# BOARD MEETING

## A G E N D A

## Thursday, 3 April 2014

### 10.00 am

### Board Room, Level 2, West Wing, Main Block
### Wakari Hospital Campus
### 371 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, 3 April 2014, 10.00 am**

**Board Room, Wakari Hospital Campus, Dunedin**

## A G E N D A

## Public Excluded Session:

**RESOLUTION:**
That the Board exclude the public for 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** | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Annual Plan Update** | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **HBL Update** | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Wakatipu Update** | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **South Link Health – Retained Earnings** | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Electronic Agendas** | Commercial sensitivity | As above, section 9(2)(i). |
| **Sensitive Expenditure and Related Policies** | To allow activities 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:* |
|---|---|---|
| **Public Excluded Advisory Committee Reports**<br>a) Disability Support and Community & Public Health Advisory Committees<br>▪ 5 March 2014<br>b) Hospital Advisory Committee<br>▪ 5 March 2014<br>c) Audit & Risk Committee<br>▪ 6 March 2014 | Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage<br><br>Annual plans are subject to Ministerial approval. | As above, sections 9(2)(f)(iv) and 9(2)(j). |
| **Contract Approvals**<br>▪ Planning & Funding<br>▪ Provider Arm | 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). |
| **Health Connect South Clinical Portal Business Case** | 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). |
| **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). |

# SOUTHERN DISTRICT HEALTH BOARD

# INTERESTS REGISTER

| Board Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB |
|---|---|---|---|
| **Joe BUTTERFIELD (Chairman)** | 21.11.2013<br><br><br><br><br><br><br><br><br><br><br><br><br>06.12.2010 | Membership/Directorship/Trusteeship:<br>1. Beverley Hill Investments Ltd<br>2. Footes Nominees Ltd<br>3. Footes Trustees Ltd<br>4. Ritchies Transport Holdings Ltd (alternate)<br>5. Ritchies Coachlines Ltd<br>6. Ritchies Intercity ltd<br>7. Robert Butterfield Design Ltd<br>8. SMP Holdings ltd<br>9. Burnett Valley Trust<br>10. Burnett Family Charitable Trusts<br>**Son-in-law:**<br>11. Partner, Polson Higgs, Chartered Accountants.<br>12. Trustee, Corstorphine Baptist Community Trust | 1. Nil<br>2. Nil<br>3. Nil<br>4. Nil<br>5. Nil<br>6. Nil<br>7. Nil<br>8. Nil<br>9. Nil<br>10. Nil<br>11. Does some accounting work for Southern PHO.<br>12. Has a mental health contract with Southern DHB. |
| **Tim WARD (Deputy Chair)** | 14.09.2009<br><br>01.05.2010<br>01.05.2010<br><br>10.12.2012 | 1. Partner, BDO Invercargill, Chartered Accountants.<br>2. Trustee, Verdon College Board of Trustees.<br>3. Council Member, Southern Institute of Technology (SIT).<br>4. Director of Southern Community Laboratories Otago-Southland. | 1. May have some Southern DHB patients and staff as clients.<br>2. Verdon is a participant in the employment incubator programme.<br>3. Supply of goods and services between Southern DHB and SIT. |
| **John CHAMBERS** | 09.12.2013 | 1. Employee Southern DHB and Vice President of ASMS (Otago Branch)<br>2. Employed 0.05 FTE as an Honorary Lecturer of the Dunedin Medical School<br>3. Director of Chambers Consultancy Ltd<br>**Wife:**<br>4. Employed by the Southern DHB (NIR Co-ordinator)<br>**Daughter:**<br>5. Employed by the Southern DHB (Radiographer) | 1. Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.<br>2. Possible conflicts between SDHB and University interests.<br>3. Consultancy includes performing expert reviews and reports regarding patient care at the request of other DHBs and the Office of the Health and Disability Commissioner. |

| Board Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB |
|---|---|---|---|
| **Neville COOK** | 04.03.2008<br>26.03.2008<br>11.02.2014 | 1. Councillor, Environment Southland.<br>2. Trustee, Norman Jones Foundation.<br>3. Southern Health Welfare Trust (Trustee). | 1. Nil.<br>2. Possible conflict with funding requests.<br>3. Southland Hospital Trust. |
| **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<br>14.08.2008<br>12.02.2009<br><br>05.09.2012<br><br>01.03.2012 | 1. Employee of Crowe Horwath NZ Ltd<br>2. Trustee of Wakatipu Plunket Charitable Trust.<br>3. Corresponding member for Health and Family Affairs, National Council of Women.<br>4. Trustee for No 10 Youth Health Centre, Invercargill.<br>5. DHB representative on the Gore Social Sector Trial Stakeholder Group. | 1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of Crowe Horwath NZ Ltd<br>2. Nil.<br>3. Nil.<br>4. Possible conflict with funding requests.<br>5. Nil. |
| **Mary GAMBLE** | 09.12.2013 | 1. Member, Rural Women New Zealand. | 1. RWNZ is the owner of Access Home Health Ltd, which has a contract with the Southern DHB to deliver home care. |
| **Anthony (Tony) HILL** | 09.12.2013 | 1. Chairman, Southern PHO Community Advisory Committee and ex officio Southern PHO Board.<br>2. Secretary/Manager, Lakes District Air Rescue Trust.<br>3. Community Representative, National Health Board Review Group, Lakes District Hospital.<br>**Daughter:**<br>4. Registrar, Dunedin Hospital. | 1. Possible conflict with PHO contract funding.<br>2. Possible conflict with contract funding.<br>3. Possible conflicts between Southern DHB and local Lakes District Hospital community interests. |
| **Tuari POTIKI** | 09.12.2013 | 1. University of Otago staff member.<br>2. Deputy Chair, Te Rūnaka o Ōtākou.<br>3. Chair, NZ Drug Foundation.<br>**Wife:**<br>4. CEO of Māori Health Provider, Otepoti. | 1. Possible Conflicts between Southern DHB and University interests.<br>2. Possible conflict with contract funding.<br>3. Nil.<br>4. Possible conflict with contract funding. |
| **Branko SIJNJA** | 07.02.2008<br><br>04.02.2009<br><br><br>22.06.2010<br><br>07.06.2012 | 1. Director, Clutha Community Health Company Limited.<br>2. 0.8 FTE Director Rural Medical Immersion Programme, University of Otago School of Medicine.<br>3. 0.2 FTE Employee, Clutha Health First General Practice.<br>4. Director of Southern Community Laboratories.<br>5. | 1. Operates publicly funded secondary health services under contract to Southern DHB.<br>2. Possible conflicts between Southern DHB and University interests.<br>3. Employed as a part-time GP. |

| Board Member | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern DHB |
|---|---|---|---|
| **Richard THOMSON** | 13.12.2001<br><br><br>23.09.2003<br>29.03.2010<br>06.04.2011<br>21.11.2013 | 1. Managing Director, Thomson & Cessford Ltd.<br>2. Chairperson and Trustee, Hawksbury Community Living Trust.<br>3. Trustee, HealthCare Otago Charitable Trust.<br>4. Chairman, Composite Retail Group.<br>5. Councillor, Dunedin City Council.<br>6. Two immediate family members are employees of Dunedin Hospital (Radiographer and Anaesthetic Technician). | 1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it.<br>2. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB.<br>3. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations.<br>4. May have some stores that deal with Southern DHB. |
| **Janis Mary WHITE (Crown Monitor)** | 31.07.2013 | 1. Member, Pharmac Board.<br>2. Chair, CTAS (Central Technical Advisory Service). | |

# SOUTHERN DISTRICT HEALTH BOARD

## INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at February 2014

| Employee Name | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern District Health Board |
|---|---|---|---|
| Peter Beirne | 20.06.2013 | Nil | |
| Sandra Boardman | 07.02.2014 | Nil | |
| Richard Bunton | 17.03.2004<br><br><br><br><br>22.06.2012<br><br>29.04.2010 | 1. Managing Director of Rockburn Wines Ltd.<br>2. Director of Mainland Cardiothoracic Associates Ltd.<br>3. Director of the Southern Cardiothoracic Institute Ltd.<br>4. Director of Wholehearted Ltd.<br>5. Chairman, Board of Cardiothoracic Surgery, RACS.<br>6. Trustee, Dunedin Heart Unit Trust.<br>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.<br>2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract.<br>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.<br>4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists.<br>5. No conflict.<br>6. No conflict.<br>7. No conflict. |
| Donovan Clarke | 02.02.2011<br><br>26.08.2013 | 1. Te Waipounamu Delegate, Te Piringa, National Māori Disability Advisory Group.<br>2. Chairman, Te Herenga Hauora (Regional Māori Health Managers' Forum).<br>3. Member, Southern Cancer Network Steering Group.<br>4. Board member, Te Rau Matatini.<br>5. Te Waipounamu Māori Cancer Leadership Group | 1. Nil.<br>2. Nil.<br>3. Nil.<br>4. Nil.<br>5. Nil. |
| Carole Heatly | 11.02.2014 | 1. Southern Health Welfare Trust (Trustee). | 1. Southland Hospital Trust. |
| Lynda McCutcheon | 22.06.2012 | 1. Member of the University of Otago, School of Physiotherapy, Admissions Committee. | 1. Lead contact for University of Otago undergraduate clinical placements (Allied Health, Scientific & Technical professions) in Southern DHB. |

| Employee Name | Date of Entry | Interest Disclosed | Nature of Potential Interest with Southern District Health Board |
|---|---|---|---|
| Lexie O'Shea | 01.07.2007 | 1. Trustee, Gilmour Trust. | 1. Southland Hospital Trust. |
| John Pine | 17.11.201 | Nil. | |
| Dr Jim Reid | 22.01.2014 | 1. Director of both BPAC NZ and BPAC Inc<br>2. Director of the NZ Formulary<br>3. Trustee of the Waitaki District Health Trust<br>4. Employed 2/10 by the University of Otago and am now Deputy Dean of the Dunedin School of Medicine.<br>5. Partner at Caversham Medical Centre and a Director of RMC Medical Research Ltd. | |
| Leanne Samuel | 01.07.2007<br>01.07.2007 | 1. Southern Health Welfare Trust (Trustee).<br>2. Member of Community Trust of Southland Health Scholarships Panel. | 1. Southland Hospital Trust.<br>2. Nil. |
| David Tulloch | 23.11.2010<br><br>02.06.2011<br><br>17.08.2012 | 1. Southland Urology (Director).<br>2. Southern Surgical Services (Director).<br>3. UA Central Otago Urology Services Limited (Director).<br>4. Trustee, Gilmour Trust. | 1. Potential conflict if DHB purchases services.<br>2. Potential conflict if DHB purchases services.<br>3. Potential conflict if DHB purchases services.<br>4. Southland Hospital Trust. |

# Minutes of the Southern District Health Board Meeting

## Wednesday, 6 March 2014, 10.40 am
## Board Room, Southland Hospital Campus, Invercargill

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| | | |
|---|---|---|
| **Present:** | Mr Joe Butterfield | Chair |
| | Mr Tim Ward | Deputy Chair |
| | Dr John Chambers | |
| | Mr Neville Cook | |
| | Ms Sandra Cook | |
| | Mrs Kaye Crowther | |
| | Mrs Mary Gamble | |
| | Mr Tony Hill | |
| | Dr Branko Sijnja | |
| | Mr Richard Thomson | |
| **In Attendance:** | Dr Jan White | Crown Monitor |
| | 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 Peter Beirne | Executive Director Finance |
| | Mrs Sandra Boardman | Executive Director Planning & Funding |
| | Mrs Leanne Samuel | Executive Director Nursing & Midwifery |
| | Mr David Tulloch | Chief Medical Officer |
| | Ms Cherie Wells | General Manager Corporate Services |
| | Ms Jeanette Kloosterman | Board Secretary (by videoconference) |



### 1.0 CHAIR'S OPENING COMMENTS

The Chair welcomed everyone to the meeting.

### 2.0 APOLOGIES

An apology was received from Mr Tuari Potiki.

### 3.0 DECLARATION OF INTERESTS

***It was resolved:***

**"That the Interests Register be noted."**

### 4.0 CONFIRMATION OF PREVIOUS MINUTES

***It was resolved:***

**"That the minutes of the 5 February 2014 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 that were not covered by the agenda.

## 6.0 ACTION SHEET

The Board reviewed the action sheet (agenda item 6).

***It was resolved:***

**"That the action sheet be received."**

## 7.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's (CEO's) monthly report (agenda item 7) was taken as read and the CEO took questions from members.

**IT System Issue**

The Board noted the CEO's assurance that IT systems were being reviewed with the assistance of the external auditor and the national IT Manager to ensure they were properly configured. The CEO also advised that suggestions in the local media that the Board had deferred expenditure on its IT infrastructure because of its deficit situation were incorrect; $2 milllion was spent on IT systems last year and at least that would be spent in the current year.

***It was resolved:***

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

## 8.0 FINANCIAL REPORT

The Executive Director Finance presented the Financial Report for the period ended 31 January 2014 (agenda item 8), then took questions from members on the financial statements.

The Board requested information on the long term investments recorded in the Balance Sheet.

***It was resolved:***

**"That the Financial Report be received.**"

## 9.0 ADVISORY COMMITTEE REPORTS

**Disability Support Advisory Committee and Community & Public Health Advisory Committee**

The minutes of the Disability Support Advisory Committee (DSAC) and Community & Public Health Advisory Committee (CPHAC) meeting held on 4 February 2014 were circulated with the agenda (item 9a).

**Rural Funding Mechanism for General Practices**

The Executive Director Planning & Funding informed the Board that the information presented at the February DSAC/CPHAC meeting stating that Queenstown practices did not meet the criteria for rural funding was incorrect. There was a list of 15 practices that did not meet the criteria but none were in the Southern DHB. This meant that Southern DHB's rural funding would not be reduced but it was unknown what the future criteria would be.

***It was resolved:***

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

Ms Cook, DSAC and CPHAC Chair, gave a verbal report on the meeting held on 5 March 2014 and tabled recommendations from the Committees on their terms of reference and the Southern DHB health profile.

***It was resolved:***

**"That the verbal report be received."**

**Disability Support Advisory Committee and Community & Public Health Advisory Committee Terms of Reference** (agenda item 9c)

The Committees recommended their terms of reference be further modified as follows:

- That a minimum of eight meetings per year be held;
- That item 8 of the Community & Public Health Advisory Committees' responsibilities be amended to read, "Providing advice, *in collaboration with the Iwi Governance Committee*, on strategies to reduce disparities ..."

***It was resolved:***

**"That the Board approve the Disability Support Advisory Committee and Community & Public Health Advisory Committee terms of reference as modified."**

**Southern District Health Profile**

Ms Cook reported that the Iwi Governance Committee had requested that Māori and Pacific Island data be recorded separately.

***It was resolved:***

**"That the Board ratify the Southern District Health Profile for DHB use and note the request for the Pacific Island and Māori statistical information to be separated out."**

**<u>Hospital Advisory Committee</u>**

The minutes of the Hospital Advisory Committee (HAC) meeting held on 4 February 2014 were circulated with the agenda (item 10a).

***It was resolved:***

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

Mr Butterfield, HAC Chair, gave a verbal report on the HAC meeting held on 5 March 2014 and informed the Board that HAC would not be meeting in April. Recommendations from the HAC on health and safety issues and its terms of reference were tabled.

***It was resolved:***

**"That the verbal report be received."**

**Occupational Health and Safety Report**

***It was resolved:***

**"That the Board:**

- **Receive the report and support the work being undertaken to address Southern DHB's strategy;**
- **Receive the report (appendix 1) and note the current accident injury reports;**
- **Receive the report (appendix 2) and note the height safety audit undertaken by Building and Property Services."**

**Hospital Advisory Committee Terms of Reference** (agenda item 10c)

***It was resolved:***

**"That the Board approve the Hospital Advisory Committee terms of reference as modified and note that the number of meetings held is to be discussed further."**

**Iwi Governance Committee**

The Board received a verbal report from Ms Cook on the meeting of the Iwi Governance Committee (IGC) held on 5 March 2014.

The Board:

- Noted that Odele Stehlin from the Waihopai Runaka had been elected Chair of IGC;
- Agreed to IGC's request that they meet monthly for the next three months and further consideration is to be given to their meeting schedule following that.

***It was resolved:***

**"That the verbal report be received."**

**Audit and Risk Committee**

**Deficit Support**

Mr Ward, Audit and Risk Committee (ARC) Chair, reported that the ARC had considered a request for deficit support for the 2013/14 financial year earlier that morning and recommended it be approved by Board.

***It was resolved:***

> **"That the Board request $4.5 million of deficit support from the Minister of Health, which was the amount budgeted to be received in December 2013 and half of the $9.0 million deficit support signalled in the Annual Plan."**

**Health Emergency Plan 2013-16**

Mr Ward, ARC Chair, informed the Board that the Health Emergency Plan for 2013-2016 had been approved by management and considered by the ARC earlier that morning.

***It was resolved:***

> **"That the Board endorse the Southern DHB Health Emergency Plan (HEP) 2013-2016 and note that it supersedes the Otago District Health Board Major Incident Emergency Plan 2005 and the Southland District Health Board Major Incident and Emergency Plan 2006-2009."**

The Board requested clarification of its role in the event of an emergency.

## 10.0 CONTRACTS REGISTER

The Funding contracts register (expenses) for February 2014 was circulated with the agenda (item 13) for members' information.

In response to members' questions, the Executive Director Finance advised that the Finance team also maintained a contracts register and payments were made in accordance with the delegations process. Funding contracts were not part of the Oracle system.

The Executive Director Planning & Funding advised that she would include information on the level of delegation with the next Funding contract register.

The Board requested information on the variation to the Student Health Services contract for after-hours services in Dunedin.

***It was resolved:***

> **"That the Board receive the contracts register and note that management will provide advice on the approval process."**

**PUBLIC EXCLUDED SESSION**

***At 11.45 am, 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 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** | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Annual Plan**<br>a) Southern Way Update<br>b) 2014/15 PBF Allocation | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Public Excluded Advisory Committee Reports**<br>a) Disability Support and Community & Public Health Advisory Committees<br>▪ 4 February 2014<br>▪ 5 March 2014<br>▪ Laboratories Contract<br>b) Iwi Governance Committee<br>▪ Draft Māori Health Plan 2014/15<br>c) Hospital Advisory Committee<br>▪ 4 February 2014<br>▪ 5 March 2014<br>▪ Contract Approvals<br>d) Audit & Risk Committee<br>▪ 6 March 2014 | Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage<br><br>Annual plans are subject to Ministerial approval. | As above, sections 9(2)(f)(iv) and 9(2)(j). |
| **Risk Report** | To allow activities 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:*** |
|---|---|---|
| **Legal Issues** | To allow activities to be carried on without prejudice or disadvantage | As above, section 9(2)(j). |

*The public session of the meeting then closed.*

Confirmed as a true and correct record:

Chairman: _____

Date: _____

# Southern District Health Board

# BOARD MEETING ACTION SHEET

## As at 25 March 2014

| Action Point No. | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| 212-2013/05<br><br>226-2013/07 | **Pharmaceuticals**<br>(Minute item 8.0) | CMO to report back on the amount of medication prescribed and dispensed to patients at any one time and any related waste and safety issues.<br><br>The matter to be referred to the Southern Health Alliance Leadership Team to consider whether any savings can be achieved by primary care, hospital services and pharmacists working together to reduce waste. | CMO | Work in progress – on SHALT agenda. The first step in this process is the demand side management of pharmaceutical expenditure project. | |
| 256-2013/12 | **Workplace Health and Safety**<br>(Minute item 10.0) | ▪ Broader report on workplace health and safety is required (ARC to consider future reporting requirements);<br>▪ Suggestion that future reporting show the trend over five years by category and by comparison with the DHB's peers. | EDHR | | May 2014 |
| 268-2014/03 | **Financial Report**<br>(Minute item 8.0) | Detail to be provided on the long term investments recorded in the Balance Sheet. | EDF | These are investments in HBL. | Completed |
| 270-2014/03 | **Health Emergency Plan 2013-16**<br>(Minute item 9.0) | The Board's role in an emergency to be clarified. | EDN&M | The SDHB governance board will support the Executive Leadership Team by horizon scanning for the future direction of the Southern DHB as the organisation moves through the Response and then | Completed |

| Action Point No. | SUBJECT | ACTION REQUIRED | BY | STATUS | EXPECTED COMPLETION DATE |
|---|---|---|---|---|---|
| | | | | onto the Recovery phases of an Emergency. This setting of the future strategy allows for the oversight to ensure that the main principles and goals for the Southern DHB are maintained.<br><br>Whilst the Incident Management Team are focussed on the short to medium term direction of the emergency, it is important for the Executive Leadership Team and SDHB Governance board to have a future facing strategy for the long term return to service provision for the community it serves. | |
| 271-2014/03 | **Funder Contracts Register**<br>(Minute item 10.0) | ▪ Management to provide information on the delegations/approval process;<br>▪ Information to be provided on the Student Health Services contract for after-hours services in Dunedin. | EDP&F | ▪ Amended register with delegation levels included in the agenda.<br>▪ Southern DHB provides funding for the Otago Polytechnic Student Health to purchase overnight cover from the Dunedin ED department. This initiative is funded from and forms part of our after-hours contract agreement with the Ministry of Health. | |
| 277-2014/03 | **Forecast**<br>(Confidential minute item 14.0) | To be recast for the April meeting. | EDF | | Completed |

# SOUTHERN DISTRICT HEALTH BOARD

| | |
|---|---|
| **Title:** | **CHIEF EXECUTIVE OFFICER'S REPORT** |
| **Report to:** | Board |
| **Date of Meeting:** | 3 April 2014 |

**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. | **Date:** n/a |
| **Approved by Chief Executive Officer:** | | **Date:** 25/03/2014 |

| | |
|---|---|
| **Prepared by:**<br><br>**Date:** 24/03/2013 | **Presented by:**<br>Carole Heatly<br>Chief Executive Officer |

**RECOMMENDATION:**

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

# CHIEF EXECUTIVE OFFICER'S REPORT

## 1. DHB FINANCIAL PERFORMANCE

The February result was a surplus of $2.8m which was unfavourable to budget by $0.3m. Year to date the result is a deficit of $3.5m for eight months, against a full year budget deficit of $9m. A detailed analysis of the financial situation is contained in the Financial Report.

## 2. PROVIDER ARM

A detailed report on Provider Arm activity is attached as agenda item 8.

## 3. PLANNING AND FUNDING

### Annual Plan, Statement of Intent (SOI), and Māori Health Plan

Southern DHB submitted the draft Annual Plan/SOI 2014/15 and Māori Health Plan 2014/15 to the Ministry of Health and National Health Board (NHB) on 14 March 2014. Formal feedback on the plans is expected 28 April.

Additional guidance from the Ministry/NHB is expected in a number of areas. Work will continue on the plans in the interim. All DHBs are scheduled to submit the second drafts of all plans by 26 May 2014.

All plans will be released publically once authorised by the Ministry of Health.

### Mental Health and Addictions

Work continues on the development of a comprehensive implementation plan for Raise HOPE – Hapai te Tumanako. Work is also underway to implement a district wide network model which will support stakeholders across mental health and addiction services to work as one sector, with a systems approach.

Aroha Ki Te Tamariki Charitable Trust (the Mirror Counselling service) is progressing establishment of the Otago/Southland exemplar co-existing mental health and alcohol and other drug service. This new service is funded as part of the Prime Minister's youth mental health initiatives. Staff recruitment is in progress and the service is expected to be officially opened in early April.

### Laboratory Services

*Clinical Laboratory Advisory Group*

A Clinical Laboratory Advisory Group (CLAG) is being established which will be responsible for on-going endorsement of any new test referral. Once endorsement is obtained from the CLAG, the new test application is then referred to senior management to approve funding. Applications declined by CLAG will be communicated to the referrer.

### Primary Care

*More Heart and Diabetic Checks*

Southern DHB is concerned about the lack of progress towards meeting the Ministry of Health (MoH) "More Heart and Diabetic" targets. Additional funding has been received from the MoH but very little progress has been made (currently just over 64%) towards the target of 90% (to be achieved by June 2014).

Southern DHB (SDHB) is to invite Karen Evison, National Programme Manager and Diabetes Champion with the National Health Board (NHB), to a meeting on 25 March with SDHB and Southern Primary Health Organisation (SPHO) management and clinical staff to discuss strategies to improve SDHB delivery of CVD Risk Assessment activities.

On-going discussions have also occurred with SPHO staff, who are in the process of recruiting additional staff to enhance the existing resource. In addition, SPHO has been trialling a new software package to improve the integrity of CVD data.

Both SDHB and SPHO are committed to achieving the MoH target by the June deadline.

### Health of Older Persons

Southern DHB was notified of variation B53 to our Crown Funding Agreement (CFA) on 28 November 2013 for an additional $382,000 per annum for two years to increase the price paid for Home and Community Support Services (HCSS). Southern DHB has agreed to use this money to increase the bulk fund for Health of Older People Restorative Home and Community Support Services in fiscal years 2013/14 and 2014/15. Providers were notified of this on 12 March 2014.

Our three HCSS Alliance providers (Access Homehealth, Healthcare NZ, and Royal District Nursing NZ) have formally communicated to us their difficulties with our bulk funded agreement to provide Home and Community Support Services to our older people. The hours of service delivered have increased since the agreement was negotiated. We are investigating and will continue discussions with providers.

## 4. DUNEDIN HOSPITAL FACILITIES

The Southern DHB Chairman wrote to the National Capital Investment Committee in October 2013 in regard to the Dunedin campus facilities, requesting the Committee's advice on the way forward for long term master planning and short term decisions such as deferred maintenance. The letter reiterated that it is clear there is a need for substantial investment in the Dunedin campus and Southern DHB faces a dilemma between maintenance of ongoing service provision and avoidance of wasteful medium term expenditure in the absence of an agreed master plan.

The Capital Investment Committee held its March 2014 meeting in Dunedin and Committee members were taken on a brief site tour and updated on issues by management. Discussion included:

- Dunedin campus overview and issues
- Recent Paeds/NICU and other 2008 master site work now completed
- Remaining Master Site 2008 priorities
- Re-lifeing analysis of campus
- Deferred maintenance

- Health Profile and future service and facilities planning
- University facilities on campus

Capital investments business cases are required to conform with the multi-stage Treasury Better Business case format. A strategic assessment is first stage in the Better Business Case process, and Southern DHB is required to work with the National Health Board and Treasury on the preparation of this strategic assessment. Based on this assessment, the Capital Investment Committee will make a yes/no decision on moving to an indicative business case, the second step.

**Discussion with University of Otago**

The Otago University/Southern DHB Joint Relations Committee agreed that SDHB follow up with the University Chief Operating Officer concerning the University occupied areas on the Southern DHB Dunedin Hospital Campus. The University contributed to the hospital campus development in about 1980 - 20% of the cost of the Ward Block. The University occupies about 20% of the Dunedin Hospital campus. There have been numerous historical discussions on this topic without resolution. There is no lease agreement despite past efforts to formalise the relationship.

The University has agreed to consider formalising the relationship and a meeting is scheduled for 26 March 2014.

**Donation from Rotary**

I am pleased to report that I have been asked to accept a cheque for $100,000 from Rotary on Saturday, 29 March, for the Children's Ward at Dunedin Hospital.

## 5. RIS/PACS

In November 2013 the Board approved a business case for a single district wide Radiology Information System (RIS) at a cost of $743,709. The Southern DHB Capital Approval Committee had already approved a Picture Archiving System (PACS) within delegations.

Both business cases were required to progress via the National Health IT Board and the Director General of Health. Formal approval was received on Monday, 25 March 2014 (subject to two minor conditions in regard to project planning and reporting). Implementation planning and procurement will now be advanced and the decision will be communicated to staff.

## 6. NEW ZEALAND NURSES ORGANISATION (NZNO)

Regular constructive meetings are being held with NZNO. Topics discussed include: vacancy management, meal break cover, care capacity demand management (CCDM), new graduates, reception/clerical support in wards, and ED staffing.

Progress has been made in a number of areas, with a roster stocktake undertaken, a commitment to CCDM process changes, new graduates start date for RNs pulled forward a month sooner than planned, ED staffing benchmarking, etc.

Carole Heatly
**Chief Executive Officer** 25 March 2014

**LATE PAPER – PUBLIC AGENDA**

**SOUTHERN DISTRICT HEALTH BOARD**

| | |
|---|---|
| **Title:** | **Wakatipu Update** |
| **Report to:** | Board |
| **Date of Meeting:** | 03 April 2014 |


**Summary:**

The issues considered in this paper are:

- Information on the Queenstown area noted in the 2014 Health Profile and implications for future service provision
- Work under way to investigate the development of a health campus on the Lakes Hospital site


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

| | |
|---|---|
| **Financial:** | Use of $400,000 oral health capital funding |
| **Workforce:** | Nil |
| **Other:** | Public/private partnership |

| | | |
|---|---|---|
| **Document previously submitted to:** | Executive Meeting | **Date:** 20/03/14 |
| **Approved by Chief Executive Officer:** | | **Date:** 26/03/14 |

| **Prepared by:** | **Presented by:** |
|---|---|
| Sandra Boardman<br>Executive Director Planning & Funding<br><br>**Date:** 26/03/14 | Sandra Boardman<br>Executive Director Planning & Funding |

**RECOMMENDATIONS:**

**The Board is asked to:**

1. **Endorse management seeking approval from the Minister of Health for the establishment of a public/private partnership on Crown land;**
2. **Approve the concept of using oral health capital funding as part of a wider child health development;**
3. **Support further development of age related residential care and other health of older peoples services by BUPA on the Lakes campus;**
4. **Support the production of a report on backlog maintenance and compliance issues at Lakes District Hospital;**

p.t.o.

5. **Support dialogue with Southern PHO about the development of an integrated family health centre;**
6. **Support continued engagement with Southern Cross regarding the level of fixed costs the DHB would accept to support a surgical facility on site;**
7. **Endorse the development of a health campus irrespective of Southern Cross involvement.**

## Introduction

This paper aims to provide the Board with an update on issues and developments in the Wakatipu area.

## 2014 Health Profile

The Profile noted that the Queenstown population has very low average deprivation (Quintile 1) and high levels of enrolment with a PHO. The estimated GP panel size of 1,157 implies that practices in the area are able to attract and retain GPs.

Hospitalisation rates for children are low, as are hospitalisation rates for diabetes. However asthma and respiratory hospitalisation rates are higher than other areas with similar level of deprivation. There are also relatively high unplanned hospitalisation rates, including high rates for injury hospitalisation; and a high rate of alcohol related presentations to ED.

Key changes in the population of the Queenstown area over the next 20 years are projected to be:

- 36% population growth from 19,400-26,400. This is the highest projected increase in the Southern DHB area, both in percentage terms and absolute numbers.
- Change in the population structure towards older age groups:
    - 2% reduction in 0 – 4 years age group
    - 1% reduction in the 5 – 14 years age group
    - 12% reduction in the 15 – 44 years age group
    - 6% increase in the 45 – 64 years age group
    - 4% increase in the 65 – 74 years age group
    - 4% increase in the 75+ years age group
- 5% increase in dependency (proxy for use of health services)

## Implications for Service Development in Wakatipu

- Demands for health services in the area will increase over the next 20 years, particularly those services for older people such as surgery, palliative care, home and community support services and age related residential care.
- Whilst the projected proportion of children under the age of 15 at 2031 will be the lowest in the Southern DHB area, children and young people will still generate significant demand for services such as primary care, oral health, public health nursing and well child services in the Queenstown area. The consolidation of primary and community services for children on a single health campus could provide a one stop shop for families, facilitate peer support for practitioners working with children, and encourage co-location of social services. Such a model would be better able to meet the needs of all families and support whānau ora than a dispersed model.
- Whilst the 15 to 44 year age group is relatively healthy, it also generates significant demand for mental health, drug and alcohol services.

## Facility Implications

As a result of the issues highlighted within the 2014 Health Profile, further work is underway to investigate:

- Transforming the Lakes District Hospital site into a comprehensive health campus for the Wakatipu region;
- Aligning the investment of $400,000 oral health funding with the development of a comprehensive ambulatory service for children and their families/whānau on the Lakes District Hospital site;
- Interest from BUPA in the expansion of rest home, hospital and respite carer support services and the future development of dementia care;
- Interest from local GP practices and Southern PHO in the establishment of an integrated family health centre as part of the health campus;
- Integrating community mental health services into the campus;
- Options for the delivery of elective surgery through a public/private partnership.

The transformation of the Lakes District Hospital site into a health campus designed to meet the future needs of the Queenstown population would require the investment of capital, not only for any new facilities. The cost of backlog maintenance is estimated to be $2.5 million. The cost of bringing the existing facility up to current Building Code Compliance is likely to be the same as a the cost of a new build. These costs would be incurred if any new structure was attached to the existing buildings.

**Direction requested from Board**

The Board is asked to:

- Endorse management seeking approval from the Minister of Health for the establishment of a public/private partnership on Crown land;
- Approve the concept of using oral health capital funding as part of a wider child health development;
- Further develop age related residential care and other health of older peoples services by BUPA on the Lakes campus;
- Produce a report on backlog maintenance and compliance issues at Lakes District Hospital;
- Seek further dialogue with Southern PHO about the development of an integrated family health centre;
- Continue engagement with Southern Cross regarding the level of fixed costs the DHB would accept to support a surgical facility on site;
- Endorse the development of a health campus irrespective of Southern Cross involvement;
- Produce a financial plan which outlines the implications of all of these issues.

Sandra Boardman
Executive Director Planning & Funding

# SOUTHERN DISTRICT HEALTH BOARD

| | |
|---|---|
| **Title:** | **EXECUTIVE DIRECTOR OF PATIENT SERVICES REPORT** |
| **Report to:** | Board |
| **Date of Meeting:** | 03 April 2014 |


**Summary:**

Considered in these papers are:

- February 2014 DHB activity.


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

| | |
|---|---|
| **Financial:** | Yes |
| **Workforce:** | Yes |
| **Other:** | No |

| | | |
|---|---|---|
| **Document previously submitted to:** | Not applicable, report only provided for the Board agenda. | **Date:** N/A |
| **Approved by:** | N/A | **Date:** N/A |

| | |
|---|---|
| **Prepared by:**<br>Executive Director of Patient Services/Deputy CEO<br>**Date:** 19/03/2014 | **Presented by:**<br>Lexie O'Shea<br>Executive Director of Patient Services |

**RECOMMENDATIONS:**

1. **That Board receive this report.**

**Executive Director of Patient Services Report – February 2014**

**Recommendation**

That the Board notes this report.

## *1. Contract Performance*

- Total elective caseweights delivered (cwd) by Southern DHB Provider Arm were 59 under plan in February 2014 (5%). Year to date elective caseweights are 277 under plan (3%).
- Total acute caseweights delivered (cwd) by the Southern DHB Provider Arm were 83 over plan in February 2014 (4%). Year to date (ytd) acute caseweights are 2,553 over revenue plan (13%).
- Elective surgical caseweights remain 3% under plan year to date, driven by lower than planned Cardiothoracic (elective volumes 33% under plan ytd, acute caseweights on plan ytd) and general surgery volumes (8% under plan).
- Elective services remain under plan ytd.

## *2. Health Targets*

**Shorter Stays in Emergency Department (ED)**

- February showed a decrease in the number of ED presentations – 5822 in 2014 and 5916 in 2013, a 1.6% decrease.
- Performance against the '6 Hour Target' across the district was 92.8% in February.
  - Dunedin ED – 92.9% for February
    - Presentations for the month of February increased slightly with 3173 in February 2014, a 5.1% increase on the 3011 presentations in 2013.
    - Initiatives as presented previously continue.
  - Southland ED – 92.6% for February
    - Presentations for the month of February decreased with 2649 in February 2014, an 8.8% decrease on the 2905 presentations in 2013.
    - Initiatives as presented previously continue.
  - The national clinical champion and Ministry of Health senior advisor for ED and acute demand will be visiting both sites early March to provide further advice as to any further initiatives that we should consider to improve this acute patient journey.

