West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Friday 14 December 2018
at 9.45am

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
Edie 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 *(Chief People Officer))*
Carolyn Gullery *(Executive Director, Planning, Funding & Decision Support)*
Dr Cameron Lacey *(Medical Director, Medical Council, Legislative Compliance and National Representation)*
Jacqui Lunday-Johnstone *(Executive Director, Allied Health)*
Dr Vicki Robertson (*Medical Director, Patient Safety and Outcomes)*
Karalyn van Deursen (*Executive Director, Communications)*
Stella Ward *(Chief Digital Officer)*
Philip Wheble (*General Manager, West Coast)*
Justine White (*Executive Director, Finance & Corporate Services)*
Kay Jenkins (*Board Secretary)*

AGENDA – PUBLIC

WEST COAST DISTRICT HEALTH BOARD MEETING
to be held at St John, Water Walk Road, Greymouth
on Friday 14 December 2018 commencing at 9.45am

KARAKIA			***9.45am***
ADMINISTRATION			
	Apologies		
1.	**Interest Register**		
2.	**Confirmation of the Minutes of the Previous Meetings** • *2 November 2018*		
3.	**Carried Forward/Action List Items**		
REPORTS FOR NOTING			***9.50am***
4.	**Chair's Update – Verbal Update**	Jenny Black *Chair*	*9.50am – 9.55am*
5.	**Chief Executive's Update**	David Meates *Chief Executive*	*9.55am – 10.10am*
6.	**Clinical Leaders Update**	Clinical Leaders	*10.10am – 10.20am*
7.	**Finance Report**	Justine White *Executive Director, Finance & Corporate Services*	*10.20am – 10.25am*
8.	**Resolution to Exclude the Public**	*Board Secretary*	*10.25am*

INFORMATION ITEMS

- NZ Health Partnerships Annual Report 2018
- 2019 Meeting Dates

ESTIMATED FINISH TIME **10.25am**

NEXT MEETING: Friday 15 February 2019

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

Name	Interests	Pecuniary (Y/N)	Type of Conflict (Actual / Perceived / Potential)
Jenny Black **Chair**	• **Chair, Nelson Marlborough District Health Board** Appointed as Chair for a third term by the Minister of Health. Member of Statutory Committees and Audit Committee.	Y	Perceived
	• **Chair, South Island Alliance Board** The South Island Alliance enables the regions five DHBs to work collaboratively to develop more innovative and efficient health services than could be achieved independently.	N	Perceived
	• **Chair, National DHB Chairs** Elected position from the National DHB Chairs.	N	Perceived
	• **West Coast Partnership Group** This is a Partnership Group set up by government to provide governance for the facilities development of the new Grey Hospital & Health Centre and a health facility at Buller.	N	Perceived
Chris Auchinvole	• **Director Auchinvole & Associates Ltd**	N	
	• **Trustee, Westland Wilderness Trust**	N	
	• **Trustee, Moana Holdings Heritage Trust**	N	
	• **Justice of the Peace** Justices of the Peace carry out important functions in the administration of documentation and justice in New Zealand	N	
	• **Daughter-in-law employed by Otago DHB**	N	
Kevin Brown	• **West Coast Electric Power Trust** - Trustee The West Coast Electric Power Trust was formed in 1992 as a consequence of the passing of the Energy Companies Act 1992. The six Trustees hold the shares of Westpower Ltd and the associated companies on behalf of the electricity consumers of the West Coast.	N	
	• **Diabetes West Coast** - Patron and Member	N	Perceived
	• **West Coast Juvenile Diabetes Association** - Trustee Diabetes West Coast provides services for people with diabetes.	N	Perceived

	• **Greymouth Riverside Lions Club** – Member • **Justice of the Peace** Justices of the Peace carry out important functions in the administration of documentation and justice in New Zealand • **West Coast Rugby League** - Hon Vice President West Coast Rugby League is a sporting organisation • **Wife** works part time at the Child and Adolescent Mental Health Service (CAMHS) in Greymouth	N N N Y	Perceived
Helen Gillespie	• **Department of Conservation** – Employee - Partnerships Manager. My current role with DOC is to lead Healthy Nature Healthy People – an initiative seeking to make a positive difference to the lives of all New Zealanders through nature. • **Husband works for New Zealand Police** – Based in Hokitika and currently working in the Traffic Safety Team • **Accessible West Coast Coalition Group** - Member - I represent the Department of Conservation in the Coalition Group. The Department, like many other agencies and organisations is seeking to create greater accessibility for people • **Kowhai Project Committee** – Member - I am a member of this committee in a voluntary capacity and am able to share examples of nature in health settings to support patients, staff and visitors.	N N N N	
Michelle Lomax	• **Daughter** is a recipient of WCDHB Scholarship • **Community Law Canterbury** - Part-time Advisor on Disability Issues • **Streetwise Charitable Trust** - Trustee	N N N	
Chris Mackenzie **Deputy Chair**	• **Development West Coast** – Chief Executive Development West Coast (DWC) was set up as a Charitable Trust in 2001 to manage, invest and distribute income from a fund of $92 million received from the Government. It is governed by a Deed of Trust which specifies DWC's Objects - to promote sustainable employment opportunities; and generate sustainable economic benefits for the West Coast, both now and into the future. • **Horizontal Infrastructure Governance Group** – Chair A Memorandum of Understanding was agreed in September 2013 between the Government and the Christchurch City Council to create this group to focus on lessons learned from one of New Zealand's most challenging civil engineering projects: rebuilding the earthquake damaged pipes, roads, bridges and retaining walls	N N	

	in the city of Christchurch 2011 - 2016. • **Mainline Steam Trust** – Trustee Mainline Steam is an organisation devoted to the restoration and operation of historic mainline steam locomotives. • **Christchurch Mayors External Advisory Group** – Member An External Advisory Group set up by Government and the Christchurch City Council to provide independent advice on Christchurch City Council's long-term capital works programme and related spending plans.	N N	
Edie Moke	• **South Canterbury DHB –** Appointed Board Member; Chair: Disability Support Advisory Committee; Deputy Chair: Maori Health Advisory Committee; and Member: Audit and Assurance Committee • **Nga Taonga Sound & Vision** - Board Member (elected); Chair: Assurance and Risk Committee; and Member: Property Committee 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.	Y N	Perceived
Peter Neame	• **White Wreath Action Against Suicide** – Board Member and Research Officer White Wreath is a non-denominational, non-political and anti-discriminatory body supporting people who have been directly affected by suicide and those who are affected by mental illness/disorders. • **Author and Publisher** of "Suicide, Murder, Violence Assessment and Prevention" 2017 and four other books.	N N	Perceived
Nigel Ogilvie	• **Westland Medical Centre** - Managing Director • **Thornton Bruce Investments Ltd** - Shareholder/Director • **Hokitika Seaview Ltd** - Shareholder • **Tasman View Ltd** - Shareholder, • **White Ribbon Ambassador for New Zealand** • **Sister** is employed by Waikato DHB • **West Coast PHO** - Board Member • **Wife** is a General Practitioner casually employed with West Coast DHB and full time General Practitioner and Clinical Director at Westland Medical Centre • **Wife** is Board Member West Coast PHO	Y N N N N N Y Y Y	Actual Perceived Actual Perceived

Elinor Stratford	• **Clinical Governance Committee, West Coast Primary Health Organisation** The West Coast PHO Clinical Governance Committee (CGC) act as an advisory committee to its Board. The CGC's role is to assist the Board with any clinical aspects that relate to its business.	N	Perceived
	• **Active West Coast** – Committee Member Active West Coast (AWC) is a network of agencies and groups committed to improving the health of West Coasters through the promotion of healthy lifestyles such as physical activity, nutrition, smokefree, youth and older person's health.	N	Perceived
	• **West Coast Sub-branch - Canterbury Neonatal Trust** – Chairperson	N	Perceived
	• **Canterbury Neonatal Trust** – Trustee The primary focus of The Neonatal Trust (Canterbury) is to support families who are going through or have been through a neonatal journey.	N	Perceived
	• **Arthritis New Zealand, Southern Regional Liaison Group** – Member Arthritis New Zealand aims to improve the life of every person affected by arthritis. They are a national not-for-profit organisation focused on raising awareness, advocating for those with arthritis and providing advice and support.	N	Perceived
	• **New Zealand Federation of Disability Information Centres** – President These groups promote and support the provision of impartial disability information and referral services.	N	Perceived
	• **Accessible West Coast Coalition Group** – Member A group that works together to improve access to all aspects of the community.	N	Perceived
	• **Kowhai Project Committee** - Chair The Kowhai Project, is a community project and is raising money to provide an inner courtyard for staff, patients and visitors including plantings for the entry and the parking areas at the new Te Nikau, Grey Hospital and Health Centre	N	Perceived
	• **MS - Parkinsons New Zealand** – West Coast Committee Member MS Parkinsons provides education, information and help people make informed decisions about living with Parkinson's.	N	Perceived
Francois Tumahai	• **Te Runanga o Ngati Waewae** – Chair This is one of 18 Ngai Tahu regional Papatipu Rūnanga which exist to uphold the mana of their people over the land, the sea and the natural resources. Te Rūnanga o Ngāti Waewae is based at Arahura a short distance from Hokitika on the West Coast.	N	
	• **Poutini Environmental** - Director	N	

	Poutini Environmental is the authorised body for resource management, cultural impact assessment and resource consent certification. • **Arahura Holdings Limited** – Chief Executive • **West Coast Regional Council Resource Management Committee** – Member Provides a broad direction and framework for managing the West Coast's natural and physical resources under the Resource Management Act 1991. • **Poutini Waiora Board** - Chair Poutini Waiora is a Maori Health and Social Service provider that delivers holistic care to whanau across Te Tai O Poutini. • **Development West Coast** – Trustee Development West Coast (DWC) was set up as a Charitable Trust in 2001 to manage, invest and distribute income from a fund of $92 million received from the Government. It is governed by a Deed of Trust which specifies DWC's Objects - to promote sustainable employment opportunities; and generate sustainable economic benefits for the West Coast, both now and into the future. • **West Coast Development Holdings Limited** – Director • **Putake West Coast** – Director This is a joint venture between Development West Coast and Putake Honey to develop a West Coast wholesale honey business. • **Ngai Tahu Pounamu** – Director Waewae Pounamu is the home of Ngāti Waewae Pounamu carving • **Westland Wilderness Trust** – Chair • **West Coast Conservation Board** – Board Member The West Coast Tai Poutini Conservation Board serves a conservation advisory role, along with offering community perspective on conservation management issues for the West Coast region. • **New Zealand Institute for Minerals to Materials Research** (**NZIMMR)** – Director • **Westland District Council** – Councillor • **Tatau Pounamu –** Committee Member	N N Y N N N N N N N N Y	Actual Perceived

MINUTES

MINUTES OF THE WEST COAST DISTRICT HEALTH BOARD MEETING
held at St John, Water Walk Road, Greymouth
on Friday 14 November 2018 commencing at 1.00pm

BOARD MEMBERS

Jenny Black (Chair); Chris Mackenzie (Deputy Chair); Chris Auchinvole; Edie Moke; Peter Neame; Nigel Ogilvie (via Teleconference); Elinor Stratford and Francois Tumahai (via teleconference).

APOLOGIES

Apologies were received and accepted from Kevin Brown, Helen Gillespie and Michelle Lomax.

EXECUTIVE SUPPORT

David Meates (Chief Executive); Karen Bousfield (Director of Nursing); Gary Coghlan (General Manager, Maori Health); Pradu Dayaram (Medical Director); Michael Frampton (Chief People Officer); Carolyn Gullery (Executive Director, Planning & Funding and Decision Support); Philip Wheble (General Manager, West Coast); Karalyn van Deursen (Executive Director, Communications); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); and Kay Jenkins (Board Secretary).

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 (21/18)
(Moved Chris Auchinvole/seconded Elinor Stratford – carried)

"That the minutes of the Meeting of the West Coast District Health Board held at St John, on Friday 28 September
2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward items were noted.

4. 2019 MEETING DATES

The Chair spoke to the proposed dates for 2019 for Board & Committee meetings. Discussion took

place regarding holding meetings at other venues.

Resolution (22/18)
(Moved: Edie Moke/seconded: Chris Mackenzie - carried)
That the West Coast DHB Board:

i. confirms support for the proposed schedule of meetings for 2019; and
ii. delegates authority to the Chief Executive, in consultation with the Chair of the Board and/or relevant Committee Chairperson, to alter the date, time or venue of a meeting, or cancel a meeting, should circumstances require this.

5. 2019 ELECTORAL PROCEDURES

The Chair spoke regarding the 2019 Electoral Procedures. It was noted that the arrangements for 2016 went very well under the same arrangements.

Resolution (23/18)
(Moved: Chris Mackenzie/seconded: Elinor Stratford - carried)
That the West Coast DHB Board:

i. confirms the appointment of Anthony Morton as the West Coast DHB Electoral Officer, in accordance with the Local Electoral Act 2001; and
ii. adopts "random" as the order of candidates' names on West Coast DHB voting documents, as permitted under Clause 31(1) of the Local Electoral Regulations 2001.

6. CHAIR'S UPDATE

Jenny Black, Chair, acknowledged the new role of Karyn Bousfield, Director of Nursing.

Ms Black advised that the Minister will be visiting the West Coast on Monday 19 November and that Damien O'Connor, MP and Clayton Cosgrove, Chair Partnership Group will join him.

The Chair's verbal update was noted

7. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, took his report as read. Mr Meates acknowledged the departure of Karen Bousfield early in January 2019.

Mr Meates provided updates as follows:

- Orthopaedics – there are some challenging issues being addressed in this area.
- Heather Simpson, Chair, Health & Disability System Review, will visit the West Coast over the next few weeks. The key message being distributed is that while the DHB Sector is not broken there are some improvements that can be made.

The update was noted.

8. FINANCE REPORT

Justine White, Executive Director, Finance & Corporate Services, presented the finance report. The report showed that the consolidated West Coast District Health Board financial result for the month of September 2018 was a deficit of $433k, which was $71k favourable to draft budget. The year to date net deficit of $990k is $146k favourable to draft budget.

It was noted that the variance around the main drivers of treatment related costs could easily change.

The finance report was noted.

GENERAL BUSINESS

The Chair invited Board member Chris Auchinvole, Board representative on the Tatau Pounamu Advisory Group to provide the Board with an update from the recent Meeting held on 19 October.

Mr Auchinvole provide the update and also advised that the current Chair, Susan Wallace has signalled a strategy meeting in the new year and she has indicated that she will be seeking to be replaced as Chair in the new year.

The update was noted.

9. RESOLUTION TO EXCLUDE THE PUBLIC
(Resolution 24/18)
(Moved Elinor Stratford/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, 8 & 9 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 28 September 2018	For the reasons set out in the previous Board agenda.	
2.	New Facility Wayfinding & Naming	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
3.	2018/19 IEA Remuneration Strategy	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
4.	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)
5.	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)
6.	Risk Management Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)

7.	People Report	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)
8.	Report from QFARC Committee	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
9.	Final Draft Annual Plan	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";

There being no further business the public open section of the meeting closed at 1.30pm

The Public Excluded section of the meeting commenced at 1.30pm and concluded at 2.40pm

_____ _____

Jenny Black, Chair Date

WEST COAST DISTRICT BOARD – BOARD MEETING
CARRIED FORWARD/ACTION ITEMS AS AT 14 DECEMBER 2018

	DATE RAISED/ LAST UPDATED	ACTION	COMMENTARY	STATUS
1.	10 August 2018	Presentation re Digital Systems	It was determined that it would be useful for the Board to receive a presentation on Digital Systems on the West Coast.	Early 2019
2.	2 November 2018	Disability Steering Group	The Alliance Leadership Team requested that the Board consider the extension of the Canterbury Disability Steering Group to include West Coast membership. Some work to come back to a future meeting.	February Meeting

CHIEF EXECUTIVE'S UPDATE

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

SOURCE: **Chief Executive**

DATE: **14 December 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.

	DELIVERING COMPREHENSIVE STABLE AND SAFE SERVICES IN THE COMMUNITY

A: Reinvigorate the West Coast Health Alliance

These key messages include examples of the Alliance leveraging our integration with Canterbury and the rest of the South Island to progress local development in areas of need. At their last meeting in November the Alliance Leadership Team (ALT):

- Endorsed the amended Oral Health Service Development Group Terms of Reference and 2018/19 work plan, subject to the inclusion of a West Coast ALT co-sponsor.
- Discussed the upcoming Hui between the South Island Regional Alliance and the local South Island Alliances to discuss how to improve regional engagement including information sharing and aligning planning to promote a greater awareness of related activities and strategic priorities across the South Island.
- Agreed to write a letter of support for a research proposal to investigate the impact of Alliancing across New Zealand.
- Noted the importance of dementia work across the whole health system and supported the work being done locally to develop more awareness and identification of this work.

B: Build Primary and Community Capacity and Capability

Primary

- **Integrated Health Services - Northern Region**
  - The Minister of Health visited on 19 November and announced to staff and the community the confirmation of the $20m investment in the new health centre for Westport.
  - Health Equity Assessment Tool (HEAT) training was delivered to Buller IFHS Workstream members.
  - Clinical documentation audit results in Foote Ward continue to improve. There has been positive staff feedback around the process.
- **South Westland Area Practice**
  - All South Westland clinics have achieved Cornerstone; Haast was accepted with the understanding of a pending new clinic.
  - Clinics are getting extremely busy with the influx of tourists.
  - Staffing has been a challenge as we continue to try to fill vacancies. A roving RNS will be starting mid January, however will require significant training to bring her up to the level required.
  - Recent bad weather caused some issues with roads being closed, but all staff worked according to the SWAP Business Continuity Plan guidelines.
- **Greymouth Medical Centre**
  - Recruitment – A RN has been appointed at GMC and commenced work at the end of November. A further 2 positions have been approved as part of the special funding from MECA negotiations and one of these positions has been offered to a NETP. The secondary services medical rostering team has been supporting the practice manager to cover gaps in the GP workforce over the last month, including looking to cover some unexpected gaps.
  - EMERGO Exercise Paitini has taken place with ongoing training of DHB teams to prepare for emergency events.
  - Public Health Nurses have joined the GMC team providing opportunities for the teams to work more closely together.

Community

- **Public Health/B4School/Vision Hearing**
  - *Public Health Nursing* – The PHN teams across the DHB are completing their years plan for HPV and HEADDSSS in the schools as the terms come to a close for 2018. It has been a successful year with some quality initiatives that have enhanced the service delivery, e.g. Buller boys 11-15 year olds support group and the same for the girls in the same age group as an after school group.
  - *B4School Service* – this service is in a positive position for achieving targets by the end of the financial year 2018/19 due to improvements in service delivery this year. Documentation has been reviewed and improved user friendly assessment gathering. As part of the management of screening for child obesity, nutritional services are now attending the "One Stop Shop" and this will provide positive and consistent messaging for parents and allow for this to be normalised for all 4 year olds and not the group screened as requiring referral. This becomes normal B4SC process.
- **District Nursing**
  - Workloads are consistent and demanding. A recent review of contacts versus nursing hours showed the busiest Grey District Nursing day in October 2018 as being 100

patient contacts delivered by the team.

- Review of data is currently being undertaken with reports versus duty roster and contacts all being reviewed for accuracy. Nurses are more aware of the importance of accurate data as these reviews are completed and outcomes discussed with the teams with a view to improvements. An excel sheet has been set up and the DN teams in Hokitika and Greymouth will start loading their daily workloads from the beginning of December following some training at the Regional DN meeting next week. This will generate a graph so closer insight to what is being done when, will be available.
- Meet and Greet continues with positive response and the inpatient and community teams working together for the best patient outcomes.

- **Clinical Nurse Specialists**
  - Poutini Waiora are holding some long term condition management events in Hokitika in November and some of our CNS team will be working alongside their staff in support. This is part of our closer working relationship that we have jointly been aiming for.
  - Our Diabetes CNSs, as part of the local diabetes team, met with the Diabetes Clinical Director from the Ministry of Health to discuss how our local services are progressing and potential future directions. We also received some very positive feedback on local results and learning in relation to diabetes quality standards.
- **Dental Service**
  - As part of the process for getting on top of our pre-school arrears, the Buller and Hokitika therapists, who have lower numbers in their area, will be spending time in Greymouth to support the Grey team.
- **Home Based Support Services**
  - HBSS are currently recruiting Support Workers coast-wide. Applicant numbers are adequate for the roles with applicant suitability being high.
  - The FIRST service is now firmly embedded within HBSS Buller.

C: Hauora Maori Update

- **Takarangi Cultural Competencies:** Our last report noted there were a number of portfolios coming through for assessment and these were all of a very high standard. The team continues to work hard to support trainees through the portfolio process. Moe Milne and Takarangi Assessor Jo Anne Morris have been to Tai Poutini and undertaken assessments of those who have completed the first stage of their portfolios. Feedback has been positive and they were generally completed to a very high standard. It must be acknowledged that Julie Lucas, Nurse Manager Clinical Services Operations was one of a group of staff who recently completed five of the necessary competencies towards her portfolio; Moe was particularly impressed with Julie's portfolio and she has subsequently been approved as an Assessor for the Takarangi framework. Our abstract submitted to the National Rural Health Conference being held in Blenheim in April 2019 has now been accepted. The focus of this will be to share early experiences of introducing the Takarangi competency framework.
- **Maori Mental Health Review:** The Maori mental health review paper was submitted to the EMT and approved to go out to stakeholders for further feedback. We are awaiting final recommendations of the Mental Health and Addiction Inquiry report which is expected late December.
- **Cancer pathway:** In October Dr Melissa Cragg visited Greymouth and provided several workshops focused on improving health literacy with regards to Maori and cancer. She

delivered to Grey Medical, High Street Medical and Poutini Waiora. The presentation covered; health literacy, cultural competency, cultural safety and whanau experience. We will continue to work with primary care to deliver these messages as a regular event.

