MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Part One Board Papers

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MidCentral District Health Board

Board Meeting

Venue: via Zoom (due to COVID-19 restrictions)

When: Tuesday 29 March 2022, 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

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 and Interim General Manager, Quality and Innovation; Tracee Te Huia, General Manager, Māori Health; Shivarn Stewart, Communications Team Leader; Margaret Bell, Board Secretary.

In attendance (part meeting)

Items 4.2 and 4.3	Neil Wanden, General Manager, Finance and Corporate Services; Darryl Ratana, Deputy Chief Financial Officer
Item 5.3	Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke, Healthy Women, Children and Youth
Item 6.1	Neil Wanden, General Manager, Finance and Corporate Services

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 15 February 2022, Part One

2.5. Matters arising

2.6. Verbal report from Board Chair

2.7. Health and Disability Advisory Committee – Verbal report from Chair and Minutes of meeting held on 1 March 2022, Part One

2.8. Finance, Risk and Audit Committee – Verbal report from Chair and Minutes of meeting held on 15 March 2022, Part One

2.9. Manawhenua Hauora – Verbal report from Manawhenua Hauora Chair

3. STRATEGIC FOCUS

3.1 No items

4. PERFORMANCE REPORTING 9.15

4.1. Chief Executive's Report

4.2. Financial Update – February 2022

4.3. Finance Report – January 2022

4.4. Health System Indicators Dashboard (formerly KPI) – Quarter One 2021/22
4.5. Non-Financial Performance Measures – Quarter Two 2021/22
4.6. Sustainability Plan

REFRESHMENT BREAK 10.10

5. DISCUSSION/DECISION PAPERS 10.20

5.1. Combined Medical Staff Association and Executive Action Plan
5.2. Nursing Workforce Update
5.3. Midwifery Workforce Update

6. INFORMATION PAPERS 10.35

Information papers for the Board to note

6.1. NZ Health Partnerships – Quarterly Update
6.2. COVID-19 Vaccinator Working Under Supervision
6.3. Use of the Official Information Act 1982 to exclude the public from meetings
6.4. Board Work Programme

7. GLOSSARY OF TERMS

8. LATE ITEMS

9. DATE OF NEXT MEETING – Tuesday 10 May 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 15 February 2022	
Electrical Substation Replacement	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)
Generator Replacement	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)
Replacement of CT Scanner and Building Works	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)
Post-Acute Community Rehabilitation Business Case	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)
Transfer to Enable New Zealand Limited – progress report	To protect information which is subject to an obligation of confidence	9(2)(ba)
Te Awa – Digital Services Work Programme	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)
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)
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 1 March 2022 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 15 March 2022 meeting**	
Workshop: Mental Health Unit Strategy	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)

Part One to finish by 10.55am

Administrative matters

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Apologies

Any apologies to be recorded?

Late items

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

Register of Interests: Summary, 1 March 2022 (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
	16.12.21	Chairperson – Horowhenua Health and Wellbeing Hub Stakeholder Advisory Group
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	Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB
		Volunteer, MidCentral DHB Medical Museum
	30.9.20	Sister-in-law is employed as a registered nurse at Whakapai Hauora
	19.11.21	Sister-in-law works as a COVID-19 vaccinator for MidCentral DHB
	1.2.22	Sister-in-law no longer works for Whakapai Hauora
Mar, Materoa	16.12.19	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
	11.2.20	Member of MDHB Cluster
		Member of local Child and Youth Mortality Review Group (CYMRG)
	5.8.20	Member of MDHB's Māori Alliance Leadership Team (MALT)
	13.7.21	Member – Te Ahu Whenua Māori Land Trust
	17.8.21	Member, Māori Provider Expert Reference Group for Transitional Health Unit
Naylor, Karen	6.12.10	Employee – MidCentral DHB
		Member and Workplace Delegate – NZ Nurses Organisation
	9.10.16	Councillor – Palmerston North City Council
Paewai, Oriana	1.5.10	Member – Te Runanga o Raukawa Governance Group
		Chair – Manawhenua Hauora
	13.6.17	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
	30.8.18	Appointed Member – Massey University Council
	13.4.21	Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board
	27.7.21	Member – Governance Board, Mana Whaikaha
	9.11.21	No longer a Board Member – Cancer Society Manawatū
		No longer a member of Nga Manu Taiko, a standing committee of the Manawatū District Council
	9.2.22	Co-Chair, Regional Skills Leadership Group, Manawatū-Whanganui
Waldon, John	22.11.18	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
	9.2.21	Has a contract with UCOL
	14.12.21	No longer contracted to UCOL
		Appointed as Research Advisor Māori to Massey University (commencing 17 January 2022)

Register of Interests: Summary, 1 March 2022 (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, 1 March 2022 (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	1.3.22	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 *(until 30 September 2021)* 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
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

Register of Interests: Summary, 1 March 2022 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
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 15 February 2022 Board meeting be approved as a true and correct record.

MidCentral District Health Board

Board Minutes

Meeting held on 15 February 2022 from 9.00am

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 (and Clinical Executive, Te Uru Kiriora); Debbie Davies, Interim General Manager, Strategy, Planning and Performance (and Operations Executive, Te Uru Kiriora); Celina Eves, Executive Director, Nursing and Midwifery; Emma Horsley, Communications Manager; Gabrielle Scott, Executive Director, Allied Health (and Interim General Manager, Quality & Innovation); Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Keyur Anjaria, General Manager, People and Culture; Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke; Neil Wanden, General Manager, Finance and Corporate Services.

THINK Hauora representatives: Chiquita Hansen, Chief Executive; Paul Cooper, Acute Care and System Integration Medical Advisor; Nicola Russell, General Manager, Clinical Quality; Dr Bruce Stewart, Chair; Angela Thomson, Network Integration Manager.

Media – 1

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

An apology from Norman Gray was received and accepted.

2.2. Late items

No items

2.3. Register of Interests Update

Oriana Paewai

- Co-Chair, Regional Skills Leadership Group, Manawatū-Whanganui.

2.4. Minutes of the Board meeting held on 14 December 2021, Part One

It was resolved that:

the Part One minutes of the 14 December 2021 Board meeting be approved as a true and correct record.

(Moved Vaughan Dennison; seconded Muriel Hancock)

2.5. Matters arising from previous minutes

No discussion.

2.6. Verbal report from the Board Chair

The Board Chair noted that there was an enormous amount of work to be done before the Board's disestablishment in less than 20 weeks' time. Governance was still required to deliver the level of services expected by the community and the Minister of Health's expectations to control expenditure, meet the agreed budget and deliver contractual activities in terms of infrastructure. There was a 'confused landscape' while the new entities of Health New Zealand and the Māori Health Authority were taking shape. It was hoped that greater clarity would be provided at a meeting of national Chairs and Chief Executives later this week.

2.7. Minutes of the Finance, Risk and Audit Committee meeting held on 1 February 2022, Part One

It was resolved that the Board:

note the unconfirmed Part One minutes of the Finance, Risk and Audit Committee meeting held on 1 February 2022.

(Moved Oriana Paewai; seconded Vaughan Dennison)

2.8. Manawhenua Hauora Chair's Report

Oriana Paewai, Manawhenua Hauora Chair provided a verbal update on the Manawhenua Hauora hui held on 31 January 2022. She noted that due to the timing of Manawhenua Hauora hui and Board meetings, it was no longer possible to prepare written reports. Due to COVID-19 restrictions, the Board to Board hui planned for today had been cancelled. A project manager had been appointed to support Manawhenua Hauora to transition into the new health structure. Priorities included the establishment of a new Board, establishing Manawhenua Hauora as a legal entity and collecting some history of Manawhenua Hauora since the establishment of District Health Boards (DHBs) in 2001.

It was resolved to:

note the Manawhenua Hauora Chair's report.

(Moved Oriana Paewai; seconded Heather Browning)

The representatives from THINK Hauora joined the meeting.

3. STRATEGIC FOCUS

3.1. COVID-19 Planning

The Chief Executive, the Clinical and Operations Executives, Te Uru Kiriora, Primary, Public and Community Health and the THINK Hauora representatives gave a presentation on the DHB's COVID-19 Coordinated Response in the Community. The whole country would move into 'Phase Two' of the COVID-19 Community Response Framework at 11.59pm today and a surge of the Omicron variant was expected to put pressure on resources. The following key points from the presentation were noted:

- Ninety-five percent of the eligible population are fully vaccinated; and 63 percent had received their booster dose.
- Primary care modelling showed that six percent of the enrolled population were considered 'high risk' and may not be able to manage at home.

- A priority is to get iwi and Māori providers ready for the Omicron outbreak, including fit testing for N95 masks. In Phase Two, only people working in high-risk areas must use N95 masks, with surgical masks suitable for general healthcare workers.
- The national Immunisation Advisory Centre was consulting on supervision numbers for an unregulated workforce to carry out vaccinations under supervision. This work group would help iwi and Māori providers to deliver the vaccination programme.

It was resolved to:

note the planning update to be presented to the Board at the February 2022 meeting.

(Moved Jenny Warren; seconded John Waldon)

The THINK Hauora representatives left the meeting.

4. PERFORMANCE REPORTING

4.1. Chief Executive's Report

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

It was resolved that the Board:

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

(Moved Muriel Hancock; seconded Karen Naylor)

The General Manager, Finance and Corporate Services joined the meeting.

4.2. Financial Report – December 2021

The General Manager, Finance and Corporate Services presented this report, which was taken as read. He noted that results were tracking well against the budget. The main cost impacts related to the pay settlement for nurses, locum SMOs and outsourced radiology and blood services.

It was resolved that the Board:

note that at its February meeting, the Finance, Risk and Audit Committee endorsed this report for the Board's consideration

note that the month operating result for December 2021 is a deficit before one-off items of $3.260m, which is $0.872m adverse to budget

note that the year to date result for December 2021 is a deficit before one-off items of $4.678m, which is $1.446m adverse to budget

note that year to date for December 2021 COVID-19 related contribution of $0.135m and Holidays Act costs of $2.775m have been incurred. Including these results in a year to date deficit after exceptional items of $7.317m, which is $0.585m adverse to budget

note that the total available cash and equivalents of $101.653m as of 31 December 2021 is sufficient to support liquidity requirements

Approve the December financial report.

(Moved Vaughan Dennison; seconded Heather Browning)

4.3. Finance Report – November 2021

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

It was resolved that the Board:

note that at its February meeting, the Finance, Risk and Audit Committee endorsed this report for the Board's consideration

note that the month operating result for November 2021 is a deficit before one-off items of $0.048m, which is $0.593m favourable to budget

note that the year to date operating result for November 2021 is a deficit before one-off items of $1.417m, which is $0.574m adverse to budget

note that year to date for November 2021 COVID-19 related contribution of $0.148m and Holidays Act costs of $2.339m have been incurred. Including these results in a year to date deficit after exceptional items of $3.608m, which is $0.151m favourable to budget

note that the total available cash and equivalents of $40.392m as of 30 November 2021 is sufficient to support liquidity requirements

approve the November financial report.

(Moved Vaughan Dennison; seconded Heather Browning)

4.4. Finance Report – October 2021

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

It was resolved that the Board:

note that at its February meeting, the Finance, Risk and Audit Committee endorsed this report for the Board's consideration

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 operating 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 have been incurred. 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 of 31 October 2021 is sufficient to support liquidity requirements

approve the October financial report.

(Moved Vaughan Dennison; seconded Heather Browning)

The General Manager, Finance and Corporate Services left the meeting.

4.5. **Sustainability Plan Report**

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

The Board Chair noted the Sustainability Plan had been developed prior to COVID-19 and commended management on their efforts to deliver the savings during these challenging times.

Further development on the production plan was needed nationally, as this would be a critical element of the new health system where funding would be activity based rather than population based.

It was resolved that the Board:

note that at its February meeting, the Finance, Risk and Audit Committee endorsed this report for the Board's consideration

note the progress in the implementation of the Sustainability Plan

note the Sustainability Plan benefits monitoring dashboard and trend analysis

note the November 2021 report indicates savings of $262,460 year to date

endorse the approach and progress made to date on the Sustainability Plan 2020-23, for the Board's consideration

approve the February 2022 Sustainability Plan report.

(Moved Muriel Hancock; seconded Materoa Mar)

The General Manager, People and Culture joined the meeting.

4.6. Health, Safety and Wellbeing

The General Manager, People and Culture presented this report, which was taken as read. He noted that sick leave had increased over November and December which correlated to the increase in sickness (stress) reported by staff during the implementation of the COVID-19 Vaccination Order (5 November 2021). Staff who were unwell provided medical certificates supporting their stress.

Around 90 percent of frontline staff have been fit tested for N95 masks and additional fit testing machines were now available to increase fit testing capacity. Special sessions would be held for staff who only work night shifts. The requirement for staff to have received their booster dose of the COVID-19 vaccination had been extended to 24 February 2022.

All DHBs are facing increased workforce pressure. The use of annual leave over the Christmas/New Year period was similar to previous years. Annual leave was approved with a caveat it could be cancelled if staff were required to respond to COVID-19.

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 1 February 2022 for consideration by the Board.

(Moved Vaughan Dennison; seconded Heather Browning)

The General Manager, People and Culture left the meeting.

The Clinical Council Chair and the Consumer Council Chair joined the meeting.

5. DISCUSSION/DECISION PAPERS

5.1. Clinical Council – six-monthly report

The Clinical Council Chair presented this report, which was taken as read.

It was resolved that the Board:

note the contents of the Clinical Council report.

(Moved Karen Naylor; seconded Lew Findlay)

The Clinical Council Chair left the meeting.

5.2. Consumer Council – six-monthly report

The Interim Consumer Council Chair presented this report, which was taken as read. He acknowledged the work of Gail Munro, the previous Chair of the Consumer Council, who was a well-respected leader and passionate about her role.

Two MDHB clinicians had given thought-provoking presentations to the Consumer Council, which highlighted that staff were under-resourced and working in inadequate facilities. The tenacity, passion and dedication of clinicians was having a positive impact on addressing inequities in health. It was suggested that the Board write to politicians and explain that unless there was greater investment and substantial changes, staff were likely to give up. The Board Chair said consideration would be given to writing a constructive letter that profiled an initiative that had a proven outcome.

The General Manager Māori Health explained that since the issues highlighted to the Consumer Council were raised, extensive work had been undertaken by the clinicians and the Pae Ora team. Any discrimination or racist behaviours by staff were challenged immediately. Strong leadership was required to address these issues and it would take time but great progress had been made locally. Recent recruitment of 55 new Māori staff was a positive achievement.

It was resolved that the Board:

note the contents of the Consumer Council report.

(Moved Muriel Hancock; seconded Lew Findlay)

The Consumer Council Chair left the meeting.

5.3. Combined Medical Staff Association and Executive Action Plan

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

It was resolved that the Board:

note the Combined Medical Staff Association (CMS) and Executive Action Plan.

(Moved Oriana Paewai; seconded John Waldon)

5.4. Nursing Workforce Update

The Executive Director, Nursing and Midwifery presented this report, which was taken as read. She noted that the Care Capacity Demand Management (CCDM) assessment had been completed by the Safer Staffing Healthy Workplaces Unit and MDHB had achieved full implementation.

The Board Chair acknowledged that 20 percent of new graduate nursing students were Māori or Pasifika.

It was resolved that the Board:

note the Nursing Workforce Report.

(Moved Jenny Warren; seconded Muriel Hancock)

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

5.5. Midwifery Workforce Update

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

The Board Chair noted the high rate of fully breastfed babies at discharge in December and the relocation of the Antenatal Clinic to beneath the Te Papaoiea Birthing Centre. He also acknowledged the work done by senior leaders in supporting staff.

It was resolved that the Board:

note the current midwifery workforce position

note the key updates to the Midwifery Action Plan.

(Moved Heather Browning; seconded Oriana Paewai)

The Clinical and Operations Executives, Te Uru Pā Harakeke left the meeting.

6. INFORMATION PAPERS

6.1. Board's Work Programme

The report was taken as read.

A Board member suggested that professional working groups be invited to meet with the Board in May and June. The Chief Executive noted that the impact of the Omicron outbreak may make it difficult to deliver the current work programme.

It was resolved that the Board:

note the Board's annual work programme.

(Moved Muriel Hancock; seconded John Waldon)

7. GLOSSARY OF TERMS

8. LATE ITEMS

No discussion.

9. DATE OF NEXT MEETING

Tuesday, 29 March 2022 – 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 14 December 2021	
Replacement of Motor Control Centre	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)
Increasing Chilled Water Capacity	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)
Annual Remuneration Parameters for IEA Staff	To carry out without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(j)
Te Awa – Digital Services Work Programme Update	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)
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)
Board only time	No decision sought	
'In Committee' minutes of the previous Finance, Risk and Audit Committee meeting	**For reasons set out in the agenda of the meeting held on 1 February 2022**	

(Moved Jenny Warren; seconded Vaughan Dennison)

Part One of the meeting closed at 11.20am

Confirmed this 29th day of March 2022

……..

Board Chair

MidCentral District Health Board

- Schedule of Matters Arising, 2021/22 as at 17 March 2022

Matter	Raised	Scheduled	Responsibility	Form	Status
Future Quality and Safety Walk-round reports to include details of actions and any themes	May 21	May 22	G Scott	Report	Scheduled
Review of car parking arrangements PNH, including readdressing all carpark feedback and suggestions (Dec 21: traffic engineering review will be carried out after detailed building plans completed for acute mental health unit and Acute Services Block)	April 17	Ongoing	N Wanden	Report	Scheduled
COMPLETED					
Provide further details of CAFS/Youthline service, including consideration of the needs of Māori	Dec 21	Feb 22	S Ambridge	Report	Completed
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	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

Matter	Raised	Scheduled	Responsibility	Form	Status
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
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 1 March 2022 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 1 March 2022 from 9.00am

via Zoom due to COVID-19 restrictions

PART ONE

Members

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

Apologies

Brendan Duffy (Board Chair).

In attendance

Kathryn Cook, Chief Executive; Dr Kelvin Billinghurst, Chief Medical Officer (and Clinical Executive, Te Uru Kiriora); Gabrielle Scott, Executive Director, Allied Health (and Acting General Manager, Quality and Innovation); 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; Lyn Horgan, Operations Executive, Te Uru Arotau and Te Uru Whakamauora; Dr David Peel, Radiation Oncologist; Angela Rainham, Locality and Intersectoral Development Manager; Michelle Riwai, General Manager, Enable New Zealand; Dr Syed Zaman, Clinical Executive, Te Uru Whakamauora.

Media – 1 Public – 0

1. KARAKIA AND HE WHAKATAU

The meeting opened with the organisational karakia.

He Whakatau – Greetings from the Chair

"This is the second to last meeting for the Health and Disability Advisory Committee (HDAC) and I wish to take this opportunity to thank Kathryn Cook, Chief Executive, and her management team who have supported and responded to HDAC. We are a sub-committee of MidCentral District Health Board (MDHB), a sub-committee of the Board who are part of the necessary governance for the oversight of healthcare. An important and necessary part are the people who rely on the DHB's services and hold us accountable in our commitment to provide better healthcare for the community. This includes members of the press and I especially acknowledge Owen and Carey Hume, whose daughter Erica died here in Palmerston North in May 2014. Owen and Carey have attended many of our meetings since. I would also acknowledge those who served on HDAC and its predecessors, the dedicated health workers, professional staff and senior management who supported this committee with their service and goodwill; not forgetting previous members of the Quality and Excellence Advisory Committee chaired by Barbara Robson, the Community and Public Health Advisory Committee chaired by Diane Anderson, with Barbara Cameron serving as her deputy."

2. ADMINISTRATIVE MATTERS

2.1. Apologies

The apology from Brendan Duffy, Board Chair was accepted.

2.2. Late items

No late items were advised.

2.3. Register of Interests Update

No updates to the Register of Interests were advised.

Materoa Mar noted the following interests in relation to agenda items for this meeting that had previously been declared:

Item 3.4 – Chair of Emerge Aotearoa

Item 6.1 – Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance

2.4. Minutes of the 23 November 2021 meeting, Part One

It was resolved that:

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

(Moved John Waldon; seconded Karen Naylor)

2.5. Matters arising from previous minutes

No discussion.

The Clinical and Operations Executives joined the meeting.

The meeting agreed to reorder some agenda items. The original agenda item numbers are used in these minutes.

3. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

3.1. Directorate Dashboard

The Operations Executive, Te Uru Rauhī, Mental Health and Addiction Services presented this report, which was taken as read. Executives provided the following responses to questions raised by Committee members.

Most District Health Boards (DHBs) had been unable to provide regular childhood immunisations at the same time as COVID-19 vaccinations due to resourcing issues. The childhood immunisation rate had been affected by the 'Anti vax' and 'No vax' movement. The best way to get people to change their mind about vaccinations is for someone who is trusted by the whānau to talk with them.

There are 3731 people on the ESPI 2 (First Specialist Assessment) waiting list – 354 have waited more than four months; 245 of those people have an appointment which is just outside of the four-month target wait time. There are 2006 patients on the ESPI 5 waiting list – 1026 have waited more than four months; 92 of these people have a date for surgery booked. Staff shortages are expected to increase as staff become unwell with Omicron. This is a challenge for the whole country and the Chief Operating Officers in the central region are working together to try and reduce surgical waiting lists.

The COVID-19 testing site on Main Street, Palmerston North has been busy and caused traffic congestion in surrounding streets. A further testing site has been set up at the Central Energy Arena Trust for people to collect Rapid Antigen Tests, with PCR testing carried out at the Main Street site.

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

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

3.3. 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. They noted that the results of the Tūngia te Ururua community engagement would be available soon. Analysis would include ethnicity and locality.

In response to a question, the Operations Executive advised that before being able to practice in New Zealand, midwifery staff from overseas were required to complete a cultural module as part of their midwifery registration. They would also be supported by the MidCentral District Health Board's (MDHB) Māori Clinical Coach and complete cultural competency training as soon as possible after commencement.

3.4. Te Uru Rauhī – Mental Health and Addiction Services

The Operations Executive, Te Uru Rauhī presented this report, which was taken as read. He offered to provide the Committee with analysis of the access to Child and Adolescent Mental Health and Addiction Services (CAFS) by locality and ethnicity. Support was available to staff who were working under increased pressure. All referrals were managed through a multi-disciplinary team process to manage any clinical risk.

3.5. 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 the all-day additional Saturday acute theatre list was full. Staff were able to 'volunteer' to work on Saturdays and were being paid overtime rates, using funding from the Ministry of Health. The detailed design phase of Stage Two of the SPIRE (Surgical Procedural Interventional Recovery Expansion) project had been completed and costings had yet to be received. Stage Two would start on 1 July 2022.

3.6. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

The Operations and Clinical Executives, Te Uru Whakamauora presented this report, which was taken as read. The Gardenview Dementia Unit in Levin closed on 25 February 2022, with all residents transitioned to other providers.

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

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

A Committee member noted the importance of connectivity between Smokefree 2025 work being done by public health and iwi Māori providers. She also noted that a kohanga reo had contacted her about the lack of progress made regarding the provision of dental services. It was agreed that the Operations and Clinical Executives from Te Uru Pā Harakeke would follow up.

It was resolved that the Committee:

note the areas highlighted in the dashboard and associated commentary.

(Moved Oriana Paewai; seconded Jenny Warren)

6 DISCUSSION/DECISION PAPERS

6.1 Māori Health Equity Dashboard – Te Ara Angitū Report – Mental Health Indicators

The Operations Executive, Te Uru Rauhī presented this report, which was taken as read.

It was resolved that the Committee:

note the equity position for each of the indicators

note the analysis, discussion and proposed next steps to improve Māori health equity and further strengthen MidCentral District Health Board's commitment to Te Tiriti o Waitangi

endorse the Te Ara Angitū report.

(Moved Muriel Hancock; seconded Stephen Paewai)

The Operations Executive, Te Uru Rauhī and the Clinical Executive, Te Uru Pā Harakeke left the meeting.

The Radiation Oncologist joined the meeting.

4. STRATEGIC FOCUS

4.1. Regional Cancer Services and Te Aho o te Kahu

The Radiation Oncologist presented this report and advised he was willing to talk to any GP practice to discuss how the programme worked.

Committee members congratulated everyone involved in developing this successful project, which was now considered to be 'business as usual'.

It was resolved that the Committee:

note the update regarding the Advisory Oncology Service.

(Moved Heather Browning; seconded Stephen Paewai)

The Operations Executive, Te Uru Pā Harakeke and Te Uru Mātai Matengau; the Operations Executive, Te Uru Arotau; the Chief Medical Officer and the Executive Director, Nursing and Midwifery left the meeting.

5. PERFORMANCE REPORTING

5.2 Pae Ora Paiaka Whaiora Report

The General Manager, Māori Health presented this report, which was taken as read. She noted that 55 FTE Māori staff had joined the DHB over the last quarter (not over the last 12 months as noted in the report). Of these, 23 people were clinical. The Chair acknowledged the support for the Māori Education Trust and its predecessor, the Māori Education Foundation (both led by Sir John Bennett) and this Board's support of Kia Ora Hauora and its predecessor, Whakatutukui Moemoea, chaired by Shane Ruwhiu.

In response to questions, it was noted that $40k per annum was available for the scholarship programme, taken from the equity funding for the Māori workforce.

It was resolved that the Committee:

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

(Moved Heather Browning; seconded Stephen Paewai)

The General Manager, Enable New Zealand joined the meeting.

5.1 Enable New Zealand Report

The General Manager, Enable New Zealand presented this report, which was taken as read. The volume of equipment issued had increased significantly since taking on the ACC Managed Rehabilitation Equipment Service (MRES) contract. It had been estimated that 35 staff would be needed to work on this contract, but only 20 had been recruited so far. A meeting had been held with the new Chief Executive of ACC which had reinforced a strong partnership approach to the delivery of the service.

It was resolved that the Committee:

endorse the Enable New Zealand Report to 31 December 2021.

(Moved Heather Browning; seconded Materoa Mar)

The General Manager, Enable New Zealand left the meeting.

5.3 Quality and Safety Dashboard

The Acting General Manager, Quality and Innovation presented this report, which was taken as read. In response to a question, she advised that the majority of complaints were from people having to wait for long periods to be seen in the Emergency Department, although the feedback was good once they were seen.

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 Jenny Warren; seconded Muriel Hancock)

6. DISCUSSION/DECISION PAPERS *(continued)*

The General Manager, People and Culture joined the meeting.

6.2 Māori Health Equity Dashboard – Workforce Indicators

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

It was resolved that the Committee:

note the progress made on workforce indicators identified for the 2021/22 year

note the analysis, discussion and proposed next steps to improve the current workforce indicators.

(Moved Stephen Paewai; seconded Lew Findlay)

The General Manager, People and Culture left the meeting.

The Locality and Intersectoral Development Manager joined the meeting.

7. INFORMATION PAPERS

7.1 Regional Services Plan – Quarter One and Quarter Two

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

A Committee member noted that Joanne Hayes had been appointed as the Manawhenua Hauora representative on the Technical Advisory Services Board.

It was resolved that the Committee:

note there is no requirement to have a Regional Services Plan presented to the Minister of Health for the 2021/22 year

note the progress made on implementing the central region's national and regional priority programmes for Quarter One and Quarter Two of 2021/22.

(Moved Muriel Hancock; seconded Karen Naylor)

7.2 Locality Plan Progress Report – Manawatū

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

It was resolved that the Committee:

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

(Moved Vaughan Dennison; seconded Jenny Warren)

The Locality and Intersectoral Development Manager left the meeting.

7.3 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 Jenny Warren; seconded Muriel Hancock)

8. GLOSSARY OF TERMS

No discussion.

9. LATE ITEMS

No discussion.

10. DATE OF NEXT MEETING

Tuesday, 24 May 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 23 November 2021 meeting held with the public present	
Serious Adverse Events (SAC 1)	To protect patient privacy	9(2)(a)

(Moved Muriel Hancock; seconded Jenny Warren)

Part One of the meeting closed at 11.28am

Confirmed this 24th day of May 2022

……..

Committee Chair

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Finance, Risk and Audit Committee meeting held via Zoom on 15 March 2022 from 9.00am

PART ONE

COMMITTEE MEMBERS
Oriana Paewai, Committee Chair
Tony Hartevelt, Deputy Committee Chair, Independent – chaired this meeting
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
Jared McGillicuddy, Internal Audit Manager
Nicki Williamson, Committee Secretary

IN ATTENDANCE (part meeting)
Gabrielle Scott, Interim General Manager, Quality & Innovation
Warren Crawley, Principal Hospital Engineer
Keyur Anjaria, General Manager, People and Culture
Sarah Fenwick, Operations Executive, Te Uru Mātai Matengau, Cancer Screening, Treatment and Support

1. KARAKIA

The Deputy Chair opened the meeting with a karakia.

2. ADMINISTRATIVE MATTERS

2.1 Apologies

Apologies were received 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 1 February 2022 be approved as a true and correct record. (Moved Vaughan Dennison; seconded Heather Browning)

2.5 Matters arising from the previous minutes

There were no matters arising from the previous minutes.

3. PERFORMANCE REPORTING

3.1 Financial Update – February 2022 - verbal

The Deputy Chief Financial Officer presented a verbal report on the February financial result. He noted February had had an outstanding result, $1.211m surplus which was $2.341m favourable to budget. The majority of the favourable result was due to ACC revenue which included back billing of NAR contracts which had been the subject of a price review. The prices were effective from December 2020 and resulted in an additional $1.7m of unbudgeted revenue. The ACC year to date result was now $2.4m favourable to budget and this would continue through to year-end. There was also a positive variance in staffing costs, except for nursing, and positive variances in clinical supplies.

Given our performance to date, the Ministry was interested in our predicted end of year result, which remains in line with the budgeted deficit. This result may improve if staff recruitment efforts do not achieve the lift in clinical staff numbers needed, though this would not ideal for front line staff. The year's result may improve if approved business cases fall behind schedule, which could have consequences for next year.

This forecast does not include the impairment of the existing patient management system which has been approved for replacement by a SaaS alternative. The amount of impairment is still to be determined but is likely to be circa $6.5m.

It was resolved that the Committee:

note the verbal update given on the February 2022 result.

(Moved Vaughan Dennison; seconded Brendan Duffy)

3.2 Finance Report – January 2022

The Deputy Chief Financial Officer presented the report, which was taken as read. The overall favourable result was made up of small positive variances partially offset by significant staff overtime. The DHB continued to receive some pay equity funding to offset payments made to staff. The year-end forecast was in-line with the budget and included a noticeable increase in staffing to fill vacancies.

It was noted that capital expenditure significantly lagged behind capital approvals. Expenditure was likely to increase as projects are well underway. Cash flow was sufficient to support this, this year and well into the 2022/23.

To provide more clarity around the cash flow a forecast would be produced that went beyond June.

It was resolved that the Committee:

note that the month operating result for January 2022 is a surplus before one-off items of $1.359m, which is $1.162m favourable to budget

note that the year to date result for January 2022 is a deficit before one-off items of $3.319m, which is $0.284m adverse to budget

note that year to date for January 2022 COVID-19 related contribution of $0.146m and Holidays Act costs of $3.194m have been incurred. Including these results in a year to date deficit after exceptional items of $6.367m, which is $0.751m favourable to budget

note that the total available cash and equivalents of $31.558m as of 31 January 2022 is sufficient to support liquidity requirements

endorse the January financial report.

(Moved Vaughan Dennison; seconded Heather Browning)

3.3 Sustainability Plan

The Interim General Manager, Quality & Innovation joined the meeting to speak to this report. The report was taken as read. Despite COVID-19, work was still progressing across most areas of work in the sustainability plan. The specialling project was nearing completion although it was difficult to recruit to workforce.

The CCDM programme for nursing meant a regular review of staffing and what was required on each ward, having Health Care Assistants on the ward was improving. Patients presenting to the wards were becoming more acute / complex and required more supervision support.

OPAL Community Service had started to recruit its team and working on the models of care. Recruitment was also an issue for this project with 16 FTE required.

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 January 2022 report indicates savings of $323,961 year to date

endorse the approach and progress made to date on the Sustainability Plan 2020-2023, for the Board's consideration.

(Moved John Waldon; seconded Vaughan Dennison)

The Interim General Manager, Quality & Innovation left the meeting.

3.4 Non-Clinical Audits Review Findings Update

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

The Committee acknowledged the work done and commitment shown by staff achieving the audit recommendations.

It was resolved that the Committee:

note the progress made on the non-clinical audit recommendations.

(Moved Vaughan Dennison; seconded Brendan Duffy)

4. STRATEGY AND PLANNING

4.1 Electrical System Strategy Report

The Principal Hospital Engineer presented the report, which was taken as read. The strategy was outlined with the proposed solutions. COVID-19, the decarbonisation programme and the environmental changes had all impacted significantly on electricity demands eg pre COVID-19 an area might have all air changed from two to four times per hour. Now, areas were having air changes between 12 to 16 times per hour, plus the heating / cooling required before the air entered the buildings.

There were two 11kV feeders to the hospital site, if one failed, the other became the back-up. The internal site network had recently had its 11kV system replaced and was now robust and future proofed.

Non-essential and essential power usage was an approximate equal 50:50 split. The hospital was currently at the maximum electrical load and usage was increasing significantly. PowerCo were struggling to supply the hospital site.

The proposed internal solution to power on site would reduce the redundancy cover, but dynamic energy management would switch essential power to the onsite generators if needed.

The solution utilised three areas: use less power / on site generation / reduce wasted power and shift demand peaks.

The current diesel on site storage supply for power generation covered seven days with the boilers running at maximum capacity. The new, larger generator would require a marginal increase in diesel usage.

The 1970's low voltage substation, whilst it was the oldest electrical infrastructure, it was not the highest risk and did not support clinical services.

There had been many learnings from the last network project upgrade which would assist with future projects.

It was resolved that the Committee:

> *endorse for Board consideration the Electrical Systems Strategy Document*
>
> *note that specific initiatives contained in the Strategy Document will require funding approval in line with the Delegations Policy.*
>
> *(Moved Vaughan Dennison; seconded John Waldon)*

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.

It was resolved that the Committee:

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

6.2 NGO Provider Contracting Process Review

The General Manager, Finance & Corporate Services and Internal Auditor presented the report, which was taken as read. Originally, when the audit programme was agreed, this had been an area to focus on. Whilst it was still important, things had changed with the health reforms.

There were no high-risk findings in the audit. FUDPAC was unique to MDHB but a very good model. The Finance Manager had made significant effort to improve dashboard visibility.

Compared to other DHBs, MDHB had an honest and consistent approach when working on recommendations and "didn't just apply a band-aid"

Contract documentation would be OK to handover to Health NZ. Health NZ and the Māori Health Authority were still to work through which contracts woud be commissioned nationally, regionally or locally.

It was resolved that the Committee:

note the internal audit on NGP Provider Contracting Processes review
endorse the work plan to implement the recommendations
(Moved Tony Hartevelt; seconded John Waldon)

The General Manager, People & Culture joined the meeting.

6.3 Holidays Act Compliance Project Update

The General Manager, People & Culture presented the report, which was taken as read.

The project was progressing well at both local and national levels. The Chief Executives continued to sign off on national decisions. The Holidays Act configurable HRI system was currently in a test environment and configuration work was being done on it during testing.