**Immunisation**

- In February 2014 Southern DHB achieved 94% against the 90% immunisation health target for coverage of children at 8 months of age and 96% against the 95% health target for coverage of children at 2 years of age.
- The Immunisation Coordinators are supporting the education and promotion of this year's Flu vaccination programme for the primary, community and DHB sectors; with special focus on improved vaccination coverage for health care staff and pregnant women.

**Better Help for Smokers to Quit**

- The February result for the Better Help for Smokers to Quit health target was 93.7% of patients offered advice and help to quit (compared to 92.2% in January). Staff in both Otago and Southland have been promoting quit smoking services across the region including the group cessation sessions that are underway in both Dunedin and Invercargill. Staff are continuing discussions with the Primary Health Organisation regarding the transition of secondary resource going towards the primary sector. There is also ongoing work on how to support the secondary sector in maintaining the 95% target with a reduction in support from the secondary coordinators.

**Shorter Cancer Wait Times**

- We are continuing to achieve the MoH target of 100% of patients starting treatment within four weeks of their first specialist assessment 100% of the time. We have been treating South Canterbury patients (based on diagnosis types and fractionation) since November 2013 at the request of Canterbury DHB who would be the usual providers for these patients. This is likely to be a long-term arrangement so a capacity sharing agreement is in the process of being formalised and initiated. This will obviously result in an increasing workload for us which is likely to continue to grow and for which we currently have the capacity. However, we will continue to monitor the impact to ensure we do not approach breaching the target.

**Improving Access to Elective Services**

- Elective surgical discharges delivered to the Southern population were 46 under plan for the month (5%). Year to date discharges are 26 over plan.

## *3. Operational Performance*

- In ESPI 2 Southern DHB is red for December and January and predicted to be red for February. Additional clinics have been held in the services at risk including general surgery, neurology, ENT orthopaedics, urology and rheumatology. These services will be amber in March 2014.
- In ESPI 5 Southern DHB is amber for December, red for January and predicted to be red for February. The services that are not compliant are general surgery, orthopaedics and urology. Plans are in place to ensure compliance in March.
- All services have plans in place to ensure both ESPI 2 and 5 are amber for March. This must be achieved to ensure there is no financial penalty for the DHB.

Lexie O'Shea, Executive Director of Patient Services

Leanne Samuel, Executive Director of Nursing and Midwifery

Mr Richard Bunton, Medical Director of Patient Services

# Southern DHB
# Hospital Advisory Committee - KPIs
# February 2014 Data

| Patient Safety and Experience - Hospital Healthcheck | | | | |
|---|---|---|---|---|
| ***Monthly*** | **Actual** | **Plan / Target** | **Variance** | **Trend/rating** |
| 3 - Improved access to elective surgical services monthly (population based) | 797 | 843 | -46 (-5.5%) | |
| 3a - Improved access to elective surgical services ytd (population based) | 6,886 | 6,860 | 26 (0.4%) | |

| Patient Safety and Experience - Performance Report | | | | |
|---|---|---|---|---|
| ***Monthly*** | Actual | Plan / Target | Variance | Trend/ rating |
| Waits for Cancer Services | 100% | 100% | 0.0% | |
| 11 - Reduced in stay in ED | 93% | 95% | -2.2% | |
| 15 - Acute Readmission Rates | 10.3% | 9.2% | -1.1% | |

| Population Health | | | | |
|---|---|---|---|---|
| 16 - Smoking cessation - hospitalised smokers provided with advice and help to quit | 94% | 95% | -1.3% | |

**Key -**

Meeting target or plan

Underperforming against target or plan but within thresholds or underperforming but delivering against agreed recovery plan

Underperforming and exception report required with recovery plan

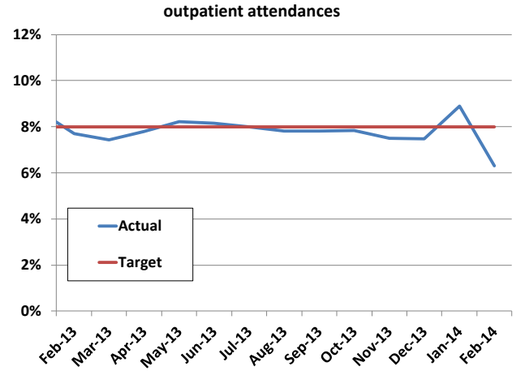
| Cost/Productivity - Hospital Healthcheck | | | | |
|---|---|---|---|---|
| ***Monthly*** | **Actual** | **Plan / Target** | **Variance** | **Trend/rating** |
| 1 - Waits >5 months for FSA | 131 | 0 | -131 | **Jan YTD data** |
| 2 - Treatment >5 months from commitment to treat | 41 | 0 | -41 | **Jan YTD data** |
| 4a - Elective caseweights versus plan (monthly provider arm delivered) | 1,127 | 1,186 | -59 (-4.9%) | |
| 4b - Elective caseweights versus plan (ytd provider arm delivered) | 9,457 | 9,735 | -278 (-2.9%) | |
| 7a - Acute caseweights versus plan (monthly provider arm delivered) | 2,408 | 2,326 | 82 (3.5%) | |
| 7b - Acute caseweights versus plan (ytd provider arm delivered) | 22,810 | 20,257 | 2553 (12.6%) | |
| 10 - Voluntary staff turnover | 0.5% | 0.3% | - | |
| 9 - Staff sick leave rates | 2.6% | 3.5% | 0.9% | |

| Cost/Productivity - Performance Report | | | | |
|---|---|---|---|---|
| ***Monthly*** | Actual | Plan / Target | Variance | Trend/ rating |
| 5 - Reduction in DNA rates | 6.3% | 8.0% | -1.7% | |
| 7 - DOSA rates | 92% | 95% | -3.0% | |
| 9 - ALoS (elective) | 3.14 | 4.02 | 0.88 (21.9%) | |
| ALoS (Acute inpatient) | 4.02 | 4.25 | 0.23 (5.4%) | |
| 14 - % ED attendances admitted | 29% | 30% | 0.8% | |
| 13 - Outlier bed days | 2.5% | | | |
| ***Quarterly*** | | | | |
| 8 - Elective Theatre utilisation | 86% | 88% | -2% | |

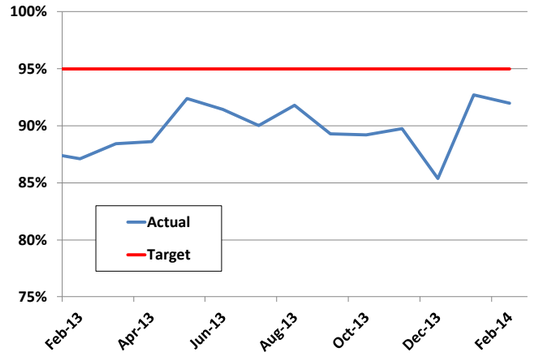
# Southern DHB
# Hospital Advisory Committee - Performance Report
# February 2014 Data

## Elective Care

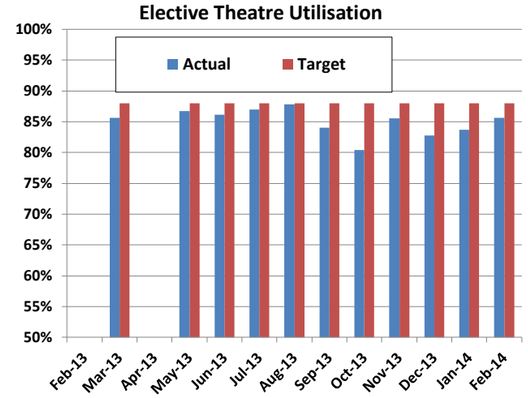
### DNA's (Did Not Attend's) as % of total scheduled outpatient attendances



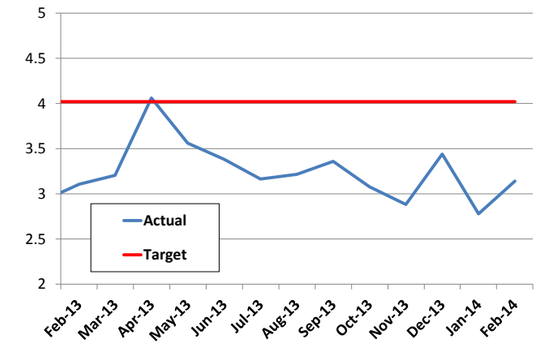

### Day of Surgery Admission (DOSA)




### Elective Theatre Utilisation

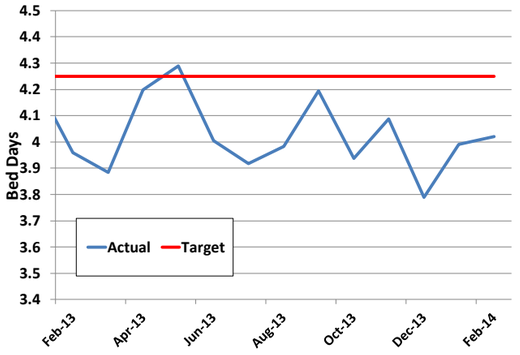



### Elective Average Length of Stay (ALoS)

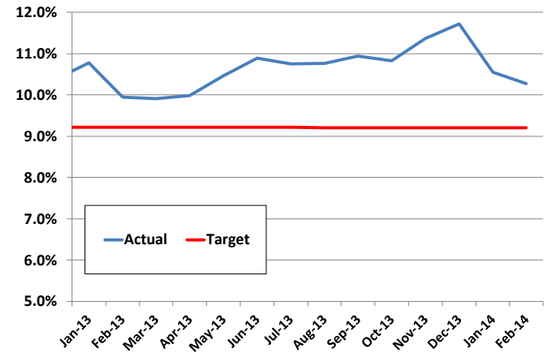



## Acute Care

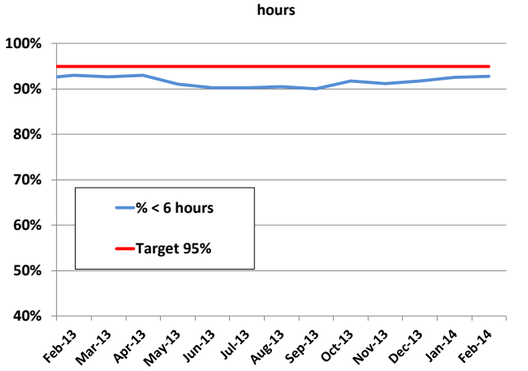
### ALoS (Acute Inpatients)



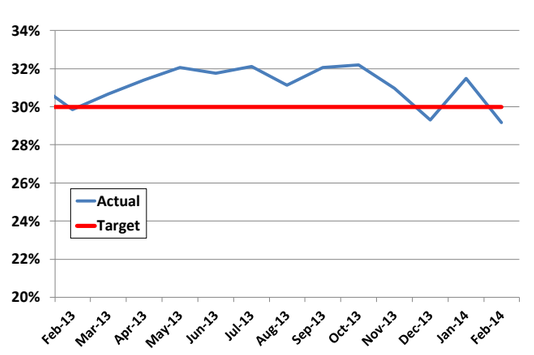

### Acute readmission rates




### Southern DHB - % of ED patients discharged or treated within 6 hours

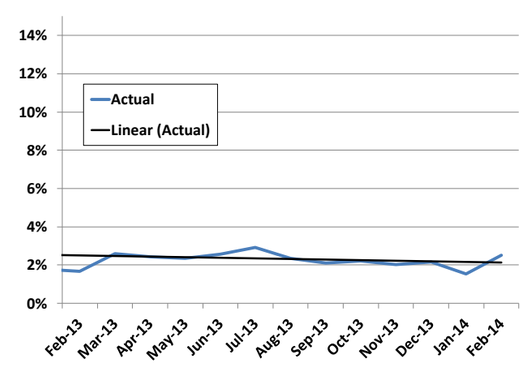



### % Ed attendances admitted




## Acute Care

### Outlier bed days as % of Bednights

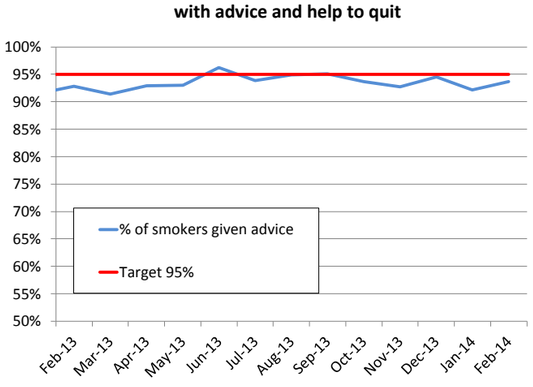



## Bed Reduction Measure

### Total Bed Nights

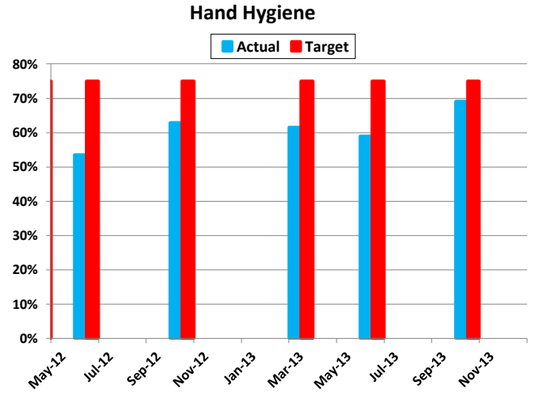

## Quality / Population Health

### Southern DHB - % of hospitalised smokers provided with advice and help to quit



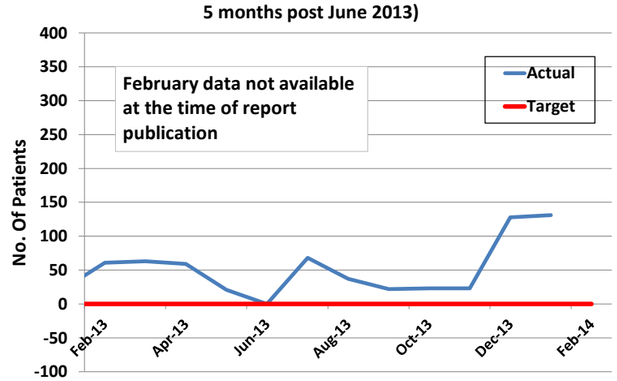

## Quality / Patient Safety / Experience

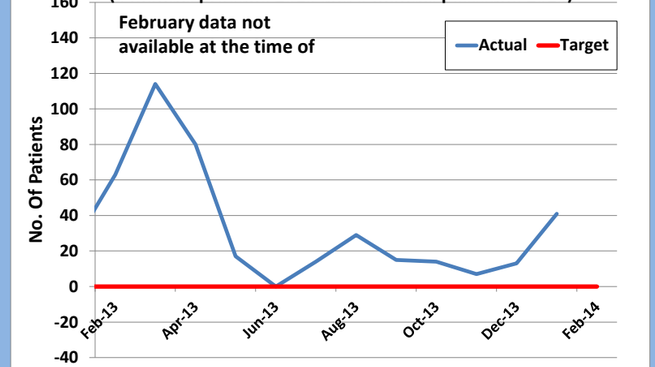
### Hand Hygiene

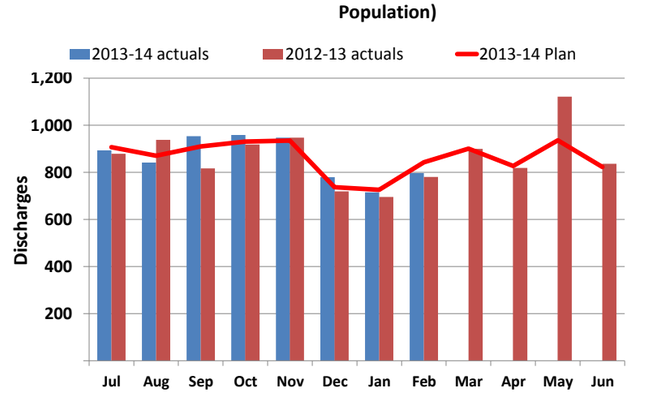


Southern DHB
Hospital Advisory Committee - Hospital Healthcheck
February 2014 Data

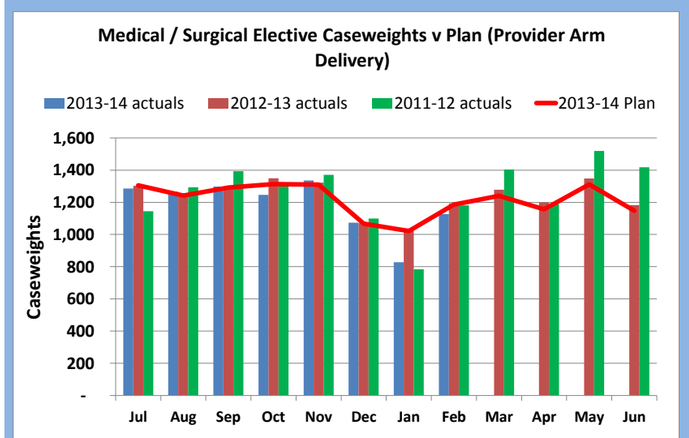
## Elective Care

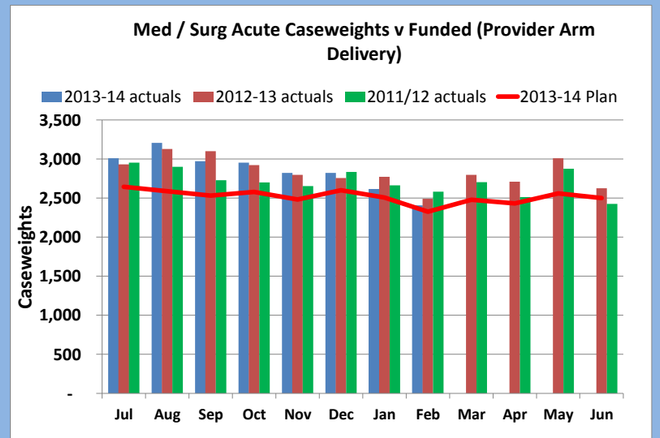


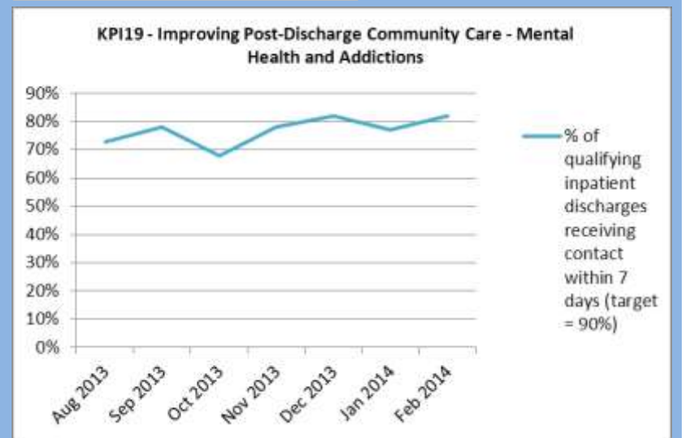




## Acute Care

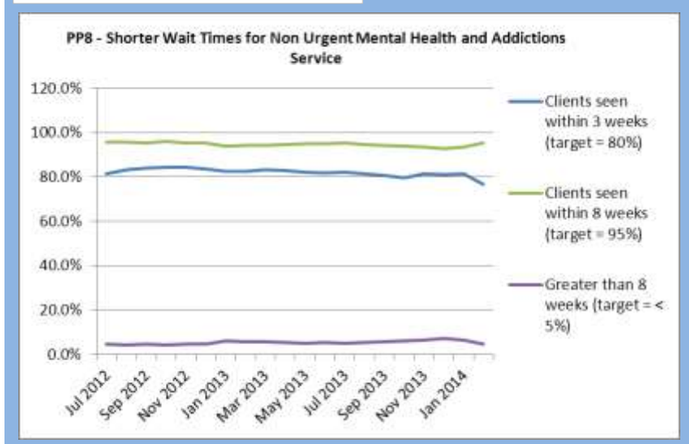


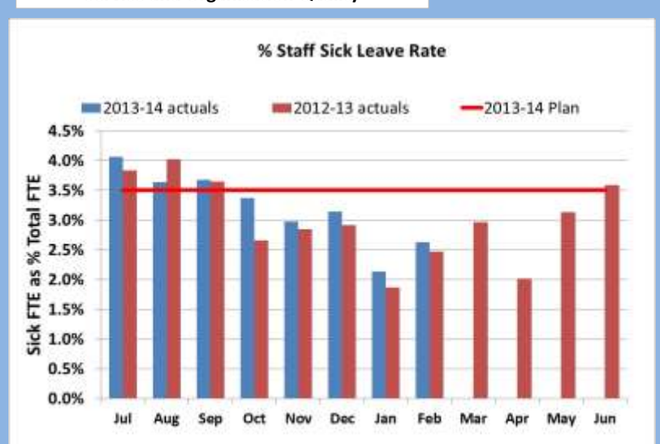

## Mental Health and Addictions

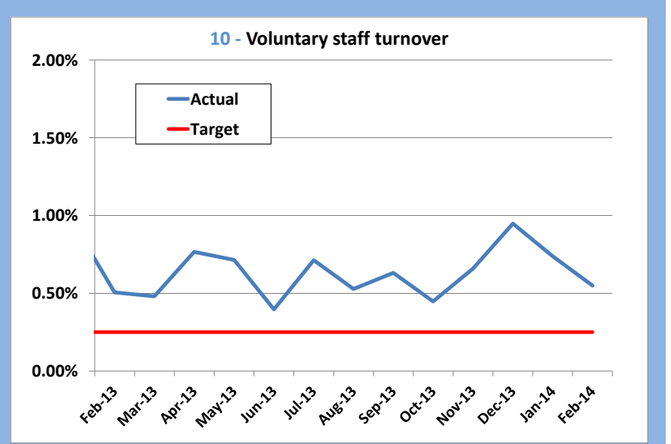



## Mental Health and Addictions




## Service and Organisation Quality



# SOUTHERN DISTRICT HEALTH BOARD

| | |
|---|---|
| **Title:** | **FINANCIAL REPORT** |
| **Report to:** | Board |
| **Date of Meeting:** | 3 April 2014 |


**Summary:**

The issues considered in this paper are:

- February 2014 year to date financial position.


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

| | |
|---|---|
| **Financial:** | As set out in report. |
| **Workforce:** | No specific implications |
| **Other:** | n/a |

| | | |
|---|---|---|
| **Document previously submitted to:** | Not applicable, report submitted directly to Board. | **Date:** n/a |
| **Approved by Chief Executive Officer:** | | **Date:** 25/03/2014 |

| | |
|---|---|
| **Prepared by:**<br>David Dickson<br>Finance Manager<br>**Date:** 19/03/14 | **Presented by:**<br>Peter Beirne<br>Executive Director Finance |

**RECOMMENDATION:**

1. **That the report be received.**

# SOUTHERN DHB FINANCIAL REPORT

**Financial Report as at:** **28 February 2014**
**Report Prepared by:** **David Dickson – Finance Manager**
**Date:** **17 March 2014**

## Recommendations:

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

## Overview Section

**Results Summary**

| Month | | | | Year to Date | | | Annual |
|---|---|---|---|---|---|---|---|
| Actual $' 000 | Budget $' 000 | Variance $' 000 | | Actual $' 000 | Budget $' 000 | Variance $' 000 | Budget $' 000 |
| 72,340 | 71,929 | 411 | Revenue | 579,366 | 574,622 | 4,744 | 862,131 |
| (26,312) | (25,371) | (941) | Less Personnel Costs | (219,830) | (217,482) | (2,348) | (329,292) |
| (43,148) | (43,412) | 264 | Less Other Costs | (362,991) | (359,464) | (3,527) | (541,879) |
| 2,880 | 3,146 | (266) | Net Surplus / (Deficit) | (3,455) | (2,324) | (1,131) | (9,040) |

The February result was a surplus $2.9m and unfavourable to budget by $0.3m. The year to date result is a deficit of $3.5m and unfavourable to budget by $1.1m.

**Operational Performance**

| Month | | | | Year to Date | | | Annual |
|---|---|---|---|---|---|---|---|
| Actual $' 000 | Budget $' 000 | Variance $' 000 | | Actual $' 000 | Budget $' 000 | Variance $' 000 | Budget $' 000 |
| (5) | 62 | (67) | Governance | (623) | (110) | (513) | 0 |
| 1,742 | 1,129 | 613 | Funder | 1,237 | 451 | 786 | (1,104) |
| 1,143 | 1,955 | (812) | Provider | (4,069) | (2,665) | (1,404) | (7,936) |
| 2,880 | 3,146 | (266) | Net Surplus / (Deficit) | (3,455) | (2,324) | (1,131) | (9,040) |

- The Governance result continues to be unfavourable with the year to date result a deficit of $0.6m.
- The Funder result for the month is a surplus of $1.7m, favourable to budget by $0.6m. The year to date result is a surplus of $1.2m and favourable to budget by $0.8m.
- The Provider result was unfavourable for the month and year to date is a deficit of $4.1m.

**Key YTD Variances**

The following are the key year to date variances;

| | |
|---|---|
| MoH Funding Subcontracts | $2.33m F |
| Medical Personnel - Outsourced | $1.08m F |
| Allied Health Personnel | $0.80m F |
| Interest & Financing Charges | $0.71m F |
| Nursing Personnel | $0.67m F |
| Accident Insurance | $0.66m F |
| Other Government Income | $0.64m F |
| Other Income | $0.56m F |
| Residential Care: Rest Homes | $0.54m F |
| Home Support | ($0.59m) U |
| Implants & Prosthesis | ($0.80m) U |
| Residential Care: Hospitals | ($0.80m) U |
| Outsourced Clinical Services | ($0.84m) U |
| Pharmaceuticals | ($1.36m) U |
| Medical Personnel | ($4.31m) U |

**Balance Sheet and Cash flow**
Cash is $10.0m at the end of February against budget of $9.6m. Although close in total there are offsetting variances. Capital expenditure is favourable by $10.5m offset against capital charge ($4.5m) and equity injections ($4.5m). An equity request of $4.5m was approved at the March Board meeting and the request is now with the Ministry of Health.

## Detail Section

This section is presented from an overall DHB result perspective.

**Revenue**
As at February 2014 revenue excluding IDF's is $5.0m above budget, with most of this having a cost offset.

| Item | $'m | Expense Line Offset (Y/N/Partial) |
|---|---|---|
| MOH Revenue to reduce imaging wait times | 0.3 | Y, Public Health |
| National screening programmes | 0.6 | Y, Public Health |
| MOH Sleepover settlement | 0.4 | Y, Personal Health |
| Electives and Ambulatory Funding | 0.3 | P, Provider Arm |
| Aged care home support funding | 0.2 | Y,DSS |
| Enhanced Alcohol and Drug Services | 0.2 | Y, Mental Health |
| Additional subcontract revenue | 0.3 | P, Funder Arm |
| CTA Revenue | 0.1 | Y, Provider -arm |
| ACC Revenue | 0.7 | P, Provider-arm |
| Other income, including Research and Donations | 1.1 | P, Provider-arm |
| Other Government funding | 0.6 | P, Provider-arm |
| All other revenue variances | 0.2 | |
| Total Revenue Variation | 5.0 | |

## Personnel Expenses

February personnel costs were $0.9m unfavourable for the month and $2.3m over budget year to date. FTE at the consolidated level are 11 favourable for the 8 months to February, with the breakdown by staff type in the table below.

| | Year to Date | | |
|---|---|---|---|
| **Full Time Equivalent Numbers** | **Actual** | **Budget** | **Variance** |
| Medical Personnel | 504 | 493 | (11) |
| Nursing Personnel | 1,589 | 1,581 | (8) |
| Allied Health Personnel | 676 | 701 | 25 |
| Support Personnel | 194 | 196 | 2 |
| Management / Administration Personnel | 684 | 687 | 3 |
| **Total Full Time Equivalents (FTE's)** | **3,647** | **3,658** | **11** |

## Medical

Medical personnel were $0.7m and 25 FTE over budget for the month. The year to date variance for medical is now $4.4m and is 11 FTE over budget. SMO costs are over budget ($1.9m) resulting from FTE levels higher than budget, less leave taken and allowances greater than budget. RMO costs are greater than budget ($2.5m) due to FTE higher than budget, less leave taken than budgeted and higher than budgeted course fees. This is partly by outsourced medical costs which are $1.1m favourable.

### *Nursing Personnel*

Nursing personnel costs were $0.1m favourable to budget for the month and $0.7m favourable year to date. This is due to FTE less than budget, as well as the ACC levy reduction and retiring gratuities (discount rate adjustment) impact.

### *Allied Health Personnel*

Allied staff costs continue to run under budget levels due to positive FTE variances and an adjustment to ACC levies.

### *Support Personnel*

Support staff costs are close to budget both for the month and year to date.

### *Management/Administration Personnel*

Management Administration FTE and costs were over budget in February mainly due to the budgeted restructure savings placed in this staff line. The budget from February onwards includes a provision for restructure of $150k per month. Much of the restructure did not proceed; however, savings are being achieved in Allied Health and other staff lines, albeit not to the planned level.

## Outsourced Expenses

Outsourced personnel costs are favourable for the month and year to date, offset in personnel costs as noted above.

Outsourced services costs are unfavourable, both for the month ($0.1m), and year to date ($0.9m). The one area of continued overspend remains Radiology Services which is $0.6m over budget year to date. The budget was set on the expectation that personnel would be in place reducing the need for this outsourcing.

**Clinical Supplies Expenses**

Clinical supplies costs are favourable for the month ($0.5m) and $1.0m unfavourable for the year to date. The items with the largest year to date unfavourable variances, and are mostly demand driven were;

| | |
|---|---|
| Shunts and Stents | $303k u |
| Air Ambulance | $292k u |
| Knee Prostheses | $287k u |
| Sutures | $282k u |
| Disposable Instruments | $256k u |
| Screws, nails and plates | $237k u |

**Infrastructure & Non-Clinical Supplies Expenditure**

Infrastructure & Non-Clinical Supplies remain on budget for the month and $1.4m favourable year to date.

The year to date variance is driven by facility costs, which are $0.2m under budget, partly related to maintenance costs, which is a timing difference. IT costs were $0.3m under budget, and interest and financing charges $0.7m under budget relating to capital charge and interest costs.

**Funder Summary**

| Month | | | | Year to Date | | | Annual |
|---|---|---|---|---|---|---|---|
| Actual $' 000 | Budget $' 000 | Variance $' 000 | | Actual $' 000 | Budget $' 000 | Variance $' 000 | Budget $' 000 |
| 68,604 | 68,107 | 497 | Revenue | 547,224 | 544,856 | 2,368 | 817,283 |
| (66,862) | (66,978) | 116 | Less Other Costs | (545,986) | (544,405) | (1,581) | (818,387) |
| 1,742 | 1,129 | 613 | Net Surplus / (Deficit) | 1,238 | 451 | 787 | (1,104) |
| | | | **Expenses** | | | | |
| (47,689) | (47,674) | (15) | Personal Health | (387,062) | (385,509) | (1,553) | (580,071) |
| (7,057) | (7,269) | 212 | Mental Health | (56,799) | (58,153) | 1,354 | (87,232) |
| (931) | (864) | (67) | Public Health | (7,640) | (6,909) | (731) | (10,363) |
| (10,335) | (10,319) | (16) | Disability Support | (87,679) | (87,023) | (656) | (130,502) |
| (153) | (154) | 1 | Maori Health | (1,221) | (1,226) | 5 | (1,840) |
| (698) | (698) | 0 | Other | (5,585) | (5,585) | 0 | (8,379) |
| (66,863) | (66,978) | 115 | Expenses | (545,986) | (544,405) | (1,581) | (818,387) |

**Personal Health Payments (Not including Provider-arm)**

Personal Health is close to budget for the month. The year to date remains $1.5m unfavourable with variances in laboratory costs ($0.4m), due to additional lab tests, Pharmaceuticals ($0.5m) due to the impact of 2012/13 costs in this year, Radiology ($0.3m), which has a revenue offset, price adjustors and premiums ($0.5m), again mostly having a revenue offset relating to the sleepover settlement funding received. IDF are $0.4m unfavourable, with a $0.1m unfavourable movement in February.

**Mental Health (Not including Provider-arm)**
Year to date costs are favourable due to the wash-up with the provider arm of $1.7m.

**Disability Support (Not including Provider-arm)**
Disability support services costs were close to budget in February, and $0.6m unfavourable year to date, with this partly offset with additional revenue received.

**IDF Wash-up - Inflows**
The IDF inpatient wash-up for February improved by $0.1m, the year to date wash-up is now unfavourable by $0.4m. There was also a favourable wash up for ARC re-located clients of $0.3m received in the month.

**IDF Wash-up - Outflows**
IDF outflows worsened against budget in February by $0.1m, with the year to date unfavourable wash-up now $0.4m.

**Forecast**
The full year forecast has been updated and has been revised; estimate is a deficit of $9.8 million, however work continues to improve upon this estimate prior to the April Board meeting.

