Distribution

Board Members
- Dot McKinnon, Chair
- Diane Anderson
- Adrian Broad
- Barbara Cameron
- Ann Chapman
- Brendan Duffy
- Michael Feyen
- Nadarajah Manoharan
- Karen Naylor
- Oriana Paewai
- Barbara Robson

Management Team
- Kathryn Cook, CEO
- Neil Wanden, General Manager, Finance & Corporate Services
- Scott Ambridge, General Manager, Enable NZ
- Craig Johnston, General Manager, Strategy, Planning & Performance
- Keyur Anjaria, General Manager, People & Culture
- Stephanie Turner, General Manager, Maori & Pacific
- Ken Clark, Chief Medical Officer
- Michele Coghlan, Acting Executive Director, Nursing & Midwifery
- Gabrielle Scott, Executive Director, Allied Health
- Chiquita Hansen, CEO, Central PHO
- Steve Miller, Chief Information Officer
- General Manager, Quality & Innovation
- Jill Matthews, PAO
- Communications Dept, MDHB
- External Auditor

National Health Board
- Peter Jane, Account Manager

Public Copies
- www.midcentraldhb.govt.nz/orderpaper

Other
- Board Records

Contact Details
Telephone 06-3508967
Facsimile 06-3550616

Next Meeting Date: 15 August 2017
Deadline for Agenda Items: 3 August 2017

MidCentral District Health Board

Agenda

Board Meeting

Part 1

Date: Tuesday, 4 July 2017
Time: 10:00 am
Place: MidCentral District Health Board Boardroom
Gate 2 Heretaunga Street
Palmerston North
MidCentral District Health Board

Board Meeting

4 July 2017

Part 1

Order

1. Administrative Matters 10.00am
   1.1 Apologies
   1.2 Late Items
   1.3 Conflicts and/or Register of Interests Update
       Pages: 7 - 9
   1.4 Minutes of the Previous Meeting
       a. Minutes
           Pages: 10 - 20
           Documentation: minutes of the Board meeting, 23 May 2017
           Recommendation: that the minutes of the previous meeting be approved as a true and correct record.
       b. Matters Arising

2. Strategic and Annual Planning 10.10am
   2.1 Locality Approach to Health and Wellbeing Plans
       Pages: 21 - 31
       Documentation: report from the Project Manager, Strategy, Planning & Performance dated 21 June 2017
       Recommendation: that progress with the development of “Health and Wellbeing Plans” be noted

3. Integration 10.20
   3.1 Manawhenua Hauora & MDHB Workplan 2016/17 Update, and, Proposed Workplan 2017/18
       Pages: 32 - 45
       Documentation: report from General Manager, Maori & Pacific Health dated 21 June 2017
       Recommendation: that progress against the shared Manawhenua Hauora and MDHB Board workplan be noted.
       that the proposed workplan for 2017/18 be endorsed
3.2 Manawhenua Hauora Minutes

Pages: 46 - 51
Documentation: minutes of the meeting held on 8 May 2017
Recommendation: that the minutes be noted.

3.3 Consumer and Clinical Council Membership

Pages: 52 - 58
Documentation: report from the Independent Chairs, Clinical and Consumer Councils and the Project Manager, Strategy, Planning & Performance dated 21 June 2017
Recommendation: that the Board note the Clinical and Consumer Council membership as endorsed by the Chief Executives of MidCentral DHB and Central PHO.

4. PERFORMANCE REPORTING

4.1 Operating Report for May/June 2017

Pages: 59 - 78
Documentation: report from the CEO dated 23 June 2017
Recommendation: that the operating report for May/June 2017 be noted.

4.2 Finance Report for MidCentral DHB – May 2017

Pages: 79 - 97
Documentation: report from the General Manager, Finance & Corporate Services dated 22 June 2017
Recommendation: that this report be noted.

4.3 Year End Audit Process

Pages: 98 - 102
Documentation: report from the General Manager, Finance & Corporate Services dated 21 June 2017
Recommendation: that the Board Chair and Deputy Board Chair be authorised to sign the Letter of Representation in respect of the year-end financial return to the Ministry of Health

4.4 Workforce Report: Six-Monthly Update

Pages: 103 - 112
Documentation: report from the Manager, Human Resource & Organisational Development dated 18 June 2017
Recommendation: the June 2017 workforce update be noted.

4.5 Integrated Services Model (“Cluster Model”)

Pages: 113 - 117
Documentation: report from the Programme Manager, Integrated Services Model dated 22 June 2017
Recommendation: that this report be noted.
A presentation on this will be provided at the meeting.
4.6 Board’s Work Programme 2017/18

Pages: 118 - 121
Documentation: report from the CEO dated 28 June 2017
Recommendation: that progress against the 2017/18 work programme be noted

5 COMMITTEE RECOMMENDED PAPERS

5.1 Emergency Department Triage Improvement Detailed Business Case

Pages: 122 - 165
Documentation: report from Operations Director, Hospital Services & Programme Manager, Business Improvement dated 19 June 2017
Recommendation: the business case with a capital expenditure of $1,976,000 for the 2017/2018 financial year be approved

5.2 Draft Internal Audit Plan 2017/18

Pages: 166 - 188
Documentation: report from the General Manager, Finance & Corporate Services dated 16 June 2017
Recommendation: that the Board approve the 2017/18 Internal Audit Plan.

5.3 Treasury Management Policy

Pages: 189 - 199
Documentation: report from the Financial Services Manager dated 16 June 2017
Recommendation: that the Board:
• note the changes proposed to the Treasury Management Policy; and approve the amended policy.

5.4 Business Improvement Update

Pages: 200 - 210
Documentation: report from the Chair, Business Improvement Group (General Manager, Enable New Zealand) and Programme Manager dated 16 June 2017
Recommendation: that the update on the Business Improvement report be noted.

6 COMMITTEE MINUTES

6.1 Finance, Risk & Audit Committee

Pages: 211 - 217
Documentation: minutes of the Finance, Audit & Risk Committee meeting, 6 June 2017
Recommendation: that the unconfirmed minutes of the meeting of the Finance, Risk & Audit Committee held on 6 June 2017 be noted.
6.2 Quality & Excellence Advisory Committee
Healthy Communities Advisory Committee

Pages: 218 - 225
Documentation: minutes of the Quality & Excellence and Healthy Communities Advisory Committees meeting, 13 June 2017
Recommendation: that the unconfirmed minutes of the meeting of the Quality & Excellence Advisory Committee and the Healthy Communities Advisory Committee held on 13 June 2017 be noted.

6.3 Enable New Zealand Governance Group

Pages: 226 - 230
Documentation: minutes of the Enable New Zealand Governance Group meeting, 13 June 2017
Recommendation: that the unconfirmed minutes of the meeting of the Enable New Zealand Governance Group meeting held on 13 June 2017 be noted.

7. LATE ITEMS

8. DATE OF NEXT MEETING

15 August 2017 Horowhenua Health Centre, 62 Liverpool Street, Levin
The meeting will include a Public Forum.

9. EXCLUSION OF 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:

<table>
<thead>
<tr>
<th>Item</th>
<th>Reason</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In committee” minutes of the previous meeting</td>
<td>For the reasons set out in the order paper of 11.4.17 meeting held with the public present</td>
<td></td>
</tr>
<tr>
<td>Integration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consumer Story</td>
<td>To protect personal privacy</td>
<td>9(2)(a)</td>
</tr>
<tr>
<td>Strategic and Operational Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2017/18 Annual Plan and Budget</td>
<td>Subject of negotiation</td>
<td>9(2)(j)</td>
</tr>
<tr>
<td>• Final Draft 2017/18 Regional Services Plan</td>
<td>Subject of negotiation</td>
<td>9(2)(j)</td>
</tr>
<tr>
<td>• Insurance – Fire Loss Limits</td>
<td>To protect the commercial position of supplies information, and the future supply of information</td>
<td>9(2)(b)&amp;(ba)</td>
</tr>
<tr>
<td>• Emergency Department Reconfiguration Business Case – Tender Evaluation</td>
<td>Subject of contractual negotiations</td>
<td>9(2)(j)</td>
</tr>
<tr>
<td>Performance Reporting</td>
<td>To protect personal privacy</td>
<td>9(2)(a)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>• CEO’s report – complaints and contracts (Health Partnerships Limited and local)</td>
<td>Subject of negotiation</td>
<td>9(2)(j)</td>
</tr>
<tr>
<td>“In committee” minutes of committee meetings:</td>
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<td></td>
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<tr>
<td>• Finance, Risk &amp; Audit Committee, 6 June 2017</td>
<td></td>
<td></td>
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<tr>
<td>o Insurance arrangements</td>
<td>Under negotiation and</td>
<td>9(2)(j)</td>
</tr>
<tr>
<td>o Central Alliance Laboratory Services</td>
<td>subject of negotiation</td>
<td></td>
</tr>
<tr>
<td>• Quality &amp; Excellence Advisory Committee &amp; Healthy Communities Advisory Committee, 13 June 2017</td>
<td>For the reasons set out in the order paper of 13.6.17 meeting held with the public present Subject of commercial negotiations and contains commercial sensitive information</td>
<td></td>
</tr>
<tr>
<td>• Enable New Zealand Governance Group, 13 June 2017</td>
<td></td>
<td></td>
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<tr>
<td>o General Manager’s Report – facilities, and, business development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance Matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CEO &amp; Board Only time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Minutes of the previous meeting</td>
<td>For the reasons set out in the order paper of 11.4.17 meeting held with the public present</td>
<td></td>
</tr>
<tr>
<td>o Other – no decisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Board only time – no decisions</td>
<td></td>
<td></td>
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</table>
## REGISTER OF INTERESTS: SUMMARY, JULY 2017

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Company/Organisation</th>
<th>Nature of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson, Diane</td>
<td>1.7.16</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Broad, Adrian</td>
<td>24.6.14</td>
<td>Manawatu Horowhenua Tararua Diabetes Trust</td>
<td>Trust Manager.</td>
</tr>
<tr>
<td></td>
<td>3.5.16</td>
<td>ACROSS – Te Kotahitanga oTe Wairua</td>
<td>Board Member.</td>
</tr>
<tr>
<td>Cameron, Barbara</td>
<td>25.4.13</td>
<td>Manawatu District Council</td>
<td>Councillor. Member &amp; Deputy Chair, Manawatu District Licensing Committee</td>
</tr>
<tr>
<td></td>
<td>1.11.16</td>
<td>Ministry of Social Development</td>
<td>Member, MSD’s Community Response Forum.</td>
</tr>
<tr>
<td></td>
<td>18.5.12</td>
<td>Otaki Community Health Trust</td>
<td>Member.</td>
</tr>
<tr>
<td></td>
<td>21.12.07</td>
<td>Gen-i</td>
<td>Son is employee.</td>
</tr>
<tr>
<td></td>
<td>29.4.16</td>
<td>Central Region’s Technical Advisory Service</td>
<td>Grandson is an employee.</td>
</tr>
<tr>
<td>Duffy, Brendan</td>
<td>1.4.17</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Feyen, Michael</td>
<td>5.12.16</td>
<td>Horowhenua District Council</td>
<td>Mayor.</td>
</tr>
<tr>
<td>McKinnon, Dot</td>
<td>5.12.16</td>
<td>Whanganui DHB</td>
<td>Chairperson. Cousin of Whanganui DHB General Manager</td>
</tr>
<tr>
<td></td>
<td>9.2.17</td>
<td>NZ DHB Chairs’ National Executive</td>
<td>Member.</td>
</tr>
<tr>
<td></td>
<td>9.2.17</td>
<td>Health Practitioners Disciplinary Tribunal</td>
<td>Member.</td>
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<tr>
<td></td>
<td>9.2.17</td>
<td>Health Sector Relationship Agreement Committee</td>
<td>Member.</td>
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<tr>
<td></td>
<td>9.2.17</td>
<td>Four Regions Trust (formerly known as Powerco Trust)</td>
<td>Chair.</td>
</tr>
<tr>
<td></td>
<td>9.2.17</td>
<td>Whanganui Eyecare and Medical Trust</td>
<td>Husband is chair.</td>
</tr>
<tr>
<td></td>
<td>21.3.17</td>
<td>Moore Law &amp; Associates</td>
<td>Legal Executive, Director and Shareholder.</td>
</tr>
<tr>
<td></td>
<td>21.3.17</td>
<td>Chardonnay Properties Limited</td>
<td>Part owner.</td>
</tr>
<tr>
<td>Naylor, Karen</td>
<td>6.12.10</td>
<td>MidCentral DHB</td>
<td>Employee.</td>
</tr>
<tr>
<td></td>
<td>22.9.15</td>
<td>New Zealand Nurses Organisation</td>
<td>Member &amp; Workplace Delegate</td>
</tr>
<tr>
<td></td>
<td>23.9.14</td>
<td>National Party</td>
<td>Husband is list MP for National Party.</td>
</tr>
<tr>
<td></td>
<td>9.10.16</td>
<td>Palmerston North City Council</td>
<td>Councillor.</td>
</tr>
<tr>
<td>Paewai, Oriana</td>
<td>1.5.10</td>
<td>Rangitane o Tamaki nui a Rua</td>
<td>CEO.</td>
</tr>
<tr>
<td></td>
<td>1.5.10</td>
<td>Te Runanga o Raukawa Governance Group</td>
<td>Member.</td>
</tr>
<tr>
<td></td>
<td>1.5.10</td>
<td>Manawhenua Hauora</td>
<td>Chair. Member, Child Health Tamariki Ora District Group.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Te Whiti ki e Uru</td>
<td>Co-ordinating Chair.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Tararua Hauora Services Charitable Trust</td>
<td>Trustee.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Central Primary Health Organisation</td>
<td>Member, Alliance Leadership Team (Central PHO Board).</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Feilding Health Care</td>
<td>Member, Clinical Governance Group.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Manawatu District Council</td>
<td>Member, Nga Manu Taiko, a standing committee of the Council.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Te Ohu Auahi Mutunga (TOAM)</td>
<td>Member, Governance Board.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Before School Checks (B4SC) Collective</td>
<td>Member.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Nga Kaitiaki o Ngati Kauwhata Inc</td>
<td>Committee member.</td>
</tr>
<tr>
<td></td>
<td>13.6.17</td>
<td>Te Tii o Ruahine Whanau Ora Alliance</td>
<td>Member.</td>
</tr>
<tr>
<td>Robson, Barbara</td>
<td>19.7.16</td>
<td>Kind Hearts Trust</td>
<td>Board Member.</td>
</tr>
<tr>
<td></td>
<td>1.11.16</td>
<td>Royal NZ College of GPs</td>
<td>Member (consumer representative), Health Care Home Standard Working Group.</td>
</tr>
<tr>
<td></td>
<td>10.12.01</td>
<td>Federation of Women’s Health Councils</td>
<td>Co-convener.</td>
</tr>
<tr>
<td></td>
<td>31.5.10</td>
<td>Medicines Review Committee</td>
<td>Consumer Representative.</td>
</tr>
<tr>
<td></td>
<td>Feb 13</td>
<td>Ministry of Health</td>
<td>Member, Electronic Oral Health Record Design Group.</td>
</tr>
<tr>
<td></td>
<td>11.10.16</td>
<td>Ernst &amp; Young</td>
<td>Daughter is an employee – Business Advisor.</td>
</tr>
</tbody>
</table>

### COMMITTEE MEMBERS

Please advise all changes to Jill Matthews, Manager, Administration & Communication

*Reflects contract value to nearest 1000/100,000.
<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Organisation/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beagley, Vicki</td>
<td>5.10.15</td>
<td>Massey University, Employee, research office.</td>
</tr>
<tr>
<td></td>
<td>5.10.15</td>
<td>Arohanui Hospice, Husband, John Freebairn, is the current chair.</td>
</tr>
<tr>
<td></td>
<td>5.10.15</td>
<td>Supportlinks/Enable New Zealand, Son receives respite care.</td>
</tr>
<tr>
<td></td>
<td>11.10.16</td>
<td>Palmerston North City Council, Member, District Licensing Committee.</td>
</tr>
<tr>
<td>Campbell, Donald</td>
<td>2.7.14</td>
<td>Nil</td>
</tr>
<tr>
<td>Emery, Dennis</td>
<td>1.9.15</td>
<td>Arohanui Hospice, Employee.</td>
</tr>
<tr>
<td></td>
<td>1.9.15</td>
<td>Manawhenua Hauora, Member.</td>
</tr>
<tr>
<td></td>
<td>1.9.15</td>
<td>Ngati Maniapoto me Ngati Kauwhata Iwi, Iwi descendent of both tribes.</td>
</tr>
<tr>
<td></td>
<td>1.9.15</td>
<td>Feilding Integrated Family Health Centre, Through the Iwi of NKONK</td>
</tr>
<tr>
<td></td>
<td>1.9.15</td>
<td>Te Tii O Ruahine Whanau Ora Trust, Chairperson / Member.</td>
</tr>
<tr>
<td></td>
<td>1.9.15</td>
<td>Whanau Ora Strategic Innovation &amp; Development Group (WOSIDG), Palmerston North</td>
</tr>
<tr>
<td></td>
<td>1.9.15</td>
<td>Whaioro Mental Health Trust – P. North, Board Member &amp; Iwi Trustee.</td>
</tr>
<tr>
<td>Godfrey, Jonathan</td>
<td>1.7.08</td>
<td>Massey University, Employee.</td>
</tr>
<tr>
<td></td>
<td>11.10.16</td>
<td>Office for Disability Issues and Statistics NZ, Member, joint working group – Disability Data and Evidence Working Group.</td>
</tr>
<tr>
<td>Hartevelt, Tony</td>
<td>14.8.16</td>
<td>Midlands Health Network Limited, Independent Director and Chairman.</td>
</tr>
<tr>
<td></td>
<td>14.8.16</td>
<td>Pinnacle Incorporated, Chair, Finance, Audit and Risk Committee.</td>
</tr>
<tr>
<td></td>
<td>14.8.16</td>
<td>Midlands Regional Health Network Community Trust, Chairman, Finance, Audit and Risk Committee.</td>
</tr>
<tr>
<td></td>
<td>14.8.16</td>
<td>Otaki Family Medicine Ltd, Independent Director designate.</td>
</tr>
<tr>
<td></td>
<td>14.8.16</td>
<td>Merck Sharpe &amp; Dohme (Merck), (NZ operations for Global Pharmaceutical Company), Elder son is NZ market access manager.</td>
</tr>
<tr>
<td></td>
<td>14.8.16</td>
<td>Fairfax Media, Younger son is news director for Stuff.co.nz</td>
</tr>
<tr>
<td>Kirkcaldie, Ewen</td>
<td>1.8.08</td>
<td>PKF Rutherfords Ltd, Director.</td>
</tr>
<tr>
<td>Kolbe, Anne</td>
<td>22.7.16</td>
<td>Kolbe Medical Services Ltd, Director and joint owner.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Communio, NZ, Senior Consultant and Contractor.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Whanganui DHB, Member, Risk &amp; Audit Committee.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Health Research Council of NZ, Employee, and, holds an adjunct appointment at Associate Professor level.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Auckland University, Husband chairs the clinical trials advisory committee.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Australian Medical Council, Husband is a member of the Medical School Advisory Committee, and leads the Medical Specialties Advisory Committee Accreditation Team.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Royal Australasian College of Physicians, Husband is a member of the College’s governance working party, and chairs the revalidation working party.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>EXCITE International, Board Member, and Chair of Advisory Council.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Medicare Benefits Schedule Review Taskforce (Australia), Senior Advisor/ Government taskforce to review the Medicare Benefits Schedule.</td>
</tr>
<tr>
<td></td>
<td>22.7.16</td>
<td>Institute of Environmental Science &amp; Research (ESR), Daughter employed as forensic scientist.</td>
</tr>
<tr>
<td></td>
<td>13.3.17</td>
<td>Siggins Miller, Australia, Senior Advisor &amp; Associate.</td>
</tr>
<tr>
<td>Kunaiti, Tawhiti</td>
<td>20.7.10</td>
<td>Central-Primary Health Organisation, Employee.</td>
</tr>
<tr>
<td></td>
<td>28.10.16</td>
<td>Central Primary Health Organisation, Wife is an employee – Contracts Administrator.</td>
</tr>
<tr>
<td></td>
<td>28.10.16</td>
<td>Manawhenua Hauora, Manawhenua representative on HCAC.</td>
</tr>
<tr>
<td></td>
<td>28.10.16</td>
<td>Te Tii O Ruahine Whanau Ora Alliance Trust, Employee – Pou Whakarae, Principal Cultural Leader.</td>
</tr>
<tr>
<td></td>
<td>28.10.16</td>
<td>Whanau Ora Strategic Innovation Development Group (WOSIDG), Member.</td>
</tr>
<tr>
<td></td>
<td>28.10.16</td>
<td>New Zealand College of Clinical Psychologists, Council Member for NZCCP as Pou Whakarae, Principal Cultural Leader.</td>
</tr>
<tr>
<td>Scott, Duncan</td>
<td>8.7.13</td>
<td>Broadway Radiology Limited, Company Director and General Manager.</td>
</tr>
<tr>
<td>Temple-Camp,</td>
<td>3.2.15</td>
<td>Breastscreen Coast to Coast, Lead Pathologist.</td>
</tr>
<tr>
<td>Cynric</td>
<td>23.7.13</td>
<td>International Academy of Pathology, Board Member.</td>
</tr>
<tr>
<td>Date</td>
<td>Name</td>
<td>Company/Product</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>1.7.08</td>
<td>Medlab Central Ltd.</td>
<td>Business Unit of Sonic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Care Ltd</td>
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<tr>
<td>1.7.08</td>
<td>MidCentral Health</td>
<td>(MCH)</td>
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<tr>
<td></td>
<td></td>
<td>as a Medical Consultant</td>
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<tr>
<td>1.7.08</td>
<td>National Coronal</td>
<td>Pathology Services</td>
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<tr>
<td></td>
<td>Advisory Group to</td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td>1.7.08</td>
<td>T-Lab</td>
<td></td>
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<tr>
<td>7.4.09</td>
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**MANAGEMENT**

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<th>Relationship/Role</th>
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<tr>
<td>1.7.16</td>
<td>Kathryn Cook</td>
<td>Aspen Pharma</td>
<td>Sister is an</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>employee.</td>
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<tr>
<td>1.7.16</td>
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<tr>
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<td>Scott Ambridge</td>
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<tr>
<td>3.8.10</td>
<td>Kenneth Clark</td>
<td>Dr Kenneth Clark Ltd</td>
<td>Private gynaecology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>practice,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Palmerston North.</td>
</tr>
<tr>
<td>3.2.16</td>
<td>Michele Coglan</td>
<td></td>
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</tr>
<tr>
<td>20.9.07</td>
<td>Michael Grant</td>
<td></td>
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</tr>
<tr>
<td>9.2.16</td>
<td>Chiquita Hansen</td>
<td>MidCentral DHB</td>
<td>Employed by MDHB</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and seconded to</td>
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<td></td>
<td></td>
<td></td>
<td>Central PHO</td>
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<tr>
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<td></td>
<td></td>
<td>8/10ths.</td>
</tr>
<tr>
<td>9.2.16</td>
<td></td>
<td>Central PHO</td>
<td>Central PHO's</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CEO.</td>
</tr>
<tr>
<td>19.2.16</td>
<td>Craig Johnston</td>
<td>Central PHO</td>
<td>Member, Alliance</td>
</tr>
<tr>
<td></td>
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<tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td>of MidCentral</td>
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<td></td>
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<td>DHB and</td>
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<td></td>
<td></td>
<td></td>
<td>works within</td>
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<td></td>
<td></td>
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<td>hospital services.</td>
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<tr>
<td>19.8.16</td>
<td>Gabrielle Scott</td>
<td>MidCentral DHB</td>
<td>Son is a casual employee of MidCentral DHB and works within various hospital services.</td>
</tr>
<tr>
<td>17.2.16</td>
<td>Stephanie Turner</td>
<td>Waingawa Ltd</td>
<td>Director. Farming</td>
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<td></td>
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<td></td>
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<td>Neil Wanden</td>
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<td>Jill Matthews</td>
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<td>Anne Amoore</td>
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<td>2002</td>
<td>Jeff Small</td>
<td>Allied Laundry Services</td>
<td>Director (appointed by MDHB's Board)</td>
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<td>Lyn Horgan</td>
<td>Coronial Services</td>
<td>Sister is Coroner</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>Muriel Hancock</td>
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<td>Greig Russell</td>
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<td>2.9.10</td>
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<td>16.2.16</td>
<td>John Manderson</td>
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*Reflects contract value to nearest 1000/100,000.
MidCentral District Health Board

Minutes of the MidCentral District Health Board meeting held on 23 May 2017 at 10.00am at Council Chambers, Tararua District Council, Gordon Street Dannevirke

Present

Dot McKinnon (Chair) Brendan Duffy
Diane Anderson Nadarajah Manoharan
Adrian Broad Karen Naylor
Barbara Cameron Barbara Robson
Ann Chapman

In Attendance

Kathryn Cook, Chief Executive Officer
MicheleCoghlan, Acting Executive Director, Nursing & Midwifery
Neil Wanden, General Manager, Finance & Corporate Services
Craig Johnston, General Manager, Strategy, Planning and Performance
Gabrielle Scott, Executive Director, Allied Health
Stephanie Turner, General Manager, Maori & Pacific
Scott Ambridge, General Manager, Enable New Zealand
Jill Matthews, Principal Administration Officer
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Dennis Geddis, Team Leader, Communications
Vivienne Ayres, Manager, DHB Planning & Accountability
Grieg Russell, Principal Advisor, CEO’s Department

Public: 40
Media: 2

Opening the meeting, the Chairperson welcomed the Mayor, Tararua District Council and members of the public.

1. Administrative Matters

1.1 Apologies

Apologies were received from board members Michael Feyen and Oriana Paewai. An apology for lateness was received from Ann Chapman, and Deputy Chair, Brendan Duffy advised he had to leave the meeting early.

1.2 Late Items

There were no late items.

1.3 Conflict and/or Register of Interests Update

There were no amendments to the Register of Interests.
2. PUBLIC FORUM

Members of the public addressed the Board and a range of issues was discussed.

- Future plans for the Tararua District. MidCentral DHB’s locality planning process was discussed and all in attendance were invited to be part of this. Management advised that in the community discussions held to date the key issues identified were: drugs and alcohol, boundary issues for those at the southern end of the district who were uncertain where to access acute services, and housing, particularly for the elderly population and children. MidCentral DHB acknowledged the immense amount of prior planning work which had been done within the district which was assisting the DHB’s locality planning.

Ann Chapman entered the meeting.

- The Manager, Tararua Health Services acknowledged the significant contribution made by the previous DHB Chairman Phil Sunderland, and General Manager, Mike Grant.

- Dannevirke Community Hospital was nearing its 20th anniversary.

- The Tararua community was passionate and resilient, but the community was now struggling. The DHB was requested to think carefully before making any decisions regarding health funding and services in the district, and to refrain for chipping away at this any further.

- The DHB’s requirement that contracted primary health providers “live within their means” was understood but providers were struggling to provide the care required. Two examples were cited - the Cancer Nurse Specialist role had been ceased, but the prevalence of cancer remained. Local midwifery services were facing increasing complexity and workload, with 12 Child, Youth & Family Service cases on their books currently.

The DHB’s CEO advised that MidCentral was committed to providing more services closer to home, and freeing up funds from hospital care for community and primary services.

- Tararua Community Youth Services had been established 21 years ago, however it was struggling to support local youth and considered that the youth voice was being unheard by the DHB. There was no cohesive health services for youth in the Tararua district. Investment in these services was sought, including alcohol and drug support, intervention programmes, rehabilitation, emergency services, and free health care for people under 24 years of age.

The Tararua Community Youth Service had supported and participated in the development of a youth health app, but when it was completed found all services listed were based in Palmerston North.

- Access to services was a significant issue for the district. This included transport, and also poor cellphone and broadband coverage.
The Mayor advised any support from the DHB for the Council’s efforts in this area would be appreciated.

- A strong plea for “action” not “words” was expressed.
- The Cancer Support Group made a plea for the appointment of a Cancer Nurse for the district. The district had not had this role for the current year and local volunteer services were struggling to cope.

The DHB undertook to respond direct to the Group regarding this matter.

- A request was made for the DHB’s mental health services to be more responsive to supporting people and families, particularly following suicide attempts, and for their to be greater collaboration between the DHB and Police. Examples were provided of young people being taken to Palmerston North Hospital following a suicide attempt where they were assessed and discharged home within four hours. Examples were also provided of the difficulty in obtaining DHB or Police support for young people in these circumstances.

The DHB stated that mental health was a priority for both the DHB, and the sector as a whole. MidCentral DHB was committed to working with its communities in this regard.

- The number and availability of ambulances within the Tararua district was considered to be insufficient. The DHB undertook to pass on this feedback and discuss it with the Order of St John, the provider of ambulance services.

- Dannevirke was a town of volunteers, and its health shuttle was staffed completely by volunteers. The DHB was requested to consider what support it could provide to this service. It was noted that in the Wellington region, shuttle staff received payment.

The DHB’s CEO advised that its district covered a large geographical area, and it was reliant on a number of communities’ shuttle services. She further advised that in respect of renal services, work was underway to increase the number of people receiving renal dialysis at home, thus negating the need for travel. The DHB was also committed to providing other services closer to patients’ homes.

Closing the public forum section of the meeting, the Chairperson thanked all members of the public for attending and their feedback.

1. **ADMINISTRATIVE MATTERS CONTINUED**

1.4 **Minutes of Previous Meeting**

a. **Minutes**

It was resolved:

*that the minutes of the previous meeting held on 11 April 2017 be confirmed as a true and correct record. (Moved Dot McKinnon; seconded Karen Naylor)*
b. **Matters Arising from the Minutes**

Water Quality: Barbara Robson clarified the comment she made at the previous meeting around notifications to the Medical Officer of Health which were largely related to food and water borne diseases as included in Part 1, Section A of the Health’s Act’s Schedule of Infectious Diseases.

Car parking revenue: following the Board’s meeting on 11 April 2017, errors in the car parking revenue paper had been identified. It was agreed that this information be provided to all members.

Business improvement: management advised that as this report was processed via the Finance, Risk & Audit Committee, the Board would receive the next update at its July meeting.

3. **INTERGRATION**

3.1 **Iwi Partner – Minutes**

It was resolved:

*that minutes of meeting held on 27 March 2017 be noted.* (Moved Dot McKinnon; seconded Diane Anderson)

4. **PERFORMANCE REPORTING**

4.1 **2017/18 Reporting Framework**

It was noted that the 2017/18 planning process had yet to be completed. Management confirmed that the reporting framework would be amended to take into account any additional reporting matters that arose during this process.

It was suggested that more frequent reporting may be required in respect of the Health Charter. The CEO advised that the Charter was being amended to reflect the DHB’s new Strategy. The Charter was being put in effect in numerous ways such as locality planning, and this would be reflected in reports on those matters.

Additional reporting on disability matters was suggested, and it was agreed that 12-weekly reports be provided on the disability system transformation project.

The different type of business cases for major capital items was discussed. The CEO advised there were two types: a strategic business case outlining options, and a detailed business case which looked at the shortlisted options. It was agreed to standardise this terminology in the work programmes.

The timing of the strategic business case for the mental health inpatient unit was raised. The General Manager, Finance & Corporate Services advised a consultant had been working with the team to explore options, working through known issues, models of care, and what these meant in terms of facility requirements. Some delays had been experienced, but the business case would enter the board approval process in June/July.
It was agreed that a site visit to the Ward would be appropriate ahead of the business case deliberations.

Management confirmed that in capital planning, cognisance was taken of the limited funding available. Realistic, functional options which took into account future requirements were sought.

It was resolved:

that the Board approve the reporting framework and work programmes for 2017/18, and the inclusion of a 12-weekly report on the disability system transformation project. (Moved Dot McKinnon; seconded Karen Naylor)

4.2 Governance Processes

The continuation of public forums was supported.

It was agreed that when the Charter was next reported to the Board, key partner agencies be invited to join the meeting, eg Police and the Order of St John.

The issue of live-streaming Board and committee meetings was discussed. It was agreed that this not be progressed at this time.

The move to concise reporting was noted and supported. A member stressed the importance of ensuring members were able to raise questions so that they could satisfy themselves that any concerns they had were being addressed.

The move away from “receiving” reports was supported, and members endorsed the three report categories – decision, endorsement or noting. Information reports would be provided to members via the Governance SharedNet site.

The importance of accurate minutes was emphasised. It was agreed these needed to make sense to all readers.

It was resolved:

that the Board:

• approve the new board/committee report template and the approach being taken to order agendas to match priority and available time;
• approve public forums and out-of-town meetings being a part of the Board’s meeting calendar;
• note the Record of Board and Committee Meetings Policy, and that this will be reviewed in three years. (Moved Karen Naylor; seconded Ann Chapman)

4.3 Enable New Zealand Limited Annual Reporting Requirements

It was resolved:

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 2017 shall incorporate
4.4 Operational Report for March/April 2017/18

4.4.1 Surgery, Whanganui District Health Board

The CEO advised that the first three individuals who had taken up the opportunity to have surgery at Whanganui DHB had been referred to that DHB. Uptake of this option had been low.

4.4.2 Inpatient Death

The death of an inpatient of Palmerston North Hospital, while missing on leave, was acknowledged by the Board. Management confirmed that a root cause analysis review was being undertaken, with external input.

4.4.3 Horowhenua Health Centre

The Board endorsed the proposal to celebrate the 10 year anniversary of the Horowhenua Health Centre. It was suggested that this reflect the Centre’s history and those involved in its establishment. This could be done by way of an advertised feature in local newspaper(s). Aligning the celebration to a new service or initiative was also suggested.

4.4.5 Master Site Plan for Palmerston North Hospital

The value of the investment in this piece of work was sought and management undertook to provide this. Information on how this work aligned to previous site master planning was also sought. Management advised that the current work would not duplicate previous planning, and the outcome would be reported to the Board in due course.

4.4.6 Consultancy Costs

Some members sought greater transparency around consultancy costs and this matter was debated. The CEO drew the Board’s attention to the Business Improvement Plan work which showed expenditure on consultancies was reducing. It was noted that some consultancy costs were capitalised as they formed part of a capital project.

4.4.7 CEO, Whanganui DHB

Members acknowledged Julie Patterson’s decision to step down from the role of CEO, Whanganui DHB later in the year. Julie’s contribution to health and support of local and regional health initiatives was also acknowledged.

4.4.8 Executive Leadership Team

The CEO advised that membership of the leadership team was being finalised, with interviews still to be held for one position, namely the General Manager, Quality & Innovation.
4.4.9 *Integrated Service Model*

The CEO confirmed that an implementation plan for the new integrated service model was being developed. This would be presented to the Board, together with a resourcing plan in due course. Mrs Cook advised it was expected the resourcing plan would be within management delegations.

The CEO further advised that the cost of the short term contract management support was being funded by the salary for the General Manager, People & Culture role. This position was currently vacant awaiting the new appointee to commence duties.

4.4.10 *Regional Clinical Portal*

The CEO advised that within the region work continued to further develop the Regional Clinical Portal.

Arrangements for service management of the Regional Clinical Portal and other regional programmes were currently being established. In line with a decision by regional DHB CEOs, this service would be provided by Capital & Coast DHB. This area was currently work-in-progress.

Whanganui DHB had implemented both the Regional Clinical Portal and the Regional Radiology Information System. Its learnings were being taken on board on MidCentral DHB.

MidCentral DHB had established a go-live date for the implementation of the Regional Clinical Portal and was currently doing data migration. This was presenting some challenges and a decision on whether to proceed with the original go-live date would be made in the very near future.

The CEO advised that the new Chief Information Officer would commence work at MidCentral DHB a week later than scheduled due to regional work commitments. Mr Miller had a great knowledge of regional systems and IT.

4.4.11 *Urology Services and centralAlliance*

An assurance was sought that the excellent new service model developed for Urology was sustainable for both MidCentral and Whanganui DHBs, and appropriate agreements or contracts established.

The CEO advised that work was continuing around the employment of the model, and an update would be provided for both Boards at the next board hui. This model of care would be considered for use in other areas as applicable, eg ophthalmology.

It was resolved:

> the operating report for March/April 2017 be noted. *(Moved Adrian Broad; seconded Ann Chapman)*

Dot McKinnon left the meeting, and Ann Chapman assumed the Chair.
4.5 Financial Report for MidCentral DHB April 2017

4.5.1 Capital Expenditure Plan

The General Manager, Finance & Corporate Service advised that the capex provisions for both the mental health redevelopment and the hospital redevelopment related to planning and preparatory work. Funds for the next stage were expected to fall in out-years and would be included in future plans.

4.5.2 Seismic Work

The General Manager, Finance & Corporate Services advised all high priority seismic work had been undertaken. Low priority areas were now being addressed, such as the Education Centre.

It was noted that an update on seismic work had been provided for the Finance, Risk & Audit Committee. Management confirmed that ongoing reports would be incorporated on the Committee’s work programme.

4.5.3 Enable New Zealand

Management advised that the financial results for all operating units within Enable New Zealand were reported as a consolidated figure within the report. Detailed reporting was provided to the Enable New Zealand Governance Group.

Dot McKinnon re-entered the meeting.

It was resolved that:

that this report be received. (Moved Ann Chapman; seconded Karen Naylor)

Dot McKinnon resumed the Chair.


The Manager, DHB Planning & Accountability advised the Ministry of Health had made a modifications to its assessment for the quarter. Shorter stays in emergency department had been reassessed as “partially achieved” (previously “non-achieved”).

The high referral decline rate for “raising healthy kids” measure was noted. While disappointing, it was agreed that this was work in progress.

Concern was expressed by one member regarding colonoscopy waiting times, and the need for additional reporting was questioned. Management advised that these wait times were included in the operating report results provided to the Quality & Excellence Advisory Committee each time it met.

A member expressed concern that the full quarterly reports were not available on the Governance SharedNet site, and requested that these be provided ahead of board meetings in future. Management undertook to look into this matter.
It was resolved:

*that the report be received.* (Moved Ann Chapman; seconded Karen Naylor)

### 4.7 Board’s Work Programme 2016/17

Management advised that a date for governance development and education had yet to be finalised. The initial dates of 16 and 30 June were not suitable to all members, and a new date would now be explored.

It was agreed that an approach be made to Manawhenua Hauora to reschedule the next board-to-board hui so that the DHB’s Chair could attend.

It was resolved:

*that the updated work programme be noted.* (Moved Dot McKinnon; seconded Diane Anderson)

### 5. COMMITTEE RECOMMENDED PAPERS

#### 5.1 Health & Safety System

The Director, Patient Safety & Clinical Effectiveness confirmed that the one health and safety committee which had been unable to meet regularly, had now met.

Work being done to ensure the safety of staff working in the community was supported. Suggestions around ensuring these staff were au fait with all functions of their vehicle, and that vehicles were equipped with survival kits in the event of an earthquake, were made. Management advised that a cost-effective solution for survival kits was currently being explored.

Staff screening – management believed that follow-up screening for this group of staff would exclude ex employees and would ensure this was made explicit in future reporting.

It was resolved:

*that this report be received.* (Moved Dot McKinnon; seconded Ann Chapman)

### 6. COMMITTEE MINUTES

#### 6.1 Finance, Risk & Audit Committee

#### 6.2 Quality & Excellence Advisory Committee

#### 6.3 Healthy Communities Advisory Committee

It was resolved:

*that the unconfirmed minutes of the meeting of the Finance, Risk & Audit Committee held on 26 April 2017 were received;*

*that the unconfirmed minutes of the meeting of the Quality & Excellence Advisory Committee held on 2 May 2017 be received; and*
that the unconfirmed minutes of the meeting of the Healthy Communities Advisory Committee held on 2 May 2017 be received. (Moved Dot McKinnon; seconded Ann Chapman)

7. **LATE ITEMS**

There were no late items.

8. **DATE OF NEXT MEETING**

4th July 2017 in MidCentral DHB’s Boardroom, Heretaunga Street, Palmerston North.

9. **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:

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<th>Item</th>
<th>Reason</th>
<th>Ref</th>
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<td>For the reasons set out in the order paper of 11.4.17 meeting held with the public present</td>
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<tr>
<td>Strategic and Operational Planning</td>
<td>Subject of negotiation</td>
<td>9(2)(j)</td>
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<tr>
<td>• Draft 2017/18 annual plan and budget progress report</td>
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<tr>
<td>Committee Recommended Papers</td>
<td>Subject of negotiation</td>
<td>9(2)(a)</td>
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<tr>
<td>Governance Matters</td>
<td>Under negotiation</td>
<td>9(2)(j)</td>
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<td>• Insurance 2017/18</td>
<td>To Protect personal privacy</td>
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<td>• External Appointments to Board Committees</td>
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<td>• CEO’s Performance Review</td>
<td>To Protect personal privacy</td>
<td>9(2)(a)</td>
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<td>• CEO &amp; Board Only time – no decisions</td>
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<td>• Board only time – no decisions</td>
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<tr>
<td>“In committee” minutes of committee meetings:</td>
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<td>• Finance, Risk &amp; Audit Committee, 26 April 2017</td>
<td>To maintain security of MDHB systems</td>
<td>9(2)(k)</td>
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<td>o Shared banking and treasury arrangement</td>
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<td>o External penetration test review</td>
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<td>• Quality &amp; Excellence Advisory Committee, 2 May 2017</td>
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<td>Healthy Communities Advisory Committee, 2 May 2017</td>
<td>For the reasons set out in the order paper of 2.5.17 meeting held with the public present</td>
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(Moved Dot McKinnon; seconded Diane Anderson)

Confirmed this 4th day of July 2017.

