MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Part One Board Pack

6 July 2021

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

Contents

AGENDA AND KARAKIA

6 July 2021

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MidCentral District Health Board

Board Meeting

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

When: Tuesday 6 July 2021, from 9.00am

PART ONE

Members

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

Apologies

In attendance

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

In attendance (part meeting)

Item 4.2	Kelly Isles, Director of Strategy
Items 4.3, 4.4	Neil Wanden, General Manager, Finance and Corporate Services; Darryl Ratana, Deputy Chief Financial Officer
Item 4.5	Judith Catherwood, General Manager, Quality and Innovation
Item 4.6	Steve Miller, Chief Digital Officer; Clive Martis, Director Digital Services
Item 4.7	Kelly Isles, Director of Strategy
Items 5.1, 5.2	Neil Wanden, General Manager, Finance and Corporate Services
Item 5.3	Wayne Blissett, Operations Executive, Pae Ora Paiaka Whaiora
Item 5.4	Keyur Anjaria, General Manager, People and Culture
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 – 25 May 2021, Part One

2.5. Minutes of Board and Finance, Risk and Audit Committee (FRAC) conjoint meeting – 15 June 2021, Part One

2.6. Matters arising

2.7. Verbal report from Board Chair

2.8. FRAC – Verbal report from Committee Chair and Minutes of FRAC meeting held on 15 June 2021, Part One

2.9. Manawhenua Hauora Chair's Report

3. STRATEGIC FOCUS

Discussion in Part Two

4. PERFORMANCE REPORTING 9.15

4.1. Chief Executive's Report

4.2. Board KPI Dashboard

4.3. Finance Update – May 2021

4.4. Finance Report – April 2021

4.5. Sustainability Plan

4.6. Te Awa Update – Digital Services Work Programme

4.7. Non-Financial Performance Measures – Quarter Three

REFRESHMENT BREAK 10.00

5. DISCUSSION/DECISION PAPERS 10.15

5.1. Year-end Audit Process

5.2. Fraud, Theft and Corrupt Actions Prevention Policy

5.3. Manawhenua Hauora and MDHB Shared Work Plan 2021/22

5.4. Psychosocial Wellbeing Strategy

6. INFORMATION PAPERS 10.45

Information papers for the Board to note

6.1. NZ Health Partnerships – Quarterly Report

6.2. Board Work Programme

7. GLOSSARY OF TERMS

8. LATE ITEMS

9. DATE OF NEXT MEETING – Tuesday 17 August 2021

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 25 May 2021	
2021/22 Budget	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Midwifery Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Nursing Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Acute Services Block and Re-lifing of Clinical Services Block	To protect negotiations, including commercial and industrial	9(2)(j)
Print Technology and Associated Services	To protect negotiations, including commercial and industrial	9(2)(j)
Upgrade of Water Systems, Palmerston North Hospital	To protect negotiations, including commercial and industrial	9(2)(j)
Step-down facility, Mental Health and Addiction Services	To protect negotiations, including commercial and industrial	9(2)(j)
Workshop – Medical Workforce	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Board only time	No decision sought	9(2)(g)(i)
'In committee' minutes of the previous Finance, Risk and Audit Committee meeting	**For reasons set out in the agenda of the FRAC meeting held on 15 June 2021**	

ADMINISTRATIVE MATTERS

6 July 2021

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Apologies

Any apologies to be noted?

Late items

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

Register of Interests: Summary, 15 June 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Board Members		
Name	**Date**	**Nature of Interest / Company/Organisation**
Browning, Heather	4.11.19	Director – HB Partners Limited
		Member – MidCentral Governance Group Mana Whaikaha
		Board Member and Chair, HR Committee – Workbridge
	26.7.20	Director and Shareholder – Mana Whaikaha Ltd
	23.10.20	Member – Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group
	9.2.21	Project Manager to lead Mana Whaikaha out of the Ministry of Health; stood down from appointed role of Deputy Chair of the MidCentral Governance Group for the MidCentral prototype
		Resigned as Director of Mana Whaikaha Ltd – effective from December 2020
Duffy, Brendan	3.8.17	Chair and Commissioner – Local Government Commission
		Member – Representation Commission
		Chairperson – Business Kapiti Horowhenua Inc (BKH)
Dennison, Vaughan	4.2.20	Councillor – Palmerston North City Council
	9.2.21	Member of Palmerston North City Council Infrastructure Committee
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
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
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)
Naylor, Karen	6.12.10	Employee – MidCentral DHB
		Member and Workplace Delegate – NZ Nurses Organisation
	9.10.16	Councillor – Palmerston North City Council

Register of Interests: Summary, 15 June 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Paewai, Oriana	1.5.10 13.6.17 30.8.18 13.4.21	Member – Te Runanga o Raukawa Governance Group Chair – Manawhenua Hauora Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs) Member Nga Manu Taiko, a standing committee of the Council – Manawatu District Council Member – Te Tihi o Ruahine Whānau Ora Alliance Board Member – Cancer Society Manawatu Appointed Member – Massey University Council Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board Member – Governance Board, Mana Whaikaha
Waldon, John	22.11.18 9.2.21	Co-director and co-owner – Churchyard Physiotherapy Ltd Co-director and researcher – 2 Tama Limited Manawatu District President – Cancer Society Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society Has a contract with UCOL
Warren, Jenny	6.11.19 12.2.21	Team Leader Bumps to Babies – Barnardos New Zealand Consumer Representatives National Executive Committee – National On Track Network Pregnancy & Parenting Education Contractor – Palmerston North Parents' Centre Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
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 14.8.16 14.8.16 7.10.19	Independent Director – Otaki Family Medicine Ltd Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company) Younger son is news director for Stuff.co.nz – Fairfax Media Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP)
Munro, Gail (HDAC)	23.3.21	Director – Eastern and Central Trust 2020 Governance Strategies Ltd 2007
Management		
Cook, Kathryn	13.4.21	Nil
Ambridge, Scott	20.8.10	Nil

Register of Interests: Summary, 15 June 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
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)
Bradnock, Barb	26.8.10	Nil
Brogden, Greg	16.2.16	Nil
Brown, Jeff		TBA
Caldwell, Vanessa	7.5.18	Nil
Catherwood, Judith	1.5.18	Nil
Davies, Deborah	18.5.18	Member, Alliance Leadership Team – Central PHO Daughter is an employee and works within hospital services – MidCentral DHB
Eves, Celina	14.5.18 20.4.20	Owner personal consulting company, UK – Celina Eves Limited (2020 moved into dormancy) Trustee – Palmerston North Medical Trust
Fenwick, Sarah	13.8.18	Nil
Free, Jennifer	6.8.20	Nil
Hansen, Chiquita	9.2.16 3.3.21	Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB CEO – Central PHO Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths Husband is employed by MidCentral DHB Executive member of General Practice New Zealand (GPNZ) Executive member of Health Care Home Collaborative
Hardie, Claire	13.8.18 13.8.18 13.8.18	Member – Royal Australian & NZ College of Radiologists Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc Member, Medical Advisory Committee – NZ Breast Cancer Foundation
Horgan, Lyn	1.5.17 18.5.18	Sister is Coroner based in Wellington – Coronial Services Member, Alliance Leadership Team – Central PHO
Howe, Jonathon	1.8.19	Nil
Matthews, Rory	20.8.20	Managing Partner, FGI (NZ) Ltd trading as Francis Health Trustee/Director Te Hopai Home and Hospital Ltd

Register of Interests: Summary, 15 June 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business – Puriri Trust and Puriri Farm Partnerships Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO Chair – National DHB Digital Investment Board
Nwosu, Andrew	10.8.18	Director UK health consulting company – AB Therapy Services
Ratana, Darryl	29.5.19	Nil
Russell, Greig	3.10.16	Minority shareholder – City Doctors Member, Education Committee – NZ Medical Council
Scott, Gabrielle	Dec 19	Son is a permanent MDHB employee and works within Digital Services
Tanner, Steve	16.2.16	Nil
Te Huia, Tracee	19.11.19	Nil
Wanden, Neil	Feb 19	Nil
Williamson, Nicki	Mar 20	Nil
Zaman, Syed	1.5.18	Nil

Resolution

That the Part One minutes of the 25 May 2021 Board meeting be approved as a true and correct record.

MidCentral District Health Board

Board Minutes

Meeting held on 25 May 2021 from 9.00am

PART ONE

Members

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

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Celina Eves, Executive Director, Nursing and Midwifery; Rory Matthews, Interim Director, Office of the Chief Executive; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Scott Ambridge, Operations Executive, Te Uru Rauhī; Keyur Anjaria, General Manager, People and Culture; Wayne Blissett, Operations Executive, Pae Ora Paiaka Whaiora; Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Judith Catherwood, General Manager, Quality and Innovation; Debbie Davies, Operations Executive, Te Uru Kiriora; Di Feck, Quality Facilitator, Quality and Innovation; Sarah Fenwick, Operations Executive, Te Uru Pā Harakeke; Claire Hardie, Clinical Executive, Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau; Jonathon Howe, Communications Manager; Kelly Isles, Director of Strategy; Sam Kilmister, Communications and Social Media Advisor; Clive Martis, Director Digital Services; Steve Miller, Chief Digital Officer; Andrew Nwosu, Operations Executive, Te Uru Whakamauora; Darryl Ratana, Deputy Chief Financial Officer; Neil Wanden, General Manager, Finance and Corporate Services.

Public – 41 (including 40 midwives)

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

Nil.

2.2. Late items

There were no late items.

2.3. Register of Interests Update

There were no amendments to the register.

2.4. Minutes of the 13 April 2021 meeting, Part One

It was resolved that:

the Part One minutes of the 13 April 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

Following the Government's Budget announcement on Thursday 20 May 2021, the funding envelope had been received from the Ministry of Health. Details of the impact on MidCentral District Health Board's (MDHB) budget for 2021/22 would be provided in Part Two of the meeting.

The workload for senior leaders and management staff was significant, including preparations for the disestablishment of District Health Boards (DHBs) at the end of June 2022 and the COVID-19 vaccination programme.

The cyber attack on the Waikato District Health Board was impacting on the whole health sector. This was a timely reminder to all Government departments to be aware of IT security.

Board members noted that a number of midwives were in attendance and asked that a spokesperson be given an opportunity to address the Board.

The Chair advised that upon learning the midwives planned to picket the Board meeting, he and the Chief Executive offered to speak with midwives to hear their concerns. That offer had been declined. The Board's Standing Orders outlined the processes for the conduct of formal meetings, including hearing from the public and receiving deputations. The group of midwives had not advised they would be attending the meeting or requested an opportunity to address the Board. Therefore, the Chair ruled that the meeting would follow the published agenda. The Chair again noted that he and the Chief Executive were happy to meet with the midwives at any time.

2.7. Minutes of the Health and Disability Advisory Committee meeting held on 27 April 2021, Part One

The Chair of the Health and Disability Advisory Committee (HDAC) provided a verbal update on the meeting.

It was resolved to:

note the unconfirmed Part One minutes of the Health and Disability Advisory Committee meeting held on 27 April 2021.

(Moved John Waldon; seconded Brendan Duffy; abstention Vaughan Dennison)

2.8. Minutes of the Finance, Risk and Audit Committee meeting held on 4 May 2021, Part One

The Chair of the Finance, Risk and Audit Committee (FRAC) provided a verbal update on the meeting.

It was resolved to:

note the unconfirmed Part One minutes of the Finance, Risk and Audit Committee (FRAC) meeting held on 4 May 2021.

(Moved Oriana Paewai; seconded John Waldon; abstention Lew Findlay)

2.9. Manawhenua Hauora Chair's Report

The report was taken as read.

It was resolved to:

note the report from the Manawhenua Hauora Chair on the Manawhenua Hauora meeting held in April 2021

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

(Moved Oriana Paewai; seconded Norman Gray)

The General Manager, Finance and Corporate Services, Chief Digital Officer and Director Digital Services joined the meeting.

3. STRATEGIC FOCUS

Discussion to be held in Part Two of the meeting.

4. PERFORMANCE REPORTING

4.1. Chief Executive's Report

The Chief Executive presented this report, which was taken as read. In response to a question, she advised that Technical Advisory Services (TAS) is a subsidiary owned by DHBs and would transition to Health NZ as part of the health system reforms next year.

A Board member observed that there were enough midwives in the district, but they didn't want to work for MDHB and were looking for an improved culture. She asked that the reputational risk be noted, along with mitigations. The Executive Director, Nursing and Midwifery acknowledged there was a lot more work to be done, but positive steps had begun with the report from Emma Farmer of Waitemata DHB and a workshop facilitated by Francis Health.

In response to questions, management advised that contingency planning was in place for the proposed strike by NZ Nurses Organisation members on Wednesday 9 June. Life Preserving Services had been agreed which meant nurses would be available in the event of an emergency. The midwifery service roster was covered for that day.

It was resolved that the Board:

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

(Moved Vaughan Dennison; seconded Muriel Hancock)

The General Manager, People and Culture joined the meeting.

4.2. Board KPI Dashboard

The Director of Strategy presented this report, which was taken as read.

It was resolved that the Board:

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

(Moved Jenny Warren; seconded Norman Gray)

A Board member asked that the meeting adjourn for morning tea to allow Board members to speak to the midwives present at the meeting. The Chair repeated his earlier ruling that the meeting agenda be followed.

4.3. Finance Update – April 2021

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

The Operations Executive and Clinical Executive, Te Uru Pā Harakeke; General Manager, Quality and Innovation; and Qualilty Facilitator joined the meeting.

Options for outsourcing elective surgery were discussed and it was agreed this would be a focus for the next HDAC report from Te Uru Arotau.

It was resolved that the Board:

note that the month operating result for April 2021 is a deficit before one-off items of $0.793m, which is $0.452m favourable to budget

note that the year to date result for April 2021 is a surplus before one-off items of $0.179m, which is $3.122m favourable to budget

note that year to date for April 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.616m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.537m, which is $0.406m favourable to budget

note that total available cash and equivalents of $48.7m as at 30 April 2021 is sufficient to support liquidity requirements

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

(Moved Oriana Paewai; seconded Vaughan Dennison)

4.4. Finance Report – March 2021

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

It was resolved that the Board:

note that the Finance, Risk and Audit Committee endorsed this report at their May meeting for Board consideration

note that the month operating result for March 2021 is a deficit before one-off items of $1.841m, which is $0.67m adverse to budget

note that the year to date operating result for March 2021 is a surplus before one-off items of $0.972m, which is $2.670m favourable to budget

note that year to date for March 2021 COVID-19 related net costs of $0.094m and unbudgeted Holidays Act related costs of $2.268m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $1.390m, which is favourable to budget by $0.307m

note that the total available cash and equivalents of $45.4m as at 31 March 2021 is sufficient to support liquidity requirements

approve the March 2021 financial report.

(Moved Oriana Paewai; seconded Vaughan Dennison)

4.5. Finance Report – February 2021

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

It was resolved that the Board:

note that the Finance, Risk and Audit Committee endorsed this report at their May meeting for Board consideration

note that the month operating result for February 2021 is a surplus before one-off items of $1.545m, which is $0.245m favourable to budget

note that the year to date operating result for February 2021 is a surplus before one-off items of $2.813m, which is $2.737m favourable to budget

note that year to date for February 2021 COVID-19 related net costs of $0.036m and unbudgeted Holidays Act related costs of $2.009m have been incurred. Including these one-off costs results in a year to date surplus after exceptional items of $0.769m

note that the total available cash and equivalents of $41.6m as at 28 February 2021 is sufficient to support liquidity requirements

approve the February 2021 financial report.

(Moved Oriana Paewai; seconded Vaughan Dennison)

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

The Operations Executive, Pae Ora Paiaka Whaiora joined the meeting.

4.6. Sustainability Plan Report

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

A Board member asked that due to budget constraints, management consider reprioritising the Sustainability Plan and reduce the number of projects. She also commented that a focus on equity appeared to be lacking. Management advised that as requested by the governors, all individual projects which impacted on the MDHB's community, had an equity focus.

The Older People's Acute Assessment and Liaison Service (OPAL) community services business case had been supported by the Operational Leadership Team in May 2021 and would progress into budget planning for 2021/22.

It was resolved that the Board:

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

note the emerging risks and mitigation plans

note the 2020/21 benefits realisation reconciliation is being progressed

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

(Moved Vaughan Dennison; seconded Materoa Mar)

4.7. Quality and Safety Walk-rounds

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

The importance of frontline staff being able to engage directly with Board members was discussed and it was suggested that less executives attend the walk-round. Board members noted the report currently provided information about the percentage of actions that had been completed, were in progress, were deferred or were not achievable. They asked that future reports provide details of these actions and any themes that arose.

A Board member noted that during a walk-round of Alcohol and Other Drug services in March 2020, staff raised an issue regarding access for wheelchair users. No action plan was submitted for this walk-round. The General Manager, Quality and Innovation noted this walk-round took place just before the COVID-19 Level 4 lockdown and may not have been recorded in the system. She offered to check with the Directorate's leadership team to ensure the action was being followed up. The General Manager, Quality and Innovation advised she would ensure that a member of the Quality and Innovation team was involved in each walk-round to provide quality assurance of the process. This would help to ensure Board members received an action plan following each walk-round they attended.

It was resolved that the Board:

note the progress to date with the Quality and Safety Walk-rounds

endorse that future walk-rounds include locations and teams from within the Directorates with Enabler functions.

(Moved Vaughan Dennison; seconded Norman Gray)

The General Manager, Quality and Innovation and the Quality Facilitator left the meeting.

The Board Chair acknowledged the public in attendance and thanked them for the courtesy and respect they had shown at the meeting. He noted that the Board's role was to support management and to hold them accountable for finding solutions. The Board Chair and Chief Executive were willing to meet with midwives to listen to concerns and try to find a constructive solution. He advised the meeting would adjourn to allow the midwives present to speak with Board members.

The meeting adjourned from 10.10 to 10.40am. Five members of the public remained (including four midwives).

The Communications Manager and the Director Digital Services left the meeting.

The General Manager, Finance and Corporate Services and the Communications and Social Media Advisor joined the meeting.

4.8. **Health, Safety and Wellbeing**

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

A Board member acknowledged the work that had been done to present the report in a dashboard format. She felt the report no longer gave sufficient detail in some areas. As an example, the Healthy Workforce Dashboard showed the number of incidents closed in 30 days was at 100 percent. Governors were interested in knowing what the incidents were and whether they were being addressed appropriately, rather than whether they were open or closed.

Board members noted that workforce shortages, including in midwifery, were a health and safety issue and should be included in this report.

The General Manager, People and Culture agreed to include commentary to support the dashboard in future reports. More details on workforce shortages would also be included if possible.

The Chief Executive advised that management would look at information that is reported through dashboards to FRAC, HDAC and the Board and try to map it out for the next Board meeting.

It was resolved that the Board:

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

note the quarterly Health, Safety and Wellbeing report

endorse the quarterly Health, Safety and Wellbeing report.

(Moved Materoa Mar; seconded Vaughan Dennison)

4.9. Workforce

The General Manager, People and Culture presented this report, which was taken as read. He noted that around 70 percent of staff who accessed Employee Assistance Programme (EAP) services did so for personal reasons, with only 30 percent for work-related reasons.

All staff who resigned were offered an exit interview. Over the January to March 2021 reporting period, 40 percent of staff had taken up the offer. Confidentiality was assured and any significant themes were provided to managers. A Board member conveyed feedback from staff who said they don't attend an exit interview or are not completely honest about their reason for leaving because they may want to work for MDHB again.

The General Manager, People and Culture noted the positive feedback from staff who had been recognised for their loyal service as part of the long service award ceremony. Board members would receive calendar invitations for future ceremonies and were welcome to attend.

It was resolved that the Board:

note the May 2021 workforce update

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

(Moved Heather Browning; seconded Vaughan Dennison)

The General Manager, People and Culture left the meeting. Four members of the public (midwives) left the meeting.

The Deputy Chief Financial Officer; the Operations Executive, Te Uru Arotau; the Operations and Clinical Executives, Te Uru Rauhī; the Clinical Executive, Te Uru Mātai Matengau; the Operations Executive, Te Uru Whakamauora; and the General Manager, Quality and Innovation joined the meeting.

4.10. Te Awa Update – Digital Services Work Programme

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

Board members noted the cyber attack currently impacting Waikato District Health Board's information technology (IT) services. The Chief Digital Officer noted that MDHB's investments in IT security meant there were a lot of firewalls and network protections in place. Waikato DHB was not yet sure how big the threat to their systems was, so had been proactive in shutting their systems down while investigations were carried out. After the Waikato DHB's issues had been resolved, they would share information and recommendations with other DHBs, including business continuity plans.

The Ministry of Health's Deputy Director-General, Data and Digital had told Chief Digital Officers to carry on with their agreed work programmes. The Chief Executive noted that Board Chairs and Chief Executives had been advised to be prudent, but not to stop work programmes because the organisations would need to continue to function from 1 July 2022 even though the DHB would be

disestablished. Management were taking a prudent approach to digital services projects to ensure clinicians were in the best possible space at the time of the transition. There was considerable stress in the sector as a result of differing messages being provided to individual groups such as Chief Executives, Chairs, Chief Financial Officers and primary care.

It was resolved that the Board:

note that due to the Government announcement on health system reforms, no new discretionary initiatives from the Te Awa Digital Health Strategy (Te Awa) roadmap will be started, apart from core legacy technology and infrastructure priorities

note the draft work programme from now until 30 June 2021 and planned work for the 2021/22 financial year

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

(Moved Oriana Paewai; seconded Muriel Hancock)

The Chief Digital Officer left the meeting.

5. DISCUSSION/DECISION PAPERS

5.1. General Approach to Contract Review and Renewal for 2021/22

The Director of Strategy presented this report, which was taken as read.

It was resolved that the Board:

note the approach to the review and renewal of contracts

note that this report was endorsed by the Finance, Risk and Audit Committee at its May meeting.

(Moved John Waldon; seconded Materoa Mar)

5.2. Enable New Zealand Limited – Annual Reporting Requirements

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

It was resolved that the Board:

approve that pursuant to section 211(3) of the Companies Act 1993, the annual report of Enable New Zealand Limited for the year ended 30 June 2021 shall incorporate the financial statements and auditor's report thereon and exclude information specified in any of the paragraphs (a) and (e) to (j) of subsection (1) of that section.

(Moved Materoa Mar; seconded Vaughan Dennison)

5.3. External Audit – Engagement Letter and Audit Plan

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

A Board member referred to Annex 1 of the Deloitte audit letter, 'Responsibilities for compliance with laws and regulations'. She suggested that reference to legislation applying to Te Tiriti o Waitangi in respect of settled iwi and their relationship with the Crown be included. The Chief Executive noted that the DHB could not edit the Office of the Auditor-General's audit requirements. As a member of the Central Government Advisory Group which advises the Office of the Auditor-General on health issues, she offered to put that suggestion forward for discussion.

It was resolved that the Board:

note that the Finance, Risk and Audit Committee endorsed this report for Board consideration at their May meeting

note the audit planning report

approve the Board Chair signing the audit engagement letter.

(Moved Jenny Warren; seconded Vaughan Dennison)

6. INFORMATION PAPERS

6.1. Board's Work Programme

This report was taken as read. It was agreed that the Board's Standing Orders, which included the process for members of the public to address the Board, either as an individual or a deputation, would be loaded on to the Stellar platform. The Standing Orders were currently on the SharedNet portal and the MDHB website.

It was resolved that the Board:

note the Board's annual work programme for 2021

endorse that the Board's work programme for 2021 be extended to 30 June 2022.

(Moved Vaughan Dennison; seconded Norman Gray)

7. GLOSSARY OF TERMS

8. LATE ITEMS

There were no late items.

9. DATE OF NEXT MEETING

Tuesday, 6 July 2021 – 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 Board meeting	For reasons set out in the agenda of the 13 April 2021 meeting.	
Government's Budget 2021	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Midwifery Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Nursing Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Replacement Echocardiography Image Vault	To protect negotiations, including commercial and industrial	9(2)(j)
2021/22 Annual Plan and Budget	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)
Fleet Replacement	To protect negotiations, including commercial and industrial	9(2)(j)
Health and Disability System Review	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Board only time	No decision sought	
'In Committee' minutes of the previous HDAC meeting	**For reasons set out in the agenda of the 27 April 2021 meeting held with the public present**	
Serious Adverse Events (SAC 1)	To protect patient privacy	9(2)(a)
Consumer Story	To protect patient privacy	9(2)(a)
'In Committee' minutes of the previous FRAC meeting	**For reasons set out in the agenda of the FRAC meeting held on 4 May 2021**	

(Moved Norman Gray; seconded Vaughan Dennison)

Part One of the meeting closed at 11.30am

Confirmed this 6th day of July 2021

……..

Board Chair

Resolution

That the Part One minutes of the 15 June 2021 conjoint meeting of the Board and the Finance, Risk and Audit Committee be approved as a true and correct record.

MidCentral District Health Board

Minutes of Conjoint Meeting of the Board and the Finance, Risk and Audit Committee

Meeting held on 15 June 2021 from 1.00pm

PART ONE

(from 1.10pm)

Present

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

Independent Finance, Risk and Audit Committee members
Simon Allan, Tony Hartevelt.

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Celina Eves, Executive Director, Nursing and Midwifery; Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance; Rory Matthews, Interim Director, Office of the Chief Executive; Darryl Ratana, Deputy Chief Financial Officer; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Neil Wanden, General Manager, Finance and Corporate Services; Margaret Bell, Board Secretary.

Apology

Norman Gray; Lew Findlay for early departure.

In attendance (part meeting)

Dr Andrew Connolly, Chief Medical Officer, Ministry of Health; Scott Ambridge, Operations Executive, Te Uru Rauhī; Keyur Anjaria, General Manager, People and Culture; Jeff Brown, Clinical Executive, Te Pā Harakeke; Vanessa Caldwell, Clinical Executive, Te Uru Rauhī; Judith Catherwood, General Manager, Quality and Innovation; Debbie Davies, Operations Executive, Te Uru Kiriora; Sarah Fenwick, Operations Executive, Te Pā Harakeke and Te Uru Mātai Matengau; Claire Hardie, Clinical Executive, Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau; Kelly Isles, Director of Strategy; Steve Miller, Chief Digital Officer; Andrew Nwosu, Operations Executive, Te Uru Whakamauora; Syed Zaman, Clinical Executive, Te Uru Whakamauora.

1. KARAKIA

The meeting began with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

An apology was received and accepted from Norman Gray. Lew Findlay advised he would need to leave the meeting early.

2.2. Late items

There were no late items.

2.3. Register of Interests Update

No changes to the register were advised.

3. LATE ITEMS

No discussion.

4. DATE OF NEXT MEETING

Tuesday 6 July 2021 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North.

5. EXCLUSION OF THE PUBLIC

It was resolved:

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

Item	Reason	Ref
2021/22 Annual Plan and Budget	To protect negotiations, including commercial and industrial To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(j) 9(2)(g)(i)
Replacement of Linear Accelerator	To protect negotiations, including commercial and industrial	9(2)(j)

(Moved Oriana Paewai; seconded Vaughan Dennison)

Part One of the meeting closed at 1.13pm

Confirmed this 6th day of July 2021

……..

Board Chair

MidCentral District Health Board

- Schedule of Matters Arising, 2020/21 as at 25 June 2021

Matter	Raised	Scheduled	Responsibility	Form	Status
Check on wheelchair access for Alcohol and Other Drug services – from walk-round March 2020	May 21	July 21	J Catherwood	Verbal update	Scheduled
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	Scheduled
Include details on workforce shortages in the Health, Safety and Wellbeing report if data is available	May 21	Aug 21	K Anjaria	Report	Scheduled
Map out information reported through dashboards to FRAC, HDAC and the Board	May 21	July 21	R Matthews	Report	Scheduled
Future Quality and Safety Walk-round reports to include details of actions and any themes	May 21	May 22	J Catherwood	Report	Scheduled
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	Scheduled
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	Scheduled
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	B Duffy	Report	Commenced
Review of car parking arrangements PNH, including readdressing all carpark feedback and suggestions (Dec 20: after traffic engineering review completed)	April 17	Ongoing	N Wanden	Report	Scheduled
COMPLETED					
Send calendar invitations for long service awards ceremonies to Board members	May 21	June 21	M Bell	Meeting invite	Completed
Schedule of Board workshops to be included in the work programme	Feb 21	April 21	M Bell	Report	Completed
Rreport on the Integrated Service Model health check to be provided to the next Board meeting	Feb 21	~~April 21~~ May 21	R Matthews	Report	Completed
Future six-monthly workforce reports to include an overview of the various contracted services and their staffing numbers; and, if possible, include reporting on employees with a disability	July 20	~~Feb 21~~ May 21	K Anjaria	Report	Completed

Matter	Raised	Scheduled	Responsibility	Form	Status
Discuss holding a Board to Board workshop with THINK Hauora	Feb 21	Feb 21	K Cook	Meeting	Completed – no longer required
Investigate the possibility of providing a breakdown of nursing and midwifery FTEs in financial reports	Feb 21	April 21	N Wanden	Report	Completed – included in Te Uru Pā Harakeke
Detail on increased Mental Health Client DNAs to be included in next HDAC report	Feb 21	April 21 HDAC	S Ambridge V Caldwell	Report	Completed – on HDAC schedule
Carry out review of register of interests	Feb 21	Feb 21	M Bell	Update	Completed
Review internal audit options and speak with other out of region DHBs	April 20	Feb 21	N Wanden	Report	Completed
Review reference to Te Tiriti o Waitangi as an essential component within the Te Wao nui a Tāne ecosystem and check with Hone Morris from Massey University	Dec 20	Feb 21	T Te Huia	Update	Completed
Report back with further details on the content and timing of the second of two Te Tiriti o Waitangi training sessions	August 20	~~Nov 20~~ ~~Dec 20~~ Feb 21	T Te Huia	Report	Completed
Report details from CCDM of the monthly variance from each clinical area on a shift-by-shift basis	August 20	Feb 21	C Eves	Report	Completed
Content of kete presented by Rangitāne o Manawatu at hui on 29 September uploaded to SharedNet	Dec 20	Dec 20	T Te Huia and M Bell	Upload to SharedNet	Completed
Meeting invitations to be sent for quarterly 'Board to Board' hui with Manawhenua Hauora in 2021	Dec 20	Dec 20	M Bell	Calendar invitations	Completed
Presentation to Minister of Health to be uploaded to SharedNet after meeting on 16 December 2020	Dec 20	Dec 20	M Bell	Upload to SharedNet	Completed
Write to iwi and Māori providers to thank them for services provided during COVID-19 lockdown	Nov 20	Dec 20	B Duffy	Letters	Completed
Make contact with Te Awa Trust to see if it would be beneficial for the Palmerston North Hospital Foundation to work with them	Sept 20	October 20	R Matthews	Verbal report from Board Chair	Completed
Provide an updated annual work programme	Nov 20	Dec 20	R Matthews	Report	Completed
Provide update on the immunisation register to a future Board meeting	Sept 20	Dec 20	D Davies	CEO Report	Completed
Include a more detailed breakdown of the 'Exceptional Items' category in financial reports	Nov 20	Dec 20 and ongoing	N Wanden	Report	Completed and ongoing
Provide breakdown of staff compensation costs that had been recorded in the draft Annual Report 2019/20	Sept 20	Dec 20	N Wanden	Report	Completed
Review of Board membership, capability and capacity	Feb 20 FRAC Mar 20 Board	~~Nov 20~~ Dec 20	B Duffy	Report	Completed

Matter	Raised	Scheduled	Responsibility	Form	Status
Board meetings with professional staff groups - scheduling on work programme	Dec 19	~~March 20~~ Nov 20	~~K Cook~~ R Matthews	Included in 2020/21 work programme	Completed
Update Governance Manual Section 18 to clarify how meeting fees calculated if combined meeting of the Board and a Statutory Committee is required	Sept 20	Dec 20	R Matthews	Report	Completed
Load Delegation of Authority Policy onto SharedNet	Nov 20	Nov 20	M Bell	SharedNet	Completed
Ensure the salaries of Spotless workers did not decrease if the supplier changed; find out whether length of service would continue for transferring workers; during tender process, consider what equity providers had around employment opportunities	July 20	Ongoing	N Wanden	Report	Completed as part of contract negotiations; new contract from 1 December 2020
Māori health dashboard to be reported to the Board quarterly, with improvement plans reported six-monthly	May 20	~~Sept 20~~ Nov 20 (d/board) Dec 20 (plan)	T Te Huia	Report	Completed – reports will be presented to HDAC
Review of Remuneration Strategy and Policy	Dec 19	Dec 20	K Anjaria	Report	Completed
Advise date for remainder of orientation tour for Board members, including off-site services	Sept 20	Oct 20	R Matthews	Advised tour to follow HDAC 24 November	Completed
Ensure Board induction programme is re-started following interruption due to COVID-19	August 20	Sept 20	R Matthews	Report	Completed – report to 29 Sept meeting
Enable NZ ownership	Dec 18	~~July 19~~ ~~May 20~~ Sept 20	~~D Andrews~~ M Riwai	Report	Completed – presentation to 29 Sept 2020 meeting
Provide information to the board on the number of women who had to be transferred during labour from a primary birthing option; also asked to consider the growth rate of the Horowhenua community	July 20	September 20	S Fenwick	Report	Completed – Reported to HDAC; will now be provided six-weekly. Growth rate consideration is part of project.
Check whether there should be more than two meetings per year of the Remuneration Committee	August 20	September 20	K Cook	Report	Completed – ToR require two meetings per year
Follow up on provision of health and safety training for Board members	August 20	December 20	K Anjaria	Report	Completed – scheduled 10 Nov 20
Provide analysis by age group on incidents of staff bullying	August 20	September 20	K Anjaria	Report	Completed – included in CEO's report Sept 20
Include two additional performance measures for the Chief Executive in 2020/21	August 20	September 20	K Anjaria	Report	Completed

Matter	Raised	Scheduled	Responsibility	Form	Status
Check whether presentation from NZHP to Board Chairs on the Health System Catalogue Business Case was available to share with Board members	August 20	September 20	N Wanden	Report to be distributed	Completed – emailed 26 August
Provide feedback to NZ Health Partnerships regarding lack of diversity on their Board of Directors; lack of outcomes for Māori and Pacific peoples in the SPE; and that the Health System Catalogue business case did not link to the Treaty of Waitangi or explain how it would benefit Māori health	August 20	September 20	N Wanden	Letter to NZHP	Completed – letter sent 21 August
Internal auditors having difficulties engaging someone with appropriate experience to conduct equity and fairness audit. General Manager, Maori Health to discuss with internal auditors	April 20	ASAP	T Te Huia	Discussion with internal auditors	Completed – review ToR signed by CEO and auditor started on 10 August
Performance improvement plan – provision of available ethnicity data	Dec 19	~~March 20~~ July 20	J Catherwood	Include in PIP report	Completed
Send a letter of congratulations and recognition to Dr Garry Forgeson for his Queen's Birthday Honour for his services to oncology	July 20	August 20	B Duffy	Letter	Completed
Update financials in the integrated hospital and community pharmacy and improved front of hospital report and return to the Board	July 20	Aug 20	N Wanden	Report	Completed
Advise the Board on the Corporate and Other figures without Enable New Zealand included	July 20	Aug 20	K Anjaria	Report	Completed

Verbal report from the Board Chair

The Board Chair will provide an update on recent activities

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Finance, Risk and Audit Committee meeting
15 June 2021 from 9.00am

PART ONE

MEMBERS

Oriana Paewai (Chair)
Tony Hartevelt (Deputy Chair) (Independent)
Simon Allan (Independent)
Heather Browning
Brendan Duffy (Board Chair)
Vaughan Dennison
John Waldon

IN ATTENDANCE

Board members
Muriel Hancock
Materoa Mar
Karen Naylor

Management
Kathryn Cook, Chief Executive
Neil Wanden, General Manager, Finance and Corporate Services
Darryl Ratana, Deputy Chief Financial Officer
Jared McGillicuddy, Internal Audit Manager, Technical Advisory Services
Kelvin Billinghurst, Chief Medical Officer
Margaret Bell, Board Secretary

IN ATTENDANCE (part meeting)

Judith Catherwood, General Manager, Quality and Innovation
Rory Matthews, Interim Director of the Office of the Chief Executive
Tracee Te Huia, General Manager, Māori Health

1. KARAKIA

The meeting opened with the organisational karakia.

The recent passing of Darryl Ratana's father was acknowledged.

2. ADMINISTRATIVE MATTERS

2.1 Apologies

An apology from the Chief Executive for lateness was accepted.

2.2 Late items

There were no late items.

2.3 Register of Interests Update

There were no changes 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 4 May 2021 be approved as a true and correct record. (Moved Vaughan Dennison; seconded John Waldon)

2.5 Matters arising

Electronic Signatures Policy
The Interim Director of the Office of the Chief Executive advised that under the Electronic Transactions Act 2002, electronic signatures were a valid way of doing business. No other District Health Boards had an Electronic Signatures Policy. MidCentral District Health Board (MDHB) required physical signatures on all contracts and financial documents requiring approval. The only exception was authorising invoices through Approval Plus. This approach was consistent across the health sector. The Committee agreed the item could be removed from the matters arising schedule.

The following items from the May meeting would be added to the schedule:
- Monitor options for Enable New Zealand in the health reforms – to become a full subsidiary of the DHB, to become a charitable trust or to transition to Health New Zealand.
- Monitor progress in development of an outcomes commissioning framework as part of the general approach to contract review and renewal.

3. PERFORMANCE REPORTING

3.1 Finance Report – April 2021

The Deputy Chief Financial Officer presented the report, which was taken as read. The April result was favourable to budget. Additional revenue had been received for the backpay of administration staff as part of pay equity and for the improvement action plan to clear waiting lists. Expenditure on clinical supplies and nursing costs were adverse to budget. Overtime across the year had been consistent. The end of year forecast for Holidays Act costs had been adjusted in line with the Ernst & Young report.

The General Manager, Quality and Innovation joined the meeting.

An amendment to the report item 2.1 – Financial Performance was noted. The first paragraph, second sentence should read:
- Net revenue for the month is $2.040m favourable to budget and is partially offset by expenditure which is $1.620m unfavourable to budget.

The Committee noted the inability to recruit staff created pressure on existing staff members. Difficulties in recruiting radiologists led to International Accreditation New Zealand (IANZ) recently suspending MDHB's accreditation of the Medical Imaging Department.

The Deputy Chief Financial Officer advised the May financial result looked positive and that a full report would be provided to the next Committee meeting.