## Financial Statements

The following financial statements are attached:

- Governance P&L
- Provider P&L
- Funder P&L
- DHB Consolidated Results P&L
- Balance Sheet
- Cashflow Statement
- Consolidated Forecast

# Southern District Health Board

***Feb-14***

| *Part 1: DHB Governance and Funding Administration* | Current Month Actual $(000) | Current Month Budget $(000) | Current Month Variance $(000) | Current Month Variance % | Year to Date Actual $(000) | Year to Date Budget $(000) | Year to Date Variance $(000) | Year to Date Variance % | Annual Budget $(000) |
|---|---|---|---|---|---|---|---|---|---|
| **Part 1.1: Statement of Financial Performance** | | | | | | | | | |
| **REVENUE** | | | | | | | | | |
| **Government and Crown Agency sourced** | | | | | | | | | |
| Internal - DHB Funder to DHB Provider | 698 | 698 | | | 5,586 | 5,586 | | | 8,379 |
| Other DHB's | - | - | | | - | - | | | - |
| Other Government | 15 | - | 15 F | | 69 | - | 69 F | | - |
| ***Government and Crown Agency Sourced Total*** | **714** | **698** | **15 F** | **2%** | **5,655** | **5,586** | **69 F** | **1%** | **8,379** |
| Other Income | - | - | | | - | - | | | - |
| **REVENUE TOTAL** | **714** | **698** | **15 F** | **2%** | **5,655** | **5,586** | **69 F** | **1%** | **8,379** |
| **EXPENSES** | | | | | | | | | |
| **Personnel Expenses** | | | | | | | | | |
| Medical Personnel | (3) | (18) | 15 F | 84% | (17) | (154) | 138 F | 89% | (233) |
| Nursing Personnel | - | (1) | 1 F | | - | (6) | 6 F | | (9) |
| Allied Health Personnel | - | - | | | - | - | | | - |
| Support Services Personnel | - | - | | | - | - | | | - |
| Management / Admin Personnel | (312) | (268) | (44) U | (16%) | (2,333) | (2,292) | (42) U | (2%) | (3,440) |
| ***Personnel Costs Total*** | **(314)** | **(286)** | **(28) U** | **(10%)** | **(2,350)** | **(2,452)** | **102 F** | **4%** | **(3,682)** |
| **Outsourced Expenses** | | | | | | | | | |
| Medical Personnel | - | - | | | - | - | | | - |
| Nursing Personnel | - | - | | | - | - | | | - |
| Allied Health Personnel | - | - | | | - | - | | | - |
| Support Personnel | - | - | | | - | - | | | - |
| Management / Administration Personnel | 28 | - | 28 F | | (80) | - | (80) U | | - |
| Outsourced Clinical Services | - | - | | | - | - | | | - |
| Outsourced Corporate / Governance Services | (108) | (79) | (28) U | (36%) | (1,005) | (635) | (369) U | (58%) | (953) |
| Outsourced Funder Services | (161) | (114) | (47) U | (41%) | (1,284) | (996) | (287) U | (29%) | (1,486) |
| ***Outsourced Services Total*** | **(241)** | **(193)** | **(47) U** | **(24%)** | **(2,368)** | **(1,632)** | **(736) U** | **(45%)** | **(2,439)** |
| **Clinical Supplies** | | | | | | | | | |
| Treatment Disposables | - | - | | (460%) | (1) | - | | (612%) | - |
| Diagnostic Supplies & Other Clinical Supplies | - | - | | | - | - | | | - |
| Instruments & Equipment | - | - | | (244%) | - | - | | (214%) | - |
| Patient Appliances | - | - | | | - | - | | | - |
| Implants & Prosthesis | - | - | | | - | - | | | - |
| Pharmaceuticals | - | - | | | - | - | | | - |
| Other Clinical Supplies | - | - | | | - | - | | | - |
| ***Clinical Supplies Total*** | **-** | **-** | | **(388%)** | **-** | **-** | | **(263%)** | **-** |
| **Infrastructure & Non Clinical Expenses** | | | | | | | | | |
| Hotel Services, Laundry & Cleaning | (2) | (1) | | (18%) | (14) | (12) | (2) U | (19%) | (18) |
| Facilities | - | - | | | - | - | | | - |
| Transport | (10) | (15) | 4 F | 29% | (97) | (138) | 41 F | 30% | (212) |
| IT Systems & Telecommunications | (2) | (9) | 7 F | 80% | (35) | (72) | 37 F | 51% | (108) |
| Interest & Financing Charges | (16) | (22) | 6 F | 29% | (125) | (176) | 51 F | 29% | (264) |
| Professional Fees & Expenses | (49) | (43) | (6) U | (14%) | (485) | (347) | (138) U | (40%) | (521) |
| Other Operating Expenses | (42) | (24) | (18) U | (73%) | (172) | (199) | 27 F | 14% | (298) |
| Democracy | (42) | (42) | | (1%) | (631) | (668) | 37 F | 5% | (837) |
| Subsidiaries & Joint Ventures | - | - | | | - | - | | | - |
| ***Infrastructure & Non-Clinical Supplies Total*** | **(163)** | **(157)** | **(6) U** | **(4%)** | **(1,560)** | **(1,612)** | **53 F** | **3%** | **(2,257)** |
| Internal Allocations | - | - | | | - | - | | | - |
| Other | - | - | | | - | - | | | - |
| **Total Expenses** | **(718)** | **(636)** | **(82) U** | **(13%)** | **(6,278)** | **(5,696)** | **(582) U** | **(10%)** | **(8,379)** |
| **Net Surplus/ (Deficit)** | **(5)** | **62** | **(67) U** | **(108%)** | **(623)** | **(110)** | **(513) U** | **(466%)** | **-** |
| *Zero Check* | - | - | | | - | - | | | - |
| Interest Costs from CHFA | - | - | | | - | - | | | - |
| Capital Charge | - | - | | | - | - | | | - |
| **Part 1.2 : Full Time Equivalent Numbers** | | | | | | | | | |
| Medical Personnel | - | 1 | | | - | 1 | | | 1 |
| Nursing Personnel | - | - | | | - | - | | | - |
| Allied Health Personnel | - | - | | | - | - | | | - |
| Support Personnel | - | - | | | - | - | | | - |
| Management / Adminstration Personnel | 29 | 27 | | | 27 | 28 | | | 28 |
| **Total Full Equivalents (FTE's)** | 29 | 28 | | | 27 | 28 | | | 28 |

# Southern District Health Board
## *Feb-14*

| *Part 2: DHB provider* | Current Month Actual $(000) | Budget $(000) | Variance $(000) | Variance % | Year to Date Actual $(000) | Budget $(000) | Variance $(000) | Variance % | Annual Budget $(000) |
|---|---|---|---|---|---|---|---|---|---|
| **Part 2.1: Statement of Financial Performance** | | | | | | | | | |
| **REVENUE** | | | | | | | | | |
| **Ministry of Health** | | | | | | | | | |
| MoH - Vote Health Non Mental Health | - | - | | | - | - | | | - |
| MoH - Vote Health Mental Health | - | - | | | - | - | | | - |
| PBF Adjustments | - | - | | | - | - | | | - |
| MoH Funding Subcontracts | - | - | | | - | - | | | - |
| MoH - Personal Health | 20 | 28 | (9) U | (31%) | 124 | 226 | (103) U | (45%) | 339 |
| MoH - Mental Health | - | - | | | - | - | | | - |
| MoH - Public Health | 10 | 11 | | (1%) | 84 | 85 | (1) U | (1%) | 127 |
| MoH - Disability Support Services | 875 | 730 | 144 F | 20% | 6,124 | 5,921 | 203 F | 3% | 8,884 |
| MoH - Maori Health | - | - | | | - | - | | | - |
| Clinical Training Agency | 602 | 544 | 58 F | 11% | 4,494 | 4,354 | 140 F | 3% | 6,531 |
| Internal - DHB Funder to DHB Provider | 36,166 | 36,453 | (288) U | (1%) | 290,101 | 291,627 | (1,526) U | (1%) | 437,441 |
| ***Ministry of Health Total*** | **37,673** | **37,767** | **(94) U** | | **300,926** | **302,213** | **(1,287) U** | | **453,322** |
| **Other Government** | | | | | | | | | |
| IDF's - Mental Health Services | - | - | | | - | - | | | - |
| IDF's - All others (non Mental health) | - | - | | | - | - | | | - |
| Other DHB's | 52 | 25 | 27 F | 107% | 211 | 202 | 10 F | 5% | 302 |
| Training Fees and Subsidies | 3 | 17 | (14) U | (83%) | 110 | 137 | (27) U | (20%) | 206 |
| Accident Insurance | 671 | 709 | (37) U | (5%) | 6,755 | 6,096 | 659 F | 11% | 9,250 |
| Other Government | 391 | 420 | (29) U | (7%) | 3,994 | 3,428 | 566 F | 17% | 5,135 |
| ***Other Government Total*** | **1,118** | **1,171** | **(53) U** | **(5%)** | **11,071** | **9,862** | **1,209 F** | **12%** | **14,893** |
| ***Government and Crown Agency Total*** | **38,791** | **38,938** | **(147) U** | | **311,997** | **312,075** | **(78) U** | | **468,215** |
| **Other Revenue** | | | | | | | | | |
| Patient / Consumer Sourced | 363 | 437 | (73) U | (17%) | 2,412 | 2,112 | 300 F | 14% | 3,265 |
| Other Income | 733 | 901 | (168) U | (19%) | 7,765 | 7,206 | 560 F | 8% | 10,809 |
| ***Other Revenue Total*** | **1,096** | **1,337** | **(241) U** | **(18%)** | **10,177** | **9,318** | **859 F** | **9%** | **14,074** |
| **REVENUE TOTAL** | **39,887** | **40,275** | **(389) U** | **(1%)** | **322,174** | **321,393** | **781 F** | | **482,289** |
| **EXPENSES** | | | | | | | | | |
| **Personnel Expenses** | | | | | | | | | |
| Medical Personnel | (8,674) | (7,928) | (746) U | (9%) | (72,488) | (68,044) | (4,444) U | (7%) | (102,133) |
| Nursing Personnel | (9,593) | (9,673) | 79 F | 1% | (80,581) | (81,240) | 659 F | 1% | (124,583) |
| Allied Health Personnel | (3,939) | (3,839) | (100) U | (3%) | (32,237) | (33,041) | 804 F | 2% | (50,086) |
| Support Services Personnel | (760) | (744) | (16) U | (2%) | (6,445) | (6,470) | 25 F | | (9,767) |
| Management / Admin Personnel | (3,030) | (2,901) | (129) U | (4%) | (25,730) | (26,236) | 506 F | 2% | (39,040) |
| ***Personnel Costs Total*** | **(25,997)** | **(25,085)** | **(912) U** | **(4%)** | **(217,480)** | **(215,030)** | **(2,450) U** | **(1%)** | **(325,610)** |
| **Outsourced Expenses** | | | | | | | | | |
| Medical Personnel | (306) | (558) | 252 F | 45% | (3,989) | (5,069) | 1,081 F | 21% | (7,474) |
| Nursing Personnel | (6) | - | (6) U | | (34) | - | (34) U | | - |
| Allied Health Personnel | (91) | (31) | (60) U | (192%) | (437) | (250) | (187) U | (75%) | (375) |
| Support Personnel | (44) | (21) | (23) U | (107%) | (256) | (171) | (85) U | (50%) | (256) |
| Management / Administration Personnel | (6) | (1) | (5) U | (527%) | (54) | (8) | (46) U | (567%) | (12) |
| Outsourced Clinical Services | (640) | (530) | (110) U | (21%) | (5,200) | (4,364) | (836) U | (19%) | (6,633) |
| Outsourced Corporate / Governance Services | (75) | (74) | (1) U | (1%) | (628) | (651) | 24 F | 4% | (972) |
| Outsourced Funder Services | - | - | | | - | - | | | - |
| ***Outsourced Services Total*** | **(1,168)** | **(1,216)** | **48 F** | **4%** | **(10,596)** | **(10,514)** | **(83) U** | **(1%)** | **(15,722)** |
| **Clinical Supplies** | | | | | | | | | |
| Treatment Disposables | (2,127) | (2,305) | 178 F | 8% | (19,567) | (19,302) | (265) U | (1%) | (29,392) |
| Diagnostic Supplies & Other Clinical Supplies | (146) | (147) | 1 F | 1% | (1,240) | (1,223) | (17) U | (1%) | (1,868) |
| Instruments & Equipment | (1,289) | (1,281) | (9) U | (1%) | (10,290) | (10,129) | (160) U | (2%) | (15,260) |
| Patient Appliances | (159) | (178) | 19 F | 11% | (1,385) | (1,367) | (18) U | (1%) | (2,081) |
| Implants & Prosthesis | (678) | (841) | 163 F | 19% | (7,245) | (6,442) | (803) U | (12%) | (9,962) |
| Pharmaceuticals | (1,220) | (1,395) | 176 F | 13% | (11,551) | (11,933) | 382 F | 3% | (18,027) |
| Other Clinical Supplies | (305) | (243) | (62) U | (26%) | (2,164) | (2,022) | (142) U | (7%) | (3,086) |
| ***Clinical Supplies Total*** | **(5,924)** | **(6,390)** | **466 F** | **7%** | **(53,442)** | **(52,417)** | **(1,025) U** | **(2%)** | **(79,676)** |
| **Infrastructure & Non Clinical Expenses** | | | | | | | | | |
| Hotel Services, Laundry & Cleaning | (1,073) | (1,056) | (17) U | (2%) | (8,682) | (8,469) | (213) U | (3%) | (12,706) |
| Facilities | (1,718) | (1,649) | (69) U | (4%) | (13,404) | (13,599) | 195 F | 1% | (20,500) |
| Transport | (317) | (303) | (14) U | (5%) | (2,652) | (2,701) | 50 F | 2% | (4,106) |
| IT Systems & Telecommunications | (894) | (873) | (21) U | (2%) | (6,825) | (7,097) | 272 F | 4% | (10,622) |
| Interest & Financing Charges | (1,174) | (1,298) | 124 F | 10% | (9,818) | (10,472) | 653 F | 6% | (15,662) |
| Professional Fees & Expenses | (146) | (109) | (37) U | (34%) | (724) | (874) | 150 F | 17% | (1,311) |
| Other Operating Expenses | (331) | (341) | 9 F | 3% | (2,621) | (2,886) | 265 F | 9% | (4,310) |
| Democracy | - | - | | | - | - | | | - |
| Subsidiaries & Joint Ventures | - | - | | | - | - | | | - |
| ***Infrastructure & Non-Clinical Supplies Total*** | **(5,654)** | **(5,630)** | **(25) U** | | **(44,724)** | **(46,097)** | **1,373 F** | **3%** | **(69,216)** |
| Other Costs and Internal Allocations | - | - | | | - | - | | | - |
| **Total Expenses** | **(38,744)** | **(38,321)** | **(423) U** | **(1%)** | **(326,243)** | **(324,058)** | **(2,185) U** | **(1%)** | **(490,224)** |
| **Net Surplus/ (Deficit)** | **1,143** | **1,955** | **(812) U** | **(42%)** | **(4,069)** | **(2,665)** | **(1,404) U** | **(53%)** | **(7,936)** |
| *Zero Check* | - | - | | | - | - | | | - |

# Southern District Health Board

***Feb-14***

| *Part 2: DHB provider* | Current Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Variance | Actual | Budget | Variance | Variance | Budget |
| | $(000) | $(000) | $(000) | % | $(000) | $(000) | $(000) | % | $(000) |
| **Part 2.1 A: Supplementary Information to Statement of Financial Performance** | | | | | | | | | |
| Depreciation - Clinical Equipment | (652) | (641) | (11) U | (2%) | (5,165) | (5,090) | (75) U | (1%) | (7,655) |
| Depreciation - Non Res Buildings & Plant | (696) | (679) | (17) U | (2%) | (5,483) | (5,395) | (89) U | (2%) | (8,100) |
| Depreciation - Motor Vehicles | (23) | (9) | (14) U | (156%) | (130) | (73) | (57) U | (79%) | (108) |
| Depreciation - Information Technology | (245) | (199) | (45) U | (23%) | (1,936) | (1,697) | (239) U | (14%) | (2,528) |
| Depreciation - Other Equipment | (55) | (37) | (18) U | (49%) | (393) | (311) | (81) U | (26%) | (468) |
| Total Depreciation | (1,671) | (1,565) | (106) U | (7%) | (13,107) | (12,566) | (541) U | (4%) | (18,860) |
| Interest Cost from Funder Loans | - | - | | | - | - | | | - |
| Interest Costs from CHFA | (346) | (401) | 55 F | 14% | (2,999) | (3,205) | 206 F | 6% | (4,808) |
| Financing Component of Operating Leases | (30) | (28) | (2) U | (8%) | (160) | (225) | 65 F | 29% | (338) |
| Capital Charge | (795) | (866) | 71 F | 8% | (6,636) | (7,015) | 379 F | 5% | (10,476) |
| **Part 1.2 : Full Time Equivalent Numbers** | | | | | | | | | |
| Medical Personnel | 516 | 492 | | | 504 | 492 | | | 492 |
| Nursing Personnel | 1,562 | 1,594 | | | 1,589 | 1,581 | | | 1,582 |
| Allied Health Personnel | 679 | 701 | | | 676 | 701 | | | 701 |
| Support Personnel | 191 | 196 | | | 194 | 196 | | | 196 |
| Management / Administration Personnel | 650 | 638 | | | 657 | 659 | | | 652 |
| **Total Full Time Equivalents (FTE's)** | 3,598 | 3,620 | | | 3,620 | 3,628 | | | 3,622 |

# Southern District Health Board

***Feb-14***

| *Part 3: DHB Funds* | Current Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Variance | Actual | Budget | Variance | Variance | Budget |
| | $(000) | $(000) | $(000) | % | $(000) | $(000) | $(000) | % | $(000) |
| **Part 3.1: Statement of Financial Performance** | | | | | | | | | |
| **REVENUE** | | | | | | | | | |
| **Ministry of Health** | | | | | | | | | |
| MoH - Vote Health Non Mental Health | 56,391 | 56,335 | 57 F | | 451,080 | 450,676 | 404 F | | 676,014 |
| MoH - Vote Health Mental Health | 7,057 | 7,062 | (5) U | | 56,456 | 56,496 | (40) U | | 84,744 |
| PBF Adjustments | - | - | | | - | - | | | - |
| MoH Funding Subcontracts | 3,232 | 3,124 | 108 F | 3% | 27,321 | 24,992 | 2,329 F | 9% | 37,488 |
| MoH - Personal Health | - | - | | | - | - | | | - |
| MoH - Mental Health | - | - | | | - | - | | | - |
| MoH - Public Health | - | - | | | - | - | | | - |
| MoH - Disability Support Services | - | - | | | - | - | | | - |
| MoH - Maori Health | - | - | | | - | - | | | - |
| Clinical Training Agency | - | - | | | - | - | | | - |
| Internal - DHB Funder to DHB Provider | - | - | | | - | - | | | - |
| ***Ministry of Health Total*** | **66,680** | **66,521** | **159 F** | | **534,857** | **532,164** | **2,693 F** | **1%** | **798,246** |
| **Other Government** | | | | | | | | | |
| IDF's - Mental Health Services | 144 | 144 | | | 1,149 | 1,149 | | | 1,723 |
| IDF's - All others (non Mental health) | 1,781 | 1,443 | 338 F | 23% | 11,218 | 11,543 | (325) U | (3%) | 17,314 |
| Other DHB's | - | - | | | - | - | | | - |
| Training Fees and Subsidies | - | - | | | - | - | | | - |
| Accident Insurance | - | - | | | - | - | | | - |
| Other Government | - | - | | | - | - | | | - |
| ***Other Government Total*** | **1,925** | **1,586** | **338 F** | **21%** | **12,367** | **12,692** | **(325) U** | **(3%)** | **19,037** |
| ***Government and Crown Agency Sourced Total*** | **68,604** | **68,107** | **497 F** | **1%** | **547,224** | **544,856** | **2,368 F** | | **817,283** |
| **REVENUE TOTAL** | **68,604** | **68,107** | **497 F** | **1%** | **547,224** | **544,856** | **2,368 F** | | **817,283** |
| **EXPENSES** | | | | | | | | | |
| **Outsourced Expenses** | | | | | | | | | |
| Outsourced Funder Services | (698) | (698) | | | (5,586) | (5,586) | | | (8,379) |
| **Payments to Providers** | | | | | | | | | |
| **Personal Health** | | | | | | | | | |
| Child and Youth | (380) | (375) | (5) U | (1%) | (3,028) | (3,002) | (25) U | (1%) | (4,504) |
| Laboratory | (2,667) | (2,639) | (27) U | (1%) | (21,507) | (21,116) | (391) U | (2%) | (31,674) |
| Infertility Treatment Services | (91) | (100) | 9 F | 9% | (728) | (800) | 72 F | 9% | (1,200) |
| Maternity | (262) | (261) | | | (2,092) | (2,089) | (3) U | | (3,135) |
| Maternity (Tertiary & Secondary) | (1,372) | (1,385) | 13 F | 1% | (10,993) | (11,081) | 88 F | 1% | (16,622) |
| Pregnancy and Parenting Education | (12) | (12) | 1 F | 5% | (87) | (99) | 11 F | 11% | (148) |
| Maternity Payment Schedule | - | - | | | - | - | | | - |
| Neo Natal | (656) | (656) | | | (5,250) | (5,250) | | | (7,875) |
| Sexual Health | (88) | (88) | | | (704) | (704) | | | (1,055) |
| Adolescent Dental Benefit | (177) | (77) | (100) U | (130%) | (1,478) | (1,530) | 52 F | 3% | (2,425) |
| Other Dental Services | - | - | | | - | - | | | - |
| Dental - Low Income Adult | (66) | (90) | 24 F | 27% | (624) | (720) | 96 F | 13% | (1,083) |
| Child (School) Dental Services | (629) | (621) | (8) U | (1%) | (4,960) | (5,101) | 140 F | 3% | (7,608) |
| Secondary / Tertiary Dental | (254) | (245) | (9) U | (4%) | (2,032) | (1,964) | (69) U | (4%) | (2,950) |
| Pharmaceuticals | (5,818) | (5,945) | 128 F | 2% | (50,390) | (49,920) | (470) U | (1%) | (75,312) |
| Pharmaceutical Cancer Treatment Drugs | (437) | (358) | (78) U | (22%) | (2,915) | (2,867) | (49) U | (2%) | (4,300) |
| Pharmacy Services | (28) | (68) | 40 F | 59% | (355) | (548) | 193 F | 35% | (821) |
| Management Referred Services | - | - | | | - | - | | | - |
| General Medical Subsidy | (40) | (127) | 87 F | 68% | (621) | (1,106) | 485 F | 44% | (1,650) |
| Primary Practice Services - Capitated | (3,458) | (3,431) | (27) U | (1%) | (27,344) | (27,448) | 104 F | | (41,172) |
| Primary Health Care Strategy - Care | (284) | (240) | (44) U | (18%) | (2,196) | (1,922) | (274) U | (14%) | (2,883) |
| Primary Health Care Strategy - Health | (340) | (286) | (54) U | (19%) | (2,840) | (2,288) | (552) U | (24%) | (3,432) |
| Primary Health Care Strategy - Other | (223) | (207) | (16) U | (8%) | (1,914) | (1,656) | (258) U | (16%) | (2,484) |
| Practice Nurse Subsidy | (16) | (17) | | 3% | (135) | (132) | (3) U | (3%) | (198) |
| Rural Support for Primary Health Pro | (1,370) | (1,371) | 1 F | | (10,981) | (10,968) | (13) U | | (16,452) |
| Immunisation | (118) | (128) | 10 F | 8% | (1,062) | (1,041) | (21) U | (2%) | (2,651) |
| Radiology | (468) | (457) | (11) U | (2%) | (4,016) | (3,657) | (359) U | (10%) | (5,486) |
| Palliative Care | (454) | (495) | 41 F | 8% | (3,921) | (3,961) | 41 F | 1% | (5,942) |
| Meals on Wheels | (53) | (53) | (1) U | (1%) | (426) | (421) | (5) U | (1%) | (632) |
| Domicilary & District Nursing | (1,378) | (1,436) | 58 F | 4% | (11,374) | (11,489) | 115 F | 1% | (17,233) |
| Community based Allied Health | (581) | (581) | | | (4,651) | (4,648) | (3) U | | (6,972) |
| Chronic Disease Management and Educa | (239) | (241) | 2 F | 1% | (1,918) | (1,930) | 11 F | 1% | (2,894) |
| Medical Inpatients | (5,619) | (5,619) | | | (44,950) | (44,950) | | | (67,425) |
| Medical Outpatients | (3,456) | (3,617) | 161 F | 4% | (28,613) | (28,937) | 324 F | 1% | (43,405) |
| Surgical Inpatients | (10,416) | (10,426) | 10 F | | (83,396) | (83,406) | 10 F | | (125,110) |
| Surgical Outpatients | (1,711) | (1,716) | 5 F | | (13,693) | (13,728) | 36 F | | (20,592) |
| Paediatric Inpatients | (641) | (641) | | | (5,124) | (5,124) | | | (7,686) |
| Paediatric Outpatients | (267) | (267) | | | (2,138) | (2,138) | | | (3,207) |
| Pacific Peoples' Health | (17) | (22) | 4 F | 20% | (144) | (172) | 28 F | 16% | (258) |
| Emergency Services | (1,621) | (1,630) | 9 F | 1% | (13,005) | (13,038) | 33 F | | (19,557) |
| Minor Personal Health Expenditure | (86) | (89) | 2 F | 3% | (674) | (708) | 34 F | 5% | (1,062) |
| Price adjusters and Premium | 665 | 795 | (130) U | (16%) | 5,886 | 6,362 | (476) U | (7%) | 9,543 |
| Travel & Accomodation | (298) | (303) | 5 F | 2% | (3,080) | (3,027) | (53) U | (2%) | (4,741) |
| Inter District Flow Personal Health | (2,264) | (2,148) | (116) U | (5%) | (17,588) | (17,186) | (401) U | (2%) | (25,780) |
| ***Personal Health Total*** | **(47,689)** | **(47,674)** | **(14) U** | | **(387,062)** | **(385,509)** | **(1,553) U** | | **(580,072)** |

# Southern District Health Board

***Feb-14***

| *Part 3: DHB Funds* | Current Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual $(000) | Budget $(000) | Variance $(000) | Variance % | Actual $(000) | Budget $(000) | Variance $(000) | Variance % | Budget $(000) |
| **Mental Health** | | | | | | | | | |
| Mental Health to allocate | - | - | | | - | - | | | - |
| Acute Mental Health Inpatients | (1,299) | (1,299) | | | (10,389) | (10,389) | | | (15,583) |
| Sub-Acute & Long Term Mental Health | (362) | (362) | | | (2,899) | (2,899) | | | (4,349) |
| Crisis Respite | (7) | (7) | | | (54) | (54) | | 1% | (82) |
| Alcohol & Other Drugs - General | (317) | (330) | 12 F | 4% | (2,752) | (2,637) | (115) U | (4%) | (3,955) |
| Alcohol & Other Drugs - Child & Youth | (8) | (24) | 16 F | 66% | (285) | (191) | (94) U | (50%) | (286) |
| Methadone | (94) | (94) | | | (750) | (750) | | | (1,125) |
| Dual Diagnosis - Alcohol & Other Drugs | (12) | (45) | 33 F | 74% | (108) | (357) | 250 F | 70% | (536) |
| Dual Diagnosis - MH/ID | (8) | (5) | (3) U | (60%) | (63) | (40) | (24) U | (60%) | (59) |
| Eating Disorder | (14) | (14) | | | (111) | (112) | | | (168) |
| Maternal Mental Health | (4) | (4) | | | (29) | (29) | | | (44) |
| Child & Youth Mental Health Services | (1,024) | (856) | (168) U | (20%) | (6,768) | (6,848) | 80 F | 1% | (10,272) |
| Forensic Services | (506) | (510) | 4 F | 1% | (4,006) | (4,078) | 72 F | 2% | (6,117) |
| Kaupapa Maori Mental Health Services | (98) | (152) | 54 F | 36% | (891) | (1,212) | 321 F | 27% | (1,818) |
| Kaupapa Maori Mental Health - Residential | - | - | | | - | - | | | - |
| Kaupapa Maori Mental Health - Inpati | - | - | | | - | - | | | - |
| Mental Health Community Services | (1,631) | (1,877) | 246 F | 13% | (14,059) | (15,014) | 956 F | 6% | (22,522) |
| Prison/Court Liaison | (46) | (44) | (2) U | (4%) | (369) | (354) | (15) U | (4%) | (531) |
| Mental Health Workforce Development | - | - | | | - | - | | | - |
| Day Activity & Work Rehabilitation S | (191) | (197) | 7 F | 3% | (1,560) | (1,579) | 19 F | 1% | (2,369) |
| Mental Health Funded Services for Older People | (35) | (35) | | | (284) | (284) | | | (426) |
| Advocacy / Peer Support - Consumer | (56) | (57) | 1 F | 1% | (423) | (456) | 33 F | 7% | (684) |
| Other Home Based Residential Support | (380) | (374) | (6) U | (2%) | (3,174) | (2,995) | (179) U | (6%) | (4,492) |
| Advocacy / Peer Support - Families | (52) | (60) | 8 F | 13% | (416) | (479) | 63 F | 13% | (720) |
| Community Residential Beds & Service | (451) | (451) | | | (3,529) | (3,607) | 78 F | 2% | (5,411) |
| Minor Mental Health Expenditure | (20) | (32) | 12 F | 37% | (350) | (258) | (92) U | (36%) | (388) |
| Inter District Flow Mental Health | (441) | (441) | | | (3,530) | (3,530) | | | (5,294) |
| ***Mental Health Total*** | **(7,057)** | **(7,269)** | **212 F** | **3%** | **(56,799)** | **(58,153)** | **1,354 F** | **2%** | **(87,232)** |
| **Public Health** | | | | | | | | | |
| Alcohol & Drug | (26) | (26) | | | (211) | (211) | | | (317) |
| Communicable Diseases | (96) | (96) | | | (772) | (772) | | | (1,158) |
| Injury Prevention | - | - | | | - | - | | | - |
| Screening Programmes | (420) | (368) | (52) U | (14%) | (3,524) | (2,943) | (581) U | (20%) | (4,414) |
| Mental Health | (22) | (22) | | | (177) | (177) | | | (265) |
| Nutrition and Physical Activity | (49) | (45) | (4) U | (9%) | (393) | (361) | (32) U | (9%) | (542) |
| Physical Environment | (36) | (36) | | | (286) | (286) | | | (428) |
| Public Health Infrastructure | (127) | (127) | | | (1,016) | (1,016) | | | (1,523) |
| Sexual Health | (12) | (12) | | | (95) | (95) | | | (143) |
| Social Environments | (38) | (38) | | | (301) | (301) | | | (452) |
| Tobacco Control | (105) | (93) | (12) U | (12%) | (866) | (747) | (118) U | (16%) | (1,121) |
| Well Child Promotion | - | - | | | - | - | | | - |
| Meningococcal | - | - | | | - | - | | | - |
| ***Public Health Total*** | **(931)** | **(864)** | **(68) U** | **(8%)** | **(7,640)** | **(6,909)** | **(732) U** | **(11%)** | **(10,363)** |
| **Disability Support Services** | | | | | | | | | |
| AT & R (Assessment, Treatment and Re | (1,976) | (1,976) | | | (15,805) | (15,805) | | | (23,707) |
| Information and Advisory | (12) | (13) | 1 F | 9% | (72) | (104) | 32 F | 31% | (156) |
| Needs Assessment | (176) | (163) | (13) U | (8%) | (1,363) | (1,304) | (59) U | (5%) | (1,956) |
| Service Co-ordination | (18) | (19) | 1 F | 6% | (163) | (155) | (8) U | (5%) | (233) |
| Home Support | (1,202) | (1,267) | 65 F | 5% | (11,022) | (10,436) | (586) U | (6%) | (15,504) |
| Carer Support | (118) | (156) | 38 F | 24% | (1,036) | (1,249) | 213 F | 17% | (1,874) |
| Residential Care: Rest Homes | (2,552) | (2,752) | 200 F | 7% | (23,347) | (23,887) | 541 F | 2% | (35,880) |
| Residential Care: Loans Adjustment | 9 | 22 | (13) U | (60%) | 133 | 178 | (45) U | (25%) | 266 |
| Long Term Chronic Conditions | (103) | (93) | (11) U | (12%) | (1,102) | (740) | (361) U | (49%) | (1,111) |
| Residential Care: Hospitals | (3,570) | (3,277) | (294) U | (9%) | (29,232) | (28,437) | (795) U | (3%) | (42,714) |
| Ageing in Place | (2) | (2) | | | (20) | (20) | | | (30) |
| Environmental Support Services | (99) | (101) | 3 F | 3% | (803) | (809) | 6 F | 1% | (1,218) |
| Day Programmes | - | - | | | - | - | | | - |
| Expenditure to Attend Treatment ETAT | - | - | | | - | - | | | - |
| Minor Disability Support Expenditure | (8) | (26) | 17 F | 68% | (73) | (206) | 134 F | 65% | (309) |
| Respite Care | (157) | (130) | (27) U | (21%) | (1,165) | (1,124) | (41) U | (4%) | (1,691) |
| Community Health Services & Support | (66) | (105) | 39 F | 37% | (495) | (839) | 344 F | 41% | (1,259) |
| Inter District Flow Disability Support | (282) | (261) | (22) U | (8%) | (2,113) | (2,085) | (28) U | (1%) | (3,128) |
| Disability Support Other | - | - | | | - | - | | | - |
| ***Disability Support Services Total*** | **(10,335)** | **(10,319)** | **(16) U** | | **(87,679)** | **(87,023)** | **(656) U** | **(1%)** | **(130,502)** |
| **Maori Health** | | | | | | | | | |
| Maori Service Development | (38) | (38) | | | (302) | (303) | | | (454) |
| Maori Provider Assistance Infrastruc | - | - | | | - | - | | | - |
| Maori Workforce Development | - | - | | | - | - | | | - |
| Minor Maori Health Expenditure | - | - | | | - | - | | | - |
| Whanau Ora Services | (115) | (116) | 1 F | 1% | (918) | (923) | 5 F | 1% | (1,386) |
| ***Maori Health Total*** | **(153)** | **(154)** | **1 F** | **1%** | **(1,221)** | **(1,226)** | **5 F** | | **(1,840)** |
| Internal Allocations | - | - | | | - | - | | | - |
| **Total Expenses** | **(66,862)** | **(66,978)** | **116 F** | | **(545,986)** | **(544,405)** | **(1,582) U** | | **(818,387)** |
| **Summary of Results** | | | | | | | | | |
| Subtotal of IDF Revenue | 1,925 | 1,586 | 338 F | 21% | 12,367 | 12,692 | (325) U | (3%) | 19,037 |
| Subtotal all other Revenue | 66,680 | 66,521 | 159 F | | 534,857 | 532,164 | 2,693 F | 1% | 798,246 |
| **Revenue Total** | **68,604** | **68,107** | **497 F** | **1%** | **547,224** | **544,856** | **2,368 F** | | **817,283** |
| Subtotal of IDF Expenditure | (2,988) | (2,850) | (138) U | (5%) | (23,231) | (22,801) | (430) U | (2%) | (34,202) |
| Subtotal all other Expenditure | (63,874) | (64,127) | 253 F | | (522,756) | (521,603) | (1,152) U | | (784,185) |
| ***Expenses Total*** | **(66,862)** | **(66,978)** | **116 F** | | **(545,986)** | **(544,405)** | **(1,582) U** | | **(818,387)** |
| **Net Surplus/ (Deficit)** | **1,742** | **1,129** | **613 F** | **54%** | **1,237** | **451** | **786 F** | **174%** | **(1,104)** |
| *Zero Check* | - | - | | | - | - | | | - |

