MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Part One Board Papers

14 December 2021

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Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

Contents

Agenda and karakia

14 December 2021

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MidCentral District Health Board

Board Meeting

Venue: Board Room, Gate 2, Heretaunga Street, Palmerston North

When: Tuesday 14 December 2021, from 9.00am

PART ONE

Members

Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Norman Gray, Muriel Hancock, Materoa Mar, Karen Naylor, Oriana Paewai, John Waldon, Jenny Warren.

Apologies

Nil

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Debbie Davies, Interim General Manager, Strategy, Planning and Performance; Celina Eves, Executive Director, Nursing and Midwifery; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Emma Horsley, Communications Manager; Margaret Bell, Board Secretary.

In attendance (part meeting)

Items 4.2, 4.3	Neil Wanden, General Manager, Finance and Corporate Services; Darryl Ratana, Deputy Chief Financial Officer
Item 4.4	Judith Catherwood, General Manager, Quality and Innovation
Item 4.5	Steve Miller, Chief Digital Officer
Item 4.6	Jess Long, Advisor, Planning and Accountability
Item 5.2	Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke
Item 5.4	Judith Catherwood, General Manager, Quality and Innovation

Please contact the Board Secretary if you require a print copy – email boardsupport@midcentraldhb.govt.nz before noon on the working day prior to the meeting

1. KARAKIA 9.00

He Karakia Timata

Kia hora te marino	May peace be widespread
Kia whakapapa pounamu te moana	May the sea be smooth like greenstone
He huarahi ma tātou I te rangi nei	A pathway for us all this day
Aroha atu, aroha mai	Give love, receive love
Tātou I a tātou I ngā wa katoa	Let us show respect for each other
Hui e taiki e	

2. ADMINISTRATIVE MATTERS 9.05

2.1. Apologies

2.2. Late items

2.3. Register of Interests Update

2.4. Minutes of Board meeting held on 9 November 2021, Part One

2.5. Matters arising

2.6. Verbal report from Board Chair

2.7. HDAC – Verbal report from Committee Chair and Minutes of HDAC meeting held on 23 November 2021, Part One

2.8. FRAC – Verbal report from Committee Chair and Minutes of FRAC meeting held on 30 November 2021, Part One

2.9. Manawhenua Hauora Chair's Report

3. STRATEGIC FOCUS

No items

4. PERFORMANCE REPORTING 9.15

4.1. Chief Executive's Report

4.2. Financial Update – October 2021

4.3. Finance Report – September 2021

4.4. Sustainability Plan

4.5. Te Awa Update – Digital Services Work Programme

4.6. Non-Financial Performance Measures – quarterly report

REFRESHMENT BREAK 10.00

5. DISCUSSION/DECISION PAPERS 10.15

5.1. Combined Medical Staff Association and Executive Action Plan

5.2. Midwifery Workforce Update

5.3. Nursing Workforce Update

5.4. Consumer and Clinical Council – Terms of Reference

5.5. MidCentral DHB's Alcohol Position Statement

6. INFORMATION PAPERS 10.50

Information papers for the Board to note

6.1. Board Work Programme

7. GLOSSARY OF TERMS

8. LATE ITEMS 10.55

9. DATE OF NEXT MEETING – Tuesday 15 February 2022

10. EXCLUSION OF THE PUBLIC

Recommendation

That the public be **excluded** from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated.

Item	Reason	Reference
'In committee' minutes of the previous Board meeting	For reasons set out in the agenda of 9 November 2021	
Replacement of Instrument Washers in Sterile Services Unit	To protect negotiations, including commercial and industrial	9(2)(j)
Patient Transfer Services Contract Renewal	To protect negotiations, including commercial and industrial	9(2)(j)
Mosaiq as a Service Business Case	To protect negotiations, including commercial and industrial	9(2)(j)
Next Generation Computing Business Case	To protect negotiations, including commercial and industrial	9(2)(j)
Health Sector Reforms – Transition Plan for MDHB	To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials	9(2)(f)(iv)
Workshop – Allied Health	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Minutes of Remuneration Committee meeting 9 December 2021	To protect personal privacy	9(2)(a)
Chief Executive's employment	To protect personal privacy	9(2)(a)
Board only time	No decision sought	
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	**For reasons set out in the agenda of the 23 November 2021 meeting held with the public present**	
Serious Adverse Events (SAC 1) Report	To protect patient privacy	9(2)(a)
'In committee' minutes of the previous Finance, Risk and Audit Committee meeting	**For reasons set out in the agenda of the 30 November 2021 meeting**	

Administrative matters

14 December 2021

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Apologies

Any apologies to be noted?

Late items

Opportunity to advise any late items to be discussed at the meeting

Register of Interests: Summary, 26 November 2021

(Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)

Board Members		
Name	**Date**	**Nature of Interest / Company/Organisation**
Browning, Heather	4.11.19	Director – HB Partners Limited
		Member – MidCentral Governance Group Mana Whaikaha
		Board Member and Chair, HR Committee – Workbridge
	26.7.20	Director and Shareholder – Mana Whaikaha Ltd
	23.10.20	Member – Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group
	9.2.21	Project Manager to lead Mana Whaikaha out of the Ministry of Health; stood down from appointed role of Deputy Chair of the MidCentral Governance Group for the MidCentral prototype
		Resigned as Director of Mana Whaikaha Ltd – effective from December 2020
	12.7.21	Appointed to the Support and Consultation for End of Life Choice in New Zealand (SCENZ) Group – a statutory part-time role within the Ministry of Health.
Duffy, Brendan	3.8.17	Chair and Commissioner – Local Government Commission
		Member – Representation Commission
		Chairperson – Business Kapiti Horowhenua Inc (BKH)
	17.8.21	Trustee – Eastern and Central Community Trust
Dennison, Vaughan	4.2.20	Councillor – Palmerston North City Council
	9.2.21	Member of Palmerston North City Council Infrastructure Committee
	14.9.21	Employee – Homes for People, Kaitiaki, Public Relations
		Director – Social Impact Property, Property and Support Services
		Partner – Dennison Rogers-Dennison, Accommodation Services
		Trustee – Manawatū Whanganui Disaster Relief Fund
		Chair – Camp Rangi Woods Trust
		Board Member – Softball New Zealand
		Patron – Manawatū Softball Association
		Wife is a Partner – Dennison Rogers-Dennison, Accommodation Services
		Wife is an employee – Homes for People, Kaitiaki, Support Worker
		Wife is an employee – Healthcare NZ, Community Support Worker
		Father is Managing Director, Exclusive Cleaning Services
Findlay, Lew	1.11.19	President, Manawatu Branch and Director Central District - Grey Power
		Councillor – Palmerston North City Council
		Member – Abbeyfield
	16.2.21	Vice President Manawatū Branch and Board Member of Grey Power New Zealand
Gray, Norman	10.12.19	Employee – Wairarapa DHB
		Branch Representative – Association of Salaried Medical Specialists

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Hancock, Muriel	4.11.19 30.9.20 19.11.21	Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB Volunteer, MidCentral DHB Medical Museum Sister-in-law is employed as a registered nurse at Whakapai Hauora Sister-in-law works as a COVID-19 vaccinator for MidCentral DHB
Mar, Materoa	16.12.19 11.2.20 5.8.20 13.7.21 17.8.21	Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance Chair – EMERGE Aotearoa Matanga Mauri Ora Ministry of Health Mental Health and Addiction Chair, 'A Better Start – E Tipu Rea', National Science Challenge, Liggins Institute, University of Auckland Member of MDHB Cluster Member of local Child and Youth Mortality Review Group (CYMRG) Member of MDHB's Māori Alliance Leadership Team (MALT) Member – Te Ahu Whenua Māori Land Trust Member, Māori Provider Expert Reference Group for Transitional Health Unit
Naylor, Karen	6.12.10 9.10.16	Employee – MidCentral DHB Member and Workplace Delegate – NZ Nurses Organisation Councillor – Palmerston North City Council
Paewai, Oriana	1.5.10 13.6.17 30.8.18 13.4.21 27.7.21 9.11.21	Member – Te Runanga o Raukawa Governance Group Chair – Manawhenua Hauora Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs) Member Nga Manu Taiko, a standing committee of the Council – Manawatū District Council Member – Te Tihi o Ruahine Whānau Ora Alliance Board Member – Cancer Society Manawatū Appointed Member – Massey University Council Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board Member – Governance Board, Mana Whaikaha No longer a Board Member – Cancer Society Manawatū No longer a member of Nga Manu Taiko, a standing committee of the Manawatū District Council
Waldon, John	22.11.18 9.2.21	Co-director and co-owner – Churchyard Physiotherapy Ltd Co-director and researcher – 2 Tama Limited Manawatu District President – Cancer Society Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society Has a contract with UCOL

Register of Interests: Summary, 26 November 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Warren, Jenny	6.11.19	Team Leader Bumps to Babies – Barnardos New Zealand
		Consumer Representatives National Executive Committee – National On Track Network
		Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre
	12.2.21	Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
	1.7.21	Enhancing NZ Clinical Trials – member of Consumer Focus Group (run by the Liggins Institute with funding from the Ministry of Health and Health Research Council)
		No longer Team Leader Bumps to Babies – Barnados New Zealand
	15.10.21	No longer Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre
	4.11.21	No longer a member of the Locality Advisory Group for Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
	9.11.21	Contract with Horowhenua Life to the Max
	19.11.21	Contract with The Horowhenua Company
Committee Members		
Allan, Simon (FRAC)	2.6.20	Deputy Chair – Manawatu Branch of Cancer Society
		MDHB Rep – THINK Hauora
		Palliative Care Advisory Panel (Ministry of Health advisory body)
		Director of Palliative Care – Arohanui Hospice
		Chair of Board – Manawatu Badminton Association
Hartevelt, Tony (FRAC)	14.8.16	Independent Director – Otaki Family Medicine Ltd
	14.8.16	Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company)
	14.8.16	Younger son is news director for Stuff.co.nz – Fairfax Media
	7.10.19	Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP)
	14.10.21	Resigned as Independent Chair of the Primary Care Caucus for PSAAP negotiations
Paewai, Stephen (HDAC)	24.11.21	Trustee – THINK Hauora
		Member of MDHB's Consumer Council (Interim Chair from November 2021)
		Member of THINK Hauora's Clinical and Digital Governance Committee
		Beneficiary of Rangitane o Tamaka nui a Rua Inc Society
		Trustee – Te Tahua Trust
		Trustee – Te Ohu Tiaki o Rangitane Te Ika a Maui Trust
		Director – Rangitane o Te Ika a Maui
		Board member – Tararua REAP
		Member – Lottery Community Manawatū/Whanganui
		Wife is an employee of MCI and Associates, accounting practice
		Brother-in-law is a senior manager, ACC

Register of Interests: Summary, 26 November 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Management		
Cook, Kathryn	13.4.21	Nil
Ambridge, Scott	20.8.10	Nil
Amoore, Anne	23.8.04	Nil
Anjaria, Keyur	17.7.17	Wife is a user of the Needs Assessment and Service Co-ordination Service – MDHB
Bell, Margaret	28.7.20	Nil
Billinghurst, Kelvin	6.8.20	Fellow of the Royal College of Medical Administration (RACMA) Coordinator for the Indigenous Health Programme – RACMA Member of the Rural Policy Advisory Group – RACMA Fellow of the Australasian College of Health Service Managers (ACHSM)
Brogden, Greg	16.2.16	Nil
Brown, Jeff		TBA
Catherwood, Judith	1.5.18	Nil
Davies, Deborah	18.5.18	Member, Alliance Leadership Team – Central PHO Daughter is an employee and works within hospital services – MidCentral DHB
Eves, Celina	20.4.20	Trustee – Palmerston North Medical Trust
Fenwick, Sarah	13.8.18	Nil
Free, Jennifer	6.8.20	Nil
Hansen, Chiquita	9.2.16 3.3.21	Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB CEO – Central PHO Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths Husband is employed by MidCentral DHB Executive member of General Practice New Zealand (GPNZ) Executive member of Health Care Home Collaborative
Hardie, Claire	13.8.18 13.8.18 13.8.18	Member – Royal Australian & NZ College of Radiologists Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc Member, Medical Advisory Committee – NZ Breast Cancer Foundation
Horgan, Lyn	1.5.17 18.5.18	Sister is Coroner based in Wellington – Coronial Services Member, Alliance Leadership Team – Central PHO
Horsley, Emma	6.9.21	Husband is employed by MDHB

Register of Interests: Summary, 26 November 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business – Puriri Trust and Puriri Farm Partnerships Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO Chair – National DHB Digital Investment Board
Ratana, Darryl	29.5.19	Nil
Russell, Greig	3.10.16	Minority shareholder – City Doctors Member, Education Committee – NZ Medical Council
Scott, Gabrielle	Dec 2019	Son is a permanent MDHB employee and works within Digital Services
Tanner, Steve	16.2.16	Nil
Te Huia, Tracee	13.7.21	Member of the No Ngā Hau e whā branch of the Māori Women's Welfare League
Wanden, Neil	February 2019	Nil
Williamson, Nicki	March 2020	Nil
Zaman, Syed	1.5.18	Nil

Resolution

That the Part One minutes of the 9 November 2021 Board meeting be approved as a true and correct record.

MidCentral District Health Board

Board Minutes

Meeting held on 9 November 2021 from 9.00am

(held via Zoom due to COVID-19 restrictions)

PART ONE

Members

Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Muriel Hancock, Materoa Mar, Karen Naylor, Oriana Paewai, John Waldon, Jenny Warren.

Apologies
Norman Gray.

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Debbie Davies, Interim General Manager, Strategy, Planning and Performance; Celina Eves, Executive Director, Nursing and Midwifery; Emma Horsley, Communications Manager; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Keyur Anjaria, General Manager, People and Culture; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Judith Catherwood, General Manager, Quality and Innovation; Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke; Kelly Isles, Director of Strategy, Planning and Accountability; Steve Miller, Chief Digital Officer; Darryl Ratana, Deputy Chief Financial Officer; Neil Wanden, General Manager, Finance and Corporate Services.

Combined Medical Staff Association: Dr Nathalie de Vries, Chair; Dr Thomas Carter; Mr Geoff Anderson.

Media – 1

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

An apology was received and accepted from Norman Gray.

2.2. Late items

There were no late items.

2.3. Register of Interests Update

Jenny Warren

- No longer a member of the Locality Advisory Group (Tararua and Ōtaki/Horowhenua) for the Primary Maternity project.
- Contract with Horowhenua Life to the Max

Oriana Paewai

- No longer a Board member of the Cancer Society, Manawatū
- No longer a member of Nga Manu Taiko, a standing committee of the Manawatū District Council

Karen Naylor – in relation to item 5.3 Midwifery Workforce Update

- Work in Gynaecology Assessment Unit, which is mentioned in Item 5.3, Midwifery Workforce Update. No decision required by Board; agreed could participate in discussion.

2.4. Minutes of the Board meeting held on 28 September 2021, Part One

It was resolved that:

the Part One minutes of the 28 September 2021 Board meeting be approved as a true and correct record.

(Moved John Waldon; seconded Vaughan Dennison)

2.5. Matters arising from previous minutes

The matters arising schedule would be updated to indicate timing for the review of car parking arrangements at Palmerston North Hospital.

The Executive Director, Allied Health; the Clinical Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth; the General Manager, Quality and Innovation; and the Director of Strategy, Performance and Accountability joined the meeting.

2.6. Verbal report from the Board Chair

The Board Chair noted the intense effort made by staff to encourage people to be vaccinated against COVID-19. He had observed the reluctance of some people at a pop-up clinic in Shannon and was impressed by the positive interaction of the team when encouraging people to be vaccinated. The target of achieving 90 percent of the population to be double vaccinated was always going to be a challenge and the results so far were encouraging.

2.7. Minutes of the Finance, Risk and Audit Committee meeting held on 19 October 2021, Part One

It was resolved that the Board:

note the unconfirmed Part One minutes of the Finance, Risk and Audit Committee meeting held on 19 October 2021.

(Moved Vaughan Dennison; seconded Oriana Paewai)

2.8. Manawhenua Hauora Chair's Report

This report would be discussed at the combined hui with Manawhenua Hauora members later today.

It was resolved to:

note the report from the Manawhenua Hauora Chair on the Manawhenua Hauora hui held in September 2021

note the General Manager, Māori Health's response to the Chair's report.

(Moved Oriana Paewai; seconded Heather Browning)

3. STRATEGIC FOCUS

Discussion in Part Two of the meeting.

4. PERFORMANCE REPORTING

4.1. Chief Executive's Report

The Chief Executive presented this report, which was taken as read. She outlined the work being done to communicate with staff to encourage and support them to comply with the Vaccination Order which requires all health and disability sector employees to have

their first COVID-19 vaccination by 11.59pm on 15 November 2021. An update would be provided to the Board on 15 November to advise the number of staff who were not vaccinated and what actions were being taken to address any impact.

The Chief Executive acknowledged the work of the Director of Strategy, Planning and Accountability, who would be moving to a new role with THINK Hauora. She thanked her for the contribution she had made to the DHB over the last seven years.

Board members noted the milestone reached in the commencement of the Surgical Procedural Interventional Recovery Expansion (SPIRE) project; that Palmerston North Hospital was placed third in the Inaugural Golden Hip Awards 2021; and acknowledged the work done to respond to the End of Life Choice Act.

It was resolved that the Board:

note the update of key local, regional and national matters.

(Moved Vaughan Dennison; seconded Muriel Hancock)

4.2. **Board KPI Dashboard**

The Director of Strategy, Planning and Accountability presented this report, which was taken as read. She noted the plans in place across all localities to improve immunisation rates, particularly in Horowhenua. Improvements were planned for the February dashboard report which would cover the 12 health system indicators and avoid duplication of Non-Financial Performance Measures reporting. The Health System Indicators (HSIs) would continue to be presented for Māori and non-Māori across all indicators.

A Board member expressed concern about difficulties in enrolling newborns with GPs in the Horowhenua and the impact that had on immunisation rates and the First 1000 Days project. The Interim General Manager, Strategy, Planning and Performance advised that an update on the nurse-led practitioner clinic would be provided to the next Health and Disability Advisory Committee meeting.

On behalf of the Board, the Chair also acknowledged the work of the Director of Strategy, Planning and Accountability and wished her well in her new role with THINK Hauora.

It was resolved that the Board:

note the areas highlighted in the KPI dashboard and associated commentary.

(Moved Brendan Duffy; seconded Oriana Paewai)

The Director of Strategy, Planning and Accountability left the meeting.

4.3. Finance Report – September 2021

The General Manager, Finance and Corporate Services and the Deputy Chief Financial Officer presented this report, which was taken as read.

In response to a question, the Deputy Chief Financial Officer noted that work had been done last year with Ernst and Young regarding Holiday Pay miscalculations resulting from the payroll system used by all District Health Boards. It had been estimated that around $100k per week needed to be allowed by MidCentral District Health Board (MDHB) to rectify the issue. Once the payroll system had been corrected, this would be included as a payroll cost.

It was resolved that the Board:

note that the month operating result for September 2021 is a deficit before one-off items of $3.351m, which is $0.162m adverse to budget

note that the year to date result for September 2021 is a deficit before one-off items of $1.992m, which is $1.304m adverse to budget

note that year to date for September 2021 COVID-19 related contribution of $0.150m and Holidays Act costs of $1.478m have been incurred. Including these results in a year to date deficit after exceptional items of $3.320m, which is $0.883m adverse to budget

note that the total available cash and equivalents of $31.454m as at 30 September 2021 is sufficient to support liquidity requirements

note this is an interim finance report and that a full report will come to the Board for consideration at its December meeting.

(Moved Vaughan Dennison; seconded Oriana Paewai)

4.4. Finance Report – August 2021

The General Manager, Finance and Corporate Services and the Deputy Chief Financial Officer presented this report, which was taken as read.

It was resolved that the Board:

note that this report was endorsed by the Finance, Risk and Audit Committee at their 19 October meeting

note that the month operating result for August 2021 is a surplus before one-off items of $0.542m, which is $0.798m adverse to budget

note that the year to date operating result for August 2021 is a surplus before one-off items of $1.420m, which is $1.140m adverse to budget

note that year to date for August 2021 COVID-19 related contribution of $0.149m and Holidays Act costs of $0.922m have been incurred. Including these results in a year to date deficit after exceptional items of $0.577m, which is $0.816m adverse to budget

note that the total available cash and equivalents of $38.777m as at 31 August 2021 is sufficient to support liquidity requirements

approve the August financial report.

(Moved Vaughan Dennison; seconded Oriana Paewai)

4.5. Sustainability Plan Report

The General Manager, Quality and Innovation presented this report, which was taken as read. She noted that issues raised at the Finance, Risk and Audit Committee meeting regarding the nurse specialling project and improving the readability of savings targets clearer was being progressed.

The Board Chair noted the effort of the management team in achieving genuine savings through the Sustainability Plan.

It was resolved that the Board:

note the Finance, Risk and Audit Committee endorsed this report at its October meeting, for Board consideration

note the Sustainability Plan benefits baseline and monitoring dashboard

note August 2021 indicates a negative variance to plan of $25,060 year to date

note the progress in the implementation of the Sustainability Plan

approve the approach and progress made to date on the Sustainability Plan 2020-2023.

(Moved Oriana Paewai; seconded Karen Naylor)

The General Manager, Quality and Innovation and the Deputy Chief Financial Officer left the meeting.

The Chief Digital Officer joined the meeting.

4.6. Te Awa Update – Digital Services Work Programme

The Chief Digital Officer presented this report, which was taken as read.

It was resolved that the Board:

note the Digital Services work programme covering planned work for the 2021/22 financial year

note the progress since the last reporting period

note the national and regional activity that may impact on the planned work programme.

(Moved John Waldon; seconded Muriel Hancock)

The Chief Digital Officer left the meeting.

The General Manager, People and Culture joined the meeting.

4.7. Health, Safety and Wellbeing

The General Manager, People and Culture presented this report, which was taken as read.

It was resolved that the Board:

note the quarterly Health, Safety and Wellbeing report

note that the Health, Safety and Wellbeing report was endorsed by the Finance, Risk and Audit Committee at its meeting on 19 October 2021 for submission to the Board.

(Moved Jenny Warren; seconded Karen Naylor)

4.8. Workforce Update

The General Manager, People and Culture presented this report, which was taken as read. He noted that there is now extra effort in place to recruit to nursing and midwifery positions. The overall vacancies were consistent, despite staff numbers increasing.

It was resolved that the Board:

note the workforce update

note the challenges and opportunities being undertaken to address workforce concerns identified within the report.

(Moved Lew Findlay; seconded Muriel Hancock)

The General Manager, People and Culture left the meeting.

The Chair and members of the Combined Medical Staff Association joined the meeting.

5. DISCUSSION/DECISION PAPERS

5.1. Combined Medical Staff Association and Executive Action Plan

The Chief Executive and the Chair of the Combined Medical Staff Association (CMS) presented this report, which was taken as read.

The Chief Executive noted that a consultation paper on the proposed changes to clinical leadership of Te Uru Arotau, Acute and Elective Specialists Service had been released. Feedback would close on 22 November and be considered before a final decision was released. Other matters on the action plan would be discussed and monitored at Medical Reference Group (MRG) meetings.

The CMS Chair noted the importance of good communication between management and clinicians, particularly leading up to the new health structure in 2022. Geoff Anderson raised issues relating to mitigations for the Surgical Procedural Interventional Recovery Expansion (SPIRE) project and the Crest Hospital contract. The Board Chair noted that the CMS Chair had been invited to the meeting to discuss the action plan and to raise any issues that could not be addressed by management. The SPIRE project had already commenced and the contract with Crest Hospital was scheduled for discussion later at this meeting.

Geoff Anderson left the meeting.

The Chief Executive advised that the CMS Chair had been kept informed of progress with the SPIRE project and the Crest Hospital contract negotiations. Board members suggested deferring this discussion until it was possible to have a face-to-face meeting. The Board Chair offered to have an informal meeting with the CMS Chair. Tom Carter asked that the small action group set up to develop goals and a shared action plan be reconvened, with the inclusion of some Board members.

The Board Chair advised he had looked closely at the organisational structures that the Chief Executive and the Executive Team were responsible for and was impressed with the level of opportunity for staff to engage in discussions and decision-making. The issues raised by CMS related to management, not governance and should not be discussed at a Board meeting.

It was resolved that the Board:

> *note the current progress in delivering the Combined Medical Staff Association (CMS) and Executive Action Plan.*
>
> *(Moved Brendan Duffy; seconded John Waldon)*

The Chair of the Combined Medical Staff Association and Tom Carter left the meeting.

5.2. MidCentral District Health Board and Manawhenua Hauora Combined Work Plan Update

The General Manager, Māori Health and the Manawhenua Hauora Chair presented this report, which was taken as read.

The Manawhenua Hauora Chair noted that the issue of immunisation rates had been raised with Hon Peeni Henare, Associate Minister of Health (Māori Health) during his visit to the district on 28 October. While the focus was on COVID-19 vaccinations, with messaging around 'Get vaccinated or else', this wasn't helpful in retaining the trust and confidence of the community. A request had been made for national messaging to strongly encourage people to get vaccinated against COVID-19, while also accepting their reasons for not doing so.

It was resolved that the Board:

note the progress made against the MidCentral District Health Board and Manawhenua Hauora Combined Work Plan 2021/22.

(Moved Muriel Hancock; seconded Lew Findlay)

The Operations Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth, joined the meeting.

Heather Browning left the meeting.

5.3. Midwifery Workforce Update

The Operations Executive, Te Uru Pā Harakeke presented this report, which was taken as read. She noted that Auckland University of Technology (AUT) hoped to offer a nursing to midwifery transition course in Semester Two, 2022. Ward 24 would be required to close for a four-week period from the end of November to enable COVID-19 facilities work to be completed. To provide additional bed capacity during this period, the antenatal clinic would be relocated to Te Papaioea Birthing Centre. It was hoped to provide a full 24-hour service at the Birthing Centre from April 2022.

A Board member noted the increase in consumer surveys completed during October and asked what the percentage of Māori responding was. The Operations Executive offered to make this information available at the next meeting. The key findings of the maternity culture survey released in July 2021 would be made available on the Stellar platform.

It was resolved that the Board:

note the current midwifery workforce position

note the key updates to the Midwifery Action Plan.

(Moved Lew Findlay; seconded Oriana Paewai)

The Operations Executive Te Uru Pā Harakeke left the meeting.

5.4. Nursing Workforce Update

The Executive Director, Nursing and Midwifery presented this report, which was taken as read.

It was resolved that the Board:

note the Nursing Workforce Report.

(Moved Muriel Hancock; seconded Materoa Mar)

5.5. Technical Advisory Services Annual General Meeting and Annual Report

The Interim General Manager, Strategy, Planning and Performance presented this report, which was taken as read.

It was resolved that the Board:

approve that the Board Chair, Brendan Duffy, represent MidCentral District Health Board (MDHB) at the Technical Advisory Services (TAS) AGM on 2 December 2021; and in the event the Board Chair is unable to attend, either the Deputy Board Chair, Oriana Paewai, or the Chief Executive, Kathryn Cook, attend as a proxy to represent MDHB

approve that the recommendations included in the Notice of TAS Annual General Meeting be supported.

(Moved Oriana Paewai; seconded Muriel Hancock)

Heather Browning rejoined the meeting.

5.6. Allied Laundry Services Annual General Meeting

The General Manager, Finance and Corporate Services presented this report, which was taken as read. In response to questions from Board members, he offered to seek an update from the Chief Executive of Allied Laundry regarding water usage, mitigation strategies and impacts of the proposed Three Waters Reform (drinking water, waste water, storm water).

It was resolved that the Board:

note the notice of Annual General Meeting for Allied Laundry Services Limited and the Report to Shareholders

appoint Neil Wanden, General Manager, Finance and Corporate Services as MidCentral DHB's proxy at Allied Laundry Services Limited's Annual General Meeting in November 2021, and instruct him to support the recommendations as included in the Notice of Annual General Meeting dated 5 October 2021.

(Moved Vaughan Dennison; seconded Lew Findlay)

6. INFORMATION PAPERS

6.1. NZ Health Partnerships Limited

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

It was resolved that the Board:

note the update on the activities of New Zealand Health Partnerships Limited (NZHP).

(Moved John Waldon; seconded Vaughan Dennison)

6.2. **Board's Work Programme**

The report was taken as read. The following changes were agreed:

Annual Plan and Budget 2022/23
Remove from the work programme as MDHB is only required to provide information for 2022/23 to establish a budget for Health New Zealand. To ensure the Board has oversight and can ensure that any emerging risks are being addressed, this information will be incorporated into the MDHB Transition to Health New Zealand updates, which are on the work programme.

Memorandum of Understanding between MDHB and Manawhenua Hauora (triennial review due September 2021)
Remove from the work programme. It had been agreed with Manawhenua Hauora this would not be reviewed due to the transition to Health New Zealand and the Māori Health Authority in 2022.

Chief Executive's Performance Review
Bring forward to May 2022 so this can be completed before the Board is disestablished.

It was resolved that the Board:

note the Board's annual work programme.

(Moved Vaughan Dennison; seconded Muriel Hancock)

7. GLOSSARY OF TERMS

8. LATE ITEMS

No discussion.

9. DATE OF NEXT MEETING

Tuesday, 14 December 2021 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North *(subject to any COVID-19 restrictions)*.

10. EXCLUSION OF PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	***Reason***	***Ref***
'In Committee' minutes of the previous Board meeting	For reasons set out in the agenda of 28 September 2021	
2020/21 Annual Report and Financial Statements	To maintain the effective conduct of public affairs through free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any public service agency or organisation in the course of their duty	9(2)(g)(i)
Replacement of High Acuity Patient Monitors	To protect negotiations, including commercial and industrial	9(2)(j)
e-Prescribing and Administration Business Case	To protect negotiations, including commercial and industrial	9(2)(j)
Laboratory Results Electronic Sign Off Business Case	To protect negotiations, including commercial and industrial	9(2)(j)
Regional Common Patient Administration System (webPAS) as a Service Business Case	To protect negotiations, including commercial and industrial	9(2)(j)
SPIRE Construction Contract	To protect negotiations, including commercial and industrial	9(2)(j)
Construction Contract for EDOA/MAPU Unit	To protect negotiations, including commercial and industrial	9(2)(j)
Capital Intentions	To protect negotiations, including commercial and industrial	9(2)(j)
Health Sector Reforms – Transition Plan for MDHB	To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials	9(2)(f)(iv)
Special Delegation of Authority	To protect negotiations, including commercial and industrial	9(2)(j)
Board only time	No decision sought	
'In Committee' minutes of the previous FRAC meeting	**For reasons set out in the agenda of the meeting held on 19 October 2021**	

(Moved Karen Naylor; seconded John Waldon)

Part One of the meeting closed at 11.30am

Confirmed this 14th day of December 2021

……..

Board Chair

MidCentral District Health Board

- Schedule of Matters Arising, 2021/22 as at 6 December 2021

Matter	Raised	Scheduled	Responsibility	Form	Status
Provide an update on Allied Laundry's water usage, mitigation strategies and impacts of the proposed Three Waters Reform	Nov 21	~~Dec 21~~ Feb 22	N Wanden	Report	Scheduled
Future Quality and Safety Walk-round reports to include details of actions and any themes	May 21	May 22	J Catherwood	Report	Scheduled
Review of car parking arrangements PNH, including readdressing all carpark feedback and suggestions (Dec 20: after traffic engineering review completed)	April 17	Ongoing	N Wanden	Report	Verbal update at December meeting
COMPLETED					
Future Non-financial Monitoring Performance quarterly reports on adolescent oral health to show how the inequity was being addressed and whether it had improved	Sept 21	Dec 21	D Davies J Long	Report	Completed
Provide an update on colonoscopy wait times for the next quarter, particularly for non-urgent and surveillance colonoscopies	Sept 21	Dec 21	D Davies J Long	Report	Scheduled – March 2022 HDAC
Advise what percentage of Māori responded to maternity consumer surveys completed in October	Nov 21	Dec 21	S Fenwick	Report	Completed
Discuss process for receiving reports from CMS	Sept 21	Nov 21	B Duffy	Board only	Completed
Advise Board members of the process for conducting annual Board evaluation (on work programme for November 2021)	Sept 21	Nov 21	B Duffy	Board only	Completed
Key findings of maternity services culture survey to be loaded to Stellar (under 2021 documents)	Nov 21	Nov 21	S Fenwick M Bell	Report	Completed
Include updates on MDHB's plan to transition to Health New Zealand on the work programme	Sept 21	Nov 21	M Bell	Report	Completed
Internal audit report – Māori Health Equity Review to be included on the agenda for a future MDHB and Manawhenua Hauora Board hui	April 21	~~Aug 21~~	T Te Huia	Report to Manawhenua Hauora	Superseded
Prepare new costings for Horowhenua Respite Facility – email to Board members for approval	Aug 21	Sept 21	V Caldwell S Ambridge	Email	Completed
Report on process for calculating fees for Council members in line with Cabinet Fees Framework	Aug 21	Sept 21	J Catherwood M Bell	Report	Completed
Write to the Ministry of Health to highlight issues faced by migrant GPs in gaining residency	Aug 21	Sept 21	C Hansen	Letter	Completed – response received

Matter	Raised	Scheduled	Responsibility	Form	Status
Report on options for Enable New Zealand in the health reforms – FRAC meeting then Board	July 21	Sept 21	M Riwai	Report	Completed – 7 Sept FRAC; Sept Board
Summary of discussion from Medical Workforce Workshop held 6 July 2021 to be loaded on Stellar	Aug 21	Aug 21	M Bell	Upload Stellar	Completed
Discuss recruitment of a person with lived experience of disability to become a member of HDAC with the Consumer Council chair	Dec 20	~~Feb 21~~ ~~May 21~~ Aug 21	B Duffy	Report	Not proceeding – impact of health system reforms
Present a draft health sector reforms transition plan for MDHB	July 21	Aug 21	V Caldwell	Report	Completed
Provide more detailed commentary about incidents in Health, Safety and Wellbeing dashboard reports, including how they are being addressed	May 21	Aug 21	K Anjaria	Report	Completed
Include details on workforce shortages in the Health, Safety and Wellbeing report if data is available	May 21	Aug 21	K Anjaria	Report	Completed
Provide breakdown by service area for incidents of staff shortages, including location, what was being recorded, why it was being recorded and what was being done to address the issue	Feb 21	~~May 21~~ Aug 21	K Anjaria	Report	Completed
Write letter of congratulations to former Board member, Barbara Cameron, on receiving QSM in Queen's Birthday Honours	July 21	July 21	B Duffy	Letter	Completed
Check on wheelchair access for Alcohol and Other Drug services – from walk-round March 2020	May 21	July 21	J Catherwood	Verbal update	Completed
Send calendar invitations for long service awards ceremonies to Board members	May 21	June 21	M Bell	Meeting invite	Completed

Verbal report from the Board Chair

The Board Chair will provide an update on recent activities

Resolution

That the Part One minutes of the 23 November 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.

MidCentral District Health Board

Health and Disability Advisory Committee Minutes

Meeting held on 23 November 2021 from 9.00am
Board Room, Gate 2, Heretaunga Street, Palmerston North
(and via Zoom due to COVID-19 restrictions)

PART ONE

Members

John Waldon (Committee Chair), Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Norman Gray, Muriel Hancock, Materoa Mar (Deputy Committee Chair), Karen Naylor, Oriana Paewai, Jenny Warren.

Apologies

Stephen Paewai.

In attendance

Kathryn Cook, Chief Executive; Dr Kelvin Billinghurst, Chief Medical Officer (and Clinical Executive, Te Uru Kiriora); Judith Catherwood, General Manager, Quality and Innovation; Debbie Davies, Interim General Manager, Strategy, Planning and Performance (and Operations Executive, Te Uru Kiriora); Emma Horsley, Communications Manager; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Scott Ambridge, Operations Executive, Te Uru Rauhī; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Sarah Fenwick, Operations Executive, Te Pā Harakeke and Te Uru Mātai Matengau; Dr Claire Hardie, Clinical Executive, Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau; Angela Rainham, Locality and Intersectoral Development Manager; Michelle Riwai, General Manager, Enable New Zealand, Gabrielle Scott, Executive Director, Allied Health; Dr Syed Zaman, Clinical Executive, Te Uru Whakamauora.

THINK Hauora – Chiquita Hansen, Chief Executive; Nicola Russell, General Manager, Clinical Quality; Kylie Faas, General Manager, Knowledge and Insights, Dr Bruce Stewart, Board Chair.

Media – 1 Public – 2

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

The apology from Stephen Paewai, the Interim Chair of the Consumer Council (following resignation of Gail Munro) was accepted.

2.2. Late items

No late items were advised.

2.3. Register of Interests Update

The following updates to the Register of Interests were advised.

Jenny Warren

Add – Contract with The Horowhenua Company.

Muriel Hancock

Add – Sister-in-law is employed as a COVID-19 vaccinator for MidCentral District Health Board.

2.4. Minutes of the 14 September 2021 meeting, Part One

It was resolved that:

> *the Part One minutes of the 14 September 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.*
>
> *(Moved Brendan Duffy; seconded Heather Browning)*

2.5. Matters arising from previous minutes

No discussion.

3. STRATEGIC FOCUS

The meeting agreed to re-order the Strategic Focus items.

The Locality and Intersectoral Development Manager joined the meeting.

3.2 Population Profile Update – with a future focus

The Locality and Intersectoral Development Manager presented this report, which was taken as read.

Committee members noted the need to use the data to improve services, particularly for Māori and Pacific people. A breakdown of ethnicity for Territorial Local Authority (TLA) data was needed to ensure data was used appropriately.

The Locality and Intersectoral Development Manager noted that the population was growing faster than predicted by Statistics New Zealand in each locality within the MDHB region. Further work would be done to ensure health services met the needs of the population, including refugees who often had complex health needs.

The Chief Executive responded to concerns raised about the different population numbers used by TLAs and District Health Boards (DHBs). As a Government agency, MidCentral DHB (MDHB) was obliged to use data provided by Statistics New Zealand. Following the establishment of Health New Zealand and the Māori Health Authority in July 2022, DHB boundaries would no longer exist. People could choose where they received their health care and funding would be based on services provided rather than population numbers.

It was resolved that the Committee:

note the detailed work being carried out to understand the differences between data used by MidCentral DHB and local authorities in the region

note the special needs of Māori, Pasifika, refugee and other population groups; and that the current population profile gives statistics for these groups but does not identify how that information needs to be utilised in service provision

note the current population profile for the district; and recognise that in planning future services, population projections from a variety of sources should be considered, as Statistics New Zealand projections have under-estimated the actual population in recent years.

(Moved Vaughan Dennison; seconded Brendan Duffy)

The Locality and Intersectoral Development Manager left the meeting.

The THINK Hauora Chief Executive; the Board Chair; the General Manager, Clinical Quality; and the General Manager, Knowledge and Insights joined the meeting.

3.1. Primary Care Access and Affordability Update

The THINK Hauora representatives presented this report, which was taken as read. They noted that the population in the district continued to grow and that General Practice Team enrolment numbers for Māori continued to increase.

THINK Hauora noted that the comparison of consultation rates between 2020 and 2021 had been affected by COVID-19 lockdowns, testing and the vaccine rollout. The number of patients redirected through the Emergency Department Redirection to General Practice programme was increasing. Analysis showed the number of Māori and Pacific people was higher than non-Māori and also showed lower deprivation scores. Data would continue to be monitored through Primary Options for Acute Care and more detail would be included in the next report to the Committee.

The Committee noted that a new GP practice would open in Ashhurst in April 2022.

It was resolved that the Committee:

note the update of various activities contributing to primary care access and affordability.

(Moved John Waldon; seconded Jenny Warren)

The THINK Hauora Chief Executive; the Board Chair, the General Manager, Clinical Quality; and the General Manager, Knowledge and Insights left the meeting.

The Clinical and Operations Executives joined the meeting.

4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

4.1. Directorate Dashboard

The Operations Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth presented this report, which was taken as read.

A Committee member noted the impact of occupational therapy vacancies on discharge planning and length of stay for patients. The Executive Director, Allied Health advised that the community wait list was being reviewed and that MDHB was working with a contracted provider and Whanganui DHB to support the service.

The Clinical Executive, Te Uru Pā Harakeke noted that GPs had been encouraged to diagnose asthma in children so they could access the Community Child Health Team's Child Health Asthma Service. The DHB, in conjunction with THINK Hauora, had held education sessions on managing respiratory difficulties without needing hospital level care.

4.2. Te Uru Rauhī – Mental Health and Addiction Services

The Operations Executive, Te Uru Rauhī presented this report, which was taken as read. He noted the significant decrease in occupancy of inpatient beds, with 18 people in the unit today.

The Adult Integrated Model of Care, Te Mātāpuna o te Ora, was expected to be fully deployed from April 2022. COVID-19 had impacted the timeframes and a 'signpost check in' would be carried out in February 2022.

4.3. Te Uru Arotau – Acute and Elective Specialist Services

The Operations Executive, Te Uru Arotau presented this report, which was taken as read. She noted that MDHB was one of five DHBs taking part in the Ministry of Health's (the Ministry) weekend discharge pilot. Community infusion sites were being set up – two in Palmerston North and one in Tararua.

4.4. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

The Operations and Clinical Executives, Te Uru Whakamauora presented this report, which was taken as read.

Committee members raised concerns around the waiting list for non-urgent Occupational Therapy referrals. The Operations Executive advised that a pilot was about to begin, where SupportLinks would carry out assessments outside of the hospital.

4.5. Te Uru Pā Harakeke – Healthy Women, Children and Youth

The Operations and Clinical Executives, Te Uru Pā Harakeke presented this report, which was taken as read. In response to a question, she advised that only one permanent midwife had indicated she would not be vaccinated against COVID-19. Due HR processes related to the COVID-19 Vaccination Order were being followed.

A Committee member raised a question about the software to facilitate the process of fast and efficient referral, data gathering and whānau ora outcomes approach for the Child Development Service Referral Integration Project. The Clinical Executive advised that the project brought the education, Child, Adolescent and Family Services and the health sector together to provide wrap-round care. The focus was on getting an improved outcome for children.

4.6. Te Uru Mātai Matengau – Cancer Screening, Treatment and Support

The Operations Executive and the Clinical Executive, Te Uru Mātai Matengau presented this report, which was taken as read.

4.7. Te Uru Kiriora – Primary, Public and Community Health

The Operations and Clinical Executives, Te Uru Kiriora presented this report, which was taken as read. As at 22 November, 91 percent of the eligible population had received their first dose of the COVID-19 vaccine and 82 percent were fully vaccinated. There

was now around 11,000 people unvaccinated in the district. Ten Supported Isolation and Quarantine (SIQ) facilities were now available in the region if required.

It was resolved that the Committee:

note the areas highlighted in the dashboard and associated commentary.

(Moved John Waldon; seconded Muriel Hancock)

The Clinical Executives and Operations Executives left the meeting.

The General Manager, Enable New Zealand joined the meeting.

5. PERFORMANCE REPORTING

5.1. Enable New Zealand Report

The General Manager, Enable New Zealand presented this report, which was taken as read. She noted that the Managed Rehabilitation Equipment Services (MRES) contract with ACC was launched last week. Since then, 270 pieces of equipment had been processed each day.

The Committee Chair asked that percentages be added to the ethnicity data charts in future reports.

It was resolved that the Committee:

endorse the Enable New Zealand Report to 31 October 2021.

(Moved John Waldon; seconded Muriel Hancock)

The General Manager, Enable New Zealand left the meeting.

5.2. Pae Ora Paiaka Whaiora Report

The General Manager, Māori Health acknowledged the passing of Delwyn Te Oka's husband and said it was fitting that the Pae Ora report started with Te Ohu Auahi Mutunoa (TOAM smoking cessation service), as this service is led by Delwyn. No reira, moe mai, moe mai, moe mai ra e te Rangatira. The report was then taken as read. She noted that Blair McKenzie, Regional Commissioner for Social Development, Ministry of Social Development, had been appointed as the Regional Partnership Services Leadership (RPSL) Chair.

It was resolved that the Committee:

note the progress update for the Pae Ora Paiaka Whaiora Māori Health Directorate.

(Moved Materoa Mar; seconded Vaughan Dennison)

5.3. Quality and Safety Dashboard

The General Manager, Quality and Innovation presented this report, which was taken as read. In response to a question about whether the increase in complaints from Māori patients related to specific issues, she agreed to include narrative in future reports.

Committee members asked that concerns highlighted through inpatient surveys regarding the cleanliness of rooms and wards be addressed.

It was resolved that the Committee:

note the content of the Quality and Safety Dashboard

endorse the improvement activities planned for the next quarter.

(Moved Karen Naylor; seconded Vaughan Dennison)

6. DISCUSSION/DECISION PAPERS

6.1. Quality Account – Quarter One 2021/22

The General Manager, Quality and Innovation presented this report, which was taken as read.

