BOARD MEETING

A G E N D A

Thursday, 4 October 2012

10.30 am

Board Room, Level 2, West Wing, Main Block
Wakari Hospital Campus
271 Taieri Road, Dunedin

Our Vision:
Better Health, Better Lives, Whānau Ora

Our Mission:
We work in partnership with people and communities to achieve their optimum health and wellbeing. We seek excellence through a culture of learning, inquiry, service and caring.

Remember to visit our Website at www.southerndhb.govt.nz

SOUTHERN DISTRICT HEALTH BOARD MEETING

Thursday, 4 October 2012, 10.30 am
Board Room, Wakari Hospital Campus, Dunedin

A G E N D A

Confidential Session:

RESOLUTION:

That the Board move into committee to consider the agenda items listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 32, Schedule 3 of the NZ Public Health and Disability Act 2000 for the passing of this resolution are as follows:

General subject:	***Reasons for passing this resolution:***	***Grounds for passing the resolution:***
Previous Public Excluded Board Minutes	As per reasons set out in previous agenda	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.
Review of Public Excluded Action Sheet	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i), 9(2)(j), and 9(2)(a).
Annual Plan	Plan is subject to Ministerial approval	As above, sections 9(2)(f)(iv) and 9(2)(j).
Public Excluded Advisory Committee Reports a) Disability Support Advisory Committee and Community & Public Health Advisory Committee ▪ 3 October 2012 b) Hospitals Advisory Committee ▪ 5 September 2012 ▪ 3 October 2012 ▪ Southland Hospital Cafeteria Extension c) Clinical Advisory Committee ▪ 3 October 2012 d) Audit & Risk Committee ▪ 5 September 2012 ▪ 4 October 2012 ▪ Annual Report	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Sentinel Events Report	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(j), 9(2)(a)
Risk Report	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Legal Issues	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
Organisational Change ▪ Verbal Update	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Joe BUTTERFIELD (Chairman)	01.03.2012 06.12.2010	1. Member, South Island Neurosurgical Board **Son-in-law:** 2. Partner, Polson Higgs, Chartered Accountants. 3. Trustee, Corstorphine Baptist Community Trust	1. 2. Does some accounting work for Southern PHO. 3. Has a mental health contract with Southern DHB.
Paul MENZIES (Deputy Chairman)	10.02.2010 10.02.2010 06.10.2011 02.08.2012	1. Wife a member on the Southland Child Youth Mortality Review Group. 2. Wife a member on the Child and Youth Health Advisory Committee. 3. Trustee, Southern PHO. 4. Wife a trustee of Number 10, Youth One Stop Shop, Invercargill.	1. Nil. 2. Nil. 3. Appointed as a trustee by Southern DHB. PHO is contracted to the DHB. 4. Possible conflict with funding requests.
Neville COOK	04.03.2008 04.03.2008 04.03.2008 26.03.2008	1. Board Member, Invercargill Licensing Trust. 2. Board Member, Invercargill Licensing Trust Foundation. 3. Councillor, Environment Southland. 4. Trustee, Norman Jones Foundation.	1. Possible conflict with funding requests. 2. Possible conflict with funding requests. 3. Nil. 4. Possible conflict with funding requests.
Sandra Cook	01.09.2011	1. Te Runanga o Ngāi Tahu	1. Holds a "right of first refusal" over certain Crown properties. Also seen as a Treaty partner and affiliates may hold contracts from Southern DHB from time to time.
Kaye CROWTHER	09.11.2007 14.08.2008 14.08.2008 12.02.2009 05.09.2012 01.03.2012	1. Employee of WHK South. 2. Trustee of Plunket Foundation. 3. Trustee of Wakatipu Plunket Charitable Trust. 4. Corresponding member for health and family affairs, National Council of Women. 5. Trustee for No 10 Youth Health Centre, Invercargill. 6. DHB representative on the Gore Social Sector Trial	1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of WHK. 2. Nil. 3. Nil. 4. Nil.
Mary FLANNERY	17.11.2010 10.11.2011	1. Trustee, Rural Otago Primary Health Organisation 2. Associate Solicitor, Bodkins/AWS Legal, Alexandra. 3. Partner, Tayside Farm Partnership. 4. Director, New Zealand Irrigation Board.	1. Was contracted to Southern DHB – contracts assigned to Southern PHO (will be wound up) 2. Nil 3. Nil 4. Nil

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
James <u>Malcolm</u> MACPHERSON	28.06.2005 09.03.2011 25.11.2010 25.11.2010 25.11.2010 28.08.2007 09.03.2011 09.03.2011 09.03.2011 13.12.2001 22.04.2003	1. Member Otago Polytechnic Council. 2. Contractor and Tutor, Otago Polytechnic. 3. Member Central Lakes Trust. 4. Member Roxburgh Gorge Trail Charitable Trust. 5. Part owner, Alexandra Medical Centre. 6. Co-Principal, Brilliant New Zealand Ltd. 7. Chairman, Jolendale Charitable Trust. 8. Shareholder, Medco Properties Ltd 9. Director, Centennial Health Ltd **Spouse - Susan Elizabeth Macpherson:** 10. GP Principal, Centennial Health Ltd, Alexandra. 11. Branch Medical Advisor, ACC, Alexandra.	1. (OP has training interests in common with the DHB, no) 2. (personal interest.) 3. CLT is a community funder in its region, which includes Dunstan and Lakes District Hospitals, plus a wide range of community and primary services and service providers, and is a possible future funder. 4. Nil. 5. The AMC is tenanted by all of Alexandra's GPs and a pharmacy, and is also occasionally used by related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts. 6. BNZL is a consultancy which may have an involvement with health sector organisations. 7. Nil. 8. MPL will be responsible for the tenancy of all of Alexandra's current GPs and a pharmacy and may also house other related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts, real and theoretical. 9. & 10. Board discussions relating to primary health providers or primary referred services may involve conflicts of interest. Declare where appropriate and withdraw where prudent. 11. ACC is a major customer of the DHB. Remote possibility of an influence, no personal interest.
Tahu POTIKI	15.12.2007 03.04.2008 24.11.2009 03.06.2010	1. Director, Arataki Associates. 2. Representative to Te Runanga o Ngai Tahu. 3. Trustee of Ngai Tahu Charitable Trust. 4. Board Member, Relationship Services NZ. 5. Board Member, Environmental Science and Research	1. Contracted to Southern DHB, funded provider in the past ie Araiteuru Whare Hauora Ltd. 2. & 3. Treaty Partner - affiliated providers may contract to Southern DHB. Te Runanga o Ngai Tahu has right of first refusal on disposal of property. 4. No apparent conflict. 5. CRI involved in public health research.
Branko SIJNJA	07.02.2008 04.02.2009 22.06.2010 07.06.2012	1. Director, Clutha Community Health Company Limited. 2. 0.8 FTE Director Rural Medical Immersion Programme, University of Otago School of Medicine. 3. 0.2 FTE Employee, Clutha Halth First General Practice 4. Director of Southern Community Laboratories	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Possible conflicts between Southern DHB and University interests. 3. Employed as a part-time GP.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Richard John THOMSON	13.12.2001 23.09.2003 29.03.2010 06.04.2011	1. Managing Director, Thomson & Cessford Ltd. 2. Director, Susanna Shaya Imports Ltd 3. Chairperson and Trustee, Hawksbury Community Living Trust. 4. Trustee, HealthCare Otago Charitable Trust. 5. Director, Composite Retail Group. 6. Councillor, Dunedin City Council.	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it. 2. Susanna Shaya Imports is a homeware importing company. It has no dealings with Southern DHB. 3. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 4. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 5. May have some stores that deal with Southern DHB.
Tim WARD	14.09.2009 01.05.2010 01.05.2010	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT).	1. May have some Southern DHB patients and staff as clients. 2. Verdon is a participant in the employment incubator programme. 3. Supply of goods and services between Southern DHB and SIT.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at August 2012

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Richard Bunton	17.03.2004 22.06.2012 29.04.2010	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd. 5. Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	1. The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions. 2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract. 3. This company provides private cardiological services to Otago and Southland. A potential conflict would exist if the Southern DHB were to contract with this company. 4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists. 5. No conflict. 6. No conflict. 7. No conflict.
Donovan Clarke	02.02.2011	1. Te Waipounamu Delegate, Te Piringa, National Maori Disability Advisory Group. 2. Director, Great Western Steakhouse, New Lynn, Auckland.	1. Nil. 2. Nil.
Carole Heatly	14.03.2012	Nil.	
Robert Mackway-Jones	28.08.2007	1. Close association (wife) employed by Dunedin Hospital.	1. Reporting line to Purchasing Team leader.
Lexie O'Shea	01.07.2007	1. Trustee, Gilmour Trust.	1. Southland Hospital Trust.
Lynda McCutcheon	22.06.2012	1. Member of the University of Otago, School of Physiotherapy, Admissions Committee.	
John Pine	17.11.201	Nil.	
Leanne Samuel	01.07.2007 01.07.2007	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel.	1. Southland Hospital Trust. 2. Nil. 3. Potential conflict if the DHB purchases services from this

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	01.07.2007 29.10.2009 01.10.2010	3. Member of Board of Studies at Southern Institute of Technology. 4. Southland Medical Foundation Inc (member). 5. Member of National Elective Services Productivity and Workforce Programme Steering Group.	organisation. 4. Southland Trust. 5. Nil.
David Tulloch	23.11.2010 02.06.2011 17.08.2012	1. Southland Urology (Director). 2. Southern Surgical Services (Director). 3. UA Central Otago Urology Services Limited (Director). 4. Trustee, Gilmour Trust.	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services. 3. Potential conflict if DHB purchases services. 4. Southland Hospital Trust.

Minutes of the Southern District Health Board Meeting

Thursday, 6 September 2012, 10.30 am
Board Room, Southland Hospital Campus, Invercargill

Present:	Mr Joe Butterfield	Chair
	Mr Paul Menzies	Deputy Chair
	Mr Neville Cook	
	Ms Sandra Cook	
	Mrs Kaye Crowther	
	Mrs Mary Flannery	
	Dr Malcolm Macpherson	
	Dr Branko Sijnja	
	Mr Richard Thomson	
	Mr Tim Ward	
In Attendance:	Mr Stuart McLauchlan	Crown Monitor (by videolink until 11.50 am)
	Ms Carole Heatly	Chief Executive Officer
	Mrs Lexie O'Shea	Deputy Chief Executive Officer/Executive Director Patient Services
	Mr Steve Addison	Executive Director Communications
	Mr Robert Mackway-Jones	Executive Director Finance and Funding
	Ms Melanie Naulls	Corporate Solicitor (by videolink)
	Mrs Leanne Samuel	Executive Director Nursing and Midwifery
	Mr David Tulloch	Chief Medical Officer
	Ms Cherie Wells	General Manager Corporate Services (by videolink)
	Mrs Joanne Fannin	Board Secretary

1.0 CHAIR'S OPENING COMMENTS

The Chair welcomed everyone to the meeting and advised that the Review of Performance Reporting scheduled for discussion in the confidential session would be considered in the public session. He also advised that decisions made at the Audit and Risk Committee on 5 September 2012 would be advised in public session.

2.0 APOLOGIES

An apology was received from Mr Tahu Potiki, Board member.

3.0 DECLARATION OF INTERESTS

It was resolved:

"That the Interests Register be received."

4.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

"That the minutes of the 2 August 2012 Board meeting be approved and adopted as a true and correct record."

5.0 MATTERS ARISING

There were no matters arising from the previous minutes.

Ms Sandra Cook joined the meeting at 10.35am.

6.0 ACTION SHEET

The Board meeting action sheet (agenda item 6) was received.

7.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer presented her monthly report (agenda item 7), then took questions from members.

It was resolved:

"That the Chief Executive Officer's report be received."

The Executive Director of Finance and Funding (EDFF) provided an update on Queenstown service planning noting that a media release is due out today.

The Board noted the DHB performance report for quarter four 2011/12 and management advised on strategies in place with Southern Primary Health Organisation (SPHO) to improve the performance in relation to the heart and diabetes checks.

In discussion on the National Health Board (NHB) and SDHB joint assessment of systems – Dunedin Hospital a request was made for the completion date for strategy numbers one and 13 to be updated to read 'on-going'. In relation to strategy number 10, a request was made for the CEO to provide a report on Southern DHB's relationship with the University.

The Deputy CEO/Executive Director Patient Services and Chief Medical Officer joined the meeting at 10.55am.

8.0 FINANCIAL REPORT

The Executive Director Finance & Funding presented the Financial Report for the period ended 31 July 2012 (agenda item 8) and answered members' questions on the financial statements.

It was noted:

1. The Chairman requested that leave liability be included as part of the reporting to the Hospital Advisory Committee;

2. Members endorsed the new format for the financial report.

3. The increased insurance premiums are fixed for the current financial year and management is investigating the allocation methodology for the 2013/14 year.

It was resolved:

"That the Financial Report be received."

The Crown Monitor joined the meeting via videolink at 11.05am.

9.0 REVIEW OF PERFORMANCE REPORTING

The Board received a verbal report from Mr Graham Jelley, Pricewaterhouse Cooper (PwC), on the review undertaken of the current Board performance reporting arrangements. A copy of the performance monitoring framework – Board update and examples of the proposed performance and healthcare data were tabled.

Mr Jelley responded to members' questions and it was noted:

1. A request was made that the production scheduling report around Theatres continues to be provided.

2. Until a common methodology is implemented for entry to the two base hospitals and there is evidence that productivity is similar at both sites, a request was made that separate figures continue to be provided for each site.

3. A request was made for enhanced reporting to the Disability Support Advisory Committee (DSAC) and Community & Public Health Advisory Committee (CPHAC) to allow the Board to make strategic decisions going forward on what the population needs. It was suggested that the following be added to bullet point three on page three of the PwC report under 'Principles' – 'the strategic planning going forward for delivering the care to our population and the needs that will arise as our population demographic and health needs change'.

4. A request was made for the Southern clinical services dashboard to be incorporated in the reporting.

5. A request was made for progress on the Board having access to electronic reporting.

6. A request was made that provision be made to build in specific information from information available through Southern DHB's Planning and Funding area to enhance the report, e.g. targets, best practices, trends, etc.

7. A request was made that the reporting on the A3 sheets be enlarged.

10.0 ADVISORY COMMITTEE REPORTS

Audit and Risk Committee

A verbal report was received from Mr Ward, Chair of the Audit and Risk Committee (ARC) on recommendations considered at the ARC meeting held on 5 September 2012.

Recommendations from the Committee on revenue recognition and accreditation were tabled. The recommendation on revenue recognition was endorsed by the Committee following a firm audit opinion received. It was clearly identified that some of the additional income that has been recognised has a restricted usage of it and will continue to be reported and tracked as such in the financial statements.

Revenue Recognition

It was resolved:

> **"That the Board notes the reports and further information received in relation to revenue recognition and endorses the proposed treatment of continued recognition as income and as restricted equity, noting that the total $3.9 million will remain as revenue.**"

The recommendation on accreditation was endorsed by the Committee, noting that the minimum Certification requirements have been met.

Accreditation

It was resolved:

> **"That the Board approves the proposal to defer Accreditation until the Performance Excellence and Quality Improvement Strategy and Action Plan are embedded across the organisation."**

Disability Support Advisory Committee/Community & Public Health Advisory Committee

The minutes of the DSAC & CPHAC meeting held on 1 August 2012 were circulated with the agenda (item 9).

It was resolved:

> **"That the minutes be received."**

Hospital Advisory Committee

The minutes of the Hospital Advisory Committee (HAC) meeting held on 1 August 2012 were circulated with the agenda (item 10).

It was resolved:

> **"That the minutes be received."**

The Board received a verbal report from Mr Menzies, HAC Chair, on the meeting held on 5 September 2012.

It was resolved:

"That the verbal report be received."

Iwi Governance Committee

The minutes of the Iwi Governance Committee (IGC) meeting held on 1 August 2012 were circulated with the agenda (item 11).

It was resolved:

"That the minutes be received."

The Board received a verbal report from Ms Cook and Mrs Crowther on the meeting of the Iwi Governance Committee held on 5 September 2012.

It was resolved:

"That the verbal report be received."

A recommendation from the Committee on the inclusion of a Māori Kupu on Southern DHB's logo was tabled.

It was resolved:

"That the Board endorse the inclusion of the Māori Kupu on the existing Southern District Health Board logo per the example attached."

11.0 CONTRACTS REGISTER

The Funding administration contracts register (expenses) for August 2012 was circulated with the agenda (item 12) for members' information.