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
(Moved Vaughan Dennison; seconded Heather Browning)

The General Manager, People & Culture left the meeting.

6.4 Major Projects – quarterly update

The General Manager, Finance & Corporate Services presented this report which was taken as read. The report included a framework from the Ministry on how to progress business cases, which provided clarity.

Lots of work had been done on the building blocks and site strategy – all of which were crucial to moving forward. An indepth Geotech review of the site was nearly complete.

Due to COVID-19 restrictions the Ministry had been unable to get on to site. Following on from a virtual engineer tour and walkthrough in December with the Ministry, video clips of the clinical areas from the clinicians perspective had been shown to the Ministry. This had provided the Ministry with a better understanding of the hospital site, infrastructure and physical challenges.

The new Mental Health unit had just completed design work which would be shared with the Board. The biggest issue was markets, across all areas, costs, labour, materials, quote validity periods etc. The Ministry was aware and was working with all DHBs to have a clear pathway to obtain funding quickly so that projects could remain on track.

EDOA/MAPU – car parking mobility spaces and ambulance access had been completed. There were some supply line constraints from Australia and COVID-19 could still have an impact on builders, workforce, staff and contractors.

SPIRE – there had been an issue in A Block ceiling with seismic restraints which had now been resolved. The original rework had been budgeted at over $300k but had been resolved for approximately half that cost. The issue had affected the contingency budget. The changing rooms were now complete and the staff were very happy with them. Overall, the project was making good progress.

The worst case for the project would be 60-70 days of slippage. The contractors and team had all been advised that that this was unacceptable. Approximately 50 percent of the slippage should be able to be clawed back. On a more positive note, there were now multiple contenders for Stage 2 subtrades work which would help sharpen pricing. Did not want to de-scope the project due to budget constraints.

It was resolved that the Committee:

> *note progress with the SPIRE, Medical Assessment Planning Unit / Emergency Department Observation Area Facility, Fluoroscopy, Acute Services Block / Relifing of Clinical Services Block and Acute Mental Health Unit*
>
> *note the approach being taken in respect of the Acute Mental Health Unit project budget*
>
> *note the ongoing pressure on project costs as a result of the current construction market.*
>
> *(Moved Tony Hartevelt; seconded John Waldon)*

The Operations Executive, Te Uru Mātai Matengau, Cancer Screening, Treatment and Support joined the meeting.

6.5 Post Implementation Review of Linear Accelerator Replacement

The Operations Executive, Te Uru Mātai Matengau, Cancer Screening, Treatment and Support presented the report, which was taken as read.

It was resolved that the Committee:

note the project to replace two linear accelerators at Palmerston North Hospital has been successfully completed and is delivery benefits to patients

note that in line with the Ministry of Health's requirements, a Post Occupancy Evaluation will be undertaken in April 2022.

(Moved Vaughan Dennison; seconded Tony Hartevelt)

The Operations Executive, Te Uru Mātai Matengau, Cancer Screening, Treatment and Support left the meeting.

6.6 Results of MDHB Audit

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

It was resolved that the Committee:

note the summary of audit results confirmation received from the Office of the Auditor General.

(Moved Tony Hartevelt; seconded Brendan Duffy)

6.7 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:

endorse the Committee's revised work programme.

(Moved Vaughan Dennison; seconded John Waldon)

7. GLOSSARY OF TERMS

No discussion required.

8. LATE ITEMS

There were no late items for Part One.

9. DATE OF NEXT MEETING

Tuesday, 26 April 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 1 February 2022	
Electrical Substation Replacement	To protect negotiations, including commercial and industrial	9(2)(j)
Generator Replacement	To protect negotiations, including commercial and industrial	9(2)(j)
Replacement of CT Scanner and Building works	To protect negotiations, including commercial and industrial	9(2)(j)
Post Acute Community Rehab	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 Tony Hartevelt; seconded Vaughan Dennison.

Part One of the meeting closed at 11.03am

Confirmed this 26th day of April 2022

.....
Chairperson

Manawhenua Hauora Chair’s report

The Manawhenua Hauora Chair will provide a verbal update

Strategic focus

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Strategic focus

No items for discussion at this meeting

Performance reporting

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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	21 March 2022
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

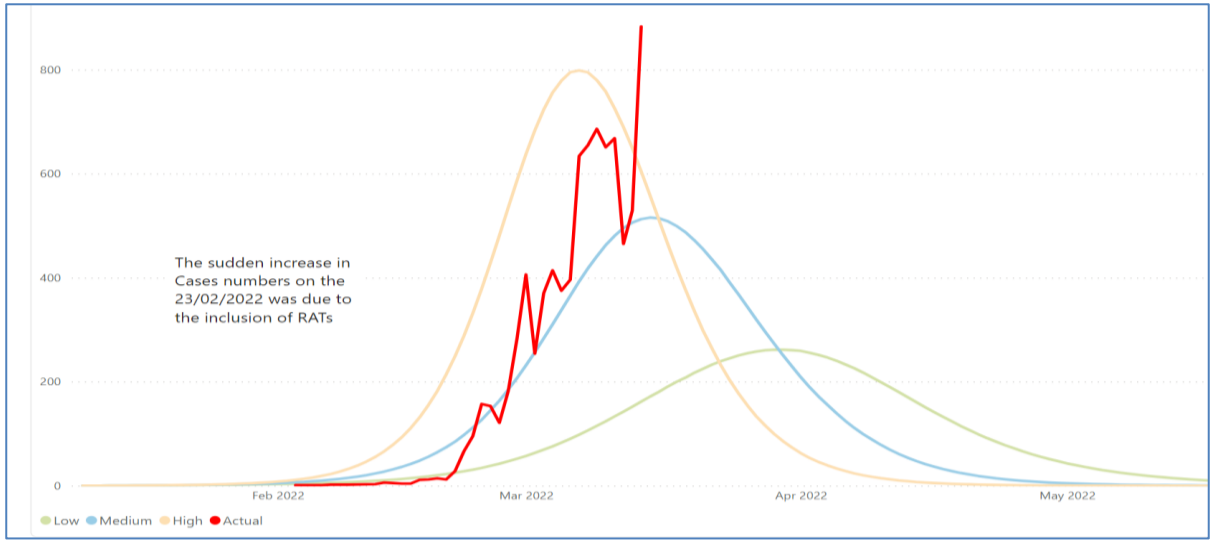
To provide the Board with an update of key local, regional and national matters. No decision is required.

2. LOCAL MATTERS

2.1 Managing COVID-19 in the Community

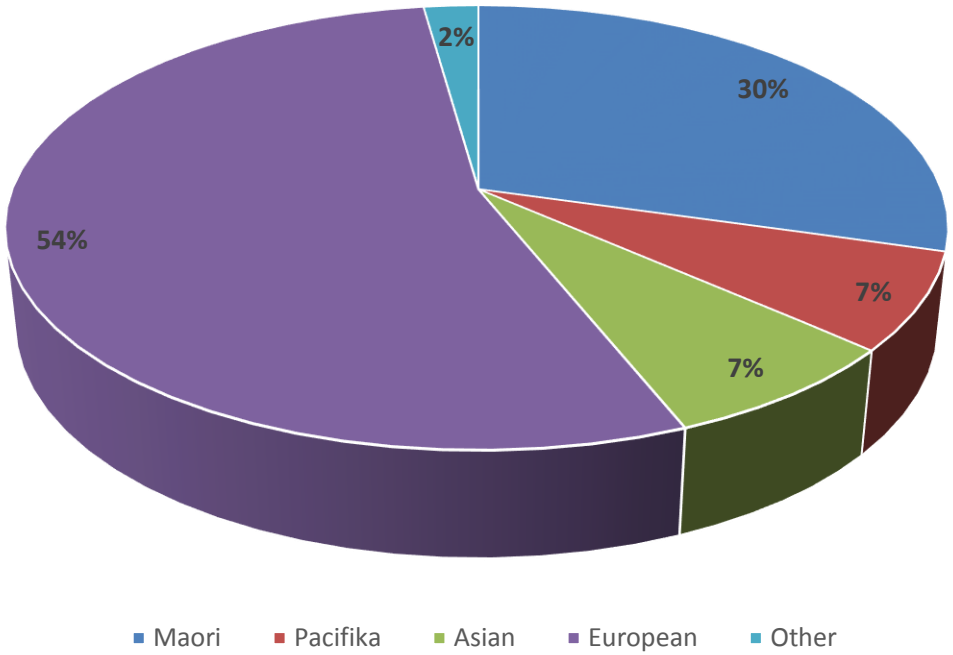
Cases across the district continue to rise for COVID (Graph One) with over 800 daily cases now having been reported regularly. MidCentral District Health Board (MDHB) experienced early cases of Omicron in late January (2 to 3 weeks behind Auckland) with rapid increases occurring a month later. This was initially seen in the Horowhenua and Otaki districts where initial higher rates across the district (418 and 1022 respectively per 100,000 population) have been reported. All localities are now seeing daily COVID cases with Palmerston North having the greatest numbers (half of all district cases). For this purpose, the Locality Hubs continue to be strengthened and to build on existing partnerships. The Central Coordination Hub meets daily to ensure appropriate coordination continues between the public health, primary, secondary and welfare streams of support enabled through Māori and iwi services.

COVID-19 Resilience – Omicron: National Modelled Cases vs Actual Cases as at 14 March



Rates in the district now are highest for Pacifika (572 per 100,000) and Māori (518 per 100,000) and are approximately twice that of Europeans (244 per 100,000), highlighting the need for a strong partnership with Māori and iwi.

Percentage Ethnicity for COVID-19 cases based on the 7 day rolling average for MDHB



The public health team remains focused on support for ARC facilities and residential care along with large exposure events (faith-based organisations and places of employment). The team is beginning to prepare for a post-COVID environment of open borders and COVID recovery. Welfare services, as reported by MSD, are experiencing high volume challenges across the country and district. Primary care has simplified its processes and is managing caseloads while increasing cases continue to be seen within hospital services. A number of our services are providing essential care on a daily basis to whānau including community services.

2.1.1 Equity

As the COVID-19 case numbers continue to grow in every locality across the district with particular growth in Horowhenua and Palmerston North, the work iwi and Māori providers are leading across localities with the COVID-19 response is paramount and the DHB is extremely appreciative of these efforts. There are five locality hubs operating across the district which are largely comprised of iwi and general practice, with the addition of other organisations such as pharmacy, local council and other NGO's connected to

support the work in their respective localities. These hubs are leading the care in the community work within their localities and are supported by MDHB, THINK Hauora and MSD.

Iwi and general practice have access to the COVID-19 positive information for their locality via the electronic care management system. Where clinical capacity exists within iwi, the clinical aspect of care in the community is shared between the general practice and the iwi. Iwi and general practice team(s) are meeting regularly to ensure they remain connected and are supporting each other with the care in the community work. As case numbers rise across localities, iwi and general practices are using risk stratification alongside community intelligence, to ensure those who need clinical assessment and active management are contacted. Locality hubs report a high number of people not reporting positive results. This community intelligence is valuable for facilitating the registration of positive results, and for ensuring necessary clinical care is provided for those we may not otherwise be aware of due to non-reporting.

Iwi are also supporting the welfare aspects of care with MSD funded connector roles present in every iwi, in addition to these roles being present in some NGO's. Welfare is being activated via a range of options including community intelligence and connections. Iwi and the NGO's with connector roles know their communities well, including those who often experience barriers with access to supports. Additionally, some rural communities do not have cellphones or internet coverage, therefore these organisations, alongside rural support networks, are ensuring necessary supports are mobilised.

The introduction of Rapid Antigen Test (RAT)s in February provided logistical and communication challenges which have been worked through across intersectoral partners. Access to these has been established in all localities with iwi and Māori providers being heavily involved with the testing aspect of the COVID-19 response, providing access to RATs and supporting Polymerase Chain Reaction (PCR) testing. There has been a significant demand for RATs and the introduction of the ability to pre-order these tests online have further increased this demand. The DHB's focus continues to be on equitable access for communities, therefore we continue to ensure providers are regularly supplied with RATs (and PPE essentials) to service the demand.

2.1.2 COVID-19 Vaccination Planning and Delivery

Vaccination remains a core focus of the mahi to continue to minimise the effects of Omicron across the rohe. The vaccination programme has continued into the next phase of delivery to all aged five years and above, alongside a strong focus on the delivery of boosters. Delivery numbers have reduced significantly in the past few weeks, and we expect to see this trend while the effect of active Omicron is within the community.

While we have onboarded more providers, we have recently seen a reduction in capacity to deliver the vaccination, particularly in the general practice settings, related to the impact of the clinical care requirements associated with Omicron cases in the rohe. We currently have 47 active providers. First-time vaccinations continue to be seen across the district at 50-80 per week.
Hours of delivery are also currently reduced, and the collective teams are experiencing the impact of COVID within staff and whanau.

The following tables provide an update of doses delivered as of 16 March 2022.

Table One: MDHB Vaccinations for 12 plus ages according to Ethnicity (7 March 2022)

		All (12+)	Māori (12+)	Pacifica (12+)
MDHB residents	**1st Dose**	147,724(96%)	23,013 (94%)	4,532 (100%)
	2nd Dose	145,519 (95%)	22,196 (91%)	4,442 (97%)
MDHB delivered	**1st Dose**	139,777	21,612	4,259
	2nd Dose	137,737	20,916	4,186
Total doses		**368,064**	**52,195**	**10,582**
Against target		**96%**	**91%**	**97%**

Table Two: MDHB and National Ethnicity vs Vaccination Coverage (5 plus)

Ethnicity	MDHB Partially (5+) %	MDHB Fully (5+) %	MDHB Booster %	National Partially (5+) %	National Fully (5+) %	National Booster %
Māori	9	75	61	8	73	59
Pacific Peoples	9	83	64	8	83	60
Asian	11	98	73	9	95	70
European	5	87	78	5	87	77
Total	6	86	75	6	86	73

Vaccination delivery continues across the iwi and Māori provider vaccination sites for 2022, however we are acutely aware of the low vaccination rates for 5-11-year-olds and the need to focus on booster doses, particularly for Māori. Factors for the low rates include delayed rollout of the programme to the 5-11-year-old age group, increased COVID-19 transmission across communities and a delay of 12 weeks before booster vaccination following COVID-19 infection, provider workforce constraints due to COVID-19 isolation and extensive involvement with response efforts, and vaccination communications being focussed on the outbreak. The DHB are working closely with iwi and Māori leaders, and the communications team to stimulate a focus on vaccinations across communities. Whilst the DHB are currently supporting providers impacted by staff absence, as staff return to work focus will continue providing vaccination opportunities across communities. Vaccination coordinators will continue to utilise their existing relationships with schools to encourage increased uptake of vaccinations for 5–11-year-olds. Providers will also continue to offer regular clinics at their physical offices alongside targeted bespoke approaches.

The COVID-19 Vaccinator Working Under Supervision (CVWUS) training is continuing in 2022 with Māori kaimahi keen to embrace the opportunity to upskill and support their communities. There are currently 21 fully trained CVWUS and 20 that are at various stages of the training. These roles are present in the majority of localities across the district and are regularly utilised in iwi and Māori led vaccination sites. Due to capacity within the DHB's iwi and Māori partnership team, Te Tihi have been engaged to continue with this training. Whilst Te Tihi are leading the engagement with providers and kaimahi regarding training, they continue to work in conjunction with the DHB Māori Nurse Educator who delivers the CPR component.

Whilst these roles have been extremely beneficial, it is pertinent to point out the kaimahi in these roles are undertaking numerous roles related to the COVID-19 response and are therefore not able to be solely utilised for the CVWUS function. As iwi and Māori provider services are heavily involved with vaccinating, testing, and care in the community work, there is a high demand on this workforce, despite MDHB relaxing iwi and Māori provider contracts to enable the pivoting of staff toward response efforts.

2.1.3 COVID-19 Vaccination Order

The COVID-19 Vaccination Order mandates that the COVID-19 booster vaccination for the health and disability workforce needs to be taken on or before 183 days (approximately 6 months) from the second dose of the vaccination. The Order applies to all MDHB employees. Any worker who does not comply with these vaccination deadlines must not continue work within the DHB unless they have a legitimate medical exemption. In light of the current Omicron outbreak, and subsequent increase in the unplanned absence of critical staff, DHBs has been provided with extensions to these deadlines by the MoH. There is one staff member who has yet to receive the booster and still falls within the deadline of 27 March. MDHB continues to encourage all their workers to take their booster vaccinations in line with the timeline applicable to them.

2.1.4 Respirator Fit testing

The purpose of mask fit testing is to ensure that respiratory protection equipment (RPE), worn by healthcare staff to prevent respiratory transmission of COVID-19, is effective to the maximum extent as is reasonably practicable. The DHB offers an array of

approved RPE, including disposable P2 type N95 face masks, respirator masks and half-hood masks. The DHB is well resourced for this activity and continues to provide fit testing to staff on a regular basis. In discharging its obligations as a responsible Person Conducting a Business or Undertaking (PCBU), the DHB continues to offer fit testing to its contracted staff (Rescue Helicopter pilots, Ventia, Duty Calls, Compass etc) as well as Primary Health Organisation staff, community providers and the Hospice, at no additional cost to them.

A fit testing programme for iwi and Māori providers who have frontline staff was held during February. Over 120 staff were fit tested across the Manawatū, Horowhenua, Ōtaki and Tararua.

2.2 Financial Update

The net result for February is a surplus of $1.211m and is $2.341m favourable to the budgeted deficit of $1.130m. This includes Holidays Act expenditure of $0.446m. Excluding this and the impact of COVID-19 results in an operating surplus of $1.737m with a favourable operating variance to the budget of $2.283m. A significant portion of the month's favourable variance is related to the back billing of ACC price increases.

The year to date result is a deficit of $5.156m, which is $3.092m favourable to the budgeted deficit of $8.248m. This includes Holidays Act expenditure of $3.639m and COVID-19 net revenue of $0.066m. Excluding these two items results in a YTD operating deficit of $1.582m and a favourable operating variance to budget of $1.999m.

2.3 Closure of the Gardenview Dementia Unit

MDHB received formal notice late last year for the closure of the Gardenview Dementia Unit in Levin in early March 2022. The Gardenview Dementia Unit closed on Friday 25 February. All 25 residents have been transitioned to other providers.

2.4 Interim Health NZ and Interim Māori Health Authority Visit

On Tuesday 8 March MDHB Fepulea'I Margie Apa, CE of the interim Health New Zealand and Riana Manuel, CE of the interim Māori Health Authority to MDHB.

This was a great opportunity to showcase some of the amazing work the health sector is doing in our district, and across the central region in partnership with iwi and THINK Hauora. Our integrated services model was well demonstrated in our kōrero with good acknowledgement by Margie and Riana, stating the partnerships and relationships in our district look to be strong and enduring, helping us achieve what we have thus far.

Riana spoke with Iwi and Māori Health providers about the new Māori Health Authority and the current issues Māori providers are facing, whilst Margie was taken on a tour of Palmerston North Hospital. Riana acknowledged our achievements for Māori COVID-19

vaccination rates for the rohe and our strong relationships across the sector with Māori and non-Māori. This opportunity to present was a good way to place our district on the map, ahead of the transition to Health NZ and the Māori Health Authority.

2.5 Major Capital Building Projects

2.5.1 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 on the first floor of Block A. This stage also includes the upgrade of the Theatre Staff Change Area within the theatre suite and this work was completed in February. Feedback from clinical staff has been very positive.

As advised previously, some issues are being encountered as the walls and ceilings are opened up. These are impacting the project cost and timeline.

The detailed design for Stage 2 is currently being costed, and the construction timeframe is reviewed. This project, and the MAPU/EDOA project, are experiencing cost pressure from supply chain disruption and scarcity of market capacity in most trades. The scope is being maintained but our ability to restrain costs against market forces is limited.

2.5.2 Acute Mental Health Unit

In the first week of March, a presentation for some of the Leadership team was given about the Developed Design for the new Mental Health Unit, part of our Capital Projects. This will also be presented to User Groups, Manawhenua Hauora, Unison, neighbours and community groups. The team received a resoundingly positive response from all for the direction the project has taken and continues to follow.

Following the completion of the Developed Design, the project will move into Detailed Design. This phase will focus on landscape, furnishings, fixtures and equipment. This piece of work, initially, will be led by iwi and the project team to ensure that the narrative of Te Waonui a Tāne and Te Whare Tapa Whā is visible throughout.

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

Work on creating the foundations for this 750m2 building is underway. New accessibility parks in front of the hospital’s main entrance opened on 7 March. These replace those displaced by the construction works in Car Park C.

2.5.4 Fluoroscopy

The new fluoroscopy machine came into use in late February. The Medical Imaging Service has been without a fluoroscopy machine for some time and staff are enjoying having this modality once again.

3 REGIONAL MATTERS

3.1 Central Regional (CR) Chief Executives (CE) meeting

On Monday 7 March the CR CEs meet and the following items were discussed.

3.1.1 Regional Digital Services Update

An update was provided to the CR CEs on the in-progress regional digital activities. The update included the financial performance year to date and high-level timeline, key program risks and key regional activity including the day 1 current state analysis and capability uplift investment bids.

3.1.2 Regional Cardiac Programme

The final scope of work that will be completed by Synergia on the Regional Cardiac Programme was tabled. The scope of work for a single system of cardiac care in the central region builds on the Central Region Cardiac Health System Plan 2016-2021.

3.1.3 Whakapakari Hunga Tautoko Project

The Central Region DHB Child and Youth Portfolio Managers (CHIRPY) submitted a paper seeking the CR CEs support to engage with the Ministry of Health for funding to implement a clinical and professional support infrastructure solution for the central region Well Child Tamariki Ora (WCTO) Māori providers. CHIRPY has requested that if sustainable funding cannot be secured via the Ministry of Health, the six central region DHBs will prioritise funding to implement the solution. This was supported by the CEs.

3.1.4 Gap analysis

In December 2021, the Minister of Health issued a letter of expectations regarding governance arrangements for regional work and outlined an expectation for strong operational delivery in relation to regional COVID-19 resilience and preparedness, integrated regional responses to minimise the impact of COVID-19 in communities, and regional initiatives that best support the use of capacity and workforce. An analysis of areas where there may be gaps in the existing regional programme and opportunities to ensure that requirements are met was presented to the CR CEs for discussion.

3.1.5 Central Region Health Emergency Response Planning Programme

The Central Regional Chief Executives (CE)s continue to monitor the workstreams under the Health Emergency Response Planning Programme. These include the Central Regional Health Emergency Plan, the Central Region Coordination Centre (CRCC) and the Resilience Plan.

An update about the progress with the Central Region Resilience Programme and the planned phasing of building the Central Region Coordination Centre was presented at the CR CEs meeting. The CEs noted the current regional risk assessment rating, regional pressure points and the planned approach to phase building capacity to continue the Central Region Coordination Centre establishment.

4 NATIONAL MATTERS

4.1 National Chief Executives Meeting - Organisation design of Health NZ

On Thursday 17 March at the National CEs meeting held in Wellington. A key agenda item was a workshop on the organisation design of Health NZ facilitated by Fepulea'i Margie Apa, Chief Executive of Interim Health NZ. Riana Manuel, Chief Executive of Interim Māori Health Authority (MHA) also joined and gave an update to the CEs on the proposed organisational design for the MHA. A key contextual element worked throughout was the proposed New Zealand Health Charter, which is nearing its final stages of development.

4.2 Transition Update

Health New Zealand (HNZ) and the Māori Health Authority (MHA) are progressing through planning and preparatory work to support the establishment of HNZ and the MHA as permanent entities on 1 July.

As a part of this work, the Pae Ora Legislation Select Committee heard from hundreds of submitters and received more than 4,600 submissions sharing their thoughts about the Pae Ora (Healthy Futures) Bill, and what they want the new health system to look like. Parliament expects the Committee's report on its findings and recommendations at the end of April.

4.3 Appointment of Aged Care Commissioner

Carolyn Cooper was appointed in February to the role of Aged Care Commissioner. Carolyn brings a wealth of health sector experience to the role which will enable her to be a strong advocate for older people. She has broad experience across the health sector in New Zealand and Australia, including executive leadership roles in District Health Boards, clinical leadership in aged care, rehabilitation and general services.

This is a wonderful opportunity to elevate the Health and Disability Commissioner (HDC)'s work to protect the rights of people receiving aged care services. The Aged Care Commissioner will be located within HDC to provide leadership and promote systemic change and improvements across the entire sector, as well as being a recognisable figure for investigating complaints.

4.4 Multi-Employer Collective Agreement Bargaining

4.4.1 FIRST Union

MDHB has a Single Employer Collective Agreement (SECA) with the FIRST Union covering pharmacists. The offer made by the DHB, which aligned with guidelines from the MoH has been rejected by the union. MDHB's offer was similar to that offered to the PSA for their members covered by the Allied Health, Technical and Scientific Officers, as that MECA covers pharmacist roles across a number of other DHBs. The Union is waiting for the Allied Health, Technical and Scientific Officers MECA to settle before reconvening negotiations.

4.4.2 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 2021 to the Association of Professional and Executive Employees (APEX), the Union representing these employees. The offer made by the DHB has been rejected and mediation to resolve matters has been unsuccessful. APEX had issued notices of strike action to all six DHBs covering various periods and dates. MDHB had received notice of partial strike action for a month from 1 March to 1 April 2022 during which, Medical Physicists would not provide Quality Assurance each Wednesday on one of the three DHB's LINAC machines. Contingency plans were in place to minimise the impact on service delivery. However, on 10 March 2022 APEX has withdrawn all notices of strike action given the increasing impact of Omicron on DHBs. DHBs are continuing to explore options to settle this MECA.

4.4.3 Association of Salaried Medical Specialists (ASMS)

Mediated bargaining continued in December 2021 with the ASMS union (which covers Senior Medical Officers). Both parties are still some distance away in terms of settling any substantial claims. The DHB bargaining team is preparing a third offer and is currently going through its approval process before this offer is made to ASMS.

4.1.5 Allied Health, Public Health & Scientific Officers

Negotiations with the Public Service Association (PSA) over this MECA have been underway since last year. The DHBs recent offer was rejected by PSA members, and the PSA issued strike notice across all DHBs for 4 March and 18 March 2022. Contingency plans were put in place and Life Preserving Services (for 4 March 2022) were agreed with the PSA. The DHBs sought an injunction to call off the strike action on the basis that the strike was unlawful, as it essentially related to pay equity bargaining, which was not a core component of the MECA bargaining. The DHBs injunction application was successful, and the strikes will now not go ahead. Negotiations are continuing using a facilitated process, with the final two days of facilitation set down for 21/22 March.

4.4.4 Pay Equity Bargaining – Nurses and Midwives (NZNO)

Negotiations over pay equity for Nurses and Midwives who are members of the NZNO has been agreed upon. The proposed pay equity settlement is now undergoing the necessary Government approvals.

4.4.5 4.1.3 Pay Equity Bargaining – Midwives (MERAS)

Negotiations over pay equity claims for Midwives who are members of the MERAS union continue. Once an agreement is reached, the settlement will be sent for Government approval.

4.4.6 Admin and Clerical (PSA) Pay Equity Claims

Negotiations 'over pay' equity for Admin and Clerical staff continue with an agreement reached in principle. The proposed pay equity settlement is now undergoing the necessary Government approvals.

Pay equity work continues with the APEX, PSA (Allied and Scientific, roles) with the parties continuing to engage, and detailed information about the many professional groups covered by this claim being sought from DHBs and staff in the roles.

Financial update – February 2022

A verbal update will be provided (as presented to the 15 March Finance, Risk and Audit Committee meeting).

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

To	Board
Author	Darryl Ratana, Deputy Chief Financial Officer
Endorsed by	Finance, Risk and Audit Committee Neil Wanden, General Manager, Finance & Corporate Services
Date	16 March 2022
Subject	**Finance Report – January 2022**

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?

RECOMMENDATION

It is recommended that the Board:

- **note** that at its March meeting, the Finance, Risk and Audit Committee endorsed this report for the Board's consideration
- **note** that the month operating result for January 2022 is a surplus before one-off items of $1.359m, which is $1.162m favourable to budget
- **note** that the year to date result for January 2022 is a deficit before one-off items of $3.319m, which is $0.284m adverse to budget
- **note** that year to date for January 2022 COVID-19 related contribution of $0.146m and Holidays Act costs of $3.194m have been incurred. Including these results in a year to date deficit after exceptional items of $6.367m, which is $0.751m favourable to budget
- **note** that the total available cash and equivalents of $31.558m as of 31 January 2022 is sufficient to support liquidity requirements
- **approve** the January 2022 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 January 2022 is a surplus before one-off items of $1.359m, which is $1.162m favourable to budget.

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

Month to Date

Surplus/(Deficit)
$1.4m
Budget Variance
$1.162m
590.6%

FTEs
2,392
Budget Variance
126
5.0%

Capex
$2.3m
Budget Variance
$4.7m
67.1%

Cash & Deposits Movement
($70.1m)
Budget Variance
($74.2m)
1809.8%

Nursing and midwifery pay equity settlements continued during the month but at much smaller levels.

Unplanned care displaced planned care leading to offsetting variances.

FTEs remain below budget with noticeable drop in admin staff during the month.

Nursing costs and locum costs continue to be over budget. Locums are due to the use of locums in MHAS. Nursing includes pay equity components offset by related revenue.

Capital approvals during the month were not significant, expenditure on approved items maintained pace.

Year to Date

Surplus/(Deficit)
($3.3m)
Budget Variance
($0.28m)
(9.4%)

FTEs
2,399
Budget Variance
46
1.9%

Capex
$18.5m
Budget Variance
$26.2m
58.6%

Cash & Deposits
$31.6m
Budget Variance
$18.0m
132.5%

Current Ratio
1.03
Budget Variance
0.22

Reduced Planned Care funding due to COVID ipacts has been compensated for by the MoH.

FTEs are below budget across medical, allied health and administration roles.

Locums for MHAS are a significant adverse variance to budget. Mitigations are being identified to reduce this variance.

Capital expenditure is lagging behind budget YTD. However, this has picked up during the last 4 months

Potential Budget Risks
Seven Risks in Total.

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

Year End

Surplus/(Deficit)
($20.2m)
Budget Variance
($1.04m)
0.0%

FTEs
2,452
Budget Variance
30
0.0%

Capex
$85.8m
Budget Variance
($1.6m)
0.0%

Cash & Deposits
$15.8m
Budget Variance
$15.0m
0.0%

Current Ratio
1.01
Budget Variance
0.20

The forecast operating deficit before one off items is $1.04m adverse to budget.

Including one-off items, forecast indicates a year-end deficit that is in line with the budget.

This excludes the impact of potential impairments as a result of the WebPAS SaaS business case, which is awaiting MoH approval.

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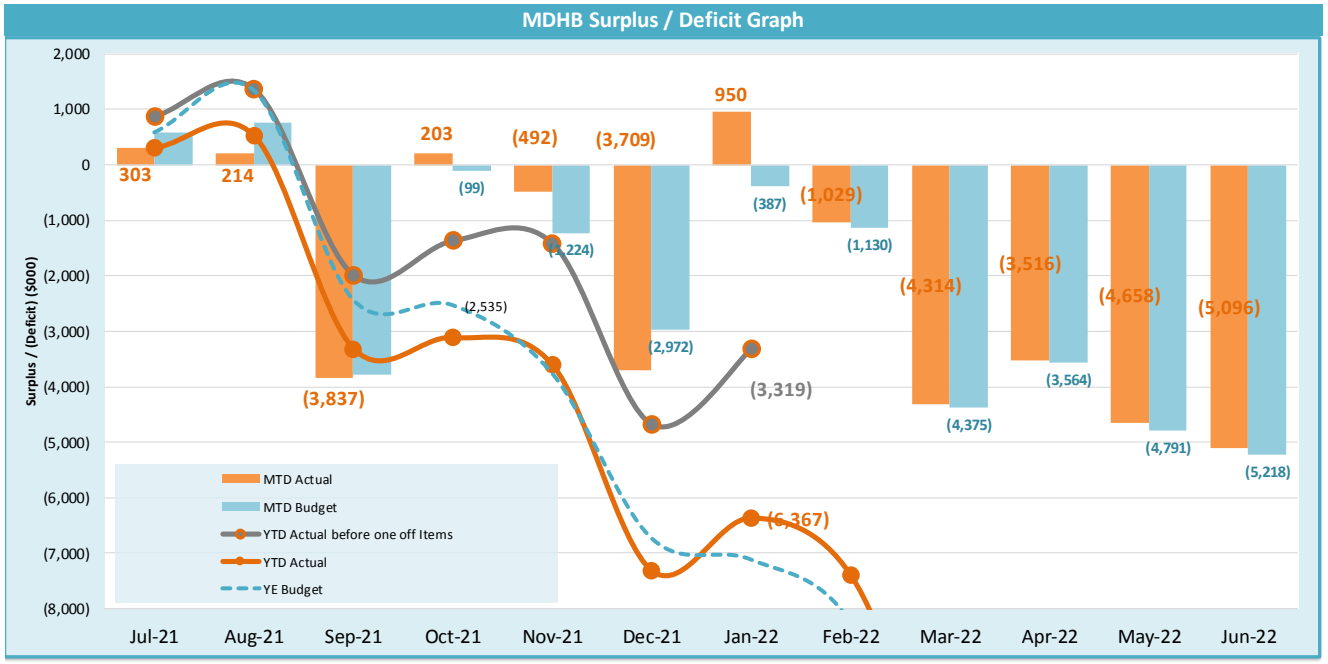
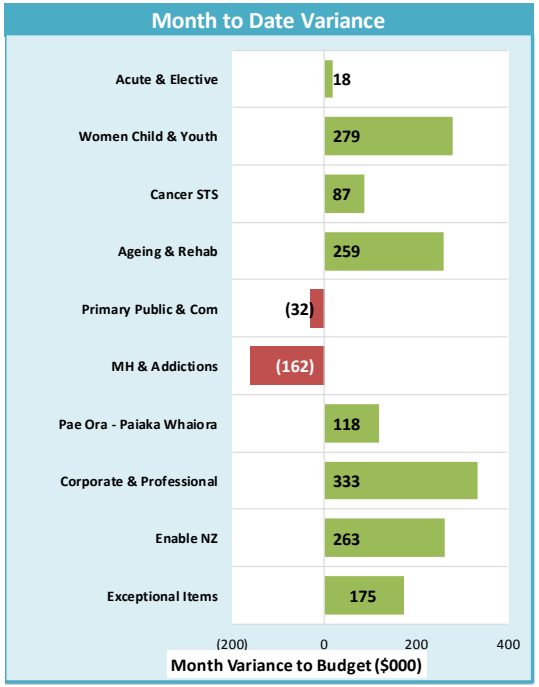
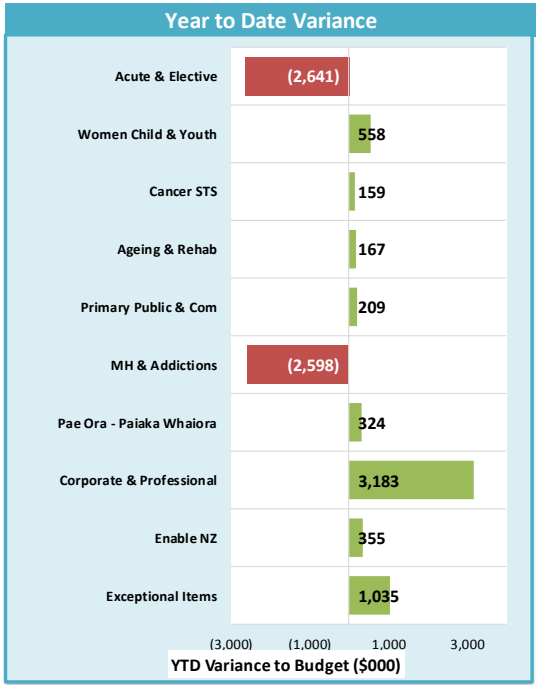
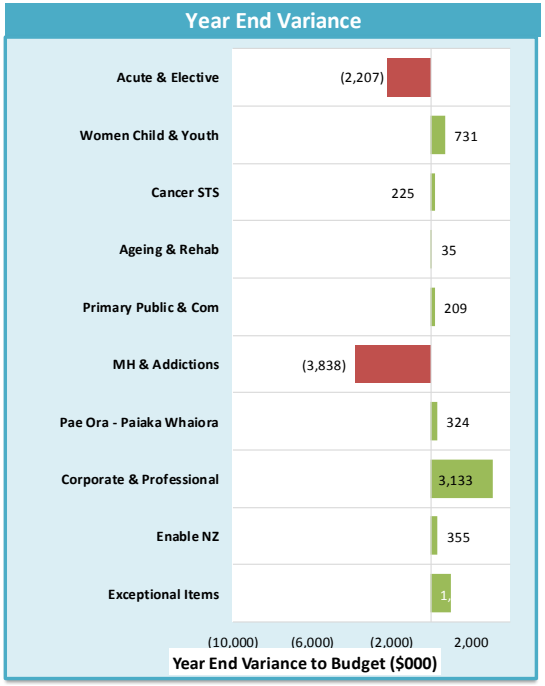
BOARD REPORT









2. FINANCIAL COMMENTARY

Adverse variances are in brackets unless stated otherwise.

