29 June 2021 Public Papers

Public Board Meeting

29 June 2021 09:00 AM - 11:00 AM

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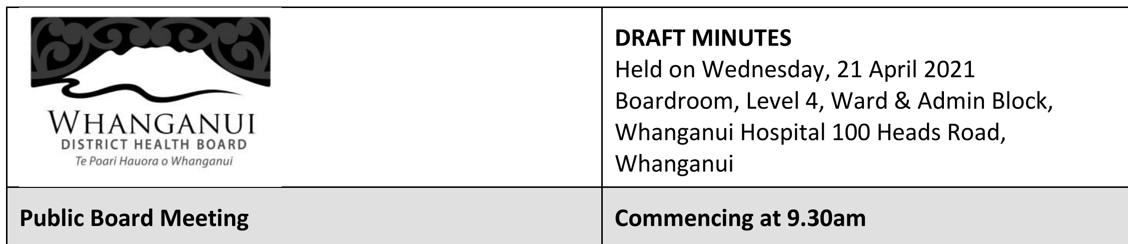
Whanganui DHB Boardroom

Interest Register

22 June 2021

Name	Date	Interest
Ken **Whelan** *Chair*	13 December 2019	Crown monitor for Waikato DHB Board member RDNZ (NZ) Chair Eastern Bay of Plenty PHO Contractor General Electric Healthcare Australasia
Annette **Main** *Deputy Chair* *Chair CSAC*	25 September 2020	Member of Whanganui Community Foundation.
Anderson-Town Talia *Chair FRAC*	2 June 2020	▪ A board member of Ratana Orakeinui Trust Incorporated ▪ A board member of Te Manu Atatu Whanganui Maori Business Network.
Adams Graham	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Anderson Charlie	16 December 2016	An elected councillor on Whanganui District Council.
	3 November 2017	A board member of Summerville Disability Support Services.
Baker-Hogan Philippa	10 March 2006	An elected councillor on Whanganui District Council.
	8 June 2007	A partner in Hogan Osteo Plus Partnership.
	24 April 2008	Her husband is an osteopath who works with some of the hospital surgeons, on a non paid basis, on occasions hospital patients can attend the private practice, Hogan Osteo Plus, which she is a Partner at.
	29 November 2013	Chair of the Future Champions Trust, supporting promising young athletes.
	3 March 2017	A trustee of Four Regions Trust.
Bennett Mary	12 April 2021	▪ member Hauora ā Iwi ▪ member Te Oranganui Trust Board ▪ member WDHB FRAC
Chandulal-Mackay Josh	10 December 2020	An elected councillor on Whanganui District Council
	21 February 2020	A member of Aged Concern Deputy Chair for Whanganui Youth Services Trust
Hylton Stuart	4 July 2014	▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society of New Zealand. ▪ The Whanganui District Licensing Commissioner, which is a judicial role and in that role he receives reports from the Medical Officer of Health and others.
	13 November 2015	An executive member of the Central Districts Cancer Society.
	2 May 2018	▪ The chairman of Whanganui Education Trust ▪ A trustee of George Bolten Trust
	2 November 2018	The District Licensing Commissioner for the Whanganui, Rangitikei and Ruapehu districts.
MacDonald Judith	22 September 2006	The chief executive of Whanganui Regional Primary Health Organisation
	11 April 2008	A director of Gonville Health Centre
	4 February 2011	A director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape
	21 September 2018	A director of Ruapehu Health Ltd
	10 November 2020	A member of the NZ Rural General Practice Network Board
Peke-Mason Soraya	19 June 2021	▪ Director, Ruapehu Health Limited ▪ Trustee, Whanganui Community Foundation ▪ Iwi Rep, Rangitikei District Council Standing Committee ▪ Whanganui Health Network Board member

21 April 2021 **Public**



	DRAFT MINUTES Held on Wednesday, 21 April 2021 Boardroom, Level 4, Ward & Admin Block, Whanganui Hospital 100 Heads Road, Whanganui
Public Board Meeting	**Commencing at 9.30am**

DRAFT

Present
Annette Main, Deputy Board Chair, Chair Combined Statutory Advisory Committee
Talia Anderson-Town, Finance Risk and Audit Chair
Graham Adams, Member
Charlie Anderson, Member
Mary Bennett, Member
Josh Chandulal-Mackay (departed at 11am)
Philippa Hogan-Baker
Stuart Hylton, Member

In attendance
Nadine Mackintosh, Executive Officer
Andrew McKinnon, General Manager Corporate
Lucy Adams, Director of Nursing/Chief Operating Officer
Ian Murphy, Chief Medical Officer
Katherine Fraser-Chapple, Acting

Guests
M Ellis, Awa FM
F Donne, member of public
Stephen Lee, member of public

1. Procedural

1.1 Karakia/reflection

A Main opened the meeting reflecting on the passing of the GM Strategy, Commissioning and Population. The tragedy of this sudden loss will be hard for all that worked closely with him with acknowledgement on the loss to his family and friends. This supersedes the news on the changes to health we will receive today.

M Bennett was welcomed as a new ministerial appointment to the board with acknowledgement of contributions already undertaken and those she will continue to provide.

1.2 Apologies

The board **accepted** apologies from K Whelan, J MacDonald, R Simpson and **noted** the early departure of 11:00am for J Chandulal-Mackay.

Moved A Main **Seconded** J Chandulal-Mackay **CARRIED**

1.3 Continuous Disclosure

1.3.1 Amendments to the Interest Register
M Bennett, member of Te Oranganui Trust
S Peke Mason, member of the Whanganui Health Network

1.3.2 <u>Declaration of conflicts in relation to business at this meeting</u>
Nil

1.4 Confirmation of minutes
<u>3 March 2021</u>
The minutes of the meeting held on 3 March 2021 were **approved** as a true and accurate record of the meeting.

Due to technical difficulties P Bakers-Hogan unable to participate in this meeting virtually.

Moved A Main **Seconded** C Anderson **CARRIED**

1.4 Matters Arising
The matters arising were received.

1.5 Board and Committee Chair Reports

1.5.1 <u>Combined Statutory Committee report</u>
The minutes were received and it was noted that the LifeCurve material is available for all members to review in the February 2021 Combined Statutory Committee Papers.

2. Presentation

2.1 Short Term Services Care
J Fowler, Associate Director of Allied Health Scientific and Technical

The purpose of this item was to address concerns from a member of public, F Donne, on the short-term services care.

Healthy at home every bed matters is important and health services will be different for each individual. It is important how we discharge people out of the hospital and back to their home in the community with the appropriate supports in place.

The presentation covered the key aspects of care for patients receiving secondary and primary care and home care supports. Our relationships with key agencies is critical to ensure we are connected and people in our communities are receiving the appropriate home care supports.

Aged concern supports are being strengthened through a partnership approach to ensure there is more understanding on their service provisions and providing a collective approach to care requirements.

The regional approach to frailty will assist with quality of life.

The review of short-term services care commenced approximately 12 months ago along with a review of our brochure and process. The review recommended that all WDHB staff holding an annual certificate can put in place short-term care support services.

Discussion was held on:
- Forming better partnerships with agency/barriers? Management advice was that this was about strengthening and where it is impacted by capacity issues we are looking at changes to the models of care. The integrated care approach includes upskilling our community partners and changes to models of care. Our partnerships are more collaborative and provide advantages.

- interRAI assessments should reduce the re-questioning that patients receive, but can be dependent on the clinical personnel.
- A whanau approach is the obvious and appropriate approach with identification of the whanau support contact for the care.
- Access to information of care developments are encouraged.
- Alternative discharge planning options, in particular process for installation of wet area requirements.

The board thanked the staff for their presentation.

3. Chief Executive report

The paper was taken as read with discussion on the education and approach for the COVID vaccination rollout to our communities.

The Board of Whanganui District Health Board:

a. **Received** the paper titled chief executive report.

b. **Noted** the activities that have been undertaken around the rohe by members of the WDHB.

c. **Noted** the passing of both R Bartley and P Malan.

d. **Noted** that the health bus was donated to the Bartley Foundation from the District Council.

CARRIED

4. Discussion

4.1 Provider Arm Report – April 2021

The paper was taken as read with some discussion on the renal and specialist services. Management informed a theatre review is being undertaken and a report will be available by the end of the year.

The Board of Whanganui District Health Board:

a. **Received** the paper titled 'Provider Arm Services'

b. **Noted** comments around operational performance for Hospital and Clinical Services, Maternal, Child and Youth Services and Primary and Community Services

Moved A Main **Seconded** J Chandulal-Mackay **CARRIED**

4.2 Financial Report

The paper was taken as read with management advice that we are currently in a good financial position and aiming to achieve our financial deficit position.

There was discussion on:
- an increase in air ambulance activity for the month noting it will not impact our financial position.
- Funder contracts in particular those to Māori providers and percentage of funding that our Maori providers receive.

The board thanked management for the great result.

Moved S Hylton **Seconded** C Anderson **CARRIED**

21 April 2021 **Public**

5. Information paper

5.1 Faster Cancer Treatment Targets

There was discussion on the variances of targets.

The Board of Whanganui District Health Board:

a. **Received** the paper Faster Cancer Treatment Targets

b. **Noted** that Ministry of Health Faster Cancer Treatment Health Target reporting for Q2 indicates 92.6% compliance with the FCT Target.

Moved S Hylton **Seconded** C Anderson **CARRIED**

5.2 Six monthly paediatrics update

The chief medical officer reported that recruitment for additional pediatricians is underway.

The Board of Whanganui District Health Board

a. **Received** the paper titled 'Six-monthly pediatrics update'

b. **Noted** the key service factor highlights for the last six months in are the following areas:
- Development of the maternity, child and youth community alliance
- Nurse Practitioner role for Gateway Assessments
- Paediatric SMO staffing
- Rural Clinics
- Paediatric Registrar
- Specialist Outreach Services

c. **Noted** the service progress for identified deficiencies

d. **Noted** the current service projects

Moved A Main **Seconded** C Anderson **CARRIED**

5.3 Smokefree Environments Regulated Products Act 1990 Proposal for Regulation Submission

The Board of Whanganui District Health Board

a. **Received** the paper titled Smokefree Environments Regulated Products Act 1990 Regulations Proposals Submission.

b. **Noted** the submission was prepared by the Whanganui District Health Board, Public Health - Health Promotion approved by the Whanganui DHB Chief Executive

c. **Noted** the submission was submitted through the parliamentary process on 15 March 2021

Action: Circulate a copy of the submission, with a remainder of board involvement in the process.

Moved A Main **Seconded** C Anderson **CARRIED**

5.4 Impact Collective – Rangitikei, Ruapehu, South Taranaki and Whanganui District Health Board

The paper was taken as read and the board thanked management for the detailed reporting.

The Board of Whanganui District Health Board

a. **Received** the paper titled Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui

b. **Noted** the key messaging for the Impact Collective

Moved G Adams **Seconded** T Anderson-Town **CARRIED**

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The board meeting adjourned at 10.50am to receive a briefing from the chair on the health reforms.

5.5 Haumoana Service – Te Hau Ranga Ora Māori Health

The paper was taken as read with management highlighting possible changes to data collection for power business intelligence.

The board discussion was held on:
- Haumoana administration role and functions
- Māori patient acknowledgement from the Haumoana service at their request
- Multi-disciplinary team meeting attendance
- Proactive to referral of service
- The only 24/7 service provided across the country

Management were thanked for the services they provide to our communities and management acknowledged and thanked the team for the work they undertaken on our behalf.

The Board of Whanganui District Health Board

a. Receive the paper titled 'Haumoana service - Te Hau Ranga Ora Māori Health'

b. Note the work of the Haumoana Health service

c. Note the Te Waka guiding principles and model

Moved A Main **Seconded** M Bennett **CARRIED**

5.6 Health and Safety
The paper was taken as read.

The Board of Whanganui District Health Board

a. **Receive** the report entitled 'Health and safety update'.

b. **Note** there were no notifiable events reported to WorkSafe New Zealand in the 2017/18, 2018/19, 2019/20 financial years or 2020/21 year-to-date.

c. **Note** the overall trend for the top five injury/incident categories indicates a slight decline over the three year period.

d. **Note** the following trends for each of the five categories:

- Aggression injuries/incidents decreased over the three year period.
- Manual handling injuries/incidents decreased over the three year period.
- Infection control injuries/incidents increased over the three year period.
- Slip, trip, falls injuries/incidents increased over the three year period.
- Struck by, bumped injuries/incidents decreased over the three year period.

Moved S Hylton **Seconded** M Bennett **CARRIED**

5.7 Maternity Services Combined Annual Report
The paper was taken as read.

The Board of Whanganui District Board **received** the paper titled Maternity Service Annual Report

Moved A Main **Seconded** G Adams **CARRIED**

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6. Resolutions to exclude public

The Board of Whanganui District Health Board members:

a. **Agreed** that the public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table.
b. **Noted** that the grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act, believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists for withholding under the Official Information Act 1982 (OIA), as referenced in the following table.

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 3 March 2021	For reasons set out in the board's agenda of 3 March 2021	As per the board agenda of 3 March 2021
Chief executive's report Committee minutes Committee Chair update	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Laboratory and Pathology services contract Allied Laundry Insurance Renewal	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)
ESPI Compliance	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

That the following person(s) may be permitted to remain after the public has been excluded because the board considers that they have knowledge that will help it. The knowledge is possessed by the following persons and relevance of that knowledge to the matters to be discussed follows:

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Person(s)	Knowledge possessed	Relevance to discussion
Chief executive, senior managers and clinicians present	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Executive Officer	Minute taking, procedural and legal advice and information	Recording minutes of board meetings, advice and information as requested by the board

Moved A Main **Seconded** S Peke-Mason **CARRIED**

The public section of the meeting concluded at 11.52am

Signed A Main
Deputy Board Chair
Whanganui District Health Board

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June 2021 **Public**

Matters Arising

29 June 2021

Topic	Action	Due date
The Te Reo o Te Rangatahi presentation – March meeting	Circulate a copy of the presentation to board members.	Completed
He Hapori Ora Progress Report – March meeting	The next update to what is going well and what is challenging and steps we are undertaking to reduce the changllenge.	September 2021
Proof of concept paper	Use the strategy to frame the paper	Underway
Smokefree Environments Regulated Products Act 1990 Proposal for Regulation Submission	Publish a copy of the submission on the resource centre in boardbooks	Completed

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry
Lead Coordination Minister for the Government's Response to the Royal Commission's Report into the Terrorist Attack on the Christchurch Mosques

27 MAY 2021

To: District Health Board (DHB) Chairs

You are all aware of the serious cyber incident at Waikato District Health Board and the impact of a loss of access to IT systems on health service delivery. This incident is a timely reminder of the critical importance of cyber security protection throughout the health and disability system.

My expectation is that all health agencies, and their contracted service providers, have appropriate cyber security protection in place.

I understand from the Ministry of Health that officials have been in regular communication with DHBs and other health sector organisations providing advice on the steps you should be taking to ensure you are protected from similar criminal activity. On 19 May DHBs and PHOs were provided with a range of advice and requested to take specific actions.

Officials are verifying that these actions have been completed and I am told that a number of PHOs are yet to confirm completion of the actions. For those yet to respond, I ask you for your prompt attention to this request for reassurance.

I am aware that Director-General of the Government Communications Security Bureau and Chief Executive of the Department of Internal Affairs are preparing additional material to assist Chief Executives across the wider public service. This is to help ensure appropriate steps are being taken to maintain cyber security resilience and be prepared to respond if an incident occurs. You can anticipate this advice to come to you via the Ministry in the next few days.

If you have any questions, please continue to engage directly with Ministry of Health officials.

Yours sincerely

Hon Andrew Little
Minister of Health

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Minutes
Public session

Meeting of the Combined Statutory Advisory Committee

held in the Board Room, Fourth Floor, Ward/Administration Building, Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 28 May 2021, commencing at 9:30am

Combined Statutory Advisory Committee (CSAC) members in attendance
Ms Annette Main (Chair)
Ms Christie Teki
Ms Debra Smith
Mr Graham Adams
Mr Josh Chandulal-Mackay
Ms Te Aroha McDonnell
Ms Phillipa Baker-Hogan
Ms Sorya Peke-Mason
Mr Frank Bristol
Ms Hayley Robinson

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive
Ms Kath Fraser-Chapple, Acting General Manager, Strategy Commissioning & Population Health
Mr Ian Murphy, Chief Medical Officer
Ms Deanne Holden, Secretariat

1. Procedural

1.1 Karakia & Welcome

The meeting was opened by the Chair with an acknowledgement to both Paul Malan and Mal Rerekura, two WDHB senior staff members who had passed suddenly in recent weeks. One minutes silence was held in their honour.

The Chair acknowledged the dedication Paul Malan had shown to the Committee as the Executive lead and passed condolence to his colleagues and whānau. Mal Rerekura was a highly respected member of the Māori Health & Equity team, again condolences were passed to his whānau and colleagues. The knowledge and mana of both men will be missed by all.

Kath Fraser-Chapple was then welcomed to Committee as Acting General Manager, Strategy Commissioning & Population Health. The Chair acknowledged the work carried out by Kath Fraser-Chapple and the Strategy & Commissioning team in preparing for the meeting, at a time of such sadness.

The Chair reminded committee members she is available either prior or post meeting to discuss any concerns or questions. All were encouraged to speak with the Chair, or Kath Fraser-Chapple directly, if there were items they would like placed on upcoming agendas.

The Chair then welcomed Hayley Robinson, Ngati Rangi, to the Committee as the final representative from Hauora ā Iwi.

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1.2 Apologies

It was resolved that apologies be accepted and sustained from the following:

Mr Charlie Anderson, Mr Ken Whelan, Ms Maraea Bellamy, Ms Heather Gifford

1.3 Conflict and register of interests update

1.3.1 Amendments to the register of interests

Sorya Peke-Mason provided the secretary with a written update noting the following:
Remove:

- Chair, Te Totarahoe o Paerangi – Ngāti Rangi (Ohakune-Raetihi)
- Labour Candidate

Add:

- Whanganui Health Network Board Member

Frank Bristol requested the following be added "advisor to consumer engagement working party"

1.3.2 Declaration of conflicts in relation to business at this meeting

There were no declaration of conflicts in relation to this part of the meeting.

1.4 Minutes of the previous committee meeting

The minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 26 February 2021 were accepted as a true and correct record with the following amendment:

1. Note that Debra Smith attended the meeting via zoom.

An error on the approved minutes of a meeting held on 21/8/2020 was noted, in relation to the confirmed attendance of Phillipa Baker-Hogan at that meeting. Ms Baker-Hogan's attendance was noted on the attendance sheet, however, not on the list of attendees. It was agreed the error would be amended and the relevant addition made to the minutes.

Moved: A Main **Seconded**: D Smith

1.5 Matters Arising

The following updates to the Matters Arising were noted:

Item 26/2-01: noted as complete
Item 26/02-3: noted as complete

Item 26/02-2: A Main advised the information has been requested from the Whanganui District Council, however, no response received as yet. Item to be carried forward.

1.6 Committee Chair's Report

The Chair advised WDHB had been well presented at the recent Hui Whakaoranga that took place on 18 May in Wellington. The hui was well attended by iwi and representatives from the Māori health and disability sector, providing an opportunity to connect and share aspirations and challenges toward delivery of a successful Whakamaua: Maori Action Plan 2020-2025.

The discussion was thought provoking, with the Chair noting the insightful the work being carried out at WDHB is not standard practice across all DHB.s She felt Whanganui DHB is a clear exemplar of excellence in its acknowledgement and connection with local Iwi and the shared vision to progress Māori health advancement.

