATE IN THE NATIONAL FOOD SERVICES PROGRAMME**		
	Target: All existing contracts executed in a timely manner and to the satisfaction of the stakeholder parties	Due: 30 June 2017	NOT ACHIEVED
17	**LEAD/FACILITATE PROGRAMME LEVEL IMPLEMENTATION**		
	Target: Implementations are completed and delivered to plan (agreed contractual schedule), and within cost (budget) for all the participating DHBs	Due: 30 June 2017	NOT APPLICABLE
18	**EMBED BENEFITS REALISATION/CONTINUOUS IMPROVEMENT PROGRAMME**		
	Target: Delivered according to agreed specification and trends are clear and concise	Due: 31 December 2016	NOT ACHIEVED
19	**ASSIST WITH THE DEVELOPMENT OF A MATURE NATIONAL PROGRAMME LEVEL GOVERNANCE FRAMEWORK**		
	Target: All participating DHBs have an established, operating governance model in place	Due: 30 June 2017	ACHIEVED

COMMENT

While the FSA and the service itself are implemented and operational, there has been a delay in finalising the Customer Service Statements, which form part of the contractual documentation for each DHB. This delay is due to the legal complexity of the documents, each of which is a standalone contract.

No further DHBs joined the FSA during 2016/17, accordingly no implementations were conducted during the year.

Benefits models for the participating DHBs have been developed but have not been confirmed by the DHBs. Complaints management processes are in place and serious complaints (those with potential implications of patient harm) are monitored by NZ Health Partnerships. To improve the performance of Compass, we are undertaking active contract management with DHBs.

All participants have a local governance model in place and operational. The overarching FSA governance transition to the new Contract Management Group commenced in early 2017/18.

Management Services

Management Services refers to the organisational functions within NZ Health Partnerships relating to governance, finance, audit, legal, risk, policy, strategy, performance, human resources, communications and engagement. These activities act as enablers for us to deliver our progammes and services for our shareholders.

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

20	**ASSIST DHBS WITH PROGRAMME AND SERVICE-RELATED CHANGE MANAGEMENT WHERE REQUIRED**		
	Target: Change management strategy for DHB Procurement Strategy approved; and other plans developed and implemented as requested	Due: On-going	ACHIEVED
21	**IMPLEMENT A BENEFITS REPORTING PROCESS**		
	Target: Benefits reported to the Board monthly	Due: 30 September 2016	NOT ACHIEVED
22	**EMBED CUSTOMER FOCUS AS A WAY OF WORKING INCLUDING UNPACKING CORE VALUES AND IMPLEMENTING INTERNAL CULTURE INITIATIVES**		
	Target: Minimum 5 per cent increase of stakeholders rating NZ Health Partnerships' customer focus as satisfactory or above	Due: 30 June 2017	NOT ACHIEVED
	Target: 5 - 10 per cent increase in staff believing we are focussed on our customers' needs	Due: 30 June 2017	ACHIEVED

COMMENT

NZ Health Partnerships' change management approach has been finalised and applied to the DHB Procurement Strategy, NOS and NIP communications plans. These are living documents that will be refreshed for the ongoing programmes and services in early 2017/18.

Our Board has requested the benefits report be submitted quarterly and this has been achieved. The change in reporting frequency aligns our reporting cycle to that of PHARMAC and MBIE. However as the target required monthly reporting we have recorded this as not achieved.

During May we conducted the Stakeholder Engagement Survey with a spread of stakeholders from all 20 DHBs plus healthAlliance

An outcome of the Stakeholder Engagement 2017 Survey is that the satisfactory or above rating for NZ Health Partnerships' customer focus was 61 per cent, only 1 percentage point more than previously. It is well below the minimum target of a 5 per cent increase. We are focused on building a strong customer service culture across our organisation. Customer service training for staff commenced this year, with more planned in 2017/18.

The People Engagement Survey 2017 was completed by 36 of our 43 staff, giving an overall engagement score of 80 per cent. This annual staff engagement survey is designed to measure what matters for the organisation including our purpose and vision, individuals' work, leadership and management, working together, growth and opportunities, culture and values.

In addition to the above, a focus was given to four additional areas that were identified for improvement being organisational engagement, reward and recognition, values and organisational leadership. Each of these improvement areas received higher scores from the previous year, with increases ranging from 11 per cent to 27 per cent in staff satisfaction.

PEOPLE ENGAGEMENT SURVEY

The People Engagement Survey 2017 results are:

	2017		2016
Purpose and Vision	85%	↑	78%
My Work	80%	-	80%
Leadership and Management	80%	↑	68%
Working Together	81%	↑	63%
Growth and Opportunities	60%	↑	55%
Culture and Values	87%	↑	72%

Note The above details a comparison with the People Engagement Survey 2016 results, showing five increased scores and one" no change".

Benefits

Benefits are reported by DHBs to NZ Health Partnerships and we are responsible for reporting these at an aggregated level. DHBs report their benefits achieved from the National Procurement Service, collaborative and local initiatives. NZ Health Partnerships also includes Shared Banking and Collective Insurance benefits by DHB. Furthermore, we receive information on the benefits achieved by DHBs participating in AoG contracts from MBIE.

Reported benefits

Reported benefits include both realised and predicted amounts. Predicted benefits are based on an actual per-unit saving multiplied by forecast volumes. Accordingly actual benefits achieved may vary.

Benefits are classified as either budgetary or non-budgetary. A budgetary benefit has a financial impact on a DHB's Statement of Income and Expenses. Non-budgetary benefits are all those that do not meet the budgetary definition, including cost avoidance, cumulative, ie contracts that started in previous financial years and qualitative benefits

Points to note

Reported benefits for the year total $67.7m against SPE target of $74.7m, a shortfall of $7.0m. The main contributor to this is Food Services, with the food target of $6.1m being set based on all 20 DHBs participating in the FSA. This has subsequently been revised, based on the six participating DHBs, with benefits from the FSA due to commence from 2017/18.

Table 11: 2016/17 total reported benefits

Programmes and services	Budgetary $000's	Non - Budgetary $000's	2016/17 Total Reported Benefits $000's	2016/17 Target as per SPE $000's	2015/16 Total Reported Benefits $000's
Programmes	0	0	0	0	0
Services					
National Procurement Service[1]	8,873	39,251	48,124	54,600	37,264
Shared Banking service	0	3,406	3,406	925	2,619
Food Service	0	0	0	6,070	0
Collective Insurance	0	2,527	2,527	2,527	5,283
Other Procurement[2]	4,871	8,781	13,652	10,569	16,221
GRAND TOTAL	**13,744**	**53,965**	**67,709**	**74,691**	**61,387**

1 - National Procurement Service includes AoG and PHARMAC contracts

2 - Other Procurement includes DHB local and collaborative procurement

Reported benefits

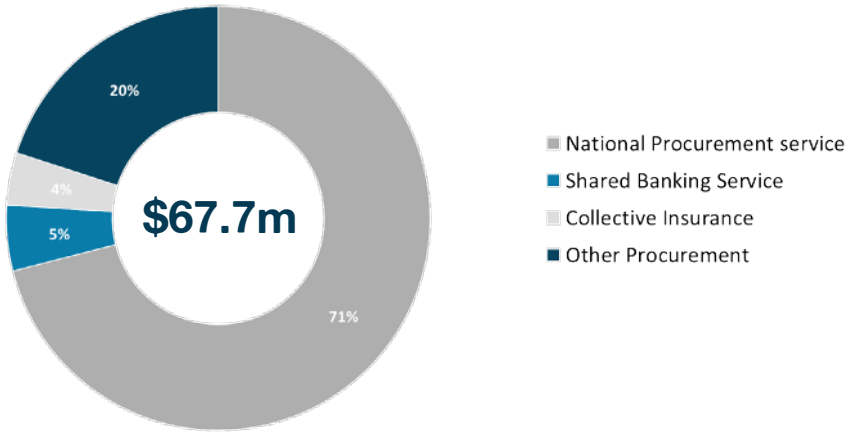

Figure 5: NZ Health Partnerships reported benefits by source 2016/17

Table 12: 2016/17 total reported benefits by DHB

DHB	Budgetary $000's	Non - Budgetary $000's	2016/17 Total Reported Benefits $000's	2015/16 Total Reported Benefits $000's
Auckland DHB	2,315	11,996	14,311	11,591
Bay of Plenty DHB	269	1,758	2,027	2,802
Canterbury DHB	1,627	4,949	6,576	6,399
Capital and Coast DHB	554	3,499	4,053	4,731
Counties Manukau DHB	2,108	6,749	8,857	4,423
Hawke's Bay DHB	98	1,074	1,172	1,059
Hutt Valley DHB	123	1,265	1,388	1,886
Lakes DHB	675	915	1,590	617
MidCentral DHB	619	1,848	2,467	2,011
Nelson Marlborough DHB	31	1,003	1,034	1,294
Northland DHB	376	2,450	2,826	2,945
South Canterbury DHB	351	113	464	595
Southern DHB	1,184	4,615	5,799	5,409
Tairawhiti DHB	99	290	389	398
Taranaki DHB	156	1,034	1,190	1,167
Waikato DHB	1,854	5,777	7,631	8,527
Wairarapa DHB	45	227	272	393
Waitemata DHB	1,060	3,355	4,415	3,604
West Coast DHB	141	338	479	484
Whanganui DHB	59	431	490	648
healthAlliance	0	279	279	404
TOTAL	**13,744**	**53,965**	**67,709**	**61,387**

Part three:

Financial statements

Statement of comprehensive revenue and expenses for the year ended 30 June 2017

		Notes	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
Revenue					
Revenue from DHBs		2	26,372	22,696	24,481
Interest revenue	NZ Health Partnerships		48	120	219
	Shared Banking		20,630	24,000	28,385
Other revenue			3,491	0	941
Total revenue			**50,541**	**46,816**	**54,026**
Expenditure					
Personnel costs		3	3,295	4,201	3,205
Depreciation and amortisation expense		8,9	437	132	2,126
Finance costs	NZ Health Partnerships		344	0	0
	Shared Banking		20,579	24,000	28,362
Other expenses		4	24,892	18,483	24,431
Total expenditure			**49,547**	**46,816**	**58,124**
Surplus / (deficit)			**994**	**0**	**(4,098)**
Other comprehensive revenue and expense			0	0	0
Total comprehensive revenue and expense			**994**	**0**	**(4,098)**

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 18.