2.1 Financial Performance

The MidCentral District Health Board (MDHB) result for January 2022 is a surplus before one-off items of $1.359m and is $1.162m favourable to budget.

Net revenue for the month is $1.721m favourable to budget, and this is partially offset by expenditure which is $0.822m adverse to budget. The year to date result is a deficit of $3.319m, which is $0.284m adverse to budget. A year to date COVID-19 related contribution of $0.146m and Holidays Act costs of $3.194m have been incurred. This results in a year to date deficit of $6.397m when these one-off items are included.

The Statement of Financial Performance is shown in the following table. A year-end forecast is shown in the table and indicates a year-end deficit that is in line with the budget. Note that this forecast excludes the impact of potential impairments as a result of the webPAS Software as a Service (SaaS) business case, which is awaiting Ministry of Health (the Ministry) approval. Also excluded are the financial impacts of the Omicron outbreak, which are not yet known.

BOARD REPORT

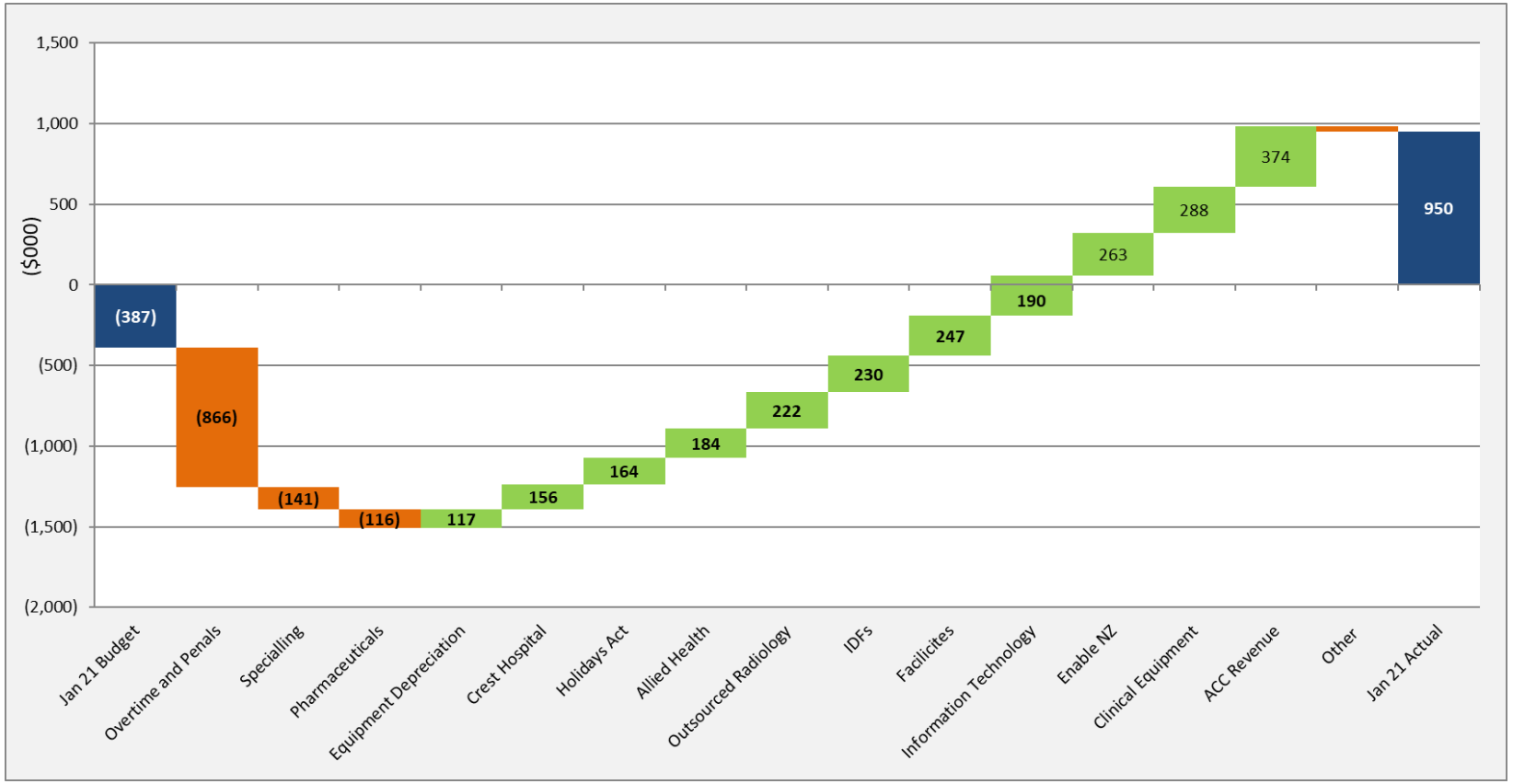
$000	January 2022			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Net Revenue	**65,978**	**64,256**	**1,721** ✓	**463,975**	**450,733**	**13,242** ✓	**787,719**	**772,680**	**15,039** ✓
Expenditure									
Medical	7,156	6,776	(380) ✗	47,682	47,914	232 ✓	83,542	85,338	1,796 ✓
Nursing	10,994	9,505	(1,489) ✗	73,402	62,924	(10,478) ✗	121,548	110,673	(10,875) ✗
Allied Health	2,693	2,877	184 ✓	21,816	23,025	1,209 ✓	39,089	40,912	1,822 ✓
Support	132	156	24 ✓	1,049	1,183	134 ✓	1,910	2,044	134 ✓
Management / Admin	2,723	2,789	66 ✓	22,061	22,194	133 ✓	38,981	39,094	113 ✓
Personnel	23,697	22,103	(1,595) ✗	166,010	157,240	(8,770) ✗	285,071	278,061	(7,010) !
Outsourced Personnel	907	342	(565) ✗	6,801	2,532	(4,269) ✗	10,635	4,685	(5,949) ✗
Sub -Total Personnel	24,604	22,444	(2,159) ✗	172,811	159,772	(13,039) ✗	295,705	282,746	(12,959) !
Other Outsourced Services	1,748	2,140	393 ✓	16,843	15,668	(1,175) ✗	29,721	27,066	(2,655) ✗
Clinical Supplies	4,829	4,944	115 ✓	37,897	37,272	(625) !	66,938	65,534	(1,404) !
Infrastructure & Non-Clinical	6,857	7,536	680 ✓	48,268	50,949	2,681 ✓	90,367	91,009	642 ✓
Provider Payments	27,153	27,303	150 ✓	193,495	191,773	(1,722) !	328,341	328,288	(53) !
Total Operating Expenditure	**65,190**	**64,368**	**(822)** !	**469,314**	**455,433**	**(13,880)** !	**811,071**	**794,643**	**(16,428)** !
Operating Surplus/(Deficit)	**788**	**(112)**	**899** ✓	**(5,339)**	**(4,701)**	**(638)** ✗	**(23,353)**	**(21,963)**	**(1,390)** ✗
Enable NZ Contribution	571	308	263 ✓	2,020	1,665	355 ✓	3,122	2,768	355 ✓
Surplus/(Deficit) Before One-Off Items	**1,359**	**197**	**1,162** ✓	**(3,319)**	**(3,035)**	**(284)** ✗	**(20,230)**	**(19,195)**	**(1,035)** ✗
Holidays Act	(419)	(583)	164 ✓	(3,194)	(4,083)	889 ✓	(6,111)	(7,000)	889 ✓
Covid-19	10	(0)	10 ✓	146	0	146 ✓	146	(0)	146 ✓
Surplus/(Deficit)	**950**	**(387)**	**1,337** ✓	**(6,367)**	**(7,119)**	**751** ✓	**(26,195)**	**(26,195)**	**0** ✓

FTE									
Medical	366.5	386.1	19.6 ↓	361.2	374.9	13.7 ↓	369.2	380.4	11.2 ↓
Nursing	1,116.8	1,157.6	40.7 ↓	1,116.5	1,115.9	(0.6) →	1,138.4	1,138.1	(0.3) →
Allied Health	419.1	443.9	24.8 ↓	423.1	439.5	16.5 ↓	433.1	442.7	9.6 ↓
Support	28.7	33.3	4.6 ↓	29.8	33.4	3.6 ↓	31.3	33.4	2.1 ↓
Management / Admin	461.3	497.2	35.9 ↓	468.2	480.8	12.6 ↓	479.6	487.0	7.3 ↓
Operating FTE	**2,392.3**	**2,518.0**	**125.7** ↓	**2,398.7**	**2,444.5**	**45.8** ↓	**2,451.7**	**2,481.5**	**29.9** ↓
Enable NZ	126.8	115.4	(11.5) ↑	116.7	115.4	(1.3) →	116.1	115.4	(0.7) →
Holidays Act	2.9	5.0	2.1 ↓	3.9	5.0	1.1 ↓	4.4	5.0	0.6 ↓
Covid-19	74.3	70.1	(4.2) ↑	82.0	79.3	(2.7) →	67.6	66.1	(1.6) →
Total FTE	**2,596.3**	**2,708.5**	**112.2** ↓	**2,601.2**	**2,644.1**	**42.9** ↓	**2,639.8**	**2,668.0**	**28.2** ↓

✓ Favourable to Budget
! Unfavourable to Budget but within 5%
✗ Unfavourable to Budget outside 5%
↓ FTE Below Budget
→ FTE Higher than Budget but within 5%
↑ FTE Higher than Budget

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

MAJOR VARIANCES TO BUDGET FOR THE MONTH



Favourable revenue is largely due to further funding for nursing and midwifery pay equity settlements paid during the month. Funding will continue monthly to offset the ongoing additional cost of pay equity. Other revenue variances include:

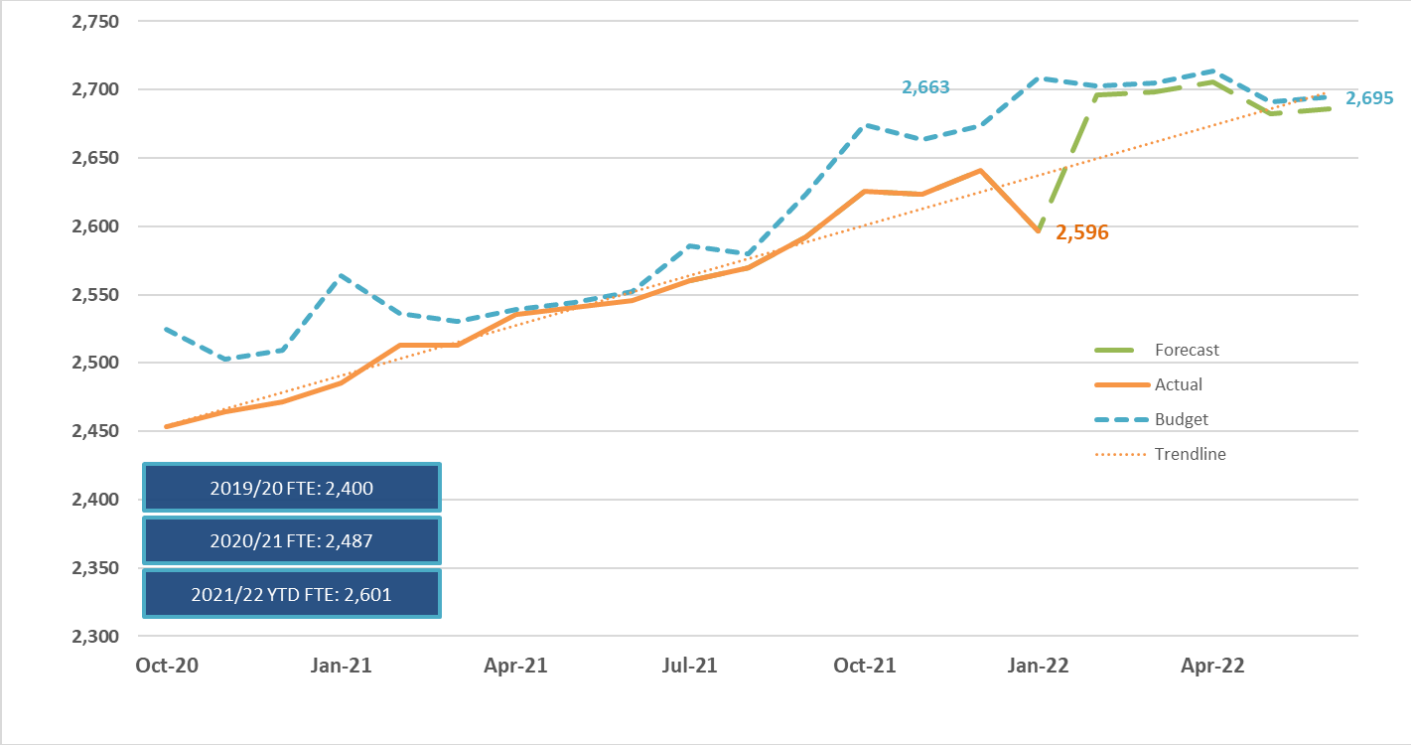
- Adverse planned care revenue of $0.730m in Te Uru Arotau - Acute and Elective Specialist Services. This is offset by unplanned (acute) activity and minor procedures that are $0.784m favourable to budget.
- Inter-District Flow (IDF) revenue that was $0.230m favourable to budget for the month.
- ACC revenue was $0.374m higher than anticipated in the budget. ACC revenue is now $0.776m favourable to budget year to date.

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

- FTEs were well below budget for the month by 112 FTE, bringing the year to date result to 43 FTE below budget. A combination of dropping FTEs and increasing expectations of recruitment in the budget has created this variance. Since last month, the reduction in FTEs of 20 has been largely in administration positions and is not anticipated to continue. Variances against budget are across all job types.

- Medical staff remain below budget by 14 FTE for the year. Te Uru Arotau – Acute and Elective Specialist Services are eight below budget due to radiologist vacancies. A further six exist in Te Uru Rauhī – Mental Health and Addiction Services. These are being covered by locums. Nursing staff are on budget for the year. There are seven vacancies relating to Medical Radiation Technicians in medical imaging. 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.

- While FTEs are below budget for the month, personnel costs (excluding Outsourced Personnel) are adverse by $1.595m. Nursing and midwifery pay equity settlements were paid during the month and accounted for $0.752m of this variance. It is expected that further payments will be forthcoming as the adjustments are completed.
- Outsourced locum costs were also adverse. As with previous months, adverse locum costs reside in Te Uru Rauhī – Mental Health and Addictions. Nursing was also a factor in the adverse Outsourced Personnel result in January
- Other Outsourced Services were favourable to budget due to radiology costs ($0.222m) and Crest ($0.156m) in Te Uru Arotau and Te Uru Mātai Matengau.
- Clinical supply costs were $0.115m favourable to budget overall due to instruments and equipment maintenance $0.219m, and lower than expected depreciation on the clinical equipment ($0.117m) being the main drivers. Adverse Pharmaceutical costs offset these favourable variances.
- Infrastructure and Non-Clinical costs are $0.680m adverse to budget, with the causes of this variance being contracted hotel, cleaning, and meal costs ($0.41m), depreciation ($0.146m), information system expenses ($0.178m) and professional fees ($0.078m).

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 $2.352m of costs offset by funding received for immunisation, surveillance, and isolation. Both revenue and expenditure are close to budget.

2.2 Financial Performance by Service

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

$000	January 2022			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Acute & Elective Specialist Services	(14,052)	(14,069)	18 ✓	(104,121)	(101,480)	(2,641) !	(180,683)	(178,476)	(2,207) !
Healthy Women, Children and Youth	(3,220)	(3,498)	279 ✓	(22,906)	(23,464)	558 ✓	(40,448)	(41,179)	731 ✓
Cancer Screening, Treatment & Support	(3,676)	(3,763)	87 ✓	(26,853)	(27,012)	159 ✓	(47,058)	(47,282)	225 ✓
Healthy Ageing & Rehabiliation	(9,278)	(9,537)	259 ✓	(66,295)	(66,462)	167 ✓	(114,490)	(114,524)	35 ✓
Primary, Public & Community	(5,533)	(5,501)	(32) !	(38,928)	(39,137)	209 ✓	(66,951)	(67,160)	209 ✓
Mental Health & Addictions	(3,913)	(3,751)	(162) !	(29,298)	(26,700)	(2,598) ✗	(50,145)	(46,307)	(3,838) ✗
Pae Ora - Paiaka Whaiora	(850)	(968)	118 ✓	(6,600)	(6,924)	324 ✓	(11,562)	(11,886)	324 ✓
Corporate & Professional Services	41,359	41,026	333 ✓	290,011	286,828	3,183 ✓	488,585	485,452	3,133 ✓
Enable NZ	521	258	263 ✓	1,670	1,315	355 ✓	2,522	2,168	355 ✓
Surplus/(Deficit) Before One-Off Items	**1,359**	**197**	**1,162** ✓	**(3,319)**	**(3,035)**	**(284)** ✗	**(20,230)**	**(19,195)**	**(1,035)** ✗
Exceptional Items	(409)	(583)	175 ✓	(3,048)	(4,083)	1,035 ✓	(5,965)	(7,000)	1,035 ✓
Surplus/(Deficit)	**950**	**(387)**	**1,337** ✓	**(6,367)**	**(7,119)**	**751** ✓	**(26,195)**	**(26,195)**	**0** ✓

✓ Favourable to Budget ! Unfavourable to Budget but within 5% ✗ Unfavourable to Budget outside 5%

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.

- Te Uru Arotau – Acute and Elective Specialist Services was close to budget for the month with favourable revenue of $0.920m offset by expenditure. Favourable revenue resulted from further pay equity funding ($0.701m) that was offset by associated nursing costs. IDFs ($0.230m) also contributed to the favourable revenue. While planned care revenue was adverse to budget, unplanned care and minor procedures offset this. The lower planned care activity had an impact on outsourced expenditure with Crest costs that were favourable to budget. In addition to pay equity payments, personnel costs were adversely affected by a higher than expected overtime and penal for both nursing and medical staff. The year-end forecast suggests that the adverse year to date variance is unlikely to reverse significantly.

- Te Uru Pā Harakeke – Healthy Women, Children and Youth Services was favourable to budget for the month largely due to further pay equity funding for nurses that is partially offset by nursing costs. This is due to timing. The year-end forecast suggests that the favourable year to date variance will remain.

- Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services is slightly favourable to budget for the month. The favourable variance is largely driven by depreciation and maintenance costs. The year-end forecast is close to budget.

- Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services is $0.259m favourable to budget for the month. ACC revenue was $0.322m higher than anticipated and is now $0.662m favourable to budget year to date. The year-end forecast is close to budget.

- Te Uru Kiriora – Primary, Public and Community Services is close to budget for the month. Adverse nursing costs were for early pay equity payments and offset by revenue. Pay equity funding received for nursing staff ($0.106m) was greater than the related nursing payments. The remainder of the adverse variance related to treatment supplies that were greater than anticipated. The year-end forecast is close to budget.

- Due to adverse personnel costs, Te Uru Rauhī – Mental Health and Addiction Services is adverse to budget by $0.162m for the month and $2.598m adverse for the year. The cost of locum cover is partially offset by medical staff vacancies. However, the net result leads to an average monthly adverse variance that is circa $0.400m. This continues the trend that has occurred throughout the year. The year-end forecast suggests that the adverse year to date variance will increase.

- Corporate and Professional Services comprises all executive and enabler functions. The favourable month result is mainly due to infrastructure expenses. Specifically, depreciation ($0.146m), information system expenses ($0.118m) and professional fees ($0.078m) are significant favourable variances. The year-end forecast includes unbudgeted costs for the implementation of several approved Software as a Service initiatives that are underway or about to commence. Despite this, the forecast suggests that the year to date favourable result will be maintained.
- Exceptional Items contains organisation-wide costs for COVID-19 and Holidays Act. Refer to sections 2.3 and 2.4 below.
- The January 2022 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	January 2022			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funding Division	6,122	7,172	(1,050) ✖	20,214	21,234	(1,020) !	41,259	41,236	23 ✓
MidCentral Provider	(6,011)	(7,817)	1,806 ✓	(29,835)	(29,668)	(167) !	(71,459)	(69,599)	(1,860) !
Enable NZ	521	258	263 ✓	1,670	1,315	355 ✓	2,522	2,168	355 ✓
Governance	318	0	318 ✓	1,584	(0)	1,584 ✓	1,482	0	1,482 ✓
Surplus/(Deficit)	**950**	**(387)**	**1,337** ✓	**(6,367)**	**(7,119)**	**751** ✓	**(26,195)**	**(26,195)**	**0** ✓

✓ Favourable to Budget ! Unfavourable to Budget but within 5% ✖ Unfavourable to Budget outside 5%

2.3 Holidays Act

Holidays Act related costs of $0.419m are $0.164m 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 of January 2022 was $50.023m 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 $2.625m has been accrued this year. The 2020/21 estimate has been subject to the year-end audit process. However, 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 January was close to budget for the month. Revenue received was $2.352m and offset operating expenditure of the same quantum. This was for immunisation activity, 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.

2.6 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 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. These can potentially affect MDHB's ability to achieve budget significantly if realised.

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.	Sustainability initiatives appear to be close to target on a year to date basis, albeit some savings targets are weighted toward the second half of the year.	
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.	At the beginning of the year, the lockdown had a noticeable impact on hospital activity and financial performance in the first quarter. DHB business as usual activities will increasingly be impacted by the current Omicron outbreak. Management has built strategies to best deal with this and limit the impact.	
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.	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, and the gap between target and actual is now closing.	

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. The additional funding support for the settlement is currently being assessed.	
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'**. While planned care activity was down on budget during the first quarter COVID-19 lockdown period, the MoH has agreed to fund planned care at the level of budget; thereby alleviating some financial pressure.	
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 moves away from on-premise solutions and 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 impacts this year's financial performance will depend on the timing of implementation.	

2.7 **Financial Position**

The main budget variances in the Balance Sheet at 31 January 2022 relate to the timing of capital expenditure being later than anticipated, resulting in lower than budgeted non-current assets. Higher cash and deposit balances and MoH invoicing has resulted in higher than budgeted current assets. As of 31 January 2022, the total available cash and deposit balances were $31.558m. Significant capital expenditure is budgeted for the 2021/22 year. While the timing of this expenditure is currently running later than planned, the projected year-end cash and deposits balance remains as budgeted at $0.256m with any significant change in this deriving from timing of capital projects.

$000	Jun-21	Jan-22		
	Actual	Actual	Budget	Variance
TOTAL ASSETS				
Non Current Assets	293,387	295,137	328,234	(33,097)
Current Assets	68,877	78,397	46,824	31,573
Total Assets	**362,264**	**373,534**	**375,058**	**(1,524)**
TOTAL EQUITY AND LIABILITIES				
Equity	207,943	209,233	216,651	7,418
Non Current Liabilities	6,278	6,110	6,203	93
Current Liabilities	148,043	158,191	152,205	(5,986)
Total Equity and Liabilities	**362,264**	**373,534**	**375,058**	**1,524**

2.8 **Cash Flows**

Overall net cash flows reflect a favourable variance to budget of $8.173m. Operating cash flows are unfavourable due to the timing of COVID-19 related activities 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	Jan-22		
	Actual	Actual	Budget	Variance
Net Cash Flow from Operating Activities	24,384	6,935	16,382	(9,447)
Net Cash Flows from Investing Activities	(20,859)	(17,486)	(44,705)	27,219
Net Cash Flows from Financing Activities	5,980	5,620	15,219	(9,599)
Net increase / (decrease) in cash	**9,505**	**(4,931)**	**(13,104)**	**8,173**
Cash at beginning of year	26,984	36,489	26,648	9,841
Closing cash	**36,489**	**31,558**	**13,544**	**18,014**

2.9 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.

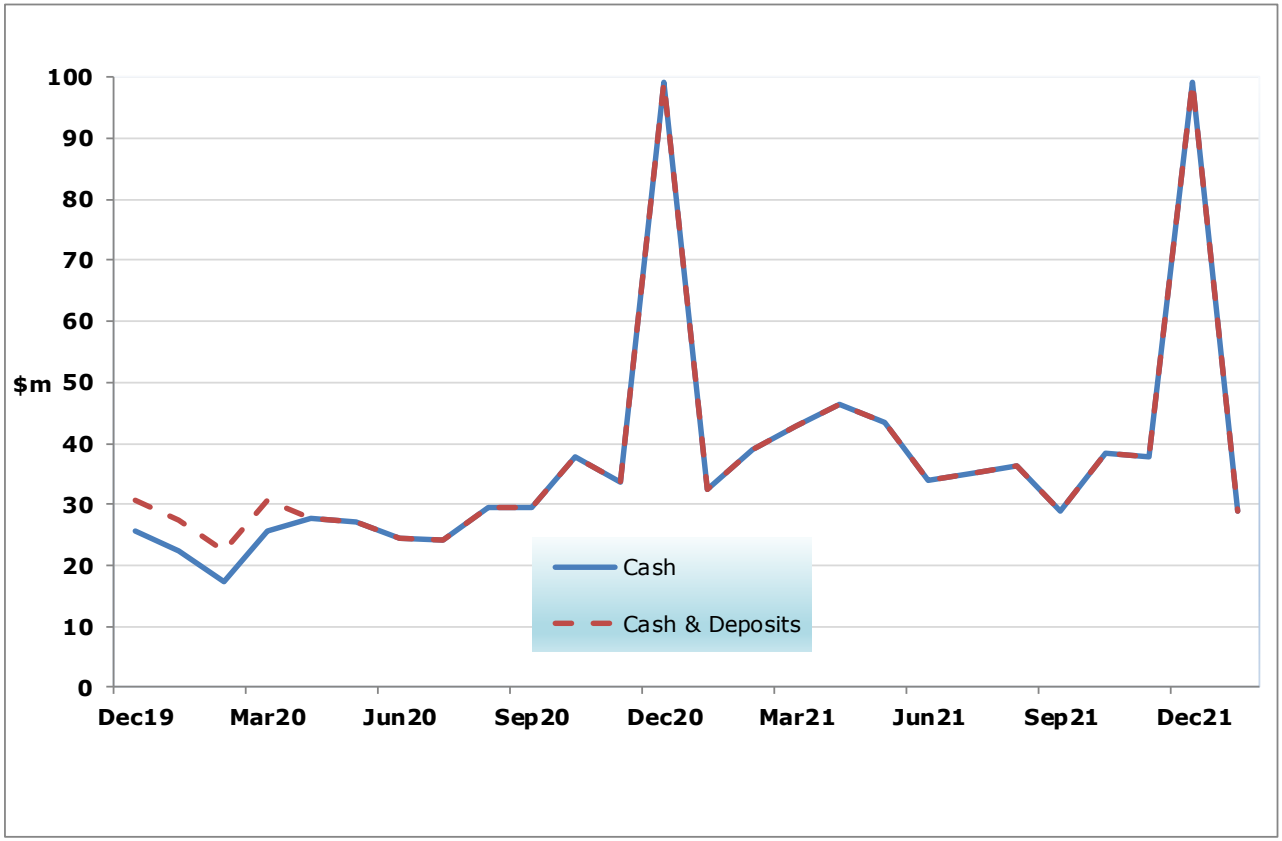
Jan-22	Rate	Value $000
NZHP Sweep Balance	0.97%	24,509
Cash in Hand and at Bank		2
Trust Accounts		2,512
Enable New Zealand		4,535
Cash Balances		31,558
Total Cash Balance		**31,558**

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

Cash Reconciliation	Jan-22 $000	Year to date $000
Cash at December 2021	101,653	36,489
Surplus / (Deficit) for mth	950	(6,367)
Depreciation / Amortisation	2,330	16,079
Non-cash donations	(129)	(776)
Sale of fixed assets	16	23
Working capital movement	(70,919)	(1,742)
Capital expenditure	(2,303)	(17,853)
Loan/finance lease repayments	(17)	(118)
Trusts movement	(23)	50
Equity injections - capital	-	5,773
Cash Balance at month end	**31,558**	**31,558**

The chart below indicates the DHB's cash balance, excluding investment and Trust Accounts. The spike in the December 2021 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 has been experiencing liquidity pressure for some time due to the continuation of operating deficits. On behalf of all DHBs, New Zealand Health Partnerships maintains ongoing discussion with the Ministry and Treasury on ways to resolve liquidity issues and the need for 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). Expenditure against these projects will need to be tightly managed due to rising construction costs. Drawdowns are underway for these projects, with the bulk occurring over the remainder of 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	1,002	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.

2.10 Statement of Capital Expenditure

Total approvals as of January are $72.570m against both the annual capex plan of $85.761m and unbudgeted capital of $1.617m. Unbudgeted capital relates to COVID-19 expenditure, which is MoH funded. Total approvals include $6.201m of software projects, initially planned as capital but approved as Software as a Service (SaaS) solutions and therefore considered an operating expense. For completeness, SaaS approvals continue to be included in this section.

There were minimal approvals during the month of January ($0.276m) with the most significant being the Enable NZ IT Programme ($0.105m) and bed replacements ($0.089m).

Capital Approvals ($000)	Jan-22	YTD
Capital Approvals	276	66,396
SaaS Aprrovals	0	6,201
Items Yet to ve Approved	(276)	14,781
Total	**0**	**87,378**
Capital Budget	0	85,761
Capex unbudgeted	0	1,617
Total	**0**	**87,378**

Capital expenditure for the month was $2.290m, bringing total spending for the year to $18.452m. January expenditure against 2021/22 approved capital items totalled $2.034m with the majority spend on SPIRE ($0.866m), plant and equipment for Omicron COVID-19 preparations ($0.337m), the fluoroscopy machine ($0.212m) and End User Computing replacements ($0.170m).

Capital Expenditure & SaaS ($000)	Jan-22	YTD
Prior Year Capex	253	4,250
Current Year Capex	2,034	13,271
Current Year SaaS	3	931
Total	**2,290**	**18,452**

Year to date expenditure on items approved in the prior year is $4.250m and reflects the usual lag between project approval and project expenditure across financial periods.

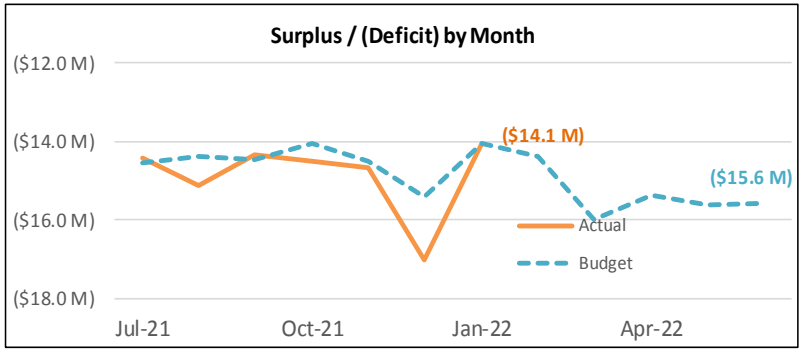
Further detail is provided in Appendix Two – Capital Expenditure. Several proposed information technology items, identified as capital when compiling the 2021/22 capex plan, are being undertaken as SaaS. Under this model, the service provider is offering a subscription to use the Software while retaining 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.