In relation to the Health Sector Reform, the Chair noted that although it is an exciting opportunity for our community to better health outcomes, there will be challenges for WDHB staff and CE in the months to come. The Chair thanked both for their continued mahi and support during this time of upheaval.

I Murphy joined meeting: 9.45am

2. Chief Executive Report
Russell Simpson

The Chair introduced R Simpson, Chief Executive WDHB. Mr Simpson provided a verbal update with a brief overview of key points shown below.

Mr Simpson thanked the Chair for her acknowledgment of Paul Malan and Mal Rerekura's passing. He also acknowledged the recent passing of Robert Bartley, a generous supporter of the WDHB who contributed significantly to the community with his recent donation which had allowed the purchase and development of a community health bus.

Mr Simpson acknowledged the mahi carried out by Alisa Stewart QSO, former Principal Nurse, Whanganui District Health Board member, Whanganui District councillor and a community support of numerous organisations. Ms Stewart was honoured as the recipient of the "Paul Harris Fellow Award" award at a recent Rotary North meeting. The award was in appreciation of the tangible and significant assistance given for the furtherance of better understanding and friendly relations among peoples of the world.

The He Hapori Ora – Thriving Communities strategy has now been launched with the values and goals being integral to all we do. The Annual Plan 2021-22 is focused on the vision outlined in the strategy and collectively places Whanganui DHB in a strong position to offer excellent health outcomes to our community, in line with the expected outcomes of the Health Sector review.

The Committee viewed the 6 minute launch video, which can be found on the WDHB website at the following link: https://www.wdhb.org.nz/about-us/he-hapori-ora-thriving-communities. Mr Simpson asked all to support the distribution of the strategy throughout their networks.

Mr Simpson confirmed a submission has been made to the Whanganui District Council for the Long Term Plan regarding the He Hapori Ora strategic vision. Council are now are working through their processes and will provide feedback in due course.

Health and Disability Review (H&DR)

R Simpson and R Kui attended the announcement of the H&DR in March. Key aspects of the review and change to sector include:

- MOH will be the steward of the new Health System
- A new Crown Entity will be created, likely named Health NZ
- A new Crown Entity will be created, likely named Maori Health Authority (MHA). The MHA will hold responsibility commissioning of Maori Health contracts
- Public Health Units will be incorporated with Health NZ
- Funding & Planning arms of DHBs will be networked across regions with employment of all DHB staff transferring to Health NZ on 1 July 2022.
- A regional commissioning framework will be developed with the MHA authority working alongside local governance & iwi

Current DHB districts will be re-defined as Regions with stakeholder engagement a key part of conversations over next few months. Further details will follow in due course to enable DHB's to operationalise the changes ensuring best health outcomes for our community and staff.

Royal assent is expected in July 2022

Risks identified:

- retaining talent.
- disruption to service delivery & performance
- undergoing major change whilst managing COVID-19 pandemic

It was noted the WDHB He Hapori Ora strategy aligns with the governments vision with S Peke-Mason confirming the Hauora a Iwi mandate captures the voice of Iwi across the catchment.

Mr Simpson asked all Committee and Board members to support the dissemination of the He Hapori Ora strategy within their networks, including Iwi and Council, to ensure awareness and a united voice throughout the region

ICT Security

Following a recent issue at Waikato DHB relating to a cyber security breach, Mr Simpson advised all WDHB systems and processes have been reviewed with extra security measures enabled. This includes Cloud based software solutions which quarantine attachments, scan for threats and release for staff to open only when deemed safe.

WDHB receives daily SitRep reports with information being shared and recommendations enacted daily throughout all DHB's.

Mr Simpson did reiterate however, that notwithstanding the above, vulnerabilities to ICT networks throughout the sector remain.

COVID-19 Vaccinations

Mr Simpson confirmed, as at 27 May 2021, locally a total of 8153 people have been vaccinated, which includes 1145 Māori. We continue to vaccinate those in groups 2 and 3. Group 3 includes:

- Over 65 or
- Those with relevant underlying health conditions or
- Māori & Pasifika aged 50 & over

In early June a major vaccination facility will open centrally with the aim for WDHB being to vaccinate more than 54,000 people in Whanganui with 2 doses by end of 2021.

Mr Simpson also noted that Maori Health Provider, Te Oranganui, (with support from WDHB), have arranged clinics in Whanganui, Waverly and Rangitikei for Group 2 members. This will soon to be expanded to extend up the Awa and include group 3.

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NZNO Strike
Mr Simpson advised that formal notification was received regarding a strike by NZNO members on the 17th May 2021. The strike will take place from 1100am -1900pm. WDHB has formally requested Life Preserving Services Nursing staff to NZNO (these are WDHB nursing staff who will come and work as per agreement with the union) with senior staff currently working on rosters to ensure enough base staff to work. Communications have gone out to staff with communications to the public due to go out next week. Senior staff are meeting 3x weekly with a large planning team and the managers of the units/wards with WDHB being supported nationally by the strike contingency team.

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3 Discussion Papers

3.1 Progressing pro-equity: Kaitakitaki work streams
R Karena, Kaitakitaki, Māori Health and Equity

A paper titled Progressing pro-equity: Kaitakitaki work streams was tabled by R Karena, on behalf of R Kui. The paper was taken as read with feedback on information provided and/or questions welcomed.

R Karena recognised the contribution to the Te Hau Ranga Ora (THRO) team and Kaitakitaki made by both Paul Malan and Mal Rerekura.

It was noted that the paper was tabled at the Board meeting on 21 April 2021. T-A McDonnell thanked those involved for the well laid out and insightful paper. Discussion following regarding the work being undertaken around addressing racism and bias. It was agreed this is not totally the responsibility of THRO and that the foundation for conversations going forward would be formed, in part, via outcomes of the H&D review.

It was resolved that the committee:

a. **Receive:** the paper titled Progressing Pro-Equity: Kaitakitaki Work Streams

b. **Note:** the challenges and opportunities articulated in the paper

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3.2 Preliminary Q3 Reporting: non-financial performance measures & detailed results K Fraser-Chapple, Acting GM Strategy Commissioning and Population Health

A paper titled Preliminary Q3 Reporting: non-financial performance measures & detailed results was tabled by K Fraser-Chapple and taken as read with the key points highlighted below:

Results are preliminary with final feedback not yet received from MOH. At the time of print not all areas were rated, however, where stated "not rated" it should be noted that results were now available and all are either partially met or met.

It was noted challenges remain against the measure "MH04: MH&A CRISIS RESPONSE" although a number of changes have taken place in this workstream. There appears to be a high percentage of "abandoned calls", which may in part be due to a change in process for overnight calls to the Crisis team. A meeting to review this change in approach will take place in June.

S Peke-Mason noted residential care for MH is not available in Whanganui and there can be long waiting lists for residential care out of district. Management noted the concern.

F Bristol highlighted favourable results against suicide measures. The suicide prevention plan, which has been codesigned with community leadership and 9 different interconnected modules is due to be rolled out soon. Significant change is expected as a results of this plan.

Clear and concise message is imperative relating to influenza immunisations, COVID-19 vaccine. Mr Simpson confirmed that WDHB social media accounts are monitored daily and we do publish reputable facts on our website, however, we have no ability to control what is said over social media.

WDHB supports a national campaign to promote the importance of child immunisation as rates are dropping nationally. Development of an Immunisation Communication Plan is included in the Draft WDHB Annual Plan for 2021-22.

It was agreed the committee:

a. **Receive** the paper titled Preliminary Q3 Reporting: non-financial performance measures & detailed results

b. **Note** that while Quarter 2 results now final (section 1), Quarter 3 results are preliminary.

DRAFT

3.3 Status update - Annual Plan 2020-21
K Fraser-Chapple, Acting GM Strategy Commissioning and Population Health

A paper titled Status update – Annual Plan 2020-21 was tabled by K Fraser-Chapple and taken as read with key points shown below:

Initial feedback received from the MOH has been overwhelmingly positive with 7 sections from the annual plan assessed by ministry as all either met or partially met. This is testament to the excellent work that is taking place thought the WDHB.

Mr Simpson acknowledged the Strategy Commissioning & Population Health team in collating the report for MOH and committee following the passing of Paul Malan and thanked them for their mahi.

Committee members confirmed the depth of information provided was very useful.

It was agreed the committee:

a. **Receive** the paper titled Status update - Annual Plan 2020-21

b. **Note** that while the Quarter 2 results are now final (section 1), Quarter 3 results are preliminary

3.4 Provider Arm Services report
I Murphy, Chief Medical Officer & A Kemp, Chief Allied Professions Officer

A paper titled "Provider Arm Services report" was tabled by I Murphy. The paper was taken as read with a summary of the key points shown below.

Mr Murphy confirmed a second Paediatric SMO has now commenced employment with a third recently interviewed.

A question was raised regarding clinical support being offered to Waikato DHB in relation to planned care in light of their recent ICT issues. Mr Murphy confirmed we would provide any supports required, however, had not received any request to do so. It was noted however, that WDHB is using ESPI capacity currently to support the Taranaki region.

G Adams noted is support for using new models of care in oral preschool such as potential use of the healthcare bus. Mr Murphy confirmed that a variety of caravans are used throughout the region including smaller caravan units. Mr Simpson advised work continues at national level around sugary drinks pressure being placed on the government for legislative changes.

It was agreed the committee:

a. **Receive** the paper titled Provider Arm Services Report – May 2021

b. **Note** comments around operational performance for Hospital and Clinical Services; Maternal Child and Youth Services and Primary and Community Services

The Chair moved that action points for all Discussion Papers, as recorded above, be accepted:

Moved: A Main **Seconded:** S Peke Mason

DRAFT

4. Information papers

4.1 Overview of WDHB Art & Archives Group Activity
Rowena Kui, GM Māori, Te Hau Ranga Ora / Art & Archives Group Sponsor

A paper titled "Overview of WDHB Art & Archives Group Activity" was tabled by the Chair on behalf of R Kui, with the paper taken as read.

A Stewart, a committee member of the art group, was introduced to Committee and available for questions. S Peke-Mason, via the Chair, thanked the art committee for their dedication and noted the improvement made to the clinical feel of the hospital by the art on display.

It was agreed the committee

a. Receive the paper titled Overview of WDHB Art & Archives Group Activity

4.2 Update on activity to improve appointments attendances
Rowena Kui, Kaiuringi Māori Health and Equity, Te Hau Ranga Ora Sponsor

A paper titled "Update on activity to improve appointments attendances" was tabled by the Chair on behalf of R Kui, with the paper taken as read.

It was noted the paper was tabled as a response to matters arising point: 26/02-03

It was agreed the committee

a. Receive the paper titled Up-date on activity to improve appointment attendances.

The Chair moved that all action points for Information Papers, as recorded above, be accepted:

Moved: A Main **Seconded:** P Baker-Hogan

DRAFT

5. Date of next meeting

The next meeting will be held on, Friday 27 August 2021 from 09:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui.

6. Reasons to exclude public

It was resolved that:

The public be excluded from the remainder of this meeting under clause 32, Schedule 3 of the New Zealand Public Health and Disability Act 2000 on the grounds that the conduct of the following agenda items in public would be likely to result in the disclosure of information for which good reason for withholding exists under sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 26 February 2021 (Public – excluded session)	For the reasons set out in the committee's agenda of 26 February 2021	As per the committee's agenda of 26 February 2021

Persons permitted to remain during the public excluded session.

That the following person(s) may be permitted to remain after the public has been excluded because the committee considers that they have knowledge that will help it. The knowledge is possessed by the following persons and relevance of that knowledge to the matters to be discussed follows.

Person(s)	Knowledge possessed	Relevance to discussion
Chief executive and senior managers and clinicians present	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Committee secretary or executive assistant	Minute taking	Recording minutes of committee meetings

Moved: A Main
Seconded: T-A McDonnell

The public session of the meeting ended at 11.32

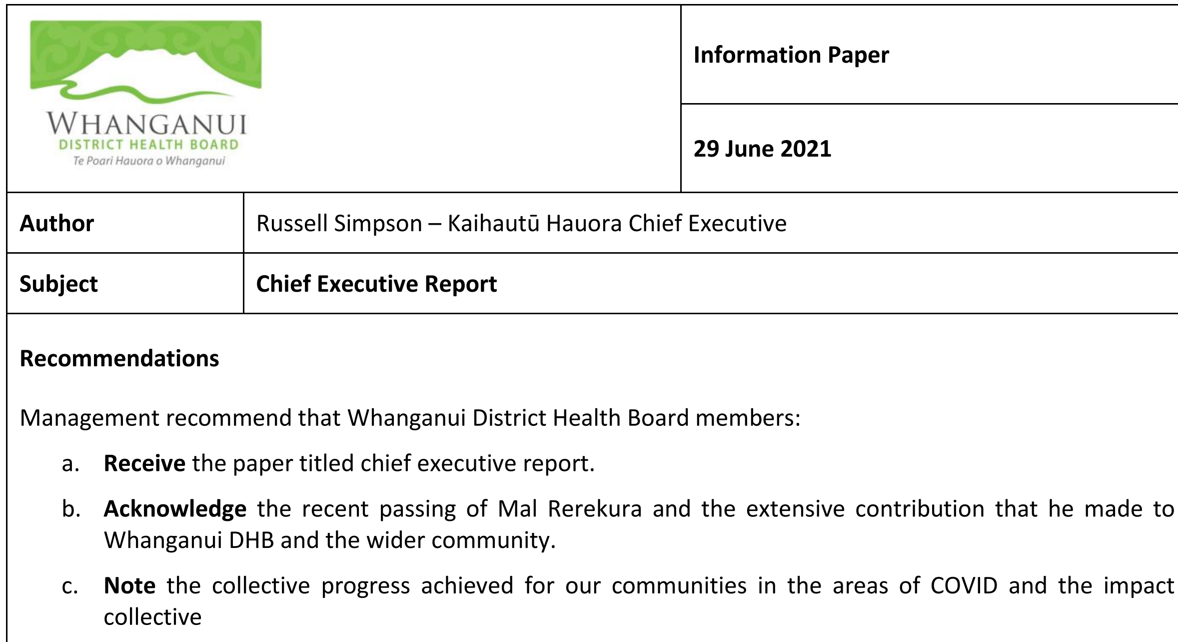
Adopted this day of 2020

………………………………………………….

Chair

DRAFT

June 2021 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	29 June 2021
Author	Russell Simpson – Kaihautū Hauora Chief Executive
Subject	**Chief Executive Report**

Recommendations

Management recommend that Whanganui District Health Board members:

a. **Receive** the paper titled chief executive report.

b. **Acknowledge** the recent passing of Mal Rerekura and the extensive contribution that he made to Whanganui DHB and the wider community.

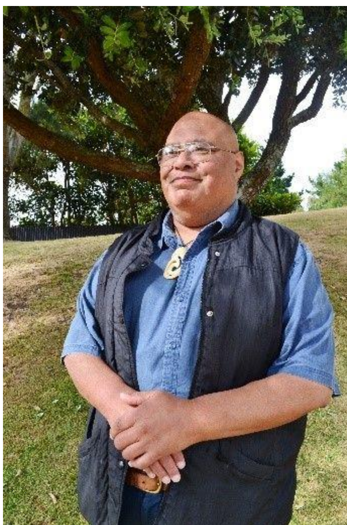
c. **Note** the collective progress achieved for our communities in the areas of COVID and the impact collective

1 Acknowledgement for Mal Rerekura

E te pāpā te tuākana a pāpā Mal kei te karanga a te Atua ki a koe, nō reira takoto mai ki te marae tūpuna Wharewhiti i roto i Ngāti Tuera Ngāti Hinearo me Kuri Aewe. E ngā ka oti tō mahi kei waenganui a tātou te hunga ora nō reira haere, haere ki te pō, haere ki te kāinga tūturu mō te tāngata, kati mō koutou. Tēnā koutou, tēnā koutou, tēnā tātou katoa

Acknowledging you pāpā Mal and the position you held among us and the elders of us. Your calling has come. Lie you on your ancestral marae Wharewhiti within the realms of Ngāti Tuera Ngāti Hinearo me Kuri Aewe. Your work with us is completed Mal therefore go well to the home of the people. Acknowledgement from all the whānau of the Whanganui DHB.

Mal made a massive contribution to Whanganui DHB and the wider community and we will miss his presence, cheeky grin and his humour. For many of you who have been through Hāpai te Hoe, your first impressions of the DHB would have been the introduction provided by Mal.



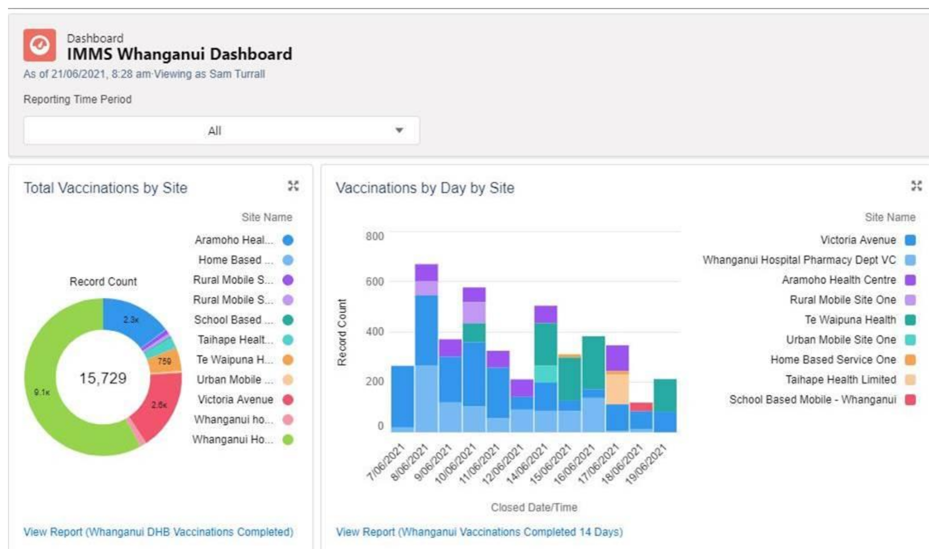
2 COVID-19 Vaccinations

The COVID vaccination roll out to the communities of the Whanganui District Health Board area is progressing well. Our implementation and planning group has representation from primary care, Māori Health Outcomes Advisory Group and Hāuora a Iwi. On 19 June 2021, 20% of the people in our district had received at least one dose of the vaccination. Of these, 13% were Māori. The planning and implementation team have developed equity plans for Māori, Pasifika and disability populations to ensure access issues are identified and mitigated.

In the last weeks of June 2021, we will be performing at 100% of the plan agreed in March, then we will be scaling up our efforts in July. Te Rito, our Whanganui town centre vaccination centre opened on Wednesday 2 June 2021 and this clinic will have capacity for 800 vaccinations a day when running with extended hours. The clinic has been set up as a wellness and vaccination centre and will have a health promotion focus, including education and health screening.

In July, as well as clinics in rural areas, we are commencing workplace vaccinations, starting with some of the Heads Rd factories. A workplace blueprint has been developed by the Ministry of Health and we will be following this.