In response to comments from Committee members, it was agreed that future reports would include more input from Pae Ora Paiaka Whaiora and the Consumer Council,consumer stories; and that readability would be improved.

It was resolved that the Committee:

note the Quarter One 2021/22 Quality Account.

(Moved Vaughan Dennison; seconded Muriel Hancock)

7. INFORMATION PAPERS

7.1. MidCentral District Health Board Position Statement on Alcohol

The Clinical Executive, Te Uru Kiriora presented this report, which was taken as read.

The Chief Executive advised that the National Chief Executives and Chairs had committed to having an alcohol statement that was consistent with the national policy statement on alcohol. Each DHB would have a local statement.

The Committee asked that the statement includes a reference to the principles of Te Tiriti o Waitangi and notes that alcohol is a carcinogen.

It was resolved that the Committee:

endorse the Alcohol Position Statement for submission to the Board.

(Moved Karen Naylor; seconded Jenny Warren)

The Clinical Executive, Te Uru Kiriora left the meeting.

The Clinical Executive, Te Uru Pā Harakeke joined the meeting.

7.2. The 15th National Child and Youth Mortality Data Report 2015-2019

The Clinical Executive, Te Uru Pā Harakeke presented this report, which was taken as read.

Committee members expressed concern and sadness at the suicide rate. A large percentage of these young people had no prior engagement with mental health services, so agencies including education, Police and Oranga Tamariki needed to work together to identify and support young people at risk. It was suggested that the issue be discussed at a Regional Interagency Network meeting.

It was resolved that the Committee:

note this report on the deaths of pēpi, tamariki and rangatahi aged from 28 days to 24 years in Aotearoa

note that this brief review of data provides a link to part of the roadmap to reducing the number of deaths and disproportionate outcomes across ethnicities, age groups, gender identity and deprivation levels.

(Moved Heather Browning; seconded Muriel Hancock)

The Locality and Intersectoral Development Manager joined the meeting.

7.3. Locality Plan Progress Report – Tararua District

The Locality and Intersectoral Development Manager presented this report, which was taken as read. She noted that as at 22 November, 88 percent of the eligible Tararua population had received their first dose of the COVID-19 vaccine; and 77 per cent were fully vaccinated. There were 1776 people eligible who had not received any vaccination.

It was resolved that the Committee:

note the progress that has been made in relation to Tararua Te Mahere Hauora (Health and Wellbeing Plan).

(Moved Muriel Hancock; seconded Karen Naylor)

The Locality and Intersectoral Development Manager and the Clinical Executive, Te Uru Pā Harakeke left the meeting.

7.4. Committee's Work Programme

The report was taken as read.

It was resolved that the Committee:

note the update on the Health and Disability Advisory Committee's work programme.

(Moved John Waldon; seconded Karen Naylor)

8. GLOSSARY OF TERMS

No discussion.

9. LATE ITEMS

No discussion.

10. DATE OF NEXT MEETING

Tuesday, 1 March 2022 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North

11. EXCLUSION OF PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	Reason	Ref
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	For reasons set out in the agenda of the 14 September 2021 meeting held with the public present	
Serious Adverse Events (SAC 1)	To protect patient privacy	9(2)(a)

(Moved John Waldon; seconded Jenny Warren)

Part One of the meeting closed at 11.45am

Confirmed this 1st day of March 2022

……..

Committee Chair

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Finance, Risk and Audit Committee meeting held in the Board Room, MidCentral District Health Board, Palmerston North on 30 November 2021 from 9.00am

(Some participants joined via Zoom due to COVID-19 restrictions)

PART ONE

COMMITTEE MEMBERS
Oriana Paewai, Committee Chair
Tony Hartevelt, Deputy Committee Chair, Independent *(via Zoom)*
Brendan Duffy, Board Chair
Heather Browning
Vaughan Dennison
John Waldon

APOLOGIES
Simon Allan, Independent

IN ATTENDANCE
Kathryn Cook, Chief Executive
Neil Wanden, General Manager, Finance and Corporate Services
Darryl Ratana, Deputy Chief Financial Officer
Tracee Te Huia, General Manager, Māori Health *(via Zoom)*
Jared McGillicuddy, Internal Audit Manager *(via Zoom)*
Nicki Williamson, Committee Secretary

IN ATTENDANCE (part meeting)
Judith Catherwood, General Manager, Quality & Innovation
Keyur Anjaria, General Manager, People and Culture

1. KARAKIA

The Chair opened the meeting with a karakia.

The Chair acknowledged the recent passing of Wiki Mulholland, a Palmerston North breast cancer drug advocate. The Mulholland family had contacted the Chair to thank the MDHB staff who had gone to the house and been so supportive.

2. ADMINISTRATIVE MATTERS

2.1 Apologies

An apology was noted from Dr Simon Allan, Independent.

2.2 Late items

There were no late items.

2.3 Register of Interests Update

There were no updates to the register of interests.

2.4 Minutes of the previous meeting

It was resolved:

that the Part One minutes of the meeting held on 19 October 2021 be approved as a true and correct record. (Moved Vaughan Dennison; seconded John Waldon)

2.5 Matters arising from the previous minutes

There were no matters arising from the previous minutes.

3. PERFORMANCE REPORTING

3.1 Financial Update – October 2021

The Deputy Chief Financial Officer presented the report, which was taken as read. He noted the satisfactory result for October which reduced the budget variance for the year to $1.1 million.

The General Manager, Māori Health joined the meeting.

While planned care revenue was down on budget, revenue offsets had helped in ACC and unplanned care areas.

FTEs were below budget although nursing was adverse from an FTE cost perspective, this was offset by medical staffing and high use of locums in Mental Health.

There were favourable variances in infrastructure – hotel services, maintenance and information technology expenses.

Forecasting for Software as a Service projects would impact later in the year along with Mental Health locum costs.

The Chairman of the Board acknowledged the positive state of the financials.

It was resolved that the Committee:

note that the month operating result for October 2021 is a surplus before one-off items of $0.622m, which is $0.137m favourable to budget

note that the year to date result for October 2021 is a deficit before one-off items of $1.370m, which is $1.167m adverse to budget

note that year to date for October 2021 COVID-19 related contribution of $0.148m and Holidays Act costs of $1.895m are $0.148m and $0.438m favourable to budget, respectively. Including these results in a year to date deficit after exceptional items of $3.117m, which is $0.581m adverse to budget

note that the total available cash and equivalents of $40.968m as at 31 October 2021 is sufficient to support liquidity requirements

note that this is an interim finance report and that a full report will come to the Committee for consideration at the February meeting. (Moved Vaughan Dennison; seconded John Waldon)

3.2 Finance Report – September 2021

The Deputy Chief Financial Officer presented the report, which was taken as read. He noted many trends over the last three months indicated heading towards an on budget year to date result.

It was resolved that the Committee:

note that the month operating result for September 2021 is a deficit before one-off items of $3.351m, which is $0.162m adverse to budget

note that the year to date operating result for September 2021 is a deficit before one-off items of $1.992m, which is $1.304m adverse to budget

note that year to date for September 2021 COVID-19 related contribution of $0.150m and Holidays Act costs of $1.478m have been incurred. Including these, the year to date deficit after exceptional items is $3.320m, which is $0.883m adverse to budget

note that the total available cash and equivalents of $31.454m as at 30 September 2021 is sufficient to support liquidity requirements

note that the revised draft budget is being reported against from September 2021

endorse the September financial report. (Moved Vaughan Dennison; seconded Brendan Duffy)

The General Manager, Quality & Innovation joined the meeting.

3.3 Sustainability Plan

The General Manager, Quality & Innovation joined the meeting via Zoom to speak to this report. The report was taken as read. There were positive signs in nurse specialling. A detailed review of nurse specialling was being undertaken which included benchmarking against other DHBs.

The Chairman of the Board commended the savings were within $70k of target.

It was resolved that the Committee:

note the progress in the implementation of the Sustainability Plan

note the Sustainability Plan benefits monitoring dashboard and trend analysis

note the October 2021 report indicates savings of $293,897 year to date

endorse the approach and progress made to date on the Sustainability Plan 2020-2023, for the Board's consideration. (Moved Heather Browning; seconded John Waldon)

The General Manager, Quality & Innovation left the meeting.

3.4 Non-Clinical Audits Update

The General Manager, Finance & Corporate Services presented the report, which was taken as read. He noted the difficulties in getting the correct resource with the skills needed for Asset Management, but a contractor had now been appointed and work would progress. The rest of the audits were progressing well.

It was resolved that the Committee:

note the progress made on the non-clinical audit recommendations. (Moved Vaughan Dennison; seconded Tony Hartevelt)

4. STRATEGY AND PLANNING

No items.

5 DISCUSSION/DECISION PAPERS

No items.

6 INFORMATION PAPERS

6.1 Internal Audit Update

The Internal Auditor presented the report, which was taken as read. The reviews were progressing although COVID-19 had created resourcing challenges due to lock downs and isolation.

It was resolved that the Committee:

note the update on the internal audit programme status report. (Moved Vaughan Dennison; seconded John Waldon)

6.2 Workforce Management and Recruitment Review

The Internal Auditor presented the report, which was taken as read. He noted that the review had focused internally within MDHB whilst being aware of national and external challenges with workforce and recruitment. The staff on IEAs were the biggest risk. The formal national recruitment process was also a risk as it was not recruiting enough staff for the sector.

Equity and cultural awareness had also been considered during the review. 58% of staff had completed cultural awareness training, although this was optional training, not mandatory.

It was noted that Allied Health faced the same recruitment challenges, which would be discussed at the next Board meeting.

There was discussion about the health reforms and how it would affect workforce, regions, staff moving. This would be for Health New Zealand to work through.

It was resolved that the Committee:

note the internal audit on Workforce Management and Recruitment review

endorse the workplan to implement the recommendations (Moved Vaughan Dennison; seconded John Waldon)

6.3 Holidays Act Compliance Project Update

The Chief Executive presented the report, which was taken as read.

The General Manager, People & Culture joined the meeting.

Locally work was progressing well. MDHB was waiting on some information from national groups to be provided which would then enable the implementation and testing of the Holidays Act compliant payroll system.

Staff COVID-19 vaccinations were then discussed.

As at 30 November of the 2825 staff, there were:

2703 who were fully vaccinated
88 who were partially vaccinated
19 who were undecided about being vaccinated
15 who were not intending to get vaccinated.

The AstraZeneca vaccine had been offered to the 34 staff who were not vaccinated. The General Manager, People & Culture was contacting all 34 staff regularly to check in with them, help them e.g. providing access to clinicians to answer questions, working with them to offer support for other employment opportunities etc.

Each case was being considered individually and worked through on its own merits. The General Manager explained how one individual had recently been bereaved and was working through the grief process before vaccination could be considered – the DHB was supporting this staff member appropriately. Another employee was currently breast feeding and had asked for a period of unpaid leave so that she could wean her child and then get vaccinated – this too had been considered favourably.

The breakdown of vaccination across ethnicity was:

Māori staff were 98% fully vaccinated
Pacifica staff were 100% fully vaccinated
Other staff were 98% fully vaccinated.

It was resolved that the Committee:

> *note the update on the Holidays Act Compliance Project, and the ongoing work being carried out to resolve non-compliance*
>
> *note that the accrual of liability as of October 2021 is $48.897m with a year to date (YTD) spend of $0.992m, and a further $1.500m accrued towards rectification costs for this financial year. (Moved Vaughan Dennison; seconded Heather Browning)*

The General Manager, People and Culture left the meeting.

6.4 Major Capital Building Projects Update

The General Manager, Finance and Corporate Services presented this report. The report was taken as read.

Due to COVID-19 the Ministry's visit to discuss the Acute Services Block had been postponed several times. The team were now working on a remote briefing.

A steering committee for the Acute Services Block re-build had been stood up with Dr Claire Hardie chairing the committee. Dr Hardie is well respected amongst her clinical colleagues and would be a very capable chair.

SPIRE was on track for the critical shut down over the Christmas period.

EDOA/MAPU had had a slight delay – the contractor due to relocate the watermain was not vaccinated and the other qualified, vaccinated contractor was off sick. This delayed the project by two weeks.

Fluoroscopy flooring had been levelled. Some parts required for the air conditioning units were delayed or not available due to COIVD-19 supply issues.

COVID-19 was having ongoing budget impacts in the building sector as well as rising environmental and sustainability impacts. These were being discussed with the Steering Committee and Ministry.

The Deputy Committee Chair commented that during the last five years he could not recall a heavier programme of investment and change and basically, hard 'yacca' for the workforce during such uncertain times. He was in awe and admiration and had huge respect for the amount of effort going in to produce extraordinary work – well done.

It was resolved that the Committee:

note progress with the SPIRE, Medical Assessment Planning Unit/Emergency Department Observation Area Facility, Fluoroscopy, Acute Services Block and Acute Mental Health Unit projects

note the flow on effect of the impact of COVID-19 on the construction sector and supply chain on costs and timelines. (Moved Tony Hartevelt; seconded John Waldon)

6.5 Committee's Work Programme

The General Manager, Finance and Corporate Services presented the report, which was taken as read.

It was resolved that the Committee:

note the Committee's annual work programme. (Moved Brendan Duffy; seconded Vaughan Dennison)

7. GLOSSARY OF TERMS

No discussion required.

8. LATE ITEMS

There were no late items for Part One.

9. DATE OF NEXT MEETING

Tuesday, 1 February 2022 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North

10. EXCLUSION OF PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	***Reason***	***Ref***
'In committee' minutes of the previous meeting	For reasons set out in the meeting agenda of 19 October 2021	
Replacement of Instrument Washers in Sterile Services Unit	To protect negotiations, including commercial and industrial	9(2)(j)
Patient Transfer Services Contract Renewal	To protect negotiations, including commercial and industrial	9(2)(j)
Mosaiq as a Service Business Case	To protect negotiations, including commercial and industrial	9(2)(j)
Next Generation Computing Business Case	To protect negotiations, including commercial and industrial	9(2)(j)
Microsoft Cloud and Software Services Agreement	To protect negotiations, including commercial and industrial	9(2)(j)
Health Reform Transition Progress	To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials	9(2)(f)(iv)

Moved Brendan Duffy; seconded Heather Browning.

Part One of the meeting closed at 10.04am

Confirmed this 1st day of February 2022

……
Chairperson

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is the Board confident that the discussion points of Manawhenua Hauora are being partnered and supported where appropriate?
- Does the Board support that Manawhenua Hauora seeks to find its fit in the reforms and lead to shape what that looks like for them in the future?
- Are there any follow up points the Board has for either the Organisational Leadership Team or Manawhenua Hauora?

To	Board
Author	Tracee Te Huia, General Manager, Māori Health
Endorsed by	Kathryn Cook, Chief Executive
Date	25 November 2021
Subject	**Manawhenua Hauora Chair's Report – and General Manager, Māori Health's response**

RECOMMENDATION

It is recommended that the Board:

- **note** the report from the Manawhenua Hauora Chair on the Manawhenua Hauora hui held on 15 November 2021
- **note** the General Manager, Māori Health's response to the Chair's report.

Strategic Alignment

This report is aligned to the DHB's 10-year strategy Ka Ao, Ka Awatea Māori Health Strategy refresh and Kaimahi Ora Whānau Ora, Māori Workforce Development Strategy refresh.

1. PURPOSE

To provide the Manawhenua Hauora Chair's report on the November 2021 Manawhenua Hauora meeting and advise the Board of management's responses to issues raised in the Chair's report.

2. SUMMARY

The report covers the following subjects:

- Iwi Updates
- Mental Health Inpatient Unit Build
- Data Sovereignty and MDHB Cloud Strategy
- Cervical and National Bowel Screening Update
- COVID-19 Response and Resilience Planning
- Mosaiq Oncology Information System Upgrade
- Sport Manawatū Cultural Competency Plan
- Iwi Māori Partnership Board Establishment Plan.

3. MDHB'S RESPONSES

3.1. Iwi Updates

MidCentral District Health Board (MDHB) is pleased to be updated by iwi on their developments including health services. This gives the Organisational Leadership Team insight and understanding about how it supports iwi wide expectations and aspirations where possible. MDHB will continue to seek out how it might support iwi into the future particularly on matters where there are health impacts such as water quality, impact of COVID-19 on iwi business and readiness for living with COVID-19.

3.2. Mental Health Inpatient Unit Build

The Facilities Team is working hard to ensure they are accepting all advice and support from iwi on the Mental Health Inpatient Unit build. MDHB understanding the importance of advice from iwi and how negative impacts could occur if advice is not considered for patients and iwi. Consultation will continue through out the build through to completion. MDHB wishes to specifically thank Chris Whai, Wayne Blissett and He Puna Hauora for their engagement and advice.

3.3. Data Sovereignty and MDHB Cloud Strategy

MDHB has agreed to continue the conversations with Te Tihi o Ruahine to map a pathway for partnership on Māori and data sovereignty, discussions to be led by Aaron McLaughlin. A report back to Manawhenua Hauora at its February meeting is expected.

3.4. COVID-19 Response and Resilience Planning

The Māori Response Team works alongside all COVID-19 delivery providers to ensure good coordination, communication and delivery is achieved. Providers have in the main, been satisfied with MDHB's coordination of services, however we do acknowledge that there is still some need for improvement and development. The Māori Alliance Leadership Team met on 25 November for MDHB to consult on the following matters related to COVID-19 planning:

- Operating Framework and Proposed Flow
- Communications Plan
- Locality Response and Supported Isolation and Quarantine (SIQ)
- Whakahaumaru, Māori COVID-19 Responsiveness Plan.

3.5. Iwi Māori Partnership Board Establishment Plan

Pae Ora has recently been engaged in the discussions with the Transition Unit and iwi related to their Establishment Plan. This has been a useful process to better understand the expectations and aspirations of local iwi on health delivery into this district in the future. While these developments are occurring, Manawhenua Hauora has committed to continuing their meetings with DHB until 30 June 2022, with dates to be confirmed at its next meeting. Fortnightly meetings will continue through to the approval for investment into the Establishment Plan by the Transition Unit.

PO BOX 1341 MAXWELLS
PALMERSTON NORTH

Meeting held 15 November 2021

IWI UPDATES

Iwi are all very busy planning and responding to the COVID vaccination roll out for their rohe. Muaūpoko Tribal Authority thanked the Pae Ora team stating that the support is nothing short of stunning. The Maori and Pasifika vaccination teams have done an amazing job to support the rohe reach 90%. However, Iwi stated there is much work to do to get Maori to 90% and would not like to see efforts wane as we move to resiliency. In particular, thank you to Dr Kelvin Billinghurst for travelling and meeting with our whanau to korero about the vaccine. This has made a difference to kaimahi being vaccinated once informed. Ka rawe.

MENTAL HEALTH INPATIENT UNIT BUILD

Manawhenua Hauora were pleased with the progress and outcomes of hui held between Manawhenua Hauora representatives, Pae Ora, He Puna Hauora and MDHB staff. This was a major milestone for the preliminary design phase, location and layout of the facility. The work Bill Krippner and the team are doing to ensure they meet iwi expectations was acknowledged. The inclusion of rongoa in future service delivery is particularly pleasing.

DATA SOVEREIGNTY AND MDHB CLOUD STRATEGY

Aaron McLaughlin and Toby Elliott presented the DHB's Cloud Strategy and the context for Data sovereignty highlighting for Manawhenua Hauora, the benefits and risks associated with taking systems to the Cloud. We were advised that Central Regions CEOs have approved the policy and process for moving information to the Cloud and that DHB now needs to partner iwi on how we might agree system Cloud management. Manawhenua Hauora acknowledge the mahi Te Tihi o Ruahine Whanau Ora Alliance are doing in the Maori Data Sovereignty space and are happy for the DHB to engage with Te Tihi to ensure there is alignment as we move to the cloud strategy.

CERVICAL AND NATIONAL BOWEL SCREENING UPDATE

Manawhenua Hauora recognise the value of Equity Leads as demonstrated by the traction Lisa Te Paiho has gained in the screening continuum. The reports were endorsed as were the initiatives to improve screening rates for Maori.

COVID-19 RESPONSE AND RESILIENCE PLANNING

At a national level, Iwi and Maori have expressed concern that engagement and action has not occurred early enough with regard to the vaccination rollout for Maori and those concerns have been raised again in the resiliency planning. Manawhenua Hauora endorse those concerns. Kia Whakahaumaru (Harm Minimisation) is a template that has been distributed to Iwi and Maori to use as they see fit in their Covid preparedness response. Similarly with the purchase and deployment of four RVs that have been fitted out to respond to the particular needs of communities within the MDHB rohe. Providers will continue to work with the Maori Covid Response team to ensure we reach as many whanau as possible not only with vaccination but also with Public Health Kaimahi Maori to respond to living with Covid in our rohe. This support was acknowledged by Pae Ora.

MOSAIQ ONCOLOGY INFORMATION SYSTEM UPGRADE

Ahead of the FRAC and board meetings in December, Manawhenua Hauora were consulted on about the upgrade for the Mosaiq Oncology Information Service. Following in depth discussion, the business case was endorsed by Manawhenua Hauora.

SPORT MANAWATU CULTURAL COMPETENCY PLAN

Dr Jeremy Hapeta, Senior Lecturer Maori Physical Education and Health, Otago University, is the mana whenua representative appointment to Sport Manawatu. He provided an overview of his role and spoke to the draft cultural competency plan tabled for Manawhenua Hauora consideration. Dr Hapeta will return with the final draft in March 2022 for endorsement by Manawhenua Hauora.

IWI MĀORI PARTNERSHP BOARD (IMPB) ESTABLISHMENT PLAN

Manawhenua Hauora has been focused on developing its Establishment Plan as required by the Transition Unit. IMPBs were funded $20K to develop a plan that will be the roadmap to establishment by 1 July, 2022. Our IMPB will require, in the first instance, establishment of a legal entity, Iwi representation endorsement on the new entity, process by which taura here (representation of Maori who do not whakapapa to this rohe) will be appointed to the Entity.

Once the Establishment Plan is approved by the Transition Unit, it will then be resourced for implementation. Specific positions will be established to ensure an Ohu Tuara (back bone support) is created to support the IMPB. Function and form will follow.

CONCLUSION

Manawhenua Hauora members are extremely busy with calls on their time and expertise coming from a multitude of government agencies. The transition to Health New Zealand and the Maori Health Authority is but one legislative change affecting all of us nationally and globally. Overlay this with the Covid-19 pandemic and you will have some understanding of the extreme pressure our people find themselves under constantly. We note that the End of Life Choice Act is now operational and our whanau and hapori will

need time to explore what this actually means in terms of tikanga as it applies to death and dying. The creation of a Ministry for Disabled People is welcome news. Again, Maori are disproportionately affected by disabling conditions. A focus on disability in our overall health system is long overdue. The soon-to-be established IMPB intends to ensure disability has a distinct voice at the governance table.

Our next Manawhenua Hauora hui is 31 January, 2022. We will have made progress with our IMPB establishment and look forward to being able to share that progress with you in person at our next Board to Board meeting (date to be confirmed). Kia pai a koutou Kihirimete me te Tau Hou. As this is our final 2021 panui to the Board, we wish you a restful Christmas and New Years.

Strategic focus

14 December 2021

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

Strategic focus

No items

Performance reporting

14 December 2021

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the report provide a useful update on local, regional and national matters?
- Are there any additional matters that should be included as routine items in future updates?

To	Board
Author	Kelsey Tanner, Executive Assistant to the Chief Executive
Endorsed by	Kathryn Cook, Chief Executive
Date	3 December 2021
Subject	**Chief Executive's Report**

RECOMMENDATION

It is recommended that the Board:

- **note** the update of key local, regional and national matters.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler, 'Stewardship'.

1. PURPOSE

To provide the Board with an update of key local, regional and national matters. No decision is required.

2. LOCAL MATTERS

2.1. COVID-19 Vaccination Planning and Delivery

The COVID-19 vaccination programme is nearing completion of the final quarter of planned delivery. The programme continues with sufficient capacity to complete expected delivery with the 46 active delivery sites registered with the Ministry of Health (MoH). The delivery pace has slowed in recent weeks, however there remains a good percentage of first doses uptake continuing across the district. MidCentral District Health Board (MDHB) remains on target for delivery of total numbers.

Delivery is focussed on areas of lower uptake with active mobile delivery most days alongside the static delivery that continues to attract numbers.

A follow up to Super Saturday was delivered Saturday 14 November 2021 where a wide range of vaccination offerings was provided with increased whānau choosing to take up their first dose or get their second.

Hours of access are a specific focus currently with weekends and after-hours offerings alongside regular rural focussed activities. These are being delivered in partnership with the District Health Board (DHB) mobile teams, the Māori and iwi teams and General Practice partners.

Use of the online national booking system, 'BookMyVaccine' has reduced as we moved into the provision of many clinics with no booking necessary. Primary care continues to operate a primarily booking based delivery, with a range of providers providing walk-in capacity daily. Bookings can still be made if this is preferred.

On 29 November, access to the AstraZeneca vaccine as a choice for those that have chosen not to have the Pfizer vaccine became available. Additionally, a third booster dose is now available for anyone who has had their second dose at least six months ago.

Communications continue around our vaccination programme and are in an amplification phase. Ensuring people who may be hesitant are receiving the right messages at the right time to make a positive choice and effectively connecting with our hard to reach and hesitant groups. This focus will be supported through multiple communications channels including mainstream media, social media, leaders within the community and our internal communications channels.

The following table provides an update of doses delivered as at 6 December 2021.

		All ethnic groups as at (% of 12+ population)	Māori (% of 12+ population)	Pacific (% of 12+ population)
MDHB residents vaccinated anywhere	Received first dose	142,107 (93%)	21,045 (87%)	4,212 (94%)
	Received two doses	130,036 (86%)	17,299 (71%)	3,740 (84%)
Vaccinations delivered in MDHB	Received first dose	135,603	19,769	3,987
	Received two doses	124,826	16,263	3,537
	Received third dose	2,612	786	47
Total doses administered locally		**263,041**	**36,818**	**7,571**
Residents vaccinated against total target		**93 %**	**87 %**	**94 %**

We remain focussed on working with our iwi and Māori partners to increase vaccination uptake for these populations to ensure our programme achieves an equitable delivery and vaccination coverage. For the over forties, the equity gap for vaccination is rapidly closing. Under forties remain a challenge that disproportionately impacts Māori due to the different demographics with a younger population.

2.1.1. Equity

The uptake rates have increased since last reported with the largest percentage increase for Māori whānau.

Vaccination clinics continue at the existing nine iwi partnered vaccination sites across the district. In addition to these, more bespoke approaches are now being provided across localities to reach those yet to present for a vaccination. These approaches are varied and are determined through insights provided through data, and through community intel from the coordinator, roles engaging their communities. The bespoke approaches are providing vaccination clinics at workplaces, schools, parks, community centres and other service providers. Whilst these clinics are generating smaller vaccination numbers, these clinics are seeing a higher proportion of Māori as well as many first dose vaccinations.

With the introduction of four mobile vehicles across the district, MDHB has been working with iwi providers to ensure the vehicles are suitably equipped to provide mobile COVID-19 vaccinations. This includes ensuring MDHB safety and quality standards are maintained with vaccination delivery. The ordering of vaccines will occur via the iwi and Māori engagement team of the vaccination

programme, along with any additional staffing requirements. Iwi intend to utilise the data and insights provided by Te Tihi, and community intelligence, to determine the most appropriate locations for the vehicles to offer vaccinations. The DHB will ensure this is aligned with the overall programme delivery to offer vaccinations in areas not being serviced, to avoid any duplication of effort.

As vaccination percentages rise, the numbers of those yet to be vaccinated across localities and communities is becoming clearer. Through the mesh block data, the DHB is identifying areas with little vaccination uptake and are getting out into communities to promote vaccinations and drop pamphlets into letterboxes ahead of the vaccination campervan arriving in communities. DHB staff are also working alongside the coordinator roles to begin door-knocking at households in streets with low vaccination uptake. Working alongside the coordinator roles with this approach will help to ensure this approach is as safe and effective as possible.

2.1.2. Managing COVID-19 in the Community

Managing COVID-19 in the community planning is progressing well, with an Operating Framework agreed as presented to the Board at the November 2021 meeting, and significant consultation and engagement is currently underway to consolidate the plan and increase our resilience ratings across key areas.

With the recent occurrence of a small number of Delta COVID-19 positive whānau in our community, the teams have been refining the operating model to support an effective response, with all thus far successfully self-isolating in their own homes. The Supported Isolation and Quarantine (SIQ) programme has now secured 16 isolation bubbles spanning Tararua, Horowhenua and Palmerston North localities. Current activation has been for manaaki referrals.

To further support iwi and Māori provider COVID-19 readiness, MDHB is working to quickly progress training for COVID-19 testing over the next fortnight, moving across the localities beginning with Ōtaki and Levin, followed by Tararua, Manawatū and Palmerston North. The training incorporates the following three parts:

1. Online module on COVID-19 swabbing (this will take approximately an hour with a certificate provided upon completion)
2. Face to face training session (approximately 3 hours) with the MDHB Māori Nurse Educator
3. Half-day orientation and live training at the testing site (575 Main Street, Palmerston North).

Additional training for donning and doffing personal protection equipment (PPE) as well as N95 mask fit testing will also occur in early December 2021. This training will increase the overall capacity for managing COVID-19 in the community and will ensure the safety of iwi and Māori provider staff as they provide support to their communities.

2.1.3. Future strategic considerations

The vaccination planning team is completing the transition of the programme post December 2021. Nationally the delivery operating model remains to be agreed upon, with the inclusion of 5 to 11-year-olds pending approval. Retaining the core DHB workforce will be critical to ensure the ongoing delivery of this vaccination within the broader national integrated immunisation programme currently under development.

The local COVID-19 planning is on track to have a confirmed operating model implemented by 1 January 2021 to ensure effective management of those living with COVID-19 in our rohe.

2.1.4. COVID-19 Vaccination Order

The MoH has announced the COVID-19 Public Health Response (Vaccinations) Order 2021 (the Order) which requires health and disability sector employees to have their first COVID-19 vaccination by 11.59pm on 15 November 2021 and to be fully vaccinated by 1 January 2022. Any worker who does not comply with these vaccination deadlines must not work in a role that requires them to be vaccinated under this Order. The order applies to all MDHB employees.

MDHB has communicated with employees and contractors to advise them of the Order and the requirement to be vaccinated by the above dates MDHBs has been implementing nationally consistent processes to ensure the provisions of the Order are met.

MDHB managers have access to reports, which are updated each day, to show each employee's vaccination, fit-testing and vulnerability status.

2.1.5. Staff Vaccination Status

As at 6 December, almost 97 percent of the MDHB's permanent and temporary workforce have reported as being fully vaccinated and another 2 percent as being partially vaccinated (and have booked their next dose). This brings the total to 99 percent of the DHBs staff as being either fully or partially vaccinated.

The number of staff who have indicated that they have not been vaccinated or are undecided has been dropping steadily over the last few weeks (34 staff as at 30 November 2021). MDHB continues to encourage these staff to consider getting vaccinated, including providing them with the option of getting vaccinated with the AstraZeneca vaccine.

A table providing a breakdown of permanent and temporary staff numbers by ethnicity and professional groups is provided below.

Numbers by Ethnicity	Fully vaccinated	Partially vaccinated	No. intention	Undecided	Total
Māori	248	20	1	4	273
Pacific	41	1	0	0	42
Other	2414	67	14	15	2510
Total	2703	88	15	19	2825
Numbers by Professional group					
Medicine	350	2	1	0	353
Allied Health	475	13	1	5	494
Nursing	1202	49	5	10	1266
Midwifery	48	4	1	0	53
Management/Admin	574	18	6	4	602
Support	54	2	1	0	57
Total	**2703**	**88**	**15**	**19**	**2825**

2.1.6. Respirator Fit-testing

The DHB continues to offer an array of approved Respiratory protective equipment (RPE), including disposable P2 type N95 face masks, respirator masks, half-hoods, and full hoods to keep staff safe from airborne transmission of COVID-19. The DHB is resourced to provide fit-testing to staff on a regular basis and has scheduled daily clinics until all staff are fully fit-tested. In discharging its obligations as a responsible Person Conducting a Business or Undertaking (PCBU), the DHB has also been fit-testing its contracted staff (Rescue Helicopter pilots, Ventia and Compass) at no additional cost to them. since the last report, the DHB has acquired a second fit testing machine and is running two parallel clinics to accommodate greater staff, students, and contractor numbers.

2.2. Financial Update

The result for November 2021 is a deficit before one-off items of $0.048m and is $0.593m favourable to budget. Net revenue for the month is $5.248m favourable to budget, and this is largely offset by expenditure which is $4.660m adverse to budget. The year to date result is a deficit of $1.417m, which is $0.574m adverse to budget.

A year to date COVID-19 related contribution of $0.148m and Holidays Act costs of $2.464m have been incurred. This results in a year to date deficit of $3.608m when these are included. This year to date deficit is $0.151m favourable to budget.

2.3. 2021/22 Annual Plan

The MDHB 2021/22 Annual Plan was jointly approved by the Minister of Health and the Minister of Finance on 17 November. The letter of approval has been published on our website together with the approved Annual Plan.
Performance.

2.4. New Youthline Service

Child and Adolescent Family (CAFS) MH&A Services has worked with Youthline to develop a service that will support young people and their whānau who are being supported by CAFS. The service will provide community support, skill-building and emotional regulation skills to support independence. The service will also provide brief intervention to Young People who have accessed CAFS and would benefit from community based brief intervention and support rather than specialist services. This service will greatly increase the continuation of care and opportunity for recovery. The service commenced on 1 December.

2.5. Quality and Safety Walk-Rounds

The Quality and Safety Walk-Round timetable has been suspended until early 2022. This is due to the impact of COVID-19 and the additional workload this is placing on our workforce currently.

The walk-round timetable will be reviewed in early 2022 when management will reconsider opportunities to refresh the timetable. The trial of virtual walk-rounds using Zoom was well received and will continue to be used when the timetable is re-established.

2.6. End of Year Event

With the resurgence of COVID-19 in the community and uncertainties around workplace gatherings, a decision was made to cancel the end of year barbecue at Horowhenua and Palmerston North. In the past, the event was very well received by staff and served as an opportunity for the DHB to thank its staff who have worked very hard during the year. To maintain the concept, the DHB invited ideas from staff about an alternate way of recognising our staff.

Responses received acknowledged the circumstances around the decision and overwhelmingly suggested that individual platters or boxes of food be provided to teams so that staff could enjoy a bit of cheer within their 'bubbles'. This is now being organised over 15, 16 and 17 December.

2.7. Annual Staff Awards

The DHB introduced the inaugural staff awards to coincide with the end of year barbecue last year. These awards spanned a variety of categories including our values and a Chief Executive Award. These awards were well attended by staff. Unfortunately, the award

event will now be postponed as the DHB staff manage the resurgence of COVID-19 in the community. At this stage, it is anticipated that an award function will be held around Easter time (subject to circumstances at that time) and will be supported by a small 'food event'. More information about this will be forthcoming in the new calendar year.

2.8. Major Capital Building Projects

2.8.1. Ward 24 Oxygen Upgrade

Work commenced on Monday 29 November to upgrade the oxygen supply in Ward 24 to support an increased number of patients in the event it is required to be used as a COVID-19 ward. Ward 24 will be closed for three weeks and plans are in place with the clinical teams.

The Antenatal Clinic was temporarily relocated to Te Papaioea Birthing Centre on 22 November 2021, as part of this upgrade. Discussions are ongoing regarding an alternative location for the clinic, with an outcome expected by December 2021.

2.8.2. Fluoroscopy

Work continues to have the new fluoroscopy machine in place, commissioned and operational in February 2022.

2.8.3. SPIRE (Surgical Procedural Interventional Recovery Expansion)

Stage 1 construction is underway and involves the establishment of a new Day of Surgery Admission and Recovery area and the expansion of the Endoscopy Unit.

Preparatory work is now occurring for the work to be done within the theatre suite over the Christmas/New Year period to expand the Staff Change area and develop the shell of a Procedure Room within the current staff room. The fit-out of the Procedure Room will then be undertaken around July 2022 when the creation of new theatres and the cath lab gets underway.

While this work is being done, temporary staff facilities will be created utilising theatre space. It is important that this work is completed by the end of January when all existing theatres will be fully operational. All materials required have been ordered and decanting plans are being finalised.

The detailed design for Stage 2 is on track for completion of the documentation in February 2022.

MDHB received confirmation on 1 December from the Director General of the MoH, that the requested $30.9m increased budget for SPIRE is approved. This will allow work to continue at pace to deliver the scope of the project.

2.8.4. Medical Assessment Planning Unit (MAPU)/Emergency Department Observation Area (EDOA) Unit

Construction work is underway following a Whakawhātea Karakia (site blessing).

This initial work includes diversion of the water and fibre optic supply away from the area on which the facility will be built and establishing new accessibility car parks to ensure these are ready and available before the existing ones are closed to make way for the new facility.

The construction area for Emergency Department Observation Area and the Medical Assessment Planning Unit will be fenced, cleared, and made ready by late December. This is so foundations work can start as soon as the Maycroft construction team are back on-site in early January.

From a service perspective, planning is underway to ensure everything is ready and in place to enable a smooth commissioning process. Equipment is being ordered and joint planning occurring with Digital Services regarding amendments necessary to patient management and other systems to reflect the increased bed numbers which will be accommodated.

2.8.5. Acute Mental Health Unit

The project will embark on the Developed Design phase next month.

Looking ahead, preparations are underway for the engagement of a main contractor to lead the construction phase. Service specifications will be completed to enable MDHB to go market in mid-January, seeking tenders from interested companies.
The Unit will be sited in the car park behind Board Office, extending into the area where Pullar Cottage is located. Registrations of Interest for the removal of Pullar Cottage close in early December.

3. REGIONAL MATTERS

3.1. Central Region Health Emergency Response Planning Programme

3.1.1. Central Regional Health Emergency Plan

At the Central Regional (CR) Chief Executives (CE)s meeting on 2 December, the Central Region Health Emergency Response Plan was endorsed by the CEs. This plan will be loaded onto the intranet and Stella once signed by all the CEs.

3.1.2. Central Region Coordination Centre (CRCC)

At the October 2021 Central Region CE Forum meeting, an update was provided on the Central Region Coordination Centre establishment workstream. The CR CEs agreed with the purpose, goals and approach and requested that a plan be developed to outline the role and function of a coordinated regional readiness response for the Central region and investment/resourcing requirements.

The draft guideline and operating procedures for a Central Region Coordination Centre, which are still under development, was presented to the CR CEs. This provides a proposed approach and resourcing that would be required to respond regionally, for both a rapid response over a short time frame and for a more sustained response over a longer timeframe.

3.1.3. Resilience Plan

Further to the update provided to the CR CEs October meeting, regional resilience work is progressing at pace with increasing pressure from the Centre to ensure the sector has the capacity and capability to manage a surge over the Christmas period and beyond. The Central Region has now completed the Health Emergency Response Plan and is in the process of transitioning its programme into discrete programmes of work as follows:

- hospital and specialist services
- primary care and community
- workforce
- mental health and addiction.

4. NATIONAL MATTERS

4.1. Multi-Employer Collective Agreement Bargaining

4.1.1. NZ Nurses Organisation (NZNO)

The NZNO Nursing and Midwifery Multi-Employer Collective Agreement (MECA) has been ratified by NZNO members and is currently being implemented by MDHB. All payments including lump sum, pay equity and backpays are on track to be paid progressively over the next few pay periods with all payments being made by the period ending 19 December 2021.

4.1.2. Midwifery Employee Representation and Advisory Services (MERAS)

The Midwifery MECA has been ratified by MERAS members and has been implemented by MDHB with agreed payments having been made. PSA Mental and Public Health Nursing

The PSA Nursing MECA has been ratified and implemented by the MDHB.

4.1.3. Pay Equity Bargaining – Nurses and Midwives

The above MECA settlements (Nursing and Midwifery) include interim pay equity base salary adjustments and pay equity lump sum payments as an interim measure and are in anticipation of the pay equity claim for nurses and midwives being settled. The parties are continuing to work in partnership to progress the pay equity claims process to determine the extent of historical sex-based undervaluation and to reach an agreed pay equity settlement by the end of November 2021.

4.1.4. PSA Allied Health, Public Health and Scientific Offers

DHBs have made an offer to the PSA to settle this MECA within the agreed bargaining strategy endorsed by the MoH and consistent with the Government's Expectations and Pay Guidance. DHBs are waiting to hear if this offer has been accepted by PSA members with the outcome expected prior to Christmas.

4.1.5. FIRST Union

The DHB has a Single Employer Collective Agreement (SECA) with the FIRST Union, covering pharmacists. An offer has now been made to settle this SECA which is consistent with the offer being made for the national PSA Allied, Public Health and Scientific MECA in which covers Pharmacists within several other DHBs. MDHB is waiting to hear from FIRST Union regarding the offer.
4.3.7 Medical Physicists

Six DHBs, including MDHB, employ Medical Physicists within their Cancer Treatment Services. An offer to settle this MECA was made at the end of October to the Association of Professional and Executive Employees (APEX) the Union representing these employees. APEX has advised that their members have rejected the DHBs offer with APEX asserting its view that a substantial pay increase was

necessary. Mediation has been unsuccessful, and APEX have issued notices of strike action to all six DHBs covering various period and dates. MDHB's period of strike action is a full withdrawal of labour by Medical Physicists for a 24-hour period on 3 December 2021. Contingency plans are in place to minimise the impact on service delivery. Cover for life-preserving services over the period of strike action has been agreed with APEX.

4.1.6. Other Pay Equity Claims

The agreement reached between DHBs and the Public Service Association (PSA) in November 2020 has now progressed to the next stage. All clerical/administration roles have been mapped to nationally agreed role profiles, so they can be accurately placed within agreed salary ranges based on the role profiles. This exercise is being led nationally and DHBs and the PSA are waiting for the outcome of the process.

Pay equity work continues with the APEX, PSA (Allied and Scientific, roles) with the parties continuing to engage.

5. ORGANISATIONAL LEADERSHIP TEAM AND STAFFING MATTERS

5.1. Te Uru Pā Harakeke Leadership Change Proposal

Following the implementation of the Integrated Service Model (ISM) in 2018 a review of the Tier 3 leadership structure within clusters was conducted. Several changes were made, including the overall scope of services led by each cluster, and roles were scoped and organised to provide effective leadership of services and workforces under the new operating model.

Te Uru Pā Harakeke's leadership model was established with no middle manager between the Operations Executive and charge level roles. While this has worked well, recent changes to operational leadership mean it's a good opportunity to look at how effective the current model is and to make sure there is adequate support for leaders across the service.

5.2. Clinical Executive Leadership in Acute and Elective Specialist Services Cluster

A paper proposing changes to the Clinical Executive roles within the Acute and Elective Specialist Services Cluster was put out for consultation on 1 November. After considering all feedback, a final decision document was prepared.

The key changes within the document are the disestablishment of the Clinical Lead roles and the establishment of two clinical executive positions. The next step is to implement the changes that have been agreed upon in a timely manner.

FINANCE, RISK AND AUDIT COMMITTEE REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is the current financial performance and trend in performance sustainable?
- Is there critical financial information that you need for governance that is not included in this report?
- Is the DHB sufficiently able to trade solvently?

To	Board
Author	Darryl Ratana, Deputy Chief Financial Officer
Endorsed by	Neil Wanden, General Manager, Finance and Corporate Services
Date	1 December 2021
Subject	**Financial Update – October 2021**

RECOMMENDATION

It is recommended that the Board:

- **note** that the month operating result for October 2021 is a surplus before one-off items of $0.622m, which is $0.137m favourable to budget
- **note** that the year to date result for October 2021 is a deficit before one-off items of $1.370m, which is $1.167m adverse to budget
- **note** that year to date for October 2021 COVID-19 related contribution of $0.148m and Holidays Act costs of $1.895m are $0.148m and $0.438m favourable to budget, respectively. Including these results in a year to date deficit after exceptional items of $3.117m, which is $0.581m adverse to budget
- **note** that the total available cash and equivalents of $40.968m as at 31 October 2021 is sufficient to support liquidity requirements
- **note** that this is an interim financial report and that a full report will be provided to the February 2022 meeting for the Board's consideration.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'.