It was resolved:

"That the register be received."

PUBLIC EXCLUDED SESSION

***At 11.45am, it* was *resolved*:**

"That the public be excluded from the meeting for consideration of the following agenda items."

(The public session of the meeting then closed.)

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Previous Public Excluded Board Minutes	As per reasons set out in previous agenda	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.
Review of Public Excluded Action Sheet	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i), 9(2)(j), and 9(2)(a).
Annual Plan	Plan is subject to Ministerial approval	As above, sections 9(2)(f)(iv) and 9(2)(j).
Public Excluded Advisory Committee Reports a) Disability Support Advisory Committee and Community & Public Health Advisory Committee ▪ 1 August 2012 b) Hospitals Advisory Committee ▪ 1 August 2012 ▪ 5 September 2012 c) Clinical Advisory Committee ▪ 1 August 2012 ▪ 5 September 2012 d) Audit & Risk Committee ▪ 2 August 2012 ▪ 14 August 2012 ▪ 5 September 2012 ▪ Accreditation	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Contract Approvals	Commercial sensitivity	As above, section 9(2)(i).
Sentinel Events Report	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(j), 9(2)(a)

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Risk Report	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Legal Issues	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
Organisational Change ▪ Verbal Update	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
Review of Performance Reporting	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
CEO Remuneration (Board members only)	Personal privacy and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(j), 9(2)(a)

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board

BOARD MEETING ACTION SHEET

As at 24 September 2012

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
044-2011/02 60-2011/05	**Smokefree Environment Amendment Bill** (Minute item 9.0)	A draft policy statement on smokefree environments to be developed and submitted to CPHAC to provide direction to future service provision in this area. Timeframe to be provided for completion of the draft policy statement.	EDFF PHS	To be progressed as part of the South Island Public Health work stream. Southern DHB does have its own policy that was created in March 2010 and is due for review in 2012.	3 October 2012
184-2012/08	**Alcohol Harm Reduction Strategy** (Minute item 9.0)	Education and one-way door policy to be included in the Alcohol Harm Reduction Strategy.	EDFF	This is being progressed by Public Health South.	
185 – 2012/09	**CEO's Report** (Minute item 7.0)	1. The NHB and SDHB joint assessment of systems – Dunedin Hospital is to be up-dated with the completion date for strategy numbers one and 13 to read on-going. 2. The CEO is to provide a report on Southern DHB's relationship with the University of Otago.	GMCS CEO	The next report is due for the November 2012 Board meeting and is to be updated as outlined. Included in CEO's report.	8 November 2012 Completed
186 – 2012/09	**Financial Report** (Minute item 8.0)	Leave liability is to be included as part of the reporting to the Hospital Advisory Committee.	EDPS	The action point has been transferred to the HAC action sheet.	
187 – 2012/09	**Review of Performance Reporting** (Minute item 9.0)	A number of suggested actions were highlighted during the PwC presentation and these have been transferred to the HAC action sheet.	EDPS	The action point has been transferred to the HAC action sheet.	

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	4 October 2012

Summary:

The issues considered in this paper are:

- Monthly DHB activity.

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	No specific implications.
Workforce:	No specific implications.
Other:	No specific implications.

Document previously submitted to:	Not applicable, report submitted directly to Board. Detailed Provider Arm information contained in HAC agenda papers and Planning & Funding information in DSAC/CPHAC agenda papers.	**Date:** n/a
Approved by Chief Executive Officer:		**Date:** 26/09/12

Prepared by: GM Planning & Funding Executive Director Patient Services General Manager Corporate Services **Date:** 24/09/12	**Presented by:** Carole Heatly Chief Executive Officer

RECOMMENDATIONS:

1. **That the Board receive the report.**

CHIEF EXECUTIVE OFFICER'S REPORT

1. DHB FINANCIAL PERFORMANCE

The August result was unfavourable to budget by $0.8m and the year to date result is unfavourable by $0.3m.

A detailed analysis of the financial situation is contained in the Financial Report.

2. PROVIDER ARM

Contract Performance

- Elective **caseweights** delivered (cwd) for Southern DHB were 58 below plan in August 2012 (4%). Year to date elective caseweights are 31 below plan (1%).
- Acute **caseweights** delivered (cwd) by the Southern DHB Provider Arm were 332 over plan in August 2012 (13%). Year to date acute caseweights are 571 over plan (11%).
- Health Target Elective **discharges** delivered for Southern DHB were 38 above plan in August 2012 (4%). Year to date discharges are 129 above plan (7%)**.**

Financial Performance

- An unfavourable variance of $841k was recorded in the Provider Arm for the month of August 2012. Year to date the result is unfavourable by $999k.
- Revenue for August 2012 was favourable by $400k. Expenses for August 2012 were unfavourable against plan by $1,241k.

3. PLANNING AND FUNDING

Primary & Community

Pharmacy

100% of contracts are signed, although still with some appeals in process around dispensing ratios. Workshops have now been held around the region and a peer support group has met in Invercargill with GPs to assist with implementation.

PHO Health Promotion Plans

Recruitment of the Team Leader and three 0.5 FTE roles is complete and plans under way. Integration of health promotion activity with long term conditions treatment plans and Year on Year of Care is a key focus.

Clinical Programmes Proposal

Approval and funding was given from October 2011 for the clinical programmes Initiating Insulin in Primary Care, Sexual Health and CVD risk assessments. The PHO has completed roll out of these programmes and is now preparing to roll out the Long Term Conditions Programme, the Year on Year of Care Programme based on the Mosgiel Year of Care pilot project. Initial workshops have been held for providers and additional workshops will be organised via the Health Navigator group.

Free Under 6 Visits After Hours

Discussions continue with Southern PHO and individual practices as we work towards 100% access across the district. As the plan for after hours care across the district is finalised, access to after hours care for under 6 year-olds will be incorporated.

Health of Older Persons – Home & Community Support Proposal

The Expression of Interest (EOI) document for the new service model has been released. A full set of reports in included the Community & Public Health and Disability Advisory Committees' agenda.

Mental Health & Addictions

Following the launch of Raise Hope – Hapaia te Tumanako, the Mental Health and Addictions Strategic Plan terms of reference (TOR) were developed to establish an implementation advisory group (IAG). This group will provide sector and community input into the monitoring and evaluation of the plan. The TOR for the Implementation Advisory Group (IAG) was released in August, along with a call for self-nominations. The response was very good – many more nominations were received than there were roles available on the group. Appointments have now been made.

Release of RFP – Housing and accommodation services based in Dunedin. A Request for Proposal (RFP) was released in August, seeking proposals to deliver Housing and Recovery Services based in Dunedin. This RFP follows on from earlier consultation on the proposal for change for future service provision in Hulme House. Responses close on 26 September.

World Mental Health Day/Mental Health Awareness Week - runs from 8-14 October and most providers have events planned to promote mental health and reduce stigma and discrimination. Planning and Funding (Mental Health and Addiction) is supporting this important time for mental health promotion by raising awareness of events via our publications and website section.

4. RELATIONSHIP WITH OTAGO UNIVERSITY

Southern DHB, and its former entities, and the University of Otago have a 130 year relationship history. There have been varying degrees of collaboration over the organisations' long history; however the most recent work to revisit the relationship and develop further links commenced in earnest in October/November 2011.

As a first step the DHB's Executive Management Team met with the Division of Health Sciences Executive in February 2012. The aim of the meeting was to understand the other's strategic direction and imperatives, identify and/or revisit common objectives and explore how to optimise these, and identify the vision for working together. The outcome of the meeting was the development of a work plan.

The focus of the work plan is to understand the relationship and the different streams of work being undertaken between the University and the DHB. The first step is to therefore undertake a stock-take which includes review of the collaborative framework, the Memorandum of Understanding, the formal and informal structures and processes in place, building occupancy and agreements, and joint staff.

The next, or indeed parallel, aspect of the work plan is to generate further opportunities for collaboration that will be of benefit to the two organisations. This includes meeting with other Divisions or Faculties to identify opportunities; the next scheduled for November with the School of Business. Other work includes development of a communications plan, and establishing links between various staff, such as the Human Resources teams to review workforce planning and protocols for joint clinical staff.

The actions from the work plan span through to 2013. Further progress against the work plan will be reported early next year.

Carole Heatly
Chief Executive Officer 25 September 2012

SOUTHERN DHB FINANCIAL REPORT

Financial Report as at: **31 August 2012**
Report Prepared by: **Robert Mackway-Jones, Exec Director Finance & Funding**
Date: **20 September 2012**

Recommendations:

- **That the Board note the Financial Report**

Overview Section

Results Summary

(NB: as the annual plan hasn't been approved, we have not published any annual figures in this report)

Month				Year to Date			Annual
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000	Budget $' 000
71,160	70,416	744	Revenue	141,967	140,850	1,117	
(27,641)	(27,393)	(248)	Less Personnel Costs	(53,750)	(53,918)	168	
(46,964)	(45,651)	(1,313)	Less Other Costs	(92,403)	(90,820)	(1,583)	
(3,445)	(2,628)	(817)	Net Surplus / (Deficit)	(4,186)	(3,888)	(298)	

- The August result was a deficit of $3.4m which was unfavourable to budget by $0.8m
- The YTD result is now worse than budget by $0.3m

Operational Performance

Month				Year to Date			Annual
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000	Budget $' 000
(166)	(62)	(104)	Governance	(141)	(113)	(28)	
(657)	(785)	128	Funds	(667)	(1,395)	728	
(2,622)	(1,780)	(842)	Provider	(3,378)	(2,379)	(999)	
(3,445)	(2,627)	(818)	Net Surplus / (Deficit)	(4,186)	(3,887)	(299)	

- The YTD Governance result is unfavourable with communications costs and provisions for expenditure to the South Island Alliance and Central Technical Advisory Services (formerly DHBNZ functions) being higher than budgeted. There was a catch-up of these cost provisions in August
- The YTD Funds result is favourable but $0.6m of the variance relates to mental health expenditure
- The Provider result was unfavourable and now has a significant unfavourable YTD variance with large variances in clinical supplies, outsourced clinical services and insurance premiums

Key YTD Variances

- $0.4m of Mental Health expenditure not incurred due to unfilled FTE positions
- $0.3m of below budget NGO mental health expenditure
- $0.3m of higher ACC revenues
- ($0.4m) of unfavourable annual leave growth
- ($1.0m) of unfavourable variance with clinical supply costs
- ($0.6m) of unfavourable outsourcing costs
- ($0.2m) of unfavourable insurance premium costs with an expected year end variance of around $1.4m for this
- ($0.2m) of unfavourable variance in outsourced clinical services

Capital Expenditure
The detail and likely timing of the current programme is being finalised. Baseline capital expenditure is budgeted at $16.7m with a further $18.8m for specific building projects and the LINAC. There is also around $14m to carry over from the 2011/12 year.

Balance Sheet and Cashflow
Cash is $32m at the end of August compared to budget of $16.7m. This is mainly attributable to timing differences with planned capital expenditure, particularly capital not yet committed from the 2011/12 programme. Account receivables and payables are both within budgeted parameters. Overall working capital is slightly outside of budgeted, however this is due to the mix of crown debt categorised as current.

Detail Section

This section is presented from an overall DHB result perspective.

Revenue
YTD, revenue is $0.4m above budget however the bulk of this has associated cost offsets.

Item	$'m	Expense Line Offset (Y/N/Partial)
Devolvement of Vaccine funding	0.4	Y, Personal Health Pharmaceuticals
PHO Performance Management funding	(0.1)	Y, Personal Health PHO Other
ACC Revenue	0.3	P, Provider-arm
Other Government funding	0.1	P, Provider-arm
Breast screening service funding	0.1	P, Provider-arm, various
Research funding	0.2	Y, Provider-arm, various
All other revenue variances	0.1	
Total Revenue Variation	1.1	

Personnel Expenses

FTE

Category	March	April	May	June	July	August	Budget	Variance
Medical Personnel	481	475	469	464	458	464	476	12
Nursing Personnel	1,583	1,597	1,574	1,573	1,581	1,564	1,571	7
Allied Health Personnel	685	690	689	692	697	692	695	3
Support Personnel	192	191	187	186	188	185	197	12
Management/Administration Personnel	694	699	689	696	692	689	694	5
Total Full Time Equivalents (FTE's)	3,635	3,652	3,608	3,611	3,616	3,594	3,632	38

FTE numbers have dropped since last month, particularly in nursing. There are 18 FTE in the mental health area (10 in allied, 4 nursing) where unfilled positions result in a funding claw back between the DHB funder/provider.

Medical
The combined costs YTD between salaries and medical outsourcing is unfavourable by $0.2m. The YTD salary variance itself is minimal however there were a number of underlying YTD variances:

- ($0.1m) of unfavourable annual and statutory leave impacts
- $0.7m of variation due to base FTE being 25 below budget
- ($0.3m) of additional overtime payments (11 FTE equivalent)
- ($0.3m) of lump sum settlement to RMO's (minimal impact by year end)

Nursing
YTD Salary costs were $0.2m over budget comprising of:

- ($0.2m) of overtime payment variance (6 FTE)
- ($0.2m) of unfavourable annual leave variation
- $0.2m of below budget indirect salary costs

Allied
YTD Salary costs were $0.2m below budget with FTE overall in line with budget. However there is around 10 FTE funded positions for mental health vacancies which impacts by around $180k. Overtime costs were $0.1m over budget (5 FTE).

Support
The favourable variance is offset by outsourcing costs.

Management/Admin
Approximately a third of the YTD variance is from the Governance area where costs have been budgeted to undertake clinical pathways development with the remainder in the provider and attributable to timing issues of salary settlements and FTE slightly below budgeted levels.

Leave Liability
Annual leave liability is $25.7m (excluding joint clinical staff). The table below has been restated for adjustments to the valuation of leave and shows the dollar value by staff category and the hours.

	Closing March	Closing June	Closing July	Closing August	Movement August
1. Medical SMO	5,992,751.43	6,146,586.66	6,255,388.01	6,561,731.15	306,343.14
1. Medical MOSS	380,462.15	434,338.37	275,969.41	231,153.20	-44,816.21
1. Medical RMO	1,109,709.04	1,421,132.03	1,449,571.06	1,475,368.66	25,797.60
1. Medical House Officers	162,670.64	242,020.71	228,466.29	260,546.05	32,079.76
2. Nursing	8,792,007.83	9,408,222.38	9,406,336.01	9,647,588.97	241,252.96
3. Allied	2,814,796.41	3,197,065.94	3,232,734.47	3,317,722.60	84,988.13
4. Support	735,123.66	806,041.34	813,190.48	832,711.94	19,521.46
5. Management Admin	2,976,118.92	3,192,775.63	3,246,613.36	3,361,845.40	115,232.04
Totals	**22,963,640.08**	**24,848,183.06**	**24,908,269.09**	**25,688,667.97**	**780,398.88**
Hours	Closing March	Closing June	Closing July	Closing August	Movement August
Senior Doctors	48,983.66	50,866.37	50,197.56	51,500.78	1,303.21
RMO & House Officers	22,227.58	28,560.05	28,707.21	29,814.24	1,107.02
Nursing	254,773.89	271,949.34	271,876.49	277,738.48	5,862.00
Allied	85,752.62	96,881.78	97,565.49	100,026.57	2,461.08
Support	32,045.47	34,963.94	35,292.25	35,800.13	507.89
Management / Admin	102,845.66	110,766.30	111,255.08	113,254.80	1,999.72
Totals	**546,628.87**	**593,987.78**	**594,894.08**	**608,134.99**	**13,240.92**

After minimal leave growth in July, August has seen an increase of around 13,000 hours. Across all the staff categories there is a $0.4m unfavourable variance to budget for the 2 months. Across the course of a full year, the budget is set assuming leave is taken at the same rate it is earned. Last year this component varied by around $2m unfavourably, hence there is a particular focus on leave management in the current year.

Outsourced Services Expenses
Outsourced costs are $0.6m over budget YTD; this is a significant unfavourable variance particularly given the budgeted outsourced elective work has not been needed and is providing a $0.2m favourable buffer. The main areas with unfavourable variances include radiology ($0.2m), mammography ($0.1m) and the vitreoretinal service ($0.1m). These costs are incurred to support the current service provision or where internal staff resource is vacant. On the current trend, there will likely be a large variance at year end as much of the cost has no offsets or other cost mitigations.