Current data from the COVID Immunisation Register (CIR):



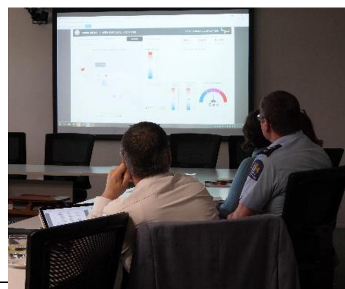
3 Impact Collective Update

The Impact Collective Rangitīkei, Ruapehu, South Taranaki and Whanganui have undertaken two in person sessions since the last report. A workshop for the governance team, educating them on the United Nations 17 Sustainable Development Goals was held. A report following the workshop outlined the goals that were identified as 'most important' to the governance team, these were (in order of importance):

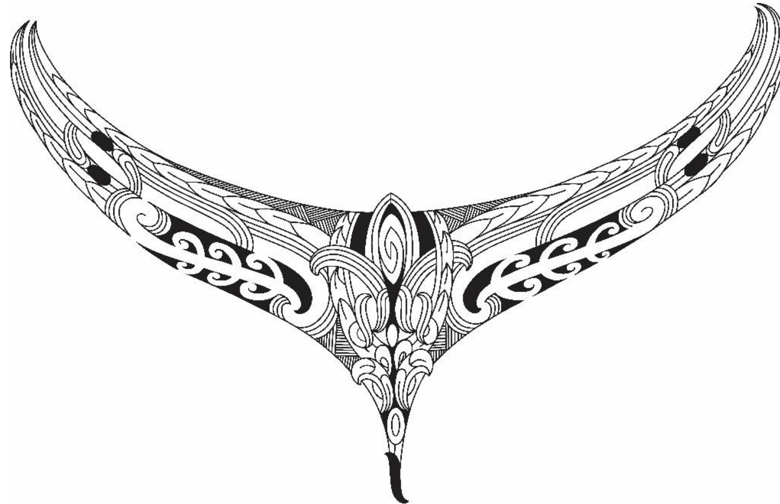
- SDG 17: Partnerships for the Goals,
- SDG 10: Reduce Inequalities,
- SDG 11: Sustainable Cities and Communities,
- SDG 1: No Poverty,
- SDG 15 Life on Land and
- SDG 12: Responsible Consumption and Production.

The biggest take away for the team was the association to a global framework of goals that encourage the collective to support their communities to thrive.

The second session focused on the presentation of the Impact Collective Charitable Trust Deed. The team were able to seek clarification around changes to organisations and structure and the effects on the formation of a trust and legal indemnification. These clauses were strengthened, and the deed is currently sitting with the Governance Team for final comments prior to signing. Furthermore, within the session, the team from DOT loves Data came and presented the wire framework for how the data will be presented in the dashboard. Previous examples were presented giving the team insights into the level of detail that they will be able to see (you can see a live example from the Napier City Council here - https://thepulse.napier.govt.nz/). DOT are working closely with the National Iwi Chairs and the Department of Statistics around data sensitivity and sovereignty concerns.

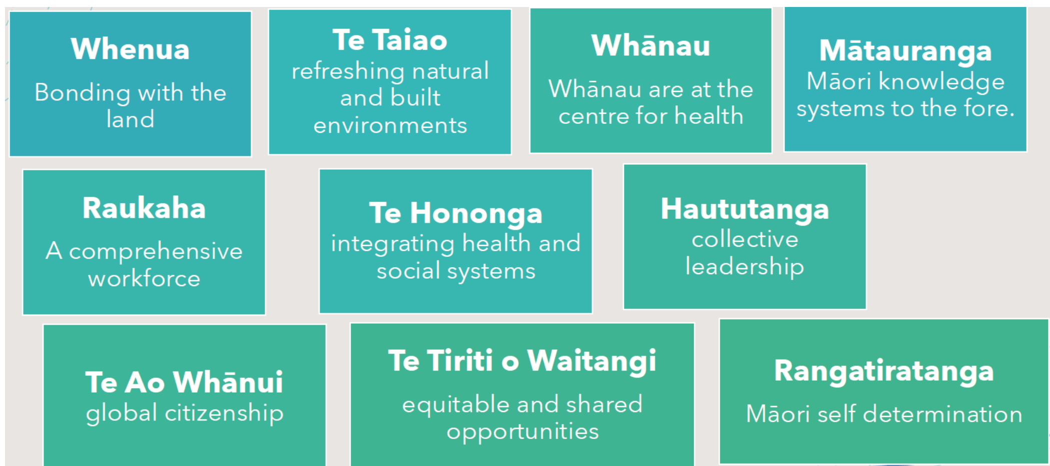


The team worked with a local Whanganui tanga design Ngahina Gardiner to design the Impact Collective logo – this will enable the Impact Collective to have its own identity rather than being affiliated to any one group, agency or Iwi. The logo developed represents the 'Manu Taki' – the lead bird flying in a 'V' formation, supported by those around them. All elements represented have meaning to the Impact Collective and visually demonstrates the journey the team are on.



The Integrated Community Impact Strategist had the privilege of attending the Hui Whakaoranga event held by the Ministry of Health in Wellington in May. The hui focused on taking a generational approach to Māori Health development by learning from the past and looking forward a generation -illuminating a path towards Pae Ora.

Tā Mason Durie presented on the ten foundational pillars for success in the future – it is encouraging to see that these pillars align to the mahi that the Impact Collective are undertaking, either through the focus areas of Social, Environmental and Economic, or through the frameworks global (17SDGs), nationally (Living Standards Framework) and locally (Whānau Ora).



Tā Mason Durie's ten foundational pillars toward Pae Ora.

June 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion Paper**
	29 July 2021

Author	Lucy Adams, Chief Operating Officer and Director of Nursing
Endorsed by	Ian Murphy, Chief Medical Officer Alex Kemp, Chief Allied Professions Officer
Subject	**Provider Arm Services**

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled 'Provider Arm Services'

b. **Note** comments around operational performance for Hospital and Clinical Services, Maternal, Child and Youth Services and Primary and Community Services

Appendix 1. Whanganui DHB Performance Dashboard and definitions

1 Purpose

To provide the Board with a high-level overview of provider arm services; operational performance is noted for the months of April and May 2021.

2 Service Delivery Overview

2.1 Optimisation and Efficiency Programme

Integrated Discharge Navigator

The integrated discharge navigator pilot is underway. The navigator has been engaging with key stakeholders to understand barriers and constraints that may inhibit patients from returning to their place of residence within the agreed estimated discharge date (EDD).

Scheduling

The review of the scheduling system to improve access to planned care services for Whanganui whanau is three months into a six-month project; milestones are being tracked and reported within the monthly project status report presented to the executive leadership team using the psoda project management software. Recommendations will include a rollout plan, of which will identify resources required to implement and embed changes.

Theatre utilisation

Work is continuing on ensuring that all theatre sessions are fully booked.
The focus is on how we can address early starts and late finishes, to ensure that all booked patients have surgery, and there are no instances of cases cancelled due to "insufficient time".

A Theatre Nursing Rostering review being undertaken by TAS is now scheduled to begin 24 June 2021.

CSSD

Two new autoclave sterilisers were installed 14 – 21 May 2021. During this time there was modifications to the scheduled elective theatre lists, however we maintained one functioning steriliser throughout this transition. The theatre list modifications are being managed by the Planned Care Team.

2.2 Emergency Department and Inpatient Services:

Emergency Department data

	Total Attendances	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5	% Maori	% Pacifica	Did not waits	Ave daily attendances
April	1721	3	192	951	513	62	24	2	85	57.4
May	1814	8	246	1003	497	60	26	2	97	58.5

*Data extracted from SQL Server Reporting Services

Inpatient data

During the months of April and May 2021 the average daily ED attendances have remained around 58, however, the medical ward occupancy has remained full, with medical patients being placed in other wards.

ATR has a greater length of stay as it is a stroke and rehabilitation ward, compared to a surgical ward that continues to sit around an average of 3 days. This ward has great utilisation despite having a slightly less occupancy average than the medical ward.

	AAU		**CCU**		**Medical**		**AT&R**		**Surgical**	
	Apr	**May**	**Apr**	**May**	**Apr**	**May**	**Apr**	**May**	**Apr**	**May**
Total monthly admissions *****	179	192	33	48	121	142	47	30	151	155
Total monthly discharges **	113	130	21	24	158	184	22	29	270	284
Average Length of Stay (Days) **	0.39	0.32	2.0	1.8	5.8	6.0	11.8	13.5	3.3	3.2
Average Occupancy (all shifts) **	88%	98%	86%	89%	97%	97%	91%	90%	91%	93%
Average YTD Occupancy (July 2020- May 2021**	119%		91%		98%		91%		95%	

*****Data extracted from TrendCare; note: (1) one represents an episode of care, [includes transfers between wards, theatre etc.]

Total April admissions compared to discharges 531/584. Total May admissions compared to discharged 567/651. Variance will

be attributed to those who cross over from end of month to beginning.

** Data extracted from WebPAS through PowerBI 14.06.21

June 2021 **Public**

Acute Readmission Volumes **	AAU		CCU		Med		AT&R		Surg	
	Mar	**Apr**	**Mar**	**Apr**	**Mar**	**Apr**	**Mar**	**Apr**	**Mar**	**Apr**
48-hour	7	7	1	1	5	3	0	0	7	2
7 day	7	6	0	1	18	7	3	0	12	15
14 day	3	3	0	0	14	12	1	1	6	15
28 day	3	6	2	0	12	12	2	3	12	13
Total	**20**	**22**	**3**	**2**	**49**	**34**	**6**	**4**	**37**	**45**

** Data extracted from WebPAS through PowerBI 14.06.21

Māori Acute Readmission Volumes **	AAU		CCU		Med		AT&R		Surg	
	Mar	**Apr**	**Mar**	**Apr**	**Mar**	**Apr**	**Mar**	**Apr**	**Mar**	**Apr**
48-hour	2	1	0	0	1	0	0	0	2	0
7 day	3		0	1	6	2	2	0	2	2
14 day	1		0	0	5	3	0	0	0	3
28 day	0	2	1	0	4	4	0	0	3	2
Total	**6**	**3**	**1**	**1**	**16**	**9**	**2**	**0**	**7**	**7**
Percentage of total acute readmissions	**30%**	**14%**	**33%**	**50%**	**33%**	**26%**	**33%**	**0%**	**19%**	**15%**

**Data extracted from WebPAS through PowerBI 14.06.21

Covid vaccinations

As of 11 June 2021, vaccinations given totalled 13,508; of that, there were 9,055 first doses and 4,453 second doses. This is good progress from 8 May, where vaccinations given totalled 3,801.

Count of NHI Number	**Column Labels**			
Row Labels	**Pfizer BioNTech COVID-19 (1)**	**Pfizer BioNTech COVID-19 (2)**	**(blank)**	**Grand Total**
Aramoho Health Centre	1173	853		2026
Rural Mobile Site One	36	104		140
Rural Mobile Site Two	82	23		105
Taihape Health Limited	156	88		244
Te Waipuna Health	27	48		75
Victoria Avenue	1972	69		2041
Whanganui hospital (inactive)	184	28		212
Whanganui Hospital Pharmacy Dept VC	5425	3240		8665
(blank)				
Grand Total	**9055**	**4453**		**13508**

3 Hospital and Clinical Services (H&CS)

3.1 Workforce

Nurse Entry to Practice Programme (NETP) and Nurse Entry to Specialty Practice Programme (NESP)

The following is an overview of the system approach for NETP placements, as per request of the Board.

The NETP/NESP programmes enables nursing graduates to begin their careers well-supported, safe, skilled and confident in their clinical practice, equipped for further learning and professional development, meeting the needs of health and disability support service users and employers.

The programmes are 10-12 months duration and staff are supported by trained preceptors, managers and a nurse educator. Placements are either in the hospital or community.

The process for recruitment begins with the Nurse Educators working with hospital and community managers to seek guidance regarding the number of placements that may be available. Once there are confirmed, the Nurse Educator approaches either Te Pou or Health Workforce New Zealand to confirm funding for these placements. The Nurse Educators meet with students at UCOL our local School of Nursing and Massey to advise them how to apply and outline the process for recruitment.

Recruitment is commenced using the Nursing Advanced Choice of Employment (ACE) system, which is a national system utilised by DHBs to recruit new graduate nurses into supported first year of practice programmes. The ACE system enables graduates to apply online to multiple District Health Boards (DHBs) using one application. Graduates also identify up to three preferred practice settings including those that may not be provided by DHBs such as primary care and aged residential care. DHBs use the system to review the applications of those graduates who identified them as a preferred employer. DHBs can also supply local primary care and aged care providers with the applications of graduates who preferred those settings.

DHBs and potential employers in primary care and aged care conduct their own shortlisting process and then notify the nursing ACE system of their preferred candidates. The system then finds the best match between the graduates' preference for employer and the DHBs' preference for graduates.

A panel is selected which includes a staff member from Te Hau Ranga Ora, a Nurse Educator and a Clinical Nurse Manager. Whanganui DHB utilise an affirmative recruitment process for applicants who identify as Maori and they are automatically short listed for an interview.

The new graduates complete the year and at the end they will have completed a post graduate paper, and their Professional Development and Recognition Programme.

This year we have 11 new grads, of which 7 are Māori.

3.2 Mental Health Inpatient

A cultural review has been completed for Te Awhina and Stanford House by experts from Lakes DHB with the result being very positive.

Te Awhina

The Utilisation data for this reporting time varied, April was 80%; Te Awhina Intensive Psychiatric Care (IPC) was at 139%. May showed that Te Awhina was at 93%; and the IPC was 102%. During this timeframe Zero Seclusion was reported; and Restraint was reported with no harm occurring.

Some tangata whaiora have been acutely unwell and have required significant staffing support to ensure safety for all. Due to this the IPC occupancy has been up, constants have been required which, at times has required an increase in staffing to ensure safety for all. Staffing requirements met demand with no staff harm or staffing injuries noted.

Stanford House

Stanford house Utilisation data continues to be static at 106% (16 Tangata Whaiora).

No Seclusion or Restraints have occurred in Stanford House. Activities within Stanford House continue with significant success and all involved continue to give exemplary feedback.

'Emerge' has purchased a house for forensic intensive rehabilitation in Whanganui. 'Emerge Aotearoa' offers housing support including 24-hour, high-level care and support to clients with serious mental health issues who have a forensic history. Going forward this may/will align with Stanford House; the true outcome of this is yet to be understood.

A photography prize giving is planned for the 29 June with attendance from the Executive Director Operations, Chief Executive of Wellington DHB and the regional forensics Clinical Director.

3.3 Care Capacity Demand Management (CCDM)

Safe staffing, healthy workplaces is a national priority. Matching the capacity to care with patient demand needs consistent, focused attention. Front line staff, managers, executives, health unions and professional leaders all have a role to play. CCDM is a whole of hospital approach for managing the capacity to care on a permanent basis.

The CCDM programme has a set of standards. To meet the standards programme implementation needs to be prioritised, appropriately resourced and sequenced.

WDHB continues to successfully implement the CCDM programme. We have improved to 87% implementation with the last barrier being total implementation of all local data councils.

WDHB must now complete a full evaluation package of the programme within the next few months. This has been requested by TAS and is currently underway.

Items	Progress	Action required
Core Data Set	**Partially**	• Power BI and formal local data tools are all developed with transparency to staff. • Staff discuss the data at ward meetings in partnership with union delegates. • This needs to be rolled out to all departments.
FTE Calculation	**Completed**	• ED FTE calcs have been completed in principle, these to be understood formally before FTE/roster shifts. • 'FTE Calculations' paper has been provided to ELT. The point of difference is Maternity required two FTE.
Variance Response Management	**Completed**	• VRM is used daily with good response. • Reporting is daily/weekly/monthly and feeds into the local data councils.

Items	Progress	Action required
		• Response is analyses monthly at the CCDM operational group.

3.4 Quality

A monthly report is written by the clinical nurse managers for hospital services that detail quality indicators, themes, mitigations, and quality improvements.

Currently key action areas with a focus on quality improvements to improve the standard of nursing care include:

- clinical nurse managers undertaking daily ward rounds contacting each patient and their whānau to ensure the care they receive is meeting their expectations.
- ensuring that the patient is actively involved in the patient handovers between shifts.
- patient bedside boards are completed daily with the patient.
- a refocus on intentional rounding where nursing staff purposely tend to each patient every one or two hours putting the focus back on patients.
- reviewing the clinical audit schedule as one approach to improving the quality of patient care and is a tool which can be used to discover how well clinical care is being provided and to learn if there are opportunities for improvement. Current audits are focussed on falls, pressure injuries, fluid balance charts, early warning scores, peripheral intravenous cannulation and the newly introduced Mahi Tahi nursing assessment and patient care plan and goals.

Daisygrip reusable silicone tourniquet

As part of an infection prevention initiative, Daisygrip, reusable silicone tourniquets will be provided to all clinical areas. Tourniquets are one of the most commonly used accessories in invasive procedures. Historically seen as low risk, a recent scoping review found that most published studies showed >70% of tourniquets exhibited contamination.

Fabric tourniquets are difficult to disinfect due to the nature of their material and design. Disposable or single-use tourniquets have been introduced, but are wasteful and expensive, and often suffer from design or quality flaws. Construction material for both types can both pick up and transfer micro-organisms. As a result, facilities will often create workarounds for tourniquet use – such as single patient tourniquets – which reduce some risk, but are reliant on hand hygiene, disinfection of surrounding surfaces, as well as disinfection or disposal of the device post-discharge, due to the risk of microbial dissemination.

Daisygrip tourniquets will be used in Theatre, CCU and ED and carried on all IV and Emergency trolleys. Daisygrip, reusable silicone tourniquets or disposable tourniquets be permitted only. Personal non-washable tourniquets will no longer be approved for use. However, staff can purchase a Daisygrip for $30.00 if they wish.

ACC Know Your IV Lines programme (KYIVL)

The Whanganui District Health Board (WDHB) implemented the ACC Know Your IV Lines (KYIVL) program on 8 March 2021. The ACC funded programme is designed to reduce complications from peripheral intravenous cannula (PIVC).

The KYIVL programme provides a care bundle which targets the three stages of PIVC use:

1. Ready (insertion using aseptic technique and appropriate antiseptic)
2. Review (phlebitis monitoring) and
3. Remove (removal as soon as no longer indicated).

By implementing KYIVL programme, there is huge scope for the WDHB to decrease the number of unnecessary insertions of PIVC, improve phlebitis monitoring and documentation, increase patient's awareness of PIVC and initiate early removal when no longer required.

Project Outputs:

- The proportion of patients with a PIVC for no clear ongoing reason <10%.
- The proportion of patients with a PIVC that is unused for > 24 hrs <15%.
- Improved documentation of Phlebitis score monitoring by nursing staff to >90%.
- Improved patient experience as a result of education where patients and whanau would speak up if their cannula has not been used in the past 24 hours > 70% of patients of those willing and able to answer this question.
- Continue to monitor and capture data PIVC associated SAB's.
- Decrease in Cgov incident reports related to IV complications.

Phase 1, Planning and implementation, and the first quarterly report has been completed. Invoices for the first two milestones payments have been received on the 25th March 2021. This was within the contracted amount of $50,000 and paid on time by ACC.

3.5 Service Delivery

The purpose of this section is to provide a planned care update.

Additional Service Delivery

21 Taranaki DHB domiciled patients have been received by WDHB for surgery. 10 were removed from wait list for a number of clinical and non-clinical reasons. The remaining 11 patients received their surgery in December and January. We are continuing with this arrangement, taking additional patients where we have capacity.

ESPI 2 and ESPI 5

Whanganui DHB was non-compliant (non-compliant by more than 10 patients) for April 2021 for both ESPI 2 and ESPI 5, as per MoH final data released on 09 June 2021.

ESPI 2 is *Patients waiting longer than 4 months for their FSA* and ESPI 5 is *Patients given a commitment to treatment (surgery) but not treated within 4 months*.