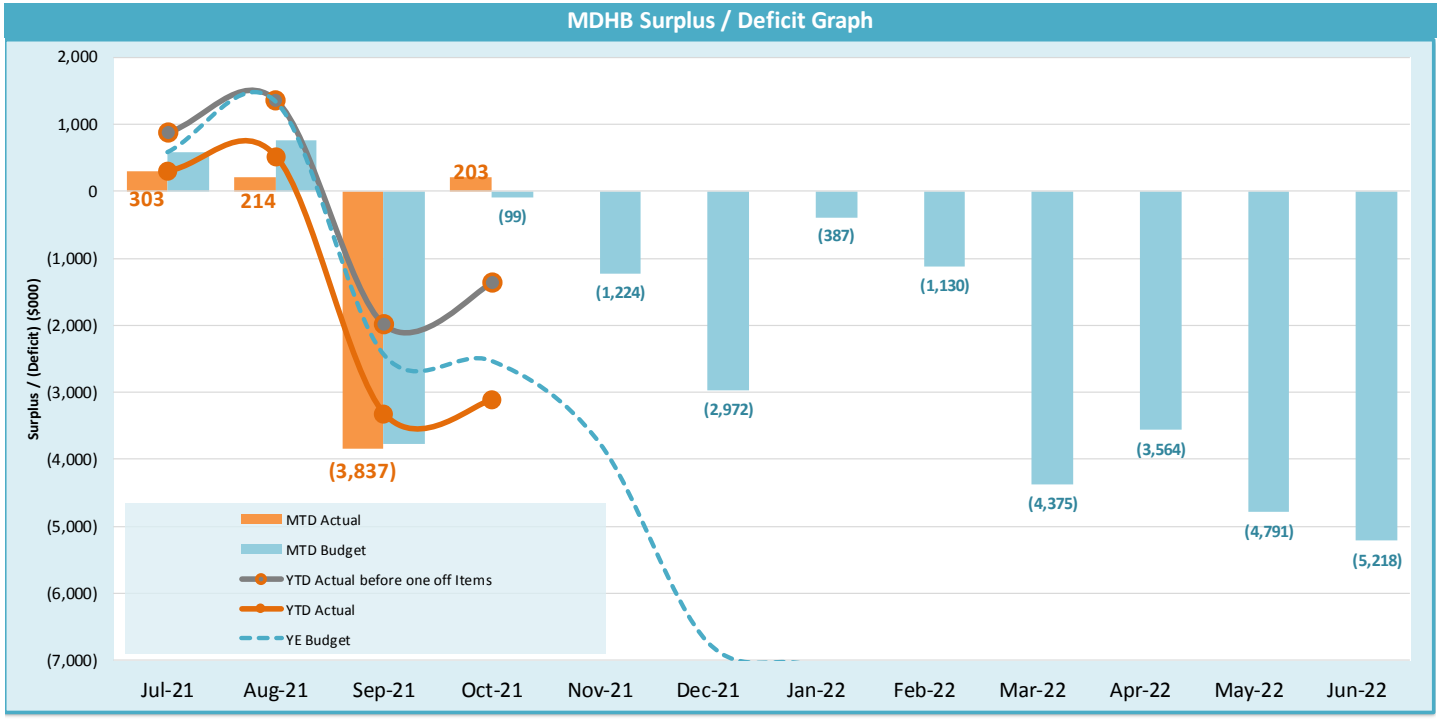
1. PURPOSE

This report is provided for information, no decision is required. This is an update paper, and a full finance report will be provided to the Board at their February 2022 meeting for consideration.

2. FINANCIAL PERFORMANCE

The MidCentral District Health Board (MDHB) result for October 2021 is a surplus before one-off items of $0.622m and is $0.137m favourable to budget. Net revenue for the month is $2.204m favourable to budget, and this is largely offset by expenditure which is $2.075m adverse to budget. The year to date result is a deficit of $1.370m, which is $1.167m adverse to budget.

A year to date COVID-19 related contribution of $0.148m and Holidays Act costs of $1.895m have been incurred. This results in a year to date deficit of $3.117m when these one-off items are included.



The Statement of Financial Performance is shown in the following table. Costs relating to the Holidays Act and COVID-19 are separately disclosed to easily view the underlying performance.

$000	October 2020			Year to date			Year End
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Net Revenue	**66,584**	**64,380**	**2,204** ✓	**257,682**	**257,712**	**(30)** !	**772,680**
Expenditure							
Personnel	22,101	21,846	(255) !	88,211	88,106	(105) !	278,061
Outsourced Personnel	934	373	(561) ✗	3,911	1,485	(2,426) ✗	4,685
Sub -Total Personnel	23,035	22,219	(816) !	92,123	89,592	(2,531) !	282,746
Other Outsourced Services	2,263	2,241	(23) !	9,365	8,929	(436) !	27,066
Clinical Supplies	5,751	5,238	(512) ✗	21,748	21,411	(337) !	65,534
Infrastructure & Non-Clinical	6,238	7,087	849 ✓	26,618	28,951	2,332 ✓	91,009
Provider Payments	28,850	27,277	(1,573) ✗	110,110	109,864	(246) !	328,288
Total Operating Expenditure	**66,138**	**64,063**	**(2,075)** !	**259,964**	**258,746**	**(1,218)** !	**794,643**
Operating Surplus/(Deficit)	**446**	**317**	**129** ✓	**(2,282)**	**(1,034)**	**(1,248)** ✗	**(21,963)**
Enable NZ Contribution	176	167	8 ✓	912	832	81 ✓	2,768
Surplus/(Deficit) Before One-Of	**622**	**485**	**137** ✓	**(1,370)**	**(202)**	**(1,167)** ✗	**(19,195)**
Holidays Act	(417)	(583)	166 ✓	(1,895)	(2,333)	438 ✓	(7,000)
Covid-19	(2)	0	(2) ✗	148	0	148 ✓	(0)
Surplus/(Deficit)	**203**	**(99)**	**302** ✓	**(3,117)**	**(2,535)**	**(581)** ✗	**(26,195)**

As with last month, a large portion of the favourable revenue variance relates to the timing of community provider payments. These payments are $1.573m adverse to budget and are offset by favourable revenue to fund the payments. The remaining favourable revenue relates to positive outcomes across the DHB. These include:

- unplanned (acute) activity and minor procedures in Te Uru Arotau, Acute and Elective Specialist Services ($0.344m)
- ACC revenue for activity in Te Uru Whakamauora, Healthy Ageing and Rehabilitation Services ($0.192m)
- drug trial and haemophilia revenue in Te Uru Mātai Matengau, Cancer Screening, Treatment and Support Services ($0.166m).

These favourable revenue variances were partially offset by Planned Care, which was $0.462m adverse for the month due to displacement by the acute work noted above.

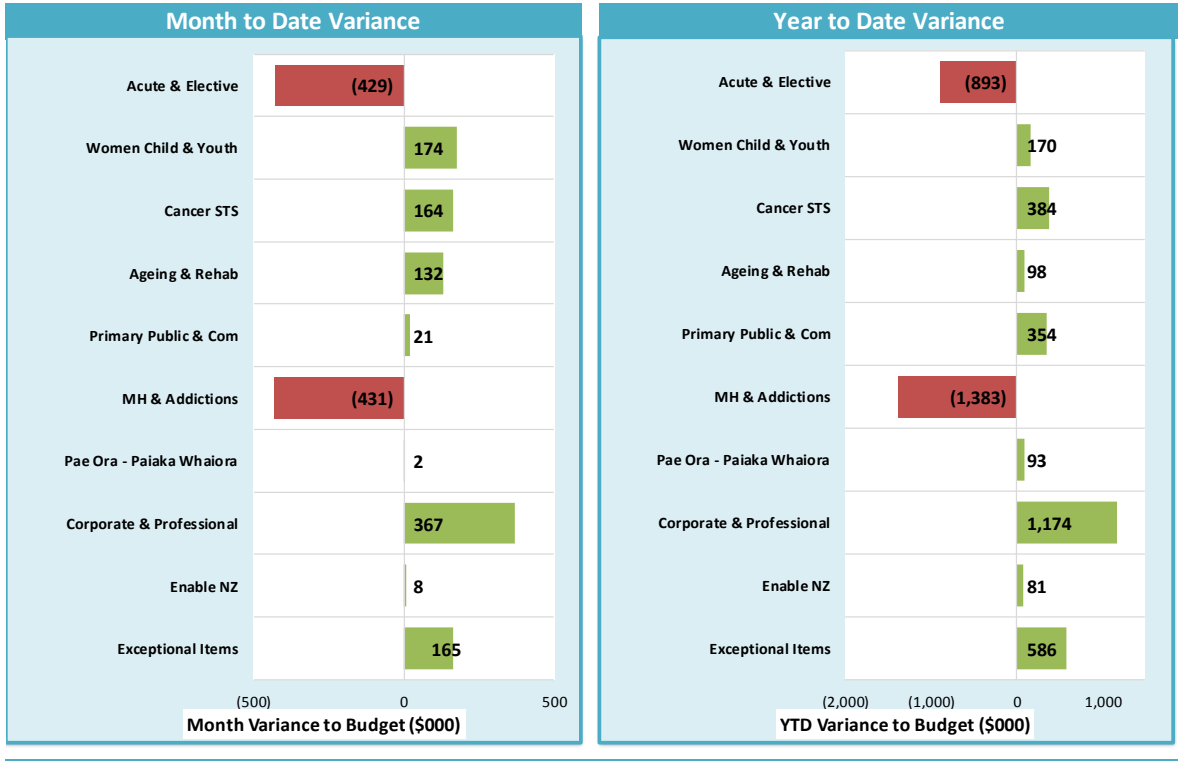
Significant variances in operating expenditure for the month are highlighted below.

- FTEs remain below budget by 49 for the month and 29 FTE year to date. However, they have increased by 34 since last month. The majority of the increase is in nursing (24 FTE), with the remainder in medical (6 FTE) and Allied Health (4 FTE). Te Uru Arotau is the primary beneficiary of the increase (22 FTE).
- While FTEs are below budget for the month, personnel costs (excluding Outsourced Personnel) are adverse by $0.255m. The variance primarily relates to nursing, which is $0.481m adverse for the month and $0.882m adverse year to date.
- Medical staff costs were also adverse for the month by $0.053m. Outsourced locum costs were also adverse and primarily responsible for the adverse Outsourced personnel result. As with previous months, adverse locum costs reside in Te Uru Rauhī, Mental Health and Addiction Services.
- Other Outsourced Services are close to budget, with favourable radiology costs offset by expenditure with Crest Hospital in Te Uru Arotau and Te Uru Mātai Matengau.
- Adverse Clinical Supplies were impacted by pharmaceuticals and treatment supply costs above budget by $0.186m and $0.377m, respectively. Higher than anticipated pharmaceuticals were driven by the use of Infliximab and respiratory drugs. Adverse treatment supplies was a result of blood products.
- Infrastructure and Non-Clinical costs are $0.849m favourable to budget, with the fundamental cause of this variance being contracted hotel, cleaning and meal costs ($0.101m), facilities ($0.158m), software maintenance costs ($0.254m) and professional fees ($0.124m).

One-off items include the Holidays Act and COVID-19 expenditure.

- Holidays Act expenditure for the month includes a $0.375m increase in the provision, with the remainder being project costs. Project costs are lower than anticipated in the budget leading to a favourable variance for the month and year to date.
- COVID-19 expenditure for the month includes $2.457m of costs offset by funding received for immunisation, surveillance and isolation.

The tables below show the month and year to date variance by service.



Both Te Uru Arotau and Te Uru Rauhī are adverse to budget. From a year to date perspective, Te Uru Arotau is adversely impacted by outsourced radiology and clinical supply costs. Te Uru Rauhī is adversely affected by locum expenses. All other services are on, or better than budget.

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Is the current financial performance and trend in performance sustainable?
- Are the variations from budget sufficiently well explained and reasonable?
- Is there key financial information that you need for governance not included in this report?
- Is the DHB able to trade solvently?

To	Board
Author	Darryl Ratana, Deputy Chief Financial Officer
Endorsed by	Finance, Risk and Audit Committee Neil Wanden, General Manager, Finance and Corporate Services
Date	1 December 2021
Subject	**Finance Report – September 2021**

RECOMMENDATION

It is recommended that the Board:

- **note** that this report was endorsed by the Finance, Risk and Audit Committee at their November meeting for Board consideration
- **note** that the month operating result for September 2021 is a deficit before one-off items of $3.351m, which is $0.162m adverse to budget
- **note** that the year to date operating result for September 2021 is a deficit before one-off items of $1.992m, which is $1.304m adverse to budget
- **note** that year to date for September 2021 COVID-19 related contribution of $0.150m and Holidays Act costs of $1.478m have been incurred. Including these, the year to date deficit after exceptional items is $3.320m, which is $0.883m adverse to budget
- **note** that the total available cash and equivalents of $31.454m as at 30 September 2021 is sufficient to support liquidity requirements
- **note** that the revised budget is being reported against from September 2021
- **approve** the September 2021 financial report.

Strategic Alignment This report is aligned to the DHB's strategy and key enabler, 'Stewardship'.

BOARD REPORT

1. REPORT AT A GLANCE

The operating result for September 2021 is a deficit before one-off items of $3.351m, which is $0.162m adverse to budget.

Favourable to Budget | Close to, or on Budget | Adverse to Budget

Month to Date

Surplus/(Deficit)
($3.4m)
Budget Variance
($0.162m)
(5.1%)

FTEs
2,382
Budget Variance
-100
(4.4%)

Capex
$5.2m
Budget Variance
$3.9m
42.9%

Cash & Deposits Movement
($7.3m)
Budget Variance
$6.0m
45.1%

September

The revised budget is now being reported. The September month includes year to date time adjustments.

The timing of community provider payments impacts revenue recognition with significant but offseting variances.

The lockdown continues to impact volumes and revenue, albeit the impact has reduced since last month.

Nursing costs and FTEs are adverse to budget. This is where the impact of budget reductions have had the largest impact.

Outsourced Personnel is mainly due to the use of locums in MHAS.

Noticeable increase in Capex spend and approvals during the month

Year to Date

Surplus/(Deficit)
($2.0m)
Budget Variance
($1.304m)
(189.7%)

FTEs
2,383
Budget Variance
19
0.8%

Capex
$8.1m
Budget Variance
$9.3m
53.4%

Cash & Deposits
$31.5m
Budget Variance
$6.4m
25.5%

Current Ratio
1.01
Budget Variance
0.20

Year to Date

Reduced Planned Care funding due to the lockdown has had an impact on the YTD result.

FTEs are slightly below budge with nursing FTE now above budget.

Locums for MHAS are a significant adverse variance to budget. In addition, mitigations are being considered to reduce this variance.

Capital expenditure is lagging behind budget YTD. However, we beleive this will pick up during the year

Potential Budget Risks

Seven Risks in Total.

- **Four** Low Risks
- **Nil** Medium (on watch) Risks
- **Three** Medium (Concern) Risk
- **Nil** High Risk

Year End

Surplus/(Deficit)
($19.2m)
Budget Variance
$0.00m
0.0%

FTEs
2,482
Budget Variance
0
0.0%

Capex
$85.8m
Budget Variance
$0.0m
0.0%

Cash & Deposits
$36.5m
Budget Variance
$0.0m
0.0%

Current Ratio
1.01
Budget Variance
0.20

Year End

At this point of the year, the DHB is committed to achieving the planned budget deficit. The forecast provided to the MoH reflects this.

Note that the a $19.2m deficit is prior to Holidays Act costs which are budgeted at $7.0m. This makes the total deficit $26.2m.

Also note that an updated draft budget is yet to be approved by the MoH.

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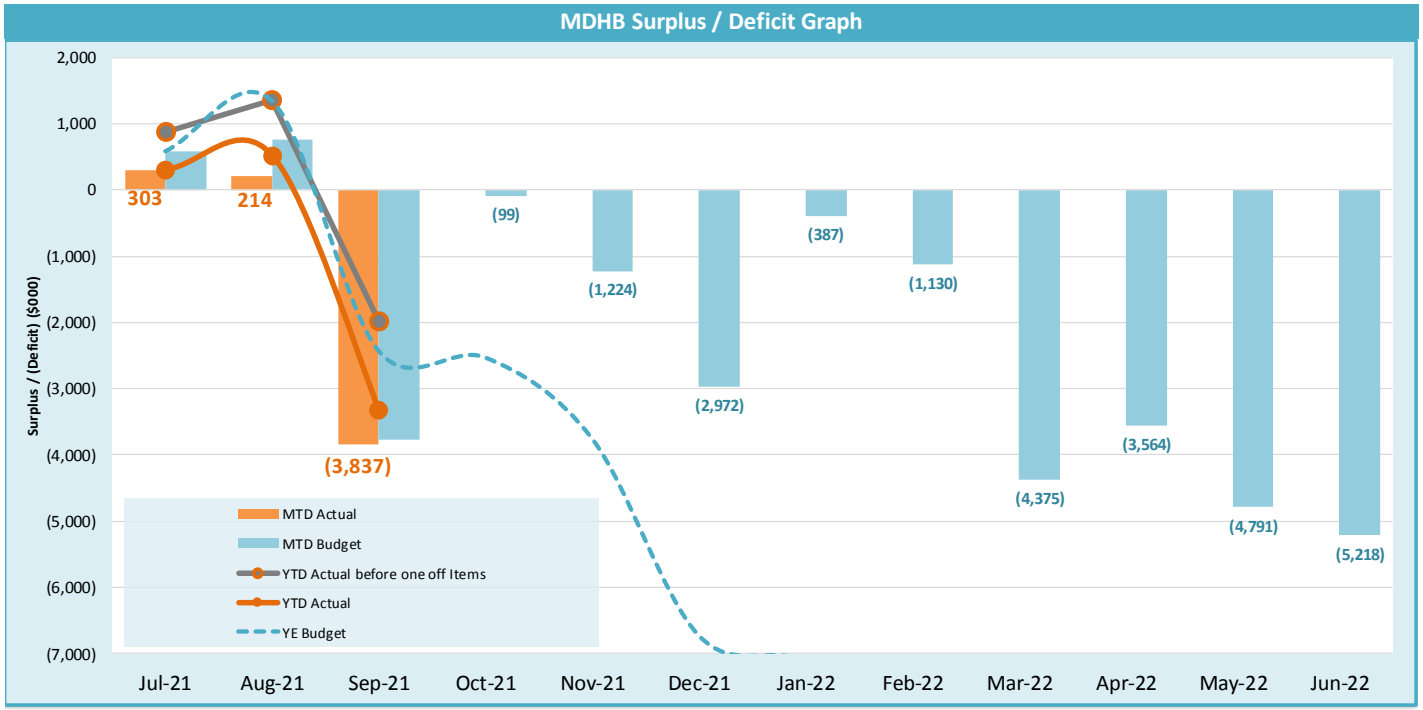
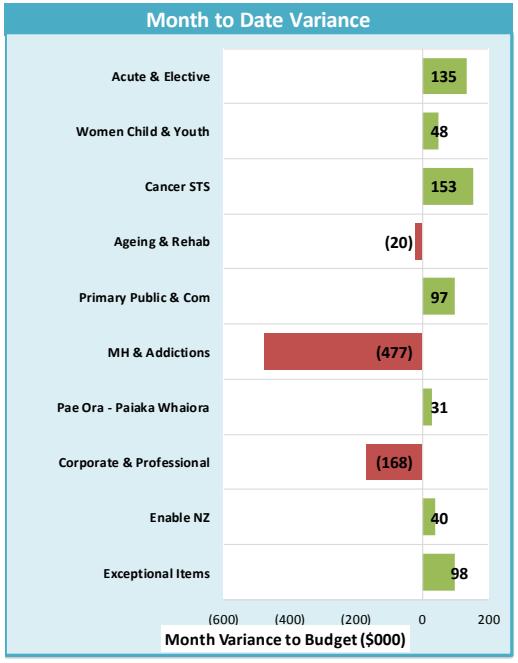
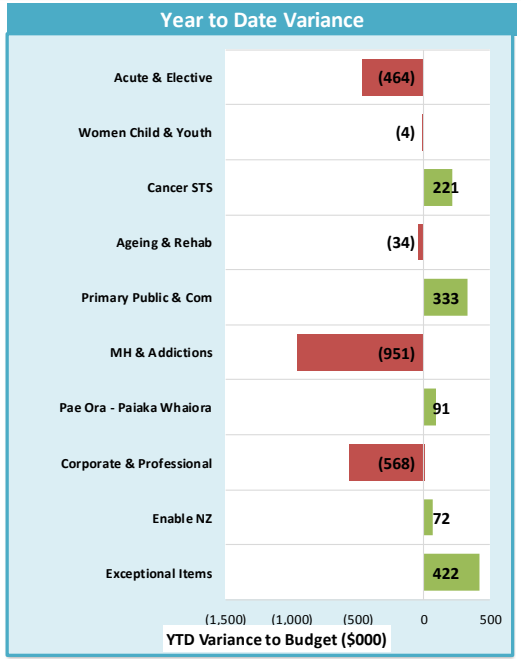

MDHB Surplus / Deficit Graph
Surplus / (Deficit) ($000)
2,000
1,000
0
(1,000)
(2,000)
(3,000)
(4,000)
(5,000)
(6,000)
(7,000)
303
214
(3,837)
(99)
(1,224)
(2,972)
(387)
(1,130)
(4,375)
(3,564)
(4,791)
(5,218)
MTD Actual
MTD Budget
YTD Actual before one off Items
YTD Actual
YE Budget
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22


Month to Date Variance
Acute & Elective 135
Women Child & Youth 48
Cancer STS 153
Ageing & Rehab (20)
Primary Public & Com 97
MH & Addictions (477)
Pae Ora - Paiaka Whaiora 31
Corporate & Professional (168)
Enable NZ 40
Exceptional Items 98
(600) (400) (200) 0 200
Month Variance to Budget ($000)


Year to Date Variance
Acute & Elective (464)
Women Child & Youth (4)
Cancer STS 221
Ageing & Rehab (34)
Primary Public & Com 333
MH & Addictions (951)
Pae Ora - Paiaka Whaiora 91
Corporate & Professional (568)
Enable NZ 72
Exceptional Items 422
(1,500) (1,000) (500) 0 500
YTD Variance to Budget ($000)

2. FINANCIAL COMMENTARY

Adverse variances are in brackets unless stated otherwise.

2.1 Financial Performance

The MidCentral District Health Board (MDHB) result for September 2021 is a deficit before one-off items of $3.351m, which is $0.162m adverse to budget. Net revenue for the month is $4.559m favourable to budget and is offset by expenditure which is $4.760m adverse to budget. The year to date result is a deficit of $1.992m, which is $1.304m adverse to budget.

A year to date COVID-19 related contribution of $0.150m and Holidays Act costs of $1.478m have been incurred. This results in a year to date deficit of $3.320m when these one-off items are included.

The Statement of Financial Performance is shown in the following table. Costs relating to the Holidays Act and COVID-19 are disclosed separately to view the underlying performance. Note that the revised budget deficit of $26.195m is now being reported. Changes have been made to both the budget deficit and the planned timing of expenditures. The September month includes year to date time adjustments because the previous month budgets cannot be altered. Given this, September budget variances are not necessarily a good measure of run rate.

While the financial performance to date is behind budget, the forecast presented to the Ministry of Health indicates a year-end deficit in line with the revised budget.

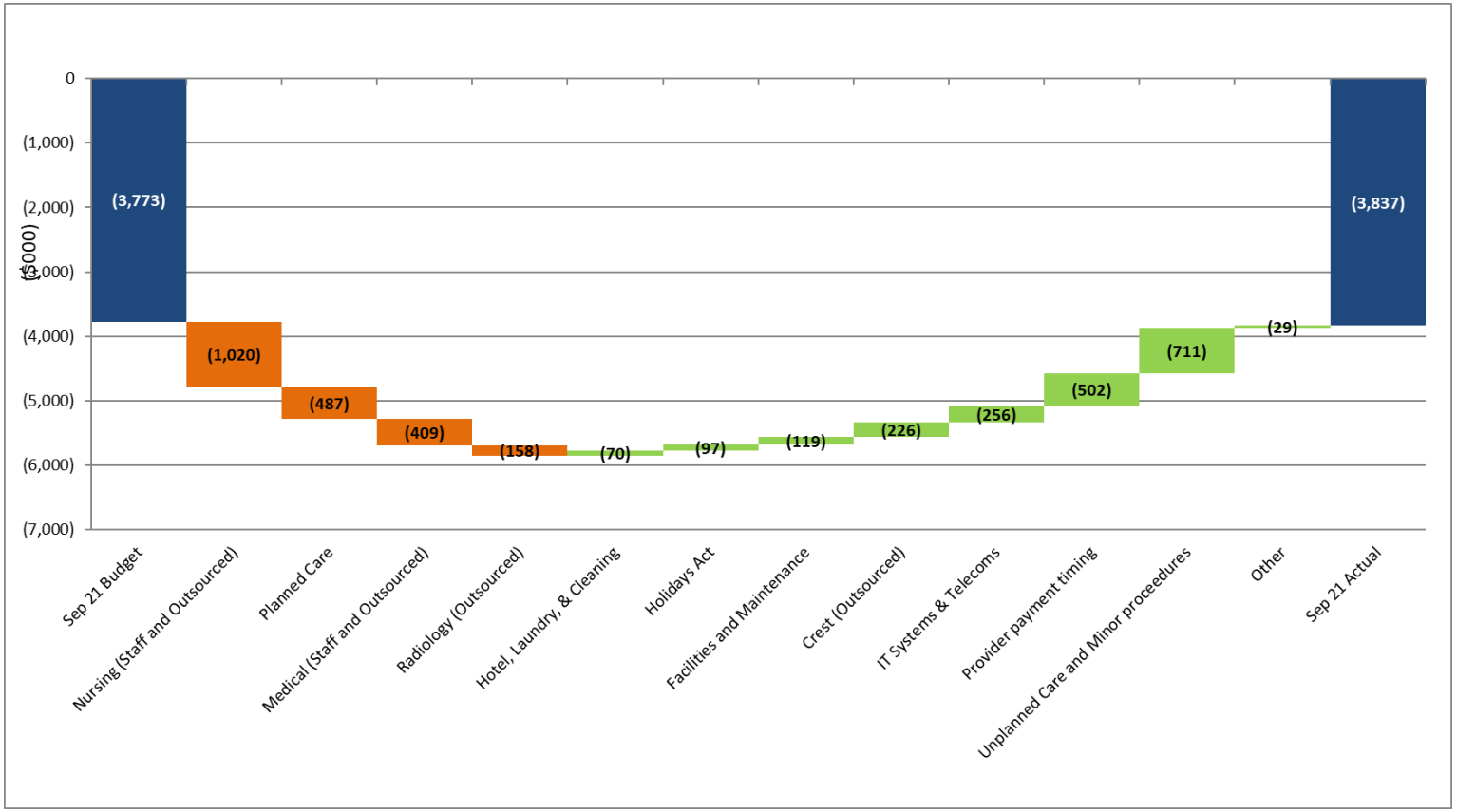
BOARD REPORT

$000	September 2020 Actual	September 2020 Budget	September 2020 Variance	Year to date Actual	Year to date Budget	Year to date Variance	Year End Budget
Net Revenue	**64,496**	**59,937**	**4,559**	**191,098**	**193,332**	**(2,234)**	**772,680**
Expenditure							
Medical	6,673	6,779	106	19,883	20,361	478	85,338
Nursing	8,715	7,696	(1,019)	26,298	25,897	(401)	110,673
Allied Health	3,273	3,337	64	9,566	9,944	377	40,912
Support	146	174	29	453	510	57	2,044
Management / Admin	3,360	3,125	(236)	9,909	9,548	(361)	39,094
Personnel	22,167	21,111	(1,056)	66,110	66,260	150	278,061
Outsourced Personnel	976	484	(491)	2,978	1,113	(1,864)	4,685
Sub -Total Personnel	23,143	21,596	(1,548)	69,088	67,373	(1,714)	282,746
Other Outsourced Services	2,308	2,359	51	7,101	6,688	(413)	27,066
Clinical Supplies	5,319	5,339	20	15,997	16,173	175	65,534
Infrastructure & Non-Clinical	6,453	6,970	517	20,380	21,864	1,483	91,009
Provider Payments	31,064	27,263	(3,801)	81,260	82,586	1,327	328,288
Total Operating Expenditure	**68,287**	**63,527**	**(4,760)**	**193,826**	**194,684**	**858**	**794,643**
Operating Surplus/(Deficit)	**(3,791)**	**(3,590)**	**(201)**	**(2,729)**	**(1,352)**	**(1,376)**	**(21,963)**
Enable NZ Contribution	440	400	40	737	665	72	2,768
Surplus/(Deficit) Before One-O	**(3,351)**	**(3,190)**	**(162)**	**(1,992)**	**(687)**	**(1,304)**	**(19,195)**
Holidays Act	(486)	(583)	97	(1,478)	(1,750)	272	(7,000)
Covid-19	1	(0)	1	150	(0)	150	(0)
Surplus/(Deficit)	**(3,837)**	**(3,773)**	**(64)**	**(3,320)**	**(2,437)**	**(883)**	**(26,195)**

FTE							
Medical	353.9	372.3	18.3	354.5	369.3	14.8	380.4
Nursing	1,106.0	978.6	(127.3)	1,107.4	1,094.0	(13.4)	1,138.1
Allied Health	422.9	435.5	12.7	423.0	435.0	12.0	442.7
Support	28.9	33.4	4.5	30.3	33.4	3.1	33.4
Management / Admin	470.7	462.9	(7.8)	467.4	470.4	2.9	487.0
Operating FTE	**2,382.4**	**2,282.8**	**(99.6)**	**2,382.6**	**2,402.1**	**19.4**	**2,481.5**
Enable NZ	108.5	115.4	6.9	110.0	115.4	5.3	115.4
Holidays Act	4.3	5.0	0.7	4.2	5.0	0.8	5.0
Covid-19	96.7	220.0	123.3	77.1	73.7	(3.4)	66.1
Total FTE	**2,591.9**	**2,623.2**	**31.2**	**2,573.9**	**2,596.1**	**22.2**	**2,668.0**

Major variances to budget for the month drove the result as indicated in the graph below.

MAJOR VARIANCES TO BUDGET FOR THE MONTH



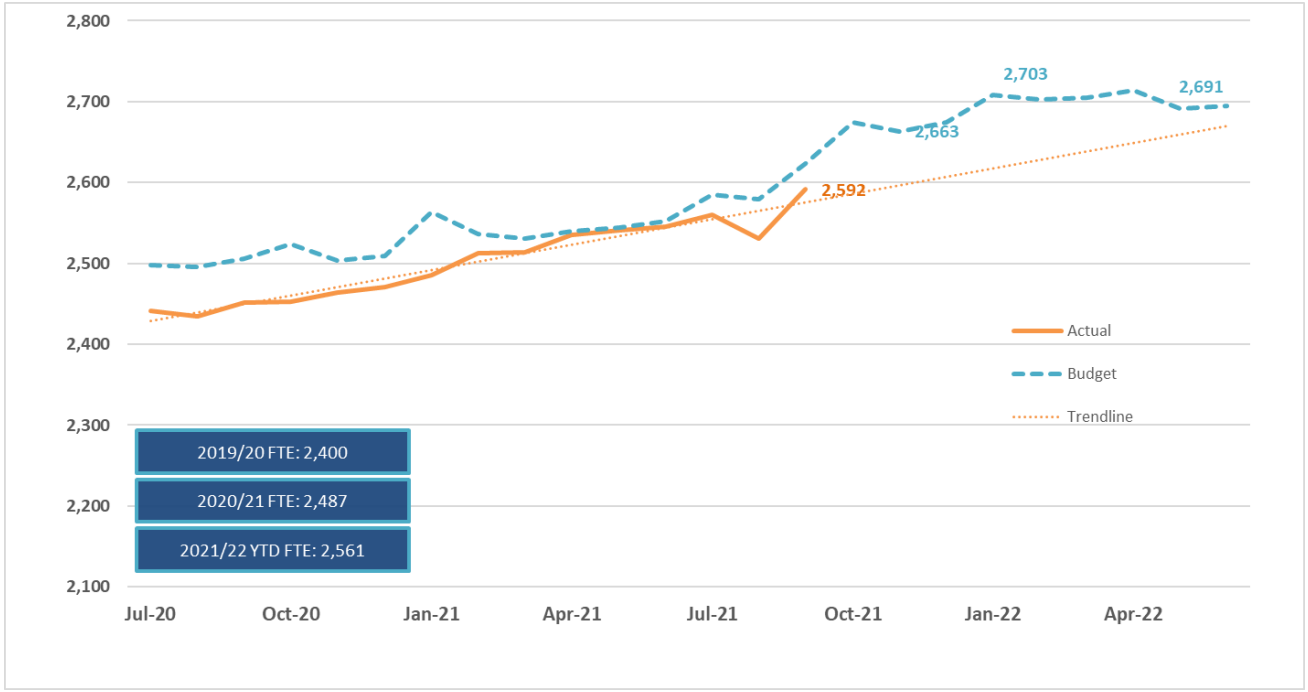
Revenue variances of significance for the month are as follows:

- A large portion of the adverse revenue variance relates to the timing of community provider payments. These payments are $3.801m adverse to budget and offset by $4.301m favourable revenue, the difference being timing. Significant and offsetting variances in these two items are not uncommon as this is dependent on community provider activity which is challenging to predict monthly. September partially reverses the result from August, where revenue was significantly adverse and community provider payments favourable.
- Planned Care activity in Te Uru Arotau, Acute and Elective Specialist Services was adverse for the month ($0.487m). This is due to the lockdown, which continued to impact activity and volumes, albeit the impact has reduced since last month. This was more than offset by funding for unplanned care and minor procedures.

Full-time Equivalent staffing (FTE) for the month are as follows:

- Overall, FTEs are 31 favourable to budget for September. However, the month variance is somewhat misleading as the revised budget includes year-to-date changes. This is particularly the case for nursing FTE and COVID-19, where significant budget changes were made. A better indication against budget is the year to date variance which is discussed below.
- Medical staff are below budget by 14 FTE for the year, with ten in Te Uru Arotau. These largely relate to radiologist vacancies. A further seven exist in Te Uru Rauhī, Mental Health and Addiction Services. These vacancies are being covered by locums.
- Nursing staff are 16 FTE above budget for the year. Since May, the trend has seen a stagnation in attempts to recruit to vacancies which goes against the long-term trend of increasing staff numbers. The change from FTEs that have been lower than the budget in prior months to a position where FTEs are slightly above budget is due to a budget reduction. Note that these budget reductions have been phased to ensure a reduced effect over the year.
- Allied Health FTEs are 15 FTE below budget for the year with seven vacancies relating to Medical Radiation Technicians in medical imaging (Te Uru Arotau).
- The table below shows the total FTEs by month for this year.

TOTAL EMPLOYED FTES BY MONTH



Significant variances in operating expenditure for the month are highlighted below.

- The adverse variance in Personnel costs (excluding Outsourced Personnel) of $1.056m primarily relates to the year to date changes in the revised budget. It is mainly due to nursing, which is $1.019m adverse. On a year to date basis, nursing is $0.401m adverse to budget, and administration is $0.361m adverse. Favourable variances in other job categories offset these.
- On a year to date basis, average salary costs are in line with the budget. Staff overtime costs have been reduced by 15 percent when compared to the previous two months.
- On a year to date basis, locums for Te Uru Rauhī is more than 60 percent of the variance in outsourced personnel. In turn, half of this is offset by favourable medical staff costs. Finance is working with Te Uru Rauhī to better understand this variance, the likelihood that it will continue and any ability to recover from it. Other directorates make up a further 15 percent of the year to date locum costs but have limited favourable offsets in medical staff. The remainder is in outsourced nursing (15 percent) and administration.
- Other Outsourced Services are close to budget overall. Crest Hospital expenditure which is $0.226m favourable to budget for the month in Te Uru Arotau is primarily offset by adverse outsourced radiology ($0.156m)
- Clinical Supplies are close to budget for the month with clinical equipment depreciation favourable by $0.077m and diagnostic supplies favourable by $0.061m.
- Infrastructure and Non-Clinical costs are $0.517m favourable to budget for the month. The fundamental cause of this variance is IT depreciation and software maintenance costs ($0.256m), facilities and maintenance ($0.119m) and contracted hotel, cleaning and meal costs ($0.070m). These three items are also driving the favourable year to date variance.

One-off items include the Holidays Act and COVID-19 expenditure.

- Holidays Act expenditure for the month includes a $0.375m increase in the provision, with the remainder being project costs. Project costs are lower than anticipated in the budget leading to a favourable variance for the month and year.
- COVID-19 expenditure for the month includes $1.834m of costs that are more than offset by reimbursing funding received for immunisation, surveillance and isolation. The revenue variance of $0.627m and offsetting expenditure variance are timing in nature.

2.2 Financial Performance by Service

The statement of 'Net Revenue and Expenditure by Service' is shown in the table below.

$000	September 2020			Year to date			Year End
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Acute & Elective Specialist Services	(14,332)	(14,466)	135 ✓	(43,880)	(43,416)	(464) !	(178,476)
Healthy Women, Children and Youth	(3,225)	(3,273)	48 ✓	(9,837)	(9,833)	(4) !	(41,179)
Cancer Screening, Treatment & Support	(3,751)	(3,903)	153 ✓	(11,140)	(11,361)	221 ✓	(47,282)
Healthy Ageing & Rehabiliation	(9,475)	(9,455)	(20) !	(28,373)	(28,339)	(34) !	(114,524)
Primary, Public & Community	(5,484)	(5,581)	97 ✓	(16,468)	(16,801)	333 ✓	(67,160)
Mental Health & Addictions	(4,262)	(3,785)	(477) ✗	(12,423)	(11,472)	(951) ✗	(46,307)
Pae Ora - Paiaka Whaiora	(962)	(993)	31 ✓	(2,888)	(2,979)	91 ✓	(11,886)
Corporate & Professional Services	37,750	37,918	(168) !	122,430	122,998	(568) !	485,452
Enable NZ	390	350	40 ✓	587	515	72 ✓	2,168
Surplus/(Deficit) Before One-Off Items	**(3,351)**	**(3,190)**	**(162)** ✗	**(1,992)**	**(687)**	**(1,304)** ✗	**(19,195)**
Exceptional Items	(485)	(583)	98 ✓	(1,328)	(1,750)	422 ✓	(7,000)
Surplus/(Deficit)	**(3,837)**	**(3,773)**	**(64)** !	**(3,320)**	**(2,437)**	**(883)** ✗	**(26,195)**

Items of note which impacted service financial performance for the month are outlined below. Further details are provided in Appendix One – Financial Performance by Service.

- The Te Uru Arotau favourable result for the month of $0.135m is due to favourable nursing costs. The remaining expenditure was close to budget, albeit favourable outsourced costs for Crest Hospital ($0.226m) were offset by adverse outsourced radiology ($0.187m). Revenue was close to budget. Planned care revenue was $0.487m adverse to budget. This was offset by funding for minor procedures and unplanned (acute) care. Planned care continued to be impacted by the COVID-19 restrictions but not to the same extent as the previous month.
- Te Uru Pā Harakeke, Healthy Women, Children and Youth Services is favourable to budget by $0.048m for the month largely as a result of favourable nursing costs. Year to date, this directorate is on budget.
- The month result for Te Uru Mātai Matengau, Cancer Screening, Treatment and Support Services is favourable to budget by $0.153m. This is the result of favourable Inter-District Flow (IDF) funding and breast screening income.

- Te Uru Whakamauora, Healthy Ageing and Rehabilitation Services is close, albeit adverse, to budget for the month. ACC revenue was less than anticipated ($0.031m), and hotel costs were adverse ($0.021m). These were partially offset by Allied Health vacancies.
- Te Uru Kiriora, Primary, Public and Community Services is favourable to budget for the month by $0.097m. Personnel costs were $0.049m favourable to budget, mainly in medical staff. The remainder of the favourable variance was due to treatment supplies and pharmaceuticals.
- Due to adverse personnel costs, Te Uru Rauhī is adverse to budget by $0.477m for the month and $0.951m adverse for the year. The cost of locum cover is partially offset medical staff vacancies. However, the net result is leading to an average monthly adverse variance of circa $0.200m. Adverse nursing FTE and overtime also contributed to the monthly result.
- Corporate and Professional Services comprises all executive and enabler functions. The month result was due to favourable personnel costs (including outsourced personnel), IT depreciation and software maintenance costs ($0.256m), facilities and maintenance ($0.119m) and contracted hotel, cleaning and meal costs ($0.070m).
- Exceptional Items contains organisation-wide costs for COVID-19 and Holidays Act. Refer to sections 2.3 and 2.4 below.
- The September 2021 result for Enable New Zealand is due to favourable income from trading activities and procurement rebates. Trading activities include direct sales, equipment hire, equipment refurbishment and freighting of complex equipment.

A Statement of Net Revenue and Expenditure by Division is shown in the table below.

$000	September 2020			Year to date			Year End
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Funding Division	(2,089)	(2,088)	(1) !	4,422	4,724	(302) ✗	41,236
MidCentral Provider	(2,535)	(2,034)	(501) ✗	(9,133)	(7,675)	(1,458) ✗	(69,599)
Enable NZ	390	350	40 ✓	587	515	72 ✓	2,168
Governance	398	0	398 ✓	805	0	805 ✓	0
Surplus/(Deficit)	**(3,837)**	**(3,772)**	**(64)** !	**(3,320)**	**(2,437)**	**(883)** ✗	**(26,195)**

2.3 Holidays Act

Holidays Act related costs of $0.486m are $0.097m favourable to the budget for the month. Of this, $0.375m is an increase to the Holidays Act provision. The remainder relates to project costs. The Holidays Act is a national issue faced by all DHBs, and the expectation is that this will require separate funding to remediate. The Government has signalled that it will provide this funding once all DHBs are in a position to rectify it.

The value of the Holidays Act provision as at September 2021 was $48.523m and is held in the balance sheet. A significant increase in the provision was recognised last year to reflect the estimate undertaken by Ernst Young. A further $1.125m has been accrued this year. The adequacy or otherwise of these provisions will not be confirmed until the individual remediation calculations are substantially complete.

2.4 COVID-19

Net expenditure during September was close to budget for the month. Revenue received was $1.835m and offset operating expenditure of the same quantum. This was largely for immunisation activity but also included surveillance and isolation facilities. The positive year to date result reflects revenue used to fund equipment purchases in support of immunisation activity. The equipment is recognised as an asset and held in the balance sheet rather than an operating expense.

2.5 Budget Risks

The majority of risks identified last year remain relevant for this financial year. The Holidays Act project has been removed as a risk. While this remains a significant project, the Ministry of Health (the Ministry) is funding all costs and therefore, this risk is offset. In addition, the webPAS SaaS risk has been incorporated into a general cloud technology budget risk. As information technology increasingly turns away from on-premise to cloud solutions, this transfers the financial burden from capital to operating costs.

A summary of 2021/22 budget risks is outlined below. If realised, these have the potential to affect MDHB's ability to achieve budget significantly.

Risk	Low	Medium (Watch)	Medium (Concern)	High
Indicator				

Risk	Comment	Status
Achieving Sustainability and Saving Plan Objectives		
Sustainability initiatives of $2.050m are included in the budget. These must be achieved to help absorb any unexpected shocks to the DHB.	It is too early in the year to assess progress toward achieving sustainability and saving plan targets.	
Ongoing Impacts of COVID-19		
The recent outbreak confirms that this is far from over. The impact of further episodes is disruptive to the DHB and its budget.	The most recent lockdown had a noticeable impact on hospital activity and financial performance in September. Lower than expected Planned Care revenue is an obvious example of this. COVID-19 outbreaks and periodic lockdowns will likely become commonplace. Management is building strategies to best deal with this.	
Timing of staff recruitment		
The budget reflects average vacancy levels based on the assumption that not all positions will be recruited. It also includes phasing adjustments because the need to fill positions will occur gradually throughout the year.	To date, the variance between budgeted and actual FTEs suggests a high number of vacancies. Given this, the timing of recruitment appears as low risk at this point. However, FTEs have been reduced in the revised budget to reflect the difficulty in recruiting staff.	
Future MECA settlements		
The budget assumption is for a modest 1.5 percent increase in wage settlements based on the Government's expectation. Recent nursing strikes suggest not all employee groups will necessarily accept this.	Negotiations with the NZNO and MERAS are near completion. It is too early to assess the likely impact of settlement arrangements, including any additional funding support for the settlement.	
Achieving Planned Care targets		
The Ministry proposed targets require an increase in output to achieve similar revenue levels as in 2020/21. This will need to be carefully managed given the potential disruption due to SPIRE construction.	Refer to "**Ongoing Impacts of COVID-19**" as this is the main risk to planned care targets. Comprehensive planning for the SPIRE project is in place - refer to "**Hospital Capacity**".	
Hospital Capacity		

Hospital bed capacity was very high during 2020/21 due to growing demand. In addition, the SPIRE and EDOA/MAPU PODS project construction activity will increase this year.	Hospital bed occupancy remains high. Surgical leads have endorsed a comprehensive SPIRE transition plan to ensure ongoing theatre capacity during construction. This includes access to Crest facilities and other contingency arrangements if required. MAPU-EDOA is currently in the design phase.	
Cloud Technology		
Many proposed information technology solutions favour software as a Service (SaaS) and Platform as a Service (PaaS). This move away from on-premise solutions will transfer the financial burden from capital to operating costs.	Recent business cases such as e-referrals, e-triage and the digitisation of outpatient communication were planned as capital projects but will be implemented as SaaS and therefore become an operating expense. Other projects will likely favour a SaaS approach. The degree to which this impact this year's financial performance will depend on the timing of implementation.	

