TAIRAWHITI DISTRICT HEALTH BOARD

MEETING OF THE TAIRAWHITI DISTRICT HEALTH BOARD

Tuesday, 26 May 2015
commencing 9.00am

Venue: Board Room, Tairawhiti District Health

MEDICATION SAFETY CAMPAIGN

The Mission of the Health Quality & Safety committee (HQSC) is to work with everyone to ensure New Zealand has the highest quality health care. To achieve this mission, the HQSC is aiming to improve quality, safety and experience of care.

The current Health Quality & Safety Commission's *Open* focus is on reducing harm from medication error in our hospitals, general practices, aged care facilities and across the entire health and Disability sector.

"We aim to reduce the harm caused by medication errors and make sure the right people, get the right medicine, in the right dose, at the right time and by the right route."
(Carmela Petagna, Senior Portfolio Manager, Medication Safety Campaign).

For the Medication Safety Programme to be successful, the support of the entire health and disability sector is needed.

MEETING OF THE TAIRAWHITI DISTRICT HEALTH BOARD

Tuesday, 26 May 2015

A G E N D A

9.00am	**Meeting Commences**
10.15am	**Presentation: Telehealth (Sumita Prabhakaran, Psychiatrist, Community Mental Health)**

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLVED that:
In accordance with the provisions of Schedule 3, of the NZ Public Health and Disability Act 2000, that the public be excluded from the following part of the of the proceedings of this, meeting namely:

The reason for passing this resolution and the grounds on which the resolution is based, together with the particular interest or interests protected by the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public areas are as follows:

Item/s	Reason(s) under Clause 33 for passing this resolution in relation to each item:	Ground(s) under Clause 32 for passing this resolution
12	As shown on resolution to exclude the public in Minutes.	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32(a)]
16.1-2	**Negotiations or Commercial Activities** – The disclosure of that information would not be in the public interest because of the greater need to enable TDH to carry on, without prejudice or disadvantage, negotiations. [OIA 1982 S.9 (2) (j) & (i)	

RESOLUTION TO READMIT THE PUBLIC

ADOPTED:
(1) That the public be readmitted
(2) Recommendations be released unless further investigations are required prior to final resolution.
(3) The Executive be delegated authority after the meeting to determine which items should be made publically available for the purposes of publicity or implementation.

17. PUBLIC RELEASE OF IN COMMITTEE DECISIONS

DATE OF NEXT MEETING: 26 May 2015 commencing at 9.00am

BOARD MEMBERS' REGISTER OF INTERESTS

MEMBER	INTEREST DECLARED	ROLE
Craig Bauld	Gisborne District Council	Councillor
	TDH Child & Adolescent Mental Health Services (CAMHS)	Daughter an employee
Clive Bibby	Tokomaru Bay Heritage Trust	Project Manager/Fundraiser
	Reynolds Hall Trust	Fundraiser
	Kanuka Ridge Mentoring	Director
	Kanuka Ridge Partnership	Managing Partner
	East Coast Solutions	Director
Barbara Clarke	STAND Children's Services	National Board Member
	Children's Health Camp Charitable Trust	Trustee
	Sunny Day Trust (Sunshine Bus)	Chairperson
	EIT Tairawhiti	Nursing Education Stakeholder Reference Group
	TLab	Director
Geoff Milner	GMA Chartered Accountants	Principal
	Ngati Porou Seafoods Group of Companies	Director
	Eastland Community Trust	Trustee
	Horouta Sports Club Inc	Chairman
	Tairawhiti Maori Business Network Inc	Executive Member
	Kaiti Medical Centre	Client
	Tairawhiti Laundry Services Limited	Director
	Eastern & Central Community Trust	Chair
Erana Reedy	Radio Ngati Porou	Chief Executive/Journalist
	Te Runanga o Ngati Porou	External Communications Service Contractor
	Te Aowera Marae Committee	Trustee
	Waipiro A29 Inc	Member
	Waitaiki Farm Partnership	Chair
	Te Whakaruruhau o Nga Reo Irirangi Maori	Executive Committee Member
	Ruatoria Health Clinic	Client
David Scott (Chair)	Three Rivers Medical Centre	Wife an employee
	Treescape Farm Partnership	Partner in Business
	Treescape Consultancy	Business Consultant
	Te Kuri a Tuatae Marae	Trustee
	East Coast Rural Support Trust	Rural Support Co-ordinator
	Gisborne District Council Civil Defence	Shift Volunteer/Media Liaison Officer
	Gisborne Herald	Casual non-paid columnist
	Middle Mount Company Ltd	Director
Kathy Sheldrake	Gisborne West Rotary Club	Member
	TMS Sport Promotions Limited	Director
	Justice of the Peace/Marriage Celebrant	
Rehette Stoltz	Gisborne District Council	Deputy Mayor
	Sport Gisborne Tairawhiti	Trustee
	Tairawhiti Positive Aging Trust	Trustee
	E Tu Elgin Community Group	Member

	Husband employed by Tairawhiti District Health	Deon Stoltz (Senior Medical Officer)
	Deon Stoltz Medical Services	Director
	Art in Public Places	Trustee
	Social Sector Trials Committee	Chair
Maaka Tibble	Te Rimu Ahuwhenua Trust	Responsible Trustee
	Taurawharona Farming Inc	Chair
	Turanga Health Hauora	Tane Ropu
	Tairawhiti Special Olympics Committee	Member
	Henry Rongomau Bennett Scholarship Foundation	Member
	NZQA Maori Qualifications Services	Disabilities Advisor
	Wife an employee of TDH	Roberta Tibble (Community Mental Health)
	Son an employee of TDH	Kahurangi (Community Mental Health)
	City Medical	Client
	Iwi Chairs Forum Monitoring Mechanism	Member
Matthew Todd	Matt Todd Holdings Limited	Director
	Worlds Edge Developments Limited	Director
	Eastland Group Limited*	Chief Executive & Director of numerous subsidiaries
	GisVin Limited	Director
	Tairawhiti Laundry Services Ltd	Director
	Gisborne Holdings Limited and its subsidiary Tauwhareparae Farms Limited.	Director
Brian Wilson	Gisborne City Pharmacies	Independent Pharmacy Contractor
	B & P Wilson Family Trust	Trustee
	Gisborne District Council	Councillor
	YMCA	Director
	Gisborne Surf Lifesaving Charitable Trust	Trustee
	Medirest Ltd	Wife an employee
	TLab	Director

TWON Chair		
Na Raihania	Whanau Trusts	Trustee
	Hawkes' Bay DHB Iwi Relationship Board	Member

TAIRĀWHITI DISTRICT HEALTH BOARD

MINUTES
TAIRĀWHITI DISTRICT HEALTH BOARD MEETING
Tuesday 28 April 2015 commencing at 9.00am

Present	David Scott (Board Chair) Kathy Sheldrake Barbara Clarke Clive Bibby Matt Todd Brian Wilson Geoff Milner Craig Bauld Rehette Stoltz Maaka Tibble Erana Reedy
Attending	Lynsey Bartlett (Acting Chief Executive) Na Raihania (Chair, TWON) Mike Costello (GM Finance) Virginia Brind (GM Planning, Funding & Population Health) Toni Lexmond (Communications Manager) Joyce O'Donnell (Minutes)
Public	Wynsley Wrigley (Media) Representatives of the Service and Food Workers Union
Karakia	Clive Bibby. Maaka Tibble led the Board in paying respects to Nellie Brooking (previous Chief Executive, Ngati Porou Hauora) on her passing.
Presentation	Stu Potter (TDH Kaupapa Vision & Values)

ITEM 1: APOLOGIES

Jim Green (Chief Executive)

ITEM 2: INTERESTS

5.1 Changes to Register

Nil

5.2 Conflicts Related to Any Item on the Agenda

Nil

ITEM 3: MINUTES OF PREVIOUS MEETING

ADOPTED

The public minutes of the Tairawhiti District Health Board meeting held on 31 March 2015 confirmed as a true and accurate record.

ITEM 4: MATTERS ARISING FROM THE MINUTES

Noted

ITEM 5: ACTION ITEMS

Noted

ITEM 6: CORRESPONDENCE

Nil

ITEM 7: PATIENT QUALITY & SAFETY

Nil

ITEM 8: REPORTS

8.1 Performance Dashboard

Noted

8.2 Chair's Report

Noted

8.3 Chief Executive's Report

Noted and the Acting Chief Executive responded to questions throughout, in particular in relation to the cancer treatment access health target and associated referral/treatment timelines.

The Board were notified that, following his injury, the Chief Executive has received medical clearance to return to work progressively but that the Acting Chief Executive continues with that delegation for the next two weeks.

9.41am Representatives of the Service & Food Workers Union left the meeting

East Coast Review

Management indicated they were following up with Ngati Porou partners as to progress in relation to the East Coast Review.

E Tipu E Rea

The GM Planning, Funding & Population Health confirmed that whilst E Tipu e Rea and the Children's Team had a different genesis and focus, they shared the same kaupapa of improving the health and wellbeing of children in Tairawhiti. She explained both entities were aware of the need to avoid duplication in service provision; and that the implementation of the Collective Impact Framework will contribute to the organisation of workstreams.

The Board noted that E Tipu e Rea were further along in their establishment and service implementation but that discussion amongst the team reflected a likelihood that the two entities will merge in the future.

The GM Planning & Funding responded also to questions about the Pepi-pod programme and Eating Disorder consultations via Telehealth.

8.4 Finance Report

Noted and the GM Finance spoke of the financial challenges faced by the organisation which are a continued focus of the Board's Finance Audit and IT Committee.

8.5 Board Sub-Committee reports

Noted

8.6 TWON report

Noted

Whanau Ora

The Board agreed with TWON's suggestion for a TDH position statement on Whanau Ora in so much as it will inform negotiations with other agencies and will assist in establishment a framework for measuring outcomes. TWON are progressing this work.

ITEM 9 INFORMATION ITEMS

9.1 Tairawhiti Wellbeing – a collective impact framework

Noted. The Board were in favour of the initiative but commented that the concept was not new and it would be important to develop meaningful targets and measure outcomes (as opposed to developing strategy). The GM concurred and advised the initial focus will be on defining what 'wellbeing' means in Tairawhiti and develop targets to meet that. The Board noted the implementation plan will include revised timeframes.

9.2 Disposal of Western Rural Properties

Noted

ITEM 10 DECISION ITEMS

10.1 Kaupapa, Values & Behaviours

The Board received an explanation from Stu Potter and noted the implementation plan outlined in the paper.

ADOPTED:

The recommendation to approve the Tairawhiti District Health Kaupapa, Values and Behaviours.

ITEM 11 GENERAL BUSINESS

Nil

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLVED that:

In accordance with the provisions of Schedule 3, of the NZ Public Health and Disability Act 2000, it was agreed that the public now be excluded from the following part of the of the proceedings of this meeting to discuss the general subject matter/s as follows:

12 **In Committee Minutes**
13 **In Committee Action Items**
14 **In Committee reports from TDH Advisory Committees**
15 **Information Items**
- 15.1 Options to Improve Dental Services on the East Coast (update)
- 15.2 National Food Services Proposal

16 **Decision Items**
- 16.1 National Finance, Procurement and Supply Chain (FPSC) programme: Business Change Case and Case for System Implementation
- 16.2 Health Benefits Limited (HBL) Transition

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which would be prejudiced by the holding of the whole or the relevant part of the proceedings of the meeting in public areas are as follows:

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15.1-2 16.1-2	**Commercial Activities/Negotiations** – The disclosure of that information would not be in the public interest because of the greater need to enable TDH to carry on, without prejudice or disadvantage, negotiations. [OIA 1982 S.9 (2) (i) and (j)]	

The Chair of TWON, the Acting Chief Executive, GMs Finance and Planning, Funding & Population Health, the Communications Manager and the Minute Secretary were invited to remain for facilitation of Board discussion and recording.

The meeting continued with the public excluded.

ITEM 17 PUBLIC RELEASE OF IN COMMITTEE DECISIONS

There were no In Committee decisions released from the public excluded session.

Meeting Closed: 12.10pm

DATE OF NEXT MEETING:
26 May 2015 commencing 9.00am in the TDH Boardroom

…….. …….
Chair Date

Tairawhiti District Health Board

ACTIONS SCHEDULE

AGENDA ITEM 5

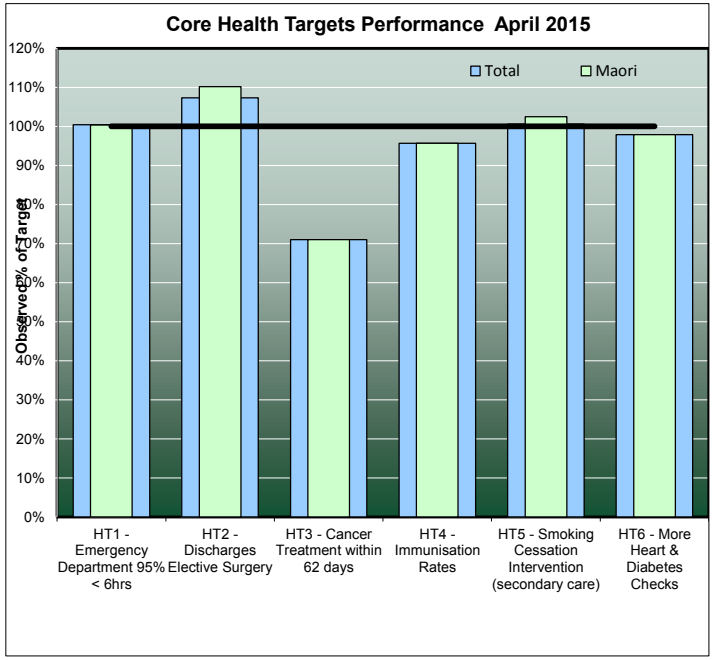
Item	*Description*	*Who*	*Deadline*
Carried over			
Ex HAC (May)	Review of Clinical Board Terms of Reference to Board. • *An updated terms of reference of the Clinical Board to reflect an improved pathway of clinical governance has not been agreed. On reflection, the Chair of Clinical Board has concluded that changes to one aspect of the system need to be made in the context of consideration of the whole system. The Chair of Clinical Board, with agreement of the CE, will be accountable for proposing a system of clinical governance which addresses reporting and accountability structures, supporting committees, and clinical governance processes. This will be followed by a consultation process. The time frame is to be determined between the Clinical Board Chair and the CE.*	Ros Iversen	February
Progress Against TDH Annual Plan 2014	Provide summary feedback against the unachieved results together with remedial plans to HAC, CPHAC and TWON. • *Carry over as scheduled*	Virginia Brind	July 2015
Progress Against TDH Public Health Plan 2014	Note the request to amend the future reporting format (similar to Annual Plan Progress report) for enhanced readability. • *Carry over as scheduled*	Virginia Brind	July 2015
Access to Elective Surgery Dashboard Indicators	1. Provider Arm/Communications and Health Promotion collaborate on developing a family/whanau check list. • *Carry over as scheduled* 2. Discuss at TIC specifically in relation to bowel cancer. • *Noted to discuss at TIC and verbally report back.*	Virginia Brind Lynsey Bartlett	June 2015
Active Transport Position Statement	Develop a more detailed TDH position statement (with evidence/examples under a whole of health approach) • *On agenda*	Virginia Brind	June 2015
April 2015			
Nil			

Tairawhiti District Health Dashboard

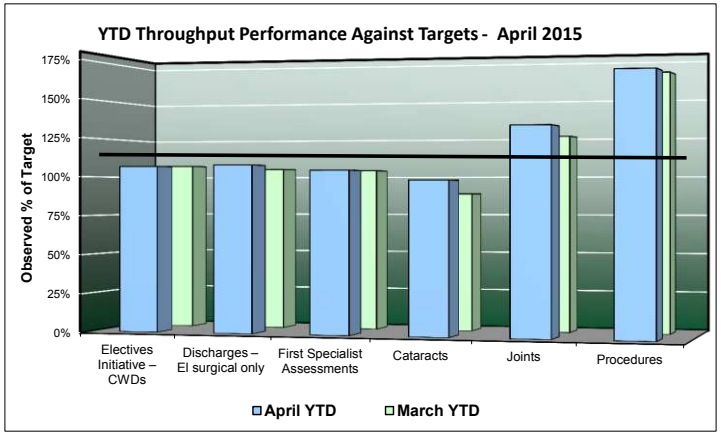
Var* - Variance to budget/target/expected:
Favourable result (*fav.*)
Unfavourable result (*unf.*)

Trend Arrows - Comparing last 3 months to last 12 months.
Favourable (black arrow) ↗
Unfavourable (white arrow) ↗

	April-2015				Trends (Monthly Averages)			
Patient Safety and Quality	**Actuals**	**Var***	**Target**	**March-15**	**Last 12 Months**		**Last 3 Months**	
Patient Falls	10	*unf.*	6	11	9.3	*unf.*	11.0	↗
Severity Assessment Code 1 Events	0	*fav.*	0	0	0	*fav.*	0	↘
Severity Assessment Code 2 Events	1	*unf.*	0	1	0.4	*unf.*	0.7	↗
Emergency Department 95% < 6hrs								
- Maori	95.4%	*fav.*	95%	96.7%	95.8%	*fav.*	96.5%	↗
- All	95.5%	*fav.*	95%	95.8%	95.6%	*fav.*	95.9%	↗
Smoking Cessation Intervention Primary Care (Q2 14/15)								
- Maori	90.1%	*fav.*	90%	94.4%	87.3%	*fav.*	93.0%	↗
- All	90.1%	*fav.*	90%	94.4%	87.4%	*fav.*	93.0%	↗
Smoking Cessation Intervention Secondary Care								
- Maori	95.1%	*fav.*	95%	97.3%	96.6%	*fav.*	97.1%	↗
- All	96.0%	*fav.*	95%	94.7%	96.2%	*unf.*	95.6%	↘
Immunisation at 8 months (by ethnicity)								
- Maori	88.7%	*unf.*	90%	89.7%	91.1%	*unf.*	90.3%	↘
- All	90.9%	*fav.*	90%	92.0%	91.7%	*fav.*	92.3%	↗
Immunisation at 2 years (by ethnicity)								
- Maori	93.5%	*unf.*	95%	90.4%	91.9%	*unf.*	91.0%	↘
- All	92.6%	*unf.*	95%	92.1%	92.0%	*fav.*	92.1%	↗
More Heart and Diabetes Checks (Q2 14/15)								
- Maori	86.2%	*unf.*	90%	85.5%	83.6%	*fav.*	85.7%	↗
- All	88.1%	*unf.*	90%	88.2%	86.5%	*fav.*	88.2%	↗
Faster Cancer Treatment (note: change of Cancer Health Target to 85% of patients waiting <62 days - implemented 1 March 2015)	71%	*unf.*	85%	74%	73%	*fav.*	73%	↗
Decubitus Ulcers	2	*fav.*	2	2	2.4	*fav.*	2.0	↘
Hand Hygiene - % 5 Moments	67%	*unf.*	80%	67%	71%	*unf.*	67%	↘
Complaints	8	*unf.*	7	9	9.8	*fav.*	7.7	↘
Reduced Hospital acquired Infections	0	*fav.*	N/A	0	2.4	*fav.*	0.0	↘
Reduced Medication Errors	10	*fav.*	N/A	12	10.0	*unf.*	12.0	↗
Medication Charting Errors	3.3%	*fav.*	N/A	3.5%	5.8%	*fav.*	4.0%	↘