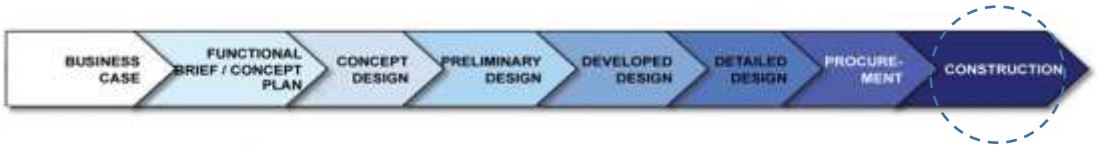
- **Maori Pregnancy and Parenting Programmes:** Work to develop a pathway for pregnant Maori wahine to participate in a kaupapa Māori labour, birth and parenting programme designed for young pregnant women and their families/whānau is underway. This programme is being developed in partnership with Poutini Waiora and is in response to very low numbers of Maori accessing Pregnancy and Parenting Education.
- **Hauora Maori Health Workforce New Zealand 2018 Training Fund:** The 2018 Hauora Maori Training Fund is close to completion. This fund is available to applicants who show a commitment to developing formal competencies in their current roles. People were encouraged to apply to complete a clinically and culturally focused NZQA accredited certificate relevant to a Maori work setting. We have had success this year with our applicants graduating with Diplomas and Certificates in Level 5 Whanau Ora under Tipu Ora, Social Work papers at Massey and a Bachelor of Business is being worked through. Funding requests and applications have been sent out to all appropriate areas for 2019 funding requests.

	DELIVERING MODERN FIT FOR PURPOSE FACILITIES

A: Facilities Maintenance Report

- The protected pohutukawa tree at Grey hospital has been pruned and assessed by an arborist. It is now safe to be underneath and it is expected to fill out and grow back in time.
- The Grey Hospital Pedestrian Bridge has been lifted onto site and design sign off for the altered access is with Opus and the Grey District Council.
- Buller complex has received its annual Building Warrant of Fitness
- Grey District Council approval for a 45 year extension on the now permanent container housing the Main Switchboard is still awaiting confirmation.
- The relocation of the laundry and medical records to the old garage area has affected our ability to comply with Hazardous Substances and New Organisms regulations for the diesel tank due to its proximity to the building. An application for an exemption has been lodged with Worksafe and is being processed.
- Boiler No 1 has passed visual inspection on its final Annual Survey with steam pressure testing to de done in December
- Two more steam leaks have been repaired during November in Grey Base as has a hot water feed pipe which ruptured during the night under the Reefton Hospital Medical wing.

B: Partnership Group Update



Grey

- Fletcher is currently projecting a hospital and IFHC handover date for March 2019.
- The external cladding on the building is taking shape and is progressing well with Nu wall

and tile installation continuing to be installed. Note, these external cladding materials are part of a façade build-up that includes a rain screen, which has already been installed meaning the building is weather tight.

- The Vacuum Insulated Evaporator (VIE) tank area which holds the oxygen supply for the hospital is progressing well and the tank will be installed in the coming weeks.
- The boiler house work onsite is progressing well and in ground service connections between the boiler house and the main build continue.
- As the IFHC is close to completion this area has been locked down with restricted access in preparation for commissioning.
- The maternity area and the general ward are also well progressed with vinyl having been laid, doors installed, ceiling grid in place and walls painted. Additionally, the ensuite fixtures have been installed.
- The framing and preparation of internal walls in the radiology and pharmacy areas have now progressed and services are starting to be installed. Additionally, theatre linings are also installed.
- Significant work on site continues with the installation of electrical and mechanical services and this is most evident with progress in the operating theatres.
- DHB procurement of furniture, fixtures and equipment is very well advanced and remains on track. All high risk items have been purchased and are in storage awaiting installation.
- Migration commissioning strategy work is ongoing with all parties progressing interface planning with existing services, such as the hospital generator, at the time of the move. Robust plans are being developed for the move. This work is inextricably linked with the migration planning for the move from the existing hospital to the new facility and migration planning meetings with all clinical and support services are underway.

Buller

- On 19 November, the Minister of Health visited the existing facility in Buller and announced the joint minister's approval of $20M for the Buller IFHC.

	RECONFIGURING SECONDARY AND TRANSALPINE SERVICES

A: Hospital Services includes Secondary Mental Health Services

Nursing

- Culture and Communication – Work is well underway to establish bedside handover. A trial has started in the surgical ward and will move to medical in December. A number of nurses have completed the first part of their Takarangi Competency portfolios. One senior nurse has become an assessor for the DHB. CNMs are working hard to ensure staff working with patients are well informed by attending staff handover and discussing the vision and values of the WCDHB and what is happening with the facilities. Following an extensive consultation period with staff, a new care plan has been implemented for trial throughout the WCDHB. This is to ensure consistency of documentation and ensures the patient has been included in their planned care. This will be audited in mid December to see if any changes need to occur before coming out of draft.
- Enabling Workforce – Work continues with the integration through telehealth between CCU and CDHB ICU. The new ventilator has arrived and training is underway. Staff from CDHB ICU intend to visit over the next few months to meet the team on the West Coast, build relationships and get a better understanding on how rural works.

- Clinical – Hospital services occupancy is slightly up from last month at 79%. Grey Base continues to work towards CCDM with a visit from the Safe Staffing Healthy Workplaces unit this month. Findings showed actualisation data had improved for Maternity, Kahurangi and IPU; staff within these areas attended IRR (Inter-Rater Reliability) training and this shows. We have seen a 40% decrease in overtime this month however casual hours have increased by 37%. This is due to relatively high sick leave and orientation of new staff with a 100% increase in orientation hours. The inpatient wards are now fully staffed for the first time this year. ED still continues to have vacancies with an increase of triage two and three presentations.

Medical

- We have interest in our general surgery vacancy but little interest in the physician vacancies. We are working with two clinicians around RHM vacancies looking to a start date in early 2019.
- The RMO recruitment has been successful for 2019 and continues to remain strong with continued interest from RMOs; however continued RMO shortages in CDHB have led to one of our CBA RMOs remaining in Christchurch for the coming quarter.

Allied Health

- The Allied Health, Scientific and Technical workforce are excited to welcome our new Executive Director, Jacqui Lunday-Johnstone who joined the West Coast and Canterbury DHBs at the beginning of November.
- The MoH has also announced the appointment of the first Chief Allied Health Professions Officer this month; our colleague from the Bay of Plenty DHB, Martin Chadwick. The West Coast works closely with Martin and his rural Allied Health Services as well as in the Technologies spaces, so we look forward to Rural Allied Health being well represented at the Ministry. Martin commences in the role next February.
- Our recent new graduate recruitment for Physiotherapy has seen three offers accepted to join our team in the New Year. This will bring a change to the way we structure our first year of practice programme for the physios, with one rotation for each new graduate based at the Buller Integrated Family Health Service.
- We are also recruiting for new graduate Occupational Therapists and Social Workers and are working to partner with the nursing workforce team to deliver new graduate orientation and training in inter-professional ways. This will further formalise the collaborations Allied Health and Nursing have fostered at our DHB and we hope to work with Otago University to capture the progress and learnings over the next year.
- The transalpine Allied Health leaders continue to develop the RUFUS (rurally focused urban specialist) model of service delivery for all of our Child Development Services. This means that experienced clinicians, both from CDHB and from WCDHB, can support their transalpine colleagues to deliver the specialist care required for this high needs client group. A recent secondment of Janette Balfe, Ashburton Allied Health Manager, to our services has opened up further opportunities to clearly articulate and establish RUFUS as a core feature of rural health care delivery both here and in CDHB rural areas.
- Work continues on the ePharmacy programme that will align the electronic medication management systems with the SI regional plan. This piece of work is crucial due to the current system Windose no longer being supported technically.
- The last key task before the holiday season will be a whole of system hui to explore how Restorative and Rehabilitative care should be delivered on the West Coast. Facilitated by Brian Dolan from People and Capability (check out the #endPJparalysis movement on social media) and sponsored by Karyn Bousfield (DON) and Jane George (ADAH) this day

is set to challenge and inspire us to ensure our services really honour our communities needs and goals.

- The Allied Health workforce and leaders would like to thank the Board for all their support and guidance this year and wish you all happy holidays.

Mental Health

- **Operational Excellence**
  - Mental Health Services as a whole are working towards the accreditation process that takes place in February. All teams are actively engaged and good progress is being made.
  - Transition planning training is being delivered to staff and the focus is on increasing the numbers and quality of transition plans in place for clients.
  - Documentation of care pathways, processes and procedures continues within the CAMHS service; again progress is steady and positive.
  - Additional support is being brought in for the Rata AOD service due to continued high levels of referrals; this commences during December and will remain ongoing until recruitment processes have been completed.
  - The Kahurangi unit continues to implement changes to meet the ARC requirements; good progress has been made to date.
  - The Clinical Nurse Manager role for the Kahurangi unit is currently being advertised and it is anticipated interviews will take place in early December.

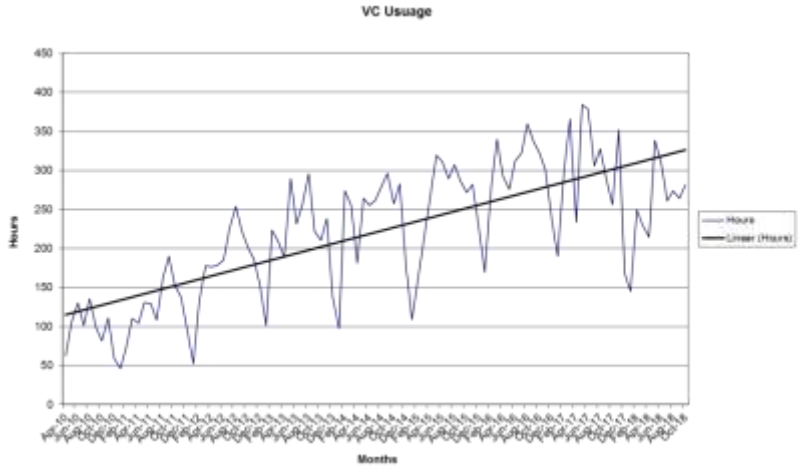
	DEVELOPING TRANSPORT AND TELEMEDICINE SERVICES

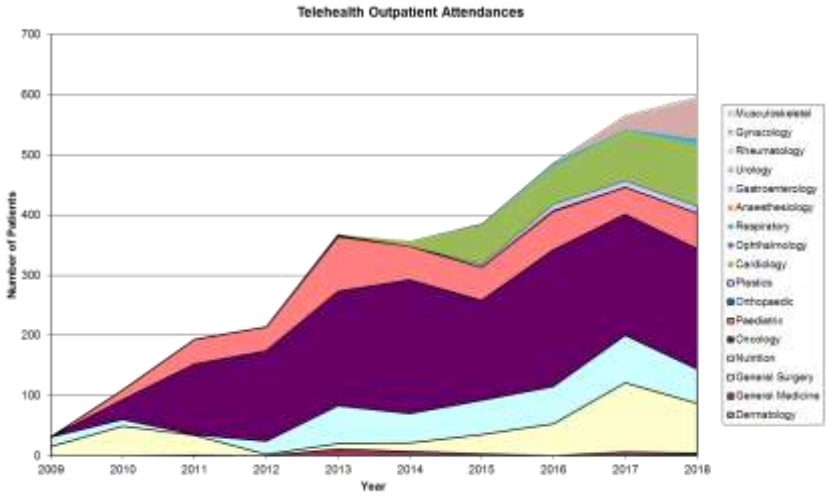
A: Improve Transport Options for Patient Transfers

- The following transport initiatives are in place to support the safe transfer of patients:
  - St John community health shuttle to assist people who are struggling to get to health appointments in Greymouth.
  - Non-acute patient transport to Christchurch through ambulance transfer.
  - The extension of the Buller Red Cross contract, to provide a subsidised community health shuttle transport service between Westport and Grey Base Hospital, through to August 2020.
- Telehealth continues to be an option supported throughout the West Coast to reduce unnecessary patient travel and the DHB recently participated in the National Telehealth Survey to add support for this service.
- The Minister of Health approved the National Travel Assistance Policy Review Report in late November. The Ministry will need to agree the next steps; this will likely occur in the New Year. Final decisions about adoption, funding and implementation of the proposed changes put forward will then 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

- Telemedicine technology has been used for a geriatrician consult with a patient from the community for the first time, with great success. Now that the process has been tested it can be rolled out further - saving patient and specialist time.
- ACC has approved the West Coast DHB's submission for our early supported discharge service (FIRST) as meeting their funding criteria. FIRST provides people with a short period (up to 6 weeks) of intensive rehabilitation so they are able to regain their functionality after an injury or illness. This service supports people to remain at home for longer. Having met the ACC criteria means the West Coast DHB can now claim a daily rate for ACC patients in the community who are receiving support from the FIRST 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 October 2018 was a deficit of $815k, which was $150k unfavourable to draft budget. The year to date net deficit of $1,806k is $311k favourable to budget as included in the latest draft annual plan.

	Monthly Reporting			Year to Date		
	Actual $'000	Budget $'000	Variance $'000	Actual $'000	Budget $'000	Variance $'000
Governance Arm	(177)	(150)	(27)	(614)	(607)	(7)
Funder Arm	(604)	33	(637)	245	158	87
Provider Arm	(34)	(548)	514	(1,437)	(1,668)	231
Consolidated Result	**(815)**	**(665)**	**(150)**	**(1,806)**	**(2,117)**	**311**

B: Effective Clinical Information Systems

- **eReferrals:** Stage 3 – electronic triage: eReferrals Stage 3, eTriage has gone live for ten services including Plastics, Gynaecology, General Surgery, General Medicine, Diabetes, Nutrition, Podiatry, Cardiology and Neurology, with Dermatology going live in September. Sacoma, Neurosurgery and Nephrology is scheduled for December. Planning is underway for ENT, Urology, Rheumatology, Orthopaedics, Paediatrics and Physiotherapy.
- **New Facility Work:** The new fibre optic cable has been installed into the new facility. The computer hardware which allows ISG to move its services over into the new build has now been ordered. The wireless capex request has been approved. Next focus areas are printing devices, ordering of telephone handsets, ordering of wireless equipment and completion of Audio Visual capex request.
- **Telehealth Replacement:** The new TeleHealth system is progressing slowly. Contract negotiations to allow integration with legacy provider has been completed. Implementation of the system has struck a number of technical issues but these are nearly resolved. Daily project meetings occurring to keep progressing.
- **Patient Trak:** The electronic nursing observation tool, Patient Trak, widely deployed within the CDHB is now also being deployed into WCDHB. Mobile devices have arrived on site and orders are about to be raised for wireless components. Cabling completed for Buller.
- **eOrders:** Scoping is underway with the implementation of radiology eOrders. This will allow a safer process for ordering of radiology tests, allowing clinical staff to order electronically and then providing electronic sign-off.
- **Titanium:** Capex request being prepared for the implementation of Titanium dental software into WCDHB for both hospital based dental treatment and community. This will be a multi phased project with the initial capex request focused on the Titanium software and a future capex request providing for digital scanning.
- **Microsoft Licensing:** WCDHB has been part of the All of Government 2018 Microsoft negotiation which has now completed successfully. The benefits to WCDHB are both strategically and tactically significant. Strategically it will allow a cost effective and smoother migration to cloud based services in the medium to long term. Tactically WCDHB will be able to upgrade its Microsoft Office productivity suite to a more modern and compatible version.

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

- **Proactive Media Releases**
  - Hospital-Based Midwives Industrial Action
  - West Coast DHB announces name of new health facilities in Greymouth
  - Avoiding a Legionnaires' Spring Spike

- **Media Responses**
  - Greymouth Medical Centre appointment wait times
  - GP recruitment at Buller Health
  - Buller Health announcement
  - Patients being moved from Kahurangi back to rest homes
  - The recent West Coast case of paratyphoid
  - Latest concept designs for the planned Buller Health facility
  - Median times that people live after entering a rest home
  - Recruitment of Community-based Diversional Therapist in Westport
- **Social media posts**
  - Mental Health Awareness week promotions
  - Cyber Security Awareness week promotions
  - Patient Safety week promotions
  - Expressions of interest for West Coast Alliance chairperson vacancy
  - Expressions of interest for Consumer Council vacancies
- **Publications**
  - CE Update – 12 November 2018
  - Public notice: Consumer Council vacancies (West Coast Messenger)

	PROMOTING HEALTHY ENVIRONMENTS AND LIFESTYLES

Key Achievements/Issues of Note

- **Pertussis:** A New Zealand-wide pertussis outbreak was declared in September 2017. We first started to see an upsurge in pertussis cases on the West Coast in February of this year, initially in the Buller District, though there have now been cases in all three districts. The region still has higher than our usual inter-epidemic levels of pertussis activity and our notification rates are currently the highest in NZ. There have been 137 cases from October 2017-September 2018, with 17 more in October and 19 so far in November.
- **Drinking Water:** West Coast Councils have received their reports from the Annual Drinking Water Compliance Survey. CPH's Drinking Water Assessor has requested information from the councils on how they plan to address non-compliances. The Drinking Water Assessor and Medical Officer of Health had a follow up meeting with water staff and the CEO at Westland District Council last month and we will be having a similar meeting in the Buller district early in December. The purpose of these meetings is to ensure that each council has a clear plan of action with timelines for achieving full compliance with the Drinking Water Standards for New Zealand and the Health Act's drinking water provisions.
- **Nutrition:** CPH welcomed a new nutrition health promoter, Heather Allington, to their team last month. This is a fixed term position for one year and strengthens the ability to deliver on the Ministry and West Coast DHB nutrition contracts. CPH's nutrition health promoters supported Poutini Waiora in Kawatiri with the delivery of Ko Wai Ahau, a 10 week programme for 10-12 rangatahi who have been through youth justice or Oranga Tamariki. Our staff worked with the students and delivered cooking and nutrition sessions which were well received by these rangatahi. We have also run two more early childhood nutrition workshops which reached 13 parents and caregivers from target groups in Westport. An Appetite for Life course has been run in Greymouth, with 14

participants completing the course who were primarily referred through a local personal trainer and primary care.

- **Smokefree and Alcohol:** CPH has also welcomed a new health promoter, Sarah Wilson, who joined us in October. She will be working in the area of alcohol and smokefree. Sarah is working with the Events Manager for the Wildfoods Festival to help make the event Smokefree and developing a Smokefree policy with them. Our Alcohol Licensing Officer has been working with Police and District Licensing Inspectors (collectively termed the tri-agencies) to report on special licence applications for the annual race meetings held in various locations across the Coast over summer. The tri-agencies are in the process of meeting with applicants to ensure that they have alcohol harm reduction measures in place such that punters can have a good day out at these popular community events without alcohol-related harm.
- **Gaming Machine Gambling:** In Buller, there has been an application by the Youthtown Trust for new gaming machine venue with nine machines in one of the local hotels. There are already two gaming machine venues in Reefton with 15 machines between them. The population of Reefton is just over 1,000 and this means that there is already 1 gaming machine for every 68 people. If the application is granted there will be 1 for every 43 people. The current council policy (which was due for review this year but has not yet been reviewed) would allow this. CPH, as part of Active West Coast, has contributed to an objection to this application.

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

Approved for release by: David Meates, Chief Executive

West Coast DHB national performance measures report

Quarter 1 2018/19: July - September 2018

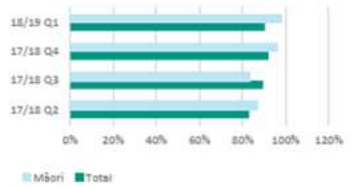
Dashboard Indicators

This report presents current performance against the national performance measures formerly referred to as national health targets. A new set of high-level measures are being developed, however these have not yet been released.

These measures still reflect West Coast's performance in areas of significant public and government interest and continue to be tracked by the Ministry as part of the DHB's quarterly performance reporting suite. The targets remain in place. We will continue to present performance across these priority areas. Three of the measures focus on patient access and three focus on prevention.

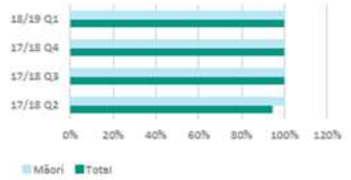
Supplementary indicators

Better help for smokers to quit: secondary smoking



This measures reflects patients in our hospitals, identified as smokers, being offered advice and help to quit smoking.

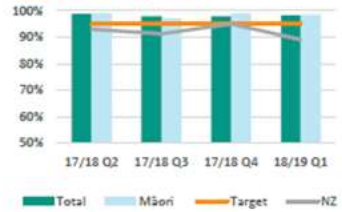
Better help for smokers to quit: maternity smoking



The Ministry sources this data for DHBs from the national Maternity Data Set. It should be noted that the source of the data only represents around 80% of all pregnancies nationally and the measure is still considered developmental. Results are provided for

Shorter stays in ED — 98%

*Patients admitted, discharged or transferred ED within six hours. Target: **90%***



The West Coast continues to achieve the national ED target, with 98% of patients admitted, discharged or transferred from ED within six hours during quarter one.

Improved access to elective surgery — 105%

Patients receiving planned surgery
*Year-end target: **1,916***

The West Coast DHB provided 490 elective surgical discharges, higher than anticipated, delivering 105% of planned discharges for quarter one.

Faster cancer treatment — 72%

*Patients getting their first cancer treatment within 62 days. Target: **90%***

This quarter 72% of patients received treatment on time. Small numbers are challenging with this result reflecting only three patients who were not seen within the 62 day period.

A breach analysis is underway and every non-compliant case is individually followed up. Most non-compliant cases are physically, psychologically, or diagnostically complex.

Increased immunisation — 77%

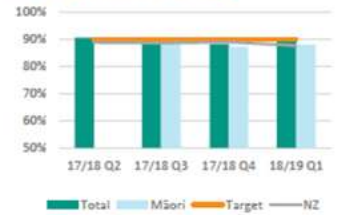
Eight-month-olds fully immunised

Five children were missed this quarter, a drop in performance compared to last quarter.

Overall, 94% of eligible (consenting) 8-month-olds were fully immunised. Strong results were achieved for Asian (100%) children.

Better help for smokers to quit — 90%

*Patients in the community who smoke are offered help to quit. Target: **90%***



West Coast health practitioners have reported giving 4,723 smokers cessation advice in the 15 months ending September 2018. This represents 89.8% of smokers against the 90% target.

Maori rates were also high with 88% of Maori smokers offered advice and support to quit in the past quarter.

Raising healthy kids — 89%

Children with obesity referred for support
*Target: **95%***

In quarter one, 17 children were identified as obese and offered referrals for support. Eleven were acknowledged with one child already under care. Three families declined.

Two referrals were acknowledged outside of the 30 day target. Both were to the same primary care practice and follow up education regarding the target has been provided. Both children have since been seen at the practice.

Produced by Canterbury and West Coast DHB Planning and Performance team. PTO for data definitions.