It was resolved that the Committee:

note that the month operating result for April 2021 is a deficit before one-off items of $0.793m, which is $0.452m favourable to budget

note that the year to date result for April 2021 is a surplus before one-off items of $0.179m, which is $3.122m favourable to budget

note that year to date for April 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.616m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.537m, which is $0.406m favourable to budget

note that total available cash and equivalents of $48.7m as at 30 April 2021 is sufficient to support liquidity requirements

endorse the April financial report. (Moved John Waldon; seconded Vaughan Dennison)

3.2 Sustainability Plan

The General Manager, Quality and Innovation presented the report, which was taken as read. She noted the full one-year benefits realisation reconciliation against the Sustainability Plan would be presented to the next Committee meeting. As requested by the Board, the Sustainability Plan had been refreshed and streamlined. This was not expected to release staff resources but would help to reduce the burden of reporting.

The Chief Executive joined the meeting.

It was resolved that the Committee:

note the emerging risks and mitigation plans

note the 2020/21 benefits realisation reconciliation is in progress

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

endorse the refreshed Sustainability Plan 2020-2023 for Board consideration. (Moved Simon Allan; seconded Heather Browning)

The General Manager, Quality and Innovation left the meeting.

4. STRATEGY AND PLANNING

Discussion will be held at the conjoint meeting of Finance, Risk and Audit Committee (FRAC) and the Board following this meeting.

5 DECISION PAPERS

5.1 Treasury Management Policy

The Deputy Chief Financial Officer presented the report, which was taken as read. The Committee noted the changes were minor and mostly related to role titles.

It was resolved that the Committee:

note that the Treasury Management Policy has been reviewed and there are minimal changes

approve the amended policy. (Moved Vaughan Dennison; seconded Heather Browning)

5.2 Year-end Financial Reporting

The Deputy Chief Financial Officer presented the report, which was taken as read. An external valuer had carried out a formal valuation this year as part of a three-yearly cycle. In response to a question, he noted that the revised valuation had been built into this year's budget and would have a significant impact on depreciation. A separate valuation for insurance purposes was carried out as part of the collective insurance agreement for all District Health Boards (DHBs).

The current webPAS patient management system was shared by six DHBs, with only three using the system. MDHB's investment in webPAS has been $9.43m. A business case to move webPAS to a vendor Software as a Service (SaaS) was being developed. This would mean the DHBs would be renting a space, rather than owning an asset.

The Committee noted the significant financial impact of the Holidays Act, write downs from impairment and the pending changes to the health sector. It was expected that a Letter of Comfort from the Ministers of Health and Finance would be required to satisfy the going concern considerations.

The General Manager, Māori Health joined the meeting.

It was resolved that the Committee:

note the accounting treatment considerations for financial valuations, impairment and Holidays Act liability for the 2021/22 Annual Report Financial Statements. (Moved John Waldon; seconded Vaughan Dennison)

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 Oriana Paewai; seconded Vaughan Dennison)

6.2 Internal Audit Report – Māori Health Equity System Review

The Internal Auditor presented the report, which was taken as read. All eight recommendations had been accepted by management and would be implemented this year.

The Committee discussed ways to build the Māori workforce and the importance of recognising institutional racism and storytelling. The DHB's Communications Team needed to be involved in sharing the report's findings and the anti-racism message with all staff.

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

Committee members noted the importance of challenging instances of racism at an individual level and for clinicians to reflect on their practice.

It was resolved that the Committee:

note the internal audit on Māori Health Equity System review

endorse the work plan to implement the recommendations. (Moved Oriana Paewai; seconded Vaughan Dennison)

The General Manager, Māori Health left the meeting.

6.3 Internal Audit Report – Clinical Audit Activity and Support Review

The Internal Auditor presented the report, which was taken as read. It was noted that clinicians had been involved in the audit.

It was resolved that the Committee:

note the internal audit on Clinical Audit Activity and Support review

endorse the work plan to implement the recommendations. (Moved Simon Allan; seconded Vaughan Dennison)

6.4 Non-Clinical Audits Update

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

It was resolved that the Committee:

note the progress made on the non-clinical audit recommendations. (Moved Oriana Paewai; seconded John Waldon)

6.5 Major Projects Update

The General Manager, Finance and Corporate Services presented the report, which was taken as read. At the request of the Committee, he outlined construction activities that had already occurred as part of the Surgical Procedural Interventional Recovery Expansion (SPIRE) programme and the schedule for the next phases of work.

Issues raised by the Combined Medical Staff (CMS) relate to transition rather than theatre design. Theatre capacity would be reduced briefly over the Christmas break 2021, then for seven months from July 2022. Mitigations included an agreement with Crest Hospital who are building a new theatre that will be available for MDHB's use; surgeons would be asked to work flexible hours, including weekend and evening lists; and arrangements would be made with Wairarapa and Whanganui DHBs.

A production plan to quantify the impact of reduced capacity was being developed in conjunction with clinicians to determine the preferred options. This would be a 'living document'.

The Palmerston North Hospital Medical Trust had provided $300k to be used to enhance technology in the new Clinical Suite. This area would be blessed in July and be named the Laurie McCool Learning Centre.

The Board Chair noted the detailed work that had been done to develop scenarios and options and to anticipate any potential risks. Clinicians had been involved in the mitigation planning. The objective was to continue to provide the same level of service that was currently provided.

It was resolved that the Committee:

note the progress with the SPIRE, Medical Assessment Planning Unit, Emergency Department Observation Area unit, Fluoroscopy and Acute Mental Health unit projects. (Moved Oriana Paewai; seconded Simon Allan)

6.6 Seismic Programme Report

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

The Committee congratulated the paper's author, the Director Facilities and Estate Management, on providing a valuable contextual paper.

It was resolved that the Committee:

note the Seismic Programme Report including the processes in place to:

- *assess and monitor MidCentral District Health Board properties*
- *address identified building issues and implement remediation plans*
- *agree mitigation strategies where remediation is not possible. (Moved Vaughan Dennison; seconded Heather Browning)*

The Interim Director of the Office of the Chief Executive left the meeting.

6.7 Asset Management Planning

The General Manager, Finance and Corporate Services presented the report, which was taken as read. The Ministry of Health (the Ministry) had confirmed the linear accelerator replacement would be funded from the regional outreach programme. MDHB would need to spend approx. $600k for initial advice needed to prepare a business case to seek funding for the Acute Services Block.

Management noted that when the budget for 2021/22 was set, the programme of work would need to be reviewed. Items may need to be moved due to lack of resources. Some of the work was inter-dependent and if it didn't go ahead, it would have an impact on other planned work.

A Committee member expressed concern over the number of digital assets that were classed as being 'beyond useful and economic life'. Digital services should improve the service provided by clinicians, who could not be expected to do that without the right tools.

The Chief Executive noted that work had begun on moving to a Cloud-based SaaS and rebuilding the Storage Area Network (SAN). The Government's 2021 Budget included a substantial contribution to data and digital infrastructure over the next four years. All DHB Chief Digital Officers were working with the Ministry to improve digital services on a regional and national basis as part of the health sector reform.

It was resolved that the Committee:

note the systems and processes utilised to support asset management across the DHB

note the draft 2020/21 Capital Expenditure Plan. (Moved Tony Hartevelt; seconded Vaughan Dennison)

6.8 Legislative Compliance

The General Manager, Quality and Innovation presented the report, which was taken as read. She noted this report covered a two-year period, as it was not provided last year due to the impact of COVID-19.

It was resolved that the Committee:

note the development of a policy governance framework which is currently under implementation

note that pending health reform and structural change are likely to create new national and regional legal compliance arrangements

note that MidCentral District Health Board has arrangements in place to ensure legislative compliance across all areas of the business

endorse the approach to legal compliance arrangements within MidCentral District Health Board. (Moved Oriana Paewai; seconded Vaughan Dennison)

6.9 Privacy Maturity Assessment Framework

The General Manager, Quality and Innovation presented the report, which was taken as read. She noted the previous self-assessment approach focused on compliance, whereas the Beta test for this year's assessment looked at outcomes and people-centred approaches to privacy. Although this was a self-assessment, Beta testing results may be moderated.

The Committee noted the difficulties clinicians faced in having private conversations with patients in a ward setting. This was an issue for clinicians nationally. Management noted that clinical privacy had been considered when planning new buildings at MDHB. Although this was not part of the assessment, a comment would be included in the submission to the Government Chief Privacy Officer.

A Committee member raised a concern about the last sentence of the sentence of the commentary under Core Expectations Element CE1. Management acknowledged that the DHB was not a kaitiaki of Māori data sovereignty and agreed to amend that statement.

It was resolved that the Committee:

note the ratings within the Privacy Maturity Assessment Framework for MidCentral District Health Board

endorse the framework for submission to the Office of the Government Chief Privacy Officer. (Moved Oriana Paewai; seconded John Waldon)

6.10 Ministry of Health Radiation Safety of Site Inspection

The General Manager, Quality and Innovation presented a verbal report regarding the overdue requirement for the dosimeter to be calibrated. She advised that calibration was usually carried out every two years, but this had been extended to every three years. Any calibration change required was usually very minimal. Clinicians had confirmed there were no patient safety risks related to the uncalibrated dosimeter.

The General Manager, Quality and Innovation left the meeting.

7. GLOSSARY OF TERMS

No discussion required.

8. LATE ITEMS

There were no late items for Part One.

9. DATE OF NEXT MEETING

Tuesday, 27 July 2021 – 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 order paper of 4 May 2021	
Print Technology and Associated Services	To protect negotiations, including commercial and industrial	9(2)(j)
Upgrade of Water Systems	To protect negotiations, including commercial and industrial	9(2)(j)
Cyber Security Assurance Response and Recovery	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 Oriana Paewai; seconded Simon Allan)

Part One of the meeting closed at 11.42am

Confirmed this 27th day of July 2021

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Chairperson

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

To	Board
Author	Tracee Te Huia, General Manager Māori Health
Endorsed by	Kathryn Cook, Chief Executive
Date	17 June 2021
Subject	**Manawhenua Hauora Chair's Report – General Manager, Māori Health's Response**

Key questions the Board should consider in reviewing this paper:

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

RECOMMENDATION

It is recommended that the Board:

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

Strategic Alignment

This report is aligned to the DHB's 10-year strategy and Ka Ao, Ka Awatea Māori Health Strategy.

1. PURPOSE

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

2. SUMMARY

The report covers the following:

- Iwi updates and nominations for the Māori Health Authority
- Pae Ora Paiaka Whaiora report
- COVID-19 vaccination programme
- Whānau Ora Commissioning Agency
- Health Reform
- 2021/2022 Combined Board to Board Work Plan.

3. MDHB'S RESPONSES

Iwi updates

It is a tribute to iwi that they have embraced the imminent change due to health reforms and are already preparing for how they might work in the future. Iwi have agreed to use time well in the Manawhenua Hauora meetings on strategic matters only and therefore most work will be endorsed or approved by email. Nominations have been called for Health New Zealand and the Māori Health Authority. Manawhenua Hauora unanimously agreed that iwi nominations for Materoa Mar for the Māori Health Authority and Betty Lou Iwikau for Health New Zealand be submitted. These nominations have been submitted.

Pae Ora Paiaka Whaiora Report

An update on progress was provided to Manawhenua Hauora by the General Manager, Māori Health. It was with regret that the resignation of Wayne Blissett, Operations Executive Pae Ora was received in June. Wayne has worked for MDHB for five years, leading large projects to improve Māori health equity. Wayne's last day with MDHB is 9 July 2021, after which he will take up a role with Rangitāne o Manawatu leading out their Treaty pathway for Oranga Tamariki and related health projects. Wayne will be sorely missed by the DHB. Board members have been invited to attend his farewell in the Board Room from 2 to 4pm on 9 July 2021.

COVID Vaccination Programme

Overall, the rollout of the COVID-19 vaccination programme for Māori has been progressing well with Adele Small, Tumu Rautaki and Bonnie Matehaere, Māori Health Nurse Educator, co-leading the response. The Ministry of Health's Māori Directorate has distributed resource to enable iwi and Māori providers to vaccinate in location sites conducive to whānau Māori. MDHB partnered with the Ministry of Social Development to employ people who were unemployed to assist in the administration and navigation roles for the COVID-19 programme. MDHB is tracking well in terms of its vaccination rates for Māori and the team are well placed to continue this good work. MDHB acknowledges the leadership of iwi leaders and Te Tihi o Ruahine Alliance in this space.

Whānau Ora Commissioning Agency

Manawhenua Hauora is preparing itself for strengthened partnership across the health sector from 1 July 2022. Thoughtful consideration is going into the roles and responsibilities for iwi across the new entities namely Health New Zealand, Māori Health Authority, Public Health Agency and relationships throughout the different layers of national, regional, district and locality network levels. A piece of work has been completed by the Whānau Ora Commissioning Agency looking into unbundling resources to increase investment into Māori health in the future. Given the overall financial constraints in the system, and the yet to be decided appropriation for the Māori Health Authority, it is vital MDHB continues to invest into the good work being done in this district. Discussions will be held between Manawhenua Hauora and the Transition Unit in July.

Health Reforms

It's exciting to see the vibrance in Māori health related to the health reforms. Conversations have been occurring across the region as well as within the MDHB district about iwi relationships and how these might transform to lead out on designing and delivering services to Māori populations. Manawhenua Hauora agrees they are well poised to lead out on a prototype funded by the Transition Unit. This will be discussed in July, alongside other work occurring to ensure iwi are ready for the transition. Manawhenua Hauora acknowledges the work MDHB has done in the partnership with local iwi over the last five years and the strengthened focus on Māori health equity.

2021/2022 Combined Board to Board Work Plan

Following the combined Board to Board meeting in June, the finalised shared work plan is now with the Board for sign off. As discussed in the Manawhenua Hauora Chair's report, the Board should have confidence that this plan is supported by Manawhenua Hauora, who will be formally approving it at their meeting on 12 July 2021.

IWI UPDATES

Iwi updates are now being received by email to increase the time in meetings to discuss the way forward. In general, all iwi are pressing on with their claims and other government agency partnerships.

NOMINATIONS FOR THE MĀORI HEALTH AUTHORITY

Materoa Mar has been endorsed and submitted as a Manawhenua Hauora nomination for the Māori Health Authority.
Betty Lou Iwikau has been endorsed and submitted as a Manawhenua Hauora nomination for Health NZ.

PAE ORA PAIAKA WHAIORA REPORT

Manawhenua Hauora thanked Pae Ora for the good work that is occurring. The General Manager Māori Health gave an update on the Māori data sovereignty policy and guideline being developed by Wairarapa and Capital and Coast DHBs. Should these documents be approved by central regions CEOs, these will be adopted by these DHBs. Manawhenua Hauora will be asked to endorse the policy and guideline following CEO endorsement. Given the recent debacle at Waikato DHB on 19 May, the GM advised that the issue of data storage has now become critical.

COVID VACCINATION PROGRAMME

Adele Small Tumu Rautaki for Pae Ora provided an update on the roll out of COVID. Iwi acknowledged the work that both Adele and Bonnie Matehaere are doing to ensure that Māori get good coverage and that the services being delivered are both accessible and culturally acceptable. Additional funding via the Ministry is a great help to the providers who need to ensure the model of delivery works for our people. All providers are engaged and working well together. Well done to the team.

WHĀNAU ORA COMMISSIONING AGENCY

Brad Norman from the Whānau Ora Commissioning Agency provided a presentation which was well received. Analysis on the national Māori provider funding for the last five years and further analysis on Māori population descent numbers and equity adjusters was presented describing how funding might be unbundled for the Māori Health Authority. Discussions continue in this space with Te Tihi leading on behalf of the whanau ora collective for this district.

HEALTH REFORM

Quite an extensive amount of korero was had related to the health reform and the proposed changes. Manawhenua Hauora discussed its current role and responsibility back to DHB and how this could be transformed for the new environment. Iwi viewed the group having greater responsibility for commissioning and planning sign off for health services in the future. Manawhenua Hauora could also see how it could extend its scope to engage all other sectors in its operations after 1 July. Moving to a whanau ora approach at a governance level was preferred. The opportunity for including matauranga Māori into the health agenda was also suggested.

2021-2022 COMBINED BOARD TO BOARD WORK PLAN

The draft shared workplan was endorsed following discussions at the Board to Board meeting on the 25 May. Manawhenua Hauora agreed that the plan provided a good road map for the next 12 months leading into transition. Manawhenua Hauoras view is that if we can protect the improvements in Māori health and we can increase our focus over the next 12 months we will be doing well. Its important over this time that boards are guided by strong principles that ensure transparency, commitment, and partnership. We understand that the final copy of the plan will be tabled for our approval at the 12 July meeting and with the DHB Board at its meeting on the 6 July. The DHB Board can have confidence that we are unanimously supportive of this direction.

STRATEGIC FOCUS

6 July 2021

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

Strategic focus

Discussion in Part Two of today’s meeting

PERFORMANCE REPORTING

6 July 2021

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

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

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

To	Board
Author	Kathryn Cook, Chief Executive
Endorsed by	
Date	29 June 2021
Subject	**Chief Executive's Report**

RECOMMENDATION

It is recommended that the Board:

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

Strategic Alignment

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

1. PURPOSE

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

2. LOCAL MATTERS

2.1. Meetings with iwi, councils and MPs

The Board Chair and I have been meeting with iwi, council representatives and MPs from throughout the MDHB district to discuss our shared priorities and plans for the district and their community/constituents. Meetings with Rangitāne o Tamaki Nui a Rua, Muaūpoko and Ngāti Raukawa ki te Tonga's new leadership team were held in June. Meetings have been scheduled with Ngāti Kauwhata and with the Mayor and newly-appointed Chief Executive of Manawatū District Council in August. A date has yet to be confirmed to meet with the MP for Ikaroa-Rawhiti.

At the request of the MP for Manawatū, the Chief Executive of THINK Hauora and I met with him to discuss the GP shortage in the district. The Wairarapa MP requested a follow-up meeting, which has been arranged for November 2021. In accordance with advice received from the Minister of Health, all meetings with MPs have been notified to his office before taking place.

2.2. Replacement Linear Accelerator (LINAC)

At the conjoint meeting of the Board and the Finance, Risk and Audit Committee on 15 June, approval was given to purchase a Varian Linear Accelerator.

Confirmation has now been received that the Ministers of Health and Finance have agreed to allocate Crown Capital funding of up to $4.5 million for the purchase of a third LINAC, as part of the region's LINAC replacement programme. A special condition of approval is that the machine could be moved to either Hawke's Bay or Taranaki DHB in the future, if considered clinically appropriate. Transport costs would be covered by Crown funding.

2.3. Long Service Awards

The next Long Service Awards ceremony will be held on Tuesday 20 July 2021, from 10am until 12.30pm. The ceremony is expected to be held at the MDHB Education Centre – however, if the Education Centre is still being used for the COVID-19 vaccination programme at that date, the ceremony will instead take place in the Board Room.

A meeting invitation has been issued to all Board members, who are welcome to attend if available. Meeting invitations have also been sent for ceremonies planned for 26 October 2021, 22 February 2022 and 19 April 2022.

2.4. Adult secondary mental health services

Consultation on the integrated model of care for clinical and kaupapa Māori service delivery closed on 14 May 2021. The 62 responses received were carefully considered before the final decision document was released on 17 June. The implementation plan includes a staged approach that is expected to take between nine and 12 months.

2.5. School Dental Service Centenary

The School Dental Service became a health profession 100 years ago. Members of MDHB's dental service, private clinicians and representatives from the AUT and Otago University training schools celebrated the milestone over a lunch in May. Attendees enjoyed a fashion parade of old uniforms and visited a school dental service to see how equipment has changed over the decades.

2.6. Palmerston North City Council

The Palmerston North City Council held a Premiere Gala Business Dinner at the Regent Theatre on Friday 25 June 2021 to celebrate Palmerston North's 150th anniversary. MDHB's 'Table for Eight' included representatives from the Board, THINK Hauora, Enable New Zealand, the Clinical Council and Consumer Council.

2.7. Cyber Security

A new Cyber Awareness Training platform from Mimecast has been provided for everyone who has a MDHB email address. This includes a series of modules covering a wide range of subject matter. Users will receive reminders to complete the modules and the Digital Services team will provide reports to Executives on the number of staff who have completed the training. When new MDHB email accounts are created (such as when staff join the organisation), they will be automatically added to the system and receive catch up emails to go through all the available modules.

2.8. International Accreditation New Zealand (IANZ) Accreditation

MDHB's Medical Imaging Department was notified by IANZ that its accreditation would be suspended from 9 June 2021. This was due to radiologist vacancies that are being recruited to. The suspension is not related to the quality of services provided. IANZ and MDHB are working together to ensure accreditation can be regained as soon as possible.

2.9. Major Projects

2.9.1. Emergency Department Observation Area (EDOA)/Medical Assessment and Planning Unit (MAPU) Pods

The architects are working on the detailed design, which includes a modular approach to building construction to maximise the space within the unit. Each service has developed the fit-out requirements for each room.

2.9.2. SPIRE (Surgical Procedural Interventional Recovery Expansion)

The developed design process for both Stage 1 and Stage 2 is progressing well. A new theatre layout has been developed which will increase the size of the current largest theatre and provide greater flexibility for the theatre team. A production plan is being developed to quantify the impact of reduced theatre capacity and to forecast theatre output following the completion of SPIRE, including the time it will take to catch up on production lost during the construction phase.
After concerns were raised by the Combined Medical Staff (CMS), I arranged for Dr Andrew Connolly, the Ministry of Health's Chief Medical Officer, to visit the site to provide an independent view of the issues raised. Dr Connolly met with CMS representatives, toured the site and met with Board members on 15 June.

2.9.3. Fluoroscopy

The procurement process for both the fluoroscopy machine and the design/build component of the project is compete. The quantity surveyor is carrying out a reassessment of costs based on the tender outcome, which will inform the contract negotiations.

2.9.4. Acute Mental Health Unit

The Mental Health and Addiction Service has carried out detailed analysis of the model of care and patient journeys, which will be incorporated in the design. A geotechnical investigation of the site has been completed and no issues of significance were identified. The schedule of risks developed as part of the business case are being reviewed to develop a risk plan and mitigations to enable these to be monitored.

2.10. COVID-19 Vaccination Planning

COVID-19 vaccination continues to increase in scale across the rohe, working toward fully vaccinating MDHB's eligible (16 years and over) population of 145,000 individuals. Against the plans submitted to the Ministry, MDHB remains above target for delivery as to the tiers and total numbers. This has seen the weekly vaccination delivery scale from 1200 to 7000 over the past six-week period. At the peak of scheduled delivery, more than 12,000 vaccinations will be delivered each week by a range of providers.

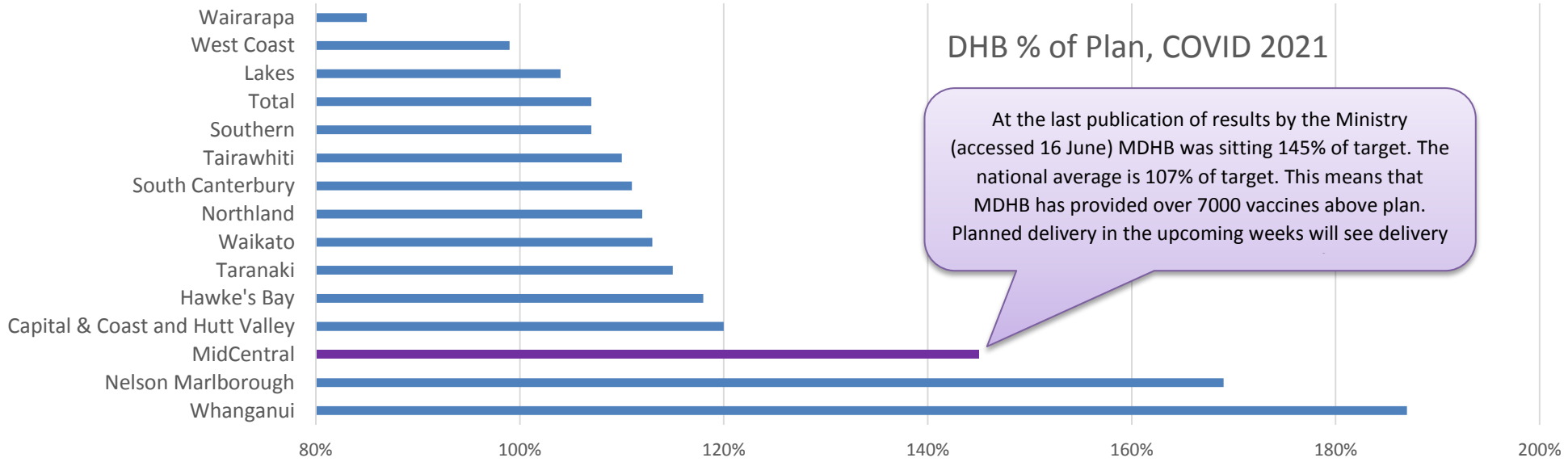
The capacity of the district to reach this target for COVID-19 vaccinations has been substantially increased as iwi, Māori and primary health care practices are registered. There are now 25 active delivery sites registered with the Ministry of Health (the Ministry), with an average of 10 sites delivering vaccinations each week. Delivery is now spanning broader hours and some weekends as the

programme scales to provide optimal accessibility and ensure a range of options are available to residents, especially those in rural and remote locations.

Group Three vaccinations have commenced, with a focus on over-65s, people with relevant underlying health conditions and people who have a disability aged under 65 years. MDHB also continues to promote access and deliver to anyone in Group One or Two who present for vaccination. All residents in aged care facilities are scheduled to complete their two doses by early July.

A delivery model focused on providing access continues to build with a blend of iwi and Māori providers, general practice, community pharmacies and community hub sites. The MDHB's vaccinator and administrative workforce continues to grow to ensure sufficient workforce to deliver at scale. To augment this, the training programme for a supervised workforce (non-regulated) is now available. The workforce stream is reviewing the approach to identify ways to supplement the existing workforce.

A key opportunity in developing this workforce lies in enhancing the workforce equity makeup to support effective engagement and delivery. Fixed vaccination sites and mobile 'pop up' sites are in operation and Pae Ora Paiaka Whaiora is leading the iwi and Māori engagement stream.



As the programme scales, a carefully constructed invitation strategy is being implemented to ensure whānau are invited according to their eligible group, in a way that provides choice of vaccination delivery location. This will have some minor locality variations which are being monitored to ensure equity. The locality delivery planning is aligned to equity targets which will be monitored at a locality level as delivery to Group Three progresses.

Migration to the National Invitation and Booking System (NIBS) (Book My Vaccine) is planned for early July. Locally this will be available for all bookings at community hubs and sites without electronic booking systems. At this stage, general practices delivering vaccinations will use their existing electronic invitation and booking system, though they can 'opt on' to this system if they choose.

Discussions are being held at a national level regarding the potential for workplace delivery and further age bands as they become eligible. Workplace vaccination is being assessed as an opportunity to improve equitable access for priority populations. Locally, this is being considered to reach workplaces with high numbers of Māori and Pasifika staff. The planning team is also considering the delivery approach for 12 to 15-year-olds, which is expected to be approved by Cabinet in late June.

Ensuring local public communications are aligned to national communication continues to be of critical importance as the country moves toward delivering to the wider population of Group Four from September. Key to this will be clear information regarding how and where to book.

Current challenges and risks include the ability to complete the necessary recruitment to deliver to the scale required in Group Four, and the necessity for a successful transition to the NIBS to support the scale of invitation and bookings required.

3. REGIONAL MATTERS

3.1. Regional Services Plan

The region has agreed five priority work programmes as integral to this year's Regional Service Plan.

- Planning for Sustainable Complex Care (Tertiary) Sustainability
- Developing Regional Single Systems of Care Prototyping Orthopaedics
- Developing a Plan for Regional Specialist Mental Health and Addiction Services
- Implementing the Regional Cardiology Plan
- Developing a Regional Frailty Model of Care.

3.1.1. Regional Complex Care Sustainability Update

The regional Chief Executives have agreed to discontinue this programme, which is expected to be developed nationally as part of the health sector reform transition process.

3.1.2. Single System of Care Update

Synergia have facilitated regional workshops with orthopaedic stakeholders at each DHB. Notes are being prepared and proposed solutions for a clinical network will be developed. Synergia presented an update to Te Koro Matua ki Ikaroa on the key gaps and opportunities to address equity across the orthopaedic planned care pathway. The draft report is expected toward the end of July.

3.1.3. Mental Health and Addictions Services Update

Extensive engagement has been undertaken across the central region with DHBs, Non-Government Organisation providers, whānau and consumer groups to develop the final report from Francis Health, which concludes Phase One. The report includes a wide range of both lived experience and system-oriented recommendations. As part of Phase Two, TAS will use the report to draft programme work streams to be reviewed by the Steering Group at the end of June. A noting paper will be prepared for the Regional Partnership Group meeting in July.

3.1.4. Regional Cardiology Plan Update

The Regional Cardiac Network has reviewed and revised the cardiac KPI indicators. Work has commenced in primary care to progress an Atrial Fibrillation initiative. A review of clinical risk and solutions regarding the development of a total cardiology service in MidCentral and Hawke's Bay DHBs has begun.

3.1.5. Frailty Model of Care Update

Francis Health have consulted on the Frailty Framework with Māori and Pacific providers. They have also met with Ambulance Services to explore options for trialling an iteration of interRAI ED Screener. The first draft of the report from Francis Health has been submitted to TAS. A revised draft report is being developed based on TAS feedback and is expected to be completed by the end of June. It will then be presented to the Regional Partnership Group's meeting in July.

4. NATIONAL MATTERS

4.1. National Chief Executives meeting 10 June

The meeting included an update following the Waikato DHB cyber security attack. This outlined the timeline, recovery steps, work completed in the sector and a future strategy to reduce the risk for the health sector.

The Transition Unit provided an update on their work programme and the future system operating model. Future funding flows from Health New Zealand are starting to be considered. Work has begun with the Health Quality and Safety Commission to develop the consumer voice framework. Locality prototyping is expected to commence in September/October 2021. Work has begun to identify the key information Health New Zealand requires from DHBs prior to the 1 July 2022 transition, from both a fiscal and risk perspective. Investment principles to guide decisions during the transitional period are being developed.

TAS provide support to the national Chief Executives and the work programme. The 2021/22 year has been budgeted at the same amount as the 2020/21 financial year.

4.2. Association of Salaried Medical Specialists (ASMS)

Bargaining continues between DHBs and the Association of Salaried Medical Specialists (the union covering senior doctors). It is understood that ASMS will be seeking a stop work meeting of up to two hours, as provided for in the Senior Medical and Dental Officers Collective Agreement. The purpose of the stop work meeting will be for ASMS to update their members on progress being made to settle this collective agreement and to seek feedback from their members on the next steps. If a stop work meeting notice is received, MDHB will work to ensure that as many Senior Medical Officers as possible can attend. ASMS is required to make arrangements with MDHB to ensure essential activities are maintained during the period of the stop work meeting.

4.3. Resident Doctors' Association (RDA) Collective Bargaining

Bargaining continues for the Resident Doctors' Association (junior doctors). An offer for settlement has been made to the union, who will be taking the offer to members for ratification. The results of the ratification ballot are expected to be known by 5 July.

4.4. NZ Nurses Organisation (NZNO) Strike

In accordance with strike notice issued by the NZNO, nursing, midwifery and health care assistants covered by the NZNO Multi-Employer Collective Agreement (MECA) withdrew their labour on Wednesday 9 June 2021 between 11am and 7pm. The strike action covered all NZNO members working at Palmerston North Hospital, Horowhenua Health Centre and other MDHB facilities. MDHB maintained Life Preserving Services for its patients as part of the agreement mutually agreed with NZNO prior to the strike action. DHB and NZNO negotiation parties have agreed to reconvene on 30 June and 1 July 2021 to recommence bargaining, with assistance from an independent facilitator. It is understood that NZNO will run a further strike action ballot from Monday 28 June until Tuesday 6 July 2021. In line with the preferences expressed by NZNO members in response to a survey, the ballot is expected to include options for multiple strike days.

4.5. Pay Equity and Multi-Employer Collective Agreement (MECA)/Single Employer Collective Agreement (SECA) Bargaining Update

The following progress has been made by the District Health Board (DHB) negotiating team across various workforces and unions with pay equity claims.

- The agreement reached between DHBs and the Public Service Association (PSA) in November 2020 included a commitment to pay an interim adjustment amount to clerical and administration employees covered by the claim in the first quarter of 2021. Following funding from the Ministry, MDHB paid this interim amount to affected staff in April 2021. The remaining work

associated with this claim is being led nationally between the PSA and DHBs and is expected to be completed by the middle of 2021. DHBs expect an update on the implementation of the second phase of implementing this claim by 30 June 2021.

- Negotiations with NZNO, the Association of Professional and Executive Employees (APEX), PSA (Allied and Scientific, and Nursing roles) and the Midwifery Employee Representatives and Advisory Services (MERAS) unions continue on pay equity claims.

4.6. End of Life Choice Act 2019

The End of Life Choice Act 2019 provides for an assisted dying service to be available in New Zealand from 7 November 2021. Information received from the Ministry on the implementation of the Act is being shared with staff as it is received. The Ministry's website includes an online module for health professionals and an information sheet on the Act. A forum on assisted dying will be held in late September.

4.7. Health and Disability Sector Reform

Given the strong interest in the Hauora Māori work stream, including the establishment of the Māori Health Authority, the Transition Unit joined the combined Board and Manawhenua Hauora meeting on 25 May 2021 to discuss this work stream. Weekly Zoom meetings have been held for all Chief Executives to coordinate transition efforts.

An update from the Transition Unit of the Department of the Prime Minister and Cabinet was sent to all Board members as part of the Chief Executive's weekly email on Friday 18 June 2020. Expressions of interest for Interim Board members for both the Māori Health Authority and Health New Zealand closed on 18 June.

5. ORGANISATIONAL LEADERSHIP TEAM AND STAFFING MATTERS

5.1. Change of Operational Leadership – Te Uru Whakamauora

Andrew Nwosu, Operations Executive for Te Uru Whakamauora, Healthy Ageing and Rehabilitation, resigned from his role, effective from 30 June 2021. The easing of travel restrictions and family reasons were pivotal in Andrew's decision to leave after nearly three years. While the future structure of Te Uru Whakamauora is considered, Lyn Horgan, the Operations Executive of Te Uru Arotau, Acute and Elective Specialist Services, will provide support to Te Uru Whakamauora. A consultation document will be released in early July.

5.2. Midwifery Leadership

The Midwifery Leadership decision document was released by Te Uru Pā Harakeke, Healthy Women, Children and Youth, on 24 June. The decision paper outlined enhanced midwifery leadership to ensure high standards of safety for staff, wāhine and pēpi 24 hours a day.

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the dashboard provide insight on key areas of performance for the Board in an easy-to-understand format?

To	Board
Author	Kelly Isles, Director of Strategy, Planning and Accountability Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance
Endorsed by	Kathryn Cook, Chief Executive
Date	16 June 2021
Subject	**Board KPI Dashboard**

RECOMMENDATION

It is recommended that the Board:

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

Strategic Alignment

This report is aligned to the District Health Board's (DHB's) strategy and key enabler, 'Stewardship'.

1. INTRODUCTION

This report provides a regular overview of key performance metrics, applying a Māori health equity perspective to all measures (as appropriate) and highlighting where there are significant changes in trends.

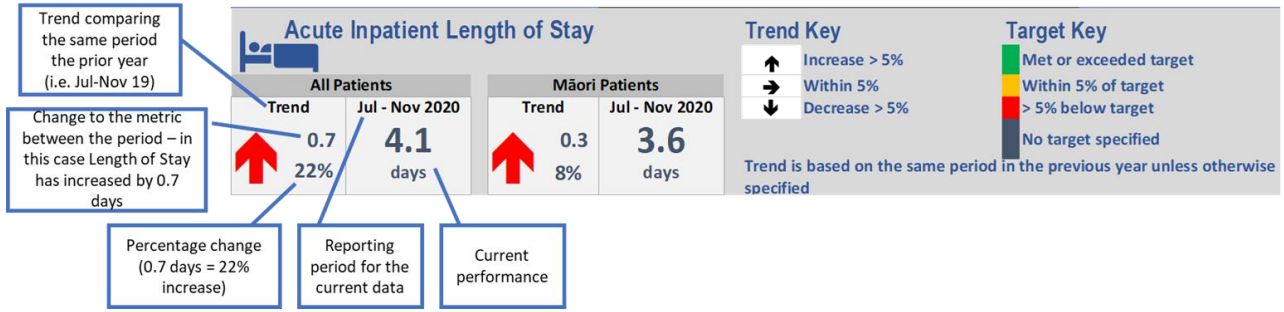
The dashboards in this report present a high level overview of key indicators. In future the quarterly non-financial Board reports will be closely linked, where appropriate, to these reports and provide a closer look at areas of concern, difference or non-performance to explain why this has occurred and the work being undertaken or planned to address this.

The data and trends in the following dashboards are compared to the same period in the previous year. It's important to note the following dashboards in this report are in direct comparison to the April reporting period last year when the country was in a national lockdown. While we can draw some assumptions from the data, it is difficult to directly compare the two periods. Therefore, for this report the focus is on areas of continued challenge or non-performance, in particular:

- Smoking Brief Advice (SBA)
- Immunisations
- Discharges from Mental Health Services
- Acute Inpatient Length of Stay.

