West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Friday 23 March 2018
at 1.00pm

St John
Water Walk Road
Greymouth

ALL INFORMATION CONTAINED IN THESE MEETING PAPERS IS SUBJECT TO CHANGE

MEMBERS

WEST COAST DISTRICT HEALTH BOARD

BOARD MEMBERS

Jenny Black (Chair)
Chris Mackenzie (Deputy Chair)
Chris Auchinvole
Kevin Brown
Helen Gillespie
Michelle Lomax
Eddie Moke
Peter Neame
Nigel Ogilvie
Elinor Stratford
Francois Tumahai

EXECUTIVE SUPPORT

David Meates (*Chief Executive)*
Karyn Bousfield *(Director of Nursing)*
Gary Coghlan (*General Manager, Maori Health)*
Mr Pradu Dayaram *(Medical Director, Facilities Development)*
Michael Frampton *(General Manager, People & Capability)*
Carolyn Gullery *(General Manager, Planning & Funding)*
Dr Cameron Lacey *(Medical Director, Medical Council, Legislative Compliance and National Representation)*
Dr Vicki Robertson (*Medical Director, Patient Safety and Outcomes)*
Karalyn van Deursen (*Strategic Communications Manager)*
Stella Ward *(Executive Director, Allied Health)*
Philip Wheble (*General Manager, West Coast)*
Justine White *(General Manager, Finance)*
Kay Jenkins (*Board Secretary)*

AGENDA – PUBLIC

WEST COAST DISTRICT HEALTH BOARD MEETING
to be held at St John, Water Walk Road, Greymouth
on Friday 23 March 2018 commencing at 1.00pm

KARAKIA			***1.00pm***
ADMINISTRATION			***1.05pm***
	Apologies		
1.	**Interest Register**		
2.	**Confirmation of the Minutes of the Previous Meetings** • *9 February 2018*		
3.	**Carried Forward/Action List Items**		
REPORTS FOR DECISION			***1.10pm***
4.	**WCDHB Public Health Plan 2018-19**	Kerry Marshall *Community and Public Health*	*1.10pm – 1.20pm*
REPORTS FOR NOTING			***1.20pm***
5.	**Chair's Update (Verbal Update)**	Jenny Black *Chairperson*	*1.20pm – 1.25pm*
6.	**Chief Executive's Update**	David Meates *Chief Executive*	*1.25pm – 1.40pm*
7.	**Clinical Leader's Update**	Cameron Lacey *Medical Director* Pradu Dayaram *Medical Director* Stella Ward *Executive Director, Allied Health*	*1.40pm – 1.50pm*
8.	**Finance Report**	Justine White *General Manager, Finance*	*1.50pm – 2.00pm*
9.	**Wellbeing Health & Safety Update**	Michael Frampton *General Manager, People & Capability*	*2.00pm – 2.10pm*
10.	**Resolution to Exclude the Public**	*Board Secretary*	*2.10pm*

INFORMATION ITEMS

- NZ Health Partnerships – Annual Report 2016/17
- NZ Health Partnerships – Quarter Two Report 2017/18
- 2018 Meeting Dates

ESTIMATED FINISH TIME 2.10pm

NEXT MEETING: Friday 11 May 2018

KARAKIA

E Te Atua i runga rawa kia tau te rangimarie, te aroha, ki a matou i tenei wa Manaaki mai, awhina mai, ki te mahitahi matou, i roto, i te wairua o kotahitanga, mo nga tangata e noho ana, i roto i tenei rohe o Te Tai Poutini mai i Karamea tae noa atu ki Awarua.

That which is above all else let your peace and love descend on us at this time so that we may work together in the spirit of oneness on behalf of the people of the West Coast.

WEST COAST DISTRICT HEALTH BOARD MEMBERS INTERESTS REGISTER

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

	Disclosure of Interest
Jenny Black **Chair**	• Chair, Nelson Marlborough District Health Board • Life Member of Diabetes NZ • Chair, South Island Alliance Board • Chair, National DHB Chairs
Chris Auchinvole	• Director Auchinvole & Associates Ltd • Trustee, Westland Wilderness Trust • Trustee, Moana Holdings Heritage Trust • Justice of the Peace • Daughter-in-law employed by Otago DHB
Kevin Brown	• Trustee, West Coast Electric Power Trust • Wife works part time at CAMHS • Patron and Member of West Coast Diabetes • Trustee, West Coast Juvenile Diabetes Association • President Greymouth Riverside Lions Club • Justice of the Peace • Hon Vice President West Coast Rugby League
Helen Gillespie	• Employee, DOC – Healthy Nature, Healthy People Project Coordinator • Husband works for New Zealand Police • Member - Accessible West Coast Coalition Group • Member - Kowhai Project Committee
Michelle Lomax	• West Coast Community Trust – Trustee • St John Youth – Area Youth Manager • Employee - Damien O'Connor's Electorate Office • Daughter is a recipient of WCDHB Scholarship
Chris Mackenzie	• Development West Coast – Chief Executive • Horizontal Infrastructure Governance Group – Chair • Mainline Steam Trust – Trustee • Christchurch Mayors External Advisory Group - Member
Edie Moke	• South Canterbury DHB – Appointed Board Member • Nga Taonga Sound & Vision - Board Member (elected) Nga Taonga is the newly merged organisation that includes the following former organisations: The New Zealand Film Archive; Sounds Archives Nga Taonga Korero; Radio NZ Archive; The TVNZ Archive; Maori Television Service Archival footage; and Iwi Radio Sound Archives.
Peter Neame	• White Wreath Action Against Suicide – Board Member and Research Officer • Author and Publisher of "Suicide, Murder, Violence Assessment and Prevention" 2017 and four other books.

Nigel Ogilvie	• Chairman, Life Education Trust • Managing Director, Westland Medical Centre • Shareholder/Director, Thornton Bruce Investments Ltd • Shareholder, Hokitika Seaview Ltd • Shareholder, Tasman View Ltd • White Ribbon Ambassador for New Zealand • Wife is a General Practitioner casually employed with West Coast DHB and full time General Practitioner and Clinical Director at Westland Medical Centre • Sister is employed by Waikato DHB • Board Member West Coast PHO • Wife is Board Member West Coast PHO
Elinor Stratford	• Clinical Governance Committee, West Coast Primary Health Organisation • Committee Member, Active West Coast • Chairperson, West Coast Sub-branch - Canterbury Neonatal Trust • Trustee, Canterbury Neonatal Trust • Member, Arthritis New Zealand, Southern Regional Liaison Group • President, New Zealand Federation of Disability Information Centres • Member, West Coast Coalition Group • Chair, Kowhai Project Committee
Francois Tumahai	• Te Runanga o Ngati Waewae - Chair • Poutini Environmental - Director/Manager • Arahura Holdings Limited - Director • West Coast Regional Council Resource Management Committee - Member • Poutini Waiora Board - Co-Chair • Development West Coast – Trustee • West Coast Development Holdings Limited – Director • Putake West Coast – Director • Waewae Pounamu – General Manager • Westland Wilderness Trust – Chair • West Coast Conservation Board – Board Member

MINUTES

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

MINUTES OF THE WEST COAST DISTRICT HEALTH BOARD MEETING
held at St John, Water Walk Road, Greymouth
on Friday 9 February 2018 commencing at 10.15am

BOARD MEMBERS

Jenny Black (Chair); Chris Auchinvole; Kevin Brown; Helen Gillespie; Michelle Lomax; Edie Moke; Peter Neame; Nigel Ogilvie; and Elinor Stratford.

APOLOGIES

Apologies were received and accepted from Chris Mackenzie and Francois Tumahai.

EXECUTIVE SUPPORT

David Meates (Chief Executive); Karen Bousfield (Director of Nursing); Gary Coghlan (General Manager, Maori Health); Karalyn van Deursen (Strategic Communications Manager); Stella Ward (Executive Director, Allied Health); Philip Wheble (General Manager, West Coast); Justine White (General Manager, Finance & Corporate Services); Lee Harris (Communications Manager); and Kay Jenkins (Minutes).

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
There were no declarations of interest for items on today's agenda

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

2. CONFIRMATION OF MINUTES OF THE PREVIOUS MEETINGS

Resolution (1/18)
(Moved Michelle Lomax/seconded Nigel Ogilvie – carried

"That the minutes of the Meeting of the West Coast District Health Board held at St John, on Friday 8 December 2017 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward items were noted.

4. CHAIR'S UPDATE

The Chair, Jenny Black, spoke about the Health Relationship Services Agreement (HRSA) which is a tripartite forum consisting of representatives from District Health Boards (DHBs), the Council of

Trade Unions (CTU) and affiliated unions and the Crown represented by senior Ministry of Health officials. She advised that the group meets twice a year and the last forum was around Ageing Workforce and changing the way we do things to enable people to work longer.

The Board noted that the West Coast DHB no longer has the oldest workforce in New Zealand due to the work undertaken around Graduate Nursing.

The Chair also advised that she had her first meeting with the Acting Director General, Stephen McKernan and the message for us all is Business as Usual.

Ms Black commented that the new Government has just completed its first 100 days and two health issues have been addressed during this time: A Mental Health Review and a Bill to review the law around medicinal cannabis.

She also advised that she has been in the company of the new Minister of Health on several occasions and his message remains the same.

The Chair's update was noted

5. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, took his report as read.

Mr Meates acknowledged the team here on the West Coast who dealt with the storms over the last week. He commented that the commitment and professionalism shown was outstanding and while everyone should be acknowledge for this there were a couple of examples that demonstrated this commitment:

In South Westland we had Rural Nurse's that helped the community cope with hundreds of stranded visitors with no power. Great work by the facilities & maintenance team managing some of the issues with power and damage across the Coast so we could keep services going. In Westport the team managed the evacuation of the Dunsford Ward residents and two patients from Foote Ward as the water rose. The new Acting Clinical Nurse Manager in Westport has only been in the job a month but handled things very well with the assistance of one of the admin team. We had a District Nurse wade the knee high water to get to a patient at home.

He also acknowledged the team involved in the emergency management as they did a fantastic job and the communications team who ensured the community was getting good messaging both just before and through the event.

The Board asked that the teams be thanked on their behalf.

Mr Meates highlighted the Alliance approach and the work of the Alliance Leadership Team in terms of plans and the range of recommendations that continue to impact and influence health services on the West Coast.

He also highlighted the integrated health services in Buller where leadership frameworks have been consulted on and recruitment commenced.

The Board noted that there is ongoing extensive consultation with clinical teams in Buller around the IFHC. Discussion took place regarding the incorrect information in the media around this project.

A point was raised regarding suicide statistics and it was noted that suicide statistics are compiled on a two year retrospective basis due to the coronial process. A request was made for statistics regarding suicides to be provided to the Board along with an update on suicide prevention.

Discussion took place regarding the mental health inquiry taking place nationally which has a focus on the community component of mental health.

Discussion also took place around the move of clients from Dunsford to O'Conor home. It was noted that there will be an announcement regarding the closure of Dunsford on 1 March.

The update was noted.

6. CLINICAL LEADERS UPDATE

Karen Bousfield, Director of Nursing, presented the Clinical Leaders Update which was taken as read. Ms Bousfield commented that this report gives a snapshot across the West Coast health system.

The Board noted that this year has seen the successful completion of the first locally supported nurse to achieve Nurse Practitioner status and another nurse is close to achieving Nurse Practitioner status with four others at varying stages of their pathways.

It was also noted that the theatre nurse who was working through her Registered Nurse First Surgical Assist (RNFSA) training has successfully completed the programme. This role was well planned for by the theatre team, and is now implemented. Her advanced skills will be an important addition to the theatre team, and we already have another nurse expressing an interest in this specialist training.

Ms Bousfield advised that there is a lot taking place in the Quality & Safety space with the roll out of Patientrack and the National Early Warning Score (EWS) commencing over the next six weeks. She also advised that Korero mai (talk to me), which is a Health Quality & Safety Council programme, is also to be introduced in 2018.

The update was noted.

7. FINANCE REPORT

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

The consolidated West Coast District Health Board financial result for the month of December 2017 was a deficit of $282k, which was $68k favourable to budget. The year to date position of a net deficit of $1.458m is $11k unfavourable to budget.

The Board noted that January results are just being finalised.

Discussion took place regarding the flu season and when and if this is likely to hit. The Board noted that heavy penetration of vaccinations will be important. It was agreed that vaccinations would be made available for Board members.

The comment was made that being six months through the year the result of $11k unfavourable feels quite comfortable. Ms White commented that the next six months will be completely different to the first six months of the financial year as there are some larger costs coming up and pressure is on teams to use money wisely.

The financial report was noted.

8. WELLBEING HEALTH & SAFETY UPDATE

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

Ms White advised that there have been some new hazard substance and organism rules issued and these will be updated over the next few months and steps taken to ensure compliance.

The update was noted.

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (2/18)
(Moved Edie Moke/seconded Helen Gillespie – carried)

That the Board:

i resolve 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 New Zealand Public Health and Disability Act 2000 (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 8 December 2017	For the reasons set out in the previous Board agenda.	
2.	West Coast DHB Risk Tolerance Statement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
3.	Emerging Issues Verbal Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
4.	Clinical Leaders Emerging Issues	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	S9(2)(j) S9(2)(a)
5.	People & Capability Update – Verbal Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons	S9(2)(j) S9(2)(a)
6.	Workshop Feedback	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
7.	Grey Hospital Realignment	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)

iii notes that this resolution is made in reliance on the New Zealand Public Health and Disability Act 2000 (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";

There being no further business the public open section of the meeting closed at 11.40am

The Public Excluded section of the meeting commenced at 11.45am and concluded at 1.50pm with a half hour break for lunch.

_____ _____

Jenny Black, Chair Date

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

WEST COAST DISTRICT BOARD – BOARD MEETING
CARRIED FORWARD/ACTION ITEMS AS AT 23 MARCH 2018

	DATE RAISED/ LAST UPDATED	ACTION	COMMENTARY	STATUS
1.	8 December 2017	Mental Health	An update of the Mental Health Review	11 May 2018

DRAFT WEST COAST DHB PUBLIC HEALTH PLAN 2018-19

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Community and Public Health**

DATE: **23 March 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The Public Health Annual Plan is generated as a Ministry of Health requirement. The attached Plan will be presented to the Ministry of Health as a first draft by end March and final draft by end May 2018.

2. RECOMMENDATION

That the Board:

i. endorse the draft West Coast DHB Public Health Annual Plan, 2018-19.

3. SUMMARY

The draft West Coast DHB Public Health Annual Plan 2018-19 is prepared as part of the Community and Public Health (C&PH) contract with the Ministry of Health.

4. DISCUSSION

The Plan is based on a new template which was developed in 2017 by the South Island Public Health Services and agreed by the Ministry of Health. The majority of outcomes in the Plan are shared across the South Island Public Health Services, with the priorities and some outcomes tailored to the West Coast DHB.

The Plan has two functions:

- as a companion document to the West Coast DHB Annual Plan 2018-19, as the West Coast DHB Public Health Annual Plan,
- as the basis of the Community & Public Health contract with the Ministry of Health.

5. APPENDICES

Appendix 1: Draft West Coast DHB Public Health Plan 2018-19

Report prepared by: Annabel Begg, Public Health Specialist, Community & Public Health
Approved for release by: Evon Currie, General Manager, Community & Public Health

THE WEST COAST HEALTH SYSTEM
– supporting you to be well

West Coast District Health Board Public Health Plan 2018-19

Draft 13 March 2018

CONTENTS

1. INTRODUCTION

a. Keeping our people well

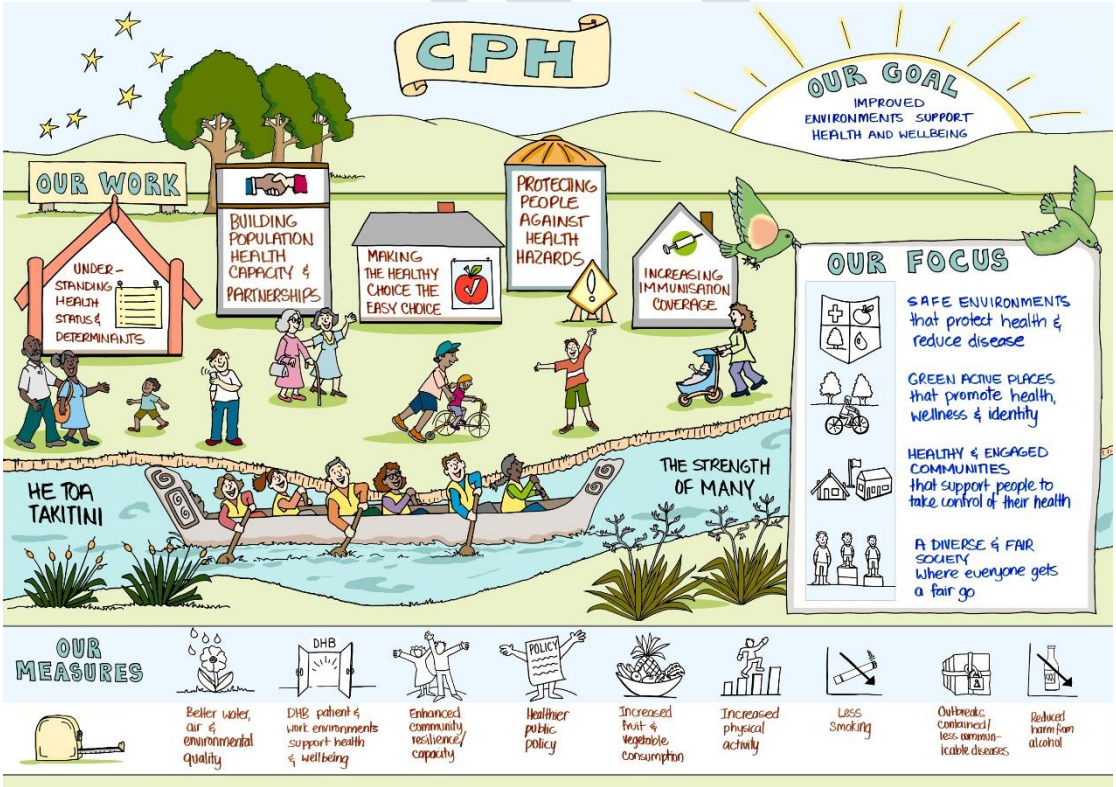
Public health is the part of our health system that works to keep our people well. Our goal is to improve, promote and protect the health and wellbeing of populations and to reduce inequities. Our key strategies are based on the five core public health functions[1]:

1. Information: sharing evidence about our people's health and wellbeing (and how to improve it)
2. Capacity-building: helping agencies to work together for health
3. Health promotion: working with communities to make healthy choices easier
4. Health protection: organising to protect people's health, including via use of legislation
5. Supporting preventive care: supporting our health system to provide preventive care to everyone who needs it (e.g. immunisation, stop smoking).