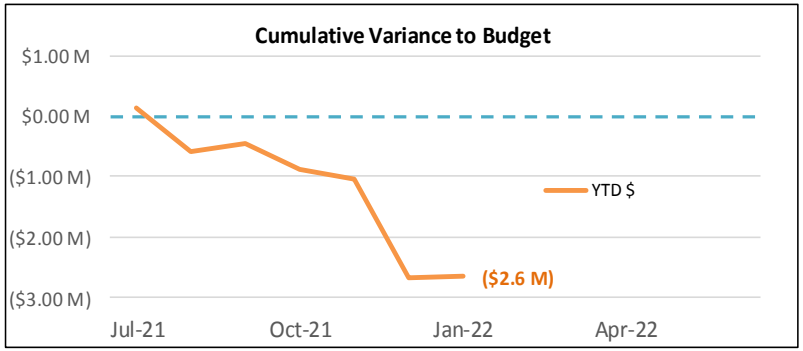
APPENDIX ONE – FINANCIAL PERFORMANCE BY SERVICE

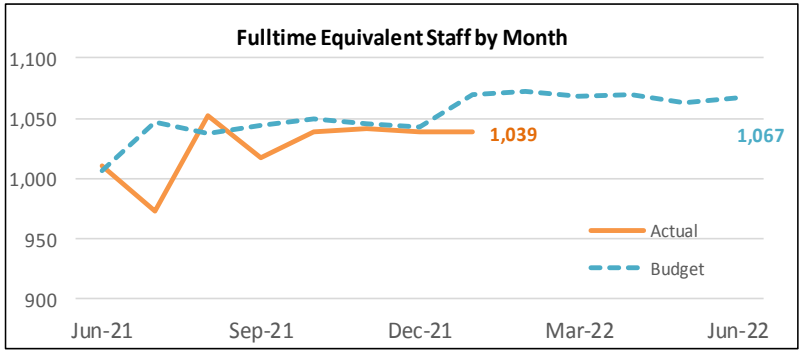
Te Uru Arotau – Acute and Elective Specialist Services

$000	January 2022		Year to date		Year End	
	Actual	Variance to Budget	Actual	Variance to Budget	Forecast	Variance to Budget
Net Revenue	**2,702**	**920**	**17,068**	**4,368**	**27,479**	**5,642**
Expenditure						
Personnel	11,342	(1,349)	75,975	(5,272)	128,752	(4,861)
Outsourced Personnel	40	0	563	(259)	870	(354)
Sub -Total Personnel	11,382	(1,349)	76,538	(5,532)	129,622	(5,215)
Other Outsourced Services	931	264	9,424	(668)	16,489	(1,188)
Clinical Supplies	2,936	50	23,813	(1,162)	42,291	(1,891)
Infrastructure & Non-Clinical	602	133	5,086	346	8,698	661
Total Operating Expenditure	**15,851**	**(902)**	**114,861**	**(7,016)**	**197,102**	**(7,633)**
Provider Payments	19	0	148	7	468	(216)
Corporate Services	883	0	6,179	0	10,593	0
Surplus/(Deficit)	**(14,052)**	**18**	**(104,121)**	**(2,641)**	**(180,683)**	**(2,207)**

FTE						
Medical	233.2	11.1	231.0	9.1	233.4	8.5
Nursing	527.7	7.4	519.6	0.6	525.2	0.3
Allied Health	134.1	4.0	132.4	5.6	135.3	3.3
Support	16.0	3.1	16.9	2.1	17.8	1.2
Management / Admin	127.6	5.7	128.5	2.0	130.0	1.2
Total FTE	**1,038.6**	**31.3**	**1,028.5**	**19.3**	**1,041.7**	**14.4**



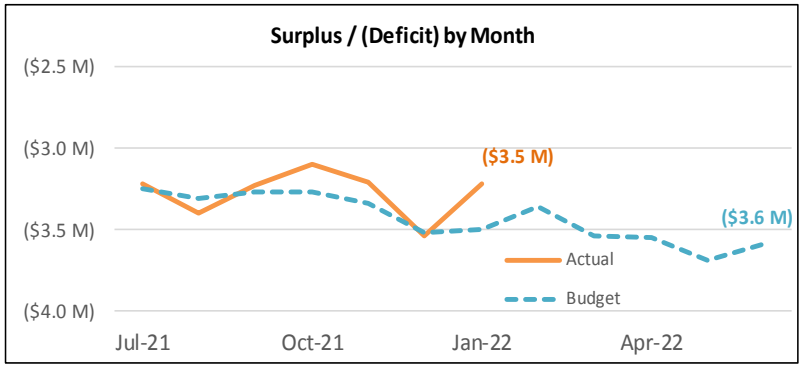


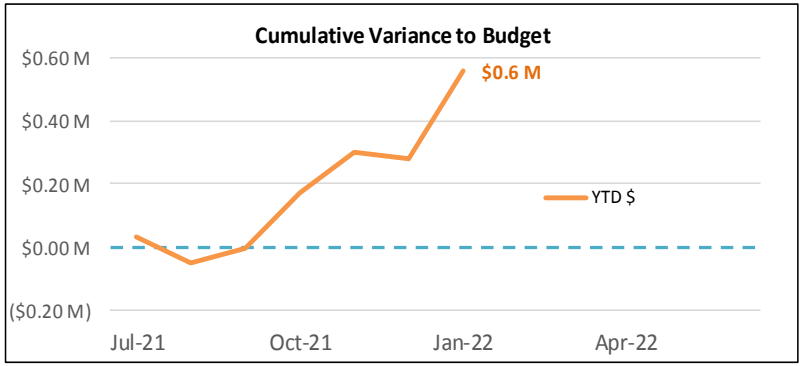


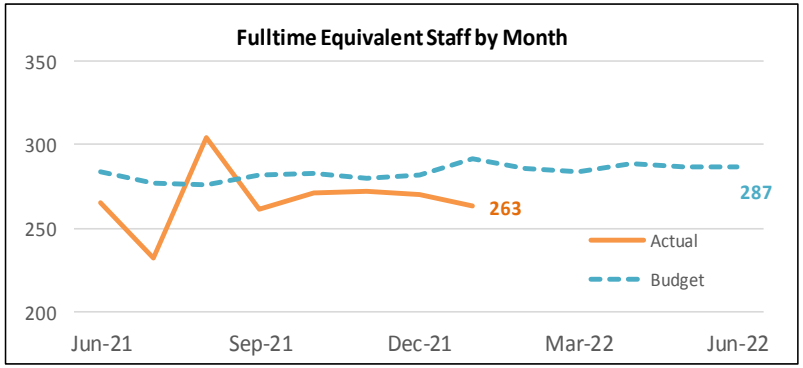
Te Uru Pā Harakeke – Healthy Women, Children and Youth Services

$000	January 2022		Year to date		Year End	
	Actual	Variance to Budget	Actual	Variance to Budget	Forecast	Variance to Budget
Net Revenue	**583**	**127**	**4,135**	**902**	**6,420**	**899**
Expenditure						
Personnel	2,765	69	18,941	(299)	32,833	(11)
Outsourced Personnel	9	6	273	(153)	369	(168)
Sub -Total Personnel	2,774	75	19,214	(452)	33,201	(179)
Other Outsourced Services	72	(8)	688	(185)	1,242	(315)
Clinical Supplies	340	2	2,356	141	4,171	141
Infrastructure & Non-Clinical	152	78	1,494	145	2,620	178
Total Operating Expenditure	**3,337**	**148**	**23,751**	**(350)**	**41,234**	**(174)**
Provider Payments	452	4	3,196	7	5,472	7
Corporate Services	14	0	95	0	162	0
Surplus/(Deficit)	**(3,220)**	**279**	**(22,906)**	**558**	**(40,448)**	**731**

FTE						
Medical	44.8	1.5	44.2	0.5	45.2	0.3
Nursing	111.3	15.0	116.8	5.0	119.1	3.2
Midwives	31.9	4.1	30.8	4.0	32.7	2.0
Allied Health	52.0	5.0	53.1	2.9	54.9	1.7
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	23.3	2.9	22.7	1.4	23.4	0.8
Total FTE	**263.2**	**28.4**	**267.6**	**13.8**	**275.3**	**8.0**



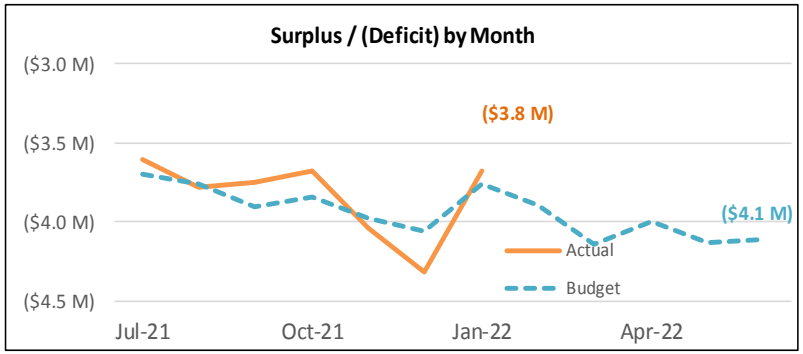


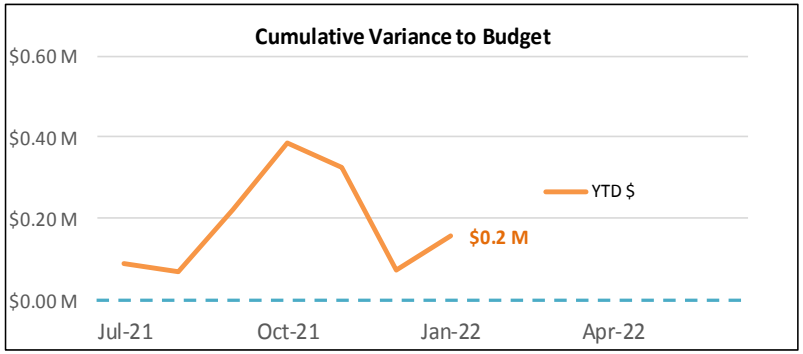


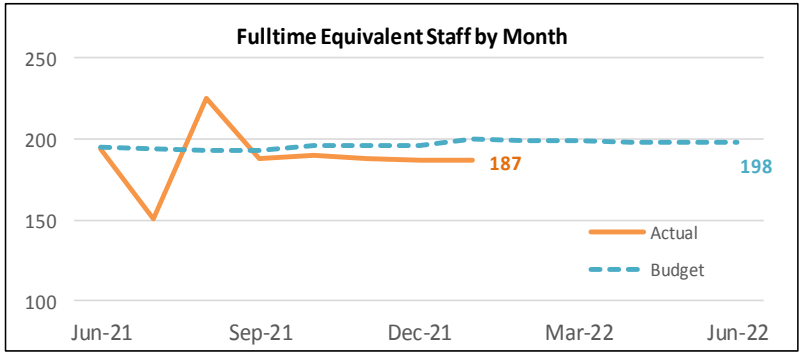
Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services

$000	January 2022 Actual	January 2022 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**653**	**13**	**5,684**	**317**	**9,830**	**965**
Expenditure						
Personnel	1,922	(89)	14,065	(307)	24,394	(126)
Outsourced Personnel	8	(4)	38	53	49	64
Sub -Total Personnel	1,930	(93)	14,104	(254)	24,443	(62)
Other Outsourced Services	542	68	4,532	(262)	7,658	(337)
Clinical Supplies	1,118	57	8,565	238	15,569	(462)
Infrastructure & Non-Clinical	120	39	996	114	1,774	114
Total Operating Expenditure	**3,710**	**72**	**28,197**	**(164)**	**49,445**	**(746)**
Provider Payments	400	2	2,806	6	4,815	6
Corporate Services	219	0	1,533	0	2,629	0
Surplus/(Deficit)	**(3,676)**	**87**	**(26,853)**	**159**	**(47,058)**	**225**

FTE						
Medical	38.8	3.6	39.4	1.3	40.8	0.8
Nursing	55.0	6.6	54.5	6.0	56.9	3.5
Allied Health	60.7	4.6	62.3	1.6	63.5	1.0
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	32.2	(1.8)	31.4	(1.4)	30.9	(0.8)
Total FTE	**186.6**	**13.0**	**187.7**	**7.6**	**192.1**	**4.4**



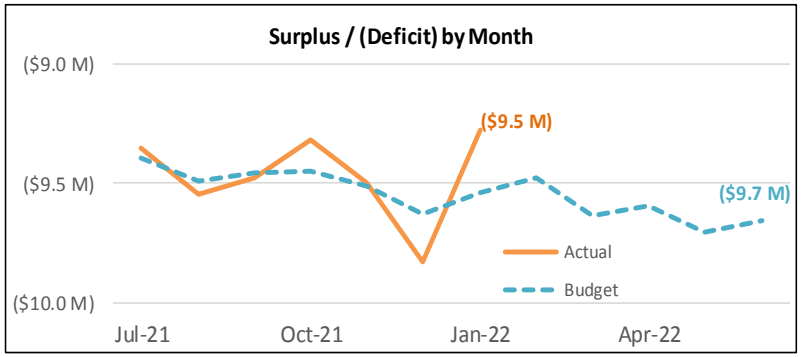


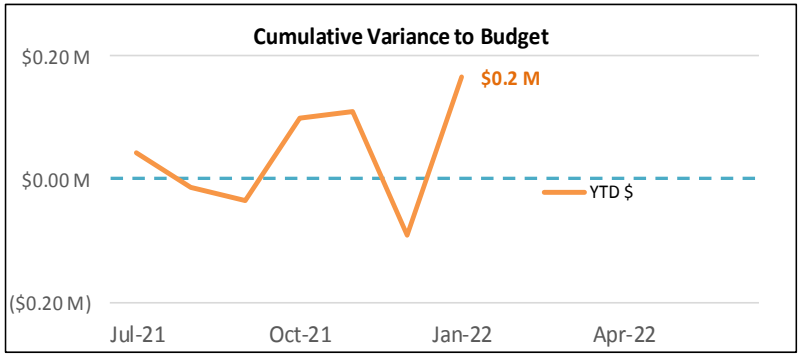


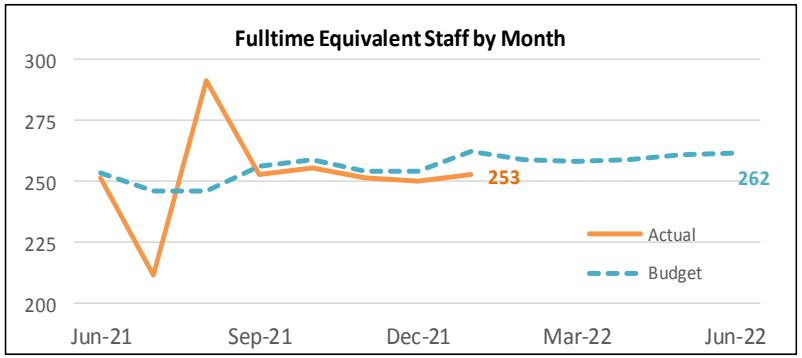
Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services

$000	January 2022 Actual	January 2022 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**889**	**503**	**4,490**	**1,469**	**6,594**	**1,469**
Expenditure						
Personnel	2,213	(181)	14,976	(850)	25,658	(850)
Outsourced Personnel	10	(10)	126	(125)	126	(125)
Sub -Total Personnel	2,223	(191)	15,102	(975)	25,785	(975)
Other Outsourced Services	48	12	475	(36)	785	(36)
Clinical Supplies	183	(34)	1,219	(139)	2,033	(187)
Infrastructure & Non-Clinical	181	(33)	1,218	(162)	2,051	(247)
Total Operating Expenditure	**2,636**	**(245)**	**18,014**	**(1,312)**	**30,654**	**(1,445)**
Provider Payments	7,442	0	52,150	10	89,364	10
Corporate Services	89	0	622	0	1,066	0
Surplus/(Deficit)	**(9,278)**	**259**	**(66,295)**	**167**	**(114,490)**	**35**

FTE						
Medical	15.1	1.2	15.6	0.0	16.4	0.0
Nursing	128.4	2.5	128.2	(3.0)	127.6	(1.7)
Allied Health	93.3	5.4	92.2	5.2	95.2	3.0
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	16.1	0.7	16.3	(0.3)	16.3	(0.2)
Total FTE	**252.8**	**9.8**	**252.3**	**1.9**	**255.5**	**1.1**



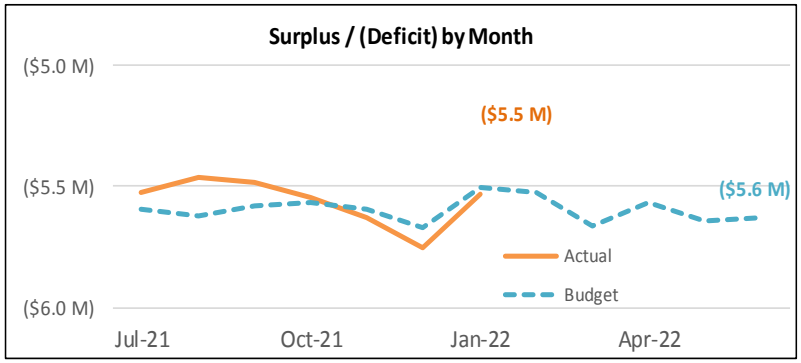


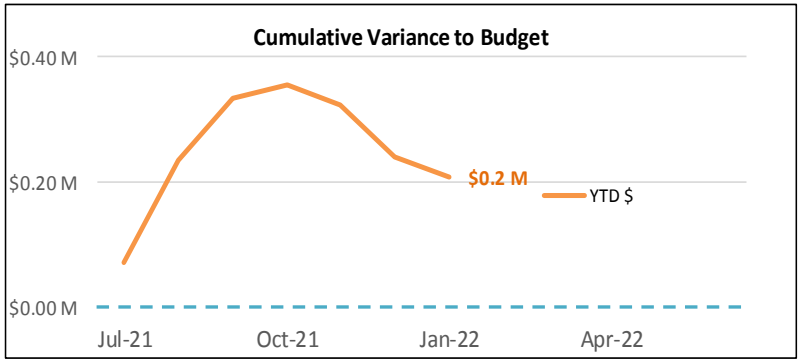


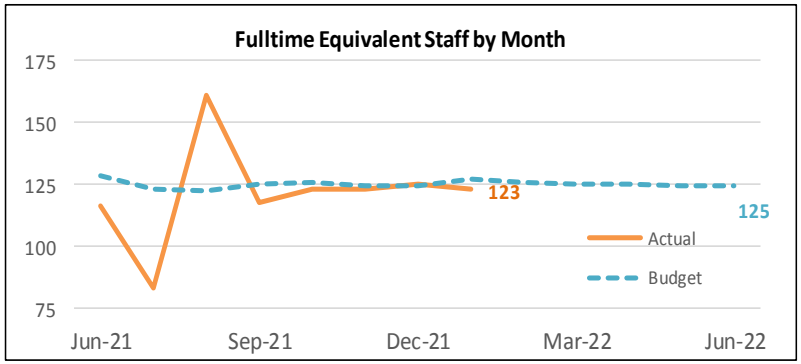
Te Uru Kiriora – Primary, Public and Community Services

$000	January 2022		Year to date		Year End	
	Actual	Variance to Budget	Actual	Variance to Budget	Forecast	Variance to Budget
Net Revenue	**830**	**81**	**5,821**	**652**	**9,564**	**652**
Expenditure						
Personnel	1,027	(103)	7,446	(619)	12,419	(619)
Outsourced Personnel	0	(0)	0	(0)	0	(0)
Sub -Total Personnel	1,027	(103)	7,446	(619)	12,419	(619)
Other Outsourced Services	5	9	35	64	104	64
Clinical Supplies	204	(24)	1,401	41	2,459	41
Infrastructure & Non-Clinical	102	6	690	70	1,230	70
Total Operating Expenditure	**1,338**	**(113)**	**9,572**	**(445)**	**16,211**	**(445)**
Provider Payments	4,921	0	34,448	2	59,056	2
Corporate Services	104	0	728	0	1,248	0
Surplus/(Deficit)	**(5,533)**	**(32)**	**(38,928)**	**209**	**(66,951)**	**209**

FTE						
Medical	1.8	0.3	1.6	0.5	1.8	0.3
Nursing	77.9	4.2	77.8	2.2	78.7	1.3
Allied Health	25.6	1.6	25.5	1.2	26.2	0.7
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	17.9	(1.7)	17.5	(1.5)	16.8	(0.9)
Total FTE	**123.2**	**4.3**	**122.4**	**2.3**	**123.5**	**1.4**



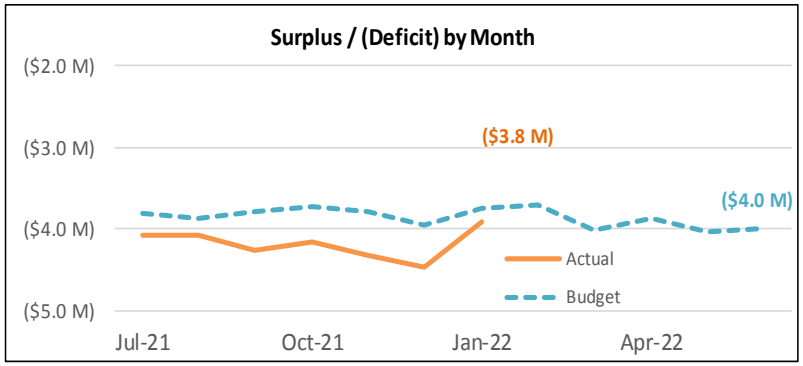


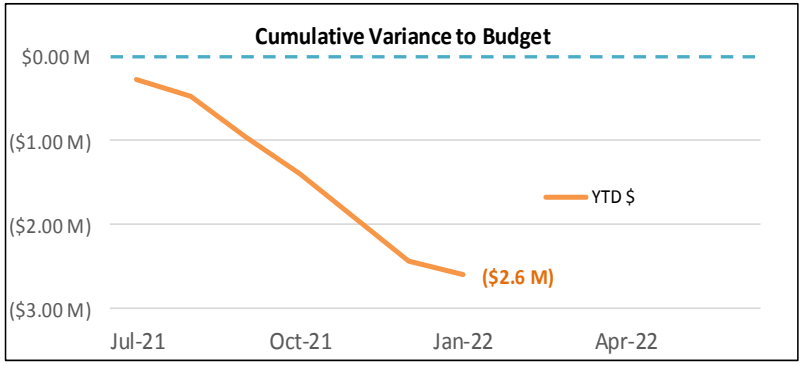


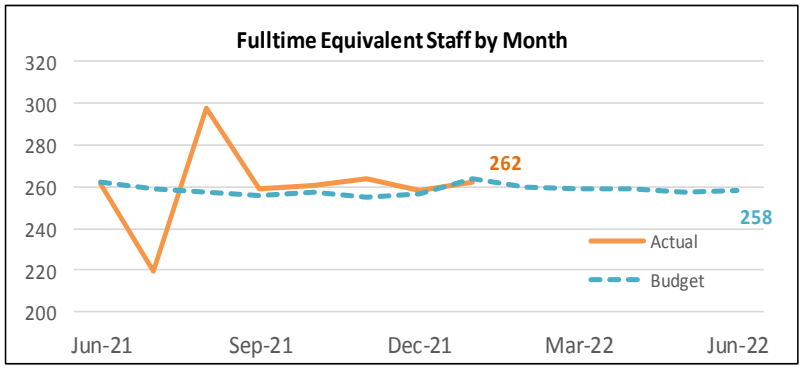
Te Uru Rauhī – Mental Health and Addiction Services

$000	January 2022		Year to date		Year End	
	Actual	Variance to Budget	Actual	Variance to Budget	Forecast	Variance to Budget
Net Revenue	**259**	**196**	**1,533**	**1,102**	**1,847**	**1,102**
Expenditure						
Personnel	2,355	(151)	17,097	(1,170)	28,514	(829)
Outsourced Personnel	364	(260)	3,169	(2,337)	5,254	(3,920)
Sub -Total Personnel	2,719	(410)	20,266	(3,507)	33,768	(4,748)
Other Outsourced Services	61	(42)	403	(63)	501	(63)
Clinical Supplies	19	(3)	154	(31)	240	(31)
Infrastructure & Non-Clinical	120	98	1,240	(100)	2,450	(100)
Total Operating Expenditure	**2,919**	**(358)**	**22,062**	**(3,702)**	**36,959**	**(4,942)**
Provider Payments	1,238	1	8,673	2	14,870	2
Corporate Services	14	0	96	0	164	0
Surplus/(Deficit)	**(3,913)**	**(162)**	**(29,298)**	**(2,598)**	**(50,145)**	**(3,838)**

FTE						
Medical	20.1	4.7	19.1	5.7	21.5	3.3
Nursing	158.5	(0.3)	159.7	(4.4)	157.6	(2.6)
Allied Health	43.0	(2.5)	43.9	(3.4)	42.5	(2.0)
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	40.5	(0.2)	37.5	(0.1)	38.0	(0.0)
Total FTE	**262.0**	**1.8**	**260.1**	**(2.1)**	**259.5**	**(1.2)**



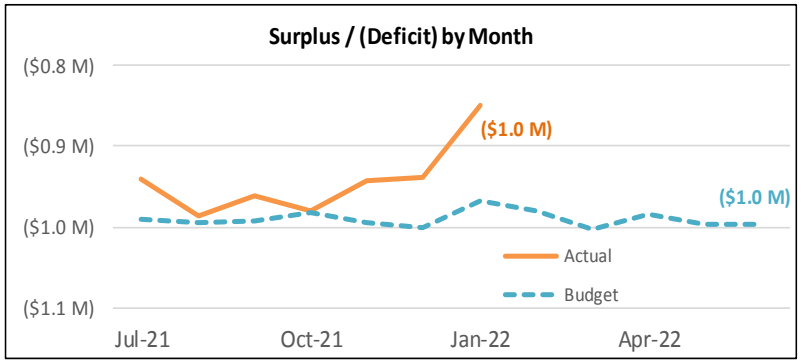


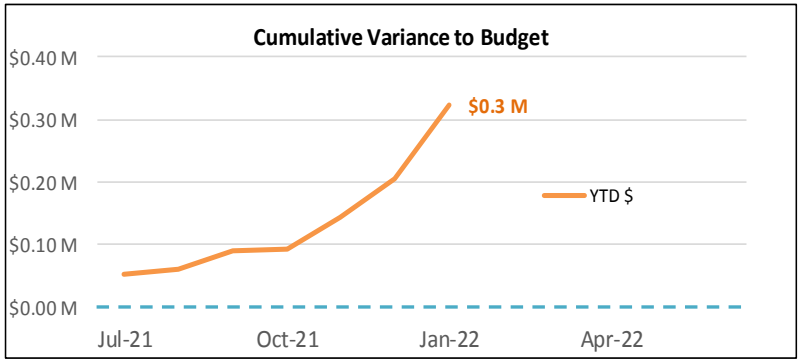


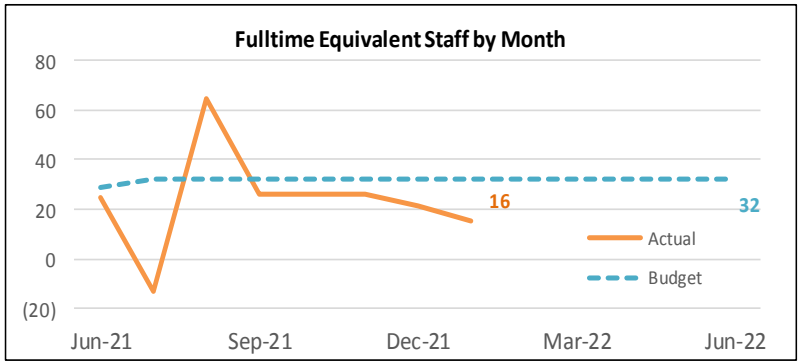
Pae Ora – Paiaka Whaiora Directorate

$000	January 2022		Year to date		Year End	
	Actual	Variance to Budget	Actual	Variance to Budget	Forecast	Variance to Budget
Net Revenue	**104**	**9**	**799**	**44**	**1,350**	**44**
Expenditure						
Personnel	65	148	1,279	440	2,536	440
Outsourced Personnel	0	0	1	(1)	1	(1)
Sub -Total Personnel	65	148	1,280	439	2,537	439
Other Outsourced Services	0	2	85	(73)	94	(73)
Clinical Supplies	0	0	2	1	4	1
Infrastructure & Non-Clinical	58	(40)	215	(88)	303	(88)
Total Operating Expenditure	**123**	**110**	**1,582**	**278**	**2,939**	**278**
Provider Payments	831	0	5,817	2	9,973	2
Corporate Services	0	0	0	0	0	0
Surplus/(Deficit)	**(850)**	**118**	**(6,600)**	**324**	**(11,562)**	**324**

FTE						
Medical	0.0	0.0	0.0	0.0	0.0	0.0
Nursing	3.5	5.2	6.2	2.5	7.3	1.4
Allied Health	3.6	7.1	7.0	3.7	8.6	2.2
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	8.4	4.4	10.6	2.2	11.5	1.3
Total FTE	**15.6**	**16.7**	**23.9**	**8.4**	**27.4**	**4.9**



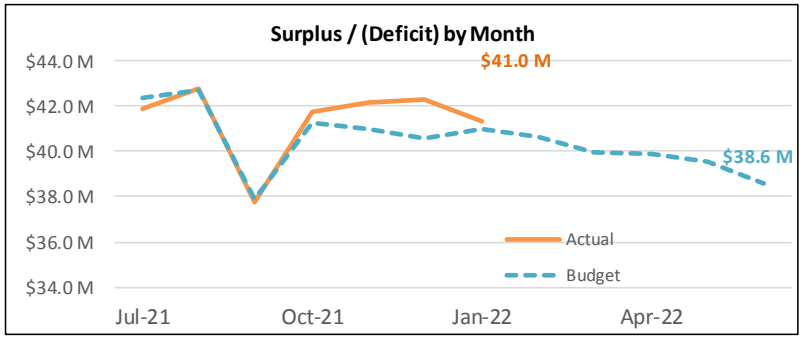


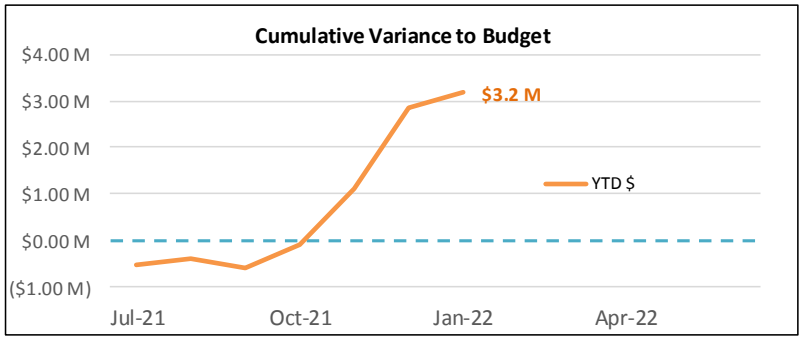


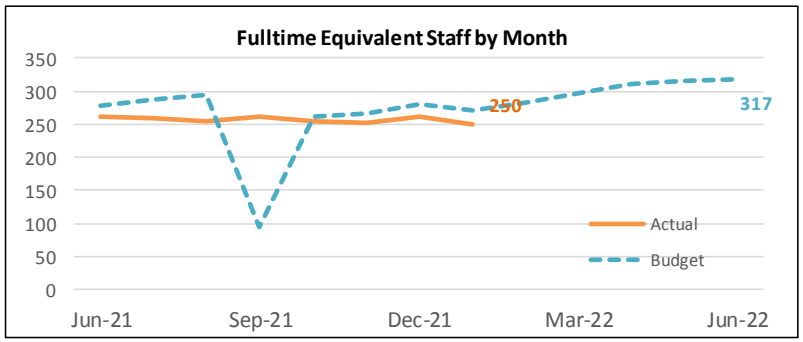
Corporate and Professional Services

$000	January 2022 Actual	January 2022 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**59,960**	**(127)**	**424,446**	**4,389**	**725,380**	**5,013**
Expenditure						
Personnel	2,009	61	16,230	(692)	29,964	(154)
Outsourced Personnel	476	(298)	2,632	(1,446)	3,965	(1,446)
Sub -Total Personnel	2,484	(236)	18,862	(2,139)	33,929	(1,601)
Other Outsourced Services	88	89	1,202	48	2,847	(706)
Clinical Supplies	29	66	387	288	868	288
Infrastructure & Non-Clinical	5,523	398	37,330	2,356	71,290	6
Total Operating Expenditure	**8,124**	**317**	**57,781**	**553**	**108,933**	**(2,013)**
Provider Payments	11,849	143	86,258	(1,759)	144,324	133
Corporate Services	(1,372)	0	(9,603)	0	(16,462)	0
Surplus/(Deficit)	**41,359**	**333**	**290,011**	**3,183**	**488,585**	**3,133**

FTE						
Medical	12.9	(2.8)	10.3	(3.4)	10.3	(2.0)
Nursing	22.6	(3.9)	22.7	(13.4)	33.3	(7.8)
Allied Health	6.8	(0.3)	6.8	(0.5)	6.9	(0.3)
Support	12.7	1.5	12.8	1.5	13.4	0.9
Management / Admin	195.3	25.9	203.7	10.3	212.7	6.0
Total FTE	**250.3**	**20.4**	**256.3**	**(5.4)**	**276.6**	**(3.1)**



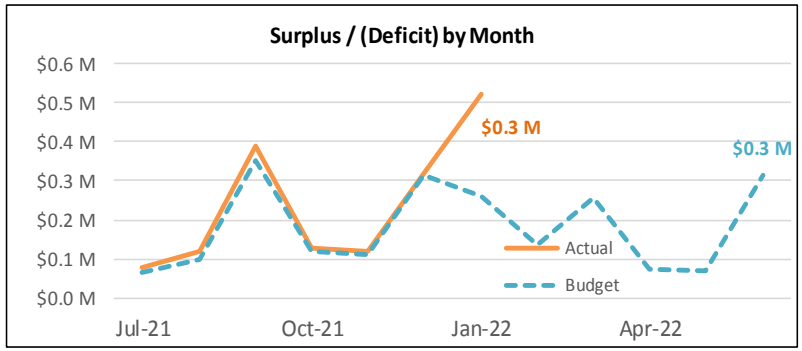


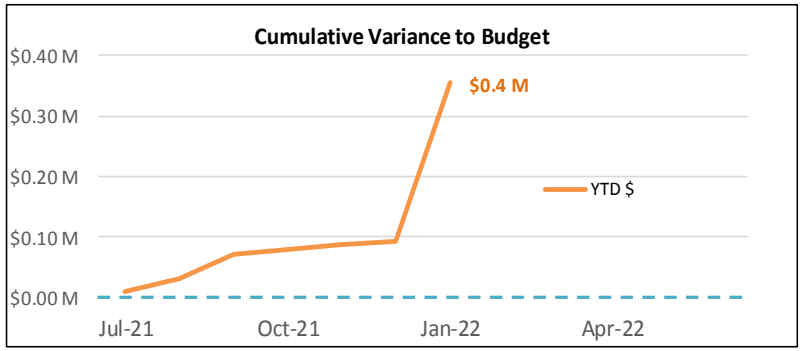


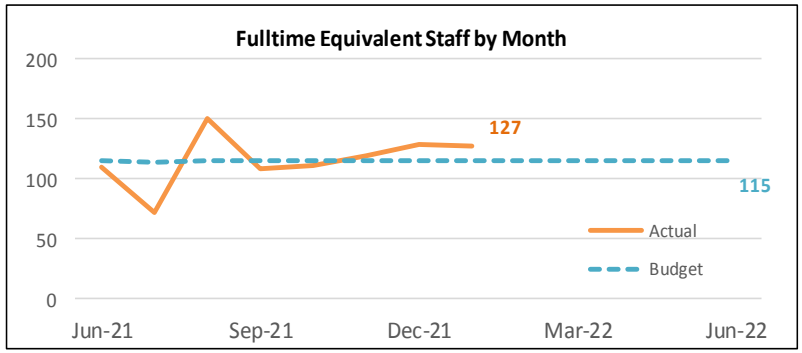
Enable New Zealand

$000	January 2022 Actual	January 2022 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**6,614**	**3,334**	**28,017**	**5,591**	**44,053**	**5,591**
Expenditure						
Personnel	753	2	5,488	6	9,373	6
Outsourced Personnel	25	3	298	(99)	438	(99)
Sub -Total Personnel	777	4	5,786	(93)	9,811	(93)
Other Outsourced Services	11	(11)	42	(42)	42	(42)
Clinical Supplies	5	0	36	2	59	2
Infrastructure & Non-Clinical	5,249	(3,065)	20,133	(5,103)	31,018	(5,103)
Total Operating Expenditure	**6,042**	**(3,072)**	**25,997**	**(5,236)**	**40,931**	**(5,236)**
Provider Payments	0	0	0	0	0	0
Corporate Services	50	0	350	0	600	0
Surplus/(Deficit)	**521**	**263**	**1,670**	**355**	**2,522**	**355**

FTE						
Medical	0.0	0.0	0.0	0.0	0.0	0.0
Nursing	0.0	0.0	0.0	0.0	0.0	0.0
Allied Health	22.4	8.7	22.4	8.7	26.0	5.0
Support	27.0	(11.0)	21.6	(5.6)	19.3	(3.3)
Management / Admin	77.5	(9.2)	72.6	(4.3)	70.8	(2.5)
Total FTE	**126.8**	**(11.5)**	**116.7**	**(1.3)**	**116.1**	**(0.7)**