CLINICAL LEADERS UPDATE

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

SOURCE: **Clinical Leaders**

DATE: **14 December 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

Care Capacity Demand Management

As part of the District Health Board Nurses MECA agreement an Accord was signed by The New Zealand Nurses Association (NZNO) District Health Boards (DHBs) and the Director General of Health.

The purpose of the Accord is to record the commitment and assurance of the Parties to ensure that staffing levels for nurses and midwives employed DHBs are safe, and to describe the actions that are to be taken. A significant portion of this includes a commitment to the effective implementation and monitoring of Care Capacity Demand Management (CCDM) to address workforce issues.

Attached are two documents for information. The first is the CCDM programme overview from the CCDM website, and the second is the WCDHB CCDM high level plan. The below link takes you to the formal CCDM website where more detailed information is available:

https://www.ccdm.health.nz/

The WCDHB is in a good position to fully implement CCDM with an acuity tool being well utilised (TrendCare) and robust data available in the areas where the tool is appropriate. We have a TrendCare Coordinator in place, and are currently advertising for a CCDM Coordinator to supplement the roll out of the programme over the next 12 months.

The Board will be kept up to date with progess.

4. CONCLUSION

The Clinical Leaders will continue to work across a range of activities to promote a sustainable West Coast health care service.

Report prepared by: Clinical Leaders

Care Capacity Demand Management Programme

The CCDM programme has a set of tools and processes

CCDM stands for Care Capacity Demand Management. The CCDM Programme is a set of tools and processes that help DHBs better match the capacity to care with patient demand. The goal is quality patient care, quality work environment and best use of health resources.

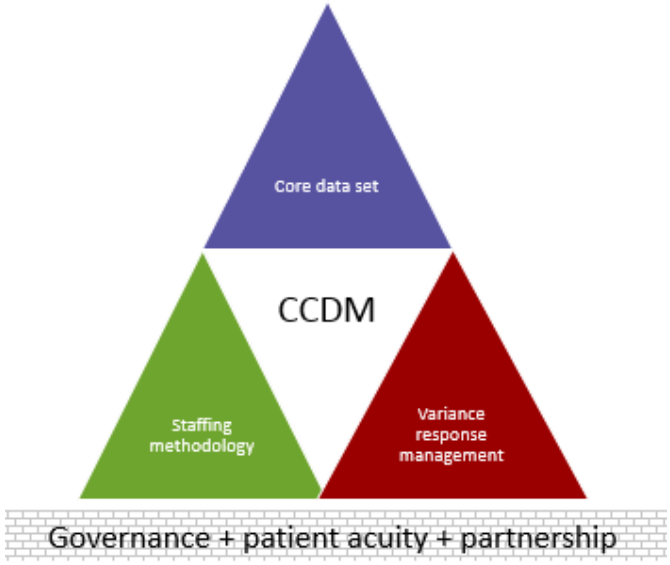
Safe staffing, healthy workplaces is a national priority. Patient care and staffing change every shift, every day. Matching capacity with demand needs consistent, focused attention. Front line staff, managers, executives, health unions and professional leaders all have a role to play. CCDM is a whole of hospital approach for managing capacity to care on a permanent basis.

The CCDM programme is built on a foundation of governance, patient acuity and partnership. Governance provides the operational structure in partnership with the health unions to coordinate CCDM. Patient acuity is the hours of care needed by patients. Staff can then be allocated to meet those hours of care. Partnership refers to the DHB and health union working actively together to achieve staff staffing, healthy workplaces. These three foundations need to be in place for the success of the programme.

The CCDM programme has several components

The CCDM programme has 3 other components – core data set, staffing methodology and variance response management. Each component is dependent on the other to achieve the programme goals - quality patient care, quality work environment and best use of health resources. The core data set is a set of measures for monitoring how you are doing. The staffing methodology has tools for establishing acuity based staffing. Variance response management assists DHBs to respond to variance in the moment and over time.

The programme has a set of standards. In order to meet the standards programme implementation needs to be prioritised, appropriately resourced and sequenced. The Programme Consultants from the Safe Staffing Healthy Workplaces (SSHW) Unit are available to support you using the tools and processes. They are also experts in sequencing CCDM programme implementation. There are roadmaps for each of the programme components. They provide detailed directions and identify intersections between the components. The journey starts with establishing CCDM governance.



WEST COAST DHB CCDM high level plan – key deliverables

Standard	No.	Key deliverables	Timelines
1.0 Governance The CCDM governance group (organisation and ward/unit) ensure that care capacity demand management is planned, coordinated and appropriate for staff and patients.	1	In accordance with CCDM Programme Standard 1.0 – CCDM Governance and utilising the process documented in the CCDM Governance roadmap including and initial evaluation of partnership we will establish the WCDHB CCDM Council. This will include agreeing CCDM council membership, Terms of Reference (TOR)and implementing Regular CCDM Council meetings	April 2019 timed with the move to the new facility
	2	The TrendCare Coordinator role will be supported to transition into the CCDM Coordinator role as the programme is implemented with the partners agreeing the appropriate level of FTE to be applied to this position to ensure it can be effective in supporting full implementation of the CCDM Programme by June 2021	April 2019 timed with the move to the new facility
	3	We will formalise the partnership and undertake planned workshops to agree the partnership relationship	November 2018
	4	A robust communication plan will be developed and implemented to all ensure staff receive education and information regarding CCDM and the importance of TrendCare data to programme success	November 2018
2.0 Patient acuity The validated patient acuity tool underpins care capacity demand management for service delivery.	1	In accordance with CCDM Programme Standard 2.0 –Validated patient acuity tool WCDHB will establish TrendCare data accountability at every level of the DHB. This will ensure TrendCare data accuracy and the data utilisation of the data as a trusted information source to base CCDM activity and measure DHB CCDM performance	ongoing
	2	The planned upgrade will be implemented as per the upgrade cycle	August 2018

	3	The TrendCare Coordinator and the WCDHB TrendCare Steering Committee will continue to oversee improvement in and appropriate use of the tool according to the current TrendCare Gold Standards. The DHB will undertake continuous improvement to TrendCare utilisation as per an agreed TrendCare Improvement Plan which includes ongoing Inter Rater Reliability (IRR) testing	Ongoing
	4	We will ensure the acuity tool remains a priority for the DHB, and the ISGG group continues to support and be an active member of the CCDM governance process	Ongoing
3.0 Core data set The organisation uses a balanced set of CCDM measures (core data set) to evaluate the effectiveness of care capacity and demand management overtime and to make improvements.		The CCDM Core data set project plan will be developed and agreed in accordance with CCDM Programme Standard 3- Core data set and utilising the process documented in the CCDM Programme Core data set roadmap	May 2019
	1	We will set up ward based local data councils, develop TOR, and implement workshops.	September 2018
	2	Establish the core data set	May 2019
	3	The Core Data Set will be reviewed in partnership by the WCDHB CCDM Council at every Council meeting. The data set will be used as the basis for organisational CCDM decision making, activity and performance measurement	Ongoing
4.0 Staffing methodology A systematic process is used to establish and budget for staffing FTE, staff mix and skill mix to ensure the provision of timely, appropriate and safe services.	1	Review current Staffing Methodology and complete activity in accordance with CCDM Programme Standard 4-Staffing methodology and utilising the process documented in the CCDM Programme Staffing Methodology roadmap	November 2019
	2	Full implementation of agreed CCDM staffing recommendations following implementation of the CCDM staffing methodology will be undertaken to ensure staffing realignment in the new facility	November 2019
5.0 Variance response management The DHB uses a variance response management system to provide the right staff numbers, mix and skills at all times for effective patient care delivery.	1	We will review and update WCDHB VRM tools and processes in accordance with CCDM Programme Standard 5-Varience response management and utilising the process documented in the CCDM Programme Variance Response Management roadmap including Smart 5's and current escalation plans that are already in place	November 2019

Opportunities Discovery report will be completed We will need to re-embed and familiarise staff across the District Health Board of the CDDM programme and refresh TrendCare Champions The WCDHB will continue to be connected to the SSHW unit, through formal and informal channels – phone calls as required. The agreed plan is to roll out CCDM fully when we are in the new Greymouth facility in early 2019. During the intervening time we continue to work towards embedding as many elements of CCDM that we can with the support of a dedicated Programme Consultant from the SSHW Unit. Our focus remains on data accuracy, variance management and workforce development to ensure confidence, competence and appropriate skill sets to support the flexible approach to staffing. We look forward to utilising the SSHW Unit software for FTE Calculations with dedicated support from the SSHW Unit . Using the 23 measures for Core Data Set.
Challenges: Moving into the new facility in 2019 will be challenging with the need to assimilate into the new building, finishing the refining of models of care and new ways of working, while fully implementing CCDM. However, while a challenge this will be very welcome by the teams. Our focus also remains in the challenge of ensuring all staff are IRR tested by full CCDM implementation, and the embedding of this important component. From a workforce perspective, we have ongoing challenges with skill mix due to small teams and a number of senior staff changing roles or moving overseas.

FINANCE REPORT

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

SOURCE: **Executive Director, Finance & Corporate Services**

DATE: **14 December 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 31 October 2018.

3. DISCUSSION

Overview of October 2018 Financial Result

The consolidated West Coast District Health Board financial result for the month of October 2018 was a deficit of $815k, which was $150k unfavourable to draft budget. The year to date net deficit of $1,806k is $311k favourable to budget as included in the latest draft annual plan.

	Monthly Reporting				Year to Date				Full Year 18/19
	Actual	Budget	Variance	%Var	Actual	Budget	Variance	%Var	Budget
Operating Revenue									
Crown and Government sourced	11,523	11,891	(368)	(3.1%)	47,467	47,558	(91)	(0.2%)	143,217
Inter DHB Revenue	0	0	0	0.0%	1	0	1	0.0%	0
Inter District Flows Revenue	231	145	86	59.3%	666	581	85	14.6%	1,735
Patient Related Revenue	572	595	(23)	(3.9%)	2,276	2,361	(85)	(3.6%)	6,860
Other Revenue	78	63	15	23.8%	237	244	(7)	(2.9%)	740
Total Operating Revenue	12,404	12,694	(290)	(2.3%)	50,647	50,744	(97)	(0.2%)	152,552
Operating Expenditure									
Personnel costs	5,398	5,862	464	7.9%	22,822	23,003	181	0.8%	69,123
Outsourced Services	0	0	0	0.0%	0	0	0	0.0%	0
Treatment Related Costs	696	660	(36)	(5.5%)	2,467	2,620	153	5.8%	7,750
External Providers	3,490	3,392	(98)	(2.9%)	13,299	13,538	239	1.8%	40,523
Inter District Flows Expense	1,874	1,870	(4)	(0.2%)	7,493	7,482	(11)	(0.2%)	22,455
Outsourced Services - non clinical	135	111	(24)	(21.6%)	466	446	(20)	(4.6%)	1,334
Infrastructure and Non treatment related costs	1,049	998	(51)	(5.1%)	4,028	3,909	(119)	(3.1%)	12,566
Total Operating Expenditure	12,642	12,893	251	1.9%	50,576	50,998	422	0.8%	153,751
Result before Interest, Depn & Cap Charge	(238)	(199)	(39)	19.6%	71	(254)	(325)	128.0%	(1,199)
Interest, Depreciation & Capital Charge									
Interest Expense	0	0	0	0.0%	0	0	0	0.0%	0
Depreciation	452	341	(111)	(32.6%)	1,377	1,364	(13)	(0.9%)	3,400
Capital Charge Expenditure	125	125	0	0.0%	500	500	0	0.0%	1,488
Total Interest, Depreciation & Capital Charge	577	466	(111)	(23.8%)	1,877	1,864	(13)	(0.7%)	4,888
Net Surplus/(deficit)	(815)	(665)	(150)	(22.6%)	(1,806)	(2,117)	311	14.7%	(6,087)
Other comprehensive income									
Gain/(losses) on revaluation of property									
Total comprehensive income	**(815)**	**(665)**	**(150)**	**(22.6%)**	**(1,806)**	**(2,117)**	**311**	**14.7%**	**(6,087)**

in thousands of New Zealand dollars

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

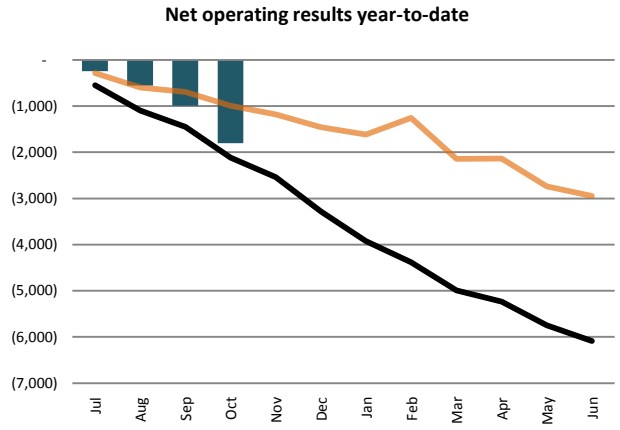
Report prepared by: Justine White, Executive Director, Finance & Corporate Services

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – OCTOBER 2018

Net operating results

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	(815)	(665)	(150)	23% ✗	(1,806)	(2,117)	311	-15% ✓



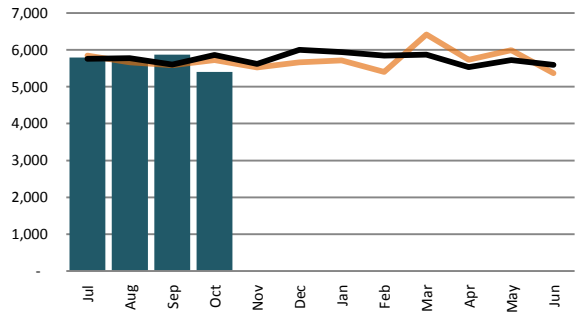
Over the last few financial years West Coast DHB has been in the process of implementing our new model of care in readiness for our new Grey Health Hospital/IFHC. Full implementation needs to be co-ordinated with the completion of the new facility. New ways of working need to be embedded before we move into the new facility. Our draft plan has been submitted based on the building being completed in the first quarter of 2019, delays in the rebuild not only increase the cost of the build (influencing out-years capital charge and depreciation costs), but will impact operational expenditure where we have either factored savings; or periods costs of embedding new models of care in our old facility in our draft plan. These efficiencies are at risk as the facilities delays continue, and will impact detrimentally on our planned financial results.

2018/19 YTD Actual 2017/18 YTD Actual 2018/19 YTD Budget

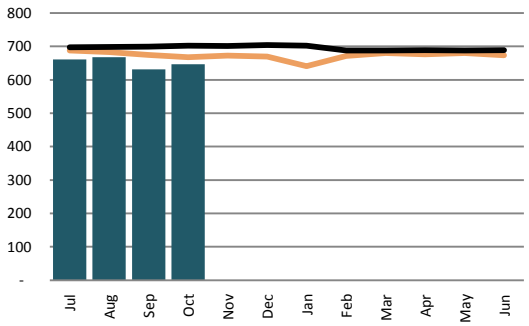
Personnel costs & FTE

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Medical	1,378	1,539	161	10%	✓	6,003	6,116	113	2%	✓
Nursing	2,543	2,545	2	0%	✓	10,139	9,945	(194)	-2%	✗
Allied Health	865	1,007	142	14%	✓	3,732	3,916	184	5%	✓
Support	75	98	23	23%	✓	374	388	14	4%	✓
Management & Admin	537	673	136	20%	✓	2,573	2,637	64	2%	✓
Total	**5,398**	**5,862**	**464**	8%	✓	**22,821**	**23,002**	**181**	1%	✓

Personnel costs (incl Locums)



Personnel FTE (accrued)



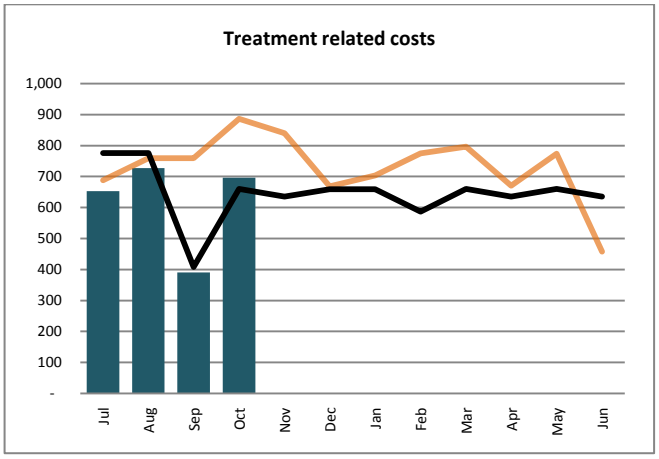
Although better use of stabilised rosters and leave planning has been embedded within the business, there remains reliance on short term placements, which are more expensive than permanent staff.

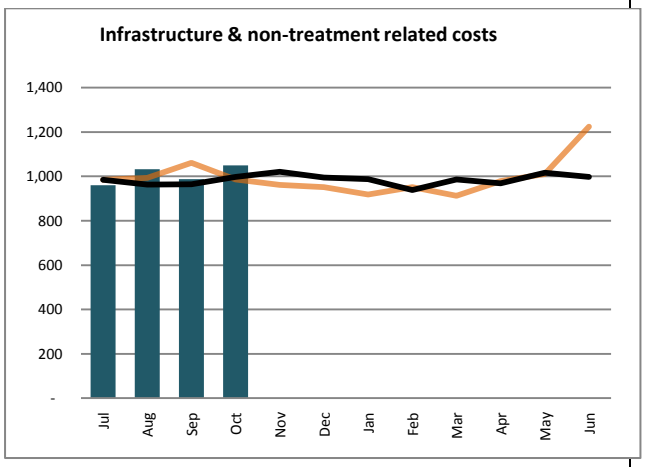
The Ministry of Health has a keen focus on ensuring DHBs do not exceed their management and administration staff FTE numbers. There are many ways FTE can be calculated, depending on the purpose. Using Ministry of Health calculations we remain under our overall management and administration staff cap. 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.

2018/19 YTD Actual 2017/18 YTD Actual 2018/19 YTD Budget

Treatment and non-treatment related costs

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Treatment related costs	696	660	(36)	-5% ✗	2,467	2,620	153	6% ✓
Non Treatment related costs	987	950	(36)	-4% ✗	4,025	3,868	(157)	-4% ✗





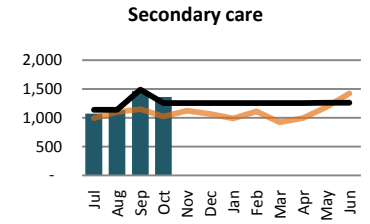
Treatment related costs favourable variance is driven from lower volumes of high cost pharmaceuticals and PCTs. It is still too early in the year to bank these YTD savings. Our DHB has low volumes of these types of drugs and if we have one or two patients prescribed these high cost medicines our pharmaceuticals cost will increase significantly.

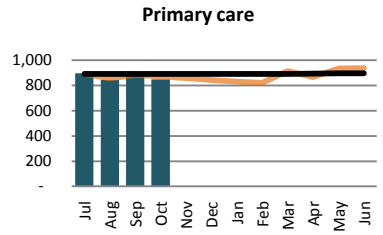
Overall we are continuing to monitor to ensure overspend in **non-treatment related costs** is limited where possible.

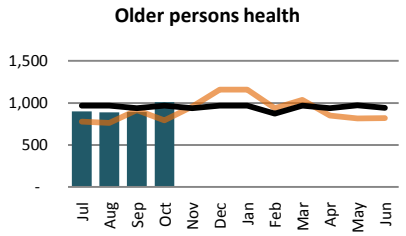
2018/19 YTD Actual 2017/18 YTD Actual 2018/19 YTD Budget

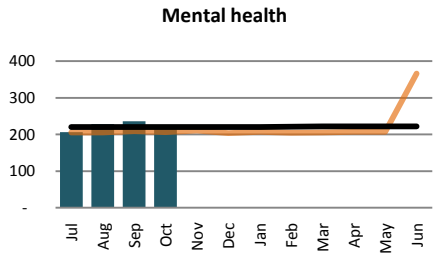
External provider & inter district flows costs

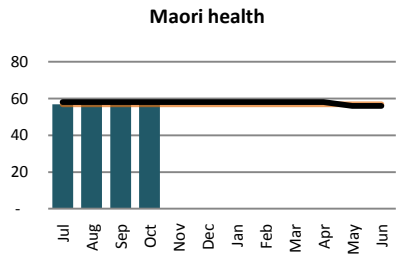
	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Secondary Care	1,362	1,256	(106)	-8%	✗	5,032	5,025	(7)	0%	✗
Primary Care	849	890	41	5%	✓	3,471	3,560	89	2%	✓
Older Person's Health	1,008	968	(40)	-4%	✗	3,684	3,841	157	4%	✓
Mental Health	214	220	6	3%	✓	884	880	(4)	0%	✗
Maori Health	57	58	1	2%	✓	228	232	4	2%	✓
IDF	1,874	1,870	(4)	0%	✗	7,493	7,482	(11)	0%	✗
Outsourced Clinical	135	111	(24)	-22%	✗	466	446	(20)	-5%	✗
Total	5,499	5,373	(126)	-2%	✗	21,258	21,466	208	1%	✓

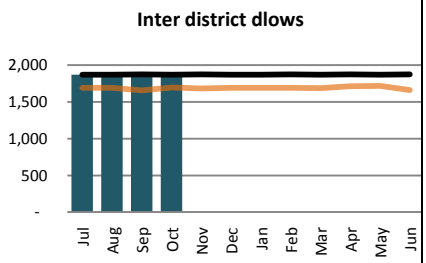












YTD Provider payments are showing a favourable result to draft plan of $208K. The favourable variance is mainly driven by lower bed occupancy in ARC facilities. This may turn around depending on a change in occupancy in ARC. Capacity constraints within the system require continued monitoring of trends and demand for services.

Financial position

	Month Actual $'000	Month Budget $'000	Month Variance $'000			Annual Budget $'000
Equity	23,903	23,591	312	1%	✓	100,302
Cash	11,200	10,381	819	8%	✓	10,630

The equity and cash position compared to budget reflect the delay in commencing the Grey Base rebuild. Our available cash is reflecting the artificial inflation due to the delayed capex spend due to the delay in the Grey rebuild.