# Southern District Health Board
***Feb-14***

| *Part 4: DHB Consolidated* | Current Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Variance | Actual | Budget | Variance | Variance | Budget |
| | $(000) | $(000) | $(000) | % | $(000) | $(000) | $(000) | % | $(000) |
| **Part 4.1: Statement of Financial Performance** | | | | | | | | | |
| **REVENUE** | | | | | | | | | |
| **Ministry of Health** | | | | | | | | | |
| MoH - Vote Health Non Mental Health | 56,391 | 56,335 | 57 F | | 451,080 | 450,676 | 404 F | | 676,014 |
| MoH - Vote Health Mental Health | 7,057 | 7,062 | (5) U | | 56,456 | 56,496 | (40) U | | 84,744 |
| PBF Adjustments | - | - | | | - | - | | | - |
| MoH Funding Subcontracts | 3,232 | 3,124 | 108 F | 3% | 27,321 | 24,992 | 2,329 F | 9% | 37,488 |
| MoH - Personal Health | 20 | 28 | (9) U | (31%) | 124 | 226 | (103) U | (45%) | 339 |
| MoH - Mental Health | - | - | | | - | - | | | - |
| MoH - Public Health | 10 | 11 | | (1%) | 84 | 85 | (1) U | (1%) | 127 |
| MoH - Disability Support Services | 875 | 730 | 144 F | 20% | 6,124 | 5,921 | 203 F | 3% | 8,884 |
| MoH - Maori Health | - | - | | | - | - | | | - |
| Clinical Training Agency | 602 | 544 | 58 F | 11% | 4,494 | 4,354 | 140 F | 3% | 6,531 |
| Internal - DHB Funder to DHB Provider | - | - | | | - | - | | | - |
| ***Ministry of Health Total*** | **68,187** | **67,834** | **353 F** | **1%** | **545,682** | **542,750** | **2,932 F** | **1%** | **814,127** |
| **Other Government** | | | | | | | | | |
| IDF's - Mental Health Services | 144 | 144 | | | 1,149 | 1,149 | | | 1,723 |
| IDF's - All others (non Mental health) | 1,781 | 1,443 | 338 F | 23% | 11,218 | 11,543 | (325) U | (3%) | 17,314 |
| Other DHB's | 52 | 25 | 27 F | 107% | 211 | 202 | 10 F | 5% | 302 |
| Training Fees and Subsidies | 3 | 17 | (14) U | (83%) | 110 | 137 | (27) U | (20%) | 206 |
| Accident Insurance | 671 | 709 | (37) U | (5%) | 6,755 | 6,096 | 659 F | 11% | 9,250 |
| Other Government | 407 | 420 | (13) U | (3%) | 4,063 | 3,428 | 635 F | 19% | 5,135 |
| ***Other Government Total*** | **3,057** | **2,757** | **300 F** | **11%** | **23,507** | **22,554** | **953 F** | **4%** | **33,930** |
| ***Government and Crown Agency Total*** | **71,244** | **70,591** | **653 F** | **1%** | **569,189** | **565,304** | **3,885 F** | **1%** | **848,057** |
| **Other Revenue** | | | | | | | | | |
| Patient / Consumer Sourced | 363 | 437 | (73) U | (17%) | 2,412 | 2,112 | 300 F | 14% | 3,265 |
| Other Income | 733 | 901 | (168) U | (19%) | 7,765 | 7,206 | 560 F | 8% | 10,809 |
| ***Other Revenue Total*** | **1,096** | **1,337** | **(241) U** | **(18%)** | **10,177** | **9,318** | **859 F** | **9%** | **14,074** |
| **REVENUE TOTAL** | **72,340** | **71,929** | **411 F** | **1%** | **579,366** | **574,622** | **4,744 F** | **1%** | **862,131** |
| **EXPENSES** | | | | | | | | | |
| **Personnel Expenses** | | | | | | | | | |
| Medical Personnel | (8,677) | (7,946) | (731) U | (9%) | (72,504) | (68,199) | (4,306) U | (6%) | (102,366) |
| Nursing Personnel | (9,593) | (9,673) | 80 F | 1% | (80,581) | (81,245) | 665 F | 1% | (124,592) |
| Allied Health Personnel | (3,939) | (3,839) | (100) U | (3%) | (32,237) | (33,041) | 804 F | 2% | (50,086) |
| Support Services Personnel | (760) | (744) | (16) U | (2%) | (6,445) | (6,470) | 25 F | | (9,767) |
| Management / Admin Personnel | (3,342) | (3,169) | (173) U | (5%) | (28,064) | (28,528) | 464 F | 2% | (42,481) |
| ***Personnel Costs Total*** | **(26,312)** | **(25,371)** | **(940) U** | **(4%)** | **(219,830)** | **(217,482)** | **(2,348) U** | **(1%)** | **(329,292)** |
| **Outsourced Expenses** | | | | | | | | | |
| Medical Personnel | (306) | (558) | 252 F | 45% | (3,989) | (5,069) | 1,081 F | 21% | (7,474) |
| Nursing Personnel | (6) | - | (6) U | | (34) | - | (34) U | | - |
| Allied Health Personnel | (91) | (31) | (60) U | (192%) | (437) | (250) | (187) U | (75%) | (375) |
| Support Personnel | (44) | (21) | (23) U | (107%) | (256) | (171) | (85) U | (50%) | (256) |
| Management / Administration Personnel | 22 | (1) | 23 F | | (134) | (8) | (126) U | | (12) |
| Outsourced Clinical Services | (640) | (530) | (110) U | (21%) | (5,200) | (4,364) | (836) U | (19%) | (6,633) |
| Outsourced Corporate / Governance Services | (183) | (154) | (29) U | (19%) | (1,632) | (1,287) | (345) U | (27%) | (1,925) |
| Outsourced Funder Services | (161) | (114) | (47) U | (41%) | (1,284) | (996) | (287) U | (29%) | (1,486) |
| ***Outsourced Services Total*** | **(1,409)** | **(1,409)** | | | **(12,964)** | **(12,145)** | **(819) U** | **(7%)** | **(18,161)** |
| **Clinical Supplies** | | | | | | | | | |
| Treatment Disposables | (2,127) | (2,305) | 178 F | 8% | (19,568) | (19,302) | (266) U | (1%) | (29,392) |
| Diagnostic Supplies & Other Clinical Supplies | (146) | (147) | 1 F | 1% | (1,240) | (1,223) | (17) U | (1%) | (1,868) |
| Instruments & Equipment | (1,289) | (1,281) | (9) U | (1%) | (10,290) | (10,129) | (160) U | (2%) | (15,261) |
| Patient Appliances | (159) | (178) | 19 F | 11% | (1,385) | (1,367) | (18) U | (1%) | (2,081) |
| Implants & Prosthesis | (678) | (841) | 163 F | 19% | (7,245) | (6,442) | (803) U | (12%) | (9,962) |
| Pharmaceuticals | (1,220) | (1,395) | 176 F | 13% | (11,551) | (11,933) | 382 F | 3% | (18,027) |
| Other Clinical Supplies | (305) | (243) | (62) U | (26%) | (2,164) | (2,022) | (142) U | (7%) | (3,086) |
| ***Clinical Supplies Total*** | **(5,924)** | **(6,390)** | **466 F** | **7%** | **(53,442)** | **(52,417)** | **(1,025) U** | **(2%)** | **(79,676)** |
| **Infrastructure & Non Clinical Expenses** | | | | | | | | | |
| Hotel Services, Laundry & Cleaning | (1,075) | (1,058) | (17) U | (2%) | (8,695) | (8,480) | (215) U | (3%) | (12,724) |
| Facilities | (1,718) | (1,649) | (69) U | (4%) | (13,404) | (13,599) | 195 F | 1% | (20,500) |
| Transport | (328) | (318) | (10) U | (3%) | (2,749) | (2,840) | 91 F | 3% | (4,318) |
| IT Systems & Telecommunications | (896) | (882) | (14) U | (2%) | (6,860) | (7,169) | 309 F | 4% | (10,730) |
| Interest & Financing Charges | (1,189) | (1,320) | 130 F | 10% | (9,943) | (10,648) | 705 F | 7% | (15,926) |
| Professional Fees & Expenses | (195) | (153) | (43) U | (28%) | (1,209) | (1,221) | 12 F | 1% | (1,831) |
| Other Operating Expenses | (373) | (365) | (9) U | (2%) | (2,793) | (3,085) | 292 F | 9% | (4,608) |
| Democracy | (42) | (42) | | (1%) | (631) | (668) | 37 F | 5% | (837) |
| Subsidiaries & Joint Ventures | - | - | | | - | - | | | - |
| ***Infrastructure & Non-Clinical Supplies Total*** | **(5,818)** | **(5,787)** | **(31) U** | **(1%)** | **(46,284)** | **(47,709)** | **1,425 F** | **3%** | **(71,474)** |

# Southern District Health Board

***Feb-14***

| *Part 4: DHB Consolidated* | Current Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Variance | Actual | Budget | Variance | Variance | Budget |
| | $(000) | $(000) | $(000) | % | $(000) | $(000) | $(000) | % | $(000) |
| **Payments to Providers** | | | | | | | | | |
| **Personal Health** | | | | | | | | | |
| Child and Youth | (32) | (35) | 3 F | 10% | (240) | (283) | 42 F | 15% | (424) |
| Laboratory | (2,666) | (2,639) | (27) U | (1%) | (21,504) | (21,113) | (391) U | (2%) | (31,669) |
| Infertility Treatment Services | - | (9) | 9 F | | - | (72) | 72 F | | (108) |
| Maternity | (220) | (220) | | | (1,762) | (1,759) | (3) U | | (2,640) |
| Maternity (Tertiary & Secondary) | (1) | (14) | 13 F | 95% | (20) | (108) | 88 F | 81% | (163) |
| Pregnancy and Parenting Education | (9) | (10) | 1 F | 6% | (67) | (78) | 11 F | 14% | (117) |
| Maternity Payment Schedule | - | - | | | - | - | | | - |
| Neo Natal | - | - | | | - | - | | | - |
| Sexual Health | (2) | (2) | | | (12) | (12) | | | (18) |
| Adolescent Dental Benefit | (172) | (51) | (121) U | (240%) | (1,400) | (1,320) | (80) U | (6%) | (2,110) |
| Other Dental Services | - | - | | | - | - | | | - |
| Dental - Low Income Adult | (44) | (68) | 24 F | 35% | (447) | (543) | 96 F | 18% | (817) |
| Child (School) Dental Services | (37) | (29) | (8) U | (27%) | (231) | (371) | 140 F | 38% | (513) |
| Secondary / Tertiary Dental | (139) | (139) | | | (1,109) | (1,109) | | | (1,667) |
| Pharmaceuticals | (5,560) | (5,517) | (43) U | (1%) | (47,848) | (46,494) | (1,355) U | (3%) | (70,173) |
| Pharmaceutical Cancer Treatment Drugs | - | - | | | - | - | | | - |
| Pharmacy Services | (19) | (60) | 40 F | 67% | (286) | (479) | 193 F | 40% | (718) |
| Management Referred Services | - | - | | | - | - | | | - |
| General Medical Subsidy | (40) | (127) | 87 F | 68% | (621) | (1,106) | 485 F | 44% | (1,650) |
| Primary Practice Services - Capitated | (3,458) | (3,431) | (27) U | (1%) | (27,344) | (27,448) | 104 F | | (41,172) |
| Primary Health Care Strategy - Care | (284) | (240) | (44) U | (18%) | (2,196) | (1,922) | (274) U | (14%) | (2,883) |
| Primary Health Care Strategy - Health | (340) | (286) | (54) U | (19%) | (2,648) | (2,288) | (360) U | (16%) | (3,432) |
| Primary Health Care Strategy - Other | (223) | (207) | (16) U | (8%) | (1,914) | (1,656) | (258) U | (16%) | (2,484) |
| Practice Nurse Subsidy | (16) | (17) | | 3% | (135) | (132) | (3) U | (3%) | (198) |
| Rural Support for Primary Health Pro | (1,300) | (1,301) | 1 F | | (10,419) | (10,406) | (13) U | | (15,609) |
| Immunisation | (50) | (60) | 10 F | 17% | (521) | (500) | (21) U | (4%) | (1,840) |
| Radiology | (201) | (190) | (11) U | (6%) | (1,552) | (1,522) | (30) U | (2%) | (2,283) |
| Palliative Care | (450) | (492) | 41 F | 8% | (3,894) | (3,934) | 41 F | 1% | (5,901) |
| Meals on Wheels | (20) | (19) | (1) U | (3%) | (160) | (155) | (5) U | (3%) | (233) |
| Domicilary & District Nursing | (390) | (448) | 58 F | 13% | (3,467) | (3,583) | 115 F | 3% | (5,374) |
| Community based Allied Health | (168) | (167) | | | (1,342) | (1,339) | (3) U | | (2,009) |
| Chronic Disease Management and Educa | (80) | (82) | 2 F | 2% | (643) | (655) | 11 F | 2% | (982) |
| Medical Inpatients | - | - | | | - | - | | | - |
| Medical Outpatients | (233) | (396) | 163 F | 41% | (2,955) | (3,167) | 212 F | 7% | (4,750) |
| Surgical Inpatients | (10) | (20) | 10 F | 52% | (149) | (159) | 10 F | 6% | (239) |
| Surgical Outpatients | (139) | (144) | 5 F | 4% | (1,117) | (1,153) | 36 F | 3% | (1,729) |
| Paediatric Inpatients | - | - | | | - | - | | | - |
| Paediatric Outpatients | - | - | | | - | - | | | - |
| Pacific Peoples' Health | (7) | (12) | 4 F | 36% | (66) | (93) | 28 F | 30% | (140) |
| Emergency Services | (151) | (160) | 9 F | 6% | (1,251) | (1,284) | 33 F | 3% | (1,926) |
| Minor Personal Health Expenditure | (49) | (52) | 2 F | 4% | (379) | (413) | 34 F | 8% | (619) |
| Price adjusters and Premium | (237) | (107) | (130) U | 121% | (1,333) | (857) | (476) U | 56% | (1,285) |
| Travel & Accomodation | (294) | (299) | 5 F | 2% | (3,045) | (2,993) | (53) U | (2%) | (4,690) |
| Inter District Flow Personal Health | (2,264) | (2,148) | (116) U | (5%) | (17,588) | (17,186) | (401) U | (2%) | (25,780) |
| ***Personal Health Total*** | **(19,306)** | **(19,197)** | **(109) U** | **(1%)** | **(159,664)** | **(157,689)** | **(1,975) U** | **(1%)** | **(238,342)** |
| **Mental Health** | | | | | | | | | |
| Mental Health to allocate | - | - | | | - | - | | | - |
| Acute Mental Health Inpatients | - | - | | | - | - | | | - |
| Sub-Acute & Long Term Mental Health | - | - | | | - | - | | | - |
| Crisis Respite | (5) | (5) | | (1%) | (37) | (38) | | 1% | (57) |
| Alcohol & Other Drugs - General | (83) | (59) | (24) U | (40%) | (679) | (472) | (207) U | (44%) | (708) |
| Alcohol & Other Drugs - Child & Youth | (8) | (24) | 16 F | 66% | (285) | (191) | (94) U | (50%) | (286) |
| Methadone | - | - | | | - | - | | | - |
| Dual Diagnosis - Alcohol & Other Drugs | (3) | (36) | 33 F | 91% | (41) | (290) | 250 F | 86% | (436) |
| Dual Diagnosis - MH/ID | - | - | | | - | - | | | - |
| Eating Disorder | (14) | (14) | | | (111) | (112) | | | (168) |
| Maternal Mental Health | (4) | (4) | | | (29) | (29) | | | (44) |
| Child & Youth Mental Health Services | (360) | (281) | (80) U | (28%) | (2,501) | (2,247) | (254) U | (11%) | (3,371) |
| Forensic Services | - | (4) | 4 F | | - | (29) | 29 F | | (43) |
| Kaupapa Maori Mental Health Services | (6) | (6) | | 2% | (49) | (50) | 1 F | 2% | (76) |
| Kaupapa Maori Mental Health - Residentual | - | - | | | - | - | | | - |
| Kaupapa Maori Mental Health - Inpati | - | - | | | - | - | | | - |
| Mental Health Community Services | (124) | (136) | 11 F | 8% | (948) | (1,085) | 138 F | 13% | (1,629) |
| Prison/Court Liaison | - | - | | | - | - | | | - |
| Mental Health Workforce Development | - | - | | | - | - | | | - |
| Day Activity & Work Rehabilitation S | (136) | (135) | (2) U | (1%) | (1,091) | (1,077) | (14) U | (1%) | (1,615) |
| Mental Health Funded Services for Older People | - | - | | | - | - | | | - |
| Advocacy / Peer Support - Consumer | (23) | (22) | (1) U | (3%) | (187) | (180) | (8) U | (4%) | (270) |
| Other Home Based Residential Support | (323) | (317) | (6) U | (2%) | (2,738) | (2,533) | (205) U | (8%) | (3,800) |
| Advocacy / Peer Support - Families | (52) | (60) | 8 F | 13% | (416) | (479) | 63 F | 13% | (720) |
| Community Residential Beds & Service | (451) | (451) | | | (3,529) | (3,607) | 78 F | 2% | (5,411) |
| Minor Mental Health Expenditure | (20) | (32) | 12 F | 37% | (350) | (258) | (92) U | (36%) | (388) |
| Inter District Flow Mental Health | (441) | (441) | | | (3,530) | (3,530) | | | (5,294) |
| ***Mental Health Total*** | **(2,054)** | **(2,026)** | **(28) U** | **(1%)** | **(16,523)** | **(16,208)** | **(315) U** | **(2%)** | **(24,315)** |
| **Public Health** | | | | | | | | | |
| Alcohol & Drug | - | - | | | - | - | | | - |
| Communicable Diseases | - | - | | | - | - | | | - |
| Injury Prevention | - | - | | | - | - | | | - |
| Mental Health | - | - | | | - | - | | | - |
| Screening Programmes | - | - | | | - | - | | | - |
| Nutrition and Physical Activity | (27) | (23) | (4) U | (18%) | (213) | (181) | (32) U | (18%) | (272) |
| Physical Environment | - | - | | | - | - | | | - |
| Public Health Infrastructure | - | - | | | - | - | | | - |
| Sexual Health | - | - | | | - | - | | | - |
| Social Environments | - | - | | | - | - | | | - |
| Tobacco Control | (24) | (12) | (12) U | (92%) | (201) | (100) | (101) U | (102%) | (150) |
| Well Child Promotion | - | - | | | - | - | | | - |
| Meningococcal | - | - | | | - | - | | | - |
| ***Public Health Total*** | **(51)** | **(35)** | **(16) U** | **(44%)** | **(415)** | **(281)** | **(133) U** | **(47%)** | **(422)** |

# Southern District Health Board

***Feb-14***

| ***Part 4: DHB Consolidated*** | Current Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Variance | Actual | Budget | Variance | Variance | Budget |
| | $(000) | $(000) | $(000) | % | $(000) | $(000) | $(000) | % | $(000) |
| **Disability Support Services** | | | | | | | | | |
| AT & R (Assessment, Treatment and Re | (297) | (297) | | | (2,380) | (2,380) | | | (3,569) |
| Information and Advisory | (12) | (13) | 1 F | 9% | (72) | (104) | 32 F | 31% | (156) |
| Needs Assessment | (39) | (22) | (17) U | (80%) | (266) | (173) | (93) U | (53%) | (260) |
| Service Co-ordination | 1 | - | 1 F | | (8) | - | (8) U | | - |
| Home Support | (1,202) | (1,267) | 65 F | 5% | (11,022) | (10,436) | (586) U | (6%) | (15,504) |
| Carer Support | (118) | (156) | 38 F | 24% | (1,036) | (1,249) | 213 F | 17% | (1,874) |
| Residential Care: Rest Homes | (2,552) | (2,752) | 200 F | 7% | (23,347) | (23,887) | 541 F | 2% | (35,880) |
| Residential Care: Loans Adjustment | 9 | 22 | (13) U | (60%) | 133 | 178 | (45) U | (25%) | 266 |
| Long Term Chronic Conditions | (95) | (85) | (11) U | (13%) | (1,038) | (676) | (361) U | (53%) | (1,015) |
| Residential Care: Hospitals | (3,570) | (3,277) | (294) U | (9%) | (29,232) | (28,437) | (795) U | (3%) | (42,714) |
| Ageing in Place | - | - | | | - | - | | | - |
| Environmental Support Services | (96) | (99) | 3 F | 3% | (785) | (791) | 6 F | 1% | (1,191) |
| Day Programmes | - | - | | | - | - | | | - |
| Expenditure to Attend Treatment ETAT | - | - | | | - | - | | | - |
| Minor Disability Support Expenditure | - | (17) | 17 F | | (6) | (140) | 134 F | 96% | (209) |
| Respite Care | (157) | (130) | (27) U | (21%) | (1,165) | (1,124) | (41) U | (4%) | (1,691) |
| Community Health Services & Support | (45) | (84) | 39 F | 46% | (328) | (672) | 344 F | 51% | (1,008) |
| Inter District Flow Disability Support | (282) | (261) | (22) U | (8%) | (2,113) | (2,085) | (28) U | (1%) | (3,128) |
| Disability Support Other | - | - | | | - | - | | | - |
| ***Disability Support Services Total*** | **(8,458)** | **(8,438)** | **(20) U** | | **(72,666)** | **(71,977)** | **(689) U** | **(1%)** | **(107,932)** |
| **Maori Health** | | | | | | | | | |
| Maori Service Development | (22) | (22) | | | (178) | (178) | | | (267) |
| Maori Provider Assistance Infrastruc | - | - | | | - | - | | | - |
| Moari Workforce Development | - | - | | | - | - | | | - |
| Minor Maori Health Expenditure | - | - | | | - | - | | | - |
| Whanau Ora Services | (107) | (108) | 1 F | 1% | (854) | (859) | 5 F | 1% | (1,290) |
| ***Maori Health Total*** | **(129)** | **(130)** | **1 F** | **1%** | **(1,032)** | **(1,037)** | **5 F** | | **(1,557)** |
| Internal Allocations | - | - | | | - | - | | | - |
| **Total Expenses** | **(69,461)** | **(68,783)** | **(678) U** | **(1%)** | **(582,821)** | **(576,946)** | **(5,875) U** | **(1%)** | **(871,171)** |
| **Net Surplus/ (Deficit)** | **2,880** | **3,146** | **(266) U** | **(8%)** | **(3,455)** | **(2,324)** | **(1,131) U** | **(49%)** | **(9,039)** |
| *Zero Check* | - | - | | | - | - | | | - |
| **Part 4.1 A: Supplementary Information to Statement of Financial Performance** | | | | | | | | | |
| Depreciation - Clinical Equipment | (652) | (641) | (11) U | (2%) | (5,165) | (5,090) | (75) U | (1%) | (7,655) |
| Depreciation - Non Residential Buildings & Plant | (696) | (679) | (17) U | (2%) | (5,483) | (5,395) | (89) U | (2%) | (8,100) |
| Depreciation - Motor Vehicles | (23) | (9) | (14) U | (156%) | (130) | (73) | (57) U | (79%) | (108) |
| Depreciation - Information Techology | (245) | (199) | (45) U | (23%) | (1,936) | (1,697) | (239) U | (14%) | (2,528) |
| Depreciation - Other Equipment | (55) | (37) | (18) U | (49%) | (393) | (311) | (81) U | (26%) | (468) |
| Total Depreciation | (1,671) | (1,565) | (106) U | (7%) | (13,107) | (12,566) | (541) U | (4%) | (18,860) |
| Interest Cost from Funder Loans | - | - | | | - | - | | | - |
| Interest Costs from CHFA | (346) | (401) | 55 F | 14% | (2,999) | (3,205) | 206 F | 6% | (4,808) |
| Financing Component of Operating Leases | (30) | (28) | (2) U | (8%) | (160) | (225) | 65 F | 29% | (338) |
| Capital Charge | (795) | (866) | 71 F | 8% | (6,636) | (7,015) | 379 F | 5% | (10,476) |

# Southern District Health Board

***Feb-14***

| *Part 4: DHB Consolidated* | Current Month Actual $ (000) | Previous Month Actual $(000) | Movement $(000) | Current Budget $(000) | Current Year Opening Balance Sheet $(000) | Annual Budget $(000) |
|---|---|---|---|---|---|---|
| **Part 4.2: Balance Sheet** | | | | | | |
| **Current Assets** | | | | | | |
| Petty Cash | 16 | 16 | - | 15 | 15 | 15 |
| Bank | 263 | 245 | 18 | - | (401) | - |
| Short Term Investments - HBL | 9,745 | 9,551 | 194 | 9,578 | 27,629 | 12,242 |
| Short Term Investments | - | - | - | - | - | - |
| Prepayments | 2,842 | 3,146 | (303) | 2,420 | 1,639 | 2,530 |
| Accounts Receivable | 6,149 | 7,099 | (950) | 6,000 | 7,519 | 6,000 |
| Provision for Doubtful Debts | (1,968) | (1,968) | - | (1,695) | (1,839) | (1,695) |
| Accrued Debtors | 21,058 | 18,381 | 2,677 | 25,679 | 15,707 | 26,417 |
| Inventory / Stock | 4,809 | 4,719 | 89 | 4,422 | 4,817 | 4,422 |
| ***Current Assets Total*** | **42,914** | **41,189** | **1,725** | **46,419** | **55,086** | **49,932** |
| **Non Current Assets** | | | | | | |
| Land, Buildings & Plant | 267,821 | 267,573 | 248 | 270,196 | 259,028 | 279,029 |
| Clinical Equipment (incl Finance Leases) | 107,739 | 107,406 | 332 | 123,895 | 111,928 | 126,395 |
| Other Equipment (incl Finance Leases) | 14,948 | 14,929 | 20 | 14,466 | 15,515 | 14,546 |
| Information Technology | 37,839 | 37,565 | 274 | 42,943 | 36,469 | 45,125 |
| Motor Vehicles | 2,343 | 2,323 | 20 | 1,210 | 1,484 | 1,210 |
| Provision Depreciation - Buildings & Plant | (29,979) | (29,283) | (696) | (30,081) | (24,497) | (32,787) |
| Provision Depreciation - Clinical Equipment | (71,846) | (71,271) | (575) | (80,172) | (74,745) | (82,774) |
| Provision Depreciation - Other Equipment | (11,350) | (11,294) | (55) | (12,150) | (11,787) | (12,322) |
| Provision Depreciation - Information Technology | (27,537) | (27,390) | (147) | (27,639) | (25,814) | (28,540) |
| Provision Depreciation - Motor Vehicles | (811) | (788) | (23) | (497) | (391) | (547) |
| WIP | 3,854 | 3,312 | 543 | 7,376 | 6,198 | - |
| Investment in Associates | - | - | - | 278 | - | 280 |
| Long Term Investments | 3,121 | 3,004 | 116 | 3,120 | 1,841 | 3,584 |
| ***Non Current Assets Total*** | **296,143** | **296,085** | **59** | **312,946** | **295,230** | **313,201** |
| **Current Liabilities** | | | | | | |
| Accounts Payable Control | (3,715) | (2,533) | (1,182) | (4,900) | (3,872) | (4,900) |
| Accrued Creditors | (23,730) | (25,497) | 1,767 | (32,084) | (27,670) | (33,345) |
| Income Received in Advance | (1,082) | (1,126) | 45 | (1,743) | (892) | (1,743) |
| Capital Charge Payable | (1,590) | (795) | (795) | (1,734) | (4,731) | - |
| GST & Tax Provisions | (6,297) | (6,694) | 397 | (4,393) | (4,193) | (3,418) |
| Term Loans - Finance Leases (current portion) | (1,021) | (948) | (72) | (1,120) | (943) | (1,120) |
| Term Loans - Crown (current portion) | (10,726) | (10,726) | - | (17,663) | (10,806) | (17,363) |
| Payroll Accrual & Clearing Accounts | (13,625) | (14,610) | 984 | (10,506) | (12,494) | (13,331) |
| Employee Entitlement Provisions | (43,614) | (43,441) | (173) | (43,985) | (46,597) | (43,985) |
| ***Current Liabilities Total*** | **(105,399)** | **(106,371)** | **972** | **(118,128)** | **(112,199)** | **(119,203)** |
| **WORKING CAPITAL** | **(62,485)** | **(65,182)** | **2,697** | **71,709** | **(57,114)** | **(69,271)** |
| **NET FUNDS EMPLOYED** | **233,658** | **230,902** | **2,755** | **241,237** | **238,116** | **243,929** |
| **Non Current Liabilities** | | | | | | |
| Long Service Leave - Non Current Portion | (2,994) | (2,994) | - | (3,376) | (3,085) | (3,376) |
| Retirement Gratuities - Non Current Portion | (10,730) | (10,769) | 40 | (12,688) | (11,147) | (12,688) |
| Other Employee Entitlement Provisions | (1,213) | (1,213) | - | - | (1,237) | - |
| Term Loans - Finance Leases (non current portion | (2,736) | (2,806) | 70 | (4,583) | (2,945) | (4,477) |
| Term Loans - Crown (non current portion) | (90,752) | (90,767) | 15 | (84,092) | (91,014) | (84,092) |
| Custodial Funds | - | - | - | - | - | - |
| ***Non Current Liabilities Total*** | **(108,425)** | **(108,549)** | **124** | **(104,739)** | **(109,428)** | **(104,633)** |
| **Crown Equity** | | | | | | |
| Crown Equity | (171,495) | (171,495) | - | (179,871) | (171,495) | (175,371) |
| Crown Equity Injection | - | - | - | | - | (14,721) |
| Crown Equity Repayments | - | - | - | | - | 707 |
| Trust and Special Funds (no restricted use) | (4,966) | (4,897) | (69) | | (5,085) | - |
| Revaluation Reserve | (84,515) | (84,515) | - | (85,362) | (84,515) | (85,362) |
| Retained Earnings - DHB Governance & Funding | 3,591 | 3,586 | 5 | 2,882 | 2,967 | 2,772 |
| Retained Earnings - DHB Provider | 97,206 | 98,279 | (1,073) | 91,011 | 93,256 | 96,282 |
| Retained Earnings - Funds | 34,947 | 36,689 | (1,742) | 34,842 | 36,184 | 36,397 |
| ***Crown Equity Total*** | **(125,233)** | **(122,353)** | **(2,880)** | **(136,498)** | **(128,688)** | **(139,296)** |
| **NET FUNDS EMPLOYED** | **(233,658)** | **(230,902)** | **(2,755)** | **(241,237)** | **(238,116)** | **(243,929)** |
| Zero Check | - | - | - | (0) | - | 0 |
| **Part 4.3: Statement of Movement in Equity** | | | | | | |
| Total equity at beginning of the period | (122,353) | (121,782) | | (134,322) | (128,688) | (134,322) |
| Net Results for Period | (2,880) | (571) | | 2,324 | - | 9,039 |
| Revaluation of Fixed Assets | - | - | | - | - | - |
| Equity Injections - Deficit Support | - | - | | (4,500) | - | (9,000) |
| Equity Injections - Capital Projects | - | - | | - | - | (5,721) |
| Equity Repayments | - | - | | - | - | 707 |
| Other | - | - | | - | - | - |
| Movement in Trust and Special Funds | - | - | | - | - | - |
| **Total Equity at end of the period** | **(125,233)** | **(122,353)** | | **(136,498)** | **(128,688)** | **(139,296)** |

# Board Cash Flow - Southern

***Feb-14***

| ***Part 4: DHB Consolidated*** | Current Month | | | Year to Date | | | Annual |
|---|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** | **Budget** |
| | **$(000)** | **$(000)** | **$(000)** | **$(000)** | **$(000)** | **$(000)** | **$(000)** |
| **Part 4.4 Statement of Cashflows** | | | | | | | |
| **Operating Revenue** | | | | | | | |
| Government and Crown Agency Revenue | 69,473 | 70,277 | (804) U | 565,526 | 564,600 | 926 F | 846,500 |
| Other Revenue Received | 1,024 | 1,001 | 23 F | 8,937 | 7,635 | 1,302 F | 11,851 |
| ***Total Receipts*** | **70,497** | **71,278** | **(781) U** | **574,463** | **572,235** | **2,228 F** | **858,351** |
| Payments for Personnel | (27,163) | (26,712) | (451) U | (222,215) | (219,234) | (2,981) U | (328,220) |
| Payments for Supplies | (9,174) | (10,845) | 1,671 F | (93,020) | (88,144) | (4,876) U | (133,169) |
| Interest Paid | (30) | (27) | (3) U | (2,417) | (2,615) | 198 F | (5,107) |
| Capital Charge Paid | - | - | | (9,778) | (5,275) | (4,503) U | (10,499) |
| GST (Net) & Tax | (397) | (10) | (387) U | 2,103 | 741 | 1,362 F | (69) |
| Payment to own DHB Provider (Eliminated) | - | - | | - | - | | - |
| Payment to own DHB Governance & Funding Admin | - | - | | - | - | | - |
| Payments to other DHBs | (2,974) | (2,850) | (124) U | (22,365) | (22,801) | 436 F | (34,202) |
| Payments to Providers | (28,850) | (27,723) | (1,127) U | (230,523) | (225,234) | (5,289) U | (337,910) |
| ***Total Payments*** | **(68,588)** | **(68,167)** | **(421) U** | **(578,215)** | **(562,562)** | **(15,653) U** | **(849,176)** |
| ***Net Cashflow from Operating*** | **1,909** | **3,111** | **(1,202) U** | **(3,752)** | **9,673** | **(13,425) U** | **9,175** |
| **Investing Activities** | | | | | | | |
| Interest Receipts 3rd Party | 72 | 185 | (113) U | 1,208 | 1,480 | (272) U | 2,220 |
| Sale of Fixed Assets | - | - | | 32 | - | 32 F | - |
| **Capital Expenditure** | | | | | | | |
| Land, Buildings & Plant | (261) | (830) | 569 F | (5,037) | (8,819) | 3,782 F | (10,276) |
| Clinical Equipment | (592) | (500) | (92) U | (4,765) | (8,965) | 4,200 F | (11,465) |
| Other Equipment | (16) | (40) | 24 F | (380) | (320) | (60) U | (400) |
| Information Technology | (596) | (502) | (94) U | (2,020) | (4,676) | 2,656 F | (6,583) |
| Motor Vehicles | (20) | - | (20) U | (20) | - | (20) U | - |
| Work in Progress (Check) | (204) | - | (204) U | - | - | | - |
| ***Total Capital Expenditure*** | **(1,689)** | **(1,872)** | **183 F** | **(12,222)** | **(22,780)** | **10,558 F** | **(28,724)** |
| Increase in Investments and Restricted & Trust Funds Assets | (116) | (116) | | (1,280) | (1,280) | | (1,746) |
| ***Net Cashflow from Investing*** | **(1,733)** | **(1,803)** | **70 F** | **(12,262)** | **(22,580)** | **10,318 F** | **(28,250)** |
| **Financing Activities** | | | | | | | |
| Equity Injections | - | - | | - | 4,500 | (4,500) U | 14,014 |
| **New Debt** | | | | | | | |
| Private Sector | - | - | | - | | | - |
| CHFA | - | - | | - | | | - |
| **Repaid Debt** | | | | | | | |
| Private Sector | 68 | (94) | 162 F | (731) | (852) | 121 F | (1,233) |
| CHFA | (32) | - | (32) U | (475) | (300) | (175) U | (600) |
| **Other Non-Current Liability Movement** | | | | | | | |
| Other Equity Movement | - | - | | - | - | | - |
| ***Net Cashflow from Financing*** | **36** | **(94)** | **130 F** | **(1,206)** | **3,348** | **(4,554) U** | **12,181** |
| **Net Cashflow** | **212** | **1,214** | (1,002) U | **(17,220)** | **(9,559)** | (7,661) U | **(6,894)** |
| Plus Cash (Opening) | 9,811 | 8,379 | 1,432 F | 27,243 | 19,152 | 8,091 F | 19,151 |
| Cash (Closing) | **10,023** | **9,593** | **430 F** | **10,023** | **9,593** | **430 F** | **12,257** |
| Carry Forward Check | | | | | | | |
| **Closing Cash made up of:** | | | | | | | |
| Petty Cash | 16 | 15 | 1 F | 16 | 15 | 1 F | 15 |
| Bank (Overdraft) | 263 | - | 263 F | 263 | - | 263 F | - |
| Short Term Investments | 9,744 | 9,578 | 166 F | 9,744 | 9,578 | 166 F | 12,242 |
| ***Total Cashflow Cash (Closing)*** | **10,023** | **9,593** | **430 F** | **10,023** | **9,593** | **430 F** | **12,257** |

Southern DHB
Forecast as at 28 February 2014

**Governance**

| Description | $000 YTD Actual | $000 Remaining Budget | $000 Actual + remaining budget | $000 Adjustment | $000 Full Year Forecast | $000 Full Year Budget | $000 Variance | Comment |
|---|---|---|---|---|---|---|---|---|
| **REVENUE** | | | 0 | | | | | |
| Internal revenue (DHB Fund to DHB Governance & Funding Administ | 5,586 | 2,793 | 8,379 | (1) | 8,378 | 8,379 | (1) | |
| Other Government | 69 | 0 | 69 | 32 | 101 | 0 | 101 | |
| **REVENUE TOTAL** | **5,655** | **2,793** | **8,448** | **31** | **8,479** | **8,379** | **100** | |
| **Personnel costs** | | | 0 | 0 | | | | |
| Medical Personnel | (17) | (78) | (95) | 78 | (17) | (233) | 216 | favourable variance offset in outsourced |
| Nursing Personnel | 0 | (3) | (3) | 3 | 0 | (9) | 9 | |
| Support Personnel | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Management/Administration Personnel | (2,333) | (1,149) | (3,482) | (51) | (3,533) | (3,440) | (93) | |
| **Personnel costs Total** | **(2,350)** | **(1,230)** | **(3,580)** | **30** | **(3,550)** | **(3,682)** | **132** | |
| **Expenditure** | | | 0 | 0 | | | | |
| Outsourced Services | (2,368) | (807) | (3,175) | (137) | (3,312) | (2,439) | (873) | partly offset above |
| Clinical Supplies | (0) | 0 | (0) | 0 | (0) | 0 | (0) | |
| Infrastructure & Non-Clinical Supplies | (1,560) | (645) | (2,205) | 94 | (2,111) | (2,257) | 147 | costs forecast to reduce slightly |
| **Expenditure Total** | **(3,928)** | **(1,453)** | **(5,381)** | **(43)** | **(5,423)** | **(4,697)** | **(727)** | |
| **Net Surplus / (Deficit)** | **(623)** | **110** | **(513)** | **19** | **(495)** | **0** | **(495)** | |