	April-15				April YTD		
Throughput (includes estimates of local and IDF delivery)	**Actuals**		**Target**	**March-15**	**Actuals**		**Target**
Electives Initiative – CWDs	230	*fav.*	229	258	2,258	*fav.*	2,118
Discharges – El surgical only							
- Maori	70	*fav.*	64	71	656	*fav.*	595
- All	223	*fav.*	178	212	1,775	*fav.*	1,654
First Specialist Assessments	528	*fav.*	522	727	5,530	*fav.*	5,328
Cataracts	21	*fav.*	11	3	117	*fav.*	110
Joints	16	*fav.*	8	9	117	*fav.*	78
Procedures	85	*fav.*	65	108	914	*fav.*	530

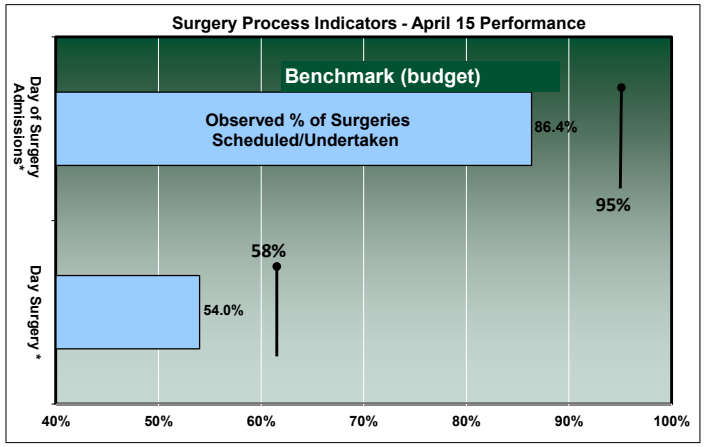


Diagnostic Waiting Times * *1 month behind due to data being collated Nationally*	**March-15**	**Target**	**Feb-15**	**12 Months to the end ofMarch 2015**		
- Coronary Angiography	67%	85% < 90 days	50%	60.4%	*unf.*	85% < 90 days
- CT	94%	75% < 43 days	92%	89.8%	*fav.*	75% < 43 days
- MRI	73%	75% < 43 days	92%	84.3%	*fav.*	75% < 43 days
- Urgent Colonoscopy	75%	50% < 15 days	80%	34.1%	*unf.*	50% < 15 days
- Non Urgent Colonoscopy	57%	50% < 43 days	52%	39.2%	*unf.*	50% < 43 days
- Surveillance Colonoscopy	75%	50% < 85 days	76%	82.2%	*fav.*	50% < 85 days

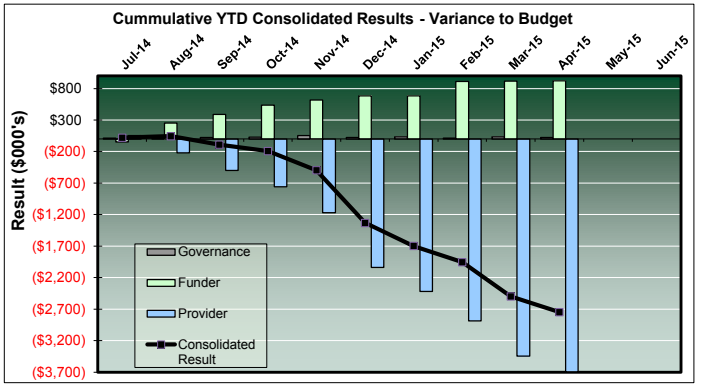
Tairawhiti District Health Dashboard

Process	Apr-15 Actuals		Apr-15 Budget	Apr-15 March-15	Trends (Monthly Average) Last 12 Months		Trends (Monthly Average) Last 3 Months	
ESPI Status	ESPIs reflect compliance across all at an organisational level							
Staff Turnover (target lowered)	8.6%	*fav.*	10.0%	8.7%	9.0%	*fav.*	8.9%	↘
Staff Injury (per 1m hours worked)	1.0	*fav.*	7.6	1.0	0.8	*fav.*	0.7	↘
Management/Admin FTEs	135.97	*fav.*	139	133.44	135.2	*fav.*	134.9	↘
Day of Surgery Admissions*	86%	*unf.*	95%	85%	88.2%	*unf.*	86.5%	↘
Day Surgery *	54%	*unf.*	58%	53%	54.4%	*unf.*	52.4%	↘
Discharge by 11								
Ward 5	15.00%	*unf.*	75.0%	14%	17.0%	*unf.*	16.6%	↘
Ward 8	30.00%	*unf.*	75.0%	25.0%	29.4%	*unf.*	26.7%	↘
Did Not Attend (DNA) outpatients	10.5%	*unf.*	10.0%	8.30%	9.3%	*unf.*	9.4%	↘
Acute Readmission Rate	3.9%	*fav.*	5.5%	6.32%	6.0%	*fav.*	5.3%	↗
Non-urgent Mental Health & Addiction waiting times								
- Mental Health waiting times (< 3 weeks)	63.0%	*fav.*	3 Weeks	67.0%	66.1%	*unf.*	65.7%	↘
- Addiction Services Waiting times (< 3 weeks)	77.0%	*fav.*	3 Weeks	72.0%	66.3%	*fav.*	73.7%	↗

** Budget uses national raw rates as a benchmark*



Financial (YTD) 2013/14 ($'000)	Apr-15 Actuals		Apr-15 Budget	Apr-15 March-15	Apr YTD Actuals		Apr YTD Budget	
Consolidated Revenue	$13,962	*fav.*	$13,563	$13,651	$137,350	*unf.*	$135,635	↗
Consolidated Expenditure	$14,342	*unf.*	$13,692	$14,178	$139,854	*unf.*	$135,391	↘
Consolidated Result	-$380	*unf.*	-$129	-$527	-$2,504	*unf.*	$244	↘
Provider Result	-$377	*unf.*	-$129	-$543	-$3,451	*unf.*	$241	↘
Governance Result	-$11	*unf.*	$0	$15	$24	*fav.*	$3	↘
Funder Result	$8	*fav.*	$0	$1	$923	*fav.*	$0	→



CHAIR'S REPORT FOR TDH BOARD – MAY 2015

AGENDA ITEM 8.2

Meetings with Chief Executive. Discussed:- TDH finances, Breast Screen Aotearoa Contract, Long Term Facilities Plan project, Jim's progress, meeting with Broadband telelink providers, new DHB vehicle, videohealth round table, mid-term Board review, selection GM Finance, ophthalmology, MoU Pacific Island, annual plan, paper on unpressurised plane.

Attended ADSAC/CPHAC Community Forum hosted by Tauawhi Men's Centre. This forum focused on a programme entitled 'Ruia Project - Gang Transformation' and was introduced using research led by Manu Caddie. One of the significant findings was that of the huge commitment and involvement by the female partners in the development and relationship with the children, as obviously their partners were often incarcerated for long periods. The research indicated that there was a role somewhere in the scenario where child health could feature. We also heard from a NGO community nurse about the difficulties (and the often unknowns) when she visited gang houses. Virginia, Te Puna Waiora Group Manager is going to investigate where TDH could fit into the Ruia programme and report back to CPHAC /ADSAC.

Contacted HealthShare CEO re the possibility of designing/administrating a mid-term TDH Board review. Followed up with a videoconference with CEO Andrew and Erica (one of his staff qualified to carry out such a review.) They have decided that this exercise would be beneficial as a tool for all the Boards in our Midland Region. Consequently we would not be charged total development costs, only the sections that relate to the carrying out/reporting on the final outcomes. I am now awaiting the HealthShare proposal.

Great to see our CEO Jim back in harness after such a devastating accident. We look forward to his perceptions of the services received including an account of his IDF status. Welcome back Jim. Thanks again to our Deputy Chief Executive Lynsey Bartlett who did a competent job as acting CEO, including picking up Jim's busy internal and external itinerary with no warning.

Recommendation:
That the Board accepts the Chair's May Report.

David Scott MNZM, JP
Chair
Tairawhiti District Health Board

CHIEF EXECUTIVE'S REPORT
30 April 2015

Health Targets

Emergency Department 6 Hours

- Rate 96% in April. Continued above target performance by the ED team.

Elective Production

- Elective discharges for the month were above target and the YTD progress is at 107% or 121 surgeries. Case weights are also at 107%. FSAs have also moved over target to 104%. TDH has been granted funding for an additional 10 bariatric surgical procedures, a total of 12. 8 have been completed to date.

Better Help for Smokers to Quit

- 96% for April. Teams are working consistently well to ensure few people are not provided with advice.
- Community 90%. Dropped back a bit.

Cancer Treatment Access

- 71% of patients referred by their GP with high suspicion of cancer and accepted by our clinicians starting their treatment within 62 days of referral. This compares with the target of 85% by 2016.

Immunisation

- Coverage 91% at 8 months. We have slipped back since gaining the 95% target in January but do expect to regain target levels by the end of the year.

Heart Checks

- Rate at 88.1%. Closing in on the 90% target

Financial

	April 15	**April 15**	**YTD Var**	**March 15**	**March 15**
Provider	Actual ($378k)	Var ($248k)	($3,694k)	Actual ($543k)	Var ($561k)
Governance	Actual ($11k)	Var ($11k)	$22k	Actual $15k	Var $18k
Funder	Actual $9k	Var $9k	$923k	Actual $1k	Var $1k
Consolidated	Actual ($380k)	Var ($251k)	($2,749k)	Actual ($527k)	Var ($542k)

The result includes a $400k non-specific expense accrual in the Provider arm. There is no IDF wash-up accrual. Latest projections for IDFs show a budget year end position is a likely outcome.

The month result is less than half that of last month and that was delivered through the reduction in deficit in the Provider Arm. It is hoped this is a trend and will lead into some reduction of the overall deficit by year end.

Comparison to prior years (Consolidated)

April	Actual	Variance
2012/13	($1,860k)	($2,021k)
2013/14	($14k)	($270k)
2014/15	($2,505k)	($2,749k)

This comparison now includes the 12/13 year as it shows a similar pattern to this year. This is related to the throughput similarities between the two years, as compared to 13/14 in which there was a reduction in acute demand at TDH.

Result Drivers

Provider

Revenue

- Ahead of budget for the month $275k. Ahead YTD by $1,148k.
- Main contributors – revenue for additional electives, transport assistance, variations to contracts including rheumatic fever funding. In the month we were advised of funding for an additional 8 bariatric surgery procedures of which we have completed 4 and accrued revenue accordingly. ACC revenue trails by $167k but was on budget for the month.

Expenditure

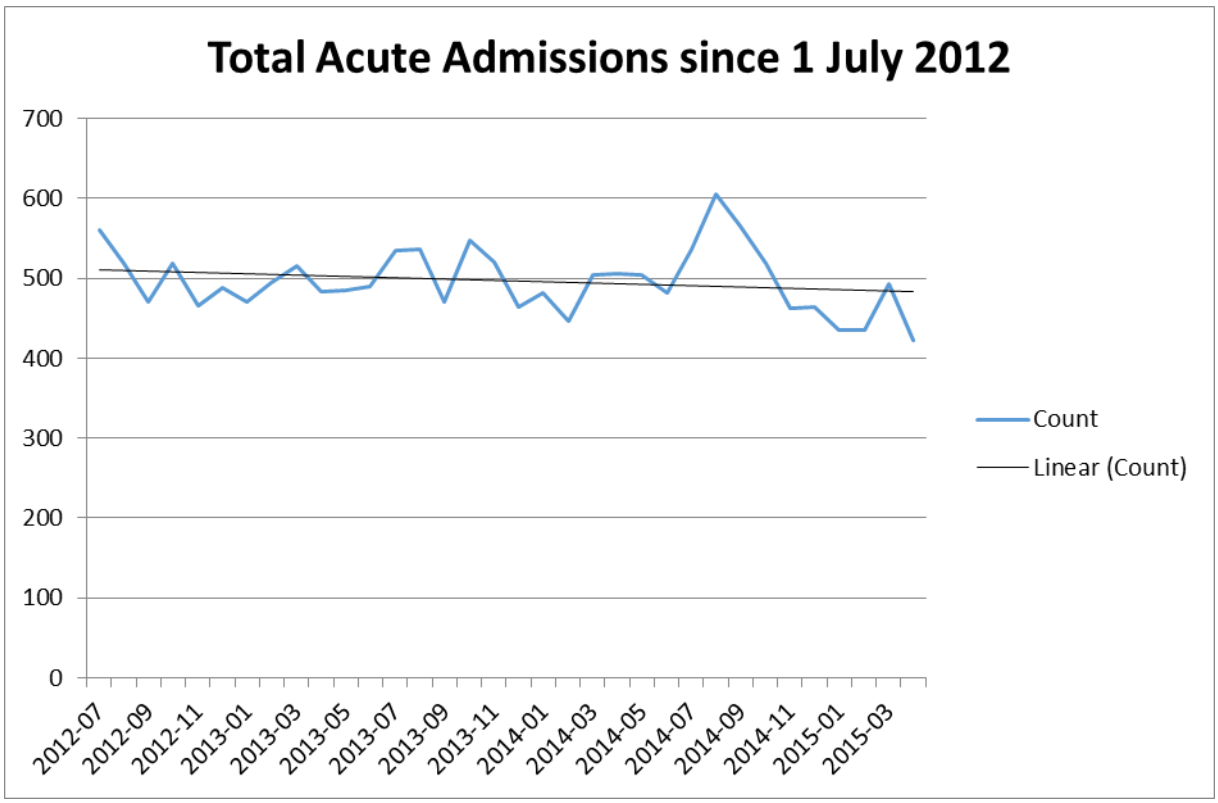
- Overspent ($523k) for the month. Overspent YTD by ($4,842k).
- Staff costs overspent by ($181k) for the month with an increase of $178k in the leave liability. Overspent YTD by ($1,157k). The trend of overspending on staff costs continues and Medical staff costs now contribute to this as we recruit into vacancies. There are also several positions recruited to stabilise service delivery such as for the sonography and MRI services. Nursing staff costs were on budget for the month which halts the overspend trend which is at ($874k).Medical was overspent by ($131k) and was compounded by a further ($85k) overspend on outsourced medical. This is actually an improved position as outsourcing costs come down with recruitment. Allied Health was overspent by ($52k) for the month and now ($132k) over for the year. Support was overspent at ($4k), ($23k) YTD, and Management/Admin underspent at $12k, underspent $142k YTD. Sick leave was up to 3.2% this month which is the same as last month and rising as winter approaches. Leave liability went up by $178k and is up by $95k since the start of the year.
- Paid FTE increased by 1 in the month and is 10 FTE up compared to last April. There were 654 FTE paid this April compared to 635 last year and 629 in 2013. This total paid FTE exceeded the FTE budget for this year (which is lowered by 6 on last year).
- Supplies and expenses overspent by ($343k) for the month and ($3,685k) YTD.
- Outsourced services overspent ($180k) for the month and ($2,007) YTD. Medical outsourced cover for gaps in the roster across several services is now reducing and this is reflecting in lower expenditure.
- Clinical supplies overspent ($204k) for the month and YTD overspent ($1,679k). This is mainly in pharmaceuticals, especially cancer treatments and the use of new approved medications in the “mab” series. Air transport was overspent despite an increased utilisation of un-pressurised flights. ($99k) YTD.
- Infrastructure and non-clinical supplies costs underspent $41k for the month and underspent $1k for the year. Security services costs were down for the month with a $6k underspend. The non-specific expense accrual is now at $400k YTD.