Holidays Act

$000	January 2022 Actual	January 2022 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget	Life to date Actual Since May 2010
Expenditure							
Personnel	389	28	2,814	104	4,899	104	50,229
Outsourced Personnel	12	35	183	149	420	149	750
Sub -Total Personnel	401	64	2,998	253	5,319	253	50,980
Infrastructure & Non-Clinical	19	100	196	637	791	637	1,519
Total Operating Expenditure	**419**	**164**	**3,194**	**889**	**6,111**	**889**	**52,499**
Surplus/(Deficit)	**(419)**	**164**	**(3,194)**	**889**	**(6,111)**	**889**	**(52,499)**

COVID-19

$000	January 2022 Actual	January 2022 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget	Life to date Actual Since March 2020
Net Revenue	**2,352**	**941**	**14,320**	**(1,641)**	**17,992**	**(1,937)**	**17,360**
Expenditure							
Personnel	572	(44)	4,620	582	6,440	582	16,650
Outsourced Personnel	52	(52)	400	(118)	400	(118)	534
Sub -Total Personnel	624	(96)	5,020	464	6,841	464	17,184
Other Outsourced Services	1,567	(684)	6,893	792	8,745	1,088	8,355
Clinical Supplies	61	(61)	271	(5)	271	(5)	364
Infrastructure & Non-Clinical	90	(90)	1,990	535	1,990	535	3,196
Total Operating Expenditure	**2,342**	**(931)**	**14,174**	**1,786**	**17,847**	**2,082**	**29,099**
Surplus/(Deficit)	**10**	**10**	**146**	**146**	**146**	**146**	**(11,739)**

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	15,377	(3,358)	2,764	12,613	0	15,377
Mental Health Redevelopment	14,503	14,503	0	859	13,644	0	14,503
Acute Services Block	1,400	0	1,400	0	0	0	0
Linear Accelerator Replacement programme	4,330	4,257	73	3,888	369	364	4,621
Planned Care Production Planning	150	150	0	25	125	0	150
SCoPE (Theatre Audit)	600	600	0	0	600	0	600
TOTAL Externally Funded Items	**33,002**	**34,887**	**(1,885)**	**7,536**	**27,351**	**364**	**35,251**
Major Items							
EDOA / MAPU PODS	5,900	7,000	(1,100)	809	6,191	0	7,000
Telemetry & Monitoring System Replacements	3,278	4,000	(722)	544	3,456	0	4,000
Medical Imaging Equipment (incl DSA machine)	3,190	0	3,190	0	0	0	0
Programme of Change Mental Health (FACT)	516	516	0	77	439	0	516
Anaesthetic Machine & Monitor Replacements	2,430	2,800	(370)	1,085	1,715	0	2,800
End User Compute Replacement Programme	1,650	3,540	(1,890)	0	3,540	0	3,540
End User Compute Break Fix	350	233	117	170	0	0	170
Computerized tomography (CT) Scanner	1,740	0	1,740	0	0	0	0
Regional Health Informatics Programme (RHIP)	1,465	1,465	0	515	950	0	1,465
Workstations for Cancer Service	1,357	0	1,357	0	0	0	0
Structural & Seismic Upgrades	1,184	310	874	0	310	0	310
Fluoroscopy Machine	1,140	1,640	0	843	797	0	1,640
Bed Replacement Programme	1,000	89	911	0	89	0	89
Water Services	1,000	1,800	(800)	0	1,800	0	1,800
Enable NZ IT Programme	800	258	542	258	0	0	258
Chiller Replacements	700	365	335	0	365	23	388
Certificate of Public Use Upgrades	500	232	268	0	232	0	232
Fire System Upgrades	500	0	500	0	0	0	0
Covid BAU	0	1,617	(1,617)	801	816	134	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**	**25,866**	**4,434**	**5,102**	**20,700**	**157**	**24,208**
Infrastructure Items							
Medical Air Upgrade & Vacuum Distribution Upgrade	500	650	0	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	150	200	0	150	0	150
Asset Management & Individual Items less than 251K	2,230	847	1,383	92	755	571	1,418
TOTAL Infrastructure Items	**3,830**	**1,647**	**2,333**	**92**	**1,555**	**571**	**2,218**

($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	20	480	645	1,145
Defibrillators	407	0	407	0	0	0	0
SSU Medivators & Washers Replacement	400	935	(535)	0	935	0	935
Endoscopy & Theatre Scopes	350	75	275	75	0	0	75
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
Patient Simulation Programme	300	111	189	0	111	0	111
Asset Management & Individual Items less than 251K	4,910	1,078	3,832	390	688	1,573	2,651
TOTAL Clinical Equipment Items	**9,575**	**2,700**	**6,875**	**485**	**2,215**	**2,218**	**4,918**
Information Technology Items							
SAN Rebuild	800	0	800	0	0	0	0
Echo Image Vault	700	700	0	43	657	0	700
Minor Works (Network, Firewalls, Servers, UPS)	600	60	540	0	60	0	60
Network Switch Upgrade	500	500	0	0	500	0	500
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	36	631	13	23	940	976
TOTAL Information Technology Items	**3,837**	**1,296**	**2,541**	**56**	**1,240**	**940**	**2,236**
TOTAL CAPITAL EXPENDITURE	**80,044**	**66,396**	**14,298**	**13,271**	**53,061**	**4,250**	**68,831**
Software as a Service Items & Others							
Programme of Change Mental Health (FACT)	2,142	2,142	0	152	1,990	0	2,142
Health System Catalogue (NZHP)	1,515	1,515	0	600	915	0	1,515
ePrescribing and Administration Planning (Medchart)	800	972	(172)	0	972	0	972
External Referrals (eTriage, eReferrals)	460	0	460	11	(11)	0	0
WebPASaaS Implementation	400	1,240	(840)	0	1,240	0	1,240
Clinical Records Management	400	332	68	168	164	0	332
TOTAL Software as a Service and other Items	**5,717**	**6,201**	**(484)**	**931**	**5,270**	**0**	**6,201**
TOTAL CAPITAL EXPENDITURE & SaaS	**85,761**	**72,597**	**13,814**	**14,202**	**58,331**	**4,250**	**75,032**

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does this report provide sufficient information in support of the Board's governance functions for monitoring and performance against the Health System Indicators?

To	Board
Author	Tracy Corbett, Advisor, Planning and Accountability, Strategy, Planning and Performance
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance
Date	10 March 2022
Subject	**Health System Indicator Dashboard – Quarter One 2021/22**

RECOMMENDATION

It is recommended that the Board:

- **note** the performance for the first quarter of 2021/22 of the Health System Indicators (HSI) as highlighted in the HSI dashboard.

Strategic Alignment

This report addresses the Government's planning priorities and DHB accountabilities as part of the Health System Indicator Framework. 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 the results of MidCentral District Health Board's (MDHB's) performance to the end of September 2021 (Quarter One, 2021/22) for the Health System Indicators (HSI).

The Board is asked to consider this information and note the mitigations in place for those areas of performance where expectations were not met this quarter.

2. BACKGROUND

The Health System Indicators Framework is a new approach to health system performance measurement. The Ministry of Health (the Ministry) and the Health Quality and Safety Commission (HQSC) worked together to develop the health system indicators framework, which sets out to improve how we measure and report on how the health and disability system is performing for New Zealanders.

The new framework replaces the previous health targets by recognising that problems require local solutions. Its emphasis is on continuous improvement at a local level, to lift overall health system performance.

The new framework builds on the System Level Measures programme that was co-designed with the health and disability sector. Work to implement the framework got underway during 2021/22.

The Government has chosen an initial set of 12 national, high-level indicators for the framework that align with its priorities and will help the health and disability system to focus on the areas where improvement is needed the most. Ten of these indicators are able to be reported and a further two indicators remain in development.

The Ministry and the HQSC will work with the Health and Disability Review Transition Unit during 2021/22 to further develop the framework and ensure it complements overarching monitoring and accountability arrangements for the future health and disability system.

The indicators are publicly available, and the results for the HSI are published quarterly on a web-based dashboard hosted by the HQSC.

The high-level Health System Indicators are:

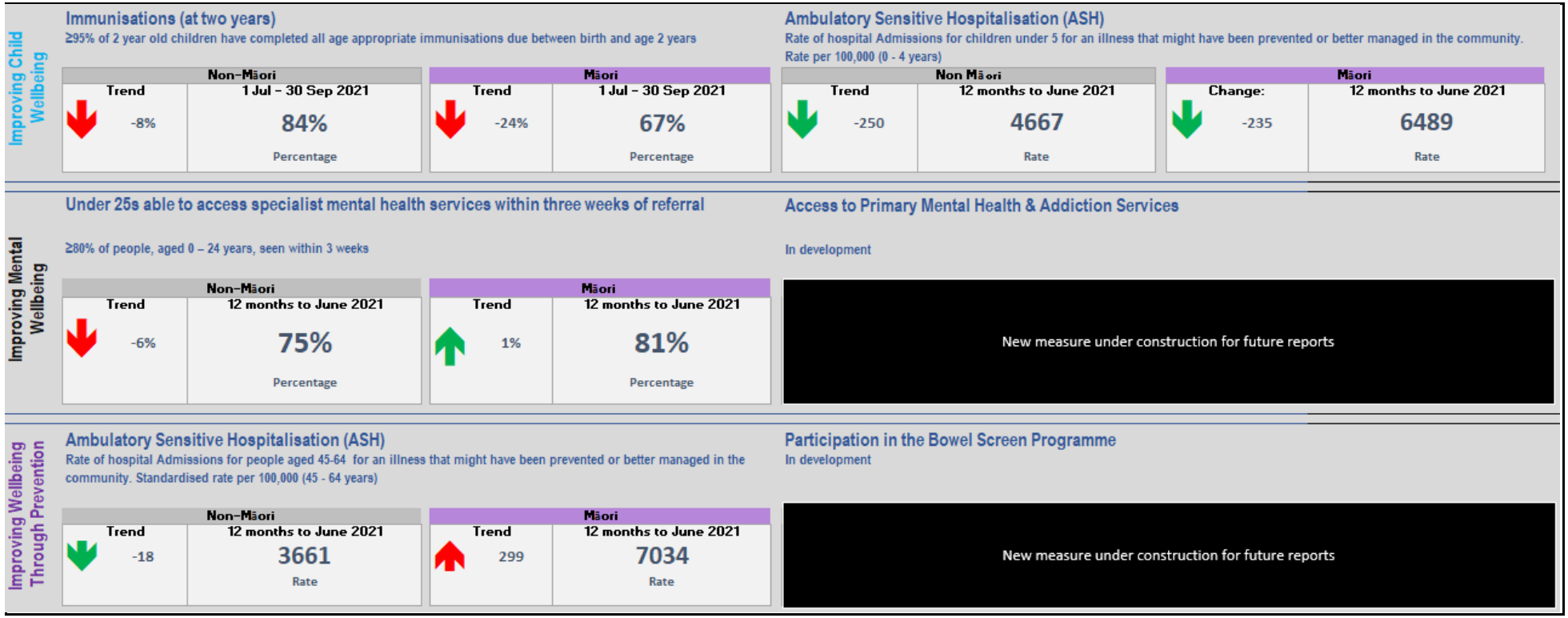
Government priority	High-level indicator	Description
Improving child wellbeing	Immunisation rates for children at 24 months	Percentage of children who have all their age-appropriate schedule vaccinations by the time they are two years old
	Ambulatory sensitive hospitalisations for children (age range 0 – 4 years)	Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community
Improving mental wellbeing	Under 25s able to access specialist mental health services within three weeks of referral	Percentage of child and youth (under 25) accessing mental health services within three weeks of referral
	Access to primary mental health and addiction services	In development
Improving wellbeing through prevention	Ambulatory sensitive hospitalisations for adults (age range 45 – 64 years)	Rate of hospital admissions for people aged 45 – 64 for an illness that might have been prevented or better managed in the community
	Participation in the bowel screening programme	In development
Strong and equitable public health system	Acute hospital bed day rate	Number of days spent in hospital for unplanned care including emergencies
	Access to planned care	People who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the delivery plan
Better primary health care	People report they can get primary care when they need it	Percentage of people who say they can get primary care from a GP or nurse when they need it
	People report being involved in the decisions about their care and treatment	Percentage of people who say they felt involved in their own care and treatment with their GP or nurse
Financially sustainable health system	Annual surplus/deficit at financial year end	Net surplus/deficit as a percentage of total revenue
	Variance between planned budget and year end actuals*	Budget versus actuals variance as a percentage of budget

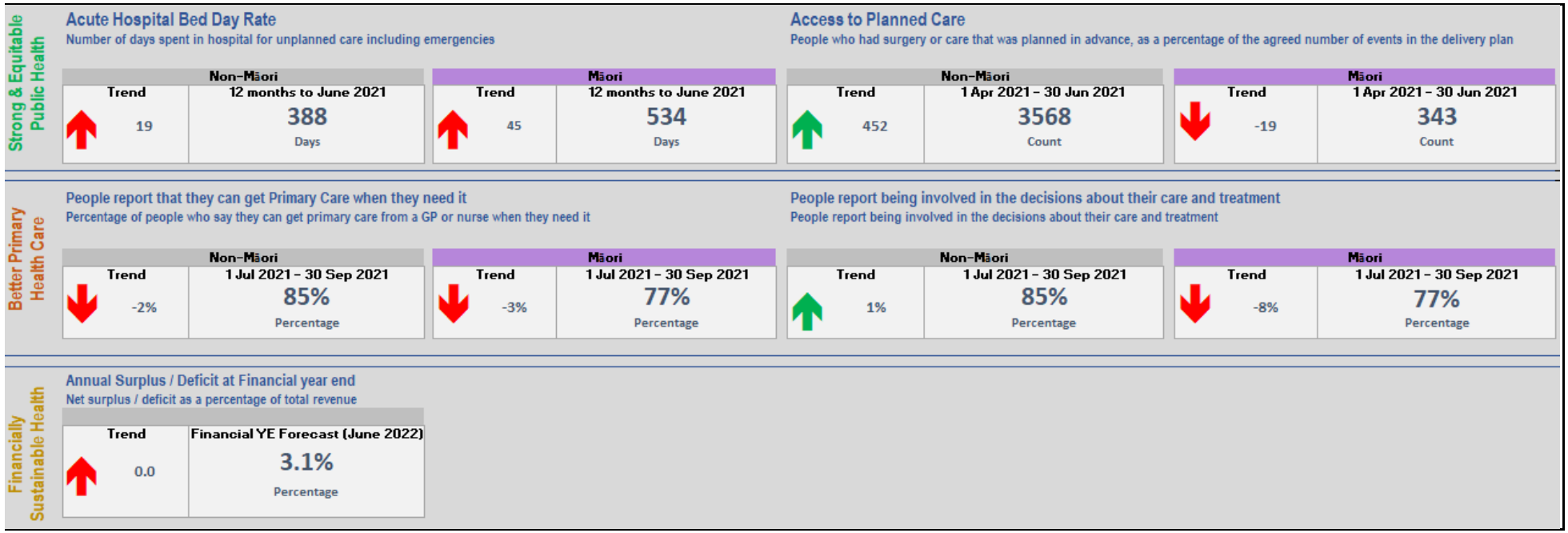
* Variance between planned budget and year end actuals is calculated at financial year end. The next result will be available in Quarter One 2022/23 for the financial year ended 30 June 2022.

3. DISCUSSION

The first update of the Health System Indicators was available in December 2021.

This shows change from baseline for most of the high-level indicators and includes DHB results. The baseline for improvement for most indicators is December 2019, as more recent data has been significantly affected by the COVID-19 response. Therefore it is not considered appropriate to use as a baseline.



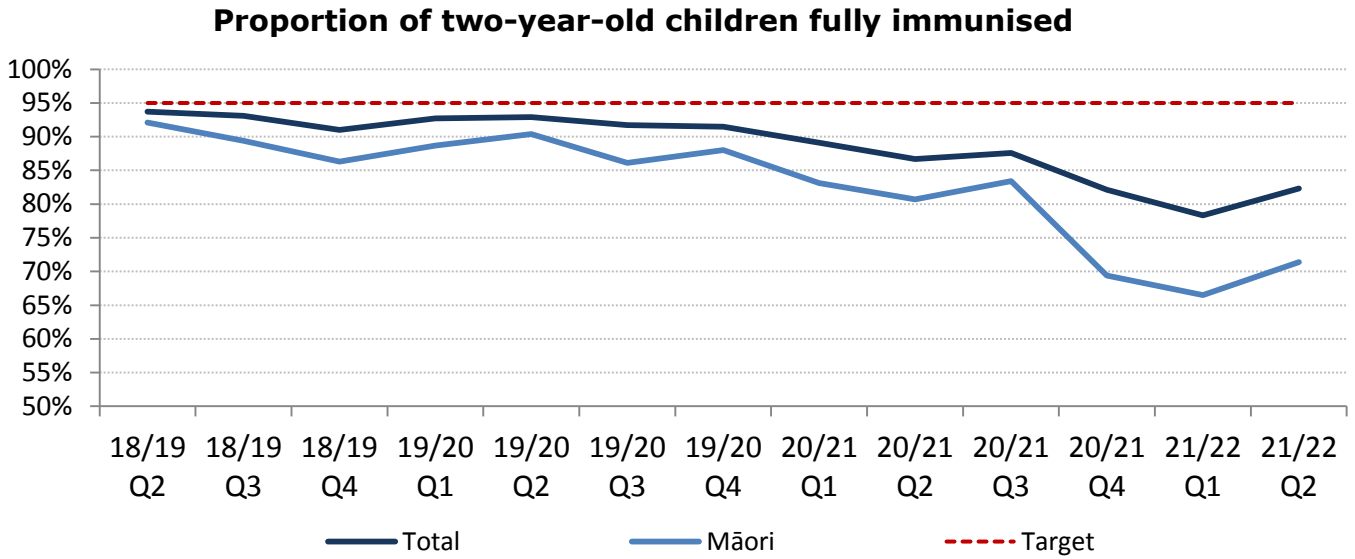


3.1 **Improving child wellbeing – immunisation rates for children at 24 months**

Overall, 81 fewer two-year-old children were fully immunised when compared with the baseline (as at December 2019) where 92.9 percent of two-year-old children were fully immunised (note all immunisations due over the period are included, not just the last dose).

For the three months to 30 September 2021, the proportion of children aged 24 months that are fully immunised was 78.3 percent (n. 441/563); 127 of whom were Māori (66.5 percent of 191 children).

The following graph shows the proportion of two-year-old children that were fully immunised over time.



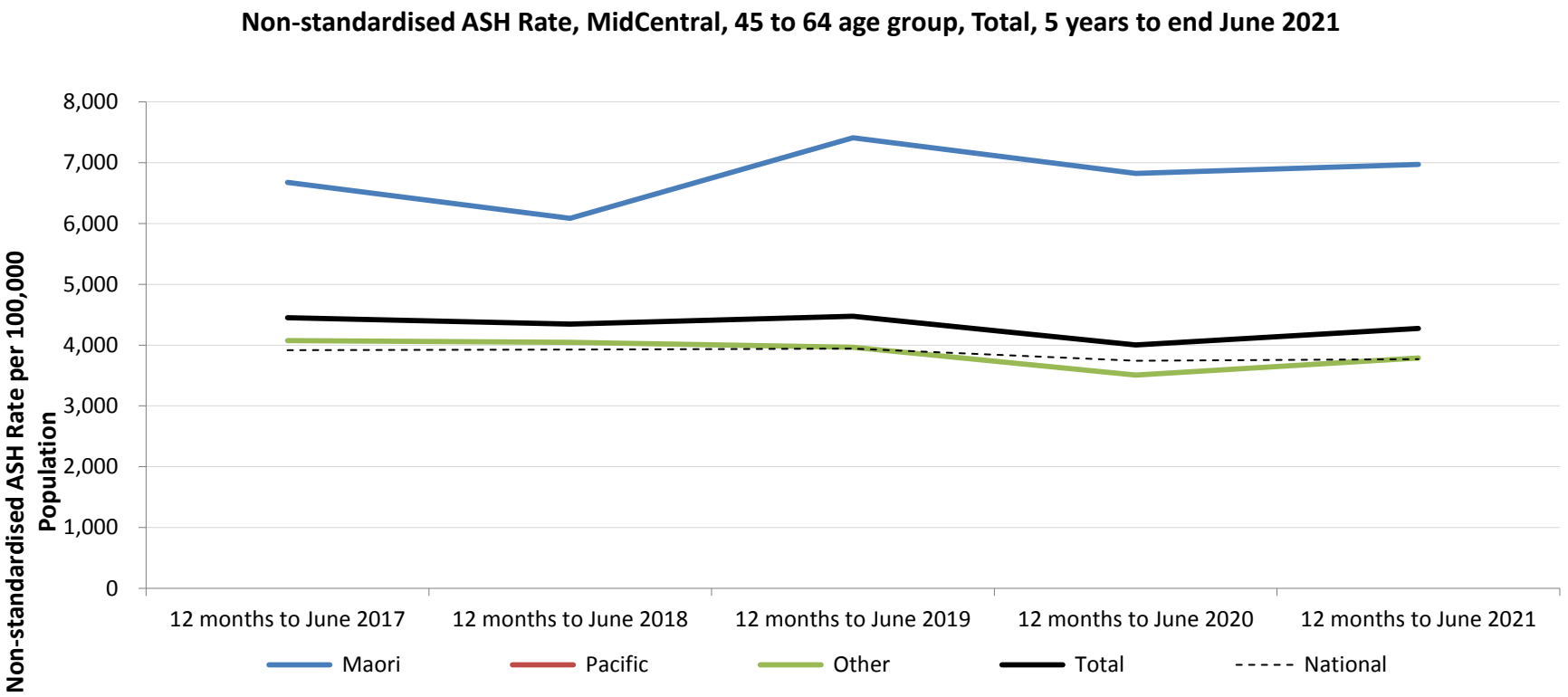
The National Immunisation Schedule change continues to have a significant impact on data of the PCV (Pneumococcal vaccine) and MMR (Measles, Mumps and Rubella vaccine) doses. Some parents of this age group have decided to wait until their child is four years old to get the MMR dose as per the previous immunisation schedule.

The most recent nationwide COVID-19 Alert Level changes in August 2021 exacerbated parental reluctancy to present to clinics or have home visits.

The immunisation team continues to work closely with General Practice, the Outreach Immunisation Service (OIS) and the National Immunisation Register (NIR) to find the children of whānau who are overdue, transient, delaying, or declining and encourage them to present to General Practice for immunisations or offer them an alternative venue for the event. This work is focused through the Ministry-agreed action plan for immunisation.

3.2 Improving child wellbeing – potentially avoidable stays in hospital for children (ASH 0-4 years)

Overall, there were 27 fewer potentially avoidable stays in hospital for children under five when compared with the baseline. For the 12 months to December 2019, the rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community was 5569 per 100,000 children. Ambulatory sensitive hospitalisations have reduced overall for the same 12-month period to June 2021 (5331 per 100,000).



The target was not met for the number of events for Māori children at 268, compared with 212 for the same period in the previous year. Similarly, the number of events for non-Māori children has increased from 301 (12 months to June 2020) to 336 for the 12 months to June 2021.

Dental conditions, asthma, upper and ENT respiratory infections, followed by gastroenteritis and dehydration were the principal diagnoses for which Māori children were hospitalised (significantly higher rates for asthma and dental conditions than non-Māori children).

3.3 Improving mental health – access to specialist mental health services

This performance measure was updated for the 2021/22 year. It replaces the 0-19-year-olds waiting time measure and target of 80 percent seen in three weeks and 95 percent seen in eight weeks. The measure now covers the 0-24-year-old age group. Data is lagged by three months.

Overall, there were 30 fewer people under 25 years old able to access specialist mental health services within three weeks of referral when compared with the baseline (12 months to end of December 2019).

The proportion of people under the age of 25 able to access specialist mental health services within three weeks of referral has reduced for the 12 months to September 2021 (77 percent) compared with the baseline period, 12 months to December 2019 (81 percent). The target for Māori (82 percent) and Pacific clients (100 percent) was achieved, but the proportion of non-Māori being seen within three weeks was below the target at 71.7 percent (n.253) of 353 clients seen.

≥80% of people, aged 0-24 years, seen within three weeks

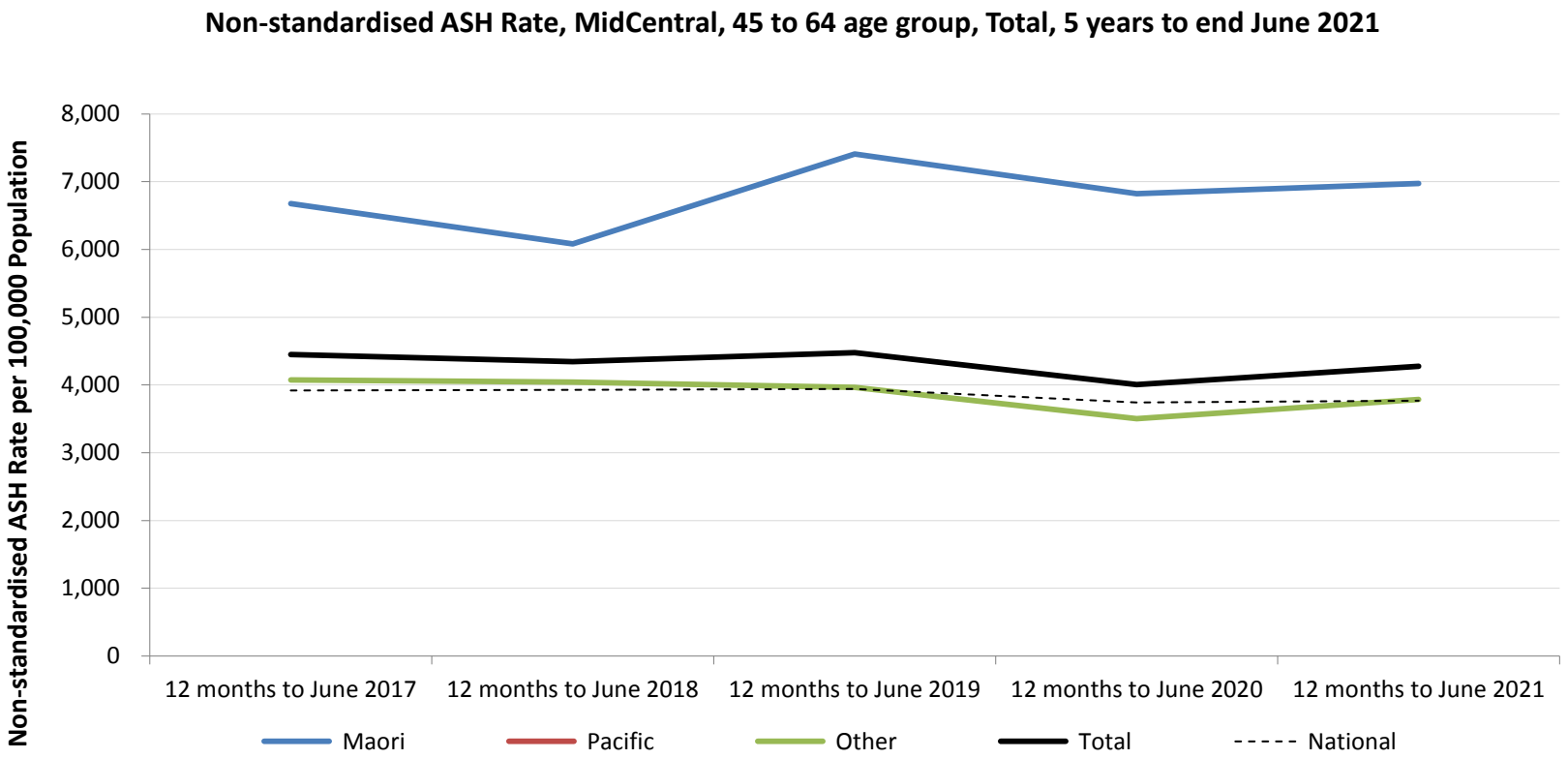
Ethnicity	Baseline: Quarter Three (12 months to December 2019)	Quarter One (12 months to June 2021)	Quarter Two (12 months to September 2021)	Quarter Three (12 months to December 2021)	Quarter Four (12 months to March 2022)
Māori		81.0%	82.0%		
Non Māori		75.0%	71.7%		
Total	**81.0%**	**77.0%**	**75.0%**		

3.4 Improving wellbeing through prevention – potentially avoidable stays in hospital for adults (ASH 45 – 64 years)

Overall, there were 23 more potentially avoidable stays in hospital for people aged 45-64 years when compared with the baseline (12 months to end of December 2019).

For the 12 months to June 2021, the rate of hospital admissions for people aged 45-64 years for an illness that might have been prevented or better managed in the community was 4164 per 100,000. Ambulatory sensitive hospitalisations have not changed significantly when compared with the same 12-month period to December 2019 (4114 per 100,000).

The ambulatory sensitive hospitalisation (ASH) rate was 4053 per 100,000 total 45-64 years population for the 12 months ending September 2021 (6574 for Māori and 3609 for Other ethnicity groups). This rate is derived from a total of 1951 admissions (477 for Māori and 1474 for non Māori) over these 12 months.



Significant disparity in rates between Māori and non-Māori is evident over the past five years. The non-standardised ASH rate for MDHB has also consistency been higher than the national rates (national rate of 3770 per 100,000 for the 12 months as at 30 June 2021) as seen in the graph above.

Angina and chest pain, myocardial infarction, chronic pulmonary obstructive disease) followed by cellulitis and congestive heart failure were the ASH conditions representing the top 10 hospitalisation categories for Māori (significantly higher rates for myocardial infarction and cellulitis than non-Māori).

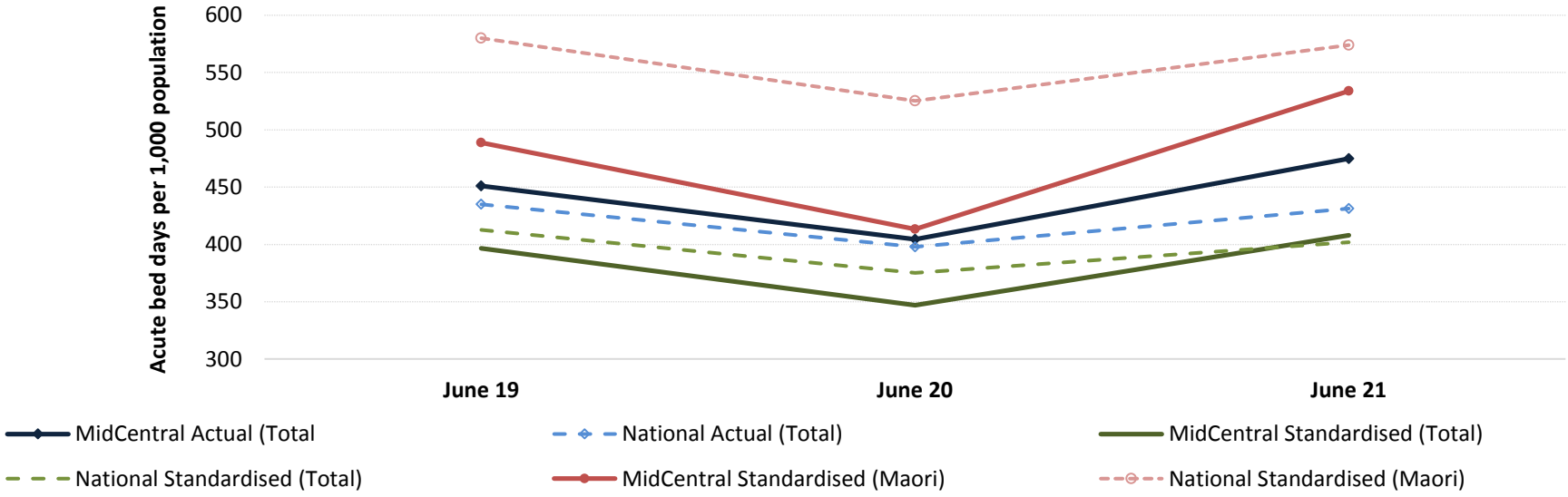
3.5 Strong and equitable public health system – acute bed day rates

Overall, 3377 more days were spent in hospital for unplanned care including emergencies when compared with the baseline, an acute bed day rate of 389 per 1000 people. (12 months to end of December 2019).

For the 12 months to June 2021, the number of days spent in hospital for unplanned care including emergencies was 408 days per 1000 people for the 12 months to June 2021, a slight increase when compared with the baseline.

For the 12 months ending June 2021, there were 24,049 acute stays by MDHB residents that utilised 88,418 acute bed days (DHB of service), producing an actual rate of 475 per 1000 population (408 when standardised). Of these, 19.5 percent (4700) of the acute stays were by Māori but utilised proportionately fewer (15.7 percent) of the total acute bed days. However, the standardised rate at 534.0 per 1000 Māori population remains higher than for non-Māori.

Acute hospital bed days per 1000 population (age standardised and actual rates) over three years – MidCentral DHB of domicile



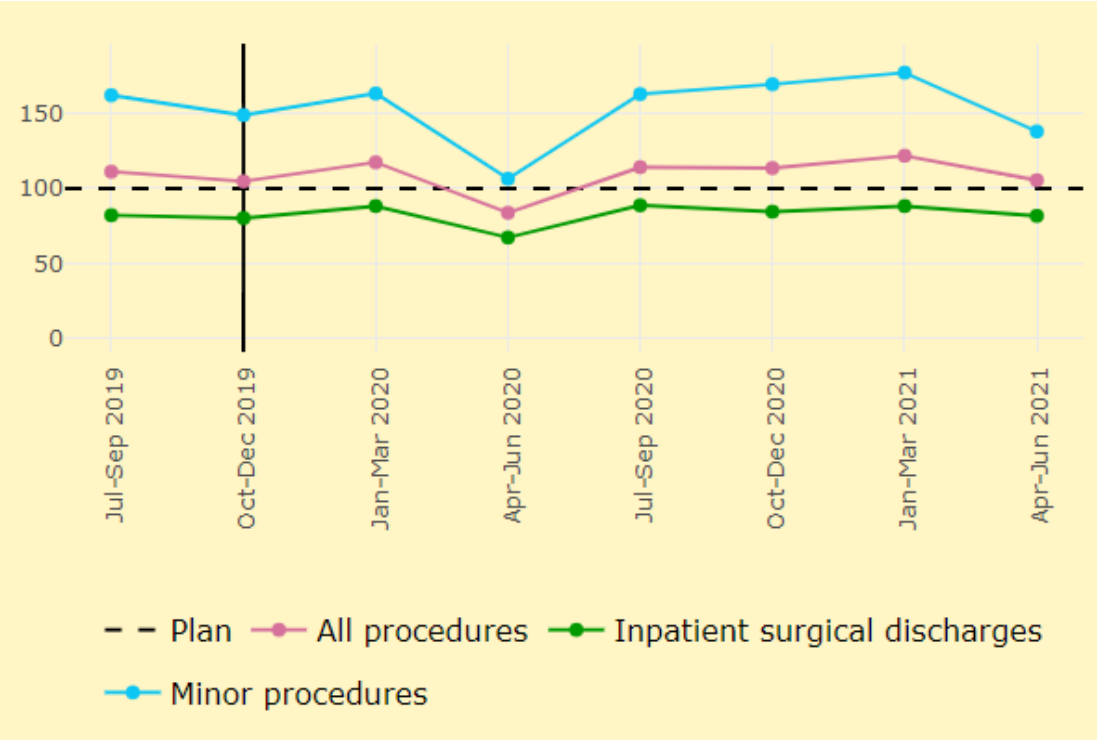
An action plan regarding MDHB Shorter Stays in ED performance has been shared with the Ministry. Hospital flow and capacity issues are challenges, with the increased presentations to ED and subsequent admission rate with bed occupancy consistently over 100 percent.