The principles of public health work are: focusing on the health of **communities** rather than individuals; influencing **health determinants**; prioritising improvements in **Māori health**; reducing **health disparities**; basing practice on the best available **evidence**; building effective **partnerships** across the health sector and other sectors; and remaining **responsive** to new and emerging health threats.

Public health takes a life course perspective, noting that action to meet our goal must begin before birth and continue over the life span.

This plan describes how we will work to keep our people well in 2018-19.



[1] Williams D, Garbut B, Peters J. Core Public Health Functions for New Zealand. NZMJ 128 (1418) 2015. https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vo-128-no-1418-24-july-2015/6592

b. Public health and the New Zealand Health Strategy

Public health supports the "all New Zealanders live well and stay well" component of the New Zealand Health Strategy's central statement. We aim to be:

People powered

- Greater integration of prevention and population health services with treatment services planning and delivery, building on the strengths of both.
- More effective interventions by the full range of local public health providers through the application of health promotion skills that align evidence-based practice with an understanding of local needs and context.
- Public health skills help to mobilise local communities to engage with the design and development of health systems that meet their needs.

Closer to home

- Public health systems that address local environmental risk factors, such as healthy housing, working alongside personal care interventions, such as smoking and nutrition advice by health practitioners.
- Small public health and health care providers, including Māori providers, better able to call on specialist public health skills for application to local problems.
- Communities, community organisations and other agencies and community leaders better supported to develop local solutions to causes of health problems for their communities.

Value and high performance

- Effective delivery of public health initiatives with proven value, with cost-saving or cost-benefit ratios equal or better than treatment interventions.
- Improved marshalling of information and resources to address health inequalities and improve Māori health.

One team

- Improved leadership in developing prevention and population health skills and capability in local organisations, including DHBs, PHOs, Māori providers and NGOs.
- Improved capacity to support a highly-skilled prevention and population health workforce across the health system.

Smart system

- A network of capable health assessment and surveillance units across the South Island, linked to a core Ministry intelligence function, leading to better understanding of local needs.
- Effective evaluation of interventions and sharing of learnings across organisational and professional networks.

c. Regional context and priorities

The five South Island DHBs together form the South Island Alliance, which is committed to the vision of "A connected and equitable South Island health and social system that supports all people to be well and healthy".

CPH 's principal role in regional activity is as a member of the South Island Alliance's South Island Public Health Partnership Workstream (SI PHP), which aims to "Improve, promote and protect the health and well-being of populations and reduce inequities".

The SI PHP includes the manager and clinical director of each South Island public health unit, a Māori public health specialist, representatives from the South Island Alliance and the Ministry of Health, and a South Island Alliance sponsor.

The SIPHP has identified the following regional priorities for public health in 2018-2019:

- Collective impact and partnerships
- Cross-sector capacity development and initiatives to improve outcomes in the first 1,000 days
- Partnership with Te Herenga Hauora to improve Māori health
- Facilitating a health promoting health system
- A "Health in All Policies" approach during this year to the social determinants, influencing oral health, safe and warm homes, and environmental sustainability
- Strategic and operational alignment of SI public health units
- Consistent and coordinated regional strategic and operational approaches to: drinking water; community resilience and psychosocial well-being; a sustainable on call/after-hours system for SI health protection services and regional approaches to both alcohol harm reduction and the promotion of healthy eating and active lifestyles.

d. District Health Board priorities

CPH's work aligns with the West Coast DHB vision of "an integrated West Coast health system that is both clinically and financially viable, a health system that wraps care around the patient and helps people to stay well in their own community."

Our work aligns with the West Coast DHB short and medium term strategic priorities for 2018-19:

- Equitable, accessible healthcare
- An environment where people thrive
- An engaged and informed community
- Integrated, sustainable services
- Standardised and streamlined processes
- Evidence-informed decision making.

e. Statutory responsibilities

As a public health unit, CPH employs and trains medical officers of health, health protection officers, and other public health designated officers. Our staff fulfil a range of statutory responsibilities and requirements as set out in the national Public Health Service Specifications. This includes meeting statutory reporting requirements.

f. Working in partnership

We are a regional service covering Canterbury, South Canterbury and the West Coast. Although the activities signalled in this plan will largely be carried out by the staff in our Greymouth office, some activities will be led or supported by staff in the Christchurch office.

In addition to our partnership with the other South Island public health units, our work is based on strong partnerships with other parts of our health system and with other key agencies, including:

- West Coast DHB , West Coast PHO and Poutini Waiora
- Local iwi
- Local councils
- Government agencies
- Education settings
- Non-government organisations and networks (e.g. Sport Canterbury/West Coast).

g. Key challenges/ priorities for keeping our people well

The West Coast DHB has the smallest population of any DHB in New Zealand, at 32,600 people.

We also have the third largest geographical area, making the West Coast DHB the most sparsely populated DHB in the country with only 1.4 people per square kilometre.

Current key issues for our population are:

- higher levels of socioeconomic deprivation compared to the rest of New Zealand (including lower mean personal incomes and a higher proportion without educational qualifications)
- higher overall morbidity and mortality rates and a lower life expectancy compared with the New Zealand average
- almost a third (31%) of our adult population are obese, 22% are current smokers and 16% are hazardous drinkers
- poorer overall health status for our Māori population, which currently represents 12% of our population
- overall poor drinking water quality with many West Coast water supplies vulnerable to severe weather events. Council water suppliers have small rating bases and infrastructure improvements are expensive.

h. Quality improvement

Our work is underpinned by a Quality Strategy that prioritises:

- A continuous improvement culture and robust quality systems
- Accessible public health information for staff and other workers
- A highly skilled, culturally appropriate public health workforce
- Clear, robust planning and reporting
- Effective communication to staff and communities.

The following key components of health excellence will be managed by our Divisional Leadership Team in 2018-19:

- Treaty
- Leadership (including culture and communications)
- Strategy
- Partnerships
- Workforce
- Operations
- Results.

i. Reporting

- We will provide full details of statutory activities required by the Ministry of Health.
- We will provide formal reports to the Ministry of Health and our DHBs in January and July. Reports will relate to the priorities and outcomes described in this plan, and will outline key achievements for the previous six months and describe any challenges and emerging issues.

2. SURVEILLANCE / MONITORING

"Tracking and sharing data to inform public health action"

Our key surveillance/monitoring priorities for 2018-19 are:

- To monitor and report on communicable disease trends and outbreaks.
- To contribute to the inaugural South Island Population Health Report.
- To review all our surveillance and reporting systems and products

The surveillance/monitoring **outcomes** we work towards are:

- Prompt identification and analysis of emerging communicable disease trends, clusters and outbreaks.
- Robust population health information available for planning health and community services.
- Improved public understanding of health determinants.

3. EVIDENCE / RESEARCH/ EVALUATION

"Providing evidence and evaluation for public health action"

Our key evidence/research/evaluation priorities for 2018-19 are:

- To conduct and support evaluation of public health-focused initiatives.
- To provide evidence reviews and synthesis (both on a request basis and self-initiated) to support the work of our team and other public health focused work in our region.
- To collect, analyse and present data to inform public health action.

The evidence/research/evaluation **outcomes** we work towards are:

- Population health interventions are based on best available evidence and advice.
- Robust evaluation for public health initiatives.

4. HEALTHY PUBLIC POLICY

"Supporting development of health-promoting policies and approaches in other agencies"

Our key healthy public policy priorities for 2018-19 are:

- To write submissions to influence public policy including, where appropriate, on behalf of Healthy West Coast and/or WCDHB.
- To work with local authorities on policies that affect health, for example, smokefree environments and drinking water.
- To ensure a public health perspective (e.g. equity for Māori health) is part of inter-agency work, including supporting council Long Term Plan processes.

The healthy public policy **outcomes** we work towards are policies, practices and environments that support health and wellbeing, improve Māori health, and reduce disparities.

5. HEALTH-PROMOTING HEALTH SYSTEM

"Supporting development of health-promoting policies and approaches across our health system"

Our key health-promoting health system priorities for 2018-19 are:

- To contribute to a WCDHB alcohol harm reduction strategy.
- To work towards alignment of health promotion messages and approaches across the West Coast health system.
- To ensure that health system policies support health and wellbeing, improve Māori health, and reduce disparities.

The health-promoting health system **outcomes** we work towards are policies, practices and environments in healthcare settings that support health and wellbeing, improve Māori health, and reduce disparities.

6. SUPPORTING COMMUNITY ACTION

"Supporting communities to improve their health"

Our key supporting community action priorities for 2018-19 are:

- To provide access to quality health information resources.
- To partner with marae and Māori settings and organisations to deliver culturally appropriate health promotion.
- To support communities to identify and address key health priorities.
- To support the development of local initiatives to improve food security.
- To support promotion of smoking cessation services.
- To work collaboratively to increase smokefree environments across a range of settings.
- The delivery of Smokefree enforcement activities.

The supporting community action **outcomes** we work towards are:

- Workplaces, Marae and other community settings that support healthy choices and behaviours.
- Effective community action that supports healthy choices and behaviours.

7. EDUCATION SETTINGS

"Supporting our children and young people to learn well and be well"

Our key supporting community action priorities for 2018-19 are:

- Effective engagement with all education settings to identify and address key health priorities.
- To support settings to engage effectively with whānau and the wider community.
- To facilitate the provision of appropriate professional development, resources and support to education settings.

The education setting **outcomes** we work towards are:

- Increasing opportunities and support in education settings for healthy choices by students, families and staff.
- Students, families and communities involved and supported.
- Teachers supported with appropriate professional development and resources.

8. COMMUNICABLE DISEASE CONTROL

"Preventing and reducing spread of communicable diseases"

Our key communicable disease control priorities for 2018-19 are:

- To follow up notifiable diseases promptly.
- To detect and control outbreaks.
- To promote infection prevention and control and immunisation in community and healthcare settings.

The communicable disease control **outcomes** we work towards are:

- Reduced spread of communicable diseases.
- Outbreaks rapidly identified and controlled.
- Improved immunisation rates.

9. HEALTHY PHYSICAL ENVIRONMENT

"Supporting communities to improve their health"

Our key physical environment priorities for 2018-19 are:

- To work with local authorities to improve drinking water quality and security of supply.
- To meet our Ministry of Health statutory obligations in relation to the physical environment.
- To work with West Coast Regional Council to improve air quality.
- To work with West Coast Regional Council to improve recreational water quality.
- To manage risks of hazardous substances.
- To work with local authorities to ensure that their plans and policies support healthy physical environments.

The healthy physical environment **outcomes** we work towards are:

- Improved air quality.
- Improved quality and safety of drinking water.
- Improved quality and safety of recreational water.
- Improved safeguards and reduced exposure to sewage and other hazardous substances.
- Urban environments that support connectivity, mental health, and physical activity.

10. EMERGENCY PREPAREDNESS

"Minimising the public health impact of any emergency"

Our key emergency preparedness priorities for 2018-19 are:

- To review our Emergency Response plan to ensure alignment with WCDHB Health Emergency Plans.
- To ensure all staff have appropriate emergency response training.
- To participate in local emergency response exercises.
- To enhance emergency response capacity and community resilience.
- To work with local rūnaka to support emergency response capacity of iwi Māori.

The supporting emergency preparedness **outcomes** we work towards are:

- Plans, training and relationships in place.
- Public health impact of any emergencies mitigated.
- Prepared resilient communities.

11. SUSTAINABILITY

"Increasing environmental sustainability practices"

Our key sustainability priorities for 2018-19 are:

- To promote sustainability considerations including active transport in relevant submissions to local authorities.
- To support active transport in education settings.
- To reduce CPH's own environmental impact.

The sustainability **outcome** we work towards is reduced environmental impact within and outside our health system.

12. SMOKING CESSATION SUPPORT

Our key smoking cessation support priorities for 2018-19 are:

- Effective and efficient delivery of quality stop smoking services to all West Coasters who smoke.
- Enhanced health professional and community understanding of how to motivate quit attempts and make quality referrals (including self-referral) to Oranga Hā stop smoking service.

The smoking cessation support **outcome** we work towards is for more smokers to stop smoking.

13. WELLBEING AND MENTAL HEALTH PROMOTION

"Improving mental health and wellbeing"

Our key wellbeing and mental health promotion priorities for 2018-19 are:

- To maintain connections with relevant agencies to promote mental wellbeing.
- To work towards alignment of mental health promotion messages and approaches across the West Coast health system.
- To continue to support the West Coast Suicide Prevention Action and Governance Groups.

The wellbeing and mental health promotion **outcome** we work towards is co-ordinated intersectoral action to improve mental health and wellbeing.

14. ALCOHOL HARM REDUCTION

"Reducing alcohol-related harm"

Our key alcohol harm reduction priorities for 2018-19 are:

- To review and report on all alcohol license applications.
- To maintain an effective tri-agency partnership with Police and district licensing staff.
- To monitor high-risk premises and events.
- To support WCDHB to draft and implement an alcohol harm reduction strategy.
- To support schools and their communities to address alcohol-related harm among young people.

The alcohol harm reduction **outcomes** we work towards are:

- Effective working relationships with other agencies and organisations to reduce alcohol harm.
- Reduced risk of alcohol harm at and around licensed premises and events.
- A culture that encourages a responsible approach to alcohol.
- Young people are protected from alcohol harm.

CHIEF EXECUTIVE'S UPDATE

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Chief Executive**

DATE: **23 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

Its format has been reorganised around the key organisational priorities that drive the Board and Executive Management Team's work programmes. Its content has been refocused on reporting recent performance, together with current and upcoming activity.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

Health care at home / Māori Health	**DELIVERING COMPREHENSIVE STABLE AND SAFE SERVICES IN THE COMMUNITY**

A: Reinvigorate the West Coast Health Alliance

Alliance Leadership Team (ALT) Activity

At the last meeting in February the ALT:

- Noted the fantastic work being done in Palliative Care to increase the profile and capacity of services.
- Was pleased to note that the Community Health Project is progressing well.
- Agreed to sharing their recommendations with the Consumer Council and the inclusion of consumers as representatives on the Workstreams.

B: Build Primary and Community Capacity and Capability

Primary

- **Integrated Health Services - Northern Region**
  - Integration and work across all areas continues and with the Buller Health Leadership change now finalised, Reefton and Buller will have clarity of their future direction.
  - A significant recruitment process is underway to fill long standing vacancies, new positions that have been created through the new local management structure and strengthening of our community services.
- **South Westland Area Practice**
  - Remedial work is being done after the Cornerstone audits. A major issue that will not be easily resolved is that the Haast Health Centre was not fit for purpose and did not meet minimum standards for accreditation.
  - A new part time receptionist joins the team at Franz in March.
  - Consumer feedback around the South Westland health service was sought at the recent AMP show in Whataroa. Valuable information was received that the team will be looking at to continue to improve our services.
- **Greymouth Medical Centre**
  - A few corrective actions came out of the Cornerstone audit for Moana and these are currently being worked through.
  - The Greymouth Medical Centre is up for Cornerstone again this year, so activity is occurring around this.
  - The Diabetes CNS has met with the practice nurses to see how they can better integrate their diabetic annual reviews.