The following are the latest comparisons between the two years:-

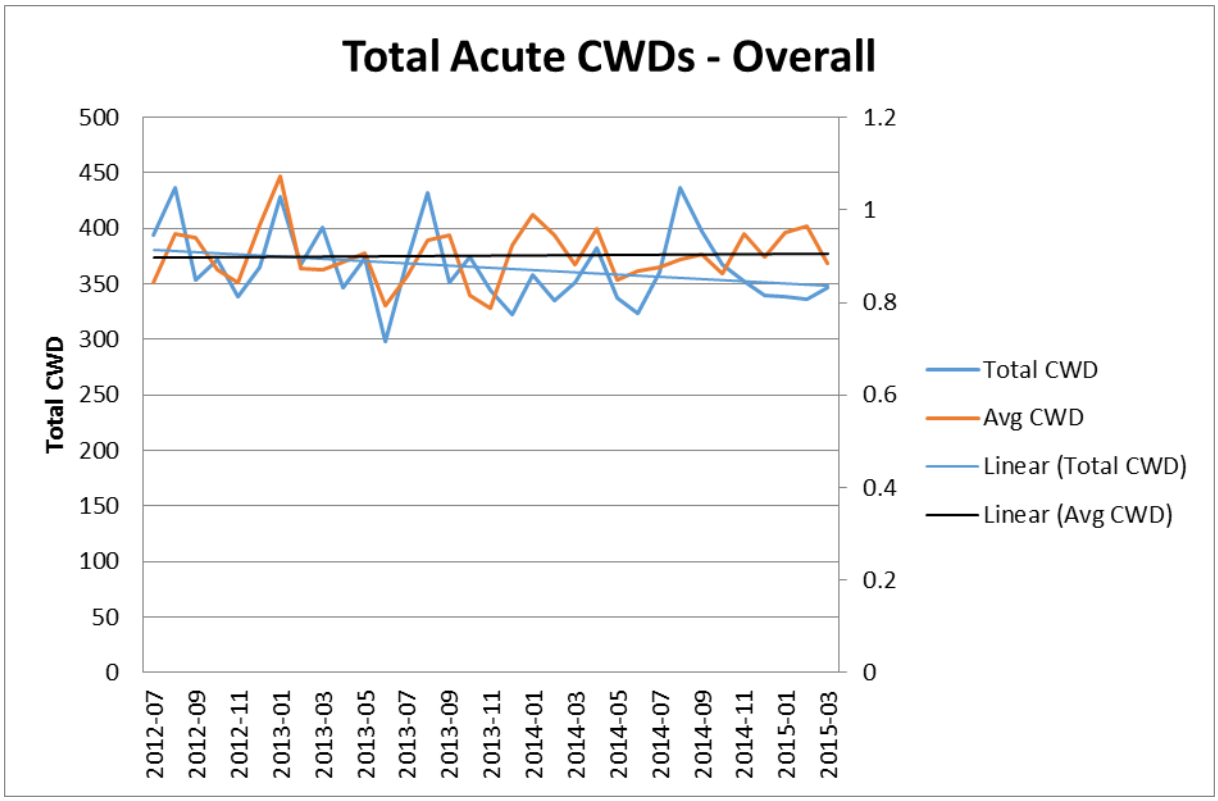
- Staff costs are up by $895k which is a 1.9% increase.
- Outsourced costs are up by $1,148k which is a 23% increase. This is now starting to track back as recruitment efforts have been successful.
- Clinical supply costs are up by $1,434k which is a 13% increase. Pharmaceuticals contribute $868k and of that cancer treatments are up $658k.
- Air Ambulance costs are down by $223k.
- Non-clinical supplies and infrastructure are down by $50k or 0.4%.

Of interest is that in April 2013 the expenditure variance YTD was ($4,341k).

Throughput in the Provider is now starting to decline again although elective services production remains high to meet timeframes. For instance joint surgery is up 62% or 48 cases. The trend on acute services is encouraging as the graph below shows.



This should flow through to expenses in May and June.

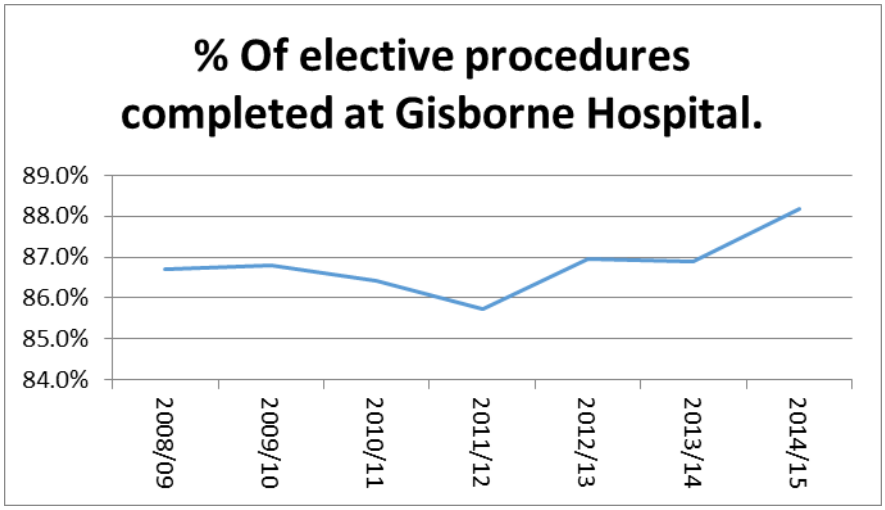


Of interest is that the case weights are roughly tracking admissions reduction with possibly a slight upward trend on the average case weight. An increase in the average case weight would be expected as it is shorter, less complicated stays that are more likely to be removed through better management of assessment and planning of care with primary care. The introduction and utilisation of Primary Options should also remove admissions with lower

case weight because these episodes of care can be managed in the community and the patient can stay at home.

The winter peak shows a lower average case weight and this lends weight to the possibilities of better managing the winter period as discussed in the section on the Nursing taskforce. Of further interest is the marked increase in average case weight as loading has come off the hospital. This again implies our plan to better support management in primary care and to assess and provide options for care that do not include admission is having an effect.

Another factor driving costs in the provider is shown in the graph below. This shows that there has been an increase in the proportion of patients having their elective procedure at Gisborne Hospital as compared to all other hospitals. This equates to around 40 patients or approximately $500k of work. This has no doubt helped in the tracking of IDFs to budget this year, but added more expenditure for TDH locally.



The table overleaf provides an update on the response plan implemented back in November.

Response to Provider Arm Overspend					
Actions Completed	**Actions in progress**	**Actions planned**	**Lowered operating cost - rest of year effect**	**Expected savings effect**	**April Update**
Recruited into locum positions and no longer requiring cover for vacancies				50	Positions recruited and locum expenditure starting to decline.
Part 2 process completed/staff to VRM and leave if not required			1FTE nurse	60	Variances to Trendcare predictions are reducing but further work to complete.
	Completion of Maternity Information System implementation		Training costs removed	20	Training completed.
Restrict training for three months.					Restriction in place.
Hold on recruitment for non-clinical positions where this can be accommodated.			Temporary effect	40	Positions on hold.
Staff leave balance reduction					Increased by $178k in April and now higher than in July 2014.
		Debt refinancing at April 2015		3	Completed and $36k saving achieved instead of $3k.
	Correction of stock take adjustment timing error			30	Completed in January.
	National procurement through health Alliance & PHARMAC		Procurement savings	48	New savings being identified.
		Hold non-essential maintenance		26	Expected to return to budget by year end.
		Hold additional security patrol		28	Continuing to underspend now.
	Changes in service to bring current outsourced service in house (breast service).			50	Still in planning.
	Regular meetings with Medical Director of flights to review decision around pressurised and if any more patients can utilise the un-pressurised service				Flights continuing to decrease and cost returning to budget. April large increase in un-pressurised flights.
		IV clinic moving to primary options	0.5FTE reduction	30	Approved through TIC and TIF.
	Stress echo service			50	Moving closer to start of service.
Reductions in FTE and positions on hold			2.0FTE	140	Started in December.
Revenue MCY, Governance, Shared Services				100	Completed with $80k in surgical services in April.
Total				**675**	

Governance and Administration

Revenue

- On budget for the month and $79k positive YTD for revenue from MoH for the East Coast Review and for the WERO challenge.

Expenditure

- Overspent ($17k) for the month and overspent ($58k) YTD.
- Staff costs overspent ($28k) for the month and overspent ($53k) YTD. All in management/admin costs. Carrying extra staffing costs for additional funded position.
- Supplies and expenses underspent $10k for the month and overspent ($4k) YTD. Month result relates to low HealthShare, consultant and Board fees costs. YTD relates to positives on HealthShare and election costs, offset by DHB Shared Services affiliation fees and expenditure on the East Coast review.

Funder

Revenue

- Positive $147k for the month and over achieved $711k YTD.
- YTD there is additional revenue for the Drinking Water Assessment Programme (first three months only), Very Low Cost Access (VLCA) including the graduate nurse positions, additional one off drug and alcohol funding, the WERO challenge, Healthy Families and the additional elective service funding.

Expenditure

- Overspent ($138k) for the month and underspent $213k YTD.
- Māori Health – over budget ($79k) YTD through costs for incontinence supplies at NPH.
- Personal Health – overspent ($77k) for the month and overspent ($12k) YTD. For the month there was a catch up on haemophilia costs. Pharmaceuticals were underspent on estimates. Year to date the main areas of overspending is the expensing of the additional revenue for VLCA, cancer drug costs, capitation and haemophilia. Drug costs are the main underspend, based on Pharmac forecast- positive $400k.
- Mental Health – underspent $77k for the month and $391k YTD. Contains accruals for possible packages of care costs.
- Public Health – overspent ($82k) for the month and overspent ($60k) YTD. Expensing of additional revenue for tobacco control and the Healthy Families programme.
- Over 65's Services – overspent ($43k) for the month and underspent $52k YTD. Home support and rest homes continue underspent while hospital level care is continuing to climb. There is also very significant expenditure on packages of care for patients placed outside the district. This is not expected to stop any time soon. The position for Over 65's services has deteriorated rapidly from a surplus of $400k three months ago.

Savings Plan

There is an improvement this month as insurance savings were higher than expected. The stress echo service has been commenced and four patients have been assessed locally.

Of particular interest is that IDF analysis has shown that elective production at Gisborne hospital has increased as a percentage of total production from 70 to 80%. This brings $500k of IDFs back to TDH and will have created the budgeted $100k saving at least. The saving will be in the Funder, the additional cost of service in the Provider.

As a result of these improvements the savings plan has largely been achieved. Unfortunately cost growth has far outstripped this and the additional plans put into place. Already for 15/16 savings of $1,350k have been identified.

Annual Plan Savings 2014/15	Budget	April Progress	Notes
	$'000	Annualised $'000	
HBL/hA/AoG	43	158	Insurance & Procurement savings
Ward staffing	96	-	Saving being assessed.
Video Conferencing	24	24	Staff travel on budget.
Local savings	150	155	All local savings on track.
IDF vs local	156	156	Savings being achieved through additional work in Provider.
Air Transport	252	252	Built into budget.
Yourself	40	-	Not yet implemented.
Stress Echo	100	100	Now implemented.
Total	**861**	**845**	
Delta		-16	
Completion percentage		98%	Supplemented by additional items

Significant Variances

Generally the overspending areas remain the same ones that have been seen all year. This month community mental Health services feature as spending on packages of care has been lower than budget in prior months. This is also now starting to change with an additional patient funded out of district.

Significant Overs and Unders		
Revenue Centre	**Variance**	**Comment/Actions**
Vote Health	$703k	Drinking Water Assessment Programme, Very Low Cost Access (VLCA) including the graduate nurse positions, additional one off drug and alcohol funding, the WERO challenge, Healthy Families and the additional elective service funding.
Personal Health side contracts	$861k	Funding for cancer treatments (overspend in hospital pharmaceuticals below), patient flow indicators programme and National Screening Unit equipment purchase funding.
Cost Centre	**Variance**	**Comment/Actions**
Nursing Staff	($874k)	Active control on staffing levels has halted the rate of change.
Outsourced Medical	($1,370k)	Staff vacancies are requiring external resource for the maintenance of volumes and call rosters. Rate is starting to decline.
Pharmaceuticals Hospital	($850k)	High use of cancer therapy ($607k).
General Suspense	($400k)	Non-specific expense accrual.
Community Pharmaceuticals	$400k	Pharmac estimate at this point. Concerns that expenditure is rising.
Mental Health Services (community)	$405k	Lower expenditure on packages of care in prior months but this is now starting to escalate.

Nursing Taskforce

The taskforce continues to meet and contribute to strategies to reduce operating costs. Tracking of variances against recommended staffing levels in the wards shows improvement and this has been reflected in a closer match of nursing staff costs to budget. Already the

utilisation of the low low bed has delivered on a safer environment for patients and reduction in the need for “watches”.

A new topic for the taskforce is winter planning. Given the detail we now have on the likely winter profile of services required, and the lower acute trend, a more formal plan is to be put into place for managing capacity over the winter months. The plan is to use capacity already within the staffing levels to better smooth the patient load between services. The aim is to improve consistency of care for patients while at the same time more closely managing costs which have tended to begin to escalate over budget in the winter period in prior years.

Throughput Volumes
The position against the Internal Service Level Agreement (ISLA) now stands at ($1,396k) year to date. This is related to the acute service delivery. Overall the service delivery is closer to budget than in prior years.

Cash Position
Cash increased by $814k over the month – net position was $1.97m in debit with the HBL-managed DHB “Pool” at the end of the month, which is $200k more in debit than the forecast balance of $1.77m debit balance, and peaked at $3.06m prior to receipt of monthly funding. The debit balance at month end is a continuation of the previous 2 months and is on a reducing trend.

Inwards: Receipts were $250k higher than expectations, with the additional receipts being mainly from the Ministry and related to quarterly funding payments.

Outwards: Cash outflow for payroll costs was $161k higher than projected, but included a one off historical PAYE on accommodation payment of $80k. Payments to non-DHB Providers were $325k higher than projected, while payments to creditors (including capital expenditure payments) was close to expectations.

The payments to HBL for TDH’s scheduled share of the capital costs associated with the Finance, Procurement and Supply Chain Programme ($629k in total) was recommenced with $210k being paid in April, with the same scheduled for May & June.

Outlook: May and June are projected to be cash negative and the month end balance is projected to trend back above the $2m level. May because it includes 2 x GST payments and June because of half-yearly Interest and Capital Charge and the annual (historical) FRS-3 Revaluation Equity repayment.

Health Benefits Ltd Update
The DHBs have now collectively agreed on the new company to replace HBL as the driver of current and future joint savings proposals in the sector. The company will be jointly owned by the DHBs and it will take a partnership approach to the co-design and implementation of the current agreed business cases and new developments as they come forward. The new company will be instituted prior to 30 June in order for HBL resources and assets to be transferred over.

Food
Now proceeding in the three Auckland DHBs with TDH also joining the national initiative (no change to the local provider) and two other DHBs close to decisions. TDH will join the service form Quarter 1 calendar 2016 and already Medirest has begun discussions with staff.

Laundry
The proposal is being discussed with particular emphasis on how the lower North Island DHBs might take part. TDH is finalising local arrangements with Gisborne Laundry Services which will be linked to the national programme.

Finance
The national proposal to move from the current state of an almost completed standardised finance system to that system been complete and rolled out across all DHBs has been supported by all DHBs. Tech 1 (the current TDH system) DHBs would be the last to transition possibly in 17/18 or later.

National Infrastructure Programme
DHBs are now starting to sign up to the infrastructure contract with IBM. TDH is still working with HBL to resolve issues around redundancy, operation and cost before any final proposal could be considered.

TDH Long Term Facilities (LTF) Plan (update)
Progress continues on the development of a Long Term Facilities Plan for the hospital campus.

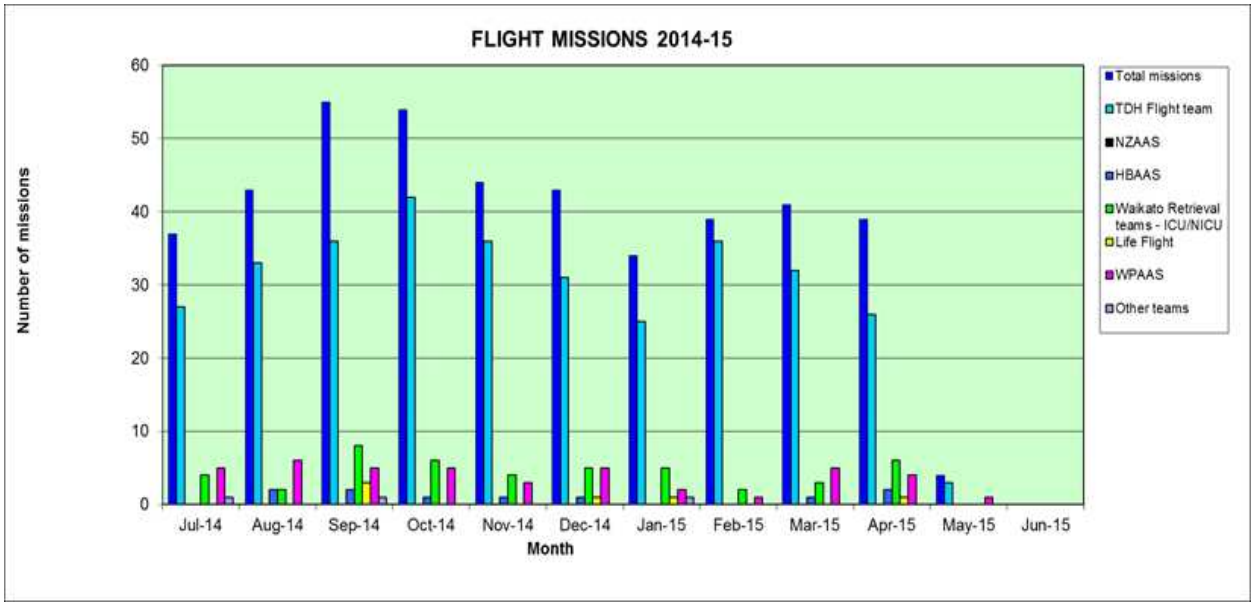
Further to the In Committee report to HAC in February and as discussed, the Project Team have awarded the contract to develop the LTF Plan to Greenstone Group who have subsequently together with Chow Hill (architects) conducted an on-site assessment of the existing buildings in terms of their structural integrity as well as looking at space and locality of existing services in terms of assessing current patient flow.

The TDH Facilities Project Team are now embarking on a communications campaign with a view to obtaining stakeholder (staff, patients, primary care) feedback and ideas of how patient flow could be improved. This is occurring through a combination of team and department meetings, and a survey. This information will be collated and together with information already provided to them such as engineers reports/ service plans etc., will form the basis for a Master Planning Day scheduled for the 25th May led by Greenstone and their Chow Hill partner.

The first draft following the Master Planning Day is expected early June.

Air Transport Service
There were 54 Patient transfers in April with 37 by TDH. 42 inpatient transfers. 12 outpatient transfers. ACC = 4 (2 < 24hrs).

There was increased use of the unpressurised plane this month. Costs were higher as Air Gisborne did not have a pressurised plane available for a week however there is an agreement in the contract that this will not adversely affect TDH so this will be adjusted.



Primary Care

E Tipu E Rea

A successful community workshop to give an update on E Tipu e Rea was held with some positive responses from the group. The next phase will be the appointment of the hub with the programme set to start 01 July 2015.

This workshop also provided an opportunity for other community providers to present on other key service developments that impact on our Tairawhiti children such as Healthy Families NZ, Children's Team, Gateway Services, Social Sector Trials, Mamas and Pepi Services, Rheumatic Fever and WINZ assistance available.