May 2021 non-compliancy update (internal data):

Specialty	ESPI 2 Outpatients Non-compliant	ESPI 5 Inpatients Non-Compliant	Narrative
Cardiology	-		
Dental	2	-	
Dermatology	-		
ENT	-	10	Malfunctioning Surgical equipment preventing certain types of surgeries - equipment now replaced
General Medicine	3		
General Surgery	-	3	
Gynaecology	14	3	Cancellation of clinics - Post-call fatigue related
Ophthalmology	-	23	Loss of surgical SMO, mitigation in place
Orthopaedics	2	4	
Paediatric Medicine	1		
Pain	-		
Rheumatology	-		
Urology	-	-	
	22	**43**	

The planned care team continue to ensure that all regular planned care theatre sessions are utilised and that any spare sessions are reallocated to other surgeons.

4 Primary and Community Services

4.1 General

Referrals continue to increase across most services, and across hospital, community, and rural settings. This is further complicated by unsuccessful recruitment into key vacancies, namely a Mental Health Pharmacist, Musculoskeletal Physiotherapist. Two social workers are starting in July which will help with inpatient flow and release the Clinical Manager who has been covering clinical. A variety of initiatives are being implemented to ensure that patients continue to have needs met in a timely manner. There has been a reduction in the Occupational Therapy waitlist.

Therapy services have initiated the following: an increased use of assistants, use of casual employees, group therapy sessions, improving triage process, engagement with telehealth and ongoing partnership with therapists in private practise. It is pleasing to note that despite the challenges in referrals and staffing, Physiotherapy and Speech and Language Therapy have continued to meet Ministry of Health waitlist targets Occupational Therapy has shown a 25% decrease in waitlist numbers since January 2021, with specific initiatives of dedicated community time and use of telehealth. Two Occupational Therapy and two Social Work students start Monday that will be able to support caseload management.

Pharmacy has experienced increased pressure both from the dispensing of the COVID-19 vaccine, and an international shortage of some pharmaceuticals meaning resource is diverted to ensuring that supplies of products are available and sourcing alternatives. Dedicated funding for Pharmacy FTE for COVID-19 has been sourced and appointed to. Changes to rosters are being implemented and leadership is focussing on ensuring staff wellness with increased workload pressure.

A third Sonographer has started in Radiology and there should be a noticeable impact on the ultrasound waitlist over the next few months because of this. We continue to be reliant on a contracted echo cardiography service, with unsuccessful attempts to recruit. There is a need to identify appropriately skilled Cardiologist skills to support this role, and external expert advice has been received. Different options are being investigated to develop a long-term solution for service delivery.

A telehealth lead started this month on a fixed term contract for a year. This role was previously covered by the Clinical Informatician in addition to her substantive post. An external review of telehealth, that has occurred, has considered both local and national regression in the use of telehealth. This review has identified key areas for improvement to ensure a successful rollout and embedded recommendations into the project plan.

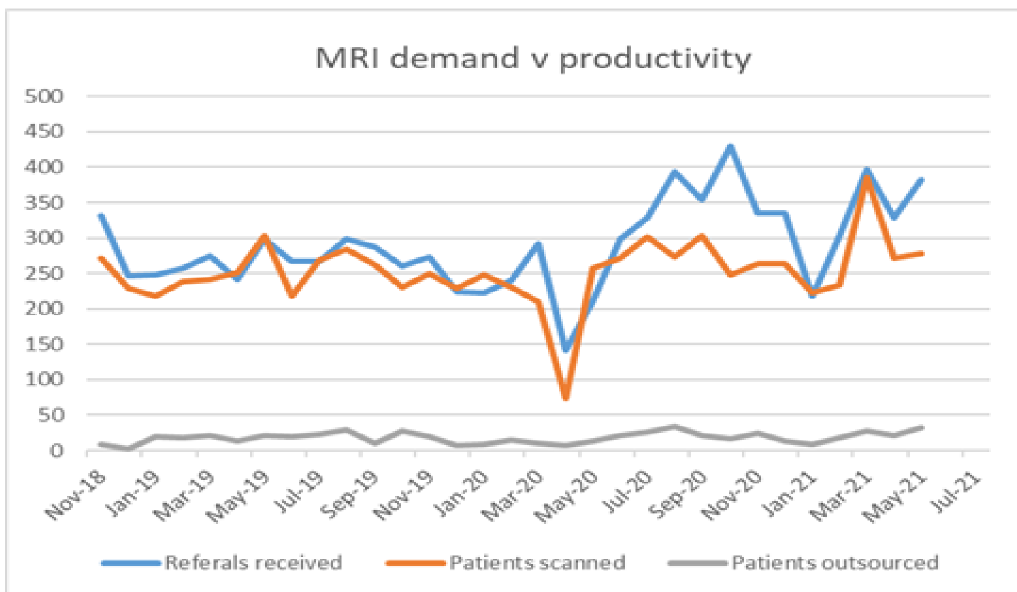
4.2 Service Delivery

The Community Mental Health and Addiction Service (CMHAS) continues to embed the national overnight telephone service for mental health crisis. The team providing this service, Whakarongohau, visited Whanganui on 1 June and met with both CMHAS leadership, Mental Health Crisis staff and consumer advocacy. The aim was to improve service delivery and reduce the waiting times for patients calling this line. Initiatives have been established and will be monitored. The team continue to work closely as part of the wider mental health service both within the DHB and connecting with our community providers.

The Radiology Department redesign continues to progress.
Increasing demand of some services including CT and MRI is a noticeable pattern. The following graph shows that despite raising demand for CT the service is managing to deliver.

MRI is currently unable to meet demand with staffing levels. We have run additional weekend shifts to try to catch up but staffing shortages due to illness are preventing us from running more. This is increasing finances for staffing in radiology.

The following graph shows the difference between demand and productivity. Although there are several reasons that could be contributing to this such as increased population and the lack of a private MRI, a deep dive into clinical reasons for referral and patterns of referral needs to be done before we can determine if this is a change in practise in referring or a genuine increase in demand that will require discussion on how to meet capacity.



The importance of collecting and understanding data across the service has been shown both in an initiative to determine inpatient needs across wards and redeploy staff to respond, and also in helping understand caseload and financial pressures across services. This is forming priority action with teams so that we can ensure the data accurately reflects provision of services. This will involve ensuring all clinicians are enabled with the ability to use data and digital systems such as TrendCare which will help improve management of staff resources, and WebPAS to capture the work they are continuing in areas such as telehealth.

There is an increase in Bariatric patients being seen, and the availability of appropriate equipment for discharge has been problematic. A bariatric working group has been established to address this issue across primary and hospital services with a bariatric bed, strollers and frames being purchased for use

across hospital and community as an early success. This will enable earlier mobilisation of bariatric patients and a more supported and enabled safe discharge process into the community.

Work on patient and whanau centred models of care that reduce duplication and streamline processes has resulted in a multidisciplinary therapy assessment tool, that is being trialled and adapted.

4.3 Future Focus

There has been increasing work in partnership with primary health, with the known need for establishment of wellness and early prevention models of care to be available for the community. This will remain a focus in terms of priority for model of care work. The need for early osteoarthritis management in the primary care setting as a non-surgical pathway has been identified and agreed as a priority for both primary care and physiotherapy. Fit for surgery has received national attention in planned care discussions and the Chief Allied Professions officer is working with the Portfolio manager and team members of this service to see how it can be best supported moving forward.

A recent review of how we manage pressure injuries and falls prevention work has identified a need for stronger working across primary and community services. In light of cessation of ACC funding for the in-home strength and balance programme, and information in this report, a review of this service will occur.

There is a work plan being developed by the regional Directors of Allied Health, where key pathways that can be delivered or supported with a regional approach are being discussed. A regional Allied workforce report has been completed that identifies workforce size across the region and where vulnerable, difficult to recruit workforces are. This will form a framework for discussion about where regional approaches are best delivered, that still enable care closest to home. Lymphoedema services and sonography training have been identified as first initiatives.

There has been dedicated funding from the Ministry of Health to engage in a Mental Health and Addiction System Collaborative Design and Implementation Support, designed to review and implement change in mental health and addiction services across all ages and all levels of wellbeing. This contract is currently in a negotiation phase.

5 Maternal, Child and Youth Services (MCYS)

5.1 General

The Maternal, Child and Youth service has now been fully operational for a year and we are positive about the changes and mahi that has been completed so far. Individual child health service teams are becoming increasingly integrated with the co-location of some services and the development of more contact pathways between the groups.

The recent support from ELT to commence a project developing a single point of entry for child health referrals has great potential to positively impact on service provision and equitable, whānau centred access to services. The ‘Transitional Care for the Neonate’ information paper submitted within these Board papers (refer reference) presents additional recommendations that would optimise care for māmā, pēpi and whānau in our rohe.

Community engagement, particularly in the maternity space, is well established with workplans involving community partners being developed.

5.2 Service Delivery

Maternity

Recruitment for a case-loading midwife for the Waimarino Maternity Service is complete, with the preferred candidate accepting the role to commence in October 2021. In addition, we have employed a causal midwife for this service who will be able to provide locum cover. In October 2021 our Waimarino service will be back to 24-hour service.

The LMC workforce is increasing with three new LMC's in the community, however two are stepping away at the end of the year. The impact of this is currently seen in the reduced number of women the DHB are caring for as they are unable to find an LMC, and the growing number of women unable to find an LMC for December and January.

Three resignations have been received from core midwifery staff. One is going to a non-practicing position, one to another DHB and one will be a local LMC. The recruitment of 2.0 FTE core midwife positions has had its end date further extended, after only one application was received.

The resignation of part-time Obstetrics and Gynaecology (O&G) consultant Mark Stegmann was accepted and will be replaced by a full-time O&G consultant. Recruitment for this position is well underway.

WHRN has discontinued its midwifery team due to lack of viability, however this has been a good collaborative exercise.

The service mapping work by the Primary and Secondary Services Interface Group has progressed to the assignment working groups. The main work streams will be led by MQSP coordinator, Rachel Taylor, and will define roles, responsibilities in the service in the maternal care continuum and produce a service directory for women to navigate services. This will be funded by MQSP and will be the main local MQSP project for the year. Other work streams include a consumer engagement project facilitated by Healthy Families (also MQSP funded) and work to integrate the Best Start tool into GP practices, socialising it with GPs, LMCs and other community stakeholders.

Positive feedback was received following the first Midwifery Forum held on 22 March 2021. The feedback is under review and will shape future forums.

Paediatrics

The Child Development Service (CDS) has been operating with skeleton staff for the past nine months, but with positions finally filled the service should be fully staffed by the end of this financial year. Team management are continuing to work with the regional CDS group and Ministry of Health team to develop the future operating model for CDS services in New Zealand.

The contracted Paediatric SMO service provider has employed a new permanent paediatrician, Dr Raj Gheevarghese, who started at the end of April. He has experience as a paediatric intensivist in South Africa and is a welcome addition to the paediatric team.

Public Health

The public heath team continue to be active in the community, successfully carrying out promotion and delivery of MMR immunisations at events such as UCOL Orientation week, the Whanganui River Traders Market, Pride Week, Waka Ama and the Kaierau Rugby Club. The MMR campaign will reduce in intensity over the next few months with the Covid-19 immunisation roll-out taking precedence.

Plans are being developed for a school-based Covid-19 immunisation roll-out in July for 16 to 18-year-old secondary school students.

Maternal Infant Child Adolescent Mental Health and Addiction Services (MICAMHAS)
The MICAMHAS team are attending a Wellbeing Wananga: Ngā manga nui honohono kau ana on 10 June. In this mahi they will be helping design a new service called Korowaitia Te Puna Waiora for people with mild to moderate mental health issues using the kaupapa Māori approach for engagement and healing.

MICAMHAS has been recognised nationally for high performance in the CAPA model of care (the Choice and Partnership Approach for Child and Youth Mental Health) and approached to present on 'CAPA and Youth Consult Groups' at the 1st International CAPA Conference being held in Canada in May 2021. Joanne Heap and Jo Hollins have pre-recorded their presentation which showcases both Whanganui and our MICAMHAS services exceptionally to an international audience.

Oral Health
Oral Health Status data is captured within the patient examination process of the Community Oral Health Service and is reported on to the Ministry of Health annually. This data relates to two cohorts of patients:

- 5-year olds relating to the oral health status of their deciduous (baby) teeth at their first assessment after commencing at school
- Year 8 patients which relates to the oral health status of their permanent (second) teeth as they complete their primary/intermediate schooling.

Results show there is consistent improvement over time for both Year 8 and 5-year-old children. The Year 8 oral health status results support our choice of model of care: assessment and management provided on site in schools. Management includes a consistent approach to prevention, restorative treatment and on-going promotion of Oral Health.

The slower and variable improvement in the preschool group is tied into the difficulties we have with 'did not attend' and 'non-attendance' amongst these youngsters. Consideration is being given to our current model of care and whether this best meets the need of this cohort. Changes might include taking a mobile dental unit provides care on site to early childhood centres, rather than expecting parents to bring their preschool children to a particular site for care.

5.3 Future Focus

The next Whanganui Maternal, Child and Youth Community Alliance meeting will be held in June 2021 with a focus on the implications for health and wellbeing on the first 1,000 days of a child's life. The Alliance is moving towards establishment of working groups that will inform our current and future service provision.

Key work streams in progress stemming from our Primary and Secondary Maternity Services Interface Group include:

- Maternity Services consumer feedback project – facilitated by Healthy Families
- Project work streams, outlining 1) the roles and responsibilities and connections. between maternal services 2) producing a service directory for women.
- Integration of the Best Start tool into GP practice and socialisation of this tool.

The second Midwifery Forum meeting for the year will be held on 13 July 2021. The forum is a platform for discussing issues, formulating solutions and improving services to the community, and will strengthen relationships between the WDHB and our LMC partners.

June 2021 Public

Appendix 1. Whanganui DHB Performance Dashboard

(data extracted 14 June 2021)

Hospital Based Care Measures

(A) ED Attendances by Month

(B) Hospital Discharges by Admission Type, by month.

(C) Acute Readmission Rates by Month (7 and 28-day rates)

(D) Outpatient clinic DNA Rate by Month and Ethnicity

(E) IDF Inpatient Outflow $ Totals by DHB and Month

(F) Faster Cancer Treatment Indicators

Commentary

ED commentary is within the body of the report.

(A) April data shows (120) less attendances compared to last month; whilst May may was slighly up, (79) attendances.

(B) Hospital Discharges by acute admissions dipped during April and were slightly up during May; whilst the acute admission – ED only showed a decline.

(C) Readmission rates, 7 days remains consistant whilst there was a 1% decline in the 28 days in April; and in May a decline of 1.2% for 7 day readmissions.

(D) Outpatient clinic DNA remain high for Maori but has increased by 1 percent for both April and May. Whilst non Maori continues to sit around 4-5%. Work is underway to improve DNAs, of which will be referred to as missed scheduled appointments. Activities to improve appointment attendance rates include, text to remind, review of booking processes, improved data to reflect DNA information, telehealth.

(E) April data is not completed; however, for May we paid a total of $1.7M in IDF.

(F) Faster Cancer Treatment 6 monthly report was presented at the last Board meeting. This graph indicates during February we reach 100%. This is a good result.

Community Based Care Measures

(G) 00-04yrs ASH Admission Rates per Population by Ethnicity

(H) 45-64yrs ASH Admission Rates per Population by Ethnicity

(I) Quarterly Immunisation Rates for Children Aged 2yrs

Commentary

All Ambulatory sensitive hospitalisations (ASH) rates are for Whanganui Hospital. Maori are more likely to be hospitalised for ambulatory sensitive conditions compared to non-Maori.

(G) The top themes for 0-4 years are dental, gastroenteritis and respiratory. The surge in March volumes were largely driven by 10 dental admissions, 7 gastro bugs and 6 respiratory illnesses. (For perspective, overall average per month in these categories is 9.5 per month, compared with 23 events in March).

(H) The top themes for 45-64 years are chest pain, heart disease, COPD/pneumonia. **NB:** May data not available at time of report.

(I) March shows a slight improvement for non-Maori whilst Maori rates dropped slightly.

Workforce Measures

(J) Turnover % Rolling 12 Month Average

(K) Sick Leave % by Month

Quality

(L) Acquired Pressure Injuries/Infections/Falls During Admission by Month

Commentary

(J) The average turnover at WDHB for April was 7.5% and May was 8.5%. WDHB average turnover is 7.8%.

(K) Sick leave was down in April (3.2%) compared to May (4.23%); of which is higher than this time last year. The thinking is this is related to the COVID vaccination. The average sick leave is 3.8%.

(L) Pressure injuries have decreased from March to April, both hospital and community acquired. However, falls during admission have increased and are also higher in April than this time last year. May data is not complete at time of report.

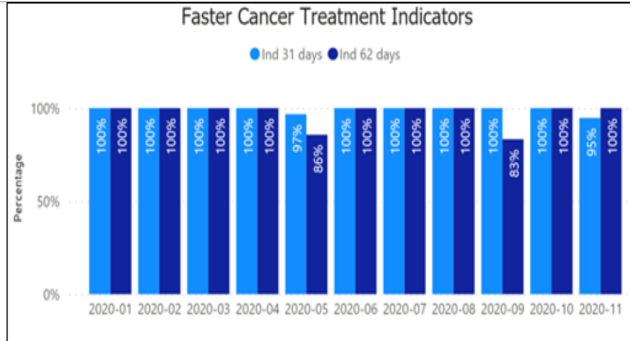
June 2021 **Public**

Whanganui DHB Performance Dashboard definitions.

Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	ED Attendances by Month
Graph B. Hospital Discharges Throughput of hospital-based services. This is an indicator of patients through the system as opposed to occupied beds. **Calculation:** count of patients discharged from inpatient events, and includes day stay patients in all services.	Hospital Discharges by Admission Type, by month.
Graph C. Readmission Rates This is the percentage of all patient discharged that return to hospital acutely within 7 and 28 days of discharge. Readmissions can be for any reason, not exclusively related to the previous event. **Calculation:** Denominator = patients discharged Numerator = patients acutely re-admitted within 7/28 days	Acute Readmission Rates by Month (7 and 28-day rates)
Graph D. Outpatient DNA Rate DNA rates indicate where we have access issues to outpatient services. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services. **Calculation:** Denominator = total patients seen Numerator = missed appointments	Outpatient clinic DNA Rate by Month and Ethnicity
Graph E. IDF Outflows Total value of IDF outflows to main DHBs for each month. This is a dollar value, so increasing prices need to be considered when comparing years. **Calculation:** Dollar value of services provided by other DHBs to WDHB.	IDF Inpatient Outflow $ Totals by DHB and Month

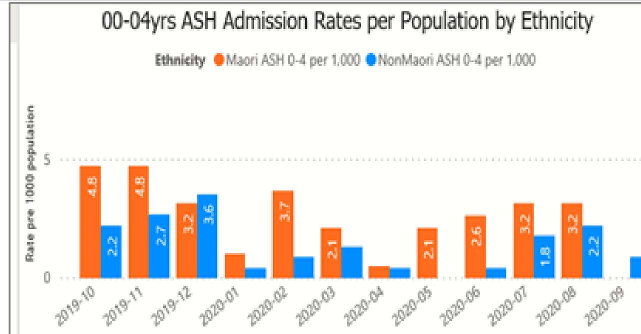
June 2021 **Public**

Graph F. Faster Cancer Treatment
Patients identified as high suspicion of cancer on referral receiving treatment within 62 days (further information provided within the paper).