Community

- **Public Health/B4School/Vision Hearing**
  - *Public Health Nursing* – Start of school year planning is underway which includes school visit scheduling, HPV catch-up clinics, assisting with flu vaccination clinics, B4School targets and supporting the newly appointed coordinator, HEADDSSS for year 9/10 planning to commence in second term. Third year students from Awa will be joining the team for experience in March and April. The new Public Health Nurse has started in Buller.
  - *B4School Service* – The newly appointed coordinator has hit the floor running and has reviewed the dates and calendar to improve this service. Use of Facebook has also been improved and the amount of activity from consumers has increased greatly and showing an increase in bookings. There is an increased confidence in ways to achieve targets.
  - *Vision Hearing Tester* – this service is keeping well abreast of the demand and the performance is achieving great results. Data collection is also under review so there will be improved access to data in iPMS.
- **District Nursing**
  - The ACC renewed contract for community nursing came into effect from 1 March. The DN regional meeting coincided with this so a VC meeting with Ashburton and a representative from ACC has introduced the changes directly to a team member from each area so this is off to a good start to ensure accuracy from the beginning. The daily workload report has been reviewed and the more in-depth data from the "Hospital At a Glance" (HAG) daily report. The team has got into the swing of being more committed to submitting this report. Ara and NMIT students are now joining the teams for a learning experience they will not forget as this is such an awesome

time for students to work and see what rural and remote community nursing has to offer. Reviewing discharge planning is ongoing as patients are more complex and staff recognise and understand the model of care going forward. The teams have been introduced to Trendcare rostering and the benefits of this in spite of the community package of Trendcare not yet being launched. There will be site visits to capture all the team members in each area to follow.

- **Clinical Nurse Specialists**
  - Clinical Nurse Specialist services continue to be a valuable part of the West Coast health system. The FTE in Buller is more secure in this team now and we are looking at options to provide cover when leave is taken.
  - The CNS Cardiac in Greymouth has recently achieved prescribing status which means she can now offer a more comprehensive service in collaboration with the medical teams. This has made her working life busier as she now has supervised sessions relating to her prescribing with a physician and needs to keep a running log regarding her reasoning for any prescribing.
- **Dental Service**
  - The two recent bad weather events have disrupted oral health services being provided. If the schools are closed, the therapists cannot be there under the terms of their contracts, so three working days have been lost over the two events.
  - The day before Waitangi Day, the schools decided to have an extra day off to make a long weekend. Some of this time was used by the therapists and assistants to undertake a review of the Health and Disability Consumer Rights as it would apply to oral health.
- **Home Based Support Services (HBSS)**
  - HBSS have recently filled the nurse position in Hokitika. This position is 0.4FTE District Nursing and 0.4FTE HBSS and has been vacant for six months.
  - HBSS has also successfully interviewed seven more casual support workers for the Buller and Hokitika areas. These applicants come with significant expertise in the role which will assist current and future staff in building the service.
  - HBSS will be presenting a three day orientation package for the above new staff that encompasses required DHB learnings and introduces the new staff to advanced concepts of support services. This orientation is a considerable change from the short two-hour process presented in the past.

C: Implement the Maori Health Plan

- **Hauora Maori Appointments**: There have been appointments made to two Maori positions within the last quarter; Marianne Klaricich commenced in the role of Maori Needs Assessor with the Complex Clinical Care Network. Marianne is Nga Puhi and comes from the Hokianga bringing with her 36 years of nursing experience in Maori and Aboriginal health. Elizabeth Lilley has accepted the role of Pukenga Tiaki for the Buller region. Elizabeth is of Ngai Tahu, Te Ati Awa and Ngati Mutunga descent and has over 30 year's Social Work experience.
- **Takarangi Cultural Competency – West Coast:** The second cohort of students was welcomed on to Arahura Marae on 1 March. We had a good representation of people from across the DHB and Community Public Health. The strategy for the implementation of the Takarangi framework is to build critical mass and to embed the framework across the sector.
- **Maori Health Workforce:** A programme of work is being progressed that is focussed on

growing and supporting our local Maori health workforce. The need for this was determined at a meeting in February, where executive and clinical leads and key representatives from People & Capability agreed that a unified commitment and strategy is required to support and progress this important Kaupapa. Imperatives include directives from the Ministry of Health/Health Workforce New Zealand and professional groups at the national level. From this meeting, the following priority areas were determined for the working team to progress:

- Apply the Heat Equity Assessment Tool (HEAT) to local recruitment/People & Capability processes, including recruitment content and policy
- Improve local workforce data
  - Collection of ethnicity data
  - Diversity of applicants
- Set measureable targets that identify how many individual allied, clerical, medical, nursing, etc. staff members are required for Maori to represent 14% of our overall health workforce by the year 2028
- Develop initiatives focussed on recruitment of local Tamariki/Rangatahi to health careers in collaboration with Mokowhiti/Kia ora Hauora

- **Hauora Maori Training Fund 2018 – Health Workforce New Zealand:** The West Coast DHB contract for Hauora Maori funding has been approved by the Ministry for the 2018 training year. We have already had 4 successful applicants to the fund with another applicant applying to study in the second semester. Two applicants will be undertaking the Diploma in Hauora Maori, one will be beginning a Bachelor in Social Work and another is exploring papers in health promotion.
- **Kia ora Hauora Rangatahi Placement:** The West Coast DHB will once again support our local Rangatahi in October this year who have expressed an interest in the health sector. The variety of expertise they will be exposed to provides a great opportunity for these Maori students to gauge where in the health sector they will want to develop a career. We will also be hosting together with the Kia ora hauora team a breakfast on 3 April that is aimed at having all schools educators promoting placements and highlighting the importance of this locally run programme.
- **Te Ara Mate Pukupuku Ki Te Waipounamu – Improving the Cancer Pathway for Maori:** The key deliverables of this piece of work are to:
  - Enhance the Cultural Competency of the health sector workforce
  - Improve relationships and communication throughout the pathway
  - Improve the current referral system
  - A focus is made on accurate ethnicity data collection within WCDHB and on ensuring datasets are complete so they can then be utilised for effective analysis
  - Develop the cancer health literacy of whanau and support service in the WCDHB
- Dr Melissa Cragg will be on the West Coast in April to provide a further update on this piece of work at education sessions planned at the DHB.

Settings	**DELIVERING MODERN FIT FOR PURPOSE FACILITIES**

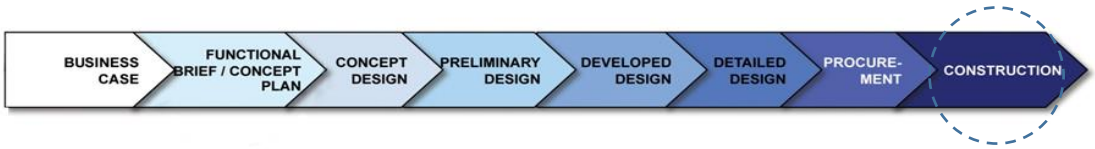
A: Facilities Maintenance Report

- During Cyclone Fehi a tree fell onto a neighbouring property at Grey Hospital causing some damage. Emergency work was completed to remove this tree and three others that presented risk were removed at the same time. They were all found to be very shallow

rooted. Flying debris also caused damage to the Whanau House and the Christchurch Radiology portacom and repairs are underway.

- Three tenders for the Grey Hospital pedestrian bridge replacement were received and evaluated and a preferred tenderer selected. The new business case is now being written.
- Grey Hospital Mental Health building chiller condenser has showed signs of corrosion after only 1 year of operation and it is believed the unit was not supplied as specified for the conditions. The warranty replacement unit has arrived and will be installed in the coming months.
- Grey Hospital Air Quality testing for Theatres 1, 2, 3, Central Sterilizing Department and the Laboratory were successfully completed.
- Buller Hospital suffered minor roofing damage from cyclone Gita and repairs have now been made.

B: Partnership Group Update



- Since the last CEO update the West Coast has had extreme weather with the remnants of Cyclone Gita and Fehi. Around 9:30am on Thursday 1 February 2018 extreme winds/rain buffeted the Grey Base site and the existing hospital were affected by flying debris and the site was closed for the day. The Ministry of Health have yet to receive a formal damage report from FCCL for either event, however it is noted that potential damages have been assessed to determine the extent of any replacements required.
- The lower ground floor and ground floor windows have been installed which brings the building closer to being weather tight.
- Internal framing continues to progress with the Integrated Family Health Centre, inpatient ward and emergency department all well progressed and the maternity and allied health areas as well as the staff amenities area completed. In-ceiling and in-wall service installation continues.
- Lift installation has also commenced since the last report.
- The boiler house continues to take shape with the installation of the tilt slab panels and the roof structure installed.
- Monthly construction programmes are being issued by Fletcher Construction Company Ltd (FCCL). This provides ongoing opportunities to review methodologies and the construction sequencing and provides the WCDHB with a regular gauge of how the project is progressing which assists with the DHB's planning for the move to the new facility.
- The WCDHB would like to thank all staff and visitors for their patience with the second closure in late February and early March of the vehicle bridge access to the existing hospital while services from the boiler house to the new hospital were installed. Again staff and visitors are reminded to please follow all traffic management and parking closures which will be well sign posted and leave sufficient time to arrive at work.

Buller

- The design of the proposed Buller IFHC has been progressing with Warren and Mahoney architects and the DHB facilities design team re-engaging clinicians in a series of user group meetings from September 2017 through until the most recent meetings on 14 and 15 February.

- At the February meetings a significantly different plan was presented by the project team for review with the Buller staff. The rational for the changes to the most recent plan was to allow for the integration of consult rooms and treatments rooms in order to better be utilised by both general practice and urgent care.
- The revised plan is consistent with the needs of the WCDHB to support health service delivery in Buller and reflects the input of over 50 DHB staff in workshops with planners.
- Note the emerging concept plan for the IFHC has been developed to be site-agnostic. Decisions about site are still to be finalised. Once the concept plan and site location are finalised, a timeline for construction can be developed.

	RECONFIGURING SECONDARY AND TRANSALPINE SERVICES

A: Hospital Services includes Secondary Mental Health Services

Hospital Services

Nursing

- Patient Trak and the NZEWS will be rolled out towards the end of March. Currently waiting for WiFi testing to be completed around Buller and Grey facilities. 10 staff have been trained so far.
- Recruitment of nursing staff continues. Currently offers are out to 3 new Registered nurses for the surgical and medical wards. 2 New Graduate Nurses started in February.

Medical

- Recruitment remains challenging in some specialties. Anaesthetic recruitment is healthy and we are now fully staffed. Both General Surgery and General Medicine remain challenging although we have stable locum cover and some offers out at present. Specialist registration with Medical Council is a barrier for us and the pathway to provisional vocational registration can be very long and complex for International Medical Graduates.
- We have commenced discussions around a transalpine general physician model.
- The RMO workforce is fully recruited until mid 2018 even with the additional resource required for RDA MECA schedule 10 changes – bargaining for the RDA MECA commenced in late February.
- The Rural Generalist Medical Workforce project has been presented at HWNZ and soon at DHB Shared Services – our "trainee" is progressing through the upskilling process well.

Allied Health

- Physiotherapy services continue to be constrained with the department at 40% staffed currently, awaiting one new appointment to commence.
- Work is progressing to further utilise Allied Health Assistants across the hospital, community and mental health settings.
- Recruitment is also ongoing for Pharmacy, Radiology, Social Work, Psychology and Occupational Therapy across Hospital Services, Mental Health and Primary & Community teams.
- Following the resignation notifications of the two Medical Radiology Technicians based at the Buller Hospital, initial conversations were held with the GPs and nursing staff who utilise the service. Their feedback has informed a consultation process which is due to commence.
- Priority is being given to gaining further insights from the data that we record for the Ministry of Health to better understand referral patterns, patient profiles and pressure points

to best utilise the resources available.

Mental Health

- **Operational Excellence**
  - The CAMHS team recently undertook a planning day with the Werry Centre. A stocktake of skills and knowledge within the team was undertaken as part of this day, and the team are confident in how they compare with other CAMHS services nationally, and other providers within our region.
  - One of our mental health nurses recently became a Nurse Practitioner. This provides significant opportunities for the service to provide easier access to care for our community.
- **Future Services Project**
  - Work continues on the design of our future mental health services on the Coast. Recent workshops around locality based services, CAMHS and AOD have added to feedback from the community and crisis response workshops.

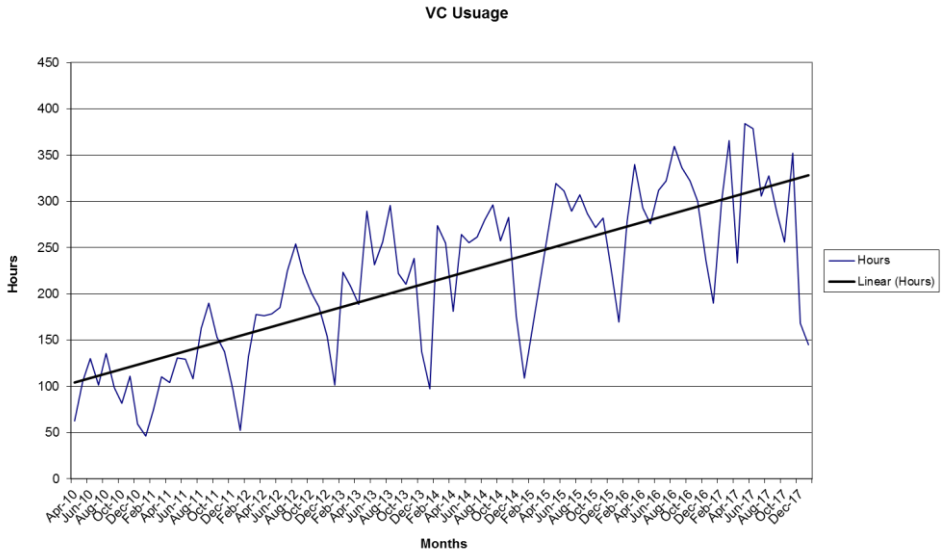
	DEVELOPING TRANSPORT AND TELEMEDICINE SERVICES

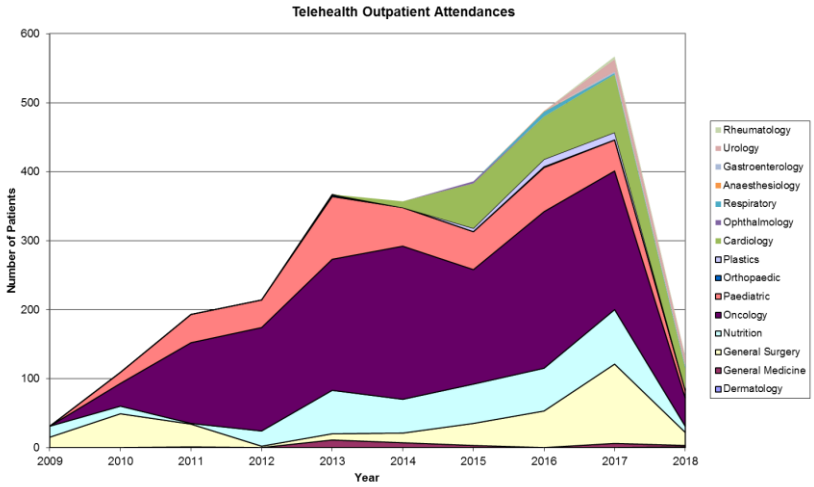
A: Improve Transport Options for Patient Transfers

- The following transport initiatives are now embedded:
  - Non-acute patient transport to Christchurch through ambulance transfer.
  - St John community health shuttle to assist people who are struggling to get to health appointments in Greymouth.
  - The Buller Red Cross contract to provide a community health shuttle transport service between Westport and Grey Base Hospital has been extended through to August 2020.
- The Ministry of Health has commenced its review of the National Travel Assistance (NTA) policy. The national NTA Policy Leadership Review Group held its second meeting on 22 February 2018. At this meeting the focus shifted from understanding issues with how the scheme currently operates, to developing high-level proposals for improvements to the scheme (and how to implement them). The Group discussed the need to re-focus the NTA scheme to better match patient needs and achieve equity; particularly for Māori, Pacific people and those living in remote rural areas. They also agreed that the scheme needs to treat patients fairly and more consistently.
- Next steps for the review include actively engaging with District Health Boards who have a key role administering the NTA, and completing detailed options analysis. There will be an opportunity for wider stakeholders to comment on the proposed recommendations before June 2018. Final decisions will be made by the Minister of Health.

B: Champion the Expanded use of Telemedicine Technology

- WCDHB has expanded its video conferencing capacity considerably within the last several years; see below graph for monthly usage details.





INTEGRATING THE WEST COAST HEALTH SYSTEM

A: Older Persons Health Services

- The Ministry of Health has indicated Pay Equity revenues will remain separate for 2018/19 and be incorporated into population based funding formulas in 2019/20. A technical working group has now been established to integrate pay equity into Home Based Support Services and Aged Related Residential Care contracts. This group will consider several options which vary from provider models to sector models and may incorporate IBT and guaranteed hours although this is yet to be discussed.
- After piloting our Flexible Integrated Rehabilitation Support Team (FIRST) in Grey, this service is now being rolled out in Buller with active recruitment for positions to support the service.