Tairawhiti Integration Forum (TIF)

The May TIF meeting considered:

- Cervical screening: PHOs described processes applied by general practices to facilitate eligible women being recruited to, and remaining on the register. This information will be included in the sector wide breast and cervical screening pathway mapping scheduled for later in May.
- E Tipu E Rea implementation: discussed the 6/5/15 sector update session, and noted that two proposals had been received for the provision of the proposed community hub and that an evaluation committee that included two community representatives was underway. The outstanding PHO E Tipu E Rea PHO allocation was also discussed (National Hauora Coalition has subsequently confirmed their contribution, Ngati Porou Hauora discussions are close to being concluded)
- Long Term Conditions: conceptual discussion around future service delivery of services for people with long term conditions, with a particular focus on people with diabetes. There was agreement that there were three main areas for investment: prevention and education incorporating a public health approach, self-management and treatment. The next step is to collate the specific models of care applied by each of the PHOs and to consider whether a district wide framework could be developed from the three models.
- TDH Facilities review: PHO representatives reiterated their earlier request that at some stage they are consulted with; it was agreed their involvement would recognise the importance of a 'whole of pathway" approach to future health services in Tairawhiti.
- NCHIP (National Child Health Information Platform): consideration of a paper outlining the form and function of NCHIP, high level and preliminary steps in the commencement of implementing NCHIP across Tairawhiti, and the need for a PHO contribution. The latter cost has been calculated on the split of PHO population of under 20 year olds. The PHOs agreed to confirm their contribution at the June TIF meeting.

Tairawhiti Integration Forum (TIC)

The action to widen TIC to include whole of general practice and other community providers seemed successful with 30 people attending May TIC. Drs Richard Vipond and Joanna Wojciechowska presented – Bay of Plenty DHB DNA project and diabetes management and service provision respectively. It is proposed that the July TIC will receive feedback on actions (re diabetes service provision) identified at the May TIC, and a presentation by TDH surgical services (bowel cancer) at the July TIC meeting.

East Coast Review

Ngati Porou Hauora and Te Runanganui o Ngati Porou have advised their data analysis has yet to be completed.

National Enrolment Service (NES) Implementation

The Ministry of Health is rolling out the NES in 2015, to assist in this process the MoH is holding a series of roadshows in June across the country and requesting that PHOs and DHBs are represented at these. The summarised key benefits of NES are:

- Centralised register with real time patient enrolment status enabling more timely payment calculation.
- Single source of truth for enrolment data to ensure accuracy of Capitation Based Funding payments.
- Validated NHI and up to date patient demographics, supporting accurate identification of patients and clinical safety.
- Validated patient addresses using eSAM service, supporting accurate assignment of deprivation-based funding.
- Processing and payment cycle reduced from 3 months to 1 month,
- Amended enrolment business rules, due to real time enrolment and timelier funding of patients.
- Improved eligibility assessment guidance to support practices in decision-making about patient eligibility for publicly funded services.
- Web services integration with PMSs, creating a seamless experience for the user when interacting with national services.

Zero fee General Practice visits and pharmacy co-payments for Under 13s Policy
Discussions are continuing with our PHOs to enable the provision of zero fee General Practice visits and pharmacy co-payments after-hours. Day-time funding and service coverage is confirmed with all Tairawhiti practices "opting-in" to the scheme. After-hours discussions are revolving around finding an appropriate funding level and service design that ensures Tairawhiti DHB meets the expectation of free after-hours services accessible for at least 95 percent of enrolled children under thirteen years of age and within 60 minutes travel time.

Community
Community Pharmacy Services Agreement (CPSA) Extension
DHB offers of voluntary variation to the CPSA agreement (the CPSA extension) have been released to individual community pharmacies, giving them 20 business days to sign up to the agreement ahead of the 1 July 2015 start date.

Health of Older People
Tairawhiti Health of Older People Service Level Alliance Team (SLAT) update
There has been no further meeting of the HOP SLAT since last month's Board report - the next meeting is at the end of May. The workstreams are now all functioning. TWON have indicated an interest in joining the EPOA/Dementia workstream and we have also approached Community Law Centre to provide a representative. A brief summary of the meetings as follows:

- Workstream 1: Integrated Model of Care is further ahead than the other two.
    - Terms of Reference and Project Scope distributed for feedback.
    - The objectives are focused on
        - development of the pathway,
        - development of a plan to establish a HOP service,
        - development of strategies to assist people to remain in their homes
        - recommend steps to implement a localised delirium pathway
    - Next meeting will look at current services and gaps and identifying a risk stratification tool
- Workstream 2: Enduring Power of Attorney (EPOA)/Dementia has had two meetings – initial aim is to identify current processes and issues around EPOA.
- Workstream 3: Elder Abuse and Neglect – one meeting only held. Looking to extend the membership further into the community. Initial aim is to develop pathways for reducing Elder Abuse and Neglect by using prevention and intervention strategies. This group is also looking to do a stocktake of current services.
- Reporting to Tairawhiti Integration Forum (TIF) will be at their June meeting.

Home and community support services (HCSS)
A regional meeting of management, including portfolio managers and analysts, has been scheduled for 8 June by HealthShare to progress further exploration of the level of interest in the region in moving to a responsive service model.

A further paper detailing conclusions from this will be tabled at a subsequent Board meeting.

Request for a proposal (RFP) for Psychogeriatric Beds in Tairawhiti.
Negotiations have commenced with the preferred provider to provide six psychogeriatric beds in Tairawhiti. A final paper seeking ADSAC approval will be considered at the June meeting.

Regional Request for a proposal (RFP) for Individualised Funding
Eight proposals were received by Waikato DHB, as lead in the RFP process. The first evaluation meeting is scheduled for 14 May. The evaluation panel consists of the five regional Long Term Services – Chronic Health Conditions (LTS-CHC) portfolio managers, a Kaupapa Maori LTS-CHC Portfolio Manager, a NASC representative, a consumer and a Performance Analyst.

Mental Health
Suicide prevention and postvention plan
Feedback from the Ministry of Health indicates that there are a couple of areas requiring attention; the final plan is due for submission in June 2015. Changes will be advised to stakeholders together with the Ministry's comments.

Service re-alignment
The implementation plan is currently out for comment with the teams at CAMHS and Mental Health and Addiction Services. The project oversight group meets again mid-May to agree the final plan although work has already begun.

Packages of care for perinatal and infant mental health
The Request for Proposal process has identified a provider and approval is now being sought from CPHAC.

Visits from regional providers for service users with addictions
In June representatives from Lifewise and the Salvation Army will be visiting Gisborne to meet with those working the mental health and addictions sector. Lifewise provide supported accommodation in Rotorua for people about to enter, or just discharged, from residential treatment programmes; while Salvation Army provide a residential treatment programme in Hamilton. The aim of the visits is to increase local awareness about the services, address any concerns and increase referrals; additionally Lifewise would like to agree a Memorandum of Understanding with TDH.

Primary options for mental health and addictions
A round of visits to general practices has begun to introduce the new service providing free GP care for those people in the care of TDH Mental Health and Addiction Services and those ready to be transitioned to primary care prior to discharge. This new service will begin in July 2015.

Child and Youth Health
Gisborne Children's Team
Naomi Whitewood, recently appointed to the role of Gisborne Children's Team Director, has made gains with the Gisborne Children's Team infrastructure.

The Local Governance Group (LGG) continue to closely monitor the progress and issues in this area with regular meetings that require their focus on communication strategies, strategic

outcomes and supporting the infiltration into their respective workforce that may contribute to the future Child Action Teams.

The Ministry led delays are causing growing concern of losing community interest. In response to that, the LGG have proposed to support a Police led initiative to begin formal community engagement, as well as, the proposal to further fund resource for the Director. This is possibly an administration/coordination role until the Directorate is prepared to recruit for the additional role of Children's Team Coordinator.

Well Child Tamariki Ora (WCTO)
The Ministry is supporting a nationwide roll-out of professional development training opportunities in 2015 aimed at supporting WCTO providers with additional skills and resources to help them encourage 'healthy lifestyle choices' with women, children and whanau. This initiative has been funded by the Ministry in recognition of the growing evidence that maternal nutrition and physical activity in pregnancy, post-partum and through extended breastfeeding, as well as infant nutrition especially in the early years across ages 0-2 years, has a significant influence on childhood obesity and a person's general health in later years.

Te Puna Oranga (Māori Health Service – Waikato District Health Board) is offering **FREE** face-to-face training sessions for health professionals in the Midland region in April and May 2015. The sessions are:

Safe Sleep & Pepi-pod Refresher Training
Mama Aroha Breastfeeding Talk Card Training

The training is being facilitated by Te Puna Oranga on behalf of the Ministry of Health, Ngā Toka Hauora (Midland Māori General Managers Forum) and in partnership with Change for our Children (CFOC) and Midland Maternity Action Group (MMAG). Training dates for Tairawhiti were 16 and 17 April.

The recently appointed Midland WCTO Quality Improvement Project Manager is Kathryn Fromont, currently clinical services lead for NCHIP /CHC service at Midlands Health Network, and starts work on 18 May 2015. Kathryn is a registered midwife and comprehensive nurse with a background in adult teaching midwifery at Wintec and has been a practice nurse. Kathryn will be invited to attend the next Tairawhiti WCTO provider meeting in August of this year

Social Sector Trials (SST)
The Social Sector Trial has been extended for a further 12 months. Planning is underway to develop actions past June 2015.

The Social Sector Trial Youth and Whanau Hub pilot (the Hub, also known as AMP) has commenced: it will offer a range of coordinated, positive, pro-social activities each Saturday for 12 weeks.

The Hub's intent is to provide multiple benefits to young people and their families and in addition to providing activities will also be a place where young people and families can connect with health promotion messages and social marketing messaging such as anti-bullying, positive parenting and family violence prevention.

The Hub continues to attract tamariki and rangatahi of all ages: at this stage it is noticeable however that the same children and parents are returning each Saturday. Advertising the event has been minimal therefore possibly explains the smaller than anticipated numbers of participants. It is envisaged that once the 'word is out' there will be an increase in numbers. To determine the success of 'AMP' the organisers are evaluating each of the event workshops.

He Oranga Whanau Healthy Families NZ
He Oranga Whanau Healthy Families NZ was successfully launched at Te Poho o Rawiri marae on 17 April 2015. Despite being the last collective to be signed off for the provision of the Healthy Families NZ He Oranga Whanau has been the first collective nationally to be launched.

Part of the launch progamme was showcasing Turanga Health's service delivery philosophy and model though its marae based physical activity programme, Tu kaha Marae, and their industry workplace initiative focusing on better food choices. This was followed by a demonstration at Waikirikiri Park by Tairawhiti Softball Association who is using the sport of softball to engage whanau in low decile at risk communities. This is a partnership developed between softball and softball organisers, and whanau, and with a focus on influencing change.

The Collective met as a whole group on 8 May to discuss next steps- what and by whom.

Tobacco Control
WERO Challenge
The WERO Challenge has attracted eleven teams from Tairawhiti entering the competition which began 1 April 2015. This is more than double the WERO national office's expectation of no more than five teams for both the April and September WERO competitions.

The work of the local The WERO coordinator, Di Akurangi, must be acknowledged as being a key factor in achieving this result: she has spent a considerable amount of time working with community groups such as Maori Women's Welfare League, Turanga Ararau, Te Wananga o Aotearoa, Sports Clubs getting teams to recruit teams.

The TDH Social Environments Health promotion advisor is supporting to two of the five teams affiliated to Tairawhiti Maori Women's Welfare League. Members who have tried quitting previously are now aware of the proper procedures to use support tools ie lozenges, gum and patches. Some members have very high readings of carbon monoxide in their lungs. Cessation Practitioner training for the members is also currently being investigated. .

Ngati Porou Hauora Cessation Service Quit coach is providing support to these teams.

A one day quit training workshop facilitated by the national WERO office was arranged for each of the WERO team coaches to give them an understanding of quitting. Teams are not incentivised until each member has been breathalysed. There has been an increase of WERO team members accessing the gyms. Both Turanga Health and Ngati Porou Hauora Aukati Kai Paipa services are working at full capacity to provide smoking cessation support to each of the WERO teams.

World Smoke free Day / Month
Taki Tahi Toa Mano (Tairawhiti Smokefree Coalition) has begun planning activities leading up to World Smoke free Day. Activities include:

- A Smokefree CBD submission hearing to Gisborne District Councils 2015-2025 Long Term Plan (see below)
- Surveying retailers in Central Business Districts response to a Smokefree CBD
- Smoke free Flash Mob dance at Heipipi reserve with up to 50 participants confirmed.

Smoke-free CBD
TDH will be represented at the Gisborne District Council Hearings on the long-term plan in respect of the submission to make the Central Business District smoke-free. Staff have been gathering the views of the retailers by way of interviews this month and there is strong support for this proposal. They are understandably concerned about the economic impact this may have, however, evidence from the 2004 introduction of smoke-free bars (which had a similar concern) will be presented alongside the survey results.

Population Health

Alcohol and Smokefree Sidelines

The Poverty Bay Hockey association has shown interest in promoting the EASE UP Alcohol and Smoke free Sidelines project in support of the new hockey turf. Hockey will be an addition to the existing sports codes promoting the sidelines project, Tairawhiti Rugby League, East Coast Rugby, Tairawhiti Softball and Poverty Bay Rugby.

The project manager has been liaising with GDC to seek approval to erect signage at Harry Barker Reserve, Waikirikiri Reserve, East Coast (Uawa, Tokomaru Bay, Hicks Bay and Whakarua Park)

The Health Promotion Agency Community Action on Alcohol Regional Manager is meeting the Alcohol and Smokefree Sidelines Steering Group and current sports codes involved with the Sidelines project. This will provide an opportunity for the steering group to discuss sustainable funding to continue the project post 2016.

Rheumatic Fever

The rheumatic fever awareness raising campaign has begun with radio advertising utilising local role models. The key messages being 'should your child present with a sore throat take them to your GP nurse free of charge' and 'Sore Throats Matter'. A localised poster and a booklet is in development and will be distributed throughout the district. The messages are consistent with the national RF prevention campaign 'Living Well Together' the campaign is also supported by Ministries of Social Development, Housing and WINZ. Discussions are currently being had with Community Corrections (Ministry of Justice) to support the campaign.

The Rheumatic Fever Steering group will be moving toward a Rheumatic Fever Governance Group structure shortly and planning is underway to determine its membership. This change is important as it signals the increased maturity of RF prevention activity across Tairawhiti by separating out district wide governance from the operational level. It is anticipated that the RF Governance group will be more equally balanced between TDH personal and community representatives. This revised membership reflects growing recognition and acceptance of the importance community based organisations have in reducing Tairawhiti rheumatic fever rates.

The Ministry has asked that the Rheumatic Fever 'living well together' resources developed by Tairawhiti Rheumatic Fever Awareness Campaign (TRAC) be put on hold until mid -June due to a National Rheumatic Fever Healthy Homes report containing some areas of sensitivity. In the meantime TRAC will continue promoting 'sore throats matter' and providing support to both the Rheumatic Fever coordinator and Rheumatic Fever Kaiawhina.

Exit of Food Safety Contract

In December 2014 Ministry for Primary Industries (MPI) notified all public health units of their intention to bring services for food safety and suitability back in house as of 1 July 2015. In response to this, public health units requested the Ministry of Health to develop a national Memorandum of Understanding (MoU) with MPI to cover the interface between food borne disease and human health rather than each PHU developing their own. A draft MoU was prepared for discussion; however there is still concern over the level and agreement of response particularly for national outbreaks involving food (the recent milk powder contamination and Yersinia national outbreak being two examples of mixed response). No agreement has yet been reached.

Central North Island Drinking Water Assessment Unit (CNIDWAU)

Tairawhiti is part of the Central North Island Drinking Water Assessment Unit. This unit is comprised of Tairawhiti, Hawkes Bay, MidCentral/Whanganui, Taranaki and Regional Public Health Wellington and operates under a partnership agreement. The unit is an IANZ

accredited inspection body and manages the activities of the designated Drinking Water Assessors (DWA) in accordance with standards set by IANZ.

A request has recently been received from Toi Te Ora (the public health service of Lakes/Bay of Plenty) to join CNIDWAU as their current partnership model with Waikato has been disbanded. The unit has been looking at the capacity of current DWA's with required workloads and whether this work should be undertaken as a national Unit. This will be discussed at a CNIDWA management meeting later in May along with the request from Toi Te Ora to join the Unit.

FINANCIAL REPORT FOR APRIL 2015

AGENDA ITEM 7.5

SUMMARY FINANCE REPORT	This Month		Year to Date	
	Actual	Variance	Actual	Variance
	$000s	$000s	$000s	$000s
1.0 Operating Results				
Funds:	9	9	923	923
Governance	(11)	(11)	24	21
Provider	(378)	(249)	(3,452)	(3,693)
Consolidated	**(380)**	**(251)**	**(2,505)**	**(2,749)**
Result "drivers"				
Funds (Community):				
Revenue	5,911	38	59,141	407
Operating Costs	5,902	(29)	58,218	516
Governance:				
Revenue	203	6	2,050	80
Operating Costs	214	(17)	2,026	(59)
Provider:				
Revenue	7,767	274	76,079	1,148
Operating Costs	8,145	(523)	79,531	(4,841)
2.0 Capital	**$000s**	**$000s**	**$000s**	**$000s**
Cost of additions	73	147	3,135	(175)
Commitments*			893	
Contribution to HBL FPSC Capex**	210	(210)	210	419
Accrued Capital Charge***	222	0	2,223	22
3.0 Cash Flows	**$000s**	**$000s**	**$000s**	**$000s**
Consolidated**	814	380	(4,017)	(2,436)
4.0 Cash and Bank Balances				
Consolidated			(1,970)	(2,436)
5.0 Cash & Bank Projections	**Flows**		**Balances**	
	1 month	2 months	1 month	2 months
	$000s	$000s	$000s	$000s
Consolidated***	(583)	(549)	(2,553)	(3,102)

Negative variances (i.e. worse than budget) are shown in brackets.

* Includes IT/IS ($37k); Clinical equipment ($266k); Regional e-Pharms ($122k); HBL FPSC ($420k).
Building works ($47k - incl. Maternity Birthing Pool $43k).

** Variance caused by part-payment of 2014-15 capital installments. Balance to be paid over May & June.

*** This is the Capital Charge cost expensed and the variance from that budgeted. Capital Charge is paid up-to-date.

**** Quarterly funding received and no GST payment in April.

***** 2 x GST payments plus a 2nd HBL Capital payment in May, with the final to be paid in June; PHARMAC Rebate expected.
- Half-yearly Interest and Capital Charge and the annual (historical) FRS-3 Revaluation Equity repayment.