Statement of financial position as at 30 June 2017

	Notes	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
ASSETS				
Current assets:				
Cash and cash equivalents	5	86,758	5,339	110,566
Receivables	6	9,118	11,533	11,851
Investments - Shared Banking	7	130,000	139,822	120,000
Prepayments		537	0	48
DHB Shared Banking Facility	10a	50,840	0	26,691
Total current assets		277,253	156,694	269,156
Non-current assets:				
Receivables	6	4,520	0	7,466
Investments - Shared Banking	7	0	0	20,000
Property, plant and equipment	8	57	796	78
Intangible assets	9	64,082	57,768	55,757
Total non-current assets		68,659	58,564	83,301
Total assets		**345,912**	**215,258**	**352,457**
LIABILITIES				
Current liabilities				
Payables	10	11,962	9,959	11,668
DHB Shared Banking Facility	10b	264,462	139,822	269,469
Employee entitlements	11	176	334	177
Income in advance		256	0	1,307
Total current liabilities		276,856	150,115	282,621
Non-current liabilities				
Payables	10	6,555	0	9,018
Employee entitlements	11	0	0	0
Income in advance		689	0	0
Total non-current liabilities		7,244	0	9,018
Total liabilities		**284,100**	**150,115**	**291,639**
Net assets		**61,812**	**65,143**	**60,818**

	Notes	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
EQUITY				
Contributed capital	12	64,916	68,633	64,916
Accumulated surplus / (deficit)	12	(3,104)	(3,490)	(4,098)
Total equity		**61,812**	**65,143**	**60,818**

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 18.

Statement of changes in equity for the year ended 30 June 2017

	Notes	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
Balance at 1 July		60,818	68,633	0
Total comprehensive revenue and expenses for the year		994	(3,490)	(4,098)
Owner transactions				
Contributed capital		0	0	64,916
Balance at 30 June	12	**61,812**	**65,143**	**60,818**

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 18.

Statement of cash flows for the year ended 30 June 2017

	Notes	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
Cash flows from operating activities				
Receipts from DHBs		30,072	22,680	19,139
Receipts from other revenue		2,864	0	3,625
Interest received		23,140	124,000	28,787
Payments to suppliers		(24,662)	(4,256)	(24,084)
Payments to employees		(3,296)	(15,441)	(3,244)
Interest paid		(24,419)	(124,000)	(29,607)
Net DHB Sweep account movements with DHBs		(29,156)	0	(223,755)
Goods and services tax (net)		390	52	368
Net cash flow from operating activities		**(25,067)**	**3,035**	**(228,771)**
Cash flows from investing activities				
Funds from deposits		2,021,000	0	3,290,000
Purchase of property, plant, and equipment		(10)	0	(6)
Purchase of intangible assets		(8,731)	(2,970)	(3,735)
Funds to deposit		(2,011,000)	0	(3,195,000)
Net cash flow from investing activities		**1,259**	**(2,970)**	**91,259**
Cash flows from financing activities				
Cash transferred		0	0	248,078
Proceeds from borrowing		0	0	0
Repayment interest		0	0	0
Net cash flow from financing activities		**0**	**0**	**248,078**

	Notes	2016/17 Actual $000's	2016/17 Budget $000's	2015/16 Actual $000's
Net (decrease) / increase in cash and cash equivalents		**(23,808)**	**65**	**110,566**
Cash and cash equivalents at the beginning of the year		110,566	5,274	0
Cash and cash equivalents at the end of the year	**5**	**86,758**	**5,339**	**110,566**

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 18.

Reconciliation of net surplus/(deficit) to net cash flow from operating activities

	2016/17 Actual $000's	2015/16 Actual $000's
Net surplus/ (deficit)	994	(4,098)
Add / (less) non-cash items		
Fair value adjustment from Service Provider fees	588	0
Depreciation and amortisation expense	437	2,126
Total non-cash items	1,025	2,126
Add / (less) movements in statement of financial position items		
(Inc)/dec in debtors and other receivables	5,679	(9,077)
(Inc)/dec in prepayments	(489)	(48)
Inc/(dec) in creditors and other payables	(2,757)	10,446
Inc/(dec) in income in advance	(362)	1,307
Inc/(dec) in employee entitlements	(1)	177
Inc/(dec) in DHB sweep account	(29,156)	(223,755)
Inc/(dec) transferred from prior year	0	(5,849)
Net movements in working capital items	(27,003)	(226,799)
Net cash flow from operating activities	**(25,067)**	**(228,771)**

The accompanying financial notes form part of these financial statements.

Part four:

Financial notes

Contents: financial notes

1. Statement of accounting policies

Reporting entity

NZ Health Partnerships Limited is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing NZ Health Partnerships' operations includes the Crown Entities Act 2004. NZ Health Partnerships is a multi-parent Crown subsidiary, owned by the 20 District Health Boards, which have equal Class A shareholding and voting rights.

NZ Health Partnerships' primary objective is to operate as a co-operative undertaking, and enable DHBs to collectively maximise shared services opportunities for the national good. NZ Health Partnerships does not operate to make financial return.

NZ Health Partnerships has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for NZ Health Partnerships are for the year ended 30 June 2017, and were approved by the Board on 9 February 2018.

The adoption of the annual report was delayed due to a technical accounting issues that was not resolved until after the statutory timeframe. Further information on this can be found in note 15.

Basis of preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the year.

Statement of compliance

These financial statements of NZ Health Partnerships have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements have been prepared to comply with Public Benefit Entity Standards (PBE Standards) for a Tier 1 entity.

These financial statements comply with PBE Standards.

Presentation currency and rounding

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

Standards issued that are not yet effective and have not been early adopted

Financial instruments

In January 2017, the External Reporting Board (XRB) issued PBE IFRS 9 Financial Instruments. This replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with earlier application permitted.

The main changes under the standard are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses
- Revised hedge accounting requirements to better reflect the management of risks.

The timing of adoption of PBE IFRS 9 will be guided by the Treasury's decision on when the Financial Statements of Government will adopt PBE IFRS 9. NZ Health Partnerships has not yet assessed the effects of the new standard.

Impairment of re-valued assets

In April 2017, the XRB issued Impairment of Re-valued Assets, which now clearly scopes in re-valued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a Re-valued Asset can be impaired without having to revalue the entire class of-asset to which the asset belongs. The timing of adoption of this amendment will be guided by the Treasury's decision on when the Financial Statements of Government will adopt the amendment.

Summary of significant accounting policies

Significant account policies are included in the notes to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

Significant accounting policies

Revenue

Interest revenue

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

Expenditure

Finance costs

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

Goods and services tax

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

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

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is

classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

The budget figures are derived from the Statement of Performance Expectations (SPE) as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost allocation

NZ Health Partnerships has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

Critical accounting judgements and estimates

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

Critical judgement in applying accounting policies

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

- Capitalisation of National Oracle Solution (NOS) programme (previously known as Finance, Procurement and Supply Chain programme) - refer to note 9
- Impairment of NOS Assets - refer to note 9
- Treatment of contractual settlement with third party provider of Infrastructure as a Service – refer to note 15.

2. Revenue

Accounting policy

Funding from DHBs

NZ Health Partnerships is funded through revenue received from the DHBs, which is restricted in its use for the purpose of NZ Health Partnerships meeting its objectives as specified in the Statement of Intent. The breakdown of revenue for programmes and services are on pages 24 and 25. Revenue is recognised as revenue when earned and is reported in the financial period to which it relates.

There were no donations received during the year.

3. Personnel costs

Accounting policy

Superannuation schemes

Defined benefit schemes.

NZ Health Partnerships has no obligations to contribute to any defined benefit superannuation funds.

Defined contribution schemes.

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

	2016/17 Actual $000's	2015/16 Actual $000's
Salaries and wages	3,219	3,176
Defined contribution plan employer contributions	77	67
Increase/(decrease) in employee entitlements from balance transferred	(1)	(38)
Total personnel costs	**3,295**	**3,205**

Employer contributions to defined contribution plans include contributions to KiwiSaver.

Employee remuneration

The Company paid short-term benefits in excess of $100,000 by way of remuneration including salary and benefits to 11 employees during the year.

	2016/17 Actual	2015/16 Actual
Total remuneration paid or payable:		
$100,000 - $109,999	3	0
$110,000 - $119,999	3	2
$130,000 - $139,999	1	2
$140,000 - $149,999	0	1
$150,000 - $159,999	0	1
$170,000 - $179,999	1	1
$220,000 - $229,999	1	0
$230,000 - $239,999	0	2

	2016/17 Actual	2015/16 Actual
$240,000 - $249,999	1	0
$310,000 - $319,999	1	0
Total employees	**11**	**9**

During the year ended 30 June 2017, 2 employees received compensation and other benefits in relation to cessation totalling $126k (2015/16: 8 employees totalling $285k).

Board member remuneration

The total value of remuneration paid or payable to each Board member during the year was:

	2016/17 Actual $000's	2015/16 Actual $000's
Peter Anderson (Chair)	58	34
Sue Suckling (Chair, resigned January 2016)	0	34
Lee Mathias (resigned February 2017)	19	29
Terry McLaughlin	29	22
Murray Cleverley (resigned June 2017)	29	29
Joanne Hogan	29	7
Deryck Shaw	29	29
Phil Sunderland (sudden death December 2016)	14	29
Kevin Atkinson (started March 2017)	10	0
Rabin Rabindran (started March 2017)	10	0
Total Board member remuneration	227	213

There have been no payments made to committee members appointed by the Board who are not Board members during the financial year (2015/16: none).

NZ Health Partnerships has provided a deed of indemnity to Directors for certain activities undertaken in the performance of NZ Health Partnerships' functions.

NZ Health Partnerships has affected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board Directors received compensation or other benefits in relation to cessation (2015/16: none).