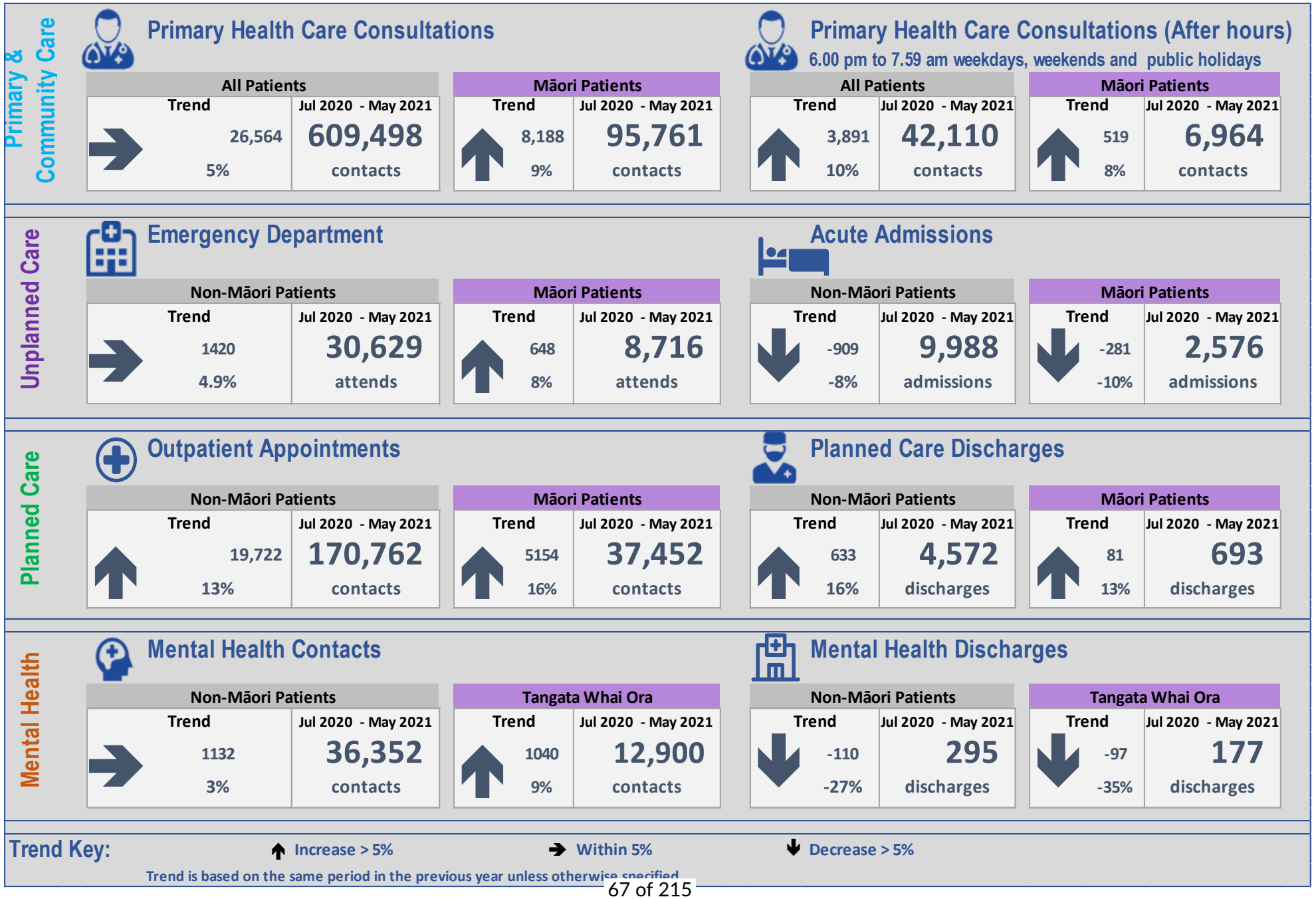
Overall, there are no significant changes noted for the KPI indicators compared to the last reporting period in May.

The metrics follow the format outlined below. Green or red trend arrows are used to indicate favourable and unfavourable trends. Where a target exists for a particular metric, the 'Current performance' is colour coded as per the key below.



The underlying data for some metrics will change over time, due to a clinical coding lag. This is particularly relevant for recent data.

2. SERVICE VIEW



2.1. Service View Commentary

2.1.1. Primary and Community Care

Primary Health Care Consultations (PHC Consultations)	
Changes compared to last reporting period	Consultations are up slightly in May 2021 compared to the start of the year as the country approaches winter and flu Season.
Changes compared to this time last year	The same time last year was more complex due to COVID-19 moving into lockdown on 25 March 2020, which resulted in a large surge in people collecting repeat prescriptions, this resulted in large consultation numbers for March 2020. As expected, this was followed by a reduction in consultations during the April lockdown period.

2.1.2. Unplanned Care

Acute Admissions	
Changes compared to last reporting period	No significant changes are noted for acute admissions from the last reporting period. They remain lower by eight and ten percent for Non-Māori and Māori patients respectively. Whilst the acute admissions remain lower, this measure does not show the acuity and complexity of patients admitted during the period. There has been a reduction in the number of children admitted acutely, in part, due to the public health messaging of the importance of hand hygiene and staying home when unwell.

Emergency Department	
Changes compared to last reporting period	No significant changes are noted.
Changes compared to this time last year	Unplanned care saw an increase in presentations to the Emergency Department (ED) for both Non-Māori and Māori at 4.9 percent and eight percent respectively. Although this increase appears high it needs to be taken into consideration the impact of lockdown in the previous comparative period, where there was a significant reduction in Emergency Department presentations.

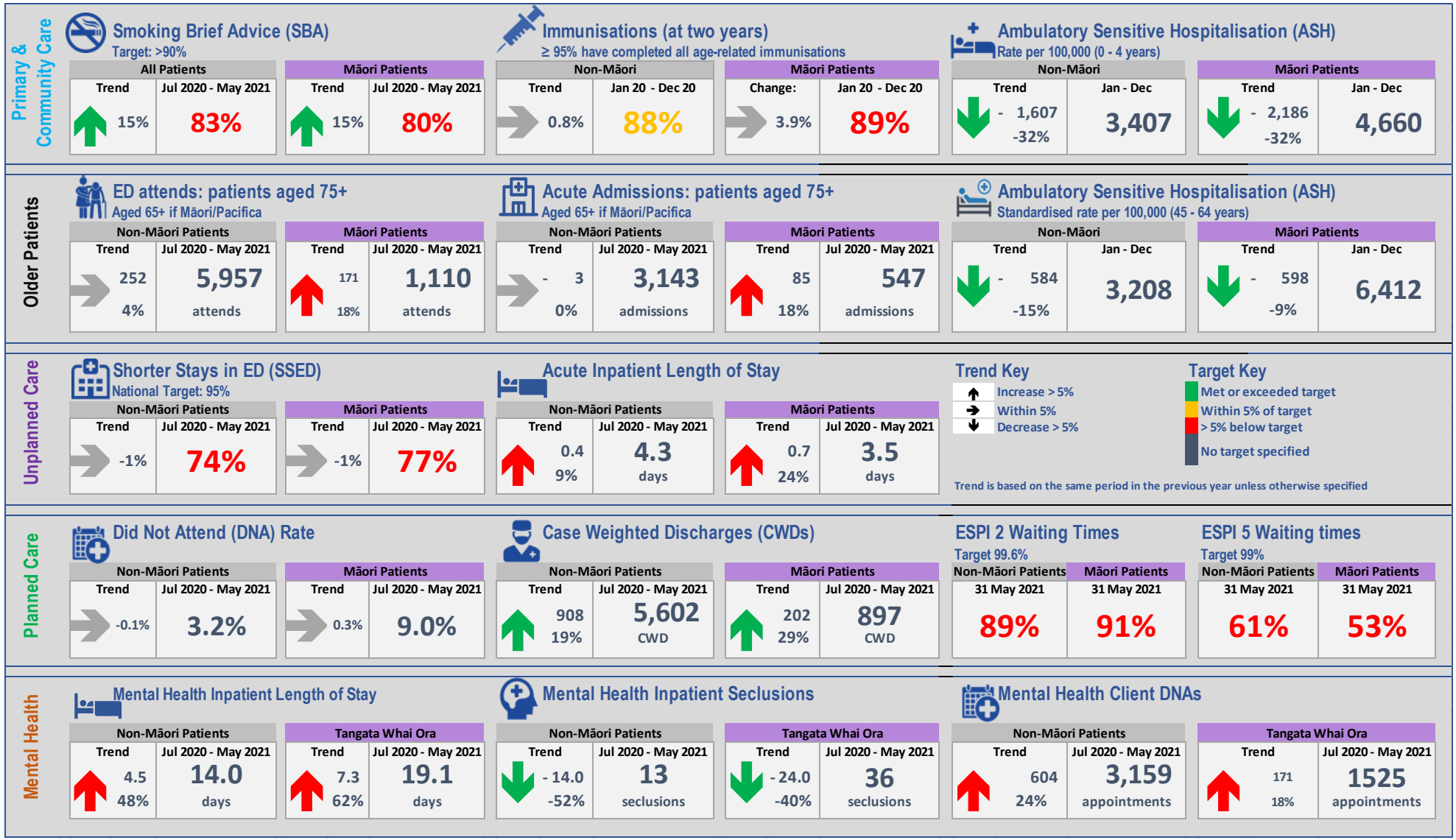
2.1.3. Planned Care

Outpatient Appointments and Planned Care Discharges	
Changes compared to last reporting period	No significant changes are noted for planned care from the last reporting period.
Changes compared to this time last year	As expected, outpatient contacts and planned discharges have increased. This is largely a result of the COVID-19 lockdown along with the partnership with Crest Hospital. Learnings from COIVD-19 and digital enablement going forward will help reduce the impact of future out breaks of COVID-19 lockdowns on outpatient appointments in some cases.

2.1.4. Mental Health

Mental Health Contacts and Mental Health Discharges	
Changes compared to last reporting period	No significant changes are noted. Discharges from Mental Health Services have reduced significantly, which is consistent with the increased length of stay seen in the inpatient metrics. Actions to improve this KPI were outlined in the last reporting period.
Changes compared to this time last year	People accessing Mental Health and Addictions services have seen increased contacts particularly for Children and Adolescent Family Services and Adult Community Mental Health and Addictions services in the Horowhenua and Tararua localities. Despite this increase people are being seen within defined parameters. Every person seen is assessed against risk and appropriately supported, noting that the proposed Integrated Model of Care prioritises resources for Māori and localities

3. PERFORMANCE VIEW



3.1. Performance View Commentary

3.1.1 Primary and Community

Smoking Brief Advice (SBA)	
Changes compared to last reporting period	No significant changes are noted. Smoking brief advice rates continue to be held at the new level achieved in December 2020
Changes compared to this time last year	A significant 15% uplift in SBA rates has been achieved on the same time last year, for both Total and Māori. This reflects a significant input from THINK Hauora supported by the PHC network.
Actions for improvement	THINK Hauora aims to lift performance to 85% by the end of June 2021. This will be achieved by: • Focused PHO resource for practices needing support to lift performance • Proactive contacting of current smokers who need brief advice, not waiting to present at practice • Growing evidence-base for number of enrolled smokers with disconnected phone numbers or no contact current details, to support quality improvement activities • Monitor practices delivering COVID vaccinations to ensure BAU activities (including SBA) do not slip

Immunisations	
Changes compared to last reporting period	No significant changes are noted. Both Nation-wide, and District-wide reductions in immunisation rates to below Herd Immunity rate. District immunisation rates have been static/or reducing consistently for the past 18 months. Māori continue to be less likely to have been fully immunised on time across all milestone ages.
Changes compared to this time last year	Last year immunisation levels were affected by the lockdown which meant that many children could not come into general practice when they were due (e.g., April and May). This year there is a heightened sense of awareness around immunisations which poses different challenges, some presented by COVID. These include: • Increased discussion amongst whanau and communities about immunisations, triggered by COVID, which is increasing anxiety and misinformation resulting in vaccination hesitancy (reported by community outreach, general practice and THINK Haora Imms Team) • Increased and rigorous campaigning by anti-vax campaigners (particularly in Horowhenua) • Mobility of Māori and Pasifika whānau (particularly in the Horowhenua) and access to general practice • Pressure on the vaccination workforce (general practice and community outreach) with the roll out of the COVID vaccine and developing the new systems to do so.
Actions for improvement	THINK Hauora already undertaking remediation action to lift performance, including: • Maintaining a focus on completion of childhood immunisation recalls by all vaccinators within general practice. • Target practice overdue lists and ring and support whānau to book appointments convenient for them • Strengthening connections and processes with outreach providers such as Te Waka Huia, timely sharing of data and resource to monitor referral trends and implement other solutions for community immunisation clinics – i.e.: afterhours/weekends. • Training sessions for staff on how to use and access immunisation stats to increase timely monitoring and dissemination of information to stop data silos. • Monitor practices delivering COVID vaccinations to ensure BAU activities (including childhood immunisations) do not slip.

3.1.2 Older Patients

Older Patients	
Changes compared to last reporting period	No significant changes are noted. Additional information on OPAL is outline in the non – financial reporting.
Changes to compared to this time last year	There is no significant change in the trend compared to this time last year.

3.1.3 Unplanned Care

Shorter Stays in ED	
Changes compared to last reporting period	ED attendances show no significant change from the last reporting period. Overall performance in ED continues to be impacted by high occupancy in inpatient wards (at over 100 percent). This is due to the increased acuity and complexity that impacts inpatient length of stay.
Actions for improvement	A refreshed plan is in place. Bed availability to move patients out of ED is a major factor. The new model for acute admissions continues to be piloted for medical services. This actively encourages patients to be placed into the appropriate inpatient ward. For example, MAPU for patients with expected length of stay less than 48 hours. Due to bed availability at times of significant presentations, bed block can hinder this. The directorate met with the Clinical Council in May to discuss acute demand and some of the plans in place. The Clinical Council were very supportive of the approach. The Clinical Council acknowledged that all DHBs are under significant acute pressure. Additional information on the initiatives for unplanned care will be provided to HDAC as part of the Directorate Dashboard.

3.1.4 Planned Care

Planned Care	
Changes compared to last reporting period	No significant changes are noted.
Actions for improvement	There are 396 non-Māori patients waiting longer than four months for a First Specialist Appointment (FSA); 265 have been booked for a FSA; and 186 of these patients have been allocated an appointment to be seen before the end of June 2021. There are currently 67 Māori patients waiting longer than four months for an FSA. Out of these, 44 patients have already been allocated an appointment to be seen, of which 30 will be seen by the end of June 2021. While ESPI5 remains an area of challenge MDHB has been working in partnership with Crest Hospital to provide outsourced surgery to further improve performance in this area.

3.1.5 Mental Health

Mental Health	
Changes compared to last reporting period	No significant changes are noted.
Actions for improvement	The average length of stay is currently being affected by five individuals (three non-Māori, two Māori) who have been inpatients for over 100 days, as detailed in the last report. These service users require long term rehabilitation in the community, work is currently underway with a provider to formalise a supported accommodation option in the community. There is consistently five or fewer seclusions per month, which is a significant reduction. The duration of seclusion (or hours spent in seclusion) has been greatly reduced. The Ward continues to strive towards the zero-seclusion goal by identifying patterns and addressing these. Further improvements and reductions in seclusion are anticipated over the next 15 months of the project. Access to and choice of appointments are stated as the most common reason for Did Not Attends (DNAs). Service users who miss appointments are followed up by the clinical teams and where possible, another appointment is immediately offered. Analysis of the data shows disproportionately high rates of DNAs for Māori when compared to non-Māori. Anecdotal feedback suggests this is related to a lack of cultural options available for Māori when accessing secondary mental health and addictions services.

4. METRIC DEFINITION

The underlying data for some metrics will change over time, due to a clinical coding lag. This is particularly relevant for recent data.

4.1. Service View Metric Definitions

Metric	Definition	Exclusions
Primary Care consultations (All)	All primary care consultations that occur in general practice/ IFHC settings (incl. virtual, casual).	COVID-19 testing centres; community and marae-based clinics; primary care consults at THINK Hauora; community based mental health; ACC, Immunisations and Maternity. Excludes Masonic Medical, 1 July 2019 to 13 October 2019 only. Data is missing for Tararua Medical Centre and Village Medical (i.e. 5,300 patients) for 2019 due to these practices refusing to sign data sharing Schedules. They are included for 2020.
Primary Care Consultations (after hours)	Subset of consultations that are 6.00 pm to 7.59 am weekdays, weekends and observed public holidays	As above
People in Aged Residential Care	TBC	
Emergency Department	Number of presentations to the emergency department	
Acute Admissions	Number of patients admitted acutely to the DHB (admission type 'AC')	M05 - Emergency Department specialty
Outpatient Appointments	Outpatient appts attended - based on Booking Date between parameters	
Planned Care Discharges	Planned care discharges between the reporting period - includes local and IDF inflow	
Mental Health Contacts	The number of client-related activities (as per MoH definition) that involved client participation (DNAs, Family without Client and Service co-ordination activities omitted, written correspondence and SMS messages sent to clients omitted).	
Mental Health Discharges	Mental health ward discharges	

4.2. Performance View Metric Definitions

Metric	Definition	Exclusions
Smoking Brief Advice (SBA)	Percentage of current smokers (or recent ex-smokers) who have received brief advice to quit smoking or an offer of cessation support in the last 15 months	Patients not enrolled with THINK Hauora; non-coded smoking status and SBA; smokers under 16 years of age
Immunisations (at two years)	As per the Ministry definition used in the non-financial metrics	
Ambulatory Sensitive Hospitalisation (ASH)	As per the Ministry definition used in the non-financial metrics	
Ambulatory Sensitive Hospitalisation (ASH)	As per the Ministry definition used in the non-financial metrics	
Shorter Stays in ED (SSED)	Ministry definition - patients discharged from the emergency department within 6 hours of arrival in the department	
Acute Inpatient Length of Stay	The average length of stay for acutely admitted patients discharged during the reporting period with an admission type of (AC)	
ESPI 2 Waiting Times	As per the Ministry definition used in the non-financial metrics	
Did Not Attend (DNA) Rate	Patients who did not attend their booked outpatient appointment	
ESPI 5 waiting times	As per the Ministry definition used in the non-financial metrics	
Case Weighted Discharges (CWDs)	The case weight derived from eligible coded planned care inpatient discharges	
Mental Health Inpatient Length of Stay	The average length of stay for mental health admitted patients discharged during the reporting period	
Mental Health Inpatient Seclusion rate	The number of seclusion events in the reporting	
Mental Health Client DNAs	The number of unattended booked appointments	
ED attends: patients aged 75+	Presentations at the ED for patients aged over 75 years or Māori and Pacific patients aged over 65 years	
Acute Admissions: patients aged 75+	Acute inpatient admissions for patients aged over 75 years or Māori and Pacific patients aged over 65 years	

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

To	Board
Author	Darryl Ratana, Deputy Chief Financial Officer
Endorsed by	Neil Wanden, General Manager, Finance and Corporate Services
Date	17 June 2021
Subject	**Financial Update – May 2021**

Key questions the Board should consider in reviewing this paper:

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

RECOMMENDATION

It is recommended that the Board:

- **note** that the month operating result for May 2021 is a surplus before one-off items of $0.219m, which is $0.735m favourable to budget
- **note** that the year to date result to May 2021 is a surplus before one-off items of $0.399m, which is $3.857m favourable to budget
- **note** that year to date to May 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act costs of $2.978m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.680m, which is $0.779m favourable to budget
- **note** that the total available cash and equivalents of $45.9m as at 30 May 2021 is sufficient to support liquidity requirements
- **note** that this is an interim finance report and that a full report will be presented to the Board for consideration at its August meeting.

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

1. PURPOSE

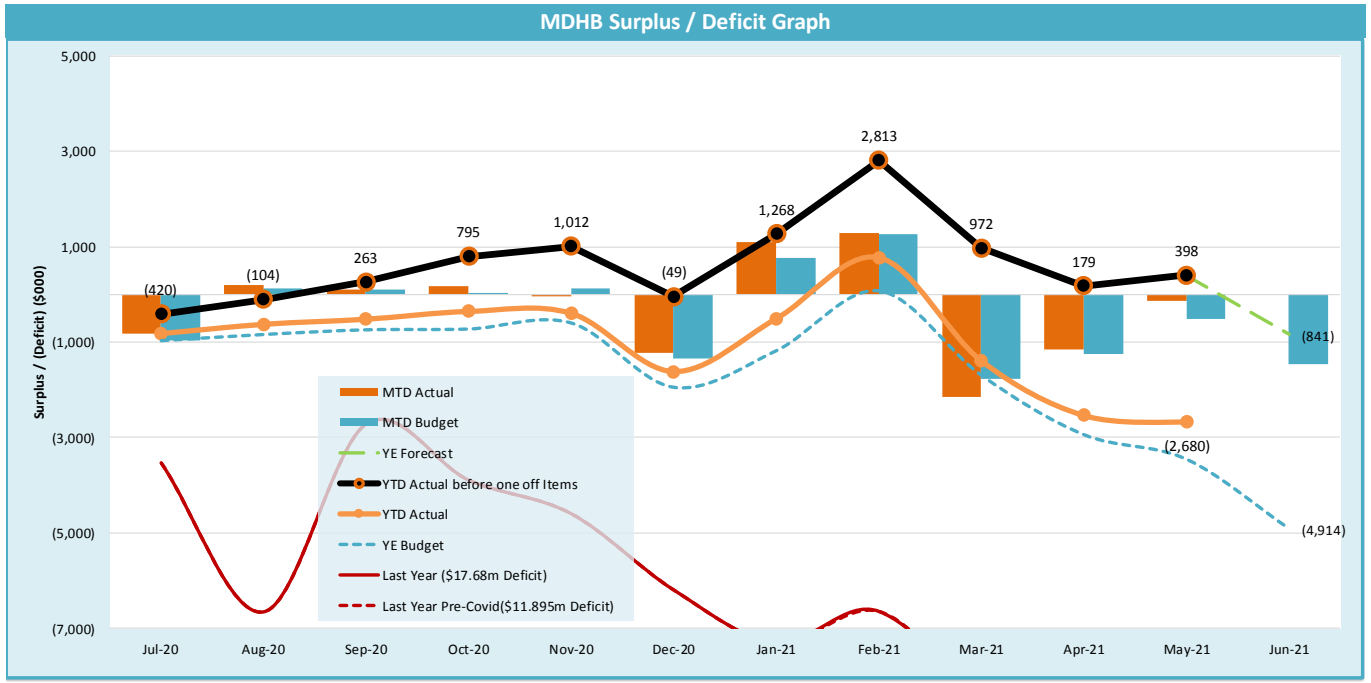
This report is provided for information and consideration by the Board. No decision is required. This is an update paper and a full finance report will be provided to the Finance, Risk and Audit Committee meeting on 27 July 2021.

2. FINANCIAL PERFORMANCE

The MidCentral District Health Board's (MDHB) result for May 2021 is a surplus before one-off items of $0.219m, which is $0.735m favourable to budget. Net revenue for the month is $2.745m favourable to budget and is partially offset by expenditure $2.053m adverse to budget. The year to date result is a surplus of $0.399m, which is $3.857m favourable.

Year to date COVID-19 related net costs of $0.100m and unbudgeted Holidays Act costs of $2.978m have been incurred. This results in a year to date deficit of $2.680m when these one-off costs are included.

The financial performance to date and projected trends are consistent with outperforming budget at an operating level, excluding the impact of the Holidays Act, COVID-19 and any year-end valuations. The current forecast suggests a year-end deficit before one-off items of $0.841m, which is $4.073m favourable to budget. The following chart shows the progress of monthly performance against budget.



The Statement of Financial Performance is shown in the following table. Note that unbudgeted costs relating to the Holidays Act and COVID-19 are separately disclosed so that the underlying performance can be easily viewed.

$000	May 2021			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Current Forecast	Budget	Variance
Net Revenue	**63,096**	**60,351**	**2,745** ✓	**676,102**	**663,746**	**12,356** ✓	**737,057**	**724,207**	**12,850**
Expenditure									
Medical	6,701	6,958	257 ✓	69,956	75,520	5,564 ✓	76,676	82,828	6,152
Nursing	9,095	8,501	(594) ✗	96,839	92,823	(4,016) !	105,904	101,337	(4,567)
Allied Health	3,151	3,200	49 ✓	32,889	34,846	1,957 ✓	36,144	38,251	2,107
Support	155	151	(4) !	1,600	1,684	84 ✓	1,764	1,848	84
Management / Admin	3,204	3,092	(112) !	32,911	33,627	716 ✓	36,372	36,921	549
Personnel	22,307	21,902	(405) !	234,195	238,500	4,305 ✓	256,860	261,186	4,326
Outsourced Personnel	863	315	(548) ✗	10,355	3,460	(6,895) ✗	11,098	3,788	(7,311)
Sub -Total Personnel	23,170	22,217	(953) !	244,550	241,961	(2,590) !	267,958	264,974	(2,984)
Other Outsourced Services	2,220	2,043	(177) ✗	25,474	22,452	(3,022) ✗	27,837	24,540	(3,297)
Clinical Supplies	5,119	4,958	(161) !	56,624	54,422	(2,203) !	62,050	59,539	(2,511)
Infrastructure & Non-Clinical	6,525	5,975	(550) ✗	65,311	64,880	(431) !	71,505	70,889	(616)
Provider Payments	26,031	25,820	(211) !	286,160	285,070	(1,089) !	311,095	310,890	(205)
Total Operating Expenditure	**63,065**	**61,012**	**(2,053)** !	**678,120**	**668,785**	**(9,335)** !	**740,445**	**730,831**	**(9,613)**
Operating Surplus/(Deficit)	**31**	**(661)**	**692** ✓	**(2,018)**	**(5,039)**	**3,021** ✓	**(3,387)**	**(6,624)**	**3,237**
Enable Contribution	188	145	43 ✓	2,416	1,580	836 ✓	2,546	1,710	836
Surplus/(Deficit) Before One-Off Items	**219**	**(516)**	**735** ✓	**399**	**(3,459)**	**3,857** ✓	**(841)**	**(4,914)**	**4,073**
Holidays Act	(362)	0	(362) ✗	(2,978)	0	(2,978) ✗	(38,349)	0	(38,349)
Covid-19	(0)	0	(0) ✗	(100)	0	(100) ✗	(100)	0	(100)
Surplus/(Deficit)	**(143)**	**(516)**	**373** ✓	**(2,680)**	**(3,459)**	**779** ✓	**(39,291)**	**(4,914)**	**(34,377)**

Favourable revenue primarily relates to both Planned Care activity and Inter-District Flow (IDF) revenue in Te Uru Arotau – Acute and Elective Specialist Services and Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services.

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

- The adverse variance in Personnel costs (excluding Outsourced Personnel) of $0.405m relates to nursing and administration staff. The trend of monthly unfavourable variances in nursing for Te Uru Rauhī – Mental Health and Addiction Services and Te Uru Arotau continue. Administration staff costs also feature in these to Directorates, as well as in Corporate and Professional Services.
- Favourable medical staff costs are offset by outsourced locum costs that are $0.275m adverse and mainly feature in Te Uru Rauhī – Mental Health and Addiction Services. The remainder of the unfavourable variance in Outsourced Personnel is in nursing and in administration (Digital Services).
- FTEs are 2,402 for the month, a slight decrease from last month and 27 FTE below budget. The FTE variance pattern mirrors personnel cost variances with nursing FTEs above budget (by 17 FTE), offset by other categories. The forecast is that the DHB will end the year on 2,437 FTEs and reflects a 137 FTE increase since June 2020.
- Other Outsourced Services are adverse to budget mainly due to Outsourced Radiology expenditure of $0.388m in Te Uru Arotau and Te Uru Mātai Matengau.
- Treatment supplies ($0.120m) in Te Uru Arotau is the source of adverse clinical supply expenditure.
- Infrastructure and Non-Clinical costs are $0.550m adverse to budget. The fundamental cause of this variance is the unbudgeted costs of goods sold in the hospital pharmacy ($0.267m). This is offset by unbudgeted income. The remainder largely relates to IT depreciation and software maintenance costs.

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

- Unbudgeted Holidays Act expenditure for the month includes a $0.100m increase in the provision, with the remainder being project costs.
- COVID-19 expenditure for the month includes $0.492m of immunisation costs, fully offset by reimbursing revenue.

3. YEAR-END FORECAST

The current year-end forecast projection before one-off items is for a deficit of $0.841m. This is a $4.073m improvement on the budget approved by the Board.

The forecast after one-off items is for a deficit of $39.291m which leads to a significant variance to budget. The forecast now incorporates the year-end adjustment for the updated Holidays Act liability estimate. Projected Holidays Act expenditure of $38.349m includes project costs and the impact of the revalued liability.

The projected year-end cash and deposit balances are $26.648m, which is better than the budget by $18.983m.

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 and Corporate Services
Date	16 June 2021
Subject	**Finance Report – April 2021**

Key questions the Board should consider in reviewing this paper:

- Is the current financial performance and trend in performance sustainable?
- Are the unfunded risks from COVID-19 and Holidays Act compliance manageable in the near term?
- 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 this paper was endorsed by the Finance, Risk and Audit Committee at their 15 July meeting
- **note** that the month operating result for April 2021 is a deficit before one-off items of $0.793m, which is $0.452m favourable to budget
- **note** that the year to date result for April 2021 is a surplus before one-off items of $0.179m, which is $3.122m favourable to budget
- **note** that year to date for April 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.616m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.537m, which is $0.406 favourable to budget
- **note** that the total available cash and equivalents of $48.7m as of 30 April 2021 is sufficient to support liquidity requirements
- **approve** the April financial report.

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

1. REPORT AT A GLANCE

The result for April 2021 is a deficit before one-off items of $0.793m, which is $0.452m favourable to budget

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

Month to Date

Surplus/(Deficit)
($0.8m)
Budget Variance
$0.452m
36.3%

FTEs
2,408
Budget Variance
16
0.6%

Capex
$1.2m
Budget Variance
$6.9m
85.3%

Cash & Deposits Movement
$3.3m
Budget Variance
$6.4m
206.5%

Month Successes

* Medical Staff close to budget with adverse Outsourced offset by own staff vacancies
*Additional funding for specific projects and pay equity
* FTEs within budget but gap is closing

Month Challenges

* Adverse Acute and Elective and Mental Health and Addictions Service (MHAS).
* High Acute and Elective and High Ward 21 demand
* Adverse nursing costs - Outsourced and own staff
* Adverse Treatment supplies, instrument & pharmaceuticals
* Capex well behind budget but has a positive impact on cash

Forecast Accuracy

Actual result for April favourable by $0.083m to the forecast anticipated for the month.

Year to Date

Surplus/(Deficit)
$0.2m
Budget Variance
$3.122m
106.1%

FTEs
2,352
Budget Variance
54
2.2%

Capex
$17.9m
Budget Variance
$25.4m
58.7%

Cash & Deposits
$48.7m
Budget Variance
$32.7m
204.4%

Current Ratio
1.01
Budget Variance
0.20

Year to Date Trends

* Favourable Planned Care The current level of activity is unlikely to continue.
* Personnel Costs adverse to budget due to nursing. Year end forecast suggests this will continue. FTE gap to budget is closing.
* Positive Cluster (WC&Y, PPCH, CSTS) and Enable NZ contributions.
* Adverse IT depreciation that is offset by favourable depreciation else where.
* Adverse Acute and Elective and Mental Health and Addictions Service (MHAS).

Potential Budget Risks

Eight Risks in Total. No change since last month

Four Low Risks (no change)
Four Tolerable Risks (No change)
Nil Emerging Risk (no change)
Nil Risk Materialised (no change)

Year End Forecast

Surplus/(Deficit)
($0.8m)
Budget Variance
$4.12m
83.9%

FTEs
2,365
Budget Variance
45
1.9%

Capex
$27.3m
Budget Variance
$26.2m
49.0%

Cash & Deposits
$22.9m
Budget Variance
$15.3m
200.3%

Current Ratio
0.85
Budget Variance
0.20

Year End Forecast

This forecast was provided to the MoH in May and includes April year to date actuals.

A year end deficit before one off items that is $4.1m favourable to budget is projected. This is prior to absorbing an estimated $38.5m of unbudgeted Holidays Act and Covid-19 costs.

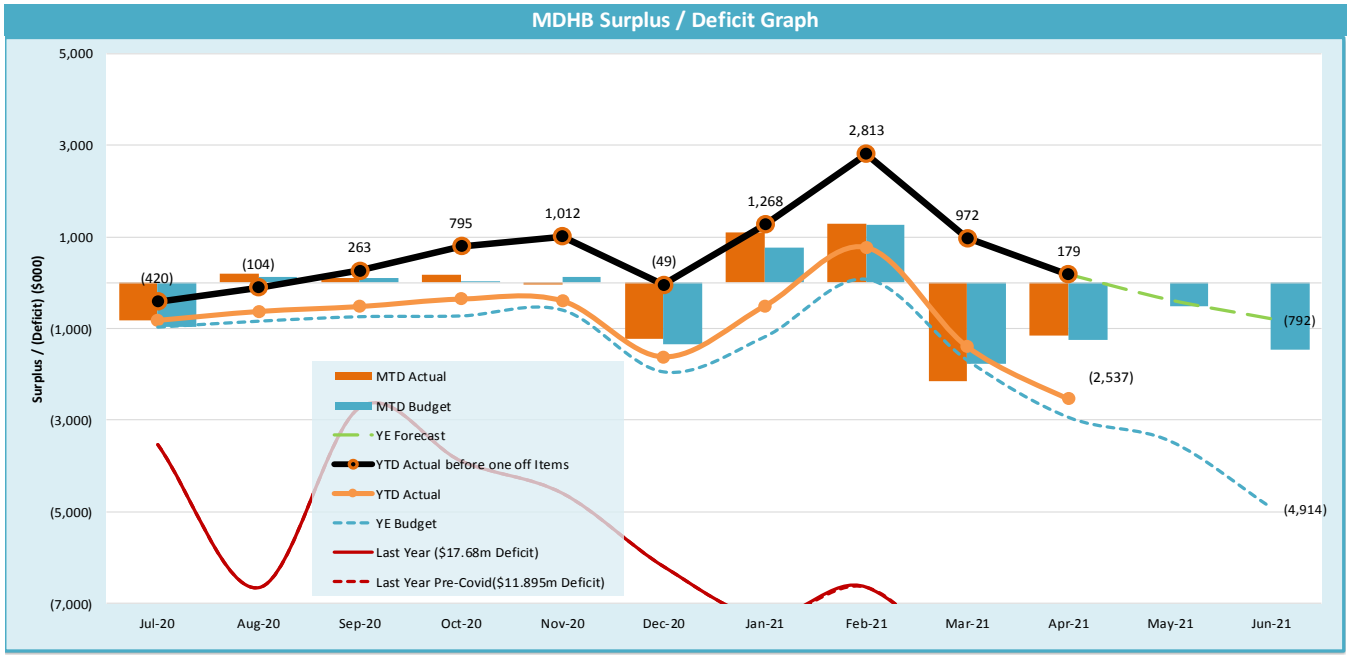
Significant challenges include, Acute and Elective and MHAS. HAR (Healthy Ageing) is now back on track after a number of monthly positive results. MHAS has identified savings which have been incorporated into the forecast.

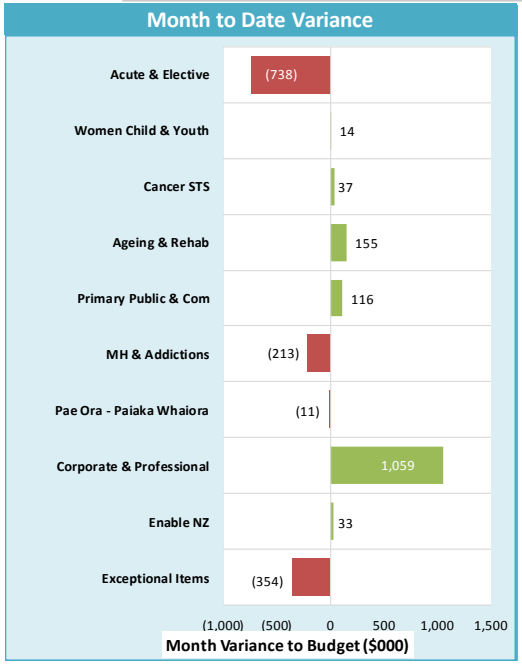
While projected employed FTEs are lower than budget, this is partially offset by outsourced staff. Note that June 2021 FTEs are anticipated to be at 2,420. This is 25 more FTE than the current month.

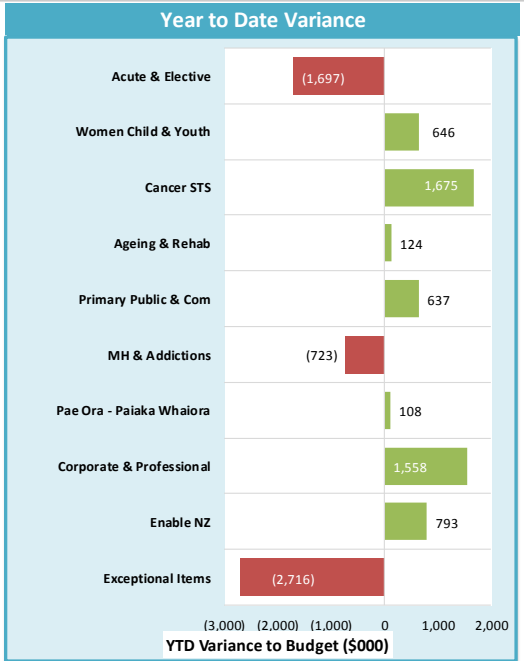
The current forecast for capital expenditure and cash balances reflects delays in capital projects leading to a positive year to date cash position before those deferred outgoings occur.

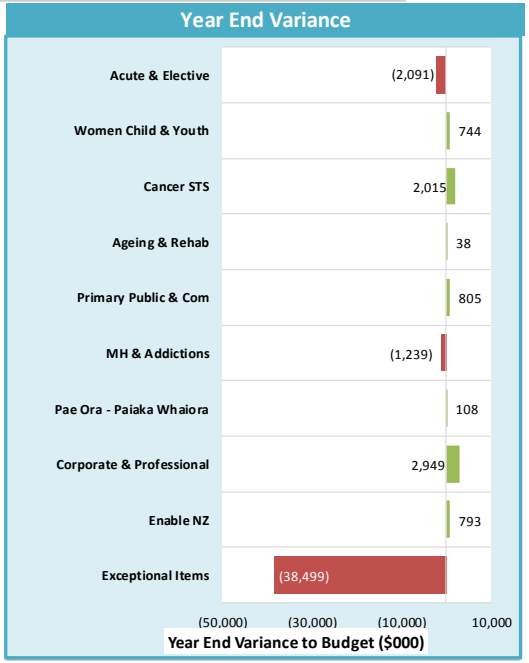
The Current Ratio is a measure of liquidity. It is defined by the Ministry of Health as current assets over current liabilities (excluding employee entitlement provisions). As a comparison, the latest reported average for peer DHBs is 0.6

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 April 2021 is a deficit before one-off items of $0.793m and is $0.452m favourable to budget. Net revenue for the month is $2.040m favourable to budget and is partially offset by expenditure which is $1.620m favourable to budget. The year to date result is a surplus of $0.179m, which is $3.122m favourable to budget.

Year to date COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.616m have been incurred. This results in a year to date deficit of $2.537m when these one-off costs are included.

The financial performance to date and projected results for the remaining two months suggests the budget will be outperformed at an operating level before the inclusion of the Holidays Act, COVID-19 and any year-end valuations are considered. The current forecast suggests a year-end deficit before one-off items of $0.792m, which is $4.122m favourable to budget.

