

Distribution

Board Members

- ☐ Phil Sunderland, Chairman
- ☐ Diane Anderson
- ☐ Adrian Broad
- ☐ Lindsay Burnell
- ☐ Barbara Cameron
- ☐ Ann Chapman
- ☐ Kate Joblin
- ☐ Nadarajah Manoharan
- ☐ Karen Naylor
- ☐ Richard Orzecki
- ☐ Barbara Robson

Management Team

- ☐ Murray Georgel, CEO
- ☐ Mike Grant, Interim General Manager, MCH/
General Manager, Corporate Support
- ☐ Scott Ambridge, General Manager, Enable NZ
- ☐ Craig Johnston, Acting General Manager, Funding &
Planning
- ☐ Jill Matthews, PAO
- ☐ Communications Dept, MDHB
- ☐ External Auditor

National Health Board

- ☐ Nicola Holden, Account Manager

Public Copies

- ☐ www.midcentraldhb.govt.nz/orderpaper

Other

- ☐ Board Records

Contact Details

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Next Meeting Date: 19 May 2015
Deadline for Agenda Items: 5 May 2015

MIDCENTRAL DISTRICT HEALTH BOARD

A g e n d a

Board Meeting

Part 1

Date: Tuesday, 7 April 2015

Time: 10.00am

Place: MidCentral DHB Offices
Board Room
Gate 2, Heretaunga Street
Palmerston North

MIDCENTRAL DISTRICT HEALTH BOARD

Board Meeting

7 April 2015

Part 1

Order

1. APOLOGIES

2. 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

4. MINUTES OF PREVIOUS MEETING

4.1 Minutes

Pages: 4.1 – 4.8

Documentation: minutes of 24 February 2015

Recommendation: that the minutes of the previous meeting held on 24 February 2015 be confirmed as a true and correct record.

4.2 Matters Arising from the Minutes

5. BOARD COMMITTEES

5.1 Group Audit Committee

Pages: 5.1 – 5.6

Documentation: unconfirmed minutes of Group Audit Committee meeting, 24 February 2015

Recommendation: that the unconfirmed minutes of the meeting of the Group Audit Committee held on 24 February 2015 be received and the recommendations contained therein approved.

5.2 Matters Arising

5.3 Hospital Advisory Committee

Pages: 5.7 – 5.12
Documentation: unconfirmed minutes of Hospital Advisory Committee meeting, 17 March 2015
Recommendation: that the unconfirmed minutes of the meeting of the Hospital Advisory Committee held on 17 March 2015 be received and the recommendations contained therein approved.

5.4 Matters Arising

5.5 Disability Support Advisory Committee

Pages: 5.13 – 5.16
Documentation: unconfirmed minutes of Disability Support Advisory Committee meeting, 17 March 2015
Recommendation: that the unconfirmed minutes of the meeting of the Disability Support Advisory Committee held on 17 March 2015 be received and the recommendations contained therein approved

5.6 Matters Arising

5.7 Community & Public Health Advisory Committee

Pages: 5.17 – 5.22
Documentation: unconfirmed minutes of Community & Public Health Advisory Committee meeting, 17 March 2015
Recommendation: that the unconfirmed minutes of the meeting of the Community & Public Health Advisory Committee held on 17 March 2015 be received and the recommendations contained therein approved.

5.8 Matters Arising

6. WORK PROGRAMME

Pages: 6.1 – 6.7
Documentation: report from the CEO dated 27 March 2015
Recommendation: that the updated 2014/15 work programme be noted.

7. OPERATIONAL REPORTS

7.1 CEO's Report

Pages: 7.1 – 7.34
Documentation: report from the CEO dated 27 March 2015
Recommendation: that the report be received; and,

that the audit engagement letter, as contained in the CEO's report dated 27 March 2015, be approved.

8. GOVERNANCE ISSUES

8.1 CEO Recruitment

Pages: 8.1 – 8.2
Documentation: report from the Chairman dated 25 March 2015
Recommendation: that the report be received.

8.2 Signatories and Credit Card Approval

Pages: 8.3 – 8.5
Documentation: report from the Interim General Manager MidCentral Health & Support Services dated 26 March 2015
Recommendation: that M Georgel ceases as a Westpac account signatory effective on the 2nd May 2015

that K Cook becomes a Westpac account signatory on the 4th May 2015

that S Wilson be removed as a Westpac account signatory with immediate effect

that M Georgel ceases to be a Westpac credit card holder effective on the 2nd May 2015

that K Cook replaces M Georgel as a Westpac credit card holder with a credit limit of \$8,000 effective on the 4th May 2015

that C Channing replaces R Brown as a signatory for Ministry of Health Loan documentation with immediate effect

that C Channing replaces R Brown as an Authorised Officer, with immediate effect, authorising Westpac to rely on notices or instructions on behalf of the Acceding Party with regards to the Shared Banking and Treasury Services Master Agreements

9. LATE ITEMS

10. DATE OF NEXT MEETING

Tuesday, 19 May 2015 at the Bush Multi-Sport Park, 57 Huxley Street, Pahiatua. To include a public forum.

11. 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:

<i>Item</i>	<i>Reason</i>	<i>Ref</i>
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous agenda	

<p>“In Committee” Minutes of Committee Meetings:</p> <ul style="list-style-type: none"> • Hospital Advisory Committee, 17 March 2015 • Community & Public Health Advisory Committee, 17 March 2015 • Disability Support Advisory Committee, 17 March 2015 • Remuneration Committee: CEO’s performance review and measures, and Remuneration Package 	<p>For the reasons set out in the Committees' order paper 17.3.15 meeting held with the public present</p> <p>For the reasons set out in the Committees' order paper 17.3.15 meeting held with the public present</p> <p>For the reasons set out in the Committees' order paper 17.3.15 meeting held with the public present</p> <p>To protect personal privacy</p>	9(2)(a)
<p>Strategic Matters</p> <ul style="list-style-type: none"> • 2015/16 Planning Process • HBL Transition & Proposal 	<p>Subject of negotiation</p> <p>Subject of negotiation</p>	<p>9(2)(j)</p> <p>9(2)(j)</p>
<p>Operational Matters</p> <ul style="list-style-type: none"> • CEO’s report: HBL business cases, and, strategic reviews 	<p>Subject of negotiation and under obligation of confidence</p>	<p>9(2)(j)</p> <p>9(2)(ba)</p>
<p>Governance Matters</p> <ul style="list-style-type: none"> • Insurance Update • Banking and Treasury Agreement Amendments 	<p>Contains competitive pricing information</p> <p>Contains commercially sensitive information</p>	<p>9(2)(j)</p> <p>9(2)(j)</p>

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the MidCentral District Health Board meeting held on 24 February 2015 at 10.00am
at MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street,
Palmerston North

PRESENT

Phil Sunderland (Chair)
Diane Anderson
Adrian Broad
Lindsay Burnell
Barbara Cameron
Ann Chapman

Kate Joblin
Nadarajah Manoharan
Karen Naylor
Richard Orzecki
Barbara Robson

Unconfirmed Minutes

IN ATTENDANCE

Murray Georgel, Chief Executive Officer
Mike Grant, Interim General Manager, MidCentral Health/Corporate Services
Craig Johnston, Acting General Manager, Funding & Planning
Jill Matthews, Principal Administration Officer
Jeff Small, Group Manager, Commercial Support Services
Lyn Horgan, Operations Director, Hospital Services
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Brian Woolley, Manager, Knowledge & Information Management
Michele Coghlan, Director of Nursing
Dennis Geddis, Communications Officer
Scott Ambridge, General Manager, Enable New Zealand
David Andrews, Operations Manager, Enable New Zealand
Stephanie Turner, Director, Maori Health & Disability
Chris Channing, Finance Manager (part meeting)

Public (3)
Media (1)

1. APOLOGIES

An apology for lateness was received from Lindsay Burnell, Board Member.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendments to the Register of Interests

Barbara Robson advised a short (two meeting) interest, being a member (consumer representative) of the Royal NZ College of GPs' working group for the review of the aiming for excellence standard.

Murray Georgel advised his board membership of Health Benefits Limited and the Central Region's Technical Advisory Services Limited has ceased.

3.2 Declaration of Conflicts in Relation to Today's Business

The following conflicts were declared:

- Ann Chapman: CEO's report, item 8.1; there was mention of Spark
- Barbara Cameron: her interest as a Councillor, Manawatu District Council in the Feilding Integrated Family Health Centre
- Barbara Robson, consumer representative on the maternity clinical information system's working group

The Chair advised these interests had been declared and considered previously, and presented no issue. The members concerned could participate freely in any discussion.

4. MINUTES OF PREVIOUS MEETING

4.1 Minutes

It was resolved:

that the minutes of the previous meeting held on 16 December 2014 be confirmed as a true and correct record.

4.2 Matters Arising from the Minutes

There were no matters arising from the minutes.

5. BOARD COMMITTEES

5.1 Funding Audit Sub-Committee

It was resolved:

that the unconfirmed minutes of the meeting of the Funding Audit Sub-Committee held on 16 December 2014 be received and the recommendations contained therein approved.

5.2 Matters Arising

There were no matters arising from the minutes.

5.3 Hospital Advisory Committee

Barbara Robson, Committee Chair advised there was some repetition in the unconfirmed minutes and this would be resolved. She confirmed that the content was correct.

It was resolved:

that the unconfirmed minutes of the meeting of the Hospital Advisory Committee held on 3 February 2015 be received and the recommendations contained therein approved.

5.4 Matters Arising

There were no matters arising from the minutes.

5.5 Community & Public Health Advisory Committee

It was resolved:

that the unconfirmed minutes of the meeting of the Community & Public Health Advisory Committee held on 3 February 2015 be received and the recommendations contained therein approved.

5.6 Matters Arising

5.6.1 Mental Health Phone Line

A member advised she asked further questions of management regarding this matter.

5.7 Enable New Zealand Governance Group

It was resolved:

that the unconfirmed minutes of the meeting of the Enable New Zealand Governance Group held on 3 February 2015 be received and the recommendations contained therein approved.

5.8 Matters Arising

There were no matters arising from the minutes.

6. WORK PROGRAMME

The CEO advised that consideration was being given to a workshop on 17 March. This would be held between the meetings of the Hospital Advisory and the Community & Public Health Advisory Committees. The subject would be a presentation from, and discussion with, the Health Quality & Safety Commission.

The Minister of Health's requirement that a value for money workshop be held as part of the development of a detailed business case for the Master Health Service Plan was noted. Management advised that these workshops were a standard part of projects such as this and would occur at several levels.

It was resolved:

that the updated 2014/15 work programme be noted.

7. STRATEGIC MATTERS

7.1 Master Health Service Plan: Detailed Business Case Update

The approach to the development of a detailed business case was discussed and it was agreed and/or confirmed that:

- membership of the Steering Committee be expanded to include a Maori perspective
- expressions of interest would be sought for membership of the Consumer Advisory Group, and previous members could continue
- the project structure, including a Steering Committee, programme office, programme management support, programme director, etc would ensure a comprehensive range of skills were available to the project, including accounting, commercial and contracts.
- an external agency would be contracted to provide support similar to the role Sapere had played in the development of the indicative business case

The Minister of Health's requirement that the assumptions be re-tested was questioned. Management advised all assumptions contained in the indicative business case would be retested, including demand modelling. This was part of the detailed business case development process and ensured the resultant business case was robust. The value for management workshops would also challenge assumptions and these were run by independent people. The process would be transparent to the Board.

Management further advised that the re-testing of assumptions ensured changes, improvements and enhancements which had occurred since the Indicative Business Case were taken into account, eg length of stay for medical services had reduced by 1.5 days.

It was suggested that the expertise and knowledge of CEOs within the Central Region be used, and that they be part of a workshop/forum. Management advised this proposition would be accommodated within the programme the work.

Information systems requirements and costs, as identified by the National Health IT Board, were discussed in respect of the project. Mike Grant advised some major infrastructure projects would be completed ahead of the master health service plan project, such as wireless network, voice over internet protocols. Other matters such as closed circuit TVs would be addressed as part of business as usual activities. The building cost allocation per square metre included the latest technology for the particular areas being developed.

The use of Master Class trips was discussed. Management confirmed that both national and international services, initiatives and service models were visited as part of the scoping process. A group of clinicians from MDHB had recently visited Hutt Valley and Capital & Coast DHBs, and trips to Waikato, North Shore and other areas would be worthwhile.

Any plans for the Master Class programme would follow the same course as previous years, being reported via the appropriate statutory committee, with details of the purpose, expected outcomes, overall costs, and the impact for MDHB. The current update regarding the Master Health Service Plan provided the Board an early signal of the Master Class programme intentions.

It was resolved:

that the report be received.

8. OPERATIONAL REPORTS

8.1 CEO's Report

8.1.1 Sector Strategy

The review of the NZ Health Strategy was discussed. The following points and/or questions were raised for consideration at the forthcoming national DHB Chairs and CEO forum:

- wider consultation with the sector and community was required; how would this be satisfied?
- A strengthened mental health perspective was required within the strategy (as opposed to be a separate strategy)
- how do DHBs work with others outside their jurisdiction, such as social services (and vice versa)

It was noted that the health strategy review was at the early stages.

Chris Channing entered the meeting.

8.1.2 Wireless Environment

The use of work or personal cellphones in the workplace was raised. Management confirmed that policies and protocols were required in this regard, eg the use of personal devices. There were a lot of learnings around this in the sector and information which was available. It was noted that the taking of photographs in the work place was covered by other policies.

8.1.3 National Health Committee

The CEO advised that the National Health Committee would be visiting MDHB on Wednesday, 25 February at 12noon. Board members were invited to participate in the visit.

8.1.4 Feilding Integrated Family Health Centre

Management confirmed that the signing ceremony would take place on Thursday, 26th February at 12.30pm at Clevely Centre.

8.1.5 Health Benefits Limited

HBL's role in the co-ordinating the sweep arrangements under the national treasury programme was noted. Management advised that future responsibility for this role would be determined through the transition process currently underway.

8.1.6 Minister's Letter of Expectations

The Minister of Health's letter of expectations was noted.

8.1.7 Performance Intervention Framework

The discussion paper regarding the PIF was discussed. The concept of consumer budget holding/risk sharing was raised in the paper. The CEO advised that co-payments existed within the public sector, however more information would be available following sector discussions.

8.1.8 Financial Position

The DHB's financial position was noted. The CEO advised management was confident the year end budget would be achieved. Some timing differences had contributed to the January result, such as MidCentral Health providing services ahead of schedule, and an over accrual for pharmaceutical expenditure.

8.1.9 Annual Plan

The delays in receiving Ministerial endorsement of MDHB's 2014/15 annual plan was raised. Management reported the Ministry had advised the delays were not a reflection of the quality of the DHB's plans. It was understood a number of DHBs plans has been delayed, and that several had been endorsed at the same time as MDHBs.

The CEO advised that the annual plan was a valuable document for the organisation as it set out its strategy and initiatives.

8.1.10 Integration of Primary and Secondary Care Services

A member questioned whether appropriate access to diagnostic services, such as MRI and CT, was being given to primary care clinicians. Management advised that MDHB had made available a range of radiology services to GPs. Access to CTs was more constrained and was linked to specific conditions, such as headaches and trans ischaemic attacks (TIAs). Further access was occurring and this was linked to the clinical care pathways.

4.6

It was agreed that this matter was best considered by the Community & Public Health Advisory Committee and that management would provide a report for its next meeting. This would provide a stocktake of current arrangements and what was planned for the future.

It was resolved:

that the report be received.

8.2 Contracts Update

It was resolved:

that the report be received.

9. GOVERNANCE ISSUES

9.1 Communication Policy

It was agreed that a definition of “health literacy” be included in the policy.

It was resolved:

that the Communication Policy be amended in line with the changes proposed in management’s report dated 9 February 2015, and that it be review in 36 months.

9.2 Manawhenua Hauora

An error in the minutes of 15 December 2014 was identified. As part of the CEO recruitment process, CPHAC had not met with Richard Stone.

Richard Orzecki reported on the discussion Manawhenua Hauora had had with the Acting General Manager, Funding & Planning. It had been suggested that four pou as contained within He Korowai Oranga could form the basis of the Maori Health Plan.

Mr Orzecki drew members’ attention to the launch of the Central PHO’s Maori Wellbeing Document. It was agreed this document be provided to all members.

The issue of Whanau Ora discussed in the minutes was raised. Management advised that a standard DHB service was Whanau Ora and this had been in place for over 10 years. Separate to this was funding for the Te Puni Kokiri national Whanau Ora programme . The two were quite separate and distinct, and the DHB whanau ora could not be withdrawn when Whanau Ora alliances/collectives were established.

It was noted that the new funding arrangements for the national Whanau Ora programme were not clear at this stage.

It was resolved:

that the minutes be received.

9.3 CEO Recruitment

It was resolved:

that the report be received.

9.4 Treasury – Debt Roll-Over

Management advised that the Board had several options regarding the rollover of these loan funds. They could roll them over for a short period (90 days) or a maximum of 10 years. MDHB's treasury policy required that loans be spread, with no more than 30% of loan funding falling due at any one time. The \$12.6m in question equated to 22% of total loan funds.

Lindsay Burnell entered the meeting.

It was agreed that the debt be rolled over as it would be required to fund the master health service plan programme of work. It was further agreed that the risk in terms of interest rates be spread, so that this occurred over two years rather than one. Management advised that the interest rates for nine and ten years was similar.

It was resolved:

that the loans of \$12.6m be rolled over; \$6.3m to April 2024, \$6.3m to April 2025 at the indicative rate of 3.31 and that the Chief Executive Office is authorised to sign all associated documentation.