Clinical Supplies Expenses
Overall clinical supplies are now over budget by $1m YTD with nearly all categories having significant unfavourable variances. This is a significant risk area as budgets have been set on acute case-weight volumes at lower levels than actual delivery last year. YTD, acute case-weights are 571 over plan which will be driving a large part of the overall variance. Another significant contributor to the YTD variance is Air Ambulance costs (other clinical supplies) which varies to budget by nearly $0.2m with a large number of flights during July.

Infrastructure & Non-Clinical Supplies Expenditure
Facility related costs are $0.2m over budget overall, a $0.1m buffer from building related depreciation being more than offset by the insurance premium issue reported last month ($0.2m YTD with YE impact of $1.4m) and electricity (spot pricing), gas (delayed savings from woodchip installation – offset by depreciation) and steam (pricing issue) utilities costs all over budget. Other areas of cost challenge include transport costs where savings factored following the fleet utilisation reviews have not been fully implemented and with hotel service costs such as laundry due to high inpatient activity.

Personal Health Payments (Not including Provider-arm)
The two main concern areas at this point involve palliative care costs and patient travel and accommodation. Around $90k of the YTD variance will correct in September but there is a very large variance with the number of short term exceptional circumstances funding being applied to manage these patients in various rest homes. The budget (based on historic usage) allows for 6 beds of use in Otago and currently there is between 17-22 beds being used monthly. There is robust criteria and service access mechanisms in place. If the current levels continue, there could be a monthly variance of around $50k. The travel and accommodation budget also has nationally consistent criteria applied for its use and is experiencing a high level of referrals based on patient need.

Mental Health (Not including Provider-arm)
$0.2m of the $0.3m favourable variance is based on demand driven services of residential support and home based support services. There is a timing issue in Child & Youth services where funding provided for the Prime Ministers initiative is to be allocated once service plans are finalised.

Disability Support (Not including Provider-arm)
Hospital level residential care is $0.2m over budget based on provisioning the current utilisation trend. July's actual utilisation was around 19 beds more than budgeted. Rest Home and Dementia level beds are tracking in line with budgeted expectations. Home support and community support costs are being managed within budget and provide a financial offset. The monthly variance in the ATR is the correction of the timing issue reported last month.

Financial Statements

The following financial statements are attached:

- DHB Consolidated Results P&L
- Balance Sheet
- Cashflow statement

Southern District Health Board

Aug-12

Part 4: DHB Consolidated	Current Month				Year to Date			
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %
Part 4.1: Statement of Financial Performance								
REVENUE								
Ministry of Health								
MoH - Vote Health Non Mental Health	55,395	55,185	210 F		110,786	110,371	416 F	
MoH - Vote Health Mental Health	6,992	6,992			13,984	13,984		
MoH Funding Subcontracts	3,087	3,050	37 F	1%	6,092	6,100	(8) U	
MoH - Personal Health	8	-	8 F		10	-	10 F	
MoH - Public Health	10	11		(3%)	21	22	(1) U	(3%)
MoH - Disability Support Services	741	747	(6) U	(1%)	1,482	1,494	(12) U	(1%)
Clinical Training Agency	547	543	4 F	1%	1,082	1,085	(3) U	
Ministry of Health Total	**66,780**	**66,528**	**252 F**		**133,456**	**133,055**	**401 F**	
Other Government								
IDF's - Mental Health Services	145	145			291	291		
IDF's - All others (non Mental health)	1,502	1,511	(9) U	(1%)	3,013	3,021	(9) U	
Other DHB's	30	25	5 F	19%	58	50	8 F	17%
Training Fees and Subsidies	28	17	11 F	66%	46	34	12 F	37%
Accident Insurance	941	707	234 F	33%	1,790	1,439	351 F	24%
Other Government	457	392	65 F	16%	925	784	141 F	18%
Other Government Total	**3,103**	**2,797**	**306 F**	**11%**	**6,123**	**5,619**	**504 F**	**9%**
Government and Crown Agency Total	**69,882**	**69,325**	**558 F**	**1%**	**139,579**	**138,674**	**905 F**	**1%**
Other Revenue								
Patient / Consumer Sourced	172	259	(87) U	(34%)	409	511	(103) U	(20%)
Other Income	1,106	832	274 F	33%	1,980	1,665	315 F	19%
Other Revenue Total	**1,278**	**1,091**	**186 F**	**17%**	**2,388**	**2,176**	**212 F**	**10%**
REVENUE TOTAL	**71,160**	**70,416**	**744 F**	**1%**	**141,967**	**140,850**	**1,117 F**	**1%**
EXPENSES								
Personnel Expenses								
Medical Personnel	(8,740)	(8,621)	(119) U	(1%)	(16,799)	(16,769)	(30) U	
Nursing Personnel	(10,062)	(9,840)	(221) U	(2%)	(19,827)	(19,677)	(150) U	(1%)
Allied Health Personnel	(4,244)	(4,315)	71 F	2%	(8,281)	(8,438)	158 F	2%
Support Services Personnel	(805)	(828)	23 F	3%	(1,538)	(1,620)	82 F	5%
Management / Admin Personnel	(3,790)	(3,789)	(2) U		(7,307)	(7,414)	107 F	1%
Personnel Costs Total	**(27,641)**	**(27,393)**	**(248) U**	**(1%)**	**(53,750)**	**(53,918)**	**167 F**	
Outsourced Expenses								
Medical Personnel	(815)	(798)	(16) U	(2%)	(1,770)	(1,597)	(173) U	(11%)
Nursing Personnel	(3)	(3)			(17)	(7)	(10) U	(154%)
Allied Health Personnel	(57)	(12)	(45) U	(372%)	(90)	(24)	(66) U	(273%)
Support Personnel	(67)	(22)	(45) U	(203%)	(110)	(44)	(66) U	(148%)
Management / Administration Personnel	-	(1)	1 F	90%	3	(3)	6 F	230%
Outsourced Clinical Services	(772)	(517)	(256) U	(49%)	(1,249)	(1,021)	(228) U	(22%)
Outsourced Corporate / Governance Services	(113)	(116)	3 F	3%	(230)	(232)	2 F	1%
Outsourced Funder Services	(152)	(92)	(60) U	(65%)	(266)	(205)	(61) U	(30%)
Outsourced Services Total	**(1,980)**	**(1,562)**	**(417) U**	**(27%)**	**(3,729)**	**(3,132)**	**(596) U**	**(19%)**
Clinical Supplies								
Treatment Disposables	(2,727)	(2,485)	(242) U	(10%)	(5,271)	(4,840)	(431) U	(9%)
Diagnostic Supplies & Other Clinical Supplies	(169)	(169)			(314)	(334)	20 F	6%
Instruments & Equipment	(1,375)	(1,276)	(99) U	(8%)	(2,711)	(2,563)	(148) U	(6%)
Patient Appliances	(175)	(171)	(4) U	(2%)	(368)	(339)	(29) U	(9%)
Implants & Prosthesis	(902)	(931)	29 F	3%	(1,859)	(1,761)	(97) U	(6%)
Pharmaceuticals	(1,787)	(1,638)	(149) U	(9%)	(3,420)	(3,237)	(184) U	(6%)
Other Clinical Supplies	(393)	(291)	(103) U	(35%)	(713)	(574)	(138) U	(24%)
Clinical Supplies Total	**(7,528)**	**(6,961)**	**(567) U**	**(8%)**	**(14,656)**	**(13,648)**	**(1,008) U**	**(7%)**
Infrastructure & Non Clinical Expenses								
Hotel Services, Laundry & Cleaning	(1,136)	(1,082)	(54) U	(5%)	(2,226)	(2,151)	(75) U	(3%)
Facilities	(1,895)	(1,821)	(73) U	(4%)	(3,811)	(3,625)	(186) U	(5%)
Transport	(374)	(329)	(45) U	(14%)	(722)	(663)	(59) U	(9%)
IT Systems & Telecommunications	(873)	(946)	72 F	8%	(1,754)	(1,889)	135 F	7%
Interest & Financing Charges	(1,310)	(1,288)	(22) U	(2%)	(2,594)	(2,584)	(10) U	
Professional Fees & Expenses	(172)	(155)	(17) U	(11%)	(290)	(290)		
Other Operating Expenses	(402)	(428)	27 F	6%	(770)	(857)	87 F	10%
Democracy	(42)	(42)		(1%)	(82)	(84)	2 F	2%
Subsidiaries & Joint Ventures	-	-			-	-		
Infrastructure & Non-Clinical Supplies Total	**(6,204)**	**(6,091)**	**(113) U**	**(2%)**	**(12,250)**	**(12,143)**	**(107) U**	**(1%)**

Southern District Health Board

Aug-12

Part 4: DHB Consolidated	Current Month				Year to Date			
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %
Payments to Providers								
Personal Health								
Child and Youth	(37)	(69)	32 F	46%	(74)	(138)	64 F	47%
Laboratory	(2,572)	(2,563)	(9) U		(5,186)	(5,133)	(53) U	(1%)
Infertility Treatment Services	-	(10)	10 F		-	(20)	20 F	
Maternity	(177)	(213)	35 F	17%	(410)	(425)	15 F	3%
Maternity (Tertiary & Secondary)	(4)	(13)	9 F	71%	(6)	(26)	20 F	77%
Pregnancy and Parenting Education	(6)	(10)	4 F	42%	(19)	(19)		2%
Adolescent Dental Benefit	(203)	(198)	(5) U	(2%)	(461)	(439)	(22) U	(5%)
Other Dental Services	-	-			-	-		
Dental - Low Income Adult	(60)	(68)	8 F	11%	(136)	(136)		
Child (School) Dental Services	(27)	(49)	22 F	45%	(77)	(99)	22 F	22%
Secondary / Tertiary Dental	(139)	(139)			(277)	(277)		
Pharmaceuticals	(6,376)	(6,253)	(123) U	(2%)	(12,461)	(12,291)	(170) U	(1%)
Pharmaceutical Cancer Treatment Drugs	-	-			-	-		
Pharmacy Services	(19)	(31)	12 F	39%	(38)	(63)	25 F	39%
Management Referred Services	-	-			-	-		
General Medical Subsidy	(153)	(120)	(33) U	(28%)	(297)	(239)	(58) U	(24%)
Primary Practice Services - Capitated	(3,354)	(3,365)	11 F		(6,705)	(6,730)	25 F	
Primary Health Care Strategy - Care	(240)	(255)	15 F	6%	(481)	(511)	30 F	6%
Primary Health Care Strategy - Health	(225)	(277)	52 F	19%	(386)	(553)	167 F	30%
Primary Health Care Strategy - Other	(206)	(287)	81 F	28%	(418)	(574)	156 F	27%
Practice Nurse Subsidy	(22)	(16)	(5) U	(34%)	(34)	(32)	(1) U	(4%)
Rural Support for Primary Health Pro	(1,378)	(1,277)	(101) U	(8%)	(2,567)	(2,554)	(13) U	(1%)
Immunisation	(82)	(75)	(7) U	(9%)	(178)	(162)	(16) U	(10%)
Radiology	(152)	(176)	24 F	14%	(301)	(351)	50 F	14%
Palliative Care	(566)	(439)	(127) U	(29%)	(1,072)	(879)	(194) U	(22%)
Meals on Wheels	(22)	(19)	(2) U	(11%)	(39)	(39)		
Domicilary & District Nursing	(460)	(393)	(67) U	(17%)	(819)	(786)	(32) U	(4%)
Community based Allied Health	(198)	(156)	(43) U	(28%)	(330)	(311)	(19) U	(6%)
Chronic Disease Management and Educa	(89)	(80)	(8) U	(10%)	(162)	(161)	(1) U	(1%)
Medical Inpatients	-	(11)	11 F		-	(23)	23 F	
Medical Outpatients	(369)	(339)	(30) U	(9%)	(733)	(678)	(54) U	(8%)
Surgical Inpatients	(44)	(36)	(7) U	(21%)	(89)	(72)	(17) U	(24%)
Surgical Outpatients	(137)	(148)	11 F	7%	(281)	(295)	15 F	5%
Paediatric Inpatients	-	-			-	-		
Paediatric Outpatients	-	-			-	-		
Pacific Peoples' Health	-	(4)	4 F		(8)	(8)		
Emergency Services	(204)	(158)	(46) U	(29%)	(354)	(317)	(37) U	(12%)
Minor Personal Health Expenditure	(67)	(82)	15 F	18%	(152)	(163)	11 F	7%
Price adjusters and Premium	(141)	(125)	(16) U	13%	(211)	(251)	40 F	(16%)
Travel & Accomodation	(490)	(426)	(64) U	(15%)	(937)	(831)	(106) U	(13%)
Inter District Flow Personal Health	(2,138)	(2,155)	17 F	1%	(4,278)	(4,310)	32 F	1%
Personal Health Total	**(20,356)**	**(20,035)**	**(322) U**	**(2%)**	**(39,976)**	**(39,895)**	**(82) U**	
Mental Health								
Mental Health to allocate	-	(17)	17 F		-	(33)	33 F	
Crisis Respite	3	(3)	7 F	200%	-	(7)	7 F	
Alcohol & Other Drugs - General	(83)	(83)			(170)	(167)	(3) U	(2%)
Alcohol & Other Drugs - Child & Youth	(39)	(39)	1 F	1%	(77)	(78)	1 F	1%
Methadone	-	-			-	-		
Dual Diagnosis - Alcohol & Other Drugs	(3)	(7)	4 F	51%	9	(14)	23 F	168%
Dual Diagnosis - MH/ID	-	-			-	-		
Eating Disorder	(17)	(14)	(3) U	(23%)	(28)	(28)		
Maternal Mental Health	(15)	(4)	(11) U	(300%)	(15)	(7)	(7) U	
Child & Youth Mental Health Services	(272)	(315)	43 F	14%	(558)	(631)	73 F	12%
Forensic Services	-	-			-	-		
Kaupapa Maori Mental Health Services	(6)	(6)		4%	(12)	(13)		2%
Mental Health Community Services	(112)	(105)	(7) U	(6%)	(219)	(210)	(9) U	(4%)
Prison/Court Liaison	-	-			-	-		
Mental Health Workforce Development	-	(1)	1 F		-	(1)	1 F	
Day Activity & Work Rehabilitation S	(123)	(135)	12 F	9%	(256)	(270)	14 F	5%
Mental Health Funded Services for Older People	-	-			-	-		
Advocacy / Peer Support - Consumer	(23)	(23)	1 F	2%	(69)	(47)	(22) U	(47%)
Other Home Based Residential Support	(285)	(315)	30 F	9%	(561)	(629)	69 F	11%
Advocacy / Peer Support - Families	(48)	(50)	2 F	5%	(142)	(101)	(41) U	(41%)
Community Residential Beds & Service	(356)	(425)	69 F	16%	(712)	(849)	137 F	16%
Minor Mental Health Expenditure	(32)	(32)	1 F	2%	(70)	(65)	(5) U	(8%)
Inter District Flow Mental Health	(431)	(431)			(862)	(862)		
Mental Health Total	**(1,841)**	**(2,006)**	**165 F**	**8%**	**(3,741)**	**(4,012)**	**271 F**	**7%**

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Southern District Health Board