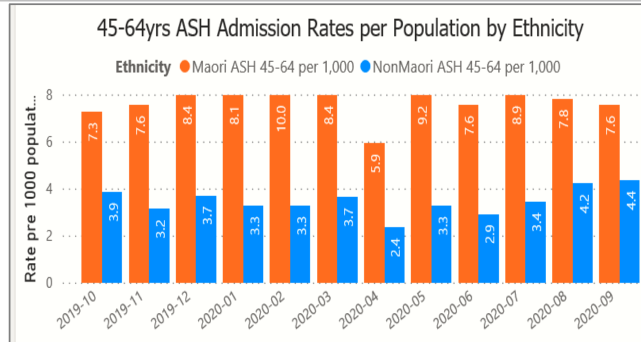


Community Based Care Measures

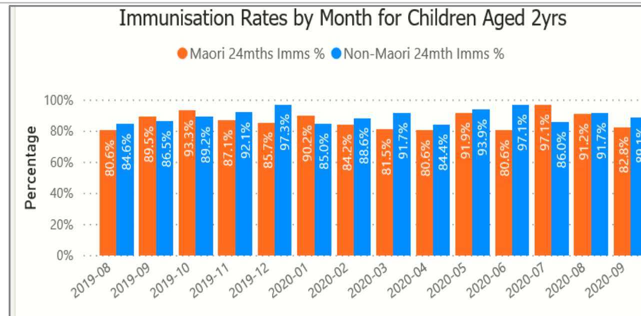
Graph G. ASH Rates 0-4 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000 population for a range of standard conditions.



Graph H. ASH Rates 45-64 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000 population for a range of standard conditions.

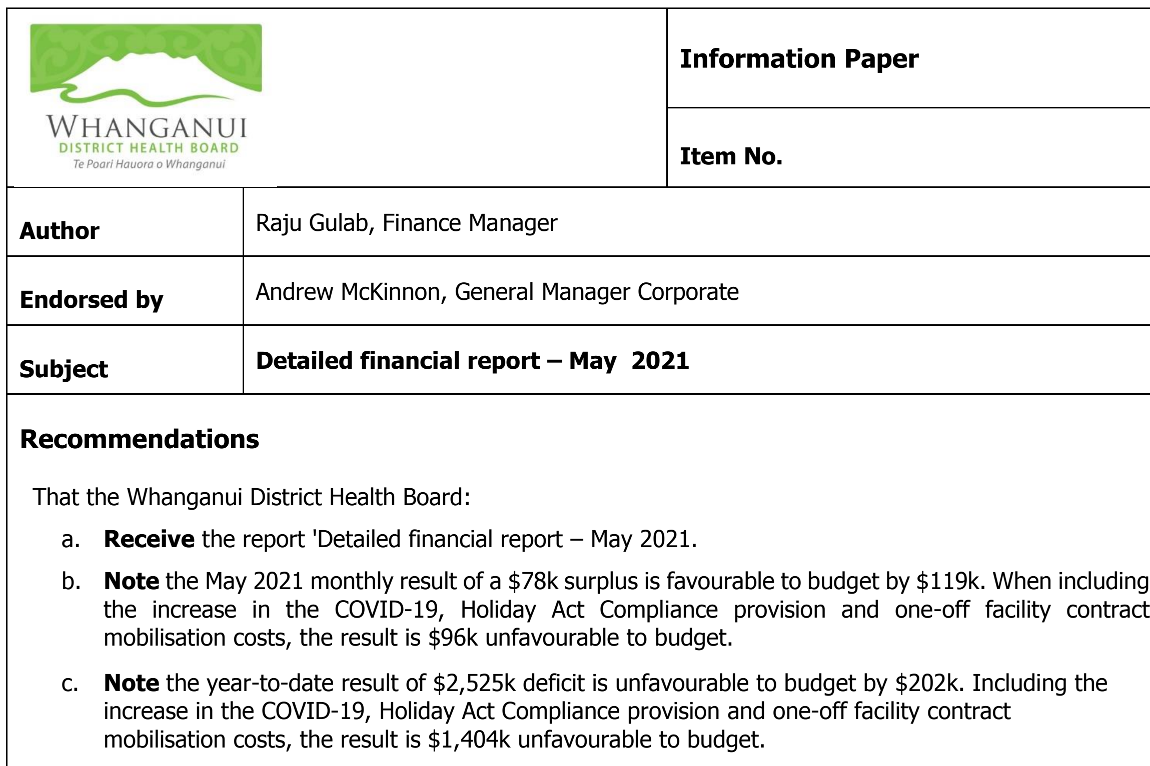


Graph I. Immunisation Rates for Children by ethnicity
Percentage of children with up to date immunisation at the age of two years
Calculation:
Denominator = total children enrolled
Numerator = total children with up to date immunisation



Workforce Measures	
Graph J. DHB Staff Turnover Rolling twelve month turnover rates is an indication of staff retention **Calculation:** Denominator = total staff numbers Numerator = new hires within the preceding twelve months	Turnover % Rolling 12 Month Average
Graph K. Sick Leave % Percentage of total paid hours taken as sick leave. This is an indication of illness levels and cost impacts when above average budgeted rates. Does not indicate where annual leave is used in place of sick leave **Calculation:** Denominator = total paid hours Numerator = hours paid as sick leave	Sick Leave % by Month
Quality	
Graph L. Pressure Injuries/Infections/Falls Patient safety and care indicators for key measures. **Calculation**: count of events each month (not individual patients)	Acquired Pressure Injuries/Infections/Falls During Admission by Month

June 2021



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No.
Author	Raju Gulab, Finance Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	**Detailed financial report – May 2021**

Recommendations

That the Whanganui District Health Board:

a. **Receive** the report 'Detailed financial report – May 2021.

b. **Note** the May 2021 monthly result of a $78k surplus is favourable to budget by $119k. When including the increase in the COVID-19, Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $96k unfavourable to budget.

c. **Note** the year-to-date result of $2,525k deficit is unfavourable to budget by $202k. Including the increase in the COVID-19, Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $1,404k unfavourable to budget.

Financial Overview – May 2021

YTD Performance	YTD IDF Net Flow	YTD CWDs
Actual deficit $2.5m (excluding Holiday Act Compliance provision and one-off facility contract costs)	$43.6m expenditure	Estimated CWDs 11,255
Against budgeted deficit of $2.3 $0.2m unfavourable to budget.	Against budgeted expenditure of $44.2m, $0.6m favourable to budget.	Against 11,048 budgeted CWDs; 207 CWD or 1.9% ahead of budget (IDF CWDs excluded).

YTD FTE	YTD Capital Expenditure
Actual FTE 953	Actual spend $6.1m
Budgeted FTE of 936, acuity running 1.8% above target and added pressure on nursing resource.	Against budgeted expenditure of $7.1m, $1m favourable, due to timing of expenditure.

June 2021

Consolidated Statement of Financial Performance for the period ended 30 May 2021

	Month				Year to Date				Annual	Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2020-21	Actual 2019-20
Revenue	24,611	24,158	453	F	271,424	270,226	1,198	F	294,806	272,259
Total Revenue	24,611	24,158	453	F	271,424	270,226	1,198	F	294,806	272,259
Less:										
Provider Health Service	(12,286)	(12,118)	(168)	U	(138,397)	(136,171)	(2,226)	U	(148,803)	(143,995)
Corporate Service	(101)	(71)	(30)	U	(840)	(1,142)	302	F	(1,221)	(1,990)
Governance	(130)	(79)	(51)	U	(889)	(868)	(21)	U	(950)	(722)
DHB Funder Division (exl IDF outflow)	(7,979)	(7,948)	(31)	U	(90,637)	(90,470)	(167)	U	(99,201)	(91,641)
Inter-district Outflow	(4,123)	(4,016)	(107)	U	(43,610)	(44,173)	563	F	(48,189)	(45,247)
ACC Contract (net)	86	33	53	F	424	275	149	F	309	265
Total expenditure	(24,533)	(24,199)	(334)	U	(273,949)	(272,549)	(1,400)	U	(298,055)	(283,330)
Net Surplus/(Deficit) before COVID-19 & HolidayPay	**78**	**(41)**	**119**	**F**	**(2,525)**	**(2,323)**	**(202)**	**U**	**(3,249)**	**(11,071)**
Revenue- COVID-19	137	-	137	F	2,381	-	2,381	F	-	3,931
Expenditure COVID-19	(301)	-	(301)	U	(2,815)	-	(2,815)	U	-	(5,444)
COVID-19	(164)	-	(164)		(434)	-	(434)		-	(1,513)
Holiday Act Costs	(42)	-	(42)	U	(500)	-	(500)	U	-	(2,820)
One-off Facility contract	(9)	-	(9)	U	(268)	-	(268)	U	-	-
One-off	(51)	-	(51)		(768)	-	(768)		-	(2,820)
Net Surplus / (Deficit)	**(137)**	**(41)**	**(96)**	**U**	**(3,727)**	**(2,323)**	**(1,404)**	**U**	**(3,249)**	**(15,404)**

Note :- F = Favourable variance; U = unfavourable variance

Overview

The operating result for the month of May 2021 was favourable to budget by $119k. When including COVID-19 and Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $96k unfavourable to budget.

Revenue

Revenue was $453k favourable to budget due to Ministry of Health (MoH) clerical pay equity settlement funding, public health funding, central regional alcohol and drug speciality service funding, inter-district inflow revenue, primary care funding (offset by costs), Taranaki DHB inpatient service revenue and outpatient clinics revenue.

Revenue- COVID- 19

Covid-19 revenue was $137k favourable to budget due to $70k pharmaceutical COVID-19 funding and $67k community testing funding.

Provider health service (Appendix 2)

Inpatient volumes were 104.8% to target in May 2021 with unplanned (acute) at 104.4% and planned (elective and arranged) at 106% of budget for the month. The value of this increased volume is approximately $277k.

Provider division was $168k unfavourable to budget due to increased personnel costs mainly in nursing and medical locum, clerical pay equity settlement costs (offset by funding), theatre consumables, radiology outsourced clinical service, general medicine inpatient service and physiotherapy. These unfavourable variances were partly offset by additional MoH clerical pay equity settlement funding, public health funding, other DHBs revenue and non-resident revenue.

June 2021

Corporate service (Appendix 2)

Corporate was $30k unfavourable to budget due to IT outsourced costs, clerical pay equity settlement costs (offset by funding) and facility contract costs.

Governance

Governance was $51k unfavourable to budget due to undertaking the data audit and developing dashboard wireframe and architecture.

DHB Funder division (exl IDF outflow) (Appendix 3)

Funder division was $31k unfavourable to budget due to higher pharmaceutical costs and health of older people costs.

Inter-district flows (Appendix 4)

Inter-district flows were $107k unfavourable to budget due to inpatient activity.

COVID-19 expenditure

COVID-19 expenditure was $301k unfavourable to budget with costs incurred mainly in operating CBAC facilities and pharmaceuticals and vaccination management and facility costs.

Year-to-date May 2021 operating result was unfavourable to budget by $202k; when including COVID-19 and Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $1,404k unfavourable to budget.

Revenue (Appendix 1)

Revenue was $1,198k favourable to budget, mainly due to MoH funding to cover the clerical pay equity settlement, central regional alcohol and drug speciality service revenue, higher inter-district flow revenue related to service changes and higher inpatient service volumes for other DHBs, student replacement revenue, ACC sexual abuse assessment and treatment service (SAAT) revenue, ACC radiology revenue, outpatient clinic revenue and non-resident patient revenue. These increases in revenue were partly offset by a reduction in capital charge funding due to the rate reduction from 6% to 5% (this reduction resulted in a lowering of the base line funding, offset by a reduction of equal amount of costs), lower ACC non-acute inpatient rehabilitation and not meeting the ACC additional revenue target.

Revenue- COVID-19 (Appendix 1)

Covid-19 revenue was $2,381k favourable to budget due to additional funding received for ongoing support of operating CBAC facilities and COVID-19 testing. However this funding was offset by COVID-19 related costs of $2,815k.

Provider division (Appendix 2)

Provider division was $2,226k unfavourable to budget due to increased nursing costs high acuity volumes, medical locum costs to cover vacancies, clerical pay equity settlement costs (offset by funding), higher volume-related theatre and ward consumable costs, high demand on patient travel, increased pharmaceutical EYE drug costs and an unmet clinical savings target. These increases were partly offset by lower outsourced service costs for radiology and unattended courses/conferences due to the COVID-19 pandemic.

Inpatient volumes were 102.4% to target year to date with unplanned (acute) 100.6% and planned (elective and arranged) 100.1% of budget year-to-date. The value of this increased volume is $1.2m.

Corporate (Appendix 2)

Corporate was $302k favourable to budget due to the capital charge rate reduction from 6% to 5% (offset by lower capital charge revenue). These lower costs were partly offset by higher IT-related costs, depreciation on IT capitalised projects bought into production and building depreciation costs relates to increased building valuations.

June 2021

Governance

Governance was $21k unfavourable to budget due to undertaking the data audit and developing dashboard wireframe and architecture.

DHB Funder division (exl IDF outflow) (Appendix 3)

Funder division was $167k unfavourable to budget due to higher primary health organisation (PHO) costs (offset by revenue), mental health additional costs (offset by revenue), higher health of older people costs, this unfavourable variance was partly offset by an in-between travel refund, lower short-term home-based support, and a higher pharmaceutical rebate.

Inter-district flows (Appendix 4)

Inter-district flows were $563k favourable to budget mainly due to lower inpatient service activities, as well as closer oversight and review of IDF costs as part of savings initiatives.

The financial wash-up impact of the non-case mix (outpatient) IDF, pharmacy IDF and PCT IDF will not be known until 27 July 2021.

COVID-19 expenditure

COVID-19 expenditure was $2,815k unfavourable to budget mainly due to other public health service operation costs of $1,246k, pharmaceutical costs of $775k (assume equal amount of expenditure occurred to offset the revenue), other supplies $234k, and personnel payroll cost of $560k.

Holiday Act provision

A provision of $500k was made to accommodate any ongoing impact on accumulated leave in the 2020-21 financial year.

Facility contract one-off

There was a one-off cost of $268k for new facility contract mobilisation, the anticipated full year cost will be $280k.

Appendix 1 - Revenue

	Month				Year to Date				Annual	Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2020-21	Actual 2019-20
Ministry of Health	23,329	23,032	297	F	258,726	257,858	868	F	281,284	259,121
Inter-district inflow	726	637	89	F	7,118	7,006	112	F	7,643	7,764
Other District Health Board (DHB)	120	56	64	F	952	523	429	F	560	612
Accident Compensation (ACC)	276	311	(35)	U	3,123	3,374	(251)	U	3,687	3,317
Other Government	6	6	-	F	246	152	94	F	197	145
Patient consumer sourced	64	30	34	F	315	323	(8)	U	353	371
Other income	90	86	4	F	944	990	(46)	U	1,082	929
COVID-19	137	-	137	F	2,381	-	2,381	F	-	3,931
Total revenue	24,748	24,158	590	F	273,805	270,226	3,579	F	294,806	276,190

Note :- F = Favourable variance; U = unfavourable variance

June 2021

Month comments

Ministry of Health

Revenue was $297k favourable to budget due to additional funding for clerical pay equity settlement, central regional alcohol and drug speciality service funding, planned care improvement funding, gout funding and public health funding.

Inter-district inflow

Inter-district inflow was $89k favourable to budget due to lower inpatient service activity.

Other District Health Board (outpatient Clinics)

Other District Health Board was $64k favourable to budget due to the increase of other district health boards (DHBs) outpatient clinic revenue and Taranaki DHB inpatient service revenue.

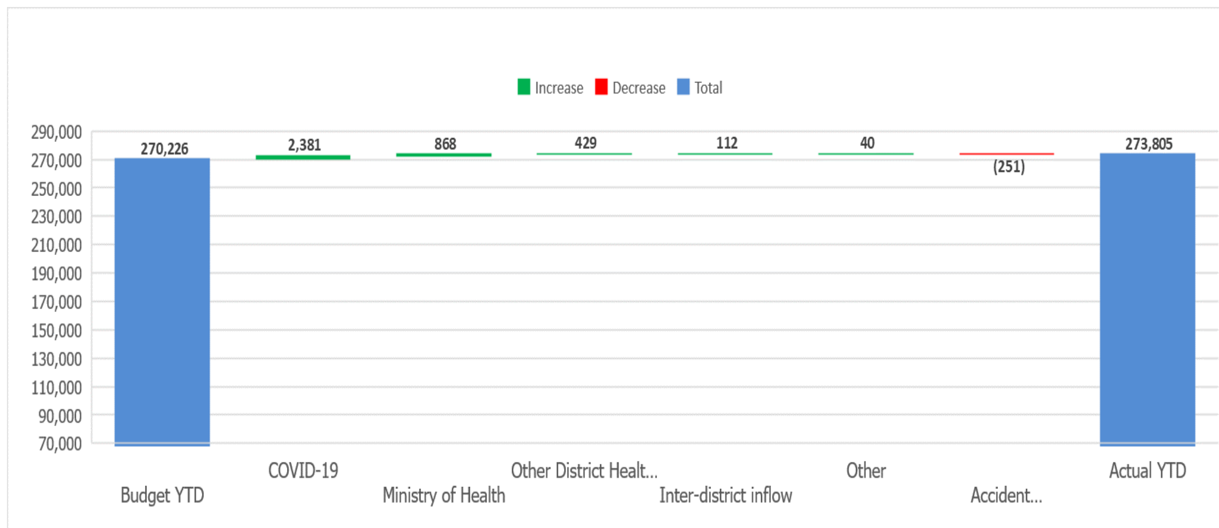
Accident Compensation (ACC)

Revenue was $35k unfavourable to budget due to meeting the additional ACC revenue target.

COVID-19 revenue

Covid-19 revenue was $137 favourable to budget due to to $70k pharmaceutical COVID-19 funding and $67k community testing funding.

Year-to-date comments



COVID-19 was $2,381k favourable to budget due to Ministry of Health funding for:

- CBAC establishment $30k
- GP based easements $62k
- Surveillance plan and testing strategy $786k
- Public health unit $450k
- HOP support $29k
- Digital enablement $182k
- Community testing $67k
- Pharmaceuticals $775k

This revenue passes on to various community health providers.

June 2021

Ministry of Health

Revenue was $868k favourable to budget due to an increase of primary care revenue and funder division side contract revenue (this increase in funding was passed on to the PHO and other health providers), clerical pay equity settlement funding, public health additional one-off funding, central regional alcohol and drug speciality service funding, planned care improvement funding, gout funding, hospice funding (offset by costs) and suicide prevention funding. This was partly offset by a reduction in capital charge funding due to the rate reduction from 6% to 5%.

Other District Health Board (outpatient Clinics)

Other District Health Board was $429k favourable to budget due to the increase of other district health boards (DHBs) outpatient clinic revenue and Taranaki DHB inpatient service revenue.

Inter-district inflow

Inter-district inflow was $112k favourable to budget due to service changes with other DHB’s and high inpatient service revenue.

Other

Other revenue was $40k favourable to budget due to Ministry of Social Development funding for the Impact Collective, established to nurture a regenerative economy within a thriving community that creates wellbeing for all people, whenua and the planet.

Accident Compensation (ACC)

Revenue was $251k unfavourable to budget due to lower ACC non-acute inpatient rehabilitation $187k and not meeting the ACC revenue target of $456k. This lower revenue was partly offset by additional funding from ACC radiology $78k, sexual abuse assessment and treatment service (SAAT) $110k, ACC injury prevention $82k, ACC implant $58k and other ACC revenue $63k.