10. LATE ITEMS

There were no late items.

11. DATE OF NEXT MEETING

Tuesday, 7 April 2015, MidCentral District Health Board Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North.

12. EXCLUSION OF THE PUBLIC

It was resolved:

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

Item	Reason	Ref
"In Committee" Minutes of the Previous Meeting	For reasons stated in the previous agenda	
"In Committee" Minutes of Committee Meetings:		
• Hospital Advisory Committee, 3 February 2015	For the reasons set out in the Committees' order paper 3.2.15 meeting held with the public present	
• Community & Public Health Advisory Committee, 3 February 2015	For the reasons set out in the Committees' order paper 3.2.15 meeting held with the public present	
• Enable New Zealand Governance Group, 3 February 2015:		
○ annual plan and budget 2015/16	Subject of negotiation and contains commercially sensitive information	9(2)(j)
○ service delivery model RFP	Subject of competitive tender process and negotiation	9(2)(j)
○ Business Case	Commercial sensitive information and subject of tender process	9(2)(j)
○ Contracts update	Subject to negotiation	9(2)(j)

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<i>Strategic Matters</i> <ul style="list-style-type: none">• <i>Annual planning 2015/16</i>• <i>Allied Laundry Shareholder Approvals</i>• <i>CEO Recruitment</i>	<i>Subject of negotiation</i> <i>Subject of negotiation and contains commercially sensitive information</i> <i>To protect personal privacy</i>	<i>9(2)(j)</i> <i>9(2)(j)</i> <i>9(a)(a)</i>
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Confirmed this 7th April 2015.

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Chairman

MidCentral District Health Board

5-1

Group Audit Committee Meeting

Minutes of the Meeting of the Group Audit Committee, held on Tuesday, 24 February 2015 at 8.15am in the Boardroom, MidCentral DHB Board Office, Heretaunga Street, Palmerston North

PRESENT:

Ann Chapman (Chair)
Kate Joblin (Deputy Chair)
Lindsay Burnell
Barbara Cameron
Karen Naylor
Phil Sunderland (ex officio)

Unconfirmed Minutes

IN ATTENDANCE:

Murray Georgel, Chief Executive Officer
Mike Grant, Interim General Manager, MidCentral Health & Support
Craig Johnston, Acting General Manager, Funding & Planning
Chris Channing, Financial Services Manager
Brian Woolley, Manager, Knowledge & Information
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Darren Horsley, Acting Risk Advisor
Scott Ambridge, General Manager, Enable New Zealand
Rebecca Bensemann, Committee Secretary

Barbara Robson, Board Member
Diane Anderson, Board Member

1. APOLOGIES

An apology for lateness was received from Kate Joblin.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendments to the Register of Interests

Murray Georgel noted he is no longer a director of Health Benefits Ltd or Central Region's Technical Advisory Services and requested that the Register of Interests be amended accordingly.

3.2 Declaration of Conflicts in Relation to Today's Business

Ann Chapman declared a conflict in relation to Item 9.4 IT Infrastructure Review in respect of her son being employed at Gen-i.

S.2

4. MINUTES

4.1 Minutes of Previous Meeting

It was recommended:

that the minutes of the previous meeting held on 16 December 2014 be confirmed as a true and correct record.

4.2 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

Lindsay Burnell sought an update with regard to Item 11.2 ePharmacy Implementation, specifically relating to further progress made against project completion.

It was suggested that this query be addressed during discussion on Item 9.3 Risk Assessment re CRISP.

There were no further matters arising from the minutes.

6. GOVERNANCE

6.1 Group Audit Work Programme

Reporting is occurring in accordance with timeline, with one exception being the Approach for Capturing Recommendations from Reviews, and Reporting Progress. It was advised that the Quality module of Riskman is to be developed further in order to capture this information. Timelines are also to be established. A further report will be furnished at the next Committee meeting on 30 June 2015.

It was recommended:

that the updated work programme for 2014/15 be noted.

7. EXTERNAL AUDIT PROGRAMME

7.1 Auditor-General's 2013/14 MidCentral DHB Audit Report to the Minister

A copy of the Office of the Auditor-General's audit report to the Minister of Health on MidCentral was reviewed.

Management advised PricewaterhouseCoopers review of data and outcomes has ensured service performance reporting information is of a reasonable standard for audit purposes, however it is envisaged that a qualified audit opinion will not be required for 2014/15.

It was recommended:

that this report be received.

7.2 Annual Report 2014/15 – Timeline

5.3

It was noted that the draft annual report be presented on 22 September 2015, and to the Board on the same day, subject to any matters raised by the Group Audit Committee. This gives sufficient time for final audit clearance to enable the accounts to be signed by the statutory deadline of 31 October 2015.

Kate Joblin joined the meeting.

It was recommended:

that the proposed timeline be approved.

8. INTERNAL AUDIT PROGRAMME

8.1 Internal Audit Programme Update

PricewaterhouseCoopers are to perform the first two reviews, with Central Region's Technical Advisory Services (TAS) to perform the remainder of the plan in the current year. TAS will perform all the reviews in the 2015/16 year.

It was noted that TAS are in the process of scoping core pieces of work, however TAS has experienced some transition issues and the Chair expressed concern that a representative was not in attendance at the meeting. Management clarified that the Committee has made it clear that TAS is expected to attend each meeting. Further, it is expected work be continually progressing against the Internal Audit plan and that this situation was almost unacceptable.

Karen Naylor noted that two reviews had been completed by PricewaterhouseCoopers, being the 'Review of elective administration processes' and the 'Review of Radiology administrative processes'. Ms Naylor asked when the Committee could expect to receive these reports. It was advised that these reports will be furnished via the Hospital Audit meeting to be held on 7 April.

It was recommended:

that the status of progress for the internal activity for the year 2014/15 be noted, and that the proposed additional review request be approved, and that the proposed internal audit plan process for 2015/16 be endorsed.

9. RISK ANALYSIS

9.1 MidCentral District Health Board Risk Plans

The Acting Risk Advisor provided a summary overview of this report. It was noted 270 risks are currently identified, of which 4 (0.014%) are overdue review.

The 2014/15 Annual Plan carries six risks reportable to the Group Audit Committee. All risks are current with no new risks identified.

Kate Joblin noted the current level of risk reporting received by the Committee but questioned the level of reporting detail provided to management. The Director, Patient Safety & Clinical Effectiveness, responded that regular reporting occurs to Senior Management Team (SMT), Operations Directors, Clinical Board and Governance Groups. Information provided includes risk profiles, reviews, controls and mitigations of identified risks. Risk awareness is more ingrained within the organisation compared to 12 months ago.

5.4

Ms Joblin queried how far throughout the organisation is the understanding and interface with risk. It was advised that understanding occurs down to charge nurse level and equivalent, however it is not quite disseminated into 'business as usual' thinking. Potential opportunity exists via the Quality module to revisit training to get more people interacting with the system.

Ms Joblin asked how well utilised the Riskman system is. The Director, Patient Safety & Clinical Effectiveness, replied there has been an increase in numbers of instance reporting. This helps to identify areas where instances are occurring and this information is fed back via Occupational Health. The system is becoming embedded throughout the organisation which provides opportunity to measure the effectiveness of controls in place, as well as assess and compare information from a year ago.

It was recommended:

that this report be received.

9.2 Risk Assessment re HBL Projects

The Chief Executive Officer commented that HBL are signalling some benefits may be lost if Allied Laundry remains regionally owned. Central region DHBs have requested the details of HBL's analysis in this regard.

It was recommended:

that the report be received.

9.3 Risk Assessment re CRISP

The Manager, Knowledge & Information, confirmed that significant progress is being made in implementing the WebPAS project, with project resources in place and/or being secured. WebPAS holds more information and it is rich in data and functionality. It will affect the way people work as certain information will need to be captured at certain points in the system. The WebPAS project continues to gather pace and initial feedback is overwhelming positive.

The Chief Executive Officer added that WebPAS may require more data input from the user but some of this information will be captured automatically. Also, that it is important to manage change effectively in order to embed WebPAS into usual business practice and workflow.

Barbara Cameron questioned whether Integrated Family Health Centres will be linked into the system. It was advised the relevant tools are coming to ensure this, however the Clinical Portal is used in primary care, with General Practice and Pharmacy currently holding a view of the hospital record.

Lindsay Burnell queried the progress made against implementation of ePharmacy. The Manager, Knowledge & Information, explained that further delays mean the completion date is now expected to be August 2015. The mitigation approach is to install a local copy of ePharmacy and continue while the other DHBs complete a business case. MidCentral DHB will then transition to the regional system when it becomes available. Management confirmed that the business case is very heavily resourced to manage this the best way possible.

It was recommended:

that the report be received.

9.4 IT Infrastructure Review

The Manager, Knowledge & Information, confirmed that all recommendations arising from the independent review of IT infrastructure systems and processes are under action or have been completed. This has removed a lot of risk. In parallel with this, good progress is being made in refreshing IT infrastructure, including the Storage Area Network (SAN).

It was noted one core finding from the Infrastructure Services Review was identification of the health service working towards nationalising and regionalising information systems. Management explained that prioritisation of regional and national programmes of work had been at the possible expense of delayed investment in a timely manner for upgrading local infrastructure. However, in 2016/17 MidCentral DHB has the ability to grow, through adding to the physical infrastructure on campus, including added storage capability, modernisation, and configuration of the physical network.

Lindsay Burnell sought an update regarding progress around the wireless environment. The Manager, Knowledge & Information, advised that cabinets and switches are in place, and wireless is connected and functional. The rollout approach has been mandated by clinical staff and will be the feature of a Communications release to all staff throughout the organisation. Of note, Maternity has been set as a high priority to receive wireless connectivity.

Barbara Robson noted that the ICT Balance Scorecard is not reported via the Group Audit Committee process. Management advised this is readily available on the staff intranet.

The Interim General Manager, MidCentral Health & Support, added that it may be worthwhile to provide a regular update to the Committee on the Maternity Information Systems Programme (MISP). It is important to understand what is required and that change management is significant.

It was recommended:

that the briefing paper be received.

10. LATE ITEMS

There were no late items.

11. DATE OF NEXT MEETING

Tuesday, 30 June 2015

The Chair acknowledged this would be the last Group Audit Committee meeting that Mr Murray Georgel would attend in his role as Chief Executive Officer. The Committee thanked Mr Georgel for his years of leadership and contribution to the organisation.

The meeting concluded at 9.10am.

S-6

Confirmed this 30th day of June 2015

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Chairperson

MidCentral District Health Board

5.7

Minutes of the Hospital Advisory Committee meeting held on 17 March 2015 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

PRESENT

Barbara Robson (Chair)
Lindsay Burnell
Kate Joblin
Karen Naylor

Richard Orzecki
Phil Sunderland
Duncan Scott
Cynric Temple-Camp

Unconfirmed Minutes

In attendance

Mike Grant, Interim General Manager, MidCentral Health & Support
Murray Georgel, CEO
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member, (part meeting)
Anne Amooore, Manager, Human Resources and Organisational Development
Lyn Horgan, Operations Director, Hospital Services
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Michele Coghlan, Director of Nursing
Syed Ahmer, Clinical Director, Mental Health Service
Brad Grimmer, Project Lead, Mental Health Service Review (part meeting)
Janine Ingram, Project Management Team, Mental Health Services (part meeting)
Vivienne Ayres, DHB Planning and Accountability (part meeting)
Kenneth Clark, Chief Medical Officer (part meeting)
Rodney Mackenzie, Manager, Business Support
Mr & Mrs Hume
Communications (1)
Media (1)

1. APOLOGIES

An apology was received from Stephen Paewai. Kate Joblin apologised for lateness.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendments to the register of interests

There were no amendments to the register of interests.

3.2 Declaration of conflicts in relation to today's business

The following conflicts of interest were noted:

Duncan Scott declared a conflict in relation to reference to the Feilding Integrated Family Health Centres and MRI waiting times, in terms of his employment with Broadway Radiology Limited.

Kate Joblin joined the meeting.

The general declaration of a conflict of interest in relation to the Operations Report was noted for Cynric Temple-Camp due to his coronial duties.

It was agreed that as the papers did not require any decisions, there was no reason why the members should not participate in any discussion.

Housekeeping

The Chair referred to the poor acoustics of the room, and asked members to speak loudly and clearly.

Mr & Mrs Hume were welcomed to the meeting. Mrs Hume had asked to speak to the committee.

Mrs Hume then spoke to the committee. She wanted to make sure:

- people did what they said they were going to do
- mental health was given its due attention within the health system
- no patient and their rights were overlooked again
- there was staff, management and governance accountability to MDHB.

Mrs Hume elaborated on the above. She felt there was a blockage of information and full disclosure, some key senior management staff were still involved with cover up, concealment and damage limitation rather than accountability and truthfulness. Self harm was now being reported which was progress. They had been told that strangulation wasn't attempted suicide, it was self harm. As there was no ongoing harm from these events, they usually didn't rate a higher SAE coding. But Mrs Hume said there was mental harm. They had noted these points as no description was given to describe self harm events in the latest report. She asked why there was a reluctance to identify publicly that it was possible for someone to die on a hospital ward utilising objects or items. They would have insisted that proper care and attention was paid to their daughter if they had been aware it was remotely possible for that to happen. In conclusion Mrs Hume stressed that committee members ask the tough questions. She also referred to the DBT, asking when it started in March, and how many patients had started that course.

At the conclusion of her address, Mrs Hume was asked if she would provide a copy of her notes for members. She agreed to do this. A committee member suggested further consideration be given to these notes in the public excluded part of the next Hospital Advisory Committee meeting.

4. MINUTES

It was recommended

that the minutes of the meeting held on 3 February 2015 be confirmed as a true and correct record.

4.1 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

Ward 21 going smoke-free

It was clarified that Ward 21 had been the only area excluded from the smoke-free policy. As from 16 March, the smoke-free policy would apply to that area as well.

6. WORK PROGRAMME

The Chair referred to her suggestion made at the November meeting for a workshop around reporting quality measures, saying it did not seem to have been noted on the work programme. It was to be based on the mental health review. It would be across the organisation, using the review as the case study. She asked that it be added to the programme.

It was recommended

that the updated work programme for 2014/15 be noted.

7. STRATEGIC PLANNING

7.1 Regional Services Plan Implementation – Quarter 2, 2014/15

It was recommended

that this report be received.

7.2 Mental Health Review update 5

The Operations Director, Specialist Community & Regional Services, briefly spoke to this report, saying the next few months would involve looking to move the focus particularly in relation to future models of care, the adequacy of the current models and how to strengthen them. This could potentially lead to consideration of a home based treatment model. This is an important consideration as it could impact on future utilisation of the inpatient unit. The key to the success of phase 2 would be undertaking engagement with patients, families, staff and the wider sector. Progress was being made with recruitment for the emergency team to start moving towards at 24 hours/7 day service. Meetings with staff and unions were under way in terms of how staff would work. An appointment was being finalised for the new service director position, with an announcement expected later this week. The anticipated start date would be mid April.

Dr Syed Ahmer also spoke to the report, advising the start date for the Dialectic Behaviour Therapy program was 26 March. The date for some clinical records to move to the clinical portal was 11 May. Moving retrospective records would start on 11 July, as the records had to be checked for correctness before they were moved.

The first revised quality report was received at the last Mental Health Service executive meeting. Copies of quality reports from Waikato and Capital & Coast DHBs were considered. They included key performance indicators specific to mental health. Quality reports would be received monthly going forward by the executive meeting, and further consideration on what, if any, additional items should be included. Trends would be considered once the monthly information was available. He went over the strategies undertaken to address concerns in terms of clinical governance. Additional comments included regular meetings with Non Governmental Organisations (NGOs) who provide accommodation (trying to strengthen the process so there was somewhere for patient to go in the community); open disclosure (now immediately make an offer to meet with the family if there is a serious event); self harm/clinical perception of what was self harm. In terms of self harm, people were only admitted if the risk could not be managed safely in the community. Self harm can become a way of coping to relieve distress. Every incident was studied very carefully to ensure the risks were managed actively. Finally, Dr Ahmer confirmed Ward 21 had gone smoke-free from the previous day, with no major issues so far.

The Director of Nursing also spoke to the report, specifically appendix 2 – Mental Health Nursing Work Plan. While it was a 12 month plan, a number of its sub-components had already been completed. Points she touched on included support for nurses who were asked to work in Ward 21, working to ensure there was appropriate accommodation for patients to use, support received from the Service Manager, Mental Health Service Whanganui DHB, and feedback from the Ministry of Health's Chief Nurse.

Members acknowledged Mrs Hume's address, noting she had agreed to provide a copy of her notes to the committee and management.

Discussion then turned to the mental health report.

Mental Health Emergency Team – 24/7 basis

Very good information regarding availability of the new service including phone numbers would need to be well advertised to patients, services, outside organisations etc.

Recruitment and Retention of Staff

The issue of double shifts and overtime was raised. Management advised nursing numbers had improved over the last quarter, and there was almost a full complement of staff. There had been some very small numbers of staff who had completed a double shift.

Home Based Treatment

The need to carefully consider this option was emphasized, with members stressing that families must be involved in the development of the service and that it must not become a default service to keep numbers down in Ward 21. Families must be able and willing to look after their family member, who would be unwell.

A member wanted to know what the breaking point would be in terms of looking after someone. Dr Ahmer explained that if it was felt the risk was escalating and the patient could not be safely managed in the home, a referral would be made to the Home Care Team. The primary concern was safety. He explained the Home Care Team would visit a couple of times a day, and that the patient was being assessed at each visit.