Aug-12

Part 4: DHB Consolidated	Current Month				Year to Date			
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %
Public Health								
Nutrition and Physical Activity	(2)	-	(2) U		(28)	-	(28) U	
Sexual Health	(1)	(1)		(1%)	(1)	(1)		(1%)
Social Environments	-	-			(1)	-	(1) U	
Tobacco Control	(11)	(12)	2 F	13%	(52)	(25)	(27) U	(110%)
Public Health Total	**(14)**	**(13)**	**(1) U**	**(6%)**	**(83)**	**(26)**	**(56) U**	**(213%)**
Disability Support Services								
AT & R (Assessment, Treatment and Re	(352)	(294)	(57) U	(20%)	(589)	(589)		
Information and Advisory	(1)	(1)	(1) U		(1)	(1)		3%
Needs Assessment	(26)	(21)	(5) U	(23%)	(43)	(43)		
Service Co-ordination	-	-			10	-	10 F	
Home Support	(1,078)	(1,106)	28 F	3%	(2,096)	(2,213)	117 F	5%
Carer Support	(162)	(143)	(18) U	(13%)	(320)	(287)	(34) U	(12%)
Residential Care: Rest Homes	(3,045)	(3,059)	14 F		(6,106)	(6,118)	11 F	
Residential Care: Loans Adjustment	10	22	(12) U	(56%)	32	44	(13) U	(28%)
Long Term Chronic Conditions	(67)	(77)	10 F	13%	(162)	(154)	(8) U	(5%)
Residential Care: Hospitals	(3,499)	(3,435)	(64) U	(2%)	(7,064)	(6,869)	(195) U	(3%)
Ageing in Place	-	-			-	-		
Environmental Support Services	(100)	(100)	(1) U	(1%)	(197)	(200)	3 F	1%
Day Programmes	(15)	(26)	11 F	43%	(43)	(52)	9 F	16%
Expenditure to Attend Treatment ETAT	-	-			-	-		
Minor Disability Support Expenditure	-	(17)	17 F		-	(33)	33 F	
Respite Care	(76)	(67)	(9) U	(14%)	(129)	(134)	5 F	4%
Community Health Services & Support	(166)	(206)	40 F	19%	(352)	(412)	61 F	15%
Inter District Flow Disability Support	(324)	(321)	(3) U	(1%)	(645)	(642)	(3) U	(1%)
Disability Support Other	-	-			-	-		
Disability Support Services Total	**(8,902)**	**(8,851)**	**(51) U**	**(1%)**	**(17,706)**	**(17,702)**	**(4) U**	
Maori Health								
Maori Service Development	(22)	(22)			(44)	(44)		
Whanau Ora Services	(116)	(109)	(7) U	(7%)	(217)	(218)		
Maori Health Total	**(138)**	**(131)**	**(7) U**	**(6%)**	**(262)**	**(262)**		
Total Expenses	**(74,605)**	**(73,044)**	**(1,561) U**	**(2%)**	**(146,153)**	**(144,738)**	**(1,416) U**	**(1%)**
Net Surplus/ (Deficit)	**(3,445)**	**(2,628)**	**(817) U**	**(31%)**	**(4,186)**	**(3,887)**	**(298) U**	**(8%)**
Zero Check	-	-			-	-		
Part 4.1 A: Supplementary Information to Statement of Financial Performance								
Depreciation - Clinical Equipment	(665)	(702)	37 F	5%	(1,333)	(1,400)	67 F	5%
Depreciation - Non Residential Buildings & Plant	(628)	(685)	56 F	8%	(1,242)	(1,351)	109 F	8%
Depreciation - Motor Vehicles	(5)	(6)	1 F	20%	(9)	(12)	3 F	26%
Depreciation - Information Techology	(350)	(377)	27 F	7%	(682)	(753)	70 F	9%
Depreciation - Other Equipment	(50)	(56)	6 F	10%	(96)	(112)	15 F	14%
Total Depreciation	(1,699)	(1,825)	127 F	7%	(3,363)	(3,628)	265 F	7%
Interest Cost from Funder Loans	-	-			-	-		
Interest Costs from CHFA	(432)	(416)	(16) U	(4%)	(868)	(831)	(36) U	(4%)
Financing Component of Operating Leases	(16)	(23)	7 F	32%	(33)	(48)	15 F	32%
Capital Charge	(846)	(821)	(26) U	(3%)	(1,661)	(1,649)	(12) U	(1%)
Medical Personnel	464	476	12 F		461	476	15 F	
Nursing Personnel	1564	1571	7 F		1572.5	1571	(2) U	
Allied Health Personnel	692	695	3 F		694.5	695	0 F	
Support Personnel	185	197	12 F		186.5	197	10 F	
Management/Administration Personnel	689	694	5 F		690.5	694	4 F	
Total Full Time Equivalents (FTE's)	3594	3632	38 F		3605	3632	27 F	

Southern District Health Board

Aug-12

Part 4: DHB Consolidated	Current Month Actual $ (000)	Previous Month Actual $(000)	Movement $(000)	Current Budget $(000)	Current Year Opening Balance Sheet $(000)
Part 4.2: Balance Sheet					
Current Assets					
Petty Cash	14	13	1	-	13
Bank	157	224	(67)	-	9,706
Short Term Investments - HBL	31,795	35,222	(3,427)	16,742	-
Short Term Investments	-	-	-	-	30,053
Prepayments	2,041	1,813	228	1,590	1,493
Accounts Receivable	4,840	7,588	(2,748)	6,432	6,196
Provision for Doubtful Debts	(1,695)	(1,695)	-	(1,813)	(1,695)
Accrued Debtors	18,722	16,820	1,902	21,005	15,540
Inventory / Stock	4,237	4,245	(8)	4,605	4,265
Assets Held for Resale	-	-	-	-	-
Current Assets Total	**60,112**	**64,230**	**(4,119)**	**48,561**	**65,571**
Non Current Assets					
Land, Buildings & Plant	243,131	240,318	2,813	252,526	240,152
Clinical Equipment (incl Finance Leases)	106,250	105,995	255	106,777	105,105
Other Equipment (incl Finance Leases)	13,028	12,925	103	13,128	12,904
Information Technology	33,451	32,474	977	35,473	32,108
Motor Vehicles	697	692	5	723	692
Provision Depreciation - Buildings & Plant	(18,142)	(17,514)	(628)	(18,387)	(16,900)
Provision Depreciation - Clinical Equipment	(78,219)	(77,617)	(602)	(79,688)	(76,971)
Provision Depreciation - Other Equipment	(11,450)	(11,400)	(50)	(11,499)	(11,354)
Provision Depreciation - Information Technology	(25,089)	(24,746)	(343)	(25,641)	(24,415)
Provision Depreciation - Motor Vehicles	(278)	(273)	(5)	(314)	(269)
WIP	16,193	22,042	(5,849)	15,967	20,869
Investment in Subsidiaries	-	-	-	-	-
Investment in Associates	277	277	-	328	277
Long Term Investments	-	-	-	-	-
Non Current Assets Total	**279,849**	**283,173**	**(3,324)**	**289,393**	**282,198**
Current Liabilities					
Accounts Payable Control	(4,544)	(5,702)	1,158	(4,707)	(5,053)
Accrued Creditors	(25,694)	(28,187)	2,493	(29,053)	(32,124)
Income Received in Advance	(2,473)	(2,781)	308	(1,566)	(1,614)
Capital Charge Payable	(1,661)	(815)	(846)	(1,649)	-
GST & Tax Provisions	(6,396)	(7,027)	631	(4,529)	(6,842)
Term Loans - Finance Leases (current portion)	(1,213)	(1,058)	(155)	(1,345)	(1,408)
Term Loans - Private (current portion)	-	-	-	-	-
Term Loans - Crown (current portion)	(18,045)	(18,045)	-	(10,895)	(28,045)
Payroll Accrual & Clearing Accounts	(13,288)	(13,751)	463	(7,990)	(11,671)
Employee Entitlement Provisions	(44,368)	(43,830)	(538)	(39,512)	(44,036)
Current Liabilities Total	**(117,682)**	**(121,196)**	**3,514**	**(101,246)**	**(130,793)**
WORKING CAPITAL	**(57,570)**	**(56,966)**	**(605)**	**(52,685)**	**(65,222)**
NET FUNDS EMPLOYED	**222,277**	**226,205**	**(3,928)**	**236,708**	**216,976**
Non Current Liabilities					
Long Service Leave - Non Current Portion	(3,376)	(3,376)	-	(3,069)	(3,376)
Retirement Gratuities - Non Current Portion	(11,487)	(11,487)	-	(10,492)	(11,487)
Other Employee Entitlement Provisions	(1,232)	(1,232)	-	(1,109)	(1,232)
Term Loans - Finance Leases (non current portio	(1,455)	(1,622)	167	(1,329)	(1,669)
Term Loans - Private (non current portion)	-	-	-	-	-
Term Loans - Crown (non current portion)	(84,500)	(84,746)	246	(91,437)	(74,732)
Custodial Funds	-	-	-	(3,725)	-
Non Current Liabilities Total	**(102,050)**	**(102,463)**	**413**	**(111,161)**	**(92,496)**
Crown Equity					
Crown Equity	(154,552)	(154,552)	-	(154,951)	(154,552)
Crown Equity Injection	-	-	-	(2,300)	-
Crown Equity Repayments	-	-	-	-	-
Trust and Special Funds	(4,849)	(4,851)	2	-	(4,851)
Revaluation Reserve	(85,362)	(85,362)	-	(85,362)	(85,362)
Revaluation Reserve - Trust Assets	-	-	-	-	-
Retained Earnings - DHB Governance & Funding	1,912	1,745	167	1,686	1,770
Retained Earnings - DHB Provider	93,257	90,568	2,689	85,526	89,814
Retained Earnings - Funds	29,366	28,709	657	29,854	28,699
Crown Equity Total	**(120,228)**	**(123,742)**	**3,515**	**(125,547)**	**(124,481)**
NET FUNDS EMPLOYED	**(222,277)**	**(226,205)**	**3,928**	**(236,708)**	**(216,976)**
Zero Check	-	-	-	-	-
Part 4.3: Statement of Movement in Equity					
Total equity at beginning of the period	(123,742)	(124,481)		(125,875)	(124,481)
Net Results for Period	3,445	741		2,628	-
Revaluation of Fixed Assets	-	-		-	-
Equity Injections / Repayments	-	-		(2,300)	-
Other	-	-		-	-
Movement in Trust and Special Funds	69	(2)		-	-
Total Equity at end of the period	**(120,228)**	**(123,742)**		**(125,547)**	**(124,481)**

Board Cash Flow - Southern

Aug-12

Part 4: DHB Consolidated	Current Month			Year to Date		
	Actual $(000)	Budget $(000)	Variance $(000)	Actual $(000)	Budget $(000)	Variance $(000)
Part 4.4 Statement of Cashflows						
Operating Revenue						
Government and Crown Agency Revenue	70,419	69,350	1,069 F	138,611	138,659	(48) U
Other Revenue Received	1,064	900	164 F	1,967	2,110	(143) U
Total Receipts	**71,483**	**70,250**	**1,233 F**	**140,578**	**140,769**	**(191) U**
Payments for Personnel	(27,566)	(35,223)	7,657 F	(51,800)	(59,755)	7,955 F
Payments for Supplies	(14,233)	(11,238)	(2,995) U	(24,718)	(22,467)	(2,251) U
Interest Paid	(16)	(23)	7 F	(251)	(266)	15 F
Capital Charge Paid	-	-		-	(2,164)	2,164 F
GST (Net) & Tax	(632)	330	(962) U	(447)	374	(821) U
Payment to own DHB Provider (Eliminated)	-	-		-	-	
Payment to own DHB Governance & Funding Admin	-	-		-	-	
Payments to other DHBs	(3,022)	(2,907)	(115) U	(7,476)	(5,814)	(1,662) U
Payments to Providers	(27,676)	(27,954)	278 F	(59,037)	(55,988)	(3,049) U
Total Payments	**(73,145)**	**(77,015)**	**3,870 F**	**(143,729)**	**(146,080)**	**2,351 F**
Net Cashflow from Operating	**(1,662)**	**(6,765)**	**5,103 F**	**(3,151)**	**(5,311)**	**2,160 F**
Investing Activities						
Interest Receipts 3rd Party	214	185	29 F	422	370	52 F
Sale of Fixed Assets	-	-		-	-	
Capital Expenditure						
Land, Buildings & Plant	(1,138)	(2,314)	1,176 F	(2,799)	(4,955)	2,156 F
Clinical Equipment	(341)	(747)	406 F	(693)	(1,494)	801 F
Other Equipment	(39)	(41)	2 F	(79)	(82)	3 F
Information Technology	(55)	(352)	297 F	(503)	(704)	201 F
Motor Vehicles	(129)	(1)	(128) U	(259)	(2)	(257) U
Total Capital Expenditure	**(1,702)**	**(3,456)**	**1,754 F**	**(4,333)**	**(7,238)**	**2,905 F**
Increase in Investments and Restricted & Trust Funds Assets	-	-		-	-	
Net Cashflow from Investing	**(1,488)**	**(3,271)**	**1,783 F**	**(3,911)**	**(6,868)**	**2,957 F**
Financing Activities						
Equity Injections	-	2,300	(2,300) U	-	2,300	(2,300) U
New Debt						
Private Sector	-	-		-	-	
CHFA	-	-		-	-	
Repaid Debt						
Private Sector	(62)	(236)	174 F	(465)	(471)	6 F
CHFA	(261)	(150)	(111) U	(261)	(150)	(111) U
Other Non-Current Liability Movement						
Other Equity Movement	(20)	-	(20) U	(18)	-	(18) U
Net Cashflow from Financing	**(343)**	**1,914**	**(2,257) U**	**(744)**	**1,679**	**(2,423) U**
Net Cashflow	**(3,493)**	**(8,122)**	4,629 F	**(7,806)**	**(10,500)**	2,694 F
Plus Cash (Opening)	35,459	24,864	10,595 F	39,772	27,243	12,529 F
Cash (Closing)	**31,966**	**16,742**	**15,224 F**	**31,966**	**16,742**	**15,224 F**
Carry Forward Check						
Closing Cash made up of:						
Petty Cash	14	-	(14) U	14	-	(14) U
Bank (Overdraft)	157	-	(157) U	157	-	(157) U
Short Term Investments	31,795	16,742	(15,053) U	31,795	16,742	(15,053) U
Total Cashflow Cash (Closing)	**31,966**	**16,742**	**15,224 F**	**31,966**	**16,742**	**15,224 F**

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Wednesday, 5 September 2012, commencing at 2.00pm in the Board Room, Community Services Building, Southland Hospital Campus

Present:	Mr Paul Menzies	Chairman
	Mr Neville Cook	
	Dr Malcolm Macpherson	
	Mr Tahu Potiki	
	Dr Branko Sijnja	
	Mr Richard Thomson	
	Mr Tim Ward	
In Attendance:	Mr Joe Butterfield	Board Chairman
	Mrs Kaye Crowther	Board member
	Ms Sandra Cook	Board member
	Ms Carole Heatly	Chief Executive Officer
	Mrs Lexie O'Shea	Executive Director of Patient Services/ Deputy CEO
	Mr Robert Mackway-Jones	Executive Director of Finance and Funding
	Mrs Leanne Samuel	Executive Director of Nursing and Midwifery
	Mr David Tulloch	Chief Medical Director
	Mr Grant Paris	Senior Business Analyst
	Mrs Joanne Fannin	Board Secretary Southland

1.0 WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. There were no apologies. It was noted that technology difficulties prevented a videolink connection to the site at Wakari Hospital.

2.0 MEMBERS' DECLARATION OF INTEREST

The Chairman called for any adjustments or amendments to the Interests Register.

Mrs Crowther's appointment as trustee of Number 10, the Youth One Stop Shop in Invercargill was noted.

3.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

"That the minutes of the 1 August 2012 Hospital Advisory Committee meeting be approved and adopted as a true and correct record."

4.0 MATTERS ARISING

There were no matters arising from the previous minutes.

5.0 ACTION SHEET

The HAC meeting action sheet was received.

6.0 EXECUTIVE DIRECTOR OF PATIENT SERVICES (EDPS) REPORT

The EDPS report was received and the Executive Director of Patient Services/Deputy Chief Executive Officer (EDPS/DCEO) responded to members' questions.

Patients given certainty and their wait times – the challenges to meet the new five month target which will take effect from the end of 2013 were highlighted. A request was made for the graph showing the number of patients given certainty and their wait time for treatment to be presented in landscape for future agendas.

Advice was received that there was a higher than average percentage of patients on active review (15% compared to the national average of 5%). Specialties with higher than average numbers, i.e. Ear Nose and Throat (ENT) and Orthopaedics are reviewing.

Radiology – breast screening review - work is progressing on the recommendations made from the various reviews undertaken. A request was made to include benefits and cost analysis when there is a change to the way in which a service is provided.

Health of Older Persons (HOP) InterRAI Assessment Tools – advice was received on work being undertaken to reduce wait times to the target of 12 weeks and this will take approximately eight months. An assurance was provided that urgent and semi-urgent referrals are managed well within the timeframes. A request was made for consideration to be given in eight months time to the possibility of reducing the target to eight weeks. It was agreed that the Provider Arm would produce the report for consideration by the Disability Support Advisory Committee/Community and Public Health Advisory Committee (DSAC/CPHAC).

The Videolink was connected at 2.50pm and the Chairman apologised for the technology failure.

Oral Health – advice was received on funding being made available by Southern PHO to improve access for high need users. It was noted this is an expansion of the services being run out of Southland Hospital and some community clinics.

Contingency Planning for June/July 2012 – advice was received on the approach taken to address the significantly high volumes experienced across both the Southland and Dunedin Hospital sites for the months of June and July 2012. Management acknowledged the district-wide team effort by staff to manage the situation. The Executive Director of Nursing and Midwifery advised on the nurse led multi-disciplinary team approach and the advantages in terms of the district-wide focus and better use of various sites within Southern DHB. The CEO advised the need to find a better way of

handling situations such as flu outbreaks so that acute beds are kept free for other emergency situations.