4. Other expenses

Accounting policy

Operating leases

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

	2016/17 Actual $000's	2015/16 Actual $000's
Fees to principal auditor, Audit New Zealand	131	128
Other Assurance Providers	158	150
Staff travel	179	224
Consultancy costs	148	1,274
Services contracted out	13,040	14,947
Contractors	3,147	1,537
Operating lease expense	256	382
Board member fees	227	213
Loss on sale	0	1,091
Other expenses	7,606	4,485
Total other expenses	24,892	24,431

Operating leases as lessee

	2016/17 Actual $000's	2015/16 Actual $000's
Rent payable under non-cancellable operating leases to the end of the lease terms are:		
– Not later than one year	170	170
– Later than one year and not later than five years	17	190
– Later than five years	0	0

NZ Health Partnerships has one performance guarantee of $229k with Westpac for Goodman Nominee Ltd.

5. Cash and cash equivalents

Accounting policy

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

	2016/17 Actual $000's	2015/16 Actual $000's
Cash at bank and on hand	60	207
Call deposits	1,830	5,950
DHB Shared Banking Facility	84,868	104,409
Total cash and cash equivalents	**86,758**	**110,566**

Amounts held within the Shared Banking Facility are not available for use by NZ Health Partnerships.

6. Receivables

Accounting policy

Short term receivables are recorded at the amount due, less any provision for un-collectability.

A receivable is considered uncollectable when there is evidence that NZ Health Partnerships will not be able to collect the amount due. The amount of the un-collectability is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

	2016/17 Actual $000's	2015/16 Actual $000's
Receivables	13,638	19,317
Less: provision for un-collectability	0	0
Total receivables	13,638	19,317
Total receivables comprises:		
Receivables (current)	9,118	11,635
Receivables (non-current)	4,520	7,466
GST receivables	0	216
Total receivables	**13,638**	**19,317**

The ageing profile of receivables at year end is detailed below:

	2016/17 Actual		
	Gross $000's	Un-collectability $000's	Net $000's
Not past due	13,602	0	13,602
Past due over 90 days	36	0	36
Total	13,638	0	13,638

	2015/16 Actual		
	Gross $000's	Un-collectability $000's	Net $000's
Not past due	19,317	0	19,317
Past due over 90 days	0	0	0
Total	19,317	0	19,317

All receivables greater than 90 days in age are considered to be past due.

NZ Health Partnerships has a very small number of receivables, and un-collectability is assessed based on individual amounts outstanding and the likelihood of non-payment.

The fair value of service credits, included within the receivables balance, have been determined using cashflows discounted at a market rate of 6.44%.

7. Investments

Accounting policy

Bank term deposits

Bank term deposits are measured at the amount invested.

	2016/17 Actual $000's	2015/16 Actual $000's
Current portion		
Term deposits with remaining durations less than 12 months	130,000	120,000
Total current portion	**130,000**	**120,000**
Non-current portion		
Term deposits with remaining durations greater than 12 months	0	20,000
Total non-current portion	**0**	**20,000**
Total investment	130,000	140,000

The carrying value of term deposits approximates their fair value.

8. Property, plant and equipment

Accounting policy

Property, plant and equipment consist of three asset classes, which are as follows:

1. Leasehold improvements
2. Furniture and office equipment
3. Information Technology.

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

Additions

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

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

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

Disposals

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

Depreciation

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

Asset type	Useful life	Rate
Leasehold improvements	5 – 14 years	7% - 20%
Furniture and office equipment	1.5 – 9.5 years	10.5% - 67%
Information technology (including phones)	2.5 – 5 years	20% - 40%

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

Impairment of property, plant, and equipment

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

Non-cash-generating assets.

Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value, less costs to sell, and value in use.

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

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

The reversal of an impairment loss is recognised in the surplus or deficit.

Breakdown of property, plant and equipment and further information

Movements for each class of property, plant and equipment are as follows:

	2016/17 Actual			
	Leasehold improvements	**Furniture and office equipment**	**Information technology**	**Total**
	$000's	**$000's**	**$000's**	**$000's**
Cost or valuation				
Balance at 1 July 2016	12	67	34	113
Contributed assets	0	0	0	0
Additions	0	7	3	10
Disposal/sales	0	0	0	0
Balance at 30 June 2017	12	74	37	123
Accumulated depreciation and impairment losses				
Balance at 1 July 2016	4	16	15	35
Depreciation expense	4	17	10	31
Elimination on disposal	0	0	0	0
Balance at 30 June 2017	8	33	25	66
Carrying amounts				
At 1 July 2016	8	51	19	78
At 30 June 2017	4	41	12	57

	2015/16 Actual			
	Leasehold improvements	Furniture and office equipment	Information technology	Total
	$000's	$000's	$000's	$000's
Cost or valuation				
Balance at 1 July 2015	0	0	0	0
Contributed assets	12	63	1,633	1,708
Additions	0	4	2	6
Disposal/sales	0	0	(1,601)	(1,601)
Balance at 30 June 2016	12	67	34	113
Accumulated depreciation and impairment losses				
Balance at 1 July 2015	0	0	0	0
Depreciation expense	4	16	443	463
Elimination on disposal	0	0	(428)	(428)
Balance at 30 June 2016	4	16	15	35
Carrying amounts				
At 1 July 2015	0	0	0	0
At 30 June 2016	8	51	19	78

The total amount of property, plant and equipment in the course of construction is $nil.

9. Intangible assets

Accounting policy

Software acquisition and development

Computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred.

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

The NOS programme (previously known as Finance Procurement and Supply Chain (FPSC) programme) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships to deliver sector wide benefits. NZ Health Partnerships holds an intangible asset recognised at the capital cost of development relating to this programme.

Amortisation

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

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

Intangible asset	Useful life	Amortisation rate
National Oracle Solution programme	15 years	6.7%
Acquired computer software	2.5 - 5 years	20% - 40%

Impairment of intangible assets

Refer to the policy for impairment of property, plant and equipment in Note 8.

Critical accounting estimates and assumptions

Estimating useful lives of software assets.

NZ Health Partnerships carrying amounts for acquired software for 1 July 2016 was $4.36m, which includes various software licenses from Oracle New Zealand (Oracle). The licences are for the NOS programme and are currently used by 11 DHBs. These software licenses have a finite life, which requires NZ Health Partnerships to estimate the useful life of the software asset.

In assessing the useful lives of software assets, a number of factors were considered, including:

- the period of time the software is intended to be in use;
- the effect of technological change on systems and platforms; and

- the expected timeframe for the development of replacement systems and platforms.

NZ Health Partnerships originally amortised the Oracle Licenses over a 5-year term based on the hardware that was purchased at the same time as the licenses and used to host the programs. This useful life has been reviewed and considered and has been changed from five to 15 years due to the following reasons:

- the hardware purchased at the same time as the licenses has since been disposed of
- the useful lives of the software has been linked to NZ Health Partnerships' shared services head agreement with DHBs
- the NOS platform provided by the licences is expected to be in use by DHBs for at least 15 years

Work In Progress - Capitalisation of National Oracle Solution Programme

The NOS programme is aimed at reducing costs in administrative support and procurement for the public health sector. A national approach to these services will combine the purchasing power of DHBs, create visibility of stock and ensure a common financial language across the health sector.

The programme was initiated in 2012. The total original proposed expenditure on the project was $87.9 million, of which $68.3 million was to be capitalised and $19.6 million was operating expenditure.

The assets that are created by the programme are held in Work in Progress (WIP). The NOS programme is not a single asset, but a bundle of assets relating to Finance, Procurement and Supply Chain. These are both tangible such as IT hardware and intangible, such as software, standard operating procedures and intellectual property.

The costs that are directly associated with the development of the NOS programme are recognised as tangible or intangible assets when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. Direct costs include project development employees, contractors, consultants and apportionment of the relevant overheads.

Indirect costs are recognised as expenses when incurred and include depreciation, software licenses and software maintenance costs.

During 2016/17, a revised approach was developed for the programme. As at 30 June, the revised approach was documented and development of a Change Control Report (CCR) was underway for our Board approval in August, then consideration by DHBs. Good progress is being made on DHB and Ministerial approval. All 20 DHBs have reaffirmed their commitment to the NOS programme and the funding required to complete the programme. Also, the amendment to Class B shares has been approved by all 20 DHBs.

Amortisation

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

Impairment of NOS assets

NZ Health Partnerships has considered the impairment of the NOS programme assets at 30 June 2017 under the applicable accounting standards, specifically PBE IPSAS 21 Impairment of Non-Cash-Generating Assets.

At 30 June 2017, 20 DHBs had made payments totalling $68m for Class B Shares in relation to the NOS programme.

In return for these payments, all DHBs gained rights to access the NOS programme assets. In the event of

liquidation or dissolution of NZ Health Partnerships, all DHBs shall be entitled to be paid from the surplus assets, an amount equal to their proportionate share of the liquidation value based on its proportional share of the total NOS programme rights that have been issued.

The NOS programme asset has been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC). The current expectation of the Board is that the NOS programme will proceed as planned and the DRC of the NOS programme assets is considered to equate to, in all material respects, the costs capitalised to date, such that the NOS programme asset is not impaired.

There are a number of considerations that were given in reaching the conclusion that are set out below:

- The NOS asset is deemed to be a non-cash-generating asset. This is on the basis that there are no cash flows directly linked to the asset. Rather, the benefit to each DHB is the potential cost savings from a negotiated national contract above the cost of each DHB negotiating a similar contract themselves. It is also noted that the Class B Shares held by each DHB are non-voting and do not carry any entitlement to dividends.
- There is no indication that the demand or need for the services provided by the asset will cease or are near cessation.
- There have been no significant long-term changes with an adverse effect on NZ Health Partnerships that has taken place during the period, or will take place in the near future, in the technological, legal, or government policy environment in which the entity operates.
- There has been no physical damage to the asset.
- There has been no significant long-term change with an adverse effect on NZ Health Partnerships that has taken place during the period, or will take place in the near future, to the extent to which, or manner in which an asset is used or expected to be used.
- There is no indication for a decision to halt the construction of the asset before it is complete or in a usable condition and sufficient funds are available or will be made available to complete the asset.
- The benefits that the programme is forecast to deliver will be in excess of the total costs of the programme including costs to date. Benefit delivery is driven by the scope of the programme and as such, it is expected that the programme is to be delivered consistent with the original scope.
- That the WIP does not include any material costs that reflect inefficiency or similar items.