Future models of care and service development were being considered. There was a lot of research that clearly showed once occupancy went above 80%, the risks went up. MCH's occupancy was about 75%, so managing the entrances and exits was important. Changing the model of care for the future would be a big piece of work. Having a successful model would rely on hearing from GPs and clinicians in the community around any concerns they might have.

When asked if Ward 21 was big enough according to international standards, Dr Ahmer said the model had moved from a ward based care system to a community based care system. He felt the design of the current ward had to change, rather than increasing the bed numbers.

A member referred to the artwork in the Whanganui DHB mental health service, which had been made by service users. He felt that was good and something MidCentral Health could consider. He also suggested it would be good to find another name instead of Ward 21.

There was reference to the number of incidents of self harm, in terms of whether the same patient's incidents had continued over more than one month. This detail of information was not available at the meeting.

A member referred to the issue of different therapeutic levels of SSRI drugs with individual patients and whether levels should be measured. He drew attention to the different suicide rates between Northern and Southern Europe involving people on these drugs. Whilst he didn't know how New Zealanders would compare, he thought it was something to be aware of.

A member asked what contact MidCentral's mental health services had with social housing providers such as Shepherd's Rest.

Kate Joblin acknowledged the work being done, and made a request for more information around numbers to be routinely reported to the Committee. She asked to see:

- The numbers in seclusion and use of restraint
- Use of the Mental Health Act.
- In terms of self harm, the current information was a good start, but she felt it could be more meaningful
- Overtime - what was happening with that work
- Occupancy
- Referral process - some information about the referral process – were time lines being followed – be good to have a snapshot.

She also asked whether patients were being seen once they were discharged from Ward 21, whether it was within seven days, acutely or planned, as this was a measure of success. Dr Ahmer said it was a national key performance indicator. Patients must be seen within seven days of discharge on a planned basis, and that recent results showed an improvement.

It was recommended

that this report be received.

7.3 Palmerston North Hospital Site Reconfiguration (Living within our means) update

The Interim General Manager, MidCentral Health spoke to this report, saying the changes being made in performance and approach would lead to a change in culture. There was investment in training for leaders, and there was also change around models of care, production and co-design, and how staff engaged with patients in their journey of care. This all led to the culture change across the organisation.

It was recommended

that this report be received.

Diane Anderson, Cynric Temple-Camp and Lindsay Burnell left the meeting.

7.4 Non-financial Monitoring Framework and Performance Measures – Report for Quarter 2, 2014/15 update

Shorter Stays in ED

Management clarified the reference to ED's recruitment process on the second page of this report, explaining a second triage nurse had been recruited for the waiting room.

Lindsay Burnell and Cynric Temple-Camp returned to the meeting.

It was recommended

that this report be received.

8. OPERATIONAL REPORTS

8.1 Provider Division Operating Report - January 2015

It was noted that the FAST clinic within the orthopaedic clinic had ceased, been reviewed, and restarted with a changed model.

Dr Kenneth Clark joined the meeting.

Falls

Management confirmed the change in falls would be attributed to a number of strategies, eg the multi disciplinary approach with the Falls Group, or the Falls Aware Ward initiative that was also being rolled out across both primary and secondary sectors.

Reference was made to the Faster Cancer Treatment initiative. Dr Temple-Camp felt the numerator should be from the day the diagnosis was picked up by the laboratory rather than when there was a suspicion of it. He thought it would be a struggle to achieve the measure.

It was recommended

that this report be received.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

28 April 2015

11. 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:

<i>Item</i>	<i>Reason</i>	<i>Reference</i>
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	

§ 12

Operations Report: Potential Serious Adverse Events and Complaints	To protect personal privacy	9(2)(a)
2015/16 Annual Plan Development – draft plan	Subject of negotiation	9(2)(j)

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Disability Support Advisory Committee held on Tuesday, 17 March 2015 at 3.30pm in the Board Room, Board Office, Gate 2, Heretaunga Street, Palmerston North Hospital

PRESENT

Lindsay Burnell (Chair)
Adrian Broad (Deputy Chair)
Barbara Cameron
Phil Sunderland (ex officio)
Nadarajah Manoharan
Tawhiti Kunaiti
Joseph Boon

Unconfirmed Minutes

IN ATTENDANCE

Murray Georgel, Chief Executive Officer
Craig Johnston, Acting General Manager Funding & Planning Division
Scott Ambridge, General Manager, Enable New Zealand
Muriel Hancock, Director Patient Safety and Clinical Effectiveness
Lydia Kirker, Communications Officer
Di Traynor, Committee Secretary

1. APOLOGY

Jonathan Godfrey

2. LATE ITEMS

There were no late items.

3. CONFLICTS OF INTEREST**3.1 Amendments to the Register of Interest**

There were no Amendments to the Register of Interest.

3.2 Declaration of Conflicts in Relation to Today's Business

There were no Declarations of Conflicts in relation to today's business.

4. MINUTES OF THE PREVIOUS MEETING**4.1 Minutes**

That the minutes of the previous meeting held on 14 October 2014 be confirmed as a true and correct record.

4.2 Recommendations to Board

The Committee noted that all recommendations contained in the minutes had been approved by the Board.

4.3 Matters Arising

There were no matters arising.

5. WORK PROGRAMME

The Chief Executive Officer spoke to his report dated 9 March 2015.

The report contained a list of all reports scheduled for consideration at the Committee's next meeting in June 2015. The Chief Executive Officer noted that the key items are the annual portfolio updates and the disability audit.

It was recommended:

that the updated work programme for 2014/15 be noted.

6. STRATEGIC ISSUES

6.1 Be.Accessible Programme

The Director, Patient Safety and Clinical Effectiveness, summarised the report dated 4 March 2015.

There have been two snapshot surveys undertaken. The second, reported at this meeting, was with staff at Horowhenua Health Centre in November 2014, with no specific findings requiring resolution. A third snapshot survey was planned in the Child and Adolescent Oral Health Service in July 2015.

The Director, Patient Safety and Clinical Effectiveness, noted that the organisation was moving towards Patient Focused Bookings to meet the needs of all people with accessibility issues.

A discussion was held about facilities for the hearing impaired. The Director, Patient Safety and Clinical Effectiveness noted that a national stock-take was taking place within District Health Boards to identify gaps and resources, including investigating Video Remote Interpreting Facilities. She noted that MidCentral District Health Board has an arrangement in place with iSign, but there were no interpreters living within the Health Board's district.

The Director commented that a Be.Accessible Project Co-ordinator had recently been appointed and that an update on progress towards development of a work programme will be tabled at the next committee meeting.

It was recommended:

that this report be received.

6.2 Disability Sector Update

The General Manager, Enable New Zealand, summarised the report dated 4 March 2015.

The General Manager noted that the Ministry of Health was currently trialing a range of models under the banner of the “new model”. The General Manager indicated that Enabling Good Lives was a favored approach due to the it’s cross-ministry funding benefit.

The General Manager expanded on the over spend situation being experienced since the introduction of the Ministry of Health’s Prioritisation Tool (the EMS contract). There are a number of factors influencing the overspend, including the introduction of an expanded Band 1 equipment list that includes items previously self-funded by clients. Enable New Zealand was working closely with the Ministry to manage these impacts.

Enable New Zealand is working on detailed planning towards a September launch of the EASIE Living & Demonstration Centre. The General Manager noted that the establishment of the Centre was a first for New Zealand, and a necessary step forward to support Enable New Zealand’s current contracts. He outlined the purpose and features of the Centre which have been designed to support the disabled and aged communities within the MidCentral District Health Board region and beyond. A discussion took place around how the Centre will function, and opportunities for partnerships in respect of funding.

On behalf of the Committee, the Chair endorsed Enable New Zealand’s initiative in developing the EASIE Living and Demonstration Centre.

It was recommended:

that this report be received.

7. CUSTOMER SATISFACTION

7.1 Patient Experience Survey Process

The Director, Patient Safety & Clinical Effectiveness, spoke to the report dated 4 March 2015.

The return rate for the national customer satisfaction survey of patients who have had an in-hospital stay sits at 49%, following two rounds of the survey.

The Director, Patient Safety & Clinical Effectiveness, noted that comparisons were unable to be made with other DHB’s, as MidCentral District Health Board was currently the only entity to include a disability focused question in the survey. The Director indicated that she was continuing to encourage other DHBs to incorporate the disability component.

It was recommended:

that this report be received.

8. DATE OF NEXT MEETING

Tuesday, 9 June 2015 at 3:30pm

Venue: MidCentral DHB Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

9. EXCLUSION OF PUBLIC

S-16

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: Agreed.

<i>Item</i>	<i>Reason</i>	<i>Ref</i>
2015-16 Planning Process	Subject of negotiation	9 (2) (j)

Confirmed this Tuesday 9 June 2015

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Chair

S-17

MidCentral District Health Board

Community & Public Health Advisory Committee Meeting

Minutes of meeting held on Tuesday, 17 March 2015 at 1pm at MidCentral District Health Board
Offices, Board Room, Gate 2, Heretaunga Street, Palmerston North

PRESENT:

Di Anderson (Chair)
Barbara Cameron (Deputy Chair)
Adrian Broad
Ann Chapman
Nadarajah Manoharan
Phil Sunderland (ex officio)
Donald Campbell
Andrew Ivory
Oriana Paewai

Unconfirmed Minutes

IN ATTENDANCE:

Murray Georgel, Chief Executive Officer
Craig Johnston, Acting General Manager, Funding & Planning
Rebecca Bensemman, Committee Secretary
Jo Smith, Senior Portfolio Manager, Health of Older Persons
Claudine Nepia-Tule, Portfolio Manager, Mental Health & Addictions
Andrew Orange, Interim Portfolio Manager, Primary Care
Vivienne Ayres, Manager, DHB Planning & Accountability
Doug Edwards, Maori Health Advisor
Janine Stevens, Public Health Medicine Registrar
Jordan Dempster, Communications Officer
Chris Hocken, Journeys to Wellbeing
Carole Koha, Te Upoko Nga Oranga o te Rae Addictions Peer Support Service

OTHER:

Public: (1)
Media: (0)

1. APOLOGIES

There were no apologies.

2. NOTIFICATION OF LATE ITEMS

There were no late items.

5-17

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1 Amendment to the Register of Interests

There were no amendments to the Register of Interests.

3.2 Declaration of Conflicts in Relation to Today's Business

Oriana Paewai declared a conflict in relation to Part II of the agenda as she is a member of the Alliance Leadership Team (ALT).

Ann Chapman declared a conflict in relation to the enclosed Planning documents as she is a member of Otaki Women's Health Group.

Barbara Cameron declared an ongoing conflict in relation to any mention of the Feilding Integrated Family Health Centre (IFHC) and noted that she is a Councillor for Manawatu District Council.

The Chair noted these conflicts and agreed that members may remain during discussions as no decisions were required.

4. MINUTES

4.1 Minutes

It was recommended:

that the minutes of the previous meeting held on 3 February 2015 be confirmed as a true and correct record.

4.2 Recommendations to the Board

It was noted that all recommendations contained in the minutes were approved by the Board.

4.3 Matters Arising from the Minutes

The Chair referred to Item 7.3 Planning & Support Operating Report, specifically Item 2.3.1 Connected Workforce NGO Primary Leadership Group, and queried whether qualitative data was available to evaluate the Connected Workforce Te Hononga Kaimahi 2013-2017 strategic work plan. The Portfolio Manager, Mental Health & Addictions, advised that analysis has included feedback from service users and that they note there has been a noticeable and definite improvement in workforce skills and competencies.

The Chair referred to Item 2.4.1 Health Integrity Line, within the Planning & Support Operating Report, and asked whether there had been any correspondence from the Ministry of Health regarding issues raised by MidCentral District Health Board (DHB) concerning the Health Integrity Line. The Chief Executive Officer advised that no response had been received to date.

Mr Nadarajah Manoharan referred to Item 6.2 Primary Maternity Unit Business Case and asked whether support and approval of this project had been received from secondary clinicians. The Acting General Manager, Funding & Planning, advised that this particular aspect would be incorporated into the next phase of the business case.

5. GOVERNANCE

5.1 2014/15 Work Programme

Reporting is occurring in accordance with the timeline.

The Chief Executive Officer advised there would be a presentation from the Central Primary Health Organisation (PHO) at the next Committee meeting on 28 April. The Committee were asked for any suggestions or areas of information that members would specifically like to be included within this presentation.

A short discussion followed, with the following areas of interest expressed: understanding the factors behind under performance on health targets (Cardiovascular Risk Assessments and Smoking indicators) and the remedial actions underway; Central PHO's financial position; some discussion about data (its availability, uses and limitations); uptake of Collaborative Clinical Pathways, how often are the pathways accessed and who is using them; and what gains have been made from merging four PHOs into one entity.

The Committee asked that these areas of interest be addressed in the forthcoming presentation to be made by the Central PHO.

It was recommended:

that the updated work programme for 2014/15 be noted.

6. STRATEGIC/SPECIAL ISSUES

6.1 Non-Financial Monitoring Framework and Performance Measures – Report for Quarter 2, 2014/15

Mr Adrian Broad complimented management on achieving Shorter Stays in the Emergency Department health target for the first time and queried whether this was a one-off occurrence. The Manager, DHB Planning & Accountability, advised that this trend had been continuing over the previous four months with the last month percentage only slightly above target. The improved result was largely due to considerable work undertaken in hospital patient flow and better management of outflows in terms of patient discharges in a timely manner. This practice was becoming more embedded within the organisation, with continuing work in primary health care also helping to achieve and maintain this particular health target.

Ms Barbara Cameron queried whether breastfeeding rates included numbers from Maori health providers, or whether the data was solely collected from Plunket. The Manager, DHB Planning & Accountability, advised that two different sets of data existed at present, which did not depict the whole picture but covered the majority of new mothers.

Mr Donald Campbell added this is a common theme with collection of data. The Manager, DHB Planning & Accountability, agreed in that there a number of instances where data issues occur. Performance targets tend to be based on a limited scope or definition which relies on measuring and quantifying outcomes for evaluation. The Committee needed to be mindful that data is not always as robust as it appears when printed on paper. This does not mean that data is necessarily inaccurate, but that often it is being used for a purpose that is different to the one it was collected for.

The Chair referred to difficulties in managing clinical governance issues when Urgent Community Care (UCC) staff and General Practice staff are engaged in various ways with clients. The Acting General Manager, Funding & Planning, agreed the importance of facilitating integrated practice and ensuring systems are in place to strengthen clinical governance understanding, and safeguard professional relationships in a robust and consistent manner.

5.20

Ms Oriana Paewai noted the quarterly survey used to assess patient experience was paper-based and questioned whether electronic tools were available to help gather information. The Manager, DHB Planning & Accountability, confirmed that no electronic interface was available at this stage (either via email or SMS) but that the response rate from the paper-based survey was one of the highest overall nationally.

Mr Adrian Broad added the public perception of MidCentral DHB's performance was limited to that information published in national newspapers. The Committee agreed that health targets were but one aspect of performance and that a balanced view required being mindful of the full and varied scope of work being undertaken across MidCentral.

It was recommended:

that this report be received.

6.2 Update: Regional Services Plan Implementation – Quarter 2, 2014/15

The Committee noted progress with implementation of the 2014/15 Regional Services Plan to date. There was no further discussion.

It was recommended:

that this report be received.

7. OPERATIONAL REPORTS

7.1 Community Referred Medical Imaging Services

This report provides an update on current investment in community referred medical imaging services. Of note, future developments include expanding rapid access to diagnostics via Collaborative Clinical Pathways. Access to services at or close to the Integrated Family Health Centres (IFHC) "health home" is of importance, as is creating opportunities to enhance access through primary health projects such as Primary Options for Acute Care (POAC). Enabling and maintaining good access to community referred medical imaging services ultimately facilitates good clinical outcomes.

It was recommended:

that this report be received.

7.2 Planning & Support Operating Report

The Acting General Manager, Funding & Planning provided a page by page overview of this report.

Item 2.1.2 Walking in Another's Shoes (WiAS) Education Programme

The Senior Portfolio Manager, Health of Older Persons, explained that a new document titled 'Living Well with Dementia' was now available. This document mirrors national principles and recommendations and provides a raft of information. A copy was provided to each Committee member for reference.

2.3.2 Rising to the Challenge NGO Integration Project Day Activity Services

The Chair noted that one of the providers has indicated its intention to withdraw and questioned whether this would be problematic for the project. The Portfolio Manager, Mental Health & Addictions, advised that the two remaining providers were willing to merge into a new entity delivering an integrated service and that work on the project would progress as usual.

Item 2.4.2 Pharmacy

The Acting General Manager, Funding & Planning, provided a further update on progress with the Community Pharmacy Services Agreement. The existing Agreement is to be rolled over from 1 July 2014 in order to create space to allow a more comprehensive reworking of the Agreement. Engagement with local community pharmacies is about to commence.

Item 2.5.1 Children's Team Update

Mr Adrian Broad noted the remarkable success of this programme and questioned whether government support may extend to similar service/s in other areas of MidCentral DHB. The Acting General Manager, Funding & Planning, advised that the Ministry is taking a cautious approach to the roll out of Children's Teams nationally, but that the DHB has included additional initiatives for vulnerable children in the draft Annual Plan.

The Committee noted this and took the opportunity to thank Barb Bradnock (absent) for her continuing work in this area.

It was recommended:

that this report be received.

7.3 Finance Report – Result of January 2015

The Acting General Manager, Funding & Planning, advised that apart from the timing difference of MidCentral Health washup and fluctuations in IDF flows, positive financial performance and forecast continue.