2.6 Financial Position

The main Balance Sheet budget variances as of 30 September 2021 are related to the timing of capital expenditure which is later than anticipated and results in lower than budgeted non-current assets. Higher cash and deposit balances and Ministry invoicing has resulted in higher than budgeted current assets. Significant capital expenditure is budgeted for the 2021/22 year, and the projected year-end cash and deposits balance remains as budgeted at negative $3.864m.

$000	Jun-21	Sep-21		
	Actual	Actual	Budget *(Draft)*	Variance
TOTAL ASSETS				
Non Current Assets	293,387	294,338	310,791	(16,453)
Current Assets	68,877	70,681	58,030	12,651
Total Assets	**362,264**	**365,019**	**368,821**	**(3,802)**
TOTAL EQUITY AND LIABILITIES				
Equity	207,943	205,765	208,314	2,549
Non Current Liabilities	6,278	6,374	6,350	(24)
Current Liabilities	148,043	152,880	154,156	1,276
Total Equity and Liabilities	**362,264**	**365,019**	**368,821**	**3,802**

2.7 Cash Flows

While total available cash and deposit balances are favourable to budget by $6.410m, overall cash flows reflect an unfavourable variance to budget of $3.431m. Operating cash flows are unfavourable due to the timing of revenue received for COVID-19 related activities and provider contracts and the net impact of working capital movements. Investing cash flows are favourable due to the timing of capital expenditure being later than budgeted. Financing activities are unfavourable due to equity injections for the SPIRE and mental health projects being later than budgeted.

$000	Jun-21 Actual	Sep-21 Actual	Sep-21 Budget *(Draft)*	Sep-21 Variance	
Net Cash Flow from Operating Activities	24,384	1,375	13,472	(12,097)	✗
Net Cash Flows from Investing Activities	(20,859)	(7,486)	(17,364)	9,878	✓
Net Cash Flows from Financing Activities	5,980	1,076	2,288	(1,212)	✗
Net increase / (decrease) in cash	**9,505**	**(5,035)**	**(1,604)**	**(3,431)**	✗
Cash at beginning of year	26,984	36,489	26,648	9,841	✓
Closing cash	**36,489**	**31,454**	**25,044**	**6,410**	✓

2.8 Cash, Investments and Debt

Cash and Investments

Trust and Special Funds are held in a separate BNZ account. These fall outside the shared banking arrangement with the BNZ that NZ Health Partnerships Limited sweeps daily. Surplus liquidity from the Enable New Zealand operating account is channelled through the main DHB accounts to obtain those benefits.

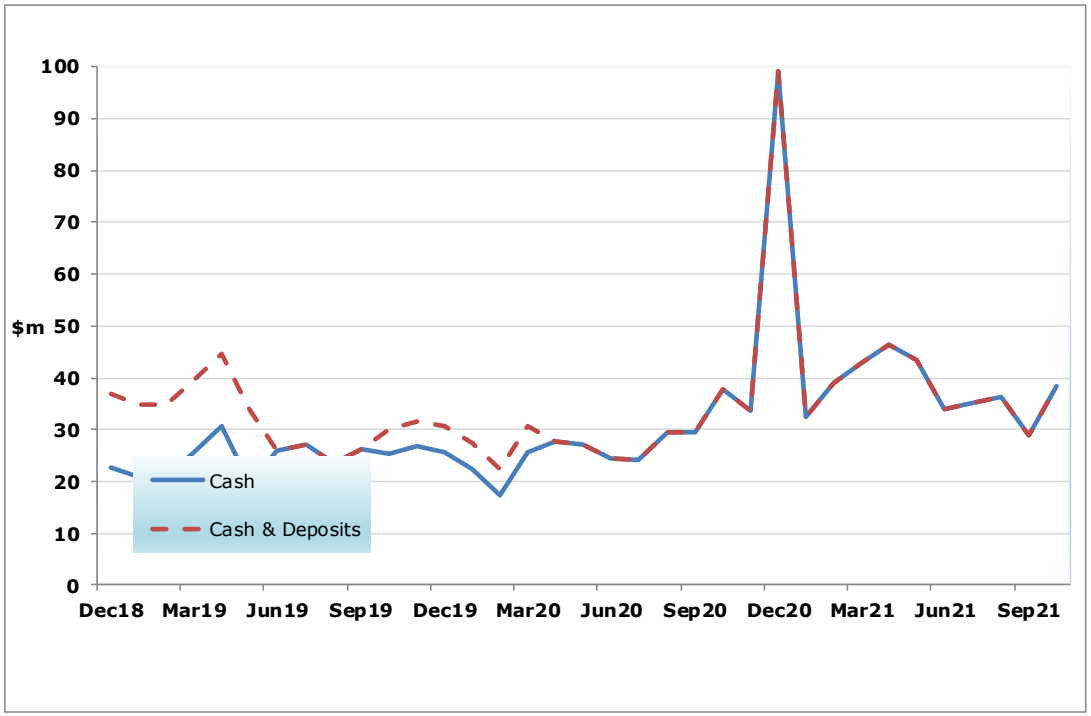
Sep-21	Rate	Value $000
NZHP Sweep Balance	0.72%	28,196
Cash in Hand and at Bank		2
Trust Accounts		2,622
Enable New Zealand Cash Balances		634
		31,454
Total Cash Balance		**31,454**

The cash reconciliation table below shows how cash has moved during the month.

Cash Reconciliation	Sep-21 $000	Year to date $000
Cash at August 2021	38,777	36,489
Surplus / (Deficit) for mth	(3,837)	(3,320)
Depreciation / Amortisation	2,224	6,801
Sale of fixed assets	-	2
Working capital movement	(943)	(2,014)
Share of associate net surplus/deficit	-	-
Capital expenditure	(4,825)	(7,755)
Loan/finance lease repayments	(17)	(50)
Trusts movement	75	160
Equity injections - capital	-	1,141
Cash Balance at month end	**31,454**	**31,454**

The chart below indicates the DHB's cash balance, excluding investment and Trust Accounts. The spike in the December 2020 cash balance reflects the early payment of January revenue by the Ministry due to the timing of the Christmas holiday period.

CASH BALANCES



The DHB sector as a whole is experiencing liquidity pressure due to the continuation of operating deficits. On behalf of all DHBs, New Zealand Health Partnerships has been in ongoing discussion with the Ministry and Treasury on ways to resolve this and the need for urgent deficit support equity injections to those DHBs who are insolvent. These pressures have not affected MDHB operations to date.

The Ministry has reassured the sector on the liquidity impacts of COVID-19 and that the cost of Holidays Act remediation will be funded when payments to remediate impacted employees (past and present) are eventually made. Despite this, these issues will likely influence the ability to fund other sector initiatives in the near term.

Net MDHB liquidity continues to be sufficient in the near term with steady levels. However, continuing operating deficits and planned capital investments will reduce overall liquidity.

The Treasury and the Ministry will provide a funding allocation of $30m towards the $35m budget for the Mental Health Unit replacement and $27.5m for an expanded perioperative suite (SPIRE programme). Funding for these projects commenced in the previous financial year. The bulk of the drawdowns will occur this and next year as construction activity increases. In addition, funding support from the Ministry to purchase a replacement Linear Accelerator has been confirmed.

Treasury Policy and Ratios

There are currently no arrangements that necessitate monitoring against Treasury Policy parameters.

Debt and Leases

The MRI finance lease is held with MCL Capital which is a New Zealand owned and operated company offering leasing solutions to New Zealand public sector organisations.

Finance Leases	Start Date	Maturity	$'000	Equipment
MCL Capital	Jun-19	May-26	1,070	MRI Scanner

The finance lease allows the DHB to spread the cost of an asset over the lease term and preserves capital, minimises the draw on cash reserves and provides budget certainty with ownership at the lease expiry.

2.9 Statement of Capital Expenditure

A total of $6.511m was approved during September, bringing total approvals to $53.327m against the annual capex plan of $85.761m. Significant approvals included the Health System Catalogue ($1.515m), the Regional Health Informatics Programme (RHIP $1.416m), Echo Site Water Services ($0.800), Image Vault ($0.700m), Medical Air Upgrade ($0.650m), and the Theatre Audit Tool (SCoPE $0.600m).

Capital Approvals ($000)	Sep-21	YTD
Approvals	6,511	53,237
Items Yet to ve Approved	(6,645)	32,831
Total	**(134)**	**86,068**
Capital Budget	0	85,761
Capex unbudgeted	(134)	307
Total	**(134)**	**86,068**

Capital expenditure for the month was $5.215m, bringing total spending for the year to $8.055m. September expenditure against 2021/22 approved items totalled $6.225m and included $3.558m for the replacement Linear Accelerator. In addition, there was expenditure against the Health System Catalogue ($0.300m), Laparoscopic Tower Replacements ($.300m), RHIP ($0.121m) along with a continuation in spending on the SPIRE project ($0.124m) and the Mental Health Redevelopment ($0.156m).

Capital Expenditure & SaaS ($000)	Sep-21	YTD
Prior Year Capex	535	1,830
Current Year Capex	4,590	6,225
Current Year SaaS	90	360
Total	**5,215**	**8,055**

Year to date expenditure on items approved in the prior year is $1.830m. This leaves $2.279m of prior-year approvals that are yet to be spent. Note that the lag between project approval and project expenditure across financial periods is typical.

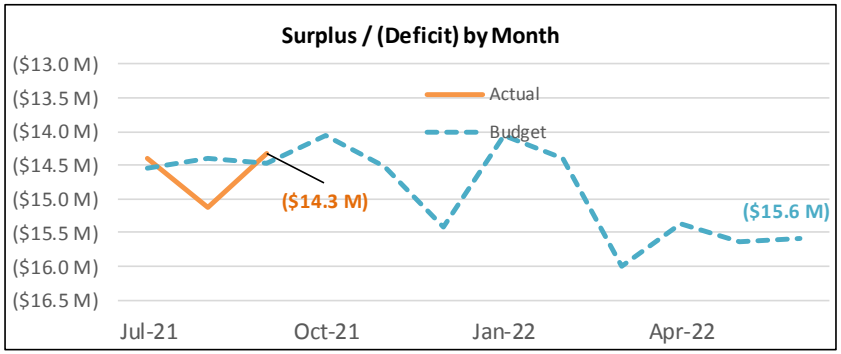
Further detail is provided in Appendix Two – Capital Expenditure. Several proposed information technology items, identified as capital when compiling the 2021/22 capex plan, are being undertaken as Software as a Service (SaaS). Under this model, the service provider is offering a subscription to use the software while retaining ownership. From an accounting perspective, this becomes an operating expense. For completeness, these items continue to be reported on the Capital Expenditure Report. However, they have now been separated within the report to assess their impact.

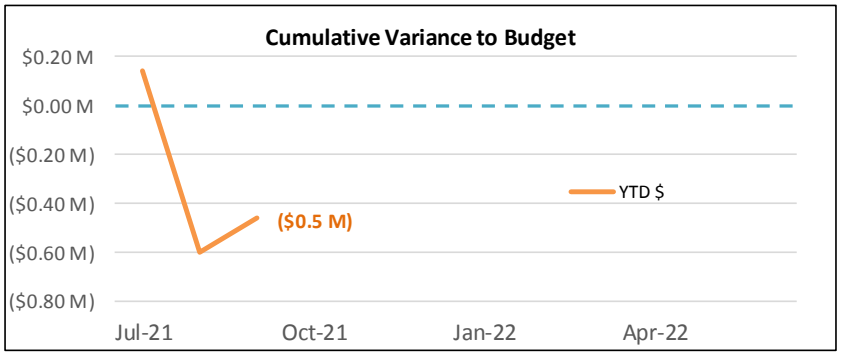
APPENDIX ONE – FINANCIAL PERFORMANCE BY SERVICE

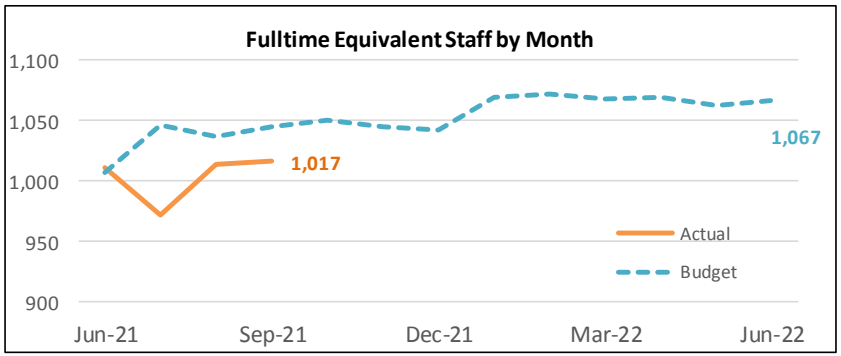
Te Uru Arotau – Acute and Elective Specialist Services

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**1,846**	**11**	**5,084**	**(302)**	**21,837**
Expenditure					
Personnel	9,844	123	29,720	355	123,891
Outsourced Personnel	66	(23)	270	(136)	516
Sub -Total Personnel	9,910	100	29,991	220	124,407
Other Outsourced Services	1,387	(15)	4,126	(416)	15,301
Clinical Supplies	3,275	(45)	9,957	(203)	40,401
Infrastructure & Non-Clinical	704	84	2,165	237	9,359
Total Operating Expenditure	**15,276**	**124**	**46,239**	**(163)**	**189,468**
Provider Payments	19	0	78	0	252
Corporate Services	883	0	2,648	0	10,593
Surplus/(Deficit)	**(14,332)**	**135**	**(43,880)**	**(464)**	**(178,476)**

FTE					
Medical	227.6	12.4	229.0	10.1	241.8
Nursing	513.9	3.0	509.5	8.0	525.5
Allied Health	132.2	5.9	131.4	6.5	138.6
Support	16.7	2.4	17.1	2.0	19.0
Management / Admin	126.7	3.4	127.0	1.9	131.2
Total FTE	**1,017.1**	**27.3**	**1,014.0**	**28.4**	**1,056.2**



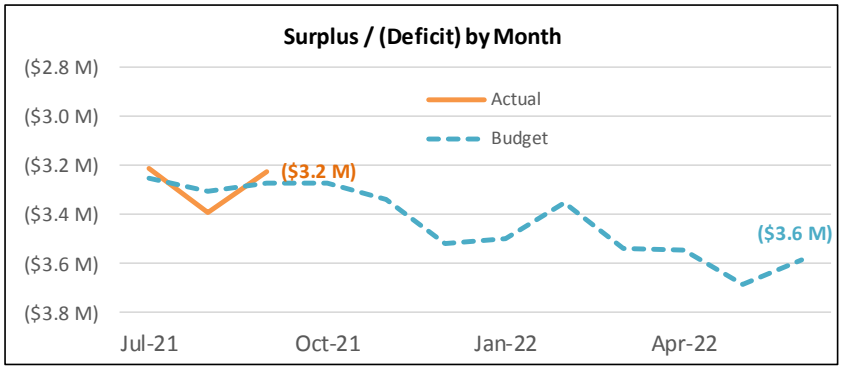


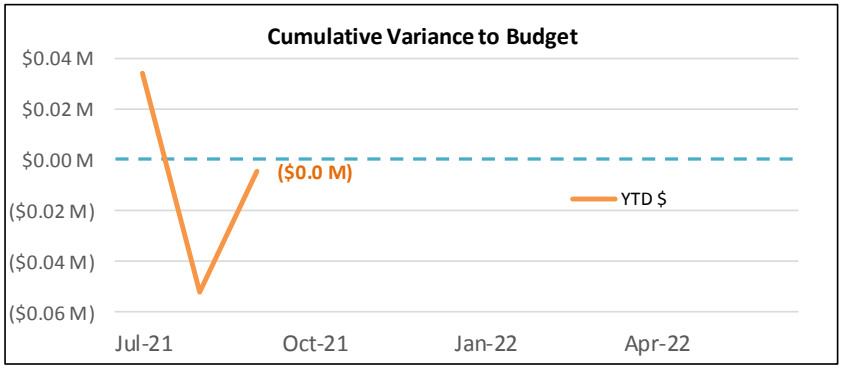


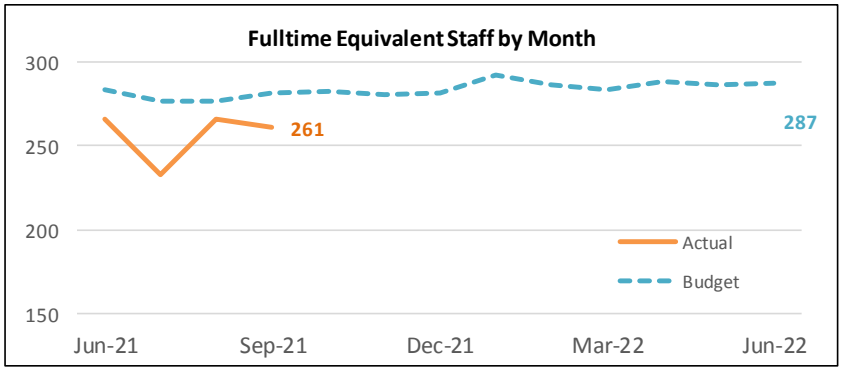
Te Uru Pā Harakeke – Healthy Women, Children and Youth Services

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**493**	**36**	**1,201**	**(199)**	**5,521**
Expenditure					
Personnel	2,479	109	7,421	333	32,822
Outsourced Personnel	89	(72)	221	(166)	201
Sub -Total Personnel	2,568	37	7,642	168	33,023
Other Outsourced Services	106	(39)	272	(62)	927
Clinical Supplies	349	11	1,018	61	4,312
Infrastructure & Non-Clinical	228	3	684	29	2,798
Total Operating Expenditure	**3,250**	**11**	**9,616**	**195**	**41,059**
Provider Payments	454	0	1,381	0	5,479
Corporate Services	14	0	41	0	162
Surplus/(Deficit)	**(3,225)**	**48**	**(9,837)**	**(4)**	**(41,179)**

FTE					
Medical	42.6	2.2	43.1	1.2	45.5
Nursing	114.0	9.1	117.6	3.4	122.4
Midwives	29.3	5.2	30.2	4.4	34.7
Allied Health	53.1	3.0	52.5	2.3	56.6
Support	0.0	0.0	0.0	0.0	0.0
Management / Admin	22.0	1.2	22.4	0.9	24.2
Total FTE	**261.0**	**20.7**	**265.9**	**12.2**	**283.4**



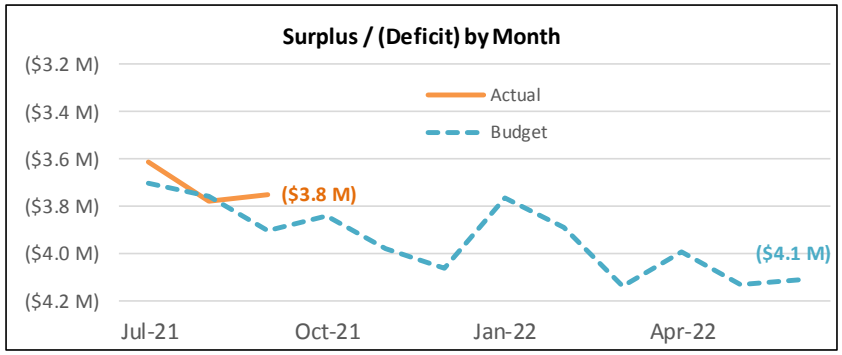


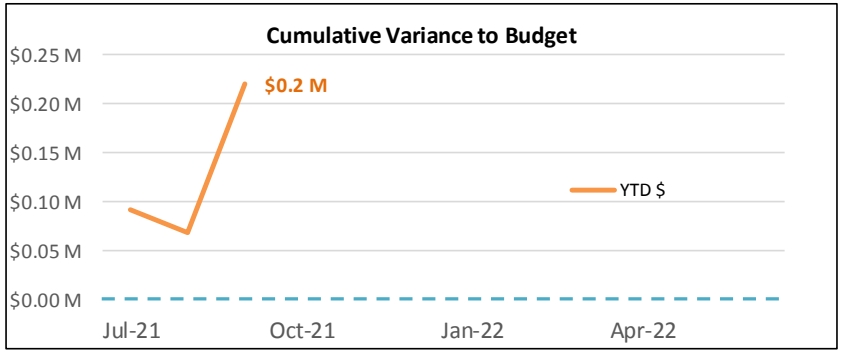


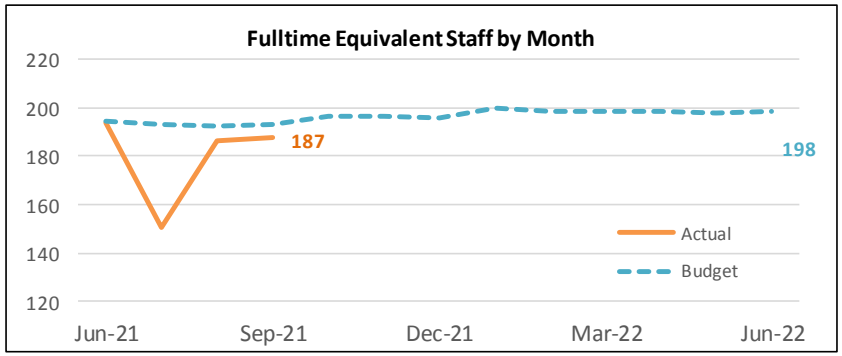
Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**865**	**140**	**2,399**	**(208)**	**8,866**
Expenditure					
Personnel	1,995	(40)	5,713	155	24,268
Outsourced Personnel	5	19	22	12	114
Sub -Total Personnel	2,000	(21)	5,735	167	24,381
Other Outsourced Services	572	38	1,817	13	7,321
Clinical Supplies	1,277	(13)	3,705	186	15,108
Infrastructure & Non-Clinical	147	8	420	61	1,888
Total Operating Expenditure	**3,995**	**13**	**11,676**	**428**	**48,698**
Provider Payments	401	0	1,205	0	4,821
Corporate Services	219	0	657	0	2,629
Surplus/(Deficit)	**(3,751)**	**153**	**(11,140)**	**221**	**(47,282)**

FTE					
Medical	39.1	0.3	38.5	0.8	41.5
Nursing	54.6	5.7	55.0	5.4	60.4
Allied Health	62.6	1.2	62.8	1.0	64.5
Support	0.0	0.0	0.0	0.0	0.0
Management / Admin	31.1	(1.6)	31.4	(1.9)	30.1
Total FTE	**187.4**	**5.7**	**187.7**	**5.3**	**196.5**



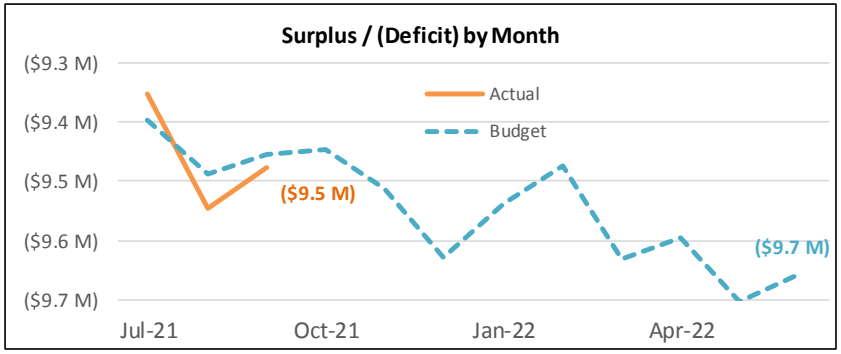


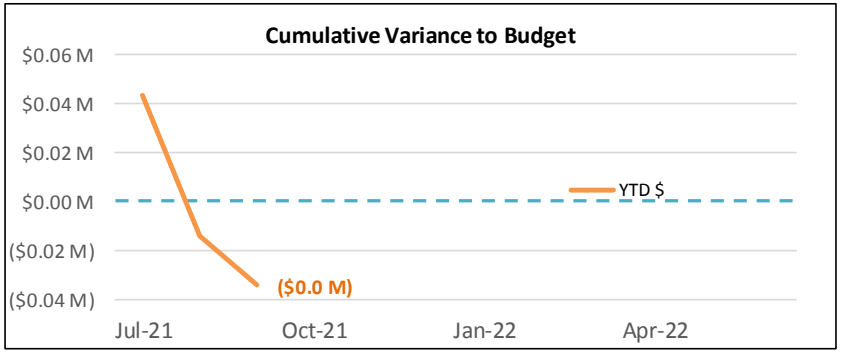


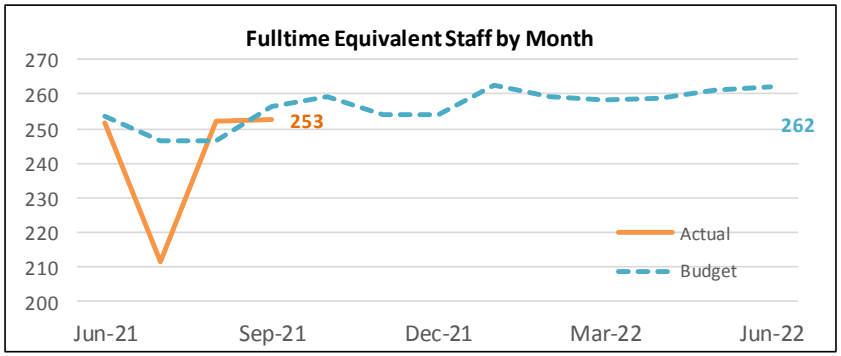
Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**405**	**(31)**	**1,276**	**(84)**	**5,124**
Expenditure					
Personnel	1,948	44	5,827	97	24,808
Outsourced Personnel	4	(4)	11	(10)	2
Sub -Total Personnel	1,952	40	5,838	87	24,810
Other Outsourced Services	76	(13)	169	23	749
Clinical Supplies	149	6	476	(7)	1,846
Infrastructure & Non-Clinical	171	(21)	510	(53)	1,804
Total Operating Expenditure	**2,349**	**11**	**6,994**	**49**	**29,209**
Provider Payments	7,443	0	22,388	0	89,374
Corporate Services	89	0	266	0	1,066
Surplus/(Deficit)	**(9,475)**	**(20)**	**(28,373)**	**(34)**	**(114,524)**

FTE					
Medical	15.6	(0.1)	15.6	(0.5)	16.4
Nursing	128.0	(2.2)	128.4	(4.4)	125.8
Allied Health	93.4	6.3	91.4	3.4	98.2
Support	0.0	0.0	0.0	0.0	0.0
Management / Admin	15.8	(0.2)	16.4	(0.5)	16.1
Total FTE	**252.8**	**3.7**	**251.8**	**(2.0)**	**256.6**



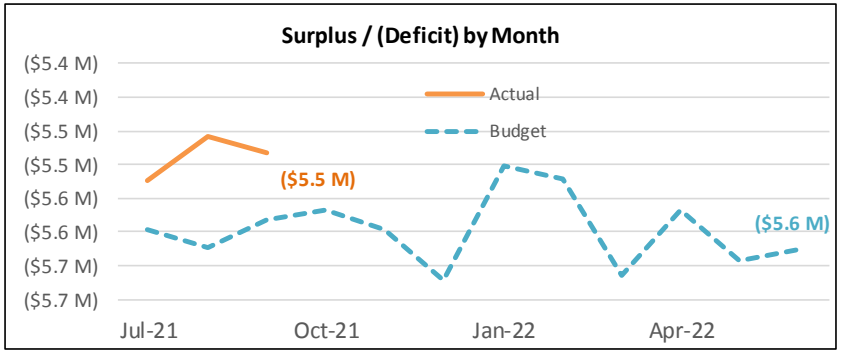


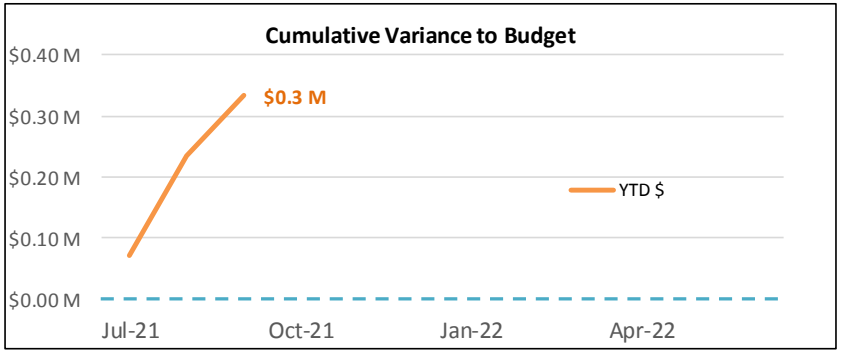


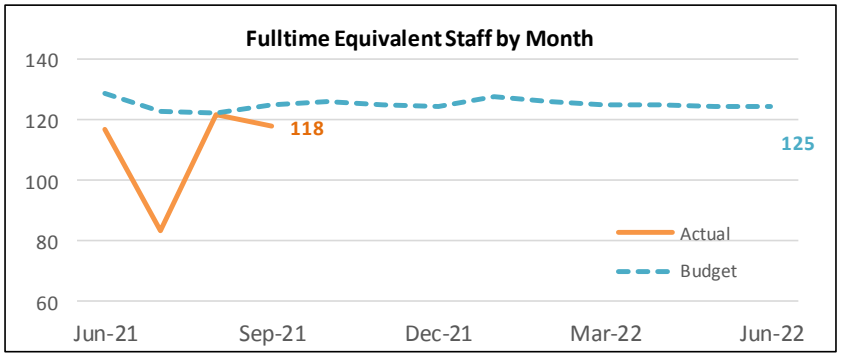
Te Uru Kiriora – Primary, Public and Community Services

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**764**	**15**	**2,278**	**105**	**8,913**
Expenditure					
Personnel	930	49	2,815	81	11,800
Outsourced Personnel	0	0	0	0	0
Sub -Total Personnel	930	49	2,815	81	11,800
Other Outsourced Services	13	1	40	3	168
Clinical Supplies	188	29	521	111	2,499
Infrastructure & Non-Clinical	104	3	294	33	1,299
Total Operating Expenditure	**1,236**	**82**	**3,670**	**228**	**15,766**
Provider Payments	4,908	0	14,763	1	59,058
Corporate Services	104	0	312	0	1,248
Surplus/(Deficit)	**(5,484)**	**97**	**(16,468)**	**333**	**(67,160)**

FTE					
Medical	0.5	1.6	1.3	0.7	2.0
Nursing	76.0	3.9	77.4	2.0	80.0
Allied Health	24.4	2.8	25.0	1.1	26.9
Support	0.0	0.0	0.0	0.0	0.0
Management / Admin	17.1	(1.1)	16.9	(1.0)	16.0
Total FTE	**118.0**	**7.1**	**120.7**	**2.7**	**124.9**



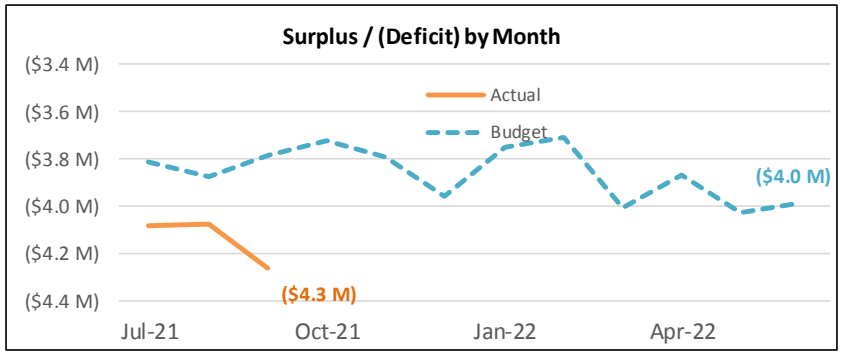


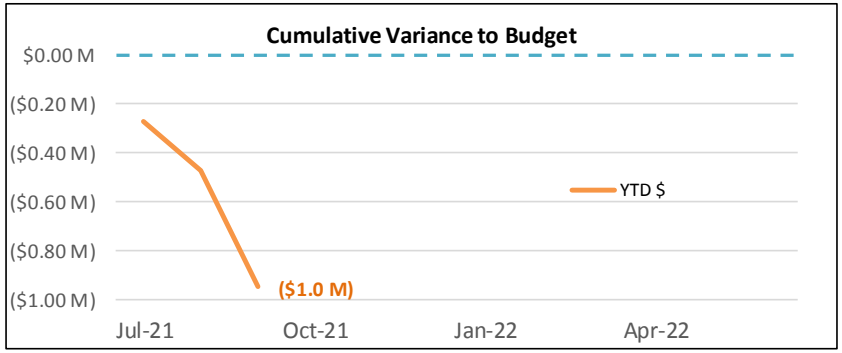


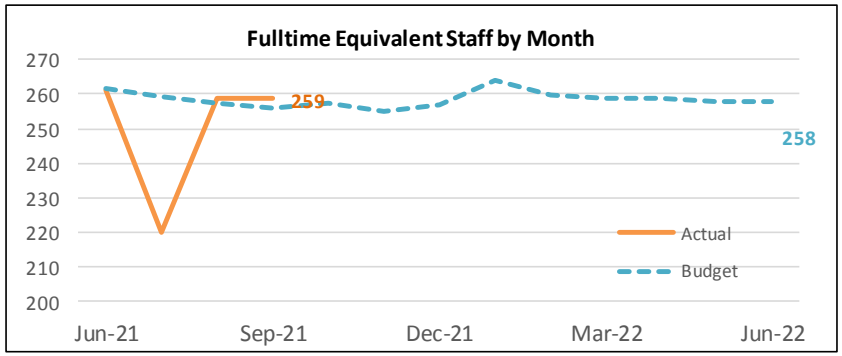
Te Uru Rauhī – Mental Health and Addiction Services

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**81**	**18**	**329**	**150**	**746**
Expenditure					
Personnel	2,269	(23)	6,670	150	27,686
Outsourced Personnel	533	(402)	1,515	(1,129)	1,335
Sub -Total Personnel	2,802	(426)	8,185	(979)	29,020
Other Outsourced Services	68	(14)	182	(22)	438
Clinical Supplies	19	(2)	81	(26)	208
Infrastructure & Non-Clinical	201	(53)	545	(74)	2,350
Total Operating Expenditure	**3,090**	**(495)**	**8,994**	**(1,101)**	**32,017**
Provider Payments	1,239	0	3,718	0	14,872
Corporate Services	14	0	41	0	164
Surplus/(Deficit)	**(4,262)**	**(477)**	**(12,423)**	**(951)**	**(46,307)**

FTE					
Medical	18.5	6.3	17.5	7.3	24.8
Nursing	160.2	(6.1)	160.4	(4.9)	155.0
Allied Health	43.2	(2.7)	45.1	(4.6)	40.5
Support	0.0	0.0	0.0	0.0	0.0
Management / Admin	36.8	(0.2)	35.9	0.8	37.9
Total FTE	**258.7**	**(2.8)**	**258.8**	**(1.4)**	**258.2**



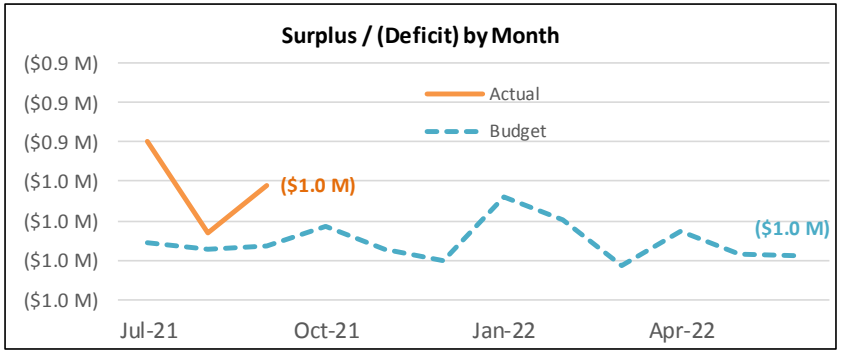


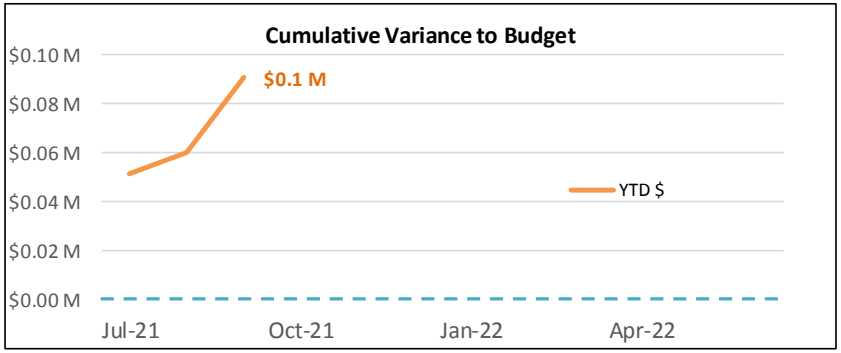


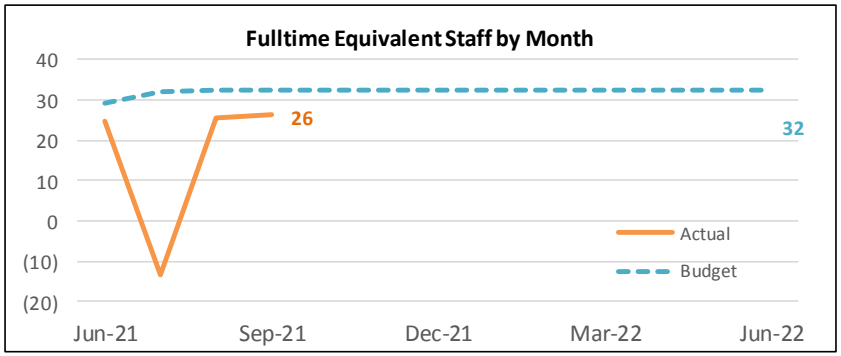
Pae Ora – Paiaka Whaiora Directorate

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**110**	**1**	**330**	**1**	**1,306**
Expenditure					
Personnel	217	34	604	148	2,976
Outsourced Personnel	0	(0)	0	(0)	0
Sub -Total Personnel	218	33	605	148	2,976
Other Outsourced Services	0	2	12	(7)	21
Clinical Supplies	1	(0)	1	0	5
Infrastructure & Non-Clinical	23	(5)	106	(52)	215
Total Operating Expenditure	**241**	**30**	**724**	**89**	**3,218**
Provider Payments	831	0	2,493	0	9,975
Corporate Services	0	0	0	0	0
Surplus/(Deficit)	**(962)**	**31**	**(2,888)**	**91**	**(11,886)**

FTE					
Medical	0.0	0.0	0.0	0.0	0.0
Nursing	7.6	1.1	6.7	2.0	8.7
Allied Health	7.4	3.4	8.1	2.7	10.8
Support	0.0	0.0	0.0	0.0	0.0
Management / Admin	11.2	1.6	11.0	1.8	12.8
Total FTE	**26.2**	**6.1**	**25.7**	**6.5**	**32.2**



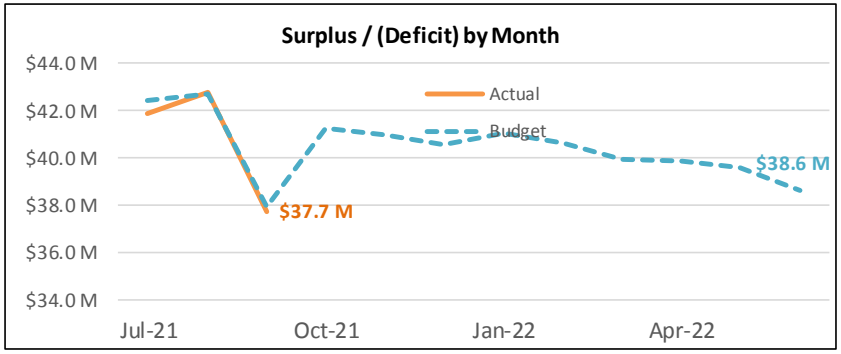


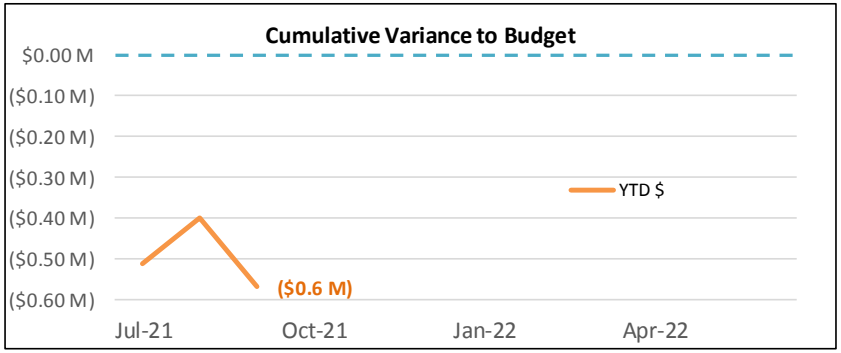


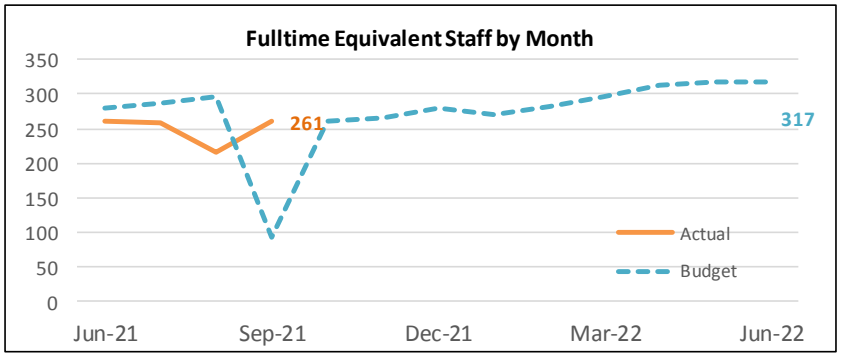
Corporate and Professional Services

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**59,932**	**4,369**	**178,201**	**(1,698)**	**720,367**
Expenditure					
Personnel	2,485	(1,352)	7,339	(1,170)	29,810
Outsourced Personnel	263	(23)	863	(446)	2,177
Sub -Total Personnel	2,748	(1,375)	8,202	(1,617)	31,987
Other Outsourced Services	86	93	483	55	2,141
Clinical Supplies	62	34	237	54	1,155
Infrastructure & Non-Clinical	4,875	499	15,657	1,303	71,295
Total Operating Expenditure	**7,771**	**(748)**	**24,579**	**(205)**	**106,578**
Provider Payments	15,769	(3,802)	35,233	1,324	144,457
Corporate Services	(1,372)	0	(4,115)	0	(16,462)
Surplus/(Deficit)	**37,765**	**(182)**	**122,505**	**(579)**	**485,793**

FTE					
Medical	10.1	(4.4)	9.5	(4.9)	8.3
Nursing	22.4	(147.0)	22.3	(29.3)	25.5
Allied Health	6.6	(7.2)	6.7	(0.5)	6.7
Support	12.2	2.1	13.2	1.2	14.3
Management / Admin	210.0	(11.0)	206.4	1.1	218.7
Total FTE	**261.3**	**(167.4)**	**258.1**	**(32.3)**	**273.5**