Breakdown of intangible assets and further information

Movements for each class of intangible asset are as follows:

	2016/17 Actual		
	Work in progress $000's	**Acquired software $000's**	**Total $000's**
Cost			
Balance at 1 July 2016	51,393	6,003	57,396
Contributed assets	0	0	0
Additions	0	0	0
Additions to WIP	8,731	0	8,731
Additions from WIP	0	0	0
Disposal/sales	0	0	0
Balance at 30 June 2017	60,124	6,003	66,127
Accumulated depreciation and impairment losses			
Balance at 1 July 2016	0	1,639	1,639
Amortisation expense	0	406	406
Disposal/sales	0	0	0
Balance at 30 June 2017	0	2,045	2,045
Carrying amounts			
At 1 July 2016	51,393	4,364	55,757
At 30 June 2017	60,124	3,958	64,082

	2015/16 Actual		
	Work in progress $000's	Acquired software $000's	Total $000's
Cost			
Balance at 1 July 2015	0	0	0
Contributed assets	46,574	5,940	52,514
Additions	0	154	154
Additions to WIP	4,819	0	4,819
Additions from WIP	0	0	0
Disposal/sales	0	(91)	(91)
Balance at 30 June 2016	51,393	6,003	57,396
Accumulated depreciation and impairment losses			
Balance at 1 July 2015	0	0	0
Amortisation expense	0	1,663	1,663
Disposal/sales	0	(24)	(24)
Balance at 30 June 2016	0	1,639	1,639
Carrying amounts			
At 1 July 2015	0	0	0
At 30 June 2016	51,393	4,364	55,757

There are restrictions over the title of NZ Health Partnerships' intangible assets, please refer to note 12 (Equity).

There are no intangible assets pledged as security for liabilities.

10. Payables

Accounting policy

Short-term payables are recorded at their face value.

	2016/17 Actual $000's	2015/16 Actual $000's
Creditors	290	1,043
Accrued expenses	9,336	9,197
Service Provider Fees	8,562	10,240
Other payables	76	133
Tax payable (GST and PAYE)	253	73
Total payables	**18,517**	**20,686**
Total payables comprises:		
Payables (current)	9,955	10,446
Payables (non-current)	0	0
Service Provider Fees (current)	2,007	1,222
Service Provider Fees (non-current)	6,555	9,018
Total payables	**18,517**	**20,686**

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms. Therefore, the carrying value of creditors and other payables approximates their fair value.

The fair value of Service Provider fees has been determined using contractual cashflows discounted using a market based rate of 6.44% as at balance date.

DHB and other Shared Banking Facility

		2016/17 Actual $000's	2015/16 Actual $000's
Auckland DHB		69,641	31,887
Bay of Plenty DHB		14,690	7,252
Canterbury DHB		(16,505)	11,117
Capital and Coast DHB		20,299	12,775
Counties Manukau DHB		20,853	31,726
Hawke's Bay DHB		15,254	14,223
Hutt Valley DHB		7,134	4,233
Lakes DHB		3,836	1,201
MidCentral DHB		26,651	24,582
Nelson Marlborough DHB		21,554	24,774
Northland DHB		12,251	2,177
South Canterbury DHB		12,557	19,155
Southern DHB		(22,706)	(9,803)
Tairawhiti DHB		(3,456)	(6,804)
Taranaki DHB		(3,349)	(8,672)
Waikato DHB		2,503	811
Wairarapa DHB		(3,183)	(1,412)
Waitemata DHB		17,813	53,631
West Coast DHB		10,743	11,795
Whanganui DHB		7,507	10,958
healthAlliance Ltd		(1,641)	6,122
healthAlliance (FPSC) Ltd		825	15
HealthShare Ltd		351	1,035
Total DHB Shared Banking Facility		**213,622**	**242,778**
Current Assets – (amounts in brackets as above)	a.	(50,840)	(26,691)
Current Liabilities	b.	264,462	269,469
Total DHB Shared Banking Facility		**213,622**	**242,778**

This balance is represented by:

Cash and cash equivalents	84,868	104,409
Term deposits	130,000	140,000
Accrued interest	(1,158)	(1,595)
Administration fee	(88)	(36)
Total	**213,622**	**242,778**

11. Employee entitlements

Accounting policy

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date and annual leave earned to but not yet taken at balance date.

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

Presentation of employee entitlements

Sick leave and annual leave are classified as a current liability.

	2016/17 Actual $000's	2015/16 Actual $000's
Current portion		
Accrued salaries and wages	57	41
Annual leave	119	136
Employee sick leave entitlements	0	0
Total current portion	**176**	**177**
Non-current portion		
Employee sick leave entitlements	0	0
Total non-current portion	**0**	**0**
Total employee entitlements	**176**	**177**

NZ Health Partnerships does not currently have any employment agreement containing long service leave entitlements. All employee entitlements relate to annual leave entitlements expected to be taken within the twelve months following the entitlement falling due.

12. Equity

Accounting policy

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Accumulated surplus/(deficit)
- Contributed Capital - Crown Equity

	2016/17 Actual $000's	2015/16 Actual $000's
Accumulated surplus/(deficit)	(4,098)	0
Surplus/(deficit) for the year	994	(4,098)
Balance at 30 June	(3,104)	(4,098)
Contributed Capital - Crown Equity		
Accumulated deficit transferred from HBL	(3,716)	(3,716)
Class B shares transferred	68,333	68,333
Capital contributions transferred	299	299
Balance at 30 June	64,916	64,916
Total equity	**61,812**	**60,818**

NZ Health Partnerships has issued 100 Class A Shares. 68.333m Class B Shares were transferred from Health Benefits Ltd (HBL) and reissued under NZ Health Partnerships.

NZ Health Partnerships has issued Class B Shares to DHBs for the purpose of funding the development of the NOS shared services. The following rights are attached to these shares:

- Class B Shares confer no voting rights
- Class B Shareholders shall have the right to access the NOS shared services
- Class B Shares confer no right to a dividend, other than a dividend to be made out of any surplus earned by NZ Health Partnerships from the NOS shared services only
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the NOS shared services assets based upon the proportion of the total number of issued and paid up Class B Shares that it holds. Otherwise, each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares
- On liquidation or dissolution of the Company, each unpaid Class B Share confers no right to a share in the distribution of the surplus assets.

13. Related party transactions

Related party disclosures have not been made for transactions with related parties that are:

- within a normal supplier or client/recipient relationship
- on terms and conditions no more or less favourable than those that it is reasonable to expect NZ Health Partnerships would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, Government departments and Crown Entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel

No transactions were entered into during the year with key management personnel apart from salaries and reimbursed expenses.

Key management personnel compensation

	2016/17 Actual $000's	2015/16 Actual $000's
Board members		
Remuneration	227	213
Full time equivalent members	6.58	6.33
Leadership team		
Remuneration	1,397	1,009
Full time equivalent members	4.67	5.83
Total key management personnel remuneration	**1,624**	**1,222**
Total full time equivalent personnel	**11.25**	**12.16**

Key management personnel include all board members, the Chief Executive, and members of the NZ Health Partnerships Executive Leadership team. For Board members, the full time equivalent is taken as the number of Board members. In establishing the new organisation, temporary personnel was taken onto the Executive Leadership team. The additional cost of these specialist resources has driven up the average salary in 2016/17.

14. Financial instruments

14A Financial instrument categories

The carrying amounts of financial assets and liabilities in each of the NZ PBE IPSAS 28 categories are as follows:

	2016/17 Actual $000's	2015/16 Actual $000's
Loans and receivables		
Cash and cash equivalents	86,758	110,566
Receivables (excluding GST)	13,638	19,101
DHB Shared Banking Facility	50,840	26,691
Investments - term deposits	130,000	140,000
Total loans and receivables	**281,236**	**296,358**
Financial liabilities measured at amortised cost		
Payables (excluding GST, PAYE and income in advance)	18,264	20,613
DHB Shared Banking Facility	264,462	269,469
Total financial liabilities measured at amortised cost	**282,726**	**290,082**

Financial assets - receivables (excluding GST)

The receivables amount includes NZ Health Partnerships' ability to call $5.88m from DHBs to meet its obligations for the Service Provider Fees (refer financial liabilities - payables below). The asset and liability amounts vary due to differences in the terms of the obligations and payments made to date by DHBs. Due to their linked nature, fair value is determined based on the contract rates used for the Service Provider Fees.

Under the contract variation NZ Health Partnerships can invoice the third party provider in respect of credits against new contracts for All of Government spend between December 2016 and February 2025. All parties expect this arrangement to negate the need for DHBs to provide any further funding to NZ Health Partnerships to meet the Service Provider Fees payment plan.

Financial liabilities - payables (excluding GST, PAYE and income in advance)

NZ Health Partnerships has elected an extended payment option for two Service Provider Fees of $8.56m, with payments over 44 and 84-month terms. Fair values are determined based on contractual cashflows discounted using market rates.

14B Financial instrument risks

NZ Health Partnerships' activities expose it to credit risk, cash flow risk and liquidity risk. NZ Health Partnerships policy does not allow any transactions that are speculative in nature to be entered into.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. NZ Health Partnerships' exposure to fair value interest rate risk is limited to its cash deposits, which are held at variable rates of interest. NZ Health Partnerships does not actively manage its exposure to fair value interest rate risk.

Cash flow interest rate risk

Cash flow interest rate risk is the risk that the cash flows from financial instruments will fluctuate because of changes in market interest rates. NZ Health Partnerships' exposure to cash flow interest rate risk is limited to term deposits. This exposure is not considered significant and is not actively managed.

Credit risk

Credit risk is the risk that a third party will default on its obligation to NZ Health Partnerships, causing it to incur a loss. Due to the timing of its cash inflows and outflows, NZ Health Partnerships invests surplus cash with registered banks.

NZ Health Partnerships has processes in place to review the credit quality of customers prior to the granting of credit. In the normal course of business, NZ Health Partnerships is exposed to credit risk from cash and term deposits with banks, debtors and other receivables. For each of these, the maximum credit exposure is best represented by the carrying amount in the statement of financial position.

NZ Health Partnerships holds no collateral or other credit enhancements for financial instruments that give rise to credit risk.

NZ Health Partnerships will ensure that any participating DHBs maximum debit balance does not exceed one month's Provider Arm revenue (consistent with Ministry of Health requirements). Escalation to the NZ Health Partnerships Chief Executive/Ministry of Health officials is required if it appears likely that this restriction will be breached, potentially including the removal of the DHB from the Sweep (immediately following receipt of monthly Ministry revenue).