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE:

Consolidated Statement of Financial Performance	April 2015			Year to Date			Annual
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Revenue							
Government and Crown Agency Sourced							
MOH - Vote Health	12,748	12,600	148	126,705	126,001	703	151,202
MOH - Personal Health	195	109	87	1,947	1,086	861	1,303
MOH - Public Health	161	143	18	1,369	1,434	(64)	1,720
MOH - Disability Support	60	61	(0)	605	605	(0)	726
Clinical Training Agency	103	102	1	984	1,019	(35)	1,223
Inter District Flows	162	162	0	1,623	1,621	2	1,945
Other DHB's	-	0	(0)	16	4	11	5
Accident Insurance	177	176	0	1,597	1,765	(168)	2,119
Government (non DHBs)	193	114	79	1,444	1,142	302	1,370
Total Government and Crown Agency	13,799	13,468	332	136,291	134,677	1,614	161,614
Patient and Consumer Sourced	15	30	(14)	213	296	(82)	355
Other Income	68	66	2	766	663	103	796
Internal Reclassification	80	-	80	80	-	80	-
Total Revenue	13,962	13,563	399	137,350	135,635	1,714	162,764
Expenditure							
Personnel Costs							
Medical Personnel	1,545	1,415	(131)	14,739	14,470	(269)	17,420
Nursing Personnel	1,963	1,956	(7)	18,741	17,868	(874)	21,597
Allied Health Personnel	921	870	(52)	8,678	8,543	(135)	10,301
Support Personnel	77	73	(4)	743	719	(23)	865
Management/Administration Personnel	763	748	(16)	7,188	7,279	91	8,769
Total Personnel Costs	5,270	5,061	(208)	50,089	48,879	(1,210)	58,952
Outsourced Services							
Medical Personnel	183	98	(85)	2,457	1,087	(1,370)	1,288
Nursing Personnel	1	-	(1)	7	-	(7)	-
Allied Health Personnel	51	10	(41)	406	104	(302)	125
Management/Administration Personnel	5	-	(5)	55	-	(55)	-
Clinical Services	353	305	(48)	3,140	2,867	(273)	3,444
Funder Services	17	22	5	172	224	52	268
Total Outsourced Services	611	436	(175)	6,237	4,282	(1,955)	5,125
Clinical Supplies							
Treatment Disposables	283	255	(28)	2,954	2,585	(370)	3,104
Diagnostic Supplies & Other Clinical	34	28	(6)	333	283	(51)	339
Instruments & Equipment	188	215	27	2,161	2,176	16	2,613
Patient Appliances	30	24	(6)	270	242	(29)	290
Implants and Prostheses	115	87	(28)	1,133	877	(256)	1,053
Pharmaceuticals	320	203	(116)	2,914	2,064	(850)	2,477
Other Clinical & Client Costs	292	246	(46)	2,628	2,489	(139)	2,988
Total Clinical Supplies	1,261	1,057	(204)	12,394	10,715	(1,679)	12,864
Infrastructure & Non Clinical Supplies							
Hotel Services, Laundry & Cleaning	264	269	5	2,636	2,678	42	3,214
Facilities	277	270	(7)	2,948	2,755	(193)	3,305
Transport	38	53	15	450	534	83	641
IT Systems & Telecommunications	166	192	26	1,725	1,944	219	2,334
Interest & Financing Charges	302	297	(4)	2,976	3,012	36	3,616
Professional Fees & Expenses	58	59	1	660	598	(62)	719
Other Operating Expenses	147	126	(21)	1,567	1,274	(293)	1,530
Democracy	25	27	3	224	276	52	331
Subsidiaries, Joint Ventures & Minority Interests	(59)	(29)	30	(350)	(290)	60	(348)
Total Infrastructure & Non Clinical Supplies	1,218	1,265	47	12,837	12,781	(55)	15,342
Provider Payments							
Personal Health Expenditure	4,187	4,118	(69)	41,087	41,184	97	49,421
Mental Health Expenditure	337	429	92	3,880	4,285	405	5,142
Public Health Expenditure	135	54	(82)	576	536	(39)	643
Disability Support Expenditure	1,134	1,091	(43)	10,854	10,906	52	13,087
Hauora Maori Services Expenditure	190	182	(8)	1,902	1,823	(79)	2,187
Total Provider Payments	5,983	5,873	(110)	58,298	58,734	436	70,481
Total Expenditure	14,343	13,693	(650)	139,854	135,391	(4,463)	162,764
Net Surplus / (Deficit)	(380)	(130)	(251)	(2,505)	244	(2,749)	0

SUMMARY CONSOLIDATED STATEMENT OF FINANCIAL POSITION:

Consolidated	April 2015 $000	June 2014 $000
EQUITY:		
Total Equity	**$ 32,655**	**$ 35,160**
REPRESENTED BY:		
ASSETS:		
Total Current Assets	**7,046**	**7,615**
Total Non-Current Assets	**64,462**	**64,133**
Total Assets	**71,508**	**71,748**
LESS LIABILITIES		
Total Current Liabilities	**22,179**	**19,802**
Total Non-Current Liabilities	**16,674**	**16,786**
Total Liabilities	**38,853**	**36,588**
NET ASSETS	**$ 32,655**	**$ 35,160**

Note: The reduction in Current Assets is mainly a reduction in cash holdings between month ends.

The increase in Current Liabilities is generated by the debit cash balance at the end of April.

FUNDS OPERATING STATEMENT:

	30 April 2015			Year to Date			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
	$000	$000	$000	$000	$000	$000	$000
Revenue							
Government Revenue	12,764	12,616	148	126,872	126,163	709	151,395
Inwards IDF Revenue	162	162	0	1,623	1,621	2	1,945
Other Revenue	10	11	(1)	109	110	(1)	132
Total Revenue	**12,936**	**12,789**	**147**	**128,604**	**127,894**	**710**	**153,472**
Expenditure							
Provider Payments:							
Personal Health	8,482	8,404	(78)	84,054	84,039	(15)	100,847
Mental Health	1,078	1,156	78	11,159	11,556	397	13,867
Public Health	153	71	(82)	772	712	(60)	854
Disability Support	1,192	1,149	(43)	11,440	11,492	52	13,791
Hauora Maori Services	190	182	(8)	1,902	1,823	(79)	2,187
Governanace and Funds Admin	203	197	(6)	2,050	1,970	(80)	2,364
Outwards IDF Expenses	1,629	1,630	1	16,304	16,302	(2)	19,562
Total Expenditure	**12,927**	**12,789**	**(138)**	**127,681**	**127,894**	**213**	**153,472**
Net Operating Result	**9**	**0**	**9**	**923**	**0**	**923**	**0**

ISLA ELIMINATIONS STATEMENT:

	30 April 2015			Year to Date			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	DAP
	$000	$000	$000	$000	$000	$000	$000
Revenue Eliminations							
ISLA Internal Revenue - Governance	203	197	6	2,049	1,970	79	2,364
ISLA Internal Revenue - Provider	6,822	6,719	103	67,414	67,190	224	80,627
Total Revenue	**7,025**	**6,916**	**109**	**69,463**	**69,160**	**303**	**82,992**
Expenditure Eliminations							
Provider ISLA:							
Personal Health	(5,856)	(5,768)	(88)	(57,871)	(57,683)	188	(69,219)
Mental Health	(812)	(797)	(15)	(7,986)	(7,972)	14	(9,566)
Public Health	(18)	(18)	0	(197)	(176)	21	(211)
Disability Support	(136)	(136)	0	(1,359)	(1,359)	0	(1,631)
Government ISLA	(203)	(197)	(6)	(2,050)	(1,970)	80	(2,364)
Total Expenditure	**(7,025)**	**(6,916)**	**(109)**	**(69,463)**	**(69,160)**	**(303)**	**(82,992)**
Net Operating Result	**0**	**0**	**0**	**0**	**0**	**0**	**(0)**

GOVERNANCE OPERATING STATEMENT:

	30 April 2015			Year to Date			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	DAP
	$000	$000	$000	$000	$000	$000	$000
Revenue							
Government Revenue	203	197	6	2,050	1,970	80	2,364
Total Revenue	**203**	**197**	**6**	**2,050**	**1,970**	**80**	**2,364**
Expenditure							
Personel Expenses	122	94	(28)	984	931	(53)	1,120
HealthShare Funder Services	18	22	4	172	224	52	268
Non Clinicial Supplies	49	54	5	645	533	(112)	642
Democracy	25	27	2	222	275	53	330
Depreciation	0	0	0	3	4	1	4
Total Expenditure	**214**	**197**	**(17)**	**2,026**	**1,967**	**(59)**	**2,364**
Net Operating Result	**(11)**	**(0)**	**(11)**	**24**	**3**	**21**	**0**

PROVIDER OPERATING STATEMENT:

	30 April 2015			Year to Date			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	DAP
	$000	$000	$000	$000	$000	$000	$000
Revenue							
ISLA Internal Revenue	6,822	6,719	103	67,414	67,189	225	80,627
Government Revenue	873	689	184	7,795	6,893	902	8,274
Patient Consurmer Sourced	15	30	(15)	213	296	(83)	355
Other Income	57	55	2	657	553	104	663
Total Revenue	**7,767**	**7,493**	**274**	**76,079**	**74,931**	**1,148**	**89,919**
Expenditure							
Personel Expenses	5,147	4,967	(180)	49,105	47,948	(1,157)	57,832
Outsourced Expenses:							
Medical Outsourced	183	98	(85)	2,457	1,087	(1,370)	1,288
Lab Outsourced	183	183	0	1,830	1,830	0	2,196
Other Outsourced	227	132	(95)	1,778	1,141	(637)	1,373
Clinical Supplies	1,144	949	(195)	11,264	9,621	(1,643)	11,551
Non Clinicial Supplies	714	754	40	7,700	7,598	(102)	9,118
Finance Costs	79	74	(5)	740	754	14	905
Depreciation	246	243	(3)	2,434	2,466	32	2,960
Capital Charge	222	222	(0)	2,223	2,245	22	2,696
Total Expenditure	**8,145**	**7,622**	**(523)**	**79,531**	**74,690**	**(4,841)**	**89,919**
Net Operating Result	**(378)**	**(129)**	**(249)**	**(3,452)**	**241**	**(3,693)**	**0**

Note: Figures in brackets are negative variances or deficits.

COMMENT:

TDH recorded a deficit for the month of $380k, which is $251k worse than the budgeted deficit for the month.

The result includes a general provision of $40k ($400k YTD). There is no provision for a negative IDF wash-up at year end June 2015, as the budgeted IDFs have been increased significantly this year and a negative wash up is not anticipated, although the situation is being monitored by Funder using the extrapolative projection model.

FUNDS:

- Reported a surplus result of $9k for the month, against a breakeven budget.
- Revenue is above budget for the month and ytd, recognising additional revenue streams – particularly for Very Low Cost Access (VLCA), Integrated Performance & Incentive Framework (IPIF) and Rheumatic Fever.
- Expenditure in Personal Health is above budget YTD, which is related to the spending of the above additional revenues, but is mitigated by reduced Pharmaceutical expenditure, which is expected to continue.
- Under-expenditure YTD in Mental Health expenditure largely relates to under-utilisation of packages of care through community-based services at this time, although more expenditure is now being applied.
- Expenditure in Public Health is below budget, but is increasing as initiatives are commenced, particularly in the WERO Challenge and Tobacco-related programmes.
- Expenditure in Disability Support is above budget for the month, but under-budget ytd, which stems from lower-than-expected demand for Home-based Support services and Residential Rest Home care, but the higher-than-expected demand for Residential Hospital-level care. There is also an expenditure stream for High-cost Rehab.
- Over-budget expenditure in Hauora Maori relates to additional resources applied to continence and stomal services through NPH.

GOVERNANCE:

- Shows a small negative result for the month but remains positive YTD.
- The over budget expenditure in personnel reflects in part the cost of additional project-based staff.
- The over-budget expenditure YTD in non-clinical supplies relates to under-budgeting for DHB Shared Services costs and cost of consultancy services for the East Coast Review.
- The under-budget expenditure in democracy comes from the reversal of an over-accrual of Election costs.

DHB PROVIDER:

- Reported a deficit result for the month, and continues negative to budget YTD.
- Revenue – Over budget for the month and the year to date, mainly due to additional funding for Faster Cancer Treatment services and reimbursement for Pharmaceutical cancer Treatments (PCTs) and Patient Transport.
- Personnel Costs – Over budget for the month and the year to date. Leave Liability increased by $178k in the month and CME Liability decreased by $9k.
- Outsourced Services – over budget. The cost of Locums and outsourced Radiology continues to be a concern, although the former is showing signs of starting to reduce. These costs are driven by clinical service and roster coverage needs.
- Clinical Supplies – continues the trend of over budget expenditure in a multitude of cost lines, with Blood, and Dressings, Renal and Dialysis costs, Cancer drugs and implants being the primary contributors. Air Ambulance costs were $16k over budget for the month and are $100k over ytd, but remain significantly less than last year.
- Non-clinical Supplies – under budget for the month and ytd.

Recommendation:
THAT Board **ACCEPTS** the Report
M Costello, G M Finance
15 May 2015

Agenda item: Consolidated Cash Flow Projection

Tairawhiti DHB - Consolidated
- Cash Flow Projection 2014-2016
Includes:
- fiscal management to budgeted result.

	2014						2015						2014/15
	July Actual $000	August Actual $000	Sept Actual $000	October Actual $000	November Actual $000	December Actual $000	January Actual $000	February Actual $000	March Actual $000	April Actual $000	May Plan $000	June Plan $000	Total $000
Operating Activities	0												
MoH NDOC Funding	14,562	14,819	17,128	15,170	14,574	29,492	1,548	14,768	15,152	15,269	14,644	15,892	183,017
Other Govt and Crown Agency	285	231	172	251	178	158	149	195	202	194	219	219	2,451
Other Receipts	253	140	185	180	236	449	134	275	408	239	472	207	3,178
Total Receipts	15,100	15,190	17,486	15,601	14,987	30,099	1,831	15,238	15,762	15,702	15,335	16,318	188,647
Net IDF payments	-1,873	-1,890	-1,874	-2,683	-1,903	-1,871	-1,871	-1,888	-1,848	-1,871	-1,880	-1,872	-23,326
Non -DHB Providers	-4,545	-4,132	-4,702	-5,715	-4,813	-4,960	-4,886	-4,282	-4,293	-4,971	-4,617	-4,636	-56,551
Payroll	-5,963	-4,946	-4,370	-4,332	-4,514	-6,141	-5,286	-4,621	-4,583	-4,737	-4,583	-4,584	-58,662
Supplier payments	-3,277	-3,561	-2,826	-3,199	-3,413	-3,348	-2,889	-2,872	-3,011	-2,758	-2,839	-2,858	-36,851
Finance & Capital Charge	-339	-2	-470	-257	-11	-1,451	-51	-2	-61	-256	-10	-1,436	-4,346
Net GST	-911	-741	-740	-903	-598	0	-1,266	-793	-826	0	-1,611	-720	-9,108
Total Payments	-16,908	-15,272	-14,982	-17,089	-15,251	-17,771	-16,249	-14,458	-14,623	-14,593	-15,540	-16,106	-188,843
Net Cashflow - Operating	-1,808	-82	2,504	-1,488	-264	12,328	-14,419	780	1,139	1,108	-205	212	-196
Investing Activities													
Sale of Fixed Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Expenditure	-416	-198	-308	-422	-474	-1,016	-362	-93	-231	-294	-378	-378	-4,571
Net Cashflow - Investing	-416	-198	-308	-422	-474	-1,016	-362	-93	-231	-294	-378	-378	-4,571
Financing Activities													
New Debt	0	0	0	0	0	0	0	0	0	4,600	0	0	4,600
Repaid Debt	0	0	0	0	0	0	0	0	0	-4,600	0	0	-4,600
New Equity	0	0	0	0	0	0	0	0	0	0	0	0	0
Repaid Equity	0	0	0	0	0	0	0	0	0	0	0	-382	-382
Net Cashflow - Financing	0	0	0	0	0	0	0	0	0	0	0	-382	-382
Net Cashflow for the period	**-2,224**	**-281**	**2,196**	**-1,911**	**-738**	**11,312**	**-14,781**	**687**	**908**	**814**	**-583**	**-549**	**-5,149**
Plus: Cash (Opening)	2,047	-177	-458	1,738	-172	-911	10,401	-4,379	-3,693	-2,784	-1,970	-2,553	2,047
Cash (Closing)	**-177**	**-458**	**1,738**	**-172**	**-911**	**10,401**	**-4,379**	**-3,693**	**-2,784**	**-1,970**	**-2,553**	**-3,102**	**-3,102**

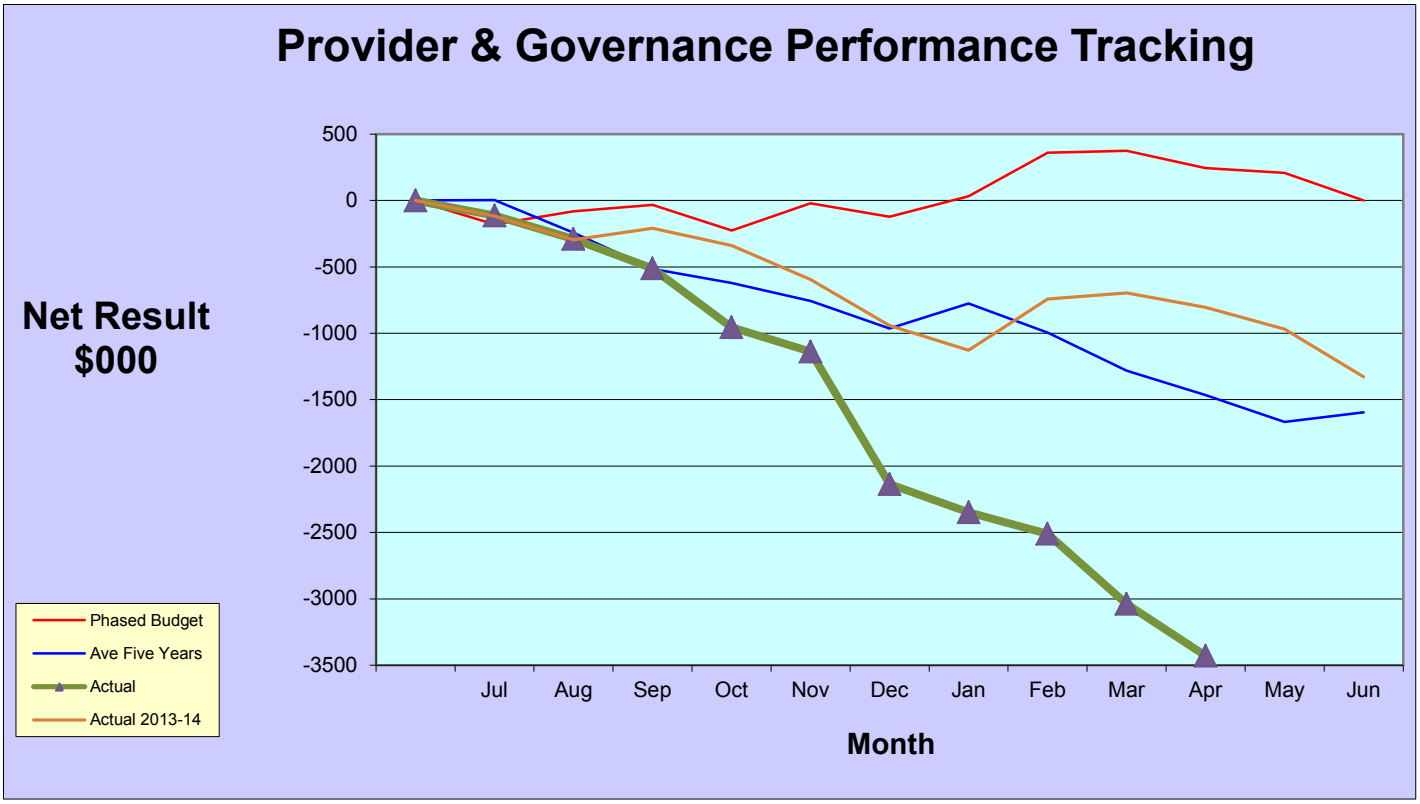
*Note 1: Cash projections are based on the December 2013 funding package and 2014 AP budgets, updated for known changes.
*Note 2: TDH has a "come and go" facility within the HBL sweep for up to $7.637 million. FAIT has approved use of up to $2 million of this.