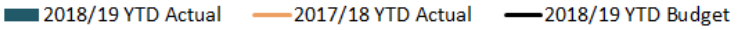
2018/19 YTD Actual 2017/18 YTD Actual 2018/19 YTD Budget

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

For period ending 31 October 2018

in thousands of New Zealand dollars

	Monthly Reporting				Year to Date				Full Year 18/19
	Actual	Budget	Variance	%Var	Actual	Budget	Variance	%Var	Budget
Operating Revenue									
Crown and Government sourced	11,523	11,891	(368)	(3.1%)	47,467	47,558	(91)	(0.2%)	143,217
Inter DHB Revenue	0	0	0	0.0%	1	0	1	0.0%	0
Inter District Flows Revenue	231	145	86	59.3%	666	581	85	14.6%	1,735
Patient Related Revenue	572	595	(23)	(3.9%)	2,276	2,361	(85)	(3.6%)	6,860
Other Revenue	78	63	15	23.8%	237	244	(7)	(2.9%)	740
Total Operating Revenue	12,404	12,694	(290)	(2.3%)	50,647	50,744	(97)	(0.2%)	152,552
Operating Expenditure									
Personnel costs	5,398	5,862	464	7.9%	22,822	23,003	181	0.8%	69,123
Outsourced Services	0	0	0	0.0%	0	0	0	0.0%	0
Treatment Related Costs	696	660	(36)	(5.5%)	2,467	2,620	153	5.8%	7,750
External Providers	3,490	3,392	(98)	(2.9%)	13,299	13,538	239	1.8%	40,523
Inter District Flows Expense	1,874	1,870	(4)	(0.2%)	7,493	7,482	(11)	(0.2%)	22,455
Outsourced Services - non clinical	135	111	(24)	(21.6%)	466	446	(20)	(4.6%)	1,334
Infrastructure and Non treatment related costs	1,049	998	(51)	(5.1%)	4,028	3,909	(119)	(3.1%)	12,566
Total Operating Expenditure	12,642	12,893	251	1.9%	50,576	50,998	422	0.8%	153,751
Result before Interest, Depn & Cap Charge	(238)	(199)	(39)	19.6%	71	(254)	(325)	128.0%	(1,199)
Interest, Depreciation & Capital Charge									
Interest Expense	0	0	0	0.0%	0	0	0	0.0%	0
Depreciation	452	341	(111)	(32.6%)	1,377	1,364	(13)	(0.9%)	3,400
Capital Charge Expenditure	125	125	0	0.0%	500	500	0	0.0%	1,488
Total Interest, Depreciation & Capital Charge	577	466	(111)	(23.8%)	1,877	1,864	(13)	(0.7%)	4,888
Net Surplus/(deficit)	(815)	(665)	(150)	(22.6%)	(1,806)	(2,117)	311	14.7%	(6,087)
Other comprehensive income									
Gain/(losses) on revaluation of property									
Total comprehensive income	**(815)**	**(665)**	**(150)**	**(22.6%)**	**(1,806)**	**(2,117)**	**311**	**14.7%**	**(6,087)**



APPENDIX 3: WEST COAST DHB STATEMENT OF FINANCIAL POSITION

As at 31 October 2018
in thousands of New Zealand dollars

	Actual	Budget	Variance	%Var	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	24,099	24,574	(475)	(1.9%)	25,341
Intangible assets	562	436	126	28.8%	446
Work in Progress	5,292	4,796	496	10.3%	4,796
Other investments	605	519	86	16.6%	519
Total non-current assets	30,558	30,325	233	0.8%	31,102
Current assets					
Cash and cash equivalents	11,200	10,381	819	7.9%	11,724
Patient and restricted funds	53	54	(1)	(1.9%)	54
Inventories	1,084	1,058	26	2.5%	1,058
Debtors and other receivables	3,471	3,726	(255)	(6.8%)	3,725
Assets classified as held for sale	0	0	0	0.0%	0
Total current assets	15,808	15,219	589	3.9%	16,561
Total assets	46,366	45,544	822	1.8%	47,663
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Employee entitlements and benefits	2,538	2,443	(95)	(3.9%)	2,443
Other	71	71	0	0.0%	71
Total non-current liabilities	2,609	2,514	(95)	(3.8%)	2,514
Current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Creditors and other payables	8,829	8,503	(326)	(3.8%)	8,503
Employee entitlements and benefits	11,025	10,936	(89)	(0.8%)	10,939
Total current liabilities	19,854	19,439	(415)	(2.1%)	19,442
Total liabilities	22,463	21,953	(510)	(2.3%)	21,956
Equity					
Crown equity	85,994	85,994	1	0.0%	85,994
Other reserves	25,681	25,681	0	0.0%	25,681
Retained earnings/(losses)	(87,772)	(88,084)	(312)	(0.4%)	(85,968)
Trust funds	0	0	0	0.0%	0
Total equity	23,903	23,591	(312)	(1.3%)	25,707
Total equity and liabilities	**46,366**	**45,544**	**822**	**1.8%**	**47,663**

2018/19 YTD Actual 2017/18 YTD Actual 2018/19 YTD Budget

APPENDIX 4: WEST COAST DHB STATEMENT OF CASHFLOW

For period ending 31 October 2018
in thousands of New Zealand dollars

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance	%Var	Actual	Budget	Variance	%Var
Cash flows from operating activities								
Cash receipts from Ministry of Health, patients and other revenue	13,875	12,661	1,214	9.6%	52,033	50,616	1,417	2.8%
Cash paid to employees	(6,142)	(5,862)	(280)	(4.8%)	(22,150)	(23,006)	856	3.7%
Cash paid to suppliers	(3,154)	(1,769)	(1,385)	(78.3%)	(8,449)	(6,596)	(1,853)	(28.1%)
Cash paid to external providers	(2,660)	(3,392)	732	21.6%	(12,329)	(13,538)	1,209	8.9%
Cash paid to other District Health Boards	(2,704)	(1,870)	(834)	(44.6%)	(8,920)	(7,482)	(1,438)	(19.2%)
Cash generated from operations	(785)	(232)	(553)	237.9%	185	(6)	191	(3329.9%)
Interest paid	0	(0)	0	100.0%	0	(0)	0	100.0%
Capital charge paid	0	(125)	125	100.0%	0	(500)	500	100.0%
Net cash flows from operating activities	(785)	(357)	(428)	119.7%	185	(506)	691	(136.6%)
Cash flows from investing activities								
Interest received	29	31	(2)	(6.5%)	112	123	(11)	(8.9%)
(Increase) / Decrease in investments	0	0	0	0.0%	0	0	0	0.0%
Acquisition of property, plant and equipment	(137)	(524)	387	73.8%	(545)	(2,097)	1,552	(74.0%)
Acquisition of intangible assets	1	0	1	0.0%	(191)	0	(191)	
Net cash flows from investing activities	(116)	(493)	377	(76.4%)	(624)	(1,974)	1,350	68.4%
Cash flows from financing activities								
Proceeds from equity injections	0	0	0	0.0%	0	0	0	0.0%
Repayment of equity	0	0	0	0.0%	0	0	0	0.0%
Cash generated from equity transactions	0	0	0	0.0%	0	0	0	0.0%
Borrowings raised								
Repayment of borrowings	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%
Net increase in cash and cash equivalents	(901)	(851)	(51)	5.9%	(438)	(2,482)	2,044	(82.4%)
Cash and cash equivalents at beginning of period	12,187	10,852	1,335	12.3%	11,724	11,727	(3)	(0.0%)
Cash and cash equivalents at end of period	**11,286**	**10,001**	**1,285**	**12.8%**	**11,286**	**9,245**	**2,041**	**22.1%**

2018/19 YTD Actual 2017/18 YTD Actual 2018/19 YTD Budget

RESOLUTION TO EXCLUDE THE PUBLIC

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

SOURCE: **Board Secretary**

DATE: **14 December 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 2 November 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.	Quarterly Service Performance Ratings	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
5.	People Report	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.	Report from Committee	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)

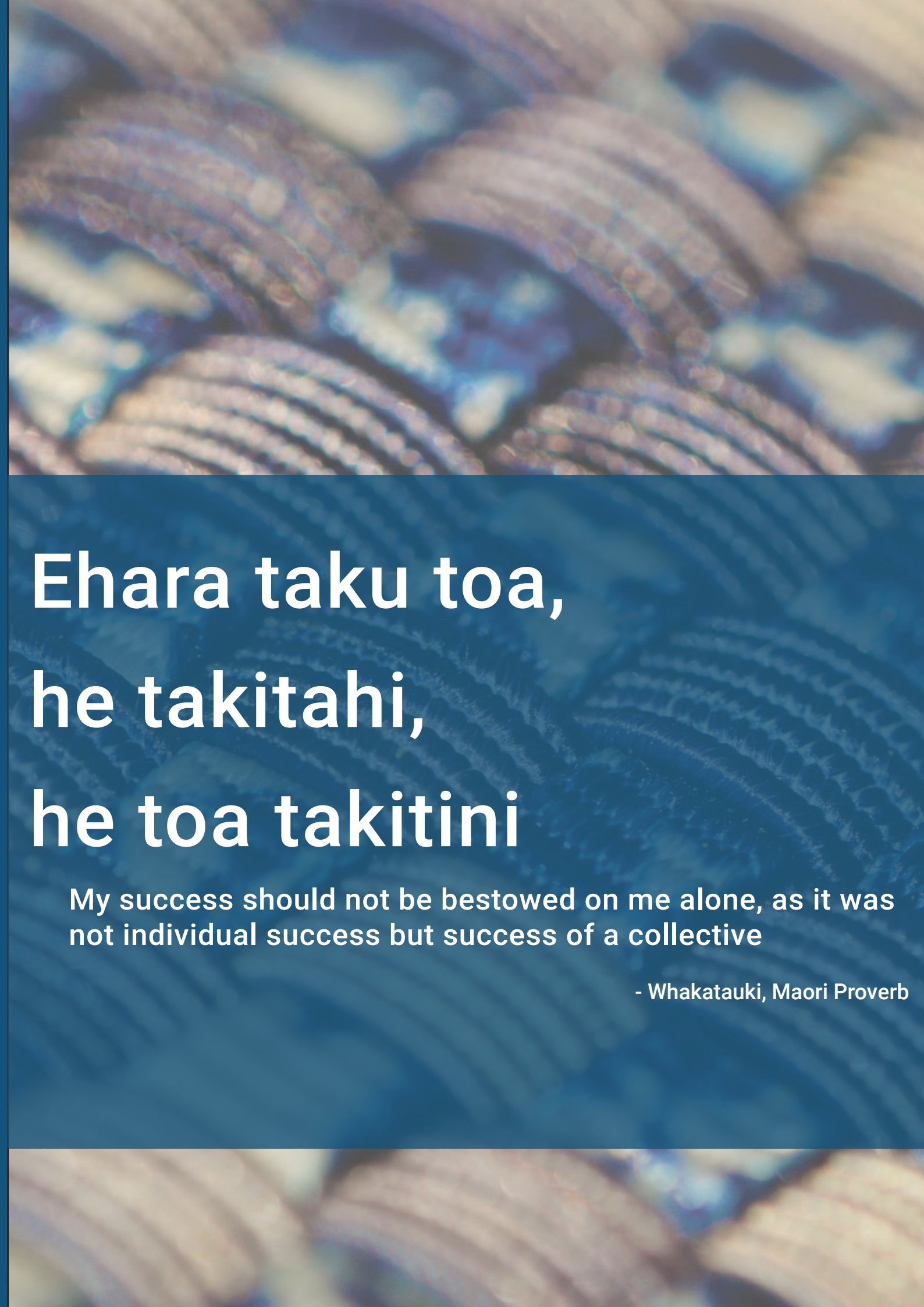
(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution must be available to any member of the public who is present and from part of the minutes of the Board".

Report Prepared by: Board Secretary

NZ HEALTH PARTNERSHIPS

Hono Ōranga Aōtearoa

Annual Report 2018



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

- Whakatauki, Maori Proverb

From the Chair
Peter Anderson

If the third year for many start-up businesses is seen as the 'break even' year, then much the same can be said for NZ Health Partnerships in 2017/18.

Rather than profit, which is the domain of most private companies, break even for our organisation means moving on from our inherited legacy and delivering real value to our District Health Board (DHB) owners and customers.

The legacy we inherited included unwarranted long-running and expensive national programmes, poorly constructed commercial contracts, inadequate vendor and contract management, and most importantly of all, mistrust and broken relationships with DHBs.

Addressing this legacy has required much of NZ Health Partnerships' focus and energy until now so reaching this point marks a major turning point for the organisation and has enabled us to shift our attention to delivering more value.

NZ Health Partnerships is now well poised to deliver major value growth for DHBs and has already made an excellent start.

In 2017/18:

- the National Procurement service completed its first full year of operations and delivered just under $6.7m in budget savings to the sector. This achievement is more significant when considered in the context of a year in which our resources were largely consumed in managing the transition of contracts to the National Procurement service
- the Shared Banking service successfully transitioned 16 DHBs and three subsidiaries to the sector's new banking partner BNZ and achieved over $4m in benefits, $1.5m more than forecast.
- the Collective Insurance service delivered $3.6m in benefits, $1.1m more than the target, and added new cyber and environmental policies for 2018/19 to address increasing risk in these areas.

Other highlights for the year under review included getting approval from all 20 DHBs for the Annual Procurement Plan 2018/19, the development of the DHB National Procurement Policy and introduction of the Procurement Lifecycle. This put in place the final building blocks needed to grow the value the National Procurement service delivers for the sector.

The Board was delighted to be in a position to approve "go-live" for the National Oracle Solution system for the First Wave of four DHBs (Canterbury, Bay of Plenty, Waikato and West Coast) on 27 June. This was a hugely significant milestone for the sector and is an example of health sector collaboration at its very best.

The year ended with a decision from the Government to continue with the First Wave implementation and support but "pause" further work pending a new business case. We welcome this level of scrutiny in the programme. It is the health sector's greatest opportunity to reduce non-labour costs and we're looking forward to working with our Government partners to ensure this programme delivers on its promises.

The Board was also very pleased to see an 11-point improvement in NZ Health Partnerships 2018 Stakeholder survey result, compared with 2017. This turnaround is testament not only to the achievements outlined above but to a concerted effort from the Executive Leadership Team to step up communication and engagement with the sector across a number of fronts. On a personal note, I was privileged to get to a number of DHB Board meetings over the course of the year and hear first-hand about the improvement.

I want to pay tribute to the hard work and dedication of our Chief Executive Megan Main and her leadership team. Regretfully Megan announced her resignation at the end of the year to take up an exciting role as Deputy Chief Executive Corporate, Governance and Information, at the Ministry of Business, Innovation and Employment. Megan played a critical role in turning our inherited legacy around and positioning the organisation for future success. Megan deserves to be very proud of the changes she led and implemented in her two and a half years at the helm.

We also ended the year with a change in our Board membership. Deryck Shaw ended his three-year term as the Central Region Representative. Pauline Lockett, the Chair of Taranaki DHB, will step into this role from July 2018.

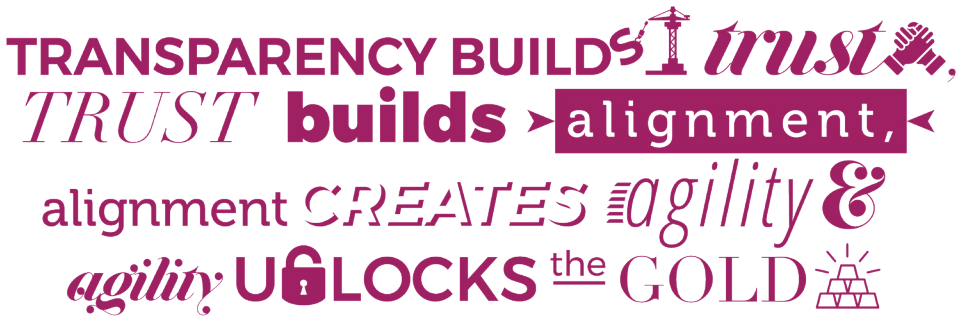
Looking ahead, with new leadership in place, we intend to deliver more value to DHBs by doing the same things differently. We will continue to collaborate with the sector to provide procurement, data analytics and services which best meets DHBs needs.

> Reaching this point marks a major turning point for the organisation and has enabled us to shift our attention to delivering more value.

But we will be doing these things in a smarter, more connected way, including making better use of technology to harness the power of data, create insights and move our work up the value chain. This will include working with DHBs to improve decision-making arrangements so we can maximise the time we spend focused on achieving better returns on the sector's investment.

Working collaboratively and in support of our shareholders remains our key focus. Once again, I would like to thank all of those who have supported and guided us over the course of the last year. We look forward to providing even greater levels of service and value in the year ahead.

Peter Anderson
NZ Health Partnerships, Chair



- Peter Anderson

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2018 YEAR IN REVIEW

NZ HEALTH PARTNERSHIPS

$4.8m

National Procurement total in-year budgetary benefits

$1.9m

National Procurement total non-budgetary benefits

NATIONAL PROCUREMENT

Annual Procurement Plan 2018/19
Approved by 20 DHBs

DHB National Procurement Policy
Approved by Joint Procurement Authority

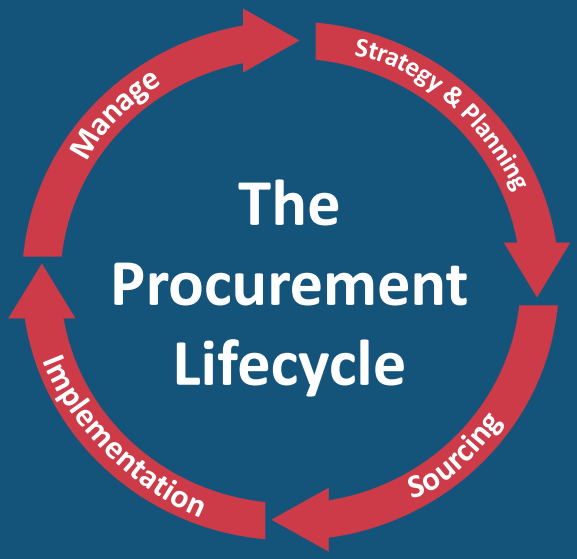
Reviewed **2542** healthAlliance national and local contracts

297 active national contracts identified

128/297 national contracts resolved and closed

Re-purposed the DataHub and improved data capacity, security and analytics

Introduction of the Procurement Lifecycle



Reframing the way procurement is viewed internally and externally

FOOD SERVICES

☑ **Standardised contract management arrangements**

ACHIEVED
Sector agreement and

ON TRACK
to resolve contractual obligations of mobilisation costs

MICROSOFT G2018

Represented DHBs at DIA negotiations

NATIONAL ORACLE SOLUTION

Change Control Report

- ☑ Approved
- ☑ Delivered to MoH

Go Live On Track

- Bay of Plenty
- Canterbury
- Waikato
- West Coast

$4m

Shared Banking benefits

$1.5m

MORE than forecast

SHARED BANKING

Customer Feedback

- **38%** Survey respondents representing 16 DHBs
- **100%** Satisfied with BNZ Shared Banking transition
- **95%** More than satisfied with the systems, processes, communications and support
- **84%** Agreed Shared Banking adds value to their role and DHBs

Up to $1.4b

Management of DHBs' daily cash balance

$19m

annual interest revenue

BNZ Transition

16/20 DHBs

Plus 3 subsidiaries

COLLECTIVE INSURANCE

$3.6m

Collective Insurance Benefits

Managed

$19b

of DHB assets

NEW

Cyber and Environmental umbrella categories

STAKEHOLDER PERCEPTIONS

83 STAKEHOLDERS

67/100 OVERALL SCORE

Progress and Improvements

Communications and Engagement

Confidence

Trust

'NZ Health Partnerships is focused on the right programmes and services'

Financial Overview

NZ Health Partnerships operates on a cost recovery basis: we aim to match our revenue with our expenses and budget to break even. DHBs provide the majority of our revenue to fund the programmes and services we provide on their behalf.

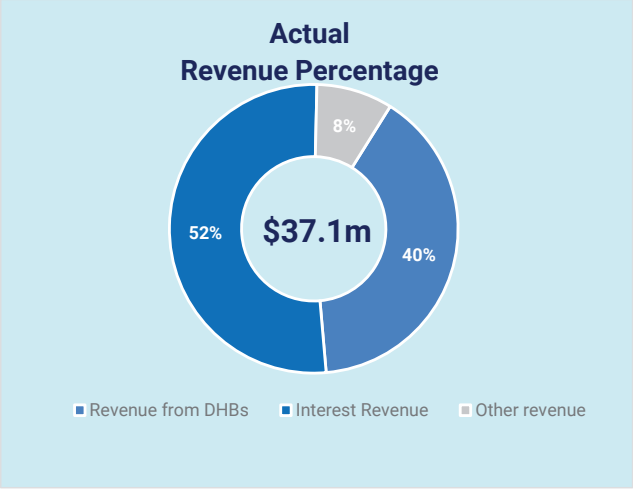
Our 2017/18 budgeted revenue and expenses were both $35.8m, meaning a budget year-end zero balance.

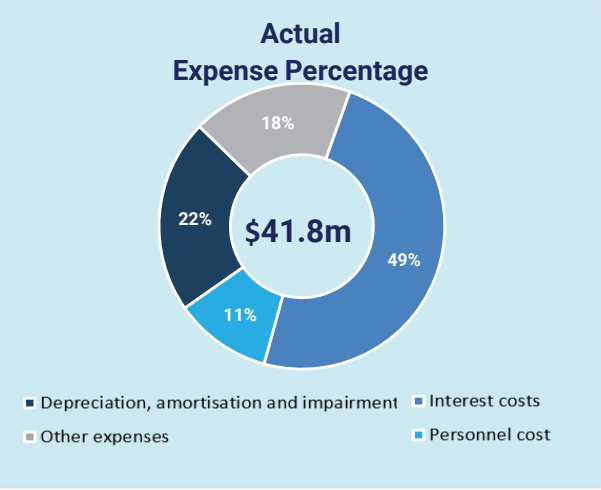
Our actual revenue for 2017/18 was $37.1m. We earned $7.4m above budget interest revenue as the provider of the Shared Banking service for the sector. This was offset by programme revenue being $4.2m below budget due to lower than planned expenses for the National Oracle Solution (NOS) programme as a result of not rolling out the NOS programme beyond the first four DHBs.

Our actual expenses for 2017/18 were $41.8m. This includes:

- $5.8m for a partial impairment of the NOS programme asset following a change in the targeted operating model.
- $7.3m above budget interest expense paid to DHBs from interest revenue earned through the Shared Banking service, offset by lower than planned expenditure on programme and service expenses.