Elective Caseweight and Discharge Performance – Mr Tim Ward highlighted that the July 2012 tables did not include the delivery of the IDFs and it was confirmed that if these had been included the result would have been on target or slightly above plan.

7.0 REPORT BY THE EXECUTIVE DIRECTOR OF NURSING AND MIDWIFERY (EDNM)

The report and Trendcare Hospital Efficiency Graphs were received and the EDNM provided a verbal update, noting that the August 2012 information was incomplete and only the July 2012 data should be considered. Key points included:

- Monthly productivity should be over 90%.
- Percentage utilisation should be over 85%.
- The impact of the critical mass staffing requirements for the smaller departments on the Southland Hospital site, i.e. Critical Care Unit, Neo Natal Intensive Care Unit and Paediatric Unit.

Advice was received on the Variance Response Management (VRM) being undertaken with the Safe Staffing Unit in the Care Capacity Demand Management (CCDM) Programme. This is now in its third month and assistance is being provided by other DHBs who are working with VRM. A request was made for a target line to be included in future graphs and for benchmarking data against other DHBs to be added and this should be available in approximately four months time. The data is live and is used on every shift in individual departments to match resource to requirement.

The Executive Director Finance and Funding (EDFF) joined the meeting at 3.10pm.

8.0 REPORT BY THE CHIEF MEDICAL OFFICER (CMO)

The report was received and taken as read and the EDNM spoke to the areas highlighted within the report.

9.0 FINANCIAL REPORT

The report was received and the Senior Business Analyst responded to members' questions.

Members' noted the improved reporting format.

A request was made for a comparative figure for the closing balance for leave liability for June 2011 to be available for the Audit and Risk Committee meeting.

Concern was raised over the impact of the annual leave and it was confirmed that the additional cost of insurance was included in the unfavourable variance of $157K. The Chairman stated the need to know with more

confidence what the monthly figures indicate for the year-end result. A request was made for a section to be included in the financial report adjusting for timing factors and identifying the assumptions being made.

Ms Sandra Cook joined the meeting at 3.30pm.

10.0 HUMAN RESOURCES (HR) DASHBOARD

The report was received and taken as read.

11.0 INFORMATION SYSTEMS (IS) DASHBOARD

The report was received and a response provided to members' questions as indicated below:

- Business Intelligence is now business as usual and is composed of comprehensive data cubes of information that management use to draw all of its reporting information from and links most of the systems. A final report on the project is pending and should be available by November 2012.

12.0 MASTER SITE PLANNING – DUNEDIN AND WAKARI HOSPITALS

The report was received and a verbal update provided on the on-going relocation of departments currently underway. The project is on track from a timing perspective. A report on the projects with timelines is to be provided for the October HAC meeting.

13.0 MAORI HEALTH ACTION PLAN (MHAP)

The MHAP was noted and taken as read.

It was resolved:

"That the management and financial reports be received and noted."

14.0 CONFIDENTIAL SESSION

***At 3.46pm, it* was *resolved*:**

"That the public be excluded from the meeting for consideration of the following agenda items:

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Previous Public Excluded Hospital Advisory Committee Minutes	As per reasons set out in previous agenda	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.
Risk Register	Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Chief Medical Officer	Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Contract Approvals	Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).

The Committee resumed in public session at 4.15pm.

The meeting closed at 4.15pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board

Minutes of the Iwi Governance Committee Meeting held on Wednesday, 5 September 2012, commencing at 11.30am in the Board Room, Community Services Building, Southland Hospital Campus

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Present:	Mrs Eleanor Murphy	Ōtākou Rūnaka – Chair
	Mr Taare Bradshaw	Hokonui Rūnaka
	Ms Sandra Cook	Board Member, Southern DHB
	Mrs Kaye Crowther	Board Member, Southern DHB
	Mr Peter Ellison	Puketeraki Rūnaka
	Mr Paul Menzies	Deputy Chairman, Southern DHB
	Mr Tahu Potiki	Board member, Southern DHB
	Ms Odele Stehlin	Waihōpai Rūnaka
	Mrs Ann Wakefield	Ōraka Aparima Rūnaka
In Attendance:	Ms Carole Heatly	Chief Executive Officer
	Mr Donovan Clarke	Kaiwhakahaere Hauora Māori
	Ms Pania Coote	District Manager Māori Health
	Mrs Joanne Fannin	Board Secretary Southland

1.0 WELCOME APOLOGIES AND KARAKIA

The Chair welcomed members to the meeting and apologies were noted from Ms Hana Morgan, Awarua Rūnaka, Deputy Chair and Ms Kingi Dirks, Moeraki Rūnaka. An apology for lateness was received from the Chief Executive Officer, Ms Carole Heatley. An opening karakia had taken place at the Ka Rūnaka session of the meeting.

It was resolved:

"That the apologies as noted be accepted."

2.0 MEMBERS' DECLARATION OF INTEREST

The Chair called for any adjustments or amendments to the Interests Register. None were advised.

3.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

"That the minutes of the 1 August 2012 Iwi Governance Committee meeting be approved and adopted as a true and correct record, subject to a change to the resolution at bullet point 5.0 to remove the words 'agreed that the matters raised are operational and the'.

4.0 MATTERS ARISING

It was noted that a hui is still to be held to address the concerns raised by the Hokonui Rūnaka.

5.0 ACTION SHEET

The Committee received the action sheet and in discussion the following was highlighted:

- **Action No. 82 – Principles of Relationship between ka Rūnaka and Southern PHO –** a meeting is to be arranged between ka Rūnaka and Southern PHO prior to the AGM in November 2012.

Ms Sandra Cook joined the meeting at 11.45pm.

- **Action No. 83 – Wānanga 7 November 2012** – it was agreed that an invitation to the Wānanga on 7 November 2012 should be extended to the IGC, the MAGMH, the Māori Health Directorate management team and the CEO, Southern PHO. Discussion was held on having one Southern District Māori Health Plan to cover both Southern DHB and the Southern PHO. The Kaiwhakahaere Hauora Māori (KHM) advised he would provide a framework for the workshop on 7 November 2012 and would get feedback and input from members to progress with populating the Strategic Plan.
- **Action No. 104 – Māori Health Targets and Outcomes** – the District Manager Māori Health (DMMH) advised that the stocktake of Māori Health contracts has been completed and is being reviewed. A document will be presented to the IGC before being forwarded to providers.

  Advice was received that any funding increase would only be supported where improved outcomes can be demonstrated.

6.0 UPDATE BY THE KAIWHAKAHAERE HAUORA MĀORI (KHM)

The KHM's report was received and the KHM responded to members' questions.

A request was made for a system to be put in place to ensure that all proposals/submissions that go through the system have Māori Health input and when submissions are presented to IGC, a summary is to be provided advising what the Māori specific issues are, how they will be addressed and advising any recommendations.

Mr Ian Macara, CEO, Southern Primary Health Organisation (SPHO) joined the meeting at 11.55pm.

7.0 SOUTHERN PHO UPDATE

The Chair welcomed the CEO SPHO to the meeting. The Chair advised that ka Rūnaka would like to meet with members of the SPHO Board and the SPHO CEO prior to the proposed signing of the Principles of Relationship (PoR) with SPHO at the AGM in Dunedin on 28 November 2012. A meeting between ka Rūnaka and SPHO is to be scheduled prior to the IGC meeting at 10.00am on 3 October 2012. The CEO SPHO is to provide an agenda for the meeting. The CEO SPHO confirmed that he had the revised targets and the SPHO Māori Health Plan (MHP) will be updated. A request was made for the SPHO PoR to be circulated to members electronically, along with the SPHO MHP.

Mr Tahu Potiki joined the meeting at 12.00pm.

Members received a verbal update from the CEO SPHO advising on achievements against the performance programme and the Clinical programme priorities with an emphasis on delivery to Māori.

The CEO joined the meeting at 12.30pm.

Members noted the services available to Māori and fully funded by the SPHO and acknowledged the work done and the outcomes being achieved. Advice was received on the process through the SPHO Māori Health Adviosry Group (MHAG) for the allocation of $400K assigned across from the former PHOs specifically for Māori Health and addressing disparities. The CEO SPHO was commended on the progress being made. A request was made that SPHO receive information from SDHB. Members received a verbal update on coverage across the Southern DHB district for after hours access.

8.0 UPDATE BY THE KAIWHAKAHAERE HAUORA MĀORI (KHM)

Members received tabled items:

- SDHB Logo with proposed 'Piki Te Ora' kupu ***(appendix 1)***.
- Ministry of Health (MoH) Performance Targets for Quarter four (from CEO's report to Board).
- National Health Board (NHB) and Southern District Health Board (SDHB) Joint Assessment of Systems – Dunedin Hospital (from CEO's report to Board).
- IGC recommendations ***(appendix 2)***.
- Māori Health intranet and website page ***(appendix 3)***
- Minutes of the Management Advisory Group Māori Health (MAGMH)

The Committee considered the options for the SDHB Logo.

It was resolved:

"That the Iwi Governance Committee recommends that the Board endorse the inclusion of the Māori Kupu on the existing Southern District Health Board logo."

The Committee considered the recommendation regarding the allocation of a dedicated Māori Nurse. Advice was received that recommendations from the MAGMH should be considered by the CEO in the first instance.

It was resolved:

"That the Iwi Governance Committee confirms receipt of the Advisory Committee application form and endorses the appointment of Shona Kapea-Maslin to the Gateway Steering Group."

The Committee received the update on the proposed Māori Health intranet and website page. A suggestion was made that the sites include a section for celebrating outcomes and achievements.

Members considered the recommendation that Dr Nicole Coupe present at the Wānanga in November and it was agreed that the November 2012 joint workshop is to focus on the strategic plan. A request was made that consideration be given to holding a further Wānanga in the New year to consider other issues such as suicide prevention, Health of the Older Persons, Diabetes, etc.

9.0 UPDATE BY CHIEF EXECUTIVE OFFICER

The CEO's report was received and the CEO responded to members' questions. The following key points were noted:

- The CEO requested that members congratulate their individual teams for their part in assisting to achieve well in the Minister's Health Targets across the Southern DHB.
- Certificates will be presented to the various surgical teams that have contributed to the success.
- The proposed initiatives across Southern DHB to improve service delivery.
- Southern DHB's financial deficit and the work being undertaken by Pricewaterhouse Cooper (PwC).
- The Southern Way key principles and expected behaviours.
- Progress on proposal for change.

10.0 GENERAL

The Chair noted that the earlier start time gave more time for consideration of the agenda and it is hoped that this can continue for future meetings.

11.0 CONCLUSION

The meeting concluded with a closing karakia.

The meeting closed at 1.30pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

SOUTHERN DISTRICT HEALTH BOARD

The Audit and Risk Committee will be considering the following report at its meeting on 4 October 2012 and will make a recommendation to Board.

Title:	**POLICY UPDATE - FRAUD**
Report to:	Audit & Risk Committee
Date of Meeting:	4 October 2012

Summary:

Fraud policy is reviewed annually, no changes are recommended.

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	N/A
Workforce:	N/A
Other:	N/A

Document previously submitted to:	N/A	**Date:**
Approved by Chief Executive Officer:	Pending	**Date:**

Prepared by: R Mackway-Jones **Date: 21/09/12**	**Presented by:** Robert Mackway-Jones, Exec Director Finance & Funding **Date: 21/09/12**

RECOMMENDATIONS:

1. **That the committee recommend the Board adopt the current fraud policy and note that no changes are required.**

Fraud Policy (District)

This policy outlines the irregularities that constitute fraud, as well as the responsibilities of Southern District Health Board (Southern DHB) employees and the Board of Directors regarding fraud.

Note: This document is authorised, but does not meet normal MIDAS documentation standards, for instance it may be a mix of policy, procedure, chart, etc.

Policy Applies to

All Southern District Health Board (Southern DHB) employees, including temporary employees and contractors.

Any person who is involved in the operation of Southern DHB, including Board members, joint appointments with third parties, volunteers and those people with honorary or unpaid staff status

Any person or provider contracted to Southern DHB, including those contracted for services and others contracted for the delivery of health care services

Policy Summary

The purpose of this policy is to:

- Provide guidelines regarding appropriate actions to follow for the reporting and investigation of suspected fraud or similar activities.
- Define fraud and provide examples of potentially fraudulent activity.
- Outline the fraud prevention strategic framework.
- Raise fraud awareness and its consequences.
- Provide guidance to reflect the public sector perspective towards fraud.
- Convey Southern DHB's attitude towards fraud.

Definitions

Southern DHB hereafter will be referred to as the DHB.

This policy adopts the definition of fraud set down by the Auditing Standard AS-206 which states:

"The term fraud refers to an intentional act by one or more individual(s) among management, those charged with governance, employees, or third parties, involving the use of deception to obtain an unjust or illegal advantage."

Examples of actions constituting fraud, misappropriation, and other fiscal wrongdoings include, but are not limited to:

- Forgery or unauthorised alteration of any document belonging to the DHB with a view to

personal gain or gain for another person.

- Accepting or offering bribes or inducements.
- Granting a contract, or engineering the granting of a contract, to a particular third party with a view to direct or indirect personal gain.
- Disclosing confidential information to third parties with a view to personal gain or gain for another person.
- Using official position to secure unwarranted benefits, privileges or profit.
- Knowingly approving for payment false or deliberately misleading invoices.
- Knowingly issuing false or deliberately misleading purchase orders.
- Presenting false credentials or qualifications.
- Knowingly submitting a false time sheet, leave form or expense claim.

The question of whether a fraud has been committed may only be determined finally following a decision by a court of law. For convenience this policy uses the term 'fraud' even though the DHB will normally be concerned with suspected, rather than proven, fraud. Invariably, some discretion will be needed by the Investigator in determining whether the matter concerned is potentially fraud or serious misconduct as each type of event can have differing consequences.

Matters of serious misconduct (e.g. theft or excessive unauthorised personal use of DHB equipment) are dealt with by the DHB's Code of Conduct and Integrity, Employment Agreements and Disciplinary policies and procedures.

Expectations

DHB Attitude Towards Fraud

Southern DHB regards fraud as totally unacceptable and will apply a principle of 'zero tolerance' to fraud.

Following internal investigation, matters of suspected fraud will be referred to the New Zealand police authorities.

Employees who commit fraud, or are suspected of fraud, will also be subject to the DHB's disciplinary procedures.

Third parties and contractors who commit fraud, or are suspected of fraud, will be subject to remedies available under contract and common law.

Recovery of money or property fraudulently obtained will be pursued wherever possible and practical. The criteria for this

will be assessed using cost/benefit analysis. Where the benefit of recovery exceeds the cost then, ordinarily, the DHB will seek to recover.

The DHB has crime/fidelity insurance cover. Insurance parties will often also seek recovery and may have differing criteria for recovery.

Staff Responsibilities

Employees must be scrupulously fair and honest in their dealings with their employer, patients, suppliers, contractors, other health service providers and their fellow employees.

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

Employees must report suspected fraud and/or breakdowns in internal control systems to their managers or other parties as detailed in the 'Fraud Notification' section below.

Contractor Provider Responsibilities

Southern DHB's contract with a provider specifies services to be delivered and the terms and conditions for payment for those services. It is the DHB's expectations that the provider:

- Delivers a quantity and quality of services that at least meet the terms and conditions of its contract.
- Claims only that funding that the terms and conditions of the contract entitle it to claim.

Deliberate claiming of payment for amounts outside the terms and conditions set out in the contract, or for services claimed to be delivered when they have not been, will be regarded as fraud by the DHB.

Management Responsibilities

Managers and governors of public entities - whether elected or appointed to office - have a duty to conduct their affairs in a fair, business-like manner, with reasonable care, skill, and caution and with due regard to the interests of taxpayers, ratepayers and others they serve.

Management is responsible for maintaining internal controls, including setting appropriate policies (and monitoring compliance with these), and maintaining proper accounting records and other appropriate management information that ensures effective stewardship of public health funds as required by the New Zealand Public Health and Disability Act 2000, and with reference to the 'Ethics Framework for the State Sector'. This is a management responsibility for each manager's respective areas.

Management should be familiar with the types of improprieties that might occur within their respective areas and be alert for any indication of irregularity.

The chief financial officer (CFO) is primarily responsible for the DHB's financial internal control systems and fraud control and is available to provide guidance as required.

The CFO is primarily responsible for communication of the fraud strategy awareness programme to employees.