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Chairperson
For:

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<tbody>
<tr>
<td>Author</td>
<td>Kelly Isles, Project Manager, Strategy Planning and Performance</td>
</tr>
<tr>
<td>Endorsed by</td>
<td>Craig Johnston</td>
</tr>
<tr>
<td>Date</td>
<td>21 June 2017</td>
</tr>
<tr>
<td>Subject</td>
<td>Locality approach to Health and Wellbeing Plans</td>
</tr>
</tbody>
</table>

**RECOMMENDATION**

It is recommended that:

- that progress with the development of “Health and Wellbeing Plans” be **noted**

**Strategic Alignment**

Achieve equity of outcomes across communities

- Engages other sectors in common community health and wellbeing agenda to reduce inequalities and improve health outcomes.

Partner with people and whānau to support health and wellbeing

- Places people, families/whānau at the centre of planning decisions and design to best meet the needs of their communities.

**Health Charter**

- Working wider than health, driving better connections and integration of health and other services to ensure people live well, stay well and get the help they need when they need it no matter who you are or where you live.
**Glossary**

AOD – Alcohol & Other Drugs  
CACTUS Programme – Youth Boot Camp Programme  
CAMHS – Child and Adolescent Mental Health Services  
CHPO – Central Primary Health Organisation  
GRx – Green Prescription  
GP – General Practice  
MidCentral DHB – MidCentral District Health Board  
NGO – Non Government Organisation  
RTLB – Resource Teacher of Learning and Behaviour  
YOSS – Youth One Stop Shop
1. **PURPOSE**

The purpose of this report is to provide an update on the development of Health and Wellbeing plans for the Horowhenua and Otaki, Manawatu and Tararua districts.

2. **SUMMARY**

The next step in the implementation of the MidCentral Strategy is the development of locality plans across the district. These plans will be ‘Health and Wellbeing plans’ and will be closely aligned to the Health Charter. They will identify the current and future health and wellness needs of each locality, local priorities for change, and actions to address these.

A standardised approach to locality planning has been developed. A planning group has been set up for each of the districts (with a separate group for Otaki) and these groups have generated an engagement plan unique to their respective localities.

There has been strong interest with over 794 people engaging in the process so far including groups, providers, organisations, iwi and the community. We revised and extended our timeframe in regards to community engagement to ensure the community has adequate time to engage in the process. The engagement phase will continue until the end of June 2018.

From the feedback so far we can see that to create “Well Communities” there are a range of factors that contribute towards good health and well being. Health and Wellbeing Plan priorities will need to focus wider than health, driving better connections and integration of health and other services to ensure people live well, stay well and get the help they need when they need it no matter who you are or where you live.

3. **BACKGROUND**

Locality planning is a population health approach which puts people, families/whānau at the centre of planning decisions and design to best meet the needs of their communities. It looks wider than health, driving better connections and integration of health and other services to ensure people live well, stay well and get the help they need when they need it no matter who you are or where you live.

Locality planning is about:
- providing a voice for communities.
- placing people, families/whānau at the centre of planning to best meet the needs of their communities.
- engaging with other sectors to address common community health and wellbeing issues to reduce inequity and improve health outcomes.

The Health and Wellbeing Plans will describe how MidCentral DHB, in partnership with intersectorial partners and communities, can better meet the identified health priority needs within each locality. There will be a Plan produced for three different localities, unique to meeting that area’s identified priority needs.
Each plan will identify 2 - 5 priority needs with actionable steps under each priority.
The plan will have short, medium and long term actions (over 1 – 5 years).

A standardised framework will be used to develop each locality plan; however each plan will be unique in how it addresses the prioritised needs identified in each locality in order to meet the communities’ specific needs. They will comprise three components; population intelligence, community engagement, and information on service provision. These components will roughly correspond to the phases of development. The final plans are expected to be brief and largely pictorial (following the lead of the MidCentral Strategy). They will identify priority projects and outcome measures. These are expected to involve a range of agencies and sectors.

Initially, it is intended that plans be developed for Manawatu, Tararua, Horowhenua and Otaki. In time there will also be a locality plan for Palmerston North.

4. **Key Components and Stages to Locality Planning**

**Key Components to Locality Planning**

- Population Health Intelligence (Stage 1 +2)
- Community engagement (Stage 3+5)
- Service Provision (stage 6)

**Seven stages to Locality Planning**

4.1 **Stage 1 and 2 Project establishment**

This project is being managed within Strategy, Planning and Performance by Kelly Isles (lead Project Manager) and Willie Kirk and more recently Craig Fluery; with support from other members of Strategy, Planning and Performance, Pae Ora and the Communications teams.

Planning Groups have been established for each locality, made up of MDHB staff (both clinical and non clinical) CPHO, Iwi, NGO, Disability and other identified representatives from each community, including a consumer representative. All the Planning Groups have had their first meeting and helped to develop the engagement plan for their respective communities.

There are a number of established committees and groups within each locality with representatives from a broad range of providers, for example the Horowhenua
Community Wellbeing Group convened by the Horowhenua District Council. Working collaboratively with these groups has been vital in the development of the locality planning approach to date. We will continue to work collaboratively with these groups throughout the process and into the future.

4.2 Stage 3 First round of Community Engagement (currently in progress – to be completed 30 June):

- This stage is about hearing the community’s voice regarding ‘where we are now’, taking a strengths based approach
- Asking the questions: *What are the strengths and key challenges/issues affecting health and wellbeing in the community?*

There has been strong interest and active participation from community groups, social service providers, organisations, iwi and the community by way of widely promoted survey, public forums, targeted workshops and conversations with key individuals and established groups within the community.

Broader engagement efforts include:
- Story boards/feedback boards/Feilding Farmers market
- Community Committees
- Surveys are also available. Hardcopies at health centres and libraries and online version promoted. (currently received over 260 responses)
- Newsletters sent to database within each locality (Horowhenua and Otaki 104, Tararua 65, Manawatu 80)
- Newspaper Advertorials and Social Media Updates

4.3 Common themes across Localities

To date we have entered approximately two thirds of the feedback from across the three localities. From this feedback we can clearly see some common themes as well as uniqueness within each locality.

It’s important to note that overall there was a very positive response from each locality highlighting many strengths within their respective communities that help to keep them healthy and well.

The workshops have engaged a diverse range of ages, ethnicities and whānau, and although some groups have particular priorities there were clear common themes across all.

To date the main common themes across all the localities in regards to key challenges are as follows:

**Responsiveness (Equity)**
- Lack of humanity / thoughtfulness in the system: “little consideration of my needs and circumstances” eg Early appointments in PN are difficult to get too (transport, responsibilities to whānau, distance, disability, cost)

**Primary Care**
- “Can’t get appointments on the day you need one”
- “No continuity of care, difficult to see your own doctor”. Trust and a relationship with your health care professional within the primary care setting are important to people in the community.
- Cost (for lower income families and older adults)

**Transport**
- “Lack of transport to access services”: This is due to a number of reasons such as no transport, inability to drive, distance to Hospital or services, limited Health shuttle times and public transport.

**Housing**
- Lack of affordable, quality housing

**Mental Health and Addiction**
- “Wait times for these services are too long” (Mental Health)
- “Difficult to access Mental Health and AOD services”

**Prevention**
- “Greater focus needed on keeping people well in communities” (Diet, exercise, smoking, life skills)

**Collaboration**
- “People involved in my healthcare don’t always work together”

### 4.4 Horowhenua and Otaki

Over 240 contributions received from Horowhenua and Otaki: To date we have received 90 survey responses from Horowhenua and Otaki and attended 11 workshops/meetings with over 150 participants, these include:

- Horowhenua Community Open Forum
- Horowhenua Disability Leadership Forum
- Older Persons Network Horowhenua
- Horowhenua Wellbeing Executive
- Betty –Lou CEO Raukawa Whanau Ora Ltd
- Di Rump CEO Muaupoko Tribal Authority
- Youth Network
- Youth Voice
- GRx Levin
- Local Management Group
- Horowhenua Children’s Team

**Common themes in regards to strengths in the community to keep people healthy and well:**

- Health Shuttle (limited in time and availability but great service)
- Te Takere
- “Everything within walking distance in town”
- “After hours GP Service”
- “Council that has some interest in community wellbeing”
- “Active Iwi”
- “Great places to play and recreate”
- “Dialysis unit in Levin”
- “Teen Parent unit at Waiopehu College, Blake House services”
- “Free doctor & nurse for youth YOSS (under 24)”
- “Mobility Vouchers - work well”
- CACTUS Programme
- Community Patrol
- The Local hospital
- “We know our neighbours and are available for each other - necessary in a rural area”
What are the key challenges affecting the health and wellbeing of your community, this list is in addition to the key challenges name above?

Primary care
- “Lack of GP services in small towns - limited hours”
- “High turnover of staff in services – cant build trust and relationships”
- “No radiology services on Saturday – lots of sporting injuries happen on Saturday”

Transport
- Shuttle times are limited
- “If living rural difficult to get to appointments (lack of transport, cost, family responsibilities)”

Mental Health and Addiction
- Family violence/Domestic Violence
- Drugs and Alcohol use
- “Wait times for these services are too long” (Mental Health)
- “Anxiety and depression support is lacking” (Mental Health)

Disability
- “Shop access signs/footpath access to shops (not accessible to people with disability)”

Other
- Safe Housing (refugee for women and families)
- “Lack of support for carers” (support for non paid carers eg grandparents and parents with children with a disability)
- “Isolation for the elderly, aging community”
- Obesity
- Water supply
- Limited employment available

Please note engagement with Otaki has not progressed; this will require a targeted approach over the next three weeks.

4.5 Manawatu

Over 244 contributions received from Manawatu: To date we have received 94 survey responses from Manawatu and attended 13 workshops/meetings with over 150 participants, these include:

- Feilding Youth Ambassadors
- Manawatu Community Services Trust
- Feilding Community Committee
- Manawatu Community Workshop
- Young at Heart - parent support group (Feilding)
- Nga Manu Taiko Hui (with Chrissy Karena)
- Sir Mason Durie presentation: Ngati Kauwhata Iwi Plan
- GRx Manawatu
- Feilding Farmers Market
- Enable NZ
- Feilding Refugee services
- Chelthenham Community Committee
- Sanson Community Committee
Common themes in regards to strengths in the community to keep people healthy and well:

- “Great neighbours, close community with good support”
- “Loads of sport, green space and reacreational opportunities”
- “Health Shuttle is good”
- “Free doctors appointments for the kids really helps”
- “sharing garden that provides free healthy foods to the community and people growing their own vegies”
- “The combined medical centre is good”
- “The rescue helicopter is important to small villages”
- “Green Perscription”
- “Himatangi Beach Community Clinic”
- “Rural support services”
- “A network of family support services eg Manchester House, Young at Heart Parent Support Group, Te Manawa Family Services, Plunkett, Salvation Army, etc”

What are the key challenges affecting the health and wellbeing of your community, this list is in addition to the key challenges name above?

Mental Health
- “Don’t know where to go to get help” (Youth Mental Health)
- “Farming stresses and pressures on people, especially their mental health. Our Men/Farmers wont ask for help when they need it.”
- “How do we support each other, how do we help our friends and family?” (Youth and Farmers in particular)

Primary Care
- “Our new Feilding Health Care Centre is brilliant, but we need more doctors, waiting list for new patients”
- “ I have to go to the afterhours as I can’t get an appointment when I need one”

Disability
- “Poor wheelchair access to hall, church, county fayre, school reserve, etc”

Other
- Affordability especially of dental care
- “Distance and transport are barriers to healthcare services”
- “Sometimes access to immediate emergency services (Ambulance) can be an issue due to long wait time”
- No Youth Specific Health Services
- “Not knowing what is available, knowing how to get what we need”
- Poor diets and access to unhealthy foods

4.6 Tararua

Over 310 contributions received: To date we have received 135 survey responses from Tararua and attended 14 workshops/meetings with over 175 participants, these include:
Common themes in regards to strengths in the community to keep people healthy and well:

- “Positive role models in community”
- “Our local nurse at Eketahuna Health Centre”
- “People know each other and are prepared to help each other, community connectedness”
- “Availability of rural health clinic and district Nurse service when required.”
- “Fantastic Dannevirke Community Hospital and staff”
- Lots of Sports!
- “Renewing prescriptions by phone, Rescue Helicopter, The Acute Clinic”
- Health shuttle to go to appointments in Palmerston north
- “Te Kete Hauora o Rangitane with the range of support services that they have that are free for our community, Whanau Ora.”

What are the key challenges affecting the health and wellbeing of your community, this list is in addition to the key challenges name above?

Primary Care
- “Can’t access doctors if you have a bill”
- “Waiting times to see a doctor are far too long”
- Attracting and retaining Doctors
- “They are great at the medical centre but understaffed and it’s hard to get an appointment with my regular GP within a month.”
- “Cost of health services”

Mental health and Addiction
- Drugs, Alcohol and Gambling
- “Maternal Mental Health (depression, anxiety) – acute threshold too high. When general counseling/support not enough, nothing available for early specialized intervention”
- “Lack of any mental health services below high criteria for CAMHS”
- “Lack of Drug & Alcohol counselling, particularly for youth, hard to access”

Other
- Seasonal Employment
- Ability to share information (privacy)
- “Poverty and hardship – many students without basic necessities of food and clothing”
- Isolation
- Travel distance to Health services locally and PN
• “Emergency access is so far away and limited”
• “Internet access and technology confidence for families”
• Lack of police staff

5. **Next Steps**

**Population Health Intelligence (June/July)**

Relevant information from local, regional and national data sets has been gathered, although further information will be required. This information includes:

- Nationally generated data sources eg NZ Census, National Minimum Data Set, New Zealand Health Survey
- District-wide data sources eg hospital utilisation data, PHO data sets, referred services data sets (eg laboratory and pharmaceutical data)
- Locally derived data sources eg enrolled population information at practice level, territorial local authority level data

This information will be used to generate a health snapshot for each locality as well as used to inform the priorities alongside the community feedback.

A data base of key documents and work within each community has been developed. This will ensure that the identified priorities are complimenting and building upon the great work that is /has already being done within each locality.

**Community Engagement (July)**

- The input from the first round of community engagement will be analysed to identify common themes.
- A list of priority areas will be identified for each locality.
- The themes will be compared to exiting data and demographics to create a list of priorities.
- Go back out to the community with the list of priorities identified.
- If broad topics are identified asking ‘why’ questions to dig deeper into the actual issues.
- Asking the community to rank those priorities and to identify opportunities to make a positive difference in those areas.
- Planning groups to provide feedback on priorities identified and potential actionable steps.

**Service Provision (July/August)**

- Looking at what currently exists in the community in regards to each priority area and the opportunities to improve/build upon/better use resources in these areas.
- Looking at the opportunities to collaborate with other agencies/organisations to make positive impacts in the identified areas.
**Writing the Plan (August)**

The plan will include:

- A summary of population health information and feedback gathered during community engagement.
- Priority areas with actionable steps towards addressing/improving/reducing inequities to be implemented over the next five years.
- A strong integration flavour and also an intersectoral component, but the key focus is on achieving health gains for and with the community of interest.

6. **RECOMMENDATION**

It is recommended:

*that progress with the development of “Health and Wellbeing Plans” be noted*

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**Kelly Isles**

**Project Manager**
For:

<table>
<thead>
<tr>
<th></th>
<th>Decision</th>
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<tbody>
<tr>
<td>✗</td>
<td>Endorsement</td>
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<td>✗</td>
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To MidCentral DHB Board

Author Stephanie Turner, General Manager, Maori & Pacific Health

Endorsed by Manawhenua Hauora

Date 21 June 2017

Subject MANAWHENUA HAUORA AND MDHB BOARD WORKPLAN 2016/17 UPDATE & PROPOSED WORKPLAN 2017/18

Recommendation

- that progress against the shared Manawhenua Hauora and MDHB Board workplan be noted.
- that the proposed workplan for 2017/18 be endorsed

Strategic Alignment

This report is aligned to MidCentral DHB’s strategy and strategic imperatives, particularly Achieving Equity of Outcomes Across Communities.

It is also aligned to the 2016/17 Māori Health Plan and the 2017/18 MDHB Draft Annual Plan.

Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AOD</td>
<td>Alcohol and Other Addictions Services</td>
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<tr>
<td>AP</td>
<td>Annual Plan</td>
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<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CPHO</td>
<td>Central Public Health Organisation</td>
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<td>CPHAC</td>
<td>Community &amp; Public Health Advisory Committee</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>GM</td>
<td>General Manager</td>
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<td>HAC</td>
<td>Hospital Advisory Committee</td>
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<tr>
<td>Iwi</td>
<td>Tribes</td>
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<tr>
<td>Kia Ora Hauora</td>
<td>National/ Regional Māori Workforce Development Programme</td>
</tr>
</tbody>
</table>
Ka Ao Ka Awa tea 2017 - 2022 – Maori Health Strategic Framework developed between CPHO, MDHB Pae Ora and Maori Providers in 2017.

MDHB  MidCentral District Health Board
MOH   Ministry of Health
MPDS  Māori Provider Development Scheme (MOH Maori Provider funding stream)
MWH   Manawhenua Hauora (Iwi Partnership Board)
Pae Ora (Base/Platform of health) Healthy Futures (DHB Māori Directorate)
PHO   Primary Health Organisation
QEAC  Quality & Excellence Advisory Committee
Rohe  District
Te Whiti Ki Te Uru Central Region Iwi Relationship Boards Network
Trendly National Māori Health Indicator Data Tool
Tukaha (Stand Strong) - Central Region Māori Health Development Conference
Whanau Ora The health and wellbeing of the family
1. **PURPOSE**

This paper provides an update of the progress against the Manawhenua Hauora and MDHB Board Workplan 202016/17 and the proposed Workplan for 2017/18, to support Māori health gain across the MidCentral DHB district.

In September 2017, the final report against the 2016/17 Workplan will be provided to the Board.

2. **Strategic Imperatives**

![MidCentral District Health Board | Te Pae Hauora o Ruahine o Taranu](image)

This report aligns with the four strategic imperatives that have become a fundamental focus for MidCentral DHB:

- achieve equity of outcomes across communities
- partner with people and whanau to support health and wellbeing
- achieve quality and excellence by design
- connect and transform primary, community and specialist care

Manawhenua Hauora actively endorses these strategic imperatives as drivers to support developing and evolving the structures, systems and processes to be fit for purpose. The integration of Māori worldview, Māori concepts, knowledge and practice models are integral to achieving the four strategic imperatives above. The shared workplan provides a governance commitment between Manawhenua Hauora and MDHB Board to achieve this through a meaningful partnership.

3. **PROGRESS TO DATE**

3.1 **2016/17 Workplan Progress Update**

As part of the Annual Planning process, Manawhenua Hauora identified key priorities for local focus. These local foci echoed some of the national priorities and were actively included in the Annual Plan for 2016/17.

Following the development of Pae Ora as an operational team, the role and function of Manawhenua Hauora has been further supported. This has seen Manawhenua Hauora actively engaged with key initiatives and developments to support Maori Health gains across the district including; Responding to the Integrated Leadership Proposal; MDHB Organisational Plan; Locality Planning; and Co-Chairing Te Whitu ki te Uru.
With the MOH removing the requirement for a standalone Maori Health Plan, Manawhenua Hauora has been an active participant in shaping and guiding the development of Ka Ao Ka Awatea, the Maori Health Strategic Framework. This Framework will guide the foci on Maori Health for the next 5 years and contains specific measures and imperatives across the continuum of health. These key activities align with the Service Level Measures and current National Health Priorities.

The shared Chair to Chair meetings have continued to strengthen the partnership between Manawhenua Hauora and MDHB Board including the new Board Members Orientation where members of Manawhenua Hauora were able to present on the Iwi Providers around the District.

A detailed progress report is attached as Appendix One for a detailed account of progress for the 2016/17 year.

3.2. 2017/18 Proposed Workplan

Manawhenua Hauora seeks to continue to be actively engaged with key initiatives and developments to support Maori Health gains across the district as they occur, both in the design and critique.

With the MOH removing the requirement for a standalone Maori Health Plan, Manawhenua Hauora will have a strong focus in monitoring progress of services to Ka Ao Ka Awatea and challenging the current inequities in health outcomes experienced by Maori in MidCentral DHB.

Manawhenua Hauora is focussed on further developing the partnership with particular commitment to the shared Chair to Chair meetings and Board to Board opportunities to further strengthen the partnership between Manawhenua Hauora and MDHB Board

The proposed Manawhenua and MDHB Board Workplan for 2017/18 is attached as Appendix Two.

4. RECOMMENDATION

It is recommended:

that the progress update of the shared Manawhenua Hauora and MDHB Board be noted.

that the proposed Manawhenua and MDHB Board Workplan for 2017/18 is endorsed.

Stephanie Turner
General Manager
Maori and Pacific Health
## Manawhenua Hauora and MidCentral DHB: 2016/17 Work Programme

<table>
<thead>
<tr>
<th>Objective</th>
<th>Focus Area</th>
<th>Measures</th>
<th>Responsibility</th>
<th>UPDATE</th>
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</thead>
<tbody>
<tr>
<td>To provide clear and cohesive leadership for Maori health across the DHB region</td>
<td>Identification of local Maori health priorities to direct investment and focus from the DHB</td>
<td>Local Maori health priorities identified, as part of the annual planning process, by November each year to direct investment and work focus areas for the DHB in context with national health indicators.</td>
<td>Incorporate local Maori health priorities into AP, budget planning and portfolio work plans as advised by Manawhenua Hauora</td>
<td>Advise priorities to MDHB</td>
</tr>
<tr>
<td>To provide direction, investment priorities and focus areas to MDHB on Maori health needs and priorities to support equity of outcomes for Māori</td>
<td>Equity assessment</td>
<td>Equity results in respect of Maori Health, including trends and emerging trends, reported to Manawhenua Hauora and MidCentral DHB’s Board</td>
<td>Provide updated Maori Health Equity Assessment</td>
<td>Provide advice on Equity needs from Maori perspective, identifying key issues for consideration in determining local Maori health priorities and strategy</td>
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<tr>
<td>Activity</td>
<td>Details</td>
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<tr>
<td>Feedback from Maori communities</td>
<td>Feedback obtained from local Maori communities through the Maori Health Strategy engagement process reported back to Manawhenua Hauora and MidCentral DHB’s Board by 30 September 2015. (Refer also Development of Maori health strategy below.)</td>
<td></td>
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<tr>
<td>Consistently Obtain Maori community feedback and provide report on same</td>
<td>Act on advice from Manawhenua Hauora to ensure a meaningful response to feedback</td>
<td></td>
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<tr>
<td>Provide advice on findings to support increased responsiveness and equity of health outcomes for Maori communities</td>
<td>Ongoing</td>
<td></td>
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**To provide strategic advice on the priorities and focus areas to MDHB across all strategic planning processes**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
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<tbody>
<tr>
<td>Strategic Imperatives Cluster development</td>
<td>Strategic imperatives will reflect Manawhenua Hauora aspirations</td>
</tr>
<tr>
<td>Consistently obtain Manawhenua Hauora input across strategic imperative development</td>
<td>Ensure the monitoring and reporting of progress against the strategic imperatives is provided Manawhenua Hauora</td>
</tr>
<tr>
<td>Advise priorities to MDHB</td>
<td>MWH Strategic Imperatives align with Maori health priorities as outlined in Ka Ao Ka Awatea Maori Health Strategy 2017-2022. Manawhenua Hauora members identified seven priorities (listed in objective 1) that they would like to see given a concentrated focus in the following five year period, in order to make significant gains in Māori Health.</td>
</tr>
</tbody>
</table>
These seven priorities, combined with the seven goals from the Whānau Ora Outcomes Framework provide the foundation that underpins Ka Ao, Ka Awatea 2017-2022.

| To provide a clear direction and purposeful strategies for Maori health gains across the district | Development of Maori health strategy | Undertake the development and contribute to the monitoring of a Maori Health Strategy that actively embraces the health and wellbeing aspirations of the Maori communities in the district. Maori Health Strategy supported by Manawhenua Hauora and recommended to MDHB via CPHAC by 30 June 2017. | Develop approach for the collective development of the Maori Health Strategy For MDHB that is achievable, aspirational and innovative to actively challenge the health inequalities currently experienced by Maori in the district | Provide advice on proposed approach and the resultant strategy | Ka Po Ka Ao Ka Awatea Maori Health Strategy reviewed and discussed with Manawhenua Hauora. |

<p>| Development of Annual Plan | MDHB's Annual Plan and Maori Health Plan for 2016/17 reviewed by Manawhenua Hauora and advice provided on effectiveness of initiatives to advance Maori health, particularly local and national Maori health priorities. | Develop Annual Plan Develop Maori Health Plan Portfolio Managers to provide presentations to Manawhenua Hauora on progress against the plans quarterly | Provide direction and advice on Annual Plan Provide direction and advice on Maori Health Plan Provide direction and challenges to portfolio managers in regards to progress on behalf of Maori communities Provide input into Annual Planning with Portfolio Managers | COMPLETED 2016/17 MWH engagement and input across annual planning; 2016-17 annual plan &amp; 2016-17 annual Maori health plan PROGRESS AGAINST PLANS Development of a reporting schedule to MWH in progress for 2017/18 period to align with MDHB reporting schedule. |</p>
<table>
<thead>
<tr>
<th>To monitor Maori health gains in the district through impacts of MDHB's health service delivery and investment</th>
<th>Equity and Health Needs Assessment (as above)</th>
<th>Monitor trends in Maori Health via the annual health needs assessment (as above) and health equity tools</th>
<th>As above</th>
<th>As above</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local, regional and national priority measures (as attached)</td>
<td>Quarterly review of results against local, regional and national Maori Health measures reported to Manawhenua Hauora and MidCentral DHB’s Board (NB: this includes Whanau Ora.)</td>
<td>Provide quarterly reports</td>
<td>Provide direction and advice on reports</td>
<td>Maori Health Plan Report received and reviewed Oct/Nov 2016. Annual Maori Health Plan Indicators Final report due September 2017 for the 2016/17 year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual report of results against the Maori Health Plan reported to Manawhenua Hauora and MidCentral DHB’s Board</td>
<td>Provide annual report</td>
<td>Provide advice on report</td>
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<td></td>
<td>Six-monthly report of progress in implementing the Maori Leadership Review reported to Manawhenua Hauora and MidCentral DHB’s Board (via HAC)</td>
<td>Provide six-monthly reports</td>
<td>Provide advice on reports</td>
<td>Completed (Pae Ora)</td>
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<td></td>
<td>Support and monitor the Regional Māori Health Priorities identified at the Central Region Combined District Health Board's Annual Forum, i.e.:</td>
<td>Provide quarterly reports</td>
<td>Provide advice on reports</td>
<td>MWH Chair is Co Chair of Te Whiti Ki te Uru and provides updates and key documents for MWH review and comment. (TWKTU Terms of Reference &amp; Regional Service Plan 2017/18 Draft 1 reviewed April 2017)</td>
<td></td>
</tr>
<tr>
<td>Provide expert advice, direction and counsel on important issues that impact on Maori at a governance level</td>
<td>Major service changes</td>
<td>Any potential Major service change proposals are actively considered by Manawhenua Hauora during the design phase to ensure any likely impact on Maori Health is considered at the earliest possible point</td>
<td>Provide report on any potential or major service proposals prior to a final position</td>
<td>Provide critique, direction and considerations on any major proposal for change with a specific focus on health gains for Maori and any potential impacts</td>
<td>Consultation with MCH Mental Health &amp; Addictions team regarding service delivery review and impact on Maori whanau (August 2016). Consultation with MCH GM People and Culture regarding the development of an Organisational Development Plan. (September 2016)</td>
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<tr>
<td>Significant service plans, eg site redevelopment and centralAlliance</td>
<td>Manawhenua Hauora direction, views and innovations are sought regarding the Master Health Service Plan being developed for MidCentral DHB as a Treaty Partner,</td>
<td>Develop indicative business case for Master Health Service Plan Ensure all aspects of the Master Health Service Plan actively considers equity of outcomes for Maori across all aspects of design, development and implementation</td>
<td>Develop business case for Master Health Service Plan</td>
<td>Provide direction. Advice, guidance and critique across all aspects of design, development and implementation of the Master Health Service Plan</td>
<td>Ongoing</td>
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<td></td>
<td>Manawhenua Hauora direction, aspirations and views are sought on the Health Charter/Strategy being developed for MidCentral DHB</td>
<td>Develop Health Charter/Strategy</td>
<td>Provide direction, advice and innovation on the design and development of the charter/strategy</td>
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<td>In Progress</td>
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<td>Supporting Arrangements</td>
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<tr>
<td>To support this work programme, the following hui arrangements have been put in place:</td>
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<td>• Biannual hui between Manawhenua Hauora and MDHB’s boards</td>
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<td>• Six-monthly review meetings between MWH’s Chair &amp; Deputy Chair and MDHB’s Chair and CEO</td>
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<tr>
<td>• Six-weekly meetings of Manawhenua Hauora, with MDHB management in attendance</td>
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<td>• Participation (through Chair) in Te Whiti Ki te Uru – the Central Region’s Maori Relationship Forum</td>
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<td>• Participation (through Chair and Deputy Chair) in annual planning workshops and other appropriate workshops, forums as necessary</td>
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<tr>
<td>• Ongoing engagement and consultation by Manawhenua Hauora with the Governors of the four Iwi Boards regarding Maori Health priorities and outcomes within our region.</td>
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## APPENDIX TWO

### Manawhenua Hauora and MidCentral DHB: 2017/18 Work Programme

<table>
<thead>
<tr>
<th>Objective</th>
<th>Focus Area</th>
<th>Measures</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide clear and cohesive leadership for Maori health across the DHB region</td>
<td>Identification of local Maori health priorities to direct investment and focus from the DHB</td>
<td>Local Maori health priorities identified, as part of the annual planning process, by November each year to direct investment and work focus areas for the DHB in context with national health indicators.</td>
<td>Incorporate local Maori health priorities into AP, budget planning and portfolio workplans as advised by Manawhenua Hauora</td>
</tr>
<tr>
<td>To provide direction, investment priorities and focus areas to MDHB on Maori health needs and priorities to support equity of outcomes for Maori</td>
<td>Equity assessment</td>
<td>Equity results in respect of Maori Health, including trends and emerging trends, reported to Manawhenua Hauora and MidCentral DHB’s Board</td>
<td>Provide updated Maori Health Equity Snapshot</td>
</tr>
<tr>
<td>To provide strategic advice on the priorities and focus areas to MDHB across all strategic planning processes.</td>
<td>Strategic Imperatives Cluster development</td>
<td>Strategic imperatives will deliver on Manawhenua Hauora aspirations</td>
<td>Consistently obtain Manawhenua Hauora input across strategic imperative development. Ensure the monitoring and reporting of progress against the strategic imperatives is</td>
</tr>
<tr>
<td>To provide a clear direction and purposeful strategies for Maori health gains across the district</td>
<td>Development of Maori health strategy</td>
<td>Undertake the monitoring of Ka Ao Ka Awatea that actively embraces the health and wellbeing aspirations of the Maori communities in the district. Maori Health Strategy supported by Manawhenua Hauora and recommended to MDHB via CPHAC by 30 June 2017.</td>
<td>Develop approach for the collective development of the Maori Health Strategy For MDHB that is achievable, aspirational and innovative to actively challenge the health inequalities currently experienced by Maori in the district provided to Manawhenua Hauora.</td>
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<tr>
<td>Development of Annual Plan</td>
<td>MDHB's Annual Plan 2017/20178 reviewed by Manawhenua Hauora and advice provided on effectiveness of initiatives to advance Maori health, particularly local and national Maori health priorities.</td>
<td>Develop Annual Plan Portfolio Managers to provide presentations to Manawhenua Hauora on progress against the plans quarterly</td>
<td>Provide direction and advice on Annual Plan Provide direction and advice on Ka Ao, Ka Awatea. Provide direction and challenges to portfolio managers in regards to progress on behalf of Maori communities</td>
</tr>
<tr>
<td>To monitor Maori health gains in the district through impacts of MDHB's health service delivery and investment</td>
<td>Equity and Health Needs Assessment (as above) Local, regional and national priority measures (as attached)</td>
<td>Monitor trends in Maori Health via the Locality Plans (as above) and health equity tools Quarterly review of results against local, regional and national Maori Health measures reported to Manawhenua Hauora and MidCentral DHB's Board (NB: this includes Whanau Ora.)</td>
<td>As above Provide quarterly reports Accurate and meaningful data profiles are provided as part of the</td>
</tr>
<tr>
<td>Provide expert advice, direction and counsel on important issues that impact on Maori at a governance level</td>
<td>Major service changes</td>
<td>Any potential Major service change proposals are actively considered by Manawhenua Hauora during the design phase to ensure any likely impact on Maori Health is considered at the earliest possible point</td>
<td>Provide report on any potential or major service proposals prior to a final position</td>
</tr>
<tr>
<td>Significant service plans, eg site redevelopment and centralAlliance</td>
<td>Manawhenua Hauora views are sought regarding the Long Term Investment Plan being developed for MidCentral DHB as a Treaty Partner,</td>
<td>Ensure all aspects of the Master Health Service Plan actively considers equity of outcomes for</td>
<td>Provide direction. Advice, guidance and critique across all aspects of design, development and</td>
</tr>
<tr>
<td>Maori across all aspects of design, development and implementation</td>
<td>Long Term Investment Plan.</td>
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</tr>
<tr>
<td>Manawhenua Hauora direction, aspirations and views are sought on the Health Charter/Strategy being developed for MidCentral DHB</td>
<td>Develop Health Charter/Strategy</td>
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</tr>
<tr>
<td>Manawhenua Hauora views sought on the CentralAlliance Strategy being developed by MidCentral and Whanganui DHBs</td>
<td>Develop Strategic Plan for CentralAlliance that actively considers both Iwi Relationship Boards perspectives as part of the Alliance</td>
<td></td>
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<td></td>
<td>Provide advice and direction on CentralAlliance Strategic Plan in partnership with Hauora A Iwi.</td>
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</tbody>
</table>

**Supporting Arrangements**

To support this work programme, the following hui arrangements have been put in place:

- Biannual hui between Manawhenua Hauora and MDHB’s boards
- Six-monthly review meetings between MWH’s Chair & Deputy Chair and MDHB’s Chair and CEO
- Six-weekly meetings of Manawhenua Hauora, with MDHB management in attendance
- Participation (through Chair) in Te Whiti Ki te Uru – the Central Region’s Maori Relationship Forum
- Participation (through Chair and Deputy Chair) in annual planning workshops and other appropriate workshops, forums as necessary
- Ongoing engagement and consultation by Manawhenua Hauora with the Governors of the four Iwi Boards regarding Maori Health priorities and outcomes within our region
**MANAWHENUA HAUORA**

Minutes of the Manawhenua Hauora hui held 8th May 2017 10.00am in the MDHB Boardroom, Palmerston North

### KARAKIA/MIHI

**Matt Matamua/ORIANA PAEWAI**

Mihi to Shane Royal Ngati Raukawa Whanau Ora representative and acknowledgement of Mike Grant after 15 years of service moving onto Wellington Free Ambulance (CEO) position – we wish him well in his venture!

### PRESENT

<table>
<thead>
<tr>
<th>Ngāti Raukawa ki te Tonga</th>
<th>Rangitâne (Manawatū/Tāmaki Nui ā Rua)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Robyn Richardson</td>
<td>Ms Danielle Harris (Deputy Chair)</td>
</tr>
<tr>
<td>Ms Paddy Jacobs</td>
<td>Oriana Paewai</td>
</tr>
<tr>
<td>Mr Shane Royal</td>
<td>Henare Kani (arrived 10.20)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ngāti Kahungunu ki Tāmaki Nui ā Rua</th>
<th>Muuūpoko</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Adele Berquist (left at 1050am)</td>
<td>Matua Matt Matamua</td>
</tr>
</tbody>
</table>

### In Attendance

Materoa Mar (left at 1050am)
Tawhiti Kunaiti (left at 1050am)
Wayne Blissett
Stephanie Turner (arrived 10.05am)
Craig Johnson (arrived 11.05am)
Debbie Te Puni, Kairangahau
Mr Dennis Emery.

### 1. APOLOGIES

- Ms Betty Lou Iwikau; and
- Ms Di Rump.

### 2. LATE ITEMS

- Consumer Council representation (selection panel)
- Maternity Governance
- Child Youth Mortality Review Group (Members support the continuation of Materoa Mar on that board)
- Transformation in the Disability Sector

### 3. MINUTES 27th March 2017

**Recommendation:** That the minutes of the meeting held 27th March 2017 were confirmed and accepted

*Moved: Matt Matamua  Seconded: Danielle Harris*

### 4. MATTERS ARISING

- Nil

### 5. CORRESPONDENCE
Correspondence (April 2017) read and tabled.

6. OPERATIONAL REPORTS

6.1 KAIRANGAHAU REPORT

- WORK PROGRAMME
  - It was agreed that the Work Programme for 2017/2018 will be reviewed following the MWH strategic workshop in June 2017. Date to be confirmed.
  - Ka Ao Ka Awatea to be included – this will be coordinated with Adele Berquist and Kairangahau.
  - Work programme to be finalised in preparation for Board to Board hui 11th September 2017.

6.2 Māori Health Directorate – Pae Ora team

- Final Decision Document Discussed
- Leadership opportunities will emerge from this;
- Change management workshop with ELT to be held within the next month;
- It was agreed that Pae Ora and Manawhenua Hauora will hold a workshop to develop a paper on restructuring impact on Hauora Maori and alignment of Ka Ao Ka Awatea, Final Decision Paper, Regional Service plan and Maori Health priorities. Date to be confirmed (June/July 2017).

7. MDHB BOARD AND COMMITTEE MINUTES & UPDATES

- QUEAC (Update provided by member Dennis Emery.)

8. GENERAL BUSINESS

8.1 KA AO KA AWATEA

UPDATE

- Tohu have been digitised and included in the latest plan;
- Structure diagram to be updated;
- Investment and Development to be highlighted;
- Currently in review for secondary care; and
- Need to be finalised by 18th of May.

DISCUSSION

- Received feedback from Raukawa Whanau Ora after reviewing the iwi paragraph
- Membership Query on Ngati Raukawa and affiliated Iwi listed within the confederation
- Include the Hauora Maori Cluster as a strategic imperative in Ka Ao Ka Awatea
Identified Priorities are process driven’; and
Is there investment in the actioning and implementation of this document?
Hauora Maori cluster inequity around contracts and service delivery to align with health outcomes. Engagement process to be developed.
Recommendation to include a section on Funding in the equity snapshot currently being developed
Mihi to the team who have developed this document
Waiting for statements of commitment from Kath Cook and Chiq Hansen
Member highlighted priority areas to be included: hospital chaplaincy, cancer care, disabilities, tino rangatiratanga and Palliative Care.
As our overall Iwi Maori population grows older, the needs in chaplaincy when hospitalised, cancer & palliative care needs become more pronounced and aged care residence and facilities see increased usage, we as Mana Whenua and Iwi health providers must retain the virtue of determining our own peoples destiny and futures – concept and notion of “tino rangatiratana”. It was agreed that these areas will be integrated into the Action items within the Plan.

8.2 WAI 2575 Inquiry
Ngati Kauwhata have lodged a claim with the Waitangi Tribunal that will be heard this week at Pipitea Marae (over 100 claims to be heard) around health inequities and health outcomes for Maori.
A copy of the WAI2575 Claim will be sent to Craig Johnson.

8.3 REGIONAL SERVICES PLAN DRAFT Tabled and discussed
The RSP Draft could align better with Ka Ao Ka Awatea; and
Te Whiti ki te Uru is the link to ensure local iwi priorities are aligned at a regional level.

8.4 FINAL DECISION DOCUMENT
Members thought the document could have highlighted the relationship with MWH and commitment to development of the Hauora Maori cluster more effectively.
Discussed the practicality of implementing integration of Hauora Maori across all clusters.
It was agreed that there will be many opportunities and leadership roles moving forward.
• There are some concerns around a bureaucratic structure creating more barriers to infiltrate;
• Integration across all clusters will be a difficult task to accomplish;
• We can be innovative in the development of the cluster.
• Restructure in terms of leadership is a positive thing for Hauora Maori

• **Recommendation:** The Consultation process around the development of a Hauora Maori cluster should commence immediately **RISK:** without a cluster things will continue as they are now. Members would like to set a timeframe.

• **Recommendation:** Manawhenua Hauora send a letter to MDBH CEO to acknowledge the commitment to developing a Hauora Maori cluster, and request a timeframe *i.e.* the cluster is developed by the 30th June.

• **Recommendation:** A Funding Framework is developed to review Hauora Maori funding and Iwi Provider contracts.

**DISCUSSION WITH CRAIG JOHNSON**

**CLUSTERS STRUCTURE**

• Each cluster will have a plan that is the heart of the cluster that will link the strategic imperatives and MidCentral Strategy;
• Confirmed the funding division will become a part of operations;
• Investment prioritisation to be developed, possibly looking at high level set budget per cluster with individual business case submissions;
• Locality plans will develop priorities that the clusters will then work with; and
• Coordinated locality approach and coordinated service approach to be woven together.

**MAORI HEALTH OBJECTIVES**

• Some difficulty working within annual plan constraints to include Hauora Maori objectives.

• It was agreed that a Midcentral action plan that is more operational opposed to the Ministry specific Annual plan would be more effective.

**CONTRACTING PROCESS AND COMMISSIONING**

• Historically held by Funding and Planning, MCH interested in reviewing this process moving forward with Manawhenua Hauora.

• Service specifications are out of date, preference for one contract to cover all services rather than individual contracts- development of a framework to review contracts would be favourable.
- **Recommendation: Develop a framework to review contracts**

**LOCALITY PLANS in progress** (Dannevirke, Levin, Otaki, Fielding)

- Feedback - It was a very prescriptive hui held in Fielding;
- These locality plans need to work for Iwi Maori within our communities - the process should not be prescriptive and guidance is needed and welcome from communities.

**ORANGA HINENGARO**

- To no to bring Oranga Hinengaro under Pae Ora this could also include Chaplaincy services – to be discussed further in Manawhenua Hauora workshop.