Ms Barbara Cameron noted the addition of the Turbokids initiative in the draft Annual Plan (as part of Child Development Team services), and asked whether it was an option to consider bringing such specialist services together. This would be a decentralised approach which supported primary care and linked in with other agencies. The Acting General Manager, Funding & Planning, explained that such an approach was the focus of several initiatives included within the Annual Plan.

The Chair added it would be helpful for the Committee to receive regular updates around development of new initiatives. It was requested such information be included in future meetings.

It was recommended:

that the report be received.

8. LATE ITEMS

There were no late items for this section of the meeting.

9. DATE OF NEXT MEETING

Tuesday, 28 April 2015

5.22

10. EXCLUSION OF PUBLIC

It was recommended:

that the public be excluded from Part 2 of this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reason stated:

<i>Item</i>	<i>Reason</i>	<i>Reference</i>
<i>"In Committee" Minutes of the Previous Meeting</i>	<i>For reasons stated in the previous agenda</i>	
<i>Refocusing Home Management Community Services</i>	<i>Subject to negotiation</i>	<i>9(2)(j)</i>
<i>Laboratory Services Contract</i>	<i>Negotiating strategy, and subject to competitive tender process</i>	<i>9(2)(j)</i>
<i>2015/16 Planning Process</i>	<i>Subject of negotiation</i>	<i>9(2)(j)</i>
<i>Central PHO Contract – Better, Sooner, More Convenient Business Case</i>	<i>Subject to negotiation</i>	<i>9(2)(j)</i>

Confirmed this 28th day of April 2015

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Chairperson

TO Board
FROM Chief Executive Officer



MIDCENTRAL DISTRICT HEALTH BOARD
To Pae Hauora o Rūhine o Tairāia

DATE 27 March 2015

SUBJECT Board's Work Programme 2014/15

MEMORANDUM

1. PURPOSE

This report provides an update of progress against the Board's 2014/15 work programme. It is provided for the Board's information and discussion. No decision is sought.

2. SUMMARY

Reporting is occurring in accordance with the timeline. We had scheduled a full report regarding the HBL food services business case however this is not yet complete. An update is provided.

An update on the Master Health Service Plan was also scheduled, including the supporting project plan and milestones. This work has been delayed awaiting the new CEO to take up office. The CEO is the key sponsor and it was considered she should be involved in this important phase of the project.

No minutes were received from Manawhenua Hauora.

Set out below is a summary of the reports provided to the Board. This includes reports provided to the Board at its last meeting, its current meeting, and those scheduled for its next meeting.

Reporting Category	Last meeting	Current Meeting	Next Meeting
Annual Plan Development	<ul style="list-style-type: none"> Update re 2015/16 AP development 	<ul style="list-style-type: none"> Annual Plan 2015/16 & Update 	Regional Services Plan Annual Plan 2015/16 Maori Health Plan 2015/16 Funding Arrangements Document 2015/16
Monitoring 2013/14 Annual (AP) & Regional (RSP) Plan Implementation	<ul style="list-style-type: none"> HBL laundry/linen services business case Master Health Service Plan: Indicative Business Case Update 	<ul style="list-style-type: none"> Update re HBL laundry/linen and food service business case HBL Transition & Proposal 	<ul style="list-style-type: none"> HBL food services business case Update re HBL linen/laundry service business case Master Health Service Plan: project plan and milestones
Sub-regional work - centralAlliance	<ul style="list-style-type: none"> Update re centralAlliance 	<ul style="list-style-type: none"> Update re centralAlliance 	<ul style="list-style-type: none"> Update re centralAlliance
Operational Matters	<ul style="list-style-type: none"> November/December/January results Contracts update 	<ul style="list-style-type: none"> February results 	<ul style="list-style-type: none"> March/April results Contracts update

COPY TO:

CEO's Department

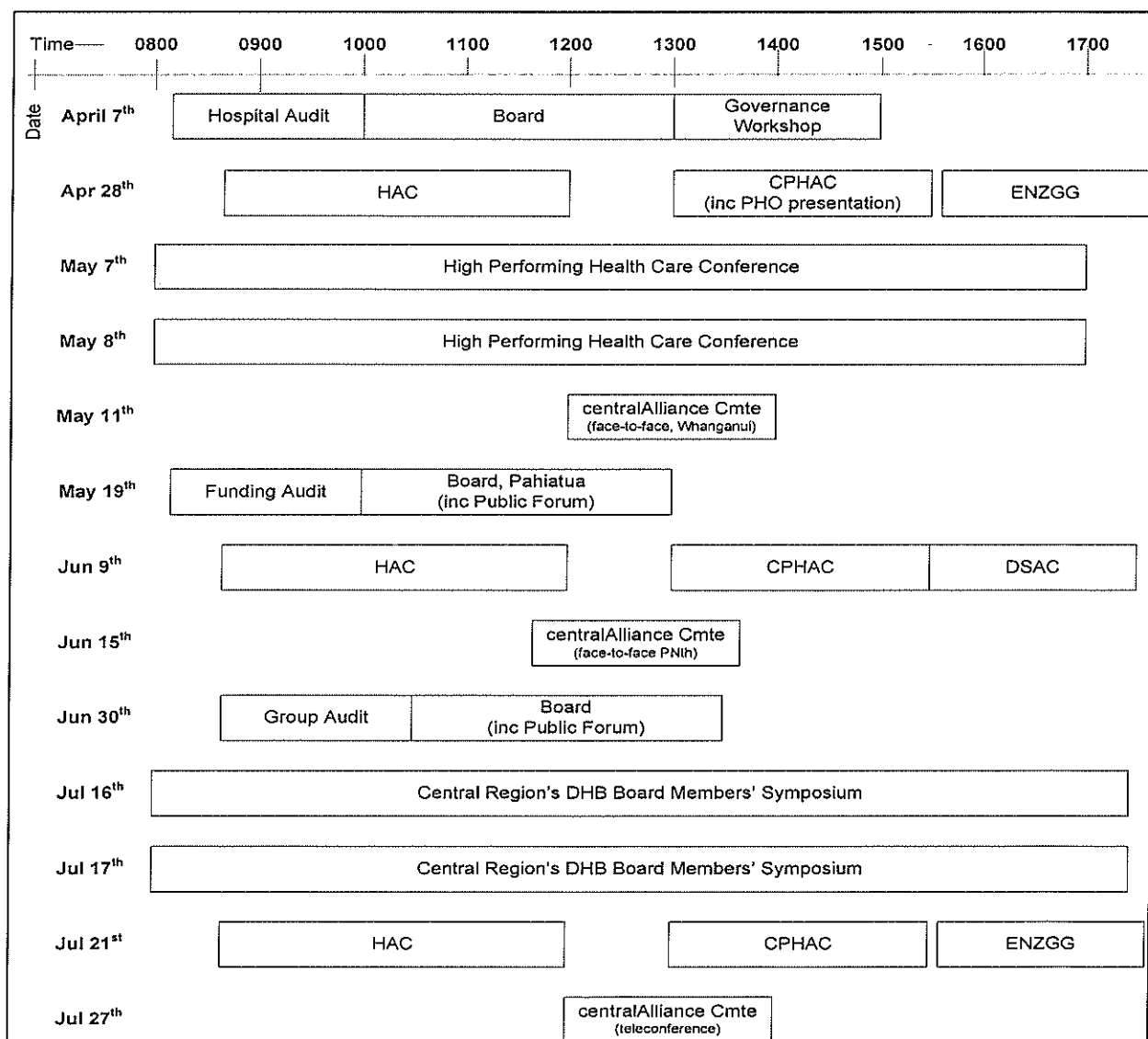
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 Fax +64 (6) 355 0616

6.2

Governance	<ul style="list-style-type: none"> • Communication policy • CEO recruitment • Loan Rollover 	<ul style="list-style-type: none"> • Insurance arrangements • CEO recruitment • Banking & treasury agreement amendments • Banking signatories and credit card approvals 	<ul style="list-style-type: none"> • 2015/16 reporting framework • Enable New Zealand annual reporting requirements
Iwi Partner	<ul style="list-style-type: none"> • Minutes 		<ul style="list-style-type: none"> • Minutes • Arrangements for the 2015 hui • Triennial review of the Memorandum of Understanding • Update against the 2014/15 work programme • Proposed 2015/16 work programme
Reporting	<ul style="list-style-type: none"> • Work programme update 	<ul style="list-style-type: none"> • Work programme update 	<ul style="list-style-type: none"> • Work programme update
Workshops	<ul style="list-style-type: none"> • Planning 	<ul style="list-style-type: none"> • Governance 	<ul style="list-style-type: none"> •

I seek the Board's feedback regarding its expectations regarding the style, content and timing of these reports, and any other reporting requirements members may have.

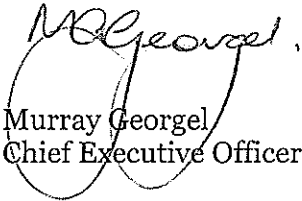
Board and committee commitments through until end of July 2015 are set out below.



3. RECOMMENDATION

It is recommended:

that the updated 2014/15 work programme be noted.



Murray Georgel
Chief Executive Officer

ID	Task Name
1	2014/15 BOARD WORK PROGRAMME
2	
3	STRATEGIC PLANNING
4	Strategic direction updated in line with workshop
5	2015/16 RSP Development
6	Regional priorities
7	Draft Regional Service Plan
8	Regional IT Plan
9	2015/16 Annual Plan Development
10	Planning assumptions
11	Planning workshop
12	Annual plan: draft 1
13	Annual plan: draft 2
14	Progress Reports
15	Update 1
16	Update 2
17	Update 3 (inc salary considerations, Oct14HAC)
18	Update 4
19	Update 5
20	Update 6
21	Update 7
22	Funding Arrangements Document Development
23	2015/16 Document (final)
24	Maori Health Plan 205/16 Development
25	Maori Health Plan (final)
26	2014/15 Annual Plan Approval
27	Details of budget changes
28	2014/15 Annual Plan Implementation
29	Living within our means: HBL & IT
30	Update 1
31	Update 2
32	Master Health Service Plan
33	Indicative business case
34	Health strategy/charter workshop
35	IBC workshop
36	IBC: update and consumer council feedback
37	Service Improvement Paper
38	Project Plan & Milestones (inc engagement/consultation)
39	Sub-Regional Planning

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May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

ID	Task Name	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
40	centralAlliance Update 1															
41	centralAlliance Update 2															
42	centralAlliance Update 3															
43	centralAlliance Update 4															
44	centralAlliance Update 5															
45	centralAlliance Update 6															
46	centralAlliance Update 7															
47	centralAlliance Update 8															
48	centralAlliance Update 9															
49	Annual Report															
50	Year end audit - authorisation to submit financial return to M															
51	2013/14 Annual Report															
52	Enable New Zealand annual report requirements															
53	Business Cases															
54	SAN															
55	HBL's laundry & linen services proposal															
56	HBL's national infrastructure platform															
57	Food services business case and cost analysis															
58	HBL's laundry & linen business case: update and outcome of re-modelling															
59	Update re HBL's laundry & linen business case															
60	Update re HBL's laundry & linen business case															
61	OPERATIONAL MATTERS															
62	CEO's Report															
63	Report 1 (results for April/May)															
64	Report 2 (results for June)															
65	Report 3 (results for July/Aug)															
66	Report 4 (results for Sep)															
67	Report 5 (results for Oct)															
68	Report 6 (results for Nov/Dec/Jan)															
69	Report 8 (results for Feb)															
70	Report 9 (results for Mch/Apr)															
71	Report 10 (results for May)															
72	Concerto - whether use in line with expectations															
73	Location of ENZ funds															
74	Seismic rating of upgraded buildings															
75	Laundry lease															
76	HBL'S FPSC business case: update															
77	Contracts															
78	Update 1															

6.6

Task Name		2015													
ID		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
79	Update 2														
80	Update 3														
81	Update 4														
82	Quality														
83	Annual report from Clinical Leadership Council														
84	Annual report for Clinical Leadership Council														
85	Quality Account														
86	GOVERNANCE ISSUES														
87	Iwi Partner (Manawhenua Hauora)														
88	Annual get-together 2014														
89	Annual get-together - arrangements 2015														
90	Triennial review of MoU														
91	Annual work programme														
92	2014/15 work programme														
93	Final work programme 14/15														
94	Update 1														
95	Update 2 re work programme														
96	2015/16 Work Programme														
97	Manawhenua Hauora Minutes														
98	12 May 2014														
99	23 June 2014														
100	4 August 2014														
101	15 September 2014														
102	3 November 2014														
103	15 December 2014														
104	2 February 2015														
105	16 March 2015														
106	Policies & Terms of Reference														
107	Delegations policy														
108	Standing Orders														
109	Code of Conduct														
110	Board Members' training policy														
111	Election protocols for staff & board members policy														
112	Communication policy														
113	Associated Organisations														
114	TAS: annual update														
115	TAS: AGM arrangements														
116	ALSL: annual update														
117	ALSL: AGM arrangements														
118	Governance Arrangements & Processes														

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ID	Task Name	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
119	Insurance arrangements	✓														
120	2015 meeting arrangements	✓														
121	2015-16 reporting framework	✓														
122	WORKSHOPS															
123	IBC	✓														
124	Health Strategy/Charter	✓														
125	Hui with Manawherua Hauora															
126	CARRIED FORWARD 2013/14	✓														
127	2013/14 Annual Plan: living within our means update	✓														
128	External committee appointments	✓														
129	2014/15 AP: update	✓														

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TO Board
FROM Chief Executive Officer
DATE 27 March 2015
SUBJECT Report for February/March



MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tairāroa

MEMORANDUM

1. Purpose of Report

This report is for the Board's information and discussion. It provides the DHB's result for the year on a consolidated basis, and discusses organisational, governance and corporate issues of note.

A decision delegating authority to the Chair to sign the audit engagement letter is sought.

2. Executive Summary

The last six weeks has seen national, regional and local projects advanced and some change in leadership roles.

Planning to ensure a DHB-owned vehicle is in place to manage national procurement and other projects is well underway and a proposal is ready for Board's consideration. The new vehicle will take over the functions currently carried out by HBL.

Locally, the news of MidCentral DHB's CEO appointment was well received and arrangements are in place to ensure a smooth handover.

We are now entering the final quarter of the 2014/15 year and are making good progress in implementing our annual plan. Financially, we expect to achieve the year end budget.

The development of annual, Maori Health and regional plans for next year is well advanced.

3. Recommendation

It is recommended:

that the report be received; and,

that the audit engagement letter, as contained in the CEO's report dated 27 March 2015, be approved.

4. Sector Matters

4.1 DIRECTOR-GENERAL OF HEALTH

Mr Chai Chuah has been appointed Chief Executive and Director-General of Health, Ministry of Health. Chai has been acting this role since November 2014.

4.1 HEALTH BENEFITS LIMITED

4.1.1 Transition Arrangements

The Interim Governance Group has advised a decision from all DHBs is required by 1 May 2015 regarding the new arrangements. A proposal regarding the recommended vehicle design, transition vehicle and transition plan is being developed for Board's consideration. Associated shareholder documents are also being compiled.

A separate report and recommendation is provided on this matter.

4.1.2 Business Case Updates

- *Finance Procurement & Supply Chain*

The latest update from HBL is:

In November 2014 the DHB-led Steering Committee agreed that that the strategic case for change remains valid and endorsed feedback received from DHBs that a common national solution is the desired end-state for the Sector. Since then, the HBL FPSC Programme team, members of the Steering Committee and DHB advisory groups have been working together to investigate a range of implementation options. This work includes:

- *supporting the National Procurement Service by accelerating the rollout of the DHB National Catalogue and the Data Hub*
- *assessing the relative merits of leveraging DHB capabilities and completing the design and build of the national solution in partnership with individual or clusters of DHBs*
- *developing a strategic implementation roadmap (timeline) that has been agreed in principle by DHB CEOs and CFOs.*

Work continues to understand options around completing the underlying technology platform, including an evaluation of how FPSC may leverage opportunities such as the National Infrastructure Platform (NIP).

The re-planning proposal will be communicated to DHBs in early April, and then discussed at the CEO forum on 13 May and the DHB Boards in May.

As advised last month, it is unlikely MDHB will transition to a national structure much before 2020 thus requiring further investment in our current system, JD Edwards. We could do so earlier if there is either material technological or financial rationale.

At the end of March, the DHB National Catalogue (Version 1.0) will be available to DHBs. This catalogue lists the goods and services that one or more DHBs currently purchase and is focused on supporting procurement benefits.

Through the national procurement process DHBs are making significant financial benefits. For the 2014/15 year benefits of \$21.6m are targeted at an agreed cost of \$10.6m. To date

savings of \$29.5m have been delivered. In addition, a further \$23.4m of non-budgetary benefits (eg cost or capex avoidance) have been achieved.

- *Laundry/Linen*

Consideration of the business case by all Central Regional DHBs and Taranaki DHB is not yet complete. HBL is also to advise the final position from a national perspective.

- *Food Services*

HBL advised that Southern and Tairāwhiti DHBs are in the process of consulting with staff and unions on the proposed changes, and that mobilisation to the new service delivery model at Auckland Metro DHBs is now underway.

Engagement continues with those DHBs that are yet to formally consider the business case. From MidCentral DHB's perspective, remodelling work on the financial assumptions is being undertaken in conjunction with Whanganui DHB, which will in turn be discussed further with HBL during April.