**Provider**

| Description | $000 YTD Actual | $000 Remaining Budget | $000 Actual + remaining budget | $000 Adjustment | $000 Full Year Forecast | $000 Full Year Budget | $000 Variance | |
|---|---|---|---|---|---|---|---|---|
| **Revenue** | | | | | | | | |
| Government & Crown Agency Sourced | 21,896 | 10,326 | 32,222 | 264 | 32,486 | 30,774 | 1,713 | Additional ACC, Research revenue and CTA |
| Non Government & Crown Agency Revenue | 10,177 | 4,756 | 14,933 | 195 | 15,128 | 14,074 | 1,054 | Additional Donations and other income |
| Internal Revenue | 290,101 | 145,814 | 435,915 | (763) | 435,152 | 437,441 | (2,289) | Mental Health internal revenue reduction offset by additional revenue transfers |
| **Revenue Total** | **322,174** | **160,895** | **483,069** | **(304)** | **482,765** | **482,289** | **477** | |
| **Personnel** | | | 0 | 0 | | | | |
| Personnel | | | 0 | 0 | | | | |
| Medical Personnel | (72,488) | (34,089) | (106,577) | (1,826) | (108,403) | (102,133) | (6,270) | Extrapolated |
| Nursing Personnel | (80,581) | (43,344) | (123,924) | 600 | (123,324) | (124,583) | 1,259 | Extrapolated and adjusted for savings Feb-June |
| Allied Health Personnel | (32,237) | (17,046) | (49,283) | 415 | (48,868) | (50,086) | 1,219 | Extrapolated |
| Support Personnel | (6,445) | (3,297) | (9,742) | 0 | (9,742) | (9,767) | 25 | |
| Management & Administration Personnel | (25,730) | (12,804) | (38,535) | (153) | (38,688) | (39,040) | 353 | Reduced budgeted restructure savings from Feb-June |
| **Personnel Total** | **(217,480)** | **(110,580)** | **(328,061)** | **(965)** | **(329,025)** | **(325,610)** | **(3,415)** | |
| **Expenditure** | | | 0 | 0 | | | | |
| Outsourced Services | (10,596) | (5,208) | (15,805) | 75 | (15,729) | (15,722) | (7) | Radiology outsourcing not budgeted with recruitment unsuccessful |
| Clinical Supplies | (53,442) | (27,259) | (80,701) | (330) | (81,031) | (79,677) | (1,354) | Costs over budget in Treatment Disposables and Implants and Prostheses |
| Infrastructure & Non-Clinical Supplies | (44,724) | (23,118) | (67,843) | (317) | (68,160) | (69,215) | 1,056 | |
| **Expenditure Total** | **(108,762)** | **(55,586)** | **(164,348)** | **(571)** | **(164,920)** | **(164,614)** | **(306)** | |
| **Net Surplus / (Deficit)** | **(4,069)** | **(5,271)** | **(9,339)** | **(1,840)** | **(11,179)** | **(7,936)** | **(3,244)** | |

**Funder**

| Description | $000 YTD Actual | $000 Remaining Budget | $000 Actual + remaining budget | $000 Adjustment | $000 Full Year Forecast | $000 Full Year Budget | $000 Variance | |
|---|---|---|---|---|---|---|---|---|
| **Revenue** | | | | | | | | |
| Government & Crown Agency Sourced | 547,224 | 272,428 | 819,651 | 411 | 820,062 | 817,283 | 2,779 | Revenue higher than budget, and has cost offset |
| **Revenue Total** | **547,224** | **272,428** | **819,651** | **411** | **820,062** | **817,283** | **2,779** | |
| **Expenditure** | | | 0 | 0 | | | | |
| Outsourced Services | (5,586) | (2,793) | (8,379) | 1 | (8,378) | (8,379) | 1 | |
| Provider Payments | | | 0 | 0 | | | | |
| Payments to Providers - Personal Health | (387,062) | (194,563) | (581,625) | 1,589 | (580,036) | (580,072) | 36 | Pharms, labs and Palliative care all ahead of budget offset by savings in medical outpatients |
| Payments to Providers - Public Health | (7,640) | (3,454) | (11,095) | (16) | (11,111) | (10,363) | (748) | Additional costs offset with revenue |
| Payments to Providers - Mental Health | (56,799) | (29,079) | (85,878) | 799 | (85,079) | (87,232) | 2,153 | Mental Health internal wash-up continuing |
| Payments to Providers - Disability Support | (87,679) | (43,479) | (131,158) | (577) | (131,735) | (130,502) | (1,233) | Forecast ahead of budget, partly offset by additional revenue |
| Payments to Providers - Hauora Maori Services | (1,221) | (615) | (1,835) | 3 | (1,833) | (1,840) | 7 | |
| **Expenditure Total** | **(545,986)** | **(273,983)** | **(819,969)** | **1,798** | **(818,171)** | **(818,387)** | **216** | |
| **Net Surplus / (Deficit)** | **1,237** | **(1,555)** | **(318)** | **2,210** | **1,892** | **(1,104)** | **2,996** | |

| | $000 YTD Actual | $000 Remaining Budget | $000 Actual + remaining budget | $000 Adjustment | $000 Full Year Forecast | $000 Full Year Budget | $000 Variance | |
|---|---|---|---|---|---|---|---|---|
| **Consolidated Result** | **(3,455)** | **(6,715)** | **(10,170)** | **388** | **(9,782)** | **(9,039)** | **(743)** | |

# SOUTHERN DISTRICT HEALTH BOARD

| | |
|---|---|
| **Title:** | **DEBT RENEWAL** |
| **Report to:** | Board |
| **Date of Meeting:** | 03 April 2014 |

**Summary:**

The issues considered in this paper are:

- Debt rollover

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

| | |
|---|---|
| **Financial:** | Yes |
| **Workforce:** | n/a |
| **Other:** | n/a |

| | | |
|---|---|---|
| **Document previously submitted to:** | n/a | |
| **Approved by Chief Executive Officer:** | | **Date:** 25/03/14 |

| **Prepared by:** | **Presented by:** |
|---|---|
| David Dickson<br>Finance Manager<br>**Date:** 19/03/14 | Peter Beirne<br>Executive Director Finance |

**RECOMMENDATION:**

**That the the rollover of $10.0m debt maturing on 15 April 2014 to a maturity date of 15 April 2023, with an indicative interest rate of 4.68%, be approved.**

## *Debt Renewal*

**RECOMMENDATION**

That the Board approve the rollover of $10.0m debt maturing on 15th April 2014 to a maturity date of 15 April 2023 with an indicative interest rate of 4.68%

| | | | |
|---|---|---|---|
| **Briefing to:** | Board | | |
| **Subject:** | Debt renewal | | |
| **Author:** | David Dickson | Date | 17/03/2014 |

**Purpose of Report :** **For Information Only** √ **Decision Required**

### Background

The current DHB debt with the CHFA (now administered by the MOH) is $97.4m with a loan of $10.0m maturing on the 15th April 2014.

The DHB is not in a position to repay debt, and historically has rolled over any debt when it comes due. The budget for 2013/14 has this as the assumption, as does the 2014/15 and out years budgets.

The current debt amounts and terms are as follows;

| Loan Name | Principal | Maturity Date | Interest Rate |
|---|---|---|---|
| **Sthn DHB 76495/76735** | **10,000,000** | **15/04/2014** | **4.28%** |
| SL008 86369/86610 | 6,000,000 | 15/04/2015 | 2.61% |
| CHFA OT DHB 54633 | 6,250,000 | 15/04/2015 | 6.55% |
| Sthn DHB 77102/77342 | 10,000,000 | 15/04/2016 | 4.75% |
| CHFA SL007 70812/71052 | 6,000,000 | 15/04/2016 | 5.75% |
| SL008 86369/86610 | 6,000,000 | 15/12/2017 | 2.94% |
| CHFA OT DHB 54634 | 10,000,000 | 15/12/2017 | 6.42% |
| Sthn DHB 76496/76736 | 10,000,000 | 15/12/2018 | 5.06% |
| Sthn DHB 77103/77343 | 7,000,000 | 15/12/2019 | 5.22% |
| Sthn DHB 81819/82059 | 4,500,000 | 15/03/2019 | 4.34% |
| Sthn DHB 81819/82059 | 5,400,000 | 15/05/2021 | 4.40% |
| Sthn DHB 81819/82059 | 1,250,000 | 15/05/2021 | 4.40% |
| SL007 70811/71051 | 5,000,000 | 15/05/2021 | 3.44% |
| Sthn DHB 86368/86608 | 5,000,000 | 15/05/2021 | 3.37% |
| Sthn DHB 77101/77341 | 5,000,000 | 15/05/2021 | 3.44% |

### Roll over

Over the past several years the cost of debt has reduced with medium and long term interest rates now historically very favourable. The indicative rate for maturity to April 2023 is 4.68%, with shorter term rates lower, May 21 at 4.49%, and April 20 at 4.40%

We have a number of loans with maturity dates of May 2021, which as at June 2014 move into the 5-7 year band, resulting in no loans with maturity dates of 7 plus years, therefore the full $10m has been recommended to have a maturity date of 2023.

The 2014-15 budget interest rate assumed for this renewal was 5% with the indicative rate as above the interest cost will be $32k less than budgeted for 2014-15. There is also $6k less interest costs than budgeted for 2013-2014 financial year with the proposed rollover.

The recommendation fit compared to the guidelines provided by the Treasury policy is as follows:

| Value | Maturity | Term | % of loan portfolio* | Range in Policy |
|---|---|---|---|---|
| $12.25m | $6.0m April 2014<br>$6.25m April 2014 | Less 1 Year | 13% | 0-20% |
| $16m | $16m April 2016 | 1-2 Years | 16% | 0-20% |
| $30.5m | $10m Dec 2017<br>$10m Dec 2018<br>$4.5m Mar 2019<br>$6m Dec 2017 | 2-5 Years | 31% | 20-35% |
| $28.65m | $7m Dec 2019<br>$21.65m May 2021 | 5-7 Years | 29% | 10-25% |
| **$10m | $10m Apr 2023 | > 7 Years | 10% | 0-25% |

*As at June 2014
** Proposed rollover

# Southern District Health Board

## Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 5 March 2014, commencing at 9.00 am, in the Board Room, Southland Hospital Campus, Invercargill

| | | |
|---|---|---|
| **Present:** | Ms Sandra Cook | Chair |
| | Mrs Kaye Crowther | |
| | Dr Branko Sijnja | |
| | Mr Tim Ward | |
| **In Attendance:** | Mr Joe Butterfield | Board Chair (from 11.00 am) |
| | Dr John Chambers | Board Member |
| | Mrs Mary Gamble | Board Member |
| | Mr Tony Hill | Board Member |
| | Mr Tuari Potiki | Board Member |
| | Mr Richard Thomson | Board Member |
| | Dr Jan White | Crown Monitor |
| | Mrs Sandra Boardman | Executive Director, Planning & Funding |
| | Mr Peter Beirne | Executive Director Finance |
| | Ms Carole Heatly | Chief Executive Officer |
| | Mrs Lexie O'Shea | Deputy CEO/Executive Director Patient Services |
| | Mr Donovan Clarke | Executive Director Māori Health/Kaiwhakahaere Hauora Māori |
| | Mr Ian Macara | Chief Executive, Southern PHO (until 10.55 am) |
| | Dr Keith Reid | Medical Officer of Health, Public Health South (by videoconference until 10.55 am) |
| | Mr David Tulloch | Chief Medical Officer |
| | Ms Jeanette Kloosterman | Board Secretary (by videoconference) |



### 1.0 WELCOME

The Chairperson welcomed everyone to the meeting.

### 2.0 APOLOGIES

Apologies were received from Messrs Neville Cook and Stuart Heal.

### 3.0 MEMBERS' DECLARATION OF INTEREST

Mr Richard Thomson informed the Committees that he was the Dunedin City Council representative on the South Dunedin Social Sector Trial.

***It was resolved:***

**"That the Interests Register be noted."**

## 4.0 PREVIOUS MINUTES

***It was resolved:***

**"That the minutes of the joint meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on 4 February 2014 be approved and adopted as a true and correct record."**

## 5.0 MATTERS ARISING

**Rural Funding Mechanism for General Practices**

The Executive Director Planning & Funding reported that the information provided to the previous meeting which inferred that Queenstown General Practices did not meet the new criteria for rural funding was incorrect. There were 15 practices that did not meet the criteria but none were from Southern DHB. A mistaken assumption was made based on modelling done by the collective DHBs in the previous year.

## 6.0 ACTION SHEET

The Committees reviewed the action sheet (agenda item 5) and requested timelines and more progressive action on pharmaceutical expenditure.

## 7.0 PLANNING & FUNDING REPORT

The Executive Director Planning & Funding presented the monthly report on Planning and Funding activities (agenda item 6), then took questions from members

The committees requested:

- A progress report on InterRAI, and
- Further information on the Clinical Laboratory Advisory Group for new lab tests.

## 8.0 SOUTHERN HEALTH ALLIANCE

The Committees considered a report from Prof Robin Gauld, Independent Chair of the Southern Health Alliance Leadership Team (SHALT), on SHALT activities and progress to date (agenda item 7) and:

- Indicated that they would like to see timelines and major KPIs included in future reports;

- Suggested that continuity of care and patient pathways should also be a focus of the acute demand work programme.

## 9.0 PUBLIC HEALTH

Dr Keith Reid, Medical Officer of Health, presented a report on Public Health South activity (agenda item 8), then took questions from members.

## 10.0 SOUTHERN PRIMARY HEALTH ORGANISATION

Mr Ian Macara, Chief Executive, Southern PHO, presented a report on Southern PHO strategic and governance matters, an update on programmes and operational activity, and the PHO's financial position (agenda item 9), then took questions from members.

Members expressed concern that some primary care health targets were not being met. Mr Macara advised that models of care and workforce development would be important for the future.

## 11.0 WORK PLAN

The Committees reviewed the draft DSAC/CPHAC work plan for 2014 (agenda item 10).

The Committees were informed that the Work Plan should be viewed alongside the reporting framework. Full reports on issues such as the Children's Action Plan would be submitted annually but progress would be included in the reporting framework.

## 12.0 TERMS OF REFERENCE

The Committees reviewed the terms of reference for the Disability Support Advisory Committee and Community & Public Health Advisory Committee (agenda item 11).

***It was resolved:***

**"That the Committees recommend the Board approve the terms of reference, subject to the following further modifications:**

- **That a minimum of eight meetings per year be held;**
- **That item 8 of the Community & Public Health Advisory Committees' responsibilities be amended to read, "Providing advice, *in collaboration with the Iwi Governance Committee*, on strategies to reduce disparities …"**

## 13.0 FINANCIAL REPORT

The Executive Director Finance presented the Funder Financial Report for the period ended 31 January 2014 (agenda item 12), then took questions from members.

## 14.0 SOUTHERN DISTRICT HEALTH PROFILE

Dr Pim Allen, Programme Director, Southern Strategic Health Services Plan, joined the meeting to present the health profile of people living in the Southern DHB area (agenda item 13), which would be used as a basis for strategy development and service planning. Dr Allen advised it was a dynamic document that would be updated as more information became available.

***It was resolved:***

**"That the Committees recommend the Board ratify the Southern District Health Profile for DHB use."**

## 15.0 INFORMATION ITEM

A report from the Controller and Auditor-General on *Regional services planning in the health sector* was circulated with the agenda for members' information (item 14) and was taken as read.

## CONFIDENTIAL SESSION

***At 10.45 am it was resolved that the public be excluded for the following agenda items.***

| *General subject:* | *Reason for passing this resolution:* | *Grounds for passing the resolution:* |
|---|---|---|
| 1. Previous Minutes | As per reasons set out in previous agenda | S 34(a), Schedule 4, 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)(i), 9(2)(j) and 9(2)(f)(iv) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations, and to maintain the constitutional convention protecting the confidentiality of advice tendered by Ministers of the Crown and officials. |
| 2. Wakatipu Reference Group Update | To allow activities and negotiations to be carried on without prejudice or disadvantage | As above, section 9(2)(j). |

| *General subject:* | *Reason for passing this resolution:* | *Grounds for passing the resolution:* |
|---|---|---|
| 3. Laboratories Contract | 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). |
| 4. Annual Plan 2014/15 | Plan is subject to Ministerial approval | As above, sections 9(2)(f)(iv) and 9(2)(j). |
| 5. Māori Health Plan 2014/15 | As above | As above. |
| 6. South Island Health Services Plan 2014/15 | As above | As above. |
| 7. Funding Envelope 2014/15 & Planning Assumptions for 2015/16 & 2016/17 | Subject to Cabinet and Government endorsement | As above, sections 9(2)(f)(iv) and 9(2)(j). |

The meeting closed at 12.45 pm.

Confirmed as a correct record:

Chairperson ……

Date ……

# Southern District Health Board

## Minutes of the Hospital Advisory Committee Meeting held on Wednesday, 5 March 2014, commencing at 2.40pm in the Board Room, Community Services Building, Southland Hospital Campus

| | | |
|---|---|---|
| **Present:** | Mr Joe Butterfield | Chairman |
| | Dr John Chambers | |
| | Mrs Mary Gamble | |
| | Mr Tony Hill | |
| | Mr Tuari Potiki | |
| | Mr Richard Thomson | |
| **In Attendance:** | Dr Jan White | Crown Monitor |
| | Ms Sandra Cook | Board member |
| | Mrs Kaye Crowther | Board member |
| | Dr Branko Sijnja | Board member |
| | Ms Carole Heatly | Chief Executive Officer |
| | Mrs Lexie O'Shea | Executive Director of Patient Services/Deputy CEO |
| | Mr Peter Beirne | Executive Director Finance |
| | Mr David Tulloch | Senior Medical Officer |
| | Ms Sandra Boardman | Executive Director Planning & Funding |
| | Mr Richard Bunton | Medical Director of Patient Services |
| | Mr Grant Paris | Senior Business Analyst (via videolink) |
| | Mrs Leanne Samuel | Executive Director Nursing and Midwifery |
| | Mrs Joanne Fannin | Board Secretary Southland |

### 1.0 WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. There were no apologies.

### 2.0 MEMBERS' DECLARATION OF INTEREST

***It was resolved:***

**"That the Interests Register be noted."**

### 3.0 CONFIRMATION OF PREVIOUS MINUTES

***It was resolved:***

**"That the minutes of the 4 February 2014 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 that were not covered by the agenda.

### 5.0 ACTION SHEET

The Committee reviewed the action sheet.

***It was resolved:***

**"That the action sheet be noted."**

### 6.0 EXECUTIVE DIRECTOR OF PATIENT SERVICES (EDPS) REPORT

The Committee received and considered the report from the EDPS.

The Committee received advice on progress with bed day savings, which is ahead of target and engagement with the New Zealand Nurses Organisation (NZNO) on staffing levels.

***It was resolved:***

**"That the report be noted."**

## 7.0 KEY PERFORMANCE INDICATORS (KPIs)

The Committee received and considered the KPI reports and the Committee received advice:

- Relating to the discharge performance and the correlation between elective discharge and elective caseweight delivery performance.
- That processes are in place to ensure delivery for elective discharge performance is being applied fairly across all specialty areas.
- That action is being taken and plans are in place to reduce the number of patients waiting for a first specialist appointment (FSA).
- That the acute readmission rates have decreased since the February 2014 meeting and noted that work is underway to better identify the services where the acute readmission rates are occurring.
- That the outlier bed days as a percentage of bed nights have decreased and noted the improvement in the day of surgery admissions.
- That the target for the number of patients given certainty and their wait time for treatment would be met.

***It was resolved:***

**"That the KPI reports be noted."**

## 8.0 FINANCIAL REPORT

The Committee received and considered the Financial Report and noted the advice that donations received were approximately $500K greater than budget year-to-date.

***It was resolved:***

**"That the report be noted."**

## 9.0 OCCUPATIONAL HEALTH AND SAFETY REPORT

The Committee received and considered the Occupational Health and Safety report.

***It was resolved:***

**"That the Hospital Advisory Committee recommends that the Board:**

- **Receive the report and supports the work being undertaken to address Southern DHB's strategy.**
- **Receives the report (appendix 1) and notes the current accident injury reports.**
- **Receives the report (appendix 2) and notes the Height Safety Audit undertaken by Building and Property Services."**

## 10.0 MASTER SITE PLANNING PROJECT DIRECTOR'S REPORT

The Committee received and considered the Master Site Planning Project Director's report.

***It was resolved:***

**"That the report be noted."**

## 11.0 TERMS OF REFERENCE

The Committee received and considered the Terms of Reference.

***It was resolved:***

**"That the Board approve the Hospital Advisory Committee Terms of Reference as modified and note that the number of meetings held is to be discussed further."**

## 12.0 CONFIDENTIAL SESSION

***At 3.25pm, 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. |
| **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). |
| **Risk**<br>**1) Risk Register**<br>**2) Serious Adverse Events** | To allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Briefing Paper Surveillance Colonoscopy** | Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Property**<br>**1) Lakes District Hospital – Heat pump update**<br>**2) Maintenance – Fraser building roof update** | Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage | As above, sections 9(2)(i) and 9(2)(j). |
| **Contracts**<br>**1) Technisonic Systems 2013 Ltd**<br>**2) BOC Ltd**<br>**3) SJ and NC Newton Property Trust**<br>**4) PHARMACO (NZ) Ltd** | 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 4.30pm.

*The meeting closed at 4.30pm.*

Confirmed as a true and correct record:

Chairman: _____ Date: _____

# Southern District Health Board

## Minutes of the Iwi Governance Committee Meeting held on Wednesday, 5 March 2014, commencing at 1.10pm in the Board Room, Community Services Building, Southland Hospital Campus

| | | |
|---|---|---|
| **Present:** | Ms Odele Stehlin | Waihōpai Rūnaka – Chair |
| | Mr Taare Bradshaw | Hokonui Rūnaka |
| | Ms Sandra Cook | Board Member, Southern DHB |
| | Mrs Kaye Crowther | Board Member, Southern DHB |
| | Ms Kingi Dirks | Moeraki Rūnaka |
| | Mr Peter Ellison | Puketeraki Rūnaka |
| | Mr Tony Hill | Board Member, Southern DHB |
| | Ms Hana Morgan | Awarua Rūnaka, Deputy Chair |
| | Mr Tuari Potiki | Board Member, Southern DHB |
| | Mrs Ann Wakefield | Ōraka Aparima Rūnaka |
| | Mr Tim Ward | Board Member, Southern DHB |
| **In Attendance:** | Mrs Mary Gamble | Board Member, Southern DHB |
| | Ms Carole Heatly | Chief Executive Officer (CEO) |
| | Ms Sandra Boardman | Executive Director Planning and Funding |
| | Mr Donovan Clarke | Executive Director of Māori Health/ Kaiwhakahaere Hauora Māori (KHM) |
| | Ms Pania Coote | District Manager Māori Health |
| | Mrs Joanne Fannin | Board Secretary Southland (BSS) |

### 1.0 WELCOME APOLOGIES AND KARAKIA

Mr Taare Bradshaw provided an opening karakia. Ms Odele Stehlin welcomed members and advised that she has been elected as the new Chair of the Iwi Governance Committee (IGC).

### 2.0 MEMBERS' DECLARATION OF INTEREST

The Chair called for any adjustments or amendments to the Interests Register. No changes were advised.

### 3.0 SOUTHERN DHB HEALTH PROFILE

Dr Pim Allen joined the meeting and provided an update on the Southern DHB Health Profile, noting that the information in the profile was drawn from a number of sources including:

- Information from the 2013 census.
- Information that Southern DHB collects routinely.
- Ministerial information.
- Information from Public Health South.

The Committee received advice:

- That the Health Profile is a living document that will be regularly updated, with a major update each time there is a new census undertaken.
- That the Health Profile is the foundation document to help the DHB identify where the key priorities are in terms of improving health outcomes for the population of Southern DHB and reduce inequalities.
- That a strategic Health Services Plan with a five to ten year focus is now being developed.
- On similar work done in other DHBs (e.g. Northland) and in Australia.
- On why Invercargill is not separated out from Southland in the Health Profile and an assurance that this would be taken into account with

the level of planning, information gathering and benchmarking being at a more detailed level in the Strategic Health Services Plan. As the profile is updated, more specific information can be added.
- On why Māori and Pacific Island people are shown as a combined statistic in the document.

Ka Runaka members on the Committee advised that that they support the document going forward provided Māori and Pacific Island people are portrayed separately within the document.

Ms Sandra Cook advised that a recommendation is going to Board supporting the document being adopted for Southern DHB use. She suggested that the recommendation could be modified and it was agreed that the following be submitted:

*"That the Board ratify the Southern District Health Profile for DHB use and note the need for the Pacific Island and Māori statistical information to be separated out for the document to be fully endorsed."*

***Dr Pim Allen left the meeting at 1.30pm.***

## 4.0 CONFIRMATION OF PREVIOUS MINUTES

***It was resolved:***

**"That the minutes of the 2 October 2013 Iwi Governance Committee meeting be approved and adopted as a true and correct record."**

## 5.0 MATTERS ARISING

There were no matters arising from the minutes.

## 6.0 ACTION SHEET

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

- **Action No. 55 and 56 – Tikaka Best Practice Policies Resource and policies –** the resource document and a number of the policies are complete and once the kupu has been added to the logo, printing and loading to Midas will progress.
- **Action No. 143 – Whānau Ora Quarter Four reporting –** a copy of the quarter four report was tabled for members' information (appendix 1) and it was noted that the requirements have been achieved.

Ms Kingi Dirks and the District Manager Māori Health (DMMH) are to liaise outside the meeting around a query raised regarding kai tahu dialect.

## 7.0 UPDATE BY THE KAIWHAKAHAERE HAUORA MĀORI (KHM)

The Committee received and considered the report and verbal update from the KHM and the Committee received advice.

- In relation to the free Nursing Clinics. The Clinics are being set up in partnership with, and will complement services already provided by, the Southern Primary Health Organisation and the data from the Clinics will be captured.
- On the Whānau Ora Commissioning Agency. The KHM suggested that when an appointment is made it would be beneficial for the five Mana Whenua Chairs and five CEOs across the South Island to meet together to discuss the relationship and how that works across Te Waipounamu.

- On Te Korowai Oranga following a recent presentation by Therese Wall.
- That the IGC has a responsibility at a Governance and service delivery level to ensure that the targets in the Māori Health Plan (MHP) are met, including the targets relating to Southern PHO.
- That the role of the IGC is as the primary source of governance advice to the Board.

## 8.0 DRAFT SOUTHERN DHB MĀORI HEALTH PLAN 2014/15

The Executive Director of Planning and Funding (EDPF) joined the meeting and provided an update for members on the planning documents under development by Southern DHB at the current time, namely:

- South Island Health Services Plan.
- Annual Plan (copy tabled for members' information).
- Māori Health Plan.

Members were invited to provide input into the Annual Plan in relation to Southern DHB priorities. The Chair requested that the Annual Plan be included in the next agenda so that members have the opportunity to provide input on the local priorities.

The Committee received and considered the Māori Health Plan and the Committee received advice:

- On the Ka Runaka/Southern PHO relationship.
- That further feedback on the MHP from the Management Advisory Group Māori Health (MAGMH) and further discussion at an IGC level needs to take place before Ka Runaka are able to sign off on the MHP.
- That the MHP is to be included in the next agenda so that members have the opportunity to provide input.
- On priorities within the MHP.
- That every service within Southern DHB has a responsibility for improving Māori Health outcomes.

## 9.0 IWI GOVERNANCE COMMITTEE WORK PLAN 2013

The draft IGC Work Plan is to be updated for the 2014 calendar year and included on the agenda for discussion at the next IGC meeting.

## 10.0 MĀORI HEALTH PLAN INDICATORS

The Committee received and considered the Māori Health Plan Indicator report prepared by Dr George Gray and the Ministry of Health (MoH) Performance Summary.

The Chair requested that a narrative be provided for the next report on what is being done to address those priorities. The CEO advised that a recovery plan should be provided for all targets that are not being met. The Business Analyst is to speak at the next meeting on the local indicators that are not currently included in the MHP.

## 11.0 UPDATE BY CHIEF EXECUTIVE OFFICER

The CEO's report was received and the CEO provided a further update on the following areas:

- Financial performance and funding challenges.
- Planning and Funding – Health of Older People and supporting people in their own homes.
- Funding allocation for Hospital and specialist services.
- Shorter stays in Emergency Departments and access to Primary Care.

- Mental Health and addictions bed numbers.
- Social sector trial and regional alcohol policy.
- Health Select Committee.
- Information Technology.

## 12.0 UPDATE BY IWI GOVERNANCE COMMITTEE CHAIR

The Committee received and noted the verbal update by the IGC Chair in relation to the following:

- ***Frequency and timeframe for meetings*** – Ka Runaka noted their concern over meeting frequency and requested that monthly meetings be held as an interim measure. Advice was received that the Board would need to ratify the holding of additional meetings. Subsequent to the meeting the Board ratified monthly meetings of IGC through till June 2014. Ka Runaka requested that a minimum of two hours be allowed for meetings.
- ***Membership*** – Ka Runaka acknowledged the additional Southern DHB Board member appointed to the IGC and noted their appreciation and expectation that any future change to the Principles of Relationship be done in consultation with Ka Runaka.

## 13.0 MINUTES FROM MANAGEMENT ADVISORY GROUP MĀORI HEALTH MEETINGS

The Committee received and noted the minutes from the MAGMH meeting held on 27 September 2013.

## 14.0 PLANNING AND FUNDING REPORTS

The Committee received and noted the Planning and Funding reports.

## 15.0 CONCLUSION

The meeting concluded with a closing karakia.

*The meeting closed at 2.34pm.*

Confirmed as a true and correct record:

Chair: _____ Date: _____

# SOUTHERN DISTRICT HEALTH BOARD

| | |
|---|---|
| **Title:** | **AUDIT & RISK COMMITTEE TERMS OF REFERENCE** |
| **Report to:** | Board |
| **Date of Meeting:** | 3 April 2014 |


**Summary:**

The Audit and Risk Committee reviewed its terms of reference at its meeting on 6 March 2014 and recommends that, with the exception of some minor amendments, they remain unchanged.

At that meeting it was agreed that finance should remain the responsibility of the full Board and the Appointments and Remuneration Advisory Committee should remain a separate committee of the Board.


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

| | |
|---|---|
| **Financial:** | n/a |
| **Workforce:** | n/a |
| **Other:** | n/a |

| | | |
|---|---|---|
| **Document previously submitted to:** | Audit & Risk Committee | **Date:** 06/03/2014 |
| **Approved by Chief Executive Officer:** | | **Date:** 25/03/2014 |

| | |
|---|---|
| **Prepared by:**<br>Jeanette Kloosterman<br>Board Secretary<br>**Date:** 18/03/2014 | **Presented by:**<br>Tim Ward<br>Chair, Audit & Risk Committee |

**RECOMMENDATION:**

1. **The Audit & Risk Committee recommends that the Board approve its terms of reference as modified.**

# AUDIT AND RISK ADVISORY COMMITTEE

## Terms of Reference

### Accountability

The Audit and Risk ~~Management~~ (A&R) Committee is constituted by the Board under clause 38 of schedule 3 to the New Zealand Public Health and Disability Act 2000 (the NZPHD Act).

The procedures of the Committee shall also comply with Schedule 3 of the Act.

Any recommendations made by the A&R Committee must be ratified by the Board prior to any release of recommendations or decisions to other parties. Any decisions that are sub-delegated and made by the A&R Committee must be ratified by the Board.

The Internal Auditor is responsible to the Board through the Chair of the A&R Committee. The Internal Auditor reports to the Committee against an agreed programme as determined by the A&R Committee.

### Objectives

The objective of the A&R Committee is to assist the Board in fulfilling its responsibilities relating across all financial management controls and risk based operational areas namely Governance, Funder and Provider-arm. These responsibilities include but are not limited to those set out in sections 41-42 of the NZPHD Act and section 51 and part 4 Crown Entities Act 2004 (CE Act) and related regulations.

### Scope

To give advice and recommendations to the Board members of the DHB on audit and risk management matters including:

1. Assurance that control mechanisms are in place to ensure compliance with legislation, regulations, and Ministry of Health strategies relating to the services provided or funded by the DHB.

2. Assurance that the DHB has appropriate service agreements, monitoring and auditing processes in place to optimise financial and operational outcomes.

3. Assurance that appropriate internal and external audits are carried out to ensure high standards of patient care, service delivery, resource management and internal control mechanisms.

4. Assurance that internal and external systems are in place to identify and manage financial, clinical and other operational risks through robust contingency planning.

5. Assurance that the level of clinical planning, policy, patient care and quality improvement activity aligns with national standards and Ministry of Health guidelines.

## Responsibilities

### Audit

1. Overseeing the development of the audit function, policies and procedures for the Board and recommending to the Board an appropriate annual audit strategy that is based on the DHB's key risk areas.

2. Assist the external auditor to identify risks and issues relevant to the external audit planning process.

3. Liaise with the internal auditor, review the internal audit scope, planning and resourcing.

4. Recommend to the Board the appointment of the internal auditor and periodically review the performance and effectiveness of the internal auditor.

5. Receive the reports of the internal and external auditors and review their findings.

6. Meet with both the internal and external auditors at least once per annum with management excluded.

7. Monitor the progress made by management in implementing recommendations arising from audit.

### Financial Controls & Reporting

8. Review all significant or statutory accounting policy changes and recommend acceptance by the Board.

9. Review the annual report with the Chief Executive Officer, ~~Chief Financial Officer~~Executive Director Finance and the external auditors and recommend acceptance by the Board.

10. Review and advise the Board regarding finance-related policies and procedures requiring Board approval, including an annual review of its delegation policy.

### Risk and Quality Management Oversight

11. Ensuring that the DHB complies with its obligations under key legislation and keeps other legislative compliance arrangements under review.

12. Review the development of risk management strategy for the DHB and monitor its implementation and risk reporting.

13. Review and monitor options for annual insurance cover within the DHB national collective approach to insurance. Any shortfall or risk identified by the Committee shall be reported to the Board.

14. Oversee as appropriate the ongoing development of a quality improvement framework and effective operational system that assures safe quality patient focused care.

15. Annual presentation of the quality and risk framework. ~~by the Quality & Risk Manager.~~

16. Fraud Hotline reporting in line with the Fraud Policy.

17. Review organisation wide risk assessment and management processes to ensure appropriate and timely action and contingency planning to manage risks, including internal control.

18. Review the approach to maintaining an effective internal control framework, including external parties such as contractors, is sound and effective.

19. Review the risk associated with capital expenditure prioritisation and any potential impacts on quality and safety standards.

20. Oversee the development of a Fraud Prevention Strategy, policies and procedures for the Board and recommending to the Board an appropriate Fraud Policy and Fraud Prevention Framework.

21. Receive and investigate disclosures under the DHB's Protected Disclosures /Whistle-Blowing Policy where it is not appropriate for these to be received and investigated by the Chief Executive.

**Membership**

All members of the Committee are to be appointed by the Board. The Board will appoint the C~~c~~hairperson.

The Committee is to comprise of Board members, supplemented with external appointees as required.

Where a person, who is not a Board member, is appointed to the Committee, the person must give the Board a statement that discloses any present or future conflict of interest, or a statement that no such conflicts exist or are likely to exist in the future.

In the absence of the appointed Chairperson, the Committee shall elect a member to act as Chairperson for the purposes of any properly constituted meeting.

The following Executive staff, while not members of the A&R Committee, ~~s~~ will be in attendance when appropriate and when requested by the Committee~~s~~:

- Chief Executive Officer
- ~~General Manager Finance & Funding~~Executive Director Finance
- Executive Management staff ~~when appropriate~~
- ~~Risk and Quality Manager when appropriate~~
- Internal Auditor & External Auditor by invitation

Committee m~~M~~embers shall be appointed for the term of the Board.

## Conflict of Interest

To be declared by members and staff when a potential conflict exists with an agenda item. A register of interests shall form part of each Committee meeting agenda.

## Meeting

Four Committee meetings are to be held per annum with additional meetings as required, in particular to meet financial reporting requirements.

## Quorum

The quorum of members of a committee is —

(a) if the total number of members of the committee is an even number, half that number; but

(b) if the total number of members of the committee is an odd number, a majority of the members.

## Review

These Terms of Reference shall be reviewed ~~annually by the Board.~~at the beginning of each Board term.

## Access and Reporting

The A&R Committee has confidential access to the internal and external auditors (and vice versa) as required to fulfil its objectives, roles and responsibilities. It also has access to the DHB's Chief Executive Officer and to any other staff through the Chief Executive Officer. The A&R Committee is authorised by the Board to obtain outside legal or other independent professional advice if necessary to fulfil its role. The A&R Committee shall report its activities via its minutes to the Board.

## Information

The following information will be supplied to the A&R Committee:

Audit

- Draft and final internal and external audit plans and strategies
- External audit engagement letter
- Internal and external audit reports/letters (draft and final)
- Schedule of action points and management reporting of progress made.