BUILDING CAPACITY TO TRANSFORM THE SYSTEM

A: Live Within our Financial Means

The consolidated West Coast District Health Board financial result for the month of February 2018 was a surplus of $360k, which was $82k unfavourable to budget. The year to date

position of a net deficit of $1.252m is $92k unfavourable to budget.

	Monthly Reporting			Year to Date		
	Actual $'000	Budget $'000	Variance $'000	Actual $'000	Budget $'000	Variance $'000
Governance Arm	0	0	0	0	1	1
Funder Arm	231	536	(305)	2,341	3,298	(957)
Provider Arm	129	(94)	223	(3,593)	(4,459)	866
Consolidated Result	360	442	(82)	(1,252)	(1,160)	(92)

B: Effective Clinical Information Systems

- **eReferrals:** Stage 3 – electronic triage: eReferrals Stage 3, eTriage has gone live for 3 services, Plastics, Gynaecology and General Surgery on 18 May. Four additional services are due to go live in March; these are General Medicine, Diabetes, Nutrition and Podiatry.
- **New Facility Work:** A procurement process involving a Request for Proposal (RFP) for a telephony system for the new facility has been completed, with implementation planning now underway. A business case for diverse fibre connectivity to the Greymouth site has been approved and implementation planning is also underway. The contract for a move to telephony over internet (SIP) has been finalised and is going through final sign off. The capital request for network switching infrastructure for the new facility was also completed and equipment is now delivered to site. Finalisation of the Audio Visual components for the new build is the current focus.
- **Telehealth RFQ:** A Telehealth Request for Quotation (RFQ) was submitted in July, closing in August. The capabilities this will introduce to WCDHB will allow increased mobility and expansion at a more sustainable price point. A business case and feasibility paper has been completed with feedback and endorsement from executive achieved. Submission of the business case will occur mid March. It is expected by next report a timeframe for implementation will be available.
- **IT Infrastructure update:** WCDHB has released a request for proposal (RFP) for its Wide Area Network (WAN). This is a joint RFP with CDHB to leverage greater buying power. The result once implemented will provide a large financial saving to WCDHB, with massive increases in bandwidth across most sites, and improved resiliency at all sites. Contracts are now completed and implementation is now underway.
- **ISG Disaster Recovery Plan (DRP):** The ISG Disaster Recovery strategy has seen considerable development and expansion with more details included and a wider scope to encompass telephony, backup recovery and infrastructure as a service, as all of these components interrelate. This strategy was approved along with the Telephony, and WAN business cases. The next phase of development is the creation of a DRP, now that the DR strategy has defined the scope of the DRP. Work on this has started and is expected to be completed by end of April.
- **Implementation of new service desk tool:** As of 1 March 2018, WCDHB has now moved to the same service desk tool as CDHB (Cherwell). This was part of the 2015 ISG Strategic Plan, and also addresses a recommendation from the 2015 Cobas review. The benefits this will provide are greatly improved communication between the ISG teams based in CDHB and WCDHB, reduced duplication, as well as benefits to WCDHB staff with updated self service tools.
- **Patient Trak:** The electronic nursing observation tool, Patient Trak, widely deployed within the CDHB is now also being deployed into WCDHB. Implementation is underway with training occurring and device selection in progress.

C: Effective two-way Communication and Stakeholder Engagement Activity Supporting Health System Transformation

Media interest

- New Buller and Grey facilities:
  - Progress on Grey facilities
  - Buller IFHC staff and community engagement
  - Buller IFHC size /capabilities/capacity
- Closure of Dunsford Ward
- Mental health services project
- Reefton gastroenteritis outbreak
- Weather-related enquiries around provision of services
- Buller x-ray services

Media releases (also posted on social media) on:

- Feedback helps mental health services plan
- Grey Base over-bridge to close temporarily
- Community and Public Health nutritionist selected for leadership course
- DHB announces closure of Dunsford aged residential care facility
- Public health advice following potential flooding
- Buller Health evacuated
- Patients asked about hospital experience
- Reefton experiences gastroenteritis outbreak

Video releases (also posted on social media) were issued on:

- Working for the DHB: Making a difference

Social media posts

- New mobile coverage for Haast
- Census reminders
- Kowhai Project updates
- Over-bridge to close temporarily
- Coping with stress following weather events
- Public health advice in relation to weather events
- 'Getting ready' messages
- Nurse Entry to Practice graduation and welcome
- Community and Public Health nutritionist selected for leadership course
- DHB announces closure of Dunsford aged residential care facility

Publications

- CE Update February/March

Healthy Environment & Lifestyles	**PROMOTING HEALTHY ENVIRONMENTS AND LIFESTYLES**

Key Achievements/Issues of Note

- **Emergency Response:** Last month saw Community and Public Health stand up its emergency management structure in response to the severe weather events associated with ex-tropical cyclones Fehi and Gita. Our staff worked closely with the West Coast

DHB's Incident Management Team on each occasion and we were also supported from our Christchurch office. Our initial roles were to provide public health advice to the general public and the Civil Defence teams at each council and to act as liaison within their Emergency Operations Centres. We have also provided support to the West Coast DHB's welfare functions, including psychosocial recovery. We have taken the opportunity to debrief our response to the two recent weather events and identified ways in which we can make our response even more efficient and effective. We were pleased to note that even in the short time between the events, we were able to make improvements in our communications and links with other agencies, including the DHB.

- **Smokefree Public Places:** Community and Public Health, as a member of Healthy West Coast, Active West Coast and the West Coast Tobacco Free Coalition made written and verbal submissions to the Grey District Council's proposed Smoke Free Public Places Policy. At their meeting on Monday 12 February, Council voted unanimously to adopt the Policy which covers outdoor spaces including the new Greymouth Town Square.
- **Smokefree Families – Little Lungs, Pūkahukahu Iti:** Community and Public Health and the West Coast Primary Health Organisation have completed work on the Little Lungs Pūkahukahu Iti project with West Coast early childhood centres. Little Lungs is a smokefree initiative to support smokefree homes and cars and aims to reduce the health effects of second hand smoke on children's developing lungs. Workshops have been held with staff from sixteen early childhood centres from Buller, Grey and Westland Districts. Early childhood centres have been provided with resources and support to help them have conversations with parents and whānau to encourage them not to smoke around their tamariki.
- **Improving Environments for Walking and Cycling Across the Coast:** Community and Public Health has been working with the three District Councils to bring Rod Tolley to the West Coast. Rod is the Director of Walk 21 and is an expert in building flourishing communities by focussing on creating walking friendly environments. He will be spending time in each of the three districts during March, and will work with each Council and give a public presentation in each centre.
- **Nutrition for All Ages:** Community and Public Health's nutrition health promoters are working in partnership with the Heart Foundation to provide intensive support to Early Childhood Centres on the West Coast. Two Early Childhood Centres have recently fulfilled the criteria to receive their Healthy Heart Awards, one at Pa-Harakeke (Gold) level and one at Rito (Bronze) level. These will be awarded at the end of March. Many other centres are working towards their awards with great passion and commitment.
- An Appetite for Life course is due to start in Hokitika in the first week of March, with 16 participants enrolled. This course is being provided in response to a request from an Early Childhood Centre, which identified the growing interest amongst parents and community members in continuing the learning begun at our early childhood centre nutrition sessions.

Report prepared by: Philip Wheble, General Manager West Coast DHB

Approved for release by: David Meates, Chief Executive

Health Target progress

Quarterly & progress data – Provisional

Target	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Target	Current Status	Progress
Shorter Stays in ED Patients admitted, discharged or transferred from an ED within 6 hours[1]	100%	99%	99%	99%	95%	✓	The West Coast continues to achieve the ED health target, with 99% of patients admitted, discharged or transferred from ED within 6 hours during quarter two.
Improved Access to Elective Surgery West Coast's volume of elective surgery	1,441	1,979	458	995	1,905	✓	This quarter, West Coast DHB provided 995 elective surgical discharges, delivering 105.2% of planned discharges.
Faster Cancer Treatment Patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer	83%	56%	69%	80%	90%	✗	Performance against the health target continued to increase this quarter to 80% 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. Small numbers are challenging with this result reflecting only three patients who were not seen within the 62 day period.
Increased Immunisation Eight-month-olds fully immunised	91%	80%	82%	83%	95%	✗	This quarter 83% of all eight-month-olds were fully immunised against the 90% target—a 1% increase on the previous quarter. Strong results were achieved for NZE and Asian tamariki while only 83% of Māori tamariki were vaccinated. Opt-off (10) and declines (1) accounted for 11 or 12.6% this quarter and continue to make meeting this target impossible
Better Help for Smokers to Quit **Hospitalised** smokers receiving help and advice to quit[2]	92%	91%	94%	91%	90%	✓	West Coast health practitioners have reported giving 4,623 smokers cessation advice in the 18 months ending December 2017. This represents 90.6% of smokers against the 90% target. The DHB is pleased to have exceeded the target this quarter not only for total population but also for Māori and High Needs
Raising Healthy Kids Percent of obese children identified at B4SC offered a referral for clinical assessment and healthy lifestyle interventions	17%	81%	90%	95%	95%	✓	Performance continues to improve, meeting target for the first time with 95% of children identified as obese at their before school check offered a referral for healthy lifestyle intervention.

[1] *Greymouth Emergency Department only*
[2] *Results may vary due to coding processes. Reflects result as at time of reporting to MoH.*

CLINICAL LEADERS UPDATE

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Clinical Leaders**

DATE: **23 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast District Health Board as a regular update.

2. RECOMMENDATION

That the Board:
i. notes the Clinical Leaders' Update.

3. SUMMARY

This report focusses on an update on suicide prevention structure and activity at the request of the Board. Suicide prevention is the domain of all the West Coast community and the DHB has a key role to play in co-ordinating and assisting the activity.

Suicide Prevention Governance

The agreed vision for suicide prevention is "Zero suicides on the West Coast". The Suicide Prevention Governance Group (SPGG) provides the oversight of planning, coordinating and monitoring suicide prevention and postvention activities in the West Coast district. The functions of SPGG are to:

1. Contribute to clinical governance at West Coast DHB by improving suicide prevention and postvention activities.
2. Provide leadership and work collectively to maximize the efficient and effective use of resources and to foster productive discussion and action towards broader suicide prevention strategies.
3. Ensure planners and developers of suicide prevention efforts do no unintended harm.
4. Maintain oversight of the response to vulnerable people with mental health needs who are at risk of suicide.
5. Ensure staff in respective agencies are working collaboratively with others to achieve agreed strategies.
6. Receive advice from the Action Group to inform the development of the work plan to reduce the rate of suicide in the West Coast district.
7. Monitor the implementation of SPGG strategies.

The members of the Governance Group are:

- Medical Director, West Coast DHB
- Medical Officer of Health West Coast
- Director of Nursing , West Coast DHB
- Chief of Psychiatry or delegate, Canterbury DHB
- Area Commander, West Coast Police
- Associate Director of Allied Health, West Coast DHB
- Clinical Director – Mental Health & Addiction, West Coast DHB

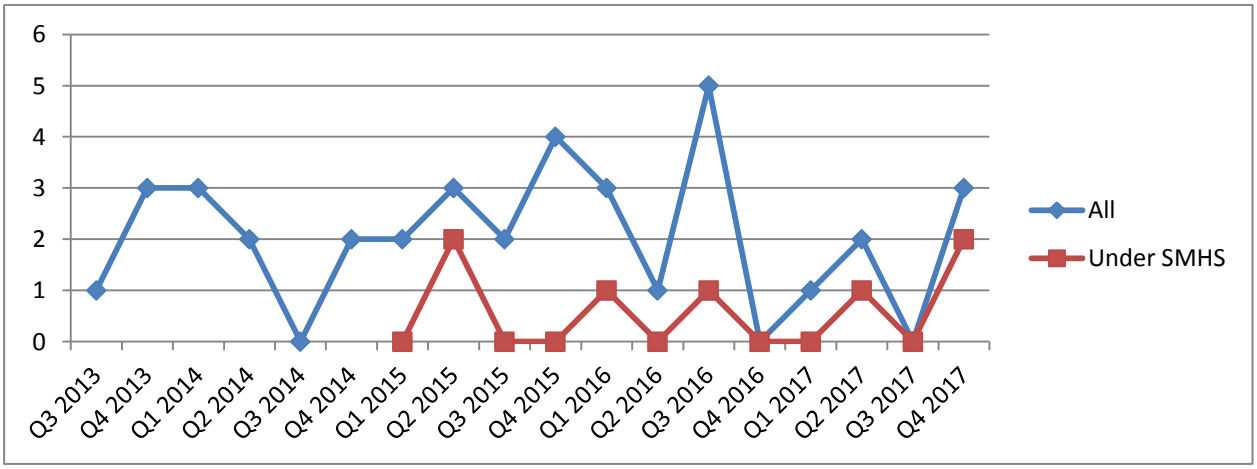
Relationship to the West Coast Suicide Prevention Action Group

The Governance Group is responsible for providing direction and oversight to improve suicide prevention and postvention activities on the West Coast. The Suicide Prevent Action Group (SPAG) is responsible for implementing the workplan developed by the Governance Group and endorsed by the Mental Health Leadership Team (MHLT) to achieve the strategies set out by the Governance Group. It also will provide advice to the Governance Group on other activities that may improve suicide prevention and postvention strategies. SPAG includes members of the broader community across Mental Health & Addiction Services, Emergency Department, Community & Public Health, New Zealand Police, NGOs (Homebuilders, Poutini Waiora), Ministry of Social Development, Ministry of Education, Ministry of Corrections, Victim Support, Primary Care Providers, and PHO Primary Mental Health Programme.

Summary of Recent Activity:

1. Target groups identified following review of post-vention cross agency work in 2016 are:
   - 20 -30 year old Maori Males
   - Over 40 Males
   - Over 40 Females
2. Following a recommendation from the Suicide Prevention Governance Group a whole of system coordination role is being developed to support activity in this area. The position will be aligned with the Canterbury Suicide Prevention Coordinators based at Pegasus Health.
3. Adoption of the UK Mental Health triage scale by crisis and community mental health teams to standardize the approach to crisis calls.
4. Localisation of Canterbury Suicide Prevention Initiative for the West Coast has been completed and is being implemented within the next couple of months. The initiative determines the frequency of follow up on the basis of the level of risk, and should lead to improved consistency of response
5. Development of a resource pack of information, and follow-up contact for people after a suicide attempt has been completed
6. Collaboration with Community and Public Health to develop mental health promotion activity that supports the areas of focus of SPGG has resulted in a workplan being developed.
7. An analysis of patterns of people presenting to emergency departments across the West Coast with suicidality or deliberate self-harm from 2017 is being prepared with the assistance of Commnuity and Public Health. This will be used to identify any additional groups for prevention activity to include.
8. A Service Leve Agreement between Police and the WCDHB has been developed to give guidance to Police staff and DHB employed health professionals to operationalise service delivery at a local level.

Provisional West Coast Region Suicide Statisitics :



Explanatory notes: Please be advised that the provisional suicide data 'by DHB Region' does not indicate that the deceased was either resident, or in the care of, that region. A suicide is initially recorded in a particular DHB region only according to the location of the death, and may be amended at a later date. As the inquiry into a suicide progresses it can be found that the location of death and/or the actual DHB provider for the individual are different to the initial recorded DHB region. Concerns were expressed by West Coast DHB SPGG as included individuals who lived off the coast resulted in large changes in population rates and the Coroner's office acknowledges these concerns and will consider an update of the title of the data and/or a footnote for the next provisional suicide release. The footnote could clarify that the data is by geographical location of death only and that the residence and health care provider of the deceased is not yet established.

4. CONCLUSION

The Clinical Leaders will continue to work across a range of activities to promote the vision of zero suicides on the Westcoast.

Report prepared by: Clinical Leaders
Karyn Bousfield, Director of Nursing
Vicki Robertson, Medical Director
Cameron Lacey, Medical Director
Stella Ward, Executive Director of Allied Health

FINANCE REPORT

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **General Manager, Finance & Corporate Services**

DATE: **23 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 of the Board of the West Coast District Health Board.

2. RECOMMENDATION

That the Board:

i. notes the financial results for the period ended 28 February 2018.

3. DISCUSSION

Overview of February 2018 Financial Result

The consolidated West Coast District Health Board financial result for the month of February 2018 was a surplus of $360k, which was $82k unfavourable to budget. The year to date position of a net deficit of $1.252m is $92k unfavourable to budget.

The table below provides the breakdown of February's result.