- *National Infrastructure Platform*

HBL has entered into an agreement with IBM to provide the National Infrastructure Platform. Through healthAlliance the four Northern Region DHBs (Northland, Auckland, Counties-Manukau and Waitemata) were first to enter into agreements.

MidCentral DHB's Board approved in principle that we would enter into the agreement with IBM to provide the National Infrastructure Platform. The transition to the Platform will be implemented over a three year period and current estimations are that MDHB will move to the platform during 2017. Detailed planning will commence prior to the move as the transition will rely heavily on local expertise to achieve a successful result.

4.2 NEW ZEALAND HEALTH STRATEGY

As advised last month, a review of the NZ Health Strategy is underway. The Ministry of Health advice is:

Following the Minister of Health's visits to all DHBs late last year, and taking account of advice to him in both the Ministry and DHBs' BIMs, Dr Coleman commissioned a refresh of the NZ Health Strategy to guide and unify the sector and set the strategic direction for health policy and delivery over the next ten years. This is in line with major strategic reviews undertaken in other like jurisdictions, placing health in a broader social context. The work is being led by the Ministry of Health and will report to the Minister of Health around the end of June 2015. The Ministry will be working closely with the DHBs on the strategy as well as engaging in targeted consultation with social service agencies, NGOs, and health service users.

We have passed on to the Ministry the Board's feedback (as per February board meeting) around the need for sector and community engagement, a strengthened mental health perspective, and an integrated approach with social sector agencies.

4.3 PERFORMANCE IMPROVEMENT FRAMEWORK

The development of a Performance Improvement Framework for the DHB sector continues.

As part of the PIF development, Murray Horn has put together a “Four Year Excellence Horizon” as provided to the Board previously. He then did an assessment of “best practice” against the six elements of the framework. This was based solely on an interview held with each DHB’s Chair and CEO. The interview was based on a series of 20 questions. The results are interesting reading – refer Appendix A.

It is now intended that a sector approach be taken to the PIF. This means rather than doing assessments for each DHB, we would expand the “testing” approach used above with the aim of identifying best practice in each of the 20 question areas as well as a better idea of what is required to support and develop this practice. The final product would highlight best practice across each of the 20 questions (and why that practice is effective), rather than 20 individual assessments with individual ratings.

This process is expected to take 18 months to complete.

From there, the next phase would be to do a detailed assessment of each DHB.

Murray Horn recommends that during the next 18 months, alongside the development of the PIF, DHBs should also look to advance the following three areas which he felt were priorities as a result of the recent assessment process:

- establishing uniformity of staff surveys within the sector
- ensuring succession planning in place at all levels of the organisation
- leadership training at all levels of the organisation

The DHB Chairs and CEOs will be considering this matter further over coming months.

5. Regional Matters

5.1 CENTRALALLIANCE

The development of the Strategic Plan for the centralAlliance is running a little behind schedule but a draft document is expected to be available for the sub-committee's meeting next month. A joint workshop of both DHB's boards and committees will be organised. This will be part of a timeline to get the document ready for public consultation.

5.2 REGIONAL SERVICES PLAN

5.2.1 Health System Plan (previously known as Regional Clinical Services Plan)

As members may recall, the Central Region DHBs initiated the developed of a Central Region Health System Plan in May 2014.

Last December work commenced on long term planning of demand and capacity for regional services, focusing initially on specialist regional services to identify areas that may require strengthening. The NZ role delineation model is being used for this work. The NZRDM is a descriptive tool that categorises clinical services by complexity. It is designed to inform potential planning scenarios, like population, service changes and workforce. It enables accurate clinical service description at hospital, facilities and service levels.

TAS, who is co-ordinating this work for the DHBs, commenced discussions with primary care representations in January 2015 to identify what work should be done with the current scope of the project to better inform the Plan's development.

Work also commenced on modelling future service requirements to meet changing health needs. This will inform planning for future capacity.

The development of this Plan will be a key feature of the upcoming Central Region's Board Members' Symposium.

5.3 REGIONAL INFORMATION SYSTEMS

The Regional Health Informatics Programme (previously known as CRISP) continues to be implemented. The expected final cost is \$59.052m, which includes \$4m contingency. To date \$27.5m has been spent.

Seed funding of \$170k has been approved for TAS to develop a Regional Management Reporting Solution. This will deliver:

- Business User Requirements
- High Level Solution Architecture Document
- Indicative Project plan
- First Draft Business Case

Three workstreams have been established to progress the programme. These are:

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- *Work stream 1. Asset Work stream*

To work with TAS and Auditors to establish contractual arrangements for managing the shared asset being created by CRISP CAPEX, and accounting arrangements to calculate asset depreciation and distribute it to DHB level on an equitable basis. (CFO led working with TAS). Expected completion date - 30 May 2015.

- *Work stream 2. Business As Usual Work stream*

To review in detail all business-as-usual costs, in particular estimates of Infrastructure as a Service (IaaS) costs. To develop fair and reasonable methods using cost drivers to attribute BAU costs directly to DHBs where possible and share them equitably where not. To explore the alternative HBL National Infrastructure Programme offer for IaaS and National wide area network (no additional cost as DHBs will have paid for this already). (CFO led). Expected completion date - 30 June 2015.

- *Work stream 3. Service Management Model*

To develop an optimal and affordable regional service delivery model for managing regional systems being created. This will be based first on the skills already employed and paid for, and will recognise additional task and complexity, and the need for regional standardisation and access (CEO led with CIO support) (TAS led, with oversight from Tim Evans to assure affordability). Expected completion date – 30 June 2015.

5.4 CENTRAL REGION'S DHB BOARD MEMBERS' SYMPOSIUM

Building on the Combined Boards Symposium 2014, a two day event has been scheduled for 16/17 July. It will be held in Masterton. The programme will include:

- Health Systems Strategy and Plan
- Dealing with the Media – Processes and Strategies
- Key Note Speaker – Sir Mason Durie – He Korowai Oranga, Ministry of Health's Maori Health Strategy
- Updates on the Regional Plan, Health Informatics, HBL transition pathways

The symposium will also provide plenty of networking opportunities.

It would be appreciated if members could advise Jill Matthews whether or not they are able to attend.

5.5 LEADERSHIP

The CEO, Hutt Valley and Wairarapa DHBs has tendered his resignation and will leave the role at the end of April. The respective Boards has determined that they will not continue with a joint role.

The role of CEO, Capital & Coast DHB is currently being advertised. Debbie Chin has been acting on an interim basis under secondment from Standards New Zealand.

Given these changes, and the pending change at MidCentral DHB, there will potentially be four new CEOs within the district. This could have some impact on the speed of change. The risk has been flagged by the Regional Governance Group.

6. Organisational Matters

6.1 ANNUAL AUDIT

Approval is sought for the audit engagement letter to be signed. The letter from the external auditors Deloitte (refer Appendix B), sets out the terms and responsibilities of the DHB and auditor in relation to the audit of the 2014/15 annual accounts. The letter was included together with the letter from the Office of the Auditor General and the Deloitte audit proposal in the Group Audit and Board papers in November 2014. The recommendation that the proposal be signed by the Board Chair on behalf of the DHB was approved however the recommendation that the Board Chair also sign the audit engagement letter was inadvertently omitted.

It is recommended that the audit engagement letter be signed by the Board Chair on behalf of the DHB.

6.2 MAORI LEADERSHIP

The Director, Maori Health & Disability has prepared a proposal for the establishment of a Maori Health Directorate. This is being considered by the Executive Leadership Team before being made available for all staff to read and comment on. A final decision will then be made.

As the Board is aware, we have eight Clinical Networks (or district management groups) which look at a specific part of the population or disease. Alongside these, a Maori Perspective Group is being formed comprising the Maori members of all eight clinical networks. The intention is they will support the development and integration of Maori worldview, leadership and expertise across all eight clinical network work programmes and ensure the work plans are integrated and effective for whanau Maori.

6.5 INFORMATION SYSTEMS

Work continues to both implement regional systems and to strengthen IT infrastructure. An update against key projects is set out below:

Regional Projects	
Patient Administration System (WebPAS)	Project resources being put in place. This is being led by the full-time project manager. Training continues for system configuration. Project structure being finalised and staff seconded to the work streams. Back-filling to occur where appropriate. Current go-live date is August 2016.
Regional Clinical Portal	Local project structure being finalised. Current go-live date is August 2015.
Regional Radiology Information System	Project manager in place. Implementation planning occurring with an indicative go-live date of August 2015.
ePharmacy	Regional requirements being established by TAS. Decision will then be made as to whether MDHB needs to progress with an interim stand-alone solution to enable it be off HOMER Pharmacy before WebPAS is in place. This is a critical dependency for WebPAS.

Local Projects	
Storage area network and server refresh	Awaiting completion of environmental upgrade (see below). Equipment on site. SAN/server commissioning to occur late April, followed by data migration. Once migration is completion, will move to a two-site SAN arrangement.
Server room environmental infrastructure upgrade	All work progressing to plan. New generator in place. New air conditioning being installed. New switchboard in place. Critical relocation of some computer racks in the server room occurs Saturday, 28 March. Expected completion date by end April.
Fibre, Cabinets & Cabling	Initial phase well advanced with four communication cabinets (including basement hub) in place. Project manager in place to complete high-level designs and costs for the remaining cabinets (approximately 40). Consulting engineers appointed following competitive tender process. Testing of wireless and telephony occurring as below in areas serviced by the new cabinets. Cabling work is largely complete.
Wireless and Telephony	<p><i>Wireless</i></p> <ul style="list-style-type: none"> • Wireless operational in Ambulatory Care on a controlled test basis and initial feedback is very positive. • Wireless to be available in ED and other departments (Sterile Services, Orthopaedics, Library, Lecture Theatre, Central Patient Administration, Gastro and Orderlies) mid-April. • Policy for use of own devices and wireless usage drafted and with staff for feedback. <p><i>Telephony</i></p> <ul style="list-style-type: none"> • A low risk implementation plan in place for roll out of new telephony equipment. • Health on Main will be the pilot site. • This will commence once a network link has been upgraded by outside contractors.
Replacement document management system	Testing completed and go-live expected early April.
Sterile supply instrument tracking system	Awaiting completion of SAN upgrade.
National dental information system (Titanium)	To be piloted at mobile (dental caravans) and fixed sites. This will get underway in April.
Hospital Operations Centre	Preferred vendor selected. Reference site visits and implementation planning study occur in April. Aiming to deliver business case to HAC and the Board in June.
Event Level Costing System	Preferred vendor selected. Project implementation plan and contractual activities occur in April

6.6 PROPERTY MATTERS

6.5.1 Seismic Works

- ***Blood Services Building and Kitchen Block***
Structural Engineers completed details of remedial strengthening works required to the first floor sections of each building. A Tender was let and work commenced on the Kitchen Block in February. The Blood Building work will possibly commence in early April. The Decanting Programme for staff and services in the Blood Building is being arranged.
- ***Education Centre and Pullar Cottage***
Work is to be undertaken in the Education Centre when maintenance is next undertaken in 2015/16. Work in Pullar Cottage will be completed by June 2015 at an estimated cost of \$40,000.
- Review of our infrastructure services/utilities site wide is continuing together with a Works Prioritisation Programme.

6.5.2 Feilding Integrated Family Health Centre - Manawatu Community Trust (MCT)

The MCT undertook an official signing of documents in the last week of February. This included the Agreement for Sale and Purchase of the Clevely buildings and Lease of Land, and is subject to all the required conditions being met in order that the final hand-over date/works commencement is agreed. MCT have indicated a date around mid-April.

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7. Financial Matters

(Amounts are in \$000s and adverse numbers are in brackets.)

7.1 STATEMENT OF FINANCIAL PERFORMANCE

Monthly results are reported to the Ministry of Health for the three divisions – Funder, Provider, and Governance. The table below shows the results for each business unit within each of these divisions.

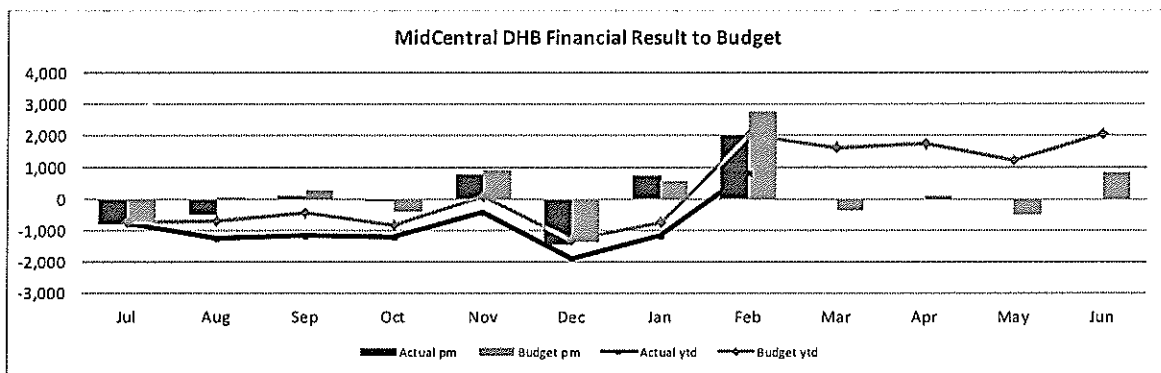
7.1.1 Consolidated Provisional Results for the Year to 28 February 2015

Feb-15 \$000	Month		Year to date		Annual Budget
	Actual	Variance	Actual	Variance	
Funding Division	1,989	16	2,504	(496)	3,300
Provider Division	(2)	(752)	(1,215)	(747)	(1,196)
Governance	23	0	(454)	89	(52)
Total DHB	2,010	(736)	835	(1,154)	2,052

The DHB is unfavourable to budget for the year. The Funding Division is favourable to budget while the Provider and Governance Divisions are unfavourable to budget.

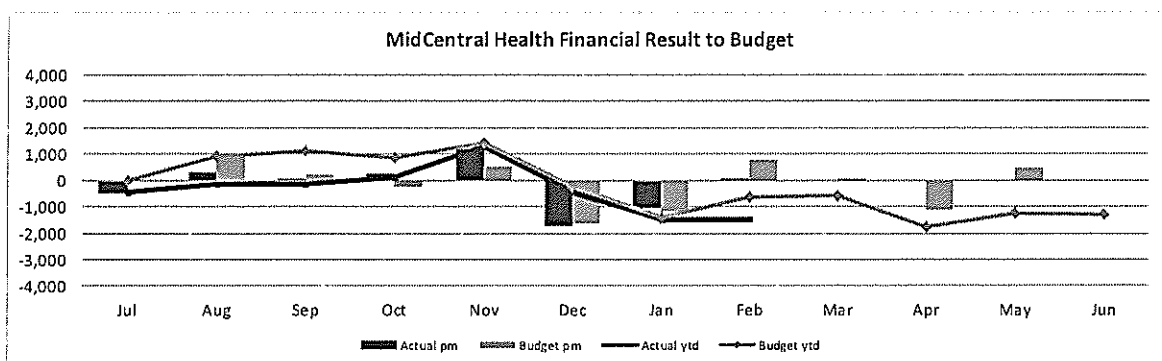
The detailed statement of financial performance is shown in Appendices C and D.

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



7.1.2 Provider Division

The performance of MidCentral Health in the year to date is shown in the following table:



7.1.3 Funding Division

The financial performance of the funding division by ring fenced areas is as follows:

Income and Expenditure r\$000	YTD			Annual		
	Actual	Budget	Variance	Forecast	Budget	Variance
Personal Health Income	267,079	265,079	2,000	399,674	397,618	2,056
Personal Health Expenditure	264,164	262,119	(2,045)	395,963	394,318	(1,645)
Personal Health Surplus/(Deficit)	2,914	2,960	(45)	3,711	3,300	411
Mental Health Income	26,963	26,560	403	40,301	39,840	461
Mental Health Expenditure	27,217	26,560	(657)	40,557	39,840	(716)
Mental Health Surplus/(Deficit)	(254)	0	(254)	(256)	0	(256)
Disability Support Income	51,826	51,232	594	77,778	76,848	931
Disability Support Expenditure	52,358	51,190	(1,167)	78,486	76,848	(1,638)
Disability Support Surplus/(Deficit)	(532)	41	(573)	(708)	0	(708)
Maori Health Income	1,362	1,338	24	2,031	2,007	24
Maori Health Expenditure	986	1,338	352	1,479	2,007	528
Maori Health Surplus/(Deficit)	376	0	376	552	0	552
Governance Income	1,637	1,637	(0)	2,456	2,456	0
Governance Expenditure	1,637	1,637	0	2,456	2,456	0
Governance Surplus/(Deficit)	0	0	0	0	0	0
Total Funder Surplus/(Deficit)	2,505	3,001	(496)	3,300	3,300	(0)

7.2 STATEMENT OF FINANCIAL PERFORMANCE

7.2.1 Financial Position

MidCentral District Health Board				
Statement of Financial Position (summary)				
	Jun 2012	Jun 2013	Feb 2015	Change
	r\$000	r\$000	r\$000	r\$000
Assets Employed				
Current Assets	84,807	88,037	86,153	(1,884)
Current Liabilities	(67,416)	(83,692)	(83,180)	512
Fixed Assets and Investments	185,697	190,024	192,178	2,154
	203,088	194,369	195,151	782
Funds Employed				
Equity	148,729	145,431	146,195	764
Term Loans	53,074	44,928	44,911	(17)
Long Term Liabilities	1,285	4,010	4,045	35
	203,088	194,369	195,151	782

(Refer Appendix E for details.)

7.2.2 Debt and Investments

7.2.2.1 Debt

This table shows the debt profile for the hospital's long term debt.