June 2021

Appendix 2 - Provider Health and Corporate Services

	Month					Year to Date					Annual	Annual
	Actual	Budget	Variance		Var %	Actual	Budget	Variance		Var %	Budget 2020-21	Actual 2019-20
Expenditure												
Medical Personnel	2,052	2,048	(4)	U		22,040	22,977	937	F		25,259	22,696
Nursing Personnel	3,590	3,577	(13)	U		40,530	39,228	(1,302)	U		42,796	42,778
Allied Personnel	1,073	1,097	24	F		11,760	12,392	632	F		13,545	12,346
Support Personnel	82	87	5	F		972	988	16	F		1,080	934
Management & Admin Perseonnel	931	990	59	F		10,866	11,221	355	F		12,270	12,061
Total Personnel(Exl other & outsourced)	**7,728**	**7,799**	**71**	**F**		**86,168**	**86,806**	**638**	**F**		**94,950**	**90,815**
Personnel Other	167	175	8	F		1,730	2,071	341	F		2,355	1,737
Outsourced Medical Personnel	428	329	(99)	U		5,303	3,548	(1,755)	U		3,883	6,433
Outsourced Allied Personnel	60	34	(26)	U		821	458	(363)	U		492	704
Outsourced Manag & Admin Personnel	68	7	(61)	U		637	72	(565)	U		78	59
Total Personnel outsourced	**723**	**545**	**(178)**	**U**		**8,491**	**6,149**	**(2,342)**	**U**		**6,808**	**8,933**
Total Personnel Expenditure	**8,451**	**8,344**	**(107)**	**U**		**94,659**	**92,955**	**(1,704)**	**U**		**101,758**	**99,748**
Outsourced Clinical Service	543	490	(53)	U		5,331	5,398	67	F		5,915	6,015
Clinical Supplies	1,477	1,428	(49)	U		16,393	15,844	(549)	U		17,300	16,107
Infrastructure & Non Clinical Supplies Costs	1,169	1,151	(18)	U		14,783	14,978	195	F		16,171	15,540
Capital Charge	187	202	15	F		2,132	2,304	172	F		2,505	2,748
Depreciation & Interest	543	559	16	F		5,767	5,681	(86)	U		6,193	5,563
Internal Allocation	17	15	(2)	U		172	153	(19)	U		182	264
Total Other Expenditure	**3,936**	**3,845**	**(91)**	**U**		**44,578**	**44,358**	**(220)**	**U**		**48,266**	**46,237**
Total Expenditure	**12,387**	**12,189**	**(198)**	**U**		**139,237**	**137,313**	**(1,924)**	**U**		**150,024**	**145,985**
Expenditure												
Medical personnel and Locum	2,480	2,377	(103)	U		27,343	26,525	**(818)**	U		29,142	29,129
Nursing Personnel	3,590	3,577	(13)	U		40,530	39,228	**(1,302)**	U		42,796	42,778
Allied Personnel	1,133	1,131	(2)	U		12,581	12,850	**269**	F		14,037	13,050
Othe Personnel costs	1,248	1,259	11	F		14,205	14,352	**147**	F		15,783	14,791
Clinical Supplies	1,477	1,428	(49)	U		16,393	15,844	**(549)**	U		17,300	16,107
Outsourced Clinical Service	543	490	(53)	U		5,331	5,398	**67**	F		5,915	6,015
Infrastructure & Non Clinical Supplies Costs	1,356	1,353	(3)	U		16,915	17,282	**367**	F		18,676	18,288
Depreciation & Interest	543	559	16	F		5,767	5,681	**(86)**	U		6,193	5,563
Internal Allocation	17	15	(2)	U		172	153	**(19)**	U		182	264
Total Expenditure	**12,387**	**12,189**	**(198)**	**U**		**139,237**	**137,313**	**(1,924)**	**U**		**150,024**	**145,985**
FTEs												
Medical	114.5	108.9	(6)	U		108.6	110.9	2	F		111.5	112.5
Nursing	487.9	460.7	(27)	U		482.8	460.7	(22)	U		460.8	462.2
Allied	160.1	160.0	(0)	U		155.5	160.3	5	F		160.3	153.4
Support	17.3	18.0	1	F		18.0	18.0	0	F		18.0	16.8
Management & Admin	166.6	169.3	3	F		169.0	169.5	0	F		170.5	177.9
Total FTEs	**946**	**917**	**(29.4)**	**U**		**934**	**919**	**(14.5)**	**U**		**921**	**923**
Case Weighted Discharges (CWD)												
Unplanned (Acute)	781	748	(33)	U	-4.4%	8,118	8,112	(6)	U	-0.1%	8,836	8,528
Planed (Elective & Arranged)	308	291	(17)	U	-6.0%	3,137	2,937	(200)	U	-6.8%	3,227	2,968
Total CWD	**1,089**	**1,039**	**(50)**	**U**	**-4.8%**	**11,255**	**11,048**	**(207)**	**U**	**-1.9%**	**12,063**	**11,496**
Further information												
General Medicine	352	295	(57)	U	-19.5%	3,632	3,193	(439)	U	-13.7%	3,478	3,728
General Surgery	209	216	6	U	3.0%	2,244	2,277	32	U	1.4%	2,488	2,582
Orthopaedics	208	210	2	U	1.2%	2,120	2,183	63	F	2.9%	2,390	1,897
Gynaecology	39	31	(8)	U	-25.3%	368	319	(49)	U	-15.3%	350	388
Emergency Medicine	107	114	7	F	6.0%	1,119	1,232	113	F	9.2%	1,342	1,096
Othter	175	174	(0)	U	-0.3%	1,772	1,845	73	F	3.9%	2,015	1,805
Total CWD	**1,089**	**1,039**	**(50)**	**U**	**-4.8%**	**11,255**	**11,048**	**(207)**	**U**	**-1.9%**	**12,063**	**11,496**

Month comments

The overall expenditure for the month of May was $198k unfavourable to budget.

Personnel

Total personnel costs were $107k unfavourable to budget mainly due to an increase in nursing personnel and medical locum costs, clerical pay equity settlement costs, outsourced allied health personnel (mainly radiology), and IT outsourced personnel costs.

June 2021

Outsourced Clinical Service

Outsourced clinical service costs were $53k unfavourable to budget mainly due to higher radiology outsourced service costs and general medicine inpatient service costs.

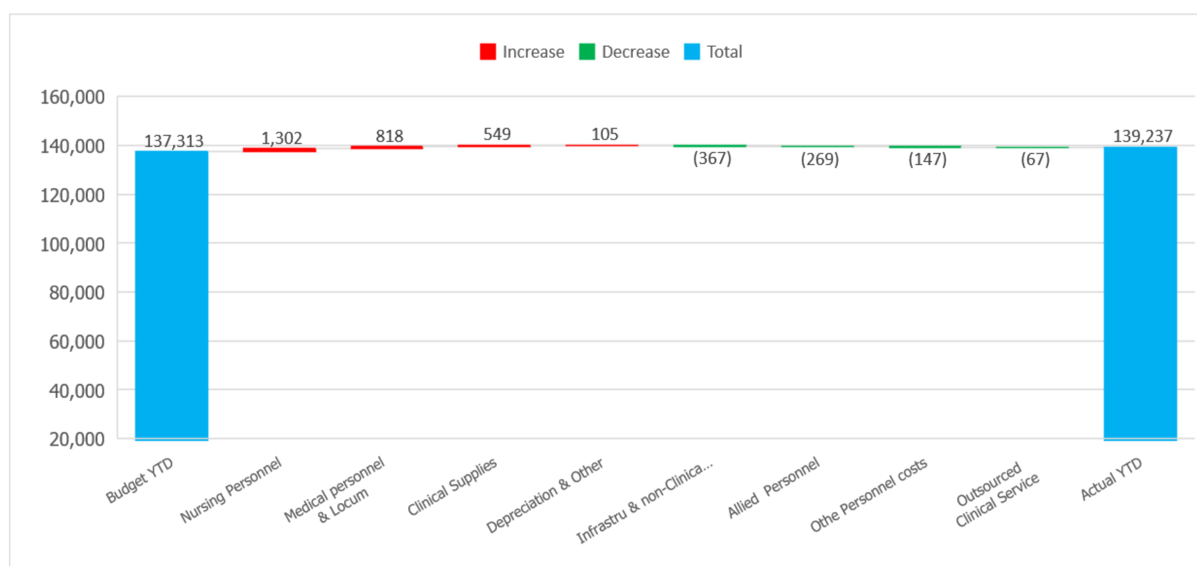
Clinical supplies

Clinical supplies costs were $49k unfavourable to budget due to higher theatre consumables costs and pharmaceutical mainly EYE drugs costs. These higher costs were partly offset by lower blood costs and district nursing consumables costs.

Infrastructure and Non-Clinical supplies

Infrastructure and non-clinical supplies costs were $18k unfavourable to budget due to telecommunication and facility contract costs.

Year-to-date comments



The overall year-to-date expenditure $1,924k unfavourable to budget.

Nursing personnel

Nursing personnel was $1,302k unfavourable to budget due to high nursing costs in the medical, surgical and ATR wards, mental health inpatient units (Te Awhina), ED, theatre, forensic service (Stanford House), ATR community service and district nursing. Staffing levels were particularly high due to clinical need.

Medical personnel

The medical personnel net unfavourable variance of $818k was mainly due to use of locums to cover vacancies. Unfavourable locum costs of $1,755k were partly offset by savings in payroll costs of $937k due to unfilled vacant positions. Locum costs were made up of ophthalmology $134k, orthopaedics $30k, RMOs $360k, anaesthetics $149k, mental health SMO $530k, gynaecology $450k, emergency $26k and dental and other units $76k.

Clinical supplies

Clinical supplies costs were $549k unfavourable to budget due to high costs in theatre consumable $419k (207, 1.9% CWDS above target), wards costs $78k (mainly treatment consumables and pharmaceutical drugs), orthotic and surgical footwear cost $115k, and high demand of patient travel $25k. These higher costs were partly offset by lower radiology, district nursing consumable costs, blood product costs and other of $63k,

June 2021

Deprecation other costs

Depreciation costs and other costs were $105k unfavourable to budget due to clinical equipment, IT projects bought into production and the impact of deprecation for 30 June 2020 land and building valuation increases (anticipated full year unfavourable impact of $60k).

Infrastructure and Non-Clinical supplies (including capital charge)

Infrastructure and non-clinical supplies costs were $367k favourable to budget due to building and other insurance savings of $103k, capital charge $172k, transport $20k, corporate training $37k, printing and stationary $19k and IT bureau and software licences $125k. These lower costs were partly offset by high security service to the mental health inpatient units AT&R surgical and medical wards $93k and various other $16k.

Allied personnel

Allied personnel costs net favourable variance of $269k favourable to budget was mainly due to vacancies in audiology, dental, physiotherapy, speech therapy, pharmacy, community mental health and health promotion. Favourable payroll savings of $632k were partly offset by outsourced costs of $363k mainly orthotics, speech therapists and radiology locum.

Other personnel

Other personnel costs were $147k favourable to budget mainly due to unattended courses and conferences as a result of the COVID-19 pandemic.

Outsourced clinical and other services

The costs of outsourced clinical and other services were $67k favourable to budget, mainly due to radiology service $57k, radiology ECHO $65k, lower CCDHB infectious disease costs $54k and various other $16k. This was partly offset by community mental health outsourced telephone service $55k, general medicine inpatient service costs $33k, and outsourced service for chronic disease service for client with HIV $37k.

Case Weighted Discharges

Year to Date estimated case weighted discharges (CWD) were 207 CWD, 1.9% higher than target. General medicine 439 CWD, 13.7% higher than planned.

Note that CWD above includes services provided at Whanganui Hospital. This CWD does not include IDF outflows and means it is not the complete result in relation to the Planned Care Target.

June 2021

Appendix 3 - DHB Funder Division

	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2020-21	Actual 2019-20
Expenditure by type										
Pharmaceuticals	1,434	1,366	(68)	U	15,675	15,729	54	F	17,173	16,052
Primary Health Organisation (PHO)	1,389	1,475	86	F	16,476	16,287	(189)	U	17,763	16,941
Home Based Support (short Term)	200	218	18	F	2,236	2,393	157	F	2,610	1,766
Other Personal Health	1,040	1,126	86	F	12,261	12,329	68	F	13,452	12,440
Health of Older People	2,502	2,386	(116)	U	28,563	28,384	(179)	U	31,472	30,236
Mental Health	938	933	(5)	U	10,601	10,284	(317)	U	11,215	9,085
Public Health	101	85	(16)	U	989	972	(17)	U	1,057	976
Maori Services	136	136	–	F	1,460	1,583	123	F	1,719	1,602
Total Other provider expenditure	**7,740**	**7,725**	**(15)**	**U**	**88,261**	**87,961**	**(300)**	**U**	**96,461**	**89,098**
Funding Admin	239	223	(16)	U	2,376	2,509	**133**	F	2,740	2,543
Total funder expenditure	**7,979**	**7,948**	**(31)**	**U**	**90,637**	**90,470**	**(167)**	**U**	**99,201**	**91,641**
	–	–	–		–	–	–		–	
Expenditure by service										
Personal Health	4,063	4,185	122	F	46,648	46,738	90	F	50,998	47,199
Health of Older People	2,502	2,386	(116)	U	28,563	28,384	(179)	U	31,472	30,236
Mental Health	938	933	(5)	U	10,601	10,284	(317)	U	11,215	9,085
Public Health	101	85	(16)	U	989	972	(17)	U	1,057	976
Maori Services	136	136	–	F	1,460	1,583	123	F	1,719	1,602
Funding Admin	239	223	(16)	U	2,376	2,509	133	F	2,740	2,543
Total Expenditure	**7,979**	**7,948**	**(31)**	**U**	**90,637**	**90,470**	**(167)**	**U**	**99,201**	**91,641**

Month comments

The overall expenditure for the month of May 2021 was $31k unfavourable to budget.

Pharmaceuticals

Pharmaceuticals was $68k unfavourable to budget due to demand, this is partly offset by a higher Pharmac rebate.

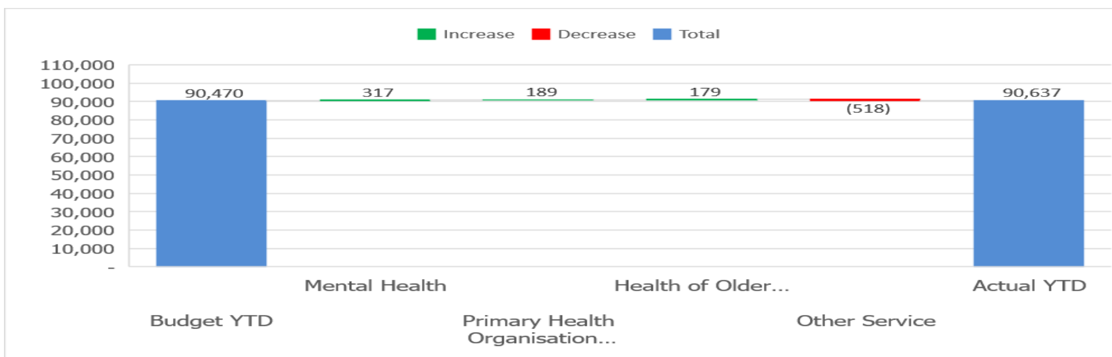
Health of older people

Short term home base support was $116k unfavourable to budget due to higher demand of rest home residential hospital care and homebase support costs.

June 2021

Year-to-date comments

The overall year-to-date expenditure was $167k unfavourable to budget.



Mental Health

Mental health service was $317k unfavourable to budget largely due to an increase in the number of mental health contracts. This is partly offset by higher revenue.

Primary Health Organisation

The Primary Health Organisation (PHO) was $189k unfavourable to budget, largely due to an increased capitation first contact service payment which indicates increases in enrolment, and the timing of the PHO system level measure capability payment. This was partly offset by increased primary care funding.

Health of older people

Health of older people was $179k favourable to budget, mainly due to higher demand of home based support, rest home residential hospital care, ageing in place and respite costs. This was partly offset by one-off in-between travel reimbursement related to the prior year.

Other service

Other service was $518k favourable to budget due to lower short term homebase support, lower other personal health costs and lower funding and admin management costs.

June 2021

Appendix 4 - Inter-district flows (IDFs)

	Month				Year to Date			Annual	Annual
	Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000	Budget 2020-21 $000	Actual 2019-20 $000
Expenditure									
Outflow inpatient	$2,194	$2,031	($ 163)	U	$22,377	$22,340	($ 37)	$24,371	$24,073
Outflow other	$1,929	$1,985	$56	F	$21,233	$21,833	$600	$23,818	$21,174
Total outflow	**4,123**	**4,016**	**(107)**	**U**	**43,610**	**44,173**	**563**	**48,189**	**45,247**
Inflow inpatient	($ 371)	($ 277)	$94	F	($ 3,155)	($ 3,050)	$105	($ 3,329)	($ 3,269)
Inflow other	($ 355)	($ 360)	($ 5)	U	($ 3,963)	($ 3,956)	$7	($ 4,314)	($ 4,495)
Total inflow	**(726)**	**(637)**	**89**	**F**	**(7,118)**	**(7,006)**	**112**	**(7,643)**	**(7,764)**
Total IDF net flow	**3,397**	**3,379**	**(18)**	**U**	**36,492**	**37,167**	**675**	**40,546**	**37,483**

Note :- F = Favourable variance; U = unfavourable variance

Year-to-date comments

Year-to-date IDF net flow was $675k favourable to budget.

Year-to-date outflow IDF expenditure was $563k favourable to budget

Inpatient IDF outflow

Inpatient IDF outflow was $37k unfavourable to budget due to an anticipated saving target only partially achieved. Costs reflect payments made in accordance with the national plan. Specialities running over budget were acute haematology, elective neurosurgery, ophthalmology, paediatrics and urology.

Other IDF outflow

Other IDF outflow was $600k favourable to budget due to prior year PCT, community pharmaceutical wash-up $132k and service changes. (The IDF's for any year are set based on historical services provided and historical volumes, if there is a change in the services delivered by another DHB for Whanganui DHB population, this could be that a service is stopped, or volumes significantly change. This will only be required for IDF categories that are not washed up at the end of the year).

Year-to-date inflow IDF revenue was $112k favourable to budget.

Inpatient IDF

Inpatient IDF inflow was $105k favourable to budget due to a higher inpatient volume for other DHBs.

Other IDF

Other IDF inflow was $7k favourable to budget due to service changes. (The IDF's for any year are set based on historical services provided and historical volumes, if there is a change in the services delivered by another DHB for Whanganui DHB population i.e. if a service is stopped or volumes significantly change. This will only be required for IDF categories that are not washed up at the end of the year).

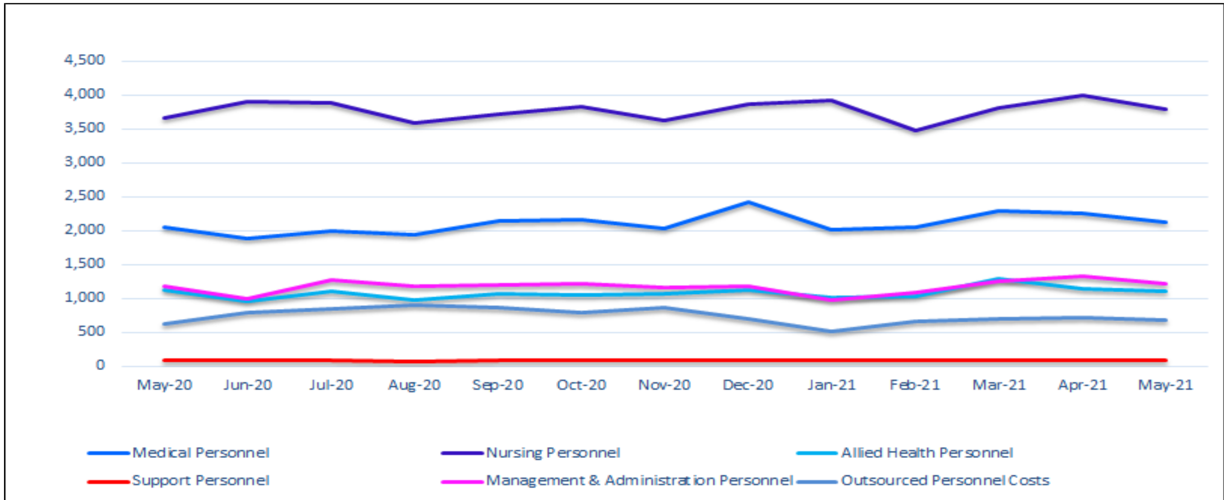
Other IDFs are made of General Medical Service (GMS), Immunisation, Laboratory, Personnel Health – NGO, - Outpatients, Pharmaceutical Cancer Treatment (PCT), Pharmacy, Primary Health Organisation (PHO), Tertiary Adjuster (TDDJ), Long Term Conditions (LTC), Health of Older People Aged Residential Care (ARC), Health of Older People Non-Inpatient AT&R, Health of Older People NGO, Health of Older People Inpatient AT&R, Health of Older People Mental Health NGO, and Mental Health Provider Arm.