3.6 Strong and equitable public health system – planned care

Every year as part of the planning cycle, a certain number of planned care interventions is agreed for the MDHB population. This indicator measures the number of people of who had surgery or care that was planned in advance, which is presented as a percentage of the agreed number of events in the delivery plan. Planned care reporting includes both inpatient surgeries and minor procedures that are provided in inpatient and outpatient hospital and community settings.

When compared with the baseline period (three months to December 2019), 5.5 percent more people had surgery or care as planned. For inpatient surgical discharges, 18.3 percent fewer people had surgery than planned. For minor procedures, 38.2 percent more people had surgery as planned.

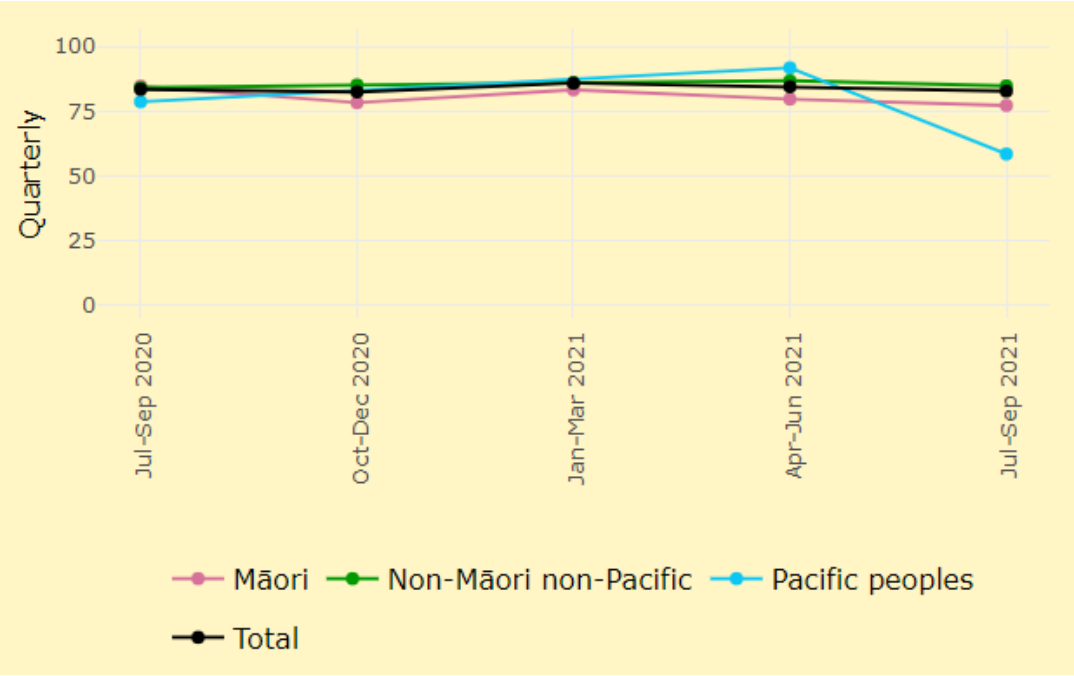
Proportion of people who had surgery or care that was planned in advance



3.7 Better primary care – involvement in decisions about care or treatment

Overall, fewer people reported they feel involved in their care and treatment with their GP or nurse (by 1.4 percentage points) for the three months ending September 2021 (83 percent). This has not significantly changed from baseline (12 months to June 2021) whereby 84.4 percent of people reported they felt involved in their care and treatment with their GP or nurse.

Proportion of primary health care survey respondents reported they felt involved in their care and treatment with their GP or nurse in the last 12 months

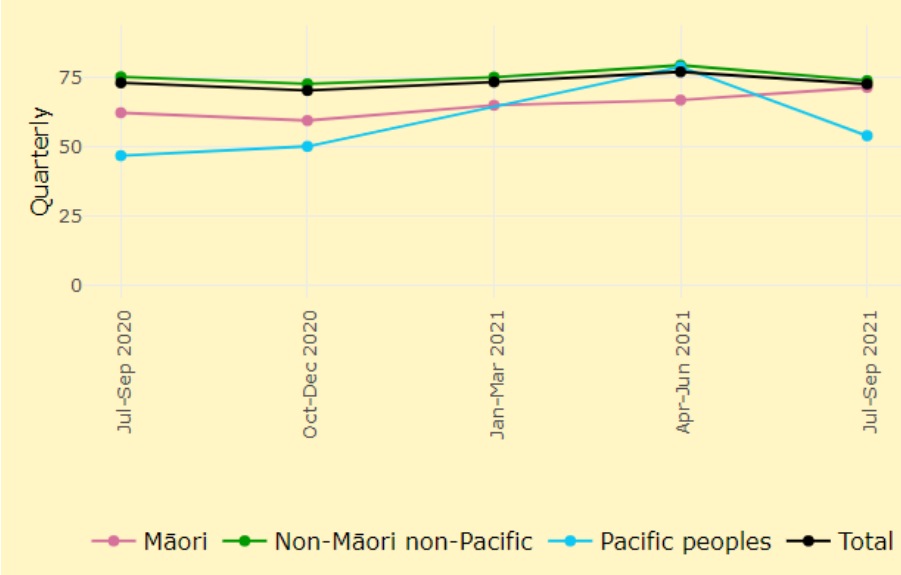


3.8 Better primary care – access to care

Overall, fewer people reported they can get care when they need it (by 1.1 percentage points) for the three months ending September 2021 (72 percent). This has not significantly changed from baseline (12 months to June 2021) whereby 74 percent of people reported they were able to access care when they needed it.

Results from the fifth patient experience survey carried out in August 2021 show that 72.1% of non-Māori and 69.8% of Māori were able to access health care from a GP or nurse when they needed it in the last 12 months, against a target of 80 percent.

Proportion of primary health care survey respondents note that they were able to get health care from a GP or nurse when they needed it in the last 12 months



3.9 Financially sustainable health system – annual surplus/deficit

This indicator shows how well MDHB and the sector has managed the annual cost for providing services relative to revenue. The actual deficit result shows the difference against planned budget.

As at 28 February 2022, MDHB has a year to date deficit excluding one-offs that is 0.3 percent of revenue. This compares to a year to date budget that is 0.7 percent of revenue. The current year-end forecast indicates that the deficit, excluding one-offs, will be 2.61 percent of revenue compared to a budgeted deficit that is 2.48 percent of revenue.

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 Board's Annual Plan deliverables?

To	Board
Author	Tracy Corbett, Advisor, Planning and Accountability Strategy, Planning and Performance
Endorsed by	Deborah Davies, Interim General Manager, Strategy, Planning and Performance
Date	10 March 2022
Subject	**Non-Financial Performance Measures – Quarter Two, 2021/22**

RECOMMENDATION

It is recommended that the Board:

- **note** the progress and performance for the second 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 Two 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 Two 2021/22.

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 December 2021 (Quarter Two), 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 Two 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 Two, there were 53 measures and deliverables reported to the Ministry. The Ministry has assessed MDHB's performance based on the specified achievement scale or criteria for each deliverable. Fifty-five percent of the deliverables were rated as 'outstanding', 'achieved' or 'satisfactory'; 32 percent were 'partially achieved' with some mitigations or improvement actions in place; 13 percent were rated as 'not achieved'.

Appendix One provides a table of the performance measures and Annual Plan deliverables submitted for Quarter Two, 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 Two can be found on Stellar – *MDHB/Board/Reports and Documents/2022 Documents/Q2 2021-22 Performance Report for Stellar*. 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 42 headline deliverables this quarter (with 53 measures), of which 29 were rated by the Ministry as either 'outstanding' or 'achieved' (55 percent) and 17 were 'partially achieved' (32 percent) with adequate mitigations or improvement actions in place. Seven (13 percent) were 'not achieved' and these are briefly discussed below.

4.1. Immunisation coverage

There are three performance measures reported in Quarter Two 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 decline for the total eligible population to 81.7 percent (from 83.3 percent last quarter) and a decline for Māori to 65.2 percent. Rates have improved for Pasifika this quarter at 84.6 percent (compared with 81.0 percent last quarter).

There are a total of 139 infants overdue to complete their schedule of immunisations at eight months of age of which, 92 (66.1 percent) identify as Māori and seven (5 percent) identify as Pasifika.

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.

Some whānau continue to describe a reluctance to have contact with illness in the general practice environment, as well as report possible challenges from reception staff about existing debt in the practice and difficulties negotiating appropriate appointment times. As a result, the immunisation clinics held at THINK Hauora in Palmerston North and in Horowhenua are being well utilised. Whilst there was a reduction in demand leading into Christmas, it is likely that the looming Omicron outbreak will drive demand for clinics outside of the general practice environment.

Home visits continue, providing an opportunity for those whānau that are not enrolled with a General Practice Team (GPT) to access immunisations and/or for those whānau reluctant to access General Practice due to COVID.

4.1.2 Children fully immunised by two years of age

An increase in reported rate of children being fully immunised up to the age of 2 years overall this quarter (note all immunisations due over the period are included, not just the last dose).

82.3 percent of children aged 24 months were recorded as being fully immunised, a 3.1 percent increase when compared with the previous quarter.

Pleasingly, there has also been an increase in the proportion of Māori children fully immunised at 24 months of age; 71.4 percent of Māori children this quarter – an increase of 3.8 percent and above the national rate of 69.7 percent for the quarter.

Rates for Pacific children also increased to 84.4 percent for the period ended 31 December 2021.

The National Immunisation Schedule change continues to have a significant impact on data of the PCV and MMR doses. Some parents of this age group have decided to wait until their child is four years old to get the MMR dose as per the previous immunisation schedule.

As noted for other milestone ages, the Immunisation team continues to work closely with General Practice, OIS and the National Immunisation Register (NIR) to find the children of whānau that are overdue, transient, delaying, and declining and encourage them to present to General Practice for immunisations or offer them an alternate 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 slightly this quarter (85.4 percent) compared with the previous quarter (85.2 percent).

Rates for Māori tamariki have remained stable this quarter, with the proportion that are fully immunised slightly decreasing (79.1 percent) compared with the previous quarter (79.3 percent).

Of concern, is the Pasifika on time immunisation rates in this age group. These have notably decreased this quarter (73.9 percent) in comparison with the previous quarter (85.7 percent).

4.2 Colonoscopy wait times

There has been a decline in performance this quarter in the waiting times for urgent colonoscopy, which are now slightly below target. For urgent referrals the target is that 90 percent receive their procedure in 14 calendar days or less.

Over the quarter, 54 (88.5 percent) of 61 patients with an urgent referral received their procedure within 14 calendar days or less. This is a reduction when compared to the previous quarter (1 July to 30 September 2021); 92.7 percent (64/69) of patients with an urgent referral received their procedure within 14 days or less.

A further reduction in the proportion of patients with a non-urgent referral received their procedure within 42 days or less. Over the quarter, 92 (19.6 percent) of 469 received their procedure within 42 days or less. The target for non-urgent referrals is that 70 percent receive their procedure in 42 calendar days or less.

The proportion of people receiving their surveillance colonoscopy within 84 days of their planned date remains below target. The target for surveillance colonoscopy is that 70 percent receive their procedure within in 84 calendar days or less. Over the quarter, 65 (51.2 percent) of 127 patients received their procedure within 84 days of the planned date. This is a slight decline in performance when compared to the previous quarter (1 July to 30 September 2021) when 52.0 percent (n. 52/100) of people received their surveillance colonoscopy within 84 days of their planned date.

The impact of the construction related to the SPIRE project and the building of the new Gastroenterology Unit has affected the decanting space available and has halved the number of operational procedure rooms.

Initiatives underway to lift performance include:

- close monitoring of wait times and monthly capacity monitoring continues
- outsourcing of colonoscopies to private provider to increase capacity and reduce waiting times for colonoscopies continues
- weekend lists are being completed and will continue during the next quarter
- a new Gastroenterologist has commenced at MDHB in January 2022 however, two vacancies for Gastroenterologists remain.

4.3 Shorter stays in Emergency Department (ED)

A further reduction in the proportion of patients presenting to ED who were admitted, transferred, or discharged within six hours over this quarter; 63.8 percent (n.7644) of 11,982 patients having shorter stays in ED. Initiatives undertaken this quarter to improve SSED and patient flow include:

- MDHB is progressing with the planned implementation of the 10 bed Flexible Acute Flow Unit; successful recruitment of registered nurses and health care assistants is required to have this open 24 hours
- A surge plan continues to be developed by the senior medical staff from ED for the rapid decant of patients in a significant incident or event
- The Variance Response Management (VRM) working group has been reinvigorated focusing on a hospital wide levelling of VRM coding
- The ED Trendcare working group has been established to plan for the implementation of Trendcare in ED

- The ED-POAC redirection continues and there is good uptake of this ongoing initiative however constraints within primary care limited its impact in December
- The establishment of professional accountabilities with patient groups in ED is currently being considered
- The Acute Demand governance group has been re-established with an initial specific focus on community initiatives that assist in reducing ED presentations
- Full employment to agreed CCDM staffing is an enabler for patient pulling from ED to wards and subsequent discharge.

4.4 Help to quit smoking – primary

There has been a decline this quarter of the proportion of enrolled patients who smoke seen by a health practitioner in primary care offered advice and help to quit smoking (79.8 percent) compared to the previous quarter (84.1 percent).

The proportion of Māori patients who smoke that were offered advice and help to quit smoking decreased this quarter (77.7 percent) compared with the previous quarter (83.0 percent). The target is 90% of enrolled patients who smoke are seen by a health practitioner in primary care will be offered advice and help to quit. Whilst not achieving target, it is notable that there is little or no difference in the proportion of Māori and non-Māori who smoke, offered advice and help to quit smoking. This highlights the consistent efforts of General Practice Teams (GPTs) and THINK Hauora Clinical Facilitators as well as the strong relationships that have been established with Māori health providers in working towards achieving health equity.

Continued monitoring of completion rates is planned for the next quarter, and the importance of ensuring that SBA is provided during any contact with a patient that is recorded as a current smoker irrespective of the status of SBA in the patient management system in use.

Further into the future, the implementation of HIRA (formerly known as the national Health Information Platform (nHIP) is expected to increase performance by enabling general practice teams' access to data from other providers who provide smoking brief advice (SBA). This will ensure all SBA data for our enrolled population is captured.

4.5 Quality of identity data and national collections

National Patient Flow data and links to NNPAC, NBRS, as well as NMDS for FSA and planned care interventions declined slightly this quarter to 77.0 percent from 77.78 percent last quarter.

A decline in the completeness of production data of PRIMHD, NMDS, NNPAC, and Primary Maternity records reported to National Collections this quarter from 91.92 percent last quarter to 78.0 percent to the end of September 2021.

However, there has been an improvement in the assessment of data reported to the NMDS. This quarter, 93.0 percent of data reported to the NMDS meet the requirements (the use of clinical statements for specific diagnosis codes extracted from the clinical record), against a target of 95 percent.

The National Patient Flow (NPF) working group continues to meet weekly to identify areas that require data cleansing and/or updating of source data as well as mapping.

APPENDIX ONE

The following table highlights the performance measures and deliverables reported to the Ministry in Quarter Two 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 Two)

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

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	N
Care capacity demand management	NA	PRIMHD	A
Shorter stays in Emergency Department	N	Management of long-term conditions	A
Help to quit smoking – hospital	P	Long term conditions	A
Healthy ageing strategy	A	Diabetes	A
Ambulatory sensitive hospitalisations (adult)	A	Cardiovascular disease	P
Treaty obligations	O	Acute heart service	P
Annual Plan Status Update	P	Stroke service	P
Better Population Outcomes Supported by Primary Health Care			
System level measures	A	Help to quit smoking – primary	N
Quality of ethnicity data	P	Annual Plan Status Update	P
Māori enrolment in PHOs	P		
Improving Sustainability			
Annual Plan Status Update	P		
He Korowai Oranga			
Annual Plan Status Update	A		
Crown Funding Agreement Reporting			
Before School Check (B4SC)	S	Primary Health care services – under 14s	S
Additional School Based Health Services	S	Sudden Unexpected Death in Infancy	S
Immunisation Coordination Service	S	NIR – Ongoing Administration Services	S

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	Gabrielle Scott, Interim General Manager, Quality and Innovation
Endorsed by	Finance, Risk and Audit Committee Kathryn Cook, Chief Executive
Date	15 March 2022
Subject	**Sustainability Plan**

RECOMMENDATION

It is recommended that the Board:

- **note** that at its March meeting, the Finance, Risk and Audit Committee endorsed this report for the Board's consideration
- **note** the progress in the implementation of the Sustainability Plan
- **note** the Sustainability Plan benefits monitoring dashboard and trend analysis
- **note** the January 2022 report indicates savings of $**323,961** year to date
- **approve** the Sustainability Plan report.

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.

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) and these are included in the report for monitoring purposes only. Reports on these initiatives are also provided to the Ministry.

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 is in Appendix Three. The dashboard is in development. Trend analysis in the form of line graphs have been added where data is available. 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 Specialing cost containment and improvement project is in the final stages. We have a clear assessment and decision-making framework in place for the clinical teams and have optimised this with the use of Mahi Tahi in the clinical areas. Two areas of work which are progressing are the environment improvements to enable and promote most effective prevention of close behavioural observation. This has commenced on Ward 29. The HCA auditing process and tool is work in progress and the upgrade to the MIYA journey board is also underway to capture specialing centrally, eliminating manual data collection.

The remaining two services are well underway in reviewing their skill mix and future workforce requirements. However, to achieve the Skill Mix project targeted savings will remain challenging. Local and regional models of care development will determine future skill mix.

Whilst there are a number of other initiatives reporting an RAG amber status, their target completion period has not been reached.

The community infusion service has successfully commenced a further update due at the end of Quarter Three.

The equipment library development requires dedicated resource and as a result has been delayed while that is being recruited. A further update will be given in Quarter Four.

The PICQ tool has been purchased and is now in use with early insights being provided to support clinical documentation and coding. Savings will be gradually seen over the third and fourth quarters.

While the DHB awaits the suite of e-projects to be implemented, there will be a delay in the achieving some savings in the associated initiatives such as outpatients transcriptions and e-communications.

The Organisational Leadership Team (OLT) will review the plan every month. OLT will consider any risk to delivery including the capacity to deliver the range of activities currently in plan. At the present time, OLT consider the plan remains deliverable.

3. BENEFITS AND SAVINGS

The 2021/22 year to date savings 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 being released from the existing and future initiatives will be 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, the 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. This has led to a number of project timelines being extended.

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, acknowledging this will be challenging in the current environment.

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 Horowhenua 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. Therapy services model of delivery planning underway	Confirm benefits measurement plan. Complete community rehabilitation proposal. Commence project implementation	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	✓		Clinical and consumer engagement underway with options being considered during engagement process	Engagement completed by end of 2021. Draft report will be shared at workshop in February. Project close February 2022	Plan to support increasing community health needs in place	Q3 2021/22
Outpatient admin redesign	Review and redesign outpatient administration service model	Gabrielle Scott	Implementation	✓		Standard booking letters have been redesigned and launched. Consumer experience education programme in development	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			Procurement plan completed. Request for proposal in progress. Business process analysis underway	Evaluation of proposals and selection of vendor	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			Procurement plan completed. Request for proposal in progress. Business process analysis underway. Digital Health Correspondence business case approved to proceed in 2022	Evaluation of proposals and selection of vendor	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	Gabrielle Scott	Implementation	✓		Co-design process ongoing. Consumer engagement underway	Conclude focus groups and in-depth interviews. Complete report and insights.	Improved access, safety, outcomes, reduced inequity for Māori and others, reduced services not engaged	Q3 2021/22
Telehealth	Implement telehealth models of care across speciality services	Claire Hardie	Implementation	✓		Procurement plan for new equipment underway. Evaluation framework underway. Site visits completed. Communication plan completed.	Procurement new hardware. Complete consumer experience survey. Identify administration champions	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. Three community sites have been contracted to provide the service. Training of staff underway.	Progress service 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	✓		Production planning underway across a range of services.	Purchase production planning software to support enterprise activities	Improved accuracy of budget planning to support effective service delivery in elective and acute services	Q3 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	✓		Tender evaluation completed	Tender to be awarded, steering group to be established.	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	✓		Tender awarded. Project plan agreed. Data requirements being considered	Confirm data requirements 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 progressing. Te Uru Whakamauora review about to commence. Measurement of skill mix change is focussed on future shape of the workforce.	Analysis of skill mix change delivered and benefits to be completed	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 being 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	Q3 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	Q4 2022/23
Clinical documentation and coding	Clinical documentation, coding and CWD capture	Lyn Horgan	Implementation			PICQ deployment and user acceptance testing underway. Review of e-discharge tool with clinical leads.	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	Q3 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			User acceptance testing underway	People and Culture to complete testing. Business change plan to be agreed. Reporting requirements to be agreed.	Improve leave capture, reduced paper	Q3 2021/22
E - Recruitment System	Implement electronic recruitment system for all workforce groups	Keyur Anjaria	Implementation			Lite version of e-recruitment tool being used. User acceptance testing underway.	Complete business change plan to extend use across enterprise	Reduction in time to recruit, reduction in paper, improved onboarding, improved productivity of people leaders	Q3 2021/22
ScOPe	Audit and theatre management tool	Lyn Horgan	Scoping	✓		Build is complete. Co-dependency on clinical portal integration has created a challenge which has delayed implemented to Q3	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

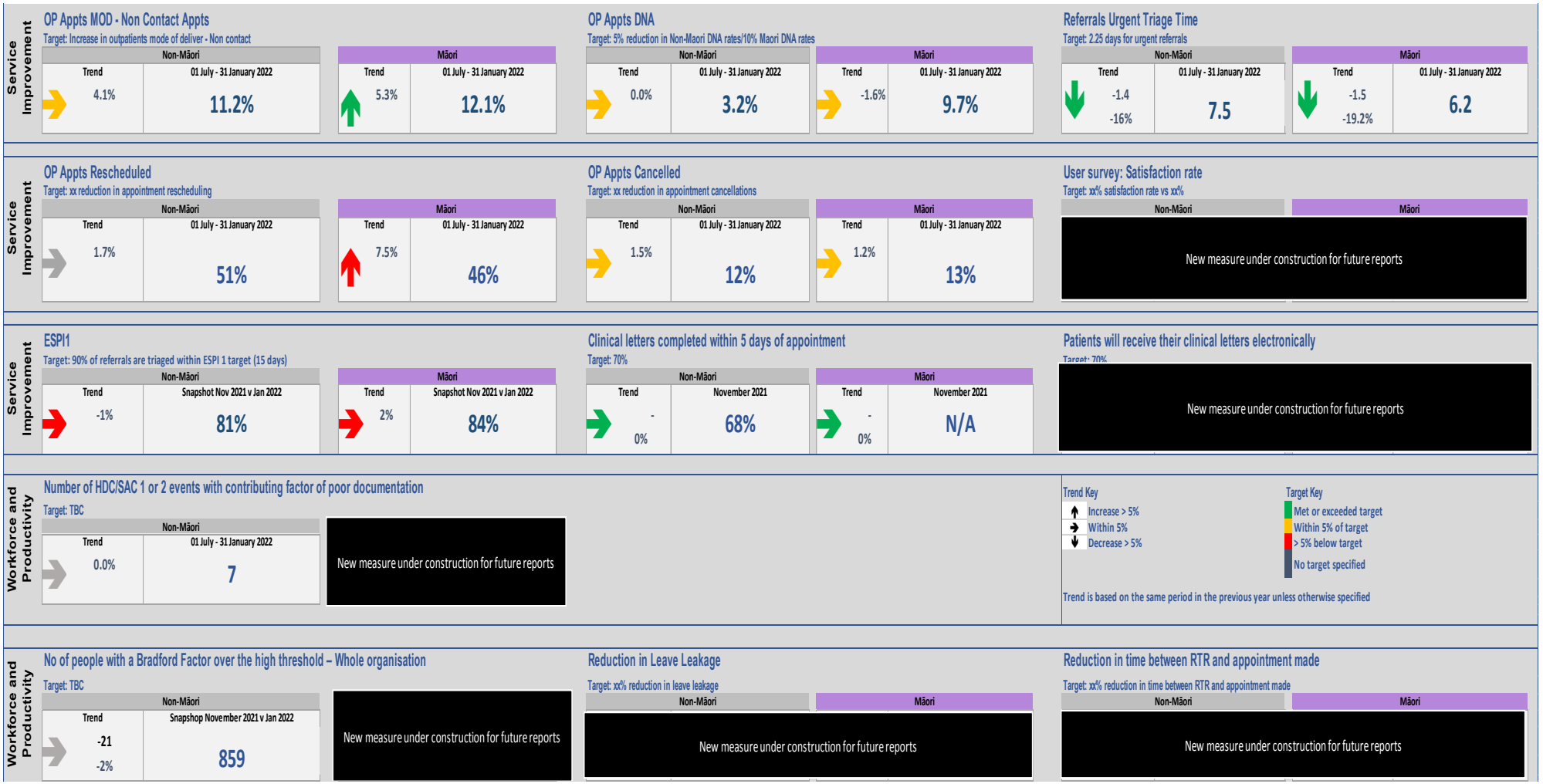
GREEN: On Track – no issues expected to impact on timelines or budget

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

Activity	Project name	Measure	Cash Releasing	RAG	Jan 22 YTD $ Target Savings YTD	Jan 22 YTD $ Actual Savings YTD	Jan 22 YTD $ % to YTD Target	Annual Target
Service Improvement	Mental Health Community Models of Care - STAR PN Realignment	Cost of Star 1 & 2	✓		$116,667	$115,500	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	✓		$175,000	$175,000	100%	$300,000
	Enhanced Stewardship of Blood	Units of Blood Wastage	✓		$58,333	$12,173	21%	$100,000
Workforce and Productivity Improvement	Reducing dependency on one to one nurse specialing	Outsourced Specialing Hours	✓		$100,000	$0	0%	$500,000
	Skillmix	Position changes	✓		$90,000	$0	0%	$300,000
	Workforce wellbeing	Sick leave FTE on rostered wards	✓		$90,000	$0	0%	$300,000

Savings and Revenue	Fleet Consolidation and management	No fleet vehicles replaced	✓		$14,000	$21,288	152%	$50,000
	Clinical Equipment Library	Equipment spend	✓		$50,000	$0	0%	$100,000
	Short Term Loan Equipment Management	Equipment spend	✓		$50,000	$0	0%	$100,000
	Clinical documentation, coding and case weight capture	CWD per discharge	✓		$50,000	$0	0%	$100,000
				Total	**$794,000**	**$323,961**	**41%**	**$2,650,000**

Discussion/Decision papers

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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	Kelsey Tanner, Executive Assistant
Endorsed by	Kathryn Cook, Chief Executive
Date	17 March 2022
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

A paper for the proposed 'meetings and level of engagement' was presented at the February meeting of the MRG and discussed separately by the CMS. Ongoing assessment of the effectiveness of meetings, engagement and outcomes will be reviewed no less than annually and lead by the Chief Medical Officer's office as part of the joint workplan with the MRG.

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	Review meeting engagement no less than annually	Complete
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 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	9 March 2022
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

January and February 2022 continued to be challenging for nursing, with high unplanned staff sick leave continuing and a hospital working at full capacity throughout the summer. Planning for COVID-19 outbreaks in our region escalated to ensure workforce preparedness. An eight-week COVID-19 Surge Workforce Training Programme commenced on 31 January 2022. Sixty-four one-hour training sessions have been scheduled, for clinical and non-clinical staff, delivered by Nurse Educators and Advanced Practice and Specialist Nurses. An online COVID-learning framework has been established on Ko Awatea Learn for all staff to complement the face-to face training. Twelve sessions were provided to Horowhenua staff and were fully subscribed. A Nurse Educator COVID-19 Resurgence position was recruited to (1 FTE) and is working with the Respiratory Team to roll out the Philips V60 NIV Training update for staff who will be caring for COVID-19 positive patients.

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 in response.

3.1 Workforce recruitment

Recruitment activity across Nursing, Midwifery and Health Care Assistants (HCAs) workforce continued with intensity. A table outlining recruitment activity over the months of October to December is provided below.

	Workgroup		
	Nursing	**Midwifery**	**Health Care Assistants**
Resignations	63*	9*	9*
Recruitments	45	3	12
Variance	-18	-6	+3

*Includes terminations resulting from COVID vaccination order

While the overall staffing variance for the quarter was negative, employment processes for the Nurse Entry to Practice (NETP)and the New Entry to Specialist Practice (NESP) was undertaken during the quarter. Thirty-eight candidates (including 14 Māori nursing students) were offered and have accepted employment with MDHB.

Maternity Services also continue to experience recruitment challenges due to the unavailability and pipeline of midwives to recruit. Registered nurses (RNs) continue to fill these positions as international recruitment campaigns are currently being run to attract more midwives.

Mental Health and Addiction Services (MHAS) took six NESPs this intake. Five was the number through the ACE (Advanced Choice of Employment) process as reported last time, but they endeavour to take others that are not eligible for ACE. They already have three nurses recruited for a mid-year NESP intake. MHAS also has the lowest vacancy rate it has had for five plus years, particularly Ward 21 who have two FTE nursing vacancies. HCAs vacancies are higher at 9.9 FTE, so alternative methods of recruitment are being explored with key stakeholders.

Community and Primary MHAS are steadily recruiting with no current challenges. Non-Government Organisation (NGO) recruitment for MHAS is poor, with high attrition and low recruitment. This is being actively monitored and discussed with each NGO and we are exploring solutions to remedy this.

3.1.1 *Careerforce Gateway Programme*

Careerforce has developed a suite of gateway packages to allow students to experience the diverse opportunities available to them in the health and wellbeing sectors, and potentially forge their career. It is available to Year 11 to 13 students.

We have 32 high school students registered this year which is a significant growth on previous years. Students started at MDHB with a powhiri on 2 March 2022. We have two streams, with Year 11/12 who complete Level 2 NZQA papers with us and the Year 12/13 stream who have an option of completing five NZQA papers.

Four of the Māori students are interested in pursuing a career in nursing and another two Māori students are interested in midwifery.

3.2 Workforce retention

The overarching aim is that the DHB's workforce reflects community demographics, is sustainable, highly qualified, appropriately credentialed, and culturally responsive to the changing needs of our communities. 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 with themes being captured centrally. This will provide a clearer picture over time of the progress being made with recruitment and retention initiatives.

Between October and December, 60 staff were recruited and 84 resignations received. A higher number than usual resignations from RNs was seen during January. These figures are being validated and is partly due to the COVID-19 Vaccination Order mandating that unvaccinated health workers are not allowed to work in healthcare. Departing RNs are reporting COVID-19 anxiety, increasing workloads and taking up international employment.

In January, three casual staff were recruited, with seven casual staff resignations received. Many of these employed in the COVID-19 Surge Workforce. Six casual staff resigned in February which included nursing students who had recently qualified and have taken up RN positions. We were fortunate to have employed 12 medical students during their summer break who reported enjoying the experience and departed at the end of January/early February to resume their medical studies.

3.3 Clinical safety

The CCDM implementation self-assessment has been completed and the Safe Staffing Healthy Workplaces Unit (SSHW) have confirmed that MDHB has achieved full implementation. The final report includes some recommendations for the DHB to continue to work on.

The CCDM Core Data Set for December 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 ongoing work 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 December, 213 patient incidents were reported. This is the same as the previous month and the lowest patient incidents have been since April 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. Twenty-two percent of shifts were below target in December; this is a decrease from 26 percent in November. The Integrated Operations Centre (IOC) continues with its ongoing mitigation strategies, to manage day-to-day nursing hours variance that contribute to shifts below target.

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 were 331 for December; up from 301 in November and significantly lower than the 487 seen in July.

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 149 percent in eight clinical service areas.

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 seven percent in December. It was noted that staff having booster doses of the COVID-19 vaccine impacted on sickness levels.

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).

Seven clinical areas noted five or more staff incidents, with the highest being in OPAL Ward (N=15). The Associate Director of Nursing together with the Charge Nurse for each area review these incidents, note the trends and themes, and put remedial actions in place. Each clinical area contributes to the overall Health and Safety Plan which is reviewed with the operational teams.

3.3.7 Community Nursing Services

Included in Appendix Three is some District Nursing Service (DNS) VRM data that has recently been provided by the quality team who have undertaken some analysis. It is early in its collation but does demonstrate the pressure on the DNS team. We have no similar process for Public Health Nursing, Tissue Viability, Community Continence, the COVID-19 Response team (vaccinations and testing) or PHC CNS Diabetes, so their workloads are largely invisible. A business case has been developed to increase the FTE in Community Continence and work is underway to re-examine the establishment FTE in DNS service.

3.4 Professional support

The Resus Quality Improvement (RQI) carts have been purchased and are expected to arrive on site this month. The marketing campaign continues to socialise the resource across teams, with positive feedback.

Supervision and coaching support are being offered to nursing and midwifery staff over the next 12 weeks.

- There is an online Coaching and Peer Support Programme for Charge Nurses and Midwives, starting 14 March 2022. This consists of nine x 45-minute zoom sessions with groups of eight people.

- New graduate NETP Nurses (N=50) are being offered weekly group professional supervision sessions, in response to the cancellation of their study days. This is to be paid time, outside their rostered shifts. Nursing External Education and Development Committee (NEED) funding has been secured to support this. As well as set sessions, there is capacity for a NETP nurses to book supervision on an 'as needs-basis'.

- NESP nurses are booked into monthly group supervision with senior nurses from MHAS. This has replaced the previous external supervisor that was evaluated poorly. This runs concurrently with monthly individual supervision, so that NESP nurses receive fortnightly supervision as a minimum.

- We are offering our frontline nursing clinical staff access to supervision (via Zoom) over the next 12 weeks, to reduce stress, anxiety and moral distress associated with the COVID-19 surge. We have secured six professional supervisors to assist with this and will fund through NEED.

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

The Transformational Leadership Programme and LEO Nightingale Challenge are fully subscribed for 2022, but re-scheduled due to COVID-19 surge.

The Advisory Group established with our Tertiary Education Programme Providers (Nursing, Midwifery and Allied Health) continues to meet with the remit of ensuring students can complete their practice placements in a timely and safe manner in a COVID-19 environment. The Occupational Health Team have been supporting fit testing of students, though not all have completed this prior to placement.

3.5.2 Connectedness

Kaiwhakaako Tapuhi Nurse Educator and Kaiwhakaako Kaiwhakawhānau Midwifery Educators (Educators) are in clinical practice settings, working alongside staff to improve safety and quality of care, support new staff in their transition to practice, enable experienced staff to continue to advance their practice, improve recruitment and decrease turnover. But whilst patient complexity continues to increase in our rohe, service delivery models evolve and FTE increases, the Kaiwhakaako Nurse and Kaiwhakawhānau Midwifery Educator establishment has remained relatively unchanged over the last 10 years. In addition, significant RN and Registered Midwife turnover is affecting staffing and skill mix across all specialities.