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

BOARD REPORT

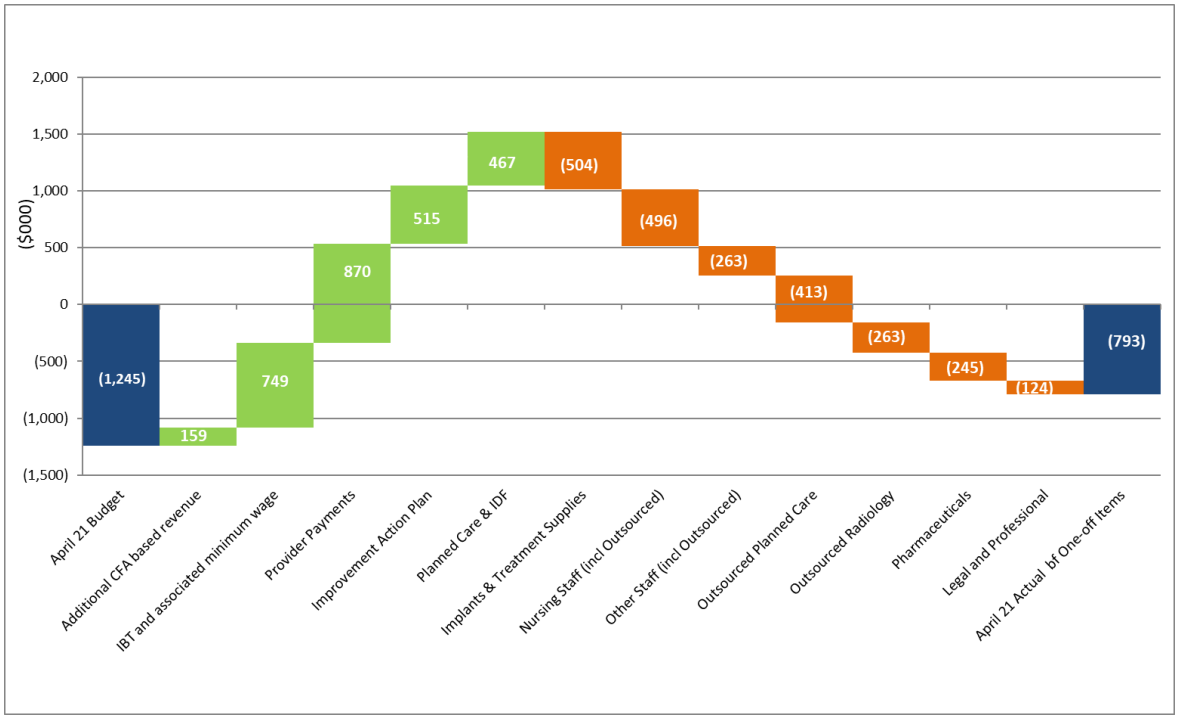
$000	April 2021			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Current Forecast	Budget	Variance
Net Revenue	**62,163**	**60,123**	**2,040** ✓	**613,006**	**603,395**	**9,611** ✓	**735,838**	**724,207**	**11,631**
Expenditure									
Medical	7,136	7,461	325 ✓	63,255	68,562	5,308 ✓	76,477	82,828	6,351
Nursing	9,230	8,735	(496) ✗	87,744	84,322	(3,421) !	105,906	101,337	(4,569)
Allied Health	3,258	3,354	96 ✓	29,737	31,646	1,908 ✓	36,102	38,251	2,149
Support	168	159	(9) ✗	1,445	1,533	88 ✓	1,760	1,848	88
Management / Admin	3,309	3,145	(163) ✗	29,707	30,535	828 ✓	36,220	36,921	702
Personnel	23,102	22,855	(247) !	211,888	216,599	4,711 ✓	256,466	261,186	4,721
Outsourced Personnel	848	292	(556) ✗	9,492	3,145	(6,347) ✗	10,985	3,788	(7,197)
Sub -Total Personnel	23,950	23,147	(803) !	221,380	219,744	(1,637) !	267,450	264,974	(2,476)
Other Outsourced Services	2,624	1,956	(668) ✗	23,254	20,409	(2,845) ✗	27,949	24,540	(3,409)
Clinical Supplies	5,366	4,647	(719) ✗	51,506	49,464	(2,041) !	62,209	59,539	(2,670)
Infrastructure & Non-Clinic	6,200	5,900	(300) ✗	58,786	58,906	119 ✓	71,141	70,889	(252)
Provider Payments	24,950	25,820	870 ✓	260,128	259,250	(878) !	310,385	310,890	506
Total Operating Expenditur	**63,089**	**61,469**	**(1,620)** !	**615,055**	**607,773**	**(7,282)** !	**739,133**	**730,831**	**(8,301)**
Operating Surplus/(Deficit)	**(926)**	**(1,346)**	**420** ✓	**(2,049)**	**(4,378)**	**2,329** ✓	**(3,295)**	**(6,624)**	**3,329**
Enable Contribution	133	101	33 ✓	2,228	1,435	793 ✓	2,503	1,710	793
Surplus/(Deficit) Before On	**(793)**	**(1,245)**	**452** ✓	**179**	**(2,943)**	**3,122** ✓	**(792)**	**(4,914)**	**4,122**
Holidays Act	(348)	0	(348) ✗	(2,616)	0	(2,616) ✗	(38,399)	0	(38,399)
Covid-19	(6)	0	(6) ✗	(100)	0	(100) ✗	(100)	0	(100)
Surplus/(Deficit)	**(1,147)**	**(1,245)**	**99** ✓	**(2,537)**	**(2,943)**	**406** ✓	**(39,291)**	**(4,914)**	**(34,377)**

FTE									
Medical	358.7	382.9	24.1 ↓	342.8	377.6	34.7 ↓	345.5	378.4	32.9
Nursing	1,122.8	1,086.7	(36.1) →	1,104.6	1,084.6	(20.0) →	1,108.1	1,085.7	(22.4)
Allied Health	432.6	433.6	1.1 ↓	415.9	427.4	11.5 ↓	417.6	428.8	11.2
Support	29.8	32.4	2.5 ↓	29.8	32.3	2.4 ↓	30.2	32.3	2.0
Management / Admin	464.4	488.5	24.0 ↓	458.4	483.5	25.1 ↓	463.6	484.7	21.2
Total FTE	**2,408.4**	**2,424.1**	**15.7** ↓	**2,351.5**	**2,405.2**	**53.7** ↓	**2,365.0**	**2,409.8**	**44.9**

✓ 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



Revenue variances of significance for the month are as follows:

- Favourable revenue is due to both Planned Care ($0.384m) and Inter-District Flows ($0.083m). Year to date, planned care activity remains strong, with elective case weighted discharges running 16 percent higher than the same period last year.
- In addition, Ministry of Health (the Ministry) funding of $0.515m was received for the Outpatient and Imaging Improvement Action Plan and $0.266m of funding was received for administration staff pay equity (offset by related costs of $0.266m).
- ACC revenue was adverse to budget for the month by $0.038m and is now $0.156m favourable for the year to date. ACC revenue will maintain a favourable variance for the remainder of the year.

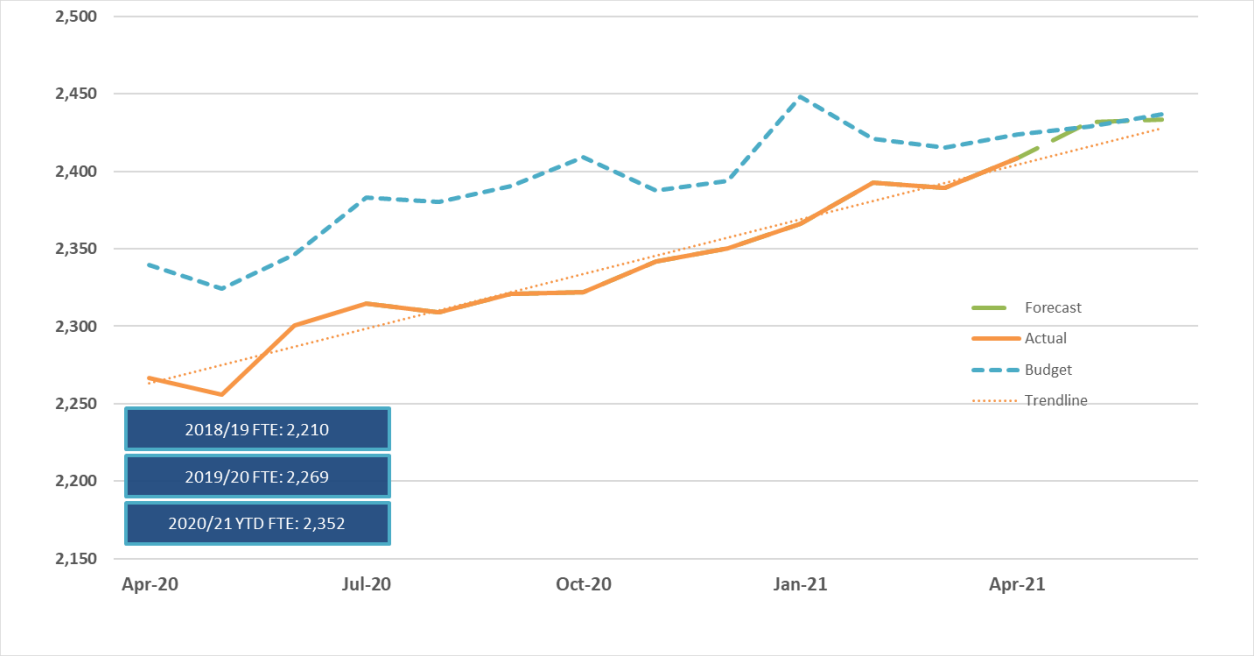
Full-time Equivalent staffing (FTE) for the month are as follows:

- Medical staff are below budget by 24 FTE for the month, with seven in Te Uru Arotau – Acute and Elective Specialist Services and 10 FTE in Te Uru Rauhī – Mental Health and Addictions Services. There are 10 long-term radiologist vacancies covered by

outsourcing. This, combined with Emergency Department FTEs that are above budget by four FTE, impacts Te Uru Arotau. In addition, locums are covering vacancies in Te Uru Rauhī.

- Nursing staff are above budget by 36 FTE for the month, with 17 in Te Uru Arotau and 12 in Te Uru Rauhī. The filling of nursing vacancies in Te Uru Arotau has outpaced budget projections. In addition, Emergency Department nursing FTEs are ahead of budget by 6 FTE. The Te Uru Rauhī variance is in Ward 21 and STAR.
- While Allied Health FTEs are close to budget, Te Uru Arotau is above budget by 17 for the month and reflects a gradual increase across the year. The increases have mainly been in pharmacy technicians, radiology MRT's and anaesthetic technicians. These are offset by various vacancies in all other Directorates with Cluster functions.
- Management staff are below budget by 24 FTE for the month in Corporate and Professional Services. This includes several small variances across services, with the most significant being in Executive Services, and Strategy, Planning and Performance.
- The table below shows the total FTEs by month for this year. The FTE forecast, represented in the graph as a green dotted line, suggests a trend towards budget. While the overall gap closes by year-end, this reflects nursing staff ahead of budget and other role types that have vacancies that are filled by outsourcing.

TOTAL EMPLOYED FTES BY MONTH



Personnel variances of significance and points to note are identified below:

- Except for administration staff, FTE variances primarily drive adverse personnel costs of $0.247m.
- Backpay for administration staff pay equity was paid during the month and offset by equivalent funding.
- Favourable medical staff variances in Te Uru Rauhī of $0.231m are more than offset by locum costs. While Te Uru Arotau medical staff FTEs are favourable overall, Emergency Department FTEs that are greater than budget is driving an adverse personnel variance for this service.
- The adverse nursing staff variance features in all Directorates with Cluster functions except for Te Uru Kiriora – Primary, Public and Community Service. The largest variances are in Te Uru Arotau ($0.152m) and Te Uru Rauhī ($0.237m).
- Expenditure on courses, conferences and professional staff fees are favourable to budget in April by $0.135m. Year to date, spending on training is $1.696m favourable to budget.
- Outsourced personnel was $0.556m adverse to budget. This was mainly due to adverse Te Uru Rauhī locum costs ($0.317m) that are partially offset by favourable employed medical staff ($0.228m). Outsourced nursing costs, which essentially represent specialling of patients, was adverse to budget for the month by $0.045m. This is comparatively low when compared to previous months. Digital Services outsourced staff of $0.062m was due to the number of recent vacancies and a high level of activity.

Other variances of significance for the month are outlined as follows:

- Other outsourced services are adverse to budget due to outsourced radiology expenditure ($0.151m) and Crest Hospital for outsourced planned care ($0.325m), both of which impact Te Uru Arotau. In addition, outsourced radiology expenditure ($0.143m) in Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services, for Breast Screening and drug trial costs, that attract additional funding, also impact.
- Adverse clinical supplies largely relate to Te Uru Arotau. The variances are in treatment supplies ($0.269m), implants, instruments and equipment used in theatre ($0.280m) and pharmaceuticals ($0.183m), where infliximab features heavily again this month. Favourable equipment depreciation continues ($0.048m favourable) due to delayed asset purchases.
- Infrastructure and Non-Clinical costs are $0.300m adverse to budget. The key causes of this variance are consultancy and legal fees ($143m) and the cost of pharmacy stock, which is offset by sales and facility costs. Legal fees related primarily to a legacy dispute. There are a number of small variances for consultancy costs, with the most significant relating to Digital Services. Financing charges are below budget due to the rate for the capital charge changing from six percent to five percent, and offset by decreased Ministry revenue to fund the charge.

2.2 Financial Performance by Service

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

$000	April 2021			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Acute & Elective Specialist Services	(14,473)	(13,735)	(738) ✖	(135,759)	(134,062)	(1,697) !	(163,773)	(161,682)	(2,091)
Healthy Women, Children and Youth	(2,914)	(2,929)	14 ✓	(27,143)	(27,789)	646 ✓	(32,832)	(33,575)	744
Cancer Screening, Treatment & Support	(3,722)	(3,759)	37 ✓	(34,694)	(36,369)	1,675 ✓	(41,798)	(43,813)	2,015
Healthy Ageing & Rehabiliation	(8,990)	(9,145)	155 ✓	(90,352)	(90,476)	124 ✓	(108,654)	(108,692)	38
Primary, Public & Community	(5,964)	(6,081)	116 ✓	(59,690)	(60,327)	637 ✓	(71,687)	(72,492)	805
Mental Health & Addictions	(4,120)	(3,907)	(213) ✖	(41,238)	(40,515)	(723) !	(49,538)	(48,298)	(1,239)
Pae Ora - Paiaka Whaiora	(581)	(570)	(11) !	(5,590)	(5,698)	108 ✓	(6,730)	(6,838)	108
Corporate & Professional Services	39,888	38,829	1,059 ✓	392,917	391,358	1,558 ✓	472,315	469,366	2,949
Enable NZ	83	51	33 ✓	1,728	935	793 ✓	1,903	1,110	793
Surplus/(Deficit) Before One-Off Items	**(793)**	**(1,245)**	**452** ✓	**179**	**(2,943)**	**3,122** ✓	**(792)**	**(4,914)**	**4,122**
Exceptional Items	(354)	0	(354) ✖	(2,716)	0	(2,716) ✖	(38,499)	0	(38,499)
Surplus/(Deficit)	**(1,147)**	**(1,245)**	**99** ✓	**(2,537)**	**(2,943)**	**406** ✓	**(39,291)**	**(4,914)**	**(34,377)**

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

Items of note that 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 had an adverse result for the month of $0.738m despite having favourable revenue. Planned care revenue and Inter-District Flows (IDF) were respectively $0.381m and $0.083m favourable to budget for the month. In addition, unbudgeted revenue of $0.515m for the Outpatient and Imaging Improvement Action Plan was received, as was $0.100m to cover back pay as part of pay equity for administration staff.
- Several expenditure items were adverse to budget, with the most noticeable being personnel costs ($0.636m), clinical supplies ($0.693m) and outsourced services ($0.453m). Personnel costs included annual leave not taken, backpay for administration staff that was funded and planned vacancies in nursing and allied staff that have been filled. While specialling costs were adverse to budget by $0.025m, this was the lowest month of activity in the last twelve months.
- Unfavourable clinical supply variances primarily relate to patient consumables used in theatre. Pharmaceuticals, particularly infliximab ($0.072m) and drugs for renal patients ($0.072m), also contributed to this variance. The increased complexity in

acute demand with increased acuity in cardiac, delirium and stroke patients continue. Radiology, Crest Hospital, and the cost of health recovery beds are driving outsourced services variance.

- Te Uru Pā Harakeke – Healthy Women, Children and Youth Services is on budget for the month. Favourable infrastructure expenditure relates to a year to date adjustment to correct laundry costs. Adverse outsourced services is due to Crest Hospital and Auckland DHB paediatric clinics.
- The favourable month result for Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services is due to favourable revenue and personnel costs partially offset by adverse outsourced services and Infrastructure expenses. Vacancies and lower levels of training expenditure are the cause of favourable personnel costs. Outsourced radiology for drug trials and increased breast screening volumes have driven Outsourced Services. Adverse infrastructure expenses are due to Picture Archiving and Communication Systems (PACS) maintenance costs.
- The favourable variance in Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services results from favourable community provider expenses. This continues an ongoing monthly trend that will continue to year-end. Adverse infrastructure expenses is driven by meal and facility costs. Medical and Allied Health staff vacancies persist.
- Te Uru Kiriora – Primary, Public and Community Services is favourable to budget for the month by $0.116m with vacancies in Allied Health that are 6.2 FTE lower than budget. Allied Health vacancies occur in both Dental and Public Health. Attempts to recruit to positions continue, however there are national shortages in some occupations such as dental therapists.
- Te Uru Rauhī – Mental Health and Addiction Services is adverse to budget by $0.213m for the month. Adverse personnel costs (including outsourced personnel) of $0.345m are due to nursing costs in Ward 21 and the STAR ward. A combination of high bed numbers and increased specialling resulted in both a high level of ordinary time and overtime. Ward 21 continues to run over its resourced bed numbers due to demand. Outsourced medical staff that is $0.336m adverse, is partially offset by medical staff that is $0.231m favourable. Income in advance of $0.855m returned by the primary health organisation will be taken into account when arriving at the full year result.
- Provider payments were favourable to budget for the month by $0.115m due to savings from provider contract rationalisation. The year-end forecast for this service is for a $1.239m adverse variance to budget.
- Corporate and Professional Services comprises all executive and enabler functions. The $1.059m favourable month result was due to both favourable revenue and lower than anticipated community provider payments. Favourable provider payments are due to the revision and release of balance sheet provisions. Favourable revenue was due to additional funding for base electives and the Haemophilia National Fund.
- Exceptional Items contains organisation-wide costs of COVID-19 and Holidays Act. Both of these are unbudgeted. The budget assumption is that the Ministry will fund any reasonable and actual COVID-19 expenditure. In addition, the Ministry required all DHBs to remove Holidays Act costs from 2020/21 budgets. Refer to sections 2.3 and 2.4 below.
- The April 2021 result for Enable New Zealand is due to favourable income from trading activities and procurement rebates. Trading activities include direct sales, equipment hire, equipment refurbishment and freighting of complex equipment.

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

$000	April 2021			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funding Division	3,094	1,866	1,228 ✓	20,993	18,838	2,156 ✓	25,903	22,522	3,381
MidCentral Provider	(4,227)	(3,212)	(1,015) ✗	(25,184)	(23,216)	(1,968) ✗	(66,855)	(29,146)	(37,709)
Enable NZ	133	101	33 ✓	2,228	1,435	793 ✓	2,503	1,710	793
Governance	(147)	(0)	(147) ✗	(575)	0	(575) ✗	(842)	0	(842)
Surplus/(Deficit)	**(1,147)**	**(1,245)**	**99** ✓	**(2,537)**	**(2,943)**	**406** ✓	**(39,291)**	**(4,914)**	**(34,377)**

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

2.3 Holidays Act

Year to date expenditure on the Holidays Act totals $2.616m. This is made up of expenditure on the compliance project of $1.416m and increases to the provision of $1.200m. Year-end expenditure is forecast to exceed $38m and is a substantial increase from the previous forecast. It includes a year-end adjustment to reflect the re-assessment of the liability estimate based on the review undertaken by Ernst Young. The year-end balance sheet provision for staff remediation for Holidays Act breaches since May 2010 is currently forecast to be $47.0m. The overall quantum is consistent with other DHB findings relative to total payroll costs.

It is important to note that the Ministry separates Holidays Act issues from the measurement of DHB performance and that DHBs were explicitly requested not to budget for this cost in the 2020/21 year. 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 it will provide this funding once all DHBs are in a position to remediate. It is most likely that this will come as an equity injection.

2.4 COVID-19

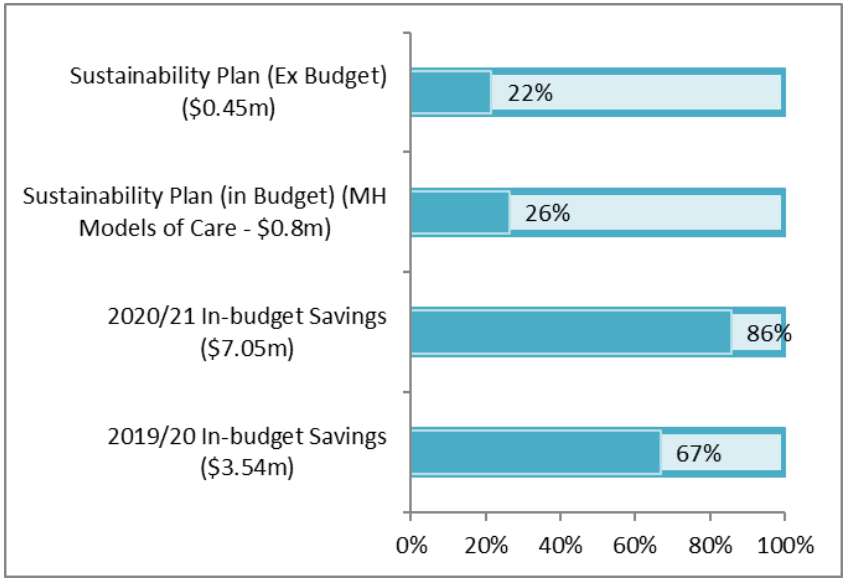
While net expenditure during April was minimal, this reflects $0.468m of immunisation funding offset by $0.474m of expenditure. Expenditure is for immunisation staff and facility costs to undertake vaccinations at the new city centre location. Staffing totalled 17 FTE for the month, and this will increase as immunisation activity expands. The year to date unbudgeted net expenditure totals $0.100m, with the month movement related to fit testing of N95 masks. Year to date net expenditure will remain unchanged for the remainder of the year, assuming no further escalation of pandemic events and a full reimbursement of the immunisation programme.

The Ministry has provided advice on the funding model for the immunisation programme, which is in line with MDHB expectations.

2.5 Sustainability and Savings Plan

The table below shows the year to date progress against the year-end target. Overall progress against the target is at 74 percent year to date. While it is unlikely the overall savings targets will be achieved, the DHB is operating well within budget when one-off items are excluded.

SUSTAINABILITY AND SAVINGS PLAN PROGRESS TO DATE



The year to date pace of in-budget savings suggest that these are slightly behind if the year-end target is to be achieved. In-budget savings for 2020/21 includes a full year saving in specialling costs of $0.50m.

2.6 Year-end Forecast

The current forecast is that MDHB will end the year with an operating deficit of $0.792m, which is favourable to the budgeted deficit of $4.914m by $4.122m. Unbudgeted Holidays Act expenditure has been adjusted to reflect a revaluation of the historical provision and now reflects the assessment undertaken by Ernst Young. This has increased the previous forecast for the Holidays Act by $34.7m and far exceeds our ability to absorb within the budget. It is important to note that the Ministry separates Holidays Act issues from the measurement of DHB performance.

The projected year-end cash and deposit balances is $22.9m, which is better than budget by $15.3m.

A number of potential risks were identified and communicated during the budget process. If realised, these will affect our ability to achieve this year's budget targets. These risks are outlined in the table below and are given the following ratings:

	Low Risk No concerns to date		Risk Unknown No evidence of risk to date. Keep in view		Risk Emerging		Risk likely to Materialise

Status	Potential Budget Risk	Current Status
	Achieving Sustainability and Saving Plan Objectives	
	While the financial impacts of some sustainability initiatives are not specifically budgeted, these must be achieved to help absorb any unplanned shocks to the DHB.	Overall savings are on target. While sustainability plan items are behind target, these are being offset by other savings that are ahead of target. An executive management lead has been assigned to each initiative to ensure they receive the appropriate level of attention and accountability. Regular reporting and monitoring of progress are in place.
	Ongoing Impacts of COVID-19	
	The impact of a second outbreak would be disruptive to the DHB and its budget. Staff annual leave will need to be carefully managed from both a staff wellbeing and financial perspective.	There have been no significant unfunded COVID-19 costs year to date. The DHB is better prepared for further outbreaks due to investments in facilities, clinical and digital equipment during the first outbreak. This will lessen the impact of initial expenditure if/when further outbreaks occur. While other outbreaks have occurred across New Zealand, the effect on MDHB has been minor to date. MoH funding advice for the immunisation programme appears to be in line with MDHB cost expectations.
	Timing of staff recruitment	
	The budget reflects average vacancy levels based on the assumption that not all positions will be able to be recruited. It also includes phasing adjustments on the basis that the need to fill positions will occur gradually throughout the year.	The year to date FTE variance is below budget by 12 FTE when all personnel costs (outsourced and employed) are considered. This trend is forecast to continue, although the gap is reducing as the year proceeds. Note that Nursing FTEs have been above budget for most of the year and are currently 20 FTE above budget. The outcome of CCDM reviews suggests additional nursing resource is required in several wards. The impact of this will impact on future years.
	Future MECA settlements	
	The budget assumption is for a modest 1.5 percent increase in wage settlements based on the Governments expectation of restraint in the Public Sector given COVID-19 and its impact on the economy.	Year to date, overall average salary costs remain below budget expectations, and this trend is forecast to continue for the remainder of the year.

	Achieving Planned Care targets	
	MoH proposed targets require an increase in output from MidCentral to achieve similar revenue levels as in 2019/20.	Planned Care activity has resulted in elective revenue is close to budget year to date.
	Hospital Capacity	
	Hospital bed capacity was increased during 2019/20 to accommodate growing demand. For 2020/21, several projects will commence being the SPIRE and EDOA / MAPU PODS projects. While the long-term benefit increases in future capacity, the short-term impact will lead to some disruption.	High bed occupancy has been experienced throughout the year to date. An experienced Project Director has been employed to help manage these projects, and planning is well underway. The PODs project is currently in the design phase and not expected to impact operations this year. SPIRE is further ahead. While some construction has commenced, only minor disruption is expected in this financial year.
	Holidays Act	
	Work to further define the financial impact is ongoing and will be revised as the project comes to a better understanding of the liability. The risk is that the liability will move because of that work, thereby affecting the planned deficit.	Year to date unbudgeted Holiday Act costs is currently being absorbed within the budget. However, significant year-end adjustments will occur that will not be able to be absorbed. This is now incorporated into the forecast. While this will impact the overall result, Holidays Act costs will be funded centrally by the Ministry of Health. For this reason, the risk rating has been changed to tolerable.
	WebPAS SaaS	
	A proposal to move from the current regional instance of WebPAS to a Software as a Service (SaaS) offering is being developed for consideration. Any move away from the current model may trigger the need to consider impairment.	The business case has experienced delays due to several issues, including data privacy. While work continues, the outcome of any proposal is uncertain at this point. Any impact on this financial year is unclear at this stage.

2.7 Financial Position

The main budget variances in the Balance Sheet at 30 April 2021 relate to timing differences in contractor payments resulting in a higher than budgeted level of current liabilities and the timing of capital expenditure being later than anticipated resulting in lower than budgeted non-current assets. This has resulted in higher than budgeted cash on hand and deposits in current assets.

$000	Jun-20	Apr-21		
	Actual	Actual	Budget	Variance
TOTAL ASSETS				
Non Current Assets	213,669	212,560	237,000	(24,440)
Current Assets	58,699	76,446	46,022	30,424
Total Assets	**272,368**	**289,006**	**283,021**	**5,985**
TOTAL EQUITY AND LIABILITIES				
Equity	158,340	162,755	170,789	8,034
Non Current Liabilities	7,713	7,113	7,348	235
Current Liabilities	106,315	119,138	104,884	(14,254)
Total Equity and Liabilities	**272,368**	**289,006**	**283,021**	**(5,985)**

As of 30 April 2021, the total available cash and deposit balances were $48.72m. Significant capital expenditure was budgeted for the 2020/21 year, and the timing of this expenditure is currently running later than planned. The projected year-end cash and deposit balances are forecast to be $22.94m, which is $15.27m favourable to the year-end cash and deposit balances budget of $7.67m.

2.8 Cash Flows

Overall cash flows reflect a favourable variance to budget of $32.729m as of 30 April 2021. Operating cash flows are favourable due to 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 required later than budgeted.

$000	Jun-20	Apr-21			
	Actual	Actual	Budget	Variance	
Net Cash Flow from Operating Activities	15,541	33,716	17,220	16,496	✓
Net Cash Flows from Investing Activities	(19,204)	(17,791)	(43,327)	25,536	✓
Net Cash Flows from Financing Activities	1,632	5,811	15,114	(9,303)	✗
Net increase / (decrease) in cash	**(2,031)**	**21,736**	**(10,993)**	**32,729**	✓
Cash at beginning of year	29,015	26,984	26,984	-	✓
Closing cash	**26,984**	**48,720**	**15,991**	**32,729**	✓

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 NZ operating account is channelled through the main DHB accounts to obtain those benefits.

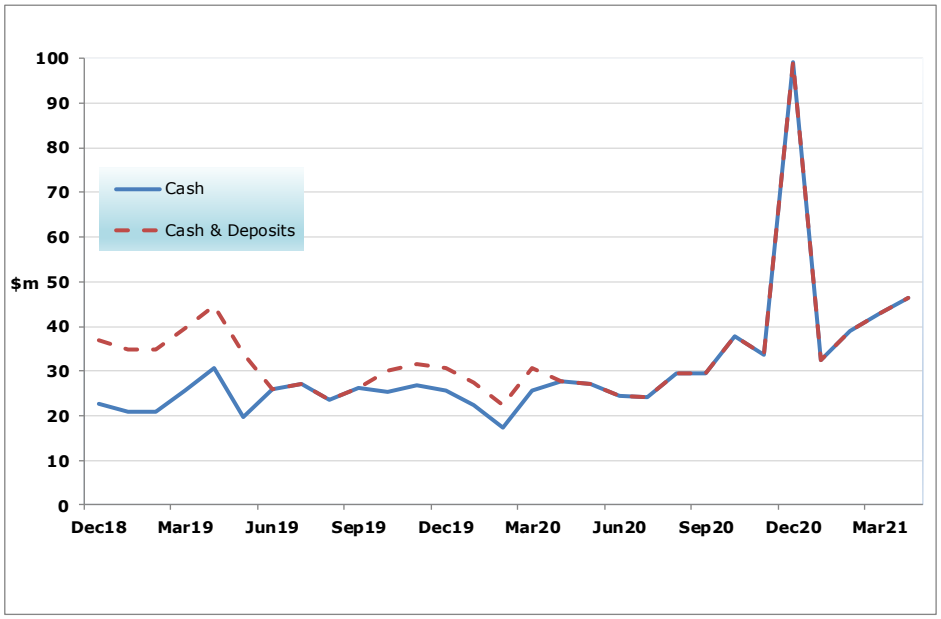
Apr-21	Rate	Value $000
NZHP Sweep Balance	0.68%	45,840
Cash in Hand and at Bank		2
Trust Accounts		2,443
Enable New Zealand		435
Total Cash Balance		48,720

Cash reconciliation tables below show how cash has moved during the month.

Cash Reconciliation	Apr-21 $000	Year to date $000
Cash at March 2021	45,372	26,984
Surplus / (Deficit) for mth	(1,147)	(2,537)
Depreciation / Amortisation	2,024	19,115
Sale of fixed assets	-	30
Working capital movement	3,350	17,555
Share of associate net surplus/deficit	-	(126)
Capital expenditure	(1,191)	(17,911)
Loan/finance lease repayments	(16)	(222)
Trusts movement	(40)	(260)
Equity injections - capital	368	6,092
Cash Balance at month end	48,720	48,720

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

CASH BALANCES



The DHB sector as a whole is experiencing liquidity pressure due to the continuation of operating deficits. New Zealand Health Partnerships, on behalf of all DHBs, has been in ongoing discussion with the Ministry and Treasury on ways to resolve this and the need for urgent deficit support equity injections to those DHBs who are insolvent. That resulted in an equity injection to the sector last October to accommodate payment timing. These pressures have not affected MDHB operations to date. However, a resolution is necessary to enable the collective treasury management and optimisation to remain viable.

The Ministry has provided reassurance to the sector on the liquidity impacts of COVID-19. Despite this, COVID-19 will influence the ability to fund other initiatives in the sector 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 are reducing the overall liquidity.

The Treasury and the Ministsry are providing 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). The increased funding commenced this financial year with the bulk of the drawdowns as major construction occurs over the next two years.

Treasury Policy and Ratios

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

Debt and Leases

Debt is held with the Energy and Efficiency Conservation Authority, which has a Crown Efficiency Loan Scheme for the purposes of assisting Government funded organisations in taking measures to reduce their energy expenditure. The loans are for the purchase and installation of equipment in this regard and are interest free.

Lender	Maturity	$'000	Rate	Type
EECA		13	0.00%	Fixed

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	1,153	MRI Scanner

The finance lease allows the DHB to spread the cost of an asset over the term of the lease 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

Capital expenditure is below the overall budget, a trend that has continued from last year. Expenditure in April totalled $1.191m. This related to the digital workplace programme clinical equipment purchases, and the SPIRE project. Year to date, expenditure on capital is $17.911m. Note that year to date depreciation is $18.694m against a budget of $19.305m.

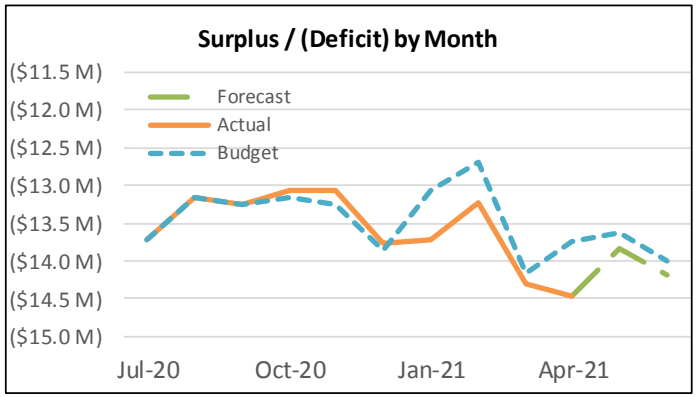
Further detail is provided in Appendix Two – Capital Expenditure.