Lender	Maturity	\$'000	Rate	Type	% of Loans maturing per year	
					Year	% loan/yr
MoH	Apr-15	7,000	6.71%	Fixed		
	Apr-15	5,600	6.54%	Fixed	2014/15	22%
	Dec-17	2,500	5.05%	Fixed		
	Dec-17	10,000	6.63%	Fixed	2017/18	22%
	Mar-19	13,000	5.01%	Fixed		
	Mar-19	2,000	3.92%	Fixed	2018/19	26%
	May-21	12,500	3.37%	Fixed	2020/21	22%
	Apr-23	4,100	4.74%	Fixed	2022/23	7%
	Total	56,700	5.24%	Average		
Unused Facility		-				
Total Facility		56,700				
EECA	May-15	880	0.00%	Fixed		

The Board approved the rollover of the debts falling due in April 2015 to 2024 and 2025 at their last meeting.

7.2.2.2 Cash and Investments

Feb-15	Average Rate	Value \$000
HBL Sweep Balance	4.03%	61,569
Cash in Hand and at Bank		3
Enable New Zealand		864
Sub total		62,436
Trust Accounts		2,821
Total Cash Balance		65,257

Enable New Zealand funds are held at the Bank of New Zealand (BNZ) and the Trust & Special Funds are held in a separate Westpac account and fall outside of the Shared Banking Arrangement at Westpac which HBL sweeps daily.

7.2.2.3 Treasury Policy & Ratios

<i>Feb-15</i>	Actual	Policy / target
<i>Policy compliance requirements</i>		
Liquidity risks		
Term deposits	None	None
Short term borrowings	None	None
Interest rate risk		
Rate	Fixed	Fixed
Rate re-setting any 1 year	26%	< 30%
Foreign exchange risk		
Capital expenditure hedged	None	Conditional
Operational expenditure hedged over \$50k pm	None	Conditional
Counterparty credit risk exposure	None	< \$10.0m
<i>Historical covenant ratios</i>		
Net debt - Loans less bank balances (ex Trusts)	(\$5.7m)	< \$56.7m
Equity	\$146.2m	> \$30m
Debt & Equity	\$140.5m	
Debt Ratio	(4.1%)	< 55.0%
YTD Interest Cover	6.14	> 3.00

7.2.2.4 Debt Position

	Jun-12 \$m	Jun-13 \$m	Feb-15 \$m
MidCentral District Health Board			
Term Loan Facility	56.7	56.7	56.7
Term Loan Facility Drawn Down	(56.7)	(56.7)	(56.7)
Debt Facility Available	-	-	-

The 2013/14 Operational Policy Framework allow for working capital financing of up to one month's total provider arm planned Crown revenue to manage short term fluctuations. Prior approval of the Ministers of Finance and Health is required.

7.2.3 Capital Expenditure (Capex)

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

7/14

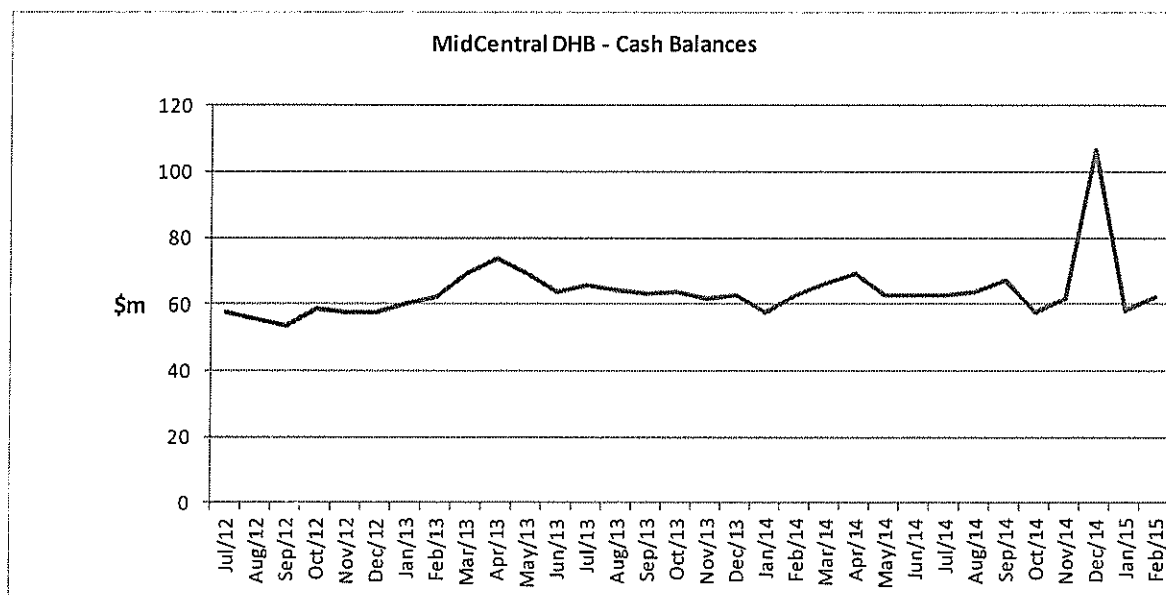
Capital Expenditure 2014/15-February 2015 Update	
	\$000's
2014/15 Plan	28,135
Earlier Years Plans Cfw'd	18,101
Total	46,236
Funded By:	
Depreciation 2014/15	16,827
EECA Loans	700
Surplus & Cash Reserves	28,709
Total	46,236
Total Spend to Manage within Annual Plan	28,135
Total to be Spent	28,135
Less Spent to 28/02/2015	11,714
Balance to Be Spent	16,421
<u>Spend YTD 28 February 2015</u>	\$000's
Digital Mammography & Whanganui BSCC	290
Seismic Work	408
Hospital E-Pharmacy Project	269
Telephony Upgrade Project	263
Maternity System	123
Bed Replacement Programme	456
Ambulatory Care Refurbishment	328
Master Health Services Plan	166
Enable-E Commerce	867
Theatre Tables	678
IV Pumps	766
Theatre Lights	487
Fibre & Cabinet Upgrade (IT)	410
Infrastructure Upgrades (IT)	385
Other (inc items under \$250k)	4,745
Total Before CRISP & HBL	10,641
CRISP & HBL	1,073
Total Capital Expenditure Spend 2014/15	11,714
Spend	
CAPEX Plan 2014/15	3,586
CAPEX Approved Prior Years	8,128
Total	11,714

The following are additions of items over \$250k and their substitutions to the Capital Expenditure Programme for the year. There is no overall change in the capital expenditure spend for the year

CAPEX Changes 2014/15:		\$'000's
Fire Penetration Work-More than initial budgeted amount required		200
Boiler Controls- More than initial budgeted amount required		50
Oncology Outpatients Clinic- Not on initial Plan		175
Hospital Operations Centre		600
Anaesthetic Monitors		500
Substitution other Commercial Support Projects		-250
Compound Products In House Service Removed		-1,000
Substitution other MCH Projects		-275
Theatre Electrics		-200
Transfer to other Commercial Support Projects		200
Net Change		0
Monthly Amount		
	Jul-14	28,135
	Aug-14	28,135
	Sep-14	28,135
	Oct-14	28,135
	Nov-14	28,135
	Dec-14	28,135
	Jan-15	28,135
	Feb-15	28,135
Net Decrease		0
Original Approved 2014/15		28,135
Cfwd CAPEX		22,077
Cath Lab moved to Master Health Services Plan		-2,600
Other Reductions		-399
SAN mainly being Leased -CAPEX spend to be reduced		-977
Cfwd Capex Feb 2015		18,101

7.3 CASH POSITION

7.3.1 Consolidated Statement of Cash Flows



7.16

The DHB's cash balance, excluding Trust Accounts, is shown in the chart above.

The big increase in the cash balance at December month end was due to the MOH January funding being paid in advance in December. The normal funding date is the 4th of the month or the previous day where the 4th is a holiday. In this case the 1st to the 4th of January were holidays, so the payment was made 31 December.


7.3.2 Cash Flow Reconciliation

\$'000	Year to date	Variance to prior month
Cash at June 2014	65,720	-
Surplus / (Deficit) to date	835	2,008
Depreciation	9,476	1,136
Sale of fixed assets	834	-
Capital expenditure	(11,713)	(949)
Working capital movement	86	2,374
Loan repayment	(17)	(69)
Trusts movement	36	(31)
Cash at month end	<u>65,257</u>	<u>4,469</u>

8. Outlook

This is my last report to the Board and I take the opportunity to thank you for your support over the past 16 years.

MidCentral DHB is in good heart and is well positioned to become a high performing health system. I wish you and the organisation well for the future and will follow your progress with interest.



Murray Georgel
Chief Executive Officer

Appendices:

- A. Performance Improvement Framework: Summary of M Horn's Assessment, March 2015*
- B. Letter from Deloitte dated 16 December 2014 re Audit Engagement Letter*
- C. Statement of Financial Performance (Consolidated)*
- D. Statement of Financial Performance (Divisional)*
- E. Statement of Financial Position,*
- F. Statement of Cash Flows*

Appendix A

Annex B: Conclusions from the DHB PIF Method Testing Interviews

The following conclusions have not been tested and are based solely on either a 60 or 90 minute interviews with Chairs and CEOs covering 20 “lead” questions. The purpose is to illustrate the method and what might surface from an approach like the one recommended (i.e., “option 3”).

The 20 questions are grouped into six elements and the comments are at that “element” level. The objective is to identify the practice described in the interviews that I think is most likely to deliver the sorts of outcomes described in the Four Year Excellence Horizon (or identify where more work is needed when this did not surface in the interviews). This has been prepared quickly to meet the March deadline, so does not pick up all of the value from the interviews.

Results

There was a high level of consistency and reasonably strong performance in DHBs ability to identify and respond to government priorities that are few in number, well specified and where there is some funding or reputational incentive to deliver the priorities (e.g., elective surgery volumes being the most dramatic example but the financial targets and 6 health targets also fall into this category).

On the other hand, there was a surprising variance in the way Chairs and CEOs described their “core business” and considerable uncertainty in how and to what extent value for money could be assessed. Given that all DHBs have the same legislative purpose (i.e., “... to improve, promote and protect the health of people and communities ... (and) ... to reduce disparities in health outcomes”), you would expect more commonality in both the way core business is described and value for money assessed.

The most useful approach to defining core business is from DHBs who focus on types of service (like prevention, early detection, treatment, long term condition management, rehabilitation and end of life care) that are drivers of “improving, promoting and protecting” health and “reducing disparities” (rather than, say, functions, like provision and funding). In terms of assessing value, the best approach was from those who used a combination of patient outcome (quality of life) measures and – for longer term preventative type services – impact on proved health risk factors. This is an important shift from a focus on intermediate hospital-based producer value measures (like length of stay) and relative cost of delivery.

Purpose and Strategy

Best practice comes from those DHBs that:

- Articulate a purpose that is motivating to staff, helps unify the external partners necessary to deliver the desired outcomes and helps management and Board identify what needs to be done and how that needs to be done;
- Really understand customer and patient “expectations” and can bring that to life in service design and delivery;
- Understand the challenges in meeting those expectations and take a longer-term and proactive view of strategy (rather than a tactical response to emerging problems); and then
- Ensure a high degree of alignment from their purpose, to their desired service mix (the what), to their target operating model (the how) and then are clear about the behaviours necessary to bring that target operating model to life.

The most effective approach seems to be to develop an articulation of purpose and the behaviours necessary to deliver to that purpose “bottom-up” through engagement and co-creation with staff,

partners and consumers (community and patients). This reinforces user-centrality and helps create the right expectations amongst staff and partners about what the DHB is here to do, the desired behaviours and those that are clearly not acceptable (and helps create the peer pressure that reinforces those behaviours).

Community and Patients

Most DHBs had well developed approaches to engaging with the community and assessing community needs, with the best approaches based on on-going and relatively intimate relationships with sub-groups (e.g., iwi, disability and locality) aimed at really finding out what communities wanted from the DHB and how well it was delivering. In some cases there is substantial and formally structured community input into service design and delivery (e.g., through consumer councils).

While all DHBs look for feedback from patients (e.g., via complaints and the national survey), the best approach is one that is proactive, on-going and systematic and provides real insight into what patients are looking for and what needs to be done to better meet user expectations. This requires discriminating feedback on a wide range of patient experience at a reasonably detailed level (rather than small variations in results at a fairly aggregate level), with reliable measures of progress over time (e.g., via a Net Promotor Score). There is scope for expanding this approach to a wider range of patient experiences (especially beyond the hospital-based services).

Most DHBs struggled in response to the question about encouraging patients and their families to play a greater role in their own care, in part because it seems such a daunting task. Technology has an important part to play in informing patient choice and shifting more control to the patient (e.g., electronic health records, patient portals, home-based monitoring). However this will only be part of the story. Some DHBs are putting much more effort into promoting greater patient involvement by: better targeting those patients where the need is greatest based on patient risk factors; scaling the degree of support based on the risk; and then tailoring the help they provide to the circumstances of each patient. For example,

- intensive and proactive case management with very frequent flyers tailoring a range of health and social service interventions that are most likely to increase independence and reduce future demand for health services;
- a similar approach for those with 2-3 long term conditions but with lower intensity and provided via the primary care home;
- patients with a single long term condition are provided with initial help to ensure that they are well placed to manage that condition themselves.

This is supplemented with proactive approaches to identify “high risk” people before they present as a real problem (e.g., school nurses to identify high risk children).

Leadership and Management

The best boards have a good sense of the different roles of directors and managers, are proactive in setting their agendas, take time to focus on longer-term and more strategic issues facing the DHB and do not see a significant difference in the contribution of elected and appointed members (albeit the latter is easier for Chairs to manage in some DHBs than in others).

There was a high correlation between leadership team coherence and the investment in leadership development, especially in the way leadership expectations are set, clinicians are given the time and the on- and off-job training they need to become leaders, and the clarity of relationship between

managers and clinicians (e.g., where clinicians really lead then managers can focus on supporting the clinical team).

As expected there was a lot of variation in the degree to which different DHBs successfully managed poor performance and focussed on addressing those issues which were hindering high levels of staff engagement, like perceived bullying. The better results saw high coverage of regular performance and development discussions with staff, including clinical staff (highest number 90% coverage); good participation in annual surveys of staff *engagement* (over 60%) with high levels of engaged staff (75% engaged or highly engaged); with well-structured and executed management responses to those issues that were preventing stronger engagement.

There is more room for common approaches to some of these areas. Some DHBs highlighted the desirability of more uniformity in the staff surveys (so that annual comparisons could be made on staff engagement and best practice more easily identified). Some Boards commented that succession planning would be easier if we developed talent across the whole health system in a more systematic way. Others pointed to the benefits gained for having common leadership training programs (that were shared with PHOs and with other DHBs): e.g., the “accelerate” program was mentioned in this regard.

Relationships

Success here relies on taking a (health or wider social sector) system view and effective partnering (with private and public health and other social service providers that only deliver elements of a solution) to deliver tailored **outcomes** for users in a relatively seamless way.

While most DHBs have made some progress in delivering better integrated health care in their districts, the fragmented nature of primary and community based providers and their existing business models frustrate partnering for outcomes (rather than contracting for activity or inputs). Some DHBs are tackling this issue by moving from alliances to something that more closely resembles a joint venture with a single “service integrator”: who holds the budget; brings together all of the service providers who are necessary to deliver a well-defined outcome (like eliminating disparities in health outcomes for Maori in the district within 5 years); and shares the risk and rewards associated with delivering that outcome. The DHB works with the service integrator and representatives of the consumers to set priorities and milestones and the integrator has the flexibility to innovate service delivery.

While progress is being made, effective DHB collaboration at the regional level is still very patchy and frustrating. However, there are sub-regional collaborations that are already realising most of the benefits you would expect from a fully integrated health system. The Canterbury-West Coast arrangement stands out in terms of integrated service delivery across DHB boundaries: one that provide a much safer, higher quality and more sustainable service to rural and remote communities for the available resource. This is facilitated by: extensive use of tele-health; common information systems (including diagnostics); shared employment arrangements (that promote multi-site specialist services, make working in remote locations less daunting and broaden the scope for leadership development and succession planning); common referral pathways; and shared governance and management amongst other things.

More effective collaboration with other social service agencies (housing, welfare, education, etc.) is an underdeveloped area with huge potential for improved health outcomes. Most DHBs have some experience of “trials” or limited collaborations in a particular locations or for a small group of users (e.g., whanau ora; children teams; social sector trials; health delivery in schools or prisons). Some

DHBs have a more systematic approach to significant sub-populations (e.g., co-ordination of a range of social services to keep older people in their homes for longer). These integrate the other social agencies into the alliance leadership teams; identify sub-populations or individuals with potentially high or complex needs; tailor a care plan to meet those needs and identify a single point of accountability in a lead agency to co-ordinate delivery of that plan. This general approach has many common elements to that taken by some DHBs to helping people take greater control of their own care (i.e., careful targeting; scaling the effort to the risk or opportunity and tailoring the response to individual circumstances).

Finances and Resources

Most DHB Chairs and CEOs saw the greatest opportunities for improvement in the ability to make better use of information and technology to support better targeting and tailoring of their own effort, provide better integrated and more seamless care to patients, and provide individuals with the information and tools to better manage their own care.

In terms of asset management, the better experience came from those DHBs who are able to smooth the impact of asset replacement and improvement on service delivery (e.g., by running surpluses to minimise the impact of debt and equity injections on future service provision).

In terms of financial management, the better experience came from those who were well informed about the cost to provide specific services and even cost to serve different patient segments, which informed investment and future service mix.