Financial Controls and Reporting

- Draft and final financial statements of the DHB for the Annual Report
- Details of any proposals to change accounting policies and their impact
- Finance related policies and procedures of the DHB and details of any planned amendments
- Asset Management Plan.

Risk Management Oversight

- Risk management policies, procedures and regular reports.

## SOUTHERN DISTRICT HEALTH BOARD

| | |
|---|---|
| **Title:** | **GOVERNANCE MANUAL** |
| **Report to:** | Board |
| **Date of Meeting:** | 3 April 2014 |


**Summary:**

- All statutory Crown entities, including District Health Boards, are expected to have a Board Governance Manual that reflects good practice standards and the range of legislation that applies to them.
- The attached manual is based on the State Services Commission guidelines for DHB Governance Manuals and was adopted by Board in February 2012. It was reviewed by the Audit & Risk Committee on 6 March 2014 and recommended changes are tracked.
- Following Board approval, the updated e-manual will be put on the DHB's website.


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

| | |
|---|---|
| **Financial:** | n/a |
| **Workforce:** | n/a |
| **Other:** | n/a |

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| **Prepared by:**<br>Jeanette Kloosterman<br>Board Secretary<br><br>**Date:** 20/02/2014 | **Presented by:**<br>Tim Ward<br>Chair, Audit & Risk Committee |

**RECOMMENDATION:**

**The Audit & Risk Committee recommends the Board approve and adopt the revised Southern DHB Governance Manual.**

# GOVERNANCE MANUAL

for the

Southern District Health Board

**Adopted by Board on ~~2 February 2012~~3 April 2014**
**~~Updated July 2013~~**

# Introduction

All statutory Crown entities, including District Health Boards (DHBs), are expected to have a board governance manual that reflects good practice standards and the range of legislation that applies to them.

This manual has been compiled to provide Southern District Health Board members with the guidance and information they may require to assist them to meet their governance responsibilities. Governance includes the generic processes by which organisations are directed, controlled and held to account. DHB governance has added obligations and complexities derived from the ethos of public service, health legislation and the impact DHBs have on individuals, businesses and communities in New Zealand.

This manual is based on the State Services Commission guidelines, *Resource for Preparation of District Health Board Governance Manuals,* which were prepared in conjunction with the Ministry of Health in 2010 and updated in September 2011 to reflect amendments to the New Zealand Public Health and Disability Act 2000.

Whilst this document contains links to relevant websites and other documents, Southern DHB does not necessarily endorse any of the material in these links, nor does it guarantee that such links and documents will remain current.

This manual will be reviewed at the commencement of each Board's term[1] and updates and/or new editions will be produced as necessary to reflect legislative changes.

[1] Next review due ~~February 2014~~Feburary 2017

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# Chapter 1: Relevant legislation

Effective governance of Crown entities requires all board members to have a good understanding of the legislative environment in which they must operate.

Every District Health Board (DHB) is a Crown Agent for the purposes of the Crown Entities Act 2004 (CE Act).

DHBs are established under the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Other key legislation that applies to DHBs includes:

- State Sector Act 1988
- Public Finance Act 1989
- Commerce Act 1986
- Official Information Act 1982
- Privacy Act 1993
- Protected Disclosures Act 2000
- Public Records Act 2005
- Various pieces of employment legislation, e.g. Employment Relations Act 2000

### *New Zealand Public Health and Disability Act 2000*

The NZPHD Act is the legislation under which DHBs were created. Board members need to be familiar with all relevant sections of that Act.

A full copy of the Act can be found at www.legislation.govt.nz

In summary, the NZPHD Act establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes District Health Boards, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations.

The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand. These include:

- To improve health and disability outcomes for all New Zealanders;
- To reduce disparities by improving the health of M~~a~~āori and other population groups;
- To provide a community voice in personal health, public health, and disability support services and to facilitate access to, and the dissemination of information for, the delivery of health and disability services in New Zealand.

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The NZPHD Act facilitates the achievement of the Government's aims by:

- Establishing DHBs to take a 'population health' focus for their geographically defined populations;
- Requiring the development of the New Zealand Health Strategy and the New Zealand Disability Strategy and an annual report to Parliament on the progress in implementing these strategies;
- Encouraging co-operation and collaboration between the agencies in the sector with the aim of delivering better care and support;

- Strengthening local community input to decision-making about health and disability support services through electing members to DHBs.

The NZPHD Act also adopts measures that recognise and respect the principles of the Treaty of Waitangi in the health and disability support sector.

The measures are a response to the Crown's desire to have greater Māaori participation in the health and disability support sector with a view to improving Māaori health outcomes, and reducing health disparities between Māaori and other population groups. The measures also reflect the Crown's overall partnership with Māaori under the Treaty of Waitangi and its commitment to protecting Māaori health.

The measures include:

- Minimum Māaori membership on Boards of DHBs;
- Provision for Māaori membership of DHB committees;
- Training for Board members to ensure they are familiar with Treaty issues, Māaori health issues, and Māaori groups or organisations in the DHB;
- A requirement for DHBs to establish and maintain processes to enable Māaori to participate in and contribute to strategies for Māaori health improvement;
- A requirement that DHBs continue to foster the development of Māaori health capacity for participating in the health and disability sector and for providing for their own needs;
- An expectation that DHBs provide relevant information to Māaori to enable effective participation.

The New Zealand Public Health and Disability Amendment Act 2010 amended the NZPHD Act to support desired reforms in the health sector to meet current challenges such as increasing demand, workforce strategies and resource constraints. Specifically the Act:

- Amends planning requirements for district health boards in order to provide for a planning and accountability framework that takes account of national, regional and local requirements; and
- Amends the objectives and functions of district health boards to ensure that district health boards work together for the most effective and efficient delivery of health services to meet national, regional and local needs; and
- Includes amendments to support the provision of shared administrative, support and procurement services across the public health system, including additional powers, such as ministerial direction, to enhance ministerial ability to require greater system collaboration and use of shared services; and
- Amends regulation-making powers in the current Act relating to arbitration and mediation to enable these powers to have wider application, particularly where there are disputes between district health boards about how national, regional, and local requirements are best provided for; and
- Requires district health boards to operate in a financially responsible manner; and
- Makes structural changes to enhance quality improvement activity, including the establishment of a new Crown agent, the Health Quality and Safety Commission; and
- Enables appointment of elected district health board members to the boards of other district health boards; and
- Requires the Minister's approval prior to establishing any new board committees.

### *Crown Entities Act 2004*

The CE Act provides a consistent framework for the establishment, governance and operation of Crown entities, as included in the various chapters of this guidance material. It clarifies the accountability relationships between Crown entities, their board members, responsible Ministers and the House of Representatives. The application of the CE Act to DHBs includes board members' individual and collective duties, the role of the responsible Minister, accountability relationships, strategic planning and Statements of Intent and reporting requirements.

Some key pieces of the CE Act and its application to DHBs are listed below, and are noted in the relevant chapters of this manual.

| **Key parts of the CE Act as it applies to DHBs** | |
|---|---|
| Government policy directions | DHBs *must give effect to* government policy when directed by the responsible Minister (i.e. the Minister of Health) (s. 103) |
| Whole of government directions | DHBs must comply with a whole of government direction from the Minister of State Services and the Minister of Finance (s. 107) |
| Appointed board members | Appointed by the Minister of Health (s. 28) |
| Term of board members | Appointed members hold office for 3 years or less (s. 32) |
| Removal of appointed board members | May be removed by the Minister of Health at his or her discretion (s. 36) |
| Remuneration of board members | Determined by the Minister of Health in accordance with the Cabinet Fees Framework[2] (s. 47) |

S. 21 of the NZPHD Act sets out a number of provisions where the CE Act does not apply to DHBs, or to their boards, board members, committee members or employees.

DHBs also differ from other statutory Crown entities in that the majority of their board members are elected by the public, rather than appointed by a Minister.

### *State Sector Act 1988*

Under the State Sector Act (s. 6), the State Services Commissioner's mandate applies to DHBs in a number of ways, including:

- To review the machinery of government, including creating, amalgamating, or abolishing agencies, and coordinating the activities of agencies;
- To advise on management systems, structures, and organisations;
- To provide advice and guidance on matters related to the integrity and conduct of employees, including making inspections and conducting investigations; and
- To set minimum standards of integrity and conduct. The State Services Commissioner has issued a code of conduct that applies to the staff of DHBs (also, see chapter on *District Health Boards as Employers*).

### *Public Finance Act 1989*

The CE Act specifies most of the provisions relating to a Crown entity's financial powers, accountability and reporting obligations.

However, the following sections of the Public Finance Act apply to Crown entities, including DHBs:

[2] http://www.dpmc.govt.nz/cabinet/circulars/co12/6~~www.dpmc.govt.nz/cabinet/circulars/co09/5.html~~

- ss. 26Z and 29A provide for the Secretary to the Treasury to request information necessary to prepare government financial statements and reporting;
- s. 36 provides that departmental chief executives are not responsible for the outputs or financial performance of Crown entities;
- s. 45I and s. 45J provide direction on the first annual report of a newly established entity and on the final annual report for a disestablished entity, and s. 45K sets out the timing of those reports;
- s. 49 provides that the Crown is not liable to contribute towards payments of the debts and liabilities of Crown entities;
- s. 74 provides that money that has remained unclaimed in a Crown entity's account for six years is to be paid to the Treasury;
- s. 80A allows for the Minister of Finance to issue instructions. Crown entities are required to comply with those instructions, which must be consistent with generally accepted accounting principles; and
- s. 81 provides for the Governor-General to make regulations for a variety of purposes.

### *Commerce Act 1986*

DHBs and their subsidiaries are interconnected bodies corporate for the purposes of the exemption from Part II of the Commerce Act under s. 44(1) (b) of that Act.

The exemption facilitates co-operative and collaborative arrangements between these public health and disability organisations, by ensuring the organisations can talk to each other without fear of breaching the Commerce Act.

The exemption does not apply to unilateral dominant behaviour of the kind regulated by s. 36 of the Commerce Act (DHBs are not exempt from action if they use their market power to seek to stop a provider entering a market, or to prevent competitive conduct, or to drive a provider out of a market).

### *Other legislation with general application to DHBs*

A considerable body of legislation applies to **DHBs as employers**, in respect of matters such as holiday entitlements, employment relations and health and safety. Employment matters are generally handled by chief executives rather than board members but, in ensuring compliance with them, the chief executive invariably acts under delegation from the board.

The **Official Information Act 1982** (the OIA) applies to DHBs. Board minutes are among the documents that can be requested under the OIA, though provisions exist for material to be withheld under certain circumstances. The general expectation, as expressed by the Chief Ombudsman for instance, is for official information to be released (either pro-actively or in response to a request), unless there are clear grounds to withhold it under the OIA.

For further guidance, see: www.ombudsmen.parliament.nz/index.php?CID=100109

The principles contained in the **Privacy Act 1993** include:

- How an organisation collects and stores personal information and what procedures are required to protect the security of that information;
- How long an organisation can keep personal information; and
- What personal information can be used for, and when it can be disclosed.

For further guidance, see: www.privacy.org.nz/how-to-comply-with-the-privacy-act/

Of particular relevance to DHBs is the **Health Information Privacy Code**, which is a code of practice established under the Privacy Act 1993 and relates specifically to the collection, use and disclosure of health information.

For further guidance, see: http://privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code/

The **Protected Disclosures Act 2000** provides for the reporting of wrong-doing in workplaces (sometimes called 'whistle-blowing') to an appropriate authority, such as the Office of the Ombudsman. All DHBs must have a protected disclosures policy. Under the Act, current or former employees of an entity, contractors and board members can make a disclosure that will be 'protected' if the information they are disclosing is about serious wrongdoing in or by the organisation, and they reasonably believe that the information is true or likely to be true.

The **Public Records Act 2005** applies to information held by DHBs that is of a kind specified by regulations made under the Act. Regulation 4 of the New Zealand Public Health and Disability (Archives) Regulations 2001 also provides that the Public Records Act applies to information that has officially been made or received by a DHB in the conduct of its affairs. Accordingly, all DHBs must comply with the requirements of the Public Records Act 2005 in relation to its record keeping.

The **Code of Rights** is a regulation under the Health and Disability Commissioner Act. It grants a number of rights to all consumers of health and disability services in New Zealand, and places corresponding obligations on providers of those services. The Code extends to any person or organisation providing, or holding themselves out as providing, a health service to the public or to a section of the public - whether that service is paid for or not.

For further guidance, see: http://www.hdc.org.nz/the-act--code/the-code-of-rights

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# Chapter 2: Objectives, functions and powers of District Health Boards

Board members must know what they and the DHB are charged with doing, and how they are empowered to carry out their functions and powers.

The role of a District Health Board (DHB) is set out in s. 25 of the Crown Entities Act (CE Act) and s. 26 of New Zealand Public Health and Disability Act 2000 (NZPHD Act).

S. 25 of the CE Act states that the board is the governing body of a statutory entity with the authority to exercise the powers and perform the functions of the entity. All decisions relating to the operation of the entity must be made by or under the authority of the board, in accordance with the CE Act or the NZPHD Act, as appropriate.

### *The objectives of a DHB*

S. 14(2) of the CE Act states that, in performing its functions, an entity must act consistently with its objectives. "Objectives" are not defined in the CE Act but include the objectives set out by s. 22 of the NZPHD Act, which are to:

a) Improve, promote, and protect the health of people and communities;

b) Promote the integration of health services, especially primary and secondary health services;

ba) Seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs;

c) Promote effective care or support for those in need of personal health services or disability support services;

d) Promote the inclusion and participation in society and independence of people with disabilities;

e) Reduce health disparities by improving health outcomes for Mā~~a~~ori and other population groups;

f) Reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;

g) Exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges, the provision of, services;

h) Foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;

i) Uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;

j) Exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations;

k) Be a good employer in accordance with s 118 of the Crown Entities Act 2004.

The DHB must consider the specific actions to be taken to meet these objectives, while being mindful of:

a) s. 3(2) of the NZPHD Act, which provides for objectives to be pursued to the extent that they are reasonably achievable within the funding provided;

b) s. 3(4) which promotes the integration of services; and

c) s. 3(5) that requires consideration of local, regional or national service configuration.

While the NZPHD Act gives the community a voice in achieving these objectives, DHBs also need to consider the overall health structure to ensure that individual items of health expenditure fit comfortably with the "big picture" of health funding.

The DHB will need to consider competing options and may, in certain circumstances, attach greater weight to certain objectives than others to attempt to achieve the purposes of the Act. In doing so, as good practice, each DHB Board should carefully record the decision-making process.

### *Functions of a DHB*

Under s. 14 of the CE Act the functions of a statutory entity are:

- The functions set out in the entity's establishing legislation (in the case of DHBs, the NZPHD Act);
- Any functions that the Minister has added in accordance with the establishing legislation; and
- Any functions that are incidental or related to, or consequential on, the entity's functions.

S. 23 of the NZPHD Act sets out a further list of DHB-specific functions which are to:

a) Ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement;

b) Actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities;

ba) To collaborate with relevant organisations to plan and co-ordinate at local, regional and national levels for the most effective and efficient delivery of health services;

c) Issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b) above;

d) Establish and maintain processes to enable Māa~~a~~ori to participate in, and contribute to, strategies for Māa~~a~~ori health improvement;

e) Continue to foster the development of Māa~~a~~ori capacity for participating in the health and disability sector and for providing for the needs of Māa~~a~~ori;

f) Provide relevant information to Māa~~a~~ori for the purposes of paragraphs (d) and (e) above;

g) Regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services;

h) Promote the reduction of adverse social and environmental effects on the health of people and communities;

i) Monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services;

j) Participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector;

k) Provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB and to the health and disability support needs of New Zealanders;

l) Provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Crown Entities Act 2004;

m) Collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes;

n) Perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of the DHB after consultation with it.

The CE Act contains several safeguards for the independence of entities in carrying out their functions and other business:

S. 113 provides that a Minister may not:

- Direct a Crown entity or member, employee or office holder of a Crown entity in relation to a statutorily independent function; or
- Require the performance or non-performance of a particular act or the bringing about of a particular result in respect of a particular person or persons.

Without limiting sub part 1 of Part 3 of the CE Act, the Minister of Health may give a DHB any directions [s. 32 of the CE Act] —

a) That specify the persons who are eligible to receive services funded under the NZPHD Act; and

b) That the Minister considers necessary or expedient in relation to any matter relating to the DHB; and

c) That are consistent with the objectives and functions of the DHB.

No such direction may require the supply to any person of any information relating to an individual that would enable the identification of the individual.

### *Powers of the Board*

The CE Act divides powers of entities into:

- Statutory powers: s. 16 provides that a statutory entity may do anything authorised by the CE Act or the entity's establishing Act. Powers may include, for example, the power to make decisions or issue a licence.

- Natural powers: s. 17 provides that boards of entities have all the powers of a natural person of full age and capacity. Boards may only act for the purpose of performing the statutory functions of the entity. The CE Act contains some specific constraints on the exercise of natural powers, for example: the requirement to consult the State Services Commissioner before agreeing to the terms and conditions of employment of a DHB's chief executive, constraints on bank accounts and limits on powers to indemnify and insure. Ministers' powers of direction, where applicable, can also act as a restraint on a board's powers.

### *Ministerial Directions*

Certain provisions of the CE Act relating to government policy and government directions, apply to the giving of ministerial directions to DHBs. Under s. 103(1) of the CE Act, the Minister of Health may direct a DHB to give effect to a government policy. S.103 is subject to s. 113 of the CE Act, under which the independence of Crown entities is safeguarded.

Under ss. 32 and 33 of the NZPHD Act, the Minister of Health may give written directions to a DHB on any matter of government policy that the Minister considers necessary, and can specify the persons who are eligible to receive services funded under the NZPHD Act. In giving any such directions, the Minister must have regard to the objectives and functions of DHBs, the New Zealand Health Strategy, the New Zealand Disability Strategy, the DHB's annual plan and any other plan the DHB is a party to. The Minister must also consult the DHB before issuing a direction notice.

Ministerial directions cannot require the supply of identifiable information about an individual.

If a direction concerns the provision of services, then it must be given in accordance with s. 33. Such a direction may not:

- Specify the price of any services;
- Require the supply of services to named individuals or organisations, or require supply of services by named individuals or organisations (however, DHBs can be specified as the provider).

Notice of directions given under s. 32 or 33 must be published in the *Gazette* and presented to the House of Representatives.

Where the Minister appoints a Crown monitor in relation to a DHB, the functions of the Crown monitor include assisting the board "in understanding the policies and wishes of the Government so that they can be appropriately reflected in board decisions" (s. 30(3)(b) NZPHD Act).

### *The Treaty of Waitangi*

The NZPHD Act includes provisions to recognise and respect the principles of the Treaty of Waitangi in the health and disability sector.

These provisions reflect the Crown's desire to have greater participation by Māaori in the health and disability sector, with a view to improving Māaori health outcomes and reducing health disparities between Māaori and other population groups. The measures also reflect the Crown's overall partnership with Māaori under the Treaty of Waitangi.

Specific provisions include:

- Minimum Māaori membership on boards of DHBs (s.29(4));
- Provision for Māaori membership of DHB committees (ss. 34, 35, 36);
- Familiarity with Treaty issues, for Māaori health issues, and for Māaori groups or organisations in the DHB (Schedule 3, clause 5);
- A requirement for DHBs to establish and maintain processes to enable Māaori to participate in and contribute to strategies for Māaori health improvement (s23(1)(d));
- Continuing to foster the development of Māaori capacity to participate in the health and disability sector and for providing for their own needs (s23(1)(e)); and
- Provision of relevant information to Māaori to enable effective participation (s23(1)(f)).

S. 3(3) of the NZPHD Act says that nothing in the Act *"entitles a person to preferential access to services on the basis of race or limits section 73 of the Human Rights Act 1993"* (which relates to measures to ensure equality).

This recognises the need for service delivery that positively reduces disparities and is targeted at population related initiatives, rather than any preferential treatment sought by an individual person.

### *Exceptions to board implementing functions and powers under legislation*

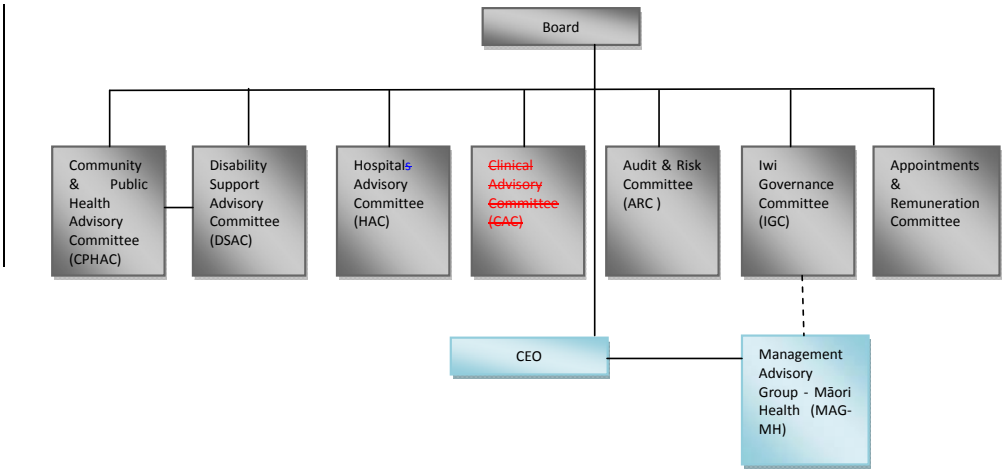
Occasionally the chief executive or other office holder in a DHB has specific statutory functions or powers under the entity's establishing legislation. For example under s 26(3) of the NZPHD Act, the board of a DHB is required to delegate to the chief executive the power to make decisions on management matters relating to that DHB.

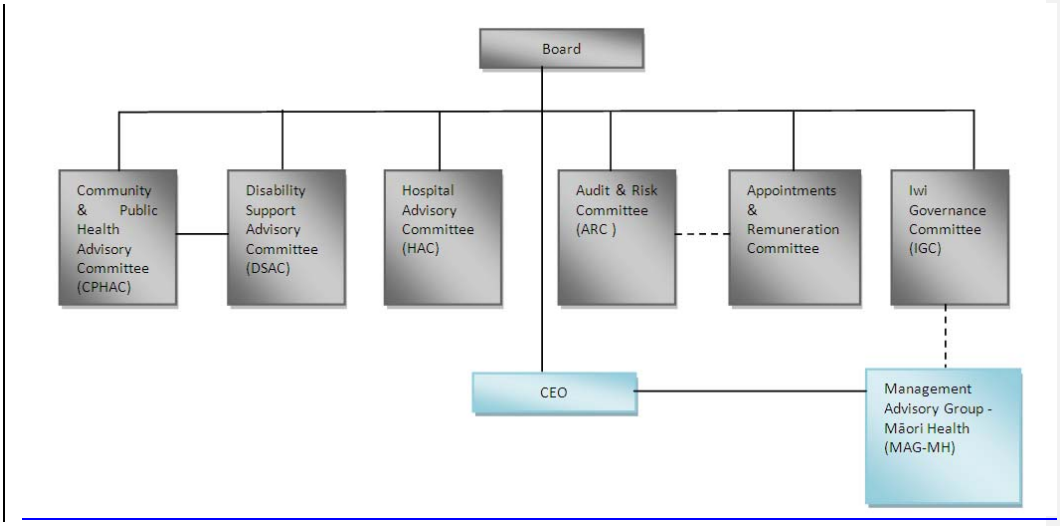
In these cases, the board is not responsible for the exercise of those powers and functions. The Board and chief executive or other office holders need to be very clear about where responsibility lies in these situations.

### *Structure*

The structure of the DHB, including the board and committees, should support the implementation of the functions and powers of the board and should be reviewed from time to time.

The current governance structure of Southern DHB is as follows:




The current executive management and governance support structure of Southern DHB is set out in Appendix 7.

# Chapter 3: Key Relationships

One of the primary purposes of the Crown Entities Act 2004 (CE Act) is "to clarify accountability relationships between Crown entities, their board members, their responsible Ministers on behalf of the Crown, and the House of Representatives" (s. 3 CE Act) in order to assist good governance of the entity.

In simple terms this can be summarised as:

- The responsible Minister is accountable to the House of Representatives;
- The governing board of the entity (i.e. the District Health Board ) is responsible to the Minister, usually through the Chair);
- The entity's chief executive is responsible to the board; and
- The staff of the entity are responsible to the chief executive.

District Health Board (DHB) members need to clearly understand the different roles, responsibilities and accountabilities of each party. This will facilitate the establishment and maintenance of mutually constructive and positive working relationships.

### *Relationship with the Minister of Health (the Minister)*

The role of the Minister is to oversee and manage the Crown's interest in, and relationship with, the DHB, and to exercise any statutory responsibilities.

Under s. 27 of the CE Act, the Minister has powers with regard to all DHBs on matters of strategic direction, targets, funding, performance, reporting and reviews. The Minister needs to exercise these powers in a way that recognises any statutorily independent functions of DHBs.

The Minister has the power to request the following information:

- The DHB must supply to the Minister of Health any information relating to the operations and performance of the DHB that the Minister requests, under s. 133 of the CE Act; and

- The DHB must supply to the Minister of Finance any information requested by the Minister in connection with the exercise of his or her powers under Part 4 of the CE Act. S. 133 is subject to s. 134 of the CE Act, which provides for where there is a good reason to refuse to supply information requested by the Minister, for example the privacy of a person. However, the reason must outweigh the Minister's need to have the information, for the discharge of Ministerial duties.

The Minister of Health is responsible to the House of Representatives for the performance of DHBs and is often expected to answer to the public for problems or controversies arising in connection with them. The Minister tables in the House each DHB's statement of intent and annual report and appears before select committees where the Minister may be asked to comment on a DHB's activities. However, the DHB itself is also accountable to the House of Representatives (s. 3 CE Act) for its own actions (see chapter *Planning and reporting*).

### *Parliamentary select committees*

One mechanism for scrutiny of DHB operations is through select committees. The most regular contact DHBs are likely to have with select committees is for financial reviews, inquiries, and occasionally when making submissions on bills. Board members should be particularly aware of the following:

- Examination of the Estimates: The estimates are the government's request for appropriations/authorisation for the allocation of resources, tabled on Budget day. DHBs do not attend the select committee when it examines the estimates, but the Minister and Ministry of Health may be questioned about the intended activities and expenditure of a DHB.

- Financial Review: The financial review is of the DHB's performance in the previous financial year and of its current operations. The select committee will provide written questions for answer, but if the DHB is asked to appear, further questions may be asked on the day.

DHB board members and staff who appear before a select committee do so in support of ministerial accountability. Generally the chair and the chief executive will represent a DHB at select committee hearings, although this is a matter for the board to decide.

DHB representatives appearing before select committees have an obligation to manage risks and spring no surprises on the Minister. This applies even when they appear on matters which do not involve ministerial accountability, such as when exercising an independent statutory responsibility or appearing in a personal capacity. Board members and employees who wish (or are invited) to make a submission to a select committee on a Bill on behalf of their DHB are expected to discuss the matter with the Minister.

Guidance on appearing before select committees needs to reflect the material contained in *Officials and Select Committee Guidelines*: www.ssc.govt.nz/officials-and-select-committees-2007. Within that guidance, the term 'official' includes board members and employees of DHBs.

### *"No Surprises" approach*

Boards are expected to engage constructively and professionally with the Minister. This is enhanced when there is a free flow of information both ways, by regular formal and informal reporting and discussion, and through an open and trusting relationship.

The enduring letter of expectations from Ministers to Crown entity boards (www.ssc.govt.nz/expectations-letter-crown-entities-dec08), expects boards to adopt a "no surprises" approach with their Minister. Any protocols adopted in this respect need to recognise that what a board considers to be "business as usual" may be seen by the Minister to come within the requirement of "no surprises".

"No surprises" means that the government expects a DHB to:

- Be aware of any possible implications of its decisions and actions for wider government policy issues;
- Advise the Minister of Health of issues that may be discussed in the public arena or that may require a ministerial response, preferably ahead of time or otherwise as soon as possible; and
- Inform the Minister in advance of any major strategic initiative.

### *Relationship with the monitoring department*

The CE Act provides for Ministers to monitor Crown entity performance against the entity's strategic direction, as agreed with the Minister and set out in the Statement of Intent (SoI) and any other relevant documents; for example, a Crown Funding Agreement.

Ministers are usually supported in this engagement with Crown entities by departmental officials who in this role are known as the 'monitoring department'. While the CE Act and the

NZPHD Act do not define such a role, the monitoring department (in this case, the Ministry of Health) provides the Minister with information about a DHB's performance, ensures its approach is consistent with government goals, and supports the appointment process for board members.

Guidance for departments on how to monitor an entity is available at: www.ssc.govt.nz/guidance-depts-crown-entities-may06.

### *Relationship with the chief executive and DHB staff*

All decisions relating to the operation of a DHB must be made by, or under the authority of, the board in accordance with s. 25 of the CE Act and the New Zealand Public Health and Disability Act 2000 (NZPHD Act).

The day-to-day management responsibilities within a DHB are delegated to the chief executive (s. 26(3), NZPHD Act). The board and the chief executive must be clear about the boundaries between governance and management and what duties have been delegated to the chief executive. Some guidance on this is provided in the *Code of Conduct for Board and Committee Members* in Appendix 1.

While the relationship between the Minister and the board is usually through the chair, this is not always practical. Board members and the chief executive must be clear about who has contact with the Minister and the Minister's office. Where a chief executive is meeting regularly with the Minister, protocols should be put in place, including feedback to the board on all such meetings.

Other issues concerning relationships and communications between board members and staff are addressed in the board's the *Code of Conduct* (Appendix 1).

### *Cooperative agreements with persons in the health and disability sector*

For a DHB to fulfil its obligations, it must "actively investigate, facilitate, sponsor and develop" co-operative agreements and arrangements with persons in the health and disability sector, in order to promote the inclusion of individuals and encourage independence (s. 23(1)(b), NZPHD Act).

DHBs can enter into co-operative agreements and arrangements under s. 24 of the NZPHD Act, for the purpose of:

- Assisting the DHB to meet its objectives set out in s. 22 of the Act; or
- Enhancing health or disability outcomes for people; or
- Enhancing efficiencies in the health sector.

A DHB may not enter into such a co-operative agreement or arrangement, unless it is given consent by the Minister (s. 24(2), NZPHD Act). Any authority given by the Minister is subject to any conditions the Minister specifies.

Further approval is also needed for DHBs to hold interests in trusts and companies (s.28, NZPHD Act).

#### South Island Alliance

Southern DHB is part of the *South Island District Health Board Alliance*, which was formed by the DHBs to enable them to work effectively together, utilising their combined resources to jointly solve problems, develop innovative solutions to health sector challenges and achieve outcomes for the people of the South Island region. The alliance aims to provide increasingly

integrated and co-ordinated health services through clinically-led service development and its implementation with a 'best for patient, best for system' framework.

**Iwi Partnership**

On 31 May 2011 Murihiku and Araiteuru Rūnaka and Southern DHB signed a collective Principles of Relationship agreement (see Appendix 3). The agreement's purpose is for all parties to work together in good faith to safeguard and improve health outcomes for Māaori in the Southern region.

# Chapter 4: Collective duties of the board and individual duties of board members

One of the goals of the Crown Entities Act 2004 (CE Act) is to clarify the roles of board members and responsible Ministers by setting out the accountabilities of each party; in particular, board members' duties and to whom those duties are owed.

S. 25 of the CE Act states that the board is the governing body of a statutory entity, with the authority, in the entity's name, to exercise the powers and perform the functions of the entity.

Collective and individual responsibility and accountability are fundamental to the integrity of the board. It is important that board members are clear about, and understand, the collective and individual duties that come with appointment to a DHB board.

Board duties are often referred to as directors' 'fiduciary duties'. The board's collective duties and members' individual duties are set out in ss. 49-57 of the CE Act. The two types of duties vary with regard to:

- Whether the duties are owed by the board as a whole, or by each member individually;
- Who they are owed to; and
- What the sanction is if the duty is breached.

All DHB board members are bound by collective and individual duties, whether they are appointed or elected members.

Board members' duties are constant and relevant to all actions undertaken by the board or individual members; a board and its members must always act in a manner consistent with these duties.

### *Collective Duties*

The collective duties of a DHB are the board's public duties which reflect that the board and the entity are part of the State Services. The collective duties are owed to the responsible Minister (s. 58(1), CE Act).

The collective duties of DHB boards are to:

- Act consistently with their objectives, functions, statements of intent and output agreement (s. 49, CE Act);
- Perform their functions efficiently and effectively, and consistently with the spirit of service to the public (s. 50, CE Act);
- Operate in a financially responsible manner (s. 51, CE Act and s.41 NZPHD Act); and
- Ensure that the DHB complies with ss. 96 to 101 of the CE Act[3].

The board of a DHB must also ensure that the DHB acts in a manner consistent with its annual plan and any national and regional plans (to which it is a party), and with any directions the Minister of Health may have issued requiring the DHB to provide or arrange for the provision of any services that are specified in the notice (ss. 27(1) and 33 of the NZPHD Act). The board of a DHB must also act in a manner consistent with s. 103 or s. 107 of the CE Act.

[3] s.28 of the NZPHD Act discusses shares in bodies corporate or interests in associations.

### *Individual duties of board members*

Individual board member duties are a mix of common law duties and duties similar to the ones in the Companies Act 1993 (common law is law that is derived from judges' decisions). The individual duties in the CE Act are owed to the entity and the Responsible Minister (s. 59). Board members' individual duties under the CE Act are to:

- Comply with the CE Act and the NZPHD Act (s. 53)
- Act with honesty and integrity (s. 54)
- Act in good faith and not at the expense of the entity's interests (s. 55)
- Act with reasonable care, diligence and skill (s. 56)
- Not disclose information, except in specified circumstances (s. 57).

### *Breach of duty*

If a DHB member does not act with good faith, or with reasonable care, the DHB may bring action against that member for breach of an individual duty (s. 59(3) of the CE Act).

Every member of the DHB board or of any committee of the board is indemnified by the DHB for[4]:

- Costs and damages for any civil liability arising from any action brought by a third party in respect of any act or omission done or omitted in his or her capacity as a member, if he or she acted in good faith and with reasonable care, in pursuance of the functions of the organisation; and
- Costs arising from any successfully defended criminal proceeding in relation to any such act or omission.

A member of a DHB board committee established or appointed under Part 3 of the NZPHD Act is not liable for any act or omission done or omitted in his or her capacity as a member, if he or she acted in good faith, and with reasonable care, in pursuance of the functions of the committee.

The Minister of Health may take action if the collective or individual duties of a DHB board have been breached. If the board does not comply with any one of its collective duties, all or any of the board members may be removed from the board. However, a board member cannot be removed if the member did not know, and could not reasonably be expected to know that the duty was being or was to be breached, or if the board member took all reasonable steps in the circumstances to prevent the duty being breached.

A board member is not liable for breach of a collective duty, other than to be removed from office (s. 58, CE Act).

The chapter *Board Appointments and Reappointments* addresses the different processes for removal from office of appointed and elected DHB board members. In addition, the Minister of Health can remove the whole board and replace it with a Commissioner.

[4] Ss. 120 to 126 of the CE Act, on protections from liability, do not apply to a 'publicly-owned health and disability organisation,' members of the board or a committee of the board of a DHB

# Chapter 5: Role of the Chair

An effective chair is vital to the good governance and performance of an entity. DHB chairs are appointed from various backgrounds and they need to understand the requirements of the role. The role has many similarities to that of a private sector board chair, but with some different elements which come from legislation or practice.