Agenda item: Consolidated Cash Flow Projection

Tairawhiti DHB - Consolidated
- Cash Flow Projection 2014-2016
Includes:
- fiscal management to budgeted resu

	2015						2016						2015/16
	July Proj. $000	Aug Proj. $000	Sept Proj. $000	Oct Proj. $000	Nov Proj. $000	Dec Proj. $000	Jan Proj. $000	Feb Proj. $000	Mar Proj. $000	Apr Proj. $000	May Proj. $000	June Proj. $000	Total $000
Operating Activities													
MoH NDOC Funding	14,953	14,953	14,953	17,072	14,953	15,445	15,502	14,953	15,651	15,502	14,953	16,356	185,244
Other Govt and Crown Agency	224	224	224	224	224	224	224	224	224	224	224	224	2,690
Other Receipts	55	213	55	55	598	95	55	458	55	55	432	115	2,241
Total Receipts	15,232	15,390	15,232	17,351	15,775	15,764	15,781	15,635	15,930	15,781	15,609	16,695	190,175
Net IDF payments	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-22,414
Non -DHB Providers	-4,668	-4,599	-4,886	-5,060	-4,836	-4,844	-4,676	-4,514	-4,518	-4,756	-4,904	-4,748	-57,007
Payroll	-6,898	-4,598	-4,498	-4,498	-4,498	-6,091	-5,155	-4,498	-4,498	-4,498	-4,498	-6,748	-60,980
Supplier payments	-2,918	-3,009	-3,132	-2,801	-3,035	-2,848	-2,930	-2,830	-2,716	-2,828	-2,963	-2,983	-34,994
Finance & Capital Charge	-341	-2	-474	-170	-10	-1,363	-51	-2	-61	-170	-15	-1,363	-4,022
Net GST	-669	-669	-704	-597	-948	-670	-758	-776	-739	-844	-779	-671	-8,826
Total Payments	-17,362	-14,746	-15,562	-14,995	-15,196	-17,683	-15,437	-14,488	-14,399	-14,965	-15,027	-18,381	-188,242
Net Cashflow - Operating	-2,130	644	-330	2,356	579	-1,920	344	1,146	1,531	816	581	-1,686	1,933
Investing Activities													
Sale of Fixed Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Expenditure	-325	-325	-325	-325	-325	-325	-325	-325	-325	-325	-325	-325	-3,903
Net Cashflow - Investing	-325	-325	-325	-325	-325	-325	-325	-325	-325	-325	-325	-325	-3,903
Financing Activities													
New Debt	0	0	0	0	0	0	0	0	0	0	1,700	0	1,700
Repaid Debt	0	0	0	0	0	0	0	0	0	0	-1,700	0	-1,700
New Equity	0	0	0	0	0	0	0	0	0	0	0	0	0
Repaid Equity	0	0	0	0	0	0	0	0	0	0	0	-382	-382
Net Cashflow - Financing	0	0	0	0	0	0	0	0	0	0	0	-382	-382
Net Cashflow for the period	**-2,455**	**319**	**-655**	**2,031**	**253**	**-2,245**	**19**	**821**	**1,205**	**491**	**256**	**-2,393**	**-2,353**
Plus: Cash (Opening)	-3,102	-5,557	-5,238	-5,893	-3,862	-3,609	-5,854	-5,835	-5,014	-3,808	-3,317	-3,061	-3,102
Cash (Closing)	**-5,557**	**-5,238**	**-5,893**	**-3,862**	**-3,609**	**-5,854**	**-5,835**	**-5,014**	**-3,808**	**-3,317**	**-3,061**	**-5,454**	**-5,454**

*Note 1: Cash projections are based on the December 2013 funding package and 2014 AP budgets, updated for known changes.
*Note 2: TDH has a "come and go" facility within the HBL sweep for up to $7.637 million. FAIT has approved use of up to $2 million of this.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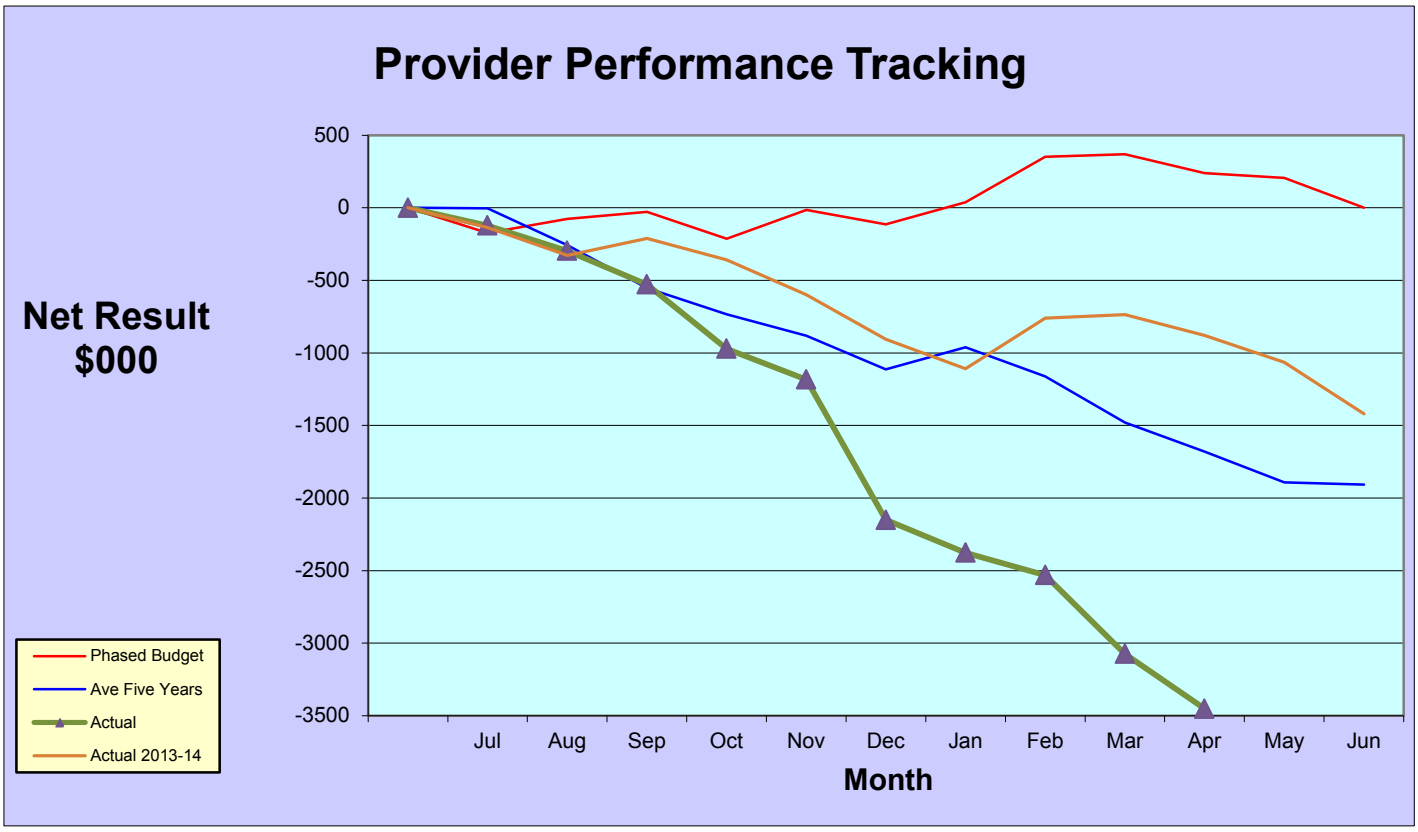
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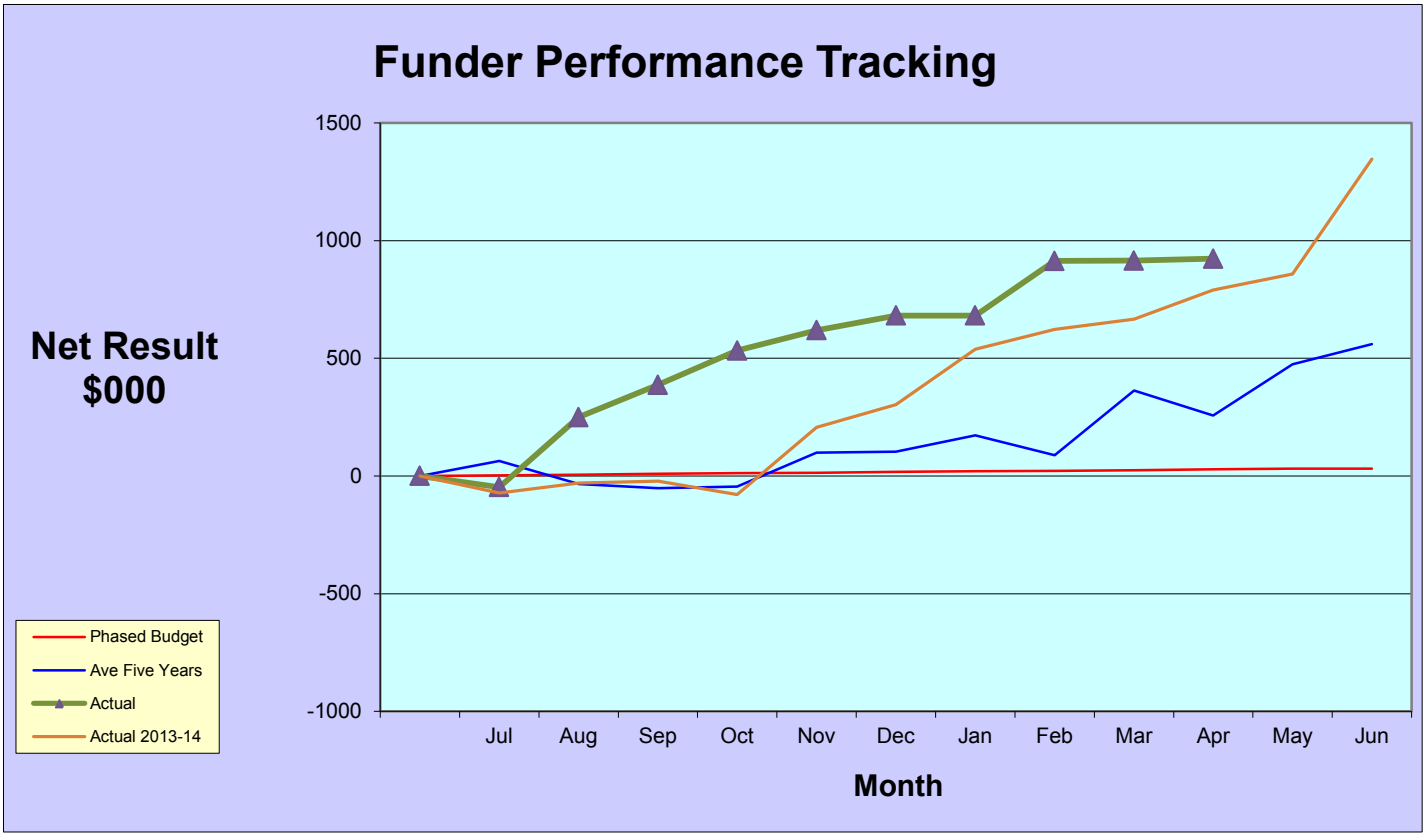
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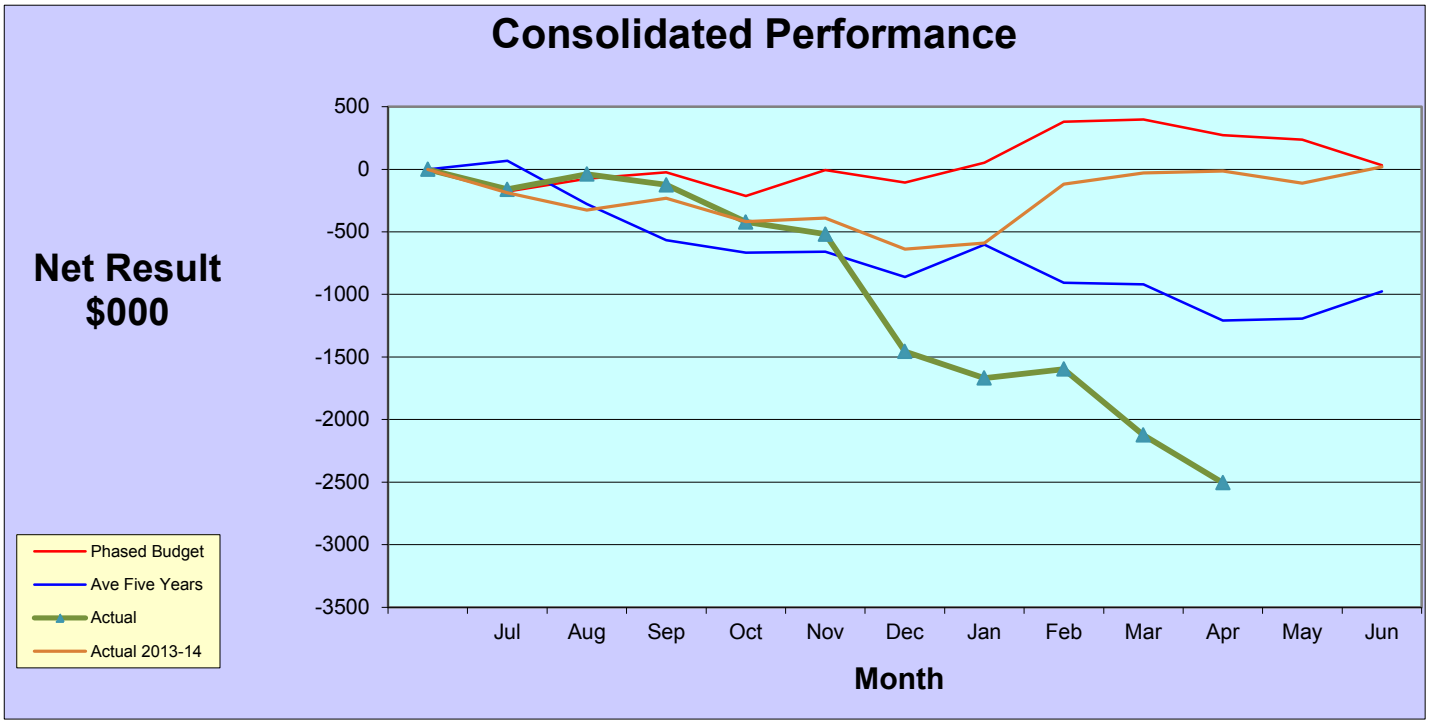
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BOARD SUB-COMMITTEE REPORTS

AGENDA ITEM 8.5

FINANCE, AUDIT & IT COMMITTEE 19.5.15	
	No decision items for consideration.
HOSPITAL ADVISORY COMMITTEE 19.5.15	
	11.1 2015/16 Capital Plan ADOPTED: The 2015/16 Capital Plan and recommends that the Board ADOPT the associated expenditure budget $4.732m.
AGED & DISABILITY SUPPORT ADVISORY COMMITTEE	
	Open Forum in May
COMMUNITY & PUBLIC HEALTH COMMITTEE	
	Open Forum in May

TWON REPORT - MAY

REPORT ITEM 8.6

E te Poari Matua tena koutou katoa,

Points of interest from the April TWON meeting:

Tairawhiti DHB Tobacco Control Plan 2015/18 (presented by Aporina Chapman)
- Re-designing of control services, Minister, 1 July 16 change of services.
- Info was sent to key stakeholders to ensure Ministry picks it up.
- MoH website information difficult to locate.

Suggest TDH Board puts pressure on this subject, and encourage other government agencies to awhi this kaupapa; a collaborative approach to communicate the message and to reinforce cross sector support to address issues.

TWON congratulates the team for their presentation it was both informative and collaborative. TWON reaffirms its support of this kaupapa.

HOP SLAT
As reported last month TWON was asked to provide a rep for the Health of Older people SLAT. Drina Hawea has agreed to participate on that SLAT.