**CONSUMER COUNCIL REPRESENTATION**

- John Hannifin Independent Chair of the Consumer Council has requested a nomination from Manawhenua Hauora to take part in the selection process.
- Robyn Richardson is interested in becoming a member of the consumer council;
- Manawhenua Hauora members support the nomination of Robyn Richardson to the selection panel of the consumer council.

**CLINICAL COUNCIL**

- Request for Maori clinicians to put their interest forward for this council;
- Maori worldview is an important component of this council; and
- Recommendation to nominate [name] or [name] to the clinical council to be discussed with and confirmed with the nominees.

**TE WHITI KI TE URU**

- Te whiti ki te uru Terms of Reference are currently under review; and
- Workshop has been confirmed for Thursday regarding the purpose of Te Whiti ki te Uru.

**GENERAL BUSINESS**

**Maternity Services**

- Members support Oriana Paewai to continue for an additional term as a Maori representative on the Maternity Governance Group

**Child Youth Mortality Review Group**

- Members support Materoa Mar to continue for an additional term on the Child Youth Mortality Review Group.

**Disability Project Group**
• Members were advised of a National Co Design project group within the Disability sector to review a nationwide transformation of disability services.

9. NEXT HUI
19th June 2017

10. KARAKIA WHAKAMUTUNGA
Closed 11.15am
For:

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<tr>
<th>Decision</th>
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<tr>
<td>Endorsement</td>
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<td>✓ Noting</td>
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</tbody>
</table>

To

Board, MidCentral DHB

Authors

Simon Allan, Clinical Council Independent Chair
John Hannifin, Consumer Council Independent Chair
Mahashweta Patel, Project Manager, Strategy Planning and Performance

Endorsed by

Kathryn Cook
Chief Executive MidCentral DHB

Chiquita Hansen
Chief Executive Central PHO

Date

21 June 2017

Subject

CONSUMER AND CLINICAL COUNCIL MEMBERSHIP

RECOMMENDATION

It is recommended that the Board:

- **note** the Clinical and Consumer Council membership as endorsed by the Chief Executives of MidCentral DHB and Central PHO.

Strategic Alignment

Consumer engagement features strongly under our Strategic Imperative of *Partnering with people and Whānau to support health and wellbeing*. The first objective under this imperative is to establish an organised consumer voice to ensure consumers actively participate at all levels of the organisation to help improve health outcomes. The establishment of a Consumer Council will help support this imperative.

The Clinical Council will provide an independent strategic clinical perspective and commentary on all matters regarding implementation of our Strategy. The Clinical Council will provide advice on plans and initiatives to achieve our four strategic imperatives.
**Glossary**

MidCentral DHB – MidCentral District Health Board
Central PHO - Central Primary Health Organisation
AoD- Alcohol and other Drugs
MDT- Multi-disciplinary Team
1. PURPOSE

This report notifies the Board of the Membership of the Consumer and Clinical Councils. It is for noting.

2. PROCESS FOR MEMBERSHIP

The MidCentral DHB Board and Committee structures have been arranged to position MidCentral DHB for the future and, in particular, to give effect to the DHB’s new Strategy. In terms of the strategic imperatives, consumer engagement features strongly under Partnering with people and Whanau to support health and wellbeing. To support the delivery of the first strategic objective, the Chief Executive Officer, MidCentral DHB has been delegated the responsibility of establishing the two councils.

In late 2016, workshops were held for both the Clinical and the Consumer Council to develop the definition of the scope and function of the councils. Following Board sign-off, chairs have been appointed to both councils; Dr Simon Allan (Clinical Council) and John Hannifin (Consumer Council). It was also agreed that membership for both Councils would be approved by the Chief Executive’s of MidCentral DHB and Central PHO.

Applications for the membership of the two Councils were opened to residents in the MidCentral district for seven weeks over the months of April and May 2017. A total of 27 applications were submitted for the Consumer Council and 20 for the Clinical Council.

Applications for the Councils reflect the strong diversity of the MidCentral community and Health Care Professional groups.

In line with guidance from Human Resources an evaluation framework was developed for the short listing of applicants. A total of 32 applicants (16 applicants of each council) were invited to participate in a discussion with the relevant selection panel.

The selection panel for the Consumer Council comprised of representatives from;

- Consumer Council Independent Chair - John Hannifin
- Manawhenua Hauora – Robyn Richardson
- MidCentral DHB – Mahashweta Patel
- Clinical Council – Simon Allan
- Maternity Consumer Representation – Jenny Warren

The selection panel for the Clinical Council comprised of representatives from;

- Clinical Council Independent Chair - Simon Allan
- Primary Care - Bruce Stewart
- Maori and Pacific Health - Stephanie Turner
- Allied Health - Di Orange
- Nursing - Barry Kean
- Consumer Council - John Hannifin
Applicants that have not been selected onto the councils have been offered the opportunity for consumer participation and strategic clinical input for MidCentral DHB going forward.

Outlined in this report is the membership of the Consumer and Clinical Council and the key expertise, experience and attributes that they would bring to the council.

3. OVERVIEW OF MEMBERSHIP

3.1 Consumer Council Membership

A total of 10 members will make up the Consumer Council this includes the Independent Chair; John Hanninfin.

Membership of the Council reflects the strong diversity of the MidCentral community. Membership is wide-ranging in age, ethnicity, employment, location of residence and health sector experience.

Consumer representation includes members that are under 24 years of age and older than 65 years. There is also middle aged members and diversity in ethnicity with members with Maori, Bhutanese, German Jewish European and New Zealand European heritage. Members reside throughout the MidCentral DHB; areas include Levin, Foxton, Dannevirke and Palmerston North.

Some members have previous consumer panel experience. There are strong connections with refugee and migrant people, rural populations, Maori and Pacific people and young people. Members also have a range of expertise and attributes. Members have had personal or family experiences of the health systems. Specific members’ have held previous leadership roles, are connected with the alcohol and drug sector, the Women’s Health Collective and Interfaith Groups.

Outlined in Table One is an overall of the selected Clinical Council Members.

3.2 Clinical Council Membership

A total of 12 members will make up the Clinical Council. This includes the Independent Chair; Dr Simon Allan.

Membership of the Clinical Council is wide-ranging, with diversity in clinical roles, experience, leadership and community involvement. Members have been involved in system change, innovation and working effectively in multidisciplinary teams.

Clinical representation includes; primary care, secondary care, child health, Maori health, mental health, psychology, clinical research, community pharmacy, nursing and the junior medical representation.

Outlined in Table Two is an overall of the selected Clinical Council Members.
### Table One: Overview of Consumer Council Membership

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Location of Residence</th>
<th>Key Experience / attributes / expertise</th>
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</thead>
<tbody>
<tr>
<td>KARIPA, Richard</td>
<td>Foxton, Horowhenua</td>
<td>Previous experience as Maori Warden, and in counselling. Diploma in Maori Kaupapa Mental Health and AoD. Consumer panel experience AoD Counsellor. Actively involved in the community.</td>
</tr>
<tr>
<td>DULAL, Indra</td>
<td>Palmerston North</td>
<td>Strong connections with refugee community and relationships with a wide range of cultures Migrant cross-cultural advisor and client interpreter. Previous consumer panel experience.</td>
</tr>
<tr>
<td>BURNS, Deborah</td>
<td>Levin, Horowhenua</td>
<td>Holds several community and voluntary roles in Horowhenua. Significant experience in research and consultation. Worked for Ethnic affairs and provided language tutoring and consultancy on attitudes research. Experience with the health sector.</td>
</tr>
<tr>
<td>FELL, Gaye</td>
<td>Palmerston North</td>
<td>Strong knowledge of the health system, DHB Board of PHO. First Executive of the MidCentral Community Pharmacy Group. Active volunteer at the Hospice. Previous consumer panel experience and undergone HQSC training.</td>
</tr>
<tr>
<td>TAFA, Epenesa</td>
<td>Palmerston North</td>
<td>Significant connections and relationships with the Pacific Island communities. Training for Manawatu Women’s rugby team. Green Prescription member. Connected with other young people.</td>
</tr>
<tr>
<td>CHONG, Helen</td>
<td>Palmerston North</td>
<td>Long term president of National Council of Women, Co President Diabetes Manawatu. Member of Palmerston North Interfaith Group. Previous consumer panel experience.</td>
</tr>
<tr>
<td>PAEWAI, Stephen</td>
<td>Dannevirke, Tararua</td>
<td>Significant health, leadership and governance experience in the Tararua. Active advocate for Tararua. Brings a Maori and rural perspective of health services.</td>
</tr>
<tr>
<td>BARDELL, Cam</td>
<td>Palmerston North</td>
<td>Strong rural and farming connections, works for AFFCO. Became involved as a consumer looking at the Mortuary system at MidCentral Health. Outgoing attitude, friendly and engaging.</td>
</tr>
</tbody>
</table>
## Table Two: Overview of Clinical Council Membership

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Professional Role/Representation</th>
<th>Key Expertise /Knowledge/ Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>AYLING, Jane</td>
<td>Clinical Director, Primary care</td>
<td>Clinical director for Feilding Health Care. Passionate and a connector both locally and nationally with significant leadership experience. Strong knowledge in service development, research, clinical and transformational leadership and quality improvement.</td>
</tr>
<tr>
<td>BAKEN, Donald</td>
<td>Research Coordinator, Clinical Psychologist</td>
<td>Significant research background and expertise, part of the Massey University, Psychology Services. Involved in health service delivery- Cancer psychology service and health conditions psychology service. Passion for quality and innovative health services.</td>
</tr>
<tr>
<td>BRADLEY, Fiona</td>
<td>Community Pharmacist</td>
<td>Young and involved in mentoring intern pharmacists. 1st community pharmacist vaccinator- system improvement. Values patient centred care and empowering people to make decisions. Part of MidCentral Community Pharmacy Group.</td>
</tr>
<tr>
<td>FATTAH, Nader</td>
<td>General Practitioner</td>
<td>Strong community connections, clinical team leader and involved in primary care governance. Enquiring mind and part of key projects in primary care. Values prevention and reducing inequalities.</td>
</tr>
<tr>
<td>PEREIRA, Nicola</td>
<td>Pediatricist</td>
<td>Deputy clinical director of child health. Involved in several key groups and committees improving outcomes. Values both consumer/family input and clinical input into planning and decision making</td>
</tr>
<tr>
<td>FLEETE, Michael</td>
<td>1st Year House Officer</td>
<td>Young, fresh perspective. Linked with junior medical profession. Previous governance experience with medical students association. Advocating for outcomes that are principled.</td>
</tr>
<tr>
<td>BOWEY, Michael</td>
<td>Charge Nurse</td>
<td>Broad knowledge, especially in hospital care Creating change in own ward to improve health outcomes of people and improving team culture. Leads MDTs and demonstrates in everyday practice the values MidCentral DHB.</td>
</tr>
<tr>
<td>DEWAR, Jan</td>
<td>Nursing Director</td>
<td>Nurse director, involved in clinical and strategic planning. Project management expertise. Wanting to co-produce outcomes for people. Well connected with inclusive attitude</td>
</tr>
<tr>
<td>FIELD, Brian</td>
<td>Social Worker</td>
<td>Social science background Undertaking PhD in mental health recovery Consumer and equity focused Values the voice of mental health on the Clinical Council</td>
</tr>
<tr>
<td>LOCKETT, Bruce</td>
<td>Managing Pathologist</td>
<td>Significant experience in systems improvement and innovation. Wanting to extend knowledge into other areas of health and to contribute to a highly effective council.</td>
</tr>
</tbody>
</table>
4. **NEXT STEPS**

Going forward, it is anticipated that the two councils will meet monthly. The first meetings will be an introduction meeting followed by orientation to the organisation.

Outlined below is an overview of the upcoming stages for the establishment of the two councils. The timeframes are an approximation and will guide the process.

*Table One: Upcoming Activities for the Consumer and Clinical Council.*

<table>
<thead>
<tr>
<th>Indicative Timeframes</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July 2017</td>
<td>Consumer and Clinical Councils take office.</td>
</tr>
<tr>
<td>Week of the 31 July 2017</td>
<td>Introduction and meet and greet meeting for the two councils.</td>
</tr>
<tr>
<td>August 2017</td>
<td>Commencement of training and orientation to the organisation. Finalising of Terms of Reference for each council.</td>
</tr>
<tr>
<td>September 2017</td>
<td>Development of annual work programme</td>
</tr>
<tr>
<td>Regular Meetings for the two Councils</td>
<td>It is anticipated that the two councils will meet approximately 10 times a year. Key dates and ongoing schedule to be determined.</td>
</tr>
</tbody>
</table>

5. **RECOMMENDATION**

It is recommended:

that the Board note the Clinical and Consumer Council membership as endorsed by the Chief Executives of MidCentral DHB and Central PHO.

**Mahashweta Patel**  
Project Manager  
Strategy, Planning and Performance
For:

<table>
<thead>
<tr>
<th>Decision</th>
<th>Endorsement</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Noting</td>
</tr>
</tbody>
</table>

To

Board

Author

Kathryn Cook, Chief Executive Officer

Endorsed by

Date

23 June 2017

Subject

Operating Report for May/June 2017

RECOMMENDATION

It is recommended that:

- the operating report for May/June 2017 be noted.

Strategic Alignment

This report is aligned to the DHB’s Annual Plan, setting out performance results across the DHB.

It also aligns to the DHB’s Strategy and Organisational Development Strategy, particularly the implementation of a new leadership structure and integrated service model.

Glossary

CCDHB – Capital & Coast District Health Board
CE – Chief Executive
DHB – District Health Board
FTE – Full Time Equivalent
HVDHB – Hutt Valley District Health Board
IT – Information Technology
NSW – New South Wales
RIS – Radiology Information System
TAS – Central Region’s Technical Advisory Service
WebPAS – Web-based Patient Administration System
1. PURPOSE

This report provides the DHB’s results for the year to date on a consolidated basis, and discussed organisational, governance and sector issues of note.

2. SUMMARY

2.1 Local Matters

Planning work continues at many levels – locality planning, master site planning, and integrated service planning.

In line with our Organisational Development Plan we plan to roll out the Standing up for Safety programme. Board support for this programme is an important pre-requisite to proceeding.

Membership of our Executive Leadership Team has been enhanced through the appointment of an Executive Director, Nursing & Midwifery.

2.2 Regional Matters

Allied Laundry Services Limited has had a very productive year. It is now 18 months since this entity took on the full laundry service for Capital & Coast and Hutt Valley DHBs, and the upgraded plant is working well.

The Regional Service Plan for 2017/18 has been developed and is the subject of a separate report.

The development of a regional strategy is to begin.

The roll-out of the Regional Health Informatics Programme continues.

2.3 National Matters

The Government’s budget for 2017/18 saw additional funding invested in health. The majority of investment is in the ongoing roll-out of current programmes, such as bowel screening. There is some new month which is currently with the Ministry of Health, eg extended contraception services. There is also new monies held by other agencies, eg additional expenditure in mental health from social investments.

3. LOCAL MATTERS

3.1 Organisational Leadership Structure

Celina Eves has been appointed to the role of Executive Director, Nursing & Midwifery and will take up this position before the end of the year.

We chose not to make an appointment following the initial recruitment round for the new role of General Manager, Quality & Innovation and are going back to the market.
Steve Miller has commenced work in the role of Chief Information Officer, and Keyar Anjaria joins us on 3 July. I look forward to introducing Steve and Keyar to members on 4 July.

3.2 Integrated Service Model

Transition planning for our move to an integrated service model (clusters) is underway, and a separate report is provided on this matter.

Nicholas Glubb, Operations Director, Specialist Community & Regional Services leaves us on 30 June to take up a role with the South Island DHB Alliance. Under the new integrated service model structure, the operations director roles are disestablished. With this in mind, interim arrangements have been put in place as to provide operational leadership of these services until such time as the clusters are in place.

3.3 Master Site Plan for Palmerston North Hospital

Destravis representatives have been on site meeting with a wide range of staff and other stakeholders to discuss future models of care and what this means in terms of facility/infrastructure requirements.

Information gathered from these for a will inform the Destravis’ report which is expected to be available in July/August and will be provided to the Board for its consideration.

A presentation on this project will be provided to the Board on 4 July.

3.4 Horowhenua Health Centre

The 10th anniversary of the Horowhenua Health Centre was celebrated on Friday, 23 June 2017 with an afternoon tea for all staff.

A small, further celebration is planned for later in the year and will be combined with the launch of the area’s Health and Wellbeing Plan and new leadership arrangements.

3.5 Clinical Governance

3.5.1 Speaking Up for Safety & Promoting Professional Accountability

MidCentral DHB is implementing the “Standing up for Safety” programme from the Cognitive Institute. This programme is a key initiative to support MidCentral DHB’s strategic imperatives and the key elements within our Organisational Development Plan, linking directly to a positive and productive work environment and living our values. It will mean that all employees will feel safe to speak up immediately about any safety, or quality issue and the receiver welcomes it. In the event that a staff member does not feel safe or comfortable to speak up, they are encouraged to raise the issue with their manager, or if this is not appropriate through a reporting system. It lays an essential foundation to ensure a culture of accountability can be effectively developed across the organisation and across the Health Sector - a number of other DHBs are considering this initiative. The key success indicators for a safe organisation is where:
• Staff love working in the organisation would recommend care for their family;
• Provides an environment where staff are confident to speak up about any issue anytime.

Expected outcomes of the programme are:
• Improved patient safety attributable to greater staff willingness to speak up for patient safety.
• Respectful, collegial communication as a first approach and reporting when necessary.

The cost of the programme is around $40k and is provided for in the 2017/18 budget as part of the implementing the Organisational Development Plan.

3.5.2 Consumer Stories

On 4 July, the first consumer story will occur as part of our governance process.

A local woman will attend the Board meeting to talk about her experience. She has already shared her story with the clinical team involved in her care.

In line with the consumer’s wish for privacy, the story will take place in the confidential section of the meeting.

3.6 Financial Position

The May result was a deficit of $1828k which was $306k adverse to the planned deficit of $1,522k. This brings the year-to-date result to a surplus of $2,222k being $565k favourable to budget. During the month the load on the hospital exceeded capacity. This had an impact on cost estimated as $500k above the normal hospital operating pressures and the combined effect exceeded our opportunities to deliver sufficient offsetting savings.

The year end forecast remains a surplus of $2m.

3.7 Information Systems

3.7.1 Regional Health Informatics Programme

The revised timeline for implementation of the Regional Health Informatics Programme at MidCentral DHB is being finalised.

Data migration issues have been experienced locally with the implementation of the Regional Clinical Portal. Due to enhancements being implemented to support Whanganui DHB and the region’s Clinical requirements, MDHB has been unable to move data into the regional production system. This has impacted the stability of the regional production systems, delaying MDHBs Data migration. This stability issue has now be resolved, and a change freeze is being applied until conclusion of MidCentral DHB’s Regional Clinical Portal implementation. At this stage, go-live is expected to be around the end of July. Implementation of Radiology Information Systems (RIS) cannot occur until the Portal is in place, and RIS is currently expected to go live at the end of August.
The implementation of the new Regional WebPAS has also slipped due to additional requirements having been identified by MidCentral DHB users as critical to go live. This matter also impacts Whanganui and Wairarapa DHBs and TAS, on behalf of the DHBs, is addressing these with the various vendors concerned. We expect go-live will now occur around October/November.

These delays, while frustrating, are not unusual with large IT projects of this nature. The focus is on ensuring sound systems are put in place, and locally, we continue to do work to prepare for the change.

These delays do have a cost impact and we are endeavouring to minimise these wherever possible.

3.7.2 Hospital Operational Centre

We are now planning the implementation of a Hospital Operational Centre information system. The Ministry of Health advised its support for our investment in this area in late May. Contract negotiations with Alcidion, a leading provider of clinical decision support systems based in Australia, were then completed and we are now focused on completing the implementation planning study. This will set out the project timeline, key milestones, and our resourcing requirements.

3.8 National Role

I have taken up the role of Chair, National DHB CEs group.

My CEO lead role with the National Infrastructure Plan ends on 30 June, and I will handover the Regional Health Informatics Programme leadership role.

3.9 Congratulations

On behalf of the management team and staff, we extend congratulations to our Board Chairperson and Deputy Chair for the Queen’s Birthday honours they were bestowed recently.

4. REGIONAL MATTERS

4.1 Allied Laundry Services Limited

Allied Laundry Services Limited has had a very productive year. As members are aware, this entity now manages the laundry for all six DHBs within the Central Region as well as Taranaki DHB.

Sixteen months ago, a major plant installation was completed and laundry volumes almost doubled as the laundry took on Capital & Coast and Hutt Valley DHBs’ work.

The laundry now processes around 85 tonnes a week and a lot of work has been done over the past year to improve systems and manage throughput.
Costs are being held, with a modest increase of 1.5 percent to take place from 1 July. This increase needs to be viewed in light of the 10 percent price decrease which occurred from March 2016.

This regional venture continues to deliver a very effective and productive service.

The General Manager, Allied Laundry Services Limited has provided a report on the 2016/17 year to shareholding DHBs (refer Appendix ##). He concludes:

"With integration and the plant installation complete the focus is on consolidation of the growth, achieving budget, meeting processing requirements and improving cash flow. All of these tasks are in hand and will be further developed over the next year.

The plant and staff have responded well to a significant change in work practices and conditions. The belief in Allied Laundry by the shareholding DHBs has been rewarded by a plant and service that is at the leading edge of laundry processing plants in New Zealand.

Allied Laundry; an organisation the shareholders can be excited about."

### 4.2 Governance

The Regional Governance Group has been working with the Institute of Directors to develop an assessment tool to evaluate a Board’s performance. It is based on a questionnaire which has been tested by the Regional Governance Group, and is based on the four pillars of governance best practice:

- determining purpose
- an effective governance culture
- holding to account
- effective compliance

It is proposed that each DHB board now look to use the tool.

MDHB will undertake its annual board evaluation process later in year using the tool. It is very similar to that used by MidCentral DHB for its last evaluation.

Nationally, DHB Chairs are looking at options to support ongoing governance development, including a partnership arrangement with the Institute of Directors.

### 4.3 Regional Strategy

Through the Regional DHB Chairs and CEO groups, a regional strategy is being developed. This work is being led by the Central Region’s Technical Advisory Service in conjunction with DHB planning staff, and we now have a clear defined vision, values and three priorities:

**Vision**: Central Region DHBs leading together to achieve New Zealand’s healthiest communities

**Values**: partnership, excellence, integrity, courage and inspire.
To realise our vision, as **partners** we will strive for **excellence**, act with **integrity**, be **courageous**, **inspire** each other.

**Priorities:**
- Digitally enabled health system
- Clinically and financially sustainable health system
- Development the workforce

A detailed work programme to progress these three strategic priorities is being developed and will be provided to all DHBs for endorsement in due course.

## 5. NATIONAL MATTERS

### 5.1 Budget

The Government’s budget for 2017/18 saw an increase in Vote Health of around $888m, with a total investment of $16.77 billion. DHBs’ share of this is an extra $1.76 billion over four years. In announcing the increase, the Minister of Health advised the additional funding includes:

- $205 million for disability support services. This includes $27 million which will go to the Enabling Good Lives programme.
- $60 million for Pharmac to provide more access to new medicines.
- $52.3 million for emergency ambulance services.
- $38.5 million to continue the roll-out of the bowel screening programme.
- $100 million through the Budget 2017 Social Investment Package for innovative new mental health services.

MidCentral DHB will receive $10.64m additional funding from that received in 2016/17. The initial advice we received from incorrect, being overstated by $5.5m due to a Ministry of Health error. This has been corrected and we are recasting our budget in line with the updated Funding Envelope.

### 5.2 General Elections

The general election period commenced on 23 June 2017, with the election day being Saturday, 23 September.

Board members are reminded that if they wish to stand for Parliament they will need to manage any potential, perceived or actual conflicts of interest. Guidelines are available and these can be found on the Governance Sharednet site.

Staff have been reminded of their responsibilities in ensuring our sites and services remain politically neutral.

### 5.3 Health Partnerships Limited

#### 5.3.1 Procurement

Work continues, with responsibility for the national procurement service moving from healthAlliance to NZ Health Partnerships. This transition occurred on 1 May 2017.
5.3.2 National Infrastructure Platform

Fourteen DHBs, including MidCentral, are participating in this programme and will migrated to an Infrastructure as a Service arrangement. The National Infrastructure Platform provides a consistent approach, framework and planning artefacts to support DHBs in their planning and their ability to get ready to connect to their chosen provider.

From Health Partnership Limited’s perspective, their involvement ends on 30 June 2017, and DHBs will then work with their chosen service provider.

MidCentral DHB has yet to determine its service provider and this will be the subject of a report to the Board in due course.

5.4 Health System Performance Programme

Through the national CEs group, the development of a health system performance programme is being progressed. The aim is to have a national programme that takes a view of DHB system performance, specifically effectiveness, efficiency and productivity.

A multi-pronged approach is planned and a briefing paper on progress was recently provided by All District Health Boards. A copy is attached for members’ information – Appendix B.

5.5 Landmark Decision re Smokefree Policy

The Supreme Court, Wellington has unanimously upheld Waitemata DHB’s smokefree policy.

Waitemata DHB has a smokefree policy like MidCentral’s, which prevents patients smoking within or on its facilities while receiving care, including in its mental health inpatient units. This policy was challenged by an inpatient of Waitemata DHB’s two acute adult inpatient mental health units around five years ago. Since then, the DHB has been seeking to uphold its policy through the judicial process.

Key points from the judgment include:

- The DHB has no obligation to provide smoking rooms in mental health units
- Nicotine replacement therapy is a humane and meaningful treatment of nicotine withdrawal symptoms
- Consultation on the DHB’s policy was adequate and upholds the quality and ethical standards expected
- The policy is reasonable, proportionate and not inconsistent with the Bill of Rights

5.6 Waitangi Tribunal – Health Services & Outcomes Inquiry

The Waitangi Tribunal has asked that around 140 claimant groups have sought to participate in the Tribunal’s Kaupapa Inquiry into health services and health outcomes.
This inquiry (Wai 2575) is currently in a planning phase and will examine breaches of the Treaty of Waitangi in health services and health outcomes for Maori. The scope, priorities and processes for the inquiry are currently being determined. The Tribunal has stated that the inquiry will not consider historical health-related grievances already settled with the Crown, or which has been fully heard and reported on by the Tribunal previously. Health related grievances which have been consolidated into other district or kaupapa inquiries currently underway will also be excluded from the inquiry.

I will keep the Board updated on this inquiry.

6. **RECOMMENDATION**

It is recommended:

*the operating report for May/June 2017 be noted.*

Kathryn Cook  
Chief Executive Officer

- **Appendix A:** Letter from Allied Laundry Services Limited dated 18 May 2017 re 2016/17 Results  
- **Appendix B:** All DHBs Briefing Paper dated 15 June 2017 re Health System Performance Programme Update
Wednesday 18th May 2017

To Chief Executive Officers and Chairman DHB Board of Representatives;
- Mid Central District Health Board
- Taranaki District Health Board
- Whanganui District Health Board
- Hawke's Bay District Health Board
- Waikato District Health Board
- Capital and Coast District Health Board
- Hutt Valley District Health Board

From;
Mark Mabbutt,
Chief Executive Officer
Allied Laundry Services Limited

The last year for Allied Laundry has been one of consolidation to manage the increased production throughout from Hutt Valley and Capital and Coast DHB’s almost doubling the plant throughout to around 85 tonnes per week. The business has adapted to the significant change process and projects continue to develop to improve systems and manage business costs. The growth and increase in complexity has certainly tested the plant and the staff and the business has responded well.

The plant is the most modern up to date in New Zealand and one the shareholding DHB’s can be proud of. A change of this nature is testing for all involved and whilst there has been significant improvements in processing, reduced labour costs and completion of change processes the plant does need to improve a little further to fulfill the vision of Allied Laundry;

Allied Laundry will set a new benchmark for regional hospital linen services and dominate the direction for industry change.

The service to all customers has settled into a pattern of supply; the Allied Laundry on site DHB teams have become part of the integrated whole of the DHB’s and are supplying a seamless service to the hospitals. The relationship with strategic partners such as Alisco, EcoLab, Spotless etc have further developed enhancing the business. Wider alliances with DHB laundry’s such as those at Canterbury and Northland are being pursued as are wider alliances with NSW Health and Melbourne based hospital laundry’s. A new linen supplier on the NZ market will be a game changer for the industry and will enable a competitive tender process for the supply of linen to Allied Laundry and the wider NZ hospital alliance Allied Laundry is leading.

Allied Laundry Services
Hospital Quba 12, Rushima St. PO Box 4355 Palmerston North 4410 Phone 0800 LAUNDRA (5828 637) alliedlaundry.co.nz
Integration and investment.

The last year has been one of significant adaptation for the plant to manage the increased processing requirements, adapt to the operations of the new plant and plant configuration and embed new system and processes. Some highlights have been:

- Plant FTE numbers have been reduced from 70 to 67 over the year and overtime has dropped from over 200 hours per week, at integration, to around 30 per week.
- To limit steam usage from MidCentral DHB, a steam generator and new building has been built at the rear of the plant. This has been a considerable unbudgeted cost however this will deliver steam at a cost effective price to the plant.
- All the IT and accounting functions have moved to cloud based software solutions with considerable benefits e.g. all accounts are e mailed out rather than posted out.
- The on site staff have now started using online tablet based ordering for linen giving the plant 'live' ordering information. Off site customers now order through a web portal rather than faxing or phoning.
- The plant has just commenced a 12 month 'Lean' program to lift peak cut percentages from 98% currently being seen to 100%.

Price increase

The Allied Laundry Board approved a budgeted 1.5% price increase, on all products, from 1 July 2017. The 1.5% price increase has been presented to the regional shareholding District Health Board CEOs and has been supported. The price increase has been introduced as there remain uncertainties around some costs such as scrubs and labour also commercial revenue has been challenging.

It is worth noting that Allied Laundry passed on an effective 10% price decrease from 1 March last year; 6% price reduction and no further lost stock charges. The Contingency Scenario forward modelling featured a 1.5% price increase each year thereafter to meet the challenge of increasing costs.

End of year result.

Last years end of year result ended on a loss of a round $50k. This year the forecast is for breakeven, or thereabouts. The breakeven budget allows for the payment of a dividend based on interest on capital to the shareholders. Given the size and complexity of the integration as well as Allied Laundry pushing the barriers of technology, IT and relationships this is a positive result. The budget for 2017/18 is similarly for breakeven recognising the cooperative nature of the business and minimal requirements for new capital investment.
Cash flow

Cash flow has come under control and is starting to build. Allied Laundry is relying less on the overdraft facility as the cash available increases. It will be a number of months more however before Allied Laundry is in the position to start to pay rebates and dividends owed to the shareholding DHB's but it is expected that unpaid rebates and dividends for 2014/15 and 2015/16 should be cleared by the end of the 2017/18 financial year.

Scrub

One area of concern is the rate of loss of scrubs. Allied Laundry has spent in the vicinity of $500k on scrubs in the last 18 months to lift volumes for CCDHB and HH/DMHB and also to replace losses across all DHB's. Allied Laundry tracks the purchasing and also those scrubs at their end of their economic life (ragging); it is apparent there is a much larger loss factor in scrubs than originally envisaged. Allied Laundry no longer undertakes a stocktake each year and does not charge a lost stock charge any further; the lost stock is built into the final price.

The loss rate in scrubs looks to be around 60% i.e. for every 10 Allied Laundry introduces as new stock 6 do not make it to the end of their life; this loss rate cannot be considered acceptable. To look to mitigate the loss rate Allied Laundry will be looking for the DHB's to take ownership, assisted by Allied laundry, of this issue and reduce the loss rate. If the loss rate cannot be reduced then a targeted price increase will need to be introduced on scrubs to cover the mounting losses.

Allied laundry will be working with the DHB's later in the year to come up with ideas and processes to enable the DHB's to manage the scrubs and reduce the loss rate.

Alliances

National Alliance
Allied Laundry is the driving force behind a national alliance of DHB hospital laundry's, being Tairawhiti, Canterbury, South Canterbury and Northland. The alliance is to bring the individual laundry’s together for:

- Shared purchasing. The national shared purchasing process is well underway and the alliance will be heading into an ‘Expression of Interest’ process led by Canterbury DHB procurement within the next 2 – 3 months for the 10 linen products that make up 90% of total linen purchasing.
- Shared information. The opportunity will be taken to have staff members travel to other laundry’s to learn and share.
Allied & Canterbury Linen’s Alliance.

Allied Laundry and Canterbury have built on the recent signing of an MoU to work closely together. Visits have taken place and will continue to over the year to share knowledge and experience and work together on shared solutions.

NSW Health Laundry’s Alliance.

Allied Laundry also has an MoU with NSW Health Laundry’s to share information and to work together. The Allied Laundry CEO travelled to Sydney last year to attend a conference with the NSW Laundry’s managers and to build on the relationship. More will be done this year to tap into this sizeable operation to gain knowledge and shared learnings.

Capital Purchasing

Capital purchasing will continue to be placed on hold for the forthcoming year with only those items considered urgent to be purchased.

Benchmarking

With each letter to the CEO’s some benchmarking is shared to graphically portray the gains being made at the laundry.

Kg’s per production FTE per working day.

The chart below shows the increase in processing per kilogram of linen per FTE for each working day; from 2010 the rate has increased from 200 kg’s per day to almost 260 kg’s per day an increase of around 30%, which is where Allied Laundry is targeting to get to.
Production Labour Cost cents per kg processed.
This chart shows the cost of productive labour per kilogram of linen processed. As can be seen the cost has hovered around $0.70 for the last 8 years, with a spike for the integration time, which has now reduced back down. The other intermittent spikes are Christmas and New Year periods. What this chart means is that each wage increase is being mitigated by increased plant performance.

Monthly Revenue.
The below chart plots the increase in monthly revenue through Allied Laundry, a significant increase over the last 5 years.

Allied Laundry Services
Hospital Gate 12, Ruakura St. PO Box 4355 Palmerston North 4410 Ph 0800 LAUNDRY (528 637) alliedlaundry.co.nz
Reusable Theatre Linen vs. Disposable Theatre Linen.

The ongoing debate between reusable theatre linen and disposable theatre linen continues. Four out of the seven DHBs serviced by Allied Laundry use a mix of reusable and disposable whilst the other three are 100% disposable. Reusable theatre linen comprises around $1m of revenue per year to Allied Laundry (9.5% of total revenue). Globally there is a trend away from disposable theatre linen due to sustainability issues however in Australia and New Zealand the current trend from reusable to disposable.

Allied Laundry faces continual pressure from disposable theatre linen products and is seeing a slow erosion of volumes and revenue in our reusable products. Given this pressure and the overall trend, Allied Laundry needs to strategically review and prepare for the potential full loss of theatre linen revenue. This would involve further significant changes within the plant, but also unfortunately include a price increase on general linen, as potential cost savings are not expected to fully offset the lost margins. As a starting point, Allied Laundry is therefore currently undertaking a comparative review of reusable and disposable theatre gowns on behalf of shareholding DHBs, to ascertain the overall best value option.

DHBs will be advised of the outcome of this comparative analysis, and then engaged in further discussions on the implications and how shareholders wish Allied Laundry to respond.

Conclusion

With integration and the plant installation complete the focus is on consolidation of the growth, achieving budget, meeting processing requirements and improving cash flow. All of these tasks are in hand and will be further developed over the next year.

The plant and staff have responded well to a significant change in work practices and conditions. The belief in Allied Laundry by the shareholding DHB’s has been rewarded by a plant and service that is at the leading edge of laundry processing plants in New Zealand.

Allied Laundry, an organisation the shareholders can be excited about.

Yours sincerely
Mark Hambott
Chief Executive Officer
Allied Laundry Services Limited
Appendix B:

All District Health Boards

Briefing Paper

<table>
<thead>
<tr>
<th>To:</th>
<th>National Chief Executives</th>
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<tbody>
<tr>
<td>From:</td>
<td>Debbie Chin (CE Sponsor Health System Performance Insights)</td>
</tr>
<tr>
<td>Subject:</td>
<td>Health System Performance Programme Update</td>
</tr>
<tr>
<td>Date:</td>
<td>15 June 2017</td>
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Purpose

The purpose of this paper is to provide an update to all DHB Chief Executive’s on the significant activity occurring with the health system performance programme (HSP Insights), the progress being made on the development of a health system performance framework for DHBs and other work that interfaces with this.

The paper requests that Chief Executives (CEs) consider the performance story they would like tested through the development of the programme, what messages they would like to provide to an incoming Health Minister and the feedback they would like to provide to Treasury on their DHB Performance Analysis.

Recommendations

It is recommended that the DHB CEs:

1. **Note** the content of this paper
2. **Discuss** The HSP Insights programme request that the CEs identify a number of hypotheses, they would be interested in the programme responding to over 2017/2018
3. **Discuss** what advice CEs would like to provide to the incoming Health Minister as areas to consider for improvements / solutions for the NZ Health sector
4. **Discuss** Treasury are seeking collective and constructive feedback on their DHB Performance Reporting and would like to receive this via the HSP Insights programme
5. **Note** TAS is leveraging the relationships it has established through the HSP Insights programme to create opportunities for co-production and partnering with the Productivity Commission, Treasury and Professor Grigg at Massey University on behalf of the DHB collective.

Summary

The Chief Executives at their September 2016 meeting endorsed the proposal for a national programme that takes a view of DHB system performance, specifically effectiveness, efficiency and productivity.
The purpose of the Health System Performance Insights (HSP Insights) programme is to support District Health Boards' (DHBs) to understand their collective and individual performance to achieve the best value (benefit per dollar invested) for public resources. It has an insight driven approach, and will provide an authoritative national view of health system performance as well as enabling local level measurement and analysis to enhance value and performance.

The first priority for the programme is to prepare a briefing for an incoming Minister and Government. Work has been commissioned to undertake a review and analysis of historical health funding and how allocation and policy decisions may have influenced health system performance. CEs are asked to consider what advice could be provided to incoming Ministers to inform health sector improvements.

**Health System Performance Framework**

The health system performance expert reference group (appendix 1) is progressing the development of a health system performance framework based on the Organisation for Economic Co-operation and Development (OECDs) framework (appendix 2) in collaboration with academics and a wide range of health stakeholders.

The framework will provide a foundational set of measures for the programme and should be flexible enough to support CEs to respond to various high level challenges on their system performance both at a local and regional level. The review and analysis of historical health funding will also inform the framework.

The HSP Insights programme request that the CEs identify a number of hypotheses they would be interested in the programme responding to over 2017/2018.

**Productivity Commission Inquiry**

As part of the budget announcements last month, the Minister of Finance asked the Productivity Commission to investigate how to measure and improve productivity in core public services. The terms of reference sets out the context for the inquiry and the inquiry scope. Essentially the terms of reference asks the Productivity Commission to provide advice on:

- how to measure efficiency of the health, education, justice and social support sectors, at both a sector and service level;
- the appropriate role of these measures in public sector performance frameworks; and
- any capability, culture or systems issues that will support agencies to measure, understand, and improve productivity.

The Productivity Commission has requested through the HSP Insights programme, that DHBs engage with the inquiry and provide relevant input, knowledge and advice. The inquiry will occur over the next eighteen months.

**Treasury – DHB Performance**

Treasury released *District Health Board Financial Performance to 2016 and 2017 Plans* on their website in May, which analyses the performance of District Health Boards (DHBs) against a set of financial indicators.

The analysis informs Treasury’s risk assessment of DHBs and the advice they are required to give, jointly with the Ministry of Health, to the Ministers of Finance and Health on annual plans.
Documenting this analysis in the form of annual overview reports provides a systematic and transparent way for Treasury to offer their perspective on the sector, and inform budgets and other advice.

It does not purport to provide a comprehensive view of health sector performance, and Treasury acknowledge the limitations of their approach.

Treasury has informed HSP Insights they are developing a set of non-financial indicators which will be published later this year on DHB performance. Whilst they haven’t confirmed the indicator set they will use, it is likely to include ambulatory sensitive hospital admissions, mental health, acute admissions, emergency department waiting times.

Treasury is supportive of this programme and believe it needs both DHBs and MOH working collaboratively.

Treasury welcome constructive feedback from CEs on their DHB Performance Reports and has requested this through the HSP Insights programme.

**Ministry of Health – Productivity Project**

TAS met with the Office of the Chief Economist at Ministry of Health in May. Ministry of Health advised they are beginning a piece of work on health sector productivity. TAS was able to provide an overview of the work being proposed through HSP Insights and has undertaken to share information on the development of the health system performance framework approach as it evolves.

The Ministry are seeking to collaborate with HSP Insights to ensure opportunities for co-production are identified. TAS is meeting with Chief Financial Officer at MOH to ascertain how this connection can be best made.

**Performance Management Framework Grant**

Professor Nigel Grigg at Massey University has received a Health Research Council grant to develop a Performance Measurement (PM) framework for secondary care.

The aim of their study is to use their expertise on performance measurement systems and structural equation modelling methodology to improve the existing PM systems (i.e. secondary care balanced scorecards) to help DHBs to identify how to improve the overall performance of their hospitals.

This work is scheduled to begin in July 2017 and Massey have signalled a wish to engage with the HSP Insights programme for alignment. Massey will also engage directly with DHBs and more advice should be available in the next two months on how that will occur.
Appendix 1: Organisations participating on the expert steering group

The following organisations are involved in the health system performance expert reference group:

- GPNZ
- Health Roundtable
- Health Quality and Safety Commission
- Massey University
- Productivity Commission
- Victoria University
- DHB representatives
Appendix 2: OECD framework for performance measurement

The OECD framework for performance measurement is the model being used by the HSP Insights programme.