Fraud Assessment & Detection

The 'Fraud Strategy Framework' component of this policy (below) identifies high risk areas for potential fraud.

Fraud risks are to be assessed regularly to ensure internal control procedures are reviewed as any form of business practice changes.

To assist with fraud prevention and detection, the DHB:

- Has an electronic hierarchy approvals system.
- Undertakes employee and vendor bank account checks.
- Uses data mining for irregular and suspicious transactions via annual internal audit.
- Maintains a centralised contracts database.
- Reports and checks high level vendor expenditure.
- Has segregation of duties.
- Has vendor creation approval processes.
- Undertakes fraud risk assessment.
- Maintains fraud awareness training.
- Has a dedicated telephone contact available (see 'Fraud Hotline' below).

Investigation Principles

All allegations of fraud will be thoroughly and fairly investigated with reference to other organisational policies as required, e.g. the Disciplinary Policy (Regional) (55569).

External agencies may be used for investigation if deemed appropriate.

Allegations should be documented and include:

- A summary of the matter of concern.
- The source of the information and explanation of how the individual became aware of the matter.
- Names and positions of any employees or third parties involved.
- Any details of significant times, dates and locations relating to the matter.
- Detail of any information and evidence to

support the allegation (documents, records, etc).

- List of any other persons who may be able to assist in any investigation.

Verbal reports however can be made: the manager to whom the matter is being reported must make notes, as above, and confirm accuracy with the person making the disclosure.

Any investigation must be fully documented.

Following internal investigation, where matters of fraud are suspected, the matter will be reported to the police and a complaint laid. This may result in criminal prosecution.

Following internal investigation, where matters of fraud or serious wrongdoing are suspected and where no criminal prosecution is likely or delayed, the DHB may exercise its rights of civil or contractual litigation if deemed appropriate.

National Fraud Hotline

Anonymous reports or calls will be treated seriously and should contain sufficient information to allow further investigation.

An 0800 number has been set up within the Audit & Compliance section of the Ministry of Health to provide an independent reporting mechanism, if required. The phone number is **0800 424 888 or email them on fraudhotline@moh.govt.nz**.

Confidentiality

It should be noted that maintaining confidentiality is particularly important as the individual(s) allegedly involved will not normally be alerted to the process of gathering and assessing evidential information. This is also to protect the rights of individual(s) involved.

The staff member discovering suspected fraud should not discuss the suspicion with anyone other than the person they report it to, or as otherwise directed by the investigator.

Employees must not attempt to investigate their concerns themselves or to contact the suspected individual(s) in an effort to determine the facts.

The DHB will make its best endeavour not to disclose any identifying information. However, confidentiality cannot be guaranteed. For example, confidentiality may not be able to be maintained where the disclosure of identifying information is in the public interest or is essential to having regard for the principles of natural justice, the effective investigation of an allegation, legal proceedings or criminal complaint.

The Protected Disclosures / Whistle-blowing Policy (Regional) (19708) and the Protected Disclosure Act 2000 detail the obligations and rights of employees and employers relating to

notification of serious wrongdoing.

The Protected Disclosures Act 2000 defines a serious wrongdoing as including:

- An unlawful, corrupt, or irregular use of public funds or public resources.
- An act, omission or course of conduct that constitutes a serious risk to public health or public safety or the environment.
- An act, omission or course of conduct that constitutes a serious risk to the maintenance of the law, including:
  - the prevention, investigation, and detection of offences and;
  - the right to a fair trial
- An act, omission, or course of conduct that constitutes an offence.
- An act, omission, or course of conduct by an employee that is oppressive, improperly discriminatory, or grossly negligent, or that constitutes gross mismanagement.

False Allegations

Individuals who make false or vexatious allegations or otherwise act in bad faith may not be afforded protection under the Protected Disclosures Act 2000 and may be dealt with under the DHB's disciplinary procedures and policies.

Fraud Notification Directives

Staff Member Suspects Fraud By:	Report it to:	Means by Which Allegation is Investigated
Another employee	Line manager who must notify the chief financial officer (CFO)	Human Resources in conjunction with CFO
Their line manager	CFO	Human Resources in conjunction with CFO
The CFO	Chief executive officer (CEO)	Human Resources in conjunction with CEO
Contractor, supplier of the provider / governance-arm	Line manager who must notify the CFO	GM of the relevant service in conjunction with the CFO
Contractor / provider of the DHB funder	GM, Planning & Funding who must then notify the CFO	GM Planning & Funding in conjunction with the CFO and the DHB's non-governmental organisation (NGO) provider/audit contractor - currently Healthpac of

		the South Island Shared Service Agency (SISSAL)
Board / committee members	CEO who must notify the Board chair and CFO	CEO in conjunction with the Board chair, CFO and Human Resources, as required
Board member suspects fraud by:	**Report it to:**	**Means by which Allegation is Investigated**
Another Board member	Board chair who must then notify the CEO & CFO	CEO in conjunction with Board chair, CFO and Human Resources, as required
Board chair	Chair of the Audit & Risk Committee Chair of A&RC must then notify the CEO & CFO	CEO in conjunction with Audit &Risk Committee chair, CFO and Human Resources, as required
All other parties	Board Chair who must then notify the CEO & CFO	The investigation will be the same as specified in the employee section above and vary according to whom the suspected party is.
If a contractor suspects fraud by:	**Report it to:**	**Means by which Allegation is Investigated**
Staff, Board members, other contractors	CFO who must then notify the CEO	Depending on the party, the investigation will be managed as above; for example, if staff, then by Human Resources & CFO, if by other contractors, then by relevant GM of service/department & CFO

Internal Procedure for Investigation Following Notification

Responsible	Actions
Investigator	1. Undertake a preliminary assessment for the purposes of seeking clarification and gathering further information. The purpose of the preliminary assessment is to: ▪ Seek clarification and determine if there is any substance to the allegation ▪ Protect employees or contractors from false or vexatious allegations ▪ Gather and protect further evidence ▪ Provide a set of recommended actions for the CEO. 2. Liaise with appropriate parties and seek such advice as deemed necessary to protect all parties.

3. Where the preliminary assessment shows a prima facie case of fraud, and has been approved by the CEO, the allegation should be investigated fully, including any assistance deemed necessary by external agencies and / or the police.

4. Where employees are involved, it may be necessary to suspend: a decision to suspend will be taken in context of the disciplinary policy and in line with the Delegation of Authority Policy (Regional) (21584).

5. Ensure full documentation is kept of any preliminary and subsequent full investigation and filed/stored appropriately.

Chief Financial Officer (CFO)

1. Is to maintain and update a central, detailed register of all fraud incidents and reports. The register is to incorporate:
    - Parties involved
    - Nature of event
    - Amounts involved and/or recovered
    - Investigation detail
    - Recommendation/outcome
    - Control environment issues/weaknesses
    - Control improvements made (if any)

2. Upon advice of a suspected fraud is to:
    - Notify the CEO.
    - Notify the Audit & Risk Committee.
    - Notify the DHB's insurers of any potential fidelity claim or incidence as required under the insurance policy.
    - Notify the internal and/or external auditor

    The notifications will give due regard to privacy issues given the suspected status of the matter at this stage.

3. On completion of the preliminary and/or full investigation:
    - Updates the above parties, as required.
    - Lodges any insurance claim.
    - Provides feedback to the reporting individual, where appropriate, regarding whether or not evidence was found to support the allegations, that the investigation (if any) is complete, and confirmation that appropriate actions were taken but not the detail of such actions.
    - Reviews and makes corrective actions to the internal control systems if the investigation reveals any deficiencies.

Chief Executive Officer (CEO)

1. On completion of the preliminary and/or full investigation:
    - Notifies the Board chair, Ministry of Health and health minister under the Ministry's 'no surprises' policy if the matter is deemed significant enough.

- Deals with all media enquiries or, in agreement with the Board chair, defers to the chair to handle certain enquiries, if appropriate.
- Following receipt of the preliminary assessment report, determines the next actions to take, including any referral to enforcement agencies.

Fraud Strategy Framework

Background

While it is not possible to eliminate fraud, it is possible to significantly reduce opportunities for fraud through adoption of multiple, aligned strategies and policies that address different aspects of the control environment where potential fraud risk exposure exists. This part of the policy explores those aspects of the control environment and outlines the strategy.

Key Risk Areas

Analysis of the DHB's spend identifies the following primary areas of exposure for exploitation by potential fraudsters. These areas are:

- Provider Arm: 50% of DHB costs
- Personnel: 65% of Provider Arm costs
- Contracts with suppliers of goods and services: 35% of Provider Arm costs
- Funder contracts with health service providers: 50% of DHB costs

The DHB will be informed of its understanding of key risks by reviewing the internal and external auditors' organisational risk assessments annually.

Fraud Control Framework

The control framework sets out the strategies that form the basis for a multi-stranded approach to fraud prevention and detection. The control framework will be supported by appropriate policies.

Human Resources

Human resource policies and processes will outline the behaviour expected of staff and management. They will project a clear expectation of honesty and full disclosure and support the creation and maintenance of an ethical work environment. Specific policies and processes are:

- Recruitment screening and declarations (e.g. CV checks, criminal record checks, registration checks, reference checks, etc).
- Development of appropriate culture (e.g. inclusion of fraud alert in the staff orientation programme).

- Ongoing Fraud Awareness training.
- Robust payroll processes (segregation of duties, review and appropriate authorities).
- Annual payroll audit/review using forensic software (e.g. IRD number checks, duplicate bank account checks, etc).
- Expenses claim policy and audit.
- Code of conduct and integrity policy.
- Policy on receiving gifts and entertainment.
- Declarations of conflicts of interest by the executive management team via the conflicts register.
- Declarations of conflicts of interest by all staff involved in a procurement project via the conflicts register held by Procurement for that project.

Internal Audit

The Internal Audit + NGO Auditing Policy (44704) sets out the investment required and focus of internal audit at the DHB. It will ensure that the mix of internal audit services employed each year is informed appropriately by an annual risk assessment.

It is envisaged that the expenditure profile of the DHB would mean there is a heavy weighting towards payroll and purchasing processes and validation. The Internal Audit Policy will be reviewed annually and the annual internal audit work plan set by the Audit & Risk (A&R) Committee, in consultation with the internal auditors.

The Internal Audit Policy will require an annual internal audit work plan and will also include guidance on matters such as, weightings for forensic audit spend, risk identification processes, the importance of committee only time with the internal auditors, the overall internal audit budget, required skill sets for internal audit personnel and the monitoring of compliance with all policies linked to the fraud control framework.

It is envisaged the annual work plan will include as a minimum:

- Fraud risk identification and assessment.
- Targeted forensic audit (including data mining), drawing on specialist skills based on target area (e.g. IT specialist for IT, procurement specialist for procurement, etc).
- Scheduled A & R Committee (without management present) interview with auditors.

- 'Closing the Loop' systems audit (i.e. tests for vendor approval, procurement process, contract and/or purchase order approval, invoice, payment, delegations of authority, etc).
- Audit of compliance with personnel anti-fraud controls.
- Control environment review, e.g. contract approval process, vendor creation control, rules-based invoice approval process, etc.
- Interface and interaction with the external audit programme and auditors.

In addition to the regular internal audit programme for the Provider Arm, a plan will be set annually for Healthpac and SISSAL audits of Funder contracts. External providers may be used from time to time for issues such as the forensic audit arising out of fraud investigation.

External Audit

While external audit is primarily influenced by the Office of the Auditor General and largely focuses on providing an opinion on financial statements, opportunities to maximise the value of the audit in a fraud control context will be utilised. This includes:

- Annual A & R Committee (without management present) interview with auditors.
- Sample transaction test — validation/ratification/ 'appropriateness'.
- Maximising the interaction between external and internal audit processes.

Delegations of Authority

The Delegation of Authority Policy is important in a fraud control context as it sets out the authority levels for expenditure and procurement. Key to its utilisation for fraud control is the setting of appropriate levels for authorisation of expenditure and ability to contract the DHB, and then monitoring compliance with these.

The Delegation of Authority Policy needs to be clear, concise and have good visibility in the organisation. The fraud control aspects therefore includes:

- Annual review by the A&R Committee (for segregation of duties, expenditure levels etc).
- Appropriate linkages with internal audit.
- Annual review of high level cumulative spend on single providers by authorised officer.

Procurement Processes

Procurement of goods and services is governed by the Procurement Policy, which covers many aspects of the process, including ensuring there is compliance with government good practice requirements. In the fraud control setting the Procurement Policy needs to ensure there are robust processes in place for the selection of suppliers and approval of contracts. It includes:

- Vendor approval processes (sign off).
- Contract review at the point of origination.
- Personal pecuniary gain and/or association.
- Central Contracts Register.
- Biannual review of said policy by the A&R Committee
- Annual review of high use suppliers, by cumulative spend, and authorising officer, by management and the A&R Committee.

Fraud Policy

This policy is in place to set out the DHB's attitude towards fraud and the appropriate response to its occurrence. Included in this policy is an outline of:

- Annual review by A&R Committee.
- Principle of zero tolerance to fraud.
- National Fraud Hotline
- Protected disclosures

Role of the Audit and Risk (A&R) Committee

A&R Committee members are appointed by the Southern DHB Board. The committee's composition will support this fraud control framework by ensuring members include persons with previous experience in one or more governance/audit committees, audit generally, and financial matters.

The A&R Committee will have an annual work plan and meeting schedule that reflects the need to effectively monitor retrospective compliance with the policies associated with this fraud control framework and the need to review the related policies annually for prospective robustness. In particular the committee will set the Internal Audit Work Plan and review the outcomes of all internal and external audits and any fraud investigations.

Associated Documents:

- Code of Conduct and Integrity (Regional) (18679)

- Disciplinary Policy (Regional) (55569)
- Delegation of Authority Policy (Regional) (21584)
- Internal Audit + NGO Auditing Policy (44704)
- Protected Disclosures / Whistle-blowing Policy (Regional) (19708)

References:

Legislation

- Protected Disclosures Act 2000, Crimes Act 1961 and Privacy Act 1993
- Auditor General Statement (AS 206)

General Notes

Scope of Practice: Ensure you are fully qualified to perform the role specified in any document.
Deviations: If you need to deviate from any procedure, policy, or guideline, make notes and follow up.
Caution — Printed Copies: Printed copies of this document cannot be relied on after the date at the bottom of the page. Check issue date and version number against the electronic version on MIDAS to ensure that they are current.