In terms of risk management, no-one had an explicit Board risk appetite statement, most DHBs appeared to have the standard risk management tools and the best experience came from those with an automated risk management system that allowed, for example, easy tracking of progress with risk remediation as well as of progress implementing the recommendations from service and other reviews.

Appendix B



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16 December 2014

The Chairperson
MidCentral District Health Board
PO Box 2056
PALMERSTON NORTH

Dear Chair

AUDIT ENGAGEMENT LETTER

This audit engagement letter is sent to you on behalf of the Auditor-General, who is the auditor of all "public entities", including MidCentral District Health Board under section 14 of the Public Audit Act 2001 (the Act). The Auditor-General has appointed me, Melissa Youngson, using the staff and resources of Deloitte, under section 32 and 33 of the Act, to carry out the annual audit of the MidCentral District Health Board's financial statements and performance information. We will be carrying out the annual audit on the Auditor-General's behalf, for the year ending 30 June 2015.

This letter outlines:

- the terms of the audit engagement and the nature, and limitations, of the annual audit; and
- the respective responsibilities of the Board and me, as the Appointed Auditor, for the financial statements and performance information.

The objectives of the annual audit are:

- to provide an independent opinion on the Board's financial statements and performance information; and
- to report on other matters relevant to the Board's financial and other management systems that come to our attention, need improvement or are significant (for example, non-compliance with statutory obligations or a lack of probity).

We will carry out the audit in accordance with the Auditing Standards issued by the Auditor-General, which incorporate the International Standards on Auditing (New Zealand) (the Auditing Standards). They require that we comply with ethical requirements, and plan and perform the audit to obtain reasonable assurance about whether the MidCentral District Health Board's financial statements and performance information are free from material misstatements.

Your responsibilities

Our audit will be carried out on the basis that the Board acknowledges that it has responsibility for:

- preparing the financial statements and performance information in accordance with legal requirements and financial reporting standards;
- having such internal control as you determine is necessary to enable you to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error; and
- providing us with:
 - access to all information of which the MidCentral District Health Board is aware that is relevant to preparing the financial statements and performance information such as records, documentation, and other matters;
 - additional information that we may request from the MidCentral District Health Board for the purpose of the audit;
 - unrestricted access to Board members and employees that we consider necessary; and
 - written confirmation concerning representations made to us in connection with the audit.

The Board's responsibilities extend to all resources, activities, and entities under its control. We expect that the Board will ensure:

- the resources, activities and entities under its control have been operating effectively and efficiently;
- it has complied with its statutory obligations including laws, regulations, and contractual requirements;
- it has carried out its decisions and actions with due regard to minimising waste;
- it has met Parliament's and the public's expectations of appropriate standards of behaviour in the public sector in that it has carried out its decisions and actions with due regard to probity; and
- its decisions and actions have been taken with due regard to financial prudence.

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A member of Deloitte Touche Tohmatsu Limited

We expect the Board and/or the individuals within the MidCentral District Health Board with delegated authority to immediately inform us of any suspected fraud, where there is a reasonable basis that suspected fraud has occurred regardless of the amount involved. Suspected fraud also includes instances of bribery and/or corruption.

The Board should have documented policies and procedures to support its general responsibilities. It should also regularly monitor performance against its objectives.

The Board has certain responsibilities relating to the preparation of the financial statements and performance information and in respect of financial management and accountability matters. These specific responsibilities are set out in Annex 1. We assume that members of the Board are familiar with those responsibilities and, where necessary, have obtained advice about them.

Our responsibilities

Carrying out the audit

We are responsible for forming an independent opinion on whether the financial statements and performance information of MidCentral District Health Board:

- comply with generally accepted accounting practice; and
- fairly reflect its position and performance.

An audit involves obtaining evidence about the amounts and disclosures in the financial statements and performance information. How we obtain this information depends on our judgement, including our assessment of the risks of material misstatement of the financial statements and performance information, whether due to fraud or error. An audit also includes evaluating the appropriateness of accounting policies and the reasonableness of accounting estimates, as well as evaluating the overall presentation of the financial statements and performance information.

We do not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Because of the inherent limitations of an audit, together with the inherent limitations of internal control, there is an unavoidable risk that some material misstatements may not be detected, even though the audit is properly planned and performed in accordance with the Auditing Standards.

During the audit, we consider internal control relevant to the Board's preparation of the financial statements and performance information, but not for the purpose of expressing an opinion on the effectiveness of the Board's internal controls.

Please note that the audit does not relieve the Board of its responsibilities. The Auditor-General expects members of the Board to be familiar with those responsibilities and, where necessary, to have obtained advice about them.

However, we will communicate to you in writing any significant deficiencies in internal control relevant to the audit of the financial statements and performance information that we have identified during the audit.

During the audit, the audit team will maintain an alertness for issues of:

- effectiveness and efficiency – in particular, how the Board and the District Health Board have carried out their activities;
- non-compliance with laws, regulations, and contractual requirements;
- waste – in particular, whether the Board obtained and applied the resources of the District Health Board in an economical manner, and whether any resources are being wasted;
- a lack of probity – in particular, whether the Board and the District Health Board have met Parliament's and the public's expectations of appropriate standards of behaviour in the public sector; and
- a lack of financial prudence.

Our independence

It is essential that the audit team and Deloitte remain both economically and attitudinally independent of MidCentral District Health Board (the District Health Board) (including management and the Board). This involves being, and appearing to be, free of any interest that might be regarded, whatever its actual effect, as being incompatible with integrity, objectivity, and independence.

To protect our independence, specific limitations are placed on us in accepting engagements with the Board other than the annual audit. We may accept certain types of other engagements, subject to the requirements of the Auditing Standards. Any such other engagements must be the subject of a separate written arrangement between the Board and myself or Deloitte.

Reporting

We will issue an audit report that will be attached to the financial statements and performance information. This report contains an opinion that provides readers with reasonable assurance on whether the financial statements and performance information have been prepared in accordance with legal requirements, are free from material misstatements, and comply with financial reporting standards. It may also contain comment on matters such as compliance with statutory obligations, and other matters that we consider may be of interest to the readers of the audit report.

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We will also issue a management letter that will be sent to the Board. This letter communicates any matters that come to our attention during the audit that, in our opinion, are relevant to the Board (for example, internal control weaknesses, probity matters, or compliance with statutory obligations). The management letter is the basis of a letter sent to the Minister and a briefing report sent to the select committee about the results of our audit. We may also provide other management letters to the MidCentral District Health Board from time to time. We will inform the Board of any other management letters we have issued.

Please note that the Auditor-General may refer to matters that are identified in the annual audit in a report to Parliament if it is in the public interest, in keeping with section 20 of the Public Audit Act 2001.

Next steps

Please acknowledge receipt of this letter and the terms of the audit engagement by signing the enclosed copy of the letter in the space provided and returning it to me. The terms will remain effective until a new Audit Engagement Letter is issued.

Annex 2 contains some additional "other" responsibilities for the audit.

If you have any questions about the audit generally, or have any concerns about the quality of the audit, you should contact me as soon as possible. If after contacting me you still have concerns, you should contact the Director of Auditor Appointments at the Office of the Auditor-General on (04) 917 1500.

If you require any further information, or wish to discuss the terms of the audit engagement further before replying, please do not hesitate to contact me.

Yours sincerely

Melissa Youngson
Deloitte
On behalf of the Auditor-General

I acknowledge the terms of this engagement and that I have the required authority on behalf of the Board.

Signature:

Name:

Title:

Date:

Annex 1 – Respective specific responsibilities of the Board and the Appointed Auditor

Responsibilities for the financial statements and performance information	
<i>Responsibilities of the Board</i>	<i>Responsibilities of the Appointed Auditor</i>
<p>You are required by legislation to prepare financial statements and, where appropriate, other accountability statements that comply with generally accepted accounting practice in New Zealand and that fairly reflect or give a true and fair view of the activities of the public entity.</p> <p>You must also ensure that any accompanying information in the annual report is consistent with that reported in the audited financial statements and performance information.</p> <p>You are required by legislation to prepare the financial statements and performance information and provide that information to us before the statutory reporting deadline. It is normal practice for you to set your own timetable to comply with statutory reporting deadlines.</p>	<p>We are responsible for carrying out an annual audit, on behalf of the Auditor-General, and to form an opinion on whether the public entity's financial statements and performance information have been prepared in accordance with legal requirements, comply with generally accepted accounting practice in New Zealand and fairly reflect or give a true and fair view of the position and performance of the public entity.</p> <p>We will also read other accompanying information to the financial statements and performance information to identify whether there are material inconsistencies with the audited financial statements and performance information.</p> <p>Materiality is one of the main factors affecting our judgement on the areas to be tested and on the timing, nature, and extent of the tests and procedures performed during the audit. In planning and performing the annual audit, we aim to obtain reasonable assurance that the financial statements and performance information do not have material misstatements caused by either fraud or error. Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence a reader's overall understanding of the financial statements and performance information.</p> <p>If we find material misstatements that are not corrected, they will be referred to in the audit opinion. The Auditor-General's preference is for you to correct any material misstatements and avoid the need for them to be referred to in the audit opinion.</p> <p>An audit also involves evaluating:</p> <ul style="list-style-type: none"> - the appropriateness of accounting policies used and whether they have been consistently applied; - the reasonableness of the significant accounting estimates and judgements made by those charged with governance; - the appropriateness of the content and measures in any non-financial accountability statements; - the adequacy of all disclosures in the financial statements and performance information; and - the overall presentation of the financial statements and performance information. <p>We will ask you for written confirmation of representations made about the financial statements and performance information. In particular, we will seek confirmation that:</p> <ul style="list-style-type: none"> - the adoption of the going concern assumption is appropriate; - all material transactions have been recorded and are reflected in the financial statements and performance information; - all instances of non-compliance or suspected non-compliance with laws and regulations have been disclosed; and - uncorrected misstatements noted during the audit are immaterial to the financial statements and performance information. <p>Any representation made does not in any way reduce our responsibility to perform appropriate audit procedures and enquiries.</p>

Responsibilities for the accounting records	
<i>Responsibilities of the Board</i>	<i>Responsibilities of the Appointed Auditor</i>
<p>You are responsible for maintaining accounting and other records that:</p> <ul style="list-style-type: none"> - correctly record and explain the transactions of the public entity; - enable you to monitor the resources, activities, and entities under its control; - enable the public entity's financial position to be determined with reasonable accuracy at any time; - enable the Board to prepare financial statements and performance information that comply with legislation (and that allow the financial statements and performance information to be readily and properly audited); and - are in keeping with the requirements of the Commissioner of Inland Revenue. 	<p>We will perform sufficient tests to obtain reasonable assurance as to whether the underlying records are reliable and adequate as a basis for preparing the financial statements and performance information.</p> <p>If, in our opinion, the records are not reliable or accurate enough to enable the preparation of the financial statements and performance information and the necessary evidence cannot be obtained by other means, we will need to consider the effect on the audit opinion.</p>

Responsibilities for accounting and internal control systems	
<i>Responsibilities of the Board</i>	<i>Responsibilities of the Appointed Auditor</i>
<p>You are responsible for establishing and maintaining accounting and internal control systems (appropriate to the size of the public entity), supported by written policies and procedures, designed to provide reasonable assurance as to the integrity and reliability of financial and, where applicable, non-financial reporting.</p>	<p>The annual audit is not designed to identify all significant weaknesses in your accounting and internal control systems. We will review the accounting and internal control systems only to the extent required to express an opinion on the financial statements and performance information.</p> <p>We will report to you separately, any significant weaknesses in the accounting and internal control systems that come to our notice and that we consider may be relevant to you. Any such report will provide constructive recommendations to assist you to address those weaknesses.</p>

Responsibilities for preventing and detecting fraud and error	
<i>Responsibilities of the Board</i>	<i>Responsibilities of the Appointed Auditor</i>
<p>The responsibility for the prevention and detection of fraud and error rests with you through the implementation and continued operation of adequate internal control systems (appropriate to the size of the public entity) supported by written policies and procedures.</p> <p>We expect you to formally address the matter of fraud, and formulate an appropriate policy on how to minimise it and (if it occurs) how it will be dealt with. Fraud also includes bribery and corruption.</p> <p>We expect you to consider reporting all instances of actual, suspected or alleged fraud to the appropriate law enforcement agency, which will decide whether proceedings for a criminal offence should be instituted. We expect you to immediately inform us of any suspected fraud where you, and/or any individuals within the MidCentral District Health Board with delegated authority have a reasonable basis that suspected fraud has occurred, regardless of the amount involved.</p>	<p>We design our audit to obtain reasonable, but not absolute, assurance of detecting fraud or error that would have a material effect on the financial statements and performance information. We will review the accounting and internal control systems only to the extent required for them to express an opinion on the financial statements and performance information, but we will:</p> <ul style="list-style-type: none"> - assess the effectiveness of internal control systems and procedures for preventing and detecting fraud and error; and - report to you the significant weaknesses in internal control systems and procedures for monitoring the prevention and detection of fraud and error that come to our notice and that we consider could be relevant to you. <p>We are required to immediately advise the Office of the Auditor-General of all instances of actual, suspected or alleged fraud.</p> <p>As part of the audit, you will be asked for written confirmation that you have disclosed all known instances of actual, suspected or alleged fraud to us.</p> <p>If we become aware of the possible existence of fraud, whether through applying audit procedures, advice from you, or management, or by any other means, we will communicate this to you with the expectation that you will consider whether it is appropriate to report the fraud to the appropriate law enforcement agency. In the event that you do not report the fraud to the appropriate law enforcement agency, the Auditor-General will consider doing so, if it is appropriate for the purposes of protecting the interests of the public.</p>

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Responsibilities for compliance with laws and regulations	
Responsibilities of the Board	Responsibilities of the Appointed Auditor
<p>You are responsible for ensuring that the public entity has systems, policies, and procedures (appropriate to the size of the public entity) to ensure that all applicable legislative, regulatory, and contractual requirements that apply to the activities and functions of the public entity are complied with. Such systems, policies, and procedures should be documented.</p>	<p>We will assess whether you have systems, policies, and procedures to ensure compliance with those legislative, regulatory, and contractual requirements that are relevant to the audit. We will either perform specific audit tests to assess whether you have complied with statutory requirements that are relevant to the audit or will maintain an awareness for possible non-compliance that may be relevant to the audit.</p> <p>The way in which we will report instances of non-compliance that come to our attention will depend on considerations of materiality or significance. We will report to you and to the Auditor-General all material and significant instances of non-compliance.</p> <p>We will also report to you any significant weaknesses that we observe in internal control systems, policies, and procedures for monitoring compliance with laws, regulations, and contractual requirements that we consider may be relevant.</p>

Responsibilities to establish and maintain appropriate standards of conduct and personal integrity	
Responsibilities of the Board	Responsibilities of the Appointed Auditor
<p>You should at all times take all practicable steps to ensure that your members and employees maintain high standards of conduct and personal integrity. You should document your expected standards of conduct and personal integrity in a "Code of Conduct" and, where applicable, support the "Code of Conduct" with policies and procedures.</p> <p>The expected standards of conduct and personal integrity should be determined by reference to accepted "Codes of Conduct" that apply to the public sector.</p>	<p>We will have regard to whether you maintain high standards of conduct and personal integrity. Specifically, we will be alert for significant instances where members and employees of the public entity may not have acted in accordance with the standards of conduct and personal integrity expected of them.</p> <p>The way in which we will report instances that come to our attention will depend on significance. We will report to you and to the Auditor-General all significant departures from expected standards of conduct and personal integrity.</p> <p>The Auditor-General, on receiving a report from us, may, at their discretion and with consideration of its significance, decide to conduct a performance audit of, or an inquiry into, the matters raised. The performance audit or inquiry will be subject to specific terms of reference, in consultation with you. Alternatively, the Auditor-General may decide to publicly report the matter without carrying out a performance audit or inquiry.</p>

Responsibilities for conflicts of interest and related parties	
Responsibilities of the Board	Responsibilities of the Appointed Auditor
<p>You should have policies and procedures to ensure that your members and employees carry out their duties free from bias.</p> <p>You should maintain a full and complete record of related parties and their interests. It is your responsibility to record and disclose related-party transactions in the financial statements and performance information in accordance with generally accepted accounting practice.</p>	<p>To help determine whether your members and employees have carried out their duties free from bias, we will review information provided by you that identifies related parties, and will be alert for other material related-party transactions. We will check that you have complied with any statutory requirements for conflicts of interest and whether these transactions have been properly recorded and disclosed in the financial statements and performance information.</p>

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Responsibilities for publishing the audited financial statements on a website	
<i>Responsibilities of the Board</i>	<i>Responsibilities of the Appointed Auditor</i>
<p>You are responsible for the electronic presentation of the financial statements and performance information on the public entity's website. This includes ensuring that there are enough security and controls over information on the website to maintain the integrity of the data presented.</p> <p>If you intend to publish or reproduce the financial statements and performance information, together with the audit report, on a website, you must, before publication, provide us with a draft version of the documents to read and must obtain our approval to include the audit report with the information you intend publishing on the website.</p> <p>If the audit report is reproduced in any medium, you should present the complete financial statements, including notes and accounting policies as well as any other accountability statements.</p> <p>If you intend to post any new material not previously read by us, you must advise us before posting the new material.</p>	<p>We will perform procedures to satisfy ourselves that the information you intend including on your website is consistent with the audited financial statements and performance information, and that the audit report will not be inappropriately associated with any information that has not been audited.</p> <p>Examining the controls over the electronic presentation of audited financial statements and performance information, and the associated audit report, on your website is beyond the scope of the annual audit.</p> <p>We will review the material on initial posting, and on notification from you that new material has been posted on the website. We do not carry out ongoing monitoring of the material on your website.</p>

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Annex 2 – Other responsibilities

To meet the reporting deadlines, we are dependent on receiving the public entity's financial statements and performance information ready for audit and in enough time to enable the audit to be completed. "Ready for audit" means that the financial statements and performance information have been prepared in accordance with legal requirements, comply with generally accepted accounting practice and fairly reflect or give a true and fair view of the activities and position of the public entity, and are supported by proper accounting records and complete evidential documentation.