![Diagram of the OECD framework for performance measurement]

For:

<table>
<thead>
<tr>
<th>Decision</th>
<th>Endorsement</th>
<th>Noting</th>
</tr>
</thead>
</table>

To | Board

Author | General Manager, Finance & Corporate Services

Endorsed by | Finance, Risk & Audit Committee & CEO

Date | 22 June 2017

Subject | FINANCE REPORT FOR MIDCENTRAL DHB – MAY 2017

RECOMMENDATION
- that this report be noted.

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

Glossary

DHB | District Health Board
ED | Emergency Department
EECA | Energy and Efficiency Conservation Authority
GST | Goods & Services Tax
HC | Health Centre
IDF | Inter District Flows
MDHB | MidCentral District Health Board
MCH | MidCentral Health
MOH | Ministry of Health
NZ | New Zealand
NZHP | New Zealand Health Partnership
RMO | Registered Medical Officer
YTD | Year to Date
1. PURPOSE

This report is provided for information and consideration. No decision is required.

2. SUMMARY

The May month result for MidCentral DHB was an operating deficit of $1,828k which was $306k unfavourable to budget for the month. This result brings the year to date actual to $2,222k surplus which is $565k favourable to budget. The year to date result includes $2,000k of unbudgeted revenue drawn from revenue previously banked. With the inclusion of this unbudgeted revenue MidCentralDHB is currently tracking $5,523k better than this time last year as is evident in the graph at Section 4.1.

The MidCentral Health Provider result continues to be a reflection of pressure on this service and the challenge of managing personnel costs within budget. This continues to be offset by significant savings in other divisions of the DHB.

With the banked revenue now uplifted and recognised, the forecast is to achieve a year end surplus of $2,000k.

3. RECOMMENDATION

It is recommended:

*that this report be received.*

Neil Wanden
General Manager – Finance & Corporate Services
4. **FINANCIAL PERFORMANCE**

[Amounts are in $’000 and adverse numbers are in brackets]

4.1 Result for the month of May 2017 and year-to-date

<table>
<thead>
<tr>
<th>May-17</th>
<th>Month</th>
<th>Year to Date</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>$'000</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>Funding Division</td>
<td>(833)</td>
<td>(1,586)</td>
<td>753</td>
</tr>
<tr>
<td>MidCentral Health</td>
<td>(935)</td>
<td>133</td>
<td>(1,069)</td>
</tr>
<tr>
<td>Enable NZ</td>
<td>(25)</td>
<td>(50)</td>
<td>25</td>
</tr>
<tr>
<td>Governance</td>
<td>(35)</td>
<td>(20)</td>
<td>(15)</td>
</tr>
<tr>
<td>Total DHB</td>
<td>(1,828)</td>
<td>(1,522)</td>
<td>(306)</td>
</tr>
</tbody>
</table>

The DHB result for the month was a deficit of $1,828k, which was unfavourable to budget for the month by $306k.

This brought the year to date result to a surplus of $2,222k which was $565k favourable to budget. This includes $2,000k of unbudgeted revenue drawn from revenue banked in previous financial years.

The performance against budget for the DHB as a whole is shown in the chart below:
4.2 Funding

Income and Expenditure for the period ended 31 May 2017 was as follows:

<table>
<thead>
<tr>
<th>$000</th>
<th>May-16</th>
<th>May-17</th>
<th>Budget</th>
<th>Variance</th>
<th>May-16</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>Revenue</td>
<td>44,785</td>
<td>45,734</td>
<td>45,686</td>
<td>48 ✓</td>
<td>490,057</td>
<td>507,465</td>
</tr>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Outsourced Services</td>
<td>205</td>
<td>484</td>
<td>484</td>
<td>0 ✓</td>
<td>2,451</td>
<td>5,319</td>
</tr>
<tr>
<td>Provider Payments</td>
<td>44,924</td>
<td>46,083</td>
<td>46,788</td>
<td>705 ✓</td>
<td>485,427</td>
<td>495,752</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>45,129</td>
<td>46,567</td>
<td>47,272</td>
<td>705 ✓</td>
<td>487,879</td>
<td>501,071</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>(343)</td>
<td>(833)</td>
<td>(1,586)</td>
<td>753 ✓</td>
<td>2,178</td>
<td>6,394</td>
</tr>
</tbody>
</table>

✓ Favourable to Budget  ❁ Unfavourable to Budget but within 5%  ❅ Unfavourable to Budget outside 5%

The Funding result for the month of May 2017 was a $833k deficit, which was a favourable variance against budget by $753k. This brought the Funding result year to date to a $5,336k favourable variance and is consistent with the revised forecast for Funding after amendment for revenue of $2,000k drawn from previously banked revenue.

The Inter District Flows (IDF) inflows and outflows remain on budget for the month. For the year to 31 May 2017 a total of $968k has been accrued and passed to MidCentral Health (MCH) in anticipation of the year end National IDF wash up for the Regional Cancer Treatment Service. This is an increase of $115k from April 2017.
The MidCentral Health (MCH) result for the month of May 2017 was a $935k deficit, which was an adverse variance against budget by $1,069k. This brought the MCH result year to date to a $7,106k adverse variance. MCH continues to make progress in addressing the challenges of increasing demand and by recruiting a permanent workforce to reduce locum reliance.

MCH Personnel costs were $603k overspent to budget for May, with MCH running at an average monthly overspend to budget in personnel of $565k. The stat day phasing that caused overspend last month provided some respite in May but reliance on outsourced personnel in the form of locums and Geneva nursing increased. Mental Health was the main area of overspend accounting for 67 per cent of the personnel deficit as this service still has increased resourcing.

Clinical supplies were over budget by $490k. This was due to high patient volumes and also high acuity which saw ward and theatre utilisation rates up, resulting in increased supply costs. Theatre in particular accounted for 40 per cent of the clinical supply overspend.

After isolating the capital charge and Debt to Equity adjustments, infrastructure and non-clinical costs were over budget by $8k.
The year to date performance of MidCentral Health is shown in the following graph:

![Graph showing financial performance](image_url)

Major changes from budget to actual for the month drove the result as follows:
ED presentations increased to 3,589 in May, with the daily average increasing to 116. Admission rates increased to 31.4 per cent with daily admissions of 36 compared to 33 in April.
Bed numbers continued to be high in May with an increase from April to an average of 339 beds at 102.5 per cent utilisation.

4.4 Enable New Zealand

The Enable New Zealand result for the month of May 2017 was a $25k deficit, which was a favourable variance against budget by $25k. This brought the Enable New Zealand result year to date to a $304k favourable variance.

Revenue has been running consistently ahead of budget across all services with the most significant gain being the Ministry of Health Hearing Contract that was awarded to Enable New Zealand in July 2016. Operating costs have increased proportionately with the revenue growth.

Enable New Zealand is forecasting a surplus of $350k.
### 4.5 Governance

#### Governance May 2017 Result

<table>
<thead>
<tr>
<th>$000</th>
<th>May-16</th>
<th>May-17</th>
<th>May-16</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td>505</td>
<td>747</td>
<td>767</td>
<td>(19)</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>792</td>
<td>1,005</td>
<td>898</td>
<td>(107)</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>52</td>
<td>62</td>
<td>33</td>
<td>(28)</td>
</tr>
<tr>
<td>Sub-Total Personnel</td>
<td>843</td>
<td>1,066</td>
<td>931</td>
<td>(135)</td>
</tr>
<tr>
<td>Other Outsourced Services</td>
<td>49</td>
<td>96</td>
<td>93</td>
<td>(3)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>(2)</td>
</tr>
<tr>
<td>Infrastructure &amp; Non-Clinical</td>
<td>384</td>
<td>261</td>
<td>405</td>
<td>144</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>1,279</td>
<td>1,428</td>
<td>1,432</td>
<td>4</td>
</tr>
<tr>
<td><strong>Operating Surplus/(Deficit)</strong></td>
<td>(774)</td>
<td>(680)</td>
<td>(665)</td>
<td>(15)</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>(500)</td>
<td>(645)</td>
<td>(645)</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit)</strong></td>
<td>(273)</td>
<td>(35)</td>
<td>(20)</td>
<td>(15)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FTE</th>
<th>Medical</th>
<th>Nursing</th>
<th>Allied Health</th>
<th>Management / Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-16</td>
<td>0.6</td>
<td>1.0</td>
<td>1.8</td>
<td>110.5</td>
</tr>
<tr>
<td>May-17</td>
<td>2.6</td>
<td>1.2</td>
<td>2.1</td>
<td>114.7</td>
</tr>
<tr>
<td></td>
<td>1.6</td>
<td>0.0</td>
<td>4.4</td>
<td>127.2</td>
</tr>
<tr>
<td></td>
<td>(1.0)</td>
<td>(1.2)</td>
<td>2.3</td>
<td>12.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.4</td>
<td></td>
</tr>
</tbody>
</table>

The Governance result for the month of May 2017 was a $35k deficit, which was an unfavourable variance against budget by $15k. This brought the Governance result year to date to a $2,036k favourable variance.

The month’s unfavourable variance is attributable to personnel termination costs offset to an extent by hardware maintenance savings.

The favourable variance in depreciation and amortisation costs arising from timing of system deployments and other savings within Governance will be passed back to MidCentral Health at the end of the financial year.

#### 4.6 Forecast

Our best estimate of the full year result remains to carry the extra $2,000k to a bottom line surplus, with an underlying operating result remaining at break-even. Currently the DHB is year to date $565k favourable to budget. The year to date performance continues to absorb the impacts of on-going pressures from volume, high cost patients and staffing levels. These will continue to be mitigated by savings achieved in other areas.
### 4.7 Contracts > $250,000

The following table details contract over $250,000 signed in the last quarter.

<table>
<thead>
<tr>
<th>Other Party</th>
<th>Contract Name</th>
<th>Purpose</th>
<th>Total Contract Value</th>
<th>Frequency</th>
<th>Start</th>
<th>Finish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geneva Health Limited</td>
<td>Temporary Health Care Assistants &amp; Hospital Aides Staffing</td>
<td>To provide Health Care Assistants &amp; Hospital Aides to cover staff in a temporary capacity</td>
<td>$550,000 pa</td>
<td>Annual</td>
<td>01.05.17</td>
<td>30.04.18</td>
</tr>
</tbody>
</table>
5. STATEMENT OF FINANCIAL POSITION

5.1 Financial Position

<table>
<thead>
<tr>
<th></th>
<th>Jun 2015 $000</th>
<th>Jun 2016 $000</th>
<th>May 2017 $000</th>
<th>Change $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Current Assets</td>
<td>195,986</td>
<td>214,989</td>
<td>213,663</td>
<td>(1,326)</td>
</tr>
<tr>
<td>Current Assets</td>
<td>81,722</td>
<td>57,148</td>
<td>65,014</td>
<td>7,866</td>
</tr>
<tr>
<td><strong>Total Equity and Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td>145,007</td>
<td>142,096</td>
<td>201,017</td>
<td>58,921</td>
</tr>
<tr>
<td>Non Current Liabilities</td>
<td>61,344</td>
<td>61,622</td>
<td>5,084</td>
<td>(56,538)</td>
</tr>
<tr>
<td>Current Liabilities</td>
<td>71,357</td>
<td>68,419</td>
<td>72,576</td>
<td>4,157</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>277,708</td>
<td>272,137</td>
<td>278,677</td>
<td>6,540</td>
</tr>
</tbody>
</table>

The change in equity shown this year is largely due to the $56.7m MOH Debt-Equity swap in February.

5.2 Debt and Investment

5.2.1 Debt

<table>
<thead>
<tr>
<th>Lender</th>
<th>Maturity</th>
<th>$’000</th>
<th>Rate</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>EECA</td>
<td></td>
<td>777</td>
<td>0.00%</td>
<td>Fixed</td>
</tr>
</tbody>
</table>

The debt is with the Energy and Efficiency Conservation Authority (EECA) which has a Crown Efficiency Loan Scheme for the purposes of assisting government funded organisations to take measures to reduce their energy expenditure. The loans are used for the purchase and installation of equipment in this regard. The loans are interest free.
5.2.2 Cash and Investments

Cash and investments at month end were:

<table>
<thead>
<tr>
<th>May-17</th>
<th>Rate</th>
<th>Value $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZHP Sweep Balance</td>
<td>2.34%</td>
<td>32,284</td>
</tr>
<tr>
<td>Cash in Hand and at Bank</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Trust Accounts</td>
<td></td>
<td>3,064</td>
</tr>
<tr>
<td>Enable New Zealand</td>
<td></td>
<td>369</td>
</tr>
<tr>
<td>Cash Balances</td>
<td></td>
<td>35,720</td>
</tr>
<tr>
<td>Term Investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 months to Jul 18</td>
<td>4.55%</td>
<td>8,250</td>
</tr>
<tr>
<td>24 months to Sep 17</td>
<td>3.94%</td>
<td>8,250</td>
</tr>
<tr>
<td>Total Cash Balance</td>
<td></td>
<td>52,220</td>
</tr>
</tbody>
</table>

Enable New Zealand funds are held at the Bank of New Zealand where the related transaction facilities are operated. The Trust & Special Funds are held in a separate Westpac account, as required of Trust accounts. These fall outside of the Shared Banking Arrangement at Westpac which NZ Health Partnerships Limited sweeps daily although surplus liquidity from Enable is channelled through the DHB accounts to obtain those benefits.

5.2.3 Cash Position

The DHB’s cash balance, excluding investment and Trust Accounts, is shown in the chart above. The movement from cash balances to deposits in August and September reflects the investment placements as a result of the amendment to the banking agreement at that time. The big increase in the cash balance at both
December month ends were due to the MOH January funding being paid in advance in December.

<table>
<thead>
<tr>
<th>Cash Reconciliation</th>
<th>Year to date $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash at June 2016</td>
<td>28,875</td>
</tr>
<tr>
<td>Surplus / (Deficit) to date</td>
<td>2,222</td>
</tr>
<tr>
<td>Depreciation</td>
<td>14,424</td>
</tr>
<tr>
<td>Sale of fixed assets</td>
<td>122</td>
</tr>
<tr>
<td>Working capital movement</td>
<td>3,481</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>(13,222)</td>
</tr>
<tr>
<td>Term investment</td>
<td>95</td>
</tr>
<tr>
<td>Loan repayment</td>
<td>(277)</td>
</tr>
<tr>
<td>Trusts movement</td>
<td>-</td>
</tr>
<tr>
<td>Equity repayment</td>
<td>-</td>
</tr>
<tr>
<td>Cash Balance at month end</td>
<td>35,720</td>
</tr>
</tbody>
</table>

5.2.4 Treasury Policy and Ratios

Performance and compliance with Treasury Policy parameters was as set out below.

<table>
<thead>
<tr>
<th>May-17</th>
<th>Actual</th>
<th>Policy / target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy compliance requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity risks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term deposits</td>
<td>$16.5m</td>
<td>$16.5m</td>
</tr>
<tr>
<td>Short term borrowings</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Interest rate risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate</td>
<td>Fixed</td>
<td>Fixed</td>
</tr>
<tr>
<td>Rate re-setting any 1 year</td>
<td>26%</td>
<td>&lt; 30%</td>
</tr>
<tr>
<td>Foreign exchange risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital expenditure hedged</td>
<td>None</td>
<td>Conditional</td>
</tr>
<tr>
<td>Operational expenditure hedged over $50k pm</td>
<td>None</td>
<td>Conditional</td>
</tr>
<tr>
<td>Counterparty credit risk exposure</td>
<td>None</td>
<td>&lt; $10.0m</td>
</tr>
</tbody>
</table>
### 5.3 Capital Expenditure

Capital expenditure in the year to date is summarised in the table below:

<table>
<thead>
<tr>
<th>Strategic Projects</th>
<th>Proposed</th>
<th>Approved</th>
<th>Total</th>
<th>Spend</th>
<th>Total</th>
<th>Reconciliation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior Years</td>
<td>YTD</td>
<td>Total</td>
<td>Mth YTD</td>
<td>6/6/17</td>
<td>Remainder</td>
</tr>
<tr>
<td>PH Hospital Reconfiguration</td>
<td>500</td>
<td>12</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>400</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>1,670</td>
<td>37</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>2,924</strong></td>
<td><strong>2,113</strong></td>
<td><strong>2,087</strong></td>
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<th>Total</th>
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<td>1,175</td>
<td>162</td>
<td>908</td>
<td>1,082</td>
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<td>1,175</td>
<td>1,175</td>
<td>162</td>
<td>908</td>
<td>1,082</td>
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<td>161</td>
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<td><strong>Total</strong></td>
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<td><strong>1,801</strong></td>
<td><strong>4,307</strong></td>
<td><strong>6,643</strong></td>
<td><strong>4,002</strong></td>
<td><strong>582</strong></td>
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<th>Spend</th>
<th>Total</th>
<th>Reconciliation</th>
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<td>239</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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There were no additions or substitutions of items over $250k to the Capital Expenditure Programme for the month.

**Appendices:**

A. **Consolidated Statement of Financial Performance**

B. **Financial Performance by Division**

C. **Consolidated Statement of Financial Position**

D. **Consolidated Statement of Cash Flows**
## Appendix A

### MidCentral District Health Board
Consolidated Statement of Financial Performance

### May-17 Actual Budget Variance

<table>
<thead>
<tr>
<th>Monthly Result</th>
<th>Actual $000</th>
<th>Budget $000</th>
<th>Variance $000</th>
<th>%</th>
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<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Govt. &amp; Crown Agency</td>
<td>51,022</td>
<td>50,977</td>
<td>45</td>
<td>0%</td>
</tr>
<tr>
<td>Patient/Consumer Sourced</td>
<td>80</td>
<td>51</td>
<td>29</td>
<td>56%</td>
</tr>
<tr>
<td>Other Income</td>
<td>948</td>
<td>924</td>
<td>24</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>52,051</strong></td>
<td><strong>51,952</strong></td>
<td><strong>98</strong></td>
<td>0%</td>
</tr>
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<td><strong>Expenditure</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>18,260</td>
<td>18,022</td>
<td>(238)</td>
<td>(1%)</td>
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<tr>
<td>Outsourced Personnel</td>
<td>611</td>
<td>113</td>
<td>(498)</td>
<td>(442%)</td>
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<tr>
<td>Sub-total Personnel</td>
<td><strong>18,870</strong></td>
<td><strong>18,134</strong></td>
<td>(736)</td>
<td>(4%)</td>
</tr>
<tr>
<td>Other Outsourced Services</td>
<td>1,924</td>
<td>1,900</td>
<td>(24)</td>
<td>(1%)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>5,072</td>
<td>4,578</td>
<td>(494)</td>
<td>(11%)</td>
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<tr>
<td>Infrastructure &amp; Non-Clinical</td>
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<td>7,043</td>
<td>(98)</td>
<td>(1%)</td>
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<tr>
<td>Provider Payments</td>
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<td>21,819</td>
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<td>4%</td>
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<td><strong>Total Expenditure</strong></td>
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<td><strong>404</strong></td>
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<tr>
<td><strong>Operating Surplus/(Deficit)</strong></td>
<td><strong>(1,828)</strong></td>
<td><strong>(1,522)</strong></td>
<td><strong>(306)</strong></td>
<td>20%</td>
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### May-17 Year to Date

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<tr>
<th>Year to Date</th>
<th>Actual $000</th>
<th>Budget $000</th>
<th>Variance $000</th>
<th>%</th>
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<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Govt. &amp; Crown Agency</td>
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<td>557,199</td>
<td>5,807</td>
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<tr>
<td>Patient/Consumer Sourced</td>
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<td>10,565</td>
<td>515</td>
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<tr>
<td><strong>Total Revenue</strong></td>
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<td><strong>568,311</strong></td>
<td><strong>6,261</strong></td>
<td>1%</td>
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<td><strong>Expenditure</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
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<td>188,309</td>
<td>(1,214)</td>
<td>(1%)</td>
</tr>
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<td>Outsourced Personnel</td>
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<td>(328%)</td>
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<tr>
<td>Sub-total Personnel</td>
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<td>Other Outsourced Services</td>
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<td>Clinical Supplies</td>
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<td>47,104</td>
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<td>76,957</td>
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<td>(1%)</td>
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<tr>
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<td>233,723</td>
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<td>1%</td>
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<td><strong>566,655</strong></td>
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<tr>
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<td><strong>1,656</strong></td>
<td><strong>565</strong></td>
<td>34%</td>
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### Appendix B

#### MidCentral District Health Board

#### Financial Performance by Division

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<th>Revenues</th>
<th>DHB Provider</th>
<th>Enable</th>
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<th>Funder</th>
<th>Variances</th>
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<td>Actual</td>
<td>Budget</td>
<td>Actual</td>
<td>Budget</td>
<td>Actual</td>
</tr>
<tr>
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<td>28,144</td>
<td>27,166</td>
<td>21,102</td>
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<th>Staff</th>
<th>Outsourced Services</th>
<th>Clinical Supplies</th>
<th>Infrastructure &amp; Non-clinical Expenses</th>
<th>Recharges</th>
<th>Total Expenditure</th>
<th>DHB Provider</th>
<th>Enable</th>
<th>Governance</th>
<th>Funder</th>
<th>Variances</th>
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<td>Actual</td>
<td>Budget</td>
<td>Actual</td>
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<td>Actual</td>
<td>Budget</td>
<td>Actual</td>
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<td>Actual</td>
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<td>57</td>
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<td>931</td>
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<td>(14.3%)</td>
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<td>(13)</td>
<td>(0.7%)</td>
<td>8</td>
<td>-</td>
<td>(8)</td>
<td></td>
<td></td>
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<tr>
<td>Clinical Supplies</td>
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<td>4,571</td>
<td>(513)</td>
<td>(10.8%)</td>
<td>5</td>
<td>4</td>
<td>(1)</td>
<td>(20.0%)</td>
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<td>1,625</td>
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<td>-</td>
<td>-</td>
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<td>(30.3%)</td>
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<td>0.0%</td>
<td>50</td>
<td>50</td>
<td>-</td>
<td>0.0%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>29,576</td>
<td>28,530</td>
<td>(1,046)</td>
<td>(3.7%)</td>
<td>3,049</td>
<td>2,339</td>
<td>(710)</td>
<td>(30.3%)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Surplus/Deficit</strong></td>
<td>(935)</td>
<td>133</td>
<td>(1,069)</td>
<td>(25)</td>
<td>(50)</td>
<td>(25)</td>
<td>(15)</td>
<td>(833)</td>
<td>1,586</td>
<td>753</td>
<td>(1,828)</td>
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</table>
### REVENUE

<table>
<thead>
<tr>
<th>Provider</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government &amp; Crown Agency</td>
<td>290,774</td>
<td>293,827</td>
<td>(3,053)</td>
</tr>
<tr>
<td>Actual</td>
<td>29,161</td>
<td>23,120</td>
<td>6,041</td>
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<td>5,340</td>
<td>5,472</td>
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<td>293,827</td>
<td>290,774</td>
<td>3,053</td>
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<tr>
<td>Patient / Consumer Sourced</td>
<td>486</td>
<td>547</td>
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<td>-</td>
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</tr>
<tr>
<td>Budget</td>
<td>-</td>
<td>-</td>
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<td>Variance (11.1%)</td>
<td>547</td>
<td>486</td>
<td>61</td>
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<tr>
<td>Other Income</td>
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<td>2,212</td>
<td>892</td>
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<tr>
<td>Variance (8.2%)</td>
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<td>4,676</td>
<td>420</td>
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<tr>
<td>TOTAL REVENUE</td>
<td>295,936</td>
<td>299,470</td>
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<td>32,266</td>
<td>25,332</td>
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<td>8,728</td>
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<tr>
<td>Variance (0.4%)</td>
<td>299,470</td>
<td>295,936</td>
<td>3,534</td>
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### EXPENDITURE

<table>
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<tr>
<th>Staff</th>
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<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff</td>
<td>58,921</td>
<td>57,314</td>
<td>(1,608)</td>
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<td>-</td>
<td>-</td>
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<td>475</td>
<td>399</td>
<td>(76)</td>
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<td>Variance (2.8%)</td>
<td>57,314</td>
<td>58,921</td>
<td>1,608</td>
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<td>Nursing Staff</td>
<td>73,970</td>
<td>72,204</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Budget</td>
<td>406</td>
<td>406</td>
<td>0.0%</td>
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<tr>
<td>Variance (2.4%)</td>
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<td>73,970</td>
<td>1,767</td>
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<td>Allied Health Staff</td>
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<td>25,934</td>
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<tr>
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<td>1,091</td>
<td>19</td>
</tr>
<tr>
<td>Budget</td>
<td>406</td>
<td>406</td>
<td>0.0%</td>
</tr>
<tr>
<td>Variance (4.2%)</td>
<td>25,934</td>
<td>24,850</td>
<td>1,084</td>
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<tr>
<td>Support Staff</td>
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<td>1,306</td>
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<td>1,245</td>
<td>1,306</td>
<td>(61)</td>
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<tr>
<td>Budget</td>
<td>1,245</td>
<td>1,306</td>
<td>(61)</td>
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<tr>
<td>Variance (4.2%)</td>
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<td>Management &amp; Admin Staff</td>
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<td>15,186</td>
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<td>245</td>
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<tr>
<td>Variance (0.7%)</td>
<td>15,186</td>
<td>15,083</td>
<td>103</td>
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<tr>
<td>Outsourced Staff</td>
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<td>971</td>
<td>(3,058)</td>
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<td>Actual</td>
<td>189</td>
<td>6</td>
<td>(183)</td>
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<td>Budget</td>
<td>820</td>
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<td>Variance (407.6%)</td>
<td>971</td>
<td>4,029</td>
<td>3,058</td>
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<td>Total Staff</td>
<td>179,099</td>
<td>172,914</td>
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<td>6,835</td>
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<td>Budget</td>
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<td>9,000</td>
<td>388</td>
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<tr>
<td>Variance (3.6%)</td>
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<td>179,099</td>
<td>6,185</td>
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<td>Outourced Services</td>
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<td>18,201</td>
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<tr>
<td>Budget</td>
<td>998</td>
<td>1,021</td>
<td>23</td>
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<td>Variance (2.2%)</td>
<td>18,201</td>
<td>18,602</td>
<td>401</td>
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<td>Clinical Supplies</td>
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<td>53</td>
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<td>Budget</td>
<td>42</td>
<td>22</td>
<td>(21)</td>
</tr>
<tr>
<td>Variance (2.1%)</td>
<td>47,029</td>
<td>47,846</td>
<td>817</td>
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<tr>
<td>Infrastructure &amp; non-clinical expenses</td>
<td>50,957</td>
<td>54,790</td>
<td>3,833</td>
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<td>4,476</td>
<td>1,633</td>
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<tr>
<td>Variance (7.0%)</td>
<td>54,790</td>
<td>50,957</td>
<td>3,833</td>
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<tr>
<td>Internal Providers</td>
<td>-</td>
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<td>-</td>
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</tr>
<tr>
<td>Budget</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Variance (0.0%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>External Providers</td>
<td>-</td>
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<tr>
<td>Personal Health</td>
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<tr>
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</tr>
<tr>
<td>Budget</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Variance (0.0%)</td>
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<td>Mental Health</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Budget</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Variance (0.0%)</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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</tr>
<tr>
<td>Budget</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Variance (0.0%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>DHB</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>DHB</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>DHB</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total External Providers</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Actual</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Budget</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Variance (0.0%)</td>
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<td>-</td>
<td>-</td>
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<td>Recharges</td>
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<td>550</td>
<td>550</td>
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<tr>
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<td>6,757</td>
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<tr>
<td>Variance (0.0%)</td>
<td>6,207</td>
<td>6,207</td>
<td>0.0%</td>
</tr>
<tr>
<td>TOTAL EXPENDITURE</td>
<td>302,712</td>
<td>299,141</td>
<td>(3,571)</td>
</tr>
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<td>Actual</td>
<td>31,764</td>
<td>25,134</td>
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<td>6,507</td>
<td>8,862</td>
<td>2,155</td>
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<td>Variance (28.4%)</td>
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<td>302,712</td>
<td>3,571</td>
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<td>SURPLUS / (DEFICIT)</td>
<td>(6,756)</td>
<td>330</td>
<td>(7,086)</td>
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<td>502</td>
<td>198</td>
<td>304</td>
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<tr>
<td>Budget</td>
<td>2,102</td>
<td>66</td>
<td>2,036</td>
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<tr>
<td>Variance (24.9%)</td>
<td>302,712</td>
<td>302,712</td>
<td>0.0%</td>
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</table>
## Appendix C

**MidCentral District Health Board**  
**Consolidated Statement of Financial Position**

<table>
<thead>
<tr>
<th></th>
<th>Jun-15 $000</th>
<th>Jun-16 $000</th>
<th>May-17 $000</th>
<th>Change $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Current Assets</td>
<td>195,986</td>
<td>214,989</td>
<td>213,663</td>
<td>(1,326)</td>
</tr>
<tr>
<td>Total Fixed Assets (refer to note)</td>
<td>194,838</td>
<td>197,273</td>
<td>195,947</td>
<td>(1,326)</td>
</tr>
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<td>Term Investments</td>
<td>0</td>
<td>16,500</td>
<td>16,500</td>
<td>0</td>
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<tr>
<td>Investments</td>
<td>1,148</td>
<td>1,216</td>
<td>1,216</td>
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<td><strong>Current Assets</strong></td>
<td>81,722</td>
<td>57,148</td>
<td>65,014</td>
<td>7,866</td>
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<td>Bank/Cash (DHB)</td>
<td>51,564</td>
<td>24,710</td>
<td>32,456</td>
<td>7,746</td>
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<tr>
<td>Investments &lt; 3 months (Enable)</td>
<td>1,320</td>
<td>1,270</td>
<td>200</td>
<td>(1,070)</td>
</tr>
<tr>
<td>Investments &lt; 3 months (Trusts)</td>
<td>746</td>
<td>895</td>
<td>1,064</td>
<td>169</td>
</tr>
<tr>
<td>Investments &gt; 3 months (Trusts)</td>
<td>2,000</td>
<td>2,000</td>
<td>2,000</td>
<td>0</td>
</tr>
<tr>
<td>Other Current Assets</td>
<td>26,092</td>
<td>28,273</td>
<td>29,294</td>
<td>1,021</td>
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<tr>
<td><strong>Total Assets</strong></td>
<td>277,708</td>
<td>272,137</td>
<td>278,677</td>
<td>6,540</td>
</tr>
<tr>
<td><strong>TOTAL EQUITY AND LIABILITIES</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Equity</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share Capital</td>
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<td>62,815</td>
<td>119,515</td>
<td>56,700</td>
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<td>88,220</td>
<td>88,220</td>
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<tr>
<td>Trust and Special Funds</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Retained Earnings</td>
<td>(6,661)</td>
<td>(8,939)</td>
<td>(6,718)</td>
<td>2,221</td>
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<tr>
<td><strong>Non Current Liabilities</strong></td>
<td>61,344</td>
<td>61,622</td>
<td>5,084</td>
<td>(56,538)</td>
</tr>
<tr>
<td>Term Loans</td>
<td>57,227</td>
<td>57,409</td>
<td>708</td>
<td>(56,701)</td>
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<tr>
<td>Long Term Liabilities</td>
<td>4,117</td>
<td>4,213</td>
<td>4,376</td>
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<tr>
<td><strong>Current Liabilities</strong></td>
<td>71,357</td>
<td>68,419</td>
<td>72,576</td>
<td>4,157</td>
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<td>Capital Charge</td>
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<td>0</td>
<td>3,493</td>
<td>3,493</td>
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<tr>
<td>Employee Benefits</td>
<td>24,867</td>
<td>24,952</td>
<td>24,325</td>
<td>(627)</td>
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<tr>
<td>GST</td>
<td>1,845</td>
<td>2,388</td>
<td>2,550</td>
<td>162</td>
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<tr>
<td>Other Current Liabilities</td>
<td>44,645</td>
<td>41,079</td>
<td>42,208</td>
<td>1,129</td>
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<td><strong>Total Equity and Liabilities</strong></td>
<td>277,708</td>
<td>272,137</td>
<td>278,677</td>
<td>6,540</td>
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</tbody>
</table>

**Note:**

<table>
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<tr>
<th></th>
<th>Jun-15 $000</th>
<th>Jun-16 $000</th>
<th>May-17 $000</th>
<th>Change $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>9,055</td>
<td>9,055</td>
<td>9,055</td>
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<td>Buildings (including fitout)</td>
<td>133,192</td>
<td>132,991</td>
<td>128,426</td>
<td>(4,565)</td>
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<td>Plant &amp; Equipment</td>
<td>42,244</td>
<td>45,049</td>
<td>47,270</td>
<td>2,221</td>
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<tr>
<td>Work in Progress</td>
<td>10,347</td>
<td>10,178</td>
<td>11,196</td>
<td>1,018</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>194,838</td>
<td>197,273</td>
<td>195,947</td>
<td>(1,326)</td>
</tr>
</tbody>
</table>
## Appendix D

### MidCentral District Health Board

#### Consolidated Statement of Cash Flows

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<tr>
<th>May-17 ($'000's)</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash From Operating</td>
<td>Actual</td>
<td>Actual</td>
<td>Actual</td>
<td>Forecast</td>
<td>Forecast</td>
</tr>
<tr>
<td>(3,262)</td>
<td>13,339</td>
<td>1,408</td>
<td>12,269</td>
<td>23,754</td>
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</tr>
<tr>
<td>Cash from Investing</td>
<td>(2,329)</td>
<td>(3,261)</td>
<td>(2,941)</td>
<td>(10,280)</td>
<td>(18,811)</td>
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<tr>
<td>Cash from Financing</td>
<td>(713)</td>
<td>(713)</td>
<td>(71)</td>
<td>(8,573)</td>
<td>(10,070)</td>
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<tr>
<td>Increase (Decrease) in Cash Held</td>
<td>(6,304)</td>
<td>9,365</td>
<td>(1,604)</td>
<td>(6,584)</td>
<td>(5,127)</td>
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<tr>
<td>Add Opening Cash Balance</td>
<td>28,881</td>
<td>22,577</td>
<td>31,942</td>
<td>30,338</td>
<td>28,881</td>
</tr>
<tr>
<td><strong>Closing Cash Balance</strong></td>
<td><strong>22,577</strong></td>
<td><strong>31,942</strong></td>
<td><strong>30,338</strong></td>
<td><strong>23,754</strong></td>
<td><strong>23,754</strong></td>
</tr>
</tbody>
</table>

The $16.5m placed on term deposit is excluded in the Closing Cash Balance.
RECOMMENDATION

It is recommended:

- that the Board Chair and Deputy Board Chair be authorised to sign the Letter of Representation in respect of the year-end financial return to the Ministry of Health.

Strategic Alignment

This report is aligned to the DHB’s strategy and key enabler "stewardship" as it covers an area of effective governance.

Glossary

DHB    District Health Board
MDHB   MidCentral District Health Board
MOH    Ministry of Health
1. PURPOSE

To seek the Board’s approval for the Board Chair and Deputy Board Chair to be authorised to sign the letter of representation in respect of the year-end financial return to the Ministry of Health.

2. SUMMARY

The year-end audit process for 2016/17 will be the same as in previous years. A draft financial return for the year will be submitted in July and an audited financial return will be submitted in early August to the Ministry of Health. The external auditors, Deloitte, will be undertaking the audit on site for the two weeks commencing 24 July.

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 August 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 has not yet been received from the National Health Board, but expectations are that it will be similar to last year’s which is attached.

The letter requires the signature of the Board Chair, one other Board member, the Chief Executive Officer and the Chief Financial Officer. Approval is sought for the Board Chair and the Deputy Board Chair 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 then review the annual accounts of the DHB, and these will be presented to the Board in September as part of the annual report. There will also be a letter of representation relating to the annual accounts which will be included in the September agenda papers.

3. RECOMMENDATION

It is recommended:

that the Board Chair and Deputy Board Chair be authorised to sign the Letter of Representation in respect of the year-end financial return to the Ministry of Health.

Neil Wanden
General Manager, Finance & Corporate Services
12 August 2016

Melissa Youngson  
Partner  
Deloitte  
PO Box 17  
HAMILTON  

Chai Chuah  
Director-General of Health  
Ministry of Health  
PO Box 5013  
WELLINGTON

Dear Melissa and Chai

Letter of Representation for the year ended 30 June 2016 – 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 2016 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 2015;
   - 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 2016 is a deficit of $2,278k.

b. Consolidated total Crown Equity as at 30 June 2016 is $142,097k.

c. The schedules contain information that accurately reflects our financial activities and cashflows during the period 1 July 2015 to 30 June 2016. Where the date of the information supplied differs from 30 June 2016, there were no significant movements in our net equity position up to 30 June 2016 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 2016 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 2016.

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 NZ IFRS 4 Insurance Contracts and PBE NZ IAS 19 Employee Benefits.

j. There have been no material events subsequent to 30 June 2016 that should be reported in the financial statements.

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 2016.
I. 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 2016.

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
12 August 2016

Kate Joblin
Board Member
12 August 2016

Kathryn Cook
Chief Executive Officer
12 August 2016

Phil Sunderland
Chairperson
12 August 2016
For:

| Decision | Endorsement | Noting |

To Board

Author Anne Amoore, Manager HROD

Endorsed by CEO

Date 18 June 2017

Subject Six Monthly Workforce Update

RECOMMENDATION
It is recommended that:
- the June 2017 workforce update be noted.

Strategic Alignment
This report aligns to MidCentral District Health Board’s Strategy, and to our Organisational Development Plan which is one of the five key enablers to support the achievement of our strategic imperatives.

Glossary
MDHB – MidCentral District Health Board
DHB – District Health Board
FTE – Full time Equivalent
ODP – Organisational Development Plan
RMO – Resident Medical Officer
SMO – Senior Medical Officer
1. **PURPOSE**

This report provides the six monthly update to the Board on our workforce measures as at 31 March 2017.

It is provided for the Board’s information and discussion. No decision is sought.

2. **SUMMARY**

Key workforce measures are monitored monthly, and reported to the Board six monthly. MDHB now has access to an improved workforce reporting tool, developed nationally to support DHBs to effectively monitor and take action in relation to key workforce measures. As the data provided for each quarter builds over time this will enable a comparison of the current quarter compared with historical data. This comparative information provided will also assist in our workforce planning and development, both locally, regionally and nationally.

Since the last report to the Board in January 2017 of particular note is the following:

- The overall growth in MDHB’s staffing numbers over the last five years is down from the previous 8 percent increase for the five years to 30 September 2016 to a 7.5 percent increase for the five years to 31 March 2017.
- Our annual turnover rate has decreased from 8.9 percent to 8.5 percent.
- Our average sick leave has reduced from 4.3 percent to 3.1 percent, however, remains above the national sick leave average of 2.9 percent. Nursing sick leave is 4.2 percent for the previous six months, above the nursing national average of 3.3 percent. The Acting Executive Director Nursing and Midwifery is leading work around identifying areas where sick leave is high to understand the reasons for this and take action as appropriate, for example, putting in place specific wellness initiatives targeted to specific areas.
- Reducing our annual leave balances continues to be a challenge. While our overall average annual leave balances have reduced from the previous average of 178.3 hours per staff member to 169 hours, this remains above the national average of 164.4 hours.
- Our accrued annual leave balances over two years entitlement have reduced from 13.7 percent to 12.4 percent, but remain high compared with the national average of 6.4 percent. Our balances are reducing slowly, down from a previous level of 15.9 percent in the 2015 year. This continues to be a key area of focus, acknowledging that it is taking longer than expected.

Our ODP contains actions to respond to the issues identified above, for example, reviewing our existing wellness and wellbeing programmes and developing enhanced tools for planning, resourcing and managing annual leave absences.
3. **KEY WORKFORCE STATISTICS**

The graphs and tables in this section of the report are intended to provide the Board with an overview of the general status of our workforce. The data used in this report is at March 2017.

3.1 **A glance at our Workforce:**

The following graphic provides a quick overview of key workforce measures, including percentage change over the last six months. The data excludes our casual workforce.

The following is data for the quarter finishing March 2017, and compares to data 6 months ago:

<table>
<thead>
<tr>
<th>Headcount</th>
<th>Contracted FTE</th>
<th>Mean FTE (average full-time status)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,484</td>
<td>2,125.1</td>
<td>0.86</td>
</tr>
<tr>
<td>% change compared to 6 months ago</td>
<td>% change compared to 6 months ago</td>
<td>% change compared to 6 months ago</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean Age (years)</th>
<th>% Over 55 years</th>
<th>% Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>47.0</td>
<td>32.1%</td>
<td>79.4%</td>
</tr>
<tr>
<td>% change compared to 6 months ago</td>
<td>% change compared to 6 months ago</td>
<td>% change compared to 6 months ago</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean Length of Service (years)</th>
<th>Annual turnover rate</th>
<th>Mean % sick Leave Hours (per FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>8.5%</td>
<td>3.1%</td>
</tr>
<tr>
<td>% change compared to 6 months ago</td>
<td>% change compared to 6 months ago</td>
<td>% change compared to 6 months ago</td>
</tr>
</tbody>
</table>

The graph below shows the professional make-up of our workforce:
Our staffing numbers within each professional group have moved over the past five years as follows. A comparison showing the movement within MDHB compared with the average movement across other medium sized DHBs is also given:

### Staffing Numbers Over The Past Five Years

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>MDHB’s Growth</th>
<th>Medium Sized DHB’s Average Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Medical</td>
<td>18.7%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Senior Medical</td>
<td>19.5%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Nursing</td>
<td>10.6%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Corporate &amp; Other</td>
<td>1.7%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Allied &amp; Scientific</td>
<td>1.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Care &amp; Support*</td>
<td>2.2%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Midwifery</td>
<td>16.3%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

*Note: Care and support grouping includes: Community Workers, Counsellors, Dental Assistants, Drug & Alcohol Counsellors/Practitioners, Child & Family Therapists/Advisors, Cultural Support Workers, Health Promotion Officers, Kaiwhina (Hauora) (Maori Health), Care Assistants/Hospital Aides/Ward Support, Recreation/Welfare Officers.