NZ Health Partnerships will monitor the Standard & Poor's long-term credit rating for the sectors transactional bank, currently Westpac. If the credit rating falls below A+ and the bank is placed on a 'negative outlook', escalating action, including discussion with the transactional bank, DHBs, and Ministry/Treasury officials, will commence.

NZ Health Partnerships will ensure that Sweep-related credit exposure to other entities is controlled and term investments shall only be made with:

- New Zealand registered and incorporated banks that are systemically important (ie Kiwibank, Westpac New Zealand Limited, Bank of New Zealand, ANZ National Bank Limited and ASB Bank Limited). Permitted exposure to such banks is unlimited
- New Zealand registered banks (not otherwise included above), subject to individual credit limits approved by NZ Health Partnerships' Board. These limits are to be reviewed 6 monthly or when the credit rating is downgraded or placed on "negative" outlook
- In all cases with a long-term Standard & Poor's credit rating of "A+" or better. This is to be confirmed at the time each term deposit is made for the bank concerned
- No credit exposure to any other party for any other Sweep-related purpose shall be accepted
- If a bank's (other than Westpac's) credit rating falls below "A+"

- If it remains at or above the minimum credit rating outlined in the Operational Policy Framework for DHB maintaining accounts with that bank, place no further deposits with that bank and let all existing deposits run to maturity
- If it falls below the minimum credit rating outlined in the Operational Policy Framework, consult with the CFO Reference Group whether to let the deposits run to maturity or immediately break them. If the deposit has more than 2 months to run to maturity, the approval of the Minister of Finance is required to break them
- If the downgrade is systemic, discuss the situation with DHB CFOs and Ministry of Health/Treasury officials before taking any action.

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counter-party default rates:

	2016/17 Actual $000's	2015/16 Actual $000's
COUNTER-PARTIES WITH CREDIT RATINGS		
Cash, cash equivalents and investments		
AA- rated	216,758	250,566
Total cash, cash equivalents and investments	**216,758**	**250,566**
COUNTER-PARTIES WITHOUT CREDIT RATINGS		
Receivables		
Existing counter-party with no defaults in the past		
Debtors and other receivables (excluding GST)	13,638	19,101
DHB Shared Banking Facility	50,840	26,691
Total receivables	**64,478**	**45,792**

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that NZ Health Partnerships will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash and the ability to close out market positions. NZ Health Partnerships manages liquidity risk by continuously monitoring forecast and actual cash flow requirements.

DHB Shared Banking Facility:

- There is a risk that a DHB does not obtain sufficient funds from NZ Health Partnerships because NZ Health Partnerships has too much of its funds invested on term deposits or because DHBs are, in total, overdrawn.

- The agreement requires DHBs to provide up to date cash forecasts to NZ Health Partnerships, which will help NZ Health Partnerships to manage this risk. Further, NZ Health Partnerships has a standby facility with Westpac that will allow it to borrow any such shortfalls up to $50m.
- Thus liquidity risk would only arise if DHBs were, in total, overdrawn in excess of this amount. Further, NZ Health Partnerships maintains a $75m 'buffer' in its sweep account before funds are placed on term deposit.
- As at 30 June 2017 there was no liquidity risk.

Contractual maturity analysis of financial liabilities

The table below analyses financial liabilities into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows.

			2016/17 Actual		
	Carrying amount $000's	**Contractual cash flows $000's**	**Less than 6 months $000's**	**6-12 months $000's**	**Greater than 1 year $000's**
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	18,264	18,264	9,490	1,187	7,587
DHB Shared Banking Facility	264,462	264,462	264,462	0	0
Total	**282,726**	**282,726**	**273,952**	**1,187**	**7,587**

			2015/16 Actual		
	Carrying amount $000's	**Contractual cash flows $000's**	**Less than 6 months $000's**	**6-12 months $000's**	**Greater than 1 year $000's**
Payables (excluding income in advance, taxes payable and grants received subject to conditions)	20,613	20,613	10,698	897	9,018
DHB Shared Banking Facility	269,469	269,469	269,469	0	0
Total	**290,082**	**290,082**	**280,167**	**897**	**9,018**

15. Prior period adjustment

In 2016/17 we agreed a variation to a contract with a third-party supplier of Infrastructure as a Service. Following this, NZ Health Partnerships sought advice on the accounting treatment of this contract and to improve the transparency of related transactions in our financial statements, have reflected some transactions in prior periods. This has necessitated adjustments to the prior period comparatives in our financial statements, with recognition of a liability and a corresponding asset in the 2015/16 financial year.

The adjustments are shown in the table below:

	2015/16 before adjustments $000's	2015/16 adjustments $000's	2015/16 after adjustments $000's
Statement of Revenue and Expenses			
Income:			
Revenue from DHB	21,631	2,850	24,481
Other income	3,791	(2,850)	941
Total income movement	**25,422**	**0**	**25,422**
Statement of Financial Position			
ASSETS			
Receivables	9,077	2,774	11,851
Total current assets movement	**9,077**	**2,774**	**11,851**
Non-current assets:			
Receivable non-current	0	7,466	7,466
Total non-current assets	0	**7,466**	**7,466**
Total assets	**9,077**	**10,240**	**19,317**
LIABILITIES			
Current liabilities:			
Payables	10,446	1,222	11,668
Total current liabilities	**10,446**	**1,222**	**11,668**
Non-current liabilities:			
Payable non-current	0	9,018	9,018
Total non-current liabilities	**0**	**9,018**	**9,018**
Total liabilities	**10,466**	**10,240**	**20,686**

The asset is included in Other Receivables in the Statement of Financial Position, which increases by $10.24m ($2.77m current and $7.46m non-current). Furthermore, $2.85m of income has been reclassified from 'Other Income' to 'Revenue from DHB' in 2015/16 in the Statement of Comprehensive Income. This ostensibly represents funding from DHBs to cover the contract payment plan, agreed as a part of back to back arrangements with DHBs.

However, under the contract variation, NZ Health Partnerships can invoice the third-party provider in respect of credits against new contracts for All of Government spend between December 2016 and February 2025. All parties expect this arrangement to negate the need for DHBs to provide further funding to NZ Health Partnerships to meet the contract payment plan.

The liability to the third-party has been recognised as 'Creditors and Other Payables' in the Statement of Financial Position, which increases by $10.24m ($1.22m current and $9.02m non-current). No payments were made in 2015/16. In 2016/17 a payment arrangement was agreed, with two concurrent payment arrangements, one over 44 months, ending July 2020 and one over 84 months, ending November 2023.

As a result of this issue the annual report was not adopted within the statutory timeframes, resulting in a breach of Statutory deadline as outlined in S156 of the Crown Entities Act 2004.

16. Contingencies

NZ Health Partnerships does not have any contingent assets or liabilities (2015/16: none).

17. Events after the balance date

There have been no material events subsequent to 30 June 2017 (2015/16: none).

18. Explanation of major variances against budget

Explanations for major variances from the NZ Health Partnerships' budgeted figures in the SPE are as follows:

Statement of comprehensive income

Revenue

DHBs

Revenue is $3.68m higher than budget due to additional revenue received to offset unbudgeted expenses.

Interest revenue

Interest Income is $3.44m lower than budget due to changes in the market conditions and lower than planned cash held in the sweep.

Other revenue

Other revenue was $3.49m higher than budget to offset unbudgeted expenses.

Expenses

Personnel costs

Personnel costs are $906k lower than budget due to lower than planned staff.

Interest expenses

Interest expense is $3.08m lower than budget due to lower than planned interest received in shared banking activities.

Other expenses

Other expenses are $6.41m higher than budget due to unbudgeted programme costs.

Statement of financial position

Net DHB shared banking facility under current asset and current liabilities

Net DHB shared banking facility under current assets and liabilities are higher than budget due to the higher than planned cash held in the sweep at balance date.

Statement of cash flows

Cash receipts and payments varied to budget due to changes in the individual DHBs' cash positions.

19. Capital management

NZ Health Partnerships' capital is its equity, which comprises capital and accumulated surplus/(deficit). Equity is represented by net assets.

NZ Health Partnerships is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities, and the use of derivatives.

NZ Health Partnerships manages its equity by prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure the company effectively achieves its objectives and purpose.

Independent auditor's report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of New Zealand Health Partnerships Limited's financial statements and performance information for the year ended 30 June 2017

The Auditor-General is the auditor of New Zealand Health Partnerships Limited (NZHP). The Auditor-General has appointed me, Athol Graham, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, of NZHP on his behalf.

Opinion

We have audited:

- the financial statements of NZHP on pages 35 to 77, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expenses, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements including a summary of significant accounting policies and other explanatory information; and
- the performance information of NZHP on pages 20 to 33.

In our opinion:

- the financial statements of NZHP on pages 35 to 77:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2017; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Standards.
- the performance information on pages 20 to 33:
    - presents fairly, in all material respects, NZHP's performance for the year ended 30 June 2017, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
            - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - complies with generally accepted accounting practice in New Zealand.

Our audit was completed on 13 February 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of the Board for the financial statements and the performance information

The Board are responsible on behalf of NZHP for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board are responsible for such internal control as they determine is necessary to enable them to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board are responsible on behalf of NZHP for assessing NZHP's ability to continue as a going concern. The Board are also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to merge or to terminate the activities of NZHP, or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to NZHP's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of NZHP's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within NZHP's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on NZHP's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause NZHP to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board are responsible for the other information. The other information comprises the information included on pages 3 to 17, 82 and 83, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of NZHP in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1 (Revised): Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests, in NZHP.

Athol Graham
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

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Auditor

The Auditor-General, pursuant to section 15 of the Public Audit Act 2001. Athol Graham, Director, Audit New Zealand was appointed to perform the audit on behalf of the Auditor-General.