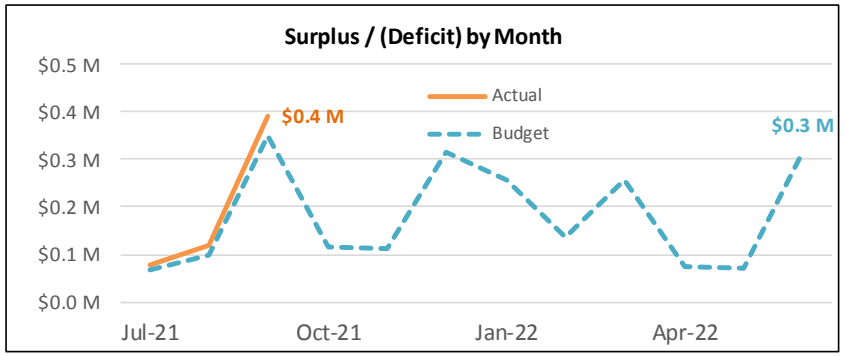


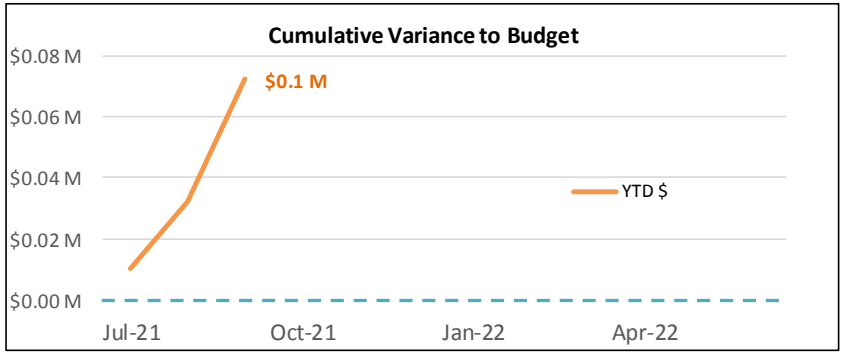


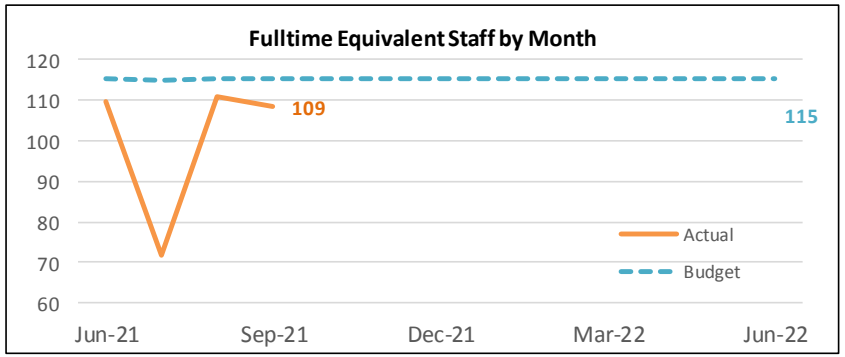
Enable New Zealand

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget
Net Revenue	**2,816**	**(535)**	**9,411**	**(162)**	**38,462**
Expenditure					
Personnel	811	(21)	2,271	101	9,379
Outsourced Personnel	26	2	110	(24)	340
Sub -Total Personnel	837	(19)	2,381	76	9,719
Other Outsourced Services	9	(9)	20	(20)	0
Clinical Supplies	5	0	15	1	61
Infrastructure & Non-Clinical	1,526	601	6,258	177	25,915
Total Operating Expenditure	**2,376**	**574**	**8,675**	**234**	**35,695**
Provider Payments	0	0	0	0	0
Corporate Services	50	0	150	0	600
Surplus/(Deficit)	**390**	**40**	**587**	**72**	**2,168**

FTE					
Medical	0.0	0.0	0.0	0.0	0.0
Nursing	0.0	0.0	0.0	0.0	0.0
Allied Health	22.9	8.2	22.6	8.5	31.1
Support	18.5	(2.5)	18.2	(2.2)	16.0
Management / Admin	67.2	1.1	69.3	(1.0)	68.3
Total FTE	**108.5**	**6.8**	**110.0**	**5.3**	**115.4**







Holidays Act

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget	Life to date Actual Since May 2010
Expenditure						
Personnel	406	11	1,215	36	5,003	48,630
Outsourced Personnel	46	1	145	(2)	569	712
Sub -Total Personnel	452	12	1,360	33	5,572	49,342
Infrastructure & Non-Clinical	34	85	118	238	1,428	1,441
Total Operating Expenditure	**486**	**97**	**1,478**	**272**	**7,000**	**50,783**
Surplus/(Deficit)	**(486)**	**97**	**(1,478)**	**272**	**(7,000)**	**(50,783)**

COVID-19

$000	September 2020 Actual	September 2020 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Budget	Life to date Actual Since March 2020
Net Revenue	**1,835**	**627**	**4,863**	**(2,962)**	**19,929**	**7,903**
Expenditure						
Personnel	805	(1,292)	1,841	840	7,022	13,871
Outsourced Personnel	25	22	122	20	283	256
Sub -Total Personnel	831	(1,270)	1,963	860	7,305	14,127
Other Outsourced Services	478	704	2,056	1,550	9,833	3,518
Clinical Supplies	28	16	71	62	266	164
Infrastructure & Non-Clinical	498	(77)	623	639	2,525	1,829
Total Operating Expenditure	**1,834**	**(626)**	**4,713**	**3,112**	**19,929**	**19,638**
Surplus/(Deficit)	**1**	**1**	**150**	**150**	**0**	**(11,735)**

APPENDIX TWO – CAPITAL EXPENDITURE

($000)	Budget	Approved Budget	Unapproved Budget	Expenditure against this years approvals	Unspent against this years approvals	Expenditure against prior year approvals	Year End Forecast of Approved Expenditure
Externally Funded Items							
SPIRE Project	12,019	12,019	0	617	11,402	0	12,019
Mental Health Redevelopment	14,503	14,503	0	376	14,127	0	14,503
Acute Services Block	1,400	0	1,400	0	0	0	0
Linear Accelerator Replacement	4,330	4,257	73	3,558	699	2	4,259
Planned Care Production Planning	150	150	0	3	147	0	150
SCoPE (Theatre Audit)	600	600	0	0	600	0	600
TOTAL Externally Funded Items	**33,002**	**31,529**	**1,473**	**4,554**	**26,975**	**2**	**31,531**
Major Items							
EDOA / MAPU PODS	5,900	5,900	0	180	5,720	0	5,900
Telemetry & Monitoring System Replacements	3,278	370	2,908	0	370	0	370
Medical Imaging Equipment (incl DSA machine)	3,190	0	3,190	0	0	0	0
Anaesthetic Machine & Monitor Replacements	2,430	2,430	0	0	2,430	0	2,430
End User Compute Replacement Programme	1,650	0	1,650	0	0	0	0
End User Compute Break Fix	350	233	117	0	0	0	0
Computerized tomography (CT) Scanner	1,740	0	1,740	0	0	0	0
Programme of Change Mental Health (FACT)	516	516	0	30	486	0	516
Regional Health Informatics Programme (RHIP)	1,465	1,465	0	291	1,174	0	1,465
Workstations for Cancer Service	1,357	0	1,357	0	0	0	0
Structural & Seismic Upgrades	1,184	0	1,184	0	0	0	0
Fluoroscopy Machine	1,140	1,640	(500)	167	1,473	0	1,640
Bed Replacement Programme	1,000	0	1,000	0	0	0	0
Water Services	1,000	1,800	(800)	0	1,800	0	1,800
Enable NZ IT Programme	800	0	800	0	0	0	0
Chiller Replacements	700	225	475	0	225	70	295
Certificate of Public Use Upgrades	500	32	468	0	32	0	32
Fire System Upgrades	500	0	500	0	0	0	0
Mammography Machines	500	0	500	0	0	0	0
Substation Project	300	0	300	0	0	0	0
Generator Replacement	300	0	300	0	0	0	0
TOTAL Major Items	**29,800**	**14,611**	**15,189**	**668**	**13,710**	**70**	**14,448**
Infrastructure Items							
Medical Air Upgrade & Vacuum Distribution Upgrade	500	650	(150)	0	650	0	650
Motor Control Centre Level A	400	0	400	0	0	0	0
Pressure Rooms (Ward 28 & Children's Ward)	350	0	350	0	0	0	0
Lighting and Egress Upgrades	350	0	350	0	0	0	0
Asset Management & Individual Items less than 251K	2,230	569	1,661	35	534	215	784
TOTAL Infrastructure Items	**3,830**	**1,219**	**2,611**	**35**	**1,184**	**215**	**1,434**

($000)	Budget	Approved Budget	Unapproved Budget	Expenditure against this years approvals	Unspent against this years approvals	Expenditure against prior year approvals	Year End Forecast of Approved Expenditure
Clinical Equipment Items							
Medical Dispense (Rest of Hospital) & Upgrades	804	0	804	0	0	0	0
Echocardiograph	504	0	504	0	0	0	0
Pendants	500	0	500	0	0	0	0
Laparoscopic Tower Replacement Programme	500	500	0	300	200	315	815
Defibrillators	407	0	407	0	0	0	0
SSU Medivators & Washers Replacement	400	0	400	0	0	0	0
Endoscopy & Theatre Scopes	350	94	256	94	0	0	94
Orthovoltage (RCTS Skin Cancer)	300	0	300	0	0	0	0
Urology Ultrasound	300	0	300	0	0	0	0
Clinical Engineering Equipment	300	0	300	0	0	0	0
Covid Expenditure-MOH Funded	0	307	0	137	170	134	441
Patient Simulation Programme	300	0	300	0	0	0	0
Asset Management & Individual Items less than 251K	4,910	377	4,533	75	302	734	1,111
TOTAL Clinical Equipment Items	**9,575**	**1,278**	**8,604**	**606**	**673**	**1,183**	**2,462**
Information Technology Items							
SAN Rebuild	800	0	800	0	0	0	0
Echo Image Vault	700	700	0	2	698	0	700
Minor Works (Network, Firewalls, Servers, UPS)	600	0	600	0	0	0	0
Network Switch Upgrade	500	0	500	0	0	0	0
CITRIX Rebuild (Server Rationalisation)	300	0	300	0	0	0	0
Miya Upgrade	270	0	270	0	0	0	0
Asset Management & Individual Items less than 251K	667	0	667	0	0	360	360
TOTAL Information Technology Items	**3,837**	**700**	**3,137**	**2**	**698**	**360**	**1,060**
TOTAL CAPITAL EXPENDITURE	**80,044**	**49,338**	**31,014**	**5,865**	**43,240**	**1,830**	**50,935**
Software as a Service Items							
Programme of Change Mental Health (FACT)	2,142	2,142	0	4	2,138	0	2,142
Health System Catalogue (NZHP)	1,515	1,515	0	300	1,215	0	1,515
ePrescribing and Administration Planning (Medchart)	800	0	800	0	0	0	0
External Referrals (eTriage, eReferrals)	460	0	460	0	0	0	0
WebPASaaS Implementation	400	0	400	0	0	0	0
Clinical Records Management	400	332	68	56	276	0	332
TOTAL Software as a Service Items	**5,717**	**3,989**	**1,728**	**360**	**3,629**	**0**	**3,989**
TOTAL CAPITAL EXPENDITURE & SaaS	**85,761**	**53,327**	**32,742**	**6,225**	**46,869**	**1,830**	**54,924**

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Is the progress with the Sustainability Plan satisfactory?

To	Board
Author	Judith Catherwood, General Manager, Quality and Innovation
Endorsed by	Finance, Risk and Audit Committee Kathryn Cook, Chief Executive
Date	30 November 2021
Subject	**Sustainability Plan**

RECOMMENDATION

It is recommended that the Board:

- **note** that the Finance, Risk and Audit Committee endorsed this report at its November meeting, for the Board's consideration
- **note** the Sustainability Plan benefits baseline and monitoring dashboard and trend analysis
- **note** the October 2021 report indicates savings of $293,897 year to date
- **approve** the approach and progress made to date on the Sustainability Plan 2020-2023.

Strategic Alignment

The report supports the MidCentral District Health Board's (MDHB) strategy and key enablers 'Stewardship' and 'Innovation'. The Sustainability Plan supports MDHB to become more sustainable through changes to models of care, systems and processes. This ensures best use of resources to meet the healthcare needs and wellbeing of the population in the MDHB region.

1. PURPOSE

To outline progress in the delivery of the Sustainability Plan for 2020-2023 which was originally approved by the Board in August 2020. A refreshed plan for 2021-23 was approved by the Board in July 2021.

This report was endorsed by the Finance, Risk and Audit Committee (FRAC) at its November 2021 meeting.

2. SUSTAINABILITY PLAN STATUS UPDATE

The Sustainability Plan is a three-year plan which outlines the approach MDHB will take to ensure the delivery of enhanced services and financial sustainability. The plan is aligned to the sustainability component of MDHB's Annual Plan. The Sustainability Plan, including a summary of progress is included as Appendix One.

In addition to the core Sustainability Plan, there are several initiatives with dedicated funding from the Ministry of Health (the Ministry) which are included in the report for monitoring purposes only. Reports on these initiatives are also provided to the Ministry. Two new initiatives have received funding from tranche two of the Ministry's Sustainability Fund. These are included in the service improvement initiatives and are estimated to be completed before the end of the 2021/22 financial year.

MDHB resources are targeted at the core initiatives. This is consistent with the plan approved by the Board.

A Sustainability Plan Benefits Framework has been developed and approved by the Board. This is contained in Appendix Two. The collective benefits across all the initiatives in the plan will be tracked via a Sustainability Plan dashboard. The Sustainability Plan dashboard, which is still in development, is in Appendix Three. Trend analysis has been added where data is available. Line graphs will be added to the next report to support this. Target trajectories remain in development for some measures. Work has also commenced to define the measurement of benefits of the Older People's Assessment and Liaison (OPAL) Community Service. These measures will be added to the dashboard in the next report.

The Organisational Leadership Team (OLT) will review the plan in November 2021. OLT will consider any risk to delivery including the capacity to deliver the range of activities currently in plan. The Board will receive this assessment in February 2022.

3. BENEFITS AND SAVINGS

Savings for the 2021/22 year to date are shown in Appendix Four. These will be added to the 2020/21 savings to create a recurrent report on the overall savings plan across the three years. Additional savings will be released from the existing and future initiatives in the plan over the next two years.

The benefits and savings include cash and non-cash releasing savings. The benefit monitoring dashboard will be reviewed continuously, on a month-to-month basis, and reported to the OLT, Finance, Risk and Audit Committee and the Board.

There have been delays in implementing several initiatives over the 2020/21 year, which have impacted the delivery of benefits and savings. COVID-19 resurgence and resilience planning has had an impact on progress in some initiatives as resources have had to be redeployed.

The nurse specialling project is currently under a full review. The project plan is being re-assessed. A new project manager has been allocated to the project to provide a fresh eyes review. An analysis of the available data including TrendCare, establishment and cost drivers of nursing expenditure is underway. This analysis will include benchmarking with other DHBs to assess how MDHB is performing. It will also review the trends in nursing expenditure (including outsourced nursing) against the bed occupancy and acuity of patients over time. A summary will be presented to FRAC at the next meeting.

The Sustainability Plan is expected to achieve $4.7 million in cash releasing savings over the three years to 2023. Initiatives that are behind schedule at present will be delivered in the 2021-2023 period. Cash releasing benefits once delivered will result in a cumulative accrual on a recurrent basis. Additional non-cash releasing benefits are also expected each year. Year Two savings are forecast to be $2.1 million. When Year One savings are added to this forecast, MDHB expects to save $2.65 million over the course of 2021/22. Year Three savings are forecast to be an additional $2.15 million.

Appendices

Appendix One	Sustainability Plan 2020-2023
Appendix Two	Sustainability Plan Benefits Framework
Appendix Three	Sustainability Plan Dashboard
Appendix Four	Sustainability Plan Savings

Appendix One – Sustainability Plan 2020-2023

Service Improvement

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
Mental Health – community model of care (Te Matapuna o te Ora)	Design and implement a new community model of care as our response to the Inquiry	Scott Ambridge	Implementation			Recruitment to new roles is nearing completion, partnering with Iwi in Horowhenau to co-design service model, professional development programme in development, digital enablers/phone system design underway	Completed recruitment processes, development of staff engagement plan, finalise policies and procedures, continue connected care record development	Improved access, safety, experience, choice, staff wellbeing, self-cares / resilience, reduced inequity for Māori, whanau focused models	Q4 2021/22
OPAL community service	Implement the OPAL community service across the district	Syed Zaman	Implementation			OPAL community planning underway. Project manager appointed. Working groups underway	Confirm benefits measurement plan. Community rehabilitation model of care to be completed	Reduced LOS, bed occupancy, re-presentations, improved experience	Q4 2021/22
Horowhenua clinical service plan	Design and plan future clinical services for the locality	Deborah Davies	Implementation	✓		Contractor continuing data modelling, work has commenced on primary care access and service model	Ongoing clinical and Maori/Iwi engagement, workshops planned for early 2022	Plan to support increasing community health needs in place	Q3 2021/22
Outpatient admin redesign	Review and redesign outpatient administration service model	Judith Catherwood	Implementation	✓		Working group agreed final stages of project plan. Implementation underway	Cultural responsiveness and consumer experience education delivery, finalise access and booking policy for consultation and implementation	Improved experience, safety, reduced services not engaged	Q4 2021/22
Outpatient e-referral/triage	Implement electronic referrals and triage across the enterprise	Lyn Horgan	Implementation			Business case approved by MDHB Board. Requirements are complete. Procurement process underway	Procurement process will be complete by end of February 2022. Implementation planning continues	Improved ESPI compliance, improved patient safety, improved clinician satisfaction	Q4 2021/22
Outpatient e – transcription and digital mail	Implement voice recognition tools and digital mailhouse	Lyn Horgan	Implementation			Business case approved by MDHB Board. Engagement with Manawhenua Hauora.	Continue work on procurement plan. Design of new processes will commence. Complete mailhouse business case refresh	Reduced expenditure and FTE, rapid electronic communications, improved clinician satisfaction	Q4 2021/22
Outpatient Navigation co-design	Co-design a model of navigation support to enable improved access to outpatient services	Judith Catherwood	Implementation	✓		Co-design process underway. Working group guiding the research to guide model of care and improvement plan	Continue research with external design expertise, finalise model of care and next steps	Improved access, safety, outcomes, reduced inequity for Māori and others, reduced services not engaged	Q2 2021/22
Telehealth	Implement telehealth models of care across speciality services	Claire Hardie	Implementation	✓		Procurement plan for new equipment underway. Pilots continue with early adopter services. Business process changes continue to be progressed including consumer information	Procurement of new digital hardware is behind schedule but is being progressed. Complete consumer information materials. Complete evaluation framework	Improved access, experience, convenience, safety and reduced travel for consumers	Q4 2021/22
Community infusion service	Develop a model of care to support our community in receiving services closer to home	Lyn Horgan	Procurement	✓		COVID-19 has impacted project delivery. Community delivery options including available space is under review. Three community sites are being considered.	Complete procurement process and commence implementation plan. Develop evaluation framework	Improved access to services, improved experience, improved facility utilisation	Q3 2021/22
Production planning	Enhance production planning expertise and capacity to support service delivery and budgeting approach	Darryl Ratana	Implementation	✓		Recruitment to additional capacity remains challenging in current environment. Production planning continuing within existing FTE. Currently working on inpatient model, surgical and cardiology production plan	Finalise recruitment and continue work programme	Improved accuracy of budget planning to support effective service delivery in elective and acute services	Q2 2021/22
First 1000 days (new)	Development of an intersectorial strategy to support the first 1000 days for tamariki across the district	Sarah Fenwick	Scoping	✓		Request for proposal released to secure external expertise to guide the project.	Select expert resources and progress project plan	Quality strategy and implementation plan, Iwi and whanau satisfaction, long term outcomes for tamariki improve	Q4 2021/22
Clinical Services Plan for Medical Imaging Diagnostics (new)	Review medical imaging services across the MDHB district/Kapiti coast and improve value and accessibility for Maori and other populations	Lyn Horgan	Scoping	✓		Request for proposal released to secure external expertise to guide the project. Evaluation of responses in progress	Select expert resources and progress project plan	Strategy and business case developed to support enhanced imaging services, long term improved consumer experience, access to imaging services, reduced services not engaged	Q4 2021/22

RAG Key: **RED:** Significant Issues – the timelines and budget will be impacted **AMBER:** Some Issues – chance of impact on timelines and budget **GREEN:** On Track – no issues expected to impact on timelines or budget

Workforce

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
Skill mix	Review clinical workforce mix across all clinical services	Celina Eves	Implementation			Review of allied health skill mix is underway. Progress has been impacted by COVID-19 resurgence. Measurement of skill mix change is focussed on future shape of the workforce.	Commence the next phase of workforce reviews. Revised schedule of work given delays due to COVID-19 planning	Reduced cost per bed day, reduced cost per CWD and reduced cost per FTE	Q4 2021/22
Reduce dependency on one to one nurse specialing	Improving ordering and clinical practices to support quality care and reduction in use of specialing	Celina Eves	Implementation			Project review underway. Detailed analysis of nursing costs, workforce deployment and trendcare data underway, including benchmarking to further assess options for improvement. Digital tool is ready to be beta tested.	Complete benefits tracking system and approval process. Complete detailed analysis on workforce use and triangulate results to inform next steps. Finalise project review and confirm next steps.	Reduced use of outsourced specialing expenditure	Q2 2021/22
Workforce Wellbeing	Implement workforce wellbeing initiatives to support all workforce groups	Keyur Anjaria	Implementation			Bradford score reporting underway. Wellbeing Index implementation plan in progress. Education for pilot group completed. Enterprise wide plan in development	Complete enterprise wide implementation plan	Improved workforce wellbeing, reduced sick leave, improved engagement	Q4 2021/22

Savings and Revenue

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
Equipment Library	Implement a central hospital equipment library	Neil Wanden	Implementation			Equipment inventory for priority items in progress. Resourcing this project is a challenge due to other priorities and demands	Recruitment following a change management process. Asset list to be verified.	Reduce expenditure, improved access to equipment, improved space utilisation	Q3 2021/22
Short-term loan equipment	Implement new procurement and distribution pathways for community equipment	Gabrielle Scott	Implementation			Financial analysis has been completed indicating current cost neutral impact. Non-financial benefits include improved delivery and installation leading to improved consumer experience	Monitor financial and non-financial benefits and consumer experience. Plan for phase two in 2022/23	Reduced expenditure, improved consumer and staff experience	Q2 2021/22
Clinical documentation and coding	Clinical documentation, coding and CWD capture	Lyn Horgan	Implementation			PICQ deployment underway. Review of e-discharge tool with clinical leads. Engagement with Australasian documentation improvement agency underway	Complete PICQ tool implementation. Evaluate benefits and plan any further steps to support improvement	Increased revenue, improved documentation and patient safety, improved relative stay index	Q1 2021/22

Digital

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
Digitisation of Clinical Records	Implement a digital scanned clinical record	Neil Wanden	Implementation			Recruitment to roles and purchase of equipment to support scanning is in progress	Establish the scanning bureaux	Reduced FTE and expenditure on storage Improved clinical and administrative team satisfaction	Q4 2021/22
E – leave management	Implement an electronic leave approval and capture system	Keyur Anjaria	Scoping			Minimum viable product development completed. Beta testing of new tool about to commence after delay with vendor	Beta test will be completed. Enterprise implementation plan will be developed	Improve leave capture, reduced paper	Q2 2021/22
E - Recruitment System	Implement electronic recruitment system for all workforce groups	Keyur Anjaria	Implementation			Lite version of e-recruitment tool was deployed in October and being used by key recruitment roles	Evaluation of lite version, next steps will be to assess full system implementation	Reduction in time to recruit, reduction in paper, improved onboarding, improved productivity of people leaders	Q2 2021/22
ScOPe	Audit and theatre management tool	Lyn Horgan	Scoping	✓		Contract is being signed to advance system to implementation. Workshops held with surgical and medical specialities in tranche one implementation phase	Implementation plan continues	Improved clinician satisfaction, improved theatre utilisation, improved safety and clinical outcomes	Q3 2021/22

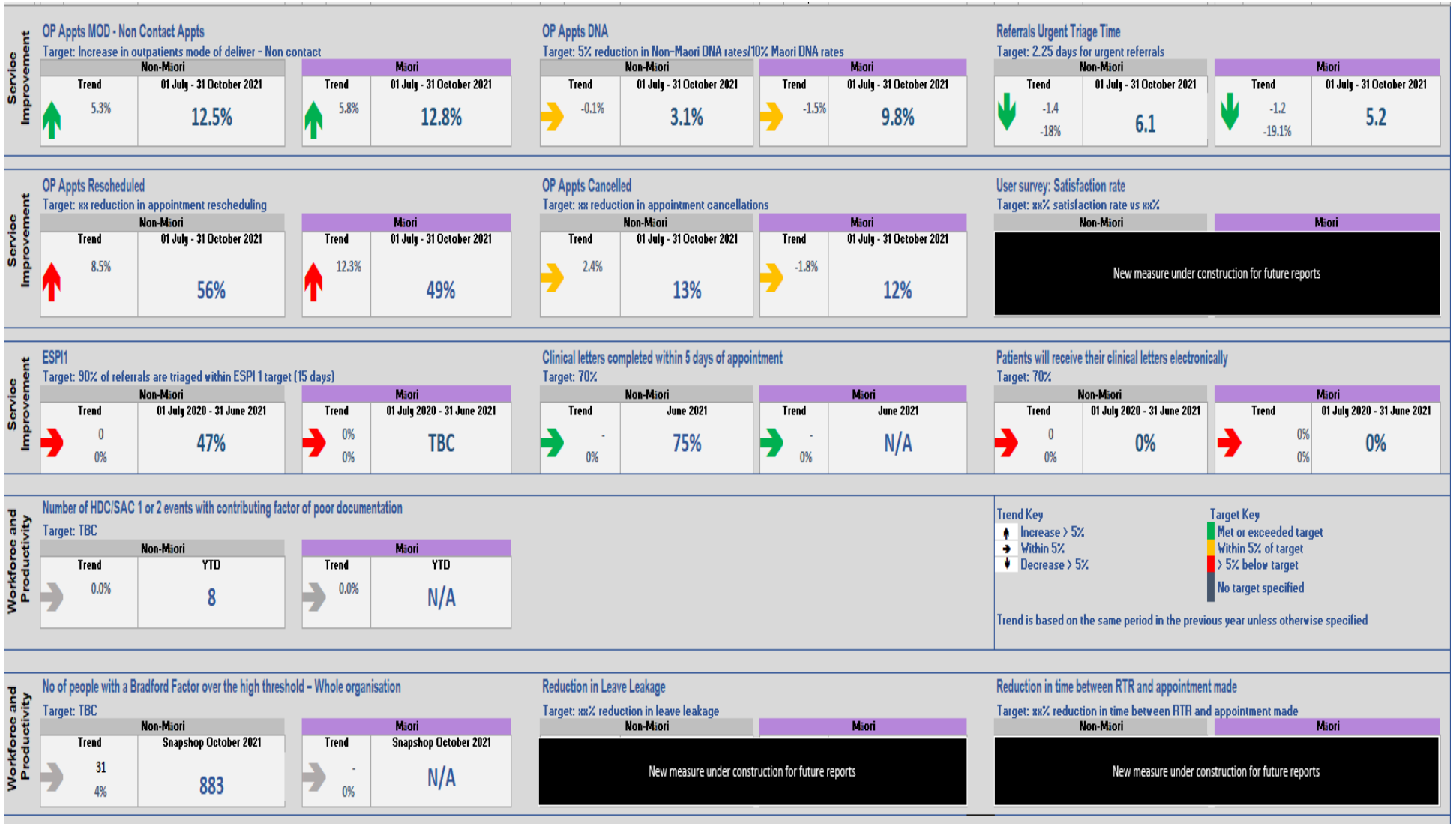
RAG Key: **RED**: Significant Issues – the timelines and budget will be impacted **AMBER:** Some Issues – chance of impact on timelines and budget **GREEN:** On Track – no issues expected to impact on timelines or budget

Appendix Two Sustainability Plan Benefits Framework

Sustainability Plan 2020/23 Benefits Framework

Quality Domains	Supporting the Delivery of The Quality Agenda						Quality Domains
	Programme Purpose	Better Outcomes	Improved Consumer Experience	Improved Workforce Experience	Affordable Healthcare	Savings	
		Sustainability Plan Benefits					
Safe Haumaru	**Service Improvement** – improving services for our community	Improved access to Kaupapa Maori MH&A services	Improved consumer experience survey results	Timely delivery of clinical correspondence via digital technology	Reduced LOS and readmission rates (OPAL and STAR)	$2.05M	Timely Wā tōtika
Effective Whaihua	**Workforce** – improving workforce wellbeing and engagement	Improved workforce utilisation (administration and clinical)	Reduced DNA rates and inequity for Māori	Improved wellbeing index rates	Reduced sick leave	$1.8M	Efficient Māia
	Savings and Revenue – improving efficiency	Reduced utilisation of outsourced nursing	Reduced rescheduling/ cancellation rates and inequity for Māori	Skill mix changes to establishment	Reduced expenditure (equipment, blood wastage, fleet)	$0.35M	
Consumer-centred Arotahi ki te kiritaki	**Digital** – improving accessibility, visualisation, productivity and collaboration	Improved compliance with ESPI 1 – faster clinical triage and response	Faster access to clinical advice	Improved speed to recruit	Reduced paper, postage and consumables	$0.5M Total $4.7M	Equitable Kia tōkeke ai
		Equity for Māori	**Digital**		**Workforce**		

Appendix Three – Sustainability Plan Dashboard



Appendix Four - Sustainability Plan Savings

					Oct 21 YTD $			
Activity	Project name	Measure	Cash Releasing	RAG	Target Savings YTD	Actual Savings YTD	% to YTD Target	Annual Target
Service Improvement	Mental Health Community Models of Care - STAR PN Realignment	Cost of Star 1 & 2	✓		$66,667	$66,000	99%	$200,000
	Mental Health Community Models of Care	FACT implementation	✓		$0	$0	0%	$300,000
	Outpatients – transcription and e communications	Paper consumables and postage spend	✓		$0	$0	0%	$300,000
	Long Term Conditions Transformation	Contract changes	✓		$100,000	$100,000	100%	$300,000
	Enhanced Stewardship of Blood	Units of Blood Wastage	✓		$33,333	$1,739	5%	$100,000
Workforce and Productivity Improvement	Reducing dependency on one to one nurse specialing	Outsourced Specialing Hours	✓		$37,500	$122,437	326%	$500,000
	Skillmix	Position changes	✓		$25,000	$0	0%	$300,000
	Workforce wellbeing	Sick leave FTE on rostered wards	✓		$25,000	$0	0%	$300,000
Savings and Revenue	Fleet Consolidation and management	No fleet vehicles replaced	✓		$3,086	$3,681	119%	$50,000
	Clinical Equiptment Library	Equipment spend	✓		$33,333	$0	0%	$100,000
	Short Term Loan Equipment Management	Equipment spend	✓		$20,000	$0	0%	$100,000
	Clinical documentation, coding and case weight capture	CWD per discharge	✓		$20,000	$0	0%	$100,000
				Total	**$363,920**	**$293,857**	**81%**	**$2,650,000**

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is progress being made as expected?
- Are there any specific risks that need to be considered, and are the actions sufficient to mitigate or manage?

To	Board
Author	Steve Miller, Chief Digital Officer
Endorsed by	Kathryn Cook, Chief Executive
Date	26 November 2021
Subject	**Te Awa Update – Digital Services Work Programme**

RECOMMENDATION

It is recommended that the Board:

- **note** the Digital Services work programme covering planned work for the 2021/22 financial year
- **note** progress since the last reporting period
- **note** the national and regional activity that may impact the planned work programme.

Strategic Alignment

This report is aligned to the MidCentral District Health Board's (MDHB) digital strategy, Te Awa.

1. PURPOSE

To provide an update on the priority projects to be delivered across various MDHB business owners, reported by Digital Services, and covering the period up to 26 November 2022.

2. BACKGROUND

In 2019, Te Awa was endorsed by the Board, the Central Primary Health Organisation (PHO), Manawhenua Hauora and the Clinical and Consumer Councils. Te Awa is aimed at enabling the delivery of improved healthcare outcomes across key performance areas for the district over a period of five years. In support of this, clinical and digital modernisation projects have been prioritised for the 2021/22 financial year.

3. THE DIGITAL WORK PROGRAMME

Appendix One provides a summary of the work programme for the 2021/22 financial year.

Since the last reporting period:

- The Mosaiq as a Service and Next Generation Computing business cases have been endorsed by the Finance, Risk and Audit Committee (FRAC) and are now tabled for Board approval.
- MDHB has contributed to an EY Cyber Assessment being undertaken across all DHBs and the Ministry of Health (the Ministry). A report on the findings is expected soon.
- Digital Transcription, Digital Communication, and Electronic Referral/Triage and Intelligent Scheduling Request for Proposals have been, or are soon to be, issued to the market.
- The Regional Common Patient Administration System (webPAS) as a Service business case is now being progressed by both Wairarapa and Whanganui DHBs for their respective FRAC and Board consideration. Upon approval, the Director-General of Health's approval will be sought. This will allow Technical Advisory Services (TAS), on behalf of the DHBs, to execute commercial vendor arrangements for this initiative to be progressed.

4. REGIONAL AND NATIONAL ACTIVITIES

4.1. Regional

Regional collaboration is occurring on the Electronic Referral/Triage and Intelligent Scheduling Request for Proposal. Work has commenced on the development of a Regional Applications Roadmap to identify further opportunities for service and resource alignment. This will include simplifying the region's Data and Digital Governance.

4.2. National

The Minister of Health is expected to make an announcement soon on the outcome of Cabinet's decision regarding the $400m Budget 2021 Digital and Data allocation health data and digital initiatives.

4.3. Microsoft G2021 Agreement/Strategic Roadmap

A single national agreement has been formalised with Microsoft, by the Ministry of Health, on behalf of all DHBs and all Sector Shared Service Agencies. This agreement formalises new Enterprise Licensing, Unified Support and License Solution Partner arrangements for the sector for the next three years. It includes substantial Azure discounts, in return for minimum sector commitments, and a strategic roadmap to support maximising the value of the sector investment in Microsoft Technologies.

4.4. HIRA (previously National Health Information Platform)

Transition Unit Activity

The Digital and Data programme is advancing work in across five key areas:

- Day 1 ICT for Corporate Health NZ
- Digital and Data for Māori Health Authority
- Digital and Data for Health New Zealand
- DHB and Shared Service Agency Day 1 Readiness
- People and Change.

An Interim NZ Health Plan is to be developed, and a Digital and Data working group has been assembled to support this.

Appendix One: Digital Work Programme as at 26 November 2021

Clinical and Business Priority Projects – underway

INITIATIVE	OVERVIEW	EXECUTIVE SPONSOR	SENIOR USER(S)	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	APPROVED DISCOVERY BUDGET	TARGET COMPLETION
Clinical Communication	Implementation of a safe and secure environment to enable clinicians to communicate on patient matters. This is expected to replace the aging paging system, WhatsAPP and other insecure mediums that clinicians are currently employing.	Lyn Horgan	TBC	Reviewed vendor (Alicidion) offering Business case and procurement plan to be developed	DRAFT	Initial Scoping	On track	TBD	Q4 FY21/22
eRecruit	Digital platform for the end-to-end recruitment process within MDHB	Keyur Anjaria	TBC	Pilot of Kiwi Health Jobs application underway	If pilot is successful a business case for a full implementation will be developed in April 2022	Initial Scoping	Delay in timeline given decision to pilot the application	Discovery $37.473k	Q4 FY21/22
Oncology Information System (Mosaiq aaS)	Upgrade of the Oncology Information System which supports Regional Cancer Treatment Service in the delivery of radiation therapy and systemic therapy treatment for cancer patients.	Sarah Fenwick	Aaron Philips	Business case endorsed by OLT. With FRAC for endorsement 30 November, and Board consideration 14 December	Project initiated and project plan developed	BC Approval	Slight delays in securing access to key personnel has impacted on the timeline	Discovery $41.8k Business Case $3.38m	Target to Commence Implementation Q2 FY21/22
Computer Physician Order Entry and eSign Off	Electronic Order Entry and Results Sign Off	Lyn Horgan	Kelvin Billinghurst Chris Daynes	Business case endorsed by OLT and FRAC. Board approved.	Project initiated and project plan developed	Initiation	On track	Discovery $85.536k Business Case $1.7m	Target to Commence Implementation Q2 FY21/22
ePrescribing	Electronic and administrative system for the prescribing of medications to inpatients and the accurate availability of information to clinicians around current prescriptions	Lyn Horgan	Lorraine Welman Kelvin Billinghurst	Business case endorsed by OLT and FRAC. Board approved. Business case submitted to Ministry for review	Ministry approval obtained	Initiation	On track	Discovery $121.318k Business Case $4.4m	Target to Commence Implementation Q4 FY21/22

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Clinical and Business Priority Projects – underway (continued)

INITIATIVE	OVERVIEW	EXECUTIVE SPONSOR	SENIOR USER(S)	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	APPROVED BUDGET	TARGET COMPLETION
Surgical Audit	Theatre management and surgical audit system (SCOPE)	Lyn Horgan	Chris Simpson Chris Daynes Alberto Ramirez-Rodriguez	Vendor contract finalised	Project Initiated and project plan developed.	Initiation	On Track	Ministry Planned Care Funding	Target to Commence Implementation Q3 FY21/22
eTriage	Electronic triage of referrals across outpatients and Allied Health	Lyn Horgan	Hagay Weinberg Tim Dunn	Business case approved by the Board Sourcing underway RFP to the market	Progress on RFP evaluation of responses 17 January 2022	Initiation	On track	Discovery - $116.171k Business case $1.7m	Target to Commence Implementation Q3 FY21/22
eReferrals	Electronic receiving of referrals across outpatients and Allied Health	Lyn Horgan	Hagay Weinberg Tim Dunn	Business case approved by the Board Sourcing underway RFP to the market	Progress on RFP evaluation of responses 17 January 2022	Initiation	On track	Discovery - $116.171k Business case $1.7m	Target to Commence Implementation Q4 FY21/22
eTranscription and Outpatient Communications	Digitise the process for creating and distributing clinical letters, mail house and digital transcription	Lyn Horgan	Hagay Weinberg Json Pryor Robyn Shaw Nadar Fattah	Business case approved by the Board Sourcing underway RFP to the market	Progress on RFP evaluation of responses 17 January 2022	Initiation	On track	Discovery - $65.028k Business case $1.86m	Target to Commence Implementation Q3 FY21/22
High Acuity Anaesthesia Monitors	Implement infrastructure to support the deployment of MindRay High Acuity Anaesthesia Monitors	Lyn Horgan	Chris Simpson Kevin Saunders Sathish Shanmuganathan Ben Duff	Business case approved Concluding contract negotiations Equipment order placed and project mobilised Network switching order placed	Completion expected mid-December 2021	Initiation	On track	Business case $6m Digital Allocation Capex $47.600k Opex $42.553k	Target to complete implementation End of Q2 FY21/22
eScheduling	Electronic clinic scheduling pilot	Lyn Horgan	Quentin King Chris Simpson Karen Nistor	On hold given clinical reprioritisation, but Urology still wishes to proceed to support sub-regional service provision to Whanganui and Wairarapa DHBs.	Part of referral and triage RFP process.	Initiation	**On Hold**	CDO DFA $243.195k	On hold

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Clinical and Business Priority Projects – underway (continued)

INITIATIVE	OVERVIEW	EXECUTIVE SPONSOR	SENIOR USER(S)	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	APPROVED BUDGET	TARGET COMPLETION
Echo Imaging Vault	Replacement/Upgrade of aged and at capacity, Cardiology Echo Image Vault system (EIV)	Lyn Horgan	Dave Tang Amanda Drifill	All equipment, cloud deployments and regional integration underway. Image migration underway.	Planned go live 9 November 2021	Implementation	Slight delay but not material	Business case $700k	Target to complete implementation End of Q2 FY21/22
Digitisation of Clinical Records	The electronic retrieval of patient notes and records	Neil Wanden	Chis Daynes	Integration requirements submitted to the region. CTAS cannot not schedule the change until early 2022. New PCs for the scanning area ordered. Delays in delivery of integration between Clinical Portal and UpSol solution given Orion Health resource constraints – ETD March 2022	Key milestones achieved, in absence of integration between Clinical Portal and UpSol solution	Implementation	Project slippage - Delays in delivery of integration between Clinical Portal and UpSol solution given Orion Health resource constraints – ETD March 2022	Business case $300k CEO approved	Target to complete implementation End of Q3 FY21/22
Connected Care	Mental Health shared care record to support new model of care.	Scott Ambridge	Brent Cooper	Contract negotiation are progressing. Iteration 0 is underway, with cloud infrastructure being deployed. First delivery of computer hardware has been delivered.	Telephony demonstration Deploy computer hardware Begin iteration 1: Configuration.	Implementation	Issues with Microsoft licencing and an Integration Platform as a service will result in slippage	Business case $1.26m Board approved	Q4 FY21/22
Advanced Hospital Analytics (SystemView)	Electronic surgical capacity viewer	Lyn Horgan	Robin Shaw	Meetings held with Ministry and other DHBs considering a regional implementation of the tool. System architecture, in particular the relationship between the database and the application is being reviewed.	Project on hold until the vendor resolves the database issues. Ministry guidance in approach to project given they are driving it.	Implementation	No agreed timeline as yet with MoH	CDO DFA $228.521k	

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Digital Modernisation Priorities (Digital Services Budget 2021/22)

INITIATIVE	OVERVIEW	EXECUTIVE SPONSOR	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	APPROVED BUDGET	TARGET COMPLETION
Network Switch Upgrade	64% of MDHB's network switches are out of support and at risk of failure. The network switches move computer traffic around and aggregate and disaggregate traffic to and from end users. The failure of the network switch infrastructure would result in catastrophic failure to the computer network	Steve Miller	Pending a discovery memo	Discovery funding approved and project mobilised	Initial Scoping	On Track	Not yet allocated	Q4 FY21/22
Telehealth	Integration of Zoom to WebPASaaS to enable the automated booking of a zoom session for patient consultation	Steve Miller	Discovery requirements complete and approved Placed on hold by the Telehealth Committee	On Hold	Initial Scoping	**On Hold**	CDO DFA $120k	Q4 FY21/22
Miya Upgrade	Upgrade the Miya Hospital Operations Centre application from on premise to cloud to enable improved serviceability and vendor support	Steve Miller	Reviewed vendor offering and awaiting revised pricing proposal	Prepare a memo for discovery funding to inform business case	Initial Scoping	On Track	Not yet allocated	Q3 FY21/22
Core Network SAN	Remediation SAN (Storage Area Network) capacity and migrating workloads to Amazon Web Services	Steve Miller	Discovery requirements complete and approved Assistance for discovery via procurement is under action	Complete discovery and design to inform business case	Initial Scoping	On Track	Discovery $151.68k	Q4 FY21/22

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Digital Modernisation Priorities (Business as Usual Budget 2021/22) – continued

INITIATIVE	OVERVIEW	EXECUTIVE SPONSOR	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	APPROVED BUDGET	TARGET COMPLETION
Netscaler Rebuild	Netscaler technology supports MDHB security and network addressing. The current environment is out of support and needs to be upgraded	Steve Miller	Pending a discovery memo	Discovery funding approved and project mobilised	Initial Scoping	On Track	Not yet allocated	Q4 FY21/22
CITRIX Rebuild	Due to organic growth the CITRIX farm is now out of date and unable to be supported. It is in need of a cloud based rebuild	Steve Miller	Pending a discovery memo	Discovery funding approved and project mobilised	Initial Scoping	On Track	Not yet allocated	Q4 FY21/22
Next Generation Computing (previously End User Compute Upgrade)	Replacement of legacy End User Compute (EUC) assets, including Windows 7 based desktops. These legacy products represent a security risk to MDHB.	Steve Miller	End user compute fleet analysis progressing Business case finalised	Complete business case OLT and FRAC Business case endorsement for Board consideration	BC Approval	On Track	Discovery $171k	Q4 FY21/22
Regional Common Patient Administration System (webPAS as a Service)	The development of the Patient Administration System in the cloud. To mitigate pending databases going out of support and improving disaster recovery and availability	Steve Miller	MDHB FRAC endorsement CEO and Board approval MWH Consultation commenced. Wairarapa and Whanganui DHB FRAC and Board approvals underway	Ministry DDG approval and TAS Contract Execution completed	BC Approval	Delays in BC approvals will impact transition timeline	Discovery phase funded from Regional DS budget	Q3 FY21/22
Zoom Rooms	Zoom Room rollout to support TeleHealth to prioritised business areas	Steve Miller	Zoom 1&2 completed and capitalised. Tranche 1 of this phase is to deploy 2 zoom rooms into the education centre. Cabling is completed and hardware deployed	Complete requirements gathering for other sites.	Implementation	On Track	CDO DFA $107k	Q2 FY21/22
WorkFlows and Fax Replacement	Replacement and automation of simple processes to reduce the reliance on fax machines to enable the decommissioning of insecure fax technology	Steve Miller	Vendor challenges have resulted in delays to the deployment of these tools. Discussions are underway to accelerate delivery.	Agreement on an accelerated delivery	Implementation	Vendor Delays, escalated	CDO DFA $111.61k	Q4 FY21/22

/

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Completed Digital Modernisation Priorities (Business as Usual Budget 2021/22)

INITIATIVE	OVERVIEW	EXECUTIVE SPONSOR	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	APPROVED BUDGET	TARGET COMPLETION
Cellular Coverage in Theatre	Cellular coverage in Theatre is poor at best. The implementation of additional aerials is expected to resolve these issues	Steve Miller	Complete		Completed	Complete	$100.017k Completed under budget	Q2 FY21/22
Exchange Online (EOL)	Migration on premise exchange to Exchange Online	Steve Miller	Closing		Completed	Complete	$472k Completed under budget	Q1 FY21/22
Multifactor Authentication	Mobile security for remote working	Steve Miller	Closing		Completed	Complete	$144k Completed under budget	Q1 FY21/22
Office 2016	Deploy Microsoft Office 2016 to get all users in MDHB to a common Office application to enable progressing to Office 365	Steve Miller	Closing		Completed	Complete	$93k Completed under budget	Q1 FY21/22

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the Board consider that this exception report, with the summary report on Stellar, provide sufficient information in support of its governance functions for monitoring the non-financial performance and progress on implementation of the MidCentral District Health Board's Annual Plan deliverables?