Over the past six months our staffing numbers within each professional group have moved as follows. A comparison showing the movement within MDHB compared with the average movement across other medium sized DHBs is also given:

### Staffing Numbers – Six Monthly Growth

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>MDHB’s Six Monthly Growth</th>
<th>Medium Sized DHB’s Six Monthly Average Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Medical</td>
<td>4.6%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Senior Medical</td>
<td>5.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Nursing</td>
<td>-0.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Corporate &amp; Other</td>
<td>No Change</td>
<td>2.4%</td>
</tr>
<tr>
<td>Allied &amp; Scientific</td>
<td>0.3%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Care &amp; Support*</td>
<td>-1.8%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Midwifery</td>
<td>3.5%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

*Note: Care and support grouping includes: Community Workers, Counsellors, Dental Assistants, Drug & Alcohol Counsellors/Practitioners, Child & Family Therapists/Advisors, Cultural Support Workers, Health Promotion Officers, Kaiwhina (Hauora) (Maori Health), Care Assistants/Hospital Aides/Ward Support, Recreation/Welfare Officers.
4.0 **KEY WORKFORCE MEASURES**

The Traffic Light System used below is to highlight areas that are not tracking as expected against established goals or where MDHB is performing poorly when compared with other DHBs.

**Lights** - **Green**: Performing Well | **Amber**: Within similar sized DHB’s | **Red**: Performing Below Expectations or Room for Improvement.

**Arrows** signify how the measure has changed over the last six months – trended up, trended down, or remained constant. An upward trend can be either positive or negative depending on the measure. **Green** has been used to signify a positive trend | **Red** to signify a negative trend to assist with interpretation.

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Six Months to 31-Mar-17</th>
<th>Previous Six Months</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td></td>
<td>2125.1</td>
<td>2115.4</td>
<td>9.7 FTE</td>
</tr>
</tbody>
</table>

MDHB staffing levels have been steadily increasing, with cumulative growth over the past five years to 31 March 2017 being 7.5 percent, down from the previous five years growth to 30 September 2016 which was 8.02 percent. The national DHB average cumulative growth was 9.9 percent over the past five years.

Over the past six months MDHB’s FTEs have increased by 9.7 FTEs (0.45 percent), with the biggest increase being in SMOs (5 percent) and RMOs (4.6 percent). Nursing FTEs have decreased slightly down 0.4 percent.

Over the past five years the most significant cumulative growth has been in Senior Medical Officers (19.5 percent), Resident Medical Officers (18.7 percent), Midwifery (16.3 percent), Nursing (10.6 percent). Allied Health has had a small increase of 1.5 percent, and Corporate 1.7 percent.
### Ethnicity

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Six Months to 31-Mar-17</th>
<th>Previous Six Months</th>
<th>National Average Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori</td>
<td></td>
<td>173</td>
<td>170</td>
<td>4.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1.8% increase)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td></td>
<td>26</td>
<td>25</td>
<td>3.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4% increase)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>235</td>
<td>218</td>
<td>4.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7.8% increase)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We had seen a steady increase in the proportion of Maori, Pacific and Asian staff over the past five years. Over the past six months, those affiliated with Maori and Pacific has increased slightly up by 1.8 percent. Asian numbers have increased by 7.8 percent with the biggest increase being within Nursing and Allied and Scientific (8 FTE respectively). While this increase is positive there is further work required to more closely match our ethnicity profile with that of the community and our ODP has initiatives to address this.

### Recruitment

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Our vacancy levels have increased over the past six months, but remain at low levels for most occupational groups, up from an average of 53 FTEs per month to 56.47 FTEs. We do not have difficulty recruiting to most vacancies.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Vacancies in Nursing have increased slightly from 2.57 percent to 2.7 percent, RMOs have decreased from 4.3 percent to .89 percent with minimal vacancies over the past six months. SMO vacancies have increased from 8 percent to 11.92 percent, however, are tracking downwards. Allied Health vacancies have increased from 2.85 percent to 3.76 percent, however vacancies are reducing. Physiotherapy and Occupational Therapy vacancies are high and recruitment initiatives continue.</td>
</tr>
</tbody>
</table>
### Turnover - Retention

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Six Months to 31-Mar-17</th>
<th>Previous Six Months</th>
<th>National DHB Average</th>
<th>Medium Sized DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Turnover</td>
<td></td>
<td>8.5%</td>
<td>8.9%</td>
<td>10.9%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

Our annualised turnover rate has decreased over the past six months which is a positive result. Over the past five years MDHB has consistently been below the national average and average for medium sized DHBs which is reflected in the figures noted above.

Turnover for each occupational group is as follows:
- Nursing 7.8 percent
- Corporate 9.2 percent
- Allied and Scientific 10.6 percent
- Care and Support 7.5 percent
- Senior Medical Officers 7.9 percent
- Residential Medical Officers No Change
- Midwifery 8.7 percent

### Sick Leave

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Six Months to 31-Mar-17</th>
<th>Previous Six Months</th>
<th>National DHB Average</th>
<th>Medium Sized DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick Leave Movement</td>
<td></td>
<td>3.1%</td>
<td>4.3%</td>
<td>2.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Lost Time Injury</td>
<td></td>
<td>4.8%</td>
<td>2.8%</td>
<td>8.8%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

MDHB’s sick leave rate has decreased overall by 1.2 percent, and by 27.9 percent when looking at actual sick leave hours paid. While this is a positive result, MDHB is tracking above the national and medium sized DHB average.

Sick leave is tracking as follows for each occupational group:
- Nursing 4.2 percent (average for all DHBs is 3.3%)
- Corporate 2.3 percent
- Allied and Scientific 2.7 percent
- Care and Support 4.2 percent
- Senior Medical Officers 0.5 percent
- Residential Medical Officers 1.4 percent
- Midwifery 2.9 percent

The Acting Executive Director Nursing and Midwifery is leading work around identifying areas where sick leave is high within our nursing workforce to understand the reasons for this and take action as appropriate, for example, putting in place specific wellness initiatives targeted to specific areas.

MDHB’s lost time injury rate has increased up from
2.8 percent to 4.8 percent, but is significantly below the national and medium sized DHB average. While numbers of staff sustaining work related injuries are low, for a number of reasons the time taken for the staff member to return to work is taking longer.

<table>
<thead>
<tr>
<th>Annual Leave</th>
<th>Status</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Six Months to 31-Mar-17</td>
<td>Previous Six Months</td>
</tr>
<tr>
<td>Annual Leave Hours</td>
<td>169</td>
<td>178.3</td>
</tr>
<tr>
<td>Greater than 2 Years</td>
<td>12.4%</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

MDHB’s overall average annual leave hours per employee has reduced from 178.30 hours to 169 hours, however, it remains slightly higher than the national and the medium sized DHB average annual leave hours per employee.

12.4 percent of staff still have annual leave balances that are greater than two years. This is down from a previous six monthly level of 13.7 percent. While this is a positive result reducing our annual leave balances is taking more time than we had anticipated.

It is understood that there has been some discussion on whether the KPI measurement for annual leave has been reported correctly and consistently by all DHBs which can distort statistical analysis. It is hoped that now there is more robust data and quality reporting is being utilised, MDHB’s results will be more in line with the national average. Regardless, our focus remains on reducing our annual leave balances.

Using the figures we have available our greater than 2 years balances within our occupational groups as follows:

Nursing/Midwifery 16.7 percent | Corporate 7.0 percent | Allied and Scientific 7.1 percent | Care and Support 2.3 percent | Senior Medical Officers 26.3 percent | Residential Medical Officers .6 percent

Over the past six months to May 2017 our overall annual leave balances have reduced by 14253
hours and our over two years balances have reduced by 1717.5 hours

### Staff Overtime

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Six Months to 31-Mar-17</th>
<th>Previous Six Months</th>
<th>National DHB Average</th>
<th>Medium Sized DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>.4%</td>
<td>.4%</td>
<td>.9%</td>
<td>.7%</td>
</tr>
</tbody>
</table>

Over the past five years MDHB has consistently been below the overtime hours paid by other DHBs, and is the lowest of all DHBs due to careful management of overtime worked.

### Age Profile

<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Six Months to 31-Mar-17</th>
<th>Previous Six Months</th>
<th>National DHB Average</th>
<th>Medium Sized DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>47.0</td>
<td>46.9</td>
<td>45.9</td>
<td>47.6</td>
</tr>
</tbody>
</table>

Our average age has steadily increased over the past five years increasing from 45.2 to 46.4 for males and 46.1 to 47.0 for females. There has also been a steady and significant increase in the proportion of our staff aged 55 and over, which over the last five years has increased from 60.9 to 61.2. The average age for MDHB (47) is higher than the National DHB average (45.9) however, it is slightly less than the medium sized DHB average (47.6).

The average age for each occupational groups is as follows:

Nursing 45.7 years | Corporate 50.9 years | Allied and Scientific 44.8 years | Care and Support 55 years | Senior Medical Officers 51.3 years | Residential Medical Officers 30.1 years | Midwifery 49.2 years

Succession planning is a key element within our ODP to ensure MDHB has the required capability and capacity to respond appropriate to our ageing workforce.
<table>
<thead>
<tr>
<th>Status</th>
<th>Trend</th>
<th>Six Months to 31-Mar-17</th>
<th>Previous Six Months</th>
<th>National DHB Average</th>
<th>Medium Sized DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MDHB’s length of service has increased slightly over the past six months and is above the national and medium sized DHB average. Within each occupational groups the average is as follows:

- Nursing 11.3 years
- Corporate 10.1 years
- Allied and Scientific 9.3 years
- Care and Support 10.7 years
- Senior Medical Officers 10.8 years
- Residential Medical Officers 1.5 years
- Midwifery 9.1 years
**RECOMMENDATION**

- that this report be noted.

**Strategic Alignment**

This report aligns and is central to the delivery of the MidCentral District Health Board’s Strategy. A key part of this refreshed strategy is the focus on achieving a more integrated and inclusive health and social system that ensures individuals, patients, family/whānau and communities are at the centre of everything we do. The integrated services model will build on the successes the organisation has already achieved in driving efficiency across the continuum of care. There is now the opportunity to further evolve our approach towards a truly integrated health system across primary, community and specialist care.

**Glossary**

MidCentral DHB – MidCentral District Health Board
1. PURPOSE

This report provides the first update to the Board of the integrated services model (or Cluster Model) change plan and direction.

It is provided for the Board’s information and discussion. No decision is sought.

2. BACKGROUND

Following the announcement on 18 April of the final decision of the new leadership structure to support the integrated services model, planning towards this new model of care has begun.

Written feedback from the final decision document and corresponding discussions with staff indicate that the integrated services model is a logical next step for MidCentral DHB. There is a strong desire from staff to start planning for change, developing the conceptual design of the clusters, and an enthusiasm to have a say and get involved.

The integrated services model, incorporating six clusters to deliver the model, will build on the successes the organisation has already had in seeking to be more integrated and inclusive. In addition, MidCentral DHB will also consider a successful European integrated services model (SCIROCCO) as part of the implementation and has already been invited by SCIROCCO partners to understand and learn from their work to date.

3. THE IMPORTANCE OF CHANGE MANAGEMENT

Implementation of the integrated services model will require careful and considered planning. Any kind of change is carried out because it provides benefits to the organisation, that when realised, will see an improved return on investment compared to the status quo.

It is vital that at the forefront of this change that continuity of care is provided to patients and the community whilst the change journey is undertaken. It is expected that all staff involved in patient and community health provision are able to continue to do their jobs without disruption and that this there is no additional risk of compromising the quality and speed of patient care.

The change management plan will be proactive and forward-thinking in its approach to co-designing the integrated services model with staff (as well as health and social service providers, patients and the community) so that each person can successfully continue to carry out their core role AND have input into the design and planning process.
With a well-managed change plan, there is inevitable investment required in both time and cost, especially initially. This is represented in the diagram below which demonstrates an initial “dip”. For MidCentral DHB this includes time taken for staff to be involved in the design of the change and the integrated services model itself; backfilling of roles; and project resourcing. The “dip” does not include compromising quality and continuity of patient care.

![Proactive Change Implementation](source)

4. **KEY COMPONENTS OF THE CHANGE PLAN**

4.1 **Governance and oversight**

A draft governance framework has been developed to ensure:
- Monitoring and appropriate action when required of quality, time, and cost of the Programme
- Risk identification, mitigation and management
- Clear and appropriate accountability and responsibility for the design and implementation of the clusters
- Ability to make decisions at the right level including clearing “roadblocks”.

4.2 **Phased approach and “Phase Transition Gateways”**

Whilst a “maturity model” of integrated services is the ultimate destination for this change, it is proposed that a phased or stepped approach is adopted. This change journey is a relatively complex one, and will take time to implement a “maturity model” of integrated care.

The diagram below provides an initial overview of this phased approach. Each phase will require passing through a “phase transition gateway” which will include a set of pre-determined (and yet to be established) criteria. If these are met, then each cluster will transition to the next phase which in turn will have a change and transition plan with a corresponding “phase transition gateway”.
The dates including the maturity model realisation of 2022 will be clarified during the change journey. The date of 2022 is proposed at this stage because it gives sufficient time to implement a considered and well planned integrated services model as well as a short enough time to provide urgency in its implementation to realise the benefits to patients, the community, providers of care and staff.

4.3 Co-design

The integrated services model at this early stage is conceptual, and the MidCentral DHB has made a commitment to using a co-design approach to establish the specifics of the “maturity model” design. The co-design approach which is strongly incorporated into the change and transition plan will include staff, providers of care, and the community (including patients).

4.4 Appointment of Clinical and Operational Executive Roles

Effective and cohesive leadership is seen as being paramount to the success of the cluster model. The transition timeline following the release of the final decision document for the new structure allows for an executive stewardship structure to lead the implementation of the integrated services model from this early stage. Two critical stewardship roles are the Clinical Executive and the Operational Executive roles.

It is important that these roles are in place early on in the process of conceptual design for this work so they can have input in shaping the integrated services model from the start. Before the recruitment process takes place, a co-design process will be undertaken to develop and document the job description for each role.
4.5 Budget

Budget 2017/18 has a $400k provision for the implementation of the integrated services model and the transition plan for the new leadership roles to support the integrated services model structure. This also includes change management support.

To further support cost efficiencies during the integrated services model implementation, there will be continued focus on moving away from a complex and overly hierarchical leadership structure that impedes clinical decision making towards decision making closer to the clinicians who provide care. Empowering employees to have creative freedom and increased decision-making power will result in a more engaged and productive workforce. Increased empowerment of staff at the front line will in turn see a reduced requirement and therefore an anticipated reduction in middle manager roles. As a result it is expected that further cost efficiencies will eventuate as an outcome of this.

5. RECOMMENDATION

It is recommended:

that this report be noted.

Andrew Tripe
Programme Manager
Integrated Services Model
RECOMMENDATION
- that progress against the 2017/18 work programme be noted.

Strategic Alignment
This report is aligned to the DHB’s Strategy and key enabler, “Stewardship”. It discusses an aspect of effective governance.

Glossary
AGM – Annual General Meeting
ENZ – Enable New Zealand
FRAC – Finance, Risk & Audit Committee
HCAC – Healthy Communities Advisory Committee
MDHB – MidCentral
MoU – Memorandum of Understanding
TAS – Central Region’s Technical Advisory Service
EY – Ernst & Young
1. **PURPOSE**

This report updates members on the 2017/18 work programme and subsequently scheduled reports.

The report is for the Committee’s consideration and no decision is required.

2. **BACKGROUND**

Each year the Board establishes a reporting framework for the DHB’s governance function. This purpose of the framework is to ensure the Board and its Committees receive the reports they require to enable them to carry out their function effectively. From the framework, work programmes for the Board and each committee are developed.

The work programme sets out planned reporting points for routine reports and project updates. When events indicate a significant increase in risk within a project, that risk will be reported in an interim update.

The Board is advised of progress against the work programme, including any additions or variations to timing, each time it meets.

3. **2017/18 WORK PROGRAMME - BRIEF UPDATES**

As advised to the Board’s Quality & Excellence and Healthy Communities Advisory Committee, the development of business cases for the upgrade of Ward 21 and the establishment of a cardiac catheter laboratory is taking longer than anticipated. Accordingly, these have been deferred until September 2017.

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

The date of the six monthly board-to-board hui with Manawhenua Hauora has been rescheduled as requested by the Board at its last meeting. This is now to take place on: **Monday, 30 October 2017 at 11.30am** and will be held in MDHB’s board room.

4. **RECOMMENDATION**

It is recommended:

- that progress against the 2016/17 work be **noted**.

Kathryn Cook  
Chief Executive Officer
## APPENDIX A – BOARD’S 2017/18 WORK PROGRAMME

<table>
<thead>
<tr>
<th>Board of MDHB: Standing Items</th>
<th>Frqncy</th>
<th>Jul</th>
<th>Aug</th>
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<td><strong>Strategic &amp; Annual Planning</strong></td>
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### Board of MDHB: Standing Items

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<td>CEO's performance review</td>
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<td>Shareholding in Allied Laundry Services Ltd: annual update &amp; AGM</td>
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*Standard Items due in Out Years: MoU with Manawhenua Hauora (August 18); Board Members expense policy (July 19); Appointment to Board Committees policy (Feb 2020); external member appointments 2020-23 term (March 2020)*

### Other Matters Raised by Board and/or ELT

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<tr>
<th>Item</th>
<th>Raised</th>
<th>Scheduled</th>
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<td>Review of car parking fees and times (as part of annual planning process)</td>
<td>Board, April 2017</td>
<td>April/May 2018</td>
<td>Scheduled</td>
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<td>Review of overall car parking arrangements at Palmerston North Hospital</td>
<td>Board, April 2017</td>
<td>2020</td>
<td>Scheduled</td>
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<td>EY review – cost of review</td>
<td>Board, April 2017</td>
<td>July 2017</td>
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<td>EY review – how findings are to be advanced</td>
<td>Board, April 2017</td>
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<td>ENZ Strategic Direction and Governance Arrangements</td>
<td>Board, Nov 2016</td>
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<td>Master site plan – value of investment</td>
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</table>
| Author   | Lyn Horgan, Operations Director, Hospital Services  
John Manderson, Programme Manager, Business Improvement |
| Endorsed by | Chief Executive Officer                       |
| Date     | 19 June 2017                                    |
| Subject  | Emergency Department Triage Improvement Detailed Business Case Covering Memo |

**RECOMMENDATION**

It is recommended that

- the business case with a capital expenditure of $1,976,000 for the 2017/2018 financial year be **approved**

**Strategic Alignment**

This investment aligns with the DHB’s Strategic Framework of Quality and Excellence by Design by supporting our people in their efforts to accommodate patient and whanau needs quickly and effectively by providing facilities that are safe, compliant and meet operational needs.

**Glossary**

ACEM – Australasian College of Emergency Medicine  
BBC – Better Business Cases  
DHB – District Health Board  
ED – Emergency Department
FRAC – Finance, Risk and Audit Committee
HDC – Health & Disability Commissioner
IBC – Indicative Business Case
ICU – Intensive Care Unit
MCH – MidCentral Health
MDHB – MidCentral District Health Board
QEAC – Quality & Excellence Advisory Committee
RCTS – Regional Cancer Treatment Service
RMO – Resident Medical Officer
SMO – Senior Medical Officer
1. PURPOSE

The purpose of this paper is to seek Board approval to reconfigure the Emergency Department (ED) waiting room facilities at a capital cost of $1,976,000. The provision of a fit for purpose physical space will mitigate safety and compliance risks and support staff in their efforts to perform more focussed and private clinical assessments and improve patient streaming.

An indicative business case was endorsed by the Finance, Risk and Audit Committee (FRAC) and the Health Quality & Excellence Advisory Committee (QEAC) in March 2017 to go to market to confirm a preferred vendor with the final detailed business case to be submitted to the July 2017 Board meeting. This has been completed with a vendor chosen and the final costings now revised based on the tendered price. This is within the project budget envelope as provided to FRAC and QEAC.

2. EXECUTIVE SUMMARY

Increasing patient numbers presenting to the Palmerston North ED, coupled with a lack of dedicated triage space, mean the current facilities are often over-crowded, over-used and therefore do not support quality and safe clinical practice or operational needs.

Some specific risks indentified:

- The patient’s right to privacy is compromised because clinical triage activities are undertaken in the ED waiting room so patients are questioned and assessed in front of other patients waiting for service.
- The potential to withhold information due to lack of privacy means clinicians risk misdiagnosis of patient needs when they are not given all the required details of a patient’s medical background and condition.
- The public layout of the ED is unwelcoming to patients and impedes operational activities and efficient processes constraining the ability of staff to deliver clinical services safely and effectively.
- Australasian College of Emergency Medicine (ACEM) training programme accreditation for 12 month rotation is at risk if physical constraints are not addressed within the agreed timeframe.

Final ACEM Report, December 2016

A follow-up visit was undertaken by the ACEM Accreditation Board in August 2016 with their final report received 9 December 2016. The inspection team made the following recommendations:

5.2.1 The proposed redevelopment has not progressed, despite the best efforts of the senior ED department staff. The current state of the department is unsuitable for the safe practice of contemporary Emergency Medicine and poses significant risk to the organisation in terms of adverse patient outcomes.

5.2.2 If the planned development is not progressed as a matter of urgency, ACEM should consider removing accreditation as it is unfair to place its trainees in such an environment.
Recommended Solution

The recommended solution is to construct facilities that:

- Support focussed staff/patient interactions and patient privacy, so that adequate and appropriate assessment of patients is done when they arrive.
- Enable staff observation of patients while they are waiting to be seen by a clinician, which enhances patient safety.
- Contribute to patient flow and efficient clinical processes, e.g. streaming of patients by minor and major needs.
- Create a warm and welcoming environment that minimises patient and staff stress.

These outcomes will be provided by:

- Construction of safe and secure triage rooms that provide acoustic and visual privacy for initial patient assessments.
- A centralised, safe and open reception desk to create a single point of contact for patients and enable nurses to manage both self-presenting and ambulance patients.
- Creation of fit for purposes waiting areas that enable patient streaming and pre and post triage separation.
- Dedicated space for ambulance trolleys.
- Improving overall acoustic performance and heat management of the ED waiting area, including addressing wind exclusion issues.
- Creation of a private room for relatives of critical patients.
- Improvements to the minor works station and procedure room to improve patient flow.

As these changes need to be accommodated within the existing building footprint and capacity they will require the relocation of some existing services. The recommended design will consider the most efficient use of existing space and this will require the reconfiguration of areas not directly related to the ED waiting area and the patient flow process, such as existing medical staff offices.

Investment

The final capital investment is $1,780,148 + approximately 11% contingency of $195,852, totalling $1,976,000 for the 2017/2018 financial year.

There are no additional operational costs required from this investment other than depreciation ($74,000) which has been allowed for in the 2017/2018 budget.

Implementation

Subject to Board approval, a robust project governance, quality assurance and change management approach will be established with clear lines of accountability and responsibility to ensure successful delivery of the project on time, and within budget while meeting the needs of our people, patients and whanau.

This project will employ quality improvement methodologies to maximise the flow benefits for patients and staff through redevelopment of the physical space.
A preferred construction contractor has been sourced by a closed tender through the MidCentral District Health Board (MDHB) panel of approved suppliers. A comprehensive implementation plan will now be developed. It is expected this project will be completed by January 2018.

3. **RECOMMENDATION**

It is recommended

> that the business case with a capital expenditure of $1,976,000 for the 2017/2018 financial year be approved

Lyn Horgan  
**Operations Director**  
Hospital Services

John Manderson  
**Programme Manager**  
Business Improvement
Document Control

Document Information

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The following sections to be completed by the Project Manager for final Business Case for July 2017 consideration  
Section 6: Options analysis:  
Summary analysis: Total cost of ownership details required (duplicate details from Section 8.1)  
Section 8: Financial Case:  
Section 8.1: Total cost of ownership  
Section 8.2: Project costs  
Section 8.3: Funding |
| 2.1     | 19 June 2017 | Detailed business case included: financials and procurement process |

Document Review

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1 Executive Summary

The purpose of this paper is to seek Board approval to reconfigure the ED waiting room facilities at a capital cost of $1,976,000. The provision of a fit for purpose physical space will mitigate safety and compliance risks and support staff in their efforts to perform more focussed and private clinical assessments, and improve patient streaming.

An indicative business case was endorsed by the Finance, Risk and Audit Committee (FRAC) and the Health Quality & Excellence Advisory Committee (QEAC) in March 2017 to go to market to confirm a preferred vendor with the final detailed business case to be submitted to the July 2017 Board meeting. This has been completed with a vendor chosen and the final costings confirmed as estimated.

Key Project Drivers

Due to increased patient numbers presenting at the Emergency Department (ED) at MidCentral Health (MCH) the current waiting room arrangements are no longer fit for purpose. The current facilities are often over-crowded, over-used and do not support safe clinical practice or operational needs.

Clinical triage activities are currently undertaken in the ED waiting room. Patients are questioned and assessed in front of other patients waiting for service. This creates risks of MDHB not meeting its legislative obligations under The Health and Disability commissioners (HDC) Code of Health and Disability Service Consumers’ Rights Regulations 1996, The Privacy Act 1993 and The Health and Safety in Employment Act 2015.

Some specific risks are:

- The current layout of the facility does not support safe and effective clinical practice. Patients assessed in a context where their conversation is likely to be overheard are more likely to withhold information that may be pertinent to their assessment. Clinicians risk misdiagnosis of patient needs when they are not given all the required details of a patient’s medical background and condition.

- Because the layout of ED no longer supports safe systems of working MDHB is at risk of failing its primary duty of care under The Health and Safety in Employment Act 2015 (S.36). (Refer to Section 2.1.3: HSWA 2015 on page 8).

- The patient’s right to privacy is compromised. Clinicians are constrained in their abilities to prioritise patient needs in a crowded and busy physical environment, and have difficulties meeting their professional obligations under The Health and Disability Commissioners (HDC) Code of Health and Disability Services Consumers’ Rights Regulations 1996 and The Privacy Act 1993.

- The design of the waiting room and reception desk is unwelcoming. Patients who feel vulnerable, threatened and alienated by their physical environment are more likely to act aggressively toward staff and other patients.
- Staff morale: Facilities that impede operational activities and efficient processes constrain the ability of staff to deliver clinical services safely and effectively. This impacts staff engagement. Lack of engagement results in higher rates of unscheduled leave, higher staff turnover and difficulties attracting and recruiting suitably qualified people to MCH.

- The Australasian College of Emergency Medicine (ACEM) accreditation have extended the ED training programme at MCH from six months to a twelve month rotation. The College has indicated that this extension should be withdrawn if the physical constraints within ED are not addressed within the agreed timeframe. Lack of ACEM accreditation for a twelve month training programme will greatly reduce the attractiveness of MCH as a place to work and the ability of MCH to attract and retain Resident Medical Officers (RMOs) and Senior Medical Officers (SMOs).

As will be noted in greater detail in section 3.1, ACEM has issued their Final Report in December 2016 stating:

"If the planned development is not progress as a matter of urgency, ACEM should consider removing accreditation as it is unfair to place its trainees in such an environment”.

Recommended Solution

The recommended solution is to construct facilities that:

- Support focussed staff/patient interactions and patient privacy, so that adequate and appropriate assessment of patients is done when they arrive.
- Enable staff observation of patients while they are waiting to be seen by a clinician, which enhances patient safety.
- Contributes to patient flow and efficient clinical processes e.g. streaming of patients by minor and major needs.
- Create a warm and welcoming environment that minimises patient and staff stress.

These outcomes will be provided by:

- Construction of safe and secure triage rooms that provide acoustic and visual privacy for initial patient assessments.
- A centralised, safe and open reception desk to create a single point of contact for patients, and enable nurses to manage both self-presenting and ambulance patients.
- Creation of fit for purpose waiting areas that enable patient streaming and pre and post triage separation.
- Dedicated space for ambulance trolleys.
- Improving overall acoustic performance and heat management of the ED waiting area, including addressing wind exclusion issues.
- Creation of a private room for relatives of critical patients.
- Improvements to the minor works station and procedure room, to improve patient flow.
As these changes need to be accommodated within the existing building footprint and capacity they will require the relocation of some existing services. The recommended design will consider the most efficient use of existing space and this will require the reconfiguration of areas not directly related to the ED waiting area and the patient flow process, such as existing medical staff offices.

**Next Steps**

Subject to Board approval, a robust project governance, independent quality assurance and change management approach will be established with clear lines of accountability and responsibility built into all aspects to ensure successful delivery of the project on time, and within budget while meeting the needs of our people, patients and whanau.

This project will employ improvement techniques to maximise the flow benefits for patients and staff through redevelopment of the physical space.

A preferred construction contractor has been sourced by a closed tender through the MDHB panel of approved suppliers. A comprehensive implementation plan will now be developed. It is expected this project will be completed by January 2018.

**2 Background and context**

**2.1 Legal and regulatory context**

MDHB acts within the legislative context of all District Health Boards, as a health services provider, and employer and a training provider. Some of the relevant acts, regulations and compliance requirements that apply are as follows:

**2.1.1 The Privacy Act 1993**

Principle 5(b) of the *Privacy Act 1993* regarding the security of personal information stipulates that:

“An agency...shall ensure that if it is necessary for the information to be given to a person in connection with the provision of a service to the agency, everything reasonable within the power of the agency is done to prevent unauthorised use or unauthorised disclosure of the information.”

This principle covers the collection as well as dissemination of personal information. Organisations collecting information must ensure that it is done in such a manner as to prevent unauthorised disclosure to third parties.

**2.1.2 The Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights Regulations 1996**

The rights of patients as consumers of health care services and the duties of providers under this Code are as follows:

RIGHT 1 (2)
Right to be Treated with Respect
Every consumer has the right to have his or her privacy respected.

RIGHT 5 (2)
Right to Effective Communication

Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

2.1.3 Health and Safety at Work Act 2015 (HSWA 2015)

The Health and Safety at Work Act 2015 identifies the responsibilities of employers to provide and maintain safe systems of work. The provision and maintenance of safe systems of work includes work processes, and can involve looking at the physical layout of the workplace and its access and egress, tools, plant, procedures and people.

Employers must ensure, so far as is reasonably practicable, the health and safety of workers, and that other persons are not put at risk by its work – this is called the ‘primary duty of care’.

2.2 Organisation context

MDHB employs just over 2,100 full-time equivalent staff. It receives Ministry of Health funding of $600M to plan, fund and provide healthcare and disability support services to the population within the following territorial local authority districts:

- Horowhenua district
- Manawatu district
- Palmerston North city
- Tararua district
- The Otaki ward of the Kapiti coast district.

Approximately half of the DHB’s population resides in Palmerston North. Across the sector the demand for hospital services continues to increase as the population ages and health needs become more complex. The population of the MidCentral District is around 174,000 people and is expected to grow to over 177,000 by 2020. This reflects an average rate of growth of 0.8% per year until 2020.

MDHB provides medical and surgical services, maternity services, child health services, elder mental health and alcohol and drug services, rehabilitation services, elder health services, public health services, associated clinical support services, and community based services. The Palmerston North based Regional Cancer Treatment Services (RCTS) also provides medical oncology, haematology and radiation oncology services to neighbouring District Health Boards (DHBs) in the Central Region. This increases demand for a number of supporting services in the Palmerston North hospital. The hospital is also a sub-regional hub for other services such as renal and cardiac services.

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MDHB is committed to “Quality Living – Healthy Lives – Well Communities”. This means better health outcomes, better health care for all.

This investment aligns with the DHB’s Strategic Framework of Quality and Excellence by supporting our people in their efforts to accommodate patient and whānau needs quickly and effectively by providing facilities that are safe, compliant and meet operational needs.

3 The current situation

Improvements to patient flow have been implemented across the DHB. The patient flow analysis continues to focus on improvements to the acute patient admission journey through the ED. The patient journey within ED is divided into three core processes:

- Initial assessment and prioritisation
- Treating clinician assessment, diagnosis and treatment
- Discharge planning or admission process.

A successful assessment and prioritisation is reliant on the nursing triage. As the majority of patients self-present to the department the capability of triage staff and the appropriateness of the waiting area as a facility are key to enhanced patient flow.

The initial assessment and prioritisation of patients when they arrive in ED is undertaken by a triage nurse. The triage nurses are required to assess patients, give the patient a brief overview as to how long they are likely to wait, advise them of their priority and discuss potential alternatives to waiting in ED, if appropriate. The triage nurse will initiate treatment and where able and appropriate, commence diagnostic investigations. The triage nurses will continue to assess the patients at regular intervals during the time that they are waiting to see a clinician.

During busy times this is undertaken in the waiting room area, in front of other patients and visitors. The triage nurse will endeavour to hold the assessment interview away from others but this is not always possible.

3.1 Other initiatives undertaken to initiate change in ED triage processes

3.1.1 Australasian College of Emergency Medicine (ACEM) Accreditation ED Report 2015

In early 2015 the ACEM Accreditation Board reviewed the suitability of extending the provision of emergency medicine registrar training at MDHB from six months to twelve months. Achieving a twelve month training programme will greatly improve MDHB’s ability to attract both RMOs and SMOs to Palmerston North.

The subsequent ACEM report identified the main impediment to achieving the twelve month training programme was the existing size and layout of the ED facilities. The report stated that the Palmerston North Hospital ED facilities are “somewhat out-dated, and particularly small for its activity”.
The report recommends that MDHB:

- Prioritises its planned whole-hospital redevelopment, especially the mooted ‘hot floor’ of ED, theatre and ICU (Intensive Care Unit).
- Proceeds with limited ED redevelopment scheduled for early 2016.

A follow-up visit was undertaken by the ACEM Accreditation Board in August 2016 with their final report received 9 December 2016. The inspection team made the following recommendations:

5.2.1 The proposed redevelopment has not progressed, despite the best efforts of the senior ED department staff. The current state of the department is unsuitable for the safe practice of contemporary Emergency Medicine and poses significant risk to the organisation in terms of adverse patient outcomes.

5.2.2 If the planned development is not progressed as a matter of urgency, ACEM should consider removing accreditation as it is unfair to place its’ trainees in such an environment.

*See appendix 5 for ACEM Letter in response to our approach*

### 3.1.2 Transforming Hospital Services at MidCentral: Palmerston North Hospital

Specialist consulting from Destravis has been engaged by MDHB to conduct a Strategic Property Planning exercise to support the MDHB Master Health Services Plan. This work will help understand the models of care and supporting requirements for the short, medium and long term and how this may impact on health needs, service delivery and the MDHB facility and campus. While mindful of the wider transformation proposal and other strategic initiatives to improve services, the safety and compliance risks identified in the ED Triage Quality Improvement Business Case have been evaluated as urgent, and the longer timeframes for the wider programme of work increases the likelihood of those risks eventuating and becoming issues.

### 3.1.3 ED Triage Quality Improvement Project 2014

A quality improvement project was initiated in October 2014 to look at the ED triage process to see how the existing physical design and patient flow processes could be improved. Patient and clinician feedback identified the need for change, and work processes were adjusted, but physical site limitations remain unaddressed. While the patient’s journey through Hospital services has significantly improved by process flow changes the patient experience continues to be negatively impacted by the lack of privacy in ED.

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2 Refer to the MDHB Detailed business case: “Reform from Within: Transforming Hospital Services at MidCentral. Palmerston North Hospital Detailed Business Case” Prepared by Helene Carbonatto, August 2014
A common example of patient satisfaction feedback:

“As a favour I brought my friends up to ED. While my friend was booking her husband into the reception, the nurse came and sat beside him and talked to him about his problem. I really didn’t want to hear all the little details about his difficulty peeing and that sometimes he was incontinent but I had no choice. I don’t know who was more embarrassed him or me. Over the next hour I got to hear everyone else’s problems. All the staff were nice but something must be done about the waiting room.”

The privacy challenges reported from the clinician’s perspective:

“As a professional and a clinician my role is to keep my patient’s safe by undertaking triage in a timely manner. Under the Health and Disability code I must maintain the privacy and confidentiality of my patients. I cannot do this in the current system. I have to ask patients personal questions in a public space and I waste time trying to have those conversations away from others often in corners of the waiting room. The first impression that our patients get of our department is that we are working in a chaotic environment and that we do not care about our patients. I feel ashamed and embarrassed but dread to think what our patients actually feel.”

Patient story 1:

A woman waiting with two young children a boy and a girl about 10 and 8. Seen waiting patiently and quietly for some time, she shifted seats and went to the receptionist at least twice. After the second time she left the building with the children.

When approached outside she explained she was upset but not angry. She said she had an injured hand and her daughter had a broken finger. The daughter’s finger had been x-rayed and the diagnosis confirmed but her own hand had not been and she wondered if it was because her daughter had a different surname than her. She had previously been into ED for her hand may be 2/3 months earlier (?) and she had left before treatment due to wait times. She said she could not stay any longer today as the children were hungry and needed food and that she had a 6mth old baby at home plus 2 other children (6 altogether).

When asked what she was going to do next about her hand – she said it was getting worse and she was having increasing difficulty holding the baby. She said she would take her daughter to her GP that afternoon but that she (the woman) did not have a GP – she had difficulty paying once and although she had completed payment she now had to pay in advance so considered herself as not having a GP. She also said that the nurse in ED had been rude to her saying that it was her own fault that things were at that stage etc – she felt
like making a complaint but just wanted to get on with things.

**Patient story 2:**

We all worry about our patients in the waiting room. Can you see the 94 year old man sitting quietly in a wheelchair in the waiting room. He has a rug on his lap because it is a cold morning. He fell overnight landing beside his bed and couldn’t get up. His daughter went to visit and found him on the floor covered in excrement. He managed to pull the bedspread over him to keep warm. She showered him and took him to his GP.

The GP referred him to the ED for assessment. He was triaged and placed in the waiting room. It won’t be long until he gets a bed. Now 4 hours later, uncomplaining, there he sits, still in the wheelchair. His daughter had to leave to attend other tasks. She doesn’t complain or enquire either. A different generation. You can see him. He is in your thoughts to bring in but other patients keep trumping him. Government targets, critical patients, departmental red flags. He is slightly slumped forward. He has not been spoken to. He is patiently waiting. Doesn’t want to make a fuss. Other people arrive. They must be sicker as they get rushed in. 5 hours in waiting room. He finally gets a bed. His diagnosis is a fractured NoF. There he sat, uncomplaining for 5 hours. No-one spoke to this man because he was quietly, patiently, waiting.

### 4 The current challenges

“A patient’s perception of privacy strongly predicts satisfaction. ED improvement efforts should focus on improving ED environmental design and continuing education of healthcare providers to protect patient privacy during their stay in the ED”.

On 31 May and 7 June, 2016 facilitated workshops were held with key ED clinical stakeholders to gain a better understanding of investment drivers and the need to invest in change. The results of these workshops have been collated and attached as *Appendix 1: Investment Map*.

The stakeholder panel identified and agreed the following key problems that require an investment in change.

- An increase in patient volumes and acuity has constrained the ability of staff to manage the workload safely within the current space. (70%)
- Well qualified and suitable people are not attracted to working at MDHB. (30%)

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An increase in patient numbers presenting at ED, combined with an overall increase in average acuity is putting pressure on existing resources. The existing ED facility was opened in June 2000, with a design capacity of 30,000 (±10%) patient presentations per year. The number of presentations per year has steadily increased since then. In the 2015/16 financial year ED had just under 45,000 presentations, which represents an approximate increase of 50% in the number of patients seeking care since the current facility was established. This increase is illustrated in the graph below:

An increase in the proportion of those patients presenting with higher acuity has also increased, as illustrated below:

The current facilities are often over-crowded, over-used and do not support safe clinical practice or operational needs. During busy times clinical triage activities have to be done in the ED waiting room. Patients are questioned and assessed in front of other patients waiting for service.

These conditions do not support staff in their efforts to meet patient privacy and communication rights outlined in the Health and Disability Services (HDC) Code. There are also risks of MDHB not meeting its legislative obligations under The Privacy Act 1993 and The Health and Safety in Employment Act 2015.

Patients assessed in a context where their conversation is likely to be overheard are more likely to withhold information that may be pertinent to their assessment. Clinicians risk misdiagnosis of patient needs when they are

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4 These statistics were extracted from the current MDHB data base via SQL
not given all the required details of a patient’s medical background and condition.

There is no appropriate space to assess mental health consumers. Staff are often required to assess mental health patients in open areas and corridors, as the department deals with higher acuity patients. This is detrimental to both mental health patients and their carers.

The design of the waiting room and reception desk is also very unwelcoming, with a wall of Perspex separating the patient from the receptionist. Both the receptionist and the patient have to raise their voices to be heard by the other person and this contributes to patient stress, as well as exacerbating the noise and sense of chaos in the waiting area.

Having to speak loudly to be heard does not support patient privacy or sense of security. Combined with the stress of seeking urgent medical attention the conditions of an over-crowded and noisy waiting room encourages many patients to leave prior to being seen by a clinician, or to act out aggressively toward staff or other patients.

These conditions impede operational activities and sound and effective processes. Clinicians are constrained in their abilities to prioritise patient needs and have difficulties meetings their professional obligations under the HDC consumer regulations. Patient dignity is not supported and patients’ rights to privacy are compromised.

This also impacts staff morale. Because the physical environment constrains the ability of staff to deliver clinical services safely and effectively some staff become stressed and disengaged. A lack of staff engagement results in higher rates of unscheduled leave, higher staff turnover, and difficulties attracting and recruiting suitably qualified people to Palmerston North Hospital to work and train.

The ability of MCH to attract RMOs and SMOs is also compromised by the current ED facilities. ACEM accreditation to extend the ED training programme at MCH from six months to a twelve month rotation may be withheld until the physical constraints within ED have been addressed. Lack of ACEM accreditation for a twelve month training programme will greatly reduce the attractiveness of MCH as a place to work.

The ED Triage Quality Improvement Project is driven by the need to mitigate these urgent operational risks. The ED Quality Improvement business case seeks change by providing facilities that will support staff in their efforts to meet patient needs in a safe and secure environment.