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	7,139	6,920	219	√	57,579	56,158	1,421	√
Governance & Administration	501	69	432	√	1,010	552	458	√
Funder	5,068	5,290	(222)	X	40,809	42,223	(1,414)	X
	12,708	12,279	429	√	99,398	98,933	465	√
EXPENSES								
Provider								
Personnel	5,251	4,940	(311)	X	43,757	43,240	(517)	X
Outsourced Services	8	12	4	√	83	95	12	√
Clinical Supplies	774	644	(130)	X	6,078	5,548	(530)	X
Infrastructure	1,036	1,011	(25)	X	8,659	8,478	(181)	X
	7,069	6,607	(462)	X	58,577	57,361	(1,216)	X
Governance & Administration	69	69	0	√	578	551	(27)	X
Funder	4,837	4,754	(83)	X	38,467	38,923	456	√
Total Operating Expenditure	11,975	11,430	(545)	X	97,622	96,835	(787)	X
Surplus / (Deficit) before Interest, Depn & Cap Charge	733	849	(116)	X	1,776	2,098	(322)	X
Interest, Depreciation & Capital Charge	373	407	34	√	3,028	3,258	230	√
Net surplus/(deficit)	360	442	(82)	X	(1,252)	(1,160)	(92)	X

4. APPENDICES

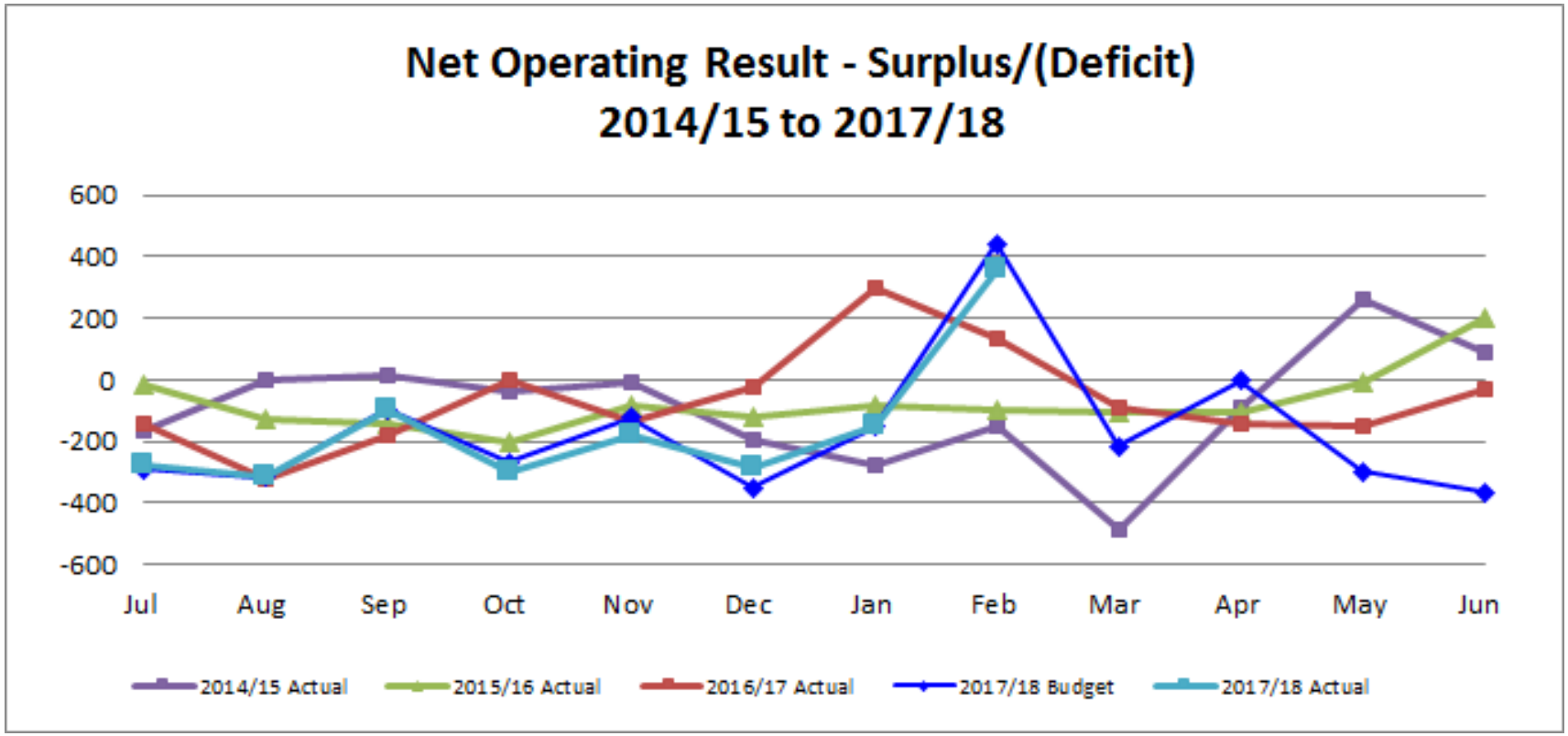
Appendix 1	Financial Result Report
Appendix 2	Statement of Comprehensive Revenue & Expense
Appendix 3	Statement of Financial Position
Appendix 4	Statement of Cashflow

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

APPENDIX 1: FINANCIAL RESULT

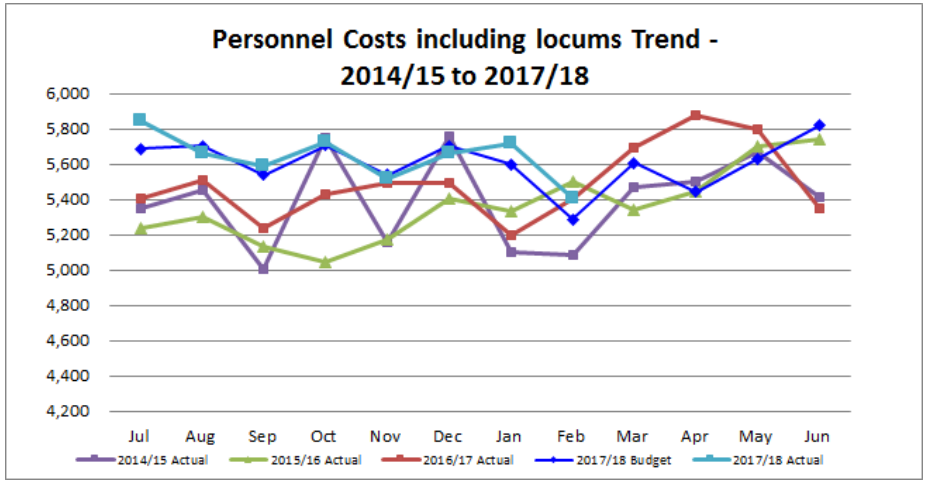
FINANCIAL PERFORMANCE OVERVIEW – FEBRUARY 2018

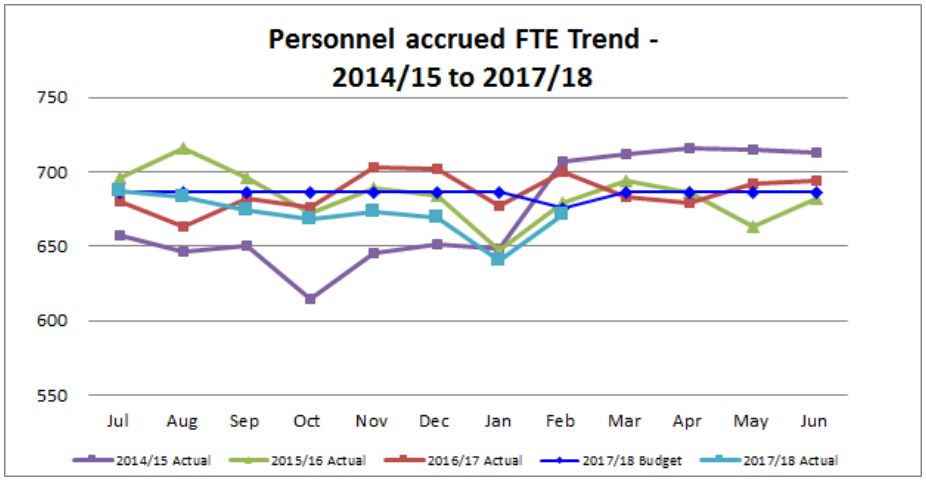
	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	360	442	(82)	-19% ✗	(1,252)	(1,160)	(92)	8% ✗



We have submitted an Annual Plan with a planned deficit of $2,041k, which reflects the financial results anticipated in the facilities business case, after adjustment for known adjustments such as the increased revenue as notified in May 2016, the actual funding provided for the 2017/18 year, and the developing situation in regard to Dunsford Ward in Buller.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

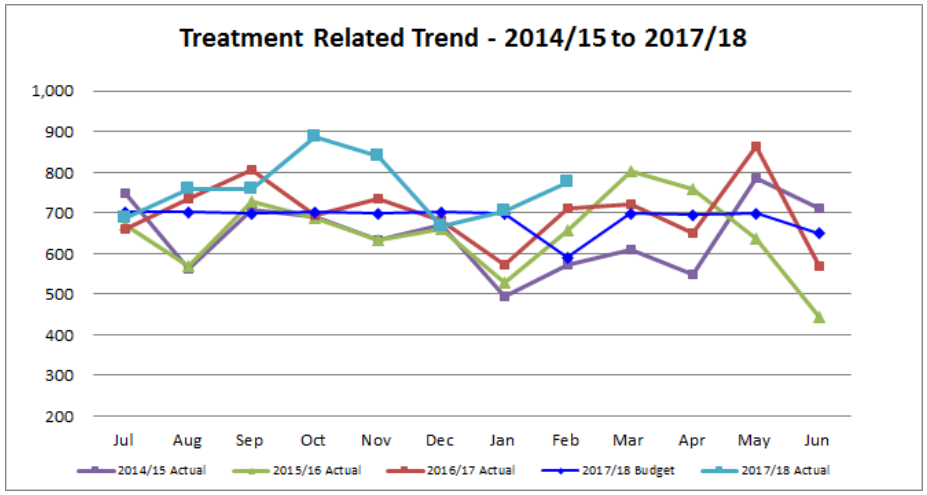


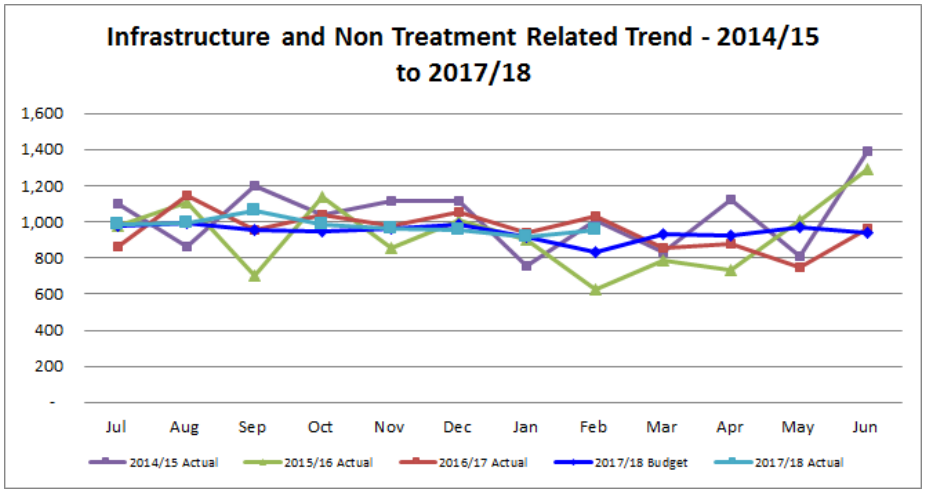


KEY RISKS AND ISSUES: Although better use of stabilised rosters and leave planning has been embedded within the business, there remains reliance on short term placements, which are more expensive than permanent staff.

The Ministry of Health has a keen focus on ensuring DHBs do not exceed their management and administration staff FTE numbers. There are many ways FTE can be calculated, depending on the purpose. Using Ministry of Health calculations we remain under our overall management and administration staff cap. Expectations from the Ministry of Health are that we should be reducing management and administration FTE each year. This is an area we continue to monitor intensively to ensure that we remain under the cap, especially with the anticipated facilities development programme.

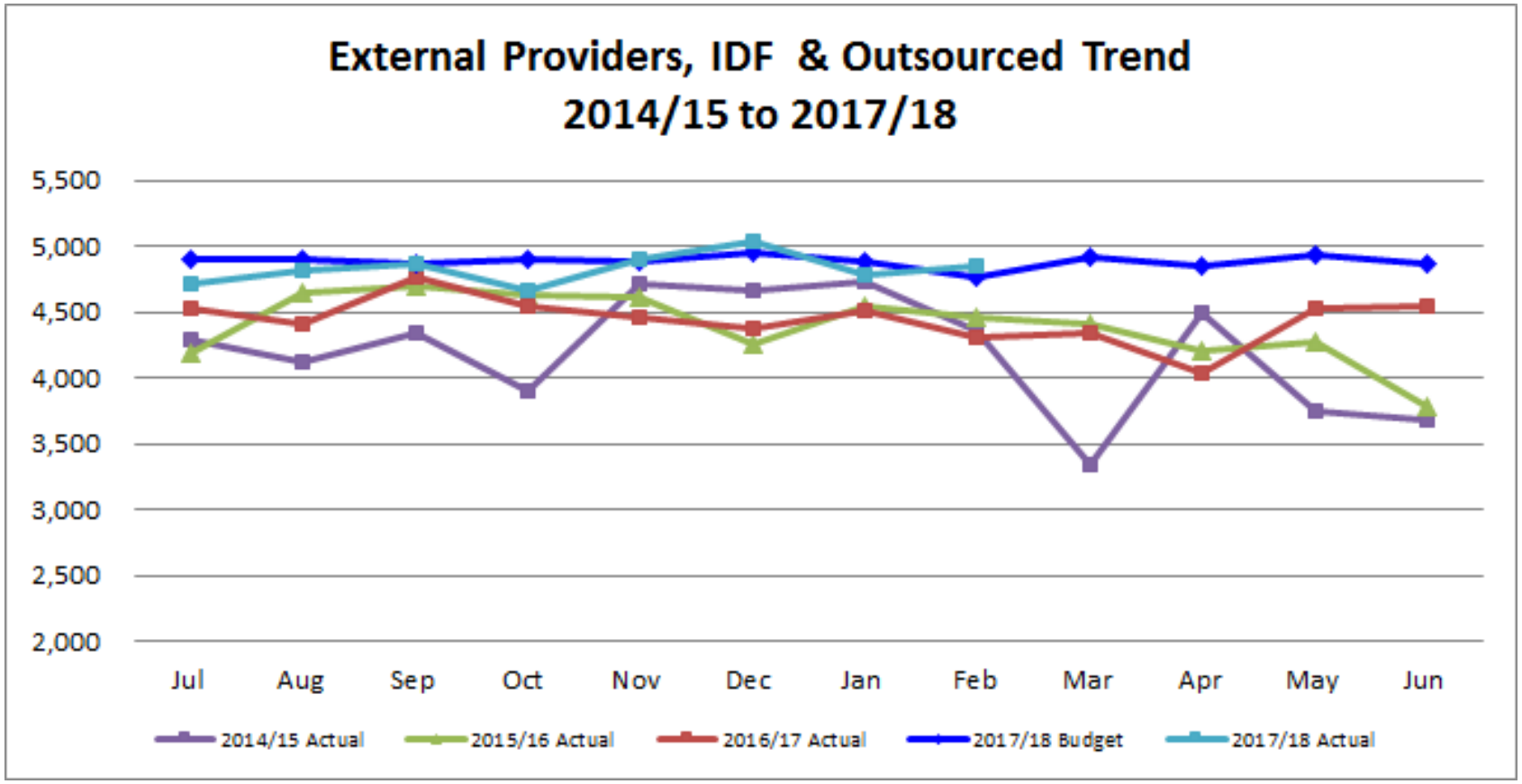
TREATMENT & NON TREATMENT RELATED COSTS





KEY RISKS AND ISSUES: High costs treatment particularly in oncology and rheumatology medicines continue to cause significant concern. Timing influences this category significantly, however overall we are continuing to monitor to ensure overspend is limited where possible.