Banker

Westpac Banking Corporation

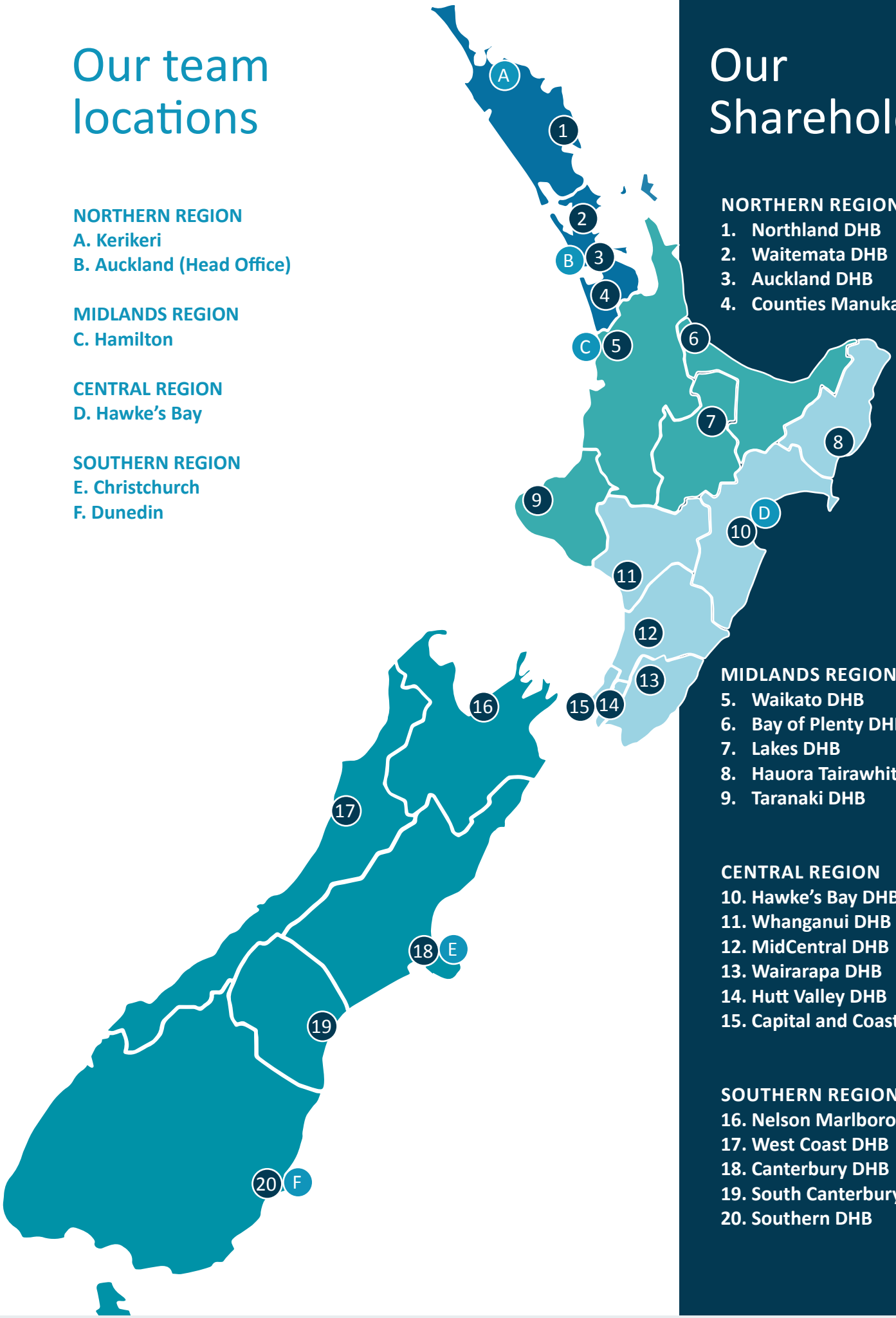
Our team locations

NORTHERN REGION
A. Kerikeri
B. Auckland (Head Office)

MIDLANDS REGION
C. Hamilton

CENTRAL REGION
D. Hawke's Bay

SOUTHERN REGION
E. Christchurch
F. Dunedin



Our Shareholders

NORTHERN REGION
1. Northland DHB
2. Waitemata DHB
3. Auckland DHB
4. Counties Manukau DHB

MIDLANDS REGION
5. Waikato DHB
6. Bay of Plenty DHB
7. Lakes DHB
8. Hauora Tairawhiti
9. Taranaki DHB

CENTRAL REGION
10. Hawke's Bay DHB
11. Whanganui DHB
12. MidCentral DHB
13. Wairarapa DHB
14. Hutt Valley DHB
15. Capital and Coast DHB

SOUTHERN REGION
16. Nelson Marlborough DHB
17. West Coast DHB
18. Canterbury DHB
19. South Canterbury DHB
20. Southern DHB

FOR INFORMATION

Subject: NZ Health Partnerships' 2017/18 Quarter 2 Report

Purpose

1. Canterbury DHB is a shareholder of NZ Health Partnerships. The purpose of this paper is to provide the Board with a high-level summary of NZ Health Partnerships' performance to the end of Q2 2017/18.

2. The full 2017/18 Quarter 2 Report is attached as **Appendix 1**, with significant updates since the end of the reporting period captured in comments throughout.

Overall Performance

3. NZ Health Partnerships' 2017/18 Statement of Performance Expectations contains 29 performance targets. The table below shows its overall performance results for Q2 and a comparison to Q1 performance.

Table 1. Overall Performance Q1 to Q2

	Achieved Achieving	Substantially Achieving	Progressing	Not Started	Not Achieved
Quarter One Jul - Sep 2017	**28% 8 of 29**	**17% 5 of 29**	**31% 9 of 29**	**24% 7 of 29**	
Quarter Two Oct - Dec 2017	**31% 9 of 29**	**24% 7 of 29**	**34% 10 of 29**	**7% 2 of 29**	**4% 1 of 29**

4. Performance in Q2 shows positive progress, with movement from 'Not Started' towards 'Achieved / Achieving', indicating that progress against deliverables is tracking well.

5. One metric is assessed as Not Achieved. This relates to the delivery of an efficient food service measure and its target of $1.8m in budgetary benefits which cannot be measured without an original expenditure baseline. Non-budgetary benefits will continue to be communicated to participating DHBs as they are realised.

NZ HEALTH PARTNERSHIPS

Quarter Two Report 2017/18

Tracking Performance

December 2017

Contents

Our purpose

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

As a co-operative, our purpose is to enable DHBs to collectively maximise shared services opportunities for the national good.

Put another way, we exist to support DHBs to serve their communities and achieve their strategic objectives.

What we do

We collaborate with DHBs as our shareholders, co-creators and customers. In partnership we identify, develop and implement initiatives for the sector's mutual benefit.

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

However, what we do is more than cost reduction. While our primary focus is on administrative, support and procurement activities, most of our work has direct or indirect clinical implications. Ultimately, patient outcomes are at the heart of our company and our operations.

Our focus

Our focus is to continue to optimise the existing portfolio of programmes and services to extract maximum value for our shareholders.

Our portfolio is grouped under two output classes:

Class One: Programmes

Continue to develop and implement our current National Oracle Solution programme.

Class Two: Services

Deliver and improve our services, including enhancing our customer centric approach.

Tracking performance

The NZ Health Partnerships Statement of Performance Expectations (SPE) 1 July 2017 to 30 June 2018 sets out performance measures and targets that we report on, to track and share our progress.

Throughout the quarterly report, the following symbols and criteria are used to display performance measure results compared to targets:

SYMBOL AND CRITERIA	DESCRIPTION
Achieving/Achieved	Target is being met/has been met or exceeded
Substantially Achieving	Target has not been met by a very slim margin
Progressing	Target has not been on-track, but work is underway and going well
Not started	Work has not started but due to start, as planned
Not achieved	Target not achieved

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

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

Overall result

Across our two output classes and management services we have 29 performance measures. Our performance for quarter two ending 31 December 2017 against these measures is:

MEASUREMENT AREA	ACHIEVED/ ACHIEVING	SUBSTANTIALLY ACHIEVING	PROGRESSING	NOT STARTED	NOT ACHIEVED
OVERALL PERFORMANCE	31% (9 of 29)	24% (7 of 29)	34% (10 of 29)	7% (2 of 29)	4% (1 of 29)

OUR PROGRAMME, SERVICES AND MANAGEMENT PERFORMANCE AGAINST THESE MEASURES ARE:

Programme

National Oracle Solution	50% (2 of 4)	25% (1 of 4)		25% (1 of 4)	

Services

Shared Banking		67% (2 of 3)	33% (1 of 3)		
Collective Insurance	67% (2 of 3)		33% (1 of 3)		
National Procurement Service	17% (1 of 6)	50% (3 of 6)	33% (2 of 6)		
Food Services		25% (1 of 4)	50% (2 of 4)		25% (1 of 4)

Management

Organisational Capability	44% (4 of 9)		44% (4 of 9)	12% (1 of 9)	

Programmes

DHBs invest in the programmes we develop. Our programme team works with DHBs as shareholders, co-creators and customers on the continued development and implementation of shared services initiatives for the national good. Once a shared service is built, it transitions to our service teams for delivery to our DHB customers.

We currently have one programme, the National Oracle Solution (NOS).

NATIONAL ORACLE SOLUTION

The NOS programme is a common software solution which will replace the many systems DHBs currently use to order, store and pay for goods and services. Once in place, for the first time the sector will have visibility of the amount all 20 DHBs spend on individual goods and services. This will enable the bulk buying power of the sector to be leveraged for procurement initiatives – ensuring value for money and the right tools for the job.

Focus for 2017/18

In 2017/18 the build of the technology and supporting infrastructure for NOS Wave 1 will be completed and tested, ready for roll out. Implementation for NOS is structured in multiple waves, with Bay of Plenty, Canterbury, Waikato and West Coast DHBs first to go live on the new system.

A change programme of this magnitude is challenging. We will capture lessons learned which will be used to inform both the planning and the implementation activities for future waves. Ultimately the DHBs will lead their own implementation and change management processes, with support from us as requested.

Quarter Two progress

By early November we had unanimous approval of the Change Control Report (CCR) with all 20 DHB Boards approving the CCR recommendations and the additional funding required to complete NOS, noting four smaller DHBs opted to defer payment of some opex costs.

The governance structure has been refreshed and strengthened, with greater sector presence including regional CE representation on the executive steering committee. The development of the core system is close to completion and is currently running successfully on the Wave 1 infrastructure in anticipation of an initial go live for the first four DHBs in July 2018.