This resulted in a $4.7m deficit for the financial year due primarily to the $5.8m impairment charge.





About Us

Who we are

Our Purpose

NZ Health Partnerships is a multi-parent Crown-entity subsidiary that is supported and owned by New Zealand's 20 DHBs.

NZ Health Partnerships' purpose is to enable DHBs to collectively maximise shared service opportunities for the national good. Put another way, NZ Health Partnerships exists 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.

With an aging population, increasing cost of new clinical equipment, and rising public demand, our initiatives are focused on creating financial efficiencies for DHBs.

By thinking, acting and investing collaboratively DHBs are able to achieve greater benefits than they would by operating independently.

However, what we do is about more than cost reduction. While the company's 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 the company and our operations.

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 (MoH), PHARMAC, Ministry of Business, Innovation and Employment (MBIE), Treasury, Department of Internal Affairs (DIA), commercial organisations and other health-sector shared services organisations.

Statutory and Compliance Requirements

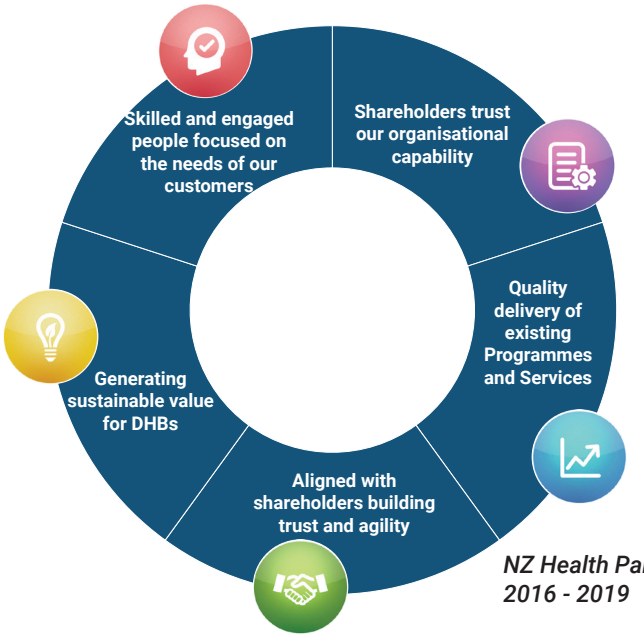
As a Crown-entity subsidiary and limited liability company, NZ Health Partnerships is required to comply with a variety of legislation including but not limited to:

- Commerce Act 1986
- Companies Act 1993
- Crown Entities Act 2004
- Employment Relations Act 2000
- Human Rights Act 1993
- Holidays Act 2003
- Health and Safety at Work Act 2015
- New Zealand Public Health and Disability Act 2000
- Official Information Act 1982
- Ombudsmen Act 1975
- Privacy Act 1993 and related codes ie Health Information Privacy Code 1994
- Protected Disclosures Act 2000
- Public Audit Act 2001
- Public Finance Act 1989

Our Direction

Owned by and working in partnership with all DHBs, we build and deliver initiatives supporting them to provide quality healthcare to their communities

The NZ Health Partnerships Strategic Business Plan 2016 - 2019 (Strategic Business Plan) aims to increase our organisational performance, continue to improve alignment with our shareholders, and to deliver value now and in the future.



NZ Health Partnerships Strategic Business Plan 2016 - 2019

Over the last year, the Strategic Business Plan's five key work streams have made the following progress:

People

- Introduced online performance management tool to better link individual priorities to organisational goals
- Strengthened leadership within the organisation through formalised training programmes, to support both internal development and external delivery

Process

- Implemented the NZ Health Partnerships Annual Organisational Plan (Organisational Plan), which sets detailed targets and measures from our accountability documents to enhance our ability to achieve our goals, and deliver what we say we will
- Established the Risk Management register for monitoring and reporting significant risks, by the NZ Health Partnerships Board (Board), and the Finance Risk and Audit Committee (FRAC)
- Improved the NZ Health Partnerships Policy Framework for drafting, implementing and reviewing our organisational policies

Delivery

- Created the new Procurement Operating Model and DHB National Procurement Policy in readiness for implementation by the year-end and/or early in the new financial year
- Developed the NZ Health Partnerships Annual Procurement Plan 2018/19, with approval from all 20 DHBs
- Delivered a total of $14.3m of in-year benefits to DHBs through our programmes and services ($4.8m budgetary benefit and $9.5m non-budgetary benefit)

Align

- Strengthened the relationship with Stakeholders through initiatives such as Chair and Chief Executive (CE) Board visits, and monthly Chief Financial Officer (CFO) updates
- Introduced a Customer Engagement Framework to formalise the way DHBs are involved in their procurement activity

Value

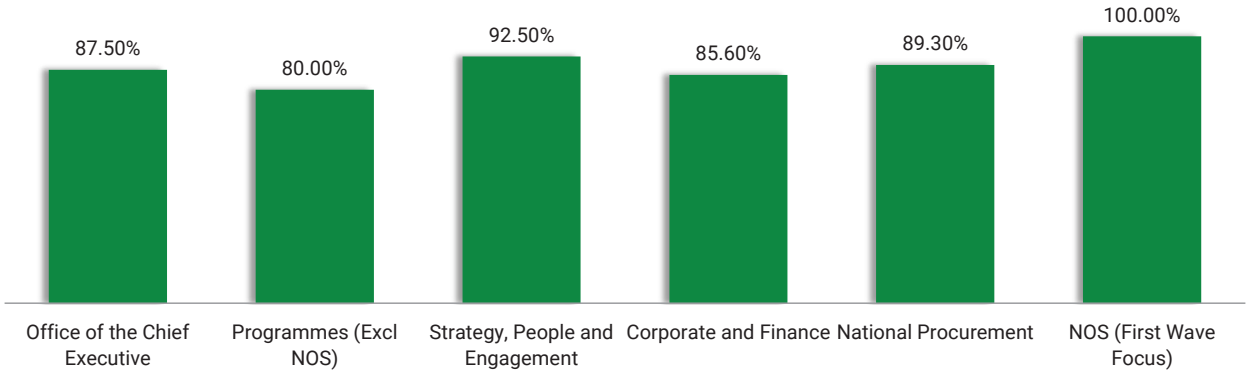
- Outlined a Value Framework as the basis for identifying and communicating the value our work provides to our shareholders, wider than just financial benefits.
- Revisited our approach to Benefits Management, with a plan to refresh the way these are managed in 2018/19 to reduce cost and complexity
- Became the voice for DHBs in the DIA-led Microsoft G2018 negotiations, as requested in-year by our shareholders.

Organisational Health

Organisational Plan

In August 2017, we established the Organisational Plan as a key management tool to support delivery of our commitments in our Strategic Business Plan, Statement of Performance Expectations 2017/18 (SPE) and Annual Plan 2017/18 (Annual Plan). Individual performance development plans and objectives support delivery of the Organisational Plan, including personal goals and value-driven behaviour measures. The month-by-month monitoring of activities to track delivery of the Organisational Plan milestones is captured in quarterly reports to the Board and FRAC.

The 2017/18 year-end closed with 87.8 per cent of the Organisational Plan milestones complete and strong performance from all teams across the organisation, ranging from 80 to 92.5 per cent completion. The key success story for the Organisational Plan is that it has led to the desired uplift in the overall achievement of our SPE and Annual Plan targets. Specifically, the 87.8 per cent achievement has given rise to a 27 point (56 per cent) increase on the previous year, and improved delivery of our commitments to the Board and shareholders.



2017/18 Organisational Plan Performance by Team

People Management

People is one of the five key workstreams in our Strategic Business Plan and is supported by a specific People Strategy 2016-2019. At the heart of this strategy is building skilled and engaged teams, focused on the needs of our customers with the capacity and capability to deliver on the organisation's programmes and services.

Number of employees

NZ Health Partnerships carefully thinks through the size of each team, balancing the need to establish the company with ensuring programme and service delivery of value to our shareholders and customers. As of 30 June 2018, we had 39 permanent employees representing 38.4 full time equivalent roles.

Performance Leadership Framework

Our Performance Leadership Framework is an integrated, organisation-wide approach to employee performance and development. It is a continuous process that aligns individuals' performance to achievement of team and organisational goals. This framework applies to all permanent employees and people engaged in fixed term contracts of six-months or longer. All other contractors and consultants meet on a regular basis with managers to discuss their work and assess their deliverables.

People development

In early 2018, the Executive Leadership Team, senior managers and senior leaders participated in three "Leading Performance" workshops focused on coaching and feedback skills for leading performance with their teams, in line with our Performance Leadership Framework.

We also participated in the MBIE graduate and intern programme for the first time, with a graduate working at NZ Health Partnerships on a six-month procurement secondment. This highly successful initiative means we will continue to be involved in the programme in future.

People Engagement

A total of 45 of our permanent employees, contractors and secondees (98 per cent of our workforce) participated in our 2018 people engagement survey. We achieved an overall people engagement score of 69 per cent. Although this result dropped 11 points from the previous year, it still rates above the NZ State Sector of 62 per cent. Our People Strategy is due for renewal in 2018/19 and the responses to the engagement survey are a key input.

For the first time, the survey contained Health, Safety and Wellbeing as one of the six key areas for staff feedback on the NZ Health Partnerships current activities and dynamics in the workplace. A total of 45 of our people (98 per cent of workforce) participated in the survey and the overall health and safety score of 96 per cent led to the highest rating result area in the survey.

Focus Groups

Five focus groups were used for staff to collaboratively identify and plan initiatives to achieve tangible outcomes in the areas of: Customer Focus, Organisational Engagement, Organisational Leadership, Reward and Recognition and Values. 24 staff members took up the opportunity to join one or more of the focus groups, and make a contribution toward ensuring NZ Health Partnerships is a great place to work - gaining new skills and insights from working together, and having fun to get to know the people across the organisation.

Customer Focus

Reward and Recognition

Organisational Leadership

Organisational Engagement

Values

Equal Employment Opportunities

NZ Health Partnerships provides equal employment opportunities to support and develop individual team members; recognise the aims, aspirations and employment of women, and the cultural differences of ethnic or minority groups; and recognise the employment requirements of people with disabilities.

Workforce demographics of permanent employees at 30 June 2018

Health, Safety and Wellbeing

Our goal is to embed legislation and policy, and focus on improving our health and safety culture.

Following the internal audit of our health and safety processes last year we continued our efforts to embed health and safety in the organisation, most notably with the maturity of the Health Safety and Wellbeing Committee, and quarterly reporting to our FRAC as well as the Board.

In 2017/18, all staff received health and safety training. There was one notifiable event and one incident of injury, both of which were opened and resolved in the third-quarter of the year. Similarly, there were two hazards identified and resolved.

Another way we measure the state of the organisation's health, safety and wellbeing situation is the amount of staff absences due to sick leave. This year the staff absence ie sick leave/total work days averaged 1.8 per cent.

Governance

Our Board

PETER ANDERSON
Chair

Independent Director
Appointed October 2015

Committee
Remuneration

TERRY MCLAUGHLIN

Independent Director
Appointed October 2015

Committee
Finance Risk and Audit (Chair)

JOANNE HOGAN

Independent Director
Appointed April 2016

Committee
Remuneration

RABIN RABINDRAN

DHB Director
Northern Region
Deputy Chair, Counties Manukau
Appointed October 2015

Committee
Finance Risk and Audit

DERYCK SHAW

DHB Director
Midlands Region
Chair, Lakes DHB
Appointed October 2015

Committee
Finance Risk and Audit

KEVIN ATKINSON

DHB Director
Central Region
Chair, Hawke's Bay DHB
Appointed March 2017

Committee
Remuneration

RON LUXTON

DHB Director
Southern Region
Chair, South Canterbury
Appointed July 2017

Committee
Finance Risk and Audit

Governance and Accountability

NZ Health Partnerships works in a commercial manner within a public sector environment. The company operates under the Board, as well as programme and service governance structures with strong DHB representation. The Board comprises four regional DHB Chairs or Deputy Chairs and three independent Directors. It is chaired by one of the independent Directors.

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

Our 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 the DHB CE Sponsor for each of our programmes and services.

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

These groups, where appropriate, also include senior representatives from other organisations such as the MoH, MBIE, DIA and PHARMAC.

Collective Insurance
Nigel Trainor
Chief Executive,
South Canterbury DHB

National Oracle Solution
David Meates
Chief Executive,
Canterbury and West Coast DHBs

National Procurement
Dr Kevin Snee
Chief Executive,
Hawke's Bay DHB
and
Dr Peter Bramley
Chief Executive,
Nelson Marlborough DHB

Food Services
Jim Green
Chief Executive,
Hauorā Tairawhiti

Shared Banking
Nigel Trainor
Chief Executive,
South Canterbury DHB

Stakeholder Perceptions

Research First conducted our third stakeholder perception survey to understand how stakeholders perceive NZ Health Partnerships, and evaluate their perceptions of our performance, communication and engagement activities. In-depth telephone interviews were held with DHB Board Chairs, CEs, CFOs, Chief Information Officers (CIOs), and Procurement Leads as well as NZ Health Partnerships' programme and service governance members.

In 2017/18, the overall stakeholder perception score of 67 (out of 100). This is a notable increase on the overall score of 56 from the previous year.

The most satisfied group for both performance and engagement was DHB Chairs, followed by Governance members, CEs and CFOs. Most stakeholder groups believe we are focused on the right programmes and services for DHBs.

The dominant theme is that we need to stay focused on ensuring delivery in the areas that we've committed to.

Our governance continues to receive strong support from the stakeholders and there was a strong indication that stakeholder perceptions of NZ Health Partnerships have matured to a steady working state. Banking and insurance continue to be the most supported services.

Overall, NZ Health Partnerships has made progress over the last year through improvements in communication and engagement, which has resulted in greater levels of confidence and trust.

Statement of Responsibility

The 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 2018.

Signed on behalf of the NZ Health Partnerships Board

Peter Anderson
Chair

31 October 2018

Terry McLaughlin
Finance Risk and Audit Committee, Chair

31 October 2018

Statement of Performance

for year ended 30 June 2018

Our Performance

The SPE set out performance measures and targets that we track and report throughout the financial year, on a quarterly basis. The Annual Report 2018 captures the year-end final results.

Performance Management Framework

In March 2018, we developed the NZ Health Partnerships Performance Management Framework to provide a measurement and management system for monitoring and reporting against our strategic goals. The framework aims to make sure that all staff are well managed and supported, and able to do their jobs to the best of their ability. By doing this, NZ Health Partnerships can deliver the best possible programmes and services, create the best value for our shareholders and customers, and make the best use of public money.

Criteria

The following symbols and criteria display the performance measure results compared to targets for each programme and service:

NZ Health Partnerships Performance Assessment Ratings

Symbol and Criteria		Description
●	Achieved	Target has been met or exceeded
●	Substantially Achieved	Target has not been met by a very slim margin
●	Progressed	Target has not been met, but work is underway and going well
●	Not Started	Work has not started but due to start, as planned (used for in-year reporting only)
●	Not Achieved	Target not achieved

Perspectives

The perspectives that underpin our performance results are quality, financial and timeliness:

NZ Health Partnerships Perspective Ratings

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 Results

Across our two output classes (programme and services, including management) we have 29 performance measures.

Our overall performance results for the year end against these measures are:

NZ Health Partnerships Overall Year End Performance

Measurement Area	Achieved	Substantially Achieved	Progressed	Not Started	Not Achieved
Overall performance	**59%**	**24%**	**10%**		**7%**
	17 of 29	7 of 29	3 of 29		2 of 29

Programmes Year End Performance

Programmes					
National Oracle Solution	**100%**				
	4 of 4				

Services Year End Performance

Services					
Shared Banking	**67%**	**33%**			
	2 of 3	1 of 3			
Collective Insurance	**100%**				
	3 of 3				
National Procurement	**50%**	**33%**	**17%**		
	3 of 6	2 of 6	1 of 6		
Food Services	**25%**	**50%**			**25%**
	1 of 4	2 of 4			1 of 4

Management Year End Performance

Management					
Organisational Capability	**45%**	**22%**	**22%**		**11%**
	4 of 9	2 of 9	2 of 9		1 of 9

Programmes

DHBs invest in the programmes we develop. The NZ Health Partnerships 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.

National Oracle Solution

CE Sponsor: David Meates, Canterbury and West Coast DHBs

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. The NOS programme will also remove unnecessary and expensive duplication of effort, is an enabler for meeting changing health sector needs and can mitigate clinical risk through more consistent traceability of products.

Focus

In 2017/18 the build of the technology and supporting infrastructure for the NOS programme First Wave 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.

Final result

NOS Performance Measures and Targets 2017/18

#	Performance Measure	Target	When	Status
1	Ensure readiness of Oracle Administration Model	Key positions filled and capability in place	30 June 2018	Achieved
2	Complete Technology Build	Solution acceptance testing successfully completed	30 June 2018	Achieved
3	Complete Solution Readiness	User acceptance testing successfully completed	30 June 2018	Achieved
4	Support First Wave DHB Implementation	Preparation for First Wave DHB implementation completed with no open action items, to start 1 July	30 June 2018	Achieved

Comment

The two principal areas of focus in 2017/18 were a re-set of the programme through a change control process and subsequent to this preparing for the first four DHBs to go live on the system on 2 July.

In our Annual Report 2016/17 we reported that the NOS programme had missed its planned implementation date for the four First Wave DHBs and that the programme needed to be re-set. In the early part of 2017/18, having taken on board the lessons to date, we prepared the NOS Change Control Report (CCR). The CCR recommended the scope of the programme remain unchanged with additional time and funding to deliver the national information technology infrastructure. The CCR re-cut the programme plans from the bottom up to ensure realistic and achievable timeframes and to ensure successful delivery, including a redesigned governance model.

By November 2017, all 20 DHBs had unanimously agreed to the report's recommendations, including provision of the additional funding. The "go-live" date for the First Wave DHBs was set for July 2018.

Once the CCR had been completed and approved by DHBs, we made relevant changes to the NOS programme. Key activities undertaken included completing the detailed design and testing of the IT infrastructure, successfully migrating the NOS system onto the infrastructure for First Wave DHBs and user acceptance testing.

Having been satisfied that all necessary work had been completed, the NZ Health Partnerships Board approved "go-live" on 27 June. This was an important milestone for programme and for the sector.

On 28 June the MoH advised us of the government's decisions on the NOS programme. The government approved deployment of the NOS programme to the first four DHBs but decided that the remainder of the programme should be "paused" while a new business case was developed.

The NOS programme system represents the health sector's greatest opportunity to reduce non-labour costs. It will also ensure DHBs' finance, procurement and supply chain systems are sustainable and adaptable to changing health sector needs and structures. It is important that DHBs and the health sector as a whole are able to realise the benefits that the NOS Programme intended to provide.

NZ Health Partnerships looks forward to working with our shareholders and stakeholders to ensure the programme is optimised to achieve this. Developing the revised business case will be a critical, early priority for 2018/19.

Programmes: Financial Perspective

	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
Revenue:			
National Oracle Solution	7,528	11,518	9,147
National Infrastructure Platform	672	1,735	2,089
Microsoft 2018	335	0	0
Total programme revenue	8,535	13,253	11,236
Expenditure:			
National Oracle Solution	11,564	11,518	7,656
National Infrastructure Platform	241	1,735	3,405
Microsoft 2018	335	0	0
Total expenditure	12,140	13,253	11,061
Surplus / (Deficit)	**(3,605)**	**0**	**175**

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

CE Sponsor: Nigel Trainor, South Canterbury DHB

On any given day we manage a cash balance of up to $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

The 2017/18 focus was the transition to BNZ as the new transactional banking provider. This new contract substantially reduces the costs of transactional banking, minimises the cost of working capital and term borrowing facilities and maximises returns for credit balances. DHBs will receive better individualised customer service through 33 BNZ Partner Centres throughout the country.

Final result

Shared Banking Performance Measures and Targets 2017/18

#	Performance Measure	Target	When	Status
5	New banking service provider implemented	Implementation of new banking service provider for 2017/18	31 December 2017	Substantially Achieved
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 $2.5m total benefits	30 June 2018	Achieved
7	Delivery of effective Shared Banking service	Delivery of Shared Banking service to DHBs satisfaction	30 June 2018	Achieved

Comment

Following a successful national tender process, BNZ became the sector's new transactional banking services provider on 8 August 2017. Our focus then turned to working closely with DHBs and BNZ to make the transition process as low risk and low impact as possible.

DHBs began transitioning to BNZ in October 2017 and by the end of the financial year 16 DHBs and three subsidiaries had made the move. DHBs agreed that the final four DHBs and one subsidiary would transition in 2018/19 following their planned "go-live" for the NOS programme First Wave in early July. The agreed target date to move all but the non-First Wave DHBs was December 2017, however the final DHB moved in June 2018 so this measure has been assessed as "substantially achieved".

We achieved or exceeded our other Shared Banking performance targets. We achieved a deposit margin of 0.41 per cent above the Official Cash Rate and delivered $4.02m in benefits.

We also refreshed our Treasury Policy and Treasury Services Agreement with DHBs.

A new initiative we implemented in 2017/18 was to provide CFOs with monthly sector updates on shared banking activities. Consistent with our value of transparency, this ensures DHBs are kept well informed of any issues or developments as they emerge.

In the final quarter of the year we surveyed operational stakeholders about their experience with the banking transition and their use of Shared Banking service. We received 18 responses from nine DHBs and a shared services provider. On a scale of 1 (poor) to 10 (excellent) both our service and the transition received an average 8/10 satisfaction rating.

Our stakeholder perception survey, included a specific question for CFOs about their satisfaction with Shared Banking. Fifteen CFOs responded, and on a scale of 0 (terrible) to 10 (excellent) our banking services rated an average of 7.4.

Collective Insurance

CE Sponsor: Nigel Trainor, South Canterbury DHB

Collectively DHBs have assets valued around $19 billion. 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

2017/18 was the time to work with DHBs and the sector's insurance broker to negotiate a new Collective Insurance Agreement that ensured that DHBs have insurance cover that meets their needs. Re-insurance included cover for Material Damage and Business Interruption, Liability Package, Motor Vehicle, Travel and Personal Accident from 2018/19.

Final result

Collective Insurance Performance Measures and Targets 2017/18

#	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	Achieved
9	Delivery of efficient Collective Insurance service	Delivery of value add Collective Insurance service including achievement of $2.5m total benefits	30 June 2018	Achieved
10	Delivery of effective Collective Insurance service	Delivery of Collective Insurance service to DHBs satisfaction	30 June 2018	Achieved

Comment

The insurance theme for 2017/18 was very much one of rising premiums and increasing market instability following a large number of local and international losses from natural disasters.