Whanau Ora
With the establishment of Te Pou Matakana it has become even more imperative that DHBs have a clearer picture for Whanau Ora (WO) in each of their own rohe. TWON is going to tackle that issue at its May meeting. Te Pare Meihana will facilitate our wananga and it is our express intent to provide a draft position on WO for both Runanga and the Board to consider. TWON comprising of community, providers and Runanga reps in conjunction with the management team invite the TDH Board members to attend. I look forward to providing a report on the outcomes of that wananga.

RECOMMENDATION:
That the Board notes the report.

Na Raihania
Tiamana
Te Waiora o Nukutaimemeha.

MIDLAND DISTRICT HEALTH BOARDS REGIONAL SERVICES PLAN: QUARTER THREE 2014/15 MINISTRY FEEDBACK

INFORMATION ITEM 9.1

Situation

The 2014/15 Regional Services Plan (RSP) describes the collective direction of the five District Health Boards (DHBs) in the Midland region. Quarterly regional progress reports against a range of national priorities, collated on behalf of the regional DHBs, are submitted to the Ministry of Health, who then provide a response. The Ministry's responses for 2014/15 Quarter three are detailed in the following table (appendix 1).

Background

The regional DHB shared vision is for all residents of Midland DHBs is to lead longer, healthier and more independent lives. For this to occur the health of the Midland populations needs to improve (Strategic outcome 1) and the health system of Midland DHBs needs to eliminate health inequalities (Strategic outcome 2). This is summarised as 'healthy communities – integrated healthcare'.

Six regional objectives are being used as stepping stones to help achieve the regional vision and the two strategic outcomes. These are:

1. Improve Māori health outcomes.
2. Integrate across continuums of care.
3. Improve quality across all regional services.
4. Build the workforce.
5. Improve clinical information systems.
6. Efficiently allocate public health system resources.

The quarterly report outlines regional progress against national priorities: it is considered that the Ministry's response should be regarded as being a relatively positive assessment, with matters being in hand to make progress on those areas not assessed as being green.

Recommendation

It is recommended that the Board notes the Quarter Three Regional Services Plan progress report, and the Ministry of Health's assessment.

Virginia Brind
GM Planning, Funding & Population Health
May 2015

Midland Region Quarterly Assessment - Quarter 3 – 01/01/2015 – 31/03/2015 (FINAL ASSESSMENT)

National Priorities	Assessors and Reviewers Identified	Ministry's Assessment Rating	Ministry Initial Feedback	Region's Response	Ministry Final Feedback Highlights/Issues
Cancer Services	*Belinda Watt/Victoria Parker* Saskia Booiman	Achieved	Date: 29/04/2015 Reviewer: Victoria Parker We are pleased to see the progress made in the primary-secondary tools work programme, and commencement of the Breast cancer tumour standard review. We are also pleased to see round one initiatives are on track, and that the psychosocial assessment tool for cancer nurse is now in implementation phase. Last quarter, the Midland region was asked to include an update on its colorectal cancer map of medicine pathway in its Q3 report. This information does not appear to have been included. Could you please comment on the progress of this work?	Date: 6.5.15 Representative: Jan Smith Map of Medicine (MoM) and Bay Navigator (BN) colorectal pathway has been developed including the national direct referral to outpatient colonoscopy. The Midland Colonoscopy project (in progress) is working towards a MoM/BN colonoscopy pathway.	Date: 12/05/2015 Reviewer: Victoria Parker Thank you for your update, we are pleased to hear that the pathway has been developed and work towards the Midland Colonoscopy project is continuing.
Cardiac Services	*Isobel Williams/Sara Chester* Karen Evison	Partially Achieved	**ACS** Date: 28/04/2015 Reviewer: Sara Chester It is good to see that in March the performance against indicator 1 across the region as a whole was met. However, the performance of Tairawhiti DHB against this indicator remains concerning. It is acknowledged that Regional Integrated Planning should support improvement against this indicator. Indicator 2 has not been met by the region, although there have been some DHBs achieving well against this measure. ACCP was discussed at the regional teleconference and patchy progress across the region was described. **Secondary Services** Date: 28/04/2015 Reviewer: Emma Doust The Midland region continues to manage its cardiac surgery waiting lists and times in line with expectations. Levels of intervention for angiography and angioplasty remain relatively low across the region and renewed focus should be given to ensuring appropriate access for patients.	Date: 7.5.15 Representative: Philippa Edwards The Ministry's assessment is appropriate	**ACS** Date: 12/05/2015 Reviewer: Sara Chester We look forward to continued progress across these indicators and reporting areas in the next quarter. **Secondary Services** Date: 13/05/2015 Reviewer: Emma Doust No further comment required.
Health of Older People	*Penny Hanning* Ross Judge	Achieved	Date: 24/04/2015 Reviewer: Penny Hanning Thank you for this report it is helpful to see the detail of the regional activity and in particular the appointment of the dementia educators appointed at Waikato and Lakes DHBs.	Date: 6.5.15 Representative: Andrew Campbell-Stokes Thank you for the assessment and comments.	Date: 15/5/15 Reviewer: Penny Hanning No further comment
Elective Services	*Jessica Smaling/Emma Doust* Clare Perry	Partially Achieved	Date: 28/4/15 Reviewer: Emma Doust We acknowledge your work in sustaining the ESPI achievement and support your ongoing focus in this area. Your partially achieved rating is due to your waiting times performance in January and February.	Date: 6.5.15 Representative: Sam MacKenzie A fair call regarding waiting times. So close but still missed with Waikato DHB unfortunately (likely in line for next month). Regarding data. We now have the updated MoH	Date: 13/05/2015 Reviewer: Emma Doust No need to fix up this quarter's report. Just need to ensure that quarter 4's performance data is up to date when submitted. We look forward to your next quarter report.

			It is pleasing to hear of the opportunities being taken to leverage off other regional work (e.g. CTAS) and share learnings where possible. We note that the performance data on p4-6 of the appendix appears to be historical, and should be updated in future quarters to match the report commentary.	data (received last Friday, 1 May) so can fix up the report, if need be? Please let us know.	
Stroke Services	*Ailsa Jacobson* Karen Evison	Not Achieved	Date: 28/04/15 Reviewer: Ailsa Jacobson This report still does not provide assurance that the region has or is assisting in supporting the development of regional solutions where there are gaps in DHBs achieving the stroke indicators. The report needs to show actual percentage achievement against the stroke indicators and commentary giving regional solutions as to how outcomes will be improved.	Date: 7.5.15 Representative: Andrew Campbell-Stokes The comments and assessment is accepted. Discussion with the Ministry has explored the development of regional solutions and data source and quality. We hope to be able to provide more assurance as part of Quarter 4 reporting.	Date: 15/05/2015 Reviewer: Ailsa Jacobson We look forward to seeing a report that has addressed gaps where regional stroke services are not improving sustainably and safely, with identified and agreed solutions
Mental Health and Addiction Services	*Barry Welsh* Rod Bartling	Achieved	Date: 23/04/15 Reviewer: Barry Welsh Thank you for your report. It is pleasing to see progress on the Infant and Perinatal Clinical Network.	Date: 7.5.15 Representative: Eseta Nonu-Reid Thank you for the assessment and comments.	Date: 14/05/15 Reviewer: Barry Welsh Thank you we look forward to your quarter four report.
Major Trauma	*Annette Pack* Jane Potiki	Achieved	Date: 24/04/2015 Reviewer: Annette Pack The region's contribution to the MTNCN through sharing the Midland Regional Trauma Guidelines with members and offering to host other DHBs' major trauma data is acknowledged and appreciated. As ongoing funding for the MRTS from 2015/16 onwards has not yet been finalised, please keep us informed if the region's capacity to meet the expectations of the Major Trauma National Service Improvement Programme are at risk.	Date: 6.5.15 Representative: Suzanne Andrew Thank you for the assessment and comments. We will inform you about the outcome of the recommendation being received at the regional CEs meeting 4 June.	Date: 13/5/2015 Reviewer: Annette Pack No further comment
Workforce	*Margareth Attwood* Ruth Anderson	Achieved	Date: 24/4/15 Reviewer: Margareth Attwood The region continues to identify retention and recruitment for rural primary care workforces as an area of concern as well as its allied health project. Both areas are supported by a remedial plan. Remaining areas are showing good progress. 80% of planned activity has occurred, therefore an 'achieved' has been noted.	Date: 7.5.15 Representative: Michael Bland Thank you for the assessment and comments.	Date: 14/5/15 Reviewer: Margareth Attwood No further comment
Information Systems	*Eileen Duddy* Tony Cooke	Partially Achieved	Date: 27/04/15 Reviewer: Eileen Duddy The changes in the report have allowed easier assessment of the priorities. There has been progress in Q3 with Hospital ePharmacy achieving a key milestone with go-live at Lakes DHB and it is tracking well for Q4 deliverables. Regional CWS planning is underway. The initiation phase is near completion. We expect the region to reach an 'achieved' status by Q4. Regional CWS Implementation plan is expected to be agreed by all DHBs in Q4 through approval of a Regional Programme Business Case.	Date: 6.5.15 Representative: Katherine Browne The comments are noted and accepted	Date: 12/05/15 Reviewer: Eileen Duddy No further comment

Assessment Rating Scale Guide

Achieved	All actions tracking to plan
Partially Achieved	Some actions not tracking to plan but adequate resolution plan provided
Not Achieved	Some actions not tracking to plan and resolution plan inadequate
Completed	Actions are completed

ACTIVE TRANSPORT POSITION STATEMENT

DECISION ITEM 10.1

Obesity in Tairawhiti is a significant population and health service issue. The NZ Health Survey 2014 suggests that nearly 38% of our population is obese; 70% of our population is either overweight or obese. Effectively, normal weight is now abnormal in our population. While excess dietary intake is the primary driver of obesity, regular exercise has a contribution to make. Exercise has independent health benefits including improving well-being and improving cardio-vascular fitness.

Active transport results in a more physically active population. This helps to prevent some chronic diseases related to inactivity, helps to reduce motor vehicle use and the impact on the environment from using carbon fossil fuels. Active transport therefore contributes to improved overall health of the population and of the environment.

Tairawhiti District Health supports strategies and initiatives that advocate, enable and mediate for active transport opportunities for our community.

This paper proposes that Tairawhiti District Health Board agrees an "Active Transport" position statement.

Background
The NZ population has become more obese, and, though there is some evidence that we are slightly more active than 10 years ago, this is still against a fall over the past 20 years (SPARC). The population of Tairawhiti is generally more active than other areas, ranking 7th amongst health board areas, with 56% of our population regularly active.

The Tairawhiti District Health Board has reaffirmed a vision to of a "Healthy Tairawhiti". Traditionally healthcare was the care and support of persons suffering from injury, or illness from an infectious disease. Over the last 40 years there has been greater emphasis on the management of chronic disease arising from changing lifestyles. Obesity and diabetes will continue to consume health care resources, with estimates that obesity and its main consequence, diabetes, will consume upwards of 30% of health care resources in the coming decades. While exercise will not of itself resolve this (dietary intake is the main contributor) sedentary lifestyles encourage food laziness.

A 2010 Ministry of Health Policy Model predicted that 10% of the NZ population would have diabetes by 2028. The Health Survey suggests that already over 5% of our population report diagnosed diabetes, almost certainly an underestimate. Predicted increases of obesity of 3% per year suggest that 10% prevalence will be reached well before 2028. Ngati and Healthy[1] found insulin resistance (a probable precursor to type II diabetes) to be present in one third of the Maori population on the Coast. However, the research also demonstrated that regular exercise reduced the prevalence of insulin resistance by 43%[2].

Health promotion
Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to

[1] http://www.otago.ac.nz/diabetes/research/otago050263.html
[2] Diabetes Res Clin Pract. 2006 Apr;72(1):68-74. Epub 2005 Sep 27.
Insulin resistance and impaired glucose metabolism in a predominantly Maori community.
Mann JI1, Tipene-Leach DC, Pahau HL, Joseph NR, Abel S, McAuley KA, Coppell KJ, Booker CS, Williams SM.

change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being[3].

The Ottawa Charter for Health Promotion (to which NZ is a signatory) has a critical role in creating transformational change in the management of chronic disease, particularly if this organisation is to achieve the Outcome 1 (People are supported to take greater responsibility for their health) and Outcome 2 (People stay well in their homes and communities) of its Annual Plan[4].

The Ottawa Charter for Health Promotion 1986 has become the overarching framework that engages people and communities to make transformational change. It has five principles:

- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Actions
- Develop Personal Skills
- Reorient Health Services
- Moving into the Future

The urban environment in which a person lives can have a significant impact on health outcomes. In the infancy of urban development, urban planning and health were intrinsically linked. With advances in medicine and with the developments in technology, this linkage has diminished. An example where the first two principles of the Ottawa Charter can be applied to improve the health of a community is in active transport.

Active transport is any self-propelled mode of transportation (such as walking, jogging, cycling, or skating) to get from one place to another. There is ample evidence demonstrating that participation in regular physical activity has substantial positive impacts on people's health and in turn, the economy (physical inactivity has been estimated to cause 13% of illness in NZ[5]). Physical inactivity leads to a range of poor health outcomes including obesity, heart disease, stroke, type II diabetes, some cancers and depression. An urban environment that supports physical activity is important to our district as:

- Rates of obesity are significant for Maori in Tairawhiti.
- While we area a relatively active district, such activity will not be expressed across the population
- 4 year old children have the highest rate of obesity nationally (as measured through the B4 School programme).
- Circulatory system diseases, including ischaemic heart disease and cerebrovascular disease, accounted for over 40% of deaths.
- There is a large and disproportionate burden of disease related to obesity (including diabetes and its long term complications, in particular for people experiencing socio-economic disadvantage, in which group Maori are overrepresented.
- Exercise can reduce insulin resistance and the probable development of type II diabetes in our community

A primary objective in creating supportive environments is to enable people to include physical activity as incidental to other aspects of their daily lives, as many people believe themselves to be too busy for exercise. The less supportive the environment, the greater the challenge becomes for other initiatives which relate to people changing behaviour to be effective. In this we should strive to do two things: "to make the healthy choice the easy choice" – to assist those who have made the decision to adopt healthier lifestyles and also to

[3] World Health Organisation: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
[4] Tairawhiti District Health Annual Plan 14/15
[5] Physical activity and health: NZ College of Public Health Medicine policy statement, 2014

"make the easy choices the healthy choices" to facilitate healthy choices in face of apathy about such a choice.

Active transport can reduce motor vehicle trips and reduce congestion which in turn leads to an improvement in air quality and a reduction in greenhouse gas emissions. Reducing traffic volume also helps make the roads safer for everyone. Walking and cycling provide affordable, basic transport. Physically, economically and socially disadvantaged people may rely on walking and cycling, so improving active transport can help achieve social equity and economic opportunity objectives by making such choices easier.

Regular exercise releases endorphins, so called internal 'feel good' hormones, which encourage more exercise in turn. Active transport strategies can facilitate an exercise habit.

Physical inactivity costs the health service as well as the general community (13% of ill-health is related to inactivity) Addressing "obesity Tairawhiti" will need to be the number one priority for the Health Board, if services are not to be overwhelmed by the direct and indirect consequences of obesity, primarily type II diabetes and cardiovascular disease.

Much of the supportive information and evidence is accessible through the links at the end of this paper.

What to do?

TDH encourages GDC to develop active transport within its forward planning. "Future Tairawhiti" should require urban planning to facilitate active transport. This means promoting and supporting safe walkways and safe cycle-ways. Safe active transport means adequate lighting; adequate road crossings and priority for walking and separated lanes for cycling. Where economics necessitates choice, priority should be given to commuter and access walk- and cycle-ways.

Safe transport means enabling children to cycle and walk to school: not only is this healthy, it normalises active transport in adulthood. Schools should be encouraged to develop walking buses and cycle pelotons.

Other agencies have a role, for example, the Police. Police can regularly use cycle patrols on cycle-ways and walkways. Cycle-based patrols could become a visible feature of Gisborne policing.

TDH and GDC should set up a working group to develop an active transport for Tairawhiti strategy.

Workplaces, starting with local government and health, should ensure that staff and services users should be supported to use active transport. This means providing safe places to lock up bicycles; good changing and showering facilities and could include allowing paid time for an active transport choice.

Equity means that GDC should ensure that those living with socio-economic disadvantage should have better access to active transport.

Recommendation

That the Board:

1. Notes the paper
2. Endorses the recommendation that Tairawhiti District Health Board adopts this Active transport position statement, and supports the following:
    - Working with government agencies to actively promote and facilitate active transport networks through the provision of healthy public policy.

- The creation of supportive environments that enable access to active transport for all population groups including children, the elderly and people with disability to provide equity across our population.
- Reorientating the health service so that all health care providers and health agencies advocate and support active transport options for both staff and patients.
- Supporting communities and groups to achieve outcomes that benefit the health of the population.

Kate Sykes
Operations Manager Population Health

Bruce Duncan
Public health Physician

May 2015

References and further information

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New South Wales Health Dept (2009). *Healthy Urban Development Checklist* at http://www0.health.nsw.gov.au/pubs/2010/pdf/hud_checklist.pdf

New South Wales Department of Planning Position Statement – Planning for Active Living (undated) at http://www.planning.nsw.gov.au/Portals/0/AboutUs/Active_Living_%20DoP_Position_Statement_new.pdf

Tairawhiti District Health (2014). *Annual Plan (2014/15) and Statement of Intent (2014-17)* at http://www.tdh.org.nz/assets/Documents/Annual-Plans-SOI-docs/TDH-AP-2014-Final.pdf

Toi te Ora Public Health Service (undated). *Position Statement – Active Transport* at http://www.ttophs.govt.nz/vdb/document/553.

Victoria Transport Policy Institute (2015): *Evaluating Active Transport Benefits and Costs* at http://www.vtpi.org/nmt-tdm.pdf.

World Health Organisation (1986). *The Ottawa Charter for Health Promotion* at http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

Physical activity and health: NZ College of Public Health Medicine policy statement, 2014 http://www.nzcphm.org.nz/media/81766/2014_11_28_physical_activity_and_health_policy_statement.pdf

Promoting physical activity at the local government level: agencies for nutrition action April 2015 http://www.ana.org.nz/sites/default/files/Snapshot.pdf

PACIFIC ISLAND COMMUNITY TRUST- TAIRAWHITI DISTRICT HEALTH MEMORANDUM OF UNDERSTANDING

DECISION ITEM 10.2

Situation
Pacific Island Community Trust (PICT) and Tairawhiti District Health (TDH) have had a Memorandum of Understanding (MoU) since 2006: this has been recently reviewed by both TDH and PICT Boards representatives.