A DHB chair's role includes:

- Providing effective leadership and direction to the board and the DHB, consistent with the Minister's expectations.
- Ensuring effective accountability and governance of the DHB, consistent with the requirements of relevant legislation including the Crown Entities Act 2004 (CE Act), (see also, the chapter *Relevant legislation*).
- Developing and maintaining sound relationships with Ministers and their advisors, including:
  - leading any formal discussions with Ministers, particularly on budget and planning cycles, including the Statement of Intent and letter of expectations (see chapter *Planning and reporting*);
  - signing-off formal governance documents (Statement of Intent, Annual Report), generally in conjunction with the deputy chair;
  - acting as spokesperson for the board, in ensuring the Minister and other key stakeholders are aware of the board's views and activities, and that Ministers' views are communicated to the board; and
  - ensuring that the Minister is kept informed under the 'no surprises' obligations (see chapter *Key relationships*).
- Acting as the leader of the DHB, including presenting its objectives and strategies externally, and representing the DHB to Government and stakeholders, including attending select committees.
- Chairing board meetings including: setting the annual board agenda (see chapter *Board meeting procedures*); setting meeting agendas; ensuring there is sufficient time to cover issues; ensuring the board receives the information it needs - before the meeting in board papers and in presentations at the meeting; considering which matters should be dealt with in the 'public included' and 'public excluded' portions of DHB board meetings, encouraging contributions from all board members; assisting discussions towards the emergence of a consensus view; and summing up so that everyone understands what has been agreed.
- Providing motivation, guidance and support to other board members to ensure they contribute effectively to the governance of the DHB.
- Taking the lead, often in conjunction with the Ministry of Health, in providing comprehensive tailored induction for new board members (see chapter *Board appointments and reappointments*).
- Ensuring that the development needs of individual board members are identified and addressed.
- Where necessary, dealing with underperformance by board members.
- Ensuring that an annual performance evaluation is conducted of the board, as well as of the chair (see chapter *Board and member performance evaluation*).
- Participating in the recruitment process for appointed board members. This is likely to include: maintaining a view on the desired composition of the board; considering

member and chair succession planning; supporting the Minister and Ministry of Health in appointing and reappointing board members (see chapter *Board Appointments and Reappointments*).

- Providing guidance and support to the chief executive to ensure the DHB is managed effectively. This includes establishing and maintaining an effective working relationship, while also taking an independent view to challenge and test management thinking (see chapter *Key relationships*).
- Overseeing the employment of the chief executive, including succession planning and organising induction for a new chief executive.
- Representing the board in formal assessments of the chief executive's performance, and in the required discussions with the State Services Commission in respect to chief executive terms and conditions at time of appointment and performance reviews (see chapter *District Health Boards as employers*).
- Ensuring that conflict of interest policies, including disclosure provisions, are in place, that members' conflicts of interest (including those of the chair) are dealt with properly, and that, where appropriate, dispensation is given to act despite being interested.
- If the chair of a DHB board is not present or is unwilling to preside at a meeting of the board, the deputy chair of the board presides, if he or she is present and willing to do so. If neither of them is present and willing to preside at a meeting of the board, the members present must elect a member who is present to preside at the meeting.

# Chapter 6: General behaviours of board members

Best practice corporate governance boards exhibit certain behaviours in order to undertake their board role effectively and in accordance with the highest ethical and professional standards, notwithstanding any legal requirements that are placed upon the board.

The list below is not exhaustive nor in order of importance, but it should assist the board to ensure appropriate behaviours are maintained.

- **Responsibility to the entity.** Members need to recognise and always act consistently with their responsibilities to the DHB and to Ministers. Members owe a duty to the organisation as a whole and are not to act purely in the interest of a specific group. They should attend induction training and board members' professional education to familiarise and update themselves with their governance responsibilities.
- **Strategic perspective.** Members need to be able to think conceptually and see the 'big picture'. They should focus as much as possible on the strategic goals and overall progress in achieving those rather than on operational detail.
- **Integrity.** Members must demonstrate the highest ethical standards and integrity in their personal and professional dealings. They should also challenge and report unethical behaviour by other board members.
- **Intellectual capacity**. Members require the intellectual capacity to understand the issues put before them and make sound decisions on the entity's plans, priorities and performance.
- **Independent judgement.** Members need to bring to the board objectivity and independent judgement based on sound thought and knowledge. They need to make up their own mind rather than follow the consensus.
- **Courage.** Members must be prepared to ask the tough questions and be willing to risk rapport with fellow board members in order to take a reasoned, independent position.
- **Respect.** Members should engage constructively with fellow board members, entity management and others, in a way that respects and gives a fair hearing to their opinions. In order to foster teamwork and engender trust, members should be willing to reconsider or change their positions after hearing the reasoned viewpoints of others.
- **Collective responsibility.** Members must be willing to act on, and remain collectively accountable for, all decisions even if individual members disagree with them. Board members must be committed to speaking with one voice once decisions are taken on a DHB's strategy and direction.
- **Participation**. Members are expected to be fully prepared, punctual and regularly attend for the full extent of board meetings. Members are expected to enhance the quality of deliberations by actively asking questions and offering comments that add value to the discussion.
- **Informed views.** Members are expected to be informed and knowledgeable about the DHB's business and the matters before the board. They should have read the board papers before meetings and keep themselves informed about the environment in which the DHB operates.
- **Understanding.** Members are expected to recognise the need for service delivery to positively reduce disparities between various population groups. Members are expected to understand Māaori health and Treaty of Waitangi issues (Schedule 3, clause 5 to the New Zealand Public Health and Disability Act 2000). This includes establishing and maintaining processes to enable Māaori to participate in and contribute to strategies for Māaori health improvement and to foster Māaori capability.
- **Financial literacy.** Boards monitor financial performance and thus all members must be financially literate. They should not rely on other members who have financial

qualifications, but should undertake training to improve their own financial skills where necessary.

- **Sector knowledge**. Members need to make themselves familiar with the activities of the entity and sector. This is likely to include attending induction sessions and ongoing background study.
- **Compliance with organisational policies**. The Southern District Health Board has a number of organisation-wide policies that are approved by the Board. Members must ensure they comply with the policies approved, including the Sensitive Expenditure Policy and Fraud Policy (see Appendices 4 and 5).

### *Code of Conduct for Board and Committee Members*

The *Code of Conduct* agreed to by Board members is set out in Appendix 1.

# Chapter 7: Members' interests and conflicts: identification, disclosure and management

The New Zealand health and disability sector is an inherently close community where relevant knowledge is in high demand from public and private entities. Conflicts of interest are an inevitable result.

To address conflicts of interest in the health and disability sector, the Ministry of Health has published *Conflicts of Interests Guidelines for District Health Boards*. These guidelines are aimed specifically at District Health Board (DHB) members. They are a resource to help board members maintain public confidence and integrity in the health sector, in those circumstances where conflicts of interest may exist and need to be managed appropriately. The guidelines discuss members' interests and conflicts and how to manage these under the provisions set out in the New Zealand Public Health and Disability Act 2000. A copy of these guidelines can be found in the Publications section of the Ministry of Health's website at: www.health.govt.nz/publication/conflict-interest-guidelines-district-health-boards

Guidance on the management of interests is also set out in the board's *Code of Conduct* in Appendix 1.

To assist with the guideline requirements for documentation, disclosure, regular review and management of members' interests, a register of interests is maintained by the board secretary and included in all board and committee agendas as a standing item.

In preparing the agenda for board or committee meetings, the chief executive officer will discuss with the chair any papers that may give rise to a conflict of interest. Where a conflict or potential conflict is identified the following will apply:

- If the item giving rise to the conflict of interest is to be discussed in the public part of the meeting, the member with the conflict of interest will receive the paper but will normally be excluded from the discussion and decision-making process. The chair may ask the member to sit in the public gallery during the relevant agenda item.
- If the item giving rise to the conflict of interest is to be discussed in the public excluded part of the meeting, the member with the conflict of interest will normally not receive the paper and will be asked to leave the meeting during the relevant agenda item.
- Any member who has concerns can raise these directly with the chair, or if the conflict of interest pertains to the chair, then the deputy chair.
- In the event that the board or committee note the conflict of interest but wish to allow the member to participate, the minutes will record why the permission was granted and what the conflicted member said during the deliberation on the matter concerned.

S.42(4) of the NZPHD Act requires the board's annual report to record all permissions to participate when interested.

# Chapter 8: Disclosure of information

In the course of their work, board members will often have access to information that is commercially sensitive or valuable, or that could be personally sensitive for others. For District Health Boards (DHBs) to be trusted, this information needs to be handled with the highest standards of care and integrity and in a manner consistent with the relevant legislation.

### *Principles*

Under s. 57 of the Crown Entities Act 2004 (CE Act), board members must not disclose to any person, or make use of or act on information they receive as a member, and to which they would not otherwise have had access, unless:

- It is in the performance of the DHB's functions;
- It is required or permitted by law; for instance, where disclosure is made in accordance with the Official Information Act 1982 (OIA);
- It is complying with the requirement for the member to disclose his or her interests;
- The member has been authorised by the board or by the Minister of Health to disclose the information; or
- The disclosure, use or act in question will not prejudice the DHB or will be unlikely to do so.

However, under s. 57(2) of the CE Act, a member may disclose, make use of, or act on such information, provided that:

- the member is first authorised to do so by the board; and
- the disclosure, use, or act in question will not, or will be unlikely to, prejudice the DHB.

Clause 32 to Schedule 3 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) contains a specific provision regarding the right of a DHB board, by resolution, to exclude the public from the whole or any part of any meeting of the board if the public conduct of the whole or the relevant part of the meeting would be likely to result in:

- the disclosure of information for which good reason for withholding would exist under ss. 6, 7, or 9 (except s. 9(2)(g)(i)) of the OIA; and/or
- disclosure of information, the public disclosure of which would:
  - i) be contrary to the provisions of a specified enactment; or
  - ii) constitute contempt of court or of the House of Representatives.

When considering obligations to provide information to parties, the privacy of individuals must be respected and the Privacy Act 1993 and the Health Information Privacy Code 1994 complied with. (Refer www.privacy.org.nz/health-information-privacy-code/.)

# Chapter 9: Gifts and hospitality

The way in which a board handles gifts and hospitality offered to its members has serious implications for the trust placed in the governance of the entity concerned. When a board member is offered gifts or hospitality, careful judgement is needed in light of the roles and responsibilities of District Health Boards (DHBs). The perception of influence being sought can be as important as the reality.

Like all Crown entities, DHBs have different constituencies and influences. A single prescriptive policy on gifts for board members is impracticable. Gifts or hospitality may be offered for various reasons including as a token of appreciation, as part of a ceremonial occasion, or as an attempt to exercise influence. While the best way of avoiding any perception of influence would be to refuse all offers of gifts and hospitality, this is unworkable in practice. However, there are a set of principles that can inform members' decisions about gifts and hospitality, and to promote transparency and consistency of approach.

## Principles

- Board members should not compromise their integrity by placing themselves under any obligation to a third party. They must always be aware of the public perception that can result from their accepting gifts or hospitality.
- Members must never solicit favours for themselves or others.
- Gifts should be declined unless they are of nominal value, so their acceptance can be judged against internal or other relevant policies.
- Timing and frequency are relevant. Offers of gifts or hospitality, even if of limited monetary value, may be of concern if offered repeatedly and/or at times when they could be seen to influence or reinforce a particular decision or action.
- The commercial influence, actual or perceived, that a gift or benefit may represent is important.
- Hospitality offered may provide opportunities for members to develop productive relationships but their presence at such occasions is potentially open to criticism.

### Practice

The exercise of common sense will usually determine whether an offer of hospitality or a gift should be accepted. Useful tests could be to consider how Parliament, the media, competing suppliers and the wider public might interpret its acceptance; the reasons that may be behind the offer, and how the member would justify accepting what has been offered.

Board members should carefully consider timing and frequency. For instance, extra vigilance is needed in considering a gift offered at a time when an entity is negotiating for purchases or services. Board members should satisfy themselves that any hospitality offered is not too frequent or elaborate given the nature of the relationship, nor is it part of a pattern of invitations which could be considered excessive.

The Southern DHB has a Sensitive Expenditure Policy that outlines the limits surrounding expenditure of a sensitive nature (attached at Appendix 4). The policy is consistent with State Services Commission (SSC) guidance that:

- Board members must not solicit gifts and benefits from, or on behalf of, anyone under any circumstances;
- Board members not accept gifts and benefits from anyone, or on behalf of anyone, who could benefit from influencing them or the DHB;
- Open and transparent practices in relation to gifts and benefits are in place, to enhance trust in the State services, and reduce any misplaced speculation;

- A principles based approach to each situation rather than the dollar value of gifts or hospitality will determine what is appropriate for board members to accept, and the practice to be followed regarding the use of benefits in kind (e.g. air points);
- Unless they are 'consumable' at the time (e.g. meals, invitation to events), gifts should be regarded as the property of the DHB;
- Context be taken into account when considering hospitality offered by stakeholders, to balance the opportunities that may be provided against the potential for criticism. For instance, does the timing coincide with a particular board decision that affects the donor; how relevant is the event or function to the DHB's role; will the board's interests genuinely be advanced by having a member present; should the DHB itself meet the costs of attendance, to avoid any perceptions of influence?
- Close scrutiny be made of offers such as invitations to attend conferences in New Zealand or overseas that may include travel, accommodation, meals, a speaking fee, and/or inclusion of a member's partner. It is essential to consider whether there would be real value to the DHB from attendance and, if so, who is best placed to represent it;
- All boards which are considering offering gifts or hospitality should think very carefully about both the cost and the public and political perception of doing so. Policies need to specify the purposes for which, and occasions on which, it is acceptable to offer gifts, and the nature and value of gifts that are appropriate to particular occasions.

**Koha**

DHBs should be clear about their approach to the question of koha, to avoid misunderstandings. Koha is a gift, token or contribution given on appropriate occasions, such as a visit by board members in conjunction with a consultation hui. It is not a transaction in the usual sense: for example, there often is no written acknowledgement of receipt.

The OAG's good practice guide on sensitive expenditure (www.oag.govt.nz/2007/sensitive-expenditure/) includes an expectation that entities will ensure that:

- their policy on koha includes the means of determining the amount of any koha;
- a koha reflects the occasion;
- koha is not confused with any other payments that a DHB makes to an organisation; and
- koha is approved in advance, at an appropriate level of authority.

**Disclosure**

As per the Board's Code of Conduct and Sensitive Expenditure Policy, members must obtain the approval of the Board chair before accepting any offer of gift or benefit. Members should seek advice from the chair (or deputy chair if the gift or benefit is being offered to the chair) or other appropriate source if they are at all uncertain about the appropriate action to take. Expenditure of the board chair must be approved by the chair of the Audit and Risk Committee.

Disclosing gifts and hospitality as soon as practicable after they are accepted, and maintaining a register of them, represents an effective and transparent way for boards to demonstrate integrity in practice, both as a model of accepted behaviour within the DHB and in respect of their stakeholders. All gifts accepted by board members should be disclosed to the board secretary as soon as practical after receipt. Details disclosed should include:

- The nature of the gift or benefit
- The approximate value of the gift or benefit
- The party providing the gift or benefit
- The rationale for accepting the gift or benefit

These details will be recorded in a register which will be available for any board member to review. The Audit and Risk Committee will review the register at least annually. Any gifts or benefits >=$500 will normally be disclosed to the board at the following meeting.

# Chapter 10: Board meeting procedures and arrangements

The procedures for District Health Board (DHB) meetings are contained in Schedule 3 to the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Key provisions include:

- All meetings of DHBs must be publicly notified during a specified time period (clause 16), but no meeting of a board is invalid because it was not publicly notified (clause 17);
- Meeting agendas and papers must be available for inspection by any member of the public at least two working days before every meeting (clause 19), and board minutes must be available for public inspection except for those meetings or parts of meetings from which members of the public were excluded (clause 21);
- No business of a DHB board can be transacted, nor any power or discretion exercised at any board meeting unless the quorum of members is present (clause 25 (1)). The quorum is defined in clause 25(2), and the consideration of declared interests and board vacancies in establishing a quorum are contained in clause 26; and
- DHB board meetings are open to the public (clauses 31 and 34), though the board has the right to exclude the public in certain circumstances (clauses 32 and 33).

Schedule 4 to the NZPHD Act contains the equivalent provisions that apply to meetings of DHBs' community and public health advisory committees, disability support advisory committees, and hospital advisory committees.

### *Standing Orders*

The Southern DHB has adopted "Standing Orders" to provide more detailed guidance on procedures and processes associated with meetings. These Standing Orders apply to the proceedings of all Southern DHB board and committee meetings, including pubic excluded sessions, and it is required that all members of the board and committees shall abide by them.

A copy of these Standing Orders are attached as Appendix 2.

### *Crown monitors*

Under s. 30 of the NZPHD Act, the Minister of Health may appoint one or more Crown monitors to any DHB board, to assist in improving the performance of that DHB. If such a Crown monitor has been appointed, the board must:

- Permit each Crown monitor appointed by the Minister in relation to the DHB to attend any meeting of the board; and
- Provide the Crown monitor with copies of all notices, documents, and other information that is provided to board members.

The functions of a Crown monitor are to:

- Observe the decision-making processes, and the decisions of the board;
- Assist the board in understanding the policies and wishes of the Government so that they can be appropriately reflected in board decisions; and
- Advise the Minister on any matters relating to the DHB, the board, or its performance.

A Crown monitor may provide to the Minister any information that the Crown monitor obtains in the course of carrying out their functions as noted above.

# Chapter 11: Board committees

Board committees can enhance the effectiveness and efficiency of boards, by allowing closer scrutiny and more efficient decision-making in different areas of board responsibility. When boards establish committees, careful consideration is required of the powers, duties, reporting procedures, membership and duration that apply to the committees.

### *Legislative basis*

Every District Health Board (DHB) must establish three advisory committees under ss 34-36 of the NZPHD Act. These are the Community and Public Health Advisory Committee (CPHAC), Disability Support Advisory Committee (DSAC), and Hospital Advisory Committee~~s~~ (HAC). Schedule 4 to the NZPHD Act contains provisions concerning the functions, membership, meeting procedures, voting, public access and disclosure of members interests relating to these committees, with ss 34-36 containing specific provision for Māori membership of these committees.

Under clause 38 of Schedule 3 to the NZPHD Act, the board of a DHB may also establish one or more committees for particular purposes, and appoint to such committees members of the board and/or other persons. As a result of the enactment of an amendment, the NZPHD Act now requires the approval of the Minister of Health before establishing a new committee of the board.

The board has the power to dismiss any committee member and to dissolve any committee. If a member is dismissed, the board must provide that person with a written statement of the reasons for their dismissal, as soon as reasonably practicable.

If a person who is not a member of the DHB board is appointed to a board committee, that person must disclose to the board any conflict of interest he or she has with the DHB at that time, or that is likely to arise in the future (Schedule 4, clause 6(3)(a)(b), NZPHD Act). However, if a DHB board member is appointed to a board committee, they do not have to disclose their already known conflicts.

### *Key considerations*

The DHB's board remains accountable for decisions that are made by its committees. Good practice for DHB board committees includes provisions such as:

- Committees should only exist where there is clear reason for them, and they assist the governance of the DHB;
- Discretionary committees should be subject to regular review as to whether they should continue;
- There should be explicit reporting requirements back to the Board, which will allow other members to question committee members and assess the effectiveness of the committee;
- An audit committee, providing oversight of the Board's financial and risk management, is widely recommended in the public sector and should include members with financial expertise, and a committee chair who is not the board chair;
- One operational matter that is often delegated to a remuneration committee is the review of the Chief Executive's performance.

### *Southern DHB Committees*

The Southern DHB currently has ~~seven~~ six board committees:

- Community and Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC), which meet jointly

- Hospital Advisory Committee (HAC)
- Audit and Risk Committee (ARC)
- Iwi Governance Committee (IGC)
- ~~Clinical Advisory Committee (CAC)~~
- Appointments and Remuneration Advisory Committee (ARAC)

Current terms of reference (TOR) for each of the above committees are attached in Appendix 6.

See Chapter 2 for a diagram of the Southern DHB's committee structure.

### *Guidance on audit committees*

For guidance on DHB audit committees see the *Audit Risk and Finance Handbook for District Health Boards*, issued by the Ministry of Health: www.health.govt.nz/publication/audit-risk-and-finance-committee-handbook-district-health-boards.

In addition, for guidance on audit committees in the New Zealand public sector, see the good practice guide issued by the Office of the Auditor-General: www.oag.govt.nz/2008/audit-committees/.

# Chapter 12: Delegations

All decisions about the operation of a District Health Board (DHB) must be made by, or under the authority of, the board in accordance with the New Zealand Public Health and Disability Act 2000 (NZPHD Act). Where a board's powers and functions have been delegated, good governance and statute mean that the board remains legally responsible for the exercise of those functions and powers exercised under the delegation.

Each DHB is required to have a policy for the exercise of its powers of delegation: the formulation, amendment or replacement of such policies must be approved by the Minister of Health (the Minister), who can specify any conditions. The board's delegations policy must be made publicly available, (Schedule 3, clauses 39 and 40, NZPHD Act). The policy is a statement of how the board intends to exercise its powers of delegation (including financial matters, statutory and regulatory powers) and the reasons for doing so. The actual delegation will be made by letter from the board to the person concerned.

The policy document should only contain reference to classes of persons to whom delegations might be made on particular matters. Particular people should not be referred to as this would result in the Minister needing to approve the policy document each time there is a change in personnel.

### Effect of Delegation

The board remains responsible for the actions of its delegates in exercising the board's powers. Boards, therefore, need to be satisfied that delegates will use powers appropriately and not expose the board to risk. All requirements applying to a board in relation to a power will apply equally to the delegate.

### To whom can the board delegate?

DHB Boards may (by written notice) delegate any of the functions, duties or powers of the board or of the DHB to:

- Any committee of the board;
- Any member of the board or employee of the DHB (either to a named person or to any member of a specified class of persons); or
- Any person or class of persons approved by the Minister for the purpose (either a named person or any member of a specified class of persons). This applies where a power is delegated to a person outside the DHB (i.e. that are not members of the board or employees).

If a delegate is to be able to further delegate a function, duty or power it should be expressly stated in the delegation authority.

### Conditions attached to delegations

There are a number of procedural checks and balances on delegating. These are designed to ensure the board always remains in control of and responsible for the exercise of functions and powers by delegates. Ss. 73 to 76 of the Crown Entity Act 2004 (CE Act), which set out the provisions relating to delegations, do not apply to DHBs (see s. 21 of the NZPHD Act). However, clauses 39 and 40 of Schedule 3 to the NZPHD Act contain the relevant provisions relating to delegations in respect of DHBs. These include:

- The delegation of a DHB board's function, duty or power is revocable at will;
- A delegate may not delegate the function, duty or power without the written consent of the board, ~~or~~ unless it is done in accordance with the provisions of the delegation;

- The board cannot delegate a function or power unless it has authorised the delegation by resolution and written notice to the delegate;
- Delegation of a function, duty or power does not prevent the board or the DHB concerned from performing that function or duty, or exercising that power;
- Clause 39(8) of Schedule 3 to the NZPHD Act contains provisions concerning the exercise of delegated functions, powers or duties when the delegate may have conflicts of interest with the DHB. A delegate who is interested in a transaction of the DHB concerned may not perform any function, power or duty under the delegation if it relates to the transaction concerned, unless the board of the DHB has given its prior written consent (clause 40); and
- A person acting under a delegation should be able to produce evidence of their authority to exercise functions and powers when asked to do so.

**Chief Executive and other staff**

Boards may give their chief executive broad delegations, which reinforces accountability and control of the DHB. Boards also have the flexibility to delegate directly to specialist staff without first delegating to the chief executive. When this approach is taken, the accountability relationship between the staff member, the chief executive and board needs to be made clear.

Under s. 26 of the NZPHD Act, the board of a DHB must delegate to the chief executive of the DHB the power to make decisions on management matters relating to the DHB. Any such delegation may be made on such terms and conditions as the board thinks fit.

**Making delegations**

Boards should take professional advice when developing their delegations policy and in making delegations.

Boards should also note the effect of delegations in clause 40 of Schedule 3, the requirements relating to delegates with conflicts in clause 39(8) of Schedule 3, and the requirement under s.26(3) for the board to delegate to its chief executive the power to make decisions on management matters relating to a DHB.

**Southern DHB Delegation Policy**

The current Southern DHB "Delegation of Board Authority Policy" is posted on the Southern DHB website: www.southerndhb.govt.nz/padocs

# Chapter 13: District Health Boards as employers

District Health Boards (DHBs) have obligations as employers; these are set out in the Crown Entities Act 2004 (CE Act) and other legislation, and in government statements.

### *Chief executive employment*

The employment of a DHB's chief executive is a key responsibility of a board.

Under s. 26 of the New Zealand Public Health & Disability Act 2000 (NZPHD Act), the board of a DHB must delegate to their chief executive the power to make decisions on management matters relating to the DHB. Any such delegation may be made on such terms and conditions as the board thinks fit.

Chief Executives of DHBs have independent responsibility for all matters relating to individual employees (such as appointment, promotion and cessation of employment) without any interference from the board, its committees or from board members (Schedule 3, clause 44(4), NZPHD Act).

The board should ensure that a robust process is followed in preparing the position description, seeking suitable candidates and selecting the chief executive. The terms and conditions for chief executives of DHBs are determined by agreement between the board and the appointee. In accordance with clause 44(1) of Schedule 3 to the NZPHD Act, these terms and conditions and any amendments to them (which includes remuneration reviews), must not be finalised without first obtaining the consent of the fees & remuneration team at the State Services Commission (contact: 04 495-6600).

The State Services Commission has model agreements which contain the standard terms and conditions for chief executives of Crown entities, including DHBs. Use of these model agreements is not mandatory but it is recommended, at least as a starting point, because they incorporate good legal practice, manage risk, and are likely to make the consultation process smoother. The model agreements can be tailored to the requirements of the particular DHB. They are available at www.ssc.govt.nz/model_agreements.

Southern DHB's chair leads the CEO employment process, supported by the Appointments & Remuneration Advisory Committee.

### *Chief Executive Performance Management*

Good practice in relation to chief executive performance management includes:

- The board defining the performance expectations of the chief executive, and the criteria against which performance will be measured;
- Ongoing and constructive discussions between chair and chief executive;
- Addressing problems early, for instance by the chair communicating and discussing non-performance concerns; and
- A formal performance evaluation process, managed by the board chair.

The Appointments & Remuneration Advisory Committee oversees and provides advice to the chair and board on this process.

### *Employer responsibilities*

#### Good employer

Under s. 118 of the CE Act, a DHB is required to operate a personnel policy that complies with the principles of being a good employer. These principles include provisions requiring:

- Good and safe working conditions;
- An equal opportunities programme;
- Impartial selection of suitably qualified people for appointment; and
- Recognition of the aims and aspirations and employment requirements of Māaori and ethnic or minority groups and the employment requirements of women and people with disabilities.

The Equal Employment Opportunities Commissioner at the Human Rights Commission has responsibility for issuing good employer and EEO guidance to Crown entities. That advice can be found at: www.neon.org.nz/crownentitiesadvice/.

**Standards of integrity and conduct**

*Standards of Integrity and Conduct* is the code of conduct issued by the State Services Commissioner under s. 57 of the State Sector Act 1988. The code applies to all staff (but not board members) of statutory Crown entities including DHBs, and to board members and staff of some subsidiaries of Crown entities. It must be reflected in each DHB's internal policies. The Code can be found at: www.ssc.govt.nz/code, together with additional guidance on its interpretation and application.

**Pay and employment conditions – government expectations**

The government's expectations for pay and employment conditions in the State sector extend to all public service employees (not just those covered by collective agreements) and to all Crown entities, including DHBs. DHBs are required to take a number of factors into account in setting pay and employment conditions, including:

- fiscal sustainability and value for money;
- contributing to the achievement of the DHB's strategic business outcomes;
- avoiding risk of flow-on implications to other parts of the State sector;
- fairness to employees and taxpayers; and
- enhancing productivity and fostering continuous improvement.

The expectations are set out in: www.ssc.govt.nz/govt-expectations-pay-employment.

The Minister of Health will require DHB boards to have regard to these expectations when establishing pay and employment conditions.

Chief executives of DHBs may enter into collective agreements on behalf of the board with any or all of the board's employees, provided the Director-General of Health has first been consulted about the terms and conditions of such an agreement (Schedule 4, clause 44(4), NZPHD Act).

***Employment code of good faith***

The Employment Relations Act 2000 contains a code of good faith for the public health sector (s. 100D(1) and Schedule 1B), which applies to DHBs. The code applies subject to other provisions of that Act and any other enactment that does not limit the duty of good faith in relation to the health sector. Further, the code of good faith for collective bargaining and the code of employment practice also applies in relation to the health sector (s. 100D(5), Employment Relations Act 2000).

# Chapter 14: Subsidiaries and ownership interests

A DHB may establish one or more subsidiaries, either partly or fully owned, to carry out its functions and contribute towards the achievement of its objectives. The parent entity remains accountable for activities and performance of a subsidiary, which are reported in the parent entity's results. Accordingly the board should ensure that it follows governance good practice in establishing any subsidiary, and in monitoring and reporting on its activities.

## *Legislative basis*

### Types of subsidiaries

"Crown entity subsidiaries" are companies that are controlled by one or more Crown entities (ss. 7 and 8, Crown Entities Act 2004 (CE Act)). Each such subsidiary is a Crown entity in itself. The Companies Act 1993 applies to such subsidiaries, and their board members are directors under that Act.

The test for control is that expressed in ss. 5 to 8 of the Companies Act 1993. Essentially this is control of the composition of the board, or greater than 50% of either the shareholding, right to dividends, or voting rights. The definition of a Crown entity subsidiary in s. 7 of the CE Act also includes multi-parent subsidiaries i.e. where several DHBs, each with less than a controlling interest, have come together to establish a company.

Some bodies established by Crown entities do not come within the definition of "Crown entity subsidiary" in s. 8 of the CE Act. These are bodies that are not companies (e.g. trusts, incorporated societies or other non-company bodies), or that are associate companies (i.e. where the test for control is not met).

### Which Crown entities may establish subsidiaries?

All Crown entities (other than corporations sole) are authorised to acquire and establish Crown entity subsidiaries.

Under s. 28 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) no DHB may, except with the consent of the Minister of Health (the Minister) or in accordance with regulations made under this Act:

a) Hold any shares or interests in a body corporate or in a partnership, joint venture, or other association of persons; or

b) Settle, be or appoint a trustee of, a trust.

The Minister's consent may be given subject to any conditions the Minister specifies. Any such conditions must be consistent with s. 97 of the CE Act.

### Rules that apply to subsidiaries

The provisions of the Companies Act 1993 apply to Crown entity subsidiaries (except as provided in s. 102 of the CE Act). As subsidiaries are Crown entities themselves, the following applies to them:

- The provisions of the CE Act;
- Other legislation that is applicable to Crown entities generally or DHBs in particular; or
- The other relevant chapters of this guidance.

The Minister's relationship is with the parent entity rather than directly with a subsidiary. Responsible Ministers generally have no power to give policy, whole of government or other directions to Crown entity subsidiaries. Accordingly, ss. 97 and 98 of the CE Act set out the obligations the parent has to ensure that the subsidiary acts in accordance with the parent's functions and objectives, and observes the same statutory limitations as are applied to the parent. Ss. 52 and 93 of the CE Act specify that one of the collective duties of the board of a DHB is to ensure that it complies with ss. 96 to 101 (relating to the formation and shareholding of subsidiaries).

For multi-parent subsidiaries, the responsible Minister of the parent DHB must agree how the restrictions and obligations on subsidiaries in the CE Act apply to the subsidiary (s. 99).

### Key considerations

The parent DHB is accountable for a subsidiary's activities, including ensuring it complies with legislative restrictions. Among other things, the board will want to put in place procedures for ensuring:

- Best practice in the identification and appointment of directors for the subsidiary, including setting appointment terms and fees (see also the chapter *Remuneration and expenses for board members*, in regard to fees for directors of subsidiaries);
- Appropriate business planning and monitoring procedures, including that public accountability documents such as statements of intent and annual reports for the DHB adequately include information on the activities of the subsidiary;
- An internal control environment is in place so that the subsidiary complies with statutory obligations and is well managed; and
- Reporting to the board of the DHB/s concerned on the activities and the performance of the subsidiary, including any exceptions that are highlighted by the internal control environment.

# Chapter 15: Planning and reporting

Key board responsibilities include strategic planning, monitoring and reporting publicly on the expected and actual performance of their District Health Board (DHB); this enables Parliament and the public to hold Crown entities accountable.

S. 42 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) confirms the requirement for all DHBs to prepare statements of intent, annual financial statements and annual reports in accordance with Part 4 of the Crown Entities Act 2004 (CE Act) and any regulations made under s. 92(1) of the NZPHD Act. The expectation that boards are fully engaged in these areas is reflected by the requirement that these two accountability documents are signed by members of the board.

In 2008, the Auditor-General issued a discussion paper on the quality of performance reporting, in which he observed that "as well as their external accountability purpose, performance reports should reflect good management practice. Such practices involve clearly articulating strategy, linking strategy to operational and other business plans, monitoring the delivery of operational and business plans, and evaluating strategy effects and results"[5].

The DHB's Operational Policy Framework further specifies the financial requirements for DHBs. An annually updated version of the DHB's Operational Policy Framework can be found through the following website: www.nsfl.health.govt.nz/.

### *Annual and Strategic Planning*

The Minister of Health (the Minister) and each DHB must agree on an annual plan for the DHB. The Minister may also direct any DHB to prepare or contribute to one or more additional plans, e.g. a regional service plan (s. 38, NZPHD Act).

All such plans must address, local, regional and national needs for health services; how health services can be properly co-ordinated to meet those needs; and the optimum arrangement for the most effective and efficient delivery of health services. They must also demonstrate how a DHB that is a party to the plan is to operate in a financially responsible manner and give effect to the purposes of the NZPHD Act; and must reflect the overall direction of, and be consistent with, the New Zealand Health Strategy and the New Zealand Disability Strategy (s. 38, NZPHD Act).

The Minister's consent must be obtained for all such plans, or amendments to them. Where there is a dispute over the contents of any plan between one or more DHBs, the Minister may issue a directive and a DHB that is a party to the dispute must give effect to the Minister's decision (s. 39 of the NZPHD Act).

#### South Island Health Services Plan

Regional Health Services Plans (HSP) are the medium term (3-5 years) accountability documents for DHBs. The South Island HSP is prepared by the five South Island DHBs and sets out the strategic context and plans for an integrated and collaborative approach to sustainable health and disability services.

Each year the South Island DHBs prepare a supplementary implementation plan to the South Island HSP which details the DHBs' regional work plans for the coming year.

Copies of the latest plans can be found on the Southern DHB website:
www.southerndhb.govt.nz/padocs

[5] *The Auditor-General's observations on the quality of performance reporting*, Office of the Auditor-General, June 2008.

**Annual Plan and Statements of Intent**

Each District Health Board (DHB) has a statutory responsibility to prepare:

- an Annual Plan for approval by the Minister of Health (Section 38 of the New Zealand Public Health and Disability Act 2000) - providing accountability to the Minister of Health
- a Statement of Intent (Section 139 of the Crown Entities Act 2004, as amended by the Section 49 of the Crown Entities Amendment Act 2013) - providing accountability to Parliament and the public at least triennially
- a Statement of Performance Expectations (New CE Act s149C) – providing financial accountability to Parliament and the public annually

The Annual Plan (AP) aligns the DHB's direction to national (Minister's Letter of Expectations, national policy), regional (South Island HSP) and local priorities. It provides clear actions on how the DHB intends to deliver on its objectives and how it will measure its success.

~~Within the AP is the Statement of Intent (SOI).~~ The purpose of the Statement of Intent (SOI) is to promote the public accountability of a Crown entity (s. 138, CE Act) by:

- Enabling the Crown to participate in the process of setting the entity's medium-term intentions and undertakings;
- Setting out for the House of Representatives those intentions and undertakings; and
- Providing a base against which the actual performance can later be assessed.

The Crown Entities Amendment Act 2013 made key changes to the CE Act 2004 that has altered the SOI requirements for DHBs.

- An SOI is produced at least once in every three-year period (New CE Act s139 (3))
- The reporting timeframe for an SOI is a minimum of four years (forthcoming year and at least the following three financial years) (New CE Act s139 (2) as amended/inserted by S49 CE Amendment Act 2013).
- A Crown Entity's responsible Minister may require the crown entity to provide a new SOI at any time (New CE Act s139A (1)).
- SOIs contain high-level strategic information as relates to four year reporting timeframe. The annual reporting requirements are provided separately in a Statement of Performance Expectations (SPE) (New CE Act s141 & s149E). The SPE includes the Financial Performance.