Following discussions with the sector's Banking and Insurance Service Performance Group (BISPG) and the wider DHBs CFOs group, DHBs agreed to retain Marsh as the sector's broker through to October 2019. This decision recognised the advantage of broker continuity in the current unstable market environment.

For 2017/18 the Collective Insurance service delivered $3.6m in benefits to the sector — substantially exceeding the $2.5m target.

We were anticipating a significant jump in the sector's insurance premiums from $9.1m in 2017/18 to up to $14.9m in 2018/19. This estimate largely reflected market conditions — particularly for Material Damage and Business Interruption cover. Other factors contributing to the expected increase were the end of a long-term sector agreement and a 12.4 per cent increase in DHB asset values. The final premium of $14.0m, included $1.1m attributable to the rise in asset values.

We were pleased to be able to successfully retain the sector's current levels of coverage and terms for 2018/19, in particular the present levels of deductibles. We expect insurers will raise these issues again in 2019/20 policy negotiations.

We also asked DHBs to identify other risks they may want to insure against. Based on their feedback, we negotiated new umbrella Cyber Crime and Environmental policies which individual DHBs are able to pick up if they wish to do so.

We held our first Annual Insurance Forum for CFOs in October 2017. This was a useful way to get all parties together to talk about the insurance risks facing the sector, long term strategies and the direction over the short to medium term. The forum was well attended and judging by the feedback was well received.

In our stakeholder satisfaction survey we also asked CFOs how satisfied they are with the Collective Insurance service. Fifteen CFOs responded and on a scale of 0 (terrible) to 10 (excellent) we received an average score of 7.6.

National Procurement

CE Sponsor: Kevin Snee, Hawkes Bay DHB and Peter Bramley, Nelson Marlborough DHB

National Procurement (formerly DHB Procurement Service) includes both implementation of the wider sector Procurement Operating Model as well as delivery of national procurement itself.

Under the new Procurement Operating Model, national procurement was transitioned from healthAlliance (FPSC) to NZ Health Partnerships from 1 May 2017.

PHARMAC will incrementally expand into national medical device procurement over the next three years. NZ Health Partnerships 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

In 2017/18 the focus was on building the foundation for a centre-led National Procurement service for DHBs, delivering agreed procurement needs and managing contracts that were transitioned from the previous National Procurement service provider.

This involved contract management, clinical engagement, supplier relationship management, policy development and technology solutions to enable a successful implementation of the Procurement Operating Model.

Final result

National Procurement Performance Measures and Targets 2017/18

#	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
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	Achieved
13	Aligned governance processes	Processes to support governance are in place and aligned to the Procurement Operating Model	30 June 2018	Progressed
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 Achieved
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	Substantially Achieved
16	Delivery of efficient procurement service	Delivery of value-add procurement service including achievement of $6.7m total benefits	30 June 2018	Achieved

Comment

In 2017/18 we put a strong platform in place to enable our shareholders to realise the significant potential value from national procurement. We visited all 20 DHBs early in the first quarter of the year to gain a clear understanding about how we could best meet their needs.

We successfully recruited a senior leadership team and staff for National Procurement. This was a significant achievement given the tight labour market for procurement expertise. A strong team is now in place with sufficient capacity to deliver our agreed plans.

We participated in the MBIE Procurement Capability Index Assessment for the first time, alongside DHBs and used the results to develop a roadmap for ongoing capability development.

We also established frameworks to guide our engagement with our customers, government partner agencies and suppliers.

We introduced a principles-based approach to clinical engagement throughout the procurement lifecycle. This was approved by the sector's JPA and is incorporated in our customer engagement framework. It is supported by procurement category plans which identify the appropriate level of clinical engagement for specific initiatives after taking into account risk, impact and complexity. Clinicians are also represented across the different procurement governance groups.

A key element to support alignment in governance process is the DHB Procurement Policy. This was introduced, on behalf of the JPA, to support the implementation of the DHB Procurement Strategy and enable DHBs to maximise the value from procurement activities. At the end of June, seven DHBs had approved the policy with the remainder expected to do so in the first quarter of 2018/19. This meant we missed our target to have the new policy in place in 2017/18 although significant work in this area means the goal has been assessed as progressed.

In 2017/18 we developed a three-year procurement plan in collaboration with DHBs. This plan provides guidance for our more detailed annual procurement plans. It also assists DHBs to coordinate local and collaborative procurement with national procurement. The plan was approved by the JPA in November slightly after the 30 September target date, giving us a substantially achieved for this measure.

We identified procurement categories that had transitioned to NZ Health Partnerships with the National Procurement service, but logically belonged with each DHB. We then agreed timeframes for moving these contracts back to local management after taking into account the capability and capacity available at each DHB. All contracts considered "local" were back with DHBs by February 2018. As this was later than our agreed target date of December 2017, this measure has been rated as substantially achieved.

The National Procurement service exceeded its agreed first year in-year target of $6.1m total benefits by $0.6m. $4.8m of these benefits were classified as budgetary benefits and $1.9m as non-budgetary benefits.

Achieving these benefits is due to a wide range of factors, in particular development of the NZ Health Partnerships procurement life-cycle, a review and consolidation of procurement categories, resolution of a large number of expired contracts, and developing a master agreement template which produced efficiencies both internally and with suppliers.

Food Services

CE Sponsor: Jim Green, Hauorā Tairawhiti

Under the Food Services Agreement (FSA), Compass Group NZ Limited (Compass) 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 supplier management are in place to ensure our participating shareholders receive the best service possible.

Focus

The focus in 2017/18 was on establishing the revised FSA governance model to better represent the needs of the six participating DHBs. We aimed to renegotiate elements of the FSA Terms and Conditions, to reflect the smaller than originally anticipated participation level and maximise service delivery and commercial opportunities for all parties involved.

Addressing the outstanding issue on mobilisation costs was a key priority for us. This was followed by providing ongoing category management support in managing supplier performance. The goal was that food services would be incorporated into National Procurement by the year-end.

Final result

Food Services Performance Measures and Targets 2017/18

#	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	Substantially Achieved
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 Achieved
19	Three-year operating plan	Delivery and sign off of one to three-year operating plan	30 June 2018	Achieved
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

In the first half of the year we successfully moved the FSA from a standalone service to active contract management under the National Procurement service. We also established a new supplier and customer relationship management framework with Compass to support this arrangement.

We undertook significant work to resolve outstanding mobilisation fees legacy issues with Compass during the year. We gained agreement from all DHBs as to acceptable outcome criteria as well as how DHBs would fund any agreed fees following negotiation. Following some substantial management changes, Compass was unable to meet to work through the final outstanding issues late in the financial year. Due to the work during the year, the position of both parties at the close of the year was fairly aligned, with just the final negotiation conversation to be had so this goal has been assessed as “substantially achieved”.

We revised the FSA governance model to better reflect the needs of the six participating DHBs. This involved establishing a Contract Management Group to give high level direction to the National Procurement service and a Food and Nutrition Technical Advisory Group to work with Compass on dietary and nutritional aspects of the service. Both groups include representatives from each of the participating DHBs.

We assessed the implementation of the new governance model as “substantially achieved” because the final governance structure was not in operation until November, slightly later than the September target date.

We also successfully developed and secured DHB and Compass agreement to a three-year Food Service Agreement operating plan, as planned.

As well as providing for ongoing supplier performance management, the plan sets out activities to be considered by DHBs and Compass, including reviews of key performance indicators and the business continuity plan.

During 2017/18 it became apparent that we would not be able to confirm achievement of the planned $1.8m in FSA benefits. This was primarily due to a lack of a clear and agreed baseline to measure progress against and the significant costs required to establish one.

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

In 2017/18 we focussed on further embedding 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 2016-2019 (People Strategy) continued 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 aimed to 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.

Final result

Organisational Capability Performance Measures and Targets 2017/18

#	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	Achieved
22	Implement Communications and Engagement Strategy	Detailed activity plan developed and implemented	30 June 2018	Achieved
23	Decision Making Framework	Development and implementation of agreed Decision Making Framework	30 June 2018	Progressed
24	Implement People Strategy	Progress against the 10 strategic work streams in line with activity plan	30 June 2018	Achieved
25	Enhance internal processes	Deliver consistent, robust and sustainable processes across NZ Health Partnerships	30 June 2018	Not Achieved
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	Substantially Achieved
27	Enhance Planning and Performance function and processes	Planning and Performance Framework and processes developed and implemented	30 June 2018	Achieved
28	Value Framework	Value Framework and processes developed and embedded	30 June 2018	Progressed
29	Delivery of effective Risk Management	Enhance risk management culture across New Zealand Health Partnerships	30 June 2018	Substantially Achieved

Comment

During the year our programmes and services were supported by tailored communication and engagement plans that aligned to our Change Management Framework. With regular refresh cycles the plans were kept up to date and recognised the different communication needs of the various audiences.

Our Communications and Engagement Strategy aims to ensure that communication is planned, timely and effective while all statutory requirements around Official Information Act (OIA) and Parliamentary questions are met. During the year we introduced Dashboards to give snapshot views of programme/ service status to governance groups and our Board and reinstated one-page summaries to Chairs and CEs, following our Board meetings.

The beginning of 2017/18 saw a new CFO for our organisation and a focus during the year was on forming stronger relationships within the wider CFO peer network. Regular attendance at CFO Forums along with monthly updates have helped keep this important stakeholder group informed of key NZ Health Partnerships activities.

In June 2018 we brought the DHB CE Sponsor group together for a strategic discussion about our programmes, services and future direction. This was a valuable way to share ideas and is an initiative we hope to make a regular occurrence.

In 2017/18 we also focused on improving collective decision making, with the development of a Decision Making Framework. The Framework aims to get agreement on how we approach decision making with our shareholders - outlining the decisions we need to make, who needs to be involved, and the role that each party plays. It also outlines mechanisms for use when decisions sit with all 20 DHBs, approaches that can be used to streamline these decisions, supporting national agility which is a key enabler for value delivery to DHBs.

We had anticipated that agreement on this would be reached and changes underway by the end of this financial year however this has not been achieved. As part of aligning to DHB planning cycles, we have moved our annual shareholder day from March to September and plan to have further discussion on this during this day. Given this, we have assessed this measure as progressed.

Our People Strategy supports delivery to our shareholders by helping to build a strong and capable workforce. In 2017/18 we focused on being a values-based organisation. Our values of Transparency, Respect, Accountability and Commitment were made visible and tangible, and are included in individual Performance and Development Plans (PDP).

We also supported leadership development through plans and programmes not just for top tier management, but other leaders in the organisation, regardless of whether they have direct reports. We replaced our intranet with one that is more flexible and cost effective to better connect our people, formalised PDP setting and introduced efficiencies in this area by moving from a paper based process to an online tool. This also allowed greater visibility of review outcomes, consistent ratings for staff, and direct links between our organisational goals and individual PDPs. We supported this with the introduction of a Remuneration Policy and also introduced Work Perks for staff based on employment linked discounts at both local and national businesses. Finally, we conducted our annual staff engagement survey - with an overall engagement score of 69 per cent- comparable to other shared service organisations and above the average for public sector.

In 2017/18 we developed and implemented a number of process improvements including the new online staff performance and development tool, a framework for developing and managing corporate policies and related processes and procedures (together with a programme of work for reviewing and updating individual policies), and a four-year Internal Audit Plan. However, in 2017/18 we had planned to undertake a current state assessment of our full suite of internal processes and then develop and implement a prioritised improvement plan. A need to reprioritise resources meant it was not possible to undertake a full review so this measure has been assessed as “not achieved”.

Our Corporate function focused on improving internal financial reporting during 2017/18 - introducing monthly executive reporting as well as refreshed reporting formats to both our FRAC and Board. In addition, during the year we provided quarterly progress reports to our shareholders and agreed our 2018/19 goals (in principle) in consultation with CFOs and CEs. Our planning process is now significantly more aligned with our DHB shareholders - ensuring that financial planning advice is available in November each year to input into DHB budgeting activity.

We created efficiencies for our DHB shareholders by combining our Annual Plan - a requirement of our shareholders' Agreement - with our SPE - a legislative requirement. This new combined SPE document means shareholders have one document to review and agree each year. As at the end of June 2018 seven DHB Boards had approved it, with the remainder due to consider it in July 2018. As not all DHB Boards have approved this key annual document at the close of the year, this measure has been marked as Substantially Achieved.

We reviewed and updated our planning and reporting timeframes to better align them with our shareholders' planning cycles and our annual procurement plan timeline. This means there is now more time for opportunities for the upcoming year to be identified and costed and agreed budgets submitted.

Getting clear on the value offering of NZ Health Partnerships was a priority within 2017/18. We agreed our overarching Value Framework which calls out that we:

- **generate value** through innovating and leveraging our unique ownership structure
- **deliver value** running collaborative programmes and services
- **enable value** through an agreed benefits reporting structure
- **support value** with a strong team and governance approach.

A Value Funnel was developed which enables opportunities and initiatives to be "triaged" to identify those worth discussing with our shareholders.

Our approach to programmes and services was formalised to reflect that they all have agreed baselines and we have committed to ensuring they all have problem statements and value propositions - clearly explaining why that initiative is important, and what it can deliver for the sector. These have not been retrospectively introduced for existing work however this will be completed early in 2018/19.

A structured benefits approach was agreed with the JPA and primarily focuses on procurement. We had aimed to develop a wider perspective on benefits with DHBs in 2017/18 but were unable to complete this. This will be completed in 2018/19.

Effective risk and issue management is essential for successfully delivering our programmes and services and therefore our reputation and our shareholders' expectations. Sound risk culture and practices is particularly important to achieving the benefits we project and effectively managing our financial functions both for the sector and our own obligations. During 2017/18 we formalised our approach to risk - including the introduction of internal audit work plans, risk action plans and regular risk reporting at executive, FRAC and Board level. To inform this, we developed a Risk Management Framework and a significant risk register which was endorsed by the FRAC and approved by the Board. We developed a risk working group with cross-organisation representation to help embed our risk approach and will be further progressing this in 2018/19.

We also stepped up our emphasis on Health and Safety. We are now regularly reporting on health and safety issues to our FRAC, have re-launched our Health, Safety and Wellbeing Committee which now meets monthly, and have included health and safety in our annual staff engagement survey.

A planned review of legislative compliance did not take place as legal resources were re-prioritised to support the contract work for National Procurement. We refreshed our Legislative Compliance Checklist but this was not rolled out through the organisation, as planned, and will be carried forward into 2018/19. Overall this measure has been assessed as substantially achieved.

Services: Financial Perspective

	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
Revenue:			
Shared Banking and Collective Insurance			
Interest Revenue from Shared Banking Facility	19,420	12,000	20,630
Shared Banking and Collective Insurance Operations	603	603	603
National Procurement	3,426	4,850	12,560
Food Services[1]	0	0	370
Management Services	5,090	5,105	5,094
NZ Health Partnerships Interest	29	0	48
Total services revenue	28,568	22,558	39,305
Expenditure:			
Shared Banking and Collective Insurance			
Interest Revenue from Shared Banking Facility	19,337	12,000	20,579
Shared Banking and Insurance Operations	673	603	477
National Procurement	5,185	4,850	12,314
Food Services[1]	0	0	478
Management Services	4,505	5,090	4,770
Total expenditure	29,700	22,543	38,618
Surplus / (Deficit)	**(1,132)**	**15**	**687**

1 *Food Service was recorded as a separate service in 2016/17, following the cessation as a national contract services supporting the participating DHBs is now included under national procurement.*

Benefits

NZ Health Partnerships reports on benefits generated by our programmes and services, as well as wider sector benefits. We are responsible for coordinating and reporting aggregated sector benefits, based on information provided by DHBs and third party providers such as PHARMAC and MBIE. These benefits are reported by NZ Health Partnerships but are realised and owned by the DHBs.

The benefits generated by NZ Health Partnerships from the Collective Insurance, National Procurement and Shared Banking services are reported to DHBs. DHBs are asked to confirm or amend the benefits relating to National Procurement as well as advise any local and collaborative benefits to be included in the aggregated reporting.

Reported Benefits

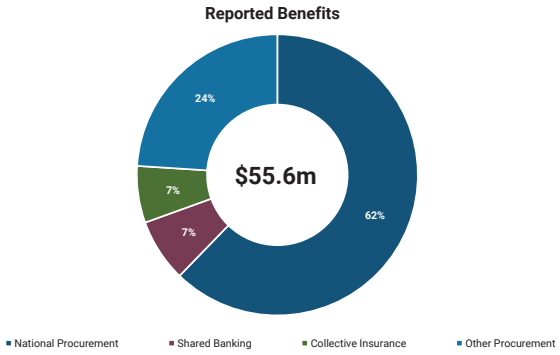
Reported benefits include both realised and predicted amounts. Predicted benefits are based on an actual per-unit saving multiplied by forecast volumes. Accordingly actual benefits achieved may vary.

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, benefits from contracts started in previous financial years and qualitative benefits.

Points to Note

Reported benefits for the year total $55.6m against SPE target of $50.4m. Shared Banking, Collective Insurance and National Procurement cumulatively exceeded their SPE targets by $3.2m.

Programmes and services	Budgetary $000's	Non-Budgetary $000's	2017/18 Total Reported Benefits $000's	2017/18 Target as per SPE $000's	2016/17 Total Reported Benefits $000's
Programmes	0	0	0	0	0
Services					
National Procurement[2]	4,803	29,798	34,601	31,400	48,124
Shared Banking	0	4,024	4,024	2,500	3,406
Food Service	0	0	0	1,810	0
Collective Insurance	0	3,629	3,629	2,500	2,527
Other Procurement[3]	3,163	10,165	13,328	12,200	13,652
TOTAL	**7,966**	**47,616**	**55,582**	**50,410**	**67,709**



2 National Procurement includes AoG and PHARMAC contracts
3 Other Procurement includes DHB, local and collaborative procurement

DHB	Budgetary $000's	Non-Budgetary $000's	2017/18 Total Reported Benefits $000's	2016/17 Total Reported Benefits $000's
Auckland DHB	955	6,330	7,285	14,311
Bay of Plenty DHB	189	1,265	1,454	2,027
Canterbury DHB	673	7,327	8,000	6,576
Capital and Coast DHB	821	3,804	4,625	4,053
Counties Manukau DHB	373	4,900	5,273	8,857
Hawke's Bay DHB	47	730	777	1,172
Hutt Valley DHB	136	1,134	1,270	1,388
Lakes DHB	431	1,213	1,644	1,590
MidCentral DHB	47	966	1,013	2,467
Nelson Marlborough DHB	87	954	1,041	1,034
Northland DHB	30	1,762	1,792	2,826
South Canterbury DHB	55	380	435	464
Southern DHB	648	4,312	4,960	5,799
Tairawhiti DHB	32	310	342	389
Taranaki DHB	37	866	903	1,190
Waikato DHB	3,106	7,514	10,620	7,631
Wairarapa DHB	10	305	315	272
Waitemata DHB	192	2,916	3,108	4,415
West Coast DHB	89	351	440	479
Whanganui DHB	8	277	285	490
healthAlliance	-	-	-	279
TOTAL	**7,966**	**47,616**	**55,582**	**67,709**

Financial Statements

for year ended 30 June 2018

Statement of Comprehensive Revenue and Expenses
for the year ended 30 June 2018

		Notes	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
Income:					
Revenue from DHB's			14,914	23,796	26,372
Interest income	NZ Health Partnerships		29	15	48
	Shared Banking		19,420	12,000	20,630
Other income			2,740	0	3,491
Total Income		2	**37,103**	**35,811**	**50,541**
Expenditure:					
Personnel costs		3	4,622	6,771	3,295
Depreciation, amortisation and impairment expense		4	7,632	145	675
Interest on Shared Banking Facility	NZ Health Partnerships		0	0	344
	Shared Banking		19,337	12,000	20,579
Interest on finance lease			526	0	282
Other expenses		6	9,723	16,880	24,504
Total Expenditure			**41,840**	**35,796**	**49,679**
Surplus/ (Deficit)			**(4,737)**	**15**	**862**
Other Comprehensive Income			0	0	0
TOTAL COMPREHENSIVE INCOME			**(4,737)**	**15**	**862**

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 20.

Statement of Financial Position
as at 30 June 2018

	Notes	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
ASSETS				
Current Assets:				
Cash and Cash Equivalents	7	156,932	98,302	86,758
Receivables	8	6,570	10,586	9,118
Investments - Shared Banking	9	75,000	150,000	130,000
Prepayments		1,627	1,456	709
DHB Shared Banking Facility	12a.	63,991	0	50,840
Total Current Assets		**304,120**	**260,344**	**277,425**
Non-Current Assets:				
Receivables	8	2,564	0	4,520
Prepayments		273	0	445
Property, Plant, and Equipment	10	2,262	33	2,667
Intangible Assets	11	63,648	54,706	64,082
Total Non-Current Assets		68,747	54,739	71,714
Total Assets		**372,867**	**315,083**	**349,139**
LIABILITIES				
Current Liabilities:				
Payables	12	16,892	7,827	11,962
DHB Shared Banking Facility	12b.	290,256	244,121	264,462
Finance Lease Liability	5	627	0	532
Employee Entitlements	13	297	173	176
Income in Advance		495	0	256
Total Current Liabilities		**308,567**	**252,121**	**277,388**
Non-current liabilities:				
Payables	12	4,688	0	6,554
Finance Lease Liability	5	2,200	0	2,828
Income in Advance		469	0	689
Total Non-Current Liabilities		7,357	0	10,071
Total Liabilities		**315,924**	**252,121**	**287,459**
Net Assets		**56,943**	**62,962**	**61,680**

	Notes	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
EQUITY				
Contributed Capital	14	64,916	62,947	64,916
Accumulated Surplus / (Deficit)	14	(7,973)	15	(3,236)
Total Equity		**56,943**	**62,962**	**61,680**

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 20.

Statement of Changes in Equity
for the year ended 30 June 2018

	Notes	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
Balance at 1 July		61,680	62,947	60,818
Comprehensive Revenue and Expense for the Year		(4,737)	15	862
Balance at 30 June	**14**	**56,943**	**62,962**	**61,680**

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 20.