June 2021

Appendix 5 - Other information

Supplementary information on costs

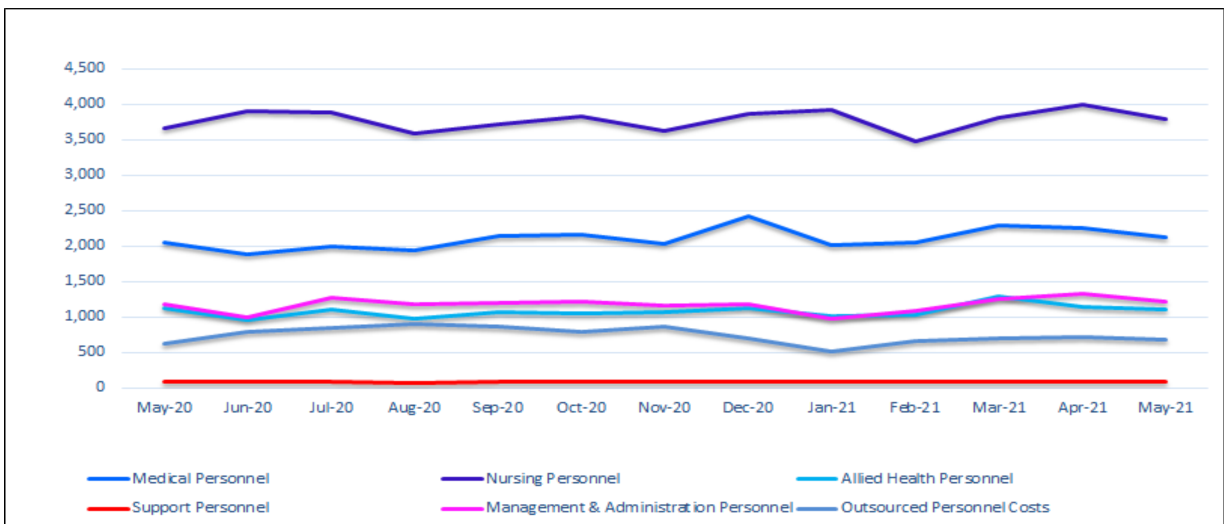
Personnel cost trends



The personnel costs downward trend in May compared to prior month is due to one more working days in the month.

The outsourced personnel costs slight downwards trend in May compared to prior month is due to lower ACC contract costs (offset by higher revenue)

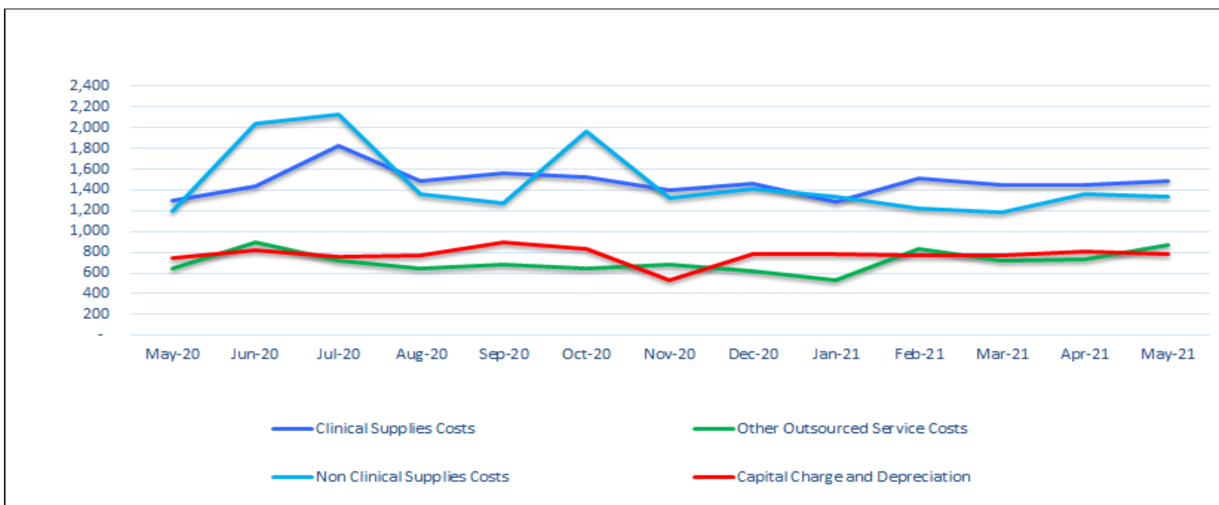
FTE trends



The FTE trend largely reflects the impact of statutory holidays and timing of leave; otherwise the trend is comparable to the prior period.

June 2021

Other operating costs



Clinical supplies slightly upward trend in May compared to the prior month is due to theatre consumables.

The non-clinical trend in May is comparable to prior month.

Other outsourced service upward trend in May is due ACC contract and general medicine costs.

Capital charge and depreciation trend in May is comparable to prior month.

June 2021

Appendix 6 - Statement of financial position

	Actual 2019-20 $000	Actual 2020-21 $000	Budget 2020-21 $000	Varinace to Budget	Annaul Budget 2020-21 $000
Assets					
Current assets					
Cash and cash equivalents	3,813	5	5	–	5
Receivables & Prepayments	6,275	7,797	6,889	908	5,492
Investments	–	–	–	–	–
Inventories	1,617	1,581	1,617	(36)	1,617
Trust /special funds	190	202	189	13	189
Patient and restricted trust funds	4	3	4	(1)	4
Total current assets	**11,899**	**9,588**	**8,704**	**884**	**7,307**
Non current assets					
Property, plant and equipment	79,602	79,997	76,588	3,409	78,310
Intangible assets	11,741	11,429	12,253	(824)	12,640
Investments in associates	1,185	1,185	1,077	108	1,102
Total non current assets	**92,528**	**92,611**	**89,918**	**2,693**	**92,052**
Total assets	**104,427**	**102,199**	**98,622**	**3,577**	**99,359**
Liabilities					
Current liabilities					
Bank Overdraft	–	(1,181)	(10,224)	9,043	(9,199)
Payables	(20,535)	(19,425)	(17,505)	(1,920)	(17,235)
Borrowings	(198)	(97)	(100)	3	(100)
Employee entitlements	(21,920)	(23,553)	(18,487)	(5,066)	(19,265)
Provisions	–	–	–	–	–
Total current liabilities	**(42,653)**	**(44,256)**	**(46,316)**	**2,060**	**(45,799)**
Non-current liabilities					
Borrowings	(486)	(397)	(398)	1	(385)
Employee entitlements	(839)	(827)	(853)	26	(805)
Total non current liabilities	**(1,325)**	**(1,224)**	**(1,251)**	**27**	**(1,190)**
Total liabilities	**(43,978)**	**(45,480)**	**(47,567)**	**2,087**	**(46,989)**
Net assets	**60,449**	**56,719**	**51,055**	**5,664**	**52,370**
Equity					
Contributed Capital	(112,409)	(112,409)	(112,409)	–	(114,651)
Accumulated surplus / (deficit)	82,698	86,439	85,422	1,017	86,349
Property revaluation reserves	(30,551)	(30,551)	(23,881)	(6,670)	(23,881)
Hospital special funds	(187)	(198)	(187)	(11)	(187)
Total equity	**(60,449)**	**(56,719)**	**(51,055)**	**(5,664)**	**(52,370)**

Total assets increased by $3.6m compared to budget due to the impact of increased land and building valuations and actual 2019-20 lower capital expenditure than forecast position included in the 2020-21 annual plan.

Total liabilities increased by $2.1m compared to budget due to accounts payable-related accrual provision and employee entitlement which was partly offset by a budgeted overdraft that was not needed.

June 2021

Appendix 7 – Cashflow

Consolidated Summary Statement of Cash Flows for the period ended 31 May 2021 ($000)

	Actual 2018-19	Actual 2019-20	Actual YTD 2020-21	Budget YTD 2020-21	Variance		Annual Budget 2020-21
Net surplus / (deficit) for year	(13,654)	(15,404)	(3,730)	(2,323)	(1,407)	U	(3,250)
							–
Add back non-cash items							–
Depreciation and assets written off on PPE	5,417	**5,566**	5,767	5,687	80	F	6,201
Revaluation losses on PPE	–	–	–	–	–	F	–
							–
Total non cash movements	**5,417**	**5,566**	**5,767**	**5,687**	**80**	**F**	**6,201**
							–
Add back items classified as investment Activity							–
(loss) / gAmn on sale of PPE	15	5	3	–	3	F	–
Profit from associates	(95)	(108)	–	–	–	F	(85)
GAmn on sale of investments				–	–	F	–
Write-down on initial recognition of financial asset	1,048	–	–				–
Movements in accounts payable attributes to Ca	268	(127)	271	–	271	F	–
							–
Total Items classified as investment Activity	**1,236**	**(230)**	**274**	–	**274**	**F**	**(85)**
							–
Movements in working capital							–
Increase / (decrease) in trade and other payables	**4,312**	**2,301**	**(1,110)**	(3,637)	2,527	F	(3,907)
Increase / (decrease) employee entitlements	**3,907**	**5,173**	**1,621**	(3,419)	5,040	F	(2,689)
				–	–	F	–
(Increase) / decrease in trade and other receivable	2,555	123	(1,522)	(207)	(1,315)	U	1,275
(Increase) / decrease in inventories	(15)	(190)	36	–	36	F	–
Increase / (decrease) in provision	–	–	–	–	–	F	–
							–
Net movement in working capital	**10,759**	**7,407**	**(975)**	**(7,263)**	**6,288**	**F**	**(5,321)**
Net cash inflow / (outflow) form operating activ	**3,758**	**(2,661)**	**1,336**	**(3,899)**	**5,235**	**F**	**(2,455)**
	–	–	–	–			–
Net cash flow from Investing (capex)	(4,572)	(3,110)	(6,124)	(7,074)	950	F	(9,697)
Net cash flow from Investing (Other)	(65)	(48)	(11)	1	(12)	U	(24)
Net cash flow from Financing	(385)	(388)	(190)	(186)	(4)	U	2,043
Net cash flow from deficit support	–	7,000	–	–			–
							–
Net cash flow	(1,264)	793	(4,989)	(11,158)	6,169	F	(10,133)
Net cash (Opening)	4,284	3,020	3,813	939	2,874	F	939
Cash (Closing)	**3,020**	**3,813**	(1,176)	**(10,219)**	**9,043**	**F**	**(9,194)**

Closing cash is ahead of budget due to a delay in the Holiday Act Compliance payment and receiving additional $1m deficit support in 2019/20.

June 2021

Capital Expenditure

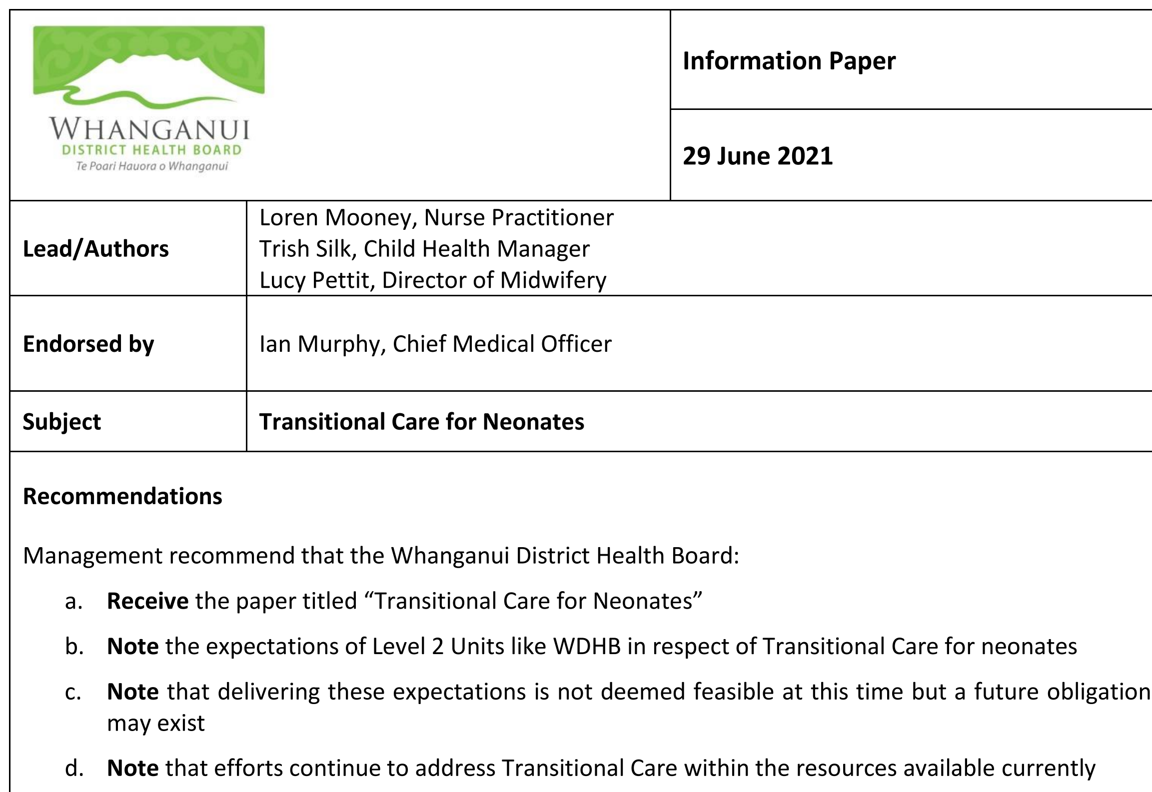
	Actual 2019-20 000	Actual 2020-21 $000	Budget 2020-21 $000	Variance to Budget	Actual 2020-21 000
Buildings & Plant	702	1,411	2,950	1,539	4,825
Clinical Equipment	1,247	2,286	2,365	79	2,537
Other Equipment	46	111	110	(1)	210
Information Technology	239	1,147	217	(930)	230
Purchase of software	838	1,169	1,432	263	1,895
Motor Vehicles	38	–	–	–	–
Total capital expenditure	**3,110**	**6,124**	**7,074**	**950**	**9,697**

Capital expenditure is $950k lower than planned due to a delay in building-related projects. IT infrastructure (partly offset by underspending in software) variance is mainly due to PC and laptop purchases (relying on remote working and new way interacting with employees and customers). Switching IT infrastructure to a cloud service would add significant new costs to WDHB.

General Manager Corporate

10 June 2021

29 June 2021 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	29 June 2021

Lead/Authors	Loren Mooney, Nurse Practitioner Trish Silk, Child Health Manager Lucy Pettit, Director of Midwifery
Endorsed by	Ian Murphy, Chief Medical Officer
Subject	**Transitional Care for Neonates**

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled "Transitional Care for Neonates"

b. **Note** the expectations of Level 2 Units like WDHB in respect of Transitional Care for neonates

c. **Note** that delivering these expectations is not deemed feasible at this time but a future obligation may exist

d. **Note** that efforts continue to address Transitional Care within the resources available currently

1 Purpose:

To provide the Board with an update on Transitional Care expectations for neonates

2 Overview

Neonatal care traditionally encompasses intensive care and special care provided within a neonatal unit.

In 2019, following the review of the National Neonatal Service, by the Paediatric Society of New Zealand; pressure was identified nationwide on all Neonatal Intensive Care Units (NICUs). Further to this, this was a need to address the heightened risk of adverse outcomes arising from sustained periods of 100 percent occupancy for Level 3 and above 85 percent for Level 2 (since 2015).

The key findings from the review highlighted a need for:

- introducing alternative models of care
- enhancing national data collection
- monitoring of where babies are in the system
- equitable service delivery for Māori

Pregnant mothers and babies being transferred are often pre-term, of non-New Zealand (NZ) European ethnicities and living in lower decile areas. The review found that Māori are over-represented in NICUs; and strongly emphasised the importance of keeping mothers and their babies together in a whānau centred, dedicated **transitional care** space. This would provide extended care in a postnatal area, thereby reducing risk and cost, while improving health, maternal attachment and breastfeeding outcomes. Alongside this, there would be a reduction in the current pressure on NICUs and SCBUs and allow mothers and babies to receive care closer to home.

As a result of this review, the Transitional Care Working Group was established by the Ministry of Health and District Health Board Chief Executive Officers of NZ. This group developed the Transitional Care for the Neonate Framework for New Zealand.

The use of Transitional care (TC) has the potential to decrease the current acuity pressures on NICU's and Special Care Baby Unit's (SCBU) nationwide and reduce delays in transfer of neonates from Level 3 to level 2 facilities.

TC envisages a dedicated whānau centred care space where families live on-site near their babies who are receiving care in these units, to help nurture confident parenting and healthy living. This will be supported by well-resourced neonatal and maternity team's, with multidisciplinary support, particularly social workers (SW) and lactation consultants (LC). A discharge planning approach would be inclusive and wrap around additional primary and community care agencies to provide support needed for families/whānau when they are home.

2.1 Current Level 2 Special Care Baby Unit arrangement

Whanganui District Health Board (WDHB), is Level 2 SCBU unit, with four cots/incubators. We have no shared cared facilities currently available for mothers who have babies in SCBU. There is one room available for mothers to room-in with their babies for 1-2 nights prior to discharge. The Maternity Service offers Mothercraft assistance for up to seven days for mothers requiring additional support, education and guidance. This is acuity dependent. Mothers with babies who require longer stays in SCBU must either stay at home or in motel accommodation near the hospital and come in to spend time with their babies.

Wellington Neonatal Unit, Level 3, is our tertiary centre and babies that are born who require tertiary support or who do not make local service admission criteria are transferred out. Our SCBU's current admission criteria is babies above 1500 grams and 32 weeks gestation.

In 2020, there were 163 babies (European 45%, Maori 39%, Samoan 4% other 12%) admitted to the WDHB SCBU unit from 745 total births in the WDHB rohe. The gestations varied from < 30 weeks to term (40 weeks). 32 transfers between tertiary and WDHB SCBU occurred.

2.2 Proposed changes for Level 2 Special Care Baby Unit arrangements

Seven out of the ten Level 2 units reported the need to increase their footprint to accommodate appropriate transitional care requirements. WDHB is one of these.

In the document, Transitional Care for the Neonate Framework, all DHB's recognised the need for TC facilities to also include communal areas, such as sitting room, kitchenette, and bathroom facilities to enable a whānau centred model of care. In addition, the Transitional Care Working Group sought consumer feedback which supported the acknowledgment made by all DHB's.

The enhancement of TC will be delivered collaboratively by our neonatal and maternity team as a shared care model of delivery, within safe staffing levels and supported by appropriate multidisciplinary team. An additional requirement that may be needed is inpatient Neuro-development therapy support which currently has no allocated FTE.