Document Data for 25546 V5

Applies to: All Southern DHB staff (Global: Yes)
What has Changed: AMENDED: Minor updates following annual review
Service Actions: Replace older printed copies with this version.
MIDAS ID: 25546 Version 5 (Old ID: n/a), **Document Type**: Policy
Issued: 30/09/2011, **Released**: 30/09/2011, **Due for Review**: 1/09/2013, **Authorised by**: Chief Financial Officer
Document Owner: Finance Group (8220 - Finance Department 8220 CFO)
Author: Robert Mackway-Jones, **Contact Name**: Robert Mackway-Jones, **Contact Phone**: 9135 (Otago)
Keywords: fraud misappropriation theft irregularities
Review Factors:

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) - SEPTEMBER 2012

PROVIDER NAME	DESCRIPTION OF SERVICES	SIGNED BY	CONTRACT/VARIATION END DATE
Presbyterian Support Southland t.a Vickery Court Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	04.10.12
Timeouts Carers Southland Trust t.a Timeout Carers Variation to Agreement	Home Based Support Services.	Peter Hay	23.09.12
Wallace's Pharmacy Limited Variation to Agreement	Pharmacy Services	Peter Hay	30.06.15
Cressida Otago Limited t.a Woodhaugh Rest Home Variation to Agreement	Long Term Support - Chronic Health Conditions - Residential	Peter Hay	30.06.13
Glenbrae Rest Home Limited Variation to Agreement	Long Term Supoprt Chronic Health Conditions - Residential	Peter Hay	30.06.13
University of Otago t.a Student Health Services Variation to Agreement	Primary Care Services	Peter Hay	30.06.13
Radius Residential Care Limited t.a Radius Fulton Care Centre Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	25.09.12
Takitimu Home Anglican Care Trust t.a Takitimu Rest Home Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	13.08.12
Oceania Care Company Limited t.a Windsor Park Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	09.07.12
Presbyterian Support Otago Incorporated t.a Ross Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	08.10.12
Presbyterian Support Otago Incorporated t.a Iona Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	27.08.12

FUNDING ADMINISTRATION

CONTRACTS REGISTER (EXPENSES) - SEPTEMBER 2012

Presbyterian Support Otago Incorporated t.a Iona Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	12.09.12
North and South No 1 Limited t.a Northanjer Rest Home Variation to Agreement	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	30.06.13
Presbyterian Support Otago Incorporated t.a Ross Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	24.10.12
Otago Community Hospice Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	17.10.12
Presbyterian Support Otago Incorporated t.a Iona Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	12.10.12
Dunedin Home Support Services Variation to Agreement	Long Term Supoprt Chronic Health Conditions - Home Based Support (Otago)	Peter Hay	31.03.13
Calvary Hospital Southland Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	24.07.12
Bainfield Park Residential Care Limited Variation to Agreement	Long Term Mental Health Residential Care Limited	Peter Hay	30.06.13
Otago Polytechnic t.a Student Health Services Variation to Agreement	Dunedin After Hours (Over Night) Primary Care	Peter Hay	30.12.12
Timeout Carers Southland Trust Variation to Agreement	Long Term Supoprt Chronic Health Conditions - Home Based Support (Southland)	Peter Hay	31.03.13
Roslyn Village Pharmacy Limited t.a Maori Hill Pharmacy Community Pharmacy Services Agreement	Provision of Pharmacy Services.	Peter Hay	30.06.15
Marne Street Hospital Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	02.07.12

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) - SEPTEMBER 2012

Presbyterian Support Otago Incorporated t.a Taieri Initiative Variation to Agreement	Community Health Services and Support	Peter Hay	30.09.12
Maniototo Health Services Limited t.a Ranfurly Hospital Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	25.10.12
Southern Primary Health Organisation Variation to Agreement	After Hours Primary Care Initiatives	Peter Hay	31.12.12
Southern Primary Health Organisation Variation to Agreement	Amendments to the PHO Service Agreement V18.0	Peter Hay	03.08.20
Arai Te Uru Whare Hauora Limited Agreement	Reducing Inequalities Contingency Funding.	Peter Hay	30.06.13
Presbyterian Support Southland t.a Peacehaven Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	05.11.12
Presbyterian Support Southland t.a Resthaven Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	05.11.12
Elsdon Enterprises Limited t.a Bradford Manor Variation to Agreement	Individual Agreement for a Named Individual.	Peter Hay	31.10.12
Uruuruwhenua Health Variation to Agreement	Whanau Ora - Maori Community Health Services	Peter Hay	31.03.13
Mosgiel Abilities Resource Centre Incorporated Variation to Agreement	Long Term Support - Chronic Health Conditions - Home Based Support (Otago)	Peter Hay	31.03.13
Presbyterian Support Otago Incorporated Variation to Agreement	Long Term Support - Chronic Health Conditions - Home Based Support (Otago)	Peter Hay	31.03.13
Healthcare of New Zealand Limited Variation to Agreement	Long Term Support - Chronic Health Conditions - Home Based Support (Otago)	Peter Hay	31.03.13

FUNDING ADMINISTRATION

CONTRACTS REGISTER (EXPENSES) - SEPTEMBER 2012

Marne Street Hospital Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	19.08.12
Marne Street Hospital Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	26.10.12
St John's Parish (Roslyn) Friends of the Aged & Needy Society t.a Leslie Groves Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	04.09.12
Marne Street Hospital Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	07.08.12
Summerfield's Frankton Pharmacy Limited Variation to Agreement	Pharmacy Services	Peter Hay	30.06.15
Oceania Care Company Limited t.a Longwood Lifestyle Village Variation to Agreement	Long Term Support - Chronic Health Conditions - Residential (Longwood)	Peter Hay	30.06.12
Oceania Care Company Limited t.a Windsor Park Variation to Agreement	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	29.10.12
Gore Health Limited Variation to Agreement	Health of Older People	Peter Hay	30.06.14
Gore Health Limited Variation to Agreement	Domicillary Services	Peter Hay	30.06.14
Gore Health Limited Variation to Agreement	Rural Hospital Medical & Surgical Services.	Peter Hay	30.06.14
Gore Health Limited Variation to Agreement	Primary Maternity Facility Services	Peter Hay	30.06.14
Presbyterian Support Southland t.a Vickery Court Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	25.08.12
Cameron House Rest Home Limited Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	26.10.12

FUNDING ADMINISTRATION

CONTRACTS REGISTER (EXPENSES) - SEPTEMBER 2012

Presbyterian Support Southland t.a Vickery Court Service Schedule	Exceptional Circumstances Palliative Care for a Named Individual.	Peter Hay	19.11.12

TOTAL AMOUNT FOR THE MONTH: $1,836,671.68

SOUTHERN DISTRICT HEALTH BOARD

Title:	**BOARD AND COMMITTEE MEETING CYCLE REPORT**
Report to:	Board
Date of Meeting:	27 September 2012

Summary:

The issues considered in this paper are:

- Alternative structures for Board and committee meeting cycles
- 2013 meeting schedule based on the current structure

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	No specific implications.
Workforce:	No specific implications.
Other:	No specific implications.

Document previously submitted to:	Not applicable, report submitted directly to Board.	**Date:**n/a
Approved by Chief Executive Officer:		**Date:** 25/09/12

Prepared by: CEO Office Manager/ Board Secretary **Date:** 21/09/2012	**Presented by:** Chief Executive Officer

RECOMMENDATION:

1. **That the Board receive and consider the report.**

BOARD AND COMMITTEE MEETING CYCLES

1. BOARD AND COMMITTEE CYCLE - DHB SHARED SERVICES PAPER JUNE 2012

This paper serves to inform and stimulate discussion re meeting frequency. A briefing paper was drafted by DHB Shared Services in June of this year to collate and compare the board and committee meeting structures and cycles across all the individual DHBs. The purpose of the paper was to provide boards with the information to determine whether current board and committee structures and meeting cycles could be improved, with a view to aligning as much as possible to best practice. The best practice guide used is that detailed in the Policy Governance model developed by Dr Carver which sets out principles by which boards should operate.

2. STATISTICAL ANALYSIS

With regard the frequency of board meetings: 12 boards meet monthly and 6 meet on a six-weekly cycle. Hospital Advisory Committees have a mix of cycles: 7 DHBs meet monthly, 5 six-weekly, 7 bi-monthly, 1 quarterly. CPHAC/DSAC meeting cycles are even more varied: 14 DHBs have separate meetings of these committees and 6 combine them. Of the meeting frequency, it is easier to describe the number of meetings per year than the cycles given the variety. The average meetings per year are 11.6, the minimum is 5 the maximum is 19 and the median is 12 meetings a year.

3. CONSIDERATIONS IN DETERMINING MEETING CYCLES

There are a number of factors to take into consideration when determining the most effective and efficient meeting cycles. For example the travel requirements for both the board and committee members and DHB staff required for the meetings. This is a cost, convenience and time consideration. Additionally, the time for the preparation of reporting prior to the meeting and subsequent actions to be carried out after the meetings is impacted by the timing of the cycles.

The DHB Shared Services report, which includes the detail of the DHB meetings and the principles of Dr Carver's Policy Governance model, is attached for members' information.

Also attached is a draft meeting schedule for 2013 based on the current meeting configuration.

Carole Heatly
Chief Executive Officer

25 September 2012

Memorandum

To:	All DHB CEs Meeting 26th June 2012
From:	DHB Shared Services
Subject:	DHB Board and Committee Structures and Best Practice
Date:	19 June 2012

Decision **Discussion** **Information**

1. The attached paper on DHB Boards and Committee Structures and Best Practice was developed at the request of the Chairs for their 18 June meeting. The paper has been updated to include late DHB returns and to incorporate further feedback.

2. The Chairs have considered the paper and noted that:

   - The paper provides useful information about how DHBs can review their practices, altering time frames and in some cases combining statutory committees within a DHB or combining statutory committees across DHBs

3. The paper is provided to DHB Chief Executives for their information and discussion.

DHB Shared Services
A national arm of TAS
nationaloffice@dhbsharedservices.health.nz
04 803 3940
PO Box 23075
Wellington 6140

Briefing Paper

To:	DHB Executive Meeting for 26th June 2012
From:	DHB Shared Services
Subject:	DHB Board and Committee Structures and Best Practice
Date:	Updated 19 June 2012

Decision **Discussion** **Information**

DHB Governance

1. Purpose

This paper describes DHB governance structures nationally; including the DHB Boards together with the types and mix of committees that support them. It also provides a high level comparison of the current arrangements taking account of, the statutory requirements, best practice considerations for governance and committee management together with, the information provided on these structures by District Health Boards (DHBs).

2. Recommendations

It is recommended that the Chairs:

1. Note the contents of this paper
2. Utilise the information provided as they consider appropriate in their capacity as DHB Chairs
3. Consider what (if any) further work could be undertaken to improve DHB Board and Committee Structures in discussion with DHBs

3. Statutory Requirements

Boards

The New Zealand Public Health and Disability Act 2000 (section 29(1)) requires DHB Boards are made up of seven elected members and up to four members appointed by the Minister. As required under the Crown Entities Act 2004 (section 49), the Board of a statutory entity must ensure that the entity acts in a manner consistent with its objectives, functions, current statement of intent, and output agreement (if any). Under clause 7 of Schedule 2 of the New Zealand Public Health and Disability Act 2000, a person is not prevented from being elected as a member of a DHB simply because the person is an employee of the DHB.

Committees

DHBs are required under the New Zealand Public Health and Disability Act 2000 (sections 34-36) to establish a:

1. Community and Public Health Advisory Committee (CPHAC) to advise on health improvement measures
2. Disability Support Advisory Committee (DSAC) to advise on disability issues
3. Hospital Advisory Committee (HAC) to advise on matters relating to hospitals

All of these committees must provide for Maori representation on the committee.

Under clause 38 of Schedule 3 of the Act DHBs may establish one or more committees of the Board for a particular purpose or purposes. Committees should only exist where there is a clear reason for them and they can assist the governance of the DHB. .Prior approval of the Minister of Health is required for all committees established by Board after 9 November 2010 (clause 38(1)(a), Schedule 3).

The Auditor General expects all public entities to consider setting up an audit committee. In lieu of establishing an audit committee, a public entity must ensure that appropriate systems and processes are in place to support the governing body or the Chief Executive to carry out their accountability and governance responsibilities in this respect[1].

The roles and responsibilities of the Board are set out in the Resource for preparation of District Health Board Governance Manuals (State Services Commission)[2].

4. Best Practice

4.1. Policy Governance

The Policy Governance model developed by Dr Carver is an internationally recognised model that focuses the Board's attention on the organisational purpose "ends" as commander, empowering others to manage operational matters while still maintaining accountability.

"Policy Governance" an integrated board leadership paradigm created by Dr Carver, is a model of governance designed to empower boards of directors to fulfil their obligation of accountability for the organizations they govern. As a generic system, it is applicable to the governing body of any enterprise. The model enables the Board to focus on the larger issues, to delegate with clarity, to control management's job without meddling, to rigorously evaluate the accomplishment of the organization; to truly lead its organization"[3].

The Policy Governance model requires that Boards govern in an organised, planned and highly disciplined manner[4] by:

- Being definite about its performance expectations
- Assigning these expectations clearly, and
- Checking to see that the expectations are being met

Policy Governance Boards use committees only to help the Board to do its own job. Policy Governance boards delegate to the CEO and is accountable for the job the CEO does, the CEO is not accountable for the job that the Board does and subsequently are not expected to direct the Board.

[1] http://www.oag.govt.nz/2008/audit-committees
[2] http://www.ssc.govt.nz/sites/all/files/governance-manual-guidance-dhb-sept11.pdf
[3] http://www.carvergovernance.com/model.htm
[4] http://media.wiley.com/assets/48/29/np_carver_jb_pgdefined.pdf

The principles of this model are outlined in Appendix Two. For any further work agreed we will investigate current New Zealand and Health specific governance models.

4.2. Boards

The Policy Governance model developed by Dr Carver sets out principles by which Boards should operate. In line with this, traits of good boards include:

- Understanding the goals of the entity and helping it to move forward
- Holding of regular and productive meetings
- Being strategic as opposed to operationally focused
- Containing a balance of independence , relevant skills, knowledge and experience
- Having in place and utilising formal processes for evaluating its performance and the performance of its committees
- Being ethical, and operating with integrity

The State Services Commission sets out the guidelines for DHB Board behaviours; these can be found in the governance manual preparation resource published by the SSC[5]. These include:

- Collective responsibility
- Strategic perspective
- Participation
- Financial literacy, and
- Sector knowledge

4.3. Types of Committees

There are generally two types of committees that boards operate, Standing Committees (committees used on a continual basis) and adhoc committees (used to address a specific piece of work). Boards should ensure that all committees have terms of reference, serve a purpose and are regularly reviewed.

Annual reviews are recommended to ensure that the committees are operating within their terms of reference, are purposeful and that committees are not performing duplicate or unnecessary tasks. It is also recommended that committee member numbers do not exceed twelve, as the larger the group the more difficult it can be to reach decisions.

4.4. Traits of a good committee

Traits of good Committee include:

- Maintaining terms of reference that clearly define the purpose of the committee, the role of members and the way in which the committee is run
- Meeting regularly
- Members understanding their roles and responsibilities
- Assigning skills appropriately; so that committee membership has the right mix of skills, abilities and experience with commitment to the roles, aims and objectives of the group
- Ensuring that Board members are not serving on too many committees and therefore spread too thin
- Regularly reviewing the role of the committees to test if they still serve a purpose, to ensure there is no duplication between committees and whether committees can be merged

[5] http://www.ssc.govt.nz/sites/all/files/governance-manual-guidance-dhb-sept11.pdf

5. Comparing DHB Boards and Committees to Statutory Requirements and Best Practice

DHBs were asked to provide details of the number of board members and meeting frequency, together with; whether they had recently changed any of these arrangements and why or otherwise planned to do so and why. They were not asked to provide information about Board performance in relation to Governance Best Practice.

All DHBs Boards meet regularly at different intervals. Most Boards meet monthly (13 DHBs), 7 meet at six weekly intervals. Tairawhiti and Taranaki DHBs do not hold a January Board meeting. Capital & Coast do not hold a meeting in January or July. Whilst all DHB Board arrangements are consistent with the statutory requirements for DHB Boards, their overall memberships vary as summarised in the section 6 below.

All DHBs Boards also meet their statutory obligations to maintain Hospital Advisory Committee, Community, Public Health Advisory Committee and Disability Support Advisory Committee. All DHBs maintain an audit committee or similar as recommended by the office of the Auditor General.
An over view of the extent to which DHB committee arrangements align with meet best practice traits is set out in the table below.

Best Practice Trait	**Comment**
Meets regularly	All committees meet regularly. The frequency ranges monthly to quarterly with the exception of committees that appropriately meet less frequently due to the nature of the role they play (e.g.: remuneration committees which generally meet up to twice per annum).
Includes members that understand their roles and responsibilities	The extent to which members understand their role was not identified in the survey. Some DHBs include specific detail in their terms of reference about the responsibilities of the committee and its member's roles.
Assigns skills appropriately, is made up of members with the right mix of skills, abilities and experience with commitment to the roles, aims and objectives of the group	The terms of reference for some DHB committees are specific about roles, including skill mix. As outlined above not all DHBs provide this level of detail in their terms of reference.
Regularly reviews committees to test if they still serve a purpose, is there duplication between committees, can committees be merged	DHBs were not asked to provide details of a review process; however some DHBs include information about review processes and their frequency in the terms of references.
Ensures that board members are not serving on too many committees and therefore spread too thin	Each committee includes board representation. Where DHBs maintain several committees there is risk that board members are over committed.
Should maintain terms of reference clearly defining the purpose of the committee, the role of members and	Terms of reference are available on DHB websites for statutory committees but not always for non statutory committees. The level

the way in which the committee is run.	of detail included in the terms of reference varies.