Statement of Cash Flows
for the year ended 30 June 2018

	Notes	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
Cash flows from Operating Activities:				
Receipts from DHBs		19,060	22,061	30,072
Receipts from Other Revenue		2,067	0	2,864
Interest Received		21,003	12,015	23,140
Payments to Suppliers		(7,810)	(15,145)	(24,892)
Payments to Employees		(4,542)	(6,771)	(3,296)
Interest Paid		(19,772)	(12,000)	(24,701)
Net Sweep Account Movements with DHB's		12,640	(121,268)	(29,156)
Goods and Services Tax (net) *		(148)	257	390
Net Cash Flow from Operating Activities		**22,498**	**(120,851)**	**(25,579)**
Cash flows from Investing Activities:				
Funds from Deposit		594,000	340,000	2,021,000
Purchase of Property, Plant, and Equipment		(198)	0	(2,858)
Purchase of Intangible Assets		(6,594)	(530)	(8,731)
Funds to Deposit		(539,000)	(235,000)	(2,011,000)
Net Cash Flow from Investing Activities		**48,208**	**104,470**	**(1,589)**
Cash flows from Financing Activities:				
Contributed Equity		0	0	0
Payments of finance leases		(532)	0	(206)
Proceeds from borrowings		0	0	3,566
Net Cash Flow from Financing Activities		**(532)**	**0**	**3,360**
Net (Decrease)/Increase in Cash and Cash Equivalents		**70,174**	**(16,381)**	**(23,808)**
Cash and Cash Equivalents at the Beginning of the Year		86,758	114,683	110,566
Cash and Cash Equivalents at the End of the Year	7	**156,932**	**98,302**	**86,758**

* The GST (net) component of operating activities reflects the net GST paid to and received from the Inland Revenue Department. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes and to be consistent with the presentation basis of the other primary financial statements.

The accompanying financial notes form part of these financial statements. Explanations of major variances against budget are provided in note 20.

Reconciliation of Net Surplus/(Deficit) to Net Cash Flow From Operating Activities

	Actual 2017/18 $000's	Actual 2016/17 $000's
Net surplus / (deficit)	(4,737)	862
Add/ (less) non-cash items		
Fair value adjustment from Service Provider Fees	(432)	588
Depreciation, amortisation and impairment expense	7,632	675
Total non-cash items	7,200	1,263
Add/ (less) movements in statement of financial position items		
(Inc)/Dec in Debtors and other receivables	5,176	5,679
(Inc)/Dec in Prepayments	(746)	(1,106)
Inc/(Dec) in Income in Advance	19	(362)
Inc/(Dec) in Creditors and other payables	2,825	(2,758)
Inc/(Dec) in Employee entitlements	121	(1)
Inc/(Dec) in Sweep Account Movements with DHB's	12,640	(29,156)
Net movements in working capital items	20,035	(27,704)
Net Cash Flow from Operating Activities	**22,498**	**(25,579)**

Financial Notes

for year ended 30 June 2018

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1 Statement of Accounting Policies

Reporting Entity

NZ Health Partnerships Limited is a Crown entity as defined by the Crown Entities Act 2004 (CEA) and is domiciled and operates in New Zealand. The relevant legislation governing NZ Health Partnerships' operations includes the CEA. NZ Health Partnerships is a multi-parent Crown subsidiary, owned by the 20 District Health Boards (DHBs), 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 a financial return.

NZ Health Partnerships has designated itself as a Public Benefit Entity (PBE) for financial reporting purposes.

During an assessment of ongoing commitments in relation to the National Technology Solution (NTS), we found a misinterpretation of the accounting treatment for one document in the arrangement, which has resulted in NZ Health Partnerships making a prior period adjustment in restating the arrangement as a finance lease. Further information on this can be found in Note 18.

Entering into a finance lease requires the authority of the Minister of Health and the Minister of Finance under Schedule 3, clause 45 of the New Zealand Public Health and Disability Act 2000 and sections 160 and 162 of the Crown Entities Act 2004. This was not obtained at the time due to the misinterpretation of the arrangement. We are in the process of seeking joint Ministerial approval for continuing the borrowing under the agreement, on and from the date such approval is granted. The financial statements for NZ Health Partnerships are for the year ended 30 June 2018 and were approved by the Board on 31 October 2018.

Basis of Preparation

These financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the year. NZ Health Partnerships operates on a cost recovery basis with support from all our DHB shareholders who underwrite all our operational and capital expenditure.

Statement of Compliance

These financial statements have been prepared in accordance with the requirements of the CEA, 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 International Financial Reporting Standards (IFRS) 9 Financial Instruments. This replaces PBE International Public Sector Accounting Standards (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 New Zealand's (Treasury) 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.

Summary of Significant Accounting Policies

Significant accounting 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.

Shared Banking Operations

NZ Health Partnerships operates as the provider of the Shared Banking service for the sector, where funds earn interest based on being held on call, or placed on term deposit.

The Statement of comprehensive income discloses the gross amount of interest earned on all funds managed within the Shared Banking service, and the gross amount of interest expenditure paid from that interest earned to the participants of the Shared Banking service.

Funds transacted through shared banking are disclosed in the Statement of Financial Position as the gross amount owing to or from the respective participants in the Shared Banking service as at the 30 June (note 12), together with the gross amount of term deposits placed on behalf of the sector (note 9). The amounts shown in the Statement of Cash Flows are the gross amounts of interest received and paid in relation to operating the Shared Banking service, together with the gross amount of term deposits made and matured during the year ended 30 June.

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 2017/18 (SPE) as approved by the NZ Health Partnerships Board (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 11
- Impairment of NOS programme assets - refer to note 11.

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. 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.

	Actual 2017/18 $000's	Budget 2017/18 $000's	Actual 2016/17 $000's
Programme revenue:			
National Oracle Solution	7,528	11,518	9,147
National Infrastructure Platform	672	1,735	2,089
Microsoft 2018	335	0	0
Total programme revenue	**8,535**	**13,253**	**11,236**
Services revenue:			
Shared Banking and Collective Insurance			
Interest Revenue from Shared Banking Facility	19,420	12,000	20,630
Shared Banking and Insurance Operations	603	603	603
National Procurement	3,426	4,850	12,560
Food Services *	0	0	370
Management Services	5,090	5,105	5,094
NZ Health Partnerships Interest	29	0	48
Total services revenue	**28,568**	**22,558**	**39,305**
Total revenue	**37,103**	**35,811**	**50,541**

* Food Service was recorded as a separate service in 2016/17. Following the cessation as a national contract services supporting the participating DHBs is now included under national procurement.

3 Personnel costs

Accounting Policy

Superannuation schemes
Defined benefit scheme

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.

	2017/18 Actual $000's	2016/17 Actual $000's
Salaries and wages	4,397	3,219
Defined contribution plan employer contributions	104	77
Increase/ (Decrease) in employee entitlements	121	(1)
Total personnel costs	**4,622**	**3,295**

Employee remuneration

The Company paid short-term benefits in excess of $100,000 by way of remuneration including salary and benefits to 16 employees during the year (2016/17: 11)

	2017/18 Actual	2016/17 Actual
Total remuneration paid or payable:		
$100,000 - $109,999	1	3
$110,000 - $119,999	3	3
$120,000 - $129,999	4	
$130,000 - $139,999	1	1
$140,000 - $149,999	1	
$150,000 - $159,999	1	
$160,000 - $169,999	1	
$170,000 - $179,999		1
$180,000 - $189,999	1	
$190,000 - $199,999		
$200,000 - $209,999		
$220,000 - $229,999		1
$230,000 - $239,999	1	
$240,000 - $249,999	1	1
$250,000 - $259,999		

	2017/18 Actual	2016/17 Actual
$260,000 - $269,999		
$270,000 - $279,999		
$280,000 - $289,999		
$290,000 - $299,999		
$300,000 - $309,999		
$310,000 - $319,999		1
$330,000 - $339,999		
$370,000 - $379,999	1	
Total employee remuneration	**16**	**11**

During the year ended 30 June 2018, one employee who received compensation and other benefits in relation to cessation totalling $9k (2016/17: two employees totalling $126k).

Board member remuneration

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

		2017/18 Actual $000's	2016/17 Actual $000's
Peter Anderson (Chair)		58	58
Lee Wanda Mathias	(resigned February 2017)	0	19
Terrance McLaughlin		29	29
Donald Murray Cleverley	(resigned June 2017)	0	29
Joanne Hogan		29	29
Deryck Jonathan Shaw	(resigned June 2018)	29	29
Phil Sunderland	(sudden death December 2016)	0	14
Kevin Atkinson	(started March 2017)	29	10
Rabin Rabindran	(started March 2017, resigned August 2018)	29	10
Ronald Luxton	(started August 2017)	28	0
Total Board Member Remuneration		**231**	**227**

There have been no payments made to committee members appointed by the Board who are not Board members during the financial year (2016/17: 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 (2016/17: none).

4 Depreciation, Amortisation and Impairment

Accounting Policy

Refer to the policy for depreciation, amortisation and impairment of property, plant and equipment, in Note 10, and intangible assets, in Note 11. The following table summarises the depreciation, amortisation and impairment set out in Note 10 and Note 11.

	2017/18 Actual $000's	2016/17 Actual $000's
Depreciation property, plant and equipment	605	269
Amortisation intangible assets	1,254	406
Impairment intangible assets	5,773	0
Total 4. Depreciation, amortisation and impairment expense	**7,632**	**675**

5 Leases

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 by 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.

Finance leases

A finance lease is a lease that transfers substantially all the risks and rewards incidental to ownership of an asset to the lessee, regardless of whether title may or may not eventually be transferred. At the commencement of the lease term, the lessee will recognise a leased asset and the associated lease obligation as a liability in the statement of financial position. The assets and liabilities shall be recognised at amounts equal to the fair value of the leased asset or, if lower the present value of the minimum lease payments.

Minimum lease payments are apportioned between a finance charge and a reduction of the outstanding finance lease liability. The finance charge is allocated to each period during the lease term so as to produce a constant periodic rate of interest on the remaining balance of the lease liability.

A finance lease gives rise to a depreciation expense as well as a finance expense which will be charged to the statement of comprehensive revenue and expense for each accounting period. Depreciation will be consistent with that for depreciable assets that are owned. Where there is no reasonable certainty that NZ Health Partnerships will obtain ownership by the end of the lease term, the asset will be depreciated over the shorter of the lease term or the assets useful life.

Operating leases as lessee

	2017/18 Actual $000's	2016/17 Actual $000's
Rent payable under non-cancellable operating leases to the end of the lease terms are:		
• Not later than one year	629	575
• Later than one year and not later than five years	1,318	1,500
• Later than five years	0	0

NZ Health Partnerships has one performance guarantee in place of $187k with Westpac for Goodman Nominee Ltd. (2016/17: $229k).

Finance leases as lessee

	2017/18 Actual $000's	2016/17 Actual $000's
Rent payable under non-cancellable finance leases to the end of the lease terms are:		
• Not later than one year	627	532
• Later than one year and not later than five years	2,200	2,828
• Later than five years	0	0
Total present value of minimum lease payments	**2,827**	**3,360**

NZ Health Partnerships has stated the lease liability at the present value of the minimum lease payments based on the 16.9% implied interest rate at the commencement of the lease. (2016/17:16.9%).

Reconciliation between the total future minimum lease payments and their present value

	2017/18 Actual $000's	2016/17 Actual $000's
Total present value of minimum lease payments	2,827	3,360
Interest expense	961	1,487
Total value future minimum lease payments	**3,788**	**4,847**

The finance lease is being disclosed as a result of a prior period adjustment. Entering into a finance lease requires the authority of the Minister of Health and the Minister of Finance under Schedule 3, clause 45 of the New Zealand Public Health and Disability Act 2000 and sections 160 and 162 of the Crown Entities Act 2004. This was not obtained at the time of entering into the arrangement. We are in the process of seeking joint Ministerial approval for continuing the borrowing under the agreement, on and from the date of such approval is granted. Further information on this can be found in Note 1 and Note 18..

6 Other Expenses

	2017/18 Actual $000's	2016/17 Actual $000's
Fees to principal auditor, Audit New Zealand	134	131
Other assurance providers	72	158
Staff travel	203	179
Board member fees	231	227
Consultancy	308	148
Services contracted out *	783	13,040
Contractors	1,852	3,147
Operating lease expenses	271	256
Other expenses	5,869	7,218
Total 5. Other Expenses	**9,723**	**24,504**

* The reduction in services contracted out is largely due to the National Procurement service transfer of staff from healthAlliance (FPSC) to NZ Health Partnerships.

7 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.

	Notes	2017/18 Actual $000's	2016/17 Actual $000's
Cash at Bank and on Hand		27	60
Call Deposit		2,791	1,830
DHB Shared Banking Facility	12c.	154,114	84,868
Total Cash and Cash Equivalents		**156,932**	**86,758**

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

8 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.

	2017/18 Actual $000's	2016/17 Actual $000's
Receivables	9,134	13,638
Less: provision for un-collectability	0	0
Total receivables	**9,134**	**13,638**
Receivables (current)	6,570	9,118
Receivable (non-current)	2,564	4,520
Total receivables	**9,134**	**13,638**

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

		2017/18 Actual	
	Gross $000's	Un-collectability $000's	Net $000's
Not past due	7,520	0	7,520
Past due over 90 days	1,614	0	1,614
Total	**9,134**	**0**	**9,134**

		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**

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

NZ Health Partnerships has a very small number of receivables. 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%.

9 Investments

Accounting Policy

Bank term deposits

Bank term deposits are measured at the amount invested.

	2017/18 Actual $000's	2016/17 Actual $000's
Current portion		
Term deposits with less than 12 months	75,000	130,000
Total current portion	**75,000**	**130,000**
Non-Current portion		
Term deposits with greater than 12 months	0	0
Total non-current portion	**0**	**0**
Total investments	**75,000**	**130,000**

The carrying value of term deposits approximates their fair value.

10 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, and

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 reliably measured.

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.

Leased assets 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:

2017/18 Actual						
	Leasehold Improvements	**Furniture and Office Equipment**	**Information Technology**	**Information Technology Leased**	**Information Technology NTS**	**Total**
	$000's	**$000's**	**$000's**	**$000's**	**$000's**	**$000's**
Cost or valuation						
Balance at 1 July 2017	12	74	37	2,848	0	2,971
Addition to WIP	0	0	0	0	0	0
Addition from WIP	0	0	0	0	0	0
Additions	0	0	5	0	195	200
Disposal	0	0	0	0	0	0
Balance at 30 June 2018	**12**	**74**	**42**	**2,848**	**195**	**3,171**
Accumulated depreciation and impairment losses						
Balance at 1 July 2017	8	33	25	238	0	304
Depreciation expense	1	11	7	569	17	605
Amortisation	0	0	0	0	0	0
Balance at 30 June 2018	**9**	**44**	**32**	**807**	**17**	**909**
Carrying Amount						
At 1 July 2017	4	41	12	2,610	0	2,667
At 30 June 2018	**3**	**30**	**10**	**2,041**	**178**	**2,262**

2016/17 Actual	Leasehold Improvements	Furniture and Office Equipment	Information Technology	Information Technology Leased	Information Technology NTS	Total
	$000's	$000's	$000's	$000's	$000's	$000's
Cost or valuation						
Balance at 1 July 2016	12	67	34	0	0	113
Addition to WIP	0	0	0	0	0	0
Addition from WIP	0	0	0	0	0	0
Additions	0	7	3	2,848	0	2,858
Disposal	0	0	0	0	0	0
Balance at 30 June 2017	**12**	**74**	**37**	**2,848**	**0**	**2,971**
Accumulated depreciation and impairment losses						
Balance at 1 July 2016	4	16	15	0	0	35
Depreciation expense	4	17	10	238	0	269
Amortisation	0	0	0	0	0	0
Balance at 30 June 2017	**8**	**33**	**25**	**238**	**0**	**304**
Carrying Amount						
At 1 July 2016	8	51	19	0	0	78
At 30 June 2017	**4**	**41**	**12**	**2,610**	**0**	**2,667**

The total amount of property, plant and equipment in the course of construction is $0.2m (2016/17 $nil).

11 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. Software training costs for staff and costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the 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 was initially called FPSC. NZ Health Partnerships holds NOS programme collateral as an intangible asset recognised at the capital cost of development relating to this programme.

Estimating useful lives of software assets

NZ Health Partnerships carrying amounts for acquired software from 1 July 2017 was $3.958m, which includes various software licenses from Oracle New Zealand (Oracle). The licenses are currently used by 11 DHBs. These software licenses have a finite life.

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; and

NZ Health Partnerships originally amortised the Oracle Licenses over a five-year term based on the hardware that was purchased at the same time as the licenses and used to host the software. In the 2017 annual accounts this useful life was reviewed and changed from five to 15 years for 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, and
- the NOS programme platform provided by the licences is expected to be in use by DHBs for at least 15 years.

Work in progress - Capitalisation of NOS programme

The NOS programme is not a single asset, but a bundle of assets relating to FPSC, and the development of the National Technology Solution (NTS) - the IT infrastructure platform on which the NOS programme would operate. These are both tangible, such as IT hardware, and intangible, such as software, standard operating procedures and intellectual property. NOS programme assets are held in Work in Progress (WIP).

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 staff, contractor and consultant time on programme development, as well as apportionment of the relevant overheads.

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

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:

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 10.

Impairment of NOS Programme Asset

At a functional level the NOS programme is intended to deliver a large number of business activities including receivables, debt collection, payables, general ledger, project and assets accounting, requisitions and purchasing, inventory management, replenishment, supply chain, national catalogue, contract management and financial and management reporting, where the depth, breadth and functionality of the solution provided exceeds that of any current DHB.

The NTS is the technical infrastructure to support the NOS programme system. The NTS is a dedicated national system, including high availability, rapid recovery from technical failure, as well as security hardened to meet current requirements, including compliance with the New Zealand Information Security Manual (NZISM).

The total original proposed expenditure on the project was $87.9m, of which $68.3m was to be capitalised and $19.6m was operating expenditure.

The NOS programme 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. Therefore, the applicable accounting standard is PBE IPSAS 21 Impairment of Non-Cash-Generating Assets.

At 30 June 2018, 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.

During 2016/17, previously identified timeframe and budget risks to the original programme resulted in the development of a revised approach which was documented in the "NOS Revised Business Case – Change Control Report" (CCR). In October 2017 all 20 DHBs approved the CCR, which reaffirmed their commitment to the NOS programme, approved a revised timeline and confirmed an additional $22.8m of capital funding to complete the project by managing the NOS programme as a series of interdependent projects, including NTS.

On 28 June 2018, the Ministry of Health (the Ministry) advised NZ Health Partnerships of Cabinet's decisions to approve up to $12m of capital funding, to allow the deployment of the NOS programme for the first four DHBs (First Wave) but "pausing" further development of the NOS programme and NTS pending a revised NOS programme business case. The Ministry also asked NZ Health Partnerships to develop a plan for the business case focused on the revised benefits to the sector and the cost to complete the project, including local implementation.

NZ Health Partnerships submitted the Plan in August 2018 and formal approval was expected in September 2018 but has been delayed beyond NZ Health Partnerships' control. The Ministry informally advised NZ Health Partnerships to proceed with the development of the business case in August 2018 and formal approval is expected in due course. In the absence of that approval, work has continued on the business case which is due to be submitted and subsequently approved by the Government in March 2019.

Following Cabinet's decisions, NZ Health Partnerships has considered the impairment of the NOS programme assets at 30 June 2018.

NZ Health Partnerships remains confident that the NOS programme will be supported and completed because:

- it would resolve current infrastructure and software needs across the sector and safeguard against system failures.
- it has been live for the First Wave DHBs since 2 July 2018.

- it will enable significant benefits to the sector, particularly procurement benefits, through increased economies of scale (including to PHARMAC who needs a national system with similar functionality to obtain expected benefits from national procurement of medical devices).
- a robust plan for the revised business case has been developed with widespread stakeholder involvement and support that effectively addresses all key matters raised by the Ministry.

Impairment of Change Management and Centralised Warehousing

The original FPSC business case was for a fully-integrated shared service environment including Change Management and Centralised Warehousing components. In 2015, the Change Management and Centralised Warehousing components were "paused" to focus development on NOS as the enabling core system. The November 2017 DHB approval of the CCR confirmed a change in the target operating model, by removing Change Management and Centralised Warehousing from the scope of the programme. The Board consider that work on these elements has been discontinued and the related costs previously capitalised as part of the the NOS programme asset have been impaired. As a result, the $3.853m of costs previously capitalised for Change Management have been fully impaired, and a partial impairment for the cost incurred on Supply Chain has been recognised, being the $1.92m cost relating to the development of centralised warehousing. The total impairment recognised in the Statement of Comprehensive Revenue and Expenses for the year ended 30 June 2018 is $5.773m.

Impairment testing of the National Technology Solution (NTS)

At 30 June 2018, $3.84m of costs had been incurred for the design of the NTS, the IT infrastructure platform upon which the NOS programme system is to operate. Following receipt of the 28 June 2018 Ministry advice of Cabinet's decision to pause further NOS development pending a revised business case, NZ Health Partnerships tested for impairment the NTS asset by determining the asset's value in use based on its depreciated replacement cost (DRC). NZ Health Partnerships considers, based on the information known to it, that the DRC of the NTS asset is in all material respects, equal to the costs capitalised to date, such that the NTS asset is not impaired. Considerations given in reaching this conclusion are set out below:

- The sector is facing critical business continuity risks from unsupported legacy technology infrastructure, and there is no indication that the demand or need for the services provided by the NTS will cease.
- The NTS design work is considered fit for purpose and potentially provides the quickest, safest way to mitigate pressing technology infrastructure risks for many DHBs. The Ministry of Health has approved DHBs continuing to underwrite $1.1m non-regrettable spend on the first build stage of NTS while it evaluates the options for mitigation of the technology infrastructure risks, including the NTS.
- The value to the sector of the NTS design work has not diminished as a result of the pause.

Impairment testing of the remaining NOS programme assets

The balance of the NOS programme asset which went into use with the First Wave DHBs on 2 July 2018, have also been tested for impairment by comparing the carrying amount of the intangible asset to its DRC.

NZ Health Partnerships' current expectation is that 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 assets in operation are not impaired.