To support the clinical areas, we are exploring the option of establishing clinical coach roles, which would be funded via FTE from unfilled vacancies. The Registered Nurse Clinical Coach works within the clinical care interface and on rostered shifts to maximise educational and coaching opportunities. They are responsible for promoting and providing targeted planned clinical education and coaching along with the Nurse Educator and Senior Nurses of the area for an identified individual nurse, nursing cohort or team.

3.5.3 Supporting at work

A range of national and international drivers have led to an increase in the number of Kaiāwhina Haumanu Hauora/HCAs and support workers employed in healthcare. An increase in the number of patients with long-term conditions, the expansion of primary and community care, the emergence of more advanced technical, pharmaceutical, and medical treatments, and a shortage of skilled, qualified health staff have all contributed to this rise (in 2021 there were 48, 500 HCAs in NZ).

We are establishing a standardised skills development pathway for Kaiāwhina Haumanu Hauora/HCAs across the rohe, while acknowledging, understanding, and enhancing the visibility of this workforce. Partnering with Careerforce, we will strengthen and accelerate the development of career pathways and skills through:

- Establishing visible and accessible career pathways
- Enabling uptake of fit for purpose qualifications and training through Careerforce for new and existing staff
- Provide access to efficient and effective training
- Provide training for new/expanded roles and skills to support the nursing, midwifery, and allied workforce.

Appendix One
Nursing Workforce Action Plan – September 2021

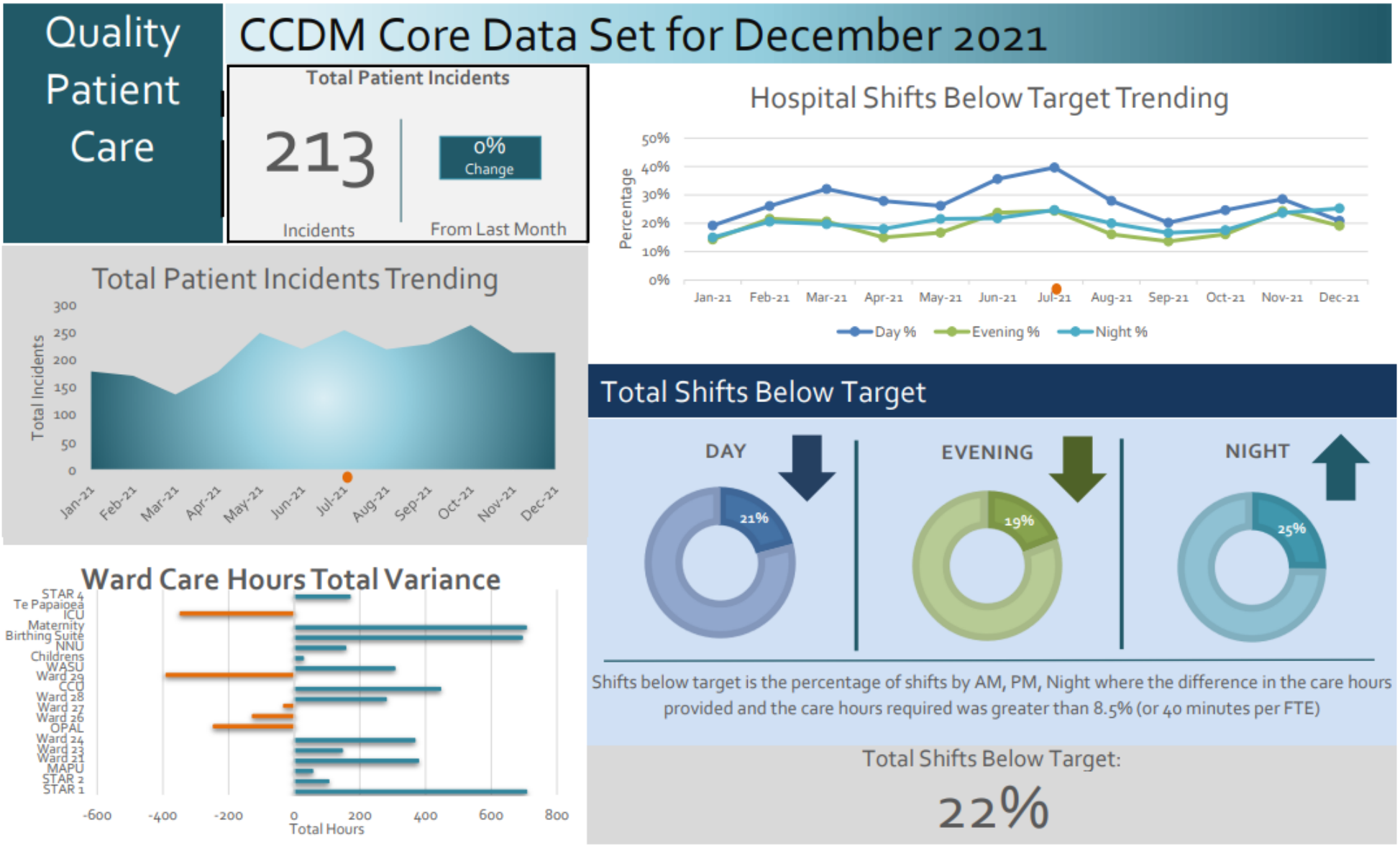
Not Started	Completed	On Track	Overdue	High Risk

	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, Star 1&2.	Ongoing	Darryl Ratana Scott Ambridge, Lyn Horgan	Awaiting ward 21 and OPAL, Star1&2 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.	Completed	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.	Completed	ADON Education NE NETP	NETP/NESP Māori and Pacifica nurses prioritised for interview. Nurse Educator Māori supports candidates with interview preparation. Eleven Māori and Pacifica nurses employed in NETP/NESP.	

Establish nursing post to oversee nursing recruitment (Senior Nurse / Nurse Consultant).	Completed	EDNM People and Culture N&M 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 New date May2022	People and Culture N&M Consultant	Improve timeliness of recruitment process. Current project in progress February 2022. Delayed due to Covid increased workload.	
Review orientation and onboarding processes.	Due December 2021 New date May2022	People and Culture N&M Consultant	Consider establishment of nursing recruitment office, workforce unit, centralised roster.	
Nursing Bureau and nursing centralised roster.	Due December 2021 New date 2022	N&M Consultant IOC Lead IOC Team	The project is in the beginning stages with the CCDM working on a proposal for CCDM council to confirm. Some delays due to current Omicron surge.	
Review current arrangements for nursing bureau.	Ongoing	N&M Consultant IOC Lead ADONs N&M Leadership	FTE has been reviewed with the ward FTE calculation processes. This is ongoing work.	
Retention				
Optimising training: offer external training opportunities funded by NEED, HWNZ and Medical Trust.	Ongoing	ADON Education NEED Committee Education & Practice Council	Expression of Interest released in September for 2022 HWNZ funding applications and fully utilised. Eleven Nurse Practitioner Candidates being funded.	
New Manager training programme developed and rolling out in 2022	Ongoing	ADON Education OD Business Partner	Progress delayed.	
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 and achieved.	
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. Further conversations regarding clinical coaching in progress with directorates.	
Confirm educational components in each clinical area.	August 2021	ADON Education	Essentials Skills revision with Education and Practice Council Completed	

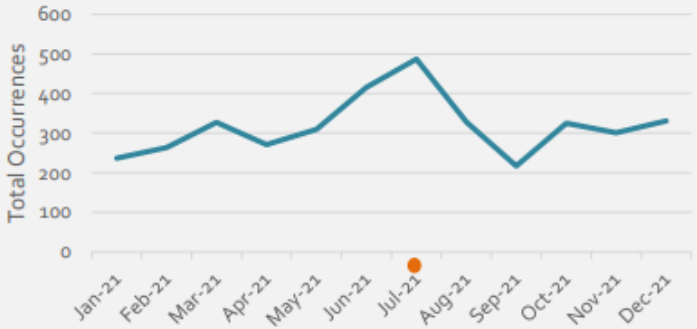
Professional				
Confirm delineation of professional roles – operational v professional.	Ongoing	EDNM Clinical Executives	Clarify roles and responsibilities for professional accountability.	
Senior nurses advanced practice plan.	Ongoing	EDNM Clinical Executives	Ensure Professional Leads are holding Ops 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, all areas reviewing skill mix. Discussions held with UCOL re ENs. Central Region DoNs supporting EN training with UCOL	
Staff Wellbeing				
Review current quarterly plans – top three priority areas identified in staff survey.	September 2021	EDNM GM People and Culture OD Business Partner	Health and Wellbeing strategy in place	
Pilot in place for Bradford scoring for monitoring/assessing staff absence.	Pilot commenced	GM People and Culture	Project commencing Feb 2022 may be delayed due to covid resurgence	
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 with more that an two year A/L balance	
Increase support for staff through access to Supervision, peer-to-peer Coaching, and cultural supervision.	Ongoing	ADON Education Supervision Project Group	Peer-to-peer coaching for Charge Nurses/Midwives commencing 21 March 2022. NETP Group supervision being offered for one hour per week for 12 weeks. All RNs/ENs offered one-to-one supervision of two hours each, with external supervisors. HCAs being offered 2 x 1 hour coaching session over six weeks. The purpose of these initiatives is to reduce stress and anxiety in staff as they face the current COVID surge and retain them in the workforce.	

APPENDIX TWO – CCDM Dashboard December 2022



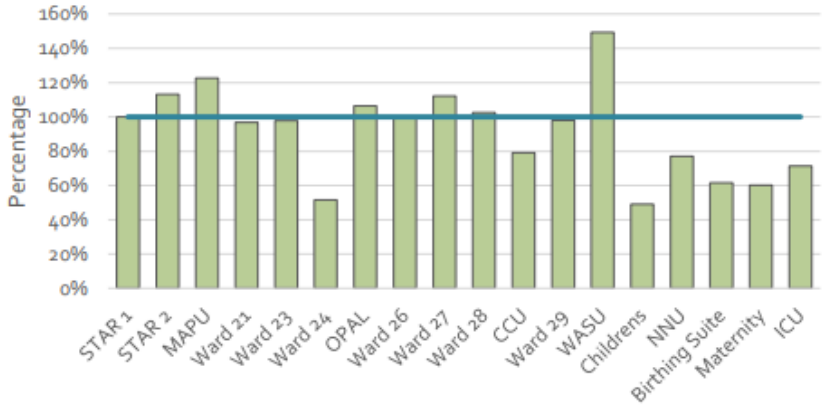
Quality Patient Care

Anticipated Care Rationing Occurrences Trending



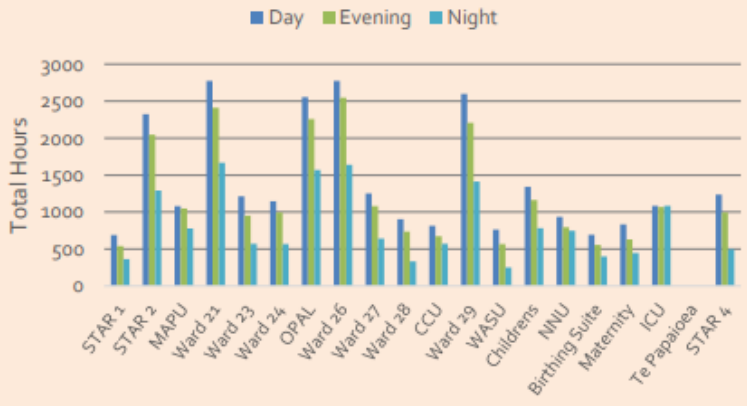
All care that was missed, delayed, sub optimally delivered or inappropriately delegated, as reported by staff. Also defined as 'care left undone' due to lack of time, material resource, poor communication or teamwork.

Ward Bed Utilisation



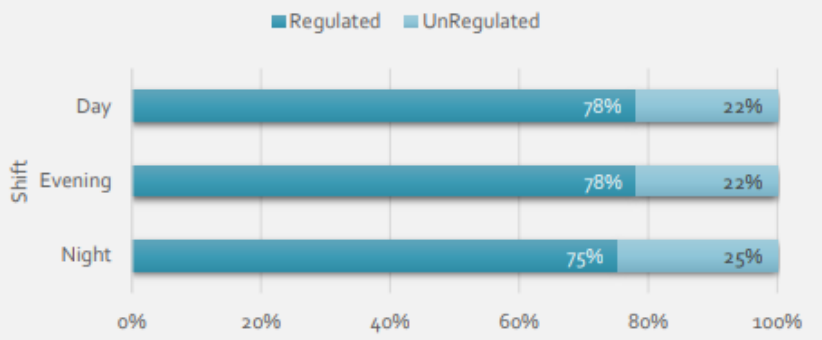
Bed utilisation reflects the throughput of patients during a calendar day – accounting for all discharges, deceased patients, admissions and transfers for the shift on which the patient received care.

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 December 2021

Unplanned Leave

6641.1

Total Hours

7%

Percentage

From Last Month

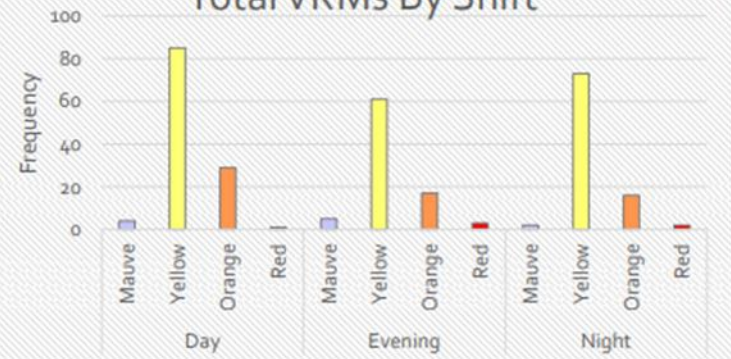
The total unplanned or short notice leave hours taken by staff e.g. sick, domestic, bereavement, ACC. This includes sick leave hours paid, unpaid or paid as annual leave. Includes staff on permanent contracts only.

Roster Gaps

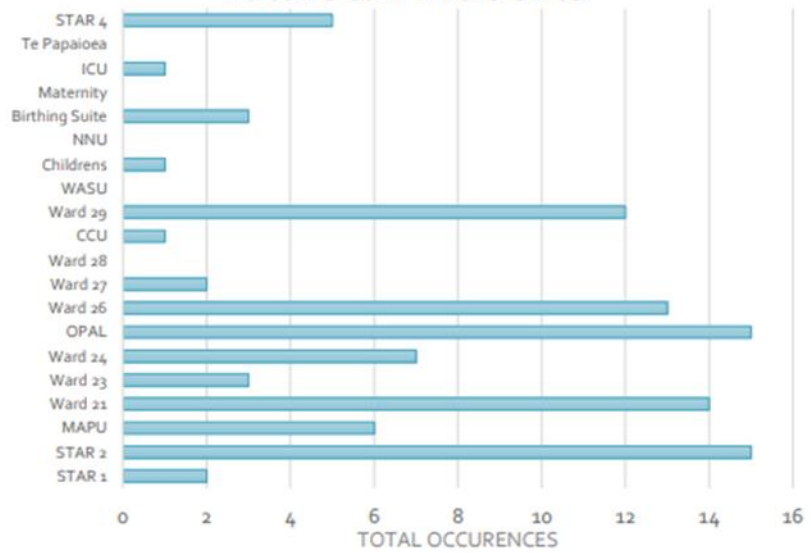
Roster gaps are the degree to which the posted/planned roster matches the roster model.

Staff Unplanned Leave Trending

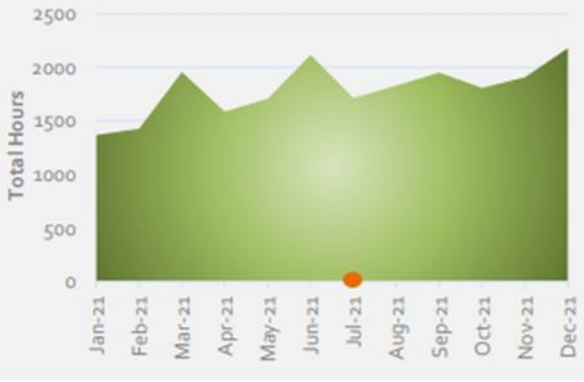
Total VRMs By Shift



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

1,026

Best Use of Health Resources

CCDM Core Data Set for December 2021

Staff Hours

4,614

Total Casual Staff Hours

5%

Casual Staff Percentage

91,472

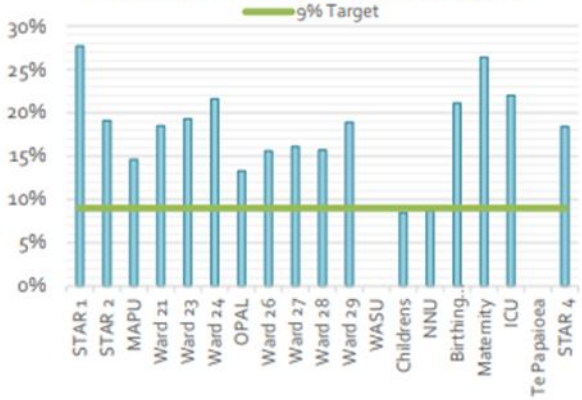
Total Nursing Staff Hours

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



19%

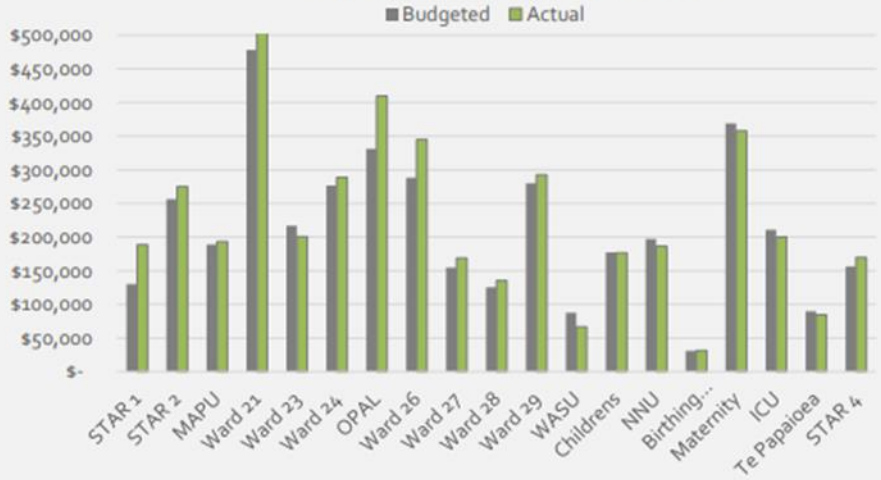
Percentage of Discharges Before 11am

363

Total Number of Patients Discharged Before 11am

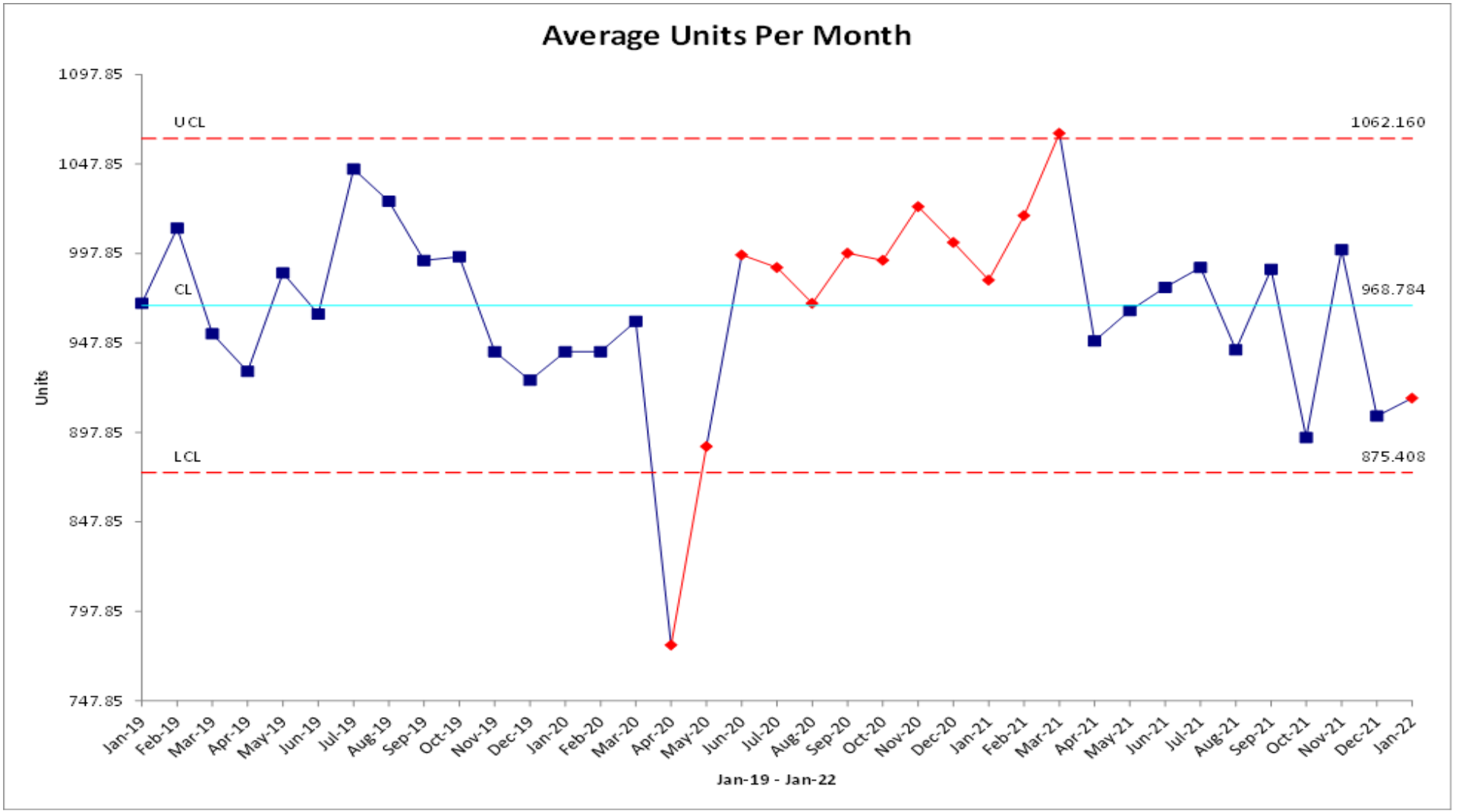
Wards Percentage of Discharges Before 11am Trending

Personnel Costs By Ward

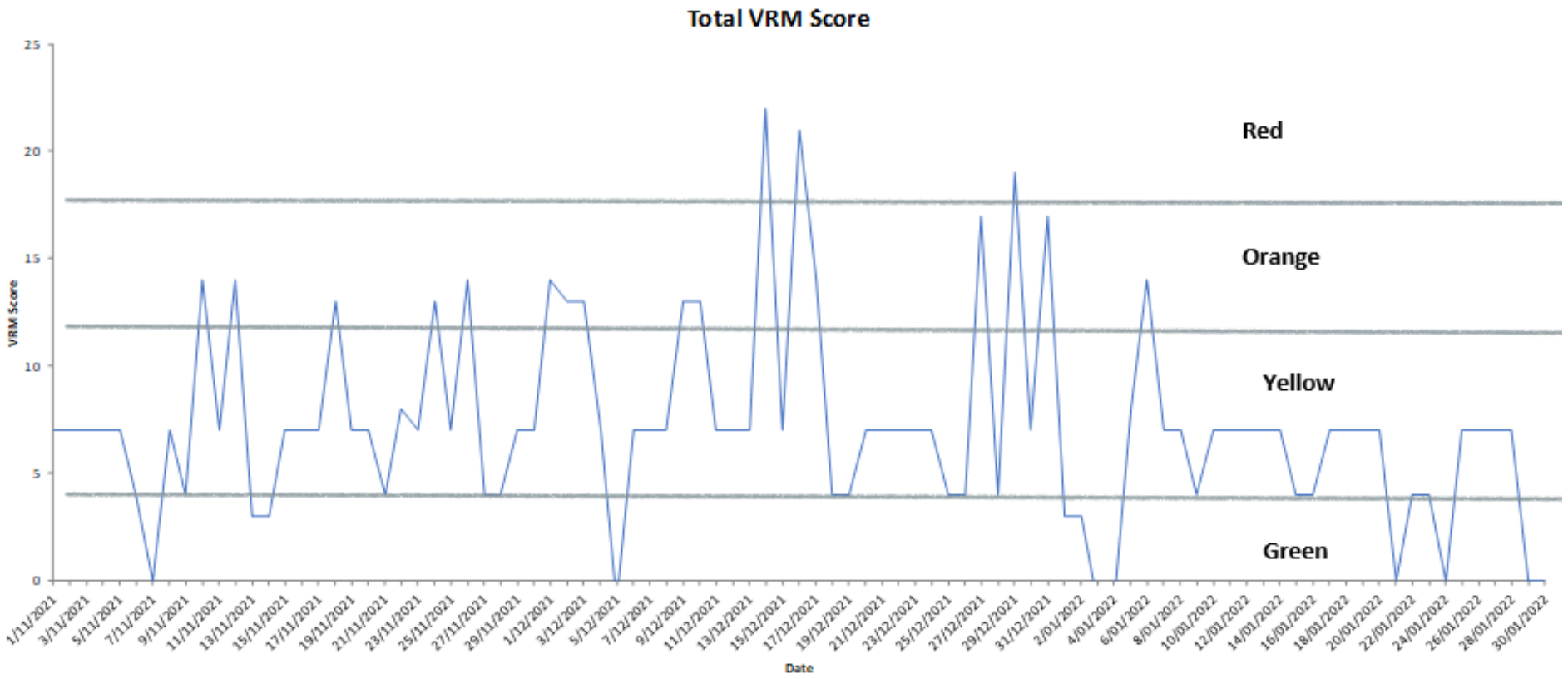


Appendix Three - District Nursing Information

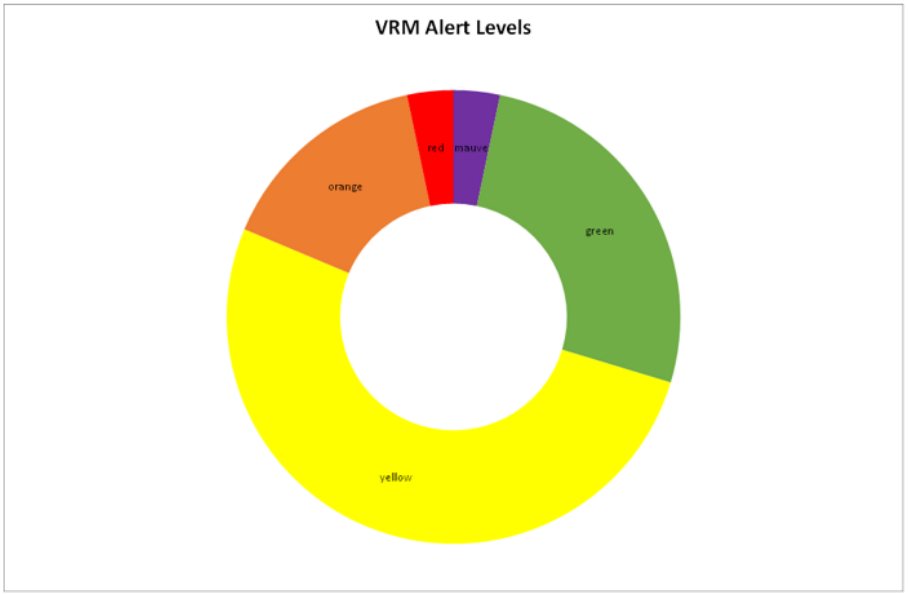
Control chart of the average units of work per month across the whole service.

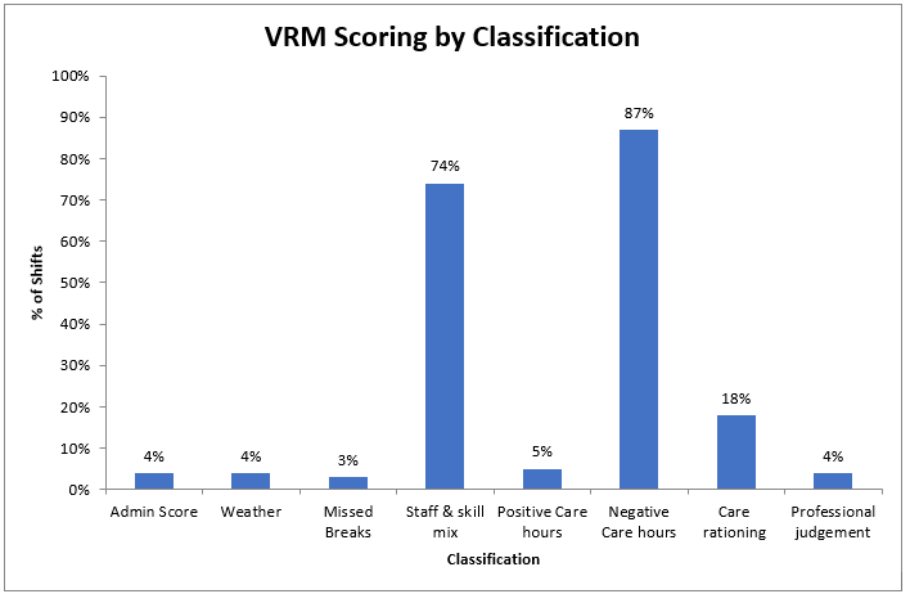


VRM Scoring 01/11 to 30/01



VRM Alert Level 01/11 to 30/01





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 and the actions in place to address them?

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	10 March 2022
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 remains 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 core midwifery FTE confirmed as part of the Care Capacity Demand Management (CCDM) programme.

As expected, and previously reported, the staffing position has not significantly improved, with two midwives remaining on leave without pay (LWOP) and one midwife remaining on non-work related Accident Compensation Corporation (ACC). One Clinical

Midwifery Manager (CMM) has resigned, and one 0.7 FTE midwife has given notice as they will be moving out of the area. These reductions total 2.8 FTE and whilst some changes are temporary, they have had a significant impact on staffing. The midwifery shortfall is mitigated by 14.4 FTE nurses. However, the overall vacancy has increased to 14.18 FTE (excluding CCDM).

Three new graduate midwives commenced on 31 January 2022. The Clinical Coach to support new graduates and return to practice midwives commenced on 10 January 2022. This role is working well with the new graduates and one return to work Midwife. Health Care Assistants and Midwifery Care Assistants have been recruited and commenced duties in January and February 2022.

Two external recruitment companies are engaged to recruit midwives internationally. Recruitment has been confirmed for one overseas midwife, with a tentative start date of May 2022. This has been delayed due to council processes.

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**

Retention payments were paid to all permanently employed midwives in December 2021 and will continue to be paid on a six-monthly basis.

The Antenatal Clinic will relocate to premises previously occupied by the Salt Rooms (below Te Papaioea Birthing Centre) following the signing of a lease agreement in December 2021. Some physical work is in the progress of being undertaken, with the Antenatal Clinic remaining at the Te Papaioea Birthing Centre until the building work is completed.

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 Lead Maternity Careers (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. Two midwives have contracts to work in the primary unit once it is operational. Advertising for the remaining FTE is underway.

In line with the external Director of Midwifery's recommendations, health care assistant (HCA) and lactation consultant hours were increased to support midwifery shortages. However, four HCAs and one lactation consultant left due to the COVID-19 vaccination mandate. The recruitment process to fill these positions has been completed for the HCAs and continues for the lactation consultant.

A draft workforce escalation plan has been developed, with union partnership. This has been shared with the midwifery team, LMC colleagues and the Ministry of Health for feedback. The final document has been confirmed, and work is underway with unions to agree acuity payments.

One formal complaint has been received since the last reporting period regarding communication and what to expect following a difficult delivery. This is being responded to. The Maternity Survey carried out in February received 16 responses, which is an increase compared to the previous reporting period. 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 continues to impact their experience.

There have been two Severity Assessment Code (SAC) 1 incidents in the reporting period; a maternal and foetal death reported as one event and an intrapartum foetal death. These will be investigated as part of the normal SAC process, with family liaisons being assigned. Staff support and debriefs have occurred for both incidents.

Despite staffing challenges, the Maternity Ward achieved the highest ever rate of fully breastfed babies at discharge for the month of January 2022 at 83.2 percent, which is to be commended.

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.

3.3 **Primary/Secondary and Obstetric Interface**

The local primary/secondary interface group paused over the holiday period and has not recommenced due to the Omicron outbreak. This will recommence when business as usual is resumed.

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, the successful candidate for the Kaiaraara Tu Ora – Midwife Specialist role has commenced. 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.

3.4 **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, one for secondary care and one for primary care.
- 24-hour Clinical Midwifery Manager (Associate Charge Midwife) cover for the Birthing Suite to ensure clinical safety on every shift.
- 24-hour Clinical Midwife Coordinator for the Maternity Ward to ensure midwifery leadership on the Maternity Ward on every shift.
- An Equity Lead position for Te Uru Pā Harakeke to strengthen the equity response.

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

No appointment has been made following the Director of Midwifery recruitment process. This role has been readvertised as an Associate Director of Midwifery, with planned interviews deferred until April 2022. The Executive Director of Midwifery maintains professional responsibility for the service at the current time.

Recruitment to the secondary care Midwifery Manager (previously known as Charge Midwife) post is complete.

The CMM (previously known as Associate Charge Midwife) posts were fully recruited to, with a graduated transition into the role agreed as core staffing levels improve. However, with the recent resignation of one of the CMMs this has been readvertised.

The plan to progress Midwifery Coordinators for the Maternity Ward, 24 hours a day has not progressed due to a lack of applications. As an alternative strategy, one Clinical Midwifery Manager role working from Monday to Friday was advertised with no applications received. Following discussion with the Midwifery Employee Representation and Advisory Services (MERAS) Organiser, an advert on the MERAS members page will be placed in March 2022 to try and generate interest in the position.

No successful candidate has been found for the Equity Lead role to date, however Te Uru Pā Harakeke remain committed to this post and are working with Pae Ora Paiaka Whaiora Hauora Māori to achieve a positive outcome.

Leadership training for senior staff was in place, however the course has been cancelled due to the COVID-19 Omicron outbreak. Staff will be reprioritised as soon as this course becomes available.

3.5 **Communications**

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

The Francis Health culture work has been paused due to the COVID-19 Omicron outbreak and staffing shortages. This will be recommenced as soon as possible.

Appendix One: Midwifery Action Plan – June 2021, updated March 2022

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 and 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.	
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.	
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.	
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. LEO course cancelled due	

Action	Target Date	Owner	Update	Status
			to hospital wide cancelling of study leave.	
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.	
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.	
Primary/Secondary interface				
Engage with LMCs regarding primary/secondary interface	Ongoing	Executive Director of Nursing and 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.	
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.	