While the Wave 1 go live is a key focus, supporting the National Technology development has also been a priority in quarter two. The National Technology design has been completed and independently reviewed by PwC Australia who commented that the design is fit for purpose and is the most comprehensive that they have reviewed. This detailed design has now been endorsed by the Joint Design Council with the build anticipated to commence in quarter three.

In mid-December we were advised by the Minister of Health that the additional funding for NOS would require Cabinet approval and that he had directed his officials to prepare a Cabinet paper for him. Deloitte has been engaged by the Ministry of Health to undertake a review of the programme to inform this paper. The timeline for completion of the Cabinet process is currently unknown, having received indications in December that 'mid February' was achievable.

Quarter Two status

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
1	Ensure readiness of Oracle Administration Model[1]	Key positions filled and capability in place	30 June 2018	ACHIEVING
	Comment: The programme is working with Oracle around the Wave 1 support model and this is on track for July 2018.			
2	Complete Technology Build	Solution acceptance testing successfully completed	30 June 2018	SUBSTANTIALLY ACHIEVING
	Comment: The programme approach changed as a result of the agreed Change Control Report and Wave 1 DHBs will now use the HealthBiS technology platform for go live in July. Solution Acceptance Testing (round two) on this platform is finished with 97% of testing complete by the end of quarter two. There were thirty seven issues identified, most of which were resolved by December with re-testing to be done in early January following the holiday close down period. The National Technology platform continues to progress however the revised (agreed) target completion date for this build is outside the 2017/18 financial year and is likely to be impacted by the Cabinet Approval process.			
3	Complete Solution Readiness	User acceptance testing successfully completed	30 June 2018	ACHIEVING
	Comment: There were no formally planned activities for the quarter however Wave 1 DHBs are well underway with preparation activities for User Acceptance Testing.			
4	Support First Wave DHB Implementation	Preparation for First Wave DHB implementation completed with no open action items, due to start 1 July 2018	30 June 2018	NOT STARTED
	Comment: There were no planned activities for the quarter			

[1] Team to support the implementation and operation of the NOS.

Services

We currently manage four commercial services on behalf of DHBs: Shared Banking, Collective Insurance, National Procurement and Food Services. These services deliver both qualitative and financial value to DHBs.

SHARED BANKING and COLLECTIVE INSURANCE

Shared Banking

On any given day we manage a cash balance of between $0.3b and $1.4b for the sector. Unlike the other services where we act as a vendor manager, NZ Health Partnerships delivers the Shared Banking Service itself. We invest funds held in a range of low risk investments to optimise the return on funds and minimise fees, while ensuring sufficient cash is available to meet all DHBs' needs.

Focus for 2017/18

In 2017/18 we will transition to BNZ as the new transactional banking provider. This new contract will substantially reduce the costs of transactional banking, minimise the cost of working capital and term borrowing facilities and maximise returns for credit balances. DHBs will receive better individualised customer service through 33 BNZ Partner Centres throughout the country.

Quarter Two progress

Strong progress continues to be made in the transition to BNZ, with delivery to the project plan across most areas.

Quarter Two status

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
5	New banking service provider implemented	Implementation of new banking service provider for 2017/18	31 December 2017	SUBSTANTIALLY ACHIEVING

Comment: Transition to BNZ has been successfully completed for the two early adopter DHBs, the eleven General Transition DHBs and three subsidiaries. The three late adopter DHBs will transition before the end of March 2018, with the final four NOS Wave 1 DHBs transitioning by December 2018. There has been good engagement with the Ministry of Health in the quarter, resulting in approval of the BNZ credit facility in late December. Also, Westpac have agreed a contract extension and work is underway to provide the documentation required to finalise this.

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
6	Delivery of efficient shared banking service	Delivery of a value added banking service including achievement of 0.10% minimum deposit margin above Official Cash Rate and $2.5 million total benefits	30 June 2018	SUBSTANTIALLY ACHIEVING

Comment: DHB CFOs received monthly updates on the Shared Banking Service performance during quarter two and we are pleased to note that the margin target continues to be exceeded each month. We were not able to complete the benefits benchmarking in quarter two - with two DHBs yet to agree their investment profile (the basis for the benchmarking). Using assumptions based on the agreed investment profiles of 18 DHBs the forecast shows that we are on track to deliver the planned $2.5 million benefits for 2017/18.

7	Delivery of effective shared banking service	Delivery of shared banking service to DHBs satisfaction	30 June 2018	PROGRESSING

Comment: We had planned to undertake stakeholder feedback on the Shared Banking Service transition in quarter two, however the DHB decision to move to an 'early adopter / late adopter' model means this has been rescheduled until quarter four, once the majority of the transitions have been completed. Now that we have completed a substantial part of transition, we intend to undertake a deep dive on banking performance with the Banking and Insurance Service Performance Group.

Collective Insurance

Collectively DHBs have assets valued around $17b. On behalf of DHBs, we seek to negotiate the best insurance deal available on a collective basis.

Working together means the sector can offer insurers a portfolio that is geographically spread with a high level of risk identification and management processes in place. Substantial cover is gained as a result from a comparatively lower premium, compared to if each DHB were to insure on an individual basis.

Focus for 2017/18

In 2017/18 we will work with DHBs and the sector's insurance broker to negotiate a new Collective Insurance agreement which ensures that DHBs have insurance cover that meets their needs. This is likely to include reinsurance for Material Damage and Business Interruption, Liability Package, Motor Vehicle, Travel and Personal Accident from 2018/19.

Quarter Two progress

The focus is now on working with our Insurance Brokers on the placement for 2018/19, in a challenging insurance environment post Kaikoura Earthquake and following unprecedented international insurance losses due to weather events. DHBs are asked to prioritise the completion of the declarations issued by Marsh in quarter two, these are critical to the insurance negotiations.

Quarter Two status

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
8	New collective insurance agreement implemented	Negotiation of new collective insurance agreement completed and selected broker is in place for 2018/19	30 June 2018	ACHIEVING

Comment: A Collective Insurance Forum was held in October with good attendance from across DHBs. The focus of this forum was to refresh DHBs' understanding of the Collective Insurance policies, inform DHBs of the global insurance landscape and discuss the strategy for the 18/19 renewal. It became clear that there was significant risk of increases in premiums due to local and international losses as the result of natural disaster and weather events.

In quarter two Marsh also sent the insurance declarations to DHBs for completion, these form the basis of the negotiation with global insurers. Responses are due back in February 2018.

9	Delivery of efficient collective insurance service	Delivery of value add collective insurance service including achievement of $2.5m total benefits	30 June 2018	ACHIEVING

Comment: Marsh has confirmed that the total non-budgetary benefit on the 17/18 insurance placement was $3.6m. Furthermore, the wording in the Personal Liability policy was reviewed and an amendment agreed. This ensures the Personal Liability policy now properly reflects the services delivered in DHBs.

10	Delivery of effective collective insurance service	Delivery of collective insurance service to DHBs satisfaction	30 June 2018	PROGRESSING

Comment: The 2018/19 renewal of the Insurance Broker contract was discussed with the Banking and Insurance Service Performance Group during quarter two, with agreement reached on what would constitute a successful negotiation round. Although we did not commence the quarterly NZ Health Partnerships performance feedback rounds with this group as planned, Marsh continued their annual 'health check' process with DHBs which looks at overall satisfaction with them as a supplier. Overall feedback has been positive and we will use the feedback to inform discussions with Marsh on behalf of DHBs.

NATIONAL PROCUREMENT SERVICE

National Procurement includes both implementation of the wider sector Procurement Operating Model as well as delivery of National Procurement Service itself.

Procurement Operating Model

In March 2017, DHB Chief Executives unanimously approved the health sector's new Procurement Operating Model. The Operating Model guides how the DHB Procurement Strategy will be operationalised. This covers approach, functions and roles within the sector.

Under the Joint Procurement Authority, we will support implementation of the model over the next two to three years. Within the model, roles and responsibilities are defined for the Ministry of Business Innovation and Employment, PHARMAC, NZ Health Partnerships (national activity) and DHBs (working both collaboratively together or locally where DHBs purchase goods and services for their individual use).

National Procurement Service

Under the new Operating Model, we took over the healthAlliance (FPSC) National Procurement Service from 1 May 2017.

PHARMAC will incrementally take over national medical device procurement over the next three years, while other medical device procurement will eventually be handled collaboratively and locally. We will work directly with PHARMAC and DHBs to manage this process.

Our ongoing role will include aligned planning, quality (policy, process and standards oversight), business information to support strategic procurement across the sector, as well as considering areas to generate value beyond medical devices.

Focus for 2017/18

In 2017/18 we will focus on building the foundation for a Centre-led National Procurement Service for DHBs, delivering agreed procurement needs and managing contracts that have been transitioned from the previous National Procurement Service provider.

This will involve contract management, clinical engagement, supplier relationship management, policy development and technology solutions to enable a successful implementation of the Operating Model.

Quarter Two progress

The National Procurement Service has made significant progress in the implementation of the Operating Model. This includes the establishment of a new Procurement Category Structure, Category Analysis Model and Benefits Management Framework that has been endorsed by Procurement Leads, the Procurement Operating Advisory Group and the Joint Procurement Authority. Furthermore, the National Procurement Service has introduced an end to end Procurement Life Cycle which incorporates clinical engagement via a reference group model.

Challenges still remain around reducing expired contracts, the transfer of local contracts and improving contract compliance. This was expressed at the CFO and CEO forum in November and December 2017 respectively. The development of a sector wide procurement policy and a focus on delivering value in the 'right' way are the key priorities for quarter three and four.

Quarter Two status

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
11	Implementation of structure to support operating model	Procurement capability and capacity is in place to support the procurement operating model	30 November 2017	ACHIEVED

Comment: We had identified a workforce planning target to ensure that the procurement function at NZ Health Partnerships was sufficiently staffed by the end of November 2017. There is currently a market shortage of appropriately skilled procurement professionals however we are pleased that all critical roles are in place, with minimal vacancies as at the target date.