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5 The Health and Disability Commissioners (HDC) Code of Health and Disability Services Consumers’ Rights Regulations 1996
Clinician view:

“For staff in the Emergency Department having a triage area that allows nursing staff to give their undivided attention to the patients that they are triaging will have a significant impact upon their ability to appropriately assess and prioritise patients. By improving patient safety and the patient experience this will increase the confidence of staff to undertake their role and to safely manage the department.

No triage nurse likes to have personal conversations through a thick piece of Perspex at reception or sitting beside a patient in the middle of the waiting room with unknown strangers listening in. By removing patients from reception or the waiting room whilst they are being assessed will reduce the noise levels. A waiting room that is noisy suggests to those present that the only way that they can be heard is to raise their own voices, thereby increasing the noise levels further. Ultimately, excess noise implies a department out of control and without direction. This is not a healthy atmosphere for patients or staff and eventually mistakes are made.”

5 Benefits sought

The stakeholder panel identified and agreed the following key benefits that warrant an investment in change:

- The MDHB ED facility is safe and compliant, and supports safe and compliant activity,
- The reputation of MDHB ED as a great place to work and train is improved.

To achieve these benefits the ED waiting room and reception spaces require reconfiguration so that:

- Spaces for focussed staff/patient interactions can be created.
- Patient flow processes are supported with appropriate spatial layout and clinical tools.
- A warm and welcoming environment can be created, especially at the reception desk.

For clinicians to meet the rights of patients triage should be undertaken in an environment that ensures that communication can occur openly, honestly and effectively. When a patient has been triaged they should feel that they have been able to impart critical information. When that conversation is occurring either at the window of a busy and noisy reception area or in the middle of a waiting area, surrounded by strangers, the patient and their family/whanau cannot feel confident that their concerns have been heard, understood or respected. For this to be achieved there is a requirement to change the physical environment so that triage can be done in a private space. Designated triage rooms will enable patients to provide full and frank information to assist staff to make informed decisions. This will reduce clinical risks associated with inadequate or incomplete information, which can impact upon the care and the clinical management of patients.
By taking the patient into a private room the focus is solely on that patient, without distractions. This supports the nurse to make considered and rationalised decisions. Enabling a focus on the patient in front of them will further the ability of the nurse to provide a better service to the patient, and reduce risks of human error associated with multi-tasking. Private triage rooms also enable staff to perform simple diagnostic tests, such as taking a blood sample, without the need to move the patient to another room or area.

The ability for staff to manage difficult conversations with patients will also be eased by the provision of private triage rooms. Occasionally patients become distressed with the information that the triage nurse tells them. Being able to conduct conversations in private is essential, not just for the patient but for other patients waiting to be seen. A separate designated area allows the nurse to leave the patient to compose themselves in a private space, thereby reducing the risk to themselves, staff and other patients.

Patient flow through the ED will also be buttressed by the provision of private triage spaces. By supporting the privacy of the patient interaction staff are more likely to garner better quality patient information, which in turn will support a greater ability to commence clinical pathways at triage, and to stream patients towards appropriate services either within or external to the department.

By achieving these outcomes the patient experience will be improved. The ability of staff to provide appropriate and respectful services to patients will be furthered by the provision of safe and compliant facilities that meet operational needs.
<table>
<thead>
<tr>
<th>Critical Success Factors</th>
<th>Broad Description</th>
<th>How does the ED Triage Improvement Project meet the critical success factors?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic fit and business needs</strong></td>
<td>How well the option:</td>
<td>The ED Triage Improvement Project aligns with the following MDHB strategic objectives:</td>
</tr>
<tr>
<td></td>
<td>- Meets the agreed investment objectives, related business needs and service</td>
<td>- Increase clinical quality and patient safety culture.</td>
</tr>
<tr>
<td></td>
<td>requirements, and</td>
<td>- Live within our means and seek efficiency gains and improvements in service</td>
</tr>
<tr>
<td></td>
<td>- Integrates with other strategies, programmes and projects</td>
<td>delivery.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improve efficiency and financial sustainability of services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improve operational efficiencies and effectiveness through collaboration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Collaborate with local and regional partners.</td>
</tr>
<tr>
<td><strong>Potential value for money</strong></td>
<td>How well the option:</td>
<td>Optimising patient-clinician interactions to improve care and untimely reduce</td>
</tr>
<tr>
<td></td>
<td>- Improves outcomes for patients</td>
<td>potential for unnecessary costs</td>
</tr>
<tr>
<td></td>
<td>- Supports operational safety and compliance</td>
<td>- Improved privacy will support the exchange of honest patient information, which</td>
</tr>
<tr>
<td></td>
<td>- Improves the reputation of MDHB ED as a great place to work and train</td>
<td>supports better quality diagnosis.</td>
</tr>
<tr>
<td><strong>Potential achievability</strong></td>
<td>How well the option:</td>
<td>The project governance framework will include change management resources. The</td>
</tr>
<tr>
<td></td>
<td>- Is likely to be delivered given the organisation’s ability to respond to the</td>
<td>Change Management Plan will include activities for the five change management</td>
</tr>
<tr>
<td></td>
<td>changes required, and</td>
<td>levers:</td>
</tr>
<tr>
<td></td>
<td>- Matches the level of available skills required for successful delivery</td>
<td>- Communications plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sponsor roadmap</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Coaching plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Training plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Resistance management plan</td>
</tr>
<tr>
<td>Critical Success Factors</td>
<td>Broad Description</td>
<td>How does the ED Triage Improvement Project meet the critical success factors?</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Potential affordability** | How well the option:  
- Can be met from likely available funding, and  
- Matches other funding constraints. | The MDHB current capital plan allowance for the ED Triage Improvements Project is $1,976,000 in the 2017/18 financial year. There are no prior approvals on these allocations. |
| **Removing clinical risk** | How well the option:  
- Reduces or eliminates clinical risk. |  
- Improves staff and clinicians working environment |
6 Options Analysis

The business case team was engaged to provide a summary of a targeted range of options. The options analysis, including costs, was undertaken by a small team of MDHB staff. The following analysis does not represent a full NZ Treasury Better Business Cases (BBC) approach.

Summary Analysis

The option to refurbish the existing space is a medium term solution to mitigate urgent risks, pending redevelopment of the whole of Palmerston North Hospital.

For the purposes of the comparison of each option the following assumptions have been made:

<table>
<thead>
<tr>
<th></th>
<th>Option 1: Do Nothing Status Quo</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital Costs</strong></td>
<td>$0</td>
<td>$1,976,000</td>
</tr>
<tr>
<td><strong>ED is safe and compliant:</strong></td>
<td>Partial - The physical space does not support staff efforts or clinical process.</td>
<td>Yes</td>
</tr>
<tr>
<td>Meets the Code of Health &amp; Disability Services Consumers Rights 1996</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meets Privacy Act 1993</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meets H&amp;S at Work Act 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACEM accreditation council approves MDHB for 12mth training</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reputation of MDHB ED as a great place to work is enhanced:</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Increased staff retention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased recruitment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preferred option</strong></td>
<td>Discounted</td>
<td>Preferred</td>
</tr>
</tbody>
</table>

Option 1: “Do Nothing” – Status Quo

This option involves continuing with the current process.

Initial assessment and prioritisation of patients when they arrive in ED is undertaken by a triage nurse. The triage nurse will initiate treatment and where able and appropriate, commence diagnostic investigations. The triage nurses will continue to assess the patients at regular intervals during the time that they are waiting to see a clinician. During busy times these activities are undertaken in the waiting room area, in front of other patients and visitors.

**Option 1 will require no capital expenditure**

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little or no change management required.</td>
<td>Staff will not be supported in their ability to meet the requirements of <em>The Health and Disability Commissioners (HDC) Code of Health and Disability Services Consumers’ Rights Regulations 1996.</em></td>
</tr>
<tr>
<td></td>
<td>The twelve month Registrar training programme may not be approved by the ACEM Accreditation Board. This will constrain the ability of MDHB to attract well qualified staff to Palmerston North Hospital.</td>
</tr>
<tr>
<td></td>
<td>Staff morale will be negatively impacted.</td>
</tr>
</tbody>
</table>

**MDHB ED is safe and compliant**

- Partial

**Reputation of MDHB ED as a great place to work is enhanced**

- No

**The option is affordable**

- Yes
Option 2: Reconfigure and refurbish the existing Emergency Department reception and waiting area, in order to construct new private triage spaces and improve patient flow.

This proposal seeks to improve patient flow, mitigate safety and privacy risks and improve the patient experience by reconfiguring and refurbishing the existing reception area and waiting room in order to:

- Establish private spaces for triage assessments.
- Create waiting rooms that support staff in their efforts to manage and stream patients by acuity.
- Construct a warm and welcoming reception area.
- Improve facilities for relatives of critical patients.

Improvements to the provision of clinical administration space and relocation of displaced special functions, such as staff offices, also form part of this work. There is no increase in bed capacity from these changes. This investment is focused on improving the triage process and patient flow.

The proposed Option 2 ED reconfiguration and refurbishment details are as follows:

**Triage Rooms:**

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three rooms (min) required, with hand washing facilities, computer access and vital sign monitoring.</td>
<td>To resolve confidentiality and privacy issues for patients by taking them to a designated area.</td>
</tr>
<tr>
<td></td>
<td>Provision of facilities that support staff capability and capacity to perform an initial patient triage, by removing distractions and providing visual and acoustic privacy.</td>
</tr>
<tr>
<td>Rooms must be large enough to take an ED or ambulance trolley.</td>
<td>Enables staff to:</td>
</tr>
<tr>
<td></td>
<td>Commence care and treatment for patients who self-present.</td>
</tr>
<tr>
<td></td>
<td>Undertake assessment that will allow them to transfer patients to other departments without the need to be seen in ED.</td>
</tr>
<tr>
<td></td>
<td>Provides a space where patients can safely wait to see an ED clinician, and a clinician can perform an ECG, insert cannula or take blood samples.</td>
</tr>
<tr>
<td>Each room to have direct entry from the waiting room and a direct entry into the department.</td>
<td>Have the triage rooms placed so that patients arriving by ambulance can be moved there and seen by a triage nurse.</td>
</tr>
<tr>
<td></td>
<td>Enable staff to safely and privately</td>
</tr>
</tbody>
</table>
move patients into the main area of ED without the need to take the patient back through the waiting area.

<table>
<thead>
<tr>
<th>One triage room to double as a minor works room. This room will have storage for dressings, sutures and possibly temporary plasters.</th>
<th>Provide a minor works area after 2am.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual connection from the triage room to the waiting area.</td>
<td>Enables the nurse to watch the waiting room while providing privacy for the patient being triaged.</td>
</tr>
</tbody>
</table>

**Reception Desk:**

<table>
<thead>
<tr>
<th>Accommodation for two (Min.) receptionists and Visitors, e.g. ambulance crew, other ED staff, clinic nurses, orderlies etc.</th>
<th>Centralise the receptionists so that they can manage both self-presenting and ambulance patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Storage for ED notes, filing, printer/photocopier etc</td>
<td>Provision of space to support administration processes</td>
</tr>
<tr>
<td>Direct access for ambulant patients and ambulance staff (single point of contact)</td>
<td>Centralise location of receptionists to support a better view of patients arriving by ambulance or self-presenting</td>
</tr>
</tbody>
</table>

**Waiting Area:**

<table>
<thead>
<tr>
<th>Separation of minor and major patients.</th>
<th>Patient streaming supports the management of patient flow. Separation of patients facilitates patient understanding of their place in the ‘queue’.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create a ‘pre’ and ‘post’ triage waiting area.</td>
<td>Create a smaller front waiting room for patients waiting for triage, waiting to go home or to another part of the hospital. Have a post triage waiting space for Minor Works and for Majors. Major patients will be more easily observed by staff and not just by the triage nurse.</td>
</tr>
<tr>
<td>Security Area.</td>
<td>Security Office to remain in close vicinity to ED waiting room, to support</td>
</tr>
<tr>
<td>requirement</td>
<td>description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| rapid response to ED waiting room incidents, especially at night. | Toilets, Telephones, Play Area. Essential ED waiting area requirements.  
Climate control and layout considerations. Resolve issues of temperature extremes, especially cold air ingress during winter  
Remove blind spots, which do not support patient and staff safety and security. |
| Negative Pressure Room:                          | Current facility is not fit for purpose due to the following: Trolleys are difficult to move in and out due to doorway constrictions. Unable to increase current door size due to structural restrictions.  
Staff are unable to readily observe patients from outside of the space, leaving the door open negates the negative pressure/isolation function.  
The current room is windowless, patients feel isolated and cut-off. |
| Relatives Room:                                  | Improved treatment of the whole family, not just the patient. This aligns with the MDHB Patient Experience strategy: Addressing what matters to the patient and their families/whānau. |
| Clinical Administration Space:                   | Improve administration efficiency. Reduce the likelihood of human error.  
Provision of adequate space for staff to perform required patient administration tasks. |
7 Procurement

The construction works and any required additional professional services has been subject to a tender process which is outlined in July 2017 Board Agenda Part 2.

The tender process will be informed by the following:

- Procurement Guidelines for Public Entities (2008)
- The Government Rules of Sourcing (The Rules) endorsed by Cabinet (CAB Min (13) 10/4A)
- MDHB Procurement Policy that is fully aligned with NZ Government Sourcing Rules.

8 Financial case

The business case team was engaged to provide a summary of project finances. The analysis was undertaken by a small team of MDHB staff. The following analysis does not represent a full NZ Treasury Better Business Cases (BBC) approach.

The final capital investment is $1,780,148 + 11% contingency of $195,852, totalling $1,976,000 as set out further in the tender report.

There are no additional staffing or consumables costs expected.

Implementation will be phased over the 28 weeks from July 2017 ensuring impact on staff and patients/whanau is minimised.

There is no specific financial benefit identified. This project is entirely focussed on improving the safe and effective delivery of service within the existing cost.

8.1 Operational Costs

The only identified incremental operating costs will be for depreciation and for capital charge/(or interest income foregone). Maintenance costs are likely to be unchanged or reduced by the refreshed fit-out. At the point of commissioning the planned Acute Services Block (Hot Floor) the re-use and value of the refurbished ED will be factored into site re-valuation.

8.2 Funding

The MDHB current capital plan includes $1,976,000 across the 2017/18 financial year for the ED Triage Improvement Project.
9 Project Scope

In Scope

- Triage Rooms (X3), large enough to take ED or ambulance trolley, with hand washing facilities, computer access and vital sign monitoring.
  - One triage room to double as a minor works room. This room will have storage for dressings, sutures and possibly temporary plasters.
  - Visual connection from the triage rooms to the waiting area.
- Reception Desk to accommodate two (min.) receptionists and visitors e.g. ambulance crew, other ED staff, clinic nurses, orderlies etc.
  - Storage for ED notes, filing, printer/photocopier etc
  - Direct access for ambulant patients and ambulance staff (single point of contact)
- Waiting Area
  - Separation of minor and major patients.
  - Create a ‘pre’ and ‘post’ triage waiting area.
  - Security Area.
  - Toilets, Telephones, Play Area.
- Relatives Room
- Negative Pressure Room, for use as an isolation area with negative pressure and en-suite facilities
- Clinical Administration Space

Out of Scope

- Design and refurbishment of the wider hospital facility. A Detailed Business Case has been compiled to assess a wider strategic programme of work to transform hospital services at MCH. The proposal covered by the Indicative Business Case (IBC) includes extensive reconfiguration, refurbishment and new construction to transform the Palmerston North Hospital facility.

10 Project Timeline

This project will be managed using the preferred MDHB Project Management methodology. The construction of the ED Triage Improvements Project is expected to start July 2017 and take 28 working weeks.
High level project delivery timeline:

It is expected handover will be in January 2018 instead of April 2018 as noted in the IBC.

Change Management activities will be coordinated with key project milestones to advise patients and staff of any impending changes or potential disruption, and support user and organisation adoption of new processes and habits.

11 Project Management activities:

11.1 Change Management

The construction of the ED triage improvements will result in some disruption to operations if not carefully managed. A Change Management Plan will be developed which will include:

- Assessing the change impact.
- Applying an appropriate structured methodology and identifying the required change management activities.
- Apply a change management process and tools to create a strategy to support adoption of the changes required by the project.
- Supporting the design, development, delivery and management of communications.
- Identifying, analysing and preparing risk mitigation tactics.

11.2 Quality Plan

A Quality Management Plan will be developed with the Project Management Plan and approved by the Project Board. The project will be subject to internal and external quality reviews. This will be undertaken by the Project Manager and Change Manager supported by wrap around project improvement and governance level assurance support.
11.3 Post Implementation Review
A post implementation review will be scheduled at completion of the project to evaluate the project from business case development to delivery of the final output.

11.4 Benefits Realisation
The Benefits Realisation Plan containing the core benefits and benefit measures outlined in Section 5: Benefits. This will be developed during project implementation planning, and evaluated and updated as part of post implementation review.

12 Constraints and Dependencies
The main project constrain is the operational flexibility and the ability of staff to accommodate changes during construction. This constraint will be considered and managed during project delivery. Detailed change impact assessment and stakeholder identification and engagement will be undertaken, and relevant activities identified in the ED Triage Improvements Project Change Management Plan and Project Management Plan.

This investment is a critical stepping stone while longer term work is completed as part of Master Health Service Planning. This long term health service planning involves considerations of physical space use and models of care.
13 Risk Management

The appointed MDHB Project Manager will conduct a detailed risk assessment workshop at the commencement of the project. The results of this workshop will be compiled into a detailed Risk Management Plan for approval by the Project Board.

Risk will be managed under the guidance of the MDHB Risk Management unit.

Risk management will follow four stages:

- Risk Identification
- Risks Quantification
- Risk Response
- Risk Monitoring and Control

A risk register will be managed and regularly updated as part of the project. As part of the process:

- Risk ownership will be assigned to relevant parties.
- Risk analysis will be completed and mitigation strategies agreed.
- Key risks will be reported in the monthly status report and presented for Project Board review.

The Project Manager will have the primary responsibility for risk management and reporting.
## 14 Project Delivery risks

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the impact of construction activities are not identified and coordinated with staff then the emergency department function may be impacted.</td>
<td>High</td>
<td>High</td>
<td>Identify change impacts early. Ensure that change impact risks are identified, registered, evaluated and that mitigation strategies are identified, adopted and followed up.</td>
</tr>
<tr>
<td>If staff are not engaged in the functional and physical changes to the ED environment then benefits will not be realised.</td>
<td>Med</td>
<td>High</td>
<td>Identify change impacts early. Ensure that change impact risks are identified, registered, evaluated and that mitigation strategies are identified, adopted and followed up. Formulate structured activities in the Change Management Plan to engage staff in the change. Identify issues early and address them openly. Involve staff in design.</td>
</tr>
<tr>
<td>Risk Description</td>
<td>Likelihood</td>
<td>Impact</td>
<td>Mitigation</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Lack of change management resources will result in slow, or no, return on investment. | Med        | High   | Identify a suitably skilled and experienced change management specialist with clearly defined roles and responsibilities, who have a proven approach to change management and delegate authority. Responsibilities of the change management specialist to include the following:  
- Change impact analysis  
- Formulation and delivery of the I and activities  
- Forming the project sponsorship roadmap/ Leadership alignment  
- Coordination with MDHB HR and Organisational Development teams  
- Stakeholder engagement and communications planning, management and implementation |
| If the project management team is not appropriately skilled then benefits will not be realised. | High       | High   | Identify a suitably skilled and experienced project team with clearly defined roles and responsibilities, who have a proven approach to project management and risk management. Recruit project managers who have sound relationship management skills. |
| If the project lacks a ‘sense of urgency’ then it will lose traction.            | Low        | High   | Break the development and implementation stages into manageable and clearly articulated steps.  
Clearly articulate how the priority of this project compares and aligns with other MDHB delivery and operational activities.  
Ensure the project is founded on realistic timescales and clearly show critical dependencies.  
Manage and communicate any delays as they occur.                                   |
15 Project Governance

Project Structure:
# Project roles and responsibilities

<table>
<thead>
<tr>
<th>Project Role</th>
<th>Name</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Executive Sponsor          | Lyn Horgan, Operations Director, Hospital Services | Keeps the project aligned with business goals.  
Is the key advocate for the project  
Ensures the project's benefits are fully realised by arranging the resources necessary to initiate and sustain the stated project outcomes.  
Ensures issues escalated from the project are solved effectively at the organisational level.  
Ensures that the project’s outputs will be sustained by ensuring that people and processes are in place to maintain it once the project completes its handover. |
<p>| Project Owner              | Carrie Naylor-Williams, Service Manager, Acute Care and Hospital Operations | Ensures the project is focused throughout its life on achieving its objectives and delivering a product that will achieve the benefits.                                                                                   |
| Senior User Representative | Helen Cosgrove, Clinical Director, Emergency Department, David Prisk, Co-Clinical Director, Emergency Department | Responsible for specifying the needs of those who will use the project’s products (deliverables).                                                                                                                                 |
| Subject Matter Experts     | ED Charge Nurse, ED Service Manager, Other MDHB resources as required | Responsible for evaluating the product against operational requirements                                                                                                                                             |</p>
<table>
<thead>
<tr>
<th>Project Role</th>
<th>Name</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>Jeff Small MDHB Commercial Services Group Manager</td>
<td>Runs the project on a day-to-day basis. Ensures the project produces the required products within the specified tolerances of time, costs, quality, scope, risk and benefits. Ensures that construction/change impacts are identified, communicated and coordinated with BAU operations.</td>
</tr>
<tr>
<td>Consultant Architect</td>
<td>Chow Hill Architects</td>
<td>Project Assurance Responsible for the quality of the products delivered by the supplier(s). Technical Advisory support</td>
</tr>
<tr>
<td>Main Contractor</td>
<td>As Outlined in July 2017 Board Agenda Part 11</td>
<td>Accountable for the quality of the products delivered. Responsible for technical integrity of the product.</td>
</tr>
</tbody>
</table>
Appendix 1: Investment Logic Map

Mid-Central DHB

Improving ED Triage
MDHB ED Triage Improvement Project

PROBLEM  ➤  BENEFIT  ➤  STRATEGIC RESPONSE  ➤  SOLUTION

An increase in patient volumes and acuity has constrained the ability of staff to manage the workload safely within the current space 85%

Well qualified and suitable people are not attracted to working at MDHB 15%

The ED layout supports staff and patient safety and legislative compliance 70%
KPI 1: Meets HSW at Work Act 2005 compliance
KPI 2: Meets Privacy Act 1993 compliance
KPI 3: Meets the Code of Health and Disability Services Consumers Rights 1996
KPI 4: College accreditation council approves MDHB for ED training

The reputation of MDHB ED as a great place to work and train is improved 30%
KPI 1: Reduction in incidents of patient aggression against staff
KPI 2: Improved staff retention

The development to support patient ‘streaming’

Create spaces for focused staff/patient interactions

Develop spaces to support patient ‘streaming’

Create dedicated space for ambulance trolleys

Enable access from reception desk to both ambulance bay and waiting area

Create safe private consultation spaces for triage

Support patient flow with appropriate spaces layoutand clinical tools

Improve accurate performance

Address heat management and wind exclusion issues

Create a warm and welcoming environment for staff and patients

Develop a reception desk that is safe and open
Appendix 2: Existing ED Layout (Not To Scale)
Appendix 3: Proposed ED Layout (Not To Scale)
Appendix 4: Waiting Room Detail (Not To Scale)
Appendix 5: ACEM Letter

13 February 2017

Mr Mike Grant
General Manager, Clinical Services and Transformation
Palmerston North Hospital
Private Bag 11036
Manawatu Mail Centre
Palmerston North 4441
New Zealand

Dear Mr Grant,

Re: Palmerston North Hospital Emergency Department Accreditation Inspection Report - Recommendations

Thank you for your correspondence of 24th January 2017, regarding the recommendations contained in the 2016 Palmerston North Hospital Emergency Department Accreditation Inspection Report.

Local members of the Accreditation Subcommittee have reviewed your response, and request that Palmerston North Hospital provide an update on progress of the business case for the Emergency Department redevelopment through the MidCentral DHB Board. Please provide an update on the status of the proposal to accreditation@acem.org.au by July 13th, 2017.

Please note that, as indicated in the inspection report, failure to adequately address the report recommendations may result in the removal of ACEM accreditation.

If you have any further queries, please direct them to me at the College.

Yours sincerely

[Signature]

DR JAMES TAYLOR
CHAIR ACCREDITATION SUBCOMMITTEE

Copies: Dr Barry Aish – Deputy Director
Dr Landman, Dr Saff – Regional Accreditation Subcommittee Members
Fiji

MidCentral District Health Board
The five nations of Waitangi – Treaty of Waitangi
For:

√ Decision
Endorsement
Noting

To
Board

Author
Neil Wanden, General Manager, Finance & Corporate Services

Endorsed by
CEO, ELT and Finance, Risk & Audit Committee

Date
16 June 2017

Subject
DRAFT INTERNAL AUDIT PLAN 2017-2018

RECOMMENDATION
It is recommended:

- that the Board approve the 2017/18 Internal Audit Plan.

Strategic Alignment
This report is aligned to the DHB’s strategy and key enabler, “Stewardship”, it discusses an aspect of effective governance.

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CTAS</td>
<td>Central Region Technical Advisory Service</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>ESPI</td>
<td>Elective Surgery Performance Indicators</td>
</tr>
<tr>
<td>FRAC</td>
<td>Finance, Risk &amp; Audit Committee</td>
</tr>
<tr>
<td>FSA</td>
<td>First Specialist Appointment</td>
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<td>GM</td>
<td>General Manager</td>
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<tr>
<td>HISF</td>
<td>Health Information Security Framework</td>
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<td>H&amp;S</td>
<td>Health &amp; Safety</td>
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<tr>
<td>IA</td>
<td>Internal Audit</td>
</tr>
<tr>
<td>MDHB</td>
<td>MidCentral District Health Board</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MSD</td>
<td>Ministry of Social Development</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>SAN</td>
<td>Storage Area Network</td>
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<tr>
<td>VCA</td>
<td>Vulnerable Children’s Act</td>
</tr>
</tbody>
</table>

COPY TO:

Finance & Corporate Services
MidCentral DHB
Heretaunga Street
PO Box 2056
Palmerston North 4440
Phone +64 (6) 350 8911
Fax +64 (6) 355 0616
1. PURPOSE

The purpose of this report is to present a draft internal audit programme for the 2017/18 year and approval is sought from the Board.

2. DISCUSSION

The draft Internal Audit Plan for 2017/18 is attached. The plan was reviewed and endorsed by FRAC at its meeting on 6 June 2017.

CTAS DHB Internal Audit has used a risk based approach to establish the plan. The paper outlines the approach taken and proposes the following reviews in Figure 4 of the report:

- Health and Safety – Health Check
- Electives (ESPI) Review
- Holiday Act Compliance Mapping Review
- Vulnerable Children’s Act Compliance
- Internal Attack and Penetration Review
- Service – Business Continuity Management Review
- Asset Management Planning

The background, risk and objective are given against each proposal. The proposed reviews are estimated to be 120 audit days which aligns to MidCentral’s allocated funded days with CTAS.

3. RECOMMENDATION

It is recommended:

*that the Board approve the 2017/18 Internal Audit Plan.*

Neil Wanden
General Manager, Finance & Corporate Services
MidCentral District Health Board

Draft Internal Audit Plan 2017/18
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INTRODUCTION

In accordance with the Institute of Internal Auditors International Standards (“Standards”), Central Region Technical Advisory Service’s (“CTAS”) DHB Internal Audit has prepared the 2017/18 Internal Audit Plan (“Plan”) showing the proposed areas for audit. This is submitted to the Finance Risk and Audit Committee (“FRAC”) for review and approval.

INTERNAL AUDIT PLANNING AND APPROVAL PROCESS

CTAS DHB Internal Audit has used a risk-based approach to establish the annual IA plan. The IA planning approach for MDHB is summarised into the following sections;

1. **MDHB’s Strategic Plan** – Understanding the MDHB strategic plan (refer Page 4.),

2. **Strategic Risks** – Review the current MDHB strategic risk assessment under each strategic risk, enterprise level risks, identifying assurance needs and potential reviews in consultation with management/FRAC members (refer Page 5.),

3. **Development of 2017/18 IA Plan** – In regard to potential reviews, identify prior assurance provided, current initiatives occurring, if other assurance activities are planned (avoiding duplication) and common regional level reviews, for 2017/18 these were identified to be Health and Safety and Business Continuity Management (refer Page 6), and

4. **Proposed 2017/18 IA plan** – For each proposed review set out the background, review objective and timing, including identifying possible alternative reviews for substitution or outlier years (refer Page 17).

The plan will be reviewed by the CEO, GM Finance and Corporate and CTAS Regional Internal Audit Manager every three months to consider possible changing priorities, with any proposed significant changes submitted to FRAC for approval.
1. MDHB’S STRATEGIC PLAN

To assist in the development of the Internal Audit Plan, a review of MDHB’s strategic plan was undertaken. The strategic plan outlines the high level future direction for MidCentral District Health Board (DHB). It lays out what the DHB aspires to achieve, including the culture and values that will underpin how this is done and identifies four Strategic Imperatives that will be used as the focus of work and to move the DHB forward. The strategic imperatives are identified as follows:

- Achieve quality and excellence by design,
- Connect and transform primary, community and specialist care,
- Partner with people and Whanau to support health and wellbeing, and
- Achieve equity of outcomes across communities.

The second part of the plan also includes a roadmap of how MDHB will achieve the four strategic imperatives and put them into action, with each imperative having three to five objectives, outlining the priorities within each. These are further followed by a series of approaches that are intended to be carried out within a five-year timeframe and have been fed into the IA planning process.

Figure 1. MDHB Our Strategy
2. MDHB STRATEGIC RISKS

To assist in the development of the Plan, MDHB’s strategic risks were obtained (see Figure 2. MDHB Strategic Risks) and a review of these undertaken to identifying potential IA reviews (see Figure 3. Strategic Risks to Potential IA Reviews – far right hand side of the table) and rational for inclusion in the Plan. Internal Audit also conducted interviews with DHB staff to gain a better understanding of these risks to inform assurance needs as well as attended the FRAC strategic risk workshop held 26 April 2017. It is noted that the current strategic risk assessment process is on-going and the mitigations, over which assurance maybe required, are yet to be identified by the strategic risk assessment process. The strategic risks and their agreed enterprise risk management rating reflects the output of the April 2017 risk workshop.

Figure 2. MDHB Strategic Risks

<table>
<thead>
<tr>
<th>ERM #</th>
<th>ERM RISK TITLE</th>
<th>INHERENT RISK RATING</th>
<th>RESIDUAL RISK RATING</th>
<th>TOLERABLE RISK TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Quality and safety of patient care</td>
<td>Critical</td>
<td>Possible/Moderate</td>
<td>Critical</td>
</tr>
<tr>
<td>2</td>
<td>Loss of financial sustainability</td>
<td>Critical</td>
<td>Possible/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>3</td>
<td>Inability to meet community health needs and models of care</td>
<td>Critical</td>
<td>Possible/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>4</td>
<td>Health &amp; Safety for staff, contractors and volunteers</td>
<td>Critical</td>
<td>Possible/Moderate</td>
<td>Moderate</td>
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<tr>
<td>5</td>
<td>Culture, accountabilities and escalation</td>
<td>Critical</td>
<td>Possible/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>6</td>
<td>Workforce pressures</td>
<td>Critical</td>
<td>Possible/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>7</td>
<td>Capacity to support innovation</td>
<td>Critical</td>
<td>Likely/Moderate</td>
<td>Minor</td>
</tr>
<tr>
<td>8</td>
<td>Breach of privacy</td>
<td>Major</td>
<td>Likely/Moderate</td>
<td>Minor</td>
</tr>
<tr>
<td>9</td>
<td>Relationship / Partnering</td>
<td>Major</td>
<td>Possible/Moderate</td>
<td>Major</td>
</tr>
<tr>
<td>10</td>
<td>Infrastructure and facilities</td>
<td>Major</td>
<td>Possible/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>11</td>
<td>Crisis Management</td>
<td>Major</td>
<td>Rare/Moderate</td>
<td>Minor</td>
</tr>
</tbody>
</table>

1 For impact criteria refer to Appendix 2. Defining Impact Criteria
3. **2017/18 IA PLAN DEVELOPMENT**

A mapping process was carried out of the strategic risks, identifying potential reviews against prior known assurance and/or other current internal activities occurring within the DHB (refer Figure 3. Strategic Risks to Potential IA Reviews). This was a complex process that included the following considerations;

- Current assessment of strategic risk,
- Identification of possible reviews,
- Linkages between the reviews and other assurance,
- Historic assurance provided,
- Wider sector themes, impacts and requirements, and
- Current change initiatives occurring and timing/impact of these activities.

The following table shows the current assessment of each strategic risk and an analysis linking the current strategic risk through to proposed reviews for inclusion within the 2017/18 IA plan. Current resourcing of IA allows for 6-7 reviews to be completed each year, and these reviews need to be prioritised across the current 11 strategic risks. Because of this prioritisation process, some of the strategic risks may not have an IA review aligned to it in any given year.

**Figure 3. Strategic Risks to Potential IA Reviews**

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Inherent Risk</th>
<th>Current Assessed Residual Risk</th>
<th>Board Target Residual Risk</th>
<th>Potential and Prior Reviews (year denotes a prior review and shading proposed 2017/18 review)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Quality and Safety of Patient Care</strong></td>
<td>Critical 25</td>
<td>Critical 15</td>
<td>Critical 10</td>
<td>- Clinical Governance (2016)</td>
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<td>- Clinical Board and sub-committee structures (2016)</td>
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<td>- Clinical policies and standards framework (2016)</td>
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<td>- The effective use of clinical indicators</td>
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<td></td>
<td>- Serious event identification, investigation, analysis and reporting (2015)</td>
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<td>- Incident management (2015)</td>
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<td>- Management of improvement opportunities</td>
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<td>- Use of clinical audit activities (2014)</td>
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<td>- Supervision and Peer review</td>
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<td>- Mortality and morbidity reviews</td>
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<td>- Drug Management and Control (2017)</td>
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<td>- Multi-disciplinary teams and evidence-based clinical decision-making</td>
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<td>- Retrospective medical record review</td>
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<td>- The use of clinical pathways, variance review and analysis</td>
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<td>- Clinical Practice Improvement (&quot;CPI&quot;)</td>
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<td></td>
<td><strong>Electives (ESPI) Review (Proposed 2017/18)</strong></td>
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<td></td>
<td>- Continuing professional development of health professionals</td>
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<td>- Credentialing of registered health professionals and services</td>
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<td></td>
<td><strong>Vulnerable Children’s Act Compliance (Proposed 2017/18)</strong></td>
</tr>
</tbody>
</table>

Patient safety is of the utmost focus at MDHB. Significant reputational damage will result from incidents caused by sub-standard care, which has been evidenced by historic events. There is a need for greater understanding and focus on clinical risk and causes of adverse clinical outcomes. The residual risk rating and target reflects the amount of further action required to address the known issues and those raised in related enquiries.

**Link to 2017/18 IA Plan**

There have been a significant number of reviews completed relating to the “Quality and Safety of Patient Care” risk in recent years. IA completed a review of Clinical Governance at a MidCentral Health level in 2016. Other “Quality and Safety of Patient Care” related IA’s have been completed over the past 2-3 years being Event Reporting, Complaint Management and Clinical Auditing, with wider reviews also occurring such as Certification, Mental Health review and Maternity review. These have resulted in a significant level of actions having being raised that require time to be implemented. Given the level of reviews that have occurred in recent years, combined with Certification being an ongoing process, it is proposed that IA focus it’s activities relating to “Quality and Safety of Patient Care” in the coming year on Electives (ESPI) and associated quality dimensions (e.g. Timeliness), as well as ensuring systems and processes have been updated to protect vulnerable children through compliance with legislation, and the focus returning to components of Clinical Governance in 2018/19.

**Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)**

- Electives (ESPI) Review
- Vulnerable Children’s Act Compliance
2. Loss of Financial Sustainability

The ability to achieve the strategic framework and associated priorities is constrained by approved budgets. The risk rating reflects that this will be an ongoing area of tension against operational and strategic objectives. Potential ability to further reduce the risk to target levels will depend on processes supporting prioritisation of fund allocation and transparency of decision making.

Link to 2017/18 IA Plan

There have been a significant number of reviews relating to (or containing elements of) the “Loss of Financial Sustainability” risk in recent years. IA have reviews in 2017 relating to Planning Alignment (which includes funding prioritisation and linkage to strategy), Budget Management, Project Management and Fraud Risk Assessment. The focus on “Loss of Financial Sustainability” is important as scarce resources need to be used in the most effective and efficient manner to achieve the strategic framework. Following on from the Planning Alignment review, it is proposed in 2017/18 a review the Asset Management Planning to ensure assets are in the right place at the right time and right condition to support services (there is also a link to the Budget Management review and deferred capital expenditure).

Events in the sector have highlighted that many DHBs have compliance issues with the Holidays Act 2003, with some having significant risks relating to costs relating to addressing the historic noncompliance, this has a direct link to financial sustainability. The National CEO Forum has agreed that all DHBs should have an IA conducted over individual DHB compliance with the Holidays Act, and this process should occur through consultation with DHB Shared Services Strategic Workforce and Unions, with Union signing off on the testing to occur. TAS IA is involved in setting this baseline in collaboration with Strategic Workforce, DHBs and Unions.

Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)
- Long Term Asset Management Planning Review
- Holidays Act 2003 Compliance Review

Potential and Prior Reviews
(year denotes a prior review and shading proposed 2017/18 review)
- Planning Alignment (2017)
- Funding Prioritisation Processes & Mechanisms (2017)
- Budget Setting (top down/bottom up) (2017)
- Long Term Asset Management Planning (Proposed 2017/18)
- Financial Sustainability Initiatives (Candidate 2018/19)
- Project Management Framework/Methodology (2017)
- Monitoring of Expenditure
- Non-resident billing
- Fraud Risk Assessment (2017)
- Capital Expenditure Planning and Prioritisation
- Holidays Act 2003 Compliance (Proposed 2017/18)
### 3. Inability to Meet Community Health Needs and Models of Care

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Inherent Risk</th>
<th>Current Assessed Risk</th>
<th>Board Target Residual Risk</th>
<th>Potential and Prior Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Critical 20</td>
<td>Major 9</td>
<td>Moderate 6</td>
<td>- Planning Alignment (2017)</td>
</tr>
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<td>- Strategic Planning Processes</td>
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<td>- Annual Plan Processes</td>
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<td>- Population Health Management</td>
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<td></td>
<td>- Funding Prioritisation Processes &amp; Mechanisms (2017)</td>
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<td>- Health Inequalities</td>
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<td></td>
<td>- Electives (ESPI) Review (Proposed 2017/18)</td>
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<td></td>
<td>- Project Health checks (based on current projects) (2017)</td>
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<td></td>
<td></td>
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<td></td>
<td>- Provider Monitoring Systems &amp; Processes/NGO Contracting (2017)</td>
</tr>
</tbody>
</table>

The medium to longer term achievement of the future model of care is significantly reliant upon a clear understanding of community health needs. This includes aspects such as:

- Desired health outcomes
- Demographic needs
- Ageing population impacts
- Areas of high risk (e.g. suicide rates, Mental health)
- Population health disparities
- Exacerbating existing inequities

Note:
The current residual risk rating reflects the perception that further work is required to improve understanding in these areas, but also that it is difficult to fully mitigate the risk given inherent uncertainties in this area.

### Link to 2017/18 IA Plan

There have been a significant number of reviews relating to (or containing elements of) the “Inability to Meet Community Health Needs and Models of Care” risk in recent years. IA has a review in 2017 relating to Planning Alignment (which includes consideration of health needs assessment, how this is being fed into the planning process and the associated intervention logic/commissioning of services) and Project Management (disciplined approach to strategic change). Several activities are occurring around the planning process and there is a need to allow time for these to occur before further review. While these activities are occurring, there is value in reviewing the elective services patient flow to see how this is meeting current needs, with a linkage also to financial impacts if poor performance occurs and risks around MoH funding.

**Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)**

- Electives (ESPI) Review
### Strategic Risk
<table>
<thead>
<tr>
<th>Inherent Risk</th>
<th>Current Assessed Residual Risk</th>
<th>Board Target Residual Risk</th>
<th>Potential and Prior Reviews (year denotes a prior review and shading proposed 2017/18 review)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health &amp; Safety for staff, contractors and volunteers</strong></td>
<td>Critical 20</td>
<td>Moderate 6</td>
<td>Moderate 6</td>
</tr>
</tbody>
</table>

The nature of MDHB activities results in significant inherent risks to staff and contractors with relation to Health & Safety. These have been further increased by the recent legislative reforms that extend the nature of the responsibilities (e.g. PCBU extends obligations to contractors) and also obligations for Board and Executive due diligence over MDHB health & safety frameworks.

**Link to 2017/18 IA Plan**

There have been several reviews targeting health and safety risks in the past 3 years, however none of these were completed within the 2016/17 IA plan (due to the level of planned activities occurring in 2016/17 and prior level of review). At a regional level, health and safety is one of two areas that have been identified by the regional CFO’s as an agreed area for review, with a review to be included within the IA Plan of each DHB to allow regional comparatives and learnings to be shared.

**Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)**
- Health and Safety Review
- Board Reporting (Proposed 2017/18)
- H&S Risk Management Framework (Proposed 2017/18)
- Third Party Provider - Contract Performance (Proposed 2017/18)
- Physical security - Staff and Patient Safety
### 5. Culture, accountabilities and escalation

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Inherent Risk</th>
<th>Current Assessed Residual Risk</th>
<th>Board Target Residual Risk</th>
<th>Potential and Prior Reviews (year denotes a prior review and shading proposed 2017/18 review)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Culture, accountabilities</td>
<td>Critical 15</td>
<td>Major 12</td>
<td>Moderate 6</td>
<td>- Organisational Development</td>
</tr>
<tr>
<td>and escalation</td>
<td></td>
<td></td>
<td></td>
<td>- Clinical Governance (2016)</td>
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<td></td>
<td>- Engagement and Culture Assessment (2015)</td>
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<td>- Clinical Leadership</td>
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<td>- KPI Setting and Alignment to Objectives</td>
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<td></td>
<td>- Processes for measuring, reporting and monitoring KPI’s</td>
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<td>- Service Management Structure and Performance (2016)</td>
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<td>- Professional Development Review (PDR)</td>
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<td>- Recruitment and Retention</td>
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</tbody>
</table>

There are a number of factors where culture can undermine the achievement of the strategy. These include aspects such as:

- Unclear or lack of accountability
- Barriers to risk reporting and escalation
- Potentially disengaged leaders and workforce

Issues in this area have also been flagged in previous investigations and drive the current residual risk rating.

#### Link to 2017/18 IA Plan

There have been external reviews completed of the Mental Health and Maternity services in 2016, resulting in a number of activities needing to occur. A clinical governance review (focused on MidCentral Heath) was completed by IA in 2016, which included reviewing structure/accountabilities and reporting/escalation, this review also resulted in a number of activities needing to occur. Given the need for actions relating to already known activities, the value of IA is seen to be in reviewing progress in addressing these either the 2018/19 or 2019/20 IA plans.

**Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)**

- No planned activities within the 2017/18 IA plan.
6. Workforce Pressures

There are a range of workforce factors that may exacerbate a number of other risk areas such as patient safety and financial sustainability. These include adequacy of skill mix, capacity, and productivity. In addition, workforce pressures will also have an impact on the ability to achieve the future model of care set out in the strategic framework.

Link to 2017/18 IA Plan
IA have reviewed Clinical Governance (2016) and Planning Alignment (2017), both touching on workforce/staff. Behind the workforce pressures there is a need to have first class workforce planning, but also recognising that the DHB can control training and development of current staff and only at best influence others around external supply of skills. For workforce planning to be effective and achieve it’s desired outcomes it must be integrated into the DHB’s strategic planning framework and human resource strategies aligned to continuously deliver the right people in the right place at the right time to achieve successful outcomes. There is a link to wider sector planning thorough Health Workforce NZ, but at a local level the DHB needs to have where possible the right people. It is proposed due to timing of planning activities and actions coming out of the planning alignment review that a Workforce Planning review be included within the 2018/19 IA plan.

Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)
- No planned activities within the 2017/18 IA plan.
7. Capacity to Support Innovation

The objectives and initiatives within the strategic framework require adequate capacity within MDHB to deliver them successfully. This relates to sufficient management energy and focus, in addition to delivering business as usual operations and other aspects such as national health targets.

The current assessment of residual risk against the target reflects uncertainty whether sufficient capacity exists.

Link to 2017/18 IA Plan

IA completed reviews in 2017 relating to Planning Alignment (which included funding prioritisation and linkage to strategy) and Project Management (disciplined approach to strategic change). It is noted the DHB is currently in deficit and going through a restructure process. Given the need for actions relating to already known activities, the value of IA is seen to be in reviewing processes in either the 2018/19 or 2019/20 IA plans.

Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)
- No planned activities within the 2017/18 IA plan.
<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Inherent Risk</th>
<th>Current Assessed Residual Risk</th>
<th>Board Target Residual Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Breach of privacy</td>
<td>Major 15</td>
<td>Minor 4</td>
<td>Minor 4</td>
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</tbody>
</table>

There are extensive information related risks to MDHB ensuring the patient private information is kept confidential and secure. The risk rating reflects significant work and independent assurance being obtained on the effectiveness of existing mitigations. However, it is also important that delivery of the future model of care is likely to increase risk in this area as integration with primary and secondary care providers will require greater exchange of information.

**Link to 2017/18 IA Plan**

Cybersecurity is seen as a risk that can evolve extremely quickly and while currently assessed as minor, security breaches on a world stage and health being seen as a good target means a vigilant focus needs to remain (e.g. "WannaCry" ransomware from Shadow Brokers). IA completed a number of reviews in the last two years relating to privacy and information security, noting the prior Health Information Security Framework (HISF) review (2016) and the External Attack and Penetration review (2017). The HISF review covered at a policy level all the areas identified under the potential review list. An Internal Attack and Penetration Review would help round out the testing of controls. The risk that has not yet been tested is what unauthorised access can an internal staff member with standard network access gain to systems and sensitive information (as well as physical security controls restricting access to restricted areas). A follow-up review of the HISF would be looked at in 2018/19, being 3 years after the previous review.

**Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)**
- Internal Network and System Penetration Testing.
- Health Information Security Framework (2016)
- Physical security - Staff and Patient Safety
- Patient Privacy and Privacy Act
- Release of Information
- Fraud Risk Assessment (2017)
- Patient Management System/Electronic Health Record
- Bring Your Own Device
- User Access Management
- Patch Management
- External Network and System Penetration Testing (2017)
- IT Security Mobile Devices
- Application Security
- Web/Internet Security
- Phishing Attack (2017)
- Internal Network Security/Wireless
- Database Security
- Operating System Security
- Remote Access Security
- Electronic Patient Record
- Internal Network and System Penetration Testing (Proposed 2017/18)
- Physical Security of IT Assets
- Data Privacy and Security
- IT Operations (Backups, Manage Environment)
- General Information Technology Computer Controls
- IT Project and Change Management
- Internet Access and E-mail Monitoring
- End User Computing (Spreadsheets/ Access Databases)
- Email Controls - Privacy
<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Inherent Risk</th>
<th>Current Assessed Residual Risk</th>
<th>Board Target Residual Risk</th>
<th>Potential and Prior Reviews (year denotes a prior review and shading proposed 2017/18 review)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Major 15</td>
<td>Major 9</td>
<td>Major 9</td>
<td>Planning Alignment (2017)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Consumer Engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clinical Governance (2016)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clinical Leadership</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Regional Projects and Initiatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strategic Planning Processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Funding Prioritisation Processes &amp; Mechanisms (2017)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Investment Model</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Provider Contracting Management (2017)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Identification and implementation of new services</td>
</tr>
</tbody>
</table>

The delivery of the strategic framework is significantly reliant upon key relationships within the community and to support the delivery of services. These include:

- Integration with other health and social services/departments (e.g. housing, MSD)
- Contracts with third parties, including Enable NZ
- Internal relationships between primary and secondary services

**Link to 2017/18 IA Plan**

IA have reviews in 2017 relating to Planning Alignment (which includes funding prioritisation and linkage to strategy) and Project Management (disciplined approach to strategic change). During the provider contracting management review (2017) it was observed that there was a strong relationship with the PHO. There are several activities occurring around the planning process and there is a need to allow time for these to occur before further review, further consideration to reviews will be given in either the 2018/19 or 2019/20 IA plans.

**Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)**

- No planned activities within the 2017/18 IA plan.
10. Infrastructure and Facilities

There are a number of risks around the management of the significant infrastructure and facilities supporting MDHB. These include:

- Current infrastructure and facilities are not fit for purpose and require remedial work e.g. MH ward 21
- Seismic building requirements are also driving remediation
- Future model of care facilities requirements create significant uncertainty around potential development of existing facilities.

The above factors are driving the gap between perceived current residual risk and targeted residual risk.

**Link to 2017/18 IA Plan**

IA have a review in 2017 relating to Planning Alignment (which includes a high-level asset management and linkage to strategy) and Project Management (disciplined approach to strategic change). There are needs to invest in the infrastructure and facilities in the next 5-10 years, some of which have been highlighted by reports such as the Mental Health review, others via growing demands (e.g. Theatre) and others to meet the needs of the future models of care. Following on from the Planning Alignment review, it is proposed in 2017/18 a review of Asset Management Planning to ensure assets are in the right place at the right time and right condition to support services (there is also a link to the Budget Management review and deferred capital expenditure).

**Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)**

- Long Term Asset Management Planning
11. Crisis Management

Any catastrophic event that occurs which could significantly impact the ongoing operation of MDHB beyond acceptable levels. This includes events such as pandemics, floods, fire, earthquake. The risk rating reflects that the impact of these types of black swan events are difficult to fully mitigate and rely upon business continuity and crisis management procedures to reduce the impact of the event.

Link to 2017/18 IA Plan

There have been limited IA reviews targeting Crisis Management in the past 3 years, with it being an element touched on by IA at a policy level within the Health Information Security Framework review (2016). A SAN failure review was independently completed in 2015 providing a level of assurance over current disaster recover capabilities. At a regional level, Business Continuity Management is one of two areas that have been identified by the regional CFO’s as an agreed area for review, with a review to be included within the IA Plan of each DHB to allow regional comparatives and learnings to be shared.

Proposed 2017/18 IA Review(s) – (refer Figure 4. 2017/18 IA Plan)
- Business Continuity Management
4. Proposed 2017/18 IA plan

The reviews identified as priority from the mapping exercise under “3. 2017/18 IA Plan Development” have been aligned against the available audit days as per the service agreement between MDHB and CTAS, under which MDHB have 120 funded audit days (less time for ongoing management/engagement activities). The reviews have been expanded on to form the 2017/18 IA plan (below in Figure 4. 2017/18 IA Plan), including the following details:
- Background and risk narrative,
- Objective,
- Timing of the review, and
- Identified deferrable reviews (those reviews that can be moved to subsequent years in the event there is a need for issues based reviews to occur).

Figure 4. 2017/18 IA Plan.

<table>
<thead>
<tr>
<th>Review Areas</th>
<th>IA Plan 2017/18</th>
<th>Proposed Review Objective</th>
</tr>
</thead>
</table>
| Health and Safety – Health Check | Q1 15 | Background and Risk
Health and Safety is recognised within the identified strategic risk “Health & Safety for Staff, Contractors and Volunteers”. Health and safety is an area where significant legislation changes have occurred in the past three years. The Board and executive management have key roles to play in ensuring all workers are kept safe, these duties revolve around understanding the risks of the DHB and that appropriate controls exist. To fulfill this duty it is essential that the Board receives independent assurance on how H&S systems and processes are operating. While it is acknowledged ACC conducts audits, these reviews are in relation to ACC regulations and don’t cover the full scope of health and safety. This is also one of two regional reviews that will be conducted on a comparative basis, with learnings across the region shared. 
Objective
The objective of this review is to ensure that the Health and Safety system and processes are implemented and functioning effectively. The review will take a cross slice of the DHB and look to see that practices are operating as expected, from resources made available to support processes, staff participation, hazard identification through to confirming that a sample of identified mitigations are actively used, including the identification of potential blind spots. |
| Electives (ESPI) Review | Q1 15 | Background and Risk
Electives is linked to the MDHB strategic risk (and other operating risks) of “Quality and safety of patient care” and “Inability to meet community health needs and models of care”. The term “elective services” covers non-emergency surgical, medical, and diagnostic hospital services. In an environment of |
<table>
<thead>
<tr>
<th>Review Areas</th>
<th>IA Plan 2017/18</th>
<th>Proposed Review Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td><strong>Holidays Act Compliance Mapping Review</strong></td>
<td>20</td>
<td><strong>Background and Risk</strong></td>
</tr>
<tr>
<td><strong>Vulnerable Children’s Act (VCA) Compliance (Deferable)</strong></td>
<td>15</td>
<td><strong>Background and Risk</strong></td>
</tr>
<tr>
<td><strong>Internal Attack and Penetration Review</strong></td>
<td>20</td>
<td><strong>Background and Risk</strong></td>
</tr>
</tbody>
</table>
as well as recognised as a critical enterprise level risk. Noting the prior Health Information Security Framework (HISF) review and the External Attack and Penetration review, the Internal Attack and Penetration Review helps round out the testing of controls. The risk that has not yet been tested by IA is what unauthorised access can an internal staff member with standard network access gain to systems and sensitive information (as well as physical security controls restricting access to restricted areas) with an element of health and safety included.

**Objective**
The objective of this review is to assess the effectiveness of the controls in place to protect sensitive data and restrict end user access to only those systems and information required to do their job. Two key systems will be identified and targeted for testing along with an element of physical security to information and resources.

### Service - Business Continuity Management Review

<table>
<thead>
<tr>
<th>15</th>
<th>Background and Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business continuity planning is linked to a number of the MDHB strategic risks (and operating risks) such as “Quality and Safety of Patient Care” and “Infrastructure and Facilities”. Business continuity planning appears to be well done at a strategic level within MDHB, with a documented plan having been independently reviewed by PwC (2013). Below this level though there is a risk that individual department and service level plans have not been appropriately established by all, leaving some in a state of being unprepared. Emergency Response has been successfully enacted on a regular basis by the DHB and not seen as being a high risk with good staff capabilities appearing to exist.</td>
<td></td>
</tr>
</tbody>
</table>

**Objective**
The objective of this review is to ensure there are reasonable processes and plans in place to support the continuity of business operations in the event of disruption, a strong focus will be placed on information systems and accessibility of information.

### Asset Management Planning (Deferable)

<table>
<thead>
<tr>
<th>20</th>
<th>Background and Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term asset management planning was covered at a high level within the planning alignment review, it is noted an area of strategic importance and also a key area within the Treasury Investor Confidence Rating. Having the right assets in the right place at the right time to support services is essential to delivery of efficient and safe services, it is linked to MDHB strategic risk of Loss of Financial Sustainability” and “Infrastructure and Facilities”. Physical assets (such as hospital buildings and clinical equipment) are integral to the health services DHBs deliver. Sound management of DHBs’ physical assets is critical to New Zealand’s future and the wellbeing of the population. In 2015, DHBs had $5.7 billion invested in physical assets and were planning more than $6 billion of capital expenditure during the 10 year period through to 2025.</td>
<td></td>
</tr>
</tbody>
</table>

**Objective**
The objective of this review is to identify and assess MDHB’s Asset Management processes to ensure there are consistent and cost-effective methodologies implemented for the management of assets to support the long-term sustainability of assets and the services they support.
## APPENDIX 2. DEFINING IMPACT CRITERIA

### STEP 1

**MDHB Risk Assessment Criteria**

<table>
<thead>
<tr>
<th>Impact/Consequence</th>
<th>Severe</th>
<th>Major</th>
<th>Moderate</th>
<th>Minor</th>
<th>Minimal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death or permanent severe loss of function that is related to the process of health care and differs from the expected outcome of that care.</td>
<td>Permanent major or temporary severe loss of function that is related to the process of health care and differs from the expected outcome of that care.</td>
<td>Permanent moderate or temporary moderate loss of function that is related to the process of health care and differs from the expected outcome of that care.</td>
<td>Permanent minor or temporary moderate loss of function that is related to the process of health care and differs from the expected outcome of that care.</td>
<td>Temporary minor loss of function.</td>
<td></td>
</tr>
<tr>
<td>Specific Incidents/Consequences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Wrong consumer or wrong procedure with risk of actual severe harm.</td>
<td>- Wrong consumer or wrong procedure with risk of actual moderate harm.</td>
<td>- Wrong consumer or wrong procedure with risk of or actual minor harm.</td>
<td>Wrong consumer or wrong procedure with risk of or actual minor harm.</td>
<td>Medication error with no harm.</td>
<td></td>
</tr>
<tr>
<td>- Suicide as inpatient.</td>
<td>- Mismanagement of radiological services.</td>
<td>- Unintended cardio-pulmonary resuscitation resulting from the process of health care.</td>
<td>- Additional monitoring interventions as a result of the incident:</td>
<td>- Increased length of stay &gt; one day.</td>
<td></td>
</tr>
<tr>
<td>- Retained item with delayed removal.</td>
<td>- Community suicide by current mental health consumer within 28 days of contact with service.</td>
<td>- Surgical or other significant intervention required.</td>
<td>- Social impact or other significant intervention required.</td>
<td>- Medication error with no harm.</td>
<td></td>
</tr>
<tr>
<td>- Failure of essential service with risk of severe consumer consequences.</td>
<td>- Missing person with a risk of serious harm to self or others.</td>
<td>- Insulting patient.</td>
<td>- Impaired image.</td>
<td>- Medication error with no harm.</td>
<td></td>
</tr>
<tr>
<td><strong>Workplace safety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death of a staff member related to work incident or suicide, or hospitalisation of three or more staff; Events involving an explosion.</td>
<td>Permanent injury to staff member, hospitalisation of two staff or lost time or restricted duty or illness for three or more staff.</td>
<td>Medical expenses lost time or restricted duties or injury/illness for one or more staff.</td>
<td>First aid treatment only with no lost time or restricted duties.</td>
<td>No injury or review required.</td>
<td></td>
</tr>
<tr>
<td>- Death of a visitor or hospitalisation of three or more visitors.</td>
<td>- Hospitalisation of up to two visitors related to incident/injury.</td>
<td>- Medical expenses incurred or treatment up to two visitors not requiring hospitalisation.</td>
<td>- Evaluation and treatment with no expenses.</td>
<td>No treatment required or refused treatment.</td>
<td></td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete loss of service or output.</td>
<td>Major loss or disruption of service(s).</td>
<td>Temporary disruption of services.</td>
<td>Minimal disruption of services.</td>
<td>No loss of service.</td>
<td></td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of assets with replacement value due to damage, fire etc &gt; $1m; Loss of cash/investments/assets due to fraud, overpayment or theft &gt; $100k.</td>
<td>Loss of assets with replacement value due to damage, fire etc &gt; $100k; Loss of cash/investments/assets due to fraud, overpayment or theft &gt; $100k.</td>
<td>Loss of assets with replacement value due to damage, fire etc &gt; $100k.</td>
<td>Loss of assets with replacement value due to damage, fire etc &gt; $100k.</td>
<td>No financial loss.</td>
<td></td>
</tr>
<tr>
<td><strong>Environment Utilities/ Property</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire requiring evacuation.</td>
<td>Loss or permanent damage of major utilities.</td>
<td>Fire that grows larger than incident stage.</td>
<td>Temporary suspension of work due to damage to property, assets.</td>
<td>Localised damage to property, assets.</td>
<td>Minimal effect on infrastructure.</td>
</tr>
<tr>
<td><strong>Organisation Reputation/ Governance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Ministerial enquiry; Major extended national media campaign; Loss of major contracts; Prosecution resulting in resignation of Chairperson/CEO.</td>
<td>Consumer unease and reduced consumer cooperation/Chairman intervention; High profile, adverse national media coverage (TV, radio and print); High number of consumers affected by an event or over year by events; Systemic breaches of informed consent or privacy.</td>
<td>Consumer unease and reduced consumer cooperation/Chairman intervention; High profile, adverse national media coverage (TV, radio and print); High number of consumers affected by an event or over year by events; Systemic breaches of informed consent or privacy.</td>
<td>Consumer unease and reduced consumer cooperation/Chairman intervention; High profile, adverse national media coverage (TV, radio and print); High number of consumers affected by an event or over year by events; Systemic breaches of informed consent or privacy.</td>
<td>Widespread consumer complaints; Adverse local media coverage (comment and print); Multiple events affects a significant number of consumers a year in total; Regular complaints or breaches of informed consent/privacy.</td>
<td></td>
</tr>
<tr>
<td>Non compliance with legislation resulting in indeterminate or prolonged suspension of service delivery (loss of Certification/ Accreditation status).</td>
<td>Non compliance with legislation resulting in indeterminate or prolonged suspension of service delivery (loss of Certification/ Accreditation status).</td>
<td>Non compliance with legislation resulting in indeterminate or prolonged suspension of service delivery (loss of Certification/ Accreditation status).</td>
<td>Non compliance with legislation resulting in indeterminate or prolonged suspension of service delivery (loss of Certification/ Accreditation status).</td>
<td>Widespread consumer complaints; Adverse local media coverage (comment and print); Multiple events affects a significant number of consumers a year in total; Regular complaints or breaches of informed consent/privacy.</td>
<td></td>
</tr>
</tbody>
</table>

**Version 2 November 2012. Source: Adapted from Health Quality & Safety Commission Severity Assessment Criteria & Hawkes Bay District Health Board Risk Criteria.**
### STEP 2

**Likelihood**

For each identified risk, determine the likelihood that the event will occur, using the table below.

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Frequent</th>
<th>Likely</th>
<th>Possible</th>
<th>Unlikely</th>
<th>Rare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is expected to occur either immediately or within a short period of time (likely to occur most weeks or months)</td>
<td>Will probably occur in most circumstances (several times a year)</td>
<td>Possibly will occur — might occur at some time (may happen every 1 to 2 years)</td>
<td>Unlikely to occur — may occur only in exceptional circumstances (may happen every 5 to 30 years)</td>
<td></td>
</tr>
</tbody>
</table>

### STEP 3

**Residual Risk Matrix**

The consequence and likelihood for each risk are mapped on the residual risk matrix, to ascertain the risk level (Critical, Major, Moderate or Minor) and the subsequent level of action required (shown in the escalation matrix).

### STEP 4

**Escalation Matrix**

<table>
<thead>
<tr>
<th>Residual Risk Rating</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical 10-25</td>
<td>- Only the Chief Executive can accept this level of residual risk.</td>
</tr>
<tr>
<td></td>
<td>- The Chief Executive and Senior Management must be informed of any risk at this level and must implement remedial action immediately.</td>
</tr>
<tr>
<td></td>
<td>- The Board must be told of this risk in the month of identification.</td>
</tr>
<tr>
<td></td>
<td>- The Chief Executive must monitor conformance with the remedial action plan.</td>
</tr>
<tr>
<td></td>
<td>- There should be contingency plans developed to deal with these risks growing.</td>
</tr>
</tbody>
</table>

| Major 5-15           | - Only Senior Management/General Manager can accept this level of residual risk. |
|                      | - The Chief Executive, Senior Management, and Professional Directors must be told of any risk of this level and remedial action must be implemented within one working week of identification. |
|                      | - The Audit Committee and the Board must be informed of these risks in the course of usual performance reporting mechanisms. |
|                      | - Senior Management must monitor conformance with the remedial action plan and risk mitigation activity in the ordinary course of performance reporting. |
|                      | - Where appropriate, there should be contingency plans developed to deal with these risks growing. |

| Moderate 3-10        | - The relevant Line/Service/Portfolio Manager/Clinical leader can accept this level of residual risk. |
|                      | - Senior Management/General Manager must be told of any risk of this level as part of MDH’s collective responsibility mechanisms. |
|                      | - The Chief Executive and Senior Management must be informed of these risks in the usual course of performance reporting. |

| Minor 1-4            | - These risks should be managed as part of business as usual. |
|                      | - These risks should be reported to the relevant member of the Senior Management Team if they grow. |

For:

| ✓ | Decision
|   | Endorsement
|   | Noting

To

Board

Author

Chris Channing, Financial Services Manager

Endorsed by

CEO and Finance, Risk & Audit Committee

Date

16 June 2017

Subject

TREASURY MANAGEMENT POLICY UPDATE

RECOMMENDATION

It is recommended that the Board:

- note the changes proposed to the Treasury Management Policy; and
- approve the amended policy.

Strategic Alignment

This report is aligned to the DHB’s strategy and key enabler, “Stewardship”.

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>MDHB</td>
<td>MidCentral District Health Board</td>
</tr>
<tr>
<td>BNZ</td>
<td>Bank of New Zealand</td>
</tr>
</tbody>
</table>
1. **PURPOSE**

   To present the revised Treasury Management Policy to the Board for approval. This has been reviewed and endorsed by the Finance, Risk & Audit Committee at its meeting on 6 June 2017.

2. **BACKGROUND**

   The Treasury Management Policy was standardised across all the District Health Boards in 2012 to take into account the move to a shared banking and treasury arrangement. The policy was further updated in 2015 to take into account the move of the treasury functions from Crown Heath Funding Agency to Health Benefits Limited and to take into account the new cash investment protocol.

   The changes resulting from the current review are minor and take into account:
   - the move of the treasury from Health Benefits Limited to NZ Health Partnerships
   - the change in banking from Westpac to Bank of New Zealand
   - the changes in delegations included in the policy to match those in the new delegation policy

   This revised policy will come into effect concurrent with the transition of banking facilities to BNZ. This policy will be reviewed and presented to the Finance, Risk and Audit Committee every three years.

3. **RECOMMENDATION**

   It is recommended that the Board:

   *note the changes proposed to the Treasury Management Policy; and approve the amended policy.*

   

   Chris Channing  
   Financial Services Manager
# POLICY

## TREASURY MANAGEMENT

<table>
<thead>
<tr>
<th>Applicable to: MidCentral District Health Board</th>
<th>Issued by: Finance Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact: Financial Services Manager</td>
<td></td>
</tr>
</tbody>
</table>

### 1. OBJECTIVES

The overarching objective of Treasury Policy is to ensure that the DHB's treasury operations are managed in an efficient, risk-averse, and non-speculative manner. Specific objectives relating to each key risk area are that:

- **Liquidity Risk** is managed to ensure that sufficient funds are available at all times to meet the DHB’s financial obligations in an orderly manner.

- **Interest Rate Risk** is managed to ensure an appropriate balance is maintained between:
  - Minimising the long-term cost of funding and
  - Minimising the volatility of funding costs from year to year.

- **Foreign Exchange Risk** is managed to minimise adverse variation to budget for approved expenditures.

- **Counterparty Credit Risk** is managed to maintain an acceptably low risk of the DHB incurring a significant financial loss as a result of a counterparty’s inability or unwillingness to meet its financial obligations.

- **Operational Risk** is managed to maintain an acceptably low risk of the DHB incurring a significant financial and/or reputational loss as a result of fraud, error, negligence, or systems failure.

- **Reporting** on treasury activities and risks (including compliance with the terms of this Policy) is compiled by suitably independent personnel and provided to the Executive and the Board on a regular basis.

### 2. LIQUIDITY RISK

#### 2.1 Definition & Objective:

Liquidity Risk is the risk that:

- In the long-term, inadequate funds exist to support required capital investment and/or re-finance existing long-term debt as it matures.

- In the short-term, inadequate funds exist to meet current liabilities as they fall due.

The **objective** of Policy is to manage Liquidity Risk, to ensure that sufficient funds are available at all times to meet the DHB’s financial obligations in an orderly manner.
2.2 Management:

2.2(a) Narrative:

The DHB’s long-term liquidity risk is currently minimal, as all long-term debt funding is expected to be provided by the Ministry of Health or its successor organisations (MOH), whose current practice is to maintain a long-dated expiry date for all debt facilities.

The DHB’s short-term liquidity risk is also considered minimal, as all short-term cash balances (positive and negative) are managed through a Shared Banking arrangement between NZ Health Partnerships Limited (NZHP) and Bank of New Zealand (BNZ). For the purposes of this Treasury Policy, key features of the Shared Banking arrangement are as follows:

- Each participating DHB’s daily cash balances are swept into a central account held by NZHP at BNZ. Swept balances are technically defined as Loans (eg. DHBs lend positive cash balances to NZHP, or borrow from NZHP to fund negative cash balances).
- NZHP is required to maintain a short-term borrowing facility with BNZ, sufficient to ensure that participating DHBs have access to their full cash balances as required.
- Participating DHBs may not maintain their own cash investments and/or short-term borrowing facilities (with the exception of EECA loans) outside the daily sweep arrangement, unless approved by NZHP.¹
- Participating DHBs remain bound by the liquidity requirements of the Ministry of Health’s Operating Policy Framework – in particular, any DHB’s net negative cash position may not exceed one month’s Funder to Provider Arm revenue + GST.

2.2(b) Policy:

- The DHB will comply with the Terms of the Shared Banking arrangement, including that:
  - No short-term borrowings outside the daily sweep mechanism will be incurred (except for EECA loans), and
  - Term Deposits or other cash investments will be entered into subject to the investment protocols agreed.
- A rolling 24-month cash flow forecast will be maintained, demonstrating that the DHB will not at any time have a negative net cash position in excess of one month’s Funder to Provider Arm revenue + GST.

3. INTEREST RATE RISK

3.1 Definition & Objective:

Interest Rate Risk is the risk that, as a result of adverse market movements, the DHB experiences:
- Unacceptable variation in its cost of funding from year to year, and / or
- Unacceptable variation in its cost of funding compared to Budget

¹ Exceptions to this rule are DHB “trust funds” (which must be kept separate from “operational” funds) and any investments / borrowings already existing as at the Shared Banking arrangement’s Commencement date (such contracts may continue until expiry, but must thereafter be incorporated into the daily sweep mechanism).
The **objective** of Policy is to manage Interest Rate Risk, to ensure that an appropriate balance is maintained between minimising the long-term cost of funding and minimising the volatility of funding costs from year to year.

### 3.2 Management:

#### 3.2(a) Narrative:
Borrowers commonly face a tension between:
- Short-term (“floating”) interest rates, which tend to offer a relatively low but volatile cost of funding, and
- Long-term (“fixed”) interest rates, which tend to offer a relatively high but stable cost of funding.

Given the largely fixed nature of the DHB’s revenues and operating costs, it is appropriate to place greater emphasis on low volatility than low cost. This is best achieved by borrowing at fixed interest rates across a range of maturity dates.

It may be possible to add value by “actively managing” the DHB’s interest rate profile (that is, adjusting it to take advantage of a market view on current interest rates and/or future movements). However, such activity is inherently speculative, and is not a core business competency of the DHB.

#### 3.2(b) Policy:
- Term debt, **to the extent permitted under Ministry of Health policy from time to time**, will be borrowed at fixed interest rates, with maturities spread over time such that the maximum amount maturing in any one year shall not exceed 30% of the total facility.
- Where a specific interest rate re-pricing risk exists (eg. the “rolling-over” of an existing loan maturity, or the drawing of a new loan), then this risk may be “hedged” (in whole or in part) for the purposes of creating Budget certainty, **PROVIDED THAT**:
  - (in the case of existing debt maturities) only loans maturing within the coming 12 months may be “hedged”
  - (in the case of expected new borrowing arising from a capital project) “hedging” may only be undertaken consistent with a strategy approved by the DHB Board at or around the time of project approval
- Permitted “hedging” may be achieved either by agreement of an interest rate in advance with MOH or by the use of financial derivative products, **PROVIDED THAT**:
  - The size of the “hedge” does not exceed the underlying exposure, and
  - The derivative contains no element of optionality.

### 4. FOREIGN EXCHANGE RISK

#### 4.1 Definition & Objective:
Foreign Exchange Risk is the risk that, as a result of adverse market movements, the DHB experiences:
- Unacceptable variation in total operating cost compared to Budget, or
- Unacceptable variation in the cost of a specific project compared to Budget.
The **objective** of Policy is to manage Foreign Exchange Risk, to ensure that adverse variation to budget for approved expenditures is minimised.

### 4.2 Management:

#### 4.2(a) Narrative:
Foreign Exchange exposures are **recognised** as follows:

- For capital items, where a specific known item of sufficient magnitude exists
- For operational purchasing, where the expected purchasing exceeds a threshold amount

Foreign Exchange exposure is **heded** using a graded scale, depending on the certainty of exposure (eg. general budget approval vs. specific purchase order).

#### 4.2(b) Policy:

- Foreign Exchange Risk from **capital items** is recognised and hedged as follows:

<table>
<thead>
<tr>
<th>Event</th>
<th>Permitted Hedge Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spot or Forward FX</td>
<td>FX Options</td>
</tr>
<tr>
<td>Capex Budget approved</td>
<td>Nil  Up to 50%</td>
</tr>
<tr>
<td>Specific item approved</td>
<td>100%  Up to 100%</td>
</tr>
<tr>
<td>Purchase Order made</td>
<td>100% Nil*</td>
</tr>
</tbody>
</table>

- Foreign Exchange Risk from **operational purchasing** is recognised where exposure to each currency exceeds NZ$50k in any month. Recognised exposures are hedged as follows:

<table>
<thead>
<tr>
<th>Event</th>
<th>Permitted Hedge Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spot or Forward FX</td>
<td>FX Options</td>
</tr>
<tr>
<td>Budgeted next 12 months</td>
<td>100%  Up to 100%</td>
</tr>
<tr>
<td>Purchase Order made</td>
<td>100% Nil*</td>
</tr>
</tbody>
</table>

*Where a Purchase Order is issued on an item previously hedged with an option the option may continue until exercised or lapsed, but may not be renewed.*

### 5. COUNTERPARTY CREDIT RISK

#### 5.1 Definition & Objective:

Counterparty Credit Risk is the risk that the DHB incurs a financial loss as a result of a counterparty’s inability or unwillingness to meet its financial obligations.

The **objective** of Policy is to manage Counterparty Credit Risk, to ensure that the DHB’s exposure to financial loss is acceptably low.

#### 5.2 Management:

#### 5.2(a) Narrative:
Credit risk typically arises from cash balances, investments, financial derivative contracts, and debtors. Risk is controlled by (where possible) only transacting with counterparties with a certain minimum credit rating, and by limiting the extent of exposure to each counterparty.

The DHB’s Shared Banking arrangement results in no credit risk exposure to other DHBs, but considerable credit risk exposure to NZHP and banks with which NZHP holds investments (to the
extent that all cash balances are held by NZHP, but NZHP will pass on any losses it incurs as a result of default by those banks).
Under the DHB Treasury Services Agreement, NZHP is limited to investing with New Zealand registered banks with a Standard & Poor’s long term credit rating of A+ or better.

5.2(b) Policy:
- NZHP will be required to find an alternative provider of DHBs’ Shared Banking services in the event that BNZ’s Standard & Poor’s credit rating falls below “A+ (stable)” (for the avoidance of doubt, an “A+” rating which is on “negative watch” shall be unacceptable).
- The DHB’s maximum credit risk exposure to any other counterparty shall not exceed $10 million.
- Credit exposure arising from financial derivative transactions (if any) shall be calculated as:
  - For FX derivatives: (notional NZ$ amount) x (maturity in years) x 8%
  - For interest rate derivatives: (notional NZ$ amount) x (maturity in years) x 4%

6. OPERATIONAL RISK

6.1 Definition & Objective:
Operational Risk (in respect of treasury management) is the risk that the DHB incurs a financial and/or reputational loss as a result of human error, fraud, negligence, or systems failures.
The objective of Policy is to manage Operational Risk, to ensure that the DHB’s exposure to financial and/or reputational loss is acceptably low.

6.2 Management:

6.2(a) Narrative:
Operational risk is typically managed through:
- The structural separation of duties (eg. between execution of transactions, cash payments & receipts, and reporting),
- The bi-lateral requirement for all transactions to be based on standard payment details (and/or other written instruction),
- The maintenance of adequate information systems to capture transactions and report on exposures, and
- Regular internal and external auditing.

6.2(b) Policy:
The Board delegates the following authorities & responsibilities for the establishment, execution, and reporting of treasury-related activities:

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>DISCRETION TO</th>
<th>PARAMETERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREIGN EXCHANGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treasury Policy</td>
<td>Board</td>
<td>Approve the Policy and agree to any changes or requests that are outside of Policy</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Officer</td>
<td>Make submissions to change the policy, or to make requests that are outside of policy</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>DISCRETION TO</td>
<td>PARAMETERS</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Entering into spot or Forward Contracts</td>
<td>Chief Executive Officer</td>
<td>Authority to transact deals up to $10 million in face value, at any one time</td>
</tr>
<tr>
<td></td>
<td>General Manager, Finance and Corporate Services</td>
<td>Authority to transact deals up to $5 million in face value, at any one time</td>
</tr>
<tr>
<td></td>
<td>Financial Services Manager</td>
<td>Authority to transact deals up to $2 million in face value, at any one time</td>
</tr>
<tr>
<td></td>
<td>Financial Accountant</td>
<td>No authority</td>
</tr>
<tr>
<td>Deal/ Settlements</td>
<td>Board</td>
<td>Approve the list of authorised signatories for settling deals</td>
</tr>
<tr>
<td></td>
<td>Chief Executive Officer</td>
<td>Can act as a backup dealer if required.</td>
</tr>
<tr>
<td></td>
<td>General Manager, Finance and Corporate Services</td>
<td>Authorised to enter into deals or leave orders with approved financial institutions.</td>
</tr>
<tr>
<td></td>
<td>Financial Accountant</td>
<td>Completes all order and deal reconciliations.</td>
</tr>
<tr>
<td></td>
<td>General Manager, Finance and Corporate Services &amp; Financial Services Manager</td>
<td>Any two signatures required from authorised signatories.</td>
</tr>
<tr>
<td>COUNTERPARTY CREDIT RISK LIMITS</td>
<td>Board</td>
<td>Approves list and changes to approved counterparties</td>
</tr>
<tr>
<td>List of approved counterparties</td>
<td>Chief Executive Officer</td>
<td>Monitoring, annual review and recommendations to add and delete names, or alter limits.</td>
</tr>
<tr>
<td>OPENING AND CLOSING OF BANK ACCOUNTS</td>
<td>Board</td>
<td>To approve opening or closing bank accounts</td>
</tr>
<tr>
<td></td>
<td>General Manager, Finance and Corporate Services</td>
<td>To be authorized signatory to change bank accounts after Board approval</td>
</tr>
<tr>
<td>CHANGES TO ACCOUNT SIGNATORIES</td>
<td>The DHB is to have a minimum of three account signatories of which the General Manager, Finance and Corporate Services must be one.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General Manager, Finance and Corporate Services</td>
<td>To maintain updated list of account signatories</td>
</tr>
<tr>
<td>ELECTRONIC FUNDS TRANSFER</td>
<td>For external payments that are made electronically, the following rules will apply: Two authorized users review and approve the transaction. One of the authorized users must be a account signatory on the account the payment is to be made from</td>
<td></td>
</tr>
<tr>
<td>TERM DEPOSITS</td>
<td>Financial Services Manager</td>
<td>Any two signatories required from authorised signatories.</td>
</tr>
</tbody>
</table>
Policy for Treasury Management

- This Treasury Policy shall be reviewed by the Finance, Risk and Audit Committee at least every three years.
- Any changes in authorised personnel or standard settlement instructions must be communicated to all relevant counterparties immediately in writing.
7. REPORTING

Reporting on treasury activities and risks (including compliance with the terms of this Policy) is compiled by suitably independent personnel and provided to the Executive and the Board on a regular basis.

7.1 Management Reporting:

The following management reporting shall be produced:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Report</th>
<th>Compiler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>• Treasury Summary (part of finance report)</td>
<td>• Financial Services Manager</td>
</tr>
</tbody>
</table>

7.2 Board Reporting:

The following Board reporting shall be produced:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Report</th>
<th>Compiler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>• Treasury Summary (part of finance report)</td>
<td>• Financial Services Manager</td>
</tr>
</tbody>
</table>

8. APPENDICES

Appendix  Glossary of Terms

9. KEYWORDS

Treasury management
Appendix

GLOSSARY OF TERMS

Fixed rate
Is defined as an interest rate repricing maturity of greater than 1 year.

Floating Rate
Is defined as an interest rate repricing maturity from overnight out to 1 year.

Interest rate swap
An agreement between two parties to exchange their interest obligations over a specific period. One party will make payments to the other based on the floating rate, while the other makes payments based on a fixed rate. Only the net of these transactions is paid or received – no principal is exchanged.

Forward rate agreement
A contract between two parties where each party agrees to fix an interest rate (contract rate) for a specified future settlement date, based on an agreed amount. No principal is exchanged. The future settlement date is a maximum of 12 months.

Interest rate option
A borrower cap is a contract, which gives the borrower the right but not the obligation to borrow an agreed notional amount at a predetermined interest rate for a specific period of time. In return for this right the borrower pays a premium to the seller of the option.

A borrower floor is a contract, which gives the lender the right but not the obligation to lend an agreed notional amount to the borrower at a predetermined interest rate for a specific period of time. In return for this right the lender pays a premium to the borrower (seller) of the option.

Government Stock
Government issued debt security around which a country’s debt market is based.

Bank bill
A debt instrument issued by a bank for a specified tenor or maturity. Most commonly used borrowing benchmark by the market. Tenor is usually for 30, 60, 90 or 180 days.

Bond forward rate agreement
An agreement that can be entered into to fix the base rate that a corporate bond, to be issued in the future by a company, will be priced off.

Swaption
The right but not the obligation to enter into an interest rate swap at some point in the future at a set rate. The borrower must pay a premium for this right.
For:

<table>
<thead>
<tr>
<th></th>
<th>Decision</th>
<th>Endorsement</th>
<th>Noting</th>
</tr>
</thead>
<tbody>
<tr>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**To**

Board

**Author**

Scott Ambridge, Chair, Business Improvement Group, General Manager, Enable New Zealand

John Manderson, Programme Manager

**Endorsed by**

Chief Executive Officer

Finance, Risk & Audit Committee

**Date**

16 June 2017

**Subject**

BUSINESS IMPROVEMENT UPDATE

**RECOMMENDATION**

- that the update on the Business Improvement report be noted.

**Strategic Alignment**

Aligned to Strategy and Annual Plan and the District Health Board’s goal of achieving financial sustainability.

**Glossary**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDHB</td>
<td>MidCentral District Health Board</td>
</tr>
<tr>
<td>EY</td>
<td>Ernst Young</td>
</tr>
<tr>
<td>DHB(s)</td>
<td>District Health Board(s)</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>CIO</td>
<td>Chief Information Officer</td>
</tr>
<tr>
<td>BBC</td>
<td>Better Business Case</td>
</tr>
<tr>
<td>PMI</td>
<td>Project Management Institute</td>
</tr>
<tr>
<td>CAPM</td>
<td>Certified Associate in Project Management</td>
</tr>
<tr>
<td>PMP</td>
<td>Project Management Professional</td>
</tr>
<tr>
<td>ILM</td>
<td>Investment Logic Mapping</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
</tbody>
</table>

**COPY TO:**

Finance & Corporate Services

MidCentral DHB
Heretaunga Street
PO Box 2056
Palmerston North 4440
1. PURPOSE

The purpose of this paper is to update the Board and Finance, Risk & Audit Committee on our Business Improvement Plan. This includes:

- Current project performance
- EY (Ernst Young) Independent Critique final report
- New approach to our improvement efforts
- Plan and Framework progress.