EXTERNAL PROVIDER COSTS

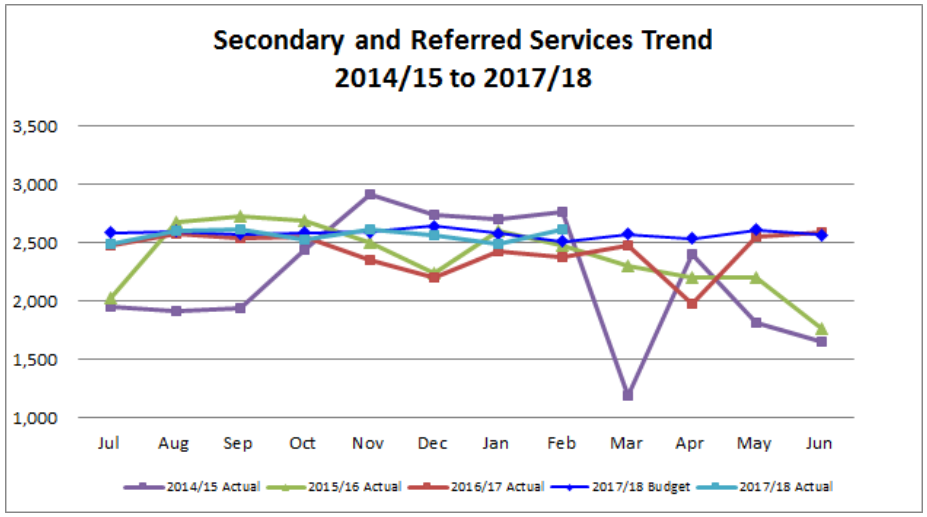


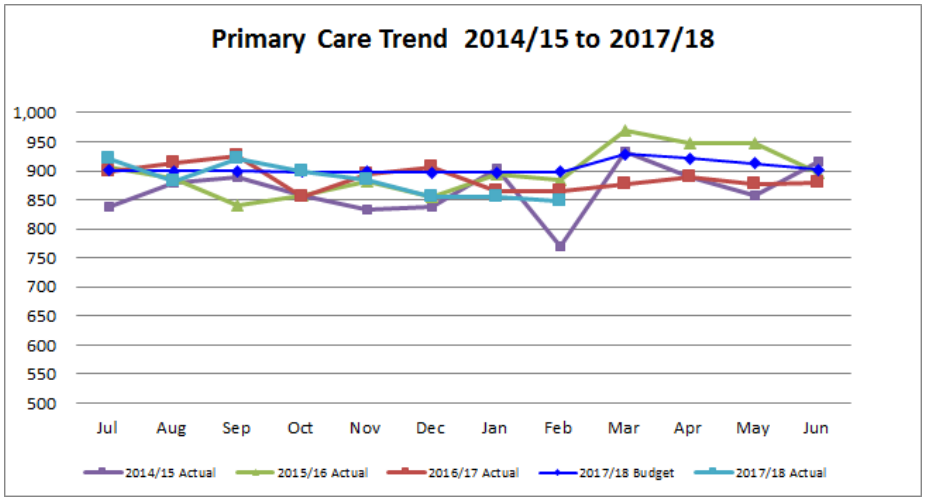
KEY RISKS AND ISSUES: Capacity constraints within the system require continued monitoring of trends and demand for services.

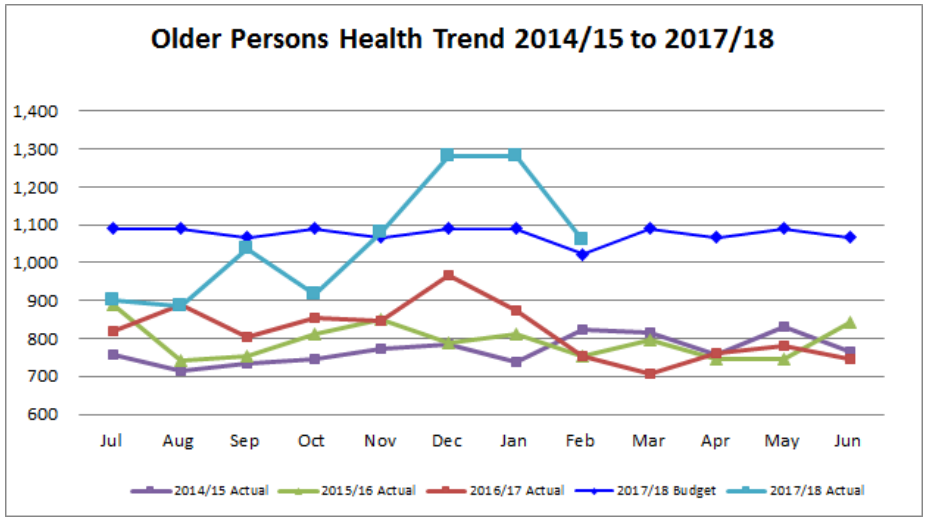
PLANNING AND FUNDING DIVISION
Month Ended February 2018

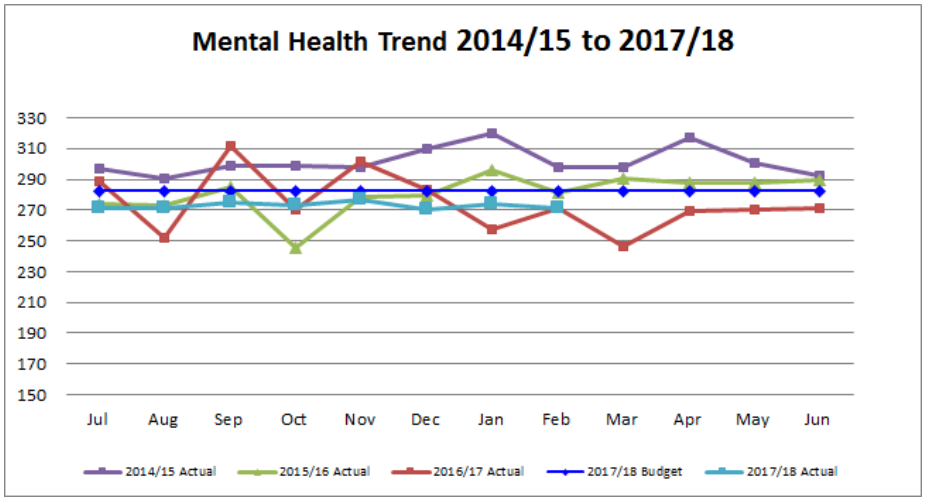
Current Month Actual $000	Budget $000	Variance $000	%		SERVICES	Year to Date Actual $000	Budget $000	Variance $000	%		2017/18 Annual Budget $000
					Primary Care						
12	29	17	60%	✓	Dental-school and adolescent	178	229	51	22%	✓	344
20	22	2	9%	✓	Maternity	170	172	2	1%	✓	259
1	1	0	21%	✓	Pregnancy & Parent	10	10	0	3%	✓	15
0	0	0		✓	Sexual Health	0	0	0		✓	0
3	5	1	31%	✓	General Medical Subsidy	27	36	9	25%	✓	55
515	526	12	2%	✓	Primary Practice Capitation	4,252	4,210	-42	-1%	✗	6,314
98	98	0	0%	✓	Primary Health Care Strategy	784	784	0	0%	✓	1,177
87	88	1	1%	✓	Rural Bonus	700	706	6	1%	✓	1,059
4	4	0	-2%	✗	Child and Youth	39	34	-6	-17%	✗	50
3	4	1	29%	✓	Immunisation	55	37	-18	-49%	✗	126
5	5	0	2%	✓	Maori Service Development	38	38	1	2%	✓	57
52	52	0	1%	✓	Whanau Ora Services	417	419	3	1%	✓	629
2	14	12	86%	✓	Palliative Care	0	111	111	100%	✓	167
7	8	1	17%	✓	Community Based Allied Health	72	67	-5	-7%	✗	101
11	14	3	20%	✓	Chronic Disease	95	113	19	17%	✓	170
28	28	0	-1%	✗	Minor Expenses	230	220	-9	-4%	✗	330
847	**898**	**51**	**6%**	✓		**7,065**	**7,188**	**122**	**2%**	✓	**10,853**
					Referred Services						
27	28	1	5%	✓	Laboratory	200	226	25	11%	✓	338
572	554	-18	-3%	✗	Pharmaceuticals	4,877	4,996	120	2%	✓	7,446
599	**582**	**-17**	**-3%**	✗		**5,077**	**5,222**	**145**	**3%**	✓	**7,784**
					Secondary Care						
188	174	-14	-8%	✗	Inpatients	1,449	1,392	-57	-4%	✗	2,088
152	155	3	2%	✓	Radiolgy services	1,169	1,236	67	5%	✓	1,854
173	105	-68	-64%	✗	Travel & Accommodation	858	843	-15	-2%	✗	1,265
1,501	1,499	-3	0%	✗	IDF Payments Personal Health	11,969	11,989	20	0%	✓	17,984
2,014	**1,933**	**-82**	**-4%**	✓		**15,445**	**15,460**	**16**	**0%**	✗	**23,191**
3,460	**3,412**	**-48**	**-1%**	✓	**Primary & Secondary Care Total**	**27,587**	**27,870**	**283**	**1%**	✓	**41,828**
					Public Health						
19	13	-6	-48%	✗	Nutrition & Physical Activity	153	103	-50	-49%	✗	155
11	11	0	1%	✓	Tobacco control	89	90	1	1%	✓	135
30	**24**	**-6**	**-25%**	✗	**Public Health Total**	**242**	**193**	**-49**	**-26%**	✗	**289**
					Mental Health						
7	7	0	1%	✓	Dual Diagnosis A&D	57	57	1	1%	✓	86
0	0	0		✓	Inpatients	0	0	0		✓	0
20	20	0	1%	✓	Child & Youth Mental Health Services	160	162	2	1%	✓	242
5	8	2	29%	✓	Mental Health Work force	53	61	8	13%	✓	91
37	61	24	39%	✓	Day Activity & Rehab	299	491	192	39%	✓	736
11	11	0	-2%	✗	Advocacy Consumer	87	86	-1	-1%	✗	129
103	82	-21	-26%	✗	Other Home Based Residential Support	823	654	-170	-26%	✗	981
11	11	0	1%	✓	Advocacy Family	88	89	1	1%	✓	133
10	16	6	39%	✓	Community Residential Beds	85	128	43	34%	✓	192
67	67	0	0%	✓	IDF Payments Mental Health	532	532	0	0%	✓	798
271	**282**	**11**	**4%**	✓		**2,184**	**2,259**	**76**	**3%**	✓	**3,389**
					Older Persons Health						
0	0	0		a	Needs Assessment	0	0	0		a	0
152	151	-1	-1%	✗	Home Based Support	1341	1205	-136	-11%	✗	1,807
2	6	4	64%	✓	Caregiver Support	34	47	13	27%	✓	71
188	273	85	31%	✓	Residential Care-Rest Homes	1,781	2,185	404	18%	✓	3,277
13	8	-4	-55%	✗	Residential Care-Community	115	65	-51	-78%	✗	97
535	482	-53	-11%	✗	Residential Care-Hospital	3,906	3,857	-49	-1%	✗	5,786
9	10	1	7%	✓	Day programmes	78	81	4	4%	✓	122
10	12	2	18%	✓	Respite Care	108	98	-10	-10%	✗	148
3	1	-1	-102%	✗	Community Health	55	10	-44	-430%	✗	15
27	1	-26	-2077%	✗	Minor Disability Support Expenditure	42	10	-31	-312%	✗	15
123	131	8	6%	✓	IDF Payments-DSS	984	1,050	67	6%	✓	1,576
1,061	**1,076**	**13**	**1%**	✓		**8,442**	**8,609**	**166**	**2%**	✓	**12,913**
1,332	**1,359**	**24**	**2%**	✓	**Mental Health & OPH Total**	**10,626**	**10,868**	**242**	**2%**	✓	**16,302**
4,822	**4,795**	**-28**	**-1%**	✗	**TOTAL EXPENDITURE**	**38,455**	**38,931**	**476**	**1%**	✓	**58,419**

EXTERNAL PROVIDER COSTS









FINANCIAL POSITION

	Month Actual $'000	Month Budget $'000	Month Variance $'000			Annual Budget $'000
Equity	23,646	25,380	(1,734)	-7%	✗	104,272
Cash	13,097	11,380	1,717	15%	✓	12,687

KEY RISKS AND ISSUES: The equity and cash position compared to budget reflect the delay in commencing the Grey Base rebuild.

APPENDIX 2: WEST COAST DHB STATEMENT OF COMPREHENSIVE REVENUE & EXPENSE

For period ending 28 February 2018

in thousands of New Zealand dollars

	Monthly Reporting				Year to Date				Full Year 17/18	Prior Year
	Actual	Budget	Variance	%Variance	Actual	Budget	Variance	%Variance	Budget	Actual
Operating Revenue										
Crown and Government sourced	11,504	11,543	(39)	(0.3%)	92,360	92,490	(130)	(0.1%)	138,695	137,591
Inter DHB Revenue	2	0	2	0.0%	12	0	12	0.0%	1	2
Inter District Flows Revenue	143	142	1	0.7%	1,140	1,136	4	0.4%	1,706	1,661
Patient Related Revenue	560	525	35	6.7%	4,872	4,751	122	2.6%	7,017	2,666
Other Revenue	500	69	431	622.5%	1,015	557	458	82.3%	834	851
Total Operating Revenue	12,709	12,279	430	3.5%	99,399	98,933	466	0.5%	148,252	142,771
Operating Expenditure										
Personnel costs	5,401	5,097	(304)	(6.0%)	45,114	44,570	(544)	(1.2%)	67,073	65,887
Outsourced Services	0	0	(0)	0.0%	2	0	(2)	0.0%	0	(9)
Treatment Related Costs	774	644	(131)	(20.3%)	6,079	5,548	(531)	(9.6%)	8,288	8,402
External Providers	3,259	3,052	(206)	(6.8%)	25,963	25,419	(545)	(2.1%)	38,162	35,843
Inter District Flows Expense	1,579	1,701	123	7.2%	12,504	13,507	1,003	7.4%	20,258	17,317
Outsourced Services - non clinical	14	18	4	21.3%	155	142	(13)	(8.8%)	214	229
Infrastructure and Non treatment related costs	951	918	(33)	(3.6%)	7,807	7,650	(157)	(2.1%)	11,412	11,446
Total Operating Expenditure	11,978	11,430	(548)	(4.8%)	97,624	96,835	(789)	(0.8%)	145,406	139,116
Result before Interest, Depn & Cap Charge	731	849	(118)	(13.9%)	1,775	2,098	323	15.4%	2,846	3,655
Interest, Depreciation & Capital Charge										
Interest Expense	0	0	0	0.0%	0	0	0	0.0%	0	343
Depreciation	254	283	29	10.4%	2,107	2,266	159	7.0%	3,400	3,373
Capital Charge Expenditure	117	124	7	5.9%	920	992	72	7.2%	1,488	739
Total Interest, Depreciation & Capital Charge	371	407	37	9.0%	3,028	3,258	230	7.1%	4,888	4,455
Net Surplus/(deficit)	360	442	(82)	18.6%	(1,252)	(1,160)	(92)	(8.0%)	(2,041)	(800)
Other comprehensive income										
Gain/(losses) on revaluation of property										
Total comprehensive income	360	442	(82)	18.6%	(1,252)	(1,160)	(92)	(8.0%)	(2,041)	(800)

APPENDIX 3: WEST COAST DHB STATEMENT OF FINANCIAL POSITION

As at 28 February 2018

in thousands of New Zealand dollars

	Actual	Budget	Variance	%Variance	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	21,907	22,923	(1,016)	(4.4%)	23,623
Intangible assets	483	416	67	16.1%	636
Work in Progress	4,033	3,194	839	26.3%	3,194
Other investments	567	567	0	0.0%	0
Total non-current assets	26,990	27,100	(110)	(0.4%)	27,453
Current assets					
Cash and cash equivalents	13,097	11,380	1,717	15.1%	10,811
Patient and restricted funds	56	74	(18)	(23.9%)	72
Inventories	1,060	1,007	53	5.3%	1,060
Debtors and other receivables	4,721	5,121	(400)	(7.8%)	4,992
Assets classified as held for sale	0	0	0	0.0%	0
Total current assets	18,935	17,582	1,353	7.7%	16,935
Total assets	45,925	44,682	1,242	2.8%	44,387
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Employee entitlements and benefits	2,849	2,703	(146)	(5.4%)	2,779
Other	70	70	(0)	(0.0%)	70
Total non-current liabilities	2,919	2,773	(146)	(5.3%)	2,848
Current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Creditors and other payables	9,163	6,965	(2,197)	(31.5%)	6,875
Employee entitlements and benefits	10,197	9,564	(633)	(6.6%)	9,557
Total current liabilities	19,360	16,530	(2,830)	(17.1%)	16,431
Total liabilities	22,279	19,303	(2,976)	(15.4%)	19,280
Equity					
Crown equity	86,062	87,492	1,430	1.6%	86,062
Other reserves	22,082	22,082	0	0.0%	22,082
Retained earnings/(losses)	(84,498)	(84,194)	304	0.4%	(83,036)
Trust funds	0	0	0	0.0%	0
Total equity	23,646	25,380	1,734	6.8%	25,108
Total equity and liabilities	45,925	44,682	1,243	2.8%	44,387

APPENDIX 4: WEST COAST DHB STATEMENT OF CASHFLOW

For period ending 28 February 2018

in thousands of New Zealand dollars

	Monthly Reporting					Year to Date			
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance
Cash flows from operating activities									
Cash receipts from Ministry of Health, patients and other revenue	12,086	12,320	(234)	(1.9%)	11,356	75,775	98,556	(22,781)	(23.1%)
Cash paid to employees	(5,730)	(5,355)	(375)	(7.0%)	(5,777)	(33,444)	(45,060)	11,616	25.8%
Cash paid to suppliers	(917)	(1,504)	587	39.0%	(938)	(9,819)	(13,035)	3,216	24.7%
Cash paid to external providers	(3,616)	(3,180)	(436)	(13.7%)	(2,679)	(18,327)	(25,441)	7,114	28.0%
Cash paid to other District Health Boards	(299)	(1,688)	1,389	82.3%	(1,388)	(10,309)	(13,505)	3,196	23.7%
Cash generated from operations	1,524	592	932	157.4%	574	3,876	1,515	2,361	155.9%
Interest paid	0	0	0	0.0%	(57)	0	0	0	0.0%
Capital charge paid	0	(124)	124	100.0%	(68)	(687)	(992)	305	30.7%
Net cash flows from operating activities	1,524	468	1,056	225.7%	449	3,189	523	2,666	510.0%
Cash flows from investing activities									
Interest received	31	35	(4)	(10.4%)	41	232	280	(48)	(17.2%)
(Increase) / Decrease in investments	0	0	0	0.0%	0	0	0	0	0.0%
Acquisition of property, plant and equipment	(678)	(208)	(470)	(226.0%)	(29)	(1,135)	(1,664)	529	(31.8%)
Acquisition of intangible assets		0	0		0		0	0	
Net cash flows from investing activities	(647)	(173)	(474)	273.8%	12	(903)	(1,384)	481	34.8%
Cash flows from financing activities									
Proceeds from equity injections	0	0	0	0.0%	0	0	1,432	(1,432)	100.0%
Repayment of equity	0	0	0	0.0%	0	0	0	0	0.0%
Cash generated from equity transactions	0	0	0	0.0%	0	0	1,432	(1,432)	100.0%
Borrowings raised					0				
Repayment of borrowings	0	0	0	0.0%	0	0	0	0	0.0%
Payment of finance lease liabilities	0	0	0	0.0%		0	0	0	0.0%
Net cash flows from financing activities	0	0	0	0.0%	0	0	0	0	0.0%
Net increase in cash and cash equivalents	877	295	582	197.4%	461	2,286	569	1,717	301.9%
Cash and cash equivalents at beginning of period	11,944	11,085	858	7.7%	8,733	10,811	10,811	(0)	(0.0%)
Cash and cash equivalents at end of year	12,821	11,380	1,440	12.7%	9,194	13,097	11,380	1,717	15.1%

WELLBEING HEALTH AND SAFETY UPDATE

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **People and Capability**

DATE: **23 March 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report provides an update on employee wellbeing, health and safety activities including a high level dashboard.