Action	Target Date	Owner	Update	Status
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. A permanent solution has been found with a move in date yet to be confirmed due to some building alterations required.	
Clinical Safety				
Revisit option for on-call senior midwife at weekends	February 2022	Director of Midwifery	Discussions regarding all senior midwives being on call being discussed with leadership team, no support for this from team.	
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 increased to 2 per shift, impacted by vaccine mandate, recommenced recruitment.	
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. In place by end of January 2022.	
Complete staffing escalation plan	February 2022	Operations Executive	Draft complete shared with all relevant staff and stakeholders.	
Senior Midwifery				
Recruit to vacant senior midwife roles	December 2021	Operations Executive Director of Midwifery	Ongoing	

Action	Target Date	Owner	Update	Status
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	Complete. Current state/desired state work underway.	
Retrain staff re speaking up for safety	September 2021	Director of Midwifery	Information has gone to all staff re speaking for safety encouraging to use etc	
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 2021.	
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 Nursing and Midwifery	Continues as indicated.	

Action	Target Date	Owner	Update	Status
To improve culture across Maternity Services		Operations Executive Clinical Executive Director of Nursing/Midwifery	Work with Francis Health on track.	

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 ongoing. **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 6 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)	
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.	
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 2021.	
Recruit to Kaiaraara Tu Ora, Midwife Specialist role	October 2021	Operations Executive	Position accepted by preferred candidate. Commenced on transition January 2022.	
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 9am to 5pm.	
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 Coordinator due for completion in April 2021. New MQSP coordinator 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 2021 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***	
Midwifery workforce meeting	Ongoing	Operations Executive	Commenced January 2021	
Midwifery Clinical Coach recruitment	October 2021	Operations Lead	Candidate commenced January 2022	
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 six 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 17 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 2022.	
Communication				
Weekly newsletter	Ongoing		Commenced with positive feedback to date.	
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.	

Information papers

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BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is the Board satisfied with progress being made by New Zealand Health Partnerships?

To	Board
Author	Neil Wanden, General Manager, Finance and Corporate Services
Endorsed by	Kathryn Cook, Chief Executive
Date	4 March 2021
Subject	**NZ Health Partnerships Limited Quarterly Update**

RECOMMENDATION

It is recommended that the Board:

- **note** the update on the activities of New Zealand Health Partnerships Limited.

Strategic Alignment

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

1. PURPOSE

To provide the Board with an update on the activities of New Zealand Health Partnerships (NZHP) during the last quarter. This paper is for information only.

2. NATIONAL PROCUREMENT

Appended to this report is a copy of the latest NZHP Business Update.

3. HEALTH SYSTEM CATALOGUE PROGRAMME

The Health System Catalogue remains on track and achieved its first three go-live milestones with two early adopter DHBs, MidCentral and Waikato.

MidCentral went live with the View the Catalogue phase in December 2021 and with the SDR release in January 2022. Waikato DHB went live with View the Catalogue in January 2022.

4. HEALTH TRANSITION UNIT

The FPIM Oracle programme team continues to work to onboard Health New Zealand and the Māori Health Authority on 1 July to meet day one activities.

The Health Transition Unit is also working on banking, insurance, procurement and supply chain as well as asset management.

Appendix One

NZ HEALTH PARTNERSHIPS
MARCH 2022, UPDATE

Hono Oranga Aotearoa NZ Health Partnerships

COVID-19 SUPPORT

Rapid sourcing and supply chain

- NZHP continues to support Ministry of Health (MoH) across a wide range of categories, including respiratory equipment, consumables and accessories, as well as laboratory diagnostic testing consumables.
- MoH has provided additional resource to support COVID-19 procurement activities.

Laboratory equipment and consumables

- A $12.0m cost reduction from July to October 2021 has been achieved by NZHP negotiating a reduced price for Serology testing. Further negotiations will commence during 2022.

NEWS

HEALTH SYSTEM CATALOGUE PROGRAMME

First customers go-live

- The programme achieved its first three go-live milestones with early adopter DHBs, MidCentral and Waikato. MidCentral went live with the View the Catalogue phase in December and with the SDR Release 1 in January. Waikato DHB went live with View the Catalogue in January.
- The programme team is supporting these initial customers during the six-week Early Life Support period, as well as continuing to deliver improvements based on feedback received.

HEALTH TRANSITION UNIT (HTU)

Day 1 Financials

- The FPIM Oracle Programme Team continues to work closely with the HTU to onboard Health NZ (HNZ) and the Māori Health Authority (MHA) to the FPIM application on 1 July, based on minimum viable requirements to meet the Day One activities.

Day 1 Banking and Insurance

- This year's insurance 2022/23 renewal strategy was agreed at the November Marsh DHB Annual Risk and Insurance Forum and was endorsed by the Interim HNZ and MHA boards in December. The strategy included seeking to mitigate property premium increases through a simplified but higher level of excess, which HNZ could absorb due to having a stronger financial position than any individual DHB.
- Activities continue to transition remaining shared service entities to the Shared Banking service ahead of 1 July 2022.

Procurement and Supply Chain

- NZHP has provided subject matter expertise and governance-level support for a paper on the aggregation and transformation of Procurement and Supply Chain presented to the HNZ Board in February.

Asset Management

- A discovery exercise is nearing completion on health system wide Asset Management Information System. This work is being done in collaboration with the MoH / HNZ Health Infrastructure Unit.

our values customer@heart Kiritaki i te manawa | OneTeam Kapa kotahi | Integrity Pono | Results Ngā otinga | Ambition Ngākaunui

NZ HEALTH PARTNERSHIPS
MARCH 2022, UPDATE

UPDATE

FPIM ORACLE PROGRAMME

New customer goes live

- Northland DHB became the most recent customer to join the FPIM solution on 1 February. This is the first northern region DHB to be onboarded. Northland is now supported day-to-day by NZHP's Technology and Operations and Data and Compliance teams.

E-Business Suite Upgrade

- Work continues on the upgrade of the FPIM application from Oracle E-Business Suite (EBS) 12.2.9 to 12.2.11 and the underlying databases from 12.1 to 19C.
- Options are being explored to mitigate the potential risk of the upgrade given the onboarding of Waitematā, Counties Manukau and Auckland DHBs, HNZ and MHA in the same timeframe. This includes splitting the database update and the EBS upgrade.

COVID-19 impact

- The move to the red traffic light setting on the 23 January has seen DHBs restrict the ability for the team to conduct on site activities. Engagements continue using digital technology, although this is not as effective as working alongside local teams.

COMING UP:

- Onboarding activities are continuing for Waitematā ahead of go-live in April with the focus on data migration, deployment planning and training.

NEWS

NATIONAL PROCUREMENT

Benefits

- National Procurement has exceeded the level of benefits set out in the SPE 2021/22 targets for Q1 and Q2. Overall, National Procurement benefits to 31 January 2022 are $9.50m, and COVID-19 and other benefits to date are $17.70m.

Air Filtration Solutions

- With over 4,430 units procured for MIQ facilities, the focus is now on meeting more of the requirements from DHBs from this panel. There is a shortage of units due to a surge in global demand and availability is being monitored on a weekly basis.

NEWS

COLLECTIVE INSURANCE

Collective insurance renewal

- The information-gathering phase is underway for the financial year 2022/23 insurance placement. DHBs and other participating agencies have submitted renewal declaration information to Marsh, with supplementary cyber information also being sought. DHB cover will be expanded to cover all HNZ and MHA activities.

Data and Analytics

The NZHP Data and Analytics (DA) Strategy is complete and has been presented to MoH, as well as the NZHP Board, the FPIM Governance Board, and Procurement and Supply Chain Transition Board, and interim HNZ CFO Rosalie Percival.

Next steps: Funding for the Data and Analytics strategy and roadmap will be discussed with the HTU and Health NZ.

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BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

To	Board
Authors	Celina Eves, Executive Director of Nursing and Midwifery Yvonne Stillwell, Associate Director of Nursing, Nursing Education and Practice Development Lesley Batten, Associate Director of Nursing, Primary, Public and Community Health Adele Small, Strategy and Integration Lead
Endorsed by	Kathryn Cook, Chief Executive
Date	15 March 2022
Subject	**COVID-19 Vaccinator Working Under Supervision (CVWUS)**

RECOMMENDATION

It is recommended that the Board:

- **note** the briefing.

Strategic Alignment

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

1. PURPOSE

To provide an update regarding the COVID-19 Vaccinator Working Under Supervision (CVWUS), in response to an issue raised at the February 2022 Board meeting.

2. BACKGROUND

The CVWUS role was established by the Ministry of Health (the Ministry) to support Aotearoa's COVID-19 vaccine programme. This new class of COVID-19 vaccinators work as non-regulated members of a COVID-19 vaccination team, within a limited scope of practice.

CVWUS can administer the Pfizer COVID-19 vaccine to pre-screened and pre-consented individuals aged 12 years and over, under the indirect direction of a suitably experienced Registered Nurse (RN) Vaccinator (Supervisor). Examples of those suitable to become a CVWUS includes but are not limited to:

- Non-regulated health workers who have health sector experience in support roles.
- Year 1 and 2 nursing students and year 1 and 2 medical students.
- Health professionals with an expired Annual Practising Certificate (APC) for over three years, for example retired practitioners.
- Health professionals who are not registered in New Zealand, for example overseas-trained practitioners.

The CVWUS workforce is ideally positioned to work in teams with a consistent membership that can provide the necessary support, guidance and supervision, and can undertake the tasks that a CVWUS cannot. A key strength of this new role is that it enables a diverse range of individuals to be involved in vaccination and particularly draws on the relationships the CVWUS already has within their communities to improve the vaccination uptake.

The Ministry were aware of the under-representation of Māori workers within the COVID-19 vaccination programme and understood that increasing the Māori workforce would support Māori vaccination uptake. Therefore, the CVWUS workforce initiative has increased the ethnic representation of the vaccination workforce and specifically supported iwi and Māori providers to increase the capacity of its vaccinating workforce by utilising current non-regulated staff in a new role.

Whilst consumer flow needs to be designed to work with the specific limitations on this workforce, the CVWUS workforce can work well in all sizes of COVID-19 vaccination clinics with appropriate staff and support in place.

CVWUS can undertake activities such as vaccinating most of the population that are 12 years and over with Pfizer and supporting the post vaccination observation of consumers. The current recommended ratio is up to six CVWUS to one supervisor.

The limitations within the scope of the CVWUS are to:

- draw up any vaccine
- gain consent from consumers
- health screen consumers for suitability of receiving vaccine
- only administer the Pfizer vaccine
- vaccinate under 12-year-olds
- vaccinate those with a history of anaphylaxis.

3. WORKFORCE RECRUITMENT

There are 21 fully trained CVWUS working across the district, with a further 22 in training (T=43). These vaccinators are working with the Māori and iwi engagement teams across the district and in MDHB sites. THINK Hauora are recruiting to these roles for their Pasifika team.

The Nurse Educator Primary Health Care, Chey Ratima, has coordinated this training programme. In November, Chey was sponsored by the Māori Women's Welfare League to become a certified resuscitation instructor and gifted a Family Resuscitation Simulation Training pack so that she could upskill iwi and Māori provider kaimahi in resuscitation as part of their vaccinator training and award them a recognised qualification.

CVWUS are also supported with further training/upskilling opportunities so they can meet legislative requirements and understand how to work safely in clinical environments. As of February 2022, CVWUS are now able to receive nine micro-credentials from the New Zealand Qualifications Authority (NZQA) in recognition of this qualification.

The CVWUS training is continuing in 2022 with further Māori kaimahi keen to embrace the opportunity to upskill and support their communities. Due to Chey's role change this year and capacity within the DHB's iwi and Māori partnership team for the COVID-19 response, Te Tihi have been engaged to lead this training. Whilst Te Tihi are leading the engagement with iwi and Māori providers and their kaimahi, they continue to work in conjunction with Chey, who delivers the CPR component.

4. NEXT STEPS

MDHB is looking at recruiting to the Health Care Assistant workforce, to support the COVID-19 response. We are working with Careerforce so that they can gain a recognised qualification.

The Organisational Leadership Team has provided an additional 9 FTE, with this workforce being able to be deployed to:

- welcoming visitors and conducting COVID-19 screening procedures
- COVID-19 testing programme
- COVID-19 Vaccinator – Working Under Supervision (CVWUS) roles.

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the Board have confidence that the OIA is now being used correctly to exclude members of the public from meetings?

To	Board
Author	Kathryn Cook, Chief Executive
Endorsed by	
Date	7 March 2022
Subject	**Use of the Official Information Act 1982 to exclude the public from meetings**

RECOMMENDATION

It is recommended that the Board:

- **note** the report on the use of the Official Information Act 1982 to exclude the public from meetings.

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 update the Board on the investigation on the use of the Official Information Act 1982 (OIA) section 9(2)(g)(i) to exclude the public from Board meetings.

2. BACKGROUND

At a meeting of the Medical Reference Group (MRG) held on 9 February 2022, Dr Colin Thompson raised an issue around the incorrect use of the OIA section 9(2)(g)(i) to exclude the public from Board meetings. He advised that MidCentral District Health Board (MDHB) had used this section over 50 times since July 2020 to exclude the public; and that this was contrary to the New Zealand Public Health and Disability Act 2000.

A copy of information provided by Dr Thompson at that meeting is included as Appendix One.

I offered to investigate the matter and report back to the Board and the MRG.

3. RELEVANT LEGISLATION

3.1. Official Information Act 1982

Section 9(2)(g)(i) states that the public can be excluded "To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of the organisation or officers and employees of any public service agency or organisation in the course of their duty."

3.2. NZ Public Health and Disability Act 2000

A copy of clause 32, which outlines the 'Right of the board to exclude public' is included as Appendix Two.

As pointed out by Dr Thompson, clause 32(a) notes that under this legislation, the public cannot be excluded from district health board meetings under section 9(2)(g)(i) of the OIA.

4. INVESTIGATION

A review has been carried out of all Board papers since July 2020 where section 9(2)(g)(i) of the OIA has been used as a reason to exclude the public from meetings. This review showed that this section has been used incorrectly as the result of a procedural error. It was not intended to avoid transparency around matters discussed by the Board.

Appendix Three shows that section 9(2)(g)(i) of the OIA has been used 27 times since July 2020. The schedule also shows that the decision to exclude members of the public from the meetings was correct – but the wrong section of the OIA was used as the reason.

5. ACTION TAKEN

A response was sent to the Chair of the Combined Medical Staff Association and Dr Colin Thompson on 18 February, outlining the investigation that was carried out and the findings.

The error in using the incorrect section of the OIA has been acknowledged, an apology offered and an assurance given that this section will not be used in future. Dr Thompson has been thanked for raising the issue and providing an opportunity to correct our processes.

MidCentral District Health Board and Management Transparency

Transparency in publicly funded crown entities is important and an expectation of the New Zealand Government [1]. 'Open and honest conversations' are included in the agreed actions of the MDHB Combined Medical Staff and Executive Action Plan.

Official Information Act 1982 (OIA)[3]

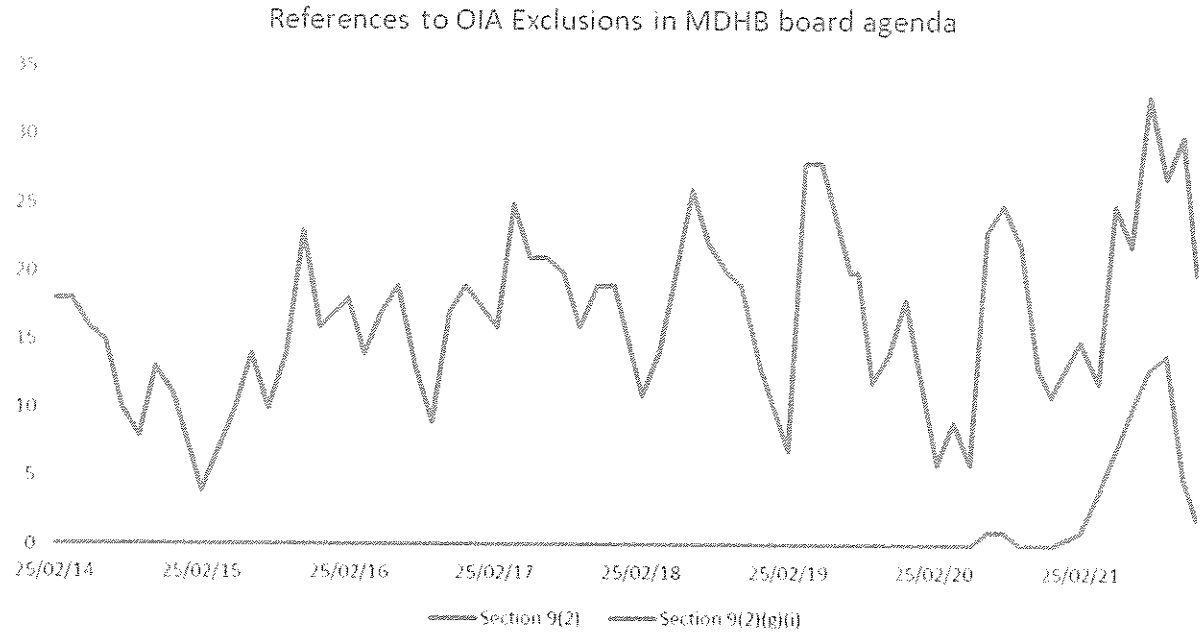
1. The principle of availability: Information should be made available unless there is a good reason for withholding it (OIA Section 5)[5].
2. Information may be withheld if, and only if, it is necessary to[6]:
    a. Section 9(2)(a): protect the privacy of natural persons; or
    b. Section 9(2)(f): maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials; or
    c. Section 9(2)(i): maintain the effective conduct of public affairs through—the 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; or
    d. Section 9(2)(h): maintain legal professional privilege; or
    e. Section 9(2)(j): enable a Minister of the Crown or any public service agency or organisation holding the information to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).

New Zealand Public Health and Disability Act 2000 (NZPHDA) [2]

1. A district health board may exclude the public on the grounds that the public conduct would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7, or 9 of the OIA.
2. However, NZPHDA Schedule 3 Clause 32(a)[2] says that the right to exclude the public does not extend to the OIA 1982 Section 9(2)(g)(i)) (see above) .

Since July 2020 Board Minutes have referred to OIA 1982 Section 9(2)(g)(i) over 50 times as the reason for excluding the public or non-publication of Minutes. The most frequent application of Section 9(2)(g)(i) has been for midwifery and nursing workforce updates, but also for the Health and Disability Review, Health Sector Reforms, Draft Capital Expenditure Plans, Combined Medical Staff Action Plans, Annual Reports, the Acute Mental Health Unit and a 'Board Only time'[4]. The frequency that MDHB has used other sections of the OIA to withhold information has also increased recently (figure).

Opinion. NZPHDA Section 3 Clause 32(a) suggests MDHB may not use OIA Section 9(2)(g)(i) to exclude members of the public, and therefore public reporting. The principle of availability requires a high level of transparency. This is needed for public accountability, is central to the OIA legislation, is fully supported by the NZPHDA and is a clear expectation of the government. If there is no good reason backed by legislation to withhold information then it is required to be made available to the public.



C Thompson

14.1.22

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30 Supplementary procedure

A board may regulate its procedure, at its meetings and otherwise, in any manner not inconsistent with this Act it thinks fit.

Admission of public

31 Admission of public

Except as provided in clauses 32 to 35, every meeting of a board must be open to the public.

Compare: 1987 No 174 s 47

32 Right of board to exclude public

A board may by resolution exclude the public from the whole or any part of any meeting of the board only on 1 or more of the following grounds:

(a) that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982:

(b) that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information the public disclosure of which would—

(i) be contrary to the provisions of a specified enactment; or

(ii) constitute contempt of court or of the House of Representatives:

(c) that the purpose of the whole or the relevant part of the meeting is to consider a recommendation of an Ombudsman made under section 30(1) or section 35(2) of the Official Information Act 1982 to the board:

(d) that the purpose of the whole or the relevant part of the meeting is to consider a communication from the Privacy Commissioner arising out of an investigation under Part 5 of the Privacy Act 2020:

(e) that the exclusion of the public from the whole or the relevant part of the meeting is necessary to enable the board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) are established in relation to all or any part of any meeting of the board.

Compare: 1987 No 174 s 48(1)

Schedule 3 clause 32(d): amended, on 1 December 2020, by section 217 of the Privacy Act 2020 (2020 No 31).

33 Resolution excluding public

(1) Every resolution excluding the public from any meeting of a board must state—

Exclusion of the public – OIA section 9(2)(g)(i) used

7 July 2020	Health and Disability System Review	Should have been 9(2)(f)(iv)
23 February 2021	Midwifery Workforce Report – Workshop	Should have been 9(2)(ba)
13 April 2021	Midwifery Workforce Report – Workshop	Should have been 9(2)(f)(iv)
13 April 2021	Nursing Workforce Engagement – Workshop	Should have been 9(2)(ba)
25 May 2021	Government's Budget 2021	Should have been 9(2)(f)(iv)
25 May 2021	Midwifery Workforce Report	Should have been 9(2)(j)
25 May 2021	Nursing Workforce Update	Should have been 9(2)(j)
25 May 2021	Health and Disability System Review	Should have been 9(2)(f)(iv)
15 June 2021	2021/22 Annual Plan and Budget	Was also excluded under section 9(2)(j)
6 July 2021	Midwifery Workforce Update	Should have been 9(2)(j)
6 July 2021	Nursing Workforce Update	Should have been 9(2)(j)
6 July 2021	Medical Workforce Workshop	Should have been 9(2)(ba)
6 July 2021	Board only time	Used in error – box usually blank
17 August 2021	CMS and Executive Action Plan	Should have been 9(2)(ba)
17 August 2021	Midwifery Workforce Update	Should have been 9(2)(j)
17 August 2021	Nursing Workforce Update	Should have been 9(2)(j)
17 August 2021	Draft Capital Expenditure Plan	Should have been 9(2)(j)

17 August 2021	Final Draft Budget and Annual Plan 2021/22	Should have been 9(2)(j)
17 August 2021	Health Sector Reforms – Transition Plan MDHB	Should have been 9(2)(f)(iv)
17 August 2021	Board only time	Used in error – box usually blank
28 September 2021	CMS and Executive Action Plan	Should have been 9(2)(ba)
28 September 2021	MDHB 2020/21 Draft Ann Report and Fin Stms	Should have been 9(2)(j)
28 September 2021	Enable NZ 2020/21 Draft Annual Report	Should have been 9(2)(j)
28 September 2021	Budget and Annual Plan 2021/22 Update	Should have been 9(2)(j)
28 September 2021	Board only time	Used in error – box usually blank
9 November 2021	2020/21 Annual Report and FinancialStatements Update	Should have been 9(2)(j)
14 December 2021	Allied Health Workshop	Should have been 9(2)(ba)

9(2)(ba)
To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under theauthority of enactment

9(2)(g)(i)
To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crownor members of an organisation or officers and employees of any public service agency or organisation in the course of their duty

9(2)(f)(iv)
To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown andofficials

9(2)(j)
To protect negotiations, including commercial and industrial

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	17 March 2022
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. 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. A number of items on the work programme are due after the disestablishment of the Board on 30 June 2022. These are still shown on the work programme for information only.

Psychosocial Wellbeing Strategy
This has been developed into a plan, which will be presented to Manawhenua Hauora for feedback. It will then be provided to the Board for information only.

Individual Employment Agreement Remuneration Parameters
This was approved at the Board's February meeting.

Board to Board hui
The quarterly hui scheduled for February was cancelled due to COVID-19 meeting restrictions.

Professional Work Groups – Nursing and Midwifery
The workshop has been deferred. It is important that staff are able to engage face-to-face with Board members and due to COVID-19 restrictions, this Board meeting is being held via Zoom only. As we are expecting the COVID-19 Omicron peak in March/April, it is important that all available clinical staff are working 'on the floor'.

Contract Renewal and Planning Outcomes Framework
This report is provided to the Board each year and is due to be presented to the May meeting. At the Finance, Risk and Audit Committee meeting in February, it was agreed it was inappropriate for the Board to approve contracts that will become the responsibility of Health New Zealand. Therefore this item has been removed from the work programme.

All other reporting is occurring in line with the work programme.

MidCentral District Health Board Work Programme	Frequency	Feb	Mar	May	June	Responsibility
Key updates						
Chief Executive's Report to provide an update on key progress of the DHB	Each meeting	**X**	**X**	**X**	**X**	**CEO**
FRAC Minutes and verbal update from the FRAC Chair to update the Board on key Committee discussions	Each meeting	**X** Nov/Feb	**X** Mar	**X** Apr	**X** June	**FRAC Chair**
HDAC Minutes and verbal update from the HDAC Chair to update the Board on key Committee discussions	Following HDAC mtg		**X** Mar		**X** May	**HDAC Chair**
Strategy and Planning						
Health Sector Reforms – Transition Plan for MDHB to update the Board on planning and priorities to support the smooth transition to Health New Zealand and the Māori Health Authority	Each meeting	**X**	**X**	**X**	**X**	**GM SPP**
Contract Renewal and Planning Outcomes Framework to update Board on review of planning outcomes achieved and general approach to contracting for the year ahead	Annual			**X**		**GM SPP**
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	Part of Transition Plan report					**GM SPP and GM F&CS**
Workforce Strategy to establish/review the strategy, based on the national framework (support the execution of the DHB's Strategy)	Triennial (due 2023)					**GM P&C**
Organisational Development Plan to review/refresh (relevant and supports the execution of the DHB's Strategy)	Triennial (due Nov 2022)					**GM P&C**
Quality improvement						
Quality Account to determine the Quality Account for the financial year (via HDAC)	Annual (due Dec)					**GM Q&I**
Quality and Safety Walk-rounds to provide the Board with a summary of the walk-rounds over the last 12 months	Annual			**X**		**GM Q&I**
Workforce						
Health, Safety and Wellbeing to monitor the implementation of the H&S Strategy, mitigations required, priorities for the future, including investment	Quarterly	**X**		**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**		**GM P&C**
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**				**ED N&M**

MidCentral District Health Board Work Programme	Frequency	Feb	Mar	May	June	Responsibility
IEA Remuneration Parameters to consider the remuneration parameters for annual changes to staff on IEA agreements (following Remuneration Committee)	Annual		**X**			**GM P&C**
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 March 2023)					**GM P&C**
Health and Safety Workshop	Annual (due Nov)					**GM P&C**
Preventing Occupational Violence Strategy to monitor the implementation, priorities, investment and adequacy of any mitigations	Part of H&S report					**GM P&C**
Performance						
Financial Performance to monitor 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	Each meeting	**X**	**X**	**X**	**X**	**GM F&CS**
DHB Performance Metrics (aka Board KPI/HSI Dashboard) to monitor high level KPIs/Hospital System Indicators across the DHB	Quarterly	**X**		**X**		**GM SPP**
Digital Strategy – implementation of roadmap to monitor implementation, challenges and opportunities, priorities and initiatives/investments for the future, and confirm the appropriateness of any mitigations	Each meeting	**X**	**X**	**X**	**X**	**CDO**
Sustainability Plan to monitor the implementation of the performance improvement programme	Each meeting	**X**	**X**	**X**	**X**	**GM Q&I**
Non-Financial Performance Measures to monitor the overall performance of the DHB	Quarterly		**X** Q2			**GM SPP**
CEO's Performance Review	Annual			**X**		**Chair**
Audit						
Enable New Zealand Limited Annual Reporting Arrangements to determine annual reporting requirements of this paper company	Annual			**X**		**GM F&CS**
Annual Accounts to determine the annual accounts for the financial year and to determine Enable NZ Limited annual reporting requirements	Annual (due Sept)					**GM F&CS**
Year-end Audit Process (Government) to determine year-end financial result for inclusion in Government accounts	Annual (due July)					**GM F&CS**
Iwi Partnerships						
Manawhenua Hauora Update to update the Board on the Manawhenua Hauora discussions	Each meeting	**X**	**X**	**X**	**X**	**MWH Chair**
Board to Board Hui to monitor progress against shared work programme, including opportunities and challenges	Quarterly	**X**		**X**		**GM M**
Memorandum of Understanding to review the Memorandum of Understanding	Triennial – not required					**GM M**
MDHB and Manawhenua Hauora Joint Work Programme to monitor progress against shared work programme, including opportunities and challenges	Six-monthly			**X**		**GM M**

MidCentral District Health Board Work Programme	Frequency	Feb	Mar	May	June	Responsibility
Partnership						
Clinical Council to consider the work, findings and recommendations from the Clinical Council, provide endorsement or support as required	Six-monthly	**X**				**GM Q&I**
Consumer Council to consider the work, findings and recommendations from the Consumer Council, provide endorsement or support as required	Six-monthly	**X**				**GM Q&I**
Professional Work Groups Professional group to meet with Board	Four-monthly		**ED N&M**			**Prof Leads**
Governance of Shareholding Companies						
to monitor the annual results and plans of shareholding companies and determine actions in respect of AGM recommendations						
NZ Health Partnerships Limited	Quarterly		**X**			**GM F&CS**
Allied Laundry Services Limited	Annual (Nov)					**GM F&CS**
Technical Advisory Services Limited AGM (DHB Shared Services)	Annual (Nov)					**GM SPP**
Regional Services Plan to approve the draft and final regional budget and priorities	Annual (July)					**GM SPP**
Board Governance Arrangements						
Board Governance arrangements and Committee Terms of Reference	Triennial or as required					**Chair**
Annual Reporting Framework (Work Programme)	Annual (Nov)					**CEO**
Annual Board Evaluation	Annual (Nov)					**GM P&C**
Annual Meeting Schedule	Annual (Aug)					**CEO**
Committee Membership	Triennial					**Chair**
External Committee Membership and Appointments	Triennial					**Chair**
Te Tiriti o Waitangi	Triennial					**GM M**
Review of Board policies Review of policies related to the Board or those requiring Board approval	As required					**CEO**

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 17 March 2022

Date	Time	Topic
15 February 2022	Following Board meeting	Manawhenua Hauora Board to Board hui *(cancelled due to COVID-19 restrictions)*
1 March 2022	Following HDAC meeting	Consumer Story
29 March 2022	Following Board meeting	Acute Mental Health Unit
16 May 2022	Following Manawhenua Hauora hui	Manawhenua Hauora Board to Board hui
TBA	TBA – half day	Wall Walk *(postponed from 28 January 2022 due to COVID-19 restrictions)*

Glossary of terms

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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**
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**
AMHU	**Acute Mental Health Unit**
Anti- VEGF	**Anti-Vascular Endothelial Growth Factor**
AoG	**All of Government**
AP	**Annual Plan** The organisation's plan for the year.
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**
AWS	**Amazon Web Services**
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.
CCTV	**Closed Circuit Television**
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)**
CNGP	**Carbon Neutral Government Programme**
CNM	**Clinical Nurse Manager**
CNS	**Clinical Nurse Specialist**
COI	**Committee of Inquiry**
ComM	**Communications Manager**
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	**Computer 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.
CTAS	**Central Technical Advisory Services** (also TAS)

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**
DS	**Digital Services**
DSA	**Detailed Seismic Assessment**
DSA	**Digital Subtraction Angiography**
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**
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.
ETA	Energy Transition Accelerator
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**
FSL	**Fire Service Levies**
FTE	**Full Time Equivalent** The hours worked by one employee on a full-time basis.
FU	**Follow Up**
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**
HQSC	**Health, Quality and Safety Commission**
HR	**Human Resources**
HRC	**Health Research Council**
HRIS	**Human Resources Information System**
HROD	**Human Resources and Organisational Development**
HSWA	**Health and Safety at Work Act**
Hui	**Formal meeting**
HV	**High Voltage**
HVAC	**Heating, Ventilation and Air Conditioning**
HVDHB	**Hutt Valley District Health Board**

HWIP	**Health Workforce Information Programme**
HWNZ	**Health Workforce New Zealand**
IA	**Internal Audit**
IAAS	**Infrastructure as a Service**
IAP	**Incident Action Plans**
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**
Insourced	**Delivered directly by the DHBs via its staff**
IOC	**Integrated Operations Centre**
IOL	**Intraocular Lens**
IOT	**Internet of Things**

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**
LED	**Light Emitting Diode**
LEO	**Leading an Empowered Organisation**
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**
MBIE	**Ministry of Business, Innovation and Employment**

MCH	**MidCentral Health**
MCIS	**Maternity Clinical Information Service**
MDBI	**Material Damage and Business Interruption**
MDHB	**MidCentral District Health Board**
MDM	**Master Data Management**
MDT	**Multi-disciplinary Team**
MECAs	**Multi Employer Collective Agreements**
MEED	**Midwifery External Education and Development Committee**
MERAS	**Midwifery Employee Representation and Advisory Service**
MFA	**Multi-Factor Authentication**
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**
MRES	**Managed Rehabilitation Equipment Service** An ACC contract (Enable NZ)
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**
NCEA	**National Certificate of Educational Achievement**
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**
NHAWG	**National Holidays Act Working Group**
NNU	**Neo Natal Unit**
NOS	**National Oracle Solution**
NP	**Nurse Practitioner**
NPC	**Nurse Practitioner Candidate**
NPTP	**Nurse Practitioner Training Programme**
NZ	**New Zealand**
NZCOM	**New Zealand College of Midwives**
NZCPHCN	**New Zealand College of Primary Health Care Nurses**
NZCRMP	**New Zealand Code of Radiology Management Practice**
NZD	**New Zealand Dollar**
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**
O&G	**Obstetrics and Gynaecology**
OAG	**Office of the Auditor-General**
OD	**Organisational Development**
ODP	**Organisational Development Plan**
OE	**Operations Executive** (of a service)
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.
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**
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.
PNCC	**Palmerston North City Council**
POAC	**Primary Options for Acute Care**
POCT	**Point of Care Testing**
PPE	**Personal Protective Equipment**
Powhiri	**Formal Māori Welcome**
PPA	**Promoting Professional Accountability**
PPC	**Public, Primary and Community**
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**
PSe	**PS Enterprise**
PSR	**Protective Security Requirements**
PVC	**Poly Vinyl Chloride**
QEAC	**Quality & Excellence Advisory Committee**
QHP	**Qualified Health Plan**
Qlik	**Qlik Sense Data Visualisation Software (Dashboard Analytics)**
Q&SM	**Quality and Safety Markers**
RACMA	**Royal Australasian College of Medical Administrators**
RDHS	**Regional Digital Health Services**
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)**
RP	**Risk Priority**
RSI	**Relative Stay Index**
RSO	**Research Support Officer**
RSP	**Regional Service Plan**
RTL	**Round Trip Logistics** A technology platform.
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**
SFIA	**Skills Framework for the Information Age**
SGOC	**Shared Goals of Care**
SIEM	**Security Information Event Monitoring**
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**
SOR	**Standard Operating Responses**
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)
SSDF	**State Sector Decarbonisation Fund**
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** (also CTAS)
TCO	**Total Cost of Ownership**
tC02e	**tons of carbon dioxide equivalent**
TCU	**Transitional Care Unit**
THG	**Tararua Health Group Limited**
TKMPSC	**Te Kawa Maataho Public Service Commission** (formerly State Services Commission)
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**
Y	**Yes**
YD	**Yes and delegable**
YOSS	**Youth One Stop Shop**

YTD	Year To Date

Late items

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Late items

Discussion on any late items advised at the start of the meeting

Date of next meeting

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Date of next meeting

Tuesday, 10 May 2022

Exclusion of the public

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Exclusion of public

Resolution:

That the public be excluded from this meeting in accordance with the Official Information Act 1982, section 9 for the following items for the reasons outlined in the agenda.