12	An operational clinical engagement framework	A clinical engagement framework is developed which supports the operating model, approved by Joint Procurement Authority (JPA) and implementation is underway	30 June 2018	SUBSTANTIALLY ACHIEVING

Comment: The draft clinical engagement framework outlines a clinical reference group model which has been adopted during quarter two, with nomination processes now in place. New links have been formed with both Product Evaluation Health New Zealand (PEHNZ) and the Northern Region Clinical Practice Committee. It was anticipated that the draft clinical engagement framework would be incorporated into the sector wide procurement policy during the quarter, however this policy is still under development.

13	Aligned governance processes	Processes to support governance are in place and aligned to the procurement operating model	30 June 2018	PROGRESSING

Comment: A draft of the sector wide procurement policy is underway and initial discussions have been held with the Procurement Operations Advisory Group and Joint Procurement Authority. Further work is needed to finalise, socialise and work through approval processes by the target date of 30 June 2018.

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
14	Enhance planning across multi-year processes	A rolling three-year plan for procurement has been established, operationalised and approved by JPA	30 September 2017	SUBSTANTIALLY ACHIEVING

Comment: A multi-year plan was completed and made available to all DHBs via the InfoSite during quarter two. The first of two national procurement leads workshops was also held to support collaborative approaches to procurement planning and working. Quarter three will focus on the procurement plan for FY18-19.

15	Transition of non-national contracts to DHBs	Procurement capability and capacity plans are in place to ensure DHBs are ready to receive non-national contracts, and all non-national contracts have been moved to suitable owners/ managers	31 December 2017	PROGRESSING

Comment: The Joint Procurement Authority has approved the transition of 17 categories back to local DHB management and work has commenced on agreeing timelines for this with each DHB. We must ensure DHBs are ready for the transition and will continue to work on this with DHBs in quarter three.

16	Delivery of efficient procurement service	Delivery of value-add procurement service including achievement of $6.1m total benefits	30 June 2018	SUBSTANTIALLY ACHIEVING

Comment: A number of activities to support benefit delivery were completed during the quarter including standardisation of benefit reporting and active contract management to resolve 22% of expired contracts. We also concluded the Peritoneal Dialysis National tender in December 2017 which will lead to an estimated additional cost reduction of $1.8m (annualised) in financial benefits to the sector, which will be reported from quarter 3, following contract execution. The total financial benefits reported as at quarter two remains at $2.1m YTD, of which $1.7m is actual and $400k forecast. A focus in quarter three will be to work to realise the forecast amount.

DHB CIOs approached NZ Health Partnerships in quarter two to seek our involvement in the Microsoft G2018 licencing renewal being led by the Department of Internal Affairs (DIA). The health sector has asked NZ Health Partnerships to aggregate the sector's requirements, leveraging its significant spend, and provide a single point of contract between DHBs and the DIA, as well as ensuring a good procurement process and strategy is in place. This approach will give the sector the best possible position to minimise any cost increases and retain flexible usage rights.

FOOD SERVICES

Under the Food Services Agreement (FSA), Compass Group NZ is contracted to provide patient meals, meals-on-wheels, cafeteria services, ward supplies and optional services for six DHBs.

Our focus is on ensuring appropriate governance, contract and vendor management are in place to ensure our participating shareholders receive the best service possible.

Focus for 2017/18

In 2017/2018 we will establish the revised FSA governance model and progress the expectations of the participating DHBs to renegotiate elements of the Terms and Conditions of the FSA, to reflect the smaller participation level and maximise service delivery and commercial opportunities for all parties involved.

Addressing the outstanding issue on mobilisation costs is a key priority for us. This is followed by providing ongoing category management support in managing supplier performance. It is expected that food services will be incorporated into National Procurement by the end of FY17-18.

Quarter Two progress

In quarter two, we formed a new contract management team and implemented the revised FSA governance model. The Contract Management Group for the FSA met for the first time in December 2017 and finalised all terms of references. In November 2017 we began the negotiation process for mobilisation costs with Compass, with commitment to meet weekly until resolved. The FSA contract management team aims to resolve this by quarter three.

Quarter Two status

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
17	Transition programme to active contract management	Vendor and customer relationship management framework is in place with active reporting and tracking of benefits realisation	31 December 2017	PROGRESSING
	Comment: Weekly meetings have been established between our contract management team and the vendor to work through the mobilisation cost issue with a target to resolve by quarter three.			
18	Implement revised FSA governance model	Establishment of FSA Contract Management Group and associated strategy and operating model, with participation from all six DHBs	30 September 2017	SUBSTANTIALLY ACHIEVING
	Comment: The revised FSA governance model is in place and the first meeting of the FSA Contract			

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
	Management Group was held in December 2017. Although this measure has now been fully achieved, it was not done so by the target quarter one date, so has been rated as substantially achieved.			
19	Three-year operating plan	Delivery and sign off of one to three-year operating plan	30 June 2018	PROGRESSING
	Comment: NZ Health Partnerships have established a dedicated Food Services Agreement (FSA) Contract Management Team. An operating plan has been established with resolving mobilisation cost as the first priority. The operating plans also include KPI review, Business Continuity Plan review and going supplier performance management. The FSA contract will transition into the national procurement portfolio in the future.			
20	Delivery of efficient food Service	Delivery of value-add food service including achievement of $1.8m total benefits	30 June 2018	NOT ACHIEVED
	Comment: Budgetary benefits cannot be measured without the original baseline expenditure. However, there may be non-budgetary benefits achieved through contract management activity. This may include value-added service in mobilisation cost negotiations, centralising nutrition data and quality improvement process for KPI review.			

ORGANISATIONAL CAPABILITY

Our work is supported by a lean team providing a range of core functions including Finance, Risk Management, Audit and Compliance; as well as Strategy, Business Performance, Human Resources, Change Management, Communications and Engagement. These are collectively known as Organisational Capability.

Focus for 2017/18

In 2017/18 we will implement the Communications and Engagement Strategy to ensure improved communication from all levels of the organisation and further enhance relationships with key DHB stakeholders.

The execution of the People Strategy will continue to build a skilled and engaged workforce with the right capabilities, where people are focused on our strategic priorities and commitments made to our shareholders.

In addition to the continuous improvement of finance, accounting, legal, planning and performance processes, we will develop a range of corporate advancements including the creation of a Decision Making Framework, a new Value Framework, and a more effective Risk Management model.

Quarter Two progress

Refreshed Communication Plans have been developed and approved for both NOS and Procurement; while strong progress was made this quarter on the Value Framework and Decision Making Framework which will be ready for consultation with shareholders at the end of the year. Good progress has also been made on the Risk Management Framework and in particular, operational risk management at a programme and service level. We continue to work on our strategic risk maturity.

Quarter Two status

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
21	Embed Change Management Framework	Change Management Framework reviewed and applied to Programmes and Services as required	30 June 2018	ACHIEVING

Comment: Change Management activity in 2017/18 is focussed around the implementation of the Procurement Operating Model and supporting the work of the National Procurement Service at NZ Health Partnerships. In quarter two the communications and engagement plan, incorporating the NZ Health Partnerships Change Management Framework methodologies, was approved.

22	Implement Communications and Engagement Strategy	Detailed activity plan developed and implemented	30 June 2018	ACHIEVING

Comment: Our organisational communications policy and sign off protocol was refreshed in quarter two, supporting both a more consistent communication approach across the business and

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS

transparency for our shareholders. Our 2017 Stakeholder Survey highlighted a number of improvement opportunities which in quarter two were finalised in an internal action plan. We continued to support our key programme (NOS) through the development of a communications plan which was approved by the NOS Executive Steering Committee; and confirmation of a committed communication resource for the programme.

23	Decision Making Framework	Development and implementation of agreed Decision Making Framework	30 June 2018	PROGRESSING

Comment: A review of key existing documentation (e.g. Governance Charter, programme and services Terms of Reference) was completed to help inform the development of the Decision Making Framework. This highlighted some areas which could be improved in order to provide greater decision making consistency across our programmes and services. Draft problem statements and value propositions have also been completed for each of our programmes and services, which will be taken to the relevant governance groups for refinement and approval.

24	Implement People Strategy	Progress against the 10 strategic work streams in line with activity plan	30 June 2018	ACHIEVING

Comment: To better support internal communication and collaboration, our existing intranet was refreshed - replacing an inefficient platform with one that is more cost effective and provides greater functionality. We also refreshed our Remuneration Policy to include organisational and functional team scores which help build collective accountability for meeting our commitments to shareholders. Other highlights in the quarter include all staff completing customer mindset training, the development of an organisation-wide training plan and completing leadership development plans for each of our Executive Leadership Team members.

25	Enhance internal processes	Deliver consistent, robust and sustainable processes across NZ Health Partnerships	30 June 2018	NOT STARTED

Comment: There were no planned activities for this measure in quarter two

26	Delivery of effective Corporate Services Functions	On time delivery and continuous improvement of finance, accounting and legal services provided to NZ Health Partnerships and our stakeholders	30 June 2018	PROGRESSING

Comment: Internal executive monitoring of financial information has been embedded with the refinement of both executive and board reporting during the quarter. Quarterly SPE reporting was provided to shareholders and planning for 2018/19 also commenced with indicative funding plans presented to DHB CFOs in November. The 2016/17 Annual Report was drafted within legislated

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
	timelines however delays resulting from Audit New Zealand's decision on a technical issue have meant this was not able to be published as planned during the quarter. This is expected to be completed in quarter three.			
27	Enhance Planning and Performance function and processes	Planning and Performance framework and processes developed and implemented	30 June 2018	ACHIEVING
	Comment: Internal planning and performance processes have now been developed and implemented, with regular performance review sessions being held at executive level.			
28	Value Framework	Value framework and processes developed and embedded	30 June 2018	PROGRESSING
	Comment: Our Board has approved the development plan for, and scope of, the Value Framework. The scope includes a Value Filter which was created in quarter two to assess the comparative merits of any longer-term opportunities to create value for our shareholders. We remain confident in delivery of this framework by 30 June 2018 for consultation with shareholders in early-2018/19			
29	Delivery of effective Risk Management	Enhance risk management culture across New Zealand Health Partnerships	30 June 2018	PROGRESSING
	Comment: A three year internal audit work-plan has been approved by our Board. Our risk management framework is being embedded, with good progress made on operational risk management at programme / project and service levels through regular reporting and action plans. Work continues to uplift risk maturity at a strategic level. Prioritisation of resources to key shareholder deliverables means that a planned review of relevant legislative compliance was deferred to later in the year.			

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