2. RECOMMENDATION

That the Board:
i. Notes the Wellbeing Health & Safety Update

3. SUMMARY

General
A range of wellbeing, health and safety activities continue to progress. These are outlined below.

Wellbeing:
Work is underway to confirming the 2018 wellbeing programme for our people based on the outcomes of 2017.

Health and Safety:
- A Safe Manual Handling Workshop has been held to address an identified need within Theatres. The training provider was from Canterbury. Note: it is very difficult to find external providers who can travel to the West Coast and there is no capacity for a Physiotherapist within the WCDHB to provide this education.
- The roll-out of changes to Safety1st employee event forms continue with the final Closing Manager education sessions to be held before the changes are fully enacted. It is anticipated that the changes to the system will be finalised in March.

Occupational Health:
- In response to the national Pertussis (whooping cough) outbreak clinics have been held across the West Coast with good uptake. These will continue to be offered in conjunction with the Influenza campaign once it commences.
- Planning has started for the 2018 Influenza campaign. Authorised Vaccinators from throughout the DHB are assisting with the campaign.

Health and Safety Systems Review

Health and Safety Systems Improvement This is the opportunity to ensure our people are healthy and safe when they're at work. This goes beyond just being compliant – it's about doing the right thing for our people	On-going	●	↓ TBC number of injuries ↓ TBC days lost to injury

New approach to health and safety: Changes are being made to our health and safety system to ensure we have the right number of health and safety representatives, in the right areas, with access to the right training and support. In 2017 a new approach aimed at improving engagement and participation in health and safety matters was piloted at Burwood and Ashburton Hospitals, and at Canterbury Health Laboratories. The pilots resulted in greater clarity over who was responsible for which work areas, and enabled a more appropriate spread of health and safety representatives. It is proposed that these changes be rolled out across the West Coast in due course.

Policy and procedure framework: Working groups have been established in the areas as endorsed by the Health and Safety Governance Group. The purpose of the working groups is to review and develop policies and procedures, linked to the new framework. This month the new Hazardous Substances Policy and updated Health and Safety at Work Policy were addressed by the working groups. The final drafts are being prepared. The Violence and Aggression Working Group is active now, the first draft of the violence management procedures is being developed with engagement occurring across both sides of the divide to understand the needs and opportunities around violence management. The first Contactor Management Working Group meeting was held this month with a number of learnings that will form our planned approach to consistent management of contractors across various West Coast and Canterbury departments.

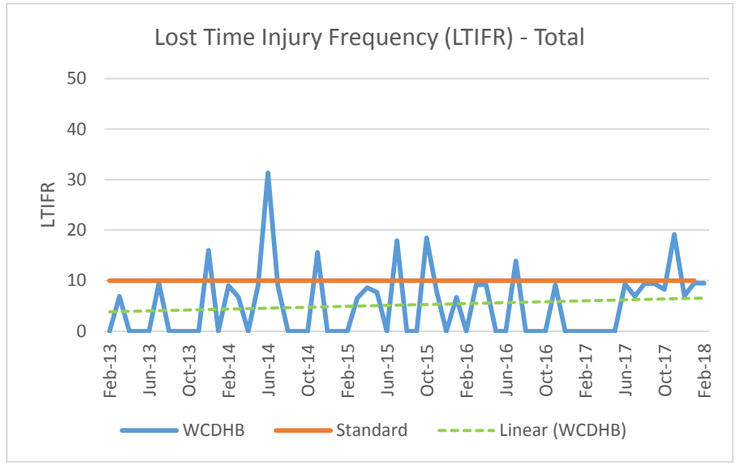
The key activity for Q1 2018 (January – March) includes reviewing the outcomes achieved in 2017 and setting the 2018 programme of work. This is based on the remaining recommendations from the 2016 external review of our health and safety systems.

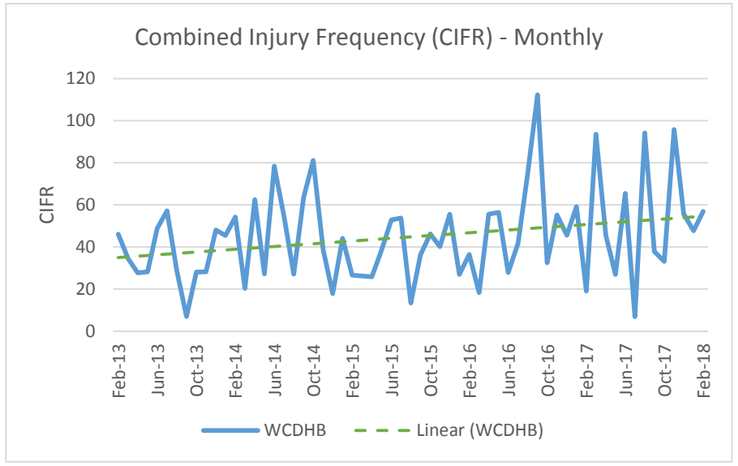
4. APPENDICES

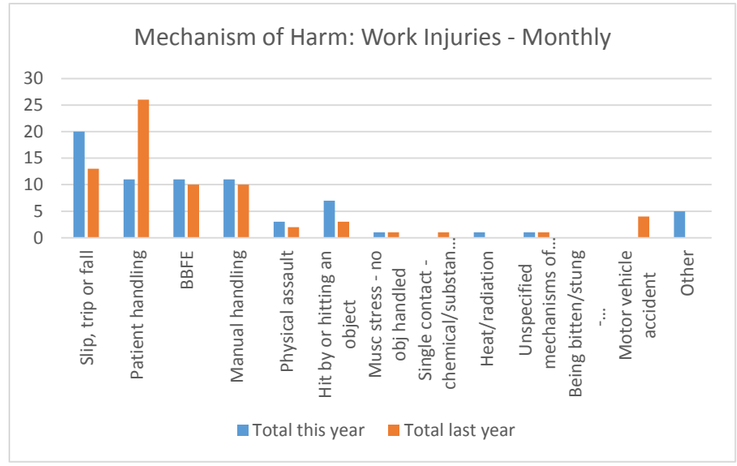
Appendix 1: Wellbeing, Health and Safety Dashboard

Report prepared by: Mark Lewis, Manager Wellbeing Health
Report approved by: Michael Frampton, General Manager, People and Capability

Wellbeing, Health and Safety Dashboard: West Coast District Health Board (February 2018)





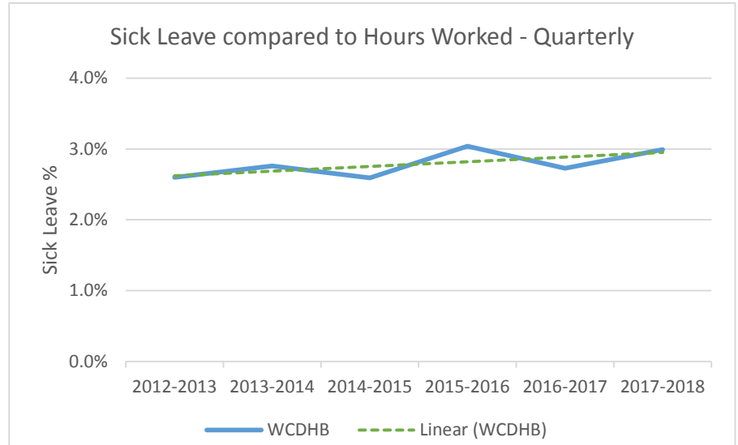


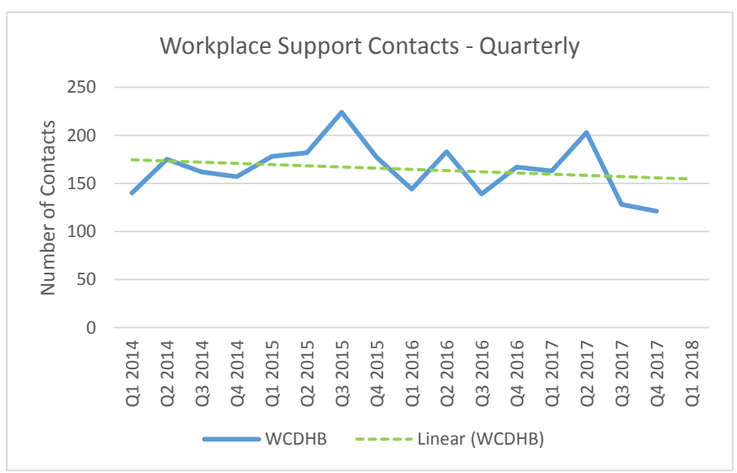
Worksafe Notifiable Events - Monthly

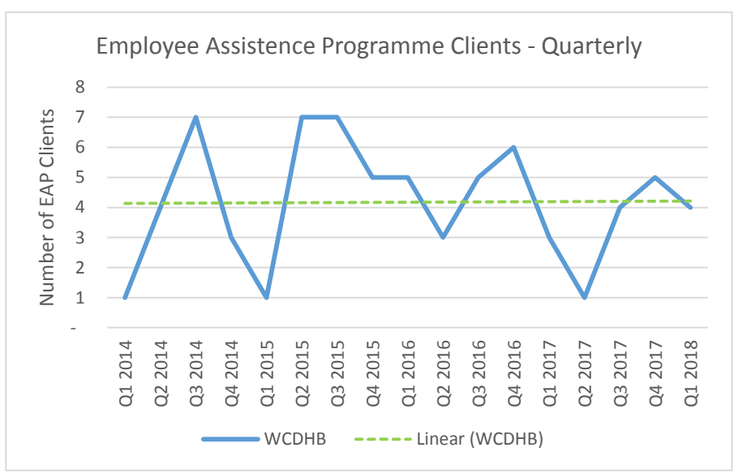
Event	Dec-17	Jan-18	Feb-18
Death	-	-	-
Notifiable illness or injury	-	-	-
Notifiable incident	-	-	-

Duty Holder Review	Dec-17	Jan-18	Feb-18
Death	-	-	-
Notifiable illness or injury	-	-	-
Notifiable incident	-	-	-

Please note: The above are raw scores.







Prepared by: Mark Lewis, Manager Wellbeing Health and Safety
Approved by: Michael Frampton, General Manager People and Capability

Lost Time Injury Frequency (monthly)

Description:

Lost time injury frequency rates are based on the number of lost time injuries per million hours worked. The loss time injury frequency is compared to the ACC Healthcare Levy Risk Group Average of 10 [standard].

Comment:

Lost time injuries per million hours worked have increased slightly over the five year reporting period. The rate remain below the ACC health sector average for now.

Focus:

People and Capability will continue to support managers with maintaining Risk Registers and completing risk assessments as well as continuning to provide proactive education sessions across the WCDHB, as evidenced by the Safe Manual Handling Education delivered to Theatre staff this month.

Combined Injury Frequency (monthly)

Description:

Combined injury frequency is a ratio based on the number of all ACC accepted medical treatment claims per million hours worked.

Comment:

Total medical treatment claims continue to increase over the five year reporting period. The predominate injury is muscular strains and sprains with the main mechanism being patient handling.

Focus:

People and Capability will continue to work with managers and staff to identify hazards associated with work layout, task variability and environmental issues.

Mechanism of Harm: Employee Events (rolling 12 months)

Description:

Number of Employee Events as reported on Safety1st in the last 12 month period compared to the previous 12 months.

Comment:

The main mechanisims of harm are: Slip/trip or fall, patient handling, manualing handling and BBFE.

Focus:

Changes to the workplace incident form in Safety1st may result in an increase in events recorded. Work is ongoing to provide Safe Manual Handling Education in high risk areas.

Worksafe Notifiable Events (monthly)

Description:

Events reported and confirmed by WorkSafe that meet the legislative definition of notifiable.

Comment:

Nothing to report.

Focus:

People and Capability will continue to support managers with maintaining Risk Registers and completing risk assessments.

Sick Leave (quarterly)

Description:

Sick leave taken compared to hours worked.

Comment:

Sick leave taken compared to hours worked is trending up slightly over the last five years.

Focus:

People and Capability will continue to monitor the situation over the next quarter and work with Operational Leadership to support our people to stay well and healthy at work.

Workplace Support (quarterly)

Description:

Number of contacts in relation to organisational headcount.

Comment:

Workplae Support contacts remains relatively static relative to WCDHB headcount.

Focus:

People and Capability will continue to monitor the situation over the next quarter and work with Operational Leadership to support our people to stay well and healthy at work.

Employee Assistance Programme (quarterly)

Description:

Number of clients in relation to organisational headcount.

Comment:

Employee Assistance Programme contacts remains static relative to WCDHB headcount, noting that with the low number of our people accessing this service we expect to see quarter by quarter variance.

Focus:

People and Capability will continue to monitor the situation over the next quarter and work with Operational Leadership to support our people to stay well and healthy at work.

Prepared by: Mark Lewis, Manager Wellbeing Health and Safety
Approved by: Michael Frampton, General Manager People and Capability

RESOLUTION TO EXCLUDE THE PUBLIC

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Board Secretary**

DATE: **23 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, Clause 32 and 33, and the West Coast DHB Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATION

That the Board:

i resolve that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5 & 6 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 New Zealand Public Health and Disability Act 2000 (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 9 February 2018	For the reasons set out in the previous Board agenda.	
2.	Emerging Issues Verbal Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	9(2)(j) S9(2)(a)
3.	Clinical Leaders Emerging Issues	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	S9(2)(j) S9(2)(a)
4.	People Strategy Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	S9(2)(j) S9(2)(a)
5.	Annual Planning Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
6.	Grey Hospital Realignment Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)

iii notes that this resolution is made in reliance on the New Zealand Public Health and Disability Act 2000 (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 New Zealand Public Health and Disability Act 2000 (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) (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 from part of the minutes of the Board".