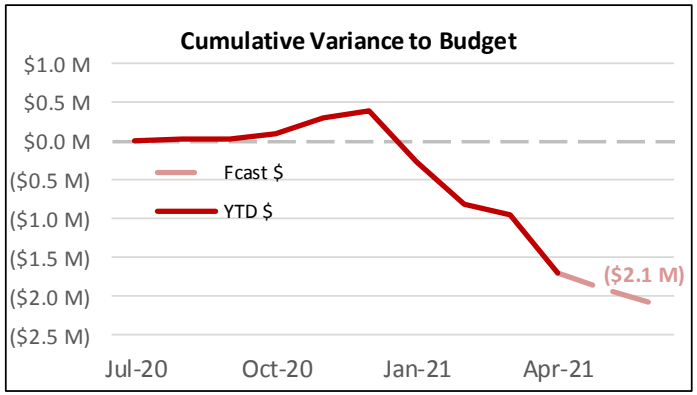
APPENDIX ONE – FINANCIAL PERFORMANCE BY SERVICE

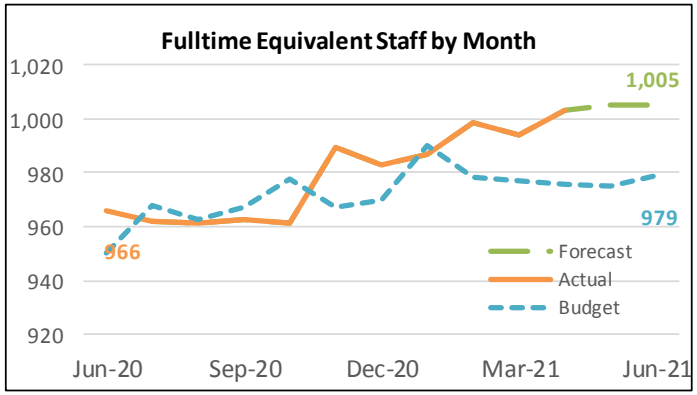
Te Uru Arotau – Acute and Elective Specialist Services

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**2,579**	**1,304**	**20,093**	**6,727**	**25,384**	**9,320**
Expenditure						
Personnel	10,292	(509)	93,354	(800)	112,817	(1,076)
Outsourced Personnel	196	(127)	2,643	(1,902)	3,004	(2,112)
Sub -Total Personnel	10,487	(636)	95,996	(2,702)	115,821	(3,188)
Other Outsourced Services	1,463	(453)	12,869	(2,319)	15,405	(2,719)
Clinical Supplies	3,466	(693)	32,160	(2,581)	40,069	(4,463)
Infrastructure & Non-Clinical	751	(288)	5,749	(859)	6,962	(1,079)
Total Operating Expenditure	**16,168**	**(2,069)**	**146,774**	**(8,461)**	**178,256**	**(11,448)**
Provider Payments	1	28	232	55	290	55
Corporate Services	883	0	8,845	(18)	10,611	(18)
Surplus/(Deficit)	**(14,473)**	**(738)**	**(135,759)**	**(1,697)**	**(163,773)**	**(2,091)**

FTE						
Medical	229.7	7.4	218.7	14.7	220.8	13.1
Nursing	486.7	(16.6)	480.2	(8.5)	481.5	(9.9)
Allied Health	137.1	(14.9)	126.0	(4.4)	126.8	(5.0)
Support	16.6	2.4	16.7	2.2	17.1	1.9
Management / Admin	118.4	4.0	119.6	2.6	120.1	2.2
Total FTE	**988.5**	**(17.6)**	**961.2**	**6.6**	**966.3**	**2.1**

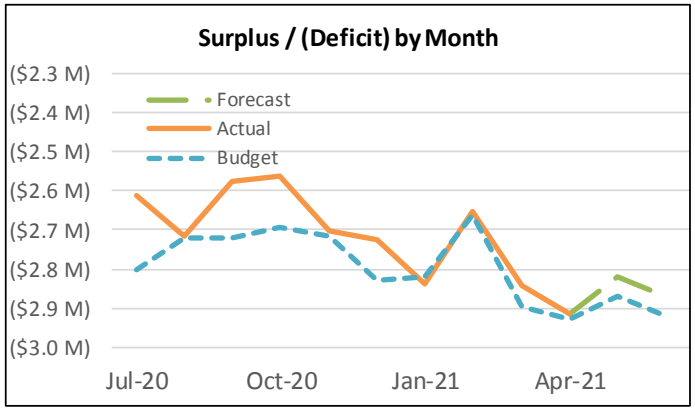


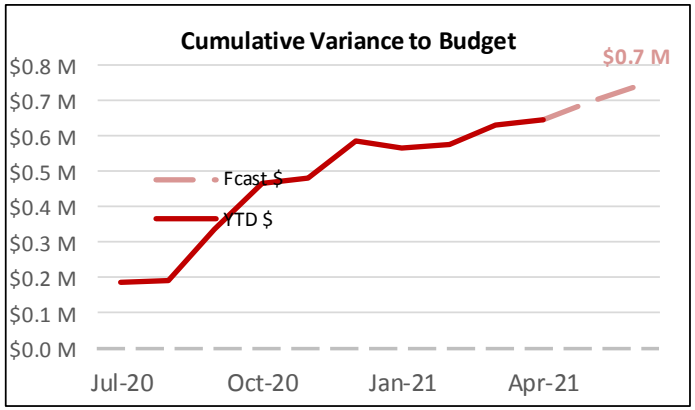




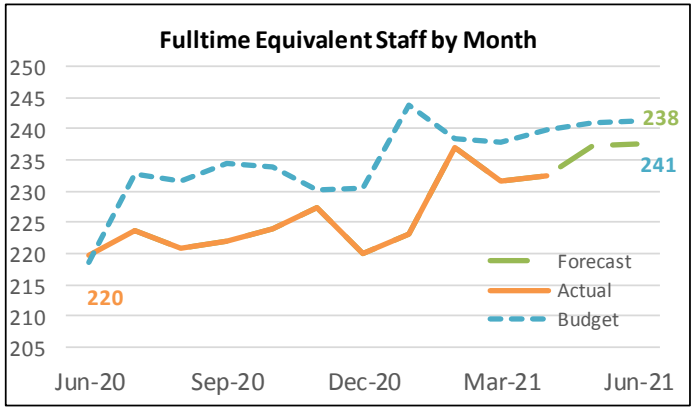
Te Uru Pā Harakeke – Healthy Women, Children and Youth Services

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**452**	**6**	**4,657**	**112**	**5,627**	**166**
Expenditure						
Personnel	2,424	(2)	21,466	1,040	26,025	1,200
Outsourced Personnel	1	18	580	(379)	652	(409)
Sub -Total Personnel	2,425	16	22,046	662	26,677	792
Other Outsourced Services	115	(49)	934	(237)	1,146	(307)
Clinical Supplies	257	(1)	2,851	(144)	3,439	(182)
Infrastructure & Non-Clinical	106	40	1,356	193	1,649	215
Total Operating Expenditure	**2,903**	**6**	**27,187**	**474**	**32,911**	**518**
Provider Payments	450	3	4,478	60	5,385	60
Corporate Services	14	0	135	0	162	0
Surplus/(Deficit)	**(2,914)**	**14**	**(27,143)**	**646**	**(32,832)**	**744**





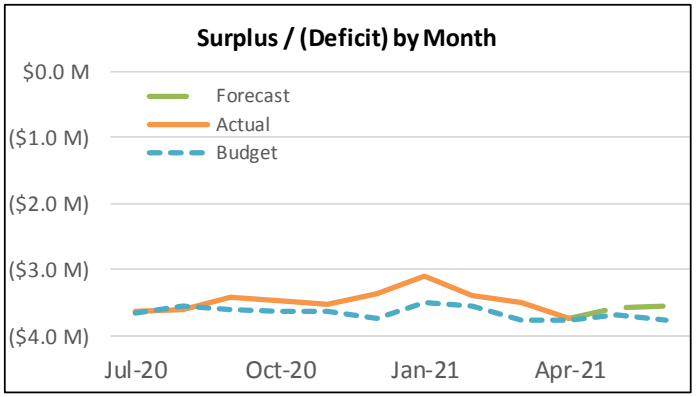
FTE						
Medical	44.0	1.0	41.7	3.0	41.9	2.9
Nursing	117.5	(0.4)	113.2	1.3	147.3	(32.2)
Midwives	35.2	2.6	32.7	3.9	35.5	1.4
Allied Health	14.8	1.7	14.9	0.8	15.2	0.6
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	21.0	(0.1)	20.4	0.5	20.5	0.4
Total FTE	**232.5**	**4.8**	**223.0**	**9.5**	**260.4**	**(26.9)**

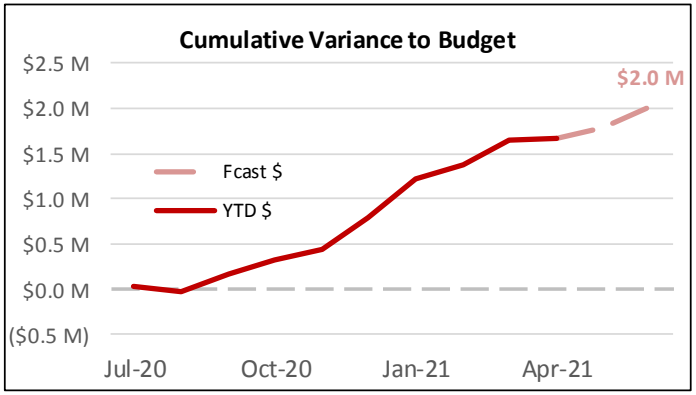


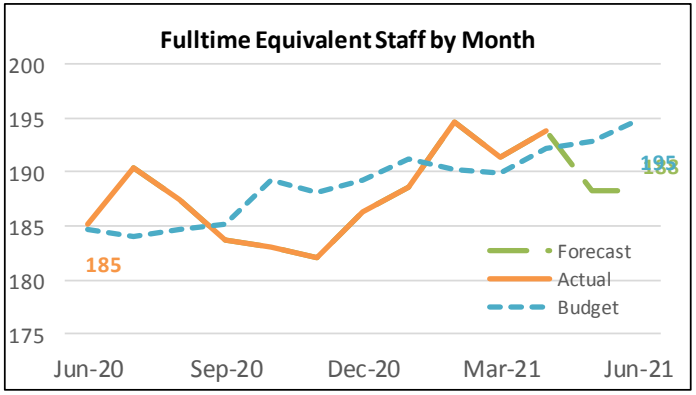
Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**881**	**120**	**8,574**	**(67)**	**11,402**	**969**
Expenditure						
Personnel	1,961	92	18,409	857	22,111	1,176
Outsourced Personnel	(0)	4	72	(39)	79	(39)
Sub -Total Personnel	1,961	96	18,481	818	22,190	1,137
Other Outsourced Services	712	(151)	5,850	14	7,107	(55)
Clinical Supplies	1,146	26	11,374	1,089	14,854	148
Infrastructure & Non-Clinical	178	(60)	1,465	(211)	1,726	(216)
Total Operating Expenditure	**3,996**	**(90)**	**37,171**	**1,710**	**45,878**	**1,013**
Provider Payments	388	6	3,906	33	4,694	33
Corporate Services	219	0	2,191	0	2,629	0
Surplus/(Deficit)	**(3,722)**	**37**	**(34,694)**	**1,675**	**(41,798)**	**2,015**

FTE						
Medical	38.8	2.2	39.1	1.1	39.1	1.2
Nursing	59.9	(3.9)	55.8	(1.1)	55.8	(0.8)
Allied Health	63.9	1.4	62.9	1.2	62.9	1.4
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	31.2	(1.5)	30.0	(0.8)	30.0	(0.7)
Total FTE	**193.7**	**(1.9)**	**187.8**	**0.3**	**187.8**	**1.2**



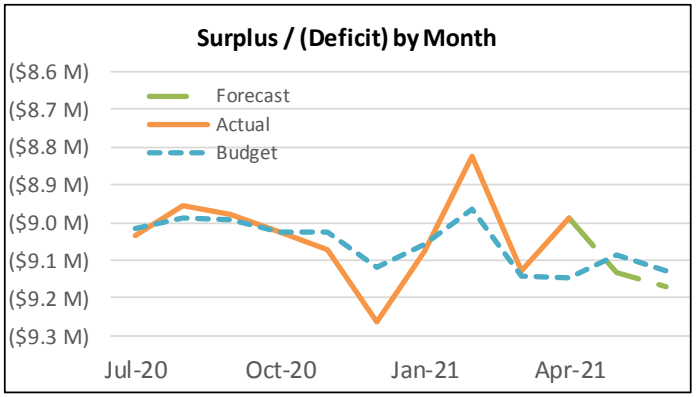


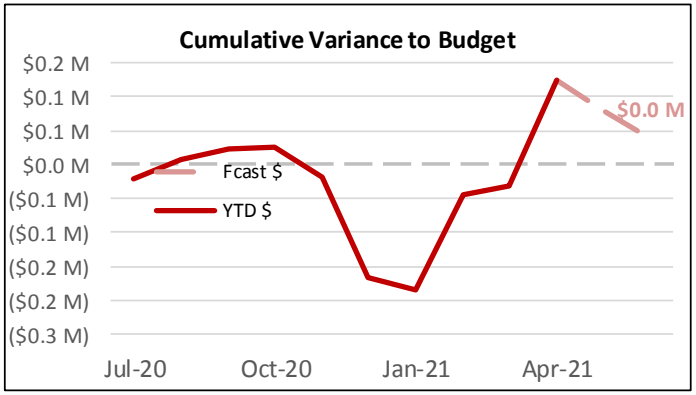


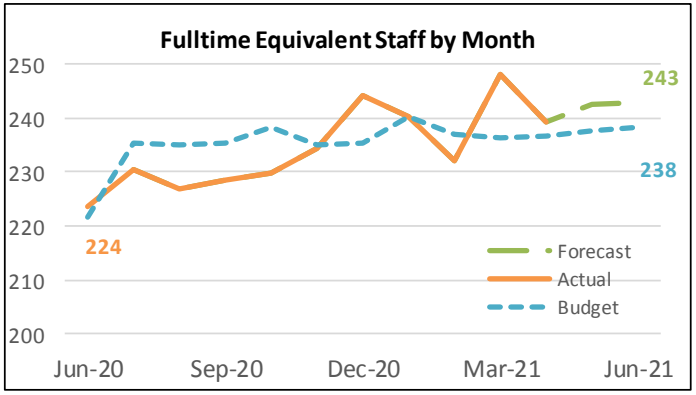
Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**432**	**38**	**4,430**	**184**	**5,298**	**184**
Expenditure						
Personnel	1,825	45	17,461	346	21,172	322
Outsourced Personnel	56	(21)	858	(481)	972	(519)
Sub -Total Personnel	1,881	24	18,318	(136)	22,144	(198)
Other Outsourced Services	40	6	576	(93)	674	(93)
Clinical Supplies	150	(15)	1,661	(215)	1,971	(230)
Infrastructure & Non-Clinical	154	(55)	1,237	(172)	1,464	(181)
Total Operating Expenditure	**2,226**	**(41)**	**21,793**	**(615)**	**26,253**	**(701)**
Provider Payments	7,107	158	72,101	554	86,632	554
Corporate Services	89	0	888	0	1,066	0
Surplus/(Deficit)	**(8,990)**	**155**	**(90,352)**	**124**	**(108,654)**	**38**

FTE						
Medical	14.8	3.5	15.0	2.9	15.0	2.9
Nursing	110.5	(6.5)	109.2	(4.4)	109.9	(5.1)
Allied Health	92.8	3.1	89.8	5.2	90.3	4.9
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	15.5	(0.7)	13.9	0.9	14.1	0.7
Total FTE	**233.6**	**(0.7)**	**227.8**	**4.7**	**229.3**	**3.4**



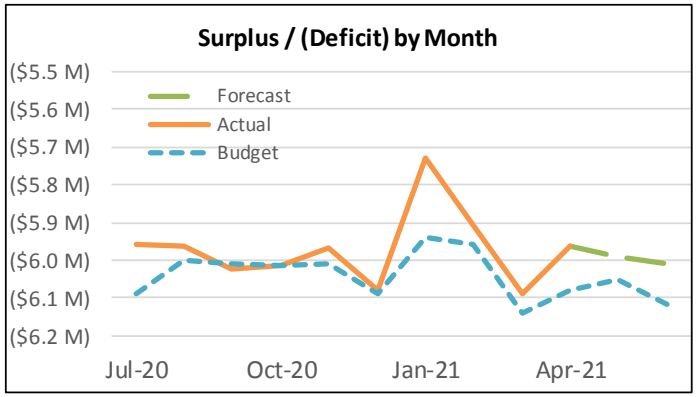


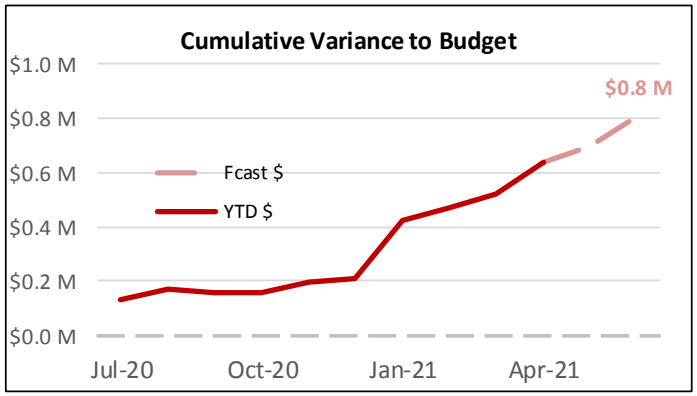


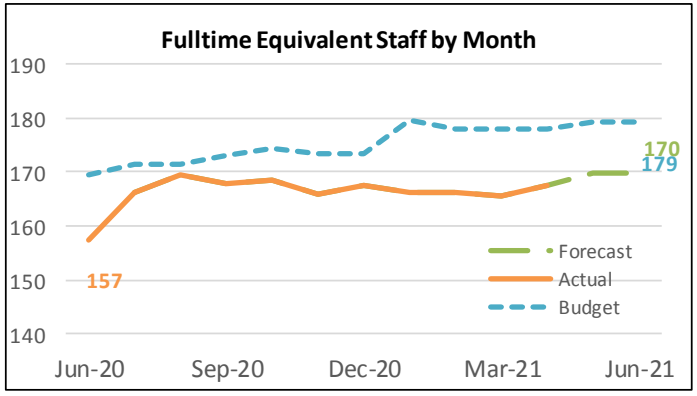
Te Uru Kiriora – Primary, Public and Community Services

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**753**	**26**	**7,186**	**(74)**	**8,642**	**(74)**
Expenditure						
Personnel	1,280	80	12,242	650	14,737	824
Outsourced Personnel	0	0	7	(4)	8	(4)
Sub -Total Personnel	1,280	80	12,249	646	14,745	820
Other Outsourced Services	65	(1)	660	22	799	22
Clinical Supplies	224	(6)	2,412	(106)	2,881	(106)
Infrastructure & Non-Clinical	146	17	1,540	126	1,881	121
Total Operating Expenditure	**1,714**	**90**	**16,861**	**688**	**20,307**	**857**
Provider Payments	4,899	0	48,992	5	58,791	5
Corporate Services	104	0	1,023	18	1,231	18
Surplus/(Deficit)	**(5,964)**	**116**	**(59,690)**	**637**	**(71,687)**	**805**

FTE						
Medical	3.6	0.2	3.5	0.3	3.6	0.3
Nursing	82.1	1.7	79.9	3.4	80.1	3.3
Allied Health	63.4	6.2	65.6	1.7	65.6	2.1
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	18.5	2.2	18.1	2.6	18.2	2.5
Total FTE	**167.6**	**10.4**	**167.1**	**8.0**	**167.5**	**8.2**



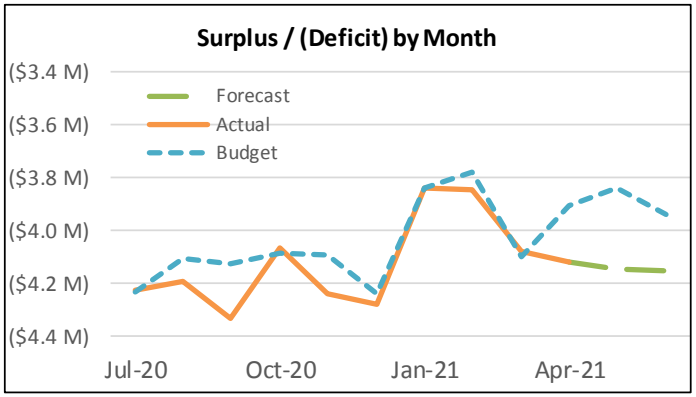


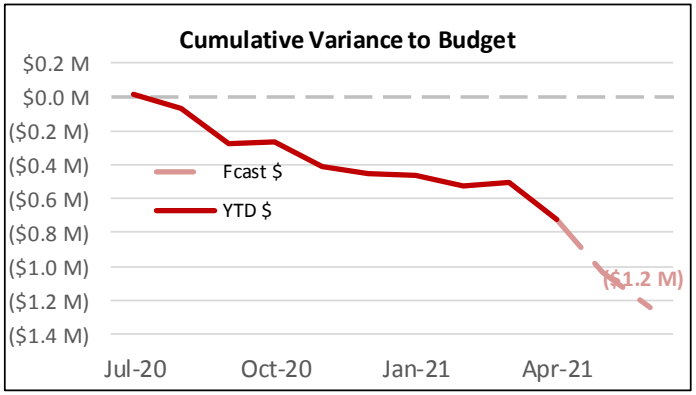


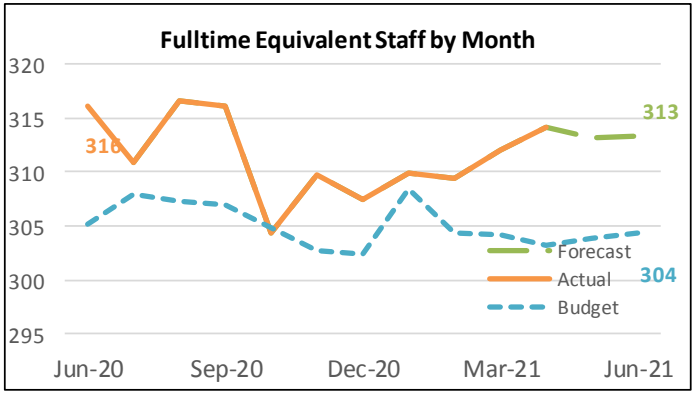
Te Uru Rauhī – Mental Health and Addictions Services

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**50**	**19**	**362**	**57**	**425**	**57**
Expenditure						
Personnel	2,502	(12)	23,281	1,796	28,393	1,578
Outsourced Personnel	448	(334)	4,123	(2,887)	4,920	(3,432)
Sub -Total Personnel	2,951	(345)	27,404	(1,091)	33,314	(1,854)
Other Outsourced Services	51	(12)	582	(176)	689	(201)
Clinical Supplies	20	(1)	209	(11)	249	(11)
Infrastructure & Non-Clinical	161	12	1,751	65	2,136	50
Total Operating Expenditure	**3,182**	**(347)**	**29,946**	**(1,213)**	**36,388**	**(2,016)**
Provider Payments	975	115	11,517	434	13,411	720
Corporate Services	14	0	137	0	164	0
Surplus/(Deficit)	**(4,120)**	**(213)**	**(41,238)**	**(723)**	**(49,538)**	**(1,239)**

FTE						
Medical	16.5	9.7	15.6	10.5	15.8	10.3
Nursing	185.8	(12.5)	186.9	(11.8)	187.1	(12.2)
Allied Health	49.2	6.7	47.7	7.7	47.7	7.8
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	41.6	0.5	40.6	1.5	41.0	1.1
Total FTE	**293.0**	**4.4**	**290.9**	**7.9**	**291.6**	**7.0**



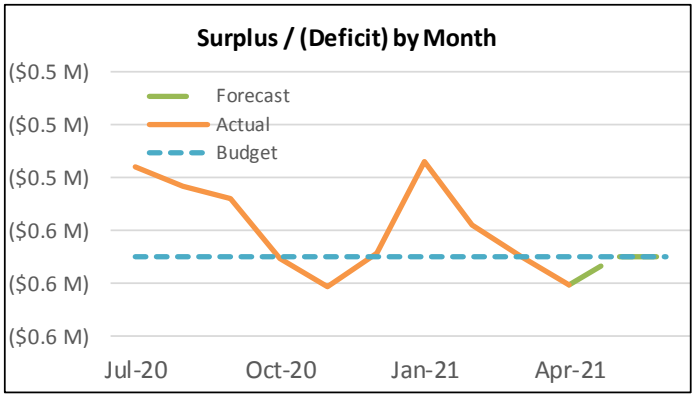


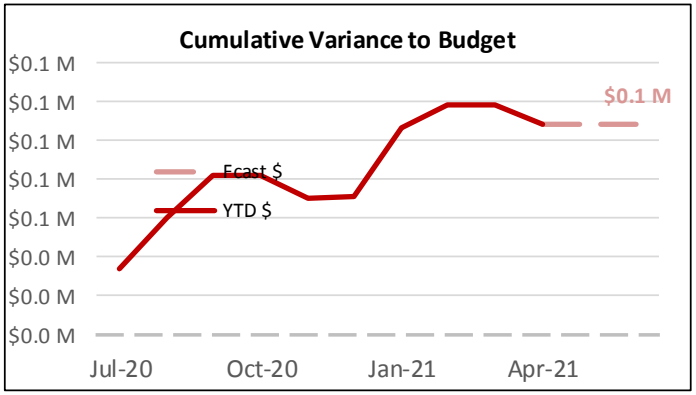


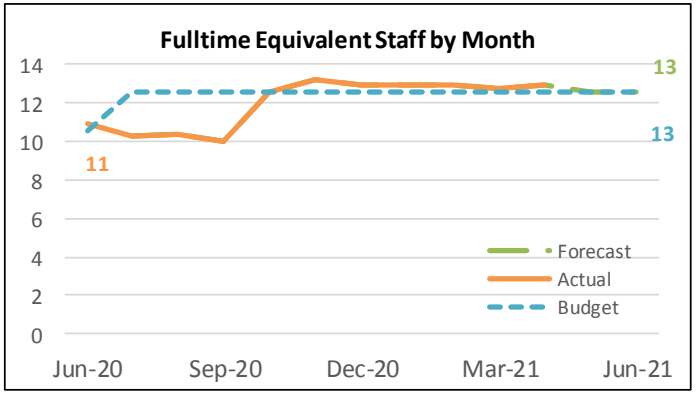
Pae Ora – Paiaka Whaiora Directorate

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**125**	**1**	**1,209**	**2**	**1,456**	**2**
Expenditure						
Personnel	103	10	956	130	1,180	130
Outsourced Personnel	0	0	0	0	0	0
Sub -Total Personnel	103	10	956	130	1,180	130
Other Outsourced Services	0	0	0	(0)	0	(0)
Clinical Supplies	0	0	2	0	2	0
Infrastructure & Non-Clinical	34	(22)	151	(32)	174	(32)
Total Operating Expenditure	**137**	**(12)**	**1,109**	**99**	**1,356**	**99**
Provider Payments	569	1	5,691	8	6,830	8
Corporate Services	0	0	0	0	0	0
Surplus/(Deficit)	**(581)**	**(11)**	**(5,590)**	**108**	**(6,730)**	**108**

FTE						
Medical	0.0	1.2	0.2	1.0	0.4	0.8
Nursing	2.0	(0.0)	1.7	0.3	1.7	0.2
Allied Health	4.5	(1.8)	3.9	(1.3)	3.7	(1.0)
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	6.4	0.3	6.3	0.5	6.3	0.4
Total FTE	**12.9**	**(0.3)**	**12.1**	**0.5**	**12.2**	**0.4**



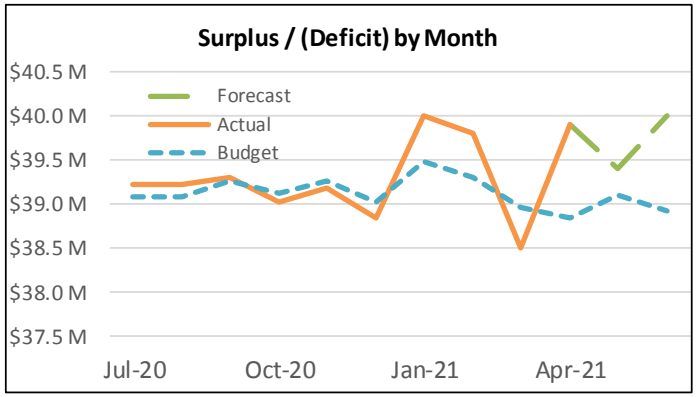


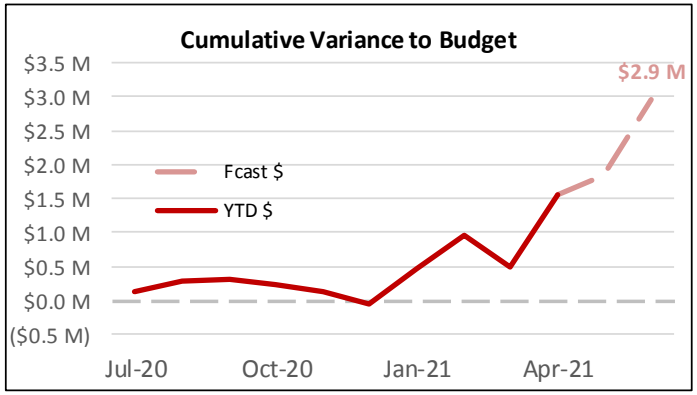


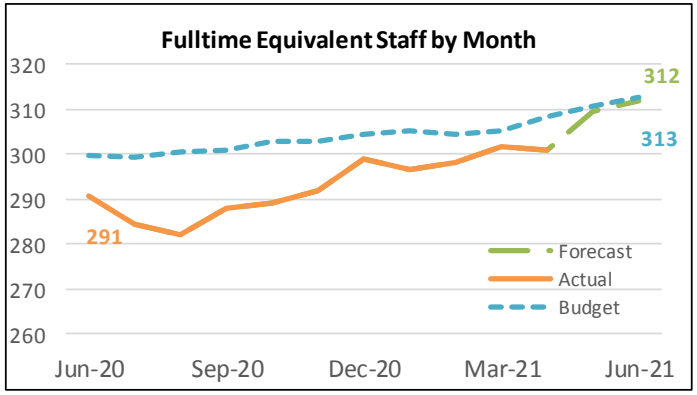
Corporate and Professional Services

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**56,890**	**526**	**566,495**	**2,671**	**679,939**	**3,342**
Expenditure						
Personnel	2,715	48	24,719	691	30,031	566
Outsourced Personnel	147	(96)	1,210	(655)	1,350	(682)
Sub -Total Personnel	2,863	(48)	25,929	35	31,380	(117)
Other Outsourced Services	178	(6)	1,782	(57)	2,128	(57)
Clinical Supplies	103	(29)	837	(73)	992	(73)
Infrastructure & Non-Clinical	4,671	57	45,537	1,009	55,235	782
Total Operating Expenditure	**7,814**	**(26)**	**74,085**	**914**	**89,735**	**536**
Provider Payments	10,560	558	113,211	(2,027)	134,351	(929)
Corporate Services	(1,372)	0	(13,718)	0	(16,462)	0
Surplus/(Deficit)	**39,888**	**1,059**	**392,917**	**1,558**	**472,315**	**2,949**

FTE						
Medical	11.5	(1.1)	8.9	1.3	8.9	1.4
Nursing	43.1	(0.5)	45.0	(3.1)	44.6	(2.6)
Allied Health	6.8	(1.2)	5.1	0.5	5.2	0.4
Support	13.2	0.1	13.1	0.2	13.2	0.2
Management / Admin	211.9	19.3	209.4	17.3	213.5	14.5
Total FTE	**286.5**	**16.6**	**281.6**	**16.2**	**285.3**	**13.8**



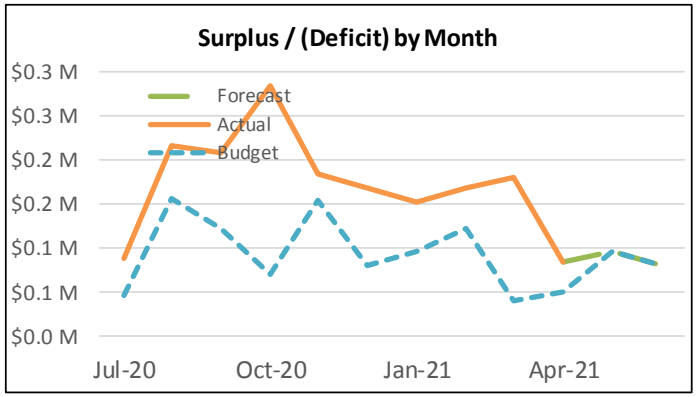


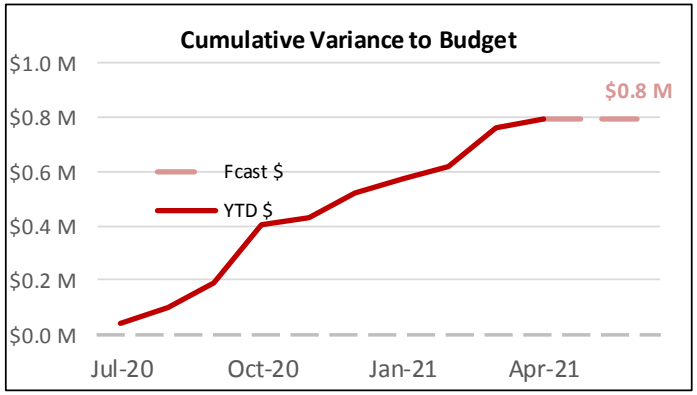


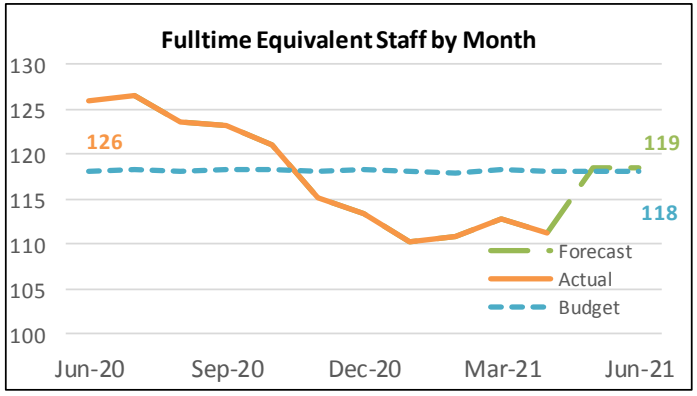
Enable New Zealand

$000	April 2021 Actual	April 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**3,550**	**556**	**31,980**	**2,033**	**37,968**	**2,033**
Expenditure						
Personnel	735	36	7,337	263	8,843	263
Outsourced Personnel	30	(3)	303	(32)	356	(32)
Sub -Total Personnel	765	33	7,640	231	9,199	231
Other Outsourced Services	0	9	41	45	58	45
Clinical Supplies	6	(0)	58	1	69	1
Infrastructure & Non-Clinical	2,647	(565)	22,012	(1,517)	26,137	(1,517)
Total Operating Expenditure	**3,417**	**(524)**	**29,752**	**(1,240)**	**35,465**	**(1,240)**
Provider Payments	0	0	0	0	0	0
Corporate Services	50	0	500	0	600	0
Surplus/(Deficit)	**83**	**33**	**1,728**	**793**	**1,903**	**793**

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	24.0	7.0	21.9	9.2	23.4	7.6
Support	17.3	(1.3)	17.7	(1.7)	17.4	(1.4)
Management / Admin	66.2	2.1	73.5	(5.2)	72.6	(4.3)
Total FTE	**107.5**	**7.8**	**113.1**	**2.3**	**113.5**	**1.9**







Holidays Act

$000	April 2021 Actual	April 2021 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	124	(124)	1,274	(1,274)	36,510	(36,510)	12,271
Outsourced Personnel	115	(115)	340	(340)	586	(586)	340
Sub -Total Personnel	238	(238)	1,614	(1,614)	37,096	(37,096)	12,611
Infrastructure & Non-Clinical	110	(110)	1,002	(1,002)	1,303	(1,303)	1,002
Total Operating Expenditure	**348**	**(348)**	**2,616**	**(2,616)**	**38,399**	**(38,399)**	**13,613**
Surplus/(Deficit)	**(348)**	**(348)**	**(2,616)**	**(2,616)**	**(38,399)**	**(38,399)**	**(13,613)**

COVID-19

$000	April 2021 Actual	April 2021 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	**468**	**468**	**3,038**	**3,038**	**3,445**	**3,445**	**3,748**
Expenditure							
Personnel	147	(147)	842	(842)	1,013	(1,013)	4,053
Outsourced Personnel	22	(22)	124	(124)	160	(160)	194
Sub -Total Personnel	169	(169)	966	(966)	1,173	(1,173)	4,246
Other Outsourced Services	172	(172)	1,408	(1,408)	1,500	(1,500)	2,286
Clinical Supplies	7	(7)	57	(57)	71	(71)	401
Infrastructure & Non-Clinical	126	(126)	707	(707)	800	(800)	2,700
Total Operating Expenditure	**474**	**(474)**	**3,139**	**(3,139)**	**3,545**	**(3,545)**	**9,634**
Surplus/(Deficit)	**(6)**	**(6)**	**(100)**	**(100)**	**(100)**	**(100)**	**(5,886)**

APPENDIX TWO – CAPITAL EXPENDITURE

($000)		Budget	Year to Date Approvals	Year to Date Expenditure	Remaining Approved Expenditure	Remaining Unapproved Budget Available	Year End Expenditure Forecast	Forecast Variance to budget
Board Approvals								
SPIRE Project	Infrastructure, Clinical Equipment, IT	9,266	9,038	2,239	6,799	0	4,312	4,954
Mental Health Redevelopment	Infrastructure, Clinical Equipment, IT	8,290	8,186	38	8,148	0	585	7,705
EDOA / MAPU PODS	Infrastructure, Clinical Equipment, IT	4,000	6,000	202	5,798	0	302	3,698
Sub Station Project	Infrastructure	2,281	2,281	1,533	748	0	1,727	554
Acute Services Block	Infrastructure Planning	700	700	0	700	0	0	700
Linear Accelerator Replacement	Clinical Equipment	4,344	4,344	3,504	840	0	4,302	42
Fluoroscopy	Clinical Equipment	1,540	1,540	0	1,540	0	400	1,140
Clinical-Monitors	Clinical Equipment	1,100	88	90	(2)	1,012	90	1,010
Laparoscopic Equipment	Clinical Equipment	670	670	91	579	0	670	0
RHIP	Information Technology	1,623	1,623	846	777	0	1,254	369
RiskMan	Information Technology	1,097	0	0	0	1,097	0	1,097
Programme of Change Mental Health & Addictions	Information Technology & Furniture and Fittings (Approval $2.802k split 20/21 $0.89m & 21/22 $1.905m)	897	897	34	863	0	250	647
Health System Catalogue	Information Technology	600	1,031	379	652	0	487	113
TOTAL Board Approvals		**36,408**	**36,398**	**8,956**	**27,442**	**2,109**	**14,379**	**22,029**
Management Approvals - Specific Items								
Medical Imaging Equipment - Various	Clinical Equipment	500	0	0	0	500	300	200
Anaesthetic Machines & Monitor Replacement	Clinical Equipment	360	0	0	0	360	0	360
Fundus Camera & Microscope	Clinical Equipment	350	242	0	242	108	350	0
Cardiograph Image Vault	Clinical Equipment	250	0	0	0	250	0	250
Decarbonisation Project	Infrastructure	414	414	213	201	0	414	0
Children's Pressure Room	Infrastructure	400	0	0	0	400	0	400
Front Door Project	Infrastructure	314	150	126	24	0	126	188
Digital Workplace Programme	Information Technology	1,850	838	1,238	(400)	0	1,768	82
Integration Strategy Implementation (IPaaS)	Information Technology	850	0	0	0	850	250	600
Planned Care - Scope	Information Technology	596	0	0	0	596	150	446
eReferrals (Triage)	Information Technology	585	0	0	0	585	50	535
Digitisation of Clinical Records	Information Technology	452	0	0	0	452	50	402
Website Upgrade	Information Technology	425	0	0	0	425	0	425
WebPASaaS Design & Implementation	Information Technology	400	16	44	(28)	384	0	400
MOH Clinical Equipment donated to DHB	Clinical Equipment		1,001	0	1,001	0	1,001	(1,001)
Covid Testing Van	Vehicles		195	0	195	0	195	(195)
Planned Care - Production Planning	Information Technology/Clinivcal Equipment	300	0	0	0	300	150	150
Management Approvals - Specific Items		**8,046**	**2,856**	**1,621**	**1,235**	**5,210**	**4,804**	**3,242**
Management Approvals - Pooled Items								
Clinical & Other Equipment	Clinical Equipment	2,790	1,215	1,164	51	(425)	1,574	1,216
Facilities & Infrastructure	Infrastructure	4,159	2,111	811	1,300	48	575	3,584
Information Technology	Information Technology	1,583	2,265	2,304	(39)	0	2,505	(922)
Covid-19	Various	714	936	936	0	0	936	(222)
Enable NZ	Various	1,000	28	28	0	972	150	850
Management Approvals - Pooled Items		**10,246**	**6,555**	**5,243**	**1,312**	**595**	**5,740**	**4,506**
TOTAL Against 2020/21 Capex Plan		**54,700**	**45,809**	**15,820**	**29,989**	**7,914**	**24,923**	**29,777**
Approvals against Prior Year Capex Plans			4,681	2,091	2,590	0	2,369	2,312
TOTAL		**54,700**	**50,490**	**17,911**	**32,579**	**7,914**	**27,292**	**32,089**
20/21 Budgeted Depreciation		24,053						
Capital Funding Support		24,538						
Value of MoH Donated Assets		1,001						
		49,592						

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Is the Board comfortable with the progress being made in the Sustainability Plan?
- Do the current priorities align with the MDHB's strategy and priorities?
- Is the Board satisfied with the mitigations in place to support the DHB to achieve its sustainability targets?
- Is the approach proposed to reduce the Sustainability Plan satisfactory?

To	Board
Author	Judith Catherwood, General Manager, Quality and Innovation
Endorsed by	Finance, Risk and Audit Committee Kathryn Cook, Chief Executive
Date	16 June 2021
Subject	**Sustainability Plan**

RECOMMENDATION

It is recommended that the Board:

- **note** the Finance, Risk and Audit Committee endorsed this report at its June meeting for the Board's consideration
- **note** the emerging risks and mitigation plans
- **note** the 2020/21 benefits realisation reconciliation is in progress
- **approve** the refreshed Sustainability Plan for 2021-2023.