We will ensure that the annual audit is completed by the reporting deadline or, if that is not practicable because of the non-receipt or condition of the financial statements and performance information, or for some other reason beyond our control, as soon as possible after that.

The work papers that we produce in carrying out the audit are the property of the Auditor-General. Workpapers are confidential to the Auditor-General and subject to the disclosure provisions in section 30 of the Public Audit Act 2001.

The Auditor-General and Audit Service Providers take seriously their responsibility to provide a safe working environment for audit staff. You are, therefore, asked to clearly inform audit staff visiting your premises what you require of them to ensure health and safety requirements are satisfied, particularly emergency evacuation procedures and any requirement to wear safety equipment, and to report accidents and hazards.

7-30

Appendix C

Statement of Financial Performance (Consolidated)

<i>Feb-15</i> <i>Monthly Result</i>	<i>Actual</i> <i>\$000</i>	<i>Budget</i> <i>\$000</i>	<i>Variance</i> <i>\$000</i>	<i>%</i>
Revenue				
Govt. & Crown Agency	48,201	48,740	(539)	(1%)
Patient/Consumer Sourced	40	81	(41)	(51%)
Other Income	1,126	1,181	(55)	(5%)
Total Revenue	49,367	50,002	(635)	(1%)
Expenditure				
Personnel	14,973	15,056	83	1%
Outsourced Personnel	456	216	(240)	(111%)
Sub-total Personnel	15,429	15,272	(157)	(1%)
Other Outsourced Services	1,376	1,294	(82)	(6%)
Clinical Supplies	4,175	3,719	(456)	(12%)
Infrastructure & Non-Clinical	6,652	7,516	864	11%
Provider Payments	19,725	19,455	(270)	(1%)
Total Expenditure	47,357	47,256	(101)	(0%)
Operating Surplus/(Deficit)	2,010	2,746	(736)	(27%)

<i>Feb-15</i> <i>Year to Date</i>	<i>Actual</i> <i>\$000</i>	<i>Budget</i> <i>\$000</i>	<i>Variance</i> <i>\$000</i>	<i>%</i>
Revenue				
Govt. & Crown Agency	391,968	390,560	1,408	0%
Patient/Consumer Sourced	362	646	(284)	(44%)
Other Income	9,513	9,663	(150)	(2%)
Total Revenue	401,843	400,869	974	0%
Expenditure				
Personnel	127,893	128,901	1,008	1%
Outsourced Personnel	2,789	1,788	(1,001)	(56%)
Sub-total Personnel	130,682	130,689	7	0%
Other Outsourced Services	12,258	11,212	(1,046)	(9%)
Clinical Supplies	35,042	33,403	(1,639)	(5%)
Infrastructure & Non-Clinical	62,310	64,467	2,157	3%
Provider Payments	160,715	159,108	(1,607)	(1%)
Total Expenditure	401,007	398,879	(2,128)	(1%)
Operating Surplus/(Deficit)	836	1,990	(1,154)	(58%)

Appendix D Statement of Financial Performance (Divisional)

Feb 15	Provider Total			Governance Total			Funder			DHB Total (exc eliminations)		
\$'000	Actual Per 8	Budget Per 8	Variance	Actual Per 8	Budget Per 8	Variance	Actual Per 8	Budget Per 8	Variance	Actual Per 8	Budget Per 8	Variance
REVENUE												
Government & Crown Agency	26,276	27,101	(825)	211	211	-	43,916	43,231	685	48,201	48,739	(538)
Patient / Consumer Sourced	40	81	(41)	-	-	-	-	-	-	40	81	(41)
Other Income	620	811	(191)	506	370	136	-	-	-	1,126	1,181	(55)
TOTAL REVENUE	26,937	27,993	(1,056)	717	580	137	43,916	43,231	685	49,368	50,001	(633)
EXPENDITURE												
Staff												
Medical Staff	4,504	4,639	135	-	-	-	-	-	-	4,504	4,639	135
Nursing Staff	5,977	5,779	(198)	1	-	(1)	-	-	-	5,978	5,779	(199)
Allied Health Staff	2,303	2,293	(10)	-	-	-	-	-	-	2,303	2,293	(10)
Support Staff	154	160	6	-	-	-	-	-	-	154	160	6
Management & Admin Staff	1,506	1,624	118	528	562	34	-	-	-	2,034	2,186	152
Outsourced Staff	422	183	(239)	34	33	(1)	-	-	-	456	216	(240)
Total Staff	14,866	14,677	(189)	562	595	33	-	-	-	15,429	15,272	(157)
Outsourced Services	1,332	1,245	(87)	44	49	5	205	205	-	1,375	1,293	(82)
Clinical Supplies	4,172	3,719	(453)	3	-	(3)	-	-	-	4,175	3,719	(456)
Infrastructure & non-clinical expenses	6,069	7,102	1,033	585	413	(172)	-	-	-	6,653	7,516	863
Internal Providers	-	-	-	-	-	-	21,997	21,599	(398)	-	-	-
External Providers												
Personal Health	-	-	-	-	-	-	12,789	12,909	120	12,789	12,909	120
Mental Health	-	-	-	-	-	-	1,174	994	(180)	1,174	994	(180)
Public Health	-	-	-	-	-	-	362	200	(162)	362	200	(162)
DSS	-	-	-	-	-	-	5,266	5,185	(81)	5,266	5,185	(81)
Maori Health	-	-	-	-	-	-	134	167	33	134	167	33
Total External Providers	-	-	-	-	-	-	19,725	19,455	(270)	19,725	19,455	(270)
Recharges	500	500	-	(500)	(500)	-	-	-	-	-	-	-
TOTAL EXPENDITURE	26,939	27,244	305	694	557	(137)	41,928	41,258	(670)	47,358	47,255	(103)
SURPLUS / (DEFICIT)	(2)	749	(751)	23	23	-	1,988	1,973	15	2,010	2,746	(736)

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Feb 15 \$000	Provider Total			Governance Total			Funder			DH8 Total (exc eliminations)		
	Actual YTD		Budget YTD	Actual YTD		Budget YTD	Actual YTD		Budget YTD	Actual YTD		Variance
		Variance			Variance			Variance			Variance	
REVENUE												
Government & Crown Agency	226,997	238	226,759	1,751	60	1,691	348,867	3,021	345,846	391,968	1,408	0.36%
Patient / Consumer Sourced	362	(284)	646	-	-	-	-	-	-	363	(283)	(43.81%)
Other Income	5,919	(787)	6,706	3,594	637	2,957	-	-	-	9,513	(150)	(1.55%)
TOTAL REVENUE	233,277	(834)	234,111	5,345	697	4,648	348,867	3,021	345,846	401,842	973	0.24%
EXPENDITURE												
Staff												
Medical Staff	38,667	838	39,505	-	-	-	-	-	-	38,667	838	2.1%
Nursing Staff	50,023	(461)	49,562	1	(1)	-	-	-	-	50,024	(462)	(0.9%)
Allied Health Staff	19,040	370	19,410	-	-	-	-	-	-	19,040	370	1.9%
Support Staff	1,404	(47)	1,357	-	-	-	-	-	-	1,404	(47)	(3.5%)
Management & Admin Staff	14,314	(202)	14,112	4,444	511	4,955	-	-	-	18,758	309	1.6%
Outsourced Staff	2,510	(986)	1,524	279	(15)	264	-	-	-	2,789	(1,001)	(56.0%)
Total Staff	125,958	(488)	125,470	4,724	495	5,219	-	-	-	130,682	7	0.0%
Outsourced Services	11,899	(1,076)	10,823	358	31	389	1,637	-	1,637	12,258	(1,046)	(9.3%)
Clinical Supplies	35,023	(1,622)	33,401	18	(16)	2	-	-	-	35,042	(1,639)	(4.9%)
Infrastructure & non-clinical expenses	57,609	3,273	60,882	4,701	(1,118)	3,583	-	-	-	62,310	2,155	3.3%
Internal Providers	-	-	-	-	-	-	184,010	(1,911)	182,099	-	-	(1.0%)
External Providers	-	-	-	-	-	-	104,613	(253)	104,360	104,613	(253)	(0.2%)
Personal Health	-	-	-	-	-	-	8,409	(460)	7,949	8,409	(460)	(5.8%)
Mental Health	-	-	-	-	-	-	1,758	(161)	1,597	1,758	(161)	(10.1%)
Public Health	-	-	-	-	-	-	44,948	(1,083)	43,865	44,948	(1,083)	(2.5%)
DSS	-	-	-	-	-	-	986	352	1,338	986	352	26.3%
Maori Health	-	-	-	-	-	-	160,715	(1,607)	159,108	160,715	(1,607)	(1.0%)
Total External Providers	-	-	-	(4,002)	-	(4,002)	-	-	-	-	-	-
Recharges	4,002	-	4,002	-	0.0%	-	-	-	-	-	-	-
TOTAL EXPENDITURE	234,492	87	234,579	5,799	(609)	5,190	346,362	(3,517)	342,845	401,006	(2,128)	(0.5%)
SURPLUS / (DEFICIT)	(1,215)	(747)	(468)	(454)	88	(542)	2,505	(496)	3,001	836	(1,155)	-

Appendix E

Statement of Financial Position

	Jun-13 \$000	Jun-14 \$000	Feb-15 \$000	Change \$000
ASSETS EMPLOYED				
Current Assets	84,807	88,037	86,153	(1,884)
Bank/Cash (DHB)	62,714	61,834	61,661	(173)
Investments < 3 months (DHB)	870	1,100	775	(325)
Investments > 3 months (DHB)	0	0	0	0
Investments < 3 months (Trusts)	2,496	2,786	2,821	35
Other Current Assets	18,727	22,317	20,896	(1,421)
Current Liabilities	(67,416)	(83,692)	(83,180)	512
Capital Charge	0	0	(1,896)	(1,896)
Employee Benefits	(25,807)	(27,132)	(25,819)	1,313
GST	(2,068)	(2,390)	(5,024)	(2,634)
Other Current Liabilities	(39,541)	(54,170)	(50,441)	3,729
Fixed Assets & Investments	185,697	190,024	192,178	2,154
Total Fixed Assets (refer to note)	184,784	189,005	191,159	2,154
Investments	913	1,019	1,019	0
Net Assets Employed	203,088	194,369	195,151	782
FUNDS EMPLOYED				
Equity	148,729	145,431	146,195	764
Share Capital	64,713	65,321	65,321	0
Revaluation Reserve	90,420	86,892	86,177	(715)
Trust and Special Funds	2,498	0	0	0
Retained Earnings	(8,902)	(6,782)	(5,303)	1,479
Non Current Liabilities	54,359	48,938	48,956	18
Term Loans	53,074	44,928	44,911	(17)
Long Term Liabilities	1,285	4,010	4,045	35
Total Funds Employed	203,088	194,369	195,151	782
Note:				
Land	13,540	8,700	8,650	(50)
Buildings (including fitout)	139,902	134,926	130,417	(4,509)
Plant & Equipment	26,742	35,841	39,737	3,896
Work in Progress	4,600	9,538	12,355	2,817
Total	184,784	189,005	191,159	2,154

7.34

Appendix F

Statement of Cash Flows

<i>Feb-15</i> (\$'000's)	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Forecast	Qtr 4 Forecast	Year Forecast
Cash From Operating	7,013	44,916	(41,036)	6,567	17,460
Cash from Investing	(1,877)	(5,067)	(5,017)	(12,776)	(24,737)
Cash From Financing	(827)	(618)	(802)	(901)	(3,148)
Increase (Decrease) in Cash Held	4,309	39,231	(46,855)	(7,110)	(10,425)
Add Opening Cash Balance	65,720	70,029	109,260	62,405	65,720
Closing Cash Balance	70,029	109,260	62,405	55,295	55,295

TO Board

FROM Chairman

DATE 25 March 2015

SUBJECT CEO Recruitment



MIDCENTRAL DISTRICT HEALTH BOARD

To Paa Hauora o Ruahine o Tairāia

MEMORANDUM

1. PURPOSE

This is the final report regarding the recruitment of a CEO for MidCentral DHB. It is for the Board's information and does not require a decision.

2. EXECUTIVE SUMMARY

The Board's decision to appoint Kathryn Cook to the role of CEO, MidCentral DHB was publicly announced on Wednesday, 4 March 2015. Kath will take up her role on Monday, 4 May 2015.

A range of key stakeholders were advised in person and/or by letter. These included the Minister and Ministry of Health, MDHB's Committee members and senior leadership roles (including clinical leadership), Manawhenua Hauora, local MPs, territorial local authorities, DHBs and national health entities. I also wrote to those community groups and individuals who has provided input into our decision-making process, thanking them for their part and advising them of the Board's decision.

Arrangements were made for Kath to visit MidCentral DHB on Friday, 20th March. This was very successful and gave Kath a high level overview of the DHB and an introduction to a range of staff. Kath met with Murray and I, the Executive Leadership Team, MidCentral Health's senior management team, the Corporate and Funding/Planning management teams, and the Central PHO's board. Site visits to Enable New Zealand and Horowhenua Health Centre were also undertaken as well as a tour of Palmerston North Hospital. At the end of the visit, Kath met with board members to discuss the day and her first impressions.

Arrangements are being made for a powhiri to be held for Kath and details will be provided to members in due course.

An orientation programme for Kath will be developed. This will include meetings with external stakeholders such as MPs, territorial local authorities, the Ministry of Health, the Regional Governance Group to name but a few. These events will be progressively undertaken.

We are indebted to Murray Georgel who has agreed to remain in office until 1 May 2015 so that there is continuity of leadership. A celebration of Murray's achievements will be held before he leaves. Details will be provided to members shortly.

COPY TO:

Chairman's Office

MidCentral DHB
Heretaunga Street
PO Box 2056
Palmerston North
Phone +64 (6) 350 8841
Fax +64 (6) 355 0616

8.2

3. RECOMMENDATION

It is recommended:

that the report be received.

Phil Sunderland
Chairman

TO The Board
FROM Interim General Manager
MidCentral Health and Support Services



MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tairāroa

DATE 26 March 2015

SUBJECT Signatories and Credit Card
Approval

MEMORANDUM

Purpose

To request approval of the Board to the proposed changes in signatories below and the issue of a credit card to the new Chief Executive Officer.

Commentary

Changes in positions have resulted in the following authorisation, signatory and credit card approvals being required by the Board. Some of the changes below are fairly old and this is because the issues to which they relate ie loans and banking amendments, do not occur regularly. S Wilson being on the Westpac system as a signatory is unexplainable as he is not reflected as a signatory on logging on to the Westpac system.

Westpac Account Signatories

M Georgel to be removed effective on the 2nd May 2015
K Cook to be added on the 4th May 2015
S Wilson to be removed.

Westpac Credit Card Holders

K Cook to replace M Georgel as a card holder on the same credit limit of \$8,000.
M Georgel's card to be cancelled, effective on the 2nd May 2015

Signatories for Ministry of Health loan documentation

C Channing, Financial Services Manager, to replace R Brown who was a signatory in his position of Financial Services Manager

Authorised Officers authorising Westpac to rely on notices or instructions on behalf of the Acceding Party with regards to the Shared Banking and Treasury Services Master Agreements

C Channing, Financial Services Manager, to replace R Brown who was a signatory in his position of Financial Services Manager

Corporate Services

MidCentral DHB
Heretaunga Street
P O Box 2056
Palmerston North
Phone +64(6) 350 8626
Fax +64(6) 355 0616

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Recommendation

It is recommended:

that M Georgel ceases as a Westpac account signatory effective on the 2nd May 2015

that K Cook becomes a Westpac account signatory on the 4th May 2015

that S Wilson be removed as a Westpac account signatory with immediate effect

that M Georgel ceases to be a Westpac credit card holder effective on the 2nd May 2015

that K Cook replaces M Georgel as a Westpac credit card holder with a credit limit of \$8,000 effective on the 4th May 2015

that C Channing replaces R Brown as a signatory for Ministry of Health Loan documentation with immediate effect

that C Channing replaces R Brown as an Authorised Officer, with immediate effect, authorising Westpac to rely on notices or instructions on behalf of the Acceding Party with regards to the Shared Banking and Treasury Services Master Agreements

Mike Grant
Interim General Manager
MidCentral Health and Support Services

Signatories – 27 March 2015

g.S

Westpac Account Signatories

M Georgel, Chief Executive Officer
C Channing, Financial Services Manager
C Kirk, Capital Accountant
H O'Connor, Finance Office Manager
M Southey, Systems Accountant
R Raman, Financial Accountant

Signing rule – any two together

Ministry of Health loan documentation

R Brown, Financial Services Manager
C Kirk, Capital Accountant
H O'Connor, Finance Office Manager
M Southey, Systems Accountant

Signing rule – any two together

Authorised Officers authorising Westpac to rely on notices or instructions on behalf of the Acceding Party with regards to the Shared Banking and Treasury Services Master Agreements

M Grant, General Manager: Planning & Support
R Brown, Financial Services Manager
C Kirk, Capital Accountant

Signing rule – any two together