Additional S.T.A.B.L.E education training will be undertaken for both the SCBU and maternity staff to upskill on current knowledge and skills for the care of babies who fit the criteria for transitional care. This has been arranged and will occur in July/August 2021.

The clinical criteria for TC include a variety of babies with clinical conditions that fit between SCBU and post-natal care, and where clinical, maternal and whānau support are needed.

- Infant born 35 weeks and above who weigh >2kg who do not require continuous monitoring
- Inability to establish full suck feeds; predicted to require 3 hourly nasogastric tube feeds
- Infants who are unable to maintain temperature following an episode of rewarming and despite skin to skin contact and/or adequate clothing. Use of incubators are expected to be short term.
- Infants monitored for hypoglycaemia who have not responded to dextrose gel and require nasogastric feeding.
- Stable infants with sepsis who required antibiotics for more than 48 hours
- Infants at risk of neonatal abstinence syndrome requiring oral medication or additional feeding and nursing support
- Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4-6 hourly
- Palliative care when parent/carer doing most of the care

In summary, the review commissioned by the Ministry of Health into neonatal care in NZ highlighted the need to look at alternative models of care to ease the burden on Level 3 units. A dedicated Transitional Care space supports a holistic, pae ora approach by enabling families/whānau to care for their babies within their own rohe. It allows for the mother to be present 24/7 throughout her baby's hospital stay, increases breastfeeding rates, maternal attachment and above all ensures a partnership approach in decision making for their baby's care. WDHB does not currently have the facilities to provide TC for babies who meet the clinical criteria. Maternity and Paediatric services have the desire and commitment to provide TC as this model of care aligns with the WDHB's He Hāpori Ora – Thriving communities strategy. Consideration to addressing the barriers to TC need to be given at a local and national level.

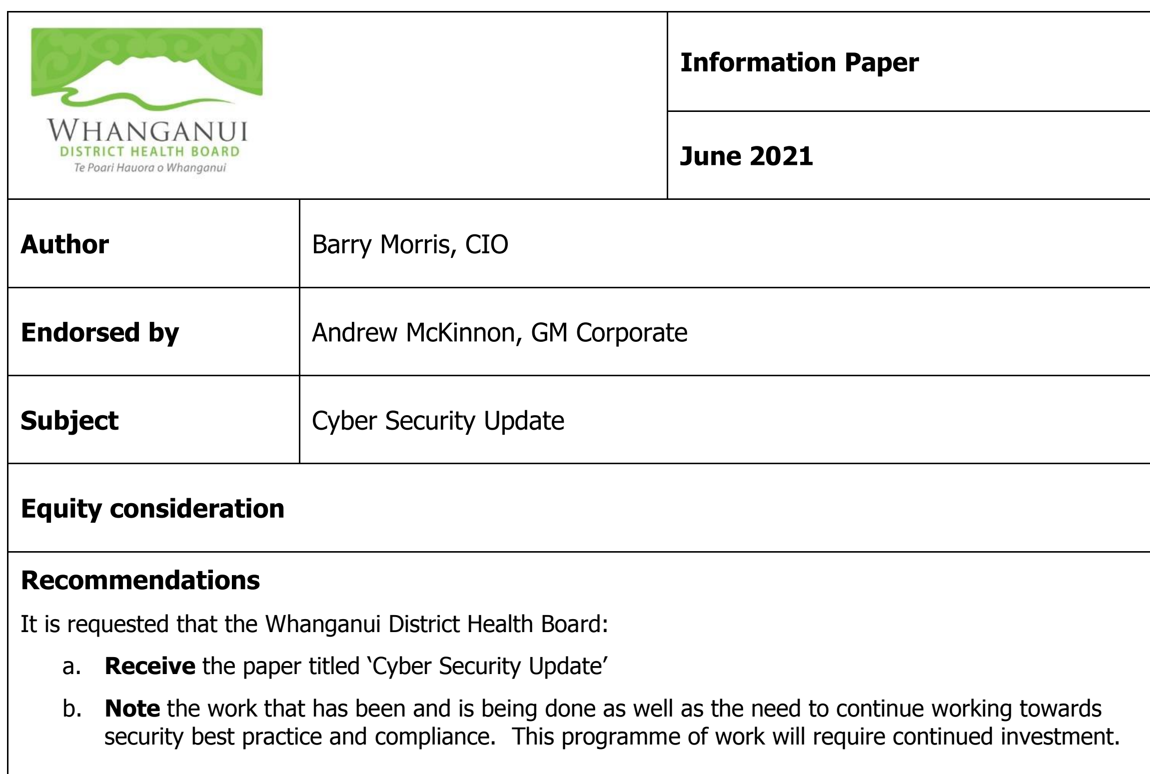
3. Next Steps

The specific recommendations for WDHB from the Framework document included increasing footprint (adjacent to SCBU) to allow for the establishment of expected transitional care facilities. In turn this will provide greater support to both mother/ whanau and the baby closer to home.

At this time, management do not deem it feasible to develop the facilities that would be preferred but note that the space exists if funding became available. There is no obligation to deliver these spaces at present, but an awareness of this potential future obligation should be noted.

In the interim staff will continue to do what they can to ensure services are as in terms of access and keeping people close. This includes STABLE training to increase our ability to bring neonates home and closer to whanau/ family as soon as possible and accommodating support on site whenever possible.

June 2021



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	June 2021
Author	Barry Morris, CIO
Endorsed by	Andrew McKinnon, GM Corporate
Subject	Cyber Security Update
Equity consideration	

Recommendations

It is requested that the Whanganui District Health Board:

a. **Receive** the paper titled 'Cyber Security Update'

b. **Note** the work that has been and is being done as well as the need to continue working towards security best practice and compliance. This programme of work will require continued investment.

1 Purpose

To update the Board on the steps we have been / are taking to protect ourselves against cyber threats.

2 Summary

We have been upgrading IT network infrastructure and strengthening our IT security over the last two years to be compliant with security standards and to lay the foundation for an uplift in our digital maturity.

Our last external penetration testing only found two minor issues that we have since remediated.

Since the cyber security incident at Waikato DHB we have reviewed our current security environment to ensure it is operating as designed. We have also been reviewing advice received from the Ministry of Health and National Cyber Security Centre and implementing recommendations as required. Recommendations not yet actioned, have been added to our programme of work.

Following on from the Waikato DHB incident we will continue with our ongoing programme of work but at an accelerated pace.

3 Actions

3.1 Infrastructure

From an infrastructure perspective, we have been busy replacing our core infrastructure. In troubleshooting some network/telephony issues we have been experiencing, remediation and rectification work has been accelerated to the best of funding available, as well as the availability of our own and external partner resources. Global supply problems for IT hardware is causing lengthy delays in procurement.

June 2021

One of the key security activities currently being completed is the segregation of our network into smaller segments. This limits any damage resulting from a successful security compromise to that small segment of the network where it originated, rather than spreading across the whole network.

As part of upgrading servers from Windows 2008, we have been hardening our server builds to best practice security recommendations. Also, we have almost completed upgrading desktops from Windows 7 to Windows 10. This allows us to have a much more controlled Windows 10 desktop configuration, again set to best practice.

A small number of our servers require application system / clinical hardware upgrades before we can complete our server OS upgrades. We are looking at network segmentation for these servers to mitigate any risk until the prerequisite updates can be completed.

All of this brings us up to date together with new up-to-date hardware that is better protected from compromise than older equipment.

3.2 Email

Email is a significant attack vector for cyber criminals.

Last year we moved our email to the Microsoft Azure Cloud and strengthened security by stepping up our MS licensing from the standard E3 license that most DHBs have, to E5 for all our users. E5 licensing provides a large suite of advanced threat protection (ATP) functionality that is already blocking thousands of junk or suspect emails for us. Note this was one of the first actions taken by Waikato DHB in the aftermath of their incident.

For example, as a result of having E5 licensing, we have been trialling "safe links and safe attachments for emails" for the last six months and following the Waikato incident we rolled it out to all users immediately.

We have also blocked emails with macros attached since the Waikato incident and are currently building an exception list of accepted use where this has broken valid business workflows.

3.3 The Human firewall

We regularly remind staff about their responsibilities as the last line of defence with emails reinforcing a common sense approach. This is especially important as new threats are constantly evolving out in the wild and well ahead of detection globally.

We are reviewing our staff orientation network training material to ensure this is very clearly stressed.

4 Advice and recommendations

The Waikato DHB incident focusses us on what we still have to do, though they still do not know exactly how it occurred and so information that other DHBs can use to remediate against this particular attack is limited. DHBs are accordingly focusing on best security practice and what advice is coming through.

4.1 CIOs

DHB CIOs are working collaboratively sharing information. It would seem that following the action we have been taking at WDHB, we are in a better position than many other DHBs who are behind with infrastructure upgrades and security hardening.

4.2 Ministry of Health

We have listened to the advice from the Ministry of Health on the 19th May.

Be aware of phishing scams

We understand that email Phishing is a potential vector for ransomware. Staff are being reminded of the threats from phishing emails.

Always update your operating system and your apps when new versions are available

We have been updating our operating systems and endeavour to update apps as new versions become available.

June 2021

Make sure you back up your files regularly

We maintain daily backups. The restoration from backups is regularly tested in restoring deleted items for our users. Key systems with the cloud have full backups and are regularly tested.

Install antivirus and anti-ransomware software on your computer if you don't already have it, and update it regularly

We do this.

Install a firewall on your computer to stop traffic from untrustworthy sources getting into your computer

Our standard desktop image has a controlled firewall.

Don't enable macros in Microsoft Office

We have blocked Macros. However for a number of valid business processes (e.g. Ministry of Health financial templates contain macros), macros are still used and so we have had to build an exception list requiring CIO approval.

Be prepared for an incident

We are prepared as much as you can be.

Have a communicated and documented plan to deal with a cyber incident

We are putting together a cyber security response plan.

Have a partner you can call if you need expert help

Spark are our partner.

4.3 National Cyber Security Centre (NCSC)

We have listened to the following advice from the National Cyber Security Bureau.

Confirm your incident management plans

Prior to the Waikato DHB incident we did not have a cyber security response plan. We are currently putting one together based on NCSC recommendations. We expect to have this completed by 30th June. Currently we operate on a Major Incident Management Plan adapted from Capital and Coast DHB.

Review your security posture in relation to ransomware with your CIO and security team

We have been addressing security tightening over the last year or so. We are up to date with our patching and are systematically upgrading critical systems. Our most critical systems - WeBPAS, Clinical Portal, RIS, eMail, Finance and Payroll are all in secure private clouds. We have accelerated security uplift with the replacement of network hardware as a result of troubleshooting issues with Teams calling.

We have a report on our on premise SQL database structure that recommends a rebuild to improve security and will be moving as quickly as possible on that. We still have 150 odd Windows 7 computers that we need to upgrade and get to Windows 10 and are looking at additional temporary contracted resource to achieve this.

Re-emphasising security aware

We are regularly reminding staff about their responsibilities as the last line of defense with emails. We will review our staff orientation network training material to ensure this is very clearly stressed.

Review your back-ups

We monitor successful completion of our backups and while we have not had to restore whole systems (on site) we regularly restore deleted files successfully. Key systems with the cloud have full backups and are regularly tested.

Review your security monitoring

This is an area where we need to improve. We have good tools but no dedicated security role to manage monitoring. Currently limited monitoring is performed. As we recruit for vacancies in our team and work with external support partners we will build this capability and upskill our team.

Use the tactical information provided by our security expert

June 2021

We have the Indicators of Compromise (IOCs) for this ransomware but currently receive an error when we try and load them into our Microsoft AzureTenant. This has been urgently logged and escalated with Microsoft. We have notified the appropriate security people at the MoH.

Security Control

The security work we have been doing over the last year is based on compliance with the New Zealand Information Security Manual (NZISM), recommendations from CERTNZ and CIS Critical Security Controls for Effective Cyber Defense

5 Still to do (accelerated programme of work)

Despite all the work that has been done and protection in place there remains much more to do to tighten security.

Complete the hardware replacement programme

- Remove the risks associated with Windows 7 Desktops and upgrade to Windows 10
- a capex for 30 more desktop PCs is awaiting approvals and we have 20 laptops to purchase.
- Once we have finished replacing the devices that can't run Windows 10 we need to push out a new Windows 10 desktop image to 100 devices currently running Windows 7 (and early versions of Windows 10) that are capable of running Windows 10.
- Network redesign - the last 29 Network switch upgrades enabling further segmentation of the network. Capex approval has already been given for these just awaiting the hardware to arrive at end of June and then the services work with Spark to roll them out.
  Incorporate the Windows Defender Advanced threat protection into Windows 10
- As part of our E5 licensing with Microsoft there are more tools available for us to implement to protect our fleet of desktop and mobile devices. We are currently planning for this.

Review our external (non-staff) users

- To improve account management and validation and ensure we have consistent controls in place for both our staff and external users.
- Quarantine files introduced through memory sticks

Mobile device management

- Our Microsoft licensing provides Intune to manage our mobile devices. We are currently towards implementing this.

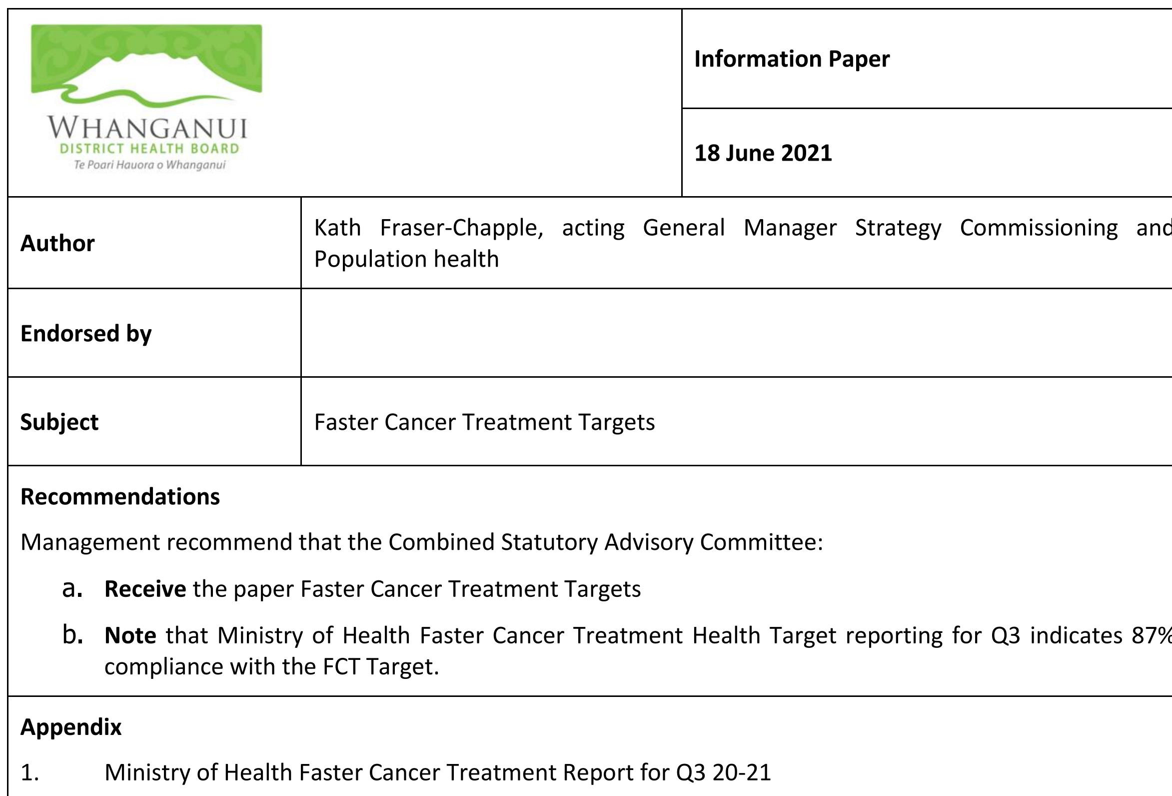
DMARC (Domain-based Message Authentication, Reporting and Conformance)

- Is an email authentication protocol. It is designed to give email domain owners the ability to protect their domain from unauthorized use, commonly known as email spoofing. The purpose and primary outcome of implementing DMARC is to protect a domain from being used in business email compromise attacks, phishing emails, email scams and other cyber threat activities.
- Implement any further recommendations coming out the NZ Cyber security bureau / Ministry of Health
- Review ICT resources and skills to monitor the security information coming out of new tools.

In the past the introduction of new security controls has caused some concern for our clinical users as it makes their jobs harder. In the current environment our users need to be more understanding of the need to so implement security controls - especially where the actions follow cyber security bureau or MoH recommendations.

It is not possible to absolutely guarantee security will make us bullet proof from cyber attacks. It is about mitigating risk by ensuring hardware and software is up to date, compliance with accepted security standards and a common sense approach from our users.

June 2021 **Public Board**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	18 June 2021
Author	Kath Fraser-Chapple, acting General Manager Strategy Commissioning and Population health
Endorsed by	
Subject	Faster Cancer Treatment Targets

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

a. **Receive** the paper Faster Cancer Treatment Targets

b. **Note** that Ministry of Health Faster Cancer Treatment Health Target reporting for Q3 indicates 87% compliance with the FCT Target.

Appendix

1. Ministry of Health Faster Cancer Treatment Report for Q3 20-21

1 Purpose

This paper provides an update on Faster Cancer Treatment (FCT) Health Target Results for Q3 2020-21.

2 Summary

Results for the Faster Cancer Treatment target for quarter tthree 20-21 are 87% of patients referred with high suspicion of cancer starting their treatment within 62 days of their referral.

3 Background

The Health Target reporting is compiled by the Ministry of Health on a DHB of domicile basis and returned to us quarterly, as an interim report followed by a final report. The information from the Ministry of Health (MoH) SS-11 report is then used to fulfil our quarterly reporting obligations around the Faster Cancer Treatment 62 Day Target and 31 Day Target measures.

The 62-day target measures the time taken for a patient referred with high suspicion of cancer or a confirmed cancer diagnosis to receive their first treatment. This is expected to be approximately 25% of all cancer patients. Patients where treatment is delayed due to patient choice or clinical considerations (eg co-morbidities or staged treatment) are excluded from the target.

The 31-day target measures the time taken between decision to treat and the patient receiving their first treatment. Patients where treatment is delayed due to patient choice or clinical considerations are excluded from the target.

4 SS-11 Faster Cancer Treatment (62-day target)

Results received from Te Aho o te Kahu for quarter three 20-21 show that 87% of patients referred with high suspicion of cancer received their first treatment within 62 days of referral. National results were also below target with 85% of patients receiving treatment within the guidelines, only four DHB's achieved above 90%.

A total of 54 referrals were within the 62-day target cohort. Of these 47 received their treatment within the timeframe.

These results closely reflect our previously reported internal calculation of 88% compliance. Due to the different collection methods between the MoH data (submitted nationally and calculated as a rolling 6-month quarter) and our local data collected by our cancer nursing team there can be variances in final numbers reported. For clarity we use the Ministry of Health reporting as our definitive results.

Local results for the start of Quarter 4 indicate that 33% of cancer referrals met the criteria for reporting, a total of 16 patients. Of these three patients experienced delays, two due to capacity and one due to the complexity of care required.

5 Faster Cancer Treatment (31-day target)

The results for Q2 have been received from the Ministry, for data collected up to 31 m=March 2021. We had a total of 216 patients in the FCT cohort for the reported timeframe with 191 receiving their treatment within 31 days of decision to treat, with a result of 88.4% against the target of 85%.

June 2021 **Public Board**

Appendix 1.