The Minister may participate in determining the content of the SOI, by agreeing with the DHB on any additional information to be incorporated; specifying the form in which any information must be presented; commenting on a draft SOI; and directing amendment in relation to some of its content (s. 145, CE Act).

An SOI flows out of a DHB's strategic planning process, and through it the board expresses its strategic thinking and future intentions. The SOI articulates the impacts, outcomes, or objectives that the DHB seeks to achieve or contribute to. It includes qualitative and quantitative (financial and non-financial) measures and standards against which future performance will be assessed. The SOI is prepared under the leadership of the board, signed off by the board, and tabled by the Minister in Parliament.

The SOI will reflect engagement with the Minister and Ministry of Health through the planning process, and should incorporate Government's health sector and all-of-government priorities.

Advice on developing robust performance measures and preparing an SOI can be found at:

- *Performance Measurement: Advice and examples on how to develop effective frameworks* www.ssc.govt.nz/performance-measurement
- *The Auditor-General's observations on the quality of performance reporting* (especially see Appendix II) www.oag.govt.nz/2008/performance-reporting
- *Forecast non-financial performance information reports: Guidance for entities* www.oag.govt.nz/2009/forecast-non-financial-performance
- *Planning and Managing for Results: Guidance for Crown Entities* www.ssc.govt.nz/planning-for-results-crownentities
- *Preparing the Statement of Intent: Guidance and Requirements for Crown Entities* www.ssc.govt.nz/guidance-crown-entities-soi
- *DHB Operational Policy Framework*: www.nsfl.health.govt.nz

**Crown Funding Agreements (Output Agreements)**

The Minister may require a DHB to have a Crown Funding Agreement (CFA) for goods or services the DHB intends to supply that are paid for by the Crown. The CFA is agreed annually between the DHB and the Minister. It is an "output agreement" for the purposes of Part 4 of the CE Act, and s. 170(2) to (5) of the CE Act applies to the CFA (s. 10(2A), NZPHD Act).

Where there is a CFA, a separate output agreement is not necessary for that DHB and cannot be required under s. 170(1) of the CE Act (s. 10(6), NZPHD Act).

The purpose of a CFA/Output Agreement is to assist the Minister and the DHB to clarify, align and manage their respective expectations and responsibilities for the funding and production of outputs, including the standards, terms and conditions under which the DHB will deliver and be paid for the outputs.

An output agreement need not be legally enforceable as an agreement (s.170(4), CE Act), but it does create legally-enforceable duties on the Board members to ensure that the DHB acts consistently with its objectives, functions, current SOI, and the current output agreement (ss. 49 and 92, CE Act).

Output agreements may also include accountability arrangements such as reporting requirements and how the relationships between the Minister, the DHB and the Ministry of Health will be managed.

**Annual Report**

DHBs report on their performance to the Minister and Parliament through their annual reports (ss. 150 – 157, CE Act). The annual report must provide information that enables an informed assessment to be made of the DHB's operations and performance for that financial year, including an assessment against the intentions, measures, and standards set out in the SOI. Through this document, the board informs stakeholders on how it is leading the performance of the DHB, and how it is using public resources. The CE Act sets out specific information that must be included, for instance the annual financial statements for the DHB, a statement of service performance, any direction given to the DHB by a Minister in writing, and the total value of the remuneration paid to each board member during the financial year (ss. 151 and 152, CE Act).

Every annual report of a DHB must also contain:

- A report on the extent to which it has met its other objectives under s. 22, NZPHD Act;
- A report on the performance of the hospital and related services the DHB owns;

- The names of any bodies corporate, partnerships, joint ventures or other associations, or trusts with which the DHB is involved, and a list of all shares and interests the DHB holds in such bodies; and
- A statement of how the DHB has given and intends to give effect to its functions specified in s. 23(1)(b) – (e) of the NZPHD Act.

The board will lead development of the annual report, including engagement as necessary with the Minister.

The Auditor-General is the DHBs' auditor, but will generally appoint another auditor to act on his or her behalf. The auditor is required to audit the annual financial statements, statement of service performance, the annual report, and any other required or agreed information.

The annual report must be in writing, be dated, and be signed on behalf of the DHB board by two board members, or by the Commissioner. A DHB must provide its annual report to the Minister of Health within 15 working days of receipt of the audit report: it is recommended that a near final draft also be provided to the Ministry of Health, to enable the Minister to be briefed on key issues.

For assistance in developing an annual report, please refer to *Preparing the Annual Report 2011~~08~~: Guidance and Requirements for Crown Entities* www.ssc.govt.nz/annual-report-guidance-crown-entities. The Minister presents the annual report to Parliament according to the timetable set out in this guidance.

The Southern DHB's latest Annual Report can be found on the Southern DHB website: www.southerndhb.govt.nz/padocs

**Enduring letter of expectations**

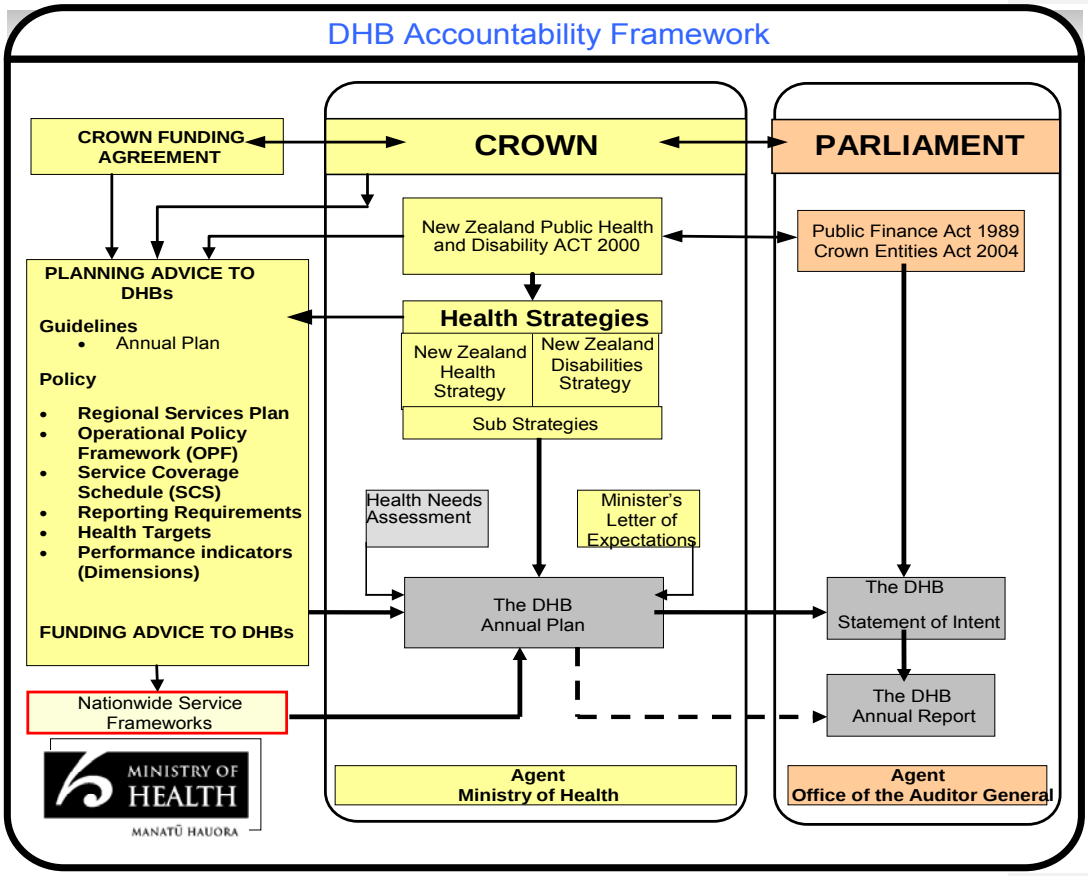
An enduring letter of expectations to Crown entities is issued periodically, with the most recent on ~~22 December 2008~~26 July 2012: see www.ssc.govt.nz/expectations-letter-crown-entities-dec08. It sets out the ongoing expectations that the Minister of Finance and the Minister of State Services have of all statutory Crown entities, including DHBs. These expectations include value for money, demonstrating performance, and engagement with Ministers and monitoring departments. An enduring letter remains 'in force' until it is replaced.

**Annual letter of expectations**

Ministers "participate in the process of setting and monitoring the entity's strategic direction and targets" (s. 27(1)(f), CE Act). Ministerial expectations for DHBs' strategic direction and their specific priorities for the planning period may be reflected in a letter of expectation from the Minister to the DHB. It may also cover expectations of a DHB's governance and performance and of the monitoring information to be provided. The letter will usually be sent to the chair before the board starts its strategic planning.

### *DHB accountability framework*

Collectively all the above planning and reporting documents and process make up a 'health sector framework'. The following is a diagrammatic view of the DHB accountability framework.




# Chapter 16: Board and member performance evaluation

Evaluating the performance of the board and of board members allows a board, led by the chair, to take stock and reflect on both these aspects of performance. The knowledge gained from the review is a means to continually improve the effectiveness of the leadership and governance of the entity.

The board should assess its own performance in relation to the board's key responsibilities, which include:

- Managing the relationship with the Minister and meeting the Minister's expectations;
- Strategic planning;
- Discharging the board's legal and ethical obligations;
- Monitoring entity performance;
- Monitoring and reviewing the performance of the chief executive; and
- Managing relationships with stakeholders.

The benefits of evaluating individual board member performance include:

- Providing feedback to individual board members, so their contribution to the board's work can be maximised;
- The ability to put in place mentoring, development or training for individual board members or the board as a whole;
- Reinforcing the accountability of the chair for the effective performance of the board; and
- Assisting the Minister of Health with succession planning, appointment and reappointment processes.

Principles of good practice in evaluating board performance are that:

- It should be undertaken regularly, preferably each year;
- A formal method provides an objective framework for evaluation;
- Board member peer review is consistent with the self-appraisal principle whereby professionals monitor their own performance;
- Confidentiality should be observed to allow for the free expression of views.

The actual process to be used each year may vary, e.g. evaluations may be managed internally or the board may be assisted by an external facilitator.

The chair is expected to offer appropriate feedback to the board and to individual members, and to provide assurance to the Ministry of Health that a process for performance evaluation is in place and that it is undertaken. A detailed outline of requirements is set out in the Operational Policy Framework for DHBs: www.nsfl.health.govt.nz.

# Chapter 17: Board appointments and reappointments

Board appointment and reappointment decisions have considerable impact on performance. Every vacancy for an appointed member on a District Health Board (DHB) creates an opportunity to reassess the future needs of the DHB, and the skills and experience that will best complement the talents of the other board members. Where possible boards, through the chair, should be involved in these processes: this could be through the Ministry of Health or direct to the Minister of Health (the Minister).

### *DHB board membership*

The board of each DHB consists of:

- Seven members elected in accordance with Schedule 2 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act); and
- Up to four members appointed by the Minister under s. 28(1)(a) of the Crown Entities Act 2004 (CE Act) which states that a responsible Minister may only appoint a person who, in the Minister's opinion, has the appropriate knowledge, skills, and experience to assist the DHB to achieve its objectives and perform its functions.

If, at an election of members of a board of a DHB, fewer than seven members are elected, the Minister may, in accordance with the procedure in s. 28 of the CE Act, appoint persons who were eligible to stand in that election to fill the vacant elected member positions. Those who are so appointed hold office in all respects as if they had been elected under the NZPHD Act.

Where a vacancy occurs in an elective position on a board, the Minister may, in accordance with the procedure in s. 28 of the CE Act, appoint a person for the remainder of the term of office of the person who vacated office.

In making appointments to a DHB board, the Minister must endeavour to ensure that:

- M~~a~~āori membership of the board is proportional to the number of M~~a~~āori in the DHB's resident population; and
- in any event, there are at least two M~~a~~āori members of the board.

### *Chair and deputy chair appointments*

The Minister must, by notice in the *Gazette*, appoint one member of the DHB board as chair of the board, and another as deputy chair. This notice may be the same as the notice appointing the member. It must state the period for which the member is appointed chair or deputy chair, and the date on which he or she comes into that office.

A member appointed chair or deputy chair, and whose appointment as such has expired:

- Continues in that office until his or her successor is appointed; and
- Is eligible for reappointment to that office so long as he or she continues to be a member of the board.

Chairs and deputy chairs retain all their responsibilities as a board member as well as any additional responsibilities deriving from their chair or deputy chair role.

#### Role of Chair in appointment processes

The Minister or Ministry of Health should generally engage with the Board chair throughout the process of appointing a DHB board member. The chair should be able to:

- Reflect his/her knowledge of the workings of the board and its less formal interactions and relationships, as part of identifying the skills needed of an appointee;
- Provide feedback on the board's annual evaluation as to the future needs of the entity (refer chapter *Board and member performance evaluation*);
- Assist with updating position descriptions; and
- Suggest nominees for consideration.

Where possible, board chairs should also be part of the selection and interview panel for appointed board members. This would not be appropriate where the chair is being assessed for reappointment or replacement.

**Desirable Attributes in Appointed Board Members**

The skills and attributes most relevant to a specific vacancy that is filled by ministerial appointment rather than election are determined by analysing the current composition of the board in question. This analysis also involves the board's chair, and considers the board's needs and the particular challenges faced by the DHB in terms of performance, health outcomes and collaboration. Other factors may also be considered (e.g. if the board is planning a major capital development).

Board appointees must have backgrounds that demonstrate strong personal integrity to enable them to meet their obligations in terms of personal behaviour and ensuring the propriety of the DHB's actions (set out in ss. 53-57 and 59 of the CE Act).

Generic skills for a board member will usually include:

- A wide perspective on, and awareness of, social, health and strategic issues;
- Integrity and a strong sense of ethics;
- Financial literacy and critical appraisal skills;
- Strong reasoning skills and an ability to actively engage with others in making decisions;
- Knowledge of a board member's responsibilities, including an ability to distinguish governance from management, understanding of collective responsibility and an appreciation of the Crown as owner;
- Good written and oral communication skills;
- An ability to contribute constructively and knowledgeably to board discussions and debates.

These qualities will usually be demonstrated through some or all of the following:

- Governance experience in significant organisations with either a commercial, public service or community focus;
- Experience at chief executive or senior management level in organisations that have commercial or public service attributes;
- Holding senior positions in relevant professional areas including, but not limited to, health, social services, finance, law, and social policy;
- Relevant governance or management experience in community or professional organisations.

In addition to the above qualities, members are often appointed for their unique abilities, such as expertise in an area of specialisation or representation.

**Conflicts of interest**

Before a chair, deputy chair or member is appointed or elected, they must declare their conflicts of interest. Members to be appointed declare their interests to the Minister of Health before their appointment (s. 31(1)(c), CE Act). Candidates for elected member positions give a statement to the electoral officer, who then discloses any conflicts of interest to the public (Schedule 2, clause 6, NZPHD Act). Further information on conflicts of interest can be found in Chapter 7: *Members' interests and conflicts: identification, disclosure and management*, and in the separate publication *Conflicts of Interest Guidelines for District Health Boards"*.

***Terms of office for DHB board members***

**Appointed members**

Under s. 32 of the CE Act, the term of office for appointed members of DHB boards is up to three years. Appointed members of the board of a DHB are eligible for reappointment unless they have held office for six consecutive years, in which case they must not be reappointed immediately unless the Minister consents in writing to them being re-appointed immediately and holding office consecutively for longer than six years but not exceeding nine years (Schedule 3, clause 2(1)(b), NZPHD Act refers). A person may hold office as an appointed member of the board of one or more DHBs.

Appointed members come into office on the date specified for that purpose in the notice appointing the member or, if no date is specified in the notice, from the date on which the notice is published in the *Gazette*.

**Elected members**

Elected members of DHB boards come into office on the 58th day after polling day. An elected member of the board of a DHB who has not ceased to hold that office earlier and is not re-elected in the next triennial board election, ceases to hold that office when the members elected in that election come into office. An elected member of a DHB board is not to hold office as an elected or appointed member of the board of any other DHB.

***Board members on more than one State sector board***

Generally, a DHB board member may be a member on more than one State sector board at any one time, as long as there is no legislation or other rule preventing this, there are no unmanageable conflicts arising from the situation and the board member has the time available to properly undertake the positions.

***Reappointment principles***

The Minister decides, in light of a DHB's strategic direction and other considerations, whether an appointed member should be reappointed when his or her term expires. Incumbent board members have no automatic right of reappointment and need to be aware that the requirements for appointment under the CE Act will apply. For example:

- s. 29: Criteria for appointment or recommendations by the responsible Minister;
- s. 30: Qualifications of members; and
- s. 31: Requirements before appointment, which includes disclosure of interests.

Incumbent board members will be required to provide updated curriculum vitae to the Minister or Ministry of Health and may be required to attend an interview. Incumbent board members who are reappointed will receive a notice of appointment and an appointment letter, which may convey the Minister's expectations of that board member.

***Board member induction and training***

Ministers, boards and monitoring departments all have responsibilities in relation to induction of new board members. The NZPHD Act (Schedule 3, clause 5) requires a board with elected or appointed members to fund and ensure the undertaking of training approved by the Minister. Training may include subjects such as board membership duties and obligations, Treaty of Waitangi issues, or M~~a~~āori groups or organisations in the district of the DHB concerned.

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The board must keep an up-to-date record of the following matters:

- The name of each member of the board and the date on which they most recently came into office as a member of the board;
- Any familiarity each member of the board has at that date with the obligations and duties of a member of a board, M~~a~~āori health issues, Treaty of Waitangi issues, and M~~a~~āori groups or organisations in the district of the DHB concerned;
- The nature of the training (if any) the board is required to fund and, to the extent practicable, have any of its members undertake and complete; and
- The date that training was completed or, if it is still in progress, the date on which it started and the date by which it is expected to have been completed or, if it has not yet started, the date on which it is expected to start.

The board secretary maintains a register of such induction and training activities. Boards are required to provide a copy of this record to the Minister if requested to do so.

***Removal from office***

The Minister may remove an appointed member of a DHB board from that office in accordance with s. 36 of the CE Act (i.e. at the Minister's discretion).

Under the NZPHD Act (Schedule 3, clause 8(1)) the Minister may remove an elected member of a board from that office by notice in the *Gazette* stating the date on which the removal takes effect, but only:

- If the Minister has first consulted the member, and the board, about the removal; and
- For a reason stated in clause 9 to Schedule 3 of the NZPHD Act. These include:
  - the Minister is satisfied that the member failed to declare an interest in circumstances where clause 6 of Schedule 2, or clause 36, required the member to do so; or
  - the Minister is satisfied that the integrity of the board, or of the DHB to which the board relates, has been seriously compromised because the member has neglected his or her duties as a member of the board, or has failed to perform his or her duties under the Act; or
  - the member has been absent from four consecutive board meetings without permission from the board or the Minister; or
  - the member has breached any of the obligations and duties of a board member, and s. 58(2) or s. 59(2) of the CE Act applies.

A chair or deputy chair may be removed from that office by the Minister by notice in the *Gazette* stating the date on which the removal takes effect, but only if the Minister has first consulted the person concerned and the board, about the removal. A chair or deputy chair removed from that office continues to be a member of the board unless removed from that

office as well, under s. 36 of the CE Act or clause 8(1) to Schedule 3 of the NZPHD Act, as the case may be.

The Minister has the power to replace a whole board with a Commissioner under s. 31 of the NZPHD Act.

Board members are not employees, and no compensation is made in the event of their removal from a board.

**Cessation of office**

Board members may resign their position at any time (s. 44, CE Act). Resignations must be made by written notice to the Minister with a copy given to the DHB. The notice must state the date on which the resignation takes effect.

The chair or deputy chair of a DHB board may resign from that office by written notice to the Minister and board stating the date on which the resignation takes effect. A chair or deputy chair who resigns from that office continues to be a member of the board unless he or she also resigns from that office (Schedule 3, clause 11, NZPHD Act).

A chair or deputy chair of a DHB board ceases to hold that office if he or she ceases to be a member of the board. A deputy chair ceases to hold that office if he or she is appointed chair of the board.

Board members are not employees, and no compensation is made in the event of their resignation from a board or non-reappointment.

# Chapter 18: Remuneration and expenses for board members

Setting fee levels that are sufficient to attract and retain talented board members is an important element of effective governance. Members do not set their own fees, remuneration and allowances but it is important for boards to understand how they are set and how to engage with the relevant fee-setting authority when fees are reviewed.

Ss. 47 and 48 of the Crown Entities Act 2004 (CE Act) provide the mechanism for setting the remuneration and expenses for board members of District Health Boards (DHBs), i.e. by the Minister of Health (the Minister) under the Cabinet Fees Framework (the Fees Framework), which applies to DHB board members, and is administered by the State Services Commission.

The Fees Framework is set out in a Cabinet Office circular. Boards using it need to be sure they are working from the latest version, as it is reviewed periodically. The current version is located at: www.dpmc.govt.nz/cabinet/circulars/co~~09/5~~12/6.html .

Field Code Changed

When a DHB board establishes a committee or a subsidiary, the board itself becomes the fee-setting authority and should then follow the provisions in the Framework.

In general:

- Board chairs are paid more than other members due to their larger role;
- Deputy chairs are paid an additional amount on top of their member fee;
- Members who receive an annual fee for board membership do not generally receive additional payment under the CE Act if they are a member of a board's committee. However, the Fees Framework does provide additional payments for DHB board members who sit on one of the DHB's three statutory committees (see Appendix 8); and
- Members of DHB committees who are not already on the DHB board may be paid a fee. The Auditor-General suggests the fee should be at a level that reflects the time it takes to properly carry out their duties. For example, this may be based on a percentage of the fee paid to a board member.

Fees under the Fees Framework are set on a fair but conservative basis to reflect a discount for the element of public service involved. The Fees Framework includes provision for fees to be reviewed periodically, which does not necessarily lead to an increase. This review is normally undertaken by the Ministry of Health on behalf of the Minister.

Under the Fees Framework, members should not receive payment as consultants from a DHB to which they are appointed. If, however, the Minister agrees that there are overriding reasons for board members to carry out consulting assignments, any proposal to do so needs to be submitted to Cabinet for consideration.

### Southern DHB fees

The fees set by the Minister of Health for the Southern DHB are set out in Appendix 8.

### Administrative matters

Board members who travel to meetings or on other board business that requires them to be away from their normal places of residence are entitled to reimbursement of actual and reasonable travelling, meal and accommodation expenses.

Expense claims should be submitted through the board secretary for approval by the chair, or in the case of the chair, by the chair of the Audit and Risk Committee. The DHB has a

sensitive expenditure policy which will assist members in recognising appropriate expenditure (see Appendix 4).

Claim forms are available from the board secretary and must be accompanied by receipts (except for mileage). Mileage expense claims must include the date and location of the meeting and the distance travelled.

The total value of remuneration paid to each board member is disclosed in the annual report of the DHB concerned (s. 152, CE Act).

Taxation matters and their impact on the way the DHB pays fees and allowances depend on the personal circumstances of the member concerned. Board members and entity management can clarify their taxation status by reference to professional advice or the Inland Revenue Department.

Board members need to take a personal decision on whether they should take out any kind of insurance protection pertaining to sickness, etc.

Board members are not entitled to any compensation or other payment or benefit relating to loss of office (s. 43, CE Act).

# Chapter 19: Liability and protection from legal claims or proceedings

To assist in attracting the best quality candidates to serve on boards and to ensure that boards act without fear or favour, the New Zealand Public Health and Disability Act 2000 (NZPHD Act) contains a regime for exclusion from liability and indemnities. The Crown Entities Act (CE Act) provisions on liability and protection from legal claims or proceedings do not apply to District Health Board (DHB) members. Instead, s. 90 of the NZPHD Act states that members of DHB boards or committees are not liable:

1. For any liability, act or omission of the organisation;
2. To the organisation for any act or omission done or omitted in their capacity as a member, if they acted in good faith and with reasonable care in pursuance of the functions of the organisation.

All boards are expected to govern well and to the best of their abilities. However, even the most careful and law-abiding board can find itself involved in legal claims and proceedings. All board members need to be aware that failing to comply with their duties may lead to personal liability, civil proceedings or criminal prosecution. Individual board members can also be held liable for actions of the board as a collective.

Although Crown entities are legally separate from the Crown, in some cases a court may decide that the Crown is liable for the entity. This will depend largely on its statutory functions and the extent of control exercised over the entity by Ministers and other central Government agencies. Every board should spend time discussing these matters as they relate to themselves and their employees, preferably with the assistance of a trained specialist, perhaps the entity's legal advisor.

### Indemnities

An indemnity is an agreement by one person to pay another person any sums owed to a third party. "Indemnification" means that the entity relies on its own resources to pay the legal costs of board members and any other persons for claims that result from board/entity actions, unless the board has decided to take out indemnity insurance.

The CE Act (s. 21) provides that members of an entity are immune from civil liability, unless they have breached an individual duty set out in the Act.

Every member of a DHB board or committee is indemnified by the DHB, in terms of s. 90 of the NZPHD Act:

- For costs and damages for any civil liability arising from any action brought by a third party in respect of any act or omission in his or her capacity as a member, if he or she acted in good faith and with reasonable care, in pursuance of the functions of the organisation; and
- For costs arising from any successfully defended criminal proceeding in relation to any act or omission.

Board members should be aware of the extent of any indemnity.

### Insurance

Insurance provides financial protection for board members and others who are covered, in the event that they are sued in conjunction with the performance of their duties as they relate

to the DHB. The NZPHD Act, however, does not contain powers for DHBs to purchase insurance for board members. To the extent that DHB board members consider it necessary in light of s. 90 of that Act, they should make their own arrangements for professional indemnity insurance to cover their work as a member of the board.

As insurance is not provided, the board must ensure that the individual member is made aware that he or she is not covered, as well as of any relevant statutory protection from liability, so the member can consider whether to make their own provision for such insurance.

# Chapter 20: Appendices

| | |
|---|---|
| **Appendix 1** | **Code of Conduct for Board and Committee Members**<br>Approved: June 2010<br>Review Date: December 2013 |
| **Appendix 2** | **Standing Orders**<br>Approved: June 2010<br>Review Date: December 2013 |
| **Appendix 3** | **Iwi Partnership: Principles of Relationship Agreement**<br>Approved: May 201~~4~~<br>Review Date: May 201~~5~~ |
| **Appendix 4** | **Sensitive Expenditure Policy**<br>Approved: December 2010<br>Review Date: December 2012 |
| **Appendix 5** | **Fraud Policy**<br>Approved: September 2011<br>Review Date: September 2013 |
| **Appendix 6** | **Committee Terms of Reference** |
| | a) Community & Public Health Advisory Committee (CPHAC)<br>Approved: ~~February 2012~~March 2014<br>Review Date: ~~December 2013~~March 2017 |
| | b) Disability Support Advisory Committee (DSAC)<br>Approved: ~~February 2012~~March 2014<br>Review Date: ~~December 2013~~March 2017 |
| | c) Hospital Advisory Committee (HAC)<br>Approved: ~~February 2012~~2013March 2014<br>Review Date: ~~February 2013~~2014March 2017 |
| | d) Audit and Risk Committee (ARC)<br>Approved: ~~June 2012~~April 2014<br>Review Date: ~~June 2013~~April 2017 |
| | ~~e) Clinical Advisory Committee (CAC)~~<br>~~Approved: April 2011~~<br>~~Review Date: April 2012~~ |
| | ~~f)~~e) Appointments and Remuneration Advisory Committee (ARAC)<br>Approved: ~~April 2012~~April 2014<br>Review Date: ~~March 2014~~April 2017 |
| **Appendix 7** | Executive Management Team and Governance Support Structure |
| **Appendix 8** | Board Members' Remuneration |

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**Comment [MSOffice1]:** Newer version approved by Board, but not implemented due to HR matters raised. P Beirne following through on this.

**SOUTHERN DISTRICT HEALTH BOARD**

| | |
|---|---|
| **Title:** | **APPOINTMENTS AND REMUNERATION ADVISORY COMMITTEE TERMS OF REFERENCE** |
| **Report to:** | Board |
| **Date of Meeting:** | 3 April 2014 |


**Summary:**

The Appointments and Remuneration Advisory Committee has reviewed its terms of reference and recommends that, with the exception of a minor amendment, they remain unchanged.


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

| | |
|---|---|
| **Financial:** | N/A |
| **Workforce:** | N/A |
| **Other:** | N/A |

| | | |
|---|---|---|
| **Document previously submitted to:** | | **Date:** |
| **Approved by Chief Executive Officer:** | | **Date:** 25/03/2014 |

| | |
|---|---|
| **Prepared by:**<br>Jeanette Kloosterman<br>Board Secretary<br><br>**Date:** 20.03.2014 | **Presented by:**<br>Joe Butterfield<br>Chair, Appointments & Remuneration Advisory Committee |

**RECOMMENDATION:**

**The Appointments & Remuneration Advisory Committee recommends that the Board approve its terms of reference as modified.**

# APPOINTMENTS & REMUNERATION ADVISORY COMMITTEE

## Terms of Reference

### Accountability

The Appointments and Remuneration Advisory Committee is constituted under section 38, Schedule 3, of the New Zealand Public Health and Disability Act 2000 (the Act).

The procedures of the Committee shall also comply with Schedule 3 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

### Objective

The objective of the Appointments and Remuneration Advisory Committee is to give the Board and Chief Executive advice on senior management appointments and major remuneration issues.

### Functions & Responsibility

The function of the Appointments and Remuneration Advisory Committee of the Southern DHB is to:

1. Give the Board advice on

    - Remuneration policy and strategy
    - Recruitment, appointment and remuneration of the Chief Executive.

2. Give the Chief Executive advice on recruitment, appointment and remuneration of senior appointments to the DHB.

The Committee may only give advice or release information to other parties under authority from the Board of the Southern DHB.

The Committee is to comply with clauses 44(1) and 44(4) of Schedule 3 of the New Zealand Public Health and Disability Act 2000, which provide that:

44(1) "*The terms and conditions of employment of a chief executive of a DHB appointed by its board are to be determined by agreement between the board and the chief executive, except that the board must not finalise those terms and conditions, or agree to any amendments to any or all of those terms and conditions once they have been finalised, without first obtaining the consent of the State Services Commissioner."*

44(4) "*In respect of any DHB, matters related to decisions on individual employees (for example, relating to the appointment, promotion, demotion, transfer, personal grievances, disciplining, or cessation of employment of an employee) are the independent responsibility of the individual for the time being acting as chief executive of that DHB, without any interference from the board of the DHB or from committees of the board (or from members of the board or of committees of the board)."*

Any recommendations or decisions of the Committee must be ratified by the Southern DHB Board (unless authority has already been delegated to the Committee).

Where the Committee has been delegated the power to make decisions or resolutions, the meetings of the Committee will be subject to clauses in Schedule 3 of the NZ Public Health and Disability Act 2000 relating to giving notice of meetings, holding meetings and admission of the public.

## Membership

All members of the Committee are to be appointed by the Board. The Board will appoint the Chairperson.

The Committee is to comprise the Board Chairman and three Board members, supplemented with external appointees as required.

## Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff.

## Quorum

The quorum of members of a committee is:

(a) if the total number of members of the committee is an even number, half that number; but

(b) if the total number of members of the committee is an odd number, a majority of the members.

## Meetings

Meetings for this Committee are to be held as required.

## Review

The Terms of Reference for this Committee shall be reviewed ~~before the end of March 2014 and then three yearly.~~at the beginning of each Board term.

## Management Support

The DHB's Chief Executive will ensure provision of management and administrative support to the Committee.

# SOUTHERN DISTRICT HEALTH BOARD

| | |
|---|---|
| **Title:** | **Contracts Register** |
| **Report to:** | Southern District Health Board |
| **Date of Meeting:** | 3 April 2014 |

**Summary:**

Amended contracts register as per the Board's recommendation.

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

| | |
|---|---|
| **Financial:** | Nil |
| **Workforce:** | Nil |
| **Other:** | Nil |

| | | |
|---|---|---|
| **Document previously submitted to:** | | **Date:** |
| **Approved by Chief Executive Officer:** | | **Date:** 25/03/14 |

| | |
|---|---|
| **Prepared by:**<br><br>Sandra Boardman<br>Executive Director Planning and Funding<br><br>**Date:** 17.03.14 | **Presented by:**<br><br>Sandra Boardman<br>Executive Director Planning and Funding |

**RECOMMENDATION:**

**1. That the Board note the attached Contracts Register.**

# FUNDING ADMINISTRATION
# CONTRACTS REGISTER (EXPENSES) - MARCH 2014

| PROVIDER NAME | DESCRIPTION OF SERVICES | ANNUAL AMOUNT | CONTRACT/VARIATION END DATE |
|---|---|---|---|
| **Contract Value of - $0 - $100,000 (Level 3)** | | | |
| Lumino Dental Ltd t.a Lumino the Dentists - Milton Dental Agreement | Service Agreement for the Provision of Oral Health Services for Adolescent and Special Dental Services for Children and | Demand Driven | 30.06.15 |
| PACT Group Variation to Agreement | Residential and Community Based Support Services | $73,073.00 | 30.06.16 |
| Ryman Healthcare Limited t.a Rowena Jackson Hospital Service Schedule | Exceptional Circumstances palliative care for a named individual | $16,130.70 | 14.04.14 |
| Presbyterian Support Otago Incorporated t.a Iona Hospital Service Schedule | Exceptional Circumstances palliative care for a named individual | $16,082.10 | 28.04.14 |
| Presbyterian Support Otago Incorporated t.a Iona Hospital Service Schedule | Exceptional Circumstances palliative care for a named individual | $16,082.10 | 23.04.14 |
| Presbyterian Support Otago Incorporated t.a Iona Hospital Service Schedule | Exceptional Circumstances palliative care for a named individual | $16,331.40 | 26.04.14 |
| BUPA Care Services NZ Ltd t.a Ascot Care Home Agreement | Long Term Support - Chronic Health Conditions | Demand Driven | 04.12.14 |
| Bainfield Gardens Limited Variation to Agreement | Vocational Support | $1,501.68 | 31.10.14 |
| Pacific Island Advisory & Cultural Trust Incorporated Variation to Agreement | Pacific People Community Linkage Worker | $45,000.00 | 31.01.15 |
| Presbyterian Support Otago Incorporated t.a Ross Hospital Service Schedule | Exceptional Circumstances palliative care for a named individual | $16,149.94 | 04.05.14 |

# FUNDING ADMINISTRATION
# CONTRACTS REGISTER (EXPENSES) - MARCH 2014

| | | | |
|---|---|---|---|
| Aroha Ki Te Tamariki Charitable Trust<br>Variation to Agreement | Child & Youth Mental Health & Alcohol & Other Drug Services | -$141,562.62 | 30.09.14 |
| Presbyterian Support Otago Incorporated t.a Ross Hospital<br>Service Schedule | Exceptional Circumstances palliative care for a named individual | $1,814.60 | 21.02.14 |
| Presbyterian Support Otago Incorporated t.a Iona Hospital<br>Service Schedule | Exceptional Circumstances palliative care for a named individual | $15,903.41 | 13.05.14 |
| Presbyterian Support Otago Incorporated t.a Ross Hospital<br>Service Schedule | Exceptional Circumstances palliative care for a named individual | $362.92 | 18.01.14 |
| Mossbrae Healthcare Ltd t.a Mossbrae Home & Hospital<br>Service Schedule | Exceptional Circumstances palliative care for a named individual | $15,061.18 | 11.05.14 |
| | **Total for this Section** | **$91,930.41** | |
| **Contract Value of - $100,000 - $500,000 (Level 2)** | | | |
| None this month | | | |
| | **Total for this Section** | **$0.00** | |
| **Contract Value of - $500,000 - 1 Million (Level 1)** | | | |
| None this month | | | |
| | **Total for this Section** | **$0.00** | |
| **Contract Value of - $1 Million and Over (Board)** | | | |
| None this month | | | |
| | **Total for this Section** | **$0.00** | |

**Total Value $91,930.41**