Strategic Alignment

The report supports the MidCentral District Health Board's (MDHB) strategy and key enablers 'Stewardship' and 'Innovation'. The Sustainability Plan supports the MDHB to become more sustainable through change 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 approved by the Board in August 2020.

2. SUMMARY

The Sustainability Plan is a three-year plan which outlines the approach MDHB will take to ensure the delivery of enhanced service and financial sustainability. The plan is aligned to the sustainability component of the MDHB's Annual Plan. The Sustainability Plan Gantt Chart is included as Appendix One. Progress against the plan is included in the dashboard in Appendix Two.

3. PROGRESS

A benefits realisation reconciliation process for the 2020/21 year has commenced. The process needs to take account of all benefits, including cash releasing, cost avoidance and non-cash releasing benefits. The reconciliation is in development and once reviewed by the Organisational Leadership Team (OLT), it will be included in the report to Finance, Risk and Audit Committee (FRAC), prior to consideration by the Board.

The Sustainability Plan covers a three-year timeline. It is expected that some projects will not deliver benefits in the first year. Several projects have not yet commenced and whilst savings are still anticipated, these have not yet been delivered. The Board should note that the majority of the financial savings and non-financial benefits are expected as the projects mature and upfront investment in improvement, change and facilitation is required before transformational change can be achieved.

The Sustainability Plan Assurance Group ensures robust governance is in place across the entire programme. This group reports to the OLT each month. OLT will proactively address all risks in delivery of the plan to ensure both financial savings and non-financial benefits are achieved. The Board will receive reports on benefits delivery and risk in all future reports.

4. MODIFICATIONS TO THE SUSTAINABILITY PLAN 2021-2023

As identified at the beginning of the planning cycle, the Sustainability Plan is cyclical in nature, and the Board should expect projects to close and new projects to emerge throughout the planning delivery period. This will reflect prioritisation by the OLT to ensure capacity is placed to achieve maximum benefit. The planning cycle previously shared with the Board is contained in Appendix Three.

At the last Board meeting, members expressed concern the plan was too broad and questioned if the range of projects were still priorities given the financial, workforce, service and reform pressures facing the DHB at this time. It was suggested the plan be reviewed and consolidated. Management were asked to consider if this would release resources to support other critical and emerging priorities and risks.

OLT have reviewed the plan and proposed a reduced and more streamlined plan. Several projects are closing toward the end of 2020/21 and have been removed from the plan as they will be completed. These adjustments have resulted in a change in the forecast savings to be delivered through the Sustainability Plan. This has resulted in forecasted savings reducing from $2.05 million in 2021/22 to $1.7 million. The overall MDHB budget objective to break even is proving a significant challenge and at the time of writing, is work in progress. As a result of this position, MDHB is likely to have a large savings plan of which the Sustainability Plan is a component. This approach will support us in meeting the Ministry of Health's expectations in annual and budget planning.

The proposed refreshed Sustainability Plan is contained in Appendix Four.

5. RISK AND MITIGATIONS

5.1. Service Improvement

5.1.1. Rehabilitation Model and Community Older People's Acute Assessment and Liaison Service (OPAL)

The business case was endorsed by OLT in May 2020. The investment in this service is currently under review as part of the 2021/22 budget planning. The project team have continued to pilot new approaches to service delivery in readiness for the implementation of the service. This service enhancement will support the long-term sustainability of the district through improved community-based services for frail older people and by delivering rehabilitation in the community setting. This approach is supported by international and local evidence to improve patient flow and reduce unnecessary presentations, readmissions and the impact of frailty and disability in our community. There is a specific focus on equity for Māori in the implementation of the new service and model of care.

5.1.2. Outpatient Redesign

The outpatient redesign programme was progressing a full business case for the Board for consideration in May 2021. Due to the impact of the forthcoming budget for 2021/22 and the changes anticipated with health reform, a different approach has been taken to delivery of the immediate improvement priorities. Business cases and proposals for individual pieces of work will be progressed to support the immediate sustainability priorities within the outpatient service. These priorities include:

- implementation of e-referrals and triage
- design of a service navigation model of care, building on existing good practice in the district
- implementation of voice recognition software and e-communications to general practice and consumers
- implementation of e-scheduling
- administration re-design to support improved consumer experience.

These priorities support improved workflows and savings and will improve the quality of care and clinical safety through more timely and effective communication systems. Measures for improvement include actions to address Māori health inequity in access to specialist services and outcomes.

5.1.3. Mental Health Community Models of Care

Te Uru Rauhī, Mental Health and Addiction Services, have concluded the consultation process with workforce, locality and consumer groups across the district to enable progression of an integrated model of clinical and kaupapa Māori service delivery. Management have reviewed all the feedback and a decision document was released in the week of 14 June 2021. An implementation plan is in place and is being progressed.

5.2. **Workforce**

5.2.1. Full Time Equivalent (FTE) Establishment

The creation of FTE establishment is a vital part of effective workforce management in MDHB. A prototype approach is currently being implemented across all directorates. It is anticipated this project will be completed by the end of June 2021.

5.2.2. Skill Mix

Scoping and scheduling work on the skill mix project has been completed. The entire workforce skill mix in all directorates will be reviewed by the end of June 2022. The implementation of Care Capacity Demand Management is how skill mix is determined for nursing staff in all wards in scope across the DHB. For the remainder of the workforce, the project has two phases: the first is a review of skill mix across other service areas; the second is the implementation of any changes or recommendations. The benefits realisation will take longer because change management will be through the process of either staff turnover or via staff development pathways. This was reflected in the original plan, which indicated this was a three-year programme of work.

5.2.3. Reducing dependency on one-to-one nurse specialing

The project plan to improve usage is well developed and achieved positive results in Quarter Two. Quarter Three results were less favourable and year to date the savings expected have not been delivered. Analysis of the latest data is showing promising results, with a decline in utilisation. The project continues to be a priority for all nursing leadership.

5.2.4. Workforce Wellbeing

This project plan is complete. Resources and training to support people leaders in using the Bradford Score have been developed. The pilot directorates will commence trailing this approach in June 2021. The Bradford Score is an internationally recognised analytics approach to enable absence management patterns to be easily interpreted. A Psychosocial Wellbeing Strategy has also been developed for the Board to consider at this meeting. The implementation plan contains a number of initiatives to support workforce wellbeing.

5.3. **Savings and Revenue**

5.3.1. Equipment Library

The project to support an equipment library has been impacted due to the insourcing of biomedical services. The insourcing is now complete, and the project team has been established to progress this initiative. A project plan is in development including a timeline for completion.

5.3.2. Short-term Loan Equipment Management

The trial of up to one year of an alternative model has commenced. Should benefits from this be realised within the first quarter, this will trigger a further extension of the approach. Due to the delay in progressing the trial, there is a risk this project will not deliver the expected benefits until later in 2021/22.

5.3.3. Fleet Management

The fleet management project was impacted by changes to facilities management providers but has commenced. The procurement process has commenced and is due to be completed by end of July 2021. Additional sustainability benefits of this initiative include a reduction in fleet omissions. The DHB has applied for funding from the State Sector Decarbonisation Fund.

5.4. Digital

5.4.1. E-recruitment and leave management

These projects are progressing, applying existing technology to support business needs. E-leave management is being implemented as a proof of concept in the Radiology Team. A business analyst is working to identify the requirements in detail and review this against the digital tools available. Full implementation will commence from July 2021. A regional procurement process has been completed to enable progression of e-recruitment with a preferred supplier. Implementation will commence in July 2021. These two projects will support a reduction in paper-based processes, enhance leave capture and speed up recruitment management and onboarding.

5.4.2. Digitisation of clinical records

The business case to support progression of this project has been approved by the Data and Digital Governance Group. The implementation plan has commenced. This project has significant clinical benefits and will achieve savings of up to $1 million dollars in FTE and storage costs from 2022/23 onwards.

5.4.3. Digitisation of corporate records

This project includes:

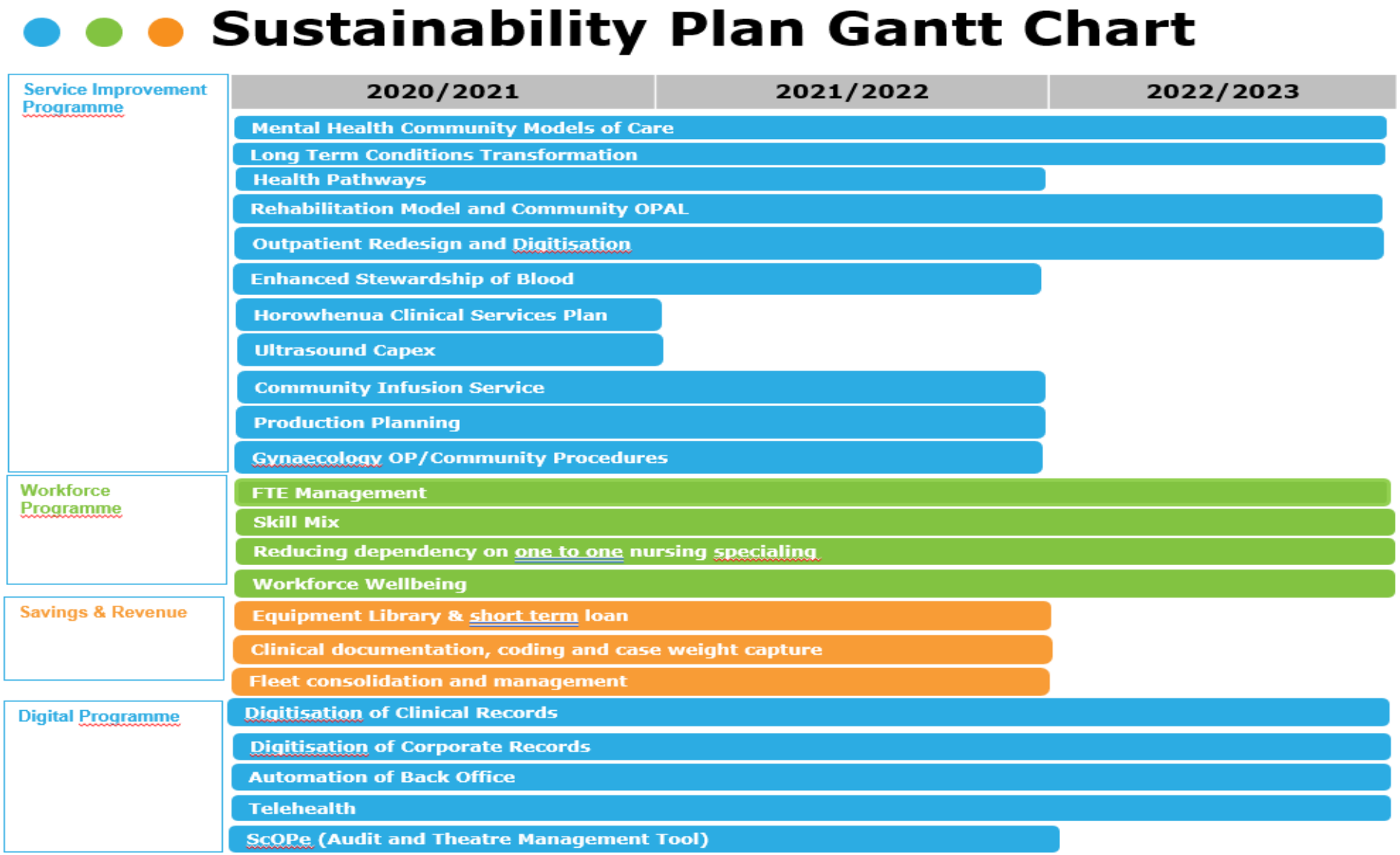
- the implementation of Office 365
- activation of a records management capability
- an upgraded SharePoint.

This supports the classification and management of digital records, minimising the need for maintaining paper and maximising ease of access and collaboration. The scope and ongoing delivery of this project is currently under review following the Board's approval of the plan to pause the delivery of the Te Awa Digital Strategy pending announcements about the health sector reforms. A business case will be required before the further progression of this project across the enterprise.

Appendices

Appendix One – Sustainability Plan Gantt Chart 2020-2023
Appendix Two – Sustainability Plan Dashboard
Appendix Three – Sustainability Planning Cycle
Appendix Four – Sustainability Plan 2021-2023 (Refreshed)

Appendix One – Sustainability Plan Gantt Chart 2020-2023



Appendix Two – Sustainability Plan Dashboard

Sustainability Plan - Dashboard

Activity	Sponsor	Project Approved	Project Plan Developed	Project Team in Place	Milestones on Track	Costs/benefits on Track	Exception report
Mental Health Community Models of Care	Scott Ambridge						
• Older Adults							Expected in year benefits curtailed due to delays in implementation. Recurrent benefits have been partially achieved. Consultation of community FACT model has concluded.
• Severe and enduring conditions (FACT)							
• Youth and addiction services (2021/22)		N/A	N/A	N/A	N/A	N/A	
Long Term Conditions Transformation	Deborah Davies						
• Improve management approach to high need populations							The initiative is aiming to significantly change the model of care with a pilot in Horowhenua. Integrated team model agreed. Pilots about to commence.
• Build a multi morbidity LTC service model							
Rehabilitation Model	Andrew Nwosu						
• Growing a community based service					N/A	N/A	Business case focussed on benefits realisation has been endorsed by OLT. Work to optimise existing resources making good progress. The initiative is a priority for the 2021/22 budget.
• Community OPAL implementation					N/A	N/A	
• Post discharge follow up model					N/A	N/A	
Outpatient Redesign and Digitisation	Judith Catherwood/ Steve Miller						
• Implement the MDHB Outpatient Model							Programme business case will not progress. Plan being revised to focus on critical delivery items for the 2021/22 year only. Projects for e referrals/triage, transcription and digital communication commenced. Navigation service model of care in progress. Benefit realisation is under review as there could be a delay in delivery linked to the vacancies and slower commencement of projects. Other programme priorities are under review by the Programme Governance Group. There is likely to be a significant change of emphasis in this area.
• Shared data set and production plan							
• Consolidate/standardise administration functions/access and booking approach							
• Implement clinical and booking digital systems							
• Telephony and communication redesign							
• Automate dictation, consumer messaging and clinical communications							
• Implement consumer real time feedback systems							

Sustainability Plan – Dashboard (2)

Activity	Sponsor	Project Approved	Project Plan Developed	Project Team in Place	Milestones on track	Costs/ benefits on track	Exception Report
Enhanced Stewardship of Blood	Claire Hardie						Wastage has increased in last period. Plan in place to address this.
Horowhenua Clinical Services Plan	Chiquita Hansen		N/A	N/A	N/A	N/A	Service planning expert is being sourced to support this work. Progress will be made once appointment in place.
Ultrasound Capex	Lyn Horgan						On track.
Community Infusion Service	Lyn Horgan					N/A	Project Manager and team in place.
Production Planning	Darryl Ratana					N/A	MoH funding to be used to progress production planning capacity/capability at MDHB. Capacity is currently being recruited.
Gynaecology OP/Community Procedures	Sarah Fenwick					N/A	Project team in place. Vacancies have impacted progress.
FTE Management	Keyur Anjaria						
• Structured approved system							Project team in place to progress enterprise establishment. Prototype tested and being implemented across enterprise.
• Established system							
Skill Mix	Celina Eves						
• Framework development							Project time line and scoping complete. Skill mix reviews underway.
• Vacancy management approach							
Reducing dependency on one to one nurse specialising	Celina Eves						Review of approval methods underway. Use remains above budget.
Workforce Wellbeing	Keyur Anjaria					N/A	Project plan finalised. Pilot in progress.
Clinical Equipment Library	Neil Wanden					N/A	Sponsorship has transferred given changes in our Executive team. A remediation plan and project team are being put in place.

Sustainability Plan – Dashboard (3)

Activity	Sponsor	Project Approved	Project Plan Developed	Project Team in Place	Milestones on track	Costs/ benefits on track	Exception Report
Short Term Loan Equipment Management	Andrew Nwsou						Proof of concept model has commenced. Delay has impacted benefits realisation.
Clinical documentation, coding and case weight capture	Lyn Horgan						Procurement of PICQ tools has delayed some activity in the project.
Fleet consolidation and management	Neil Wanden						Transition to new fleet provider ongoing.
Digitisation of Clinical Records	Neil Wanden						Business case approved. Project implementation in progress.
Digitisation of Corporate Records	Steve Miller						Project under review linked to Te Awa review of strategic resourcing.
Health Pathways	Deborah Davies/ Lyn Horgan						
• Primary Care						N/A	Project progressing ahead of schedule and with positive budget variance.
• In Hospital						N/A	Combined approach to project governance agreed. On track.
Automating Back Office	Keyur Anjaria						Project manager in place and e-recruitment and e-leave project has commenced. E leave pilot has encountered challenges creating some risk to implementation.
• Annual Leave Capture and Management						N/A	
• E-Recruitment System						N/A	
Telehealth	Claire Hardie					N/A	Implementation plan in progress through working group.
ScOPe (Audit and Theatre Management Tool)	Lyn Horgan			N/A	N/A	N/A	Funding from MoH agreed. Project about to commence.

Key

- On track
- Under development
- Behind schedule/deliverables not being met
- Equity Outcome Action
- New project added from last report
- Project is on hold/under review
- N/A Project has not reached this stage, therefore rating is not applicable

Appendix Three – Sustainability Planning Cycle

Appendix Four – Sustainability Plan (Refreshed)

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Given the pending sector changes and sector budget bids, are the Board's priorities correctly identified in the work programme?

To	Board
Author	Steve Miller, Chief Digital Officer Clive Martis, Director Digital Services
Endorsed by	Kathryn Cook, Chief Executive
Date	29 June 2021
Subject	**Te Awa Update – Digital Services Work Programme**

RECOMMENDATION

It is recommended that the Board:

- **note** that due to the Government's announcement on health system reforms, no new discretionary initiatives from the Te Awa Digital Health Strategy (Te Awa) roadmap will be started, apart from core legacy technology and infrastructure priorities
- **note** the work programme covering planned work through into the 2021/22 financial year
- **note** the national and regional activity that may impact on the planned work programme.

Strategic Alignment

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

1. PURPOSE

To provide a detailed work programme to be delivered across the MDHB project agencies covering the period to 30 June 2022.

2. BACKGROUND

In 2019, Te Awa was endorsed by the Board, the Central Primary Health Organisation (PHO), Manawhenua Hauora and the Clinical and Consumer Councils. Te Awa is aimed at enabling the delivery of improved healthcare outcomes across key performance areas for the district over a period of five years. The continued development of this work plan is now paused. However, prioritised projects from the original Clinical and Digital Modernisation streams of work are progressing.

3. THE DIGITAL WORK PROGRAMME – MARCH TO JUNE 2021

Appendix One is a refreshed summary of the Work Programme for the period from March to June 2021, and for the 2021/22 financial year. Some of the forecast costings for this work programme are indicative estimates, dependent on further review and ratification by the Data and Digital Information Governance Group (DDIGG) and subject to budget approvals.

Since the last reporting period, the migration of MDHB's Maternity Care Information System to the BadgerNet Global product was successfully completed. This was achieved through the outstanding collaboration between Te Uru Pā Harakeke, Healthy Women, Children and Youth Directorate, and Digital Services.

4. NEXT STEPS

With the recent Cabinet announcement on health sector reforms, the delivery of new initiatives has been temporarily paused. This will allow an opportunity to merge prioritised MDHB initiatives with national and regional strategies. A continuing focus is held on the delivery of key clinical digital enablement programmes.

National and regional workshops are being coordinated by the Transition Unit from the Department of Prime Minister and Cabinet. A collection of project initiatives will be prepared to build into a forward planning process in support of the Government's health sector changes. That process will impact the MDHB's work plan for the coming year. To progress the key priorities outlined in Appendix One, resources are being rapidly mobilised to complete initiative scoping and project initiation. While this highlights the significant business initiatives planned, a range of critical business continuity activities undertaken in parallel, consumes most of the Digital Services' current capacity.

Appendix One: Digital Work Programme as at 30 June 2021

Clinical/Business Priorities (New Critical Budget FY 2021/22)

INITIATIVE	OVERVIEW	BUSINESS OWNER	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	FINANCIAL	TARGET COMPLETION
eRecruit	Digital platform for the end-to-end recruitment process within MDHB	Keyur Anjaria	Project team identified, business case in development	Deliver business case for appropriate approval – likely <$100k project	Initial Scoping	On Track	MDHB Budget TBC as part of business case	Q2 FY21-22
eTriage	Electronic triage of referrals across outpatients and Allied Health	Lyn Horgan	$122k approved for pilot with two specialities within the Allied Health to confirm project implementation approach. Business Case in review	Deliver business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	Further MDHB Budget TBC as part of business case	Q3 FY21-22
Digitising Outpatient Communications	Digitise the process for creating and distributing clinical letters	Lyn Horgan	Business Case in review	Deliver business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q3 FY21-22
eReferrals	Electronic receiving of referrals across outpatients and Allied Health	Lyn Horgan	Project team identified, business case in development	Deliver business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q4 FY21-22
Computer Physician Order Entry (CPOE)	Electronic Order Entry and Results Sign Off	Lyn Horgan	Project team identified and commencing implementation planning to develop business case	Project team in place and implementation planning commenced	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q4 FY21-22
Electronic Prescribing and Administration	Electronic and administrative system for the prescribing of medications to inpatients and the accurate availability of information to Clinicians around current prescriptions	Lorraine Welman	Implementation Planning Study Completed, Project Definition Report under review. Business case to be developed.	Deliver business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q4 FY21-22

RAG Key:

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

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Clinical/Business Priorities (New Critical Budget FY 2021/22) - continued

INITIATIVE	OVERVIEW	BUSINESS OWNER	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	FINANCIAL	TARGET COMPLETION
Mosiaq as a Service	Upgrade of the Oncology Information System which supports Regional Cancer Treatment Service in the delivery of radiation therapy and systemic therapy treatment for cancer patients	Sarah Fenwick	Project team being identified with business case to developed	Deliver business case for appropriate approval	Initial Scoping		MDHB Budget TBC as part of business case	Q3 FY21-22
Echo Imaging Vault	Replacement/Upgrade of aged and at capacity, Cardiology Echo Image Vault system (EIV)	Lyn Horgan	Business case approved	Initiate project activity	Initiation	On Track	$1.7m Board approved	Q2 FY21-22
Digitisation of Clinical Records	The electronic retrieval of patient notes and records	Neil Wanden	Business Case approved	Initiate project activity	Initiation	On Track	$300k CEO approved	Q3 FY21-22
Surgical Audit	Theatre management and surgical audit system (SCOPE)	Lyn Horgan	Project team has been assembled, Vendor workshop for next steps.	Implementation Planning workshop/s completed	Initiation	On Track	MoH funded	Q3 FY21-22
Connected Care	Mental Health shared care record to support new model of care.	Scott Ambridge	Preferred supplier chosen, vendor negotiation and technical specifications being prepared	Project Initiation plan finalised and approved	Initiation	Scope, Timeline & budgets yet to be determined	$1.26m Board approved	Q4 FY21-22

RAG Key:

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

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

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

INITIATIVE	OVERVIEW	BUSINESS OWNER	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	FINANCIAL	TARGET COMPLETION
Core Network SAN	Remediation SAN (Storage Area Network) capacity and migrating workloads to Amazon Web Services	Steve Miller	Mobilising tech support and resources to progress procurement and business case. Target completion 10-12 weeks.	Procurement process concluded. Business case drafted	Initial Scoping	FY21-22 Digital BAU budget yet to be approved	Estimated $497k	Q3 FY21-22
Exchange Online (EOL)	Migration on premise exchange to Exchange Online	Steve Miller	Full migration underway	Full DHB user migration by end of Q1 FY21-22 – progressing as planned	Implementation	On Track	$137k Approved	Q1 FY21-22
Caller line identification	Migration from old phones lines to a digital enabled phone system that supports caller line identification for out-going calls from within MDHB	Steve Miller	Migration scheduled for 28/29 June 2021 to mitigate Chorus service retirement	Migration completed and project completed – on track for end of June completion	Implementation	On Track	$192k Approved	Q1 FY21-22
Zoom Rooms	Zoom Room rollout to support TeleHealth to prioritised business areas	Steve Miller	Zoom 1&2 completed and capitalised. Telehealth project determining locations for Zoom Phase 3.	Zoom Room Phase 3 deployment progressed	Implementation	On Track	$100k Approved	Q2 FY21-22 (8 Rooms)

RAG Key:

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

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

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

To	Board
Author	Barbara Ruby, Advisor, Strategy and Planning, Strategy, Planning and Performance
Endorsed by	Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance
Date	14 June 2021
Subject	**Non-financial Monitoring Framework and Performance Measures – Report for Quarter Three, 2020/21**

RECOMMENDATION

It is recommended that the Board:

- **note** the summary report on Stellar and progress made in delivering MidCentral District Health Board's Annual Plan and performance expectations for the third quarter of 2020/21
- **note** the mitigations in place for those performance measures or deliverables that were not meeting expectations for Quarter Three.

Strategic Alignment

This report addresses the Government's planning priorities and DHB accountabilities as outlined in MidCentral DHB's 2020/21 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 the District Health Board's (DHB's) progress and performance to the end of March 2021 (Quarter Three), against its commitments and accountabilities to Government as identified in the 2020/21 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 Three have been submitted to the Ministry of Health (the Ministry) as required under the DHB Non-financial Monitoring Framework and Performance Measures for 2020/21. Overall, MidCentral DHB (MDHB) is meeting or partially meeting the expectations. There have been delays to achieving some planned activities and performance indicator targets consequential to the flow-on effects of the national and local COVID-19 response in Quarters Three and Four of 2019/20.

In Quarter Three, there were 44 headline deliverables (with 64 measures). The Ministry has assessed the DHB's performance based on the specified achievement scale or criteria for each deliverable. Forty-three percent of the deliverables were rated as 'achieved' and 41 precent were 'partially achieved' with adequate mitigations or improvement actions in place.

Appendix One to this report provides a table of the performance measures and Annual Plan deliverables submitted for Quarter Three, 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 Three can be found on Stellar – *MDHB/Board/Reports and Documents/2021 Documents/NFPM Q3 Summary Performance Report*. 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 2020/21 Annual Plan Status Update Reports against the planned activities required for each of the Government's planning priorities.

The summary report 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, DHBs provide detailed reporting to the Ministry on the various activities and performance measures outlined in their annual plans.[1] This includes the deliverables of the Non-financial Monitoring Framework and Performance Measures including 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.

[1] Refer Sections 2, 4 and 5 of the 2020/21 Annual Plan.

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 2020/21 Annual Plan received approval from the Minister of Health at the end of September 2020.

The nationwide response to the COVID-19 pandemic since March 2020 has continued to have an impact on some of the performance results and progress with some of the Annual Plan activities in Quarter One. There were 44 headline deliverables this quarter (with 65 measures), of which 19 were rated by the Ministry as 'achieved' (43 percent) and 18 were 'partially achieved' (41 percent). Seven (16 percent) were 'not achieved' and these are briefly discussed below.

4.1. Immunisation coverage

There are three measures under this umbrella and despite some individual improvements, all are below target.

4.1.1. Infants fully immunised at eight months old

Results for Quarter Three shows there has been a further decline for the total eligible population (n.444/536) to 82.8 percent (from previous 86 percent last quarter) against target of 95 percent or over. There was a slight improvement for Māori to 77.8 percent (n.151/194). There has been a decline in rates for Pasifika this quarter to 74.2 percent (from 93 percent last quarter).

4.1.2. Children have completed all age-appropriate immunisations due by two years of age

Results for Quarter Three shows a slight improvement with 83.1 percent of the eligible population (n.449/540) against the target 95 percent or over. There was a slight improvement for Māori to 78.5 percent (n.150/191) and Pasifika to 74.1 percent (n.20/27). General practice has focused on this age group for the 12-month Measles, Mumps and Rubella (MMR) catch up programme in Quarter Three, which has resulted in improved performance.

4.1.3. Children fully immunised at five years of age

Overall, 83.9 percent of the eligible population (n.499/595) has been fully immunised at five years of age against the target of 95 percent or over. The figures have been accessed via a new data report and results for Quarter Three show a noticeable reduction, particularly for Māori at 75.9 percent (n.151/199) and Pasifika at 75 percent (n.27/37). This will be investigated. There has been a noted trend where some children have not been to a general practice for some time and in some cases, may have moved districts. General practice teams refer these tamariki to the Outreach Immunisation Service (OIS) so that team can attempt to use other information sources to trace the whānau and arrange a vaccination.

Actions to improve on performance for all measures include the following:

- Increased funding for a 0.4 full time equivalent (FTE) increase to strengthen the THINK Hauora Immunisation Team (1.4FTEs). This has allowed for On-Time Immunisation Clinics in Horowhenua and Palmerston North.
- THINK Hauora Immunisation Team and the National Immunisation Register continue to work collaboratively, providing General Practice Teams with support to attempt to engage with whānau.
- THINK Hauora's Immunisation Team continues to attend community events. The next one planned for Quarter Four, will have an influenza and MMR vaccination clinic being held at the local Pulse netball game in Palmerston North. Further Mana Wāhine days are planned, as well as community immunisation clinics in each district and at marae.
- Connections have been actively built between the Pasifika Health Team and THINK Hauora's Immunisation Team to access early childhood centres to discuss immunisations with parents.
- Relationships with other community service providers and with clinical teams within THINK Hauora continue to provide opportunistic ability to engage with whānau who are largely invisible within general practice (either through choice or lack of access).
- The THINK Hauora Immunisation Team is providing On-Time Immunisation Clinics in areas of the rohe that have the most need. At present, two Immunisation Facilitators provide immunisations in Horowhenua and the Immunisation Coordinator completes the service at Palmerston North. An additional Immunisation Facilitator is expected to be recruited to ensure these immunisation clinics can be consistently provided.
- Promotional activities through Facebook, radio and THINK Hauora's website continue.
- All THINK Hauora-organised and managed influenza community vaccination clinics will also include checking of childhood immunisation status and discussions about on-time vaccinations. If immunisations are required, they will be provided at the time (or arranged through a community clinic if appropriate).

4.2. **Breast feeding**

There has been a gradual improvement this quarter with 56.4 percent compared with 53.7 percent in 2018 for the eligible population that are exclusively breastfeeding at three months of age. For Māori, there has been no significant change since 2018 at 46.8 percent exclusively breastfeeding. For Pasifika, there has been a reduction with 46.6 percent exclusively breastfeeding.

MDHB has commenced implementation of the five-year Breastfeeding strategy. MDHB has provided support for a local Breast Milk bank to be set up. MDHB continues to contract with Mokopuna Ora to deliver weaving wananga to the community. The wananga incorporate Māori kaupapa based education including subjects such as breastfeeding. A peer support lactation consultation training package is being co-designed in Horowhenua focusing on Māori and Pasifika.

4.3. Shorter stays in emergency departments

The DHB's performance remains well below target, with the similar proportion (77.1 percent) of people having shorter stays in the Emergency Department (ED) from last quarter (77.8 percent). Shorter stay rates for Māori tend to be marginally higher (79.7 percent) but still well below target (95 percent).

Following on from the results of the retrospective analysis of the Older People's Acute Assessment and Liaison (OPAL) data. Te Uru Whakamauora has focused extensively on improving the model of care for acute frailty around patient experience of care, average length of stay (ALOS) and pre-noon discharges as well as better collaboration with ED and enhanced case finding on outlying wards.

This has resulted in a smoother patient journey with observable improvements in the average length of stay which has consistently stood at 5.4 days over the last five weeks. This represents a 3.7-day reduction in ALOS compared to the previous baseline of 9.1 days. Forty-five percent of patients are being discharged before noon (compared to 24 percent last year). For the month of March, OPAL also displayed an increasing trend of shorter stay patients (one day stayers). Te Uru Whakamauora is committed to ensuring these gains remain sustainable throughout the next quarter.

A range of initiatives of additional improvements include:

- An additional night Registered Medical Officer (seven days) has been established to ensure faster medical assessment.
- ED has appointed a new Senior Medical Officer (however they have not commenced yet).
- ED has a new candidate on the Nurse Practitioner (NP) pathway. The previous NP trainee has successfully completed requirements.
- A new acute flow process for internal medicine is planned. Initiating holding orders so patients can be admitted and reviewed at ward level, rather than the current dependency to hold them in ED.
- An initial trial for medical wards to be able to direct referral to Needs Assessment and Service Coordination has been extended to cover all medical and surgical wards. This is achieved through utilisation of the electronic referral within MIYA (patient journey board). This does not require social work input other than in highly complex cases.
- In addition to this, a pilot has been run successfully on Ward 26 to remove the paper referrals to Allied Health and utilise MIYA board capability. This has been rolled out to the Medical Assessment and Planning Unit also.
- Anecdotal feedback from nursing staff is that the process is faster. From an Allied Health perspective, there has been a move away from referral to 'assess for need', to 'assessing need'.
- Increased bed capacity has been facilitated through ad hoc flexibility with the Transitory Care Unit for overflow for ED.

4.4. Help to quit smoking – primary

The target of 90 percent of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit was not met this quarter. Of the eligible population 80.2 percent were given smoking brief advice. THINK Hauora has provided temporary staff to make phone calls to patients for prioritised practices, which resulted in more referrals to Te Ohu Auahi Mutunga and Quitline. This process identified that 30 percent of the phone numbers were invalid. This indicates that many of the patients who have not been given smoking brief advice have not engaged with their general practice this quarter.

THINK Hauora are employing Clinical Facilitators who will be responsible for working with prioritised communities and general practice to drive better performance.

4.5. Transition discharge planning – mental wellbeing

Rates remain stable and still not to target of 95 percent or over with 71.0 percent of clients (n. 614 of 864) discharged had a transition or wellness plan in place over this period. A similar rate for Māori clients at 72.5 percent (n.143 of 214 clients).

There has been an improvement of eight percent from the previous quarter, in the percentage of community clients with a discharge plan and a wellness plan though a decline for inpatients with a discharge plan by three percent. While all three groups remain below the 95 percent target, clients with wellness plans are at 93 percent for this quarter. Performance continues to be impacted by incomplete uploading of plans onto the system. Auditing of uploaded plans remains the most efficient method of auditing. Improvement actions therefore remain focused on increasing staff awareness of carrying out this task in timely way.

The quality of discharge plans and wellness plans have declined slightly by one percent and 2.8 percent respectively this quarter. The quality of inpatient discharge plans remains steady at 94 percent, slightly below the 95 percent target. Evidence of whānau consultation in discharge planning remains the challenge and is consistently influenced by client choice in this regard. Improvement actions therefore focused on wellness plans for the three community teams, where documentation of ‘my relapse triggers’ and ‘in order to help myself’, has been an ongoing challenge.

Appendix One

The following table highlights the performance measures and deliverables reported to the Ministry in Quarter Three 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	
A	Achieved	**S**	Satisfactory
P	Partially achieved	**B**	Further work required
N	Not achieved	**N**	Not acceptable
N/a	Not applicable		

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

Child Wellbeing			
Oral Health		Breastfeeding	**N**
Decayed, missing, filled teeth	**P**	Newborn enrolment	**P**
Carries free at 5 years	**P**	Raising healthy kids	**A**
0 – 4 years oral health enrolment	**P**	Help to quit smoking – maternity	**A**
0 – 12 years arrears	**P**	Influenza (65+ year old)	N/a
Immunisation		Annual Plan Status Update	**A**
8-month-old	**N**		
5-year-old	**N**		
2-year-old	**N**		
Mental Wellbeing			
Youth mental health initiatives	**A**	Physical health and employment	**A**
Transition (discharge) planning	**N**	Mental Health Act, CTOs (Māori)	**P**
Non urgent waiting times	**P**	Output delivery against plan	**A**
Primary mental health	**A**	Inpatient post discharge follow up	**A**
Suicide prevention and postvention	**A**	Annual Plan Status Update	**P**
Crisis response	**P**		
Outcomes for children	**A**		
Improving Wellbeing Through Prevention			
Colonoscopy waiting times	**P**	Annual Plan Status Update	**P**

Strong and Equitable Health and Disability System			
Faster cancer treatment – 31 days	A	Quality of identity data and national collections	
Faster cancer treatment – 62 days	P	NHI registrations	A
Planned care measures - overall	P	National collections	P
Care Capacity Demand Management	N/a	PRIMHD	A
Shorter Stays in ED	N	Annual Plan Status Update	P
Help to quit smoking - hospital	P		
Management of long-term conditions			
Acute heart service (overall)	A		
Stroke service (overall)	P		
Primary Health Care			
System level measures	A	Annual Plan Status Update	P
Help to quit smoking - primary	N		
Improving Sustainability			
Annual Plan Status Update	A		
He Korowai Oranga			
Annual Plan Status Update	A		

Crown Funding Agreement Variation Reports

Before School Checks	S
DHB – National SUDI prevention programme	N/a
Primary health care services – fees access	S

DISCUSSION/DECISION PAPERS

6 July 2021

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

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Does the Board have any concerns with granting approval for the Board Chair and a Board Member to sign the Letter of Representation?

To	Board
Author	Neil Wanden, General Manager, Finance and Corporate Services
Endorsed by	Kathryn Cook, Chief Executive
Date	14 June 2021
Subject	**Year-end Audit Process**

RECOMMENDATION

It is recommended that the Board:

- **approve** that the Board Chair and a Board Member be authorised to sign the Letter of Representation in respect of the 2020/21 year-end financial return to the Ministry of Health.

Strategic Alignment

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

1. PURPOSE

To seek the Board's approval for the Board Chair and a Board Member to be authorised to sign the Letter of Representation in respect of the 2020/21 year-end financial return to the Ministry of Health.

2. SUMMARY

The year-end audit process for 2020/21 will be the same as in previous years. A draft unaudited financial return for the year will be submitted in July 2021, and an audited financial return will be submitted on 9 August 2021 to the Ministry of Health. The external auditors, Deloitte, will be undertaking the audit on site for the two weeks commencing 26 July 2021.

A letter of representation, addressed to the Director-General at the Ministry of Health and the Audit Partner at Deloitte, is required as part of the 9 August 2021 return. The letter is completed at the end of the audit process and includes the final result and the final equity for the year. A draft of the letter is attached. Please note the Ministry of Health or Deloitte could require additional representations to be added if specific items arise during the audit process.

The letter requires the signatures of the Board Chair, one other Board member, the Chief Executive and the Chief Financial Officer. Approval is sought for the Board Chair and a Board Member to sign the letter on behalf of the Board. Management will confirm that it is in order for the Board members to sign the letter.