To	Board
Author	Jess Long, Advisor, Planning and Accountability, Strategy, Planning and Performance
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance
Date	29 November 2021
Subject	**Non-Financial Performance Measures – Report for Quarter One, 2021/22**

RECOMMENDATION

It is recommended that the Board:

- **note** the progress and performance for the first quarter of 2021/22 against its commitments and accountabilities to Government as identified in the 2021/22 Annual Plan and the Non-financial Monitoring Framework and Performance Measures for DHBs
- **note** the Ministry of Health's summary report for Quarter One 2021/22 is available on the Stellar platform
- **endorse** the mitigation activities in place for those performance measures or deliverables that were not meeting expectations for Quarter One.

Strategic Alignment

This report addresses the Government's planning priorities and DHB accountabilities as outlined in MidCentral DHB's 2021/22 Annual Plan and the Non-financial Monitoring Framework and Performance Measures for DHBs. It is aligned to the DHB's strategy and key enabler 'Stewardship' and discusses an aspect of effective governance.

1. PURPOSE

To provide the Board with a summary of MidCentral District Health Board's (MDHB's) progress and performance to the end of September 2021 (Quarter One), against its commitments and accountabilities to Government as identified in the 2021/22 Annual Plan and the Non-financial Monitoring Framework and Performance Measures for DHBs.

The Board is asked to consider this information and note the mitigations in place for those areas of performance where expectations were not met, or where the deliverable has been assessed as partially achieved this quarter.

2. SUMMARY

The reporting obligations of the DHB for Quarter One have been submitted to the Ministry of Health (the Ministry) as required under the DHB Non-financial Monitoring Framework and Performance Measures for 2021/22. Overall, MDHB is meeting or partially meeting the expectations.

In Quarter One, there were 45 headline deliverables (with 60 measures). The Ministry has assessed MDHB's performance based on the specified achievement scale or criteria for each deliverable. Forty-nine percent of the deliverables were rated as 'achieved' and 33 percent were 'partially achieved' with adequate mitigations or improvement actions in place.

Appendix One to this report provides a table of the performance measures and Annual Plan deliverables submitted for Quarter One, together with the Ministry's final rating received for each.

A summary report of all the deliverables, performance measures and the Annual Plan status updates for Quarter One can be found on Stellar – *MDHB/Board/Reports and Documents/2021 Documents/NFPM Q1 2021/22 Summary*. It includes time series graphs of the performance measures against the target and data by ethnicity wherever possible. The Ministry's assessment ratings for each quarter throughout the year are also noted, giving an indication of progress over time.

The summary report includes a summary of the 2021/22 Annual Plan Status Update Reports against the planned activities required for each of the Government's planning priorities. It provides a brief outline of the remedial actions to improve performance where the deliverable has not been met or the milestone not achieved by the expected date; where there is a deterioration in performance; or the performance target has not been attained.

Each service or directorate provides more detail on their performance in their respective reports to the Health and Disability Advisory Committee, including the six-monthly 'deep dive' reports on the suite of Māori health indicators, where relevant.

3. BACKGROUND

Each quarter, District Health Boards (DHBs) provide detailed reporting to the Ministry on the various activities and performance measures outlined in their annual plans, including the deliverables of the Non-financial Monitoring Framework and Performance Measures. The reports include progress on the annual System Level Measures (SLM) Improvement Plan and the required status update reports against the activities and milestones as detailed in the 2020/21 Annual Plan to progress the Government's priorities. The reporting requirements also include other accountabilities such as the Crown Funding Agreement (CFA) variation reports.

The performance measures and Annual Plan activities have all been aligned to the Government's health and disability system priorities for the year, which are:

- Improving child wellbeing (CW)
- Improving mental wellbeing (MH)
- Improving wellbeing through prevention (PV)
- Better population health outcomes supported by strong and equitable health and disability system (SS)
- Better population health outcomes supported by primary health care (PH)
- Improving sustainability
- Giving practical effect to He Korowai Oranga.

Most of the performance measures have national targets and each deliverable has prescribed expectations and criteria that are used by the Ministry for assessing and rating the performance of DHBs. These are detailed in the performance monitoring framework. Not all performance measures or deliverables are reported each quarter; some are six-monthly (Quarters Two and Four) and a few are reported annually.

Some deliverables, such as the Planned Care Measurement Suite (SS07), Acute Heart Service (SS13FA4) and Stroke (SS13FA5) have several measures or focus areas within the one deliverable, which receives an overall assessment rating from the Ministry.

It is worth noting that the results and the Ministry's assessment of the DHB's performance, based on these quarterly reports, form the basis of the DHB's performance monitoring report and 'dashboard' that the Ministry provides to the Minister of Health.

4. DISCUSSION

The 2021/22 Annual Plan received approval from the Minister of Health on 17 November 2021.

There were 45 headline deliverables this quarter (with 60 measures), of which 22 were rated by the Ministry as 'achieved' (48.9 percent) and 15 were 'partially achieved' (33.3 percent) with adequate mitigations or improvement actions in place. Eight (17.8 percent) were 'not achieved' and these are briefly discussed below.

4.1. Immunisation coverage

There are four performance measures reported in Quarter One for Immunisation Coverage. All remain below target, despite some individual improvements.

4.1.1 Infants fully immunised at eight months old

There has been a slight decline for the total eligible population (465/588) to 83.3 percent (from 84.6 percent last quarter) and a decline for Māori to 67.2 percent (131/195). Rates have remained reasonably steady for Pasifika this quarter at 81.0 percent (compared with 81.5 percent last quarter). Both at a local level and nationally, the impact of ongoing COVID-related disruption and the volume of work required in the response is visible both across the sector and in how whānau are responding.

The following initiatives continue this quarter:

- Immunisation clinics held at THINK Hauora in Palmerston North and in Horowhenua continue. Home visits have been added to provide an opportunity for whānau who are not enrolled with a General Practice Team (GPT) to access immunisations and/or for those reluctant to access General Practice due to COVID-19
- Direct referrals received from Well Child Providers for whānau not engaged with and/or enrolled with a GPT
- Data cleansing continues by a redeployed Clinical Facilitator which has enabled the Immunisation Team to dedicate increased time to contacting families, holding clinics and providing home visits
- Wider promotion of immunisation clinics on social media and to other community services.

4.1.2 Children fully immunised by two years of age

There has been a further decline in the reported rate of children being fully immunised up to the age of two years (note all immunisations due over the period are included, not just the last dose). There were 78.3 percent (n.441) of 563 children recorded as being fully immunised, 127 of whom were Māori (66.5 percent of 191 children).

The National Immunisation Schedule change continues to have a significant impact on data of the pneumococcal conjugate vaccine (PCV) and measles, mumps and rubella (MMR) doses. Some parents in this age group have decided to wait until their child is four years old to get the MMR dose, which is in line with the previous immunisation schedule.

The most recent nationwide COVID-19 Alert Level changes in August exacerbated parental reluctancy to present to clinics or have home visits. As noted for other milestone ages, the Immunisation Team continues to work closely with General Practice, Outreach Immunisation Service (OIS) and the National Immunisation Register (NIR) to find the children of whānau who are overdue, transient, delaying and declining. They are encouraged to present to General Practice for immunisations or offered an alternative venue for the event.

4.1.3 Infants fully immunised at five years of age

The proportion of eligible children fully immunised at 5 years of age has increased this quarter (85.2%) compared to the previous quarter (82.8%). Of the 2447 eligible children, 85.2% (n. 2084), were fully immunised over this quarter. Similarly, there has been an increase in the proportion of Māori tamariki (79.3%) fully immunised over the quarter (75.9% for the previous quarter). Pasifika on time immunisation rates in this age group have also increased this quarter (80.8%) in comparison with the previous quarter (73.9%).

Some whānau remain reluctant to access their general practice for childhood immunisations. The Immunisation Team is ensuring that practices and the OIS are informing patients they manage to contact, that alternatives to general practice are available as a non-respiratory illness space to vaccinate. This includes clinics provided by THINK Hauora and immunisation clinics at The Palms in Palmerston North on weekends.

4.1.4 Influenza vaccinations for people aged 65 and older

The annual result for the influenza season ending September 2021 shows a decrease in performance compared with the previous year's results, with a 5.2 percent decrease in coverage. This year, 285 fewer older people received their influenza vaccination than in 2020.

Although the target was not achieved, immunisation coverage this season was slightly above the national average for the eligible population aged 65 and older. There was a notable increase in rates for older Pacific people relative to last season.

Delivery of the influenza immunisation programme has been impacted by the timing of the COVID-19 vaccination rollout. Many older people made the decision to delay or defer their influenza immunisation until the completion of their COVID-19 vaccinations.

4.2 Breastfeeding at three months of age

There has been a slight improvement in breastfeeding rates for babies at three months of age when compared to the same period a year ago, but remains well below target. Of the 906 babies in the eligible age group that received a Well Child Tamariki Ora (WCTO) contact over this period, 56.0% (n.506) were recorded as being exclusively or fully breastfed. Rates for Māori were lower at 49.0% (n.139) of 283 Māori babies, although MidCentral DHB's rate was slightly higher than the national rate for Māori (48.0%) over this period.

Activities to support breastfeeding include:

- the establishment of a peer support programme; the Pasifika team at THINK Hauora and a Māori WCTO provider have completed training
- a 'Lactation Support' page has been developed and published on Health Pathways
- the Donor Milk Policy is under review; planned changes to include pasteurised donor human milk for use at MDHB facilities; regular engagement with Whāngai Ora milk bank to improve the process of distribution
- Baby Friendly Hospital Initiative coordinator completing a review of previous years' data to inform education and ensure requirements are met.

4.3 Colonoscopy wait times

Significant improvement in the waiting times for urgent colonoscopy, achieving target. Over the quarter, 64 (92.7%) of 69 patients with an urgent referral received their procedure within 14 days or less. This is an improvement when compared to the previous quarter (1 April to 30 June 2021); 82.4% (47/57) of patients with an urgent referral received their procedure within 14 days or less.

However, there has been a reduction in the proportion of patients with a non-urgent referral receiving their procedure within 42 days or less. Over the quarter, 131 (23.5%) of 556 received their procedure within 42 days or less.

The proportion of people receiving their surveillance colonoscopy within 84 days of their planned date remains below target. Over the quarter, 52 (52.0%) of 100 patients received their procedure within 84 days of the planned date. This is a significant improvement when compared to the previous quarter (1 April to 30 June 2021) when 18.4% (n.50/271) of people received their surveillance colonoscopy within 84 days of their planned date.

A recovery plan developed in the last quarter is progressing. Outsourcing of colonoscopies to a private provider and Saturday procedure lists have reduced the proportion of patients waiting for an urgent colonoscopy this quarter. Successful recruitment of a gastroenterologist has occurred; scheduled to commence in December 2021.

4.4 Shorter stays in Emergency Department (ED)

A significant reduction in the proportion of patients presenting to the Emergency Department (ED) who were admitted, transferred or discharged within six hours over this quarter; the lowest quarterly rate recorded for 10 years with only 68 percent (n.7932) of 11,649 patients having shorter stays in ED. A number of new initiatives are underway; notably:

- An action plan has been developed with short, medium and long-term initiatives. This has been shared with the Ministry for input/feedback. MDHB has been invited and accepted to participate in a Ministry sponsored pilot focused on weekend discharging of patients
- The direct referral from the medical wards to the Needs Assessment Service Coordination Agency (NASC) is now formally in place
- A decision is waiting for the permanent conversion of physical space at Palmerston North Hospital to a flexible acute flow unit. In the interim, the Transitory Care Unit continues to be used as required
- A surge plan is being developed by senior medical staff from ED for the rapid decant of patients if a significant incident or event occurred
- The Variance Response Management (VRM) working group has been reinvigorated, focusing on a hospital-wide levelling of VRM coding.

4.5 Help to quit smoking – hospital

The DHB remains below target – further decrease this quarter. Of the 749 hospital patients who smoke, 531 (70.9 percent) were offered brief advice and support to quit smoking. Notable increase in the proportion of Māori hospital patients who smoke that were offered brief advice and support to quit smoking this quarter (78.5 percent) compared to the previous quarter (72.9 percent).

A new initiative commenced this quarter. The Anaesthetic Department and the pre-admission clinic are working collaboratively with the DHB quit smoking provider to link patients who accept a referral to quit smoking services directly after the consultation with the anaesthetist. This has the aim of connecting patients in the same visit so that they can receive appropriate quit smoking support and can commence as soon as possible on nicotine replacement therapy.

There are significant backlogs for clinical coding and prioritised processes for coding of Emergency Department and inpatient admissions. The areas which need more improvement are the Emergency Department and the perioperative ward.

4.6 Oral health services – adolescent utilisation

The Non-Financial Performance Measures for Quarter Four 2020/21 included an update on the proportion of adolescents utilising dental services for the 2020 calendar year.

Performance as at 31 December 2021 showed there had been a decline in the proportion of adolescents utilising dental services for the year (73.1 percent) compared to the previous year's result (83.1 percent). A target of 9082 (85 percent) of adolescents utilising dental services was set for the 2020 calendar year. A total of 6563 adolescents were served during the year – from a total adolescent population of 10,685. While not to target, MDHB's utilisation rate continues to be slightly above the national average of 59 percent.

The Child and Adolescent Oral Health (CAOH) service has performed consistently for the last decade, achieving 80 percent or more, aided by a dedicated adolescent therapy team. The result for the 2020 calendar year was significantly impacted by the nationwide lockdown and alert level restrictions for COVID-19, as well as a reduction in the number of dentists in the Feilding area.

Data for this performance measure is collated by the Ministry and reported as a total percentage on an annual basis. Data for the year ended 31 December 2021 will be included in the Quarter Three 2021/22 report and will provide the utilisation rate by ethnicity.

Activity to improve utilisation for adolescents in 2021 has included introducing enduring consent for routine examinations, x-rays and preventative treatment. Recent activity to lift performance is being led by MDHB.s Oral Health Promoter and Clinical Lead for the CAOH service. The focus is on making improvements to the Combined Dental Agreement (CDA) through engagement with providers to understand their perspectives on CDA provision, ability to meet demand and capacity to extend their participation.

APPENDIX ONE

The following table highlights the performance measures and deliverables reported to the Ministry in Quarter One and the performance rating assigned by the Ministry for each of them using the following legend.

Ratings for Performance Measures, Deliverables and Status Reports		Ratings for Crown Funding Agreement Reports	
O	Outstanding	S	Satisfactory
A	Achieved	B	Further work required
P	Partially achieved	N	Not acceptable
N	Not achieved		
N/a	Not applicable		

Table 1: Performance Measures and Delivering on Priorities (Quarter One)

Child Wellbeing			
Oral Health – Preschool enrolment	P	Breastfeeding	N
Immunisation at 8 months old	N	Newborn enrolment	P
Immunisation at 5-year-old	N	Help to quit smoking – maternity	A
Immunisation at 2-year-old	N	Raising healthy kids	P
Immunisation – influenza	N	Annual Plan Status Update	A
Mental Wellbeing			
Transition (discharge) planning	P	Physical health and employment	A
Shorter waits for under 25-year-olds	A	Mental Health Act, Compulsory Treatment	P
Primary mental health initiative	A	Orders (Māori)	A
Suicide prevention and postvention	A	Output delivery against plan	A
Crisis response services	P	Inpatient post discharge follow-up	A
Outcomes for children	A	Annual Plan Status Update	
Improving Wellbeing Through Prevention			
Colonoscopy wait times	N	Annual Plan Status Update	P

Strong and Equitable Public Health and Disability System			
Faster cancer treatment – 31 days	A	Quality of identity data & national collections	
Faster cancer treatment – 62 days	A	NHI registrations	A
Planned care measures (overall)	P	National collections	P
Care capacity demand management	NA	PRIMHD	A
Shorter stays in Emergency Department	N	Management of long-term conditions	
Help to quit smoking – hospital	N	Cardiovascular disease	A
Healthy ageing strategy	A	Acute heart service	P
Annual Plan Status Update	P	Stroke service	P
Better Population Outcomes Supported by Primary Health Care			
System level measures	P	Help to quit smoking – primary	P
Annual Plan Status Update	P		
Improving Sustainability			
Annual Plan Status Update	A		
He Korowai Oranga			
Annual Plan Status Update	A		
Crown Funding Agreement Reporting			
Before School Check	S	Primary Health care services – under 14s	S
School Based Health Services	S	Sudden Unexpected Death in Infancy	S

Discussion/Decision papers

14 December 2021

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the Board have confidence that that the work plan will address the concerns previously raised by the Combined Medical Staff Association?

To	Board
Author	Kathryn Cook, Chief Executive
Endorsed by	
Date	6 December 2021
Subject	**Combined Medical Staff Association and Executive Action Plan**

RECOMMENDATION

It is recommended that the Board:

- **note** the Combined Medical Staff Association and Executive Action Plan.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler, 'Stewardship'.

1. PURPOSE

To provide an update on the action plan developed following the Combined Medical Staff Association (CMS) engagement with the Board at the workshop held on 6 July 2021 and subsequent meeting with MidCentral District Health Board (MDHB) Executive Team members.

2. BACKGROUND

As part of the Board's work programme, each of the four clinical professional groups (medical, nursing, midwifery and allied health) meet annually with the Board. This allows each group to provide direct feedback to Board members about their professions and the challenges currently faced.

Correspondence over a period of time and engagement with the CMS escalated a number of issues requiring resolution. Members of the CMS Executive gave a presentation at a Board workshop on 6 July 2021. From this, a CMS and Executive Action Plan was agreed upon.

3. THE ACTION PLAN

Current progress in delivering the action plan is outlined below.

Combined Medical Staff and Executive Action Plan

LEADERSHIP – Action	Responsibility	Timeframe	Progress
1. Open and honest conversations – call each other out if that isn't happening.	Everyone	Ongoing	
2. Consider Te Uru Arotau clinical leadership – consult at future MRG meeting	Executives	24 August	Complete
3. Better preparation for MRG meetings, including agenda, having the right people attending, maintaining work plan	CMO, Chair CMS	Discussed and approach agreed at MRG on 27 September	Complete
4. Update and strengthen Terms of Reference for MRG meeting	CMO, Chair CMS	16 November	Complete
COMMUNICATIONS – Action			
1. Monthly meeting with medical leads and executive	CEO	17 August	Complete
2. Prepare a list of current meetings and level of engagement – discussion on purpose and effectiveness	CMO, Ops Exec Te Uru Arotau	Further engagement planned	
3. Joint presentation to the Board	CEO, Chair CMS	17 August	Complete
4. CMS to advise if the group needs to meet again	CMS	Ongoing	
5. Chief Executive to attend CMS AGM and acknowledge the impact of prior decisions on clinicians	CEO	10 August	Complete
SPIRE – Action			
1. Facilitated session with larger group of surgeons and anaesthetists – attendees to be agreed, facilitator to be arranged. Mitigations to be addressed.	CEO	14 September	Complete
STRATEGIC CAPITAL INVESTMENT GROUP (SCIG) – Action			
1. Dr Thompson to attend SCIG; papers to be shared with CMS	CEO		Complete
DIGITAL – Action			
1. Digital programme to be reviewed at MRG, including confirmation of SMO representatives on priority programmes of work	CMO, CDO	24 August	Complete

BOARD REPORT

For:

	Approval
	Endorsement
x	Noting

Key questions the Board should consider in reviewing this paper:

- Are Board members sufficiently informed by this paper about the current midwifery workforce issues?
- Are Board members sufficiently informed by this paper about the actions to address these issues?

To	Board
Authors	Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke Celina Eves, Executive Director of Nursing and Midwifery
Endorsed by	Kathryn Cook, Chief Executive
Date	25 November 2021
Subject	**Midwifery Workforce Report**

RECOMMENDATION

It is recommended that the Board:

- **note** the current midwifery workforce position
- **note** the key updates to the Midwifery Action Plan.

Strategic Alignment

This report is aligned primarily to MidCentral District Health Board's (MDHB) strategy.

1. PURPOSE

To provide the Board with an update on the agreed Midwifery Action Plan.

2. BACKGROUND

As highlighted in previous papers, a shortage of midwives across New Zealand continues to affect most District Health Boards (DHBs). Despite local, national and international recruitment campaigns, midwifery recruitment and retention remain a significant documented risk for MDHB (risk 830). The number of midwives being trained, the career opportunities locally, nationally and internationally, alongside increasing acuity and handover of care, mean that recruiting and retaining midwives is increasingly complex.

3. CLINICAL RISK

An action plan is in place to mitigate the clinical workforce risk. This is included as Appendix One and covers the following areas:

- Workforce recruitment
- Workforce retention
- Clinical safety
- Primary/secondary/obstetric interface
- Senior Midwifery/Leadership
- Communication.

Actions from an external Director of Midwifery's visit have been incorporated into the overarching action plan. The following narrative provides updates on all key areas since the last reporting period.

3.1 Workforce recruitment

Palmerston North Hospital's Maternity Unit has an established midwifery budget of 49.95 full time equivalent (FTE) (comprising 42.48 FTE core midwives and 7.47 FTE senior midwives), with an additional 8.89 midwifery FTE confirmed as part of the Care Capacity Demand Management (CCDM) programme.

Since the previous reporting period, two midwives have resigned, with one relocating out of the region and the other wanting to be closer to her home base. There is only one midwife now on Accident Compensation Corporation (ACC) leave.

The workforce risk and staffing situation is expected to escalate over the next eight weeks. Two midwives have requested unpaid leave due to personal circumstances; one senior midwife is moving to a Lead Maternity Carer (LMC) practice; and one midwife has indicated she would not be vaccinated against COVID-19. The midwifery shortfall has been mitigated by 18 FTE nurses, resulting in an overall vacancy level of 5.1 FTE. This is a slight improvement from the previous reporting period, but a reduction in the number of midwives employed. In addition, four casual midwives and four healthcare assistants are currently unable to work due to the COVID-19 Vaccination Order.

Local recruitment continues with three new graduates commencing in early 2022. The Clinical Coach to support new graduates and return to practice midwives commences in mid-January 2022.

Two external recruitment companies are engaged to recruit midwives internationally, with interest from one overseas midwife being progressed. All DHBs are currently struggling with international recruitment of midwives, impacted by the global pandemic travel restrictions. There were no midwifery attendees at the return to practice event held on 6 November 2021.

Despite escalation, there is no further update on the Otago Polytechnic nurse to midwifery transition programme. Auckland University of Technology has advised they are hoping to commence a programme in Semester Two of 2022.

3.2 Workforce retention

The second retention payments will be paid to all permanently employed midwives in December 2021.

Eighteen midwives are now engaged with professional supervision. This pilot programme has been extended to a 12-month period to ensure adequate opportunity for evaluation.

The Antenatal Clinic temporarily relocated to Te Papaioea Birthing Centre on 22 November 2021, as part of the Ward 24 essential oxygen facility upgrade. Discussions are ongoing regarding an alternative location for the clinic, with an outcome expected by December 2021.

3.3 Clinical safety

To ensure clinical safety, changes to operational hours at Te Papaioea Birthing Centre that commenced on 10 May 2021 remain in place. The changes have significantly reduced roster gaps at Palmerston North Hospital which is evident in improved TrendCare data and reduced care deficit hours. Following a meeting with LMCs on 24 September 2021, interest has been received about working at the Centre, with planning in progress to increase operational hours in April/May 2022. Regular situation updates to core and LMC staff reiterate MDHB's commitment to resuming a 24-hour service at the Birthing Centre when staffing permits.

In line with the external Director of Midwifery's recommendations, healthcare assistant and lactation consultant hours have now been increased to support midwifery shortages. Administration hours are in the process of being increased to 12 hours a day.

No formal complaints have been received since the last reporting period. Following the Consumer Liaison Coordinator undertaking a targeted review process of the maternity survey, there was a significant improvement in the number of feedback surveys received. There were 65 responses received in October 2021, of which 16 were Māori (24.6 percent). The majority of wāhine indicated that they were happy or very happy with the breastfeeding support they received, along with the ability to have a support person stay with them. For others, the limitations of shared rooms and COVID-19 responses continue to impact their experience. There have been no Severity Assessment Code (SAC) incidents concerning foetal/maternal sepsis since the last reporting period.

As part of the COVID-19 response, significant planning, preparation and pathway development has been undertaken to ensure safe care delivery across all aspects of the service. These continue to be updated as information and circumstances change.

3.4 **Primary/Secondary and Obstetric Interface**

The local primary/secondary interface group continues to progress well with focused work, meeting every four to six weeks with good representation including Māori consumer, core midwifery, LMC, Māori midwives and obstetric staff. The launch of the new Maternity Clinical Information System in June 2021 should assist with primary/secondary communication once the programme gains a stable platform and testing becomes less of a requirement.

A meeting between MDHB and private providers to discuss maternal ultrasound took place on 12 November 2021, with a plan agreed and shared with the LMC and core midwifery workforce.

As part of MDHB's commitment to Te Tiriti and equity of outcomes for Māori, recruitment to the Kaiaraara Tu Ora – Primary Midwife Specialist role is in progress. This multidisciplinary role will work closely with Pae Ora Paiaka Whaiora Hauora Māori to enhance the experience and outcomes for wāhine and whānau Māori across the rohe, with expected commencement in January 2022.

3.5 **Senior Midwifery/Leadership**

The decision document regarding the change proposal to strengthen midwifery leadership was released on 23 June 2021 and confirmed the following changes:

- The Director of Midwifery role moves to professional leadership only, to ensure clinical safety and quality is prioritised
- Two Midwifery Managers (Charge Midwives – one primary and one secondary)
- 24-hour Clinical Midwifery Manager (Associate Charge Midwife) cover for the Birthing Suite
- 24-hour Clinical Midwife Coordinator for the Maternity Ward
- Equity Lead.

The current position regarding implementation of the decision is as follows.

No appointment has been made following the Director of Midwifery recruitment process. Further strategies for recruitment are being considered, with the Executive Director of Midwifery assuming professional responsibility for the service at the current time.

Recruitment to the secondary care Midwifery Manager (previously known as Charge Midwife) post is now complete and an appointment made.

While interviews for the vacant Clinical Midwifery Manager (previously known as Associate Charge Midwife) hours have taken place and jobs offers are in process, vacancies remain impacted by a further senior midwife resignation.

The plan to progress Midwifery Coordinators for the Maternity Ward 24 hours a day has not progressed due to lack of applications. Alternative strategies are being considered to ensure robust clinical safety on the Maternity Ward.

Equity Lead role interviews occurred in October 2021; however, no appointment has been made. This will be readvertised in the new year.

3.6 **Communications**

The staff weekly newsletter has recommenced, along with regular email communication from executive leaders.

The Francis Health culture work continues across the service, with the current focus on developing the leadership team. Weekly meetings with the leadership team are in progress and a face-to-face workshop is planned for 8 December 2021.

Appendix One: Midwifery Action Plan – June 2021

Key

Not Started	Completed	On Track	Overdue	High Risk

Action	Target Date	Owner	Update	Status
Recruitment				
Work with Undergraduate Midwifery training providers and RN Bridging course providers to increase number of local graduates	August 2021	Director of Midwifery	***Emma Farmer recommendation*** Executive Director Nursing & Midwifery and Operations Executive in discussions with AUT, and Otago now 2023, AUT course not yet approved	
Midwifery recruitment campaign running constantly on MDHB website, social media, Kiwi Health Jobs and SEEK, including international recruitment (via agency)	Ongoing	Director of Midwifery Operations Executive Operational Lead	Ongoing	
Ongoing midwifery recruitment with casual and fixed term contract options/family friendly hours/flexible working.	Ongoing	Director of Midwifery/ Operational Lead	New increased interest and follow up processes now in place.	
Work with Otago or AUT to fund local wāhine Māori to become midwives	September 2021	Executive Director Nursing and Midwifery/Operations Executive	***Emma Farmer recommendation*** Work in progress	
Recruit to Kaiaraara Tu Ora, Midwife Specialist role	October 2021	Operations Executive	Position offered	
Retention				
Optimising training: offer training opportunities over and above minimal Midwifery Council requirements (funded by MEED)	Ongoing	Director of Midwifery Midwifery Educator	To reset educational and training to ensure mandated requirements	
24/7 Midwifery Manager/Clinical Midwifery Manager (Birthing Suite)/Clinical Midwifery Coordinator (Maternity Ward) to provide senior midwifery supervision, minimising clinical risk	Ongoing	Operations Executive	Leadership model to enhance clinical safety in development. Decision released April 2021.Recruitment underway, however lack of applications means that this is still ongoing	

Action	Target Date	Owner	Update	Status
Leadership development for midwifery team, including shift coordinator training	Ongoing	Midwifery Manager	Midwives to access LEO course and MDHB leadership courses to prepare for leadership roles Shift coordinator training to be completed for all midwifery staff was up to date in 2020, however due to new staff a further cohort of training needs to be undertaken	
Ensure timely rostering processes, annual leave and no roster breaches	Ongoing	Midwifery Manager	Revised roster template initiative This initiative is to ensure that the roster first covers the after-hours shift and any midwifery shortages during the day can be covered with midwives in other roles. Difficulty allocating annual leave due to staffing levels Roster to be checked by Midwifery Manager 11.10.21 MERAS reporting less concerns being raised	
Midwifery Clinical Coach recruitment	October 2021	Operations Lead	Interviews October 2021 preferred candidate informed, awaiting start date	
Escalation plan for 'no midwife on maternity ward'	June 2021	Director of Midwifery	The plan was published 2020 and was due for review June 2021, this has been delayed due to no Director of Midwifery being in post	
Midwifery workforce meeting	Ongoing	Operations Executive	Commenced January 2021	
Primary/Secondary interface				
Engage with LMCs regarding primary/secondary interface	Ongoing	Executive Director of Nursing & Midwifery Medical Lead	All access agreement applications to include discussion with Executive Director of Nursing and Midwifery. Policy/procedure regarding primary/secondary interface being worked on.	

Action	Target Date	Owner	Update	Status
Regular LMC Forums	July 2021	Operations Executive	***Emma Farmer recommendation*** Discussion with regional chairs re how to progress with recommendation and implement regular LMC forums, monthly access holders meeting also in progress	
Establish improved communication between antenatal clinic and LMCs	August 2021	Executive Director Nursing and Midwifery Operations Executive	***Emma Farmer recommendation*** Discussions held with Medical Lead- discussions occurring through primary secondary interface work	
Continue to source alternative location for antenatal clinic	May 2021	Operations Executive Director of Midwifery	***Emma Farmer recommendation*** Urgent requirement to relocate antenatal clinic to ensure GDU opening. Continuing to try and source alternative location to current option, however no other option available at current time. Clinic to re relocated from 22 November 2021 for one month due to facility work	
Clinical Safety				
Revisit option for on-call senior midwife at weekends	February 2022	Director of Midwifery	Following leadership recruitment consider on call into employment of senior positions for escalation process	
Ensure use of MEWS charts/education	July 2021	Midwifery Manager	Educator to commence work to strengthen the use of MEWS in July 2021	
Increase HCA support midwives during staffing shortage	June 2021	Director of Midwifery Operational Lead	***Emma Farmer recommendation*** In progress plan to increase to 2 per shift	
Increase ward clerk support	June 2021	Director of Midwifery Operational Lead	***Emma Farmer recommendation*** in progress plan to increase to 12 hours per day June 2021. Interviews imminent.	

Action	Target Date	Owner	Update	Status
Senior Midwifery				
Recruit to vacant senior midwife roles	December 2021	Operations Executive Director of Midwifery	Ongoing	
Senior midwives to release time from roles to work on floor as and when required	Ongoing	Director of Midwifery	Ongoing to the detriment of quality and operations. Resignations so far not recruited to leave gaps in these roles with limited options to fill clinical shifts	
Leadership development and support for Senior Midwifery team	May 2021	Operations Executive Executive Director Nursing and Midwifery	Francis Health work to commence March 2021 Initial meeting held 23 May 2021	
Implement pulse checks (staff morale)	June 2021	Operations Executive Executive Director Nursing and Midwifery	Await Francis Health work	
Retrain staff re speaking up for safety	September 2021	Director of Midwifery	To be completed September 2021	
ACM development programme to compliment leadership styles	June 2021	Operations Executive Operational Lead	Francis Health work to commence March 2021	
Communications				
Staff forums	Ongoing	Operations Executive Executive Director Nursing and Midwifery	Weekly for two months - week commencing 8 March 2021 Limited engagement from staff Monthly meetings commencing May-21	
Staff meetings	Ongoing	Director of Midwifery Charge Midwife	Sarah Fenwick and Celina Eves invited. (Monthly staff appreciation award initiated) Work in conjunction with organisational awards and recognition scheme	
Regular written communication from management team	Ongoing	Operations Executive Executive Director	Continues as indicated	

Action	Target Date	Owner	Update	Status
		Nursing and Midwifery		
Action plan made available	Ongoing	Operations Executive Executive Director Nursing and Midwifery	Made available on both wards Added to Te Uru Pā Harakeke SharePoint page Available to LMC colleagues	
To improve culture across Maternity Services		Operations Executive Clinical Executive Director of Nursing/Midwifery	Work with Francis Health on track	
Weekly newsletter	Ongoing		Commenced with positive feedback to date	

Completed				
Recruitment				
Support for midwives to return to practice: • Midwifery Council fees paid, and APC paid • Up to 12 weeks paid supernumerary support across variety of clinical areas • 20 hours Professional Support to help navigate the Midwifery Council process	August 2020	Director of Midwifery	Social media campaign on going. **Recruited to this far:** 3 x RM - Return to practice support, one since withdrawn Return to Practice open day, conjunction with nursing, was held on 10 October 2020 and 6th November 2021 with little interest. Continued interest with support offered to continue from Cheryl Benn.	
Reapply for the Ministry of Health Voluntary Bonding Scheme	December 2019	Planning and Integration Lead	Bond approved by Ministry of Health January 2020	
Transfer of Te Papaioea to MDHB management April 2020, offering midwives the opportunity to work across both primary and secondary areas as an employed midwife	April 2020	Planning and Integration Lead / Operations Executive	Complete May 2021, decision made to staff Te Papaioea Birthing Unit between 8am-4pm and remaining staff deployed to PN site due to staffing shortages.	

Refresh graduate programme to offer rotation to primary birthing and extend into other areas: clinic/community	January 2020	Planning and Integration Lead	Complete	
Fixed term (6-12 month) 0.4 contracts advertised in an effort to attract those midwives who cannot currently commit to 0.6 minimum	September 2020	Director of Midwifery	Recruited to: 1 x existing staff member 1 x additional RTP staff member (note this initiative has resulted in a loss of 0.8FTE)	
Expression of Interest for midwives to work 'Family Friendly hours' as an extra (Part timers, Maternity leave, LMCs)	August 2020	Planning and Integration Lead	Advertised through social media and email 17 August 2020	
Raise the profile of MDHB Midwifery nationally and locally: • New pamphlet and midwifery banner to be created • Senior midwives engage with undergraduate programme providers (bi-monthly meetings) and visiting students on location to promote MDHB midwifery Midwifery presence at 'Sorted' Careers Expo Manawatu and 'Careers and Health' Day MDHB annually	Ongoing	Director of Midwifery/ Operational Lead	Meeting with Third Year students scheduled w/c 22 March 2021 to discuss incentives for core graduate employment. Letters sent to Graduates outlining what MDHB can offer. Attending the national virtual midwifery expo for all student midwives in September.	
Registered Nurse recruitment to Birthing Suite to complement midwives	Ongoing	Director of Midwifery/ Operational Lead	First 1.4 FTE now orientating February/March 2021 0.9 FTE commencing in Sept 21	
CCDM				
TrendCare optimisation to prepare for CCDM calculations Midwifery FTE increase gained August 2019 to maintain service quality and safety (as per TrendCare report 18/19 released August 2019)	August 2019	Director of Midwifery	Completed to CCDM Governance June 2021 Unable to fully recruit to extra midwifery FTE, so RNs temporarily appointed to midwifery FTE on maternity ward. (note this was also an Emma Farmer recommendation)	
Retention				
Retention incentive consideration	May 2021	Operations Executive	Initial conversations agreed initial retention payment for all midwives pro rata.	

			Retention payments announced to midwifery staff, payment to occur in June 2021. Next due in December 2021 Additional payment for increase to FTE. (note this was also an Emma Farmer recommendation)	
Twelve weeks supernumerary orientation for each new graduate midwife employed	Ongoing	Director of Midwifery	Ongoing and in-place	
Instituted 12 hour shifts as a choice as part of a composite eight- and 12-hour roster	Ongoing	Director of Midwifery	In place and this can change each roster	
Direction and Delegation Policy updated with input from Unions and Midwifery Council	May 2021	Director of Midwifery	Completed	
"Sole midwife" payment instituted by Midwifery Director this month	Ongoing	Director of Midwifery	Additional duties payment for any shift worked as sole Midwife on Maternity	
Community Midwifery team has been reconfigured to be case loading to improve experience for the women and job satisfaction for the midwife	August 2020	Operations Executive / Director of Midwifery	Completed with further initiatives planned.	
Dedicated Antenatal Day Unit (ADU) midwife	July 2021	Director of Midwifery	Antenatal Day Unit rostered Monday to Friday from 9:00am to 5:00 pm	
Plan to increase pastoral care for staff by developing 'professional supervision'	October 2021	Operations Lead	First cohort of midwives are enrolled in Peer-to-Peer supervision training from October 2020	
MQSP Projects (Funded) Part of the MQSP Plan is to create different opportunities for midwives to enhanced career satisfaction and expose staff to other functions within midwifery and project manage specific projects.	Ongoing	Director of Midwifery Operations Lead	MQSP Coordinator facilitating the process Recruitment of new MQSP Co-ordinator due for completion in April 2021 New MQSP co-ordinator commenced in May 2021	
Case Review Midwife	March 2021	Director of Midwifery Operations Lead	Expression of interested to be sent out in February 2021 Position to be advertised January 2021	

			Now a combined role with MQSP due to resignation Case review midwife commenced May 21 combined	
Six-weekly union partnership meetings to be commenced	Ongoing	Director of Midwifery	Six-weekly meetings occurring with MERAS and NZNO commenced 24 June 2019	
Antenatal Clinic midwife to move to Birthing Suite Monday-Thursday mornings to support Antenatal Day Unit (ADU) patients. This will support acuity on Birthing Suite. RM has resigned from this position	September 2020	Operations Executive Executive Director of Midwifery	Antenatal day unit now operating from Birthing Suite, new person now in post June 2021	
Ensure staff are paid overtime in line with MECA if work without break or beyond hours	June 2021	Charge Midwives Operations Lead	***Emma Farmer Recommendation*** Process in place for claiming overtime. All problems reported to ops lead Emma Farmer recommendation	
Complete survey re where staff would prefer to work	June 2021	Operations Lead	Survey released to staff May 2021 ***Emma Farmer recommendation***	
Primary/Secondary interface				
Liaise with the other DHB's regarding LMC relationships/communications etc	February 2021	Operations Executive / Executive Director Nursing and Midwifery / Director of Midwifery	Celina working with DOMs nationally.	
Meet with Medical Lead to discuss differing medical opinions and not complying with policy	Ongoing	Operation Executive Medical Lead	Meeting held. Medical lead to discuss with staff to encourage three-way conversations with LMCs with transfer of care. Work ongoing to update guidelines and policies	
Medical Interface				
Advise staff to discuss with Medical Lead if any further concerns regarding compliance.	February 2021	Director of Midwifery	Staff notified	
Clinical Safety				
Utilise return to work midwife to complement Charge Midwife with upskilling maternity staff	February 2021	Director of Midwifery	Unable to progress RTW New 6-month project role initiated to support Nursing professionals – recruitment underway	

			Clinical shift co-ordinators placed on Maternity 6 AM shifts per week on maternity	
Project regarding term baby clinical care delivery	February 2021	Associate Director of Nursing	Recruitment process for temporary post to be commenced March 2021 Commences 17th May 2021	
Work to release a member of staff from neonates to upskill team in clinical care of babies	February 2021	Associate Director of Nursing / Operations Executive	Off track due to staffing levels in neonates Recruitment of clinical specialty nurse currently underway – completed May 2021	
Consider structure of Induction bookings with no day 1 IOL on Fridays but adding low risk IOL to Sunday – discuss with Medical Lead	February 2021	Director of Midwifery	Agreed and actioned	
CCDM process to be completed	June 2021	Director of Midwifery	Complete June 2021	
Educator to work clinically to educate nurses and midwives	Ongoing	Executive Director Nursing and Midwifery	Increased presence of educator and also temporary Specialty Clinical Nurse	
Discuss with Director of Midwifery and Medical Lead re impact of c section on Friday	Ongoing	Operations Executive	Theatre structure and low risk features of this cohort rationalise Friday as most appropriate allocation	
Introduce low-risk caesarean wellness focus to mobilise early and discharge early	April 2021	Director of Midwifery	Initiated early mobilisation and TROC	
Ensure adequate supervision for mother and babies two hours post caesarean	March 2021	Director of Midwifery	***Emma Farmer recommendation*** Confirmed now in place	
Increase lactation support	June 2021	Director of Midwifery Operational Lead	***Emma Farmer recommendation*** in progress plan to increase to 12 hours per day by June 2021	

Senior Midwifery				
Consideration of leadership roles required to support a clinically safe and effect service	April 2021	Operations Executive / Executive Director Nursing and Midwifery / Director of Midwifery	Leadership paper and Job Descriptions sent out for consultation May 2021. Decision expected June 2021.	
Ensure ACM team are fully briefed on roster changes etc	February 2021	Director of Midwifery	Complete	
ACM attendance compliance at Senior Midwifery Meetings	February 2021	Director of Midwifery / Charge Midwives	Currently 100% attendance at fortnightly meetings increased from monthly	
No leave to be given on Friday to senior staff unless adequate cover in place	Ongoing	Operations Executive / Director of Midwifery	Complete	
Increase Associate Director of Midwifery Role to 1.0FTE	January 2021	Operations Executive	Complete	
Consult on Midwifery Director role	May 2021	Operations Executive / Executive Director Nursing and Midwifery	JD sent out for consultation in April/May 2021. Job out to recruit May 2021. Interviewed but not appointed to.	
Concern re-rostering				
Provide roster specific training	March 2021	Director of Midwifery	Referrals for ACM to access training and support from MERAS to support.	
Move roster to alternative person	January 2021	Director of Midwifery	First roster released to commence Feb 22	

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Are Board members sufficiently informed by this paper on the update of the current nursing workforce issues?
- Are Board members sufficiently informed by this paper about the actions to address these issues?

To	Board
Author	Celina Eves, Executive Director of Nursing and Midwifery
Endorsed by	Kathryn Cook, Chief Executive
Date	22 November 2021
Subject	**Nursing Workforce Update**

RECOMMENDATION

It is recommended that the Board:

- **note** the Nursing Workforce Report.

Strategic Alignment

This report is aligned primarily to MidCentral District Health Board's (MDHB) strategy.

1. PURPOSE

To provide the Board with an update regarding the nursing workforce issues raised at the April 2021 Board meeting.

2. BACKGROUND

October and November 2021 have continued to be challenging for nursing, with high unplanned staff sick leave and a hospital working at full capacity. Planning for COVID-19 outbreaks in our region to ensure infrastructure and workforce preparedness also continued.

Nurses seconded to Auckland District Health Board (ADHB) for the COVID-19 resurgence response have all returned. Locally, nurses are working with the Public Health Team, continuing to provide COVID-19 contact tracing for ADHB.

MDHB's ability to meet the expectations and needs of safe staffing have again been impacted by the above.

3. CLINICAL RISK

The action plan to mitigate the clinical workforce risk is included in Appendix One and covers the following areas:

- Workforce recruitment
- Workforce retention
- Clinical safety
- Professional support
- Staff wellbeing.

The following narrative provides updates on all key areas since the last reporting period. The Clinical Safety/Care Capacity Demand Management (CCDM) has been further expanded to delineate each measure and more clearly identify the changes that have occurred since July 2021.

3.1 Workforce recruitment

Mental Health and Addiction Services are currently implementing significant changes to the service model, which is providing new opportunities for new roles and new ways of working closer with our clients/patients. This change should provide another opportunity to attract staff to MDHB mental health service. The new service model is designed to be closely aligned with our community needs, with the mental health team partnering closely with the multidisciplinary teams for a focused service.