Report Prepared by: Board Secretary

E98

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

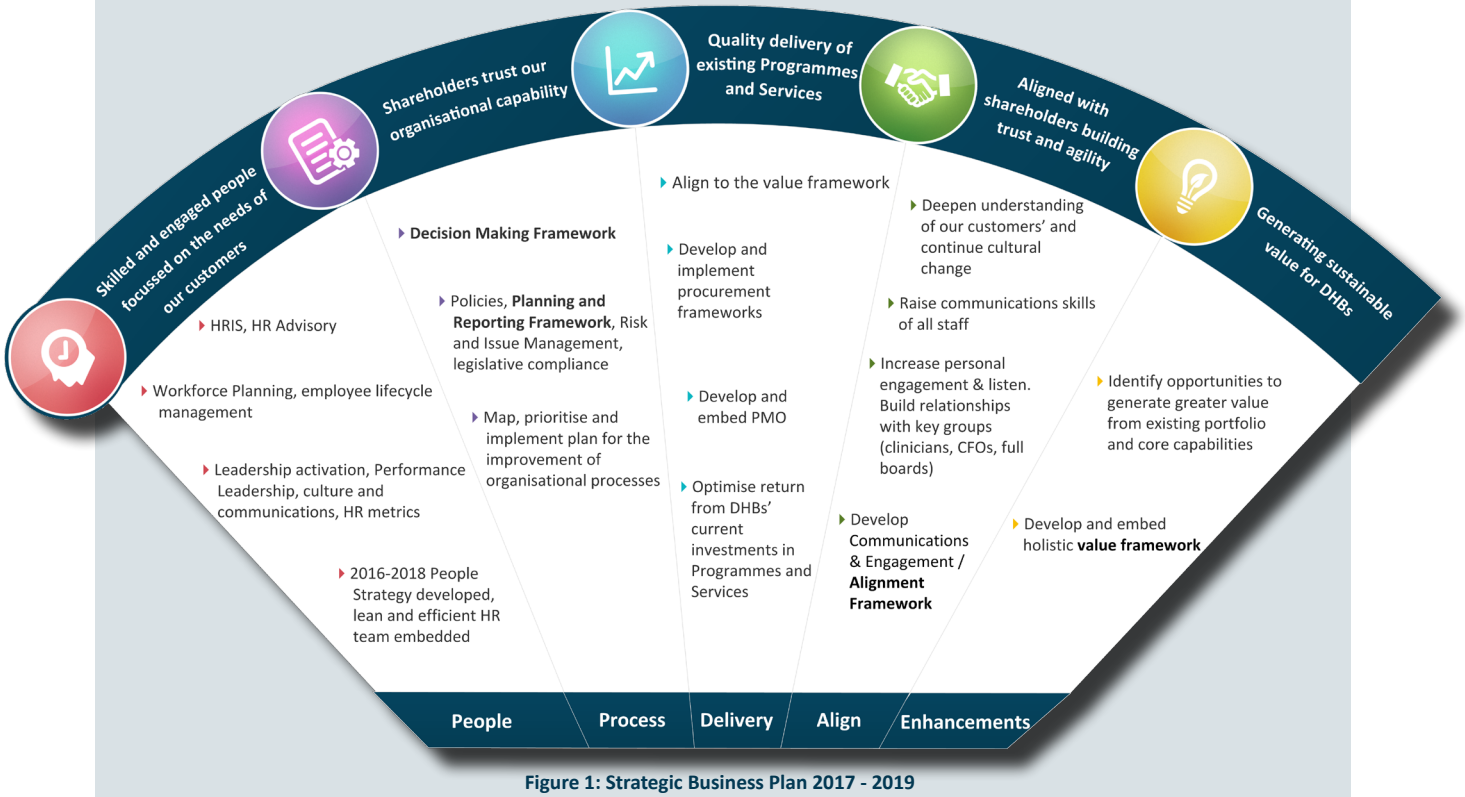


Figure 1: Strategic Business Plan 2017 - 2019

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

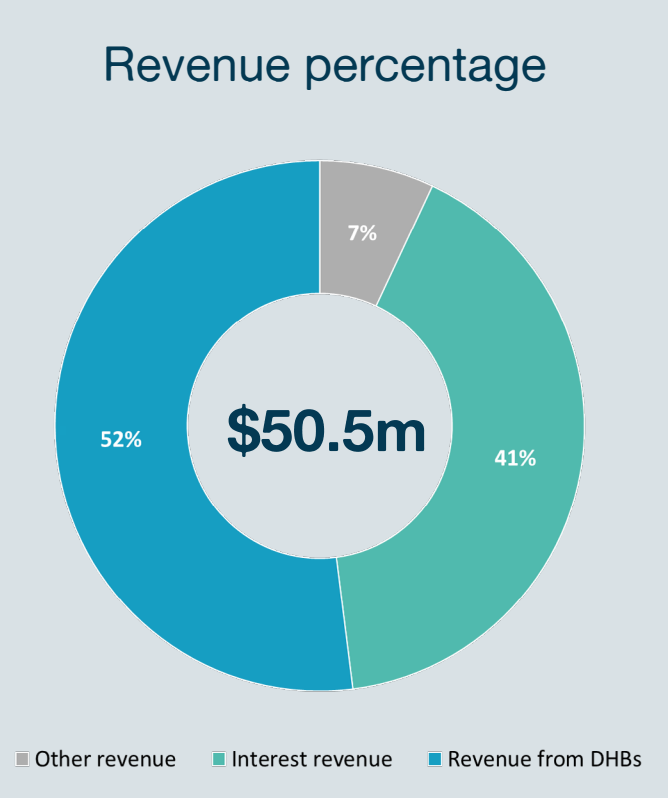


Figure 2: NZ Health Partnerships revenue sources 2016/17

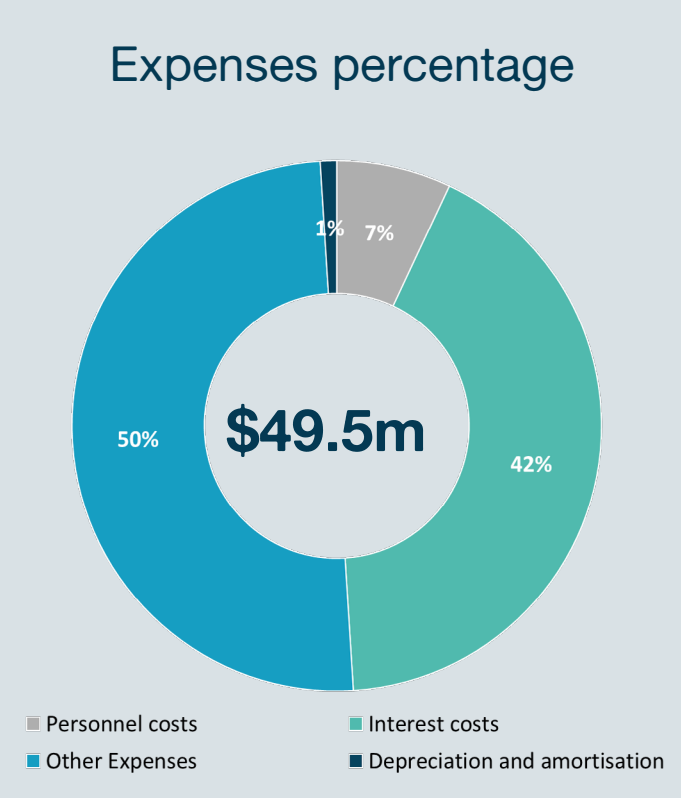


Figure 3: NZ Health Partnerships expenditure areas 2016/17

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

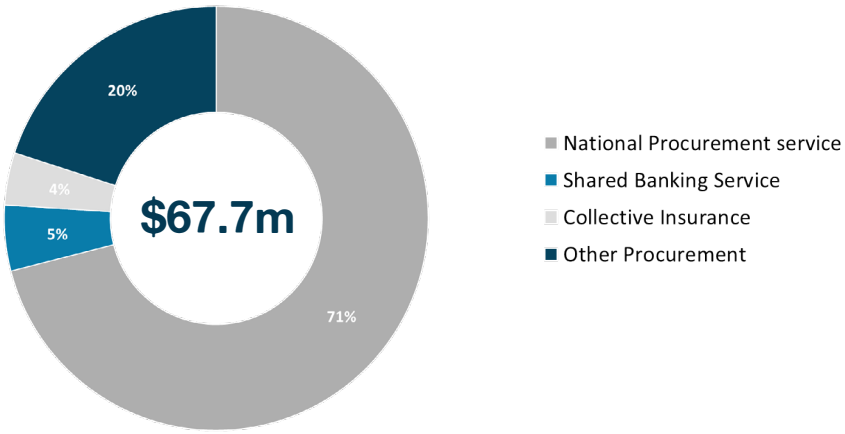


Figure 5: NZ Health Partnerships reported benefits by source 2016/17

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

Directory

Registered office

Level 2, Building 2

Central Park

660-670 Great South Road

Penrose, Auckland

New Zealand

NZBN 94290041807927

Contact address

PO Box 11-410

Ellerslie

Auckland 1061

New Zealand

Email: info@nzhealthpartnerships.co.nz | Web: www.nzhealthpartnerships.co.nz

Phone: +64 9 487 4900

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

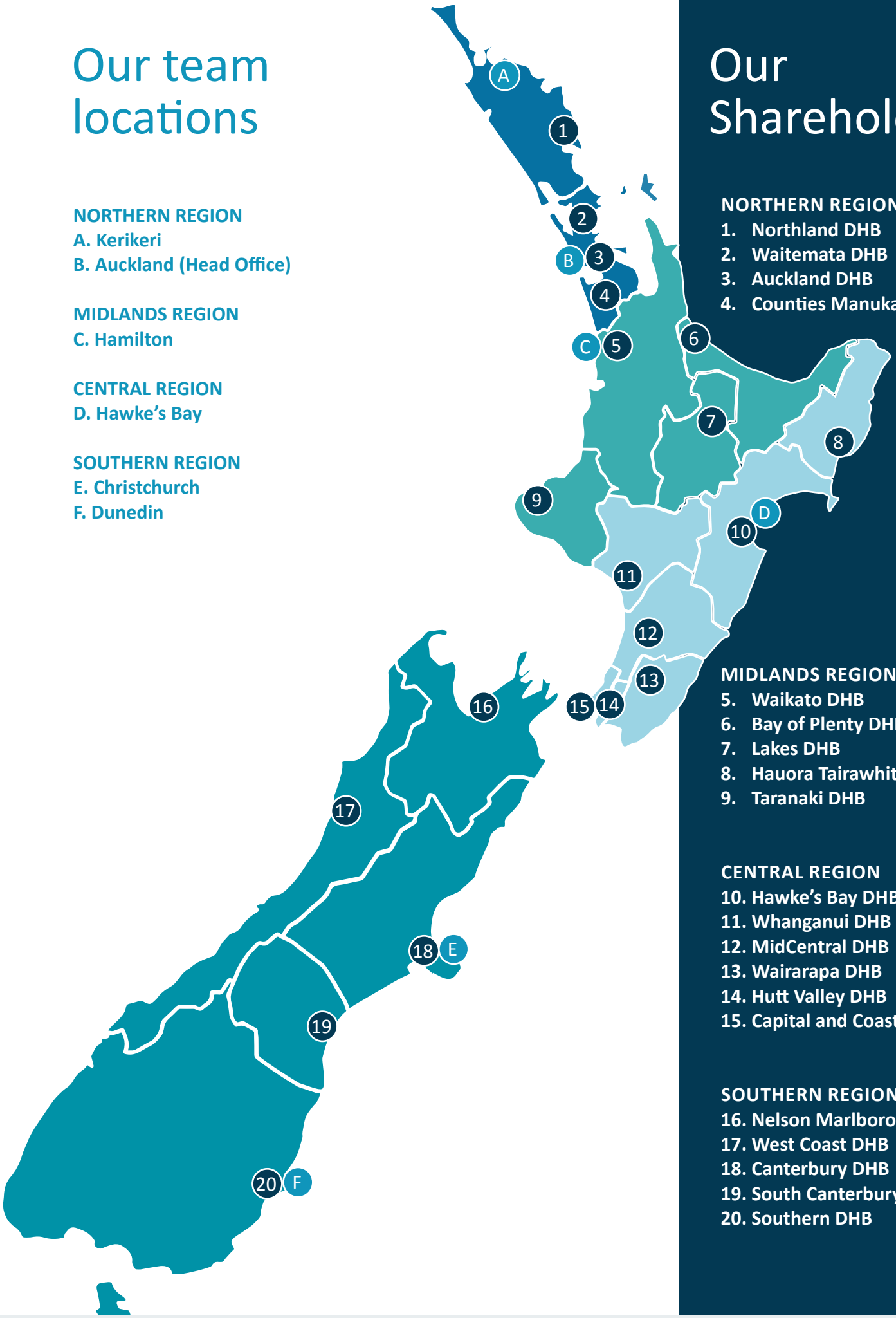
Our team locations

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. West Coast 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.

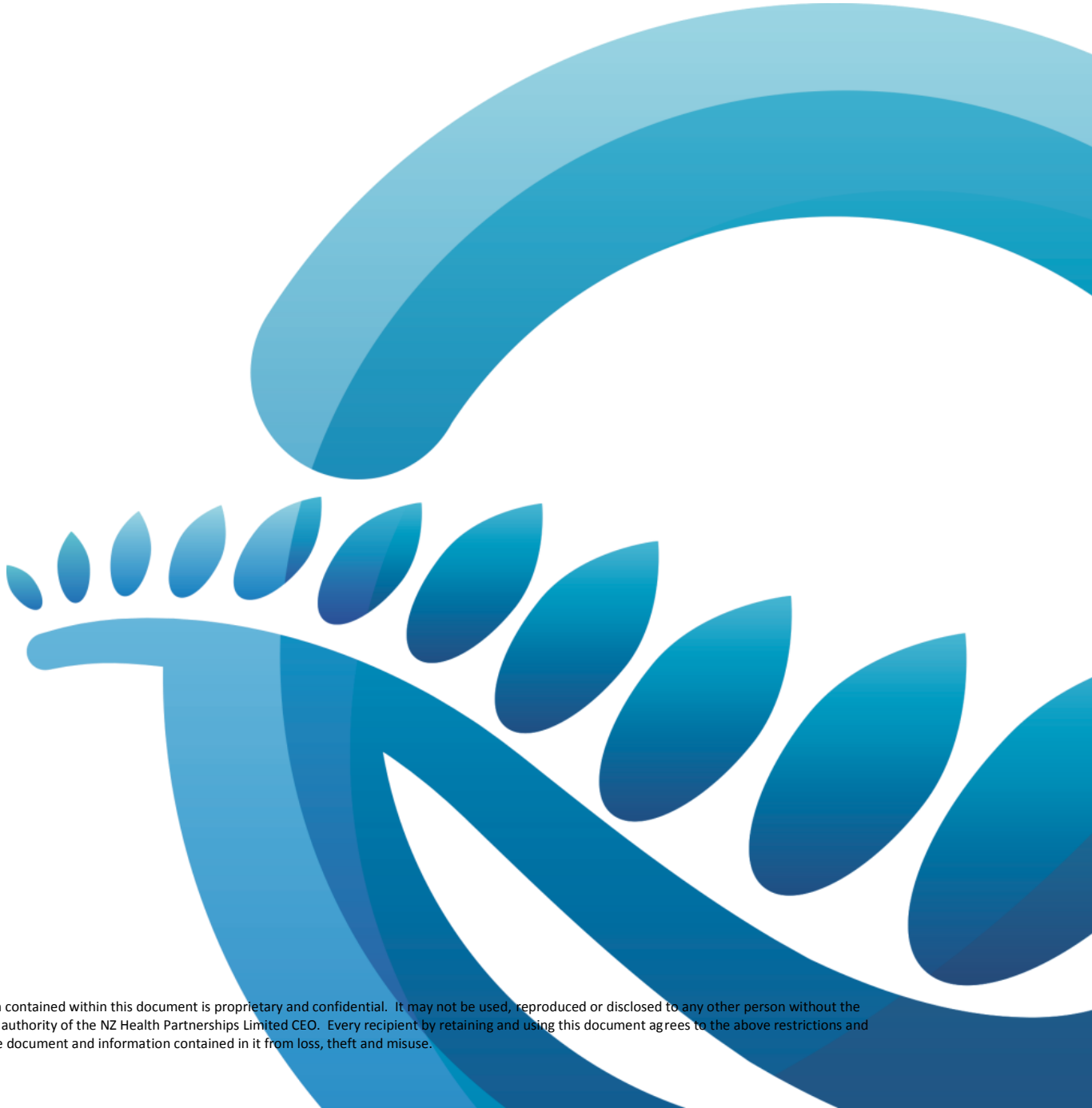
5. One metric is assessed as Not Achieved. This relates to the delivery of an efficient food service measure and its target of $1.8m in budgetary benefits which cannot be measured without an original expenditure baseline. Non-budgetary benefits will continue to be communicated to participating DHBs as 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.

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
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.

#	PERFORMANCE MEASURE	TARGET	WHEN	STATUS
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.			

Directory

Registered office

Level 2, Building 2

Central Park

660-670 Great South Road

Penrose, Auckland

New Zealand

NZBN 94290041807927

Contact address

PO Box 11-410

Ellerslie

Auckland 1061

New Zealand

Email: info@nzhealthpartnerships.co.nz

Web: www.nzhealthpartnerships.co.nz

Phone: +64 9 487 4900

REVISED FEBRUARY 2018

WEST COAST DHB – MEETING SCHEDULE

FEBRUARY – DECEMBER 2018

DATE	MEETING	TIME	VENUE
~~Friday 9 February 2018~~	BOARD MEETING	10.15am	St John, Water Walk Rd, Greymouth
Friday 23 March 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 23 March 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 26 April 2018	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 11 May 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 11 May 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 7 June 2018	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 29 June 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 29 June 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 26 July 2018	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 10 August 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 10 August 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 13 September	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 28 September	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 28 September 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 25 October 2018	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 2 November 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 2 November 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 6 December 2018	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 14 December 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth

The above dates and venues are subject to change. Any changes will be publicly notified.

REVISED FEBRUARY 2018