Once the audit of the Ministry of Health return is complete, the auditors will review the annual financial statements of MidCentral District Health Board (MDHB), and these will be presented to the Board in September as part of the draft Annual Report. There will also be a Letter of Representation relating to the annual financial statements which will be included in the November agenda papers.

Due to the structural change in the health sector and the budgeted deficit for 2021/22, this year MDHB will need to seek a Letter of Comfort from the Minister of Health and the Minister of Finance in order to satisfy the going concern basis of preparing accounts.

DATE (that on which CFIS audit clearance is received)

Bruno Dente
Partner
Deloitte
PO Box 17
HAMILTON

Dr Ashley Bloomfield
Director-General of Health
Ministry of Health
PO Box 5013
WELLINGTON

Dear Bruno and Ashley

Letter of Representation for the year ended 30 June 2021 – template provided to the Ministry of Health for the Government's Financial Statements

This representation letter is given to you in connection with your responsibility to provide audit clearance to the auditors of the Government's financial statements as to whether the financial information included in the DHB financial templates and attached schedules (the schedules) provided to the Ministry of Health fairly reflects the financial position of **MidCentral DHB** as at 30 June 2021 and of the results of its operations and cash flows for the year then ended.

The Board and management of **MidCentral DHB** confirm, to the best of our knowledge and belief, the following representations:

1 We accept responsibility for the preparation of the financial information included in the schedules provided to the Ministry of Health and the judgements made in the process of producing that template.

2 We accept responsibility for establishing and maintaining, and have established and maintained, a system of internal control procedures that provide reasonable assurance as to the integrity and reliability of the financial information in the schedules. We confirm that the system of internal control has operated adequately throughout the period.

3 We confirm that the following key financial information is fairly and appropriately reflected in the schedules:

- Opening equity balance agrees to the closing balance of 2020;
- Income in Advance;
- Accruals for primary referred expenditure (particularly community pharmaceuticals);
- PHARMAC rebate accrual;
- Accrual for Inter-district flows;
- The carrying value of land and buildings does not materially differ from fair value; and
- Revenue and expenses with other Crown owned entities (eg, Air New Zealand, New Zealand Post, energy companies).

In addition, we verify that:

a. Consolidated Net Result for the financial year ending 30 June 2021 is ……

b. Consolidated total Crown Equity as at 30 June 2021 is ……

c. The schedules contain information that accurately reflects our financial activities and cashflows during the period 1 July 2020 to 30 June 2021. Where the date of the information supplied differs from 30 June 2021, there were no significant movements in our net equity position up to 30 June 2021 that would affect the financial statements of the Government.

d. The amounts recorded in the schedules are complete.

e. We are satisfied that all guarantees, indemnities, securities and other contingent liabilities or assets that remain outstanding at 30 June 2021 have been included in the Contingencies Template.

f. We are satisfied that all contractual commitments have been disclosed accurately in the schedule on the Statement of Commitments.

g. The schedules have been prepared in accordance with the accounting policies of the Crown and Generally Accepted Accounting Practice (Public Benefit Entity Accounting Standards), as applicable for the year ending 30 June 2021, except for:

[INSERT DETAILS]

h. Transactions and balances with entities within the Crown reporting entity greater than $10 million have been confirmed with the other entity.

i. We confirm we used Treasury's central table of risk-free discount rates and CPI assumptions for valuations to comply with *PBE IFRS 4 Insurance Contracts* and *PBE IPSAS 39 Employee Benefits.*

j. There have been no material events subsequent to 30 June 2021 that should be reported in the financial statements, except for:

[INSERT DETAILS]

k. We agree to notify Treasury, the Ministry of Health and the appointed Auditor immediately of any material amendments to the schedules, or subsequent events that should be reported in the financial statements, identified after this Statement of Representation is signed but prior to the finalisation of the financial statements of the Government on 30 September 2021.

l. There are no other matters that you should be aware of in the preparation of the financial statements of the Government for the year ended 30 June 2021.

These representations are made at your request, and to supplement information obtained by you from the records of **MidCentral DHB** and to confirm information given to you orally.

Yours sincerely

Neil Wanden
Chief Financial Officer
[DATE]

[NAME]
Board Member
[DATE]

Kathryn Cook
Chief Executive Officer
[DATE]

Brendan Duffy
Chairperson
[DATE]

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Does the Board consider the Fraud Prevention Policy covers fraud, theft and corruption appropriately?

To	Board
Author	Neil Wanden, General Manager, Finance and Corporate Services
Endorsed by	Finance, Risk and Audit Committee
Date	11 June 2021
Subject	**Fraud Prevention Policy Review**

RECOMMENDATION

It is recommended that the Board:

- **note** that the Finance, Risk and Audit Committee endorsed the revised Fraud, Theft and Corrupt Actions Prevention Policy at its March 2021 meeting
- **note** that the Fraud Prevention Policy has been reviewed and a number of adjustments are proposed to improve its effectiveness
- **note** the name change from Fraud Prevention Policy to Fraud, Theft and Corrupt Actions Prevention Policy
- **approve** the revised Fraud, Theft and Corrupt Actions Prevention Policy.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'. It discusses an aspect of effective governance.

1. PURPOSE

The Fraud Prevention Policy is subject to triennial review. The review has taken into consideration the Beattie Varley report findings and several other DHB fraud policies. The review included strengthening the wording of the policy to ensure clarity and reduce ambiguity. It has also been cast more broadly to ensure that other unlawful or unacceptable conduct that is outside the legal definition of 'fraud' is also encompassed.

A copy of the Fraud, Theft and Corrupt Actions Prevention Policy, showing tracked changes, is included for the Board's consideration.

The proposed changes were endorsed by the Finance, Risk and Audit Committee at their 23 March 2021 meeting.

2. SUMMARY

The main proposed changes to the policy are as follows:

- Name changed to Fraud, Theft and Corrupt Actions Prevention Policy
- The purpose of the policy has been expanded to strengthen the policy and ensure clarity
- The definition within the policy has been expanded to provide clarity and includes exempes of fraud, theft and corruption
- Some job titles have been updated where required.

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

POLICY

FRAUD, THEFT AND CORRUPT ACTIONS PREVENTION	
Applicable to: **MidCentral District Health Board**	Issued by: **Finance and Corporate Services**
	Contact: **General Manager, Finance and Corporate Services**

1. PURPOSE

To clarify MidCentral District Health Board's (MDHB) position in relation to fraud, to identify responsibilities in relation to fraud prevention and identification, and to ensure consistency in dealing with situations where fraud is suspected or identified. MDHB regards fraud as totally unacceptable and will apply a principle of 'zero tolerance' to fraud.

It is our expectation that all employees must be scrupulously fair and honest in their dealings with their employer, patients, suppliers, contractors, other health service providers and their fellow employees.

Employees must take reasonable steps to safeguard the MDHB's funds and assets against fraud, theft, waste, loss, unauthorised use and misappropriation.

It is the responsibility of every member of staff or governance to report any instance of suspected fraud or similar wrong doing in accordance with this policy to their manager, who must report it to the General Manager, Finance & Corporate Services and / or Manager, Human Resources.

2. SCOPE

This policy shall apply to:

- MidCentral District Health Board (MDHB) employees
- Honorary staff members and students
- MDHB Board Members
- People in a business relationship with MDHB, e.g. contractors, consultants, any others contracted for the delivery of healthcare services
- volunteers

3. DEFINITION

"Fraud" is the deliberate misappropriation of information or resources that are owned or managed by MDHB, in order to obtain an unlawful advantage. It includes any intentional act by one or more individual(s) among employees, third parties, management or governance to deceive for personal gain or gain for another person.

MDHB's Code of Conduct [Policy] MDHB-5582 contains examples (without limitation) of fraudulent activity, theft and bribery, misuse of one's position for personal gain (financial or otherwise) for self or some third party.

Fraud is a crime against rights of property as defined in Part 10 of the Crimes Act 1961, and amendments.

Examples include, but are not limited to the following:

Fraudulent activity, theft or bribery (corruption) which includes (without limitation and by way of example only):

Fraudulent activity:

- any dishonest or misleading statement made by the employee
- any conduct or omission which the employee knows, or ought to know, to be dishonest, false or misleading or likely to result in loss to MidCentral District Health Board, its employees or any other person or organisation dealing with or through MidCentral District Health Board
- falsification of timesheets, or submitting false claims for expenses
- signing any document or making any statement on behalf of MidCentral District Health Board without proper authorisation
- falsifying or forging any of MidCentral District Health Board's accounts, drafts, securities or other documents or records, including any computer related activity involving the alteration, destruction, forgery or manipulation of data for fraudulent purposes
- making false declarations or providing false information
- misrepresenting or withholding criminal or employment history, qualifications or other information pertinent to MidCentral District Health Board's decision to hire or promote the employee
- conspiring with any other employee to engage in fraudulent activity.

Theft:

- dishonestly taking, dealing with or concealing any thing, document, information or software which is the property of MidCentral District Health Board or is under MidCentral District Health Board's control
- taking or without proper authorisation dealing with any monies, funds or securities belonging to MidCentral District Health Board or coming under MidCentral District Health Board's control
- theft or conversion of MidCentral District Health Board's property, supplies or other asset.

Corrupt actions:

- using the position of employment or knowledge gained from that position to improperly obtain a benefit (whether financial or otherwise) for oneself or some third party other than MidCentral District Health Board
- seeking or accepting (other than remuneration by way of normal salary) any personal fee, reward, gift, gratuity or subsidy, of any description, or attempting to extract same whether on account of any services provided in the normal course of duty or otherwise. (Unsolicited gifts of appreciation, for example, chocolates, flowers etc may be accepted, provided that such gifts are not accepted from any one source on a regular basis)
- Possession of a patient/client's property without proper authorisation or possession of another employee's, contractor's or visitor's property without that employee's, contractor's or visitor's consent
- Unauthorised possession of MidCentral District Health Board property
- Unauthorised use of MidCentral District Health Board property, equipment, materials or records, including fire protection or safety equipment
- Using the employee's position of influence over a patient/client to cause the patient/client to enter into any relationship with the employee, or do any other thing which may result in any benefit (financial or otherwise) to the employee or any relative of an employee or which might cause the patient/client to suffer any loss or detriment
- Failure to notify MidCentral District Health Board of any changes to the employee's scope of practice, criminal charges/convictions status or secondary employment where this creates a significant conflict of interest.

4. CONFIDENTIALITY

Any information in respect of a fraud or suspected fraud reported by any person will be treated with confidence until the completion of any inquiry or investigation.

Where any persons reporting any fraud or suspected fraud wish to remain anonymous and their identity be protected they can request that the matter is made under the Protected Disclosures Act 2000 (refer Policy and Procedure re Disclosure of a Serious Wrongdoing (Whistle Blowing) (MDHB-2053).

The Protected Disclosures Act 2000 provides for protection of identity. Any such request must be made to the Manager, Human Resources through the Health Integrity Line 0800 424 888.

Where anonymity is not an issue, the fraud or suspected fraud will be dealt with in the normal manner.

5. ROLES & RESPONSIBILITIES

All Employees

Responsible for:

- reporting immediately to their immediate manager or to either the General Manager, Finance & Corporate Services or the Manager, Human Resources any incidence of actual or suspected fraud they may encounter
- where notification is being made under the Protected Disclosures Act, directly to the Manager, Human Resources or through the Health Integrity Line
- treating as confidential information they may have regarding the actual or suspected fraud, and not discussing or sharing this with people not involved in any investigation.

All Managers

Responsible for:

- ensuring that appropriate controls are implemented at all levels to ensure safeguards against fraudulent activity, and for taking action to maintain these controls and minimise the possibility for fraud
- ensuring that the possibility of detection of fraud is maximised
- reporting to the General Manager Finance and Corporate Services any incidence of actual or suspected fraud they may encounter, or have reported to them by an employee.

Where a disclosure is made under the Protected Disclosures Act 2000:

Health Integrity Line

Responsible for:

- Protecting the anonymity of the informant
- Conveying information from the disclosure to the Manager, Human Resources or General Manager, Finance and Corporate Services.

Manager, Human Resources ~~& Organisational Development~~

Responsible for:

- receiving the disclosure (refer MDHB-2053)
- advising the General Manager, Finance and Corporate Services (unless this person is implicated in which case the Chief Executive ~~Officer~~ is to be advised)

- advising MDHB's Board Chair if a Board Member, or the Chief Executive ~~Officer~~ is implicated by the allegation
- ensure that the inquiry is conducted as outlined in the Disclosure of a Serious Wrongdoing (Whistle Blowing) [Procedure] MDHB-2053.

For all other incidences of actual or suspected Fraud:

General Manager, People and Culture / Manager, Human Resources ~~& Organisational Development~~

Responsible for:

- ensuring that the General Manager, Finance and Corporate Services is immediately advised of the fraud or suspected fraud
- providing advice to support adherence to MDHB's Disciplinary Procedures [Policy] MDHB-1889
- providing advice to any investigation to ensure it is conducted in accordance with the principles of procedural fairness and natural justice
- providing advice in respect of whether suspension of the staff member/s should be considered and the process for same
- providing advice in respect of any investigation outcomes, once the investigation has been completed.

General Manager, Finance and Corporate Services

Responsible for:

- ensuring adherence to MDHB's Disciplinary Procedures [Policy] MDHB-1889;
- ensuring any investigation is conducted in accordance with the principles of procedural fairness and natural justice
- together with the Manager, Human Resources ~~-~~obtaining restitution in respect of any proven occurrence
- advising the Chief Executive, General Manager/Director responsible for the service in which the fraud has been alleged
- advising MDHB's Board Chair if a Board Member or the Chief Executive ~~Officer~~ is implicated in the allegation
- determining (in consultation with the relevant General Manager and Manager, Human Resources) what steps are required to ensure that a full and thorough investigation is undertaken, which may include standing down or suspending the person who is the subject of the allegation
- promptly investigating the allegation of fraud (in consultation with the Manager, Human Resources), which may involve one of the following options:
  - setting up an internal investigation (where financial misuse is involved this would likely involve an internal audit)
  - setting up an independent investigation, and in either case
  - appointing a Designated Investigator and directing them to secure evidence to ensure it is not interfered with
- direct that MDHB's insurers are advised so that the organisation's rights to subrogation are not jeopardised
- ensuring every effort is made to gather sufficient reliable evidence to support reaching a conclusion as to whether fraud has or has not occurred
- ensuring the investigation is fully documented
- deciding (in consultation with the Chief Executive ~~Officer~~ and the General Manager, People and Culture) whether or not to involve external agencies e.g. Police, Serious Fraud Office etc (any external agency investigation will be a separate process from any MDHB investigation)

- through the Chief Executive ~~Officer~~, keeping the Board and relevant Board subcommittees, including the Finance, Risk and Audit Committee, informed until the outcome is finalised
- ensuring the ~~Manager Administration and Communications~~ Corporate Communications Manager is briefed to appropriately handle any media communications
- after resolution of any investigation, ensuring systems and procedures are reviewed to determine whether any changes are required to lessen the chance of future similar occurrences.

Designated Investigator

Responsible for ensuring:

- undertaking investigation of the suspected fraud in accordance with the principles of procedural fairness and natural justice
- preservation of all evidence including equipment or other instruments used or suspected of being used in the fraud or suspected fraud
- where preservation in its natural state is not possible, take possession and secure all evidence
- maintain records of all items secured during the investigation recording where these were from, and to whom they were given for safe custody
- protect evidence from tampering or other interference
- liaise with police investigators or other external agencies if involved
- maintain accurate records for evidential purposes should they be required
- where Police are involved update General Manager, Finance and Corporate Services of progress of investigation and ongoing Police requirements.

Chief Executive ~~Officer~~

Responsible for:

- the investigation of the allegation of fraud (in consultation with the General Manager, People and Culture), in the event that the General Manager, Finance and Corporate Services is implicated.

Board Chair responsible for:

- the investigation of the allegation of fraud (in consultation with the General Manager, Finance & Corporate Services), in the event that Board Members or the Chief Executive ~~Officer~~ is implicated.

Deputy Board Chair responsible for:

- the investigation of the allegation of fraud (in consultation with the General Manager, Finance & Corporate Services), in the event that the Board Chair is implicated.

6. PREREQUISITES

Protections

A person making a disclosure under the Protected Disclosures Act 2000 is protected from:

- retaliatory action by MDHB (including dismissal from employment) as per section 17 Protected Disclosures Act 2000);
- civil or criminal liability or disciplinary proceedings (as per section 18 Protected Disclosures Act 2000).

7. POLICY

MDHB is committed to the development and maintenance of best practice processes and procedures to prevent and detect fraud.

MDHB has a zero tolerance to fraud and will investigate all reported incidents of alleged fraud, misappropriation or similar irregularity.

Employees who consider there are grounds for an investigation into fraudulent activity should make a disclosure under the Protected Disclosures Act 2000, and investigations will be undertaken within the constraints of protected disclosure. Any employee who believes that fraud is being or has been committed within MDHB must not attempt to conduct an investigation personally or conduct any interviews or interrogations personally.

All proven incidents of fraud will be pursued through every means available, including disciplinary action, and prosecution may also result.

MDHB will pursue every reasonable course (including court ordered restitution) to obtain recovery of any loss from the individual/s concerned.

8. REFERENCES

Protected Disclosures Act 2000
Crimes Act 1961

9. RELATED MDHB DOCUMENTS

MDHB-2053	Disclosure of a Serious Wrongdoing (Whistle Blowing) [Policy and Procedure]
MDHB-5582	Code of Conduct [Policy]
MDHB-1889	Disciplinary Procedures [Policy]

10. FURTHER INFORMATION/ASSISTANCE

General Manager, Finance and Corporate Services
General Manager, People and Culture
Manager, Human Resources ~~& Organisational Development~~
Health Integrity Line 0800 424 888

11. KEYWORDS

Fraud, Fraudulent activity, Misappropriation, Irregularity, Serious wrongdoing, Disciplinary action, Prosecution, Police, Investigation, Integrity

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- How can the Board support the achievement of the activities in the shared work plan?
- How could this shared work plan be used to support the whole organisation during the pending changes?

To	Board
Author	Wayne Blissett, Operations Executive, Pae Ora Paiaka Whaiora
Endorsed by	Tracee Te Huia, General Manager, Māori Health
Date	4 June 2021
Subject	**Manawhenua Hauora and MidCentral District Health Board Shared Work Plan 2021/22**

RECOMMENDATION

It is recommended that the Board:

- **approve** the Manawhenua Hauora and MidCentral District Health Board Shared Work Plan 2021/22 for implementation.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler equity of outcomes for Māori, Te Tiriti o Waitangi Policy, Ka Ao, Ka Awatea Māori Health Strategy 2020-22 and the Ministry of Health's Whakamaua – Māori Health Action Plan 2020-2025.

1. PURPOSE

To provide the Manawhenua Hauora and MDHB Board Shared Work Plan for 2021/22 for the Board's approval, following endorsement by both Manawhenua Hauora and MDHB Board at the Board to Board meeting held on 25 May 2021.

2. SUMMARY

Building on the gains made by Manawhenua Hauora and MDHB Board with previous shared work plans, this work plan provides a focused effort between boards to ensure the effective transition during the pending health sector reforms. It is grounded on Whakamaua – Māori Health Action Plan 2020-2025 and supports continued progress in realising Pae Ora – Healthy Futures for Māori across the district and our home-grown Māori Health Strategy, Ka Ao, Ka Awatea 2020-2022.

3. BACKGROUND

This shared work plan has been developed by Manawhenua Hauora and MDHB Board to actively support and protect the gains made across Māori health over the last number of years. It consolidates the Te Tiriti o Waitangi partnership between Manawhenua Hauora and MDHB Board, keeping the focus on Māori health development and equity for Māori as priority strategic issues for the organisation. Manawhenua Hauora tabled the working draft Shared Work Plan 20021/22 at the Board to Board hui on 25 May 2021, where it received unanimous support from all present. Consequently, at the Manawhenua Hauora meeting on 31 May 2021, it was formally endorsed to be presented to MDHB for joint approval.

4. CONTEXT

The context for the development of the Manawhenua Hauora and MDHB Shared Work Plan has been against the backdrop of the announced health reforms. While the reform announcements have demonstrated the most significant changes in the last two decades, it is also in the context of continuing to advance the commitment and investment in iwi and Māori provider development and service delivery across the district. The Ka Ao, Ka Awatea strategy provides a clear framework and agreed direction of travel in clear alignment with the Ministry of Health's Whakamaua – Māori Health Action Plan 2020-2025.

This shared work plan builds on what has been achieved, protects what has been established and provides support and stability across the district in what will be year of large-scale change.

P – Protection

A - Advance

E – Equity

O – Opportunities

R – Resilience

A – Awhi – Care

Pae Ora – Healthy Futures is the ultimate destination of He Korowai Oranga and Whakamaua – Māori Health Action Plan. Manawhenua Hauora has taken Pae Ora and created a series of actions and shared commitments with the MDHB Board to actively guide and support the organisation through this period of change.

The shared work plan attached as Appendix One describes how Manawhenua Hauora and the MDHB Board together can continue to navigate and execute their Tiriti based partnership to offer stewardship, mana motuhake, equity and social inclusion in the coming year.

APPENDIX ONE: Manawhenua Hauora and MDHB Board Shared Work Plan 2021/22

FOCUS	Tuatahi Manawhakahaere - Good Governance	Tuarua Mana Motuhake – Unique and Indigenous	Tuatoru Fairness and Justice	Whakapuakitanga Cultural identity and integrity	Measures
P Protection	We will provide clear and cohesive governance leadership for iwi and Māori health across the district with a clear strategy for protecting the gains made in Māori health over the last five years during the reform ensuring we do not lose any services from the current baseline.	We will provide leadership and direction, investment priorities and focus areas across hospital and community services on iwi and Māori health needs and priorities protecting kaupapa services through the reform.	We will challenge inequity at every opportunity equity of outcomes for Māori including pay equity and equity of access to kaupapa services across the district.	We will advance acknowledgement of matauranga Māori including Rongoa as a legitimate evidential base across the hospital and health system.	The status of Manawhenua Hauora is elevated to its rightful place in the system as an equal Tiriti o Waitangi partner. Equity of funding across Iwi and Kaupapa contracts is achieved Ngā Pou o te Oranga summary audits reported Q2 and Q4 to Manawhenua Hauora.
A Advance	We will continue to advance the Whānau Ora Commissioning approach as a sustainable commissioning framework for iwi and Māori providers Advance the role of the MALT to elevate operational accountability across services to Māori whānau needs.	We will actively advance the spread and breadth of kaupapa services across the District in alignment with Ka Ao Ka Awatea through meaningful investment and commissioning strategies. Advance the Whānau Ora Commissioning model with Rangitāne o Manawatu and be open to pathways with remaining iwi in this district.	Provide direction on equity needs from iwi and Māori perspectives, identifying key issues for consideration in determining local Māori health priorities. Monitor performance quarterly using the Māori health equity dashboard Te Ara Angitū and the non-financial quarterly performance monitoring reports.	Key initiatives across Hospital and Community Health services are presented to Manawhenua Hauora for endorsement. Initiative reporting is included in Q2 and A4 reporting	Equity Dashboard Reports are presented quarterly to Manawhenua Hauora and HDAC. Progress against Ka Ao Ka Awatea is reported to Manawhenua Hauora and HDAC in Q1 and Q3.

E Equity for Māori	All parts of the hospital and health system have Māori equity actions as part of their annual plans and report against progress in the non-financial reporting of the 2021-2022 annual plan. All Equity Outcome Actions demonstrate an improvement quarterly.	Affirmative actions and shared decision making with MDHB and MWH on investments and priorities are evident in Annual and Operational Plans across the district to advance access and spread of kaupapa services.	Racism, discrimination, and stigma is actively challenged across the hospital and community services to advance social inclusion and equity of access. Incidents of racism and discrimination are recorded and reported against twice yearly.	Access to rongoa Māori and traditional healing is invested in across the district to create further opportunities for Māori to access Māori healing and therapeutic options. Matauranga Māori is promoted, supported, and invested in across the District.	Racism and Discrimination incident reporting established by Quality and Risk. Reports presented to Manawhenua Hauora six monthly with resolutions. Non-financial Reporting Q2 and Q4.
O Opportunities	The Boards will actively seek opportunities to influence and participate in the national and regional developments as the reform is implemented, focusing on stewardship of the district and Māori Health developments.	Whiti ki te Uru is invigorated and resourced to actively advance kaupapa Māori service developments across the Central Region. Manawhenua Hauora will be active participants in developments as Iwi representing the interests of the District	Central Regions GMs Māori will actively advocate and participate to ensure advancements in Māori health are protected and advanced across the Central Region, elevating regional inequity of service access, provision, and outcomes.	Opportunities to advocate and expand access to kaupapa Māori services across the health and disability system are identified and invested in, for greater choice, access and supports for Māori whānau.	Regular updates between Manawhenua Hauora and MDHB Board ensure clear communication and opportunities for influence as the reform is implemented. MDHB updates are provided as required. Manawhenua Hauora updates are provided as required.
R Resilience	Manawhenua Hauora and MDHB Board will provide consistent and courageous stewardship to build the resilience of the organisation and Iwi and Māori providers to withstand and adjust to the implementation of the reforms.	Iwi and Māori providers are invested in to ensure resilience during the reform implementation. Prioritisation and investment approaches are focused on building infrastructure and	Iwi and Māori providers have access to sustainable investment and security of contracts to ensure sustainable service delivery and development.	New investment in rongoa and kaupapa Māori service models of delivery are prioritised and implemented.	MDHB overall budget for 21/22 is consulted on with Manawhenua Hauora before it is submitted to the Ministry of health at its July meeting. Prioritised investment demonstrates building of resilience and

	MDHB will provide supports and resourcing to iwi during the transition to the new structure, ensuring iwi are prepared and ready for any change.	resilience across iwi and Māori providers. Data and Digital system of iwi and Maori providers are strengthened to properly engage in the reform.	Iwi and Māori provider contracts are secured for 2 years to support the sustainable delivery of services to Māori whānau.		infrastructure for iwi and Māori providers. MALT is further formalised as the mechanism to administer and advance iwi and Māori provider service delivery and performance.
A Awhi -Care and Support	Manawhenua Hauora and MDHB governance boards will work in partnership to ensure that all parts of the organisation are cared for and supported through the pending changes.	Manawhenua Hauora and MDHB will work in active partnership to ensure that the iwi and Kaupapa Māori providers receive the care and support they require to achieve excellence through the pending changes.	MDHB and Manawhenua Hauora Boards will provide clear communication to community to ensure whānau are kept informed of any changes to services that may differ as a result of the pending changes.	Iwi and Māori providers and their whānau whaiora have access to information about the changes in a range of formats and platforms to ensure Māori communities are well informed on any potential changes to service delivery.	A joint communications strategy is developed and resourced for Manawhenua Hauora and MDHB Board to ensure a cohesive approach to communications over the next 12 months.

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Does the Psychosocial Wellbeing Strategy include an equity perspective?
- Does the Psychosocial Wellbeing Strategy have a supporting plan to deliver key objectives?
- How is the success of the Psychosocial Wellbeing Strategy going to be monitored?

To	Board
Author	Keyur Anjaria, General Manager, People and Culture
Endorsed by	Kathryn Cook, Chief Executive Organisational Leadership Team
Date	21 June 2021
Subject	**Psychosocial Wellbeing Strategy**

RECOMMENDATION

It is recommended that the Board:

- **note** the development pathway of the Psychosocial Wellbeing Strategy
- **note** the plan to deliver the Psychosocial Wellbeing Strategy
- **approve** MidCentral District Health Board's Psychosocial Wellbeing Strategy.

Strategic Alignment

This report aligns to MidCentral District Health Board's (MDHB's) Strategy, and to the People Plan "*He kura te Tāngata A plan for our people*" which is one of the five key enablers to support the achievement of MDHB's strategic imperatives.

1. PURPOSE

To introduce the Psychosocial Wellbeing Strategy (the Strategy) for the Board's consideration and approval.

Consultation on the Strategy has been carried out with staff, union partners and the Clinical Council. The Strategy has been endorsed by the Organisational Leadership Team (OLT).

2. INTRODUCTION AND BACKGROUND

2.1. Defining the problem and developing the Strategy

In 2019, a piece of work was initiated to address violence in the workplace. A working group comprising of staff from all inpatient and community-based services, orderlies and other contracted staff who interacted with patients, and union partners was established.

Two distinct strategic pathways were developed. The first was a strategy to 'prevent occupational violence' in the workplace. This was approved by the Board in 2019 and progress on the activities are monitored by a working group comprising staff from inpatient and community-based services, with representatives from all professional groups (nursing, management, allied health, clerical and medical staff). The Board receives an annual progress report, with the last update provided in February 2021.

The second pathway was to develop a strategy to 'prevent bullying and harassment' (psychological harm) in the workplace. Through support provided to staff during the COVID-19 pandemic in 2020, it became evident staff benefited from wider psychosocial support, rather than just support related to bullying and harassment. Levels of overall staff wellbeing and perceptions of bullying and harassment in the workplace were measured in the staff engagement survey which concluded in August 2020. While the measures for bullying and harassment continued to show progress, the results suggested the need for a strategic pathway to provide wellbeing support for staff.

In addition to workforce and digital systems, the DHB has prioritised equity and cultural responsiveness in the Strategy. In developing the Strategy, the DHB has investigated and embraced three key Māori models:

1. Te Pai Mahutonga – at a macro level
2. Te Waonui a Tane, our forest environment – at a meso level
3. Te Whare tapa wha – at a micro level.

Pae Ora Paiaka Whaiora has provided partnership, input and support in integrating the 'Māori world view' and models in the development of the Strategy. The Psychosocial Wellbeing Strategy is included as Appendix One.

3. THE MENTAL HEALTH CONTINUUM

Mental health is defined by the World Health Organization as a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to their community.

The 'mental health journey' describes a continuum from being healthy to being unwell and/or absent from work. A person's placement on this continuum can shift at any point in time. Placement depends on the impact of psychosocial wellbeing through life experiences, cumulative levels of stress, work stressors, levels of resilience (natural and learned) and the degree of support available.

By deploying and leveraging tools and learnings, an employee can optimise the impact life and work experiences have on their mental health, and promptly identify and activate relevant support to manage the injury.

High quality initiatives at a preventative, mitigating and reactive level are required to support all staff, irrespective of where they find themselves on this continuum. Mental health forms the core of wellbeing and needs to be at the centre of all activities related to this Strategy.

4. CONSULTATION

This Strategy has been consulted with union partners, staff groups and committees. Feedback has overwhelmingly supported the development and delivery of this Strategy.

The views of staff groups who provided feedback serve as a barometer for how the wider workforce will receive this Strategy. There was strong support for the Māori world view to inform the development of various components of the Strategy. The Clinical Council has indicated their desire to oversee the delivery of the Strategy to ensure its success. The DHB's OLT has endorsed the Strategy for the approval of the Board.

As part of the consultation process, staff were provided with survey questions which would help in validating and prioritising activities identified to support the Strategy. All activities identified within the Strategy were overwhelmingly supported. A table, indicating the top 10 actions which staff prioritised, is provided below.

Actions	Staff response scores out of 5
Building resilience in the way teams work together	4.19
Invest in peer support programmes to enable staff to support one another	4.16
Develop more inclusive mind-sets to reduce unconscious bias in our daily interactions	4.15
Develop a framework for managers and staff to have wellbeing check-ins, coaching and mentoring conversations	4.12
Promote mental health practises through leadership training	4.06
Educational programmes about preventing bullying, harassment, and discrimination in our place of work	4.06
Building greater capacity around supporting change in the organisation	4.03
Dealing with differences in opinions (conflict) in constructive ways	4.03
Develop a fit-for-purpose online wellbeing tool kit to support both staff and managers	3.88
Build leadership commitment to promote principles of wellbeing into decision making and mental health conversations	3.81

5. GOVERNING AND IMPLEMENTING THE STRATEGY

The working group that oversees the Violence Prevention Strategy has agreed to oversee the implementation of the Psychosocial Wellbeing Strategy. This group includes representatives from areas across the DHB who lead the delivery of initiatives that apply to their area of operations.

6. MONITORING AND REPORTING

The Strategy includes an action plan to support the delivery of activities scheduled over the next two years. This will be reviewed following the changes proposed as part of the health sector reforms. Progress reports will be provided annually to the OLT, Clinical Council and the Board.

7. NEXT STEPS

Following approval of the Strategy, a one-page poster, will be designed and displayed in all staff-only areas. Regular updates will also be provided to staff and groups which have contributed to the development of this Strategy.

“Safe with Us”
Haumaru ki a tatou

A strategy to enhance the psychosocial wellbeing/hauora of employees

MidCentral District Health Board
June 2021

Contents

1. Introduction

We know having staff who are thriving in their roles provides flow-through benefits for their teams and for the organisation they represent. A key requirement for an employee to thrive is for them to have a strong sense of psychological safety. Working in an environment characterised by psychological safety, which, in its simplest form, is based on respect and the protection of basic human rights; encourages ideas and proactive decision making without fear of repercussion. A psychologically safe organisation makes every effort to protect the health and wellbeing of employees holistically. Without the security and freedom provided by these rights, it is difficult to maintain a high level of mental health (WHO, 2020) and subsequent wellbeing.

Creating a psychologically safe environment is important to us at MidCentral District Health Board (MDHB), and aligns with our People Plan, 2019-2023. Furthermore, the COVID-19 pandemic exposed the important and urgent need to support our people who work incredibly hard to support our community. Learnings from the support provided during the height of the pandemic and the results of the staff survey highlighted the need for well-rounded interventions to enhance staff mental health and wellbeing in the workplace.

As part of our approach, it's important we are connected to Kaupapa Māori. The approach taken in developing this strategy aligns with the principles of Te Whare Tapa Whā, while also acknowledging Te Wao nui a Tāne (the forest ecology) and the environment as key factors of employee wellbeing. Te Pae Mahutonga is the constellation of stars and strongly represents the value of navigation through strong leadership and inclusive workplace relationships.

The Māori worldview promotes the reciprocal responsibility of protecting tapu to maintain mana which includes psychological, metaphysical, and spiritual elements. Reference to this thinking in our psychosocial wellbeing strategy is present to build the foundation to give context to an environment where relationships of staff to staff flow onwards producing messages on building better staff/whanau relationships resulting in well communities.

This strategy is a priority for MDHB, and while focussed on psychological safety, its aim is to complement our activities across this DHB contributing to our collective wellbeing. Within this strategy, you will read about our key strategic focus areas, and the proposed delivery plan that sits within these. We strongly encourage you to participate in the development and implementation of this work plan, because this is built for you, our workforce, and our most important quality.

2. Connection to the Māori worldview

The articles and principles of Te Tiriti o Waitangi form the foundation for how the DHB meets its commitment to Māori by guiding how we govern and conduct ourselves, how true partnership is demonstrated, how beliefs, values and tikanga are cherished, and how excellence, in all its forms, is attained.

This strategy embraces the holistic approach explained through the concept of Te Wao nui a Tāne (the forest ecology) as a key factor in overall employee wellbeing. The strategy strongly supports the principle that the external and physical environment directly connects to employee wellbeing as explained through the ecosystem approach that refers to interdependence and collectivism. However, the psychosocial wellbeing strategy does not cover the full scope of wellbeing as seen through the Māori perspective. The view is rather that this strategy focus on mental, emotional, physical, spiritual and social wellbeing. A holistic approach would refer to the active connection between this specific strategy and other organisational strategies and approaches to complete interconnectedness to external environmental factors. Other organisational approaches would typically refer to the People Plan, Ahu Taumatua – Our Place, The redevelopment of Palmerston North Hospital, the overarching Health and Safety strategy, etc.

The following Māori worldview models and concepts are integral to the fundamentals of this strategy. At Macro level (Te Pae Mahutonga), Meso level (Te Wao nui a Tāne) and Micro level (Te Whare Tapa Whā) as the organisational structure to support this psychosocial wellbeing strategy:

2.1 Te Pae Mahutonga

Description	Components	Connection to the Psychosocial Wellbeing Strategy
Te Pae Mahutonga is the constellation of stars popularly referred to as the Southern Cross. It is visible low in the night sky and identifies the magnetic South Pole. The constellation has four central stars arranged in the form of a cross and two stars arranged in a straight line that points towards the cross. They are known as the two pointers.	The **four central stars** can be used to represent the four key tasks of health promotion namely: • Mauriora (Cultural identity) • Waiora (Physical environment) • Toiora (Healthy lifestyles) • Te Oranga (participation in society) **The two pointer stars are:** • Nga Manukura (Leadership) • Te Mana Whakahaere (Autonomy)	The constellation has long been used as a navigational aid and is symbolic in bringing together the significant components of health. This strategy progress these principles through: • Promoting diversity, inclusivity and constructive working relationships to progress Mauiora. • Connecting to other organisational programmes such as Ahu Taumatua – Our Place, The redevelopment of Palmerston North Hospital by encouraging a strong consideration of employee needs in redesigning our place of work, informing Waiora. • Strong alignment with Toiora, increasing healthy lifestyles by assessing psychosocial risks and putting initiatives in place to grow mental and emotional wellbeing in support of a healthy lifestyle by looking after the individual and investing in organisational systems. • Te Oranga, promoting healthy and inclusive working relationships across the organisation. • Creating an environment where organisational leaders (Nga Manukura) and influencers are confident to respond psychosocially appropriate, take care of themselves and lead healthy organisational systems and processes. • Te Mana Whakahaere as a principle, committing to staff consultation and conversation to identify joined aspirations for mental wellbeing initiatives.

2.2 Te Wao nui a Tāne (the forest ecology)

Description	Components	Connection to the Psychosocial Wellbeing Strategy
Te Wao nui a Tāne represents unity, as all trees, vegetation, bird and insect life originated from the atua (god) Tāne, all are inter-related and often inter-dependent. People were created after all these living life forms and thus are seen as junior to them, this is often why you will hear Māori refer to rākau/trees as their tuākana or senior. It is a statement of whakapapa. It serves as a daily reminder that we need to be connected in our relationships with each other to truly provide an integrated system of care for consumers and whānau. There seems to be no single Māori word or translation for ecosystem, but mātauranga Māori (Māori knowledge), te reo Māori (Māori language) and whakapapa (ancestral lineage) are all use together to explain the indigenous perspective of an intricate, holistic and interconnected relationship with the natural world and its resources.	The components of the forest involves all forms of living creatures and the core concept is around the importance of interdependence and interconnectedness between these creatures to survive sustainably. If one component were to be unwell, it would affect all others and vice versa.	This strategy acknowledges the interconnectedness of the environment, the organisational system, individuals, leaders and teams and the quality of workplace relations and support to the overall mental wellbeing of employees. It also acknowledges the complexity (and dependencies) within the ecosystem and intents to contribute towards an experience in which all who are within the ecosystem feel safe and are well taken care off. This will in turn ensure that we as an organisation take good care of our community, patients and consumers of our services. Focusing on mental wellbeing expands across our employees, our leaders, and our teams our whanau's, consumers of our services and ultimately our community. We are united as people living in this forest and although the mental wellbeing strategy is not particularly focused on the physical resources, it connects to other strategies that intends to promote a sustainable and healthy ecosystem.