In order to ensure the revised MoU is more visible and actively applied a draft PICT-TDH Action Plan (Appendix 2) has been developed and will be read as an appendum to the revised MoU.

Both draft documents have been reviewed and endorsed by TDH Leadership Team.

Recommendation
It is recommended that the Board:

1) **Endorses** both the draft Pacific Island Community Trust and Tairawhiti District health Memorandum of Understanding, and the related Pacific Island Community Trust – Tairawhiti District Health Action Plan.

Virginia Brind
GM Planning, Funding & Population Health
May 2015

Appendix 1

MEMORANDUM OF UNDERSTANDING

BETWEEN TAIRAWHITI DISTRICT HEALTH BOARD

AND

PACIFIC ISLAND COMMUNITY TRUST

DATED May 2015

"Healthy Pacific peoples achieving their full potential throughout their lives" [i]

Samoan:	***"O le ola maloloina o tangata Pasefika ose auala lea mo I latou I le olaga atoa"***
Cook Island:	***"Kia matutu katoa te iti tangata Patipika ite umuumu kite ora'anga meitaki"***
Tongan:	***"Tupulekina 'a e ola fakalukufua 'oe mo'ui lelei 'I he kakai 'o e Pasifiki"***
Tokelau:	***"Ko tangata Pahefika malolohi kua maua te hoifua maloloina I le olanga atoa"***

THIS MEMORANDUM OF UNDERSTANDING is made on the day of 2015.

BETWEEN (together called the "Parties").

1. **THE PACIFIC ISLAND COMMUNITY TRUST**, a charitable trust incorporated under the Charitable Trusts Act 1957, on (insert establishment date here) and situated in Gisborne, New Zealand; and

2. **TAIRAWHITI DISTRICT HEALTH BOARD**, a Crown entity legislated under the New Zealand Public Health and Disability Act 2000 and situated in Tairawhiti, New Zealand.

PURPOSE OF MEMORANDUM OF UNDERSTANDING

The Parties have agreed to formalise a transparent relationship to enable them to work together to improve health outcomes and achieve the shared goal of hauora pai rawa (best health and well being) for the Pacific community of Te Tairawhiti.

STATEMENT OF PRINCIPLES

1. The Parties will work together using the principles of partnership to guide the relationship and will demonstrate good faith, mutual respect, co-operation, trust and honesty.

2. The Parties enter into this relationship in full commitment to take agreed actions to improve health outcomes and achieve the shared goal of best health and wellbeing for the Pacific community of Te Tairawhiti.

3. The relationship will be characterised by commitment, consideration, excellence, integrity, openness, patience, responsibility, transparency, understanding and unity.

4. The Parties recognise this Memorandum of Understanding as an ongoing living document and agree that it will be reviewed by the Parties bi-annually to ensure its objectives and actions remain aligned with progress made towards achieving improved health outcomes, and the shared goal of best health and wellbeing, for the Pacific Community of Te Tairawhiti. Any amendments to this document will be made by mutual consent of the Parties.

5. The Parties recognise that an annually agreed Pacific Island Community Trust - Tairawhiti District Health Board Action Plan will become the document that operationalises the Memorandum of Understanding. This will be agreed by 30 July annually and progress against it will be reported six-monthly to both Boards.

AGREEMENT OF THE PARTIES

The Parties agree that this relationship is framed within the principles and objectives of the New Zealand Public Health & Disability Act 2000[1] and the Pacific Health Strategy[2] as well as the objectives and values set out in the Tairawhiti District Health Annual Plan 2014/15.

New Zealand Public Health & Disability Act 2000

The Tairawhiti District Health Board recognises and includes into the development of strategic policies and plans the statutory objectives and responsibilities of DHBs as outlined in the New Zealand Public Health & Disability Act 2000; principally to improve, promote and protect the health of our communities.

The Pacific Health Strategy

The Tairawhiti District Health Board will recognise "Ala *Mo'ui. Pathways to Pacific Health and Wellbeing 2014-2018"* [3] in its strategic policy and development planning and in meeting its Pacific health objectives and functions.

Ala Mo'ui. Pathways to Pacific Health and Wellbeing identifies the following four priority outcomes:

- Systems and services meet the needs of Pacific peoples.
- More services are delivered locally in the community and in primary care.
- Pacific peoples are better supported to be healthy.
- Pacific peoples experience improved broader determinants of health.

Government is also committed to reducing the health inequalities that exist between Pacific people and other New Zealanders through effective partnerships with peoples of all ethnic backgrounds and through active Pacific people's involvement in the sector. DHBs will be the key agents in achieving these aspirations.

Evolving from these directions, three key themes emerge:

1. Pacific peoples' aspirations to have control over the direction and shape of their own institutions, communities and development as a people.
2. Building on the gains – the Ministry of Health, District Health Boards and other health and disability agencies have a responsibility to maintain the considerable gains already made and to build on them.
3. Reducing inequalities – in implementing service changes it is critical that the changes are assessed to ensure that they will contribute to reducing inequalities and not increase inequalities. The District Health Boards will need to assess the health needs of their region, identify service coverage and areas that need to be strengthened or modified over time.

TDH Annual Plan

[1] The New Zealand Public Health & Disability Act 2000 (NZPHD Act) (www.moh.govt.nz/moh.nsf)
[2] The Pacific Health and Disability Action Plan (www.moh.govt.nz/publications/pacificactionplan)
[3] (http://www.health.govt.nz/system/files/documents/publications/ala-moui-pathways-to-pacific-health-and-wellbeing-2014-2018) .

The Situation

Te Tairawhiti has seen a doubling of its Pacific people's population in less than five years. Currently there are more than 1300[4] Pacific people, representing many different cultures with as many differences as similarities.

Pacific people experience significant health inequalities compared with non-Pacific. While overall health has improved over the past 20 years, Pacific people's mortality and morbidity rates continue to be significantly higher than non-Pacific. The top seven modifiable causes of life years lost to premature death or disability for Pacific people are:

- Diabetes
- Ischaemic Heart Disease
- Chronic Obstructive respiratory disease
- Stroke
- Lung Cancer
- Breast Cancer
- Depression

What we plan to do

TDH has a role in improving the health status of Pacific people within Tairawhiti. To achieve this we have agreed an annual Action Plan: in addition to this will:

- Develop cultural competencies for the non-pacific community workforce to improves access and reduce barriers.
- Ensure mainstream services support the development of the Pacific health workforce.
- Ensure primary and community-based providers have a clear focus on improving Pacific health outcomes.
- Improve Pacific people's access to preventative, primary and mental health services.
- Develop a strategic partnership with the Pacific community to ensure it is regularly involved in health planning, service development and implementation.
- Improve the uptake of national screening programmes for Pacific women (breast screening and cervical screening).

THEREFORE

The Tairawhiti District Health Board shall:

1. Work closely with the Pacific Island Community Trust to:
    - Support the health aspirations of nga Iwi o Pacific Island Community Trust.
    - Reduce the inequalities that exist in health between Pacific people and that of other people in the Tairawhiti region.

[4] Update with 2013 census result

2. Carry out these responsibilities through:
   - Acknowledging the standing of the Pacific Island Community Trust and their desire to meet the health outcomes and aspirations of Pacific people.
   - Collaborating with the Pacific Island Community Trust to develop and implement strategies to achieve the health aspirations and gains of its respective people.
   - Consulting with the Pacific Island Community Trust on specific strategic issues that may have an impact upon its respective peoples.

The Pacific Island Community Trust shall:

1. Work collaboratively with the Tairawhiti District Health Board to:
   - Improve health outcomes and achieve the shared goal of best health and wellbeing for the Tairawhiti Pacific community.

2. Carry out these responsibilities through:
   - Directly participating in, and contributing towards, the development of the Tairawhiti District Health Board's:
     - Annual Plan.
     - Workforce Development Plan.
   - Putting forward when required, appropriate representation and participation on reference groups established by the Tairawhiti District Health Board.
   - The Pacific Island Community Trust will continue to support health outcomes for Pacific people through political forums and mutual networks.

PROCESS

- The Pacific Island Community Trust and the Tairawhiti District Health Board members will meet annually to review this Memorandum of Understanding, to review progress over the past twelve months against the agreed Pacific Island Community trust- Tairawhiti District Health annual Action Plan, and to agree the Action Plan priorities for the following year.

- The Pacific Island Community Trust and Tairawhiti District Health Board will receive and review a six monthly progress report against the annual Action Plan.

- The Pacific Island Community Trust and the Tairawhiti District Health Board will work together to advocate at government level for increased resources that contribute to the achievement of the jointly agreed health objectives.

IN WITNESS whereof these presents have been executed this

…XX……day of…… XX…….2015.

SIGNED for and on behalf of

PACIFIC ISLAND COMMUNITY TRUST

By affixing of its common seal

_____
Trustee

_____
Trustee

_____
Trustee

_____
Trustee

_____
Trustee

In the presence of:

_____
Witness Signature

_____
Witness Name and Occupation

SIGNED for and on behalf of

TAIRAWHITI DISTRICT HEALTH BOARD

_____
David Scott MNZM, JP
Tairawhiti District Health Board Chair

In the presence of:

_____
Witness Signature

_____
Witness Name and Occupation

Date of review: XX 2016 (or as requested by either Party)

Appendix 2

PACIFIC ISLAND COMMUNITY TRUST-TAIRAWHITI DISTRICT HEALTH BOARD ACTION PLAN

(Appendum to Pacific Island Community Trust-Tairawhiti District Health Board memorandum of Understanding May 2015)

Focus area	PICT	TDH	Timeframe (tentative- to be confirmed)
Updated PICT-TDH MoU	PICT to consider what remains/is changed in current MoU. PICT and TDH to agree a regular annual/bi-annual meeting with TDH Board. PICT to consider utilisation of TDH Learning centre facilities for training	TPW (Virginia) to work with PICT to complete MoU for respective Board consideration. PICT and TDH to agree a regular annual/bi-annual meeting with TDH Board. TDH to actively support PICT utilisation of TDH Learning Centre facilities.	31/5/15 30/6/15 30/4/15
PICT centre developed as “one stop shop” for Pasifica people	PICT to investigate what general practices Pacifica people registered with. PICT to “name” their clinic. PICT to investigate potential funding sources to support their continued development. Discuss potential for alignment with Turanga Health and their mobile health service. Investigate where and what Pasifica youth were in regards to current educational focus, and future tertiary PI youth were at present as well as future tertiary plans. Investigate what academic levels the Pacifica nurses had achieved. Further investigate the patient risk stratification- workforce capacity framework being developed within general practice (Midlands Health Network) This model includes role of	TPW to provide 2013 census data specifically relating to Pasifica in Tairawhiti. TPW to investigate numbers of Pasifica people enrolled with what PHO, registered with what general practice. TDH (HR) to provide non identifiable details as to TDH’s Pasifica workforce – and work with PICT in identifying workforce development pathways/Hauora scholarships. TDH to investigate current/future potential for telehealth link with PICT centre. TDH to work with PHOs to ensure PICT is fully informed about the establishment and utilisation of patient portal access (general practice).	31/7/15 30/6/15 31/5/15 31/5/15 ongoing

	Nurse Practitioner, Nurse working under Standing Orders, and Kaiawhinia. (*this may be a future action)*		
Improve Pasifica access to and utilisation of TDH outreach services	PICT to develop picture of current service access and utilisation issues/barriers from the stories/feedback from the Pasifica communities.	TPW to coordinate a meeting of TDH outreach services with PICT to discuss service access/service utilisation and initiatives/actions to improve both.[1] Agree an annual outreach visiting schedule –review same annually.	31/5/15 30/6/15
Improve Pasifica access to and utilisation of TDH hospital services		TDH DNA project team to include PICT representation and involvement	Immediately
Youth health (noting more than 50% Tairawhiti Pasifica population is youth)	PICT to consider how best TDH could support their youth health planning.	TDH/TPW to ensure PICT representation/involvement in development of Tairawhiti Youth Health planning TDH to raise option of PICT involvement in the Tairawhiti Well-being: collective impact developments	Immediately 31/6/15

[1] Potential services could include Falls Prevention, Enduring Power of Attorney support, physical exercise and healthy eating, CVD assessments, cervical screening, smoking cessation, self-management support for long term conditions, oral health-adolescent and pre-school, school, immunisation,

GLOSSARY OF ACRONYMS at Jan 11

ACS	Acute Coronary Syndrome
ADSAC	Aged Disability Support Advisory Committee
A & E	Accident and Emergency
AIMS	Ambulatory Inpatient Medical Service
ALOS	Average Length of Stay
AMP	Asset Management Plan
AOD	Alcohol or Drugs
ASMS	Association of Salaried medical Specialists
ATR	Assessment, Treatment, Rehabilitation
ATS	Air Transport Service
BCP	Business Continuity Plan
BFHI	Baby Friendly Hospital Initiative
CAMHS	Child & Adolescent Mental Health Services
CAPEX	Capital Expenditure
CCDM	Care Capacity Demand Management
CCM	Clinical Care Manager
CCU	Coronary Care Unit
CE	Chief Executive
CEA	Collective Employment Agreement
CFA	Crown Funding Agreements
CFO	Chief Financial Officer
CHFA	Crown Health Financing Agency
CNM	Clinical Nurse Manager
CPAC	Clinical Priority Access Criteria
CPHAC	Community and Public Health Advisory Committee
CSSD	Central Sterilising Services Department
CVD	Cardio Vascular Disease
CWD	Case Weighted Discharge
CWS	Clinical Work Station
DAMHS	Director of Area Mental Health services
DNA	Did Not Attend (appointment)
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DNA	Did Not Attend
DoSU	Day of Surgery Unit
DSS	Disability Support Services
DWAP	Drinking Water Assistance Programme
ED	Emergency Department
ENS	Ear Nurse Specialist
EoI	Expressions of Interest
ESPI	Elective Services Performance Indicators
EWIS	Emergency Warning and Intercommunication System
FAIT	Finance, Audit & IT Advisory Committee
FIT	TDH RTC/CCDM (combined) Project
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
GP	General Practitioner
HAC	Hospital Advisory Committee
HBL	Health Benefits Limited
HBSS	Home Based Support Services
HCSS	Home Care Support Services
HIS-NZ	Health Information Strategy for NZ
HDC	Health & Disability Commissioner
HEAT	Health Equity Assessment Tool
HEHA	Healthy Eating, Healthy Action
HNZC	Housing New Zealand Corporation
HR	Human Resources
HRIS	Human Resource Information System
HRT	Health Round Table
HSL	HealthShare Limited
HWIP	Health Workforce Information Program
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICU	Intensive Care Unit
IDF	Inter District Flow(s)
IEA	Individual Employment Agreement
IPE	Inter Professional Education (project)
IPIF	Integrated Performance & Incentive Framework
IPRC	Injury Prevention, Rehabilitation & Compensation Act (formerly ACC Act)
IS	Information Systems
ISLA	Internal Service Level Agreement
IT	Information Technology
JUCC	Joint Union Consultative Committee
KPI	Key Performance Indicator
KKP	Knowing the People Planning
LAMP	Leadership & Management Programme
LMC	Lead Maternity Carer
MCNZ	Medical Council of New Zealand
MCY	Maternal, Child & Youth
MECA	Multi Employer Collective Agreement
MERAS	Midwifery Employee Representation & Advisory Services
MHP	Maori Health Plan
MH SMART	Mental Health Standard Measures Assessment Recovery Tools
MHINC	Mental Health Information National Collection.
MFD	Multi-Function Devices (a.k.a. Photocopiers)
MRNT	Midlands Regional Network Trust
MMR	Measles, Mumps and Rubella
MoH	Ministry of Health
MOH	Medical Officer of Health
MOSS	Medical Officer Special Scale
MRI	Magnetic Resonance Imaging
MIRB	Maori Iwi Relationship Board
NASC	Needs Assessment Service Co-ordination
NEDC	Nursing Education and Development Committee
NMPI	National Master Patient Index
NGO	Non-Government Organisation
NHB	National Health Board
NIP	National Infrastructure Programme
NNU	Neonatal Unit
NPH	Ngati Porou Hauora
NSU	National Screening Unit
NZMLWU	New Zealand Medical Laboratory Workers Union
NZNO	New Zealand Nurses Organisation
O&G	Obstetrics & Gynaecology
OIA	Official Information Act
OPD	Outpatient Department
ORL	Otorhinolaryngology
OSH	Occupational Safety and Health
OT	Occupational Therapy
OTS	Office of Treaty Settlements
PACS	Picture Archiving Computer System
PACU	Post Anaesthetic Care Unit (Recovery Room)
PBFF	Population Based Funding Formula
PDRP	Professional Development Recognition Programme (Nursing)
PHO	Primary Health Organisation
PMS	Patient Management System
PPF	Professional Practice Fellow
PSA	Public Service Association
QIF	Quality Improvement Framework
RDA	Resident Doctors Association
RIS	Radiology Information System
RFP	Request for Proposal
RMO	Registered Medical Officer
RTC	Releasing Time to Care
SFMG	Strategic Funding Management Group

SFWU	Service & Food Workers Union
SIA	Services to Improve Access
SLAT	Service Level Alliance Team
SLT	Speech Language Therapy
SMO	Senior Medical Officer
SoI	Statement of Intent
SST	Social Sector Trials
TAIN	Tairawhiti Abuse Intervention Network
TDH(B)	Tairawhiti District Health Board
TIC	Tairawhiti Integration Committee
TIF	Tairawhiti Integration Forum
TLAG	Tairawhiti Local (Mental Health) Advisory Group
TLSL	Tairawhiti Laundry Services Limited
TOR	Terms of Reference
TPOT	The Productive Operating Theatre
TPW	Te Puna Waiora (Planning, Funding & Pop Health)
TRONP	Te Runanga o Ngati Porou
TROTAK	Te Runanga o Turanganui a Kiwa
TWON	Te Waiora o Nukutaimemeha
UPS	Uninterruptible Power Supply
WACC	Weighted Average Cost of Capital
WOPs	Wellbeing of Older Persons
YTD	Year to date