A Return to Practice information day was held in November, following a comprehensive advertising campaign. Several enquires were received before and after the event from nurses and midwives but resulted in only two new Return to Practice registered nurses. Due to privacy issues, we were unable to collate data on the numbers of Registered Nurses (RNs) and Registered Midwives (RMs) in the district who were qualified but not registered with their professional body. This makes it difficult to identify the reason for the limited response, following a previously successful campaign. A Return to Practice MDHB webpage will be set up so information can be accessed by the community at any time.

3.2 Workforce retention

The overarching aim is that MDHB's workforce reflects community demographics, is sustainable, highly qualified, appropriately credentialed, and culturally responsive to the changing needs of each community. The Nurse Midwife Recruitment Consultant continues to make good progress supporting staff and streamlining the employment process.

In addition to the number of vacancies, each month the number of nursing and midwifery staff onboarding, and resignations is being captured. This will provide a clearer picture over time of the progress being made with recruitment and retention initiatives.

	August 2021 New Staff Onboarding	August 2021 Resignations	Variance	September 2021 New Staff Onboarding	September 2021 Resignations	Variance	October 2021 New Staff Onboarding	October 2021 Resignations	Variance
Registered Nurses	31	25	**+6**	18	13	**+5**	**15**	**15**	**0**
Midwives	1	0	**+1**	1	0	**+1**	**0**	**0**	**0**
Health Care Assistants /Enrolled Nurses	4	5	**-1**	4	0	**+4**	**3**	**2**	**+1**

3.3 Clinical safety

The Safe Staffing Healthy Workplaces Unit (SSHW) full implementation evaluation team visited MDHB in early November to assess the implementation of the CCDM programme. We are still awaiting the outcome of the visit.

The CCDM Core Data set for October 2021 (Appendix Two), measures quality patient care, quality work environment and best use of health resources. The data reinforces the need for increased nursing FTE and full implementation of CCDM.

3.3.1 Patient incidents

A patient incident is any event that could have or did cause harm to a patient. Patient incidents are an indicator of the quality of care provided to patients, the quality of the work environment and staffing. Lower nursing staff levels are associated with increased patient mortality, medication errors, falls and missed care.

In October, 263 patient incidents were reported – a 15 percent increase from September 2021.

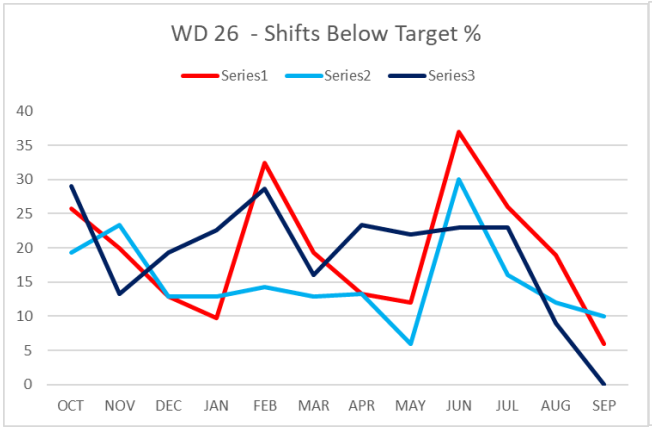
3.3.2 Shifts below target

Shifts below target are the percentage of shifts by AM, PM, N where the difference in the care hours provided and the care hours required was greater than negative 8.5 percent, or 40 minutes per FTE. Nineteen percent of shifts were below target in October, up from 17 percent in September. Shifts below target are mitigated in three ways:

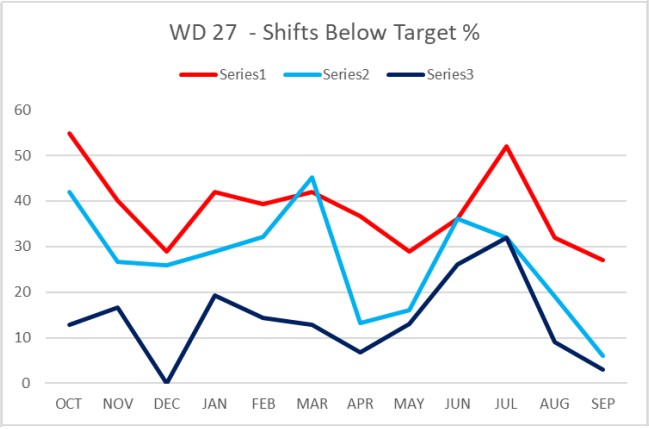
- Integrated Operations Centre (IOC) staffing allocation with the placement and movement of staff using live TrendCare acuity data.
- Variance Response Management and FTE calculations. Variance Response Management provides live information of how a clinical area is managing the demand placed on it. When this shows a clinical area is under increasing workload pressure, the Duty Nurse Manager reallocates staff to support this demand.
- FTE calculations are established using TrendCare variance hours. This helps to address these shifts long term.

Graphs One, Two and Three below show the significant reduction in shifts below target for three areas who completed FTE calculations in June/July this year.

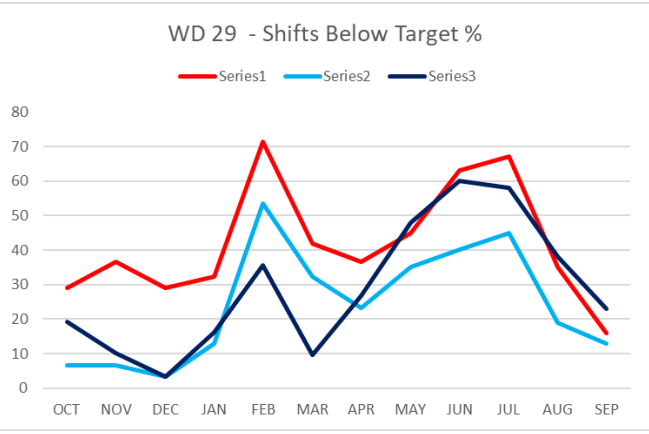
Graph One



Graph Two



Graph Three



3.3.3 Care rationing

Care rationing is all care reported by staff that was missed, delayed, sub-optimally delivered or inappropriately delegated. Care rationing impacts on the quality of care provided to patients, patient experience and staff satisfaction/engagement. Lower levels of staffing are associated with missed care. Care rationing impacts on nurse satisfaction and causes moral distress. Care rationing incidences increased in October to 325. This was significantly higher than the 217 in September, however lower than the July peak of 487.

3.3.4 Bed utilisation

Bed utilisation reflects the throughput of patients, accounting for all discharges, deceased patients, admissions and transfers for the shift on which the patient received care. The process of admitting or discharging a patient requires nursing hours in addition to those hours required to care for a patient. Increased patient turnover is associated with diminishing nursing hours.

Ward bed utilisation was 100 to 126 percent in 10 clinical service areas, up from seven areas in September.

3.3.5 Staff unplanned leave

Staff unplanned leave is the total unplanned or short notice leave hours taken by staff, for example sick, domestic, bereavement and Accident Compensation Corporation (ACC) leave. Sick leave is one indicator of the health of the workplace, with burnout and job stress increasing staff absenteeism. Staff unplanned leave increased by one percent in September.

3.3.6 Staff incidents

A staff incident is any event that is reported and could have or did cause harm to a staff member and includes accidents, needle sticks, back injuries, slips and verbal abuse. Staff incidents are more likely to occur when staff are under time pressure, tired or inexperienced or in the presence of increased workplace hazards (hours, complexity and workload).

Six clinical areas noted five or more staff incidents, with the highest being in OPAL (N=13), and Ward 26 (N=12).

3.4 **Professional support**

In October and November, the majority of face-to-face education continued, and staff are getting back on track with core training requirements.

3.5 **Staff wellbeing**

From the MDHB staff engagement survey of 2020, nursing identified three key actions of leadership, connectedness with communication that is positive and respectful, and supporting at work, where nurses can work within a blame-free culture and feel confident at work. Several measures are now in place and these actions are discussed regularly at key weekly and monthly meetings within MDHB's nursing shared governance model.

3.5.1 Leadership

This month has seen 22 staff across all disciplines and providers complete the Transformational Leadership Programme, 15 emerging nurse and midwife leaders complete the Leading an Empowered Organisation (LEO) Programme, and 16 emerging nurse and midwifery leaders nominated for the Nightingale Challenge LEO Programme commencing in December.

An advisory group has been established and is meeting weekly with Tertiary Education Programme Providers (Nursing, Midwifery and Allied Health) with the remit of developing a shared approach to ensuring students can complete their practice placements in a timely manner in a COVID-19 environment. In addition, resources have been developed to inform students and tertiary education provider staff about MDHB's requirements around COVID-19 vaccination status, including amendments to access agreements.

3.5.2 Connectedness

Leadership, communication and visibility has been further strengthened this month, with all senior nurses working hard to support their teams. Several students (Trainee Interns, Nursing, Midwifery and Allied) have responded to an Expression of Interest for COVID-19 Case Investigation, Contact Tracing and Testing and swabbing support. These are paid positions, with initial training and onboarding provided by the Associate Director of Nursing (ADON) Education and Nurse Recruitment Consultant.

The Nurse Educator Primary Health Care is supporting testing and vaccination sites, as well as iwi/Māori providers with their vaccination clinics. Māori Women's Welfare League gifted a Family Resuscitation Pack of three mannequins (infant, child, adult) so the Nurse Educator can upskill iwi/Māori providers in cardiopulmonary resuscitation (CPR). As they want their people to have a recognised qualification, they have also paid for the Nurse Educator to be trained and certified as an authorised trainer by an external provider.

3.5.3 Supporting at work

The Nursing Council of New Zealand (NCNZ) has produced a consultation document on the amendment to the Education Programme Standards in response to the COVID-19 pandemic, to support the continuity of the nursing workforce pipeline. Key aspects of public health management and practice related to an outbreak – for example vaccination, case identification through swabbing, contact tracing and case management – will be able to be credited towards clinical learning experiences for nursing students in programmes leading to registration as an RN. Paid employment of nursing students can also be considered.

This recognises that existing and well-known health and social inequities already experienced by Māori and Pacific peoples in Aotearoa New Zealand, means these communities are at substantial risk in the current pandemic. Enabling Māori and Pasifika students to work with their local communities, where they will be recognised for their work, is seen to reduce disparities for these students and their communities.

MDHB is working with community partners and Whānganui DHB to implement the Registered Nurse Prescribing in Community Health programme, by April 2022. They will complete a work-based education programme and then apply to NCNZ for prescribing authority for a limited number of medicines for minor ailments and illnesses in normally healthy people, without significant health problems. The preparation, role and responsibility for prescribing in community health is different from nurse practitioner prescribing and registered nurse prescribing in primary health and specialty teams.

The Council believes that this prescribing will:

- make care more convenient for patients
- free up medical and nurse practitioners' time
- improve patient access to healthcare
- build on the existing skills, knowledge and accountabilities of registered nurses, while creating a further pathway for Nurse Practitioner/Specialty prescribing.

Appendix One
Nursing Workforce Action Plan – September 2021

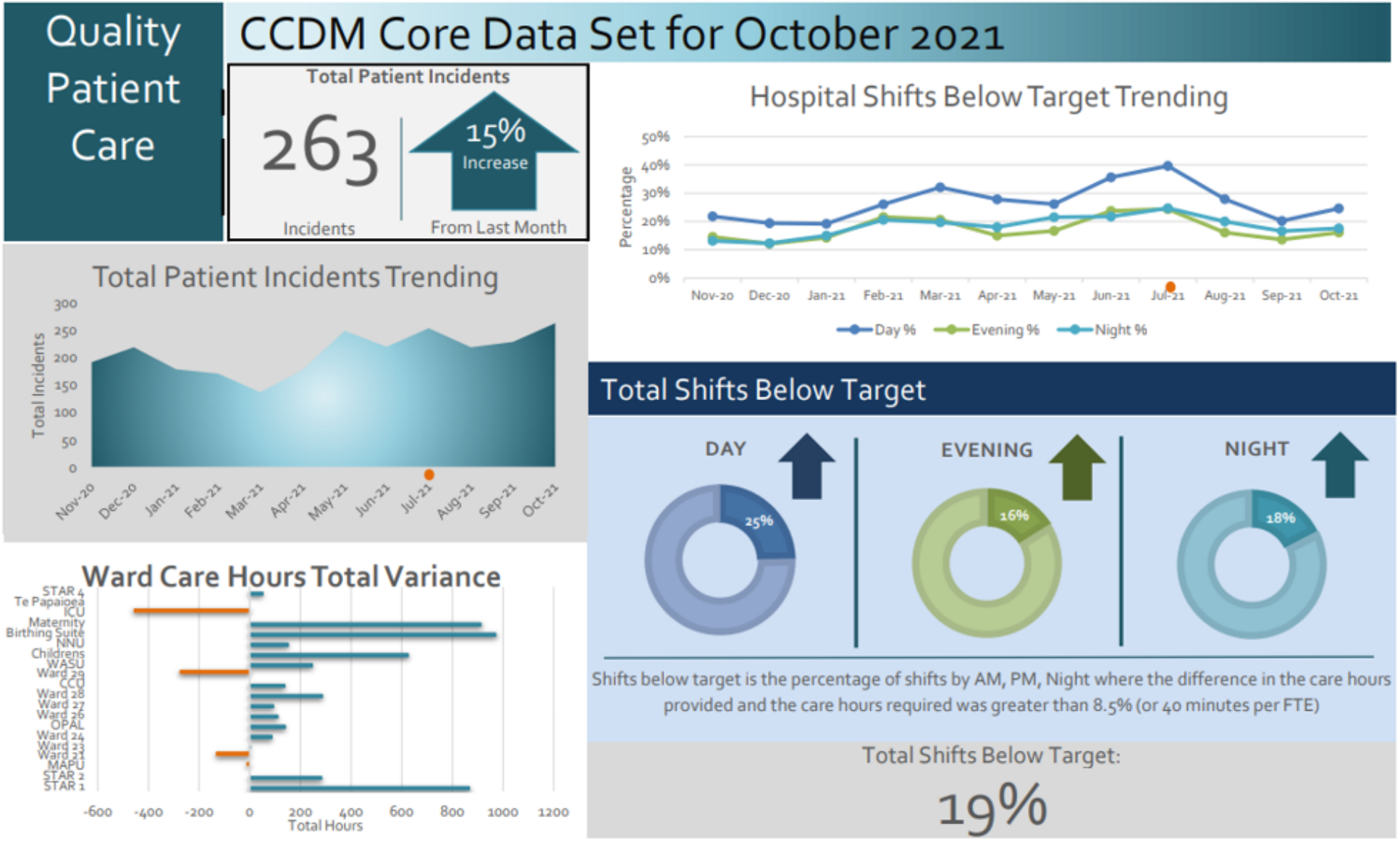
Not Started	Completed	On Track	Overdue	High Risk

	Target Date	Owner	Update	Status
Recruitment				
Deep dive work on FTE establishment, initially targeting MH&A (Ward 21) and HAR (OPAL)	Completed	Scott Ambridge Operational Executives	Work continues, gaining a better understanding of FTE figures, including clarity on headcount, overtime, penal rates, call backs and on call. This work is reported to the Board within each directorates' finance reports.	
Complete establishment FTE by directorate and move to BAU ready for budget setting	Ongoing	Operational Executives	Work continues with MHAS ward 21, OPAL, STAR wards 1/2 and 4	
Make any relevant CCDM adjustments for 21/22 budget.	Completed	Darryl Ratana Scott Ambridge		
Include Specialing in baseline budgets in high use areas. i.e., Ward 21, OPAL, Ward 26.	Ongoing	Darryl Ratana Scott Ambridge	Awaiting ward 21 and OPAL CCDM FTE calculations.	
Review long term vacancies	Ongoing	Professional Leads Nursing Recruitment Consultant Operations Executives People and Culture GM Q& I		
Ensure all Māori and Pasifika are shortlisted and recruited to vacant positions.	Ongoing	EDNM ADoNs People and Culture Senior Nurse leads Senior Midwife leads	Ensure equity within recruitment of Māori and Pasifika nurses into the workforce.	
Ensure all new graduate nurses are supported through the recruitment process especially Māori and Pasifika students.	Ongoing	ADON Education NE NETP	NETP/NESP Māori and Pasifika nurses prioritised for interview. Nurse Educator Māori supports candidates with interview preparation. Sixteen Māori nurse applications this month for NETP/NESP.	

Establish nursing post to oversee nursing recruitment (Senior Nurse / Nurse Consultant).	Completed	EDNM People and Culture Nurse Consultant Clinical Executives	Recruited and appointed. Confirmed positions are not being held.	
Review current recruitment process (current 12 weeks) – remove duplication, increase flexibility.	Due December 2021	People and Culture Nurse Consultant	Improve timeliness of recruitment process.	
Review orientation and onboarding processes.	Due December 2021	People and Culture Nurse Consultant	Consider establishment of nursing recruitment office, workforce unit, centralised roster.	
Nursing Bureau and nursing centralised roster.	Due December 2021	Nurse Consultant IOC Lead IOC Team	Consider establishment of nursing recruitment office, workforce unit, centralised roster.	
Review current arrangements for nursing bureau	August/September 2021	Nurse Consultant IOC Lead ADONs N&M Leadership	Review proposed model and FTE allocation. Review onboarding process for bureau staff and Duty Calls staff.	
Retention				
Optimising training: offer external training opportunities funded by NEED, HWNZ and Medical Trust	Ongoing	ADON Education NEED Committee Education & Practice Council	Funds fully utilised in 2021. Expression of Interest released in September for 2022 HWNZ funding applications with 145 applications received.	
New Manager training programme developed and rolling out in 2022	Ongoing	ADON Education OD Business Partner	In progress	
Six-weekly union partnership meetings to be commenced	Ongoing	EDNM People and Culture	Six-weekly meetings occurring/BAG.	
Clinical Safety				
CCDM process to be completed	December 2021	EDNM CCDM Governance Group	On track. SSH work assessment completed 9/10 November	
Clinical Nurse Educator support for all nurses: expand nursing educational team	July 2021	EDNM ADON Education	Business case developed for 21/22 year – shared with Ops Execs. Not endorsed.	
Confirm educational components in each clinical area.	August 2021	ADON Education	Essentials Skills revision with Education and Practice Council.	

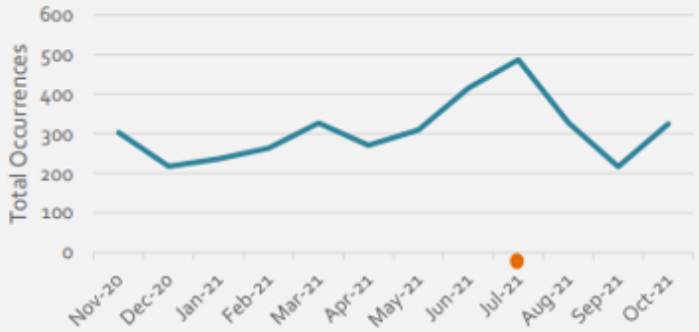
Professional				
Confirm delineation of professional roles – operational v professional.	Ongoing	EDNM Clinical Executives	Clarify roles and responsibilities for professional accountability.	
Senior nurses advanced practice plan	Ongoing	EDNM Clinical Executives	Ensure Professional Leads are holding Ops Execs to account for delivering workforce needs.	
Consider other roles working at top of scope – HCAs and Enrolled Nurses (career progression).	Ongoing	EDNM ADON Education	Improve use of enrolled nurses and HCAs; discussions held with UCOL re ENs.	
Staff Wellbeing				
Review current quarterly plans – top three priority areas identified in staff survey.	September 2021	EDNM GM People and Culture OD Business Partner		
Pilot in place for Bradford scoring for monitoring/assessing staff absence.	Pilot commenced	GM People and Culture		
Commitment to timely annual leave and rostering processes	Ongoing	EDNM ADONs Operations Leads Charge Nurses	Difficulty allocating annual leave due to staffing levels – work in progress to ensure all specialities have a plan in place for all staff leave.	
Increase support for staff through access to Supervision, peer-to-peer Coaching and cultural supervision	Ongoing	ADON Education Supervision Project Group	Stock take training and access to/uptake of supervision and coaching. Working group established to progress. Charge Nurses to undertake Pilot Programme	

APPENDIX TWO – CCDM Dashboard October 2021



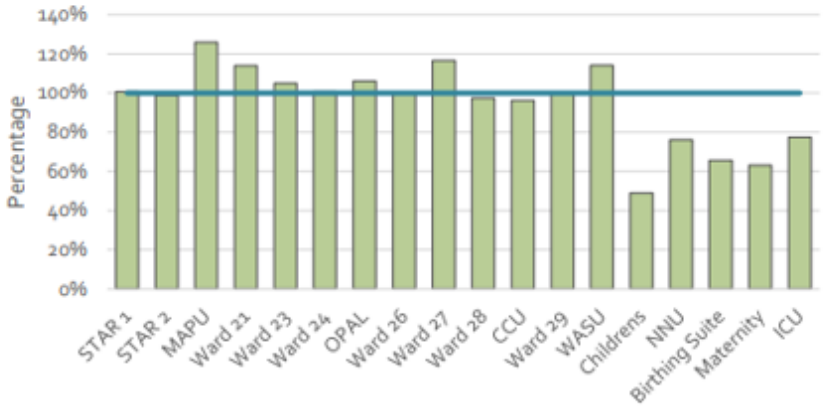
Quality Patient Care

Anticipated Care Rationing Occurrences Trending



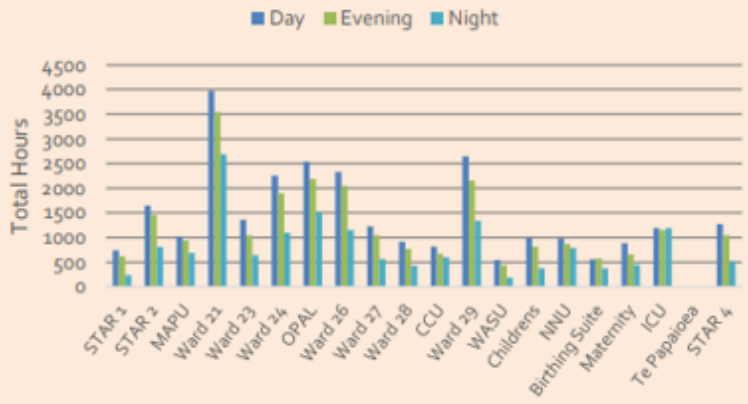
All care that was missed, delayed, sub optimally delivered or inappropriately delegated, as reported by staff. Also defined as 'care left undone' due to lack of time, material resource, poor communication or teamwork.

Ward Bed Utilisation



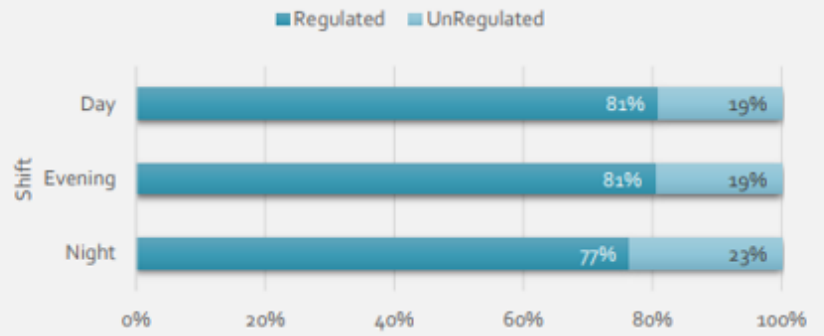
Bed utilisation reflects the throughput of patients during a calendar day – accounting for all discharges, deceased patients, admissions and transfers for the shift on which the patient received care.

Ward Total Patient Acuity



Patient acuity is the patient's level of dependence on nursing staff due to their care requirements. This is described as nursing hours required by patient acuity.

Staff Mix



The number of regulated staff (RN, RM and EN) that worked, compared with all staff that worked expressed as a percentage for AM, PM and N

Quality Work Environ-ment

CCDM Core Data Set for October 2021

Unplanned Leave

6289.5

Total Hours

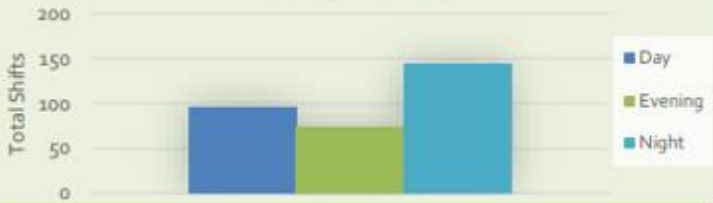
7%

Percentage

From Last Month

The total unplanned or short notice leave hours taken by staff e.g. sick, domestic, bereavement, ACC. This includes sick leave hours paid, unpaid or paid as annual leave. Includes staff on permanent contracts only.

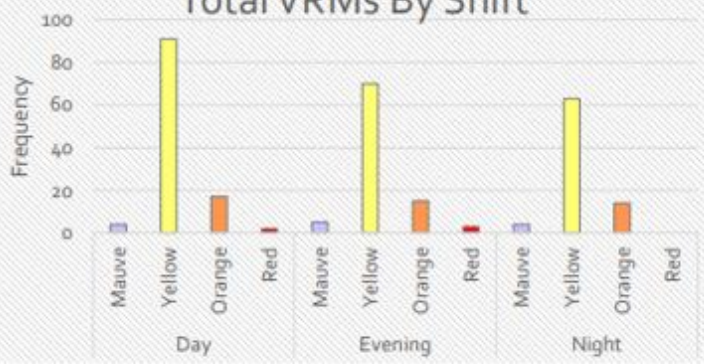
Roster Gaps



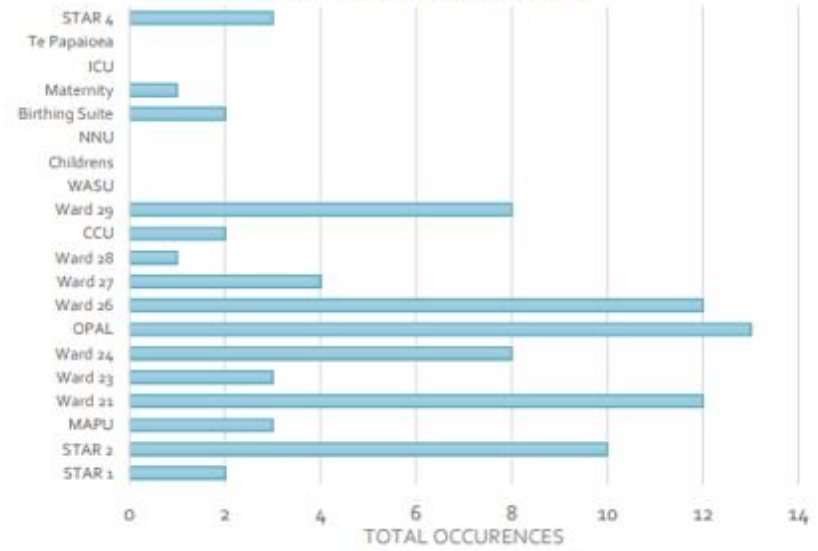
Roster gaps are the degree to which the posted/planned roster matches the roster model.

Staff Unplanned Leave Trending

Total VRMs By Shift



Total Staff Incidents



Total Staff Overtime

Overtime includes any extra paid hours that a nurse is required to work beyond their contracted hours at either end of their shift.

Total Professional Development Hours for the Month

1,316

CCDM Core Data Set for October 2021

Best Use of Health Resources

Staff Hours

5,067

Total Casual Staff Hours

5%

Casual Staff Percentage

93,072

Total Nursing Staff Hours

The total hours includes all productive (clinical and other productive hours) and non-productive (annual, sick, bereavement) hours .

ED Length of Stay Percentage

The ED Length of Stay Target is the 'Shorter Stays in Emergency Department (ED)' i.e. Patients admitted, discharged, or transferred from the ED within six hours. The target is 95%.

Excess Accrued Leave

17%

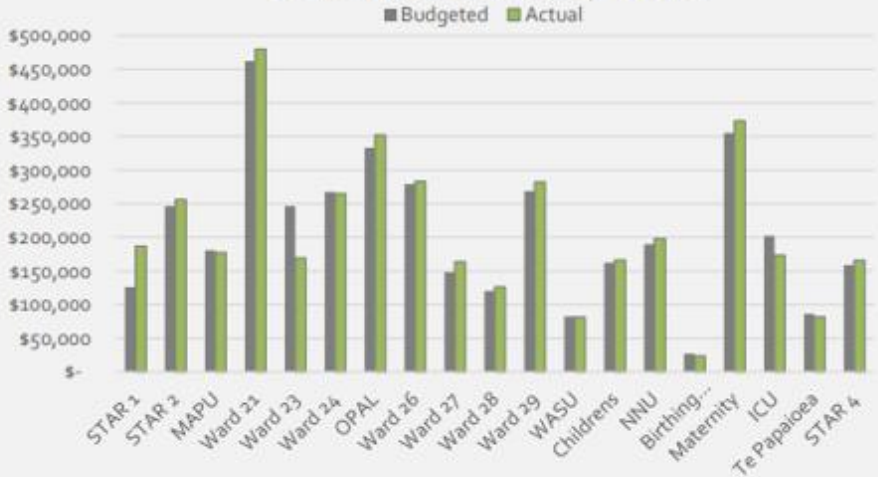
Percentage of Discharges Before 11am

333

Total Number of Patients Discharged Before 11am

Wards Percentage of Discharges Before 11am Trending

Personnel Costs By Ward



BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Does the Board agree with the variations made to the Terms of Reference for the Clinical and Consumer Councils?

To	Board
Author	Judith Catherwood, General Manager, Quality and Innovation
Endorsed by	Kathryn Cook, Chief Executive
Date	19 November 2021
Subject	**Terms of Reference – Consumer and Clinical Councils**

RECOMMENDATION

It is recommended that the Board:

- **approve** the changes made to the Terms of Reference for the Consumer and Clinical Councils.

Strategic Alignment

This report is aligned to MidCentral District Health Board's (MDHB) strategy and all strategic objectives.

1. PURPOSE

To seek Board approval for recommendations to refine and expand areas of the Terms of Reference for the Clinical and Consumer Councils.

2. CONSUMER AND CLINICAL COUNCIL TERMS OF REFERENCE

The Clinical and Consumer Council members and Chairs have reached an agreement to redefine and align their Terms of Reference (ToR) to ensure consistency between the two documents. Included in the ToR is the Clinical and Consumer Council members' new commitment to have a representative on each of the Enterprise Governance Groups to ensure they are at the forefront of planning and improvements within MDHB.

The commitment of both Councils to address equitable health outcomes for Māori and priority populations to ensure the care they require is accessible and delivered appropriately is included in the updated TORs. Membership numbers have been clarified and wording updated so the TORs of both Councils are aligned.

Titles and leadership terms have been updated to match and are consistent with changes in primary health and MDHB.

Amendments are highlighted on the revised ToRs, which are attached.

CONSUMER COUNCIL
Terms of Reference

1. PURPOSE/BACKGROUND

The Consumer Council will provide independent advice and support to the Board and Management on matters from a consumer perspective.

Consumer engagement is a key feature under the MDHB Strategic Imperative of *Partnering with people and whānau to support health and wellbeing.* The first objective under this imperative is to establish an organised consumer voice to ensure consumers actively participate at all levels of the organisation to help improve health outcomes in MDHB.

The Council will provide advice and support to assist MDHB achieve a person and whānau-centred partnership in models of care, where patients are partners in their own health care and consumer engagement and participation occurs throughout the district.

The Council will provide advice and support to assist MDHB address equitable health outcomes for Māori and priority populations to ensure the care they require is accessible and delivered appropriately.

The purpose of the Consumer Council is to advocate for consumers including using a co-design approach to the planning and performance of integrated services in MDHB cluster groups and Enterprise Clinical Governance Groups.

2. RESPONSIBILITIES/FUNCTIONS/EXPECTED OUTCOMES

The functions and responsibilities of the Consumer Council are to:

2.1 Ensure patients/ consumers and families/whānau are encouraged and supported in participating in the delivery of care and decision-making at the level they choose.

2.2 Identify and advise on priority areas of work and issues requiring consumer, whānau and community participation, including input into the development of health service priorities and strategic direction, the elimination of inequities, and the enhancement of safety and quality of services to patients and whānau.

2.3 Review safety, quality and performance data, including consumer feedback and make recommendations for service delivery improvements.

2.4 Monitor and advise on reports, development and initiatives relating to health service delivery and the availability and/or dissemination of health related information.

2.5 Ensure regular communication and networking with locality groups, the general community and relevant consumer groups.

2.6 Link with specific interest groups, as required for specific issues and problem solving.

2.7 Establish a wider pool of consumers who will be trained and utilised to support the co-design and continual improvement of services.

3. EXCLUSIONS

For the avoidance of confusion, the Consumer Council will not:

- Provide clinical evaluation of health services or individual patient care plans
- Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes already exist
- Be involved in MDHB's contracting processes.

4. MEMBERSHIP/REPRESENTATION

Members will have diverse backgrounds, networks, knowledge and skills, and must be passionate about people being able to access the best possible services and care from MDHB.

Membership of the Consumer Council will reflect the diversity of the MDHB community. However, members will not be appointed as a representative for a specific consumer group or a specific part of the population. Any consumer residing in the MidCentral DHB area is eligible to apply, except those employed by MDHB, THINK Hauora and their contracted provider organisations. If a specific perspective is required for any project, it would be sought.

The Consumer Council will consist of 10-12 appointed members for a three-year term. In addition, there will be an Independent Chair of the Consumer Council who will be appointed by the Board MDHB on the recommendation of the Chief Executive MDHB and THINK Hauora.

Members will have the option of contributing for two three-year terms with the ability to have a third term at the Chair's discretion.

A staggered approach to appointments will be taken to ensure the Consumer Council continues to benefit from members with experience as well as new perspectives.

The Chair of the Consumer Council can propose that new members be co-opted, if numbers on the Council fall below 12 during any term of office and if they have specific skills or abilities needed by the Council which are not available among existing members.

Appointment will be dependent on collective agreement with Council members, the Chair and Executive Lead.

Appointment to fill Council term positions or for co-option will be approved by the Chief Executive MDHB and THINK Hauora.

The Consumer Council will work in partnership with MDHB's Clinical Council.

5. TRAINING

Training will be provided to members of the Consumer Council regarding their role, and to equip them with the tools they need to carry it out. While attendance is voluntary, it is highly recommended that members attend whenever possible, particularly when the topics may be new to them.

6. OFFICERS AND THEIR RESPONSIBILITIES

Chair
The Chair will call for agenda items two weeks in advance of the meeting and provide the agenda and any related documents to the members one week in advance of the coming meeting.

On the request of MDHB Board Chair, the Chair of the Consumer Council has been asked to be member of the Health and Disability Advisory Committee (HDAC).

Administrative Support
- Organise, type and distribute agenda to members one week before meetings
- Record, type and distribute minutes to members
- Keep accurate records of proceedings.

Council Members
- It is an expectation that members will attend all meetings; apologies will be accepted if members are unable to attend
- Access all communications via email or other approved MDHB digital networks
- Members may resign at any time by advising the Chair in writing.

Termination
Membership of the Consumer Council may be terminated on advice of the Chair. In circumstances where there is reasonable cause to discontinue future participation, the Chair will advise MDHB through the lead Executive support for the Consumer Council. Should such circumstances arise, the individual will be notified through written correspondence from the Chief Executive, detailing the cause for termination and date that the membership conclusion will take effect.

Engagement at Consumer Council meetings and commitment to the role of the Consumer Council is vital to the success of the Council. It is expected that Council members will attend at least seven of the 10 meetings per year.

Causes for termination may include but are not limited to:
- Violence or threatened violence
- Inappropriate behavior such as harassment or discrimination
- Failure to attend meetings or give a reason for non-attendance.

The Chair may counsel members should their behaviour not be keeping in line with MDHB's values.

7. MEETING STRUCTURE

7.1 Meetings will be held on a four to six-weekly basis, with a maximum of 10 meetings per year. The Chair may call additional meetings outside of those scheduled to deal with matters that arise that are of interest to the Consumer Council.

7.2 A quorum relies on the attendance of 60 percent of committee members being present.

7.3 Meetings will continue as scheduled even if a quorum is not present but any decision making will be deferred until a quorum is reached (this may be done via email communication outside of regular meetings).

7.4 Oral or written submissions from MDHB staff regarding professional/ clinical issues may be requested/received by the Consumer Council. Other representations made to the Council will be accepted at the discretion of the Chair.

8. REPORTING/FUNDING

The Consumer Council will provide the Board with a report on a six-monthly basis. The Consumer Council will jointly present with the Clinical Council to the Board once per year.

The Council will have access to resources to advance its work programme. This will be via the identified lead Executive member of the Organisational Leadership Team (OLT). Recommendations will be made to OLT as required.

Minutes of the Council meeting and any recommendations once approved will be placed on the MDHB website.

9. REVIEW/AMENDMENTS

Variations to the Terms of Reference require endorsement by MDHB. The Consumer Council will evaluate its Terms of Reference, performance, membership and need for continuation annually.

MidCentral DHB Clinical Council
Terms of Reference

1. BACKGROUND

The Clinical Council can provide an independent strategic clinical perspective and commentary on all matters regarding the implementation of the MidCentral DHB's Strategy.

The Clinical Council will provide input on planning priorities, clinical leadership, systems and quality; on factors influencing both the health and wellbeing of the people of our district; of the local community (health outcomes); the health and wellbeing (effectiveness and robustness) of the local health sector. The Council may encourage informed debate on these matters, and will provide counsel on all issues referred to it for consideration.

The Clinical Council will support the MDHB in addressing equitable health outcomes for Māori and priority populations to ensure the care they require is accessible and delivered appropriately.

2. PURPOSE AND EXPECTATION

The Clinical Council's focus is across four broad areas, being:

Health Inequities

Quality and safety; the health outcomes and patient/client experience drive decision-making, and patient/client is seen and treated as a partner in their healthcare.

Workforce; developing a district clinical workforce which is engaged and committed to service improvement and to better patient care, and where, clinical leadership is fostered and supported.

Systems; for organising and delivering care across the sector, with an aim of involving health professionals (clinicians) in leading improvement and working in partnership with those receiving care.

- The Clinical Council may provide advice to the Board and Organisational Leadership Team of MidCentral District Health Board. It is expected that the Clinical Council will provide appropriate clinical advice and be used by the Clusters at an early stage of the following: Matters put forward by the DHB on which it is seeking and independent clinical perspective all MDHB strategies/plans and frameworks.
- The Clinical Council will have members on the Enterprise Clinical Governance Groups and provide input via these channels.
- Significant service changes or transformation work at DHB level and within the clusters.

- Clinical priories included in the development of the annual plan.
- New initiatives or concepts at work up stage e.g. new technologies in health, new workforce models or significant new clinical techniques.
- Influence and add direction/input to Sustainability plans e.g. finance, workforce or staff wellbeing.

3. FUNCTIONS/EXPECTED OUTCOMES

The Clinical Council will provide clinical knowledge or expert advice when requested, or when the Council sees fit, regarding:

- Patient safety and clinical quality.
- The impacts of a proposed system or service changes.
- Related or interdependent services.
- The health status of the population.
- The strength and effectiveness of clinical engagement, and clinical leadership.
- The most effective use of resources and prioritising that use.
- The Clinical Council will seek to include the clinical community at large by encouraging strategic input and initiatives that the DHB could consider and also, inform the clinical community at large as the activity of the Council.
- The Clinical Council can initiate, influence and monitor key initiatives to achieve good health outcomes.

The Clinical Council will work in partnership with the DHB's Consumer Council to ensure local health and disability services are organised around the needs of the people. In addition, that health literacy and consumer empowerment are promoted, as well as a co-design philosophy and approach.

4. MEMBERSHIP/REPRESENTATION

Membership of the Council will reflect that richness in diversity, i.e. a range of health professions, people from all parts of the health sector and with difference levels of experience.

~~The Board is responsible for the appointment of the Clinical Council's Chair, and on the recommendation of its CEO and the CEO of THINK Hauora. The Chair is appointed for a three year term.~~

The Clinical Council will consist of ten to twelve members for a three year term. In addition there will be an Independent Chair of the Clinical Council who will be appointed by the Board of MDHB on the recommendation of the Chief Executive MDHB and Think Hauora. The Chair of the Clinical Council may choose to make co-opting arrangements to access people who have specific skills or abilities needed by the Council. This is to ensure there is a balance of perspectives and recommendations for co-opting will be submitted to the Chief Executive of MidCentral DHB and THINK Hauora. Co-opted members shall be voting members.

Members, including the Chair will have the option of contributing for two three year terms with the ability to have a third term at the Chair's discretion.

Members may be re-appointed and a staggered approach will be taken to ensure the Clinical Council continues to benefit from members with experience as well as new perspectives.

5. OFFICERS AND THEIR RESPONSIBILITIES

Organisational Leadership Team

The General Manager, Quality and Innovation, MidCentral DHB will have responsibility for the Clinical Council. The Clinical Council will have access to funding to advance its work programme via the lead OLT member. The Clinical Council Chair will liaise with the Executive Lead with regard to appropriate resources to support the functionality of the Council.

Administration Support

The Clinical Council Administrative Support will:

- Organise, type and distribute agenda's to members seven days before meetings.
- Record, type and distribute minutes to members within seven days of meetings.
- Keep accurate records of Council proceedings.
- Undertake other administrative duties as required by Council.

Clinical Council Members will

- It is an expectation that members will attend all meetings, apologies will be accepted if members are unable to attend.
- Access all communications via email or other approved MDHB digital networks.
- Members may resign at any time by advising the Chair in writing.
- ~~Apologies will accepted for emergencies or illness~~.
- While attendance is voluntary it is recommended that members assist high level Clinical Governance committees when requested.
- Consider assisting work groups to deliver on specific initiatives.

6. MEETING STRUCTURE

The schedule for the Clinical Council meetings will be decided annually. It is anticipated that ten meetings will be held per annum.

The Chair may call additional meetings outside of those scheduled to deal with matters that arise that are of interest to the Clinical Council.

A quorum relies on the attendance of sixty percent of the committee members being present. Meetings will continue as schedule even if a quorum is not present but any decision make will be deferred until a quorum is reached (this may be done via email communication outside of regular meetings).

7. REPORTING

The Clinical Council will provide the Board with a report on a six monthly basis. The Council will have access to funding to advance its work programme via the Lead Organisational Leadership Team (OLT) member. Recommendations will be submitted to OLT via the reporting template.

8. REVIEW/ADMENDMENTS

Variations to the terms of reference require approval by the Board. The Clinical Council will evaluate its terms of reference, performance, membership and need for continuation annually.

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Does the alcohol position statement reflect the vision and values of MDHB?

To	Board
Author	Kelvin Billinghurst, Clinical Executive, Te Uru Kiriora Deborah Davies, Operations Executive, Te Uru Kiriora
Endorsed by	Health and Disability Advisory Committee Kathryn Cook, Chief Executive
Date	1 December 2021
Subject	**MidCentral District Health Board's Position Statement on Alcohol**

RECOMMENDATION

It is recommended that the Board:

- **note** the Position Statement on Alcohol was endorsed by the Health and Disability Advisory Committee at its November meeting
- **approve** the MidCentral District Health Board's Position Statement on Alcohol.

Strategic Alignment

This Position Statement aligns to the DHB's strategy and strategic imperatives, in particular partnering with people and whānau to support health and wellbeing, with a focus on equity as a priority.

1. PURPOSE

To provide an update to the Board on the MidCentral District Health Board's (MDHB) Position Statement on Alcohol.

This paper was reviewed by the Health and Disability Advisory Committee at its meeting on 23 November 2021. The Committee requested changes, including that statements around the principles of Te Tiriti o Waitangi be strengthened and that the background note that alcohol is a carcinogen. These changes have been included in the attached Position Statement on Alcohol.

2. BACKGROUND

Alcohol was identified as one of two key priorities for National Public Health Advocacy in 2020 with the District Health Board (DHB) National Chief Executives endorsing the approach of the National Public Health Advocacy Team in its support and co-ordination with DHBs on alcohol-related harm to:

- advocate for a review of the Sale and Supply of Alcohol Act 2012 and to identify key opportunities and influencers to achieve this
- support DHBs to adopt Position Statements on Alcohol and Harm Minimisation Action Plans
- support DHBs to adopt and ensure consistent measurement and implementation of key alcohol programmes including the Alcohol ABC Approach.