2.3 Te Whare Tapa Whā

Description	Components	Connection to the Psychosocial Wellbeing Strategy
The model describes health and wellbeing as a wharenui/meeting house. This model has high credibility in the health sector, the mental health sector, and in MDHB. Te Whare Tapa Whā is widely accepted and part and parcel of a New Zealand approach to individual wellbeing.	• Whenua (connection with the land or environment, and the foundation of the house) • Taha tinana (physical wellbeing) • Taha hinengaro (mental and emotional wellbeing) • Taha wairua (spiritual wellbeing) • Taha whānau (family wellbeing)	Te Whare Tapa Whā will be the framework utilised to inform and deliver a holistic approach to identify appropriate programmes, to support individual wellbeing. Increasing personal resilience is one of the key strategic focus areas and discussed in detail on p12 of this document.

3. Why does psychosocial employee wellbeing matter?

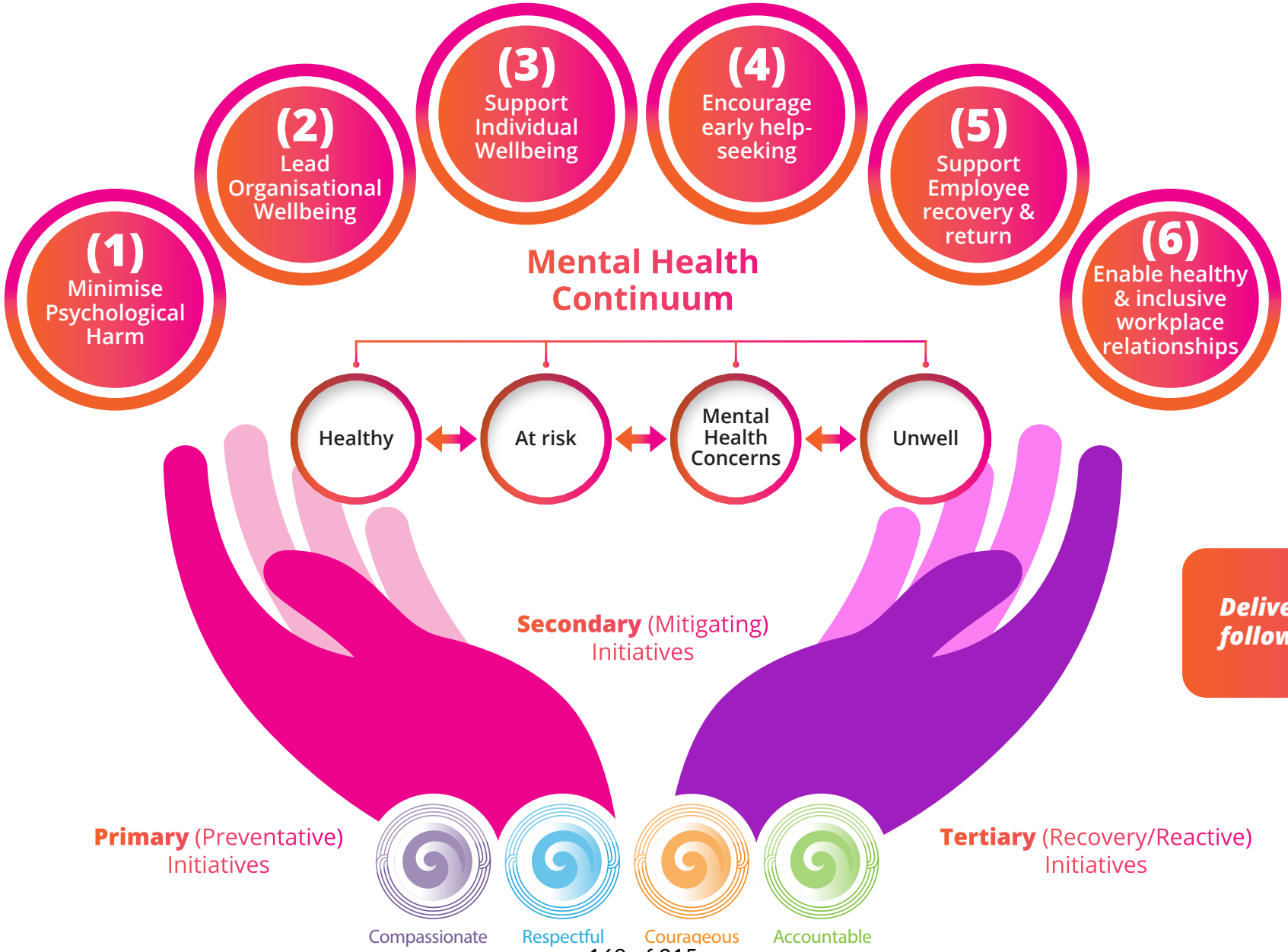
To be able to provide and sustain a safe and healthy working environment for our staff, we need to identify shared problems through discussion, careful listening and analysis combined with joint solution finding at all levels. Critical to the creation of a safe working culture is the design of fit-for-purpose systemic solutions that are built around unique needs of different groups or teams. Consultation, collaboration and participation needs to be fundamental to an approach of building psychosocial wellbeing and achieving cultural transformative outcomes.

Where do we want to go?

To create a safe environment where staff:

- are able to build and maintain the positive experiences reported in the MDHB He Kupu Kōrero Engagement Survey
- protect and take care of each other, as we do for patients
- actively support and participate in healthy support networks
- view self-care as a necessary part of our day-to-day business
- embrace individual differences
- respect tikanga
- work compassionately through their differences to restore work relationships when needed
- are inclusive and kind to each other
- keep mental health and wellbeing central to their relationships and decisions
- proactively support each other to balance expectations around service delivery and mental health
- promote safe collaboration, a sense of belonging, connectedness and cross functional team efficacy
- talk, listen and respond to each other respectfully
- feel safe to raise issues without the fear of retribution.

4. The Psychosocial Wellbeing Strategy on a page



Delivery plan to follow this page...

5. The delivery plan

Minimise Psychosocial Harm	Lead organisational wellbeing	Support individual wellbeing	Encourage early help seeking	Support employee recovery and return to work	Enable healthy and inclusive workplace relationships
2021/2022 Financial Year					
• Implement the Preventing Occupational Violence Action Plan. • Identify a suitable psychosocial risk assessment tool to assess psychosocial risks. • Develop a framework that guides managers in having structured wellbeing conversations.	• Ensure that Leadership training programmes have psychosocial responsiveness module. • Integrate principles of wellbeing into coaching, mentoring and supervisory conversations.	• Develop a one-stop, online site that has all wellbeing offerings for staff. • Establish an evidence based wellbeing peer support network. • Promote team wellbeing check-ins, through the "I matter, You matter and We matter programme".	• Identify and implement self-assessment and self-care resources. • Establish a Critical Incident Stress Management Response Group.	• Conduct return to Work surveys that feed into improvement programmes. • Enable supportive and inclusive return to work programmes.	• Run a training programme to develop inclusive mind-sets, decreasing unconscious biases. • Implement bullying and harassment prevention and awareness programme. • Develop a flexible work arrangement decision-making framework to support gender equality and the ageing workforce population.
2022/2023 Financial Year					
• Train people leaders in psychosocial risk assessment practices. • Conduct formal organisational psychosocial risk assessment and develop mitigation strategies for high-risk areas.	• Roll out coaching and mentoring programmes to all managers and people-leaders. • Build change management capability amongst managers. • Review EAP and staff support services.	• Roll-out peer support network programme. • Assess organisational offerings in terms of individual wellbeing support against Te Whare Tapa Whā model.	• Promote self-care for people leaders and staff across the organisation. • Build mental health awareness capability among staff and managers.	• Develop guidelines, for people leaders to support employee recovery.	• Invest in team development. • Expand and promote staff-led social networks and interest groups such as disabled staff, gender diverse, ethnic or special interests such as walking. • Investigate restorative justice and mediation approaches to support constructive resolution of differences in our place of work.
FOUNDATIONAL PRINCIPLES					
A steering and working group function will oversee implementation, reporting, advocacy, development and commitment to this strategy.					
Continuous consultation and partnership with people leaders and staff to ensure wellbeing initiatives are fit for purpose and serves their needs.					
Establish structures and channels to encourage staff consultation and participation in wellbeing initiatives and programmes.					
Continuous review of current people process practices, guiding documents and approaches will take place against principles of wellbeing.					
Assess all services and programmes through feedback from staff to assess impact on staff wellbeing.					

6. Psychosocial Wellbeing Strategy

Mental health Is defined by the World Health Organisation as a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and can contribute to their community.

The vision of this strategy is to ensure that our people are physically, mentally, emotionally, spiritually and socially safe with us and therefore they are able to flourish - Puawai nga kaimahi.

Employee wellbeing will be enhanced by establishing a psychosocially safe employee experience through active commitment to wellbeing so that our people are able to offer the same level of experience to users of our services, enabling quality living, healthy lives and well communities.

The mental health continuum describes a journey from being healthy to being unwell and/or absent from work. Where an individual and/or employee is placed on this continuum can shift at any point in time, depending on the impact on their psychosocial wellbeing through life experiences, cumulative levels of stress, work stressors, levels of resilience (natural and learned) and levels of support available to them. **Appendix A** contains a full description of the mental health continuum and the potential impact on staff behaviour.

By leveraging tools and strategies, we can learn to optimise the impact that life experiences can have on mental health. This continuum is dynamic and constantly changing. Mental health concerns should receive prompt identification to activate relevant support and treatment and to reverse impact of psychological injury. High quality initiatives at a preventative, mitigating and reactive level (see **Appendix B** for a full description) is required to support all of our staff, all of the time, irrespective of where they find themselves on this continuum.

The strategy to support employees on their mental health journey, is comprised of six wellbeing focus areas designed to prevent, mitigate and respond appropriately to psychosocial stressors in the workplace, independent on where any employee may find themselves on the mental health journey. MidCentral DHB believes a holistic approach as described by the Māori worldview should not only be focused on recovery, but needs to be preventative and proactive to promote psychological safety and good mental health in the workplace.

A plan to support the delivery of the strategy is presented on page 16 of this document. The delivery plan is based on priorities that have been identified by staff, through the consultation process. The following pages illustrate each of the strategic focus areas in more detail.

6.1 Minimise psychological harm

As a responsible employer, MidCentral DHB needs to be fully aware of workplace psychosocial factors that can have negative effects on the mental health and psychological wellbeing of its staff. New Zealand's Health and Safety at Work Act 2015 also requires employers to ensure the safety of their workers' mental and physical health, and to manage risks arising from exposure to hazards at work, which may cause more than just physical harm.

The Psychosocial Safety Framework provided in the figure below informs the initiates and factors that need to be considered in minimising psychological harm and increasing the levels of psychological 'safety' of employees.

Commitment to minimise psychological harm will deliver

- A systematic and objective approach to identify high-risk areas across the organisation, initiating corrective action.
- A framework to drive practices that will enable people leaders to develop a culture of psychological safety.
- Managing workplace stress as a mental health and safety hazard.

6.2 Lead Organisational Wellbeing

Resilience is broadly described as the process of negotiating, managing and adapting to significant sources of stress, change, adversity or trauma. Various factors within the individual and their environment facilitate this capacity for adaptation or 'bouncing back' in the face of adversity and stress.

Leadership at all levels is critical in identifying and supporting good mental health and wellbeing of employees. According to Edmondson (2018), leaders who want to unleash individual and collective talent must foster a psychologically safe climate where employees feel free to contribute ideas, share information and report mistakes. They would explicitly discourage stigma, discrimination, bullying and harassment, and actively foster diversity and inclusion. The NZ Mental Health Foundation states that for a positive organisational culture to permeate all areas of an organisation, it must be embedded and authentically enacted at every level to provide the standard for healthy behaviour in the workplace and build resilience at both an organisational and individual level.

Commitment to lead organisational wellbeing will deliver:

- Investment in holistic organisational wellbeing approaches.
- People leaders who are capable and confident to respond constructively to the psychosocial needs of staff.
- Evidence based wellbeing programs that increase overall psychosocial mental wellbeing at leadership, managerial, team and individual levels.
- Evidence based wellbeing programs that expand across the entire mental health continuum (preventative, mitigating and recovery)
- Effective psychosocial support mechanisms as a central part of the organisational culture, enabling recovery when challenging events (e.g. COVID-19) occur.

6.3 Support Individual Wellbeing

Increasing individual coping and personal resilience skills is vital in managing employee wellbeing in an ever-changing environment. A widely accepted New Zealand programme is based on the Māori philosophy to understand an individual's wellbeing in terms of the balances between different parts of their lives in a holistic way. This model of health: "Te Whare Tapa Whā", developed by Sir Mason Durie in the 1980s, has been adopted in developing initiatives across this focus area. The model describes health and wellbeing as a wharenui/meeting house with four walls. These walls represent taha wairua/spiritual wellbeing, taha hinengaro/mental and emotional wellbeing, taha tinana/physical wellbeing and taha whānau/family and social wellbeing. Our connection with the whenua/land forms the foundation.

By nurturing and strengthening all five dimensions, an individual supports their own health and wellbeing, as well as the health and wellbeing of their whanāu (Health Navigator NZ, 2020).

Commiment to support individual wellbeing will deliver:

- Individual wellbeing programs reaching across all aspects of tikanga, and promote all elements of Te Whare Tapa Whā.
- Staff who actively participates in wellbeing initiatives and programmes.
- Opportunities for individual wellbeing programmes are informed and designed based on staff feedback and input.
- Practices providing good job fit.

6.4 Encourage early help seeking

A key characteristic of a healthy workplace is when employees demonstrate signs of distress, they have access to established workplace systems and processes for early intervention and to prevent psychological harm. Failure or delay in initial intervention and support related to mental health challenges has significant negative impacts on teams and individuals. The concept of mental health literacy and the recognition of symptoms is crucial to enable people to make a decision about whether to seek professional help. Comprehensive and early intervention measures will enable quick and appropriate response and prevent any further harm. In the most recent staff survey (2020), MidCentral DHB staff were asked who would they talk to when they experienced bullying or harassment behaviours at work. Of the responses received, 27 per cent of staff wanted to talk to their manager, 27 per cent to the person demonstrating the behaviour and 21 per cent to their colleagues. About 20 per cent of respondents felt comfortable talking to the Human Resources team, external support or their unions. About 9 per cent of respondents reported that they would not involve anyone in the process.

The response rates indicate the need to develop strong internal support networks within the organisation and to provide them with tools, methodologies and education to respond appropriately when these outreaches occur. Such support would typically include interventions related to well-being checks/health screening, peer support schemes, workplace counselling, mental health education, such as Mental Health First Aid programmes for staff exposed to critical incidents or even advocacy.

Commitment to encourage early help seeking will deliver:

- Trusted internal and external support networks accessible to staff.
- Prevention of psychological injury.
- Compassionate and respectful conversations in the workplace about mental health.

6.5 Support employee recovery and return to work

There remains a possibility that despite all preventative measures, an employee may suffer psychological harm. When that occurs, it is important to support them through their recovery and during their integration back into work. Meaningful work plays a significant role in recovery as it provides purpose, structure, satisfaction and opportunities for employees (including social contact).

Interventions within this focus area typically focus on offering work-focused tertiary level interventions in order to improve the occupational outcomes of those who suffer a psychological injury or become 'unwell'.

A supportive and positive approach, at the time of psychological harm and subsequent injury, right through the rehabilitation process, improves the likelihood of a prompt and successful return to work. Regular communication lets the employee know that they are valued and alleviates uncertainty, fear and concerns about job security. Recovery implies creating opportunities to those impacted by mental health challenges to live meaningful lives and contribute positively to the community, either internal or external to MDHB.

Commitment to support employee recovery and return to work will deliver:

- Effective re-integration of recovered staff into their role and team.
- Retention of staff who experience challenging life events.
- Dignifying experiences of staff who suffered psychological harm.
- A sense of belonging when things are tough, promoting feelings of being safe.

6.6 Enable healthy and inclusive workplace relationships

The findings of a global study published by Van der Wier, 2019, with more than 10,000 participants, across 131 countries reported: "Positive and supportive relationships at work are important for workplace wellbeing, irrespective of the gender, personality type or geographic region." The authors of this study recommended creating work environments and cultures that foster healthy social relationships between their employees. They concluded that employee relationships formed in the workplace are the biggest contributor to workplace wellbeing and reported a score of 7.85 (from a maximum of 10) from the participants. The NZ Mental Health Foundation concurred with these findings and stated: "One of the most powerful factors underlying emotional wellbeing and reducing levels of stress is social connectedness". In order to maintain a positive emotional culture, and avoid the negative emotional consequences that can breakdown social connectedness, the Foundation recommended that:

- Workplace bullying should be recognised as a significant hazard and it is necessary to be alert to bullying behaviours, and act to eliminate them immediately
- Teams are recognised a crucial part of today's business landscape. Building a great team is essential for success. Working in a team forms a natural social group that can play an important role in maintaining wellbeing and resilience.
- Building a culture of inclusiveness, to enable employees to bring their whole selves to work, to experience the sense of self-esteem and self-confidence must be authentic, where employees can apply their strengths and talents without fear of judgement.
- Unconscious bias must be effectively dealt with, through the intentional practises of self-awareness and no tolerance of negative prejudice.
- Leaders must develop constructive and positive employee relations from the front by setting an example.

Commitment to enable healthy and inclusive workplace relationships will deliver:

- Employees who flourish and feel psychologically safe in the work place.
- Staff who experience workplace relationships as an enabler, providing them with the opportunity to be the best they can be.
- A culture of social inclusion and belonging exists within MidCentral DHB.
- Staff exhibit the organisational values (accountability, compassion, respect and courage) at all times in their interactions with one another.
- Staff is committed to build healthy working relationships.
- Openess to receive feedback and adjust our behaviours when needed.

7. Roles and responsibilities

Mental health and wellbeing is a shared responsibility between all stakeholders. Safe and healthy work in a safe and healthy work environment will be a product of shared problem identification, careful listening, analysis and discussion combined with joint solution finding between all (leaders, teams, and employees). All of us at MDHB have a role to play in improving the mental and emotional health of employees, contributing to overall wellbeing.

Line managers have a key role in shaping employees' work experiences by bringing people management policies to life. They play a vital role in every day management and must make it a priority to understand their staff, use emotional intelligence to identify issues and have the confidence and interpersonal skills to implement policies fairly and consistently while managing difficult conversations.

Employees have a personal responsibility to manage their own wellbeing and support the wellbeing of their colleagues. They have a responsibility to stay healthy and to be well informed about health and wellbeing issues, as well as being knowledgeable about DHB initiatives. Employees can recognise early signs of problems in their colleagues and should have confidence, knowledge and a pathway to intervene or escalate, in an appropriate, constructive and supportive way.

8. How will we assess the impact of strategic delivery?

Success is not one-dimensional and there are multiple metrics, factors and aspects to consider within both this DHB and progress initiated by the National Health Reform. See **Appenidix C** for relevant documents and legislation. However, psychosocial wellbeing remains the one aspect that would proof to be a consistent denominator for development during times of change offering staff the opportunity to communicate and to support one another with effective responses. Robust wellbeing information, data and participation from staff could feedback into what is important for people in this organisation to support their wellbeing.

It is therefore important to note that as this journey proceed, continuous reflection and review of delivery and impact is required for this work plan to succeed. Utilising both qualitative and quantitative data through dialogue with leaders, managers, staff and all other stakeholders would be critical. Actual progress to be monitored through:

- Increased staff participation in wellbeing programmes
- Assessment through targeted feedback surveys
- Monitoring levels of staff engagement, specifically workplace relations and wellbeing indexes on He kupu kōrero survey.
- Linking wellbeing targets to leader or manager performance agreements with the purpose to develop and support capabilities
- Enabling feedback networks through staff engagement action planning groups and feedback from newly established peer support wellbeing officers
- Conduct regular assessment of key indicators related to service provider performance and quality of services

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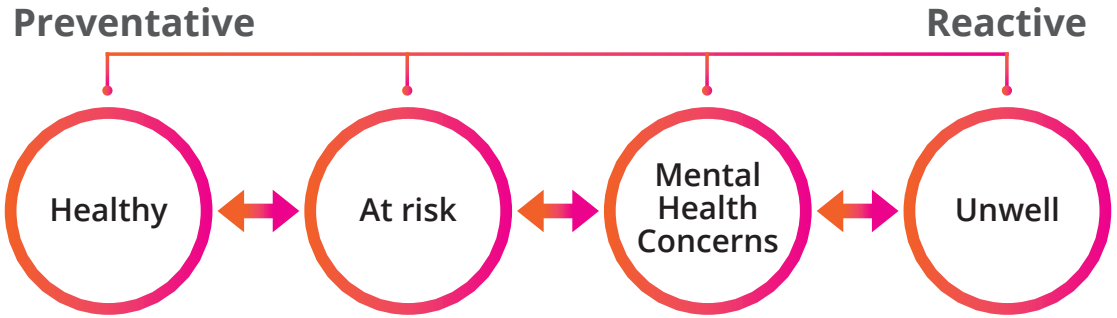
Appendix A - Framework to understand the mental health continuum



The Mental Health Guide for New Zealand Leaders (2018), published by the New Zealand Government Health and Safety Lead in conjunction with the New Zealand Defence Force clearly illustrates the impact of mental health on the individual:

	Healthy	At risk	Mental Health Concerns	Unwell
Mood	Normal mood fluctuations; Calm & takes things in stride	Irritable/impatient; Nervous; Sadness/ overwhelmed	Anger; Anxiety; Pervasively sad/ hopeless	Angry outbursts/ aggression; Excessive anxiety/panic attacks; Depressed/suicidal thoughts
Attitude	Good sense of humor; Performing well; In control mentally	Displaced sarcasm; Procrastination; Forgetfulness	Negative attitude; Poor performance or workaholic; Poor concentration/ decisions	Can't perform duties/ control behaviour or concentrate; Engaging in behaviours which appear to be markedly out of character
Sleep	Normal sleep patterns; Few sleep difficulties	Trouble sleeping; Intrusive thoughts; Nightmares	Restless disturbed sleep; Recurrent images/nightmares	Can't fall asleep or stay asleep; Sleeping too much or too little
Physical Heatlh	Physically well; Good energy level	Muscle tension/ headaches;	Increased aches and pains; Increased fatigue	Physical illnesses; Constant fatigue
Activity	Physically and socially active	Decreased activity/ socialising	Avoidance; Withdrawal	Not going out or answering phone; Changes to appetite (increased or decreased)
Habits	No/limited drug and alcohol use/gambling	Regular but controlled drug and alcohol use/ gambling	Increased drug and alcohol use/ gambling, hard to control	Frequent drug and alcohol or gambling use – inability to control with severe consequences; Out of character decision making e.g. spending

Appendix B - Levels of Intervention

New Zealand Red Cross (2015) explains that the higher the needs of those affected by psychological factors causing harm, the higher the education or training required for those responding to these needs. A discussion of these different levels follow (WorkSafe NZ, 2019): both, primary and secondary interventions are preventative and aimed at managing employees (or groups of employees) before they become 'unwell'.

Primary Interventions – (To prevent psychological harm or reduce exposure to the sources of stress)

Primary interventions focus on organisational changes and promote organisational 'healthiness' through addressing key aspects of culture and development. Interventions of this nature take a participatory approach, tailoring the intervention to different contexts, and addressing risk systematically. Involvement by employees in the design and delivery of interventions and focus on reducing the frequency, severity or intensity of by involving groups (and teams) of concerned employees, rather than the individual employee.

Secondary Interventions – (Early interventions or the development of resources to mitigate the effects of stress, changing an individual's resources could impact on their response to change) Secondary interventions increase the employees' ability to respond more constructively to difficult, stressful or challenging aspects of their work. These interventions involve education, training, information and knowledge, coaching and the provision of relevant tools to individual employees. Most interventions relate to team and/or individual activities. Trained peer groups, counsellors and/or managers would typically provide basic psychosocial support at this level of prevention.

Tertiary Interventions – (Recovery/Reactive interventions to help those already significantly affected by their work)

Tertiary interventions are engaged after, despite the other interventions, an employee (or a group of employees) has progressed along the mental health continuum where they become unwell. Examples of these could include burnout, post-traumatic stress disorder, depression or strain. These interventions are aimed at supporting the employee while they are unwell and assist with reintegrating them into the workplace.

Appendix C - Relevant Documents and/or Legislation

- ***Te Tiriti o Waitangi***
- ***Health and Safety at Work Act 2015***
- ***Employment Relations Act 2000***
- ***Human Rights Act 1993***
- ***Privacy Act 1993***
- ***Harassment Act 1997***
- ***Accident Compensation Act 2001***
- ***People Plan - 2019-2023***
- ***Ahu Taumatua – Our Place, The redevelopment of Palmerston North Hospital***
- ***Transforming Spiritual Care – A Strategy – 2016 – MDHB***
- ***Preventing Occupational Violence - A strategy and plan***
- ***Workplace responsiveness Managers/Family Violence Support Persons Guide***
- ***MDHB Policy – Responsive Workplace (Family violence/harm)***
- ***MDHB Policy - Code of Conduct***
- ***MDHB Policy – Ka Ao Ka Awatea (2020 – 22)***
- ***MDHB Policy – Preventing unacceptable behaviour, harassment and bullying***
- ***MDHB Policy – Equal Employment opportunities***

INFORMATION PAPERS

6 July 2021

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

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- 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	14 June 2021
Subject	**NZ Health Partnerships Quarterly Update**

RECOMMENDATION

It is recommended that the Board:

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

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 activities within New Zealand Health Partnerships (NZHP) during the last quarter. This paper is for information only.

2. BACKGROUND

Whilst the last quarter has seen considerable activity for NZHP, only two of their activities and progress relate directly to MidCentral District Health Board (MDHB).

3. PROCUREMENT: TIERED CARDIAC DEVICE CONTRACTS AVAILABLE FOR 10 DHBS

NZHP has secured a five-year contract for the supply of life-saving implantable cardiac devices, which are expected to make available $2.6m in collective cost savings per year to 10 DHBs across NZ. MDHB is one of the 10 participating DHBs.

4. HEALTH SYSTEM CATALOGUE PROGRAMME

The Health System Catalogue (HSC) remains on track with the approval of the data standards and completion of the operating model design. The HSC programme of work will deliver a single national procurement catalogue, national data standards, a central data repository of actual spend on medical devices and a framework for procurement compliance.

The process for the selection of the HSC spend depository register and data integration has progressed to plan. Next steps will be to clarify the pricing and ask the top two vendors in each category for their best and final offers.

The interim database to be used for data cleansing is being set up. This is a significant step for the project.

5. NZHP STATEMENT OF PERFORMANCE EXPECTATIONS 2021-2022

The NZHP Statement of Performance Expectations (SPE) document is also presented as the Annual Plan 2021/22.

NZHP believe the SPE and strategic plan will provide a strong, pragmatic roadmap to follow while Health New Zealand is being established and NZHP's future role clarified. Meanwhile, NZHP will continue to deliver the Health, Finance and Procurement Information System (FPIM Oracle) and HSC programme on time, on scope and on budget.

The 2021-2025 Strategic Plan is based around three core pillars:

1. Connect: A more connected health system
2. Analyse: Better data, better systems, for better health outcomes
3. Realise: High performance at home.

5.1. Health and Disability System Review

The review recommends a cohesive system that provides clarity on key areas, how decisions are made and how organisations are held accountable. NZHP's Strategic Plan supports the NZ Health Strategy and the review. Core programmes such as FPIM Oracle and HSC are enablers for any future convergence and structural change.

5.2. Collective Insurance

Working together means the sector offers insurers a single portfolio, worth over $22b, spread across New Zealand, with robust risk identification and mitigation processes in place.

Risk is shared and consequently, cover is gained at a lower premium compared to each DHB insuring individually. Procurement and administrative costs are also lowered by dealing with one broker.

Insurance performance measures for NZHP include:

- Deliver a collective insurance service return of $7.0m benefits to the DHBs for the 2021/22 insurance placement
- Provide expertise and regular reporting as the DHBs representative of the All of Government Alternative Risk Finance Project.

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	Rory Matthews, Interim Director of the Office of the Chief Executive
Date	29 June 2021
Subject	**Board's Work Programme**

RECOMMENDATION

It is recommended that the Board:

- **note** the Board's annual work programme.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'. It discusses an aspect of effective governance.

1. PURPOSE

To provide an update on the Board's work programme.

2. 2021 BOARD WORK PROGRAMME

The Board's work programme for 2021 was approved in December 2020. At its meeting in May 2021, the Board agreed that this work programme would be 'rolled over' for the period from 1 January to 30 June 2022.

One change has been made to the programme – the Workforce and Organisational Development reporting has been combined. This report will be presented to the Board six-monthly – in November and May.

Reporting is occurring in line with the work programme.

The following changes have been made to the workshop schedule:

- A workshop with medical staff will follow the 6 July 2021 Board meeting.
- The Risk Workshop scheduled for 6 July will now be held after the Board meeting on 17 August 2021.
- The Health and Safety Workshop scheduled for 28 September 2021 will be rescheduled and held early in 2022. Health and safety was covered as part of the Board Self-evaluation workshop with Juliet McKee from Broad Horizons held in April 2021.

MDHB BOARD Work Programme

	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Key Updates										
CEO's Report to provide an update on key progress of the DHB	Each meeting	X	X	X	X	X	X	X	X	CEO
FRAC Minutes and Verbal Update from the FRAC Chair to update the Board on key committee discussions	Each meeting Minutes	X Dec/Feb	X March	X May	X June	X July	X Sept	X Oct	X Nov	FRAC Chair
HDAC Minutes and Verbal Update from the HDAC Chair to update the Board on key committee discussions	Each meeting Minutes	X None	X Feb	X April	X None	X July	X None	X Sept	X Nov	HDAC Chair
Strategy and Planning										
DHB Strategy to review/refresh the DHB's strategy to ensure it remains relevant, and to consider how it has been advanced, and priorities for the future	Triennial (due Dec 2023)									GM SPP
Annual Plan and Budget to determine the draft and final budget and priorities for the next three years, including capex plan	One off then six-weekly from Dec-Jun	X	X	X	X				X	GM SPP 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 TBC)									GM P&C
Organisational Development Plan review/refresh (relevant and supports the execution of the DHB's Strategy)	Triennial (due Nov 2022)									GM P&C
Contract Renewal and Planning Outcomes Framework review planning outcomes achieved and general approach to contracting for year ahead	Annual			X						GM SPP
Quality Improvement										
Quality Account to determine the Quality Account for the financial year (via HDSAC)	Annual								X	GM Q&I
Quality and Safety Walk-rounds to provide the Board a summary of the walk-rounds from over the last 12 months	Annual			X						GM Q&I
Workforce										
Health and Safety to monitor the implementation of the H&S Strategy, mitigations required, priorities for the future, including investment	Quarterly	X		X		X		X		GM P&C
Health and Safety Workshop	Annual		X							GM P&C
Workforce and Organisational Development to monitor the health of the DHB's workforce, including trends and performance against workforce dashboard and adequacy of any mitigations to monitor the implementation of the OD strategy, what's changed, priorities for the future (three to five years), investment and resources required, and the adequacy of any mitigations	Six-monthly			X				X		GM P&C
Preventing Occupational Violence Strategy to monitor the implementation, priorities, investment and adequacy of any mitigations	Annual	X								GM P&C

MDHB BOARD Work Programme	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Wellbeing Plan (aka Psychosocial Wellbeing Strategy) to monitor the implementation of the DHB's health and wellbeing plans	Annual	X								GM P&C
Care Capacity Demand Management to monitor the implementation of the National Accord and local CCDM decisions	Six-monthly	X				X				ED N&M
Remuneration Policy to consider the Remuneration Policy as recommended by the Remuneration Committee	Triennial (Due Nov 2022)									GM P&C
IEA Remuneration Strategy to consider the Remuneration Strategy (IEAs) as recommended by the Remuneration Committee	Triennial (due Mar 2023)									GM P&C
IEA Remuneration Parameters to consider the remuneration parameters for annual changes to staff on IEA agreements following Rem Committee	Annual								X	GM P&C
Performance										
Financial Performance to monitor the DHB's financial performance against budget, including trends, forecasts, the impact of business improvement initiatives and opportunities and challenges, and confirm the adequacy of any mitigations	Six-weekly	X	X	X	X	X	X	X	X	GM F&CS
DHB Performance Metrics (aka Board KPI Dashboard) to monitor high level KPIs across the DHB	Six-weekly	X	X	X	X	X	X	X	X	GM SPP
Digital Strategy – implementation of roadmap to monitor implementation, challenges and opportunities, priorities and initiatives/investments for future, and confirm the appropriateness of any mitigations	Six-weekly	X	X	X	X	X	X	X	X	CDO
Sustainability Plan to monitor the implementation of the performance improvement programme	Six-weekly	X	X	X	X	X	X	X	X	GM Q&I
Non-Financial Performance Measures to monitor the overall performance of the DHB	Quarterly		X		X		X		X	GM SPP
CEO's Performance Review	Annual					X				Chair
Audit										
Annual Accounts to determine the annual accounts for the financial year and to determine Enable NZ Limited annual reporting requirements	Annual						X			GM F&CS
Year End Audit Process (Government) to determine year-end financial result for inclusion in Government accounts	Annual				X					GM F&CS
Enable NZ Limited Annual Reporting Arrangements to determine annual reporting requirements of this paper company	Annual			X						GM F&CS
Iwi Partnerships										
Memorandum of Understanding to review the Memorandum of Understanding	Triennial (due Sept 2021)						X			GM M
DHB Board and Manawhenua Hauora Joint Work Programme to monitor progress against shared work programme, including opportunities and challenges	Six-monthly		X				X			GM M

MDHB BOARD Work Programme

	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Board-to-Board Hui	Quarterly	X		X		X		X		GM M
to monitor progress against shared work programme, including opportunities and challenges										
Manawhenua Hauora Update	Six-weekly	X	X	X	X	X	X	X	X	GM M
to update the Board on the Manawhenua Hauora discussions										
Partnership										
Clinical Council	Six-monthly	X				X				GM Q&I
to consider the work, findings and recommendations from the Council, provide endorsement or support as required										
Consumer Council	Six-monthly	X				X				GM Q&I
to consider the work, findings and recommendations from the Council, provide endorsement or support as required										
Professional Work Groups	Four-monthly		ED N&M		CMO				ED AH	Prof Leads
Profession										
Governance of shareholding companies										
to monitor the annual results and plans of shareholding companies and determine actions in respect of AGM recommendations										
Regional Service Plan	Annual				X					GM SPP
to approve the draft and final regional budget and priorities										
Allied Laundry Services Limited	Annual							X		GM F&CS
Technical Advisory Services AGM (DHB Shared Services)	Annual							X		GM SPP
NZ Health Partnerships Limited	Quarterly		X		X		X		X	GM F&CS
Board Governance Arrangements										
Board Governance arrangements and Committee Terms of Reference	Triennial or as required				X					Chair
Annual Reporting Framework (work programme)	Annual			X				X		CEO
Annual Board Evaluation	Annual							X		GM P&C
Annual meeting schedule	Triennial						X			CEO
Committee membership	Triennial							X		Chair
External committee membership and appointments	Triennial							X		Chair
Te Tiriti o Waitangi	Triennial						X			GM M
Review of Board policies	As required									CEO
Review of policies related to the Board or those requiring Board approval										

Key:

CEO	Chief Executive Officer
ED N&M	Executive Director, Nursing and Midwifery
GM F&CS	General Manager, Finance and Corporate
GM M	General Manager, Māori Health
CMO	Chief Medical Officer
FRAC Chair	Chair of the Finance, Risk and Audit Committee
Chair	Board Chair of the MidCentral District Health Board
GM P&C	General Manager, People and Culture
GM Q&I	General Manager, Quality and innovation
GM SPP	General Manager, Strategy, Planning and Performance
ED AH	Executive Director, Allied Health
Prof Leads	CMO, ED N&M, ED AH
HDAC Chair	Chair of the Health and Disability Audit Committee
CDO	Chief Digital Officer

Workshop Schedule

As at 17 June 2021

Date	Time	Topic
16 February 2021	Following HDAC meeting	Stellar Board Management Platform
23 February 2021	Following Board meeting	Midwifery Workforce Engagement
13 April 2021	Following Board meeting	Board Self-evaluation (with Broad Horizons)
20 April 2021	From 9am to noon	Annual Planning and Budget
27 April 2021	Following HDAC meeting	Consumer Story
25 May 2021	Following Board meeting	Manawhenua Hauora Board to Board hui
15 June 2021	Following FRAC meeting	Conjoint meeting of Board and FRAC – 2021/22 Annual Plan and Budget
6 July 2021	Following Board meeting	Medical Workforce
13 July 2021	Following HDAC meeting	Consumer Story
17 August 2021	Following Board meeting	Annual Risk Workshop
9 November 2021	Following Board meeting	Manawhenua Hauora Board to Board hui
23 November 2021	Following HDAC meeting	Consumer Story
TBA in 2022	Following Board meeting	Health and Safety – with Buddle Findlay

GLOSSARY OF TERMS

6 July 2021

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Glossary of Terms

AC	**Assessment Centre**
ACC	**Accident Compensation Corporation** The New Zealand Crown entity responsible for administering the country's no fault accidental injury compensation scheme.
ACCPP	**Accident Compensation Corporation Partnership Plan**
ACE	**Advanced Choice of Employment**
ACT	**Acute Crisis Team**
ADL	**Activities of Daily Living**
ADON	**Associate Director of Nursing**
AESS	**Te Uru Arotau Acute and Elective Specialist Services**
ALOS	**Average Length of Stay**
Anti- VEGF	**Anti-Vascular Endothelial Growth Factor**
AoG	**All of Government**
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**
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)**
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**
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.
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**
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**
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**
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**
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**
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**
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**

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**
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)**
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)
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**
YTD	**Year To Date**

LATE ITEMS

6 July 2021

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Late items

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

DATE OF NEXT MEETING

6 July 2021

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Date of next meeting

Tuesday, 17 August 2021

EXCLUSION OF THE PUBLIC

6 July 2021

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Exclusion of public

Resolution:

That the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the items and reasons outlined in the agenda.