This report as noted above includes a comprehensive update on the final EY Independent Critique that was presented to DHB Leaders 9-10 May 2017. In addition, progress to date on the campaigned styled approach to our improvement efforts is outlined.

2. SUMMARY

2.1 Current project performance

Project results

Our Business Improvement Plan was established with 36 discrete projects for the 2016-2017 year of which 13 are now complete and only 13 to be monitored going forward as they are still providing sustainable benefits. The remaining 10 will cease 30 June 2017. After assessment it has been determined that they will not be taken forward.

Actual performance is $5,397m against a target of $5,353m for YTD April 2017 (101 percentage). The table below displays a graphical representation of performance to date.

Due to the timing of benefits being realised across the financial years, current projects have achieved 101 percentage of their expected savings YTD which is a solid improvement from 83 percent
in March 2017. We expect to land on target for the year in the absence of any unexpected challenges. For more information see section 3.

There currently six items equating to $1.4 million currently included in the draft 17/18 year budget. A number of other opportunities have been identified through this process and these will be further developed by the organisation with the aim of generating a further $4 million to $6 million in “savings” to help support the current budget deficit position.

2.2 Business Improvement Plan and Framework

Business Improvement has been positioned to support the DHB now and into the future through ensuring our improvement initiatives are aligned with our vision & strategy. This goes beyond incremental change to transform clinical and business models so that best practice becomes common practice in everything we do. This includes:

- Executive leadership, champions & navigators
- Programme Management
- Best practice standards, methods and processes
- Wrap-around support to build our internal staff.

The role of Business Improvement is ultimately to support the improvement project lifecycle:

1. Project Set-up
2. Understand and Diagnose the Problem
3. Generate Ideas and Test
4. Implement and Sustain
5. Learn and Spread.

This will ensure rigour in all aspects of understanding, scoping, implementing and evaluating. The responsibility and accountability of the Improvement sits with the identified Lead/Sponsor who works in partnership with other Leaders to ensure the benefits are fully realised collectively.

2.2.1 EY Independent Critique Findings, Recommendations & Actions

With the release of the final EY Independent Critique this has shaped the Business Improvement Group work programme going forward. As previously reported MDHB commissioned EY in November 2016 to conduct an independent high-level critique of the organisation. The key drivers were:
• Financial deficit and deteriorating performance
• Recent clinical reviews which raised a number of historical quality and safety concerns
• A recent finance and IT capability review.

The critique has been developed through document and data analysis, stakeholder engagement, and EY’s experience in leading health organisations and health systems, drawing on local and global leading practice. The final report was presented to ELT and the Board in April 2017. In early May 2017, a series of workshops were held with executive, clinical and operational leadership to fully socialise the report and seek additional feedback. There was general agreement with the findings and strong support to take action on the recommendations.

Findings

The following findings were detailed:

• Resources have increasingly been allocated to hospital based services limiting opportunities for greater investment in local provider services
• Stronger financial disciplines are needed to manage cost pressures in particular the strong growth in personnel costs e.g. medical costs have been growing faster than revenue growth
• Efficiency improvements could reduce bed capacity needs by a third going forward
• Normalising acute demand rates across general practices could produce significant savings
• The organisation needs to improve its collection, use and reporting of quality and safely information.

Recommendations

The following recommendations were made:

• Build new capability in data and analytics to align investment with priorities and drive value across the system
• Review and align the organisation behind the newly developed strategy
• Implement the organisational development strategy
• Purposefully develop the organisational culture to align with a focus on innovation and continuous improvement
• Develop new models of care to put the strategy into practice.

Actions

The findings & recommendations align with our approach going forward:

• Work to establish Clusters (integrated services) over the next 15 months has started with a robust change management plan in development
The appointment of Mr Keyur Anjaria as General Manager for People & Culture to implement our Organisation Development Strategy

The appointment of Mr Steve Millar to the new position of CIO. This role has been tasked to refresh our ICT strategy & roadmap with the initial priorities being better sharing of patient information between hospital and primary care services, and increasing our business intelligence and data analytics capability

The recruitment for a new General Manager for Quality & Innovation is underway. This new role will be tasked to provide overall organisational leadership across the areas of quality, continuous improvement, clinical governance and innovation

Significant progress has occurred with our communities in developing Locality Plans to ensure we meet the needs of our community now and into the future

The Business Improvement Plan & Framework has been developed which will underpin our improvement efforts including a new campaign styled approach to our continuous improvement efforts.

This will include a greater focus on patient flow channels, utilisation of resources and developing the models of care to take us forward.

The critique will support MidCentral DHB’s Executive and Board to deliver on the organisation’s recently established strategic priorities. The Business Improvement Group will facilitate implementation and delivery of the actions outlined.

2.2.2 Bringing together our improvements efforts

As previously reported to FRAC and the Board, Business Improvement was tasked to look at our improvement efforts to fully understand what is working and what is not working in order to scope a new approach. Over the 6-8 weeks engagement sessions with stakeholders from primary, secondary, consumer representation and with other exemplars across New Zealand occurred. This engagement identified strong support to:

- Align our improvement efforts behind a common commitment to help achieve our vision & strategy
- Build on existing talent, resources & partnerships with specialist wrap-around support to take us forward
- Start small but aim big – get the right mix of quick wins and long term system changes through new models of care
- Deploy proven industry standard methods & processes in improvement science, P3 (portfolio, programme & project) and building the compelling case to invest.

This approach would provide:

- A visible commitment to put in place the investment required to develop and deliver on our improvement programme
Better identify pockets of excellence and ensure their successes are visibly celebrated while understanding why it is working.
Put a more targeted spotlight on what is not quite working to ensure more support is given, take the time to pause & consider, or even say it is time to stop.

And will ultimately lead to:

- Improving patient and whanau outcomes, patient flow and utilisation of existing resources
- Harnessing staff creativity to seek, solve and share so best practice becomes common practice
- Providing the evidence to support new models of care now and into the future.

This campaign styled approach has been informally called 5,000 Days. This mirrors Counties DHB first two campaigns around returning health and well days back to their community safety and effectively. The final naming and messaging will be confirmed during co-design with our people and community, but the current working title is *Better Health Outcomes*.

### 2.2.3 Framework

Our Business Improvement Plan as previously reported is focused on four quadrants (*see section 4 for further information*). One particular area of focus is best practice standards, methods and processes. This is essentially about providing the rights tools to our staff to help them in project management, improvement science and putting together the case to change/invest. As part of the campaign development work, we have been working with exemplars to understand what tools have proven to be successful. This work has been about both confirming existing practice and considering more advantageous options.

Below outlines the tools that have been identified:

**Improvement techniques**
- Model for Improvement utilising PDSA cycles for quality and flow opportunities

**Understanding & building the compelling Case to Invest**
- Investment Logic Mapping (ILM) for assessing and validating proposals
- Better Business Cases (BBC) 5 case approach for evaluating and building a robust “case for change” that is aligned with strategic goals

**Programme/Project Management**
- Project Management Institute (PMI) Certified Associate in Project Management (CAPM) and Project Management Professional (PMP) training
• Programme Management to support project inter-dependencies, constraints and alignments and leveraging resources to meet multiple needs.

Bringing together training, templates, guides and exemplar examples is now underway to ensure staff have access to all the materials they need.

The toolkit with programme management (connected view) and wraparound support will provide the necessary framework supported by Executive leadership and mandate to take us forward.

2.2.4 Annual Plan and Budgeting

As noted six improvement items have been included in the budget with savings of $1.4 million. They have been deemed sufficiently robust in both timing and target while ensuring patient outcomes are maintained. An additional 13 items are being scoped for inclusion in the 17-18 budget.

With tighter integration with the budgeting & planning cycle and a new approach to our improvement efforts will ensure we maximise the results of everyone’s effort for our people & community.

2.2.5 Business As Usual – opportunities from the front line

As part of discussions with our people, opportunities that emerge are always considered. In particular, we are working the Cutting Edge DHB team to take ideas that have been proposed, but not taken forward for commercialisation. Further work is required but the key message is to acknowledge and work with our staff who have an idea to see how it could support our people and community.

It is expected the open sessions as part of the campaign co-design will identify, scope and prioritise these ideas for further work.

2.2.6 Next steps

Business Improvement is focused on identifying work we can do now, what we need for the future while not losing sight of opportunities that present unexpectedly. The focus for us is to finalise the components that make up the plan and framework in preparation to support the DHB work programme going forward.

Horizon Year 1 (2016-2017)

• Implement refocused business improvement plan & framework
• “Better Health Outcomes” campaign development
• Support 17-18 annual planning & budgeting process activities
• Support Cluster concept development

Horizons Year 2 (2017-2018)

• “Better Health Outcomes” campaign
- Support Cluster implementation
- Business improvement is fully integrated into the annual planning & budgeting process
- Supporting opportunities from the front-line.

This will be the challenge for the wider organisation, but one we are all ready to take on.

3. BUSINESS IMPROVEMENT PROGRAMME

The updated improvement projects are summarised by improvement type as follows. The most productive areas of investigation so far have been in reducing our procurement costs and achieving more efficient service delivery with a particular improvement in Pharmacy.

<table>
<thead>
<tr>
<th>Category</th>
<th>Business Improvement Plan</th>
<th>MOH Savings Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Projects</td>
<td>Average Life Cycle Stage</td>
</tr>
<tr>
<td>HOSPITAL SERVICES</td>
<td>5</td>
<td>2.2</td>
</tr>
<tr>
<td>SC&amp;RS</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>MENTAL HEALTH</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>COMMERCIAL SUPPORT</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td>PROCUREMENT</td>
<td>6</td>
<td>4.0</td>
</tr>
<tr>
<td>FUNDING &amp; PRIMARY</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>INVESTMENT CASES</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>ENABLE NZ</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td>COMPLETE</td>
<td>13</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>3.7</td>
</tr>
</tbody>
</table>

*SC&RS: Specialist Community and Regional Services*
4. BUSINESS IMPROVEMENT PLAN AND FRAMEWORK

The following is a graphical representation of our Business Improvement Plan and Framework

**Business Improvement Plan**

**Our Framework**

To ensure improvement initiatives are aligned with our vision & strategy, going beyond incremental change, to transform clinical and business models so that best practice becomes **common practice in everything we do**.
Identifying & connecting programmes of work while looking out for opportunities from the front-line.

The Broader Context – Our Role

Support opportunities from the front line

Enabling clinical & financial sustainability in our decision making

Transformational improvement support to Clusters

Supporting development and learning opportunities through the OD Plan

Integrated into the annual planning & budgeting cycle

By doing this we hope to achieve

Getting back to basics...what do we need in place to support our people achieve our vision

Looking at all opportunities to reduce waste safely and effectively

Partnering with our community and people

Getting the right mix of quick wins and long-term system change through new models of care

Ensuring our changes are effective and sustainable
5. **RECOMMENDATION**

It is recommended:

*that the update on the Business Improvement report be noted.*

Scott Ambridge  
Chair, Business Improvement Group  
*General Manager, Enable New Zealand*

John Manderson  
Programme Manager
MidCentral District Health Board
Finance, Risk & Audit Committee Meeting

Minutes of the Meeting of the Finance, Risk & Audit Committee, held on Tuesday, 6 June 2017 at 10.00am in the Boardroom, MidCentral DHB Board Office, Heretaunga Street, Palmerston North

Part I

PRESENT:
Tony Hartevelt (Chair)
Ann Chapman (Deputy Chair)
Nadarajah Manoharan
Karen Naylor
Barbara Robson
Dot McKinnon

IN ATTENDANCE:
Kathryn Cook, Chief Executive Officer (left meeting at 11.16am rejoined meeting at 12.06pm)
Neil Wanden, General Manager, Finance & Corporate Services
Craig Johnston, General Manager Strategy, Planning & Performance
Michele Coghlan, Acting Executive Director, Nursing & Midwifery
Diane Anderson, Board Member
Scott Ambridge, General Manager, Enable New Zealand
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Nicholas Glubb, Operations Director Specialist Regional & Community
Lyn Horgan, Operations Director, Hospital Services
Greig Russell, Medical Administration Trainee
Jared McGillicuddy, Central TAS
John Manderson, Programme Manager – Business Improvement Programme
Jeff Small, Group Manager, Commercial Support Services
Chris Channing, Financial Services Manager
Gabrielle Scott, Executive Director, Allied Health
Steve Tanner, Finance Manager, Funding Division
Cushla Lucas, Service Manager, Regional Cancer Treatment Service
Denise Mallon, Manager, Project Manager, CT Replacement Project
Leith Marshall, Service Delivery Manager, Information Systems
Angie Guy, Committee Secretary

1. APOLOGIES

An apology was received from Committee Member Anne Kolbe.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendments to the Register of Interests
3.2 Declaration of Conflicts in Relation to Today’s Business

Barbara Robson noted that Anne Kolbe’s interest in Auckland University had not been changed as requested at the previous meeting of 26 April. “Nature of Interest” to note that Anne Kolbe is not an employee at Auckland University and does not draw a salary.

Ann Chapman requested her TAS conflict of interest for Items 6.1 and 6.2 be noted.

Moved: K Naylor Seconded: D McKinnon Carried

4. MINUTES

4.1 Minutes

It was requested that Page 12 of the minutes be changed to read: “This audit concluded that there were some areas of moderate fraud risk identified……”

Recommendation: that the amended minutes of the previous meeting held on 26 April 2017 be confirmed as a true and correct record.

Moved: K Naylor Seconded: D McKinnon Carried

4.2 Recommendations to Board

To note that all recommendations contained in the minutes were noted by the Board.

4.3 Matters Arising from the Minutes

To be noted in the “Work Programme” that there were still points to be actioned. These points including the Health & Safety at Work Act need to remain visible so progress can be monitored.

5. GOVERNANCE

5.1 FRAC Work Programme

This programme reflects the work programme for 2017/18 and items that have been carried over. There are items that are not ready to be reported to FRAC ie Boiler Upgrade and the ISSP.

The final budget paper as proposed cannot be put forward due to timing issues. The Chair noted that the role of the Committee is to provide advice to the Board. Accordingly he asked that FRAC consider the ramifications of the budget prior to going to the Board. This would mean that FRAC would need to hold a special meeting at 8.30am on the morning of the Board’s next scheduled meeting on 4 July 2017. The full detail of funding implications arising out of the recently announced Government budget are not yet known despite the Ministry of Health expectation that MDHB’s preliminary budgetary decisions will be with the Ministry by 16th June. The Chief Executive Officer is to identify if an extension is needed.

Progress on waste minimisation was raised as not included on the work programme, the Chief Executive Officer spoke of the good work that is currently happening which will be fed back possibly through FRAC and/or Board. It was noted that water quality and typhoid shouldn’t be linked together at this stage as had been done on Page 18 of the Work Programme.

Havelock Water Incident: It is to be noted that there is now a Stage 2 of the process that will have recommendations going forward and ensuring responsibilities are decided.
Action: Chief Executive Officer to identify if an extension is needed on submitting the Budget to the Ministry of Health.

Action: Chief Executive Officer to feedback work from Environmental Sustainability Group when to hand.

Action: A special FRAC Meeting be called for 8.30am, Tuesday 4th July 2017 to discuss the final budget paper.

Recommendation: that progress against the 2016/17 work programme, and, the Committee’s work programme for 2017/18 be noted.

Moved: A Chapman  Seconded: K Naylor  Carried

6. AUDIT

6.1 Internal Audit Update

A Chapman noted her TAS conflict of interest. The paper outlined the progress against the month. It was noted that the “Controlled Drugs Management” audit was added at MDHB’s request. The Chair requested clarification of the impact of delay given there were only two projects completed and assumed the rest would roll into 2017/18 year. He was concerned that the 2017/18 year would not be able to be completed due the “snow plough” effect of delays from the current year. Mr McGillicuddy acknowledged that TAS’ workload has been high, but it is expected that a further two audits will be completed by the end of month along with the ACC audit. It is envisaged that all work will be finished by the end of June with the exception of “Controlled Drugs Management”. The delay at the beginning of the year has impacted progress. The Francis Group Report which is an independent report will be completed after June.

Recommendation: that the Committee note the update on the progress on the internal audit programme for the 2016/17 year.

Moved: D McKinnon  Seconded: K Naylor  Carried

6.2 Draft Internal Audit Plan 2017/18

A Chapman noted her TAS conflict of interest. The process of selecting reviews for the 2017/18 year was rigorous and included looking at strategic risk areas at both national and regional levels as well as prioritisation of reviews. The rationale of why they should be included is taken into consideration. In Figure 2: seven of eleven risks exceeded what the Board would consider “tolerable”. There is a need for regular engagement with the Board with regards to managing the risk. The Chair noted this was a very sound paper and an excellent piece of work. There was discussion that some would like to see more risks addressed, however the reality is that resource constraints force prioritisation of the work program. Clinical risk is still a major concern and is ongoing and it will be imperative that the Clinical Audit Committee is established so that these issues can be addressed. The Chief Executive Officer recommended that clinical risks be taken to the Quality and Excellence Committee.

Recommendation: that FRAC endorse recommendation to the Board that the 2017/18 Internal Audit Plan be approved.

Moved: K Naylor  Seconded: A Chapman  Carried

7. STRATEGIC & OPERATIONAL PLANNING

7.1 2017/18 Budget Update

The Minister’s “Letter of Expectations” stipulates that MDHB must breakeven for the year ahead. Of the additional $439m that Government has voted for Health this year the MDHB allocation is proportionally higher than we expected. Funding based on the Population Based Funding Formula is likely to erode this gain beyond 2017/18 and the additional funding level will be adjusted down to reflect the “windfall” this year. It is therefore important that the extra available is applied to short term
initiatives and not built into ongoing operating costs. With this proposed funding it will facilitate a “manageable” breakeven result as opposed to “under extreme pressure”.

Programmes of work to transform the hospital to a higher performer than it is currently are being established however. At present there are still more resources going into hospital than sustainable. To address this will result in significant pieces of work being undertaken to meet the challenges.

Recommendation: that the 2017/18 Budget Update paper regarding the funding envelope be noted by the Committee.
Moved: A Chapman    Seconded: D McKinnon    Carried

7.2 Theatre Productivity Review (Francis Group)

There has been a first meeting with clinicians who are very engaged in the programme of work and the Terms of Reference have been agreed to. Hutt Valley DHB, Capital Coast as well as Hawkes Bay have also undertaken similar work with the Francis Group.

Phase I is due to be completed in 12 weeks then another phase will follow. There is support for the Francis Group to undertake the project and the report was considered very sensible. Consideration has been given to private providers eg Crest’s theatres could be used on a temporary basis in the interim but any decision on that would not be taken until after the review. It was noted that Crest theatres would be leased, but not the services of private clinicians and that it would be for short term only relief.

Recommendation: that the Committee note the Theatre Productivity Review
Moved: K Naylor    Seconded: A Chapman    Carried

7.3 Information Systems Projects Update

Regional Health Informatics Programme, there are four aspects of the informatics, Clinical Portal is to go live first although there have been significant difficulties with data migration for both this and for RIS. Whanganui are already live on Clinical Portal with this puts constraints on MDHB. Delays to Clinical Portal could have a possible “knock-on” effects with RADA and WebPAS although as yet the buffers between projects have been sufficient to absorb any cumulative effects. The Hospital Operations Centre has received ministerial approval and a contract with the vendor Alcidion was signed on 24 May. The Implementation Planning Study is underway.

There was a very long lead time in the SSU project due to change of vendor and also the consideration of using another product.
Action: It was requested that MCIS be added into this report in future.

Recommendation: the Finance, Risk & Audit Committee note the status of various Information Systems Projects currently underway as set out in this paper.
Moved: B Robson    Seconded: Karen Naylor    Carried

7.4 Ransomware

There was a new variant of Ransomware (“Wannacry”) released globally recently. In the UK, NHS hospitals suffered significant impact. Learnings from previous experiences put MDHB in good stead. Within three hours on a Saturday morning Information Services had isolated networks, confirmed security was up to date and effective, and returned to normal service. The prompt response by the team was to be acknowledged and the Service Delivery Manager will pass this on to the team.

It was noted that previous ransomware relied on an “opportunity” to infect, this latest version however “propagated” then infected. The Service Delivery Manager will report back when discussions with other agencies/DHBs have been held.
It has been requested that Enable New Zealand should be included in the scope of testing from this point forward.

**Action:** Service Delivery Manager to report back to FRAC in August.

**Recommendation:** that the Committee note the response of MDHB to the global “WannaCry” ransomware episode.

*Moved: D McKinnon  Seconded: N Manoharan  Carried*

### 7.5 GST Compliance

This paper presented to the Committee the findings of an internal review. Whanganui had undertaken an audit so provided their questionnaire to MDHB to use as a guide. Two areas identified were: GST output tax liability on residential care payment and the amount of zero rated GST not disclosed on returns which had no financial impact on the return. These have both been corrected to be fully compliant.

**Recommendation:** that the Committee note the findings of the internal review carried out on GST processes.

*Moved: K Naylor  Seconded: T Hartevelt  Carried*

### 7.6 Progress Report Ward 21 Facilities

This paper outlined the summary of work done to date and of work still to be done. There is a Health Planner working with the team to scope longer term options as well as the strategic site planning project underway. The results will then go to ELT for consideration. It was requested that a report be sent to the Quality & Excellence Committee as well. The assessment will be completed by end July to be presented to ELT. A “Needs Analysis” will be determined first before a Business Case is commenced. Barbara Robson sought assurance that the Business Case will go to FRAC and the Board as a “staged process”. Clarity around the timeframe is needed and remains fluid at this stage.

**Recommendation:** the Finance & Audit Committee note the progress that has been made to date and the longer term options being explored.

*Moved: K Naylor  Seconded: B Robson  Carried*

### 7.7 Capital Expenditure Plan

The Hospital Operations Centre, Communication Cabinets and Regional Health Informatics Programme will have their budgets revisited if necessary as well as any other projects of significance in IT. Clinical equipment, including replacement programmes and Cathlab are works in progress and under active management.

The buildings schedule includes Ward 21 and the Acute Services Block. Currently there is evaluation work being undertaking and this will be integrated with other functional needs as an overall long-term plan. Destravis are carrying out this work at present developing options.

The deferral of work for Renal facilities will not have a negative impact due to the planned use of home dialysis and placement of three renal chairs at Horowhenua. There will be a rolling needs assessment presented to the Board on a quarterly basis.

**Recommendation:** note the proposed Capital Expenditure Plan for 2017/18 and out-years, and changes from the LTIP as set out in this paper; endorse the proposed Capital Expenditure Plan for inclusion in the Annual Plan.

*Moved: D McKinnon  Seconded: Barbara Robson  Carried*
8. PERFORMANCE REPORTING

8.1 Financial Report April 2017

April had an operating surplus of $3,472k which was $1,913k favourable to budget for the month this included the $2m uplifted banked revenue. There is now a need to maintain sound financial performance over the next two months in order to meet the $2m surplus required. Personnel costs continue to have a significant negative effect. This month Pharmac rebates have been available to offset that. There were a substantial number of patients in the month of April and this pressure will have an adverse impact on next month’s results.

Recommendation: that the financial results for April 2017 be noted.

Moved: K Naylor  Seconded: D McKinnon  Carried

8.2 Business Improvement Programme

The actual performance against target has been on target. The Ernst Young report, supported by MDHB, has been discussed at various forums and covers key points. The next step will be to develop a framework over the next year. It had been raised at a recent Board meeting that the costs and benefits of external consultants need to be understood. The business savings calculated in the plan were explained to the Committee.

Recommendation: that the update on Business Improvement report be noted by the Finance, Risk and Audit Committee

Moved: N Manoharan  Seconded: D McKinnon  Carried

9. POLICY

9.1 Treasury Management

This policy was originally standardised in 2012 when shared banking arrangements were established. Since then there has been a move from Health Benefits to New Zealand Health Partnerships and a change of bank from Westpac to BNZ. Other than reflecting those changes, the updates made to this policy have been minor to customise for MDHB changes in roles.

Recommendation: note the changes proposed to the Treasury Management Policy; and endorse the amended policy for approval by the Board.

Moved: B Robson  Seconded: K Naylor  Carried

10. BUSINESS CASE

10.1 Project Progress Report Radiation Oncology CT Scanner

The Committee was informed of the project’s progress and anticipated issues encountered due to the building being 45 years old. There was always expectation that there would be issues that would be uncovered when building commenced. At this stage the contingency is considered sufficient to cover any issues that may arise. Completion is expected to be on time and on budget.

Recommendation: that the progress outlined in this report on the replacement radiation oncology CT scanner be noted.

Moved: A Chapman  Seconded: K Naylor  Carried

11. LATE ITEMS

12. DATE OF NEXT MEETING
Tuesday, 18 July 2017, plus a special “budget” meeting on 4 July.

13. **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 reasons.

<table>
<thead>
<tr>
<th>Item</th>
<th>Reason</th>
<th>Ref</th>
</tr>
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<tbody>
<tr>
<td>“In Committee” Minutes of the previous meeting</td>
<td>For reasons stated in the previous agenda</td>
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<tr>
<td>Insurance Arrangements</td>
<td>Under negotiation</td>
<td>9(2)(j)</td>
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<tr>
<td>Central Alliance Laboratory Services</td>
<td>Commercially sensitive and subject of negotiation</td>
<td>9(2)(i)</td>
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MidCentral District Health Board

Minutes of the joint Healthy Communities Advisory Committee and Quality & Excellence Advisory Committee meeting held on 13 June 2017 commencing at 9am in the Boardroom, MidCentral District Health Board

The shared matters of interest section of the meeting commenced at 9.00am.

This section of the meeting was chaired by Brendan Duffy, Chair, Healthy Communities Advisory Committee.

PRESENT

HCAC Members
- Brendan Duffy (Chair)
- Adrian Broad (Deputy Chair)
- Barbara Cameron
- Ann Chapman
- Nadarajah Manoharan
- Dot McKinnon (ex officio)
- Vicki Beagley
- Donald Campbell
- Jonathan Godfrey

QEAC Members
- Diane Anderson (Chair)
- Karen Naylor (Deputy Chair)
- Michael Feyen
- Oriana Paewai
- Barbara Robson
- Dennis Emery
- Duncan Scott
- Cynric Temple-Camp

IN ATTENDANCE

Kathryn Cook, Chief Executive
Craig Johnston, General Manager, Strategy, Planning & Performance
Neil Wanden, General Manager, Finance & Corporate Services
Megan Doran, Committee Secretary
Gabrielle Scott, Executive Director, Allied Health
Ken Clark, Chief Medical Officer
Chiquita Hansen, CEO, Central PHO
Vivienne Ayres, Manager, DHB Planning and Accountability
1. **APOLOGIES**

There was one apology from Tawhiti Kunaiti. Adrian Broad for lateness.

2. **CONFLICT AND/OR REGISTER OF INTERESTS UPDATE**

2.1 **Amendment to the Register of Interests**

There were no amendments to the Register of Interests.

2.2 **Declaration of Conflicts in Relation to Today’s Business**

Barbara Cameron advised she is the Deputy Chair on the District Licensing Committee for the Manawatu District Council.
3. INTEGRATION

3.1 Mental Health & Addictions Update

The Service Director Mental Health & Portfolio Manager Mental Health and Addictions apologised and expressed his disappointment that the Ward 21 Acute Mental Health facility project had not progressed as far as expected. The CEO advised that the immediate facility risks identified as part of the external review had been resolved and that planning for the larger redesign exercise is underway. A co-design group including family/whanau/consumer representation and an external consultant will develop a business case. The consultant will have planned visits with the DHB over the next two weeks. A further update will be provided to the Quality & Excellence Committee at their July meeting.

The committees were advised that the Mental Health Social Sector Hui is to be held on 22 June 2017 at the Manawatu Golf Club. It was acknowledged there has been more support and interest by the Mayors of the Region, including the Tararua and Palmerston North councils.

It was recommended:

that this report be noted

3.2 Central PHO Presentation

Dr Bruce Stewart, Chair of Central PHO and Ms Chiquita Hansen, Chief Executive of Central PHO made a presentation on the activities of the PHO. This included a presentation on a redesign of the Primary Mental Health Service which is currently underway. It was highlighted that considerable resource, a 4-5 fold increase in FTE, was absolutely critical if the model was to have a change of success. This presentation was a joint effort and involved Dr David Ayling and Mr Chris Nolan, Director of Mental Health and Addictions Services for MidCentral DHB.

4. PERFORMANCE REPORTING

4.1 Health Targets – Quarter 3, 2016/17

A member queried a statement in the report that noted additional charges to patients for same day appointments. The CEO for Central PHO advised that this relates to one Palmerston North practice and the CEO and Chair of Central PHO will be meeting with that practice to discuss it.

Clarification was sought over a comment in the report on the absence of clinical leadership of the Shorter Stays in Emergency Department health target. Management noted that a very active and engaged clinical director had been leading a very successful programme of work on patient flow, but that individual had unfortunately taken up a new role in Australia. The DHB is currently looking at a further programme of work that backs into the current work being done in general medicine around staffing and rosters to look at patient flow and model of care.

Although this report states that this is only for ED, it is hospital wide.
In response to an inquiry, the Committees were advised that the DHB has now shifted to the Winter Plan with beds being opened up in the medical wards. The DHB is now in Winter Plan mode.

It was recommended:

*that this report be noted*

**4.2 201/17 RSP Update**

The Manager, DHB Planning & Accountability, noted that 75 percent of the expected milestones to the end of March had been achieved to date. It was noted that elective services, cancer wait times (faster cancer treatment) and cardiac surgery interventions continue to be areas of concern for the Central Region. For the MidCentral district, cancer wait times is an issue but elective surgery and cardiac surgery rates are good.

It was recommended:

*that this report be noted*

**4.3 2016/17 Maori Health Plan Update**

This report was introduced by Dr Janine Stevens, Public Health Physician & Maori Health Practice Leader with the Pae Ora team.

The report provides the committees with an overview of the work being undertaken by the Pae Ora Māori Health Directorate. It was noted that in September 2017 the second and final report will be provided to the committees. This will provide progress made against the Annual Māori Health Plan Indicators for the 2016/17 year.

The Pae Ora team continue to engage with staff from many departments about how they can work together to achieve the best outcomes for family/whānau. This includes ED, Paediatrics, and Allied Health areas. Much work is being done in teaching and learning areas across a range of professional disciplines and different departments particularly around cultural competence development for staff. Pae Ora continues to be involved in a wide range of leadership, governance and advisory roles across the DHB. The whānau care team are working with patients and whānau to support their journeys through the hospital system and back to their homes in the community, including the provision of accommodation at Te Whare Rapuora for whānau as needed.

A member sought advice about the Kia Ora Hauora Programme with students, is it based on the Counties Manukau programme? The Kia Ora Hauora Programme is a national programme and the Manager, Māori Health Workforce Development, regularly attends hui and career expos to help encourage Rangatahi to look at Health careers.
The Committees were advised that MidCentral DHB will be the hosts for the 2018 Tu Kaha Conference. A member asked for the Board and Committees to be advised of the dates for the conference when this information was available.

A member asked about the work that is being done to support Pacific Peoples and their families across the district. They were advised of work that has been done on a Pacific Health Plan for the district.

It was recommended:

*that the overview of the work of the Pae Ora Maori Health Directorate by noted*

### 4.4 General and Specialist Assessment and Treatment Services

**Annual Plan Update 2016/17**

It was noted that the report is aligned to the DHB’s Annual Plan and that it contains material that has already been regularly reported to the Committees through the General Manager’s Operating Reports throughout the year.

Some of the highlights in this report were examples of integrated care across the district including seasonal planning in the DHB’s winter warrant of fitness, orthopaedic first specialist assessment clinics, primary care nursing which includes the DHB’s district nursing service, and the collaboration with Kauri Health around older persons particularly supporting our older people with frailty.

There is work being undertaken to increase participation in the Breast Screening Programme for priority women, it was noted that while the DHB is meeting the target in terms of 70 percent participation for the total population, the rates for priority women still require more work to be done.

Other discussions on this report covered faster cancer treatments including the pathways. How well are GP’s adopting the pathways and are they using them well? Is the access in the diagnosis pathway giving them access to fast cancer treatment? Are GP’s given feedback in respect to their referrals? These queries were answered by Operation Director, Specialist Regional & Community.

A member raised her concern that the CCDM update with the VRM on hold, given the importance of this programme in managing workload pressure. The CEO advised that a more fulsome report would be provided on the VRM and Hospital Operations Centre, and perhaps a presentation on CCDM, would be provided to the Committees in the future.

There was concern raised at the amount of projects behind schedule reflected in the AP Schedule accompanying this report. Management gave assurance that work not completed during 16/17 would be carried over or explained in the 17/18 planning documents.

In response to a member’s query, management advised that responsibility for recruiting to vacancies sits with line managers, but that this is done in partnership
with nurse directors, clinical directors and operation directors. The process itself sits within Human Resources. The committees were further advised that in regards to recruiting a sonographer there is interest from one sonographer in Australia which is being pursued and there are currently a number of locums being made available to MidCentral DHB from other District Health Boards.

It was recommended:

\textit{that this report be noted.}

4.5 **Communicable Disease Communication Process and the Public Health Work Programme**

The Medical Officer of Health & Manager of Public Health presented to the committees.

It was recommended:

\textit{that the paper and associated presentation be noted.}

5. **CONSUMER & DISABILITY**

5.1 **Updated on Consumer and Clinical Councils**

The Intern Portfolio Manager advised that the Consumer Council received a total of 27 applications and interviews had already taken place. The Clinical Council received a total of 20 applications and interviews were currently underway. Both sets of applications have been of high calibre and diversity.

It was recommended:

\textit{that this report be noted.}

6. **COMMITTEES’ WORK PROGRAMME**

The General Manager, Strategy, Planning & Performance advised the committees that 2017/18 is going to be a little different because of changes in the format of the Annual Plan process and in the nature of the DHB’s reporting obligations to the Ministry. There are likely to be further changes as we move to optimise reporting to support governance. The intention is to provide transparency while avoiding repetition.

The CEO advised that with the Committees moving into their new memberships, the DHB needs to take a more forward approach to the agendas with a mix of presentations and more strategic content.

A member inquired about how and when workforce updates would be provided. This had previously been the subject of a separate report. The CEO advised that going
forward the DHB will be reporting against the Organisational Development plan. The CEO also advised that the General Manager for People & Culture will be starting on 3 July 2017 and would consider reporting then.

The Committees agreed that the disability component is still missing from the work programme and that this needs to be addressed.

It was recommended:

that progress against the 2016/17 work programmes, and, the Committees’ work programme for 2017/18 be noted.

7. DATE OF NEXT MEETING

25 July 2017
5 September 2017 (Shared matters of interest)

QUALITY & EXCELLENCE MATTERS
(Information only for Healthy Communities Advisory Committee)

At this point, Diane Anderson assumed the chair.

8 PERFORMANCE REPORTING

8.1 Operational Report

It was confirmed the diabetes report would be available for the July meeting.

Oncology Services for Hawkes Bay Region

The CEO confirmed the issues regarding this service were being progressed. This included agreement regarding the redesign of existing service models and a different interim funding arrangement. There was also desire in respect of regional planning for a regional focus aligning work of the cancer centres in our region. Another consideration was the new private provider on the landscape.

It was recommended

That this report be noted.
9 MEETINGS

Minutes

It was recommended:

that the minutes of the previous meeting held on 2 May 2017 be confirmed as a true and correct record subject to changing a word in the second paragraph of section 5.1 to read: “The organisational risk in the event of harm resulting from a trial where there was no ACC cover or and the trial sponsor would not cover the harm, was raised.”

9.1 Recommendations to the Board

It was noted that the board approved all recommendations contained in the minutes.

9.2 Matters Arising from the Minutes

There were no matters arising from the minutes.

10 EXCLUSION OF PUBLIC

It was recommended

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:

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</tr>
<tr>
<td>Operations Report: Potential Serious Adverse Events and Complaints and litigation</td>
<td>To protect personal privacy and to maintain legal privilege</td>
<td>9(2)(a), 9(2)(b)</td>
</tr>
</tbody>
</table>
1. ADMINISTRATIVE MATTERS

1.1 Apologies

Scott Ambridge (General Manager, Enable New Zealand)

1.2 Late Items

There were no late items identified.

1.3 Conflict and/or Register of Interest

There were no conflicts or amendments to the Register of Interest declared.

2. MINUTES OF THE PREVIOUS MEETING

2.1 Minutes

It was recommended:

that the minutes of the previous meeting held on 21 March 2017 be confirmed as a true and correct record.

2.2 Recommendations to Board
The Governance Group noted all recommendations contained in the minutes had been approved by the Board.

3. MATTERS ARISING FROM THE MINUTES
There were no matters arising from the minutes.

4. WORK PROGRAMME
The Operations Director, Enable New Zealand, spoke briefly to the work programme noting that the 2016/17 programme has been achieved. It was noted that a final evaluation report for the EASIE Living and Demonstration Centre will be tabled at the next meeting scheduled for 5 September 2017.

The Operations Director provided an update in respect of the review of ownership and governance arrangements, noting that a preferred supplier has been identified. It is expected that an update will be provided at the September meeting of the Governance Group.

It was noted that the work programme also included activity for the first quarter of the 2017/18 year.

It was recommended:

*that the Committee’s work programme be noted.*

5. STRATEGIC REPORTS

5.1 Annual Plan Implementation, Update 4
The Operations Director, Enable New Zealand, spoke to this report which included an update on activity during the period March to May 2017.

The mobile outreach service launched on 1 May has been well received. It was noted that arrangements for staff being required to work outside of normal business hours followed the appropriate Multi Employer Collective Agreement.

The level of statistical reporting on Centre activities was discussed briefly. The Operations Director noted that a certain level of reporting was undertaken by the Centre to meet current contractual requirements. It was noted that the EASIE Living Centre evaluation also recommended a review of the Centre’s reporting metrics.

It was recommended:

*that the 2016/17 Annual Plan Implementation Update 4 be noted.*

5.2 EASIE Living and Demonstration Centre Evaluation Report
The Operations Director, Enable New Zealand, spoke to this report which offered interim findings and included a number of preliminary recommendations.
The report noted that overall the EASIE Living Centre’s first year of operation had been successful. However, a number of recommendations have been made in the draft evaluation report.

The Operations Director noted that Enable New Zealand was working with the Independent Living Service Auckland to develop the Centre’s retail business. It was agreed by the Committee that it was now appropriate for the Centre to develop its commercial capability.

There was a general discussion about the current situation regarding the local disability sector. The Operations Director noted that Enable New Zealand was currently working to put together local disability coalition comprising providers, local bodies and other stakeholders to develop a work plan using the New Zealand Disability Strategy as a key reference.

The final evaluation report for the EASIE Living & Demonstration will be provided to the September Governance Group meeting.

It was recommended:

that the EASIE Living and Demonstration Centre Evaluation report be noted.

6. OPERATIONAL REPORTS

6.1 General Manager’s Operational Report 4

The Operations Director, Enable New Zealand, began a verbal report which summarised key strategic and operational matters for the organisation during the last quarter.

The General Manager, Enable New Zealand, has been attending weekly disability support services transformation co-design workshops. The workshops have resulted in the preparation of a Cabinet paper, which it is anticipated will be presented by the responsible Minister before the end of June. The next phase of the work will involve further design, along with operationalising the system that will be implemented in the MidCentral region in July 2018.

Further work is planned in respect of Future Foresight to refine the ‘techno-broker’ scenario, which will take into account the disability support services transformation.

A discussion ensued in relation to Accelerate 25. It was suggested that contact be made with Spearhead, the organisation appointed to co-ordinate the regional growth strategy. The Chief Executive noted that MidCentral District Health Board was ready to actively participate in the strategy, and that she would make inquiries at a senior level in an effort to generate some momentum.

The ownership and governance evaluation panel, comprising Governance Group and management representatives, had received proposals and subsequently met with three providers. As a result, a preferred provider had been selected to move forward with. The next steps will involve the provider gaining more
insight into the organisation through discussions with Governance Group members and management. The findings will result in a report to the Governance Group on options for consideration.

In respect of contractual matters, the Operations Director noted that Enable New Zealand continues to work with the Ministry of Health to try to understand what is driving over spending in relation to budget, particularly for the Equipment & Modification Service and the Hearing Aid Service.

The year to date revenue is tracking higher than forecast. The Operations Director noted that there was a strong emphasis on the organisation’s information technology development in order to secure contracts.

He also drew attention to the fact that no funds had been set aside in the 2017/18 budget for the transformation of the disability support system, and management believes it is prudent to hold the current 2017/18 budget due to significant uncertainty around costs and requirements in relation to the DSS transformation.

It was recommended:

that the General Manager’s Operational Report 4 be noted.

6.2 **Enable New Zealand – Risk Report**

The Programme Manager ISSP, Enable New Zealand, spoke to this report.

In response to a request by the Chair, it was agreed that future risk reports would include an action plan to move risks from a state of residual risk to tolerable risk.

It was recommended

that the Enable New Zealand Risk Report be noted.

7. **LATE ITEMS**

There were no late items.

8. **DATE OF NEXT MEETING**

Tuesday, 5 September 2017.
Venue: Conference Room, EASIE Living Centre, 585 Main Street, Palmerston North.

9. **EXCLUSION OF PUBLIC**

It was recommended:
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:

<table>
<thead>
<tr>
<th>Item</th>
<th>Reason</th>
<th>Ref</th>
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</thead>
<tbody>
<tr>
<td>“In Committee” minutes of the previous meeting</td>
<td>For reasons stated in the previous agenda</td>
<td></td>
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<tr>
<td>General Manager’s Operational Report 4</td>
<td>Subject of commercial negotiations and contains commercially sensitive information</td>
<td>9 (2) (j)</td>
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<td>• Facilities</td>
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<td>• Business Development Opportunities</td>
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Chairperson