NZ Health Partnerships has also tested the NOS programme assets WIP by determining the assets' value in use based on its DRC and considers that those assets are not impaired. Although the construction has been delayed pending decisions on the revised business case, there is no indication that the NOS programme will be discontinued in its entirety. NZ Health Partnerships conclusion is further supported by the following considerations:

- The benefit of the NOS programme to each DHB is that the potential cost savings from a negotiated national contract are expected to exceed the cost of each DHB negotiating a similar contract themselves.
- 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 in the technological, legal, or government policy environment in which the entity operates during the period or which are expected to take place in the near future, which have or are expected to have an adverse effect on NZ Health Partnerships.
- There has been no physical damage to the asset.
- There has been no significant long-term changes to the extent to which, or manner in which an asset is used or expected to be used during the period or which are expected to take place in the near future with an adverse effect on NZ Health Partnerships.
- The NOS programme WIP does not include any material costs that reflect inefficiency or similar items.

- The benefits that the programme is forecasted to deliver is expected to 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.

A number of the judgments considered above could be affected by the outcome of the revised NOS programme Business Case during the 2018/19 financial year. If this results in material changes in scope or cost/benefit assumptions, or in a decision to discontinue the programme, the NOS programme assets will be tested for impairment and a material impairment may need to be recognised in the 2018/19 financial year.

Breakdown of Intangible Assets and Further Information

Movements for each class of intangible asset are as follows:

2017/18 Actual	Work in progress	Acquired software	NTS software	Total
	$000's	$000's	$000's	$000's
Cost				
Balance at 1 July 2017	60,124	6,003	0	66,127
Additions to WIP	6,593	0	0	6,593
Additions from WIP	(4,632)	4,441	191	0
Disposal	0	0	0	0
Balance at 30 June 2018	**62,085**	**10,444**	**191**	**72,720**
Accumulated depreciation and impairment losses				
Balance at 1 July 2017	0	2,045	0	2,045
Amortisation Expense	0	1,238	16	1,254
Disposal	0	0	0	0
Impairment	5,773	0	0	5,773
Balance at 30 June 2018	**5,773**	**3,283**	**16**	**9,072**
Carrying Amounts				
Balance at 1 July 2017	60,124	3,958	0	64,082
At 30 June 2018	**56,312**	**7,161**	**175**	**63,648**

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

There are restrictions over the title of NZ Health Partnerships' intangible assets, please refer to note 14 (Equity). There are no intangible assets pledged as security for liabilities.

12 Payables

Accounting Policy

Short-term payables are recorded at their face value.

	2017/18 Actual $000's	2016/17 Actual $000's
Creditors	2,268	290
Accrued expenses	12,347	9,336
Service provider fee	6,811	8,561
Other payables	83	76
Tax payable (GST & PAYE)	71	253
Total 12. Payables	**21,580**	**18,516**
Total payables comprises:		
Payable (current)	14,769	9,955
Service provider fee (current)	2,123	2,007
Total current payables	**16,892**	**11,962**
Payable (non-current)	0	0
Service provider fee (non-current)	4,688	6,554
Total non-current payables	**4,688**	**6,554**
Total Payables	**21,580**	**18,516**

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

	Notes	2017/18 Actual $000's	2016/17 Actual $000's
Auckland DHB		95,322	69,641
Bay of Plenty DHB		21,964	14,690
Canterbury DHB		(17,376)	(16,505)
Capital & Coast DHB		17,582	20,299
Counties Manukau DHB		31,208	20,853
Hawke's Bay DHB		6,472	15,254
Hutt Valley DHB		5,874	7,134
Lakes DHB		7,038	3,836
MidCentral DHB		22,346	26,651
Nelson Marlborough DHB		18,470	21,554
Northland DHB		6,011	12,251
South Canterbury DHB		8,599	12,557
Tairawhiti DHB		(1,597)	(3,456)
Taranaki DHB		(4,578)	(3,349)
Waikato DHB		(9,517)	2,503
Wairarapa DHB		(943)	(3,183)
Waitemata DHB		29,078	17,813
West Coast DHB		11,683	10,743
Whanganui DHB		1,315	7,507
NZ Health Partnerships		2,791	0
healthAlliance Limited		868	(1,641)
HealthShare Limited		4,948	351
healthAlliance (FPSC) Limited		1,478	825
		226,265	**213,622**
Current Assets	a.	(63,991)	(50,840)
Current Liabilities	b.	290,256	264,462
		226,265	**213,622**
This balance is represented by:			
Cash and cash equivalents	c.	154,114	84,868
Term deposits		75,000	130,000
Accrued interest		(2,796)	(1,158)
Administrative fee		(54)	(88)
		226,264	**213,622**

13 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.

	2017/18 Actual $000's	2016/17 Actual $000's
Current portion		
Accrued salaries and wages	85	57
Annual leave	212	119
Employee Sick Leave Entitlements	0	0
Total current portion	**297**	**176**
Non-Current portion		
Employee Sick Leave Entitlements	0	0
Total Employee Entitlements	**297**	**176**

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.

14 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 - DHBs

	2017/18 Actual $000's	2016/17 Actual $000's
Accumulated surplus/(deficit)	(3,236)	(4,098)
Surplus/ (Deficit) for the year	(4,737)	862
Balance at 30 June 2018	**(7,973)**	**(3,236)**
Contributed Capital - DHB Equity		
Accumulated deficit transferred from HBL	(3,716)	(3,716)
Class B share transferred	68,333	68,333
Capital contributions transferred	299	299
Capital contributions from the DHBs B class share	0	0
Balance at 30 June 2018	**64,916**	**64,916**
Total Equity	**56,943**	**61,680**

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 programme 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 programme 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 programme 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 Programme 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.

15 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

	2017/18 Actual $000's	2016/17 Actual $000's
Board members		
Remuneration	231	227
Full time equivalent members	6.92	6.58
Leadership team		
Remuneration	1,307	1,397
Full time equivalent members	4.87	4.67
Total key management personnel remuneration	**1,538**	**1,624**
Total full time equivalent personnel	**11.92**	**11.25**

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 were taken onto the Executive Leadership Team. The additional cost of these specialist resources drove up the average salary in 2016/17 and, this has reduced in line with expectations.

16 Financial Instruments

16A Financial Instrument Categories

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

	2017/18 Actual $000's	2016/17 Actual $000's
Loans and receivables		
Cash and cash equivalents	156,932	86,758
Receivables (excluding GST)	9,134	13,638
DHB shared banking facility	63,991	50,840
Investments - Term deposits	75,000	130,000
Total loans and receivables	**305,057**	**281,236**
Financial liabilities measured at amortised cost		
Payables (excluding GST, PAYE & income in advance)	21,509	18,263
Present value minimum lease payments	2,827	3,360
DHB Shared Banking Facility	290,256	264,462
Total financial liabilities measured at amortised cost	**314,592**	**286,085**

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 $6.81m (2016/17: $8.56m), with payments over 32 and 62 month terms (2016/18: 44 and 84). Fair values are determined based on contractual cashflows discounted using market rates.

16B 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 Bank of New Zealand (BNZ). 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 (i.e. Kiwibank, Westpac New Zealand Limited, BNZ, 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 six-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 BNZ'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 Chief Financial Officers' 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:

	2017/18 Actual $000's	2016/17 Actual $000's
COUNTER-PARTIES WITH CREDIT RATINGS		
Cash, cash equivalent and investments		
AA-rated	231,932	216,758
Total cash, cash equivalents and investments	**231,932**	**216,758**
COUNTER-PARTIES WITHOUT CREDIT RATINGS		
Receivables		
Existing counter-party with no defaults in the past		
Debtors and other receivables (excluding GST)	9,134	13,638
DHB shared banking facility	63,991	50,840
Total debtors and other receivables	**73,125**	**64,478**

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 BNZ 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 2018 there was no liquidity risk.

Contractual maturity analysis of financial liabilities

The following table 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.

* If forecasts indicate that the sector is expected to go beyond the $50m standby facility to manage short term liquidity, discussions with DHBs and Ministry of Health will commence regarding the need for additional funding to support operating deficits or capital requirements.

2017/18 Actual	Carrying amount	Contractual cash flows	Less than 6 months	6-12 months	Greater than 1 year
	$000's	$000's	$000's	$000's	$000's
Payables (excluding income in advance, taxes payable and grants received subjected to conditions)	21,509	21,509	15,808	1,013	4,688
DHB Shared Banking Facility	290,256	290,256	290,256	0	0
Total	**311,765**	**311,765**	**306,064**	**1,013**	**4,688**

2016/17 Actual	Carrying amount	Contractual cash flows	Less than 6 months	6-12 months	Greater than 1 year
	$000's	$000's	$000's	$000's	$000's
Payables (excluding income in advance, taxes payable and grants received subjected to conditions)	18,263	18,263	9,489	1,187	7,587
DHB Shared Banking Facility	264,462	264,462	264,462	0	0
Total	**282,725**	**282,725**	**273,951**	**1,187**	**7,587**

17 Contingencies

NZ Health Partnerships has contracts for the provision of Infrastructure as a Service (IaaS) relating to the NTS programme, for which stop-cost contract penalties could result in the event NTS was discontinued.

If any IaaS provision was required as a result of the NOS programme and IT infrastructure risk mitigation reviews, and after any subsequent negotiations to mitigate any potential contract penalties, these costs would be passed through to DHBs as NOS programme operating expenditure.

In the unlikely event that there was a discontinuance of NTS and a requirement to stop the contract, for any resulting stop-cost penalties NZ Health Partnerships would have a contingent liability to the supplier, and an equal and corresponding contingent asset as a receivable from the DHBs. (2016/17: none).

18 Prior Period Adjustment

In 2016/17 contracts we had treated as operating service arrangements with Datacom for the provision of Infrastructure as a Service (Iaas), were novated from Datacom to OneSpark. In assessing the ongoing commitments in relation to the NTS programme, we concluded that fulfilment of one of these contracts is dependent on the use of a specific assets, and that the contract conveys the right to use those assets, and therefore IPSAS 13 requires that this contract should have been treated as a lease.

IPSAS 13 further requires a determination is made as to the classification of the lease based on the extent and to whom the risks and rewards incidental to ownership of a leased asset lie. Our assessment confirmed by independent professional advice is that, at the inception of the lease the present value of the minimum lease payments amounts to substantially all of the fair value of the asset, deeming the contract a finance lease.

This has necessitated adjustments to the prior period comparatives in our financial statements, with recognition of a lease asset, a prepayment asset for a support agreement included in the lease and a corresponding current and non-current lease liability together with appropriate note disclosure reconciling the total of future minimum lease payments at reporting date and their present value, as well as disclosing the future value of the minimum lease payments.

The effect of the restatement on the 2016/17 financial statements are summarised in the table below:

	2016/17 before adjustment $000's	2016/17 adjustment $000's	2016/17 after adjustment $000's
Statement of comprehensive revenue and expenses			
Expenditure:			
Depreciation, amortisation and impairment expense	437	238	675
Interest on finance lease	0	282	282
Other expenses	24,892	(388)	24,504
Total expenditure movement	**25,329**	**132**	**25,461**
Statement of financial position			
Assets			
Current Assets:			
Prepayments	537	172	709
Total current assets movement	**537**	**172**	**709**
Non-Current Assets:			
Prepayments	0	445	445
Property, Plant, and Equipment	57	2,610	2,667
Total non-current assets movement	**57**	**3,055**	**3,112**
Total assets movement	**594**	**3,227**	**3,821**

Liabilities			
Current Liabilities:			
Finance Lease Liability	0	532	532
Total Current Liabilities	**0**	**532**	**532**
Non-current liabilities:			
Finance Lease Liability	0	2,828	2,828
Total non-current liabilities movement	**0**	**2,828**	**2,828**
Total liabilities movement	**0**	**3,360**	**3,360**
Net assets movement	**594**	**(132)**	**462**
Equity			
Accumulated Surplus / (Deficit)	(3,104)	(132)	(3,236)
Total equity movement	**(3,104)**	**(132)**	**(3,236)**

The statement of comprehensive revenue and expenses has been adjusted to remove the Iaas operating service agreement expense $0.5m, offset by $0.1m charge for support expense, $0.2m depreciation expense for the leases asset, and $0.3m of finance lease interest expense.

The statement of financial position has been adjusted to include the $2.8m leased assets, $0.7m prepayment of a support charge in relation to the asset, reduced by the $0.1m charge for the 2016/17 financial year, categorised between current and non-current, together with the balance of the corresponding $3.4m finance lease liability, categorised between current and non-current.

In 2016/17 a participation agency agreement under an All of Government contract for the procurement of Iaas was amended by a change authorisation agreement which would have been treated as an operating service arrangement, save for three non-standard items which were noted as having a five-year minimum term. The three non-standard items, should have been disclosed as an operating lease commitment in the prior period.

The effect of the restatement on the 2016/17 financial statements are summarised in the table below

Operating Lease as Lessee	**2016/17 Before adjustment $000's**	**2016/17 Adjustment $000's**	**2016/17 After adjustment $000's**
Rent payable under non-cancellable operating leases to the end of the lease terms are:			
– Not later than one year	170	405	575
– Later than one year and not later than five years	17	1,483	1,500
– Later than five years	0	0	0

19 Events After the Balance Date

There have been no material events subsequent to 30 June 2018 (2016/17: none).

20 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 $8.9m lower than budget due to NZ Health Partnerships incurring lower than budgeted NOS programme and National Procurement expenses.

Interest revenue

Interest Income is $7.4m higher than budget due to changes in the market conditions and higher than planned cash held in the sweep.

Other revenue

Other revenue was $3.2m higher than budget due to unbudgeted revenue from PHARMAC regarding data from the Data Hub, as well as a fair value adjustment for receivable due to earlier than forecast collection of receivables under the contract with a third party supplier.

Expenses

Personnel costs

Personnel costs are $2.3m lower than budget due to lower than planned permanent staffing levels.

Interest expenses

Interest expense is $7.3m higher than budget due to higher than planned interest received in Shared Banking activities.

Depreciation, amortisation and impairment expenses

Depreciation, amortisation and impairment $7.6m higher than budget, $5.8m for the impairment of the NOS programme asset, and unbudgeted depreciation relating to the data hub and the treatment of a finance leased asset.

Other expenses

Other expense is $7.6m lower than budget with reduction in timing of NOS programme and National Procurement expenses, offset by revenue reduction highlighted above, together with impact of the reclassification of a contract from operating service agreement to a finance lease, reducing the operational expense but offset by increase in unbudgeted depreciation and interest expense in relation to the deemed finance lease.

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.

21 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 2018

The Auditor-General is the auditor of New Zealand Health Partnerships Limited (the Company). 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 the Company on his behalf.

Opinion

We have audited:

- the financial statements of the Company on pages 36 to 79 , that comprise the statement of financial position as at 30 June 2018, 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 the statement of accounting policies and other explanatory information; and
- the performance information of the Company on pages 18 to 35.

In our opinion:

- the financial statements of the Company on pages 36 to 79:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; 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 Reporting Standards; and
- the performance information on pages 18 to 35:
    - presents fairly, in all material respects, the Company's performance for the year ended 30 June 2018, 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 31 October 2018. This is the date at which our opinion is expressed.

The basis for our opinion is explained below and we also draw your attention to other matters. 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.

Uncertainties over the carrying value of the National Oracle Solution Programme

Without modifying our opinion, we draw your attention to the disclosures made in note 11 on page 60 to 65 in relation to the development of the National Oracle Solution (NOS) Programme assets. The disclosures outline the matters that the Board has considered in assessing whether the NOS Programme asset is impaired and how the impairment of $5.8m has been determined. Because the NOS Programme has been paused while a review of the business case is completed, there are uncertainties about the future of the NOS Programme assets, which may materially affect their future carrying value. We consider the disclosures to be adequate.

Unauthorised borrowings

Without modifying our opinion, we draw your attention to note 1 on pages 45 to 47 and note 5 on pages 52 and 53 about the Company not complying with Schedule 3, clause 45 of the New Zealand Public Health and Disability Act 2000, and sections 160 and 162 of the Crown Entities Act 2004, in that the Company entered into a finance lease without the authority of the Minister of Health and the Minister of Finance.

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 is responsible on behalf of the Company for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is responsible for such internal control as it determines necessary to enable it 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 is responsible on behalf of the Company for assessing the Company's ability to continue as a going concern. The Board is 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 the Company, or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004 and the Public Finance Act 1989.

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 the Company'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 the Company'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 the Company'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 the Company'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 the Company 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 is responsible for the other information. The other information comprises the information included on pages 1 to 17 and pages 84 and 85, 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 the Company 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 the Company.

Athol Graham
Audit New Zealand
On behalf of the Auditor-General
Auckland, New Zealand

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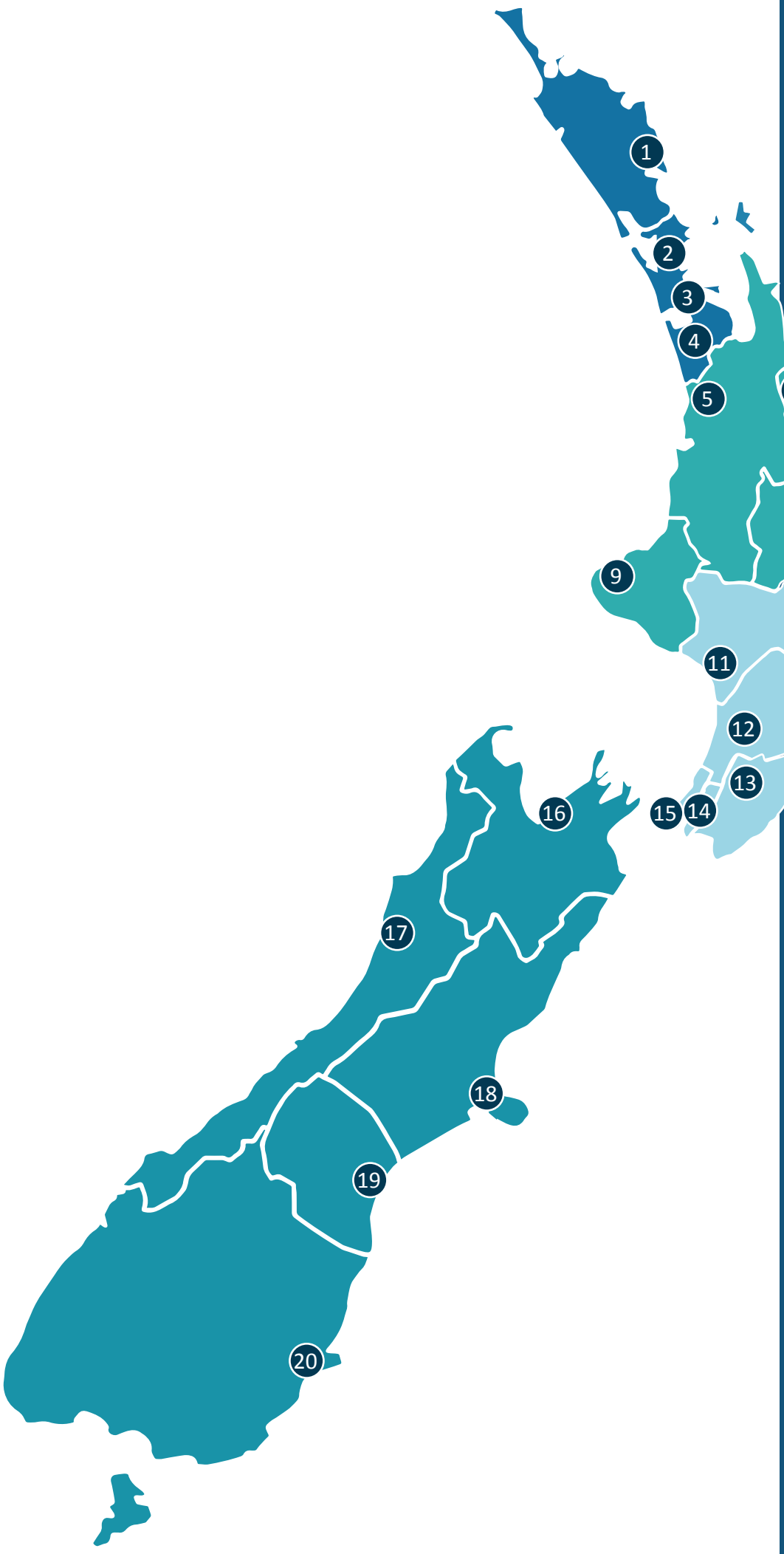
Auditor

The Auditor-General, pursuant to section 15 of the Public Audit Act 2001. Athol Graham, Director, Audit New Zealand was appointed to perform the audit on behalf of the Auditor-General.

Banker

Bank of New Zealand

Our Shareholders



NORTHERN REGION

Northland DHB	.1
Waitemata DHB	.2
Auckland DHB	.3
Counties Manukau DHB	.4

MIDLANDS REGION

Waikato DHB	.5
Bay of Plenty DHB	.6
Lakes DHB	.7
HauorāTairawhiti	.8
Taranaki DHB	.9

CENTRAL REGION

Hawke's Bay DHB	.10
Whanganui DHB	.11
MidCentral DHB	.12
Wairarapa DHB	.13
Hutt Valley DHB	.14
Capital and Coast DHB	.15

SOUTHERN REGION

Nelson Marlborough DHB	.16
West Coast DHB	.17
Canterbury DHB	.18
South Canterbury DHB	.19
Southern DHB	.20

WEST COAST DHB – MEETING SCHEDULE

FEBRUARY – DECEMBER 2019

DATE	MEETING	TIME	VENUE
Thursday 7 February 2019	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 15 February 2019	Advisory Committee Meeting	10.00am	St John, Water Walk Rd, Greymouth
Friday 15 February 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Friday 29 March 2019	Advisory Committee Meeting	10.00am	St John, Water Walk Rd, Greymouth
Friday 29 March 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 2 May 2019 (in place of ANZAC Day)	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 10 May 2019	Advisory Committee Meeting	10.00am	St John, Water Walk Rd, Greymouth
Friday 10 May 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Friday 28 June 2019	Advisory Committee Meeting	10.00am	St John, Water Walk Rd, Greymouth
Friday 28 June 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 25 July 2019	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 9 August 2019	Advisory Committee Meeting	10.00am	St John, Water Walk Rd, Greymouth
Friday 9 August 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Friday 27 September 2019	Advisory Committee Meeting	10.00am	St John, Water Walk Rd, Greymouth
Friday 27 September 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 24 October 2019	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 1 November 2019	Advisory Committee Meeting	10.00am	St John, Water Walk Rd, Greymouth
Friday 1 November 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 28 November 2019	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 13 December 2019	BOARD MEETING	10.00am	St John, Water Walk Rd, Greymouth

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