Alcohol is not an ordinary commodity[1] but an intoxicant, toxin, carcinogen, and an addictive psychotropic drug. While seen by many as a normal, harmless part of New Zealand life, it causes more harm than any other recreational drug.[2] The way alcohol is viewed, sold, supplied and marketed in New Zealand influences how much, and the way in which, people drink. Hazardous alcohol use has impacts across many sectors of society and contributes to sizeable problems in New Zealand in respect of physical and mental ill health; and social and economic burdens.[3]

Alcohol use can affect peoples' relationships, and ability to work or study. Harm from alcohol extends beyond the individual and can result in harm to children (including those exposed to alcohol during pregnancy), whānau, friends, and the wider community.[4]

The harm is not limited to those with alcohol addiction and dependence, or to those drinking excessively, but affects even those who drink low to moderate amounts.[5,6,7,8] These harms are not distributed evenly across our communities, with some population groups more affected than others.[9]

In December 2012, the government introduced the Sale and Supply of Alcohol Act 2012.[10] This act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are a broader definition of alcohol related harm; an increased role of the Medical Officer of Health, and the ability of Councils to adopt Local Alcohol Policies restricting hours, density and location for alcohol purchase or access. However, over the last decade the Government has only made limited progress towards reducing alcohol- related harm by introducing this new Act, lowering blood alcohol limits, increasing alcohol screening and brief interventions in primary health care, and increasing funding for alcohol and drug addiction services. Despite this, rates of hazardous drinking have not improved.

The MDHB position on alcohol in our communities has been developed in the context of the principles of Te Tiriti o Waitangi, which necessitate comprehensive strategies that address longstanding inequities in alcohol-related harm between Māori and non-Māori.

The appended Position Statement has been developed by the Public Health Unit (PHU) in partnership with key stakeholders. This details the key commitments, the adoption of evidence-based strategies to reduce harm, the alignment of aligned government policies and the internal and external activities that the PHU is committed to progressing. A broad summary of available evidence is provided for further reference. This complements the Nutrition and Physical Activity Policy endorsed late 2020 which is under implementation.

Note: The footnotes in this report relate to the appended Position Statement.

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

MIDCENTRAL DISTRICT HEALTH BOARD POSITION STATEMENT ON ALCOHOL

BACKGROUND:

Alcohol is not an ordinary commodity[1] but an intoxicant, toxin, and an addictive psychotropic drug. While seen by many as a normal, harmless part of New Zealand life, it causes more harm than any other recreational drug.[2] The way alcohol is viewed, sold, supplied and marketed in New Zealand influences how much, and the way in which, people drink. Hazardous alcohol use has impacts across many sectors of society and contributes to sizeable problems in New Zealand in respect of physical and mental ill health; and social and economic burdens.[3]

Alcohol use can affect peoples' relationships, and ability to work or study. Harm from alcohol extends beyond the individual and can result in harm to children (including those exposed to alcohol during pregnancy), whānau, friends, and the wider community.[4] Long term harms and consequences are seen in the strong association with cancers particularly melanoma, pancreatic and prostate cancers.

The harm is not limited to those with alcohol addiction and dependence, or to those drinking excessively, but affects even those who drink low to moderate amounts.[5,6,7,8] These harms are not distributed evenly across our communities, with some population groups more affected than others.[9]

POLICY AND LEGISLATIVE ENVIRONMENT

MDHB position on alcohol in our communities has been developed in the context of the principles of Te Tiriti o Waitangi, which necessitate comprehensive strategies that address longstanding inequities in alcohol-related harm between Māori and non-Māori.

In December 2012, the government introduced the Sale and Supply of Alcohol Act 2012.[10] This act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are a broader definition of alcohol related harm; an increased role of the Medical Officer of Health, and the ability of Councils to adopt Local Alcohol Policies restricting hours, density and location for alcohol purchase or access.

MIDCENTRAL DHB POSITION:

MDHB desires to see a reduction of alcohol-related harm. This requires the following commitments. -

1. The District Health Board acknowledges the disparity of alcohol-related harm among Maori and remains committed to –
    a. Te Tiriti o Waitangi principles of Tino rangatiratanga, Equity, Active Protection, Options and Partnership in the ongoing design, delivery and monitoring of alcohol strategies and interventions
    b. Achieving improved outcomes through the delivery of alcohol prevention and clinical services in partnership with iwi and Maori providers for the district
    c. Recognizing that any health response needs to be culturally appropriate and responsive to Maori and

d. A strong partnership between iwi and Maori providers throughout the design and deliver of services.

2. The District Health Board will lead by example –

    a. That alcohol will not be sold or provided on District Health sites / premises or at DHB events
    b. Regulate and actively monitor compassionate or extraordinary exemptions as described below
    c. Not advertising or promoting alcohol, or alcohol-related events;
    d. Not accepting sponsorship from alcohol-related entities;
    e. Ensuring no Vote Health funds are spent on alcohol;
    f. These positions will be promoted among partners and into the community

3. The adoption of effective population-based strategies to reduce harmful use of alcohol including. This includes –

    a. reducing the availability of alcohol;
    b. increasing the purchase age;
    c. supporting adequate roadside enforcement testing;
    d. increasing the price via ethanol-level-based excise tax and/or minimum unit prices;
    e. and reducing alcohol advertising and marketing.

4. Supporting all government policies that -
    a. Reduce excessive drinking by adults, young people and pregnant women;
    b. Reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes;
    c. Support the safe and responsible sale, supply and consumption of alcohol;
    d. Improve community input into local alcohol licensing decisions;
    e. Improve the operation of the alcohol licensing system.

5. Actively working towards reducing alcohol harm inequalities and promoting healthy alternatives

This requires internal and external activities such as –

1. An ongoing updated MDHB Alcohol Harm Reduction Strategy and Action Plan
2. Promoting harm reduction strategies regarding alcohol through the provision of information to –
    a. Health care professionals
    b. All staff &
    c. The public.
3. Increasing opportunities for screening and brief interventions in DHB and partner settings (emergency departments, primary care and midwifery settings).
4. Supporting public health and clinical staff in their work to; plan for, promote, support and deliver alcohol harm reduction and treatment strategies appropriate for our regions' communities.
5. Public health nurses supporting alcohol statements in schools.
6. Increasing access to treatment options for alcohol across the region with particular attention to Maori by resourcing iwi and Maori providers to deliver to Maori.

7. Actively working to increase our capacity to assess the impact of our interventions through monitoring, evaluation, and appropriate research.
8. Actively working to increase our capacity to monitor the impact of alcohol and drug-related harm on health services especially with an equity focus
9. Engaging with local government, iwi and our community partners to identify alcohol issues and support the implementation of local solutions.
10. Supporting and assisting Territorial Authorities to develop local alcohol plans that seek to reduce alcohol-related harm and working collaboratively with Police and Territorial Authorities on licensing issues and monitoring compliance.

Exemptions

Alcohol consumption may be permitted on compassionate grounds as part of palliative or end of life care.

Alcohol may also be supplied to residents in aged-care facilities, as they are considered (in the context of this policy) to be living in their own home. These exemptions may only be granted by a consulting physician, charge nurse or duty manager. Exemption approval would need to include consideration of:

- Managing the quantity of alcohol brought in to the setting
- Storage and access
- Health and safety for a patient who consumes alcohol, e.g., falls risk
- Other patients for whom the concession is not granted

APPENDIX: Summary of Evidence

Alcohol Related Harm:

Alcohol use is a major risk factor for numerous health conditions, injuries and social problems. It causes approximately 5% of deaths worldwide[11] and 5.4% of all deaths in New Zealand under 80 years old.[12] Acute harm resulting from intoxication includes: road traffic injuries and fatalities, burns, falls, drownings, poisonings, foetal alcohol spectrum disorder, assault, self-inflicted injury, family harm, suicide and homicide.

Biological effects of alcohol

Alcohol affects the brain. It alters the mood and impairs memory and psychomotor function. People who consume alcohol are less inhibited and therefore more likely to take risks and behave aggressively, leading to motor vehicle accidents and other injuries.[13] Alcohol use is linked to a wide range of major diseases, including: heart disease, cancer (e.g. breast, mouth, throat larynx, esophagus, liver, large bowel and rectum)[14], psychiatric and neurological conditions, gastrointestinal disease, and birth defects including foetal alcohol syndrome.[6] It also contributes to diabetes, sleep disorders, and infectious diseases such as pneumonia and tuberculosis.[15] Some 4% of all cancer deaths are directly attributed to alcohol with indirect effects being higher[14].

Unborn children and adolescents are particularly vulnerable to the effects of alcohol. Unborn children exposed to alcohol are at higher risk of problems with memory, language, attention, learning, visuo-spatial ability, fine and gross motor skills, and social and adaptive functioning.[16,17] Adolescent brains are still developing and therefore vulnerable to alcohol toxicity, addictive problems, under-achievement and psychiatric disorders.[18,19,20,21]

Social and Economic Alcohol-related harm

Alcohol contributes to crime in New Zealand. Research shows that nearly half of all homicides in New Zealand involved alcohol. Around 40% of interpersonal offences are known to involve alcohol, with either the offender, the victim, or both, drinking at the time. Additionally, around a third of all offenders are estimated to have consumed alcohol.[12,22] Drink driving causes substantial harm - alcohol is known to have been a factor in 1 in 5 fatal crashes between 2017 and 2018. It is also a factor in 12% of serious injury crashes and 11% of minor injury crashes.[23]

Social harm results from alcohol: Almost half of adults experienced harmful effects on friendships, social life, home life, work/study/employment opportunities, financial position, and legal problems or difficulty learning from their own or others drinking in the past year. [24]

The economic cost of alcohol-related harm in New Zealand is significant. Depending on the methodology, estimates have ranged from $1.2 billion to $7.85 billion annually.[25] Recent studies show $1.65 billion in lost productivity alone, suggesting the total economic cost of diverted resources is considerably more and well in excess of the $1.4b excise tax take from alcohol. [26,27]

Alcohol-related harm and population groups

Alcohol-related harm is experienced variably throughout the population. Men have a higher rate of alcohol-related mortality than women and Māori have a higher rate than non-Māori.[9,12,28] Evidence clearly demonstrates that Māori suffer disproportionately from a wide range of alcohol-related harms compared to non-Māori.[9] New Zealanders with lower socioeconomic status also bear a disproportionate burden of alcohol-related harm.[29, 30] Children are particularly vulnerable to alcohol-related harm caused by the drinking of other people and can suffer from increased susceptibility to child abuse, neglect and witnessing family violence if caregivers have an alcohol problem.[9,31]

Cost of alcohol-related harm to the health sector
Alcohol-related harm in New Zealand costs the health sector significant money, time and resources.[25] Intoxicated patients may also impact negatively on staff and other patients.[32] An estimated 35% of injury-based national emergency department presentations are alcohol-related [22,33,34] and studies at MDHB have put this figure between 20 and 35%, with this figure rising to 61% between hours of 10.00pm and 6.00am.[35]

NZ Drinking Pattern:

Alcohol is widely available in NZ
Alcohol is easily accessible from a wide variety of outlets and to anyone over the age of 18. In the MDHB region it can be purchased in-person, 16 hours of the day, 7 days a week and on most days of the year. It can also increasingly be purchased on-line with short delivery times.

Alcohol can be consumed either on the premises (on-licences) in bars, restaurants, cafes, hotels, pubs and clubs or at special functions; or off the premises (off-licences) when purchased from liquor stores, supermarkets, or local grocery stores.

Alcohol is more widely available now than in the past. The number of licences of all types in the MDHB region (excluding Special Licences) is over 600, with around 200 in the Palmerston North area alone.

Alcohol is relatively inexpensive: a brief search of bottle store and supermarket websites on 3/5/21 found:

- 2 litres of cask wine that could be purchased for $17 (77c per Std Drink)
- 1 litre of 13.9% vodka costing $9.99 (91c per Std Drink) and
- A 500ml 12% beer costing $4.50 ($1.13 per Std Drink).

Drinking patterns in NZ
According to recent surveys, most New Zealanders (81.5%) have drunk alcohol in the last year and over half in the previous week. [9] While 82% of those surveyed drank at or below the recommended daily limit, 18% of drinkers got drunk some or most/all of the time and 26% of past year drinkers are "hazardous drinkers". (AUDIT score $\geq$ 8.)[24] While figures are often cited indicating reductions in New Zealanders drinking (and hazardous drinking), the reduction seems to have occurred between 2006/7 and 2011/12, with no further significant reductions since then. Hazardous drinking has increased since then in some groups, particularly in Māori women and older age groups. [36] More Māori and Pacific are non-drinkers than other groups, but hazardous drinking is more common amongst those who do drink. (Māori 46%, Pacific 38% vs 26% total population) Māori also have a death rate from alcohol twice that of non- Māori. [9,12]

How the current law impacts upon these drinking patterns
The Sale of Liquor Act (1989) liberalised the sale of alcohol, allowing it to be sold widely, including from supermarkets and over a 24 hour period. In 1999 the purchase age was dropped to 18 (from 20 years), beer became available in supermarkets and alcohol could be purchased on Sundays.
Having found that the liberalisation did not lead to the projected "café style" drinking, the Law Commission produced a 2009 report "Alcohol in Our Lives – Curbing the harm" which contained 153 recommendations and led to the Sale and Supply of Alcohol Act 2012. [13]
This was intended to put more controls around the sale and supply of alcohol but did not include some measures public health advocates felt were more likely to be effective against excessive consumption and alcohol related harm. The Sale and Supply of Alcohol Act 2012 was intended to place more power in the hands of local communities but subsequent developments (driven by extensive legal action by the alcohol industry) have been described as undermining the worthy intentions of the

review. It is felt by many that this has led to measures intended to address problems like exposure in supermarkets and relative lack of community influence on the granting of local licences, not delivering their potential benefits. The provisions for Local Alcohol Policies, (intended to enhance local control of the licensing parameters), have also not delivered on their promise.) [37]

Evidence Based Strategies to Reduce Harm:

Raise prices

Evidence shows that when alcohol prices go up, consumption goes down. One of the best ways to influence the consumption of alcohol is through pricing.[1] Alcohol prices are subject to excise tax, which in New Zealand is set at a particular rate depending on which band of alcohol strength the product falls into (e.g. alcoholic beverages between 9-14% alcohol are taxed at 10%).

Currently excise tax rates are lower than those of other countries and they are also not adjusted for inflation.[22] In New Zealand there is often a price differential between on and off-licences, which encourages "pre-loading" (loading up on cheap alcohol before frequenting on-licences) and more drinking in uncontrolled private locations. In other jurisdictions, minimum unit prices for alcohol have been shown to increase the price of the cheapest alcohol that is predominantly consumed by hazardous drinkers.[38]

Raise the purchase age

Research shows that the legal purchase age affects how much youth drink. A lower purchase age has been associated with increased harm (including traffic crashes).[39] In order for a higher purchase age to be effective, it needs to be combined with adequate enforcement.[40] A higher purchase age acknowledges that the effect of alcohol and its harms is much greater on the adolescent brain as it is still developing.

Reduce alcohol accessibility

It is practically and economically effective to restrict the physical availability of alcohol in order to reduce harm. Limiting the physical availability of alcohol can be achieved through limiting the hours and days of sale, controlling outlet density and tightening the law around the granting of licences. Currently alcohol is easily purchased, and high densities of alcohol outlets have been shown to be associated with increased harm, including traffic crashes.[1,10]

Reduce marketing and advertising

Advertising of alcohol has increased in many countries including Aotearoa/New Zealand over recent decades. Prior to the 1980s there was very little alcohol advertising in New Zealand due to legislation. Now alcohol advertising is left to the self-regulation of the industry. Since 1992, advertising of alcohol has been allowed on both television and radio – albeit at restricted times (8.30pm-6am) for television. Since 1987 alcohol companies have been allowed to sponsor sports and advertise corporately.[41] Alcohol advertisements often sell the image that drinking is attractive, glamorous and fun; and these messages are particularly appealing to young people. [42,43] Alcohol advertising not only leads to greater consumption of alcohol, but also colours people's perceptions of the drinking habits of others. [1,10, 44]

Support Drink-Driving countermeasures

The risk of motor vehicle accident increases exponentially with increasing alcohol consumption.[1,45] In New Zealand, it is estimated that over a quarter of road traffic injuries across all road user groups involve alcohol. [46] A recent Health Promotion Agency survey showed 23% of drinkers drove after drinking and 13% of all respondents had been in a vehicle after the driver had been drinking. [24] It is important that strategies to address the 100 plus impaired driving fatalities include adequate and well-publicised enforcement testing as well as media strategies. [47]

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Information papers

14 December 2021

Printed from Stellar by
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BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the work programme include the topics needed to confidently govern?

To	Board
Author	Margaret Bell, Board Secretary
Endorsed by	Kathryn Cook, Chief Executive
Date	23 November 2021
Subject	**Board's Work Programme**

RECOMMENDATION

It is recommended that the Board:

- **note** the Board's annual work programme.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'. It discusses an aspect of effective governance.

1. PURPOSE

To provide an update on the Board's work programme.

2. 2021 BOARD WORK PROGRAMME

The Board's work programme for 2021 was approved in December 2020. At its meeting in May 2021, the Board agreed that this work programme would be 'rolled over' for the period from 1 January to 30 June 2022.

As noted at the last meeting, reporting on the 12 new Health System Indicators, based on the Government's six priorities for health, is planned to commence in December 2021. Modified KPI dashboards reflecting the 12 indicators at a national and district level will be reported on quarterly, starting in February 2022. The work programme has been amended to show the KPI dashboard will no longer be presented to each meeting.

The following changes requested at the November 2021 meeting have been incorporated into the work programme.

Annual Plan and Budget 2022/23
Due to the disestablishment of District Health Boards (DHBs) on 30 June 2022, the Board will not need to approve a budget for MidCentral District Health Board (MDHB). All DHBs are required to provide information for Health New Zealand to enable them to establish their budget for the 2022/23 financial year. To ensure that the Board has oversight and an opportunity to identify any emerging risks, the information provided will be incorporated into MDHB's transition to Health New Zealand updates. These reports are already on the work programme and provided to the Finance, Risk and Audit Committee and Board meetings.

Memorandum of Understanding between MDHB and Manawhenua Hauora – triennial review
Manawhenua Hauora has agreed that the review due in September 2021 was not required, due to the transition to Health New Zealand and the Māori Health Authority in 2022. It has been removed from the Board's work programme.

Chief Executive's Performance Review
This review is scheduled to be carried out in August each year. As the DHB is to be disestablished on 30 June 2022, the Chief Executive's Performance Review will now be completed in May 2022.

All reporting is occurring in line with the work programme.

BOARD REPORT

MDHB BOARD Work Programme

	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Key Updates										
CEO's Report to provide an update on key progress of the DHB	Each meeting	X	X	X	X	X	X	X	X	CEO
FRAC Minutes and Verbal Update from the FRAC Chair to update the Board on key committee discussions	Each meeting Minutes	X Dec/Feb	X March	X May	X June	X July	X Sept	X Oct	X Nov	FRAC Chair
HDAC Minutes and Verbal Update from the HDAC Chair to update the Board on key committee discussions	Each meeting Minutes	X None	X Feb	X April	X None	X July	X None	X Sept	X Nov	HDAC Chair
Strategy and Planning										
DHB Strategy to review/refresh the DHB's strategy to ensure it remains relevant, and to consider how it has been advanced, and priorities for the future	Triennial (due Dec 2023)									GM SPP
Annual Plan and Budget to determine the draft and final budget and priorities for the next three years, including capex plan	Now part of Transition Plan reporting						X	X	X	GM SPP GM F&CS
Health Sector Reforms – Transition Plan for MDHB										
to update Board on planning and priorities to support smooth transition to Health New Zealand and the Māori Health Authority	Each meeting	X	X	X						
Workforce Strategy to establish/review the strategy based on the national framework (support the execution of the DHB's Strategy)	Triennial (due TBC)									GM P&C
Organisational Development Plan review/refresh (relevant and supports the execution of the DHB's Strategy)	Triennial (due Nov 2022)									GM P&C
Contract Renewal and Planning Outcomes Framework review planning outcomes achieved and general approach to contracting for year ahead	Annual			X						GM SPP
Quality Improvement										
Quality Account to determine the Quality Account for the financial year (via HDSAC)	Annual								X	GM Q&I
Quality and Safety Walk-rounds to provide the Board a summary of the walk-rounds from over the last 12 months	Annual			X						GM Q&I
Workforce										
Health and Safety to monitor the implementation of the H&S Strategy, mitigations required, priorities for the future, including investment	Quarterly	X		X		X		X		GM P&C
Health and Safety Workshop	Annual		X							GM P&C
Workforce and Organisational Development to monitor the health of the DHB's workforce, including trends and performance against workforce dashboard and adequacy of any mitigations to monitor the implementation of the OD strategy, what's changed, priorities for the future (three to five years), investment and resources required, and the adequacy of any mitigations	Six-monthly			X				X		GM P&C
Preventing Occupational Violence Strategy to monitor the implementation, priorities, investment and adequacy of any mitigations	Annual	X								GM P&C

MDHB BOARD Work Programme	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Wellbeing Plan (aka Psychosocial Wellbeing Strategy) to monitor the implementation of the DHB's health and wellbeing plans	Annual	X								GM P&C
Care Capacity Demand Management to monitor the implementation of the National Accord and local CCDM decisions	Six-monthly	X				X				ED N&M
Remuneration Policy to consider the Remuneration Policy as recommended by the Remuneration Committee	Triennial (Due Nov 2022)									GM P&C
IEA Remuneration Strategy to consider the Remuneration Strategy (IEAs) as recommended by the Remuneration Committee	Triennial (due Mar 2023)									GM P&C
IEA Remuneration Parameters to consider the remuneration parameters for annual changes to staff on IEA agreements following Rem Committee	Annual								X	GM P&C
Performance										
Financial Performance to monitor the DHB's financial performance against budget, including trends, forecasts, the impact of business improvement initiatives and opportunities and challenges, and confirm the adequacy of any mitigations	Six-weekly	X	X	X	X	X	X	X	X	GM F&CS
DHB Performance Metrics (aka Board KPI Dashboard) to monitor high level KPIs across the DHB	Quarterly	X		X						GM SPP
Digital Strategy – implementation of roadmap to monitor implementation, challenges and opportunities, priorities and initiatives/investments for future, and confirm the appropriateness of any mitigations	Six-weekly	X	X	X	X	X	X	X	X	CDO
Sustainability Plan to monitor the implementation of the performance improvement programme	Six-weekly	X	X	X	X	X	X	X	X	GM Q&I
Non-Financial Performance Measures to monitor the overall performance of the DHB	Quarterly		X		X		X		X	GM SPP
CEO's Performance Review	Annual			X						Chair
Audit										
Annual Accounts to determine the annual accounts for the financial year and to determine Enable NZ Limited annual reporting requirements	Annual						X			GM F&CS
Year End Audit Process (Government) to determine year-end financial result for inclusion in Government accounts	Annual				X					GM F&CS
Enable NZ Limited Annual Reporting Arrangements to determine annual reporting requirements of this paper company	Annual			X						GM F&CS
Iwi Partnerships										
Memorandum of Understanding to review the Memorandum of Understanding	Triennial (due Sept 2021 – not required)									GM M
DHB Board and Manawhenua Hauora Joint Work Programme to monitor progress against shared work programme, including opportunities and challenges	Six-monthly			X				X		GM M

MDHB BOARD Work Programme

	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Board-to-Board Hui	Quarterly	X		X		X		X		GM M
to monitor progress against shared work programme, including opportunities and challenges										
Manawhenua Hauora Update	Six-weekly	X	X	X	X	X	X	X	X	GM M
to update the Board on the Manawhenua Hauora discussions										
Partnership										
Clinical Council	Six-monthly	X				X				GM Q&I
to consider the work, findings and recommendations from the Council, provide endorsement or support as required										
Consumer Council	Six-monthly	X				X				GM Q&I
to consider the work, findings and recommendations from the Council, provide endorsement or support as required										
Professional Work Groups	Four-monthly		ED N&M		CMO				ED AH	Prof Leads
Profession										
Governance of shareholding companies										
to monitor the annual results and plans of shareholding companies and determine actions in respect of AGM recommendations										
Regional Service Plan	Annual				X					GM SPP
to approve the draft and final regional budget and priorities										
Allied Laundry Services Limited	Annual							X		GM F&CS
Technical Advisory Services AGM (DHB Shared Services)	Annual							X		GM SPP
NZ Health Partnerships Limited	Quarterly		X		X		X		X	GM F&CS
Board Governance Arrangements										
Board Governance arrangements and Committee Terms of Reference	Triennial or as required				X					Chair
Annual Reporting Framework (work programme)	Annual			X				X		CEO
Annual Board Evaluation	Annual							X		GM P&C
Annual meeting schedule	Triennial						X			CEO
Committee membership	Triennial							X		Chair
External committee membership and appointments	Triennial							X		Chair
Te Tiriti o Waitangi	Triennial						X			GM M
Review of Board policies	As required									CEO
Review of policies related to the Board or those requiring Board approval										

Key:

CEO	Chief Executive Officer
ED N&M	Executive Director, Nursing and Midwifery
GM F&CS	General Manager, Finance and Corporate
GM M	General Manager, Māori Health
CMO	Chief Medical Officer
FRAC Chair	Chair of the Finance, Risk and Audit Committee
Chair	Board Chair of the MidCentral District Health Board
GM P&C	General Manager, People and Culture
GM Q&I	General Manager, Quality and innovation
GM SPP	General Manager, Strategy, Planning and Performance
ED AH	Executive Director, Allied Health
Prof Leads	CMO, ED N&M, ED AH
HDAC Chair	Chair of the Health and Disability Audit Committee
CDO	Chief Digital Officer

Workshop Schedule

As at 23 November 2021

Date	Time	Topic
16 February 2021	Following HDAC meeting	Stellar Board Management Platform
23 February 2021	Following Board meeting	Midwifery Workforce Engagement
13 April 2021	Following Board meeting	Board Self-evaluation (with Broad Horizons)
20 April 2021	From 9am to noon	Annual Planning and Budget
27 April 2021	Following HDAC meeting	Consumer Story
25 May 2021	Following Board meeting	Manawhenua Hauora Board to Board hui
15 June 2021	Following FRAC meeting	Conjoint meeting of Board and FRAC – 2021/22 Annual Plan and Budget
6 July 2021	Following Board meeting	Medical Workforce
13 July 2021	Following HDAC meeting	Consumer Story
27 July 2021	Following FRAC meeting	Medical Workforce and Combined Medical Staff Association
17 August 2021	Following Board meeting	Annual Risk Workshop
9 November 2021	Following Board meeting	Manawhenua Hauora Board to Board hui *(via Zoom, due to COVID-19 restrictions)*
23 November 2021	Following HDAC meeting	Board Workshop – COVID-19
1 March 2022	Following HDAC meeting	Consumer Story
TBA in 2022	Following Board meeting	Health and Safety – with Buddle Findlay

Glossary of terms

14 December 2021

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Glossary of Terms

AC	**Assessment Centre**
ACC	**Accident Compensation Corporation** The New Zealand Crown entity responsible for administering the country's no fault accidental injury compensation scheme.
ACCPP	**Accident Compensation Corporation Partnership Plan**
ACE	**Advanced Choice of Employment**
ACEM	**Australasian College for Emergency Medicine**
ACT	**Acute Crisis Team**
ADL	**Activities of Daily Living**
ADON	**Associate Director of Nursing**
AESS	**Te Uru Arotau Acute and Elective Specialist Services**
ALOS	**Average Length of Stay**
Anti- VEGF	**Anti-Vascular Endothelial Growth Factor**
AoG	**All of Government**
APEX	**Association of Professional and Executive Employees**
API	**Application Programming Interfaces**
ARC	**Aged Residential Care**
ASH	**Ambulatory Sensitive Hospitalisations**
AS/NZS ISO 31000	**2018 Risk Management Principles and Guidelines**
B Block	**Wards, Laboratory, Admin and Outpatients**
BAG	**Bipartite Action Group**
BAPSF	**Bereavement leave, Alternative days, Public holidays, Sick leave, Family Violence leave**
BAU	**Business as Usual**
BN	**Bachelor of Nursing**

BSCC	**Breast Screen Coast to Coast**
BYOD	**Bring Your Own Device**
CAG	**Cluster Alliance Group** A group or 10-12 members from across the health and wider sector supporting the Cluster Leadership Team to identify population health needs, planning, commissioning and evaluating services and developing models of care. Members include consumer and Māori representatives.
Capex	**Capital Expenditure**
CBAC(s)	**Community Based Assesment Centre(s)**
CCDHB	**Capital and Coast District Health Board**
CCDM	**Care Capacity Demand Management** A programme that helps the organisation better match the capacity to care with patient demand.
CCN	**Central Cancer Network**
CCU	**Critical Care Unit**
CDO	**Chief Digital Officer**
CDS	**Core Data Set**
CE	**Clinical Executive** (of a service)
CE Act	**Crown Entities Act**
CEO	**Chief Executive Officer**
CFIS	**Crown Financial Information System**
CHF	**Congestive Heart Failure**
CIMS	**Coordinated Incident Management System**
CIO	**Chief Information Officer**
CLAB	**Central Line Associated Bacteraemia**
CME	**Continuing Medical Education**
CMO	**Chief Medical Officer**

CN	**Charge Nurse(s)**
CNM	**Clinical Nurse Manager**
CNS	**Clinical Nurse Specialist**
COI	**Committee of Inquiry**
COPD	**Chronic Obstructive Pulmonary Disease** A common lung disease which makes breathing difficult. There are two main forms, Chronic bronchitis - a long term cough with mucus. Emphysema - which involves damage to the lungs over time.
COVID-19	**Novel Coronavirus**
CPAC	**Prioritisation scoring system code table**
CPB	**Combined Pharmaceutical Budget**
CPHO	**Central Primary Health Organisation**
CPI	**Consumer Price Index**
CPOE	**Computerised Physician Order Entry**
CRM	**Cyber Risk Monitoring**
CSB	**Clinical Services Block**
CT	**Computed Tomography** A CT scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body.
CTCA	**Computed Tomography Coronary Angiography** A CT scan that looks at the arteries that supply blood to the heart. Can be used to diagnose the cause of chest pain or other symptoms.
CVAD	**Central Venous Access Device**
CWDs	**Case Weighted Discharges** Case weights measure the relative complexity of the treatment given to each patient. For example, a cataract operation will receive a case weight of approximately 0.5, while a hip replacement will receive 4 case weights. This difference reflects the resources needed for each operation, in terms of theatre time, number of days in hospital, etc.

DCFO	**Deputy Chief Financial Officer**
DDIGG	**Digital and Data Informatics Governance Group**
DHB	**District Health Board**
DIVA	**Difficult Intravenous Access**
DNA	**Did Not Attend**
DNW	**Did Not Wait**
DoN	**Director of Nursing**
DOSA	**Day of Surgery Admission**
DS	**Digital Services**
DSA	**Detailed Seismic Assessment**
DSA	**Digital Subtraction Angiography**
DTS	**Designated Testing Site**
DWP	**Digital Workplace Programme**
DX	**Data Exchange** A data exchange software mechanism developed with the Social Investment Agency (SIA) to support encrypted data sharing between public services.
EAP	**Employee Assistance Programme**
EBITA	**Earnings Before Interest, Taxes and Amortisation**
ECM	**Enterprise Content Management**
ED	**Emergency Department**
EDAH	**Executive Director Allied Health**
EDG-VPSR	**Electrocadiograph – Visual Positioning System Rhythm**
EDN&M	**Executive Director, Nursing & Midwifery**
EDOA	**Emergency Department Observation Area**
EDON	**Executive Director of Nursing**

EECA	**Energy and Efficiency Conservation Authority**
ELT	**Executive Leadership Team**
EMERGO	**Emergo Train System**
EMR	**Electronic Medical Record**
EN	**Enrolled Nurse**
ENT	**Ear Nose and Throat**
ENZ	**Enable New Zealand**
EOC	**Emergency Operations Centre**
EOI	**Expresssion of Interest**
EP	**Efficiency Priority**
EPA	**Electronic Prescribing and Administration**
EPMO	**Enterprise Project Management Office**
ERCP	**Endoscopic Retrograde Cholangio Pancreatography**
ERM	**Enterprise Risk Management**
ESPI	**Elective Services Patient Flow Indicator** Performance measures that provide information on how well the District Health Board is managing key steps in the electives patient journey.
EV	**Electric Vehicle**
EWS	**Early Warning System**
EY	**Ernst & Young**
FACT	**Flexible Assertive Community Assessment Team**
FHC	**Feilding Health Care**
FHIR	**Fast Healthcare Interoperability Resources**
FIT	**Faecal Immunochemical Test**
FM	**Facilities Management**

FM Services	**Facilities maintenance and hotel services required by the DHBs**
FPIM	**Finance and Procurement Information Management System**
FPM	**Financial Planning Manager**
FRAC	**Finance, Risk and Audit Committee**
FSA	**First Specialist Appointment**
FTE	**Full Time Equivalent** The hours worked by one employee on a full-time basis.
Gap	**Analysis used to examine current performance with desired, expected performance**
GETS	**Government Electronic Tenders Service**
GHG	**Greenhouse Gases**
GM	**General Manager**
GMFCS	**General Manager, Finance and Corporate Services**
GMM	**General Manager, Māori Health**
GMPC	**General Manager, People and Culture**
GMQI	**General Manager, Quality and Innovation**
GMSPP	**General Manager, Strategy, Planning and Performance**
GP	**General Practitioner**
GST	**Goods and Services Tax**
H&S	**Health and Safety**
HaaG	**Hospital at a Glance**
HAI	**Healthcare Associated Infection**
HAR	**Te Uru Whakamauora, Healthy Ageing and Rehabilitation**
HBDHB	**Hawke's Bay District Health Board**
HCA(s)	**Health Care Assistant(s)**
HCSS	**Home and Community Support Services**

HDAC	**Health and Disability Advisory Committee**
HDU	**High Dependency Unit**
HEAT	**Health Equity Assessment Tool**
HEEADSSS	**Home, education/employment, eating, activities, drugs, sexuality, suicide and depression, safety (wellness assessment)**
HIP	**Health Infrastructure Programme**
Hira	**National Health Information Platform**
HISO	**Heath Information Security Framework**
HPCA	**Health Practitioners Competence Assurance Act 2003**
HQSC	**Health, Quality and Safety Commission**
HR	**Human Resources**
HRC	**Health Research Council**
HRIS	**Human Resources Information System**
HRT	**Health Roundtable**
HSI	**Health System Indicators**
HSWA	**Health and Safety at Work Act**
Hui	**Formal meeting**
HV	**High Voltage**
HVAC	**Heating, Ventilation and Air Conditioning**
HWIP	**Health Workforce Information Programme**
HWNZ	**Health Workforce New Zealand**
IA	**Internal Audit**
IAAS	**Infrastructure as a Service**
IANZ	**International Accreditation New Zealand**
IAP	**Incident Action Plan**

ICNet	**Infection Control Surveillance**
ICPs	**Incident Control Points**
ICPSA	**Integrated Community Pharmacy Services Agreement**
ICT	**Information and Communications Technology**
ICU	**Intensive Care Unit**
IDF	**Inter-district Flow** The default way that funding follows a patient around the health system irrespective of where the are treated.
IEA	**Individual Employment Agreement**
IFHC	**Integrated Family Health Centre** General practice teams with the patient at the centre, providing quality health care when, where and how patients need it.
IFM / IFM20	**Integrated Facilities Management**
IL	**Importance Level** Seismic assessment rating
IMAC	**Immunisation Advisory Centre**
IMT	**Incident Management Team**
IOC	**Integrated Operations Centre**
IOL	**Intraocular Lens**
IPSAS	**International Public Sector Accounting Standards**
IS	**Information Systems**
ISM	**Integrated Service Model**
ISP	**Internet Service Provider**
IT	**Information Technology/Digital Services**
ITSM	**Integrated Service Module**
IV	**Intravenous**

IVP	**Improving Value Programme**
JDE	**JD Edwards** Name of software package
Ka Ao Ka Awatea	**Māori Health Strategy for the MDHB District**
KPI(s)	**Key Performance Indicator(s)** A measurable value that demonstrates how effectively an objective is being achieved.
LAN	**Local Area Network**
LDC	**Local Data Council**
LEO	**Leading an Empowered Organisation**
LINAC	**Linear Accelerator**
LMC	**Lead Maternity Carer**
LOS	**Length of Stay**
LSP	**Leadership Success Profile**
LTC	**Long Term Condition(s)**
LV	**Low Voltage**
MALT	**Māori Alliance Leadership Team**
MAPU	**Medical Assessment and Planning Unit** *(previously known as Pods)*
MBIE	**Ministry of Business, Innovation and Employment**
MCH	**MidCentral Health**
MCIS	**Maternity Clinical Information Service** *(Badgernet)*
MDBI	**Material Damage and Business Interruption**
MDHB	**MidCentral District Health Board**
MDM	**Master Data Management**
MDT	**Multidisciplinary Team**
MECAs	**Multi-Employer Collective Agreements**

MEED	**Midwifery External Education and Development Committee**
MERAS	**Midwifery Employee Representation and Advisory Service**
MFA	**Multi Factor Authentication**
MIQ	**Managed Isolation and Quarantine**
MIT	**Medical Imaging Technologist** A radiographer who works with technology to produce X-rays, CT scans, MRI scans and other medical images.
MIYA	**MIYA Precision Platform**
MoH	**Ministry of Health**
MOU	**Memorandum of Understanding**
MRI	**Magnetic Resonance Imaging** A medical imaging technique used in radiology to form pictures of the anatomy using strong magnetic fields and radio waves.
MRSO	**Medical Radiation Officer**
MRT	**Medical Radiation Therapist(s)**
MSD	**Ministry of Social Development**
MWH	**Manawhenua Hauora**
MYFP	**Midwifery First Year of Practice Programme**
NAMD	**Neovascular Age-Related Macular Degeneration**
NARP	**Non-Acute Rehabilitation Programme**
NBSP	**National Bowel Screening Programme**
NCAMP19	**National Collections Annual Maintenance Programme 2019**
NCNZ	**Nursing Council of New Zealand**
NEAC	**National Ethics Advisory Committee**
NEED	**Nursing External Education and Development Committee**
NESP	**Nurse Entry to Specialty Practice Programme (Mental Health)**

NETP	**Nurse Entry to Practice**
NFSA	**National Food Services Agreement**
NGO	**Non Government Organisation**
NNU	**Neo Natal Unit**
NOS	**National Oracle Solution**
NP	**Nurse Practitioner**
NPC	**Nurse Practitioner Candidate**
NPTP	**Nurse Practitioner Training Programme**
NZBS	**New Zealand Blood Service**
NZCOM	**New Zealand College of Midwives**
NZCPHCN	**New Zealand College of Primary Health Care Nurses**
NZCRMP	**New Zealand Code of Radiology Management Practice**
NZHP	**New Zealand Health Partnerships**
NZHRS	**New Zealand Health Research Strategy**
NZNO	**New Zealand Nurses Organisation**
NZPHD Act	**New Zealand Public Health and Disability Act**
NZRDA	**New Zealand Resident Doctors' Association**
O&G	**Obstetrics and Gynaecology**
OAG	**Office of the Auditor-General**
OE	**Operations Executive** (of a service)
OIA	**Official Information Act 1982**
OHS	**Occupational Health and Safety**
OLT	**Organisational Leadership Team** OLT comprises all General Managers, Chief Medical Officer, Executive Directors - Nursing & Midwifery and Allied Health, General Manager of Enable NZ, all Operations Executives and Clinical Executives.

OMT	**Organisational Management Team**
OPAL	**Older People's Acute Assessment and Liaison Unit**
OPERA	**Older People's Rapid Assessment**
OPF	**Operational Policy Framework**
Outsourced	**Contracted to a third-party provider to deliver**
PaaS	**Platform as a Service**
Pae Ora Paiaka Whaiora	**(Base/Platform of health) Healthy Futures (DHB Māori Directorate)**
PACS	**Picture Archiving Communication System**
PACU	**Post Anaesthetic Care Unit**
PANE	**Proactive, Advocacy, Navigation and Education Team**
PAS	**Patient Administration System**
PBE	**Public Sector Benefit Entity**
PCBU	**Person Conducting a Business or Undertaking**
PCCL	**Patient Complexity Clinical Level**
PCT	**Pharmacy Cancer Treatment**
PDRP	**Professional Development and Recognition Programme**
PDSA	**Plan Do Study Act**
PEDAL	**Post Emergency Department Assessment Liaison**
PET	**Positron Emission Tomography**
PHC	**Primary Health Care**
PHO	**Primary Health Organisation (THINK Hauora)**
PHU	**Public Health Unit**
PICC	**Peripherally Inserted Central Catheter**

PICU	**Paediatric Intensive Care Unit**
PIN	**Provisional Improvement Notice** (section 36.2 Health and Safety at Work Act 2015)
PIP	**Performance Improvement Plan** This plan is designed to support the OLT in the prioritisation and optimisation of system wide efforts to achieve our vision. The plan was presented to the MoH as part of MDHB's 2019/20 strategic discussion.
PMS	**Patient Management System**
POAC	**Primary Options for Acute Care**
POCT	**Point of Care Testing**
PPE	**Personal Protective Equipment**
Powhiri	**Formal Māori Welcome**
PPA	**Promoting Professional Accountability**
PP&CH	**Public, Primary and Community Health**
PPPR	**Protection of Personal and Property Rights**
PR&RO	**Principal Risk and Resilience Officer**
PSA	**Public Service Association**
PSC	**Te Kawa Mataaho Public Service Commission** *(formerly State Services Commission)*
PSe	**PS Enterprise**
PSR	**Protective Security Requirements**
Qlik	**Qlik Sense Data Visualisation Software (Dashboard Analytics)**
Q&SM	**Quality and Safety Markers**
RACMA	**Royal Australasian College of Medical Administrators**
RACOP	**Royal Australasian College of Physicians**
RDHS	**Regional Digital Health Services**
RE-THINK	**Research, Equity, Technology, Health, Innovation, Networking and Knowledge**
RFP	**Request for Proposal**

RHIP	**Regional Health Infometrics Programme** Provides a centralised platform to improve access to patient data in the central region.
Risk ID	**Risk Identifer**
RM	**Registered Midwife**
RMO	**Resident Medical Officer**
RN	**Registered Nurse(s)**
RSI	**Relative Stay Index**
RSO	**Research Support Officer**
RSP	**Regional Service Plan**
Rules	**Government Procurement Rules (4th Edition 2019)**
SaaS	**Software as a Service**
SAC	**Severity Assessment Code**
SAN	**Storage Area Network**
SBA	**Smoking Brief Advice (Smoking Cessation)**
SCIG	**Strategic Capital Investment Group**
SECA	**Single-Employer Collective Agreement**
SFIA	**Skills Framework for the Information Age**
SGOC	**Shared Goals of Care**
SIEM	**Security Information Event Monitoring**
SIQ	**Supported Isolation and Quarantine**
SLA	**Service Level Agreement**
SLMs	**System Level Measures**
SME	**Subject Matter Expert(s)**
SMO	**Senior Medical Officer**

SNE	**Services Not Engaged**
SOI	**Statement of Intent**
SPE	**Statement of Performance Expectations**
SPIRE	**Surgical Procedural Interventional Recovery Expansion** A project to establish additional procedural, interventional and surgical resources within MDHB.
Spotless	**Spotless Services (NZ) Limited**
SRG	**Shareholder's Review Group**
SSC	**State Services Commission** (from 2020 - Te Kawa Mataaho Public Service Commission)
SSHW	**Safe Staffing, Healthy Workplaces**
SSIED	**Shorter Stays in Emergency Department**
SSP	**Statement of Service Performance**
SSU	**Sterile Supply Unit**
SUDI	**Sudden Unexpected Death in Infancy**
SUG	**Space Utilisation Group**
STAR	**Services for Treatment, Assessment and Rehabiliation**
TAS	**Technical Advisory Services**
TCO	**Total Cost of Ownership**
tC02e	**tons of carbon dioxide equivalent**
TCU	**Transitional Care Unit**
THG	**Tararua Health Group Limited**
TI	**Trainee Intern**
TLP	**Transformational Leadership Programme**
Trendly	A national database capture tool and dashboard that focuses on the measurement of DHBs to the National Māori Health Measures
TTOR	**Te Tihi o Ruahine Whānau Ora Alliance**

UCOL	**Universal College of Learning**
VBS	**Voluntary Bonding Scheme**
VRM	**Variance Response Management**
WDHB	**Whanganui District Health Board**
webPAS	**Web Based Patient Administration System**
webPASaas	**Web Based Patient Administration System as a Service**
WHEI	**Whole Hospital Escalation Indicators**
WOLC	**Whole of Life Cost**
YOSS	**Youth One Stop Shop**
YTD	**Year To Date**

Late items - discussion

14 December 2021

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Late items

Discussion on any late items advised at the start of the meeting

Date of next meeting

14 December 2021

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Date of next meeting

Tuesday, 15 February 2022

Exclusion of the public

14 December 2021

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Exclusion of public

Resolution:

That the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons outlined in the agenda.