Changes to Committees

A number of DHBs have made changes to their committee structures including; timing, refinement of committee focus or authority and merging of committees achieving integration of membership and agendas in some cases. For example:

- Canterbury has reviewed the timing of CPHAC and DSAC committees and is planning to review the membership in 2014. They are also planning to review their Quality, Finance, Audit and Risk Committee and Facilities Development Project Committee at that time.
- Hawke's Bay has clarified the functions of their statutory and audit committees. The meeting frequency has reduced and membership tenure is aligned to Board term. The purpose of this has been to ensure the committees develop knowledge and experience, have more in depth discussions/input on significant strategic issues and remain focussed on the goals, strategies, objectives and targets of HBDHB. To avoid duplication and because of the skill set required they have also moved monitoring of the financial performance of the provider arm from HAC to their Finance Risk and Audit Committee (FRAC).
- Hutt Valley and Capital coast run combined CPHAC and DSAC.
- Lakes have moved their CPHAC and DSAC meeting from meeting monthly to six weekly and are considering moving all statutory committee meetings to two monthly.
- Nelson has combined CPHAC and DSAC from March 2011.
- Tairawhiti have devolved authorities to committees to both determine and spend up to approved limits as negotiated with the Ministry of Health under the New Zealand Public Health & Disabilities Act. It has created a combined Age and Disability committee.
- Taranaki has combined its CPHAC and DSAC, with Iwi partners co-opted on to the committee
- Southern holds joint CPHAC and DSAC meetings.
- Waikato has combined its CPHAC and DSAC memberships and agendas and the frequency of meetings has been reduced.
- Since August 2011, Waitemata and Auckland DHBs have operated shared arrangements for PHAC and DSAC; as well as sharing the same membership and have common meetings for their Maori Health Gain Advisory Committee.

6. Research Results

DHBs were asked to provide details of their Board and Board committees including the purpose, roles that make up the committee and their responsibilities. Responses were received from 18 DHBs and confirmed. In summary:

- <u>Boards</u>
  - 17 of the 20 DHBs have 11 board members each (due to vacancies)
  - In addition to the 11 board members, BOP DHB includes one invited representative from the Maori Health Runanga
  - Hutt Valley DHB has 11 board members, plus a Crown Monitor
  - CCDHB has 10 members (due to the passing of Dr Don Urquhart-Hay last year), plus a Crown Monitor

- Hutt Valley DHB and CCDHB share four elected and appointed members across the two Boards

- Statutory Committees
  - CPHAC –14 committees ranging in size 5 to 19 members including two joint DHB committees (Auckland/ Waitemata, Hutt Valley/Capital & Coast)
  - DSAC –14 committees ranging in size from 5 to 15 including two joint DHB committees (Auckland/ Waitemata, Hutt Valley/Capital & Coast) and one Aged & Disability Support Advisory Committee (ADSAC at Tairawhiti)
  - Combined CPHAC/DSAC – 4 committees ranging in size from 10 to 14 (Northland, Waikato, Taranaki, Canterbury)
  - HAC – 20 committees ranging in size from 5 to 14 including Health Waikato Advisory Committee at Waikato DHB

- Audit Committee
  - 20 Audit and Risk Management Committees
    Variations of this committee, some including finance and IT including 1 Group Audit Committee (which is supported by a Hospital Audit Sub Committee and a Funding Audit Sub Committee)
    HVH and CCH DHBs have a common Chair for their FRAC

- Remuneration Committee
  - 10 Remuneration Committees

- Other Committees (25 in total)

  Maori Health Committees (15)
  - Maori Health Gains Council (Northland DHB) (1)
  - Maori Health Gain Advisory Committee (MHGAC) (South Canterbury and a joint committee Auckland/Waitemata)(2)
  - Iwi Maori Council – Waikato (1)
  - Maori Health Runanga - Bay of Plenty (1)
  - Te Waiora o Nukutaimemeha – Tairawhiti (1)
  - Maori Relationship Board (MRB) – Hawkes Bay (1)
  - Te Roopu Hauora o Te Arawa –Lakes (1)
  - Te Nohanga Kotahitanga o Tuwharetoa – Lakes (1)
  - Maori Partnership Board – Hutt Valley combined with Capital Coast (1)
  - Iwi Health Board – Nelson Marlborough (1)
  - Iwi Governance Committee (IGC) – Southern (1)
  - Te Iwi Kainga - Wairarapa (1)
  - Maori Health Advisory Committee - DHB Committee not a Statutory Committee – South Canterbury (1)
  - POU Committee- Counties (1) – (currently under review)

Pacific Health Committees (2)

- Sub-regional Pacific Health Strategy Group – Hutt Valley combined with Capital Coast (1)
- Pacific Health Advisory Committee (PHAC) - Counties (1)

Facility Development Committees (3)

- Campus Redevelopment Advisory Committee - Waikato (1)
- Facilities Development Project Committee - Canterbury (1)
- Facilities Management & Planning Committee (FMP) Counties (1)

Others (5)

- Health Rotorua PHO - Lakes (1)
- Clinical Board – Tairawhiti (1)
- Enable New Zealand Governance Group – Mid-Central (1)
- Nelson Marlborough Hospitals' Charitable Trust – Nelson Marlborough (1)
- Clinical Advisory Committee (CAC) – Southern (1)

The responses from DHBs are tabled in Appendix One.

7. Shared Services Agencies

A request was sent to the DHB Shared Services Agencies asking for information about their board and their board committees. A summary of the responses received is as follows, details can be found in Appendix One.

Health Share Ltd

- 5 board members made up of 5 DHB CEs

Central TAS Ltd

- 6 board members made up of 6 DHB CEs

South Island Alliance

- 5 board members made up of 5 DHB Chairs
- Alliance leadership team, made up of 4 South Island DHB CEs
- Strategic Planning and Integration Team, made up of 8 members

Appendix Two:

The Ten Principles of Policy Governance

Looking for a precise description of the 10 principles of the Policy Governance model? This official document lays out what IS and IS NOT Policy Governance.

POLICY GOVERNANCE® SOURCE DOCUMENT

Why a Source Document?

A "source" is a point of origin. A source document is a "fundamental document or record on which subsequent writings, compositions, opinions, beliefs, or practices are based." (Webster's)

Without a simply expressed clear point of source, interpretations, opinions, writings and implementations may intentionally or unintentionally diverge from the originating intent and ultimately be undifferentiated. The point of source ("authoritative source") is John Carver, the creator of Policy Governance, with Miriam Carver his fellow master teacher.

Without a simply expressed clear source document, Policy Governance is not reliably grounded and not transferable as a paradigm of governance. It is left vulnerable to interpretation, adaptation and impotence. This document has been produced by the International Policy Governance Association and approved by John and Miriam Carver as being true to source.

What Policy Governance is NOT!

1. Policy Governance is not a specific board structure. It does not dictate board size, specific officers, or require a CEO. While it gives rise to principles for committees, it does not prohibit committees nor require specific committees.
2. Policy Governance is not a set of individual "best practices" or tips for piecemeal improvement.
3. Policy Governance does not dictate what a board should do or say about group dynamics, methods of needs assessment, basic problem solving, fund raising, and managing change.
4. Policy Governance does not limit human interaction or stifle collective or individual thinking.

What Policy Governance IS!

Policy Governance is a comprehensive set of integrated principles that, when consistently applied, allows governing boards to realize owner-accountable organizations.
Starting with recognition of the fundamental reasons that boards exist and the nature of board authority, Policy Governance integrates a number of unique principles designed to enable accountable board leadership.

Principles of Policy Governance

1. **Ownership:** The board connects its authority and accountability to those who morally if not legally own the organization—if such a class exists beyond the board itself—seeing its task as servant-leader to and for that group. "Owners," as used in the Policy Governance model, are not all stakeholders, but only those who stand in a position corresponding to shareholders in an equity corporation. Therefore, staff and clients are not owners unless they independently qualify as such.

2. **Governance Position:** With the ownership above it and operational matters below it, a governing board forms a distinct link in the chain of command or moral authority. Its role is commander, not advisor. It exists to exercise that authority and properly empower others rather than to be management's consultant, ornament, or adversary. The board—not the staff—bears full and direct responsibility for the process and products of governance, just as it bears accountability for any authority and performance expectations delegated to others.

3. **Board Holism:** The board makes authoritative decisions directed toward management and toward itself, its individual members, and committees only as a total group. That is, the board's authority is a group authority rather than a summation of individual authorities.

4. **Ends Policies**: The board defines in writing the (a) the results, changes, or benefits that should come about for (b) specified recipients, beneficiaries, or other targeted groups, and (c) at what cost or relative priority for the various benefits or various beneficiaries. These are not all the possible benefits that may occur, but are those that form the purpose of the organization, the achievement of which constitutes organizational success. Policy documents containing solely these decisions are categorized as Ends in the terminology of the Policy Governance model but can be called by whatever name a board chooses, as long as the concept is strictly preserved.

5. **Board Means Policies:** The board defines in writing those behaviours, values-added, practices, disciplines, and conduct of the board itself and of the board's delegation and accountability relationship with its own subcomponents and with the executive part of the organization. Because these are non-ends decisions, they are called board means to distinguish them from ends and staff means. All board behaviours, decisions and documents must be consistent with these pronouncements. In the terminology of the Policy Governance model, documents containing solely these decisions are categorized as Governance Process and Board-Management Delegation but can be called by whatever name a board chooses, as long as the concept is strictly preserved.

6. **Executive Limitations Policies:** The board makes decisions with respect to its staff's means decisions and actions only in a proscriptive way in order simultaneously (a) to avoid prescribing means and (b) to put off limits those means that would be unacceptable even if they work. Policy documents containing solely these decisions are categorized as Executive Limitations in the Policy Governance terminology, but can be called by whatever name a board chooses, as long as the concept is strictly preserved.

7. **Policy "Sizes":** The board's decisions in Ends, Governance Process, Board-Management Delegation, and Executive Limitations are made beginning at the broadest, most inclusive level and, if necessary, continuing into more detailed levels that narrow the interpretative range of higher levels, proceeding one articulated level at a time. These documents are exhaustive, replacing or obviating board expressions of mission, vision, philosophy, values, strategy, and budget. They are called policies in the terminology of the Policy Governance model but can be called by whatever name a board chooses, as long as the concept is strictly preserved.
8. **Delegation to Management:** If the board chooses to delegate to management through a chief executive officer, it honours the exclusive authority and accountability of that role as

the sole connector between governance and management. In any event, the board never delegates the same authority or responsibility to more than one point.

9. **Any Reasonable Interpretation:** In delegating decisions beyond the ones recorded in board policies, the board grants the delegatee the right to use any reasonable interpretation of those policies. In the case of Ends and Executive Limitations when a CEO exists, that delegatee is the CEO. In the case of Governance Process and Board-Management Delegation, that delegatee is the CGO (chief governance officer) except when the board has explicitly designated another board member or board committee.

10. **Monitoring:** The board monitors organizational performance solely through fair but systematic assessment of whether a reasonable interpretation of its Ends policies is being achieved within the boundaries set by a reasonable interpretation of its Executive Limitations policies. If there is a CEO, this constitutes the CEO's evaluation.

All other practices, documents, and disciplines must be consistent with the above principles. For example, if an outside authority demands board actions inconsistent with Policy Governance, the board should use a 'required approvals agenda' or other device to be lawful without compromising governance.

Policy Governance is a precision system that promises excellence in governance only if used with precision. These governance principles form a seamless paradigm or model. As with a clock, removing one wheel may not spoil its looks but will seriously damage its ability to tell time. So in Policy Governance, all the above pieces must be in place for Policy Governance to be effective. When all brought into play, they allow for a governing board to realize owner accountability. When they are not used completely, true owner accountability is not available.

Policy Governance boards live these principles in everything they are, do, and say.

http://www.policygovernanceassociation.org/resources/principles-of-policy-governance.html

SOUTHERN DISTRICT HEALTH BOARD
DRAFT MEETING SCHEDULE 2013

MONTH	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Community and Public Health and Disability Support Advisory Committees 10.00 am	Thurs 07 (Dunedin)		Mon 08 (Qtn)		Wed 05 (Dunedin)	Wed 31 (In'gill)			Wed 02 (In'gill)		Wed 11 (In'gill)
Iwi Governance Committee 12.00 noon	Thurs 07 (Dunedin)	Wed 06 (In'gill)		Wed 01 (In'gill)		Wed 03 (Dunedin)		Wed 04 (Dunedin)		Wed 06 (Dunedin)	Wed 11 (In'gill)
Hospitals Advisory Committee 2.00 pm	Thurs 07 (Dunedin)	Wed 06 (In'gill)	Mon 08 (Qtn)	Wed 01 (In'gill)	Wed 05 (Dunedin)	Wed 03 (Dunedin) Wed 31 (In'gill)		Wed 04 (Dunedin)	Wed 02 (In'gill	Wed 06 (Dunedin)	
Clinical Advisory Committee 5.30 pm	Thurs 07 (by VC)		Mon 08 (by VC)	Wed 01 (In'gill)	Wed 05 (Dunedin)	Wed 03 (Dunedin) Wed 31 (In'gill)		Wed 04 (Dunedin)	Wed 02 (In'gill)	Wed 06 (Dunedin)	
Audit and Risk Committtee 8.00 am		Thurs 07 (In'gill)			Thurs 06 (Dunedin)		Thurs 01 (In'gill)		Thurs 03 (In'gill)		Thurs 12 (In'gill)
Board 10.00 am (unless indicated otherwise)	Friday 08 (Dunedin)	Thurs 07 (In'gill)	Tues 09 (Qtn) **9.30 am**	Thurs 02 (In'gill)	Thurs 06 (Dunedin)	Thurs 04 (Dunedin)	Thurs 01 (In'gill)	Thurs 05 (Dunedin)	Thurs 03 (In'gill)	Thurs 07 (Dunedin)	Thurs 12 (In'gill)

Key dates that impact: ***6 Feb Waitangi Day (shifted meetings forward to Thurs/Fri); 25 March is Otago Anniversary Day and 29 March, 1&2 April Easter (moved to 8&9 April as no mail delivery over Easter weekend for agendas); Mon 3 June is Queen's Birthday (agendas will need to be out early as no delivery over long weekend); Mon 28 Oct is Labour Day.*** As at 21.09.2012

Southern District Health Board

BOARD & ADVISORY COMMITTEES PROPOSED MEETING DAYS 2013

	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	
MON				1 Easter Monday			1						MON
TUE	1 New Year1			2 Southland Ann			2			1			TUE
WED	2 New Year2			3	1 Committees		3 Committees			2 Committees			WED
THU	3			4	2 BOARD		4 BOARD	1 BOARD		3 BOARD			THU
FRI	4	1	1	5	3		5	2		4	1		FRI
SAT	5	2	2	6	4	1	6	3		5	2		SAT
SUN	6	3	3	7	5	2	7	4	1	6	3	1	SUN
MON	7	4	4	8 Committees	6	3 Queens Birthday	8	5	2	7	4	2	MON
TUE	8	5	5	9 BOARD	7	4	9	6	3	8	5	3	TUE
WED	9	6 Waitangi Day	6 Committees	10	8	5 Committees	10	7	4 Committees	9	6 Committees	4	WED
THU	10	7 Committees	7 BOARD	11	9	6 BOARD	11	8	5 BOARD	10	7 BOARD	5	THU
FRI	11	8 BOARD	8	12	10	7	12	9	6	11	8	6	FRI
SAT	12	9	9	13	11	8	13	10	7	12	9	7	SAT
SUN	13	10	10	14	12	9	14	11	8	13	10	8	SUN
MON	14	11	11	15	13	10	15	12	9	14	11	9	MON
TUE	15	12	12	16	14	11	16	13	10	15	12	10	TUE
WED	16	13	13	17	15	12	17	14	11	16	13	11 Committees	WED
THU	17	14	14	18	16	13	18	15	12	17	14	12 BOARD	THU
FRI	18	15	15	19	17	14	19	16	13	18	15	13	FRI
SAT	19	16	16	20	18	15	20	17	14	19	16	14	SAT
SUN	20	17	17	21	19	16	21	18	15	20	17	15	SUN
MON	21 Southland Ann	18	18	22	20	17	22	19	16	21	18	16	MON
TUE	22	19	19	23	21	18	23	20	17	22	19	17	TUE
WED	23	20	20	24	22	19	24	21	18	23	20	18	WED
THU	24	21	21	25 Anzac Day	23	20	25	22	19	24	21	19	THU
FRI	25	22	22	26	24	21	26	23	20	25	22	20	FRI
SAT	26	23	23	27	25	22	27	24	21	26	23	21	SAT
SUN	27	24	24	28	26	23	28	25	22	27	24	22	SUN
MON	28	25	25 Otago Ann Day	29	27	24	29	26	23	28 Labour Day	25	23	MON
TUE	29	26	26	30	28	25	30	27	24	29	26	24	TUE
WED	30	27	27		29	26	31 Committees	28	25	30	27	25 Christmas Day	WED
THU	31	28	28		30	27		29	26	31	28	26 Boxing Day	THU
FRI			29 Good Friday		31	28		30	27		29	27	FRI
SAT			30			29		31	28		30	28	SAT
SUN			31			30			29			29	SUN
MON									30			30	MON
TUE												31	TUE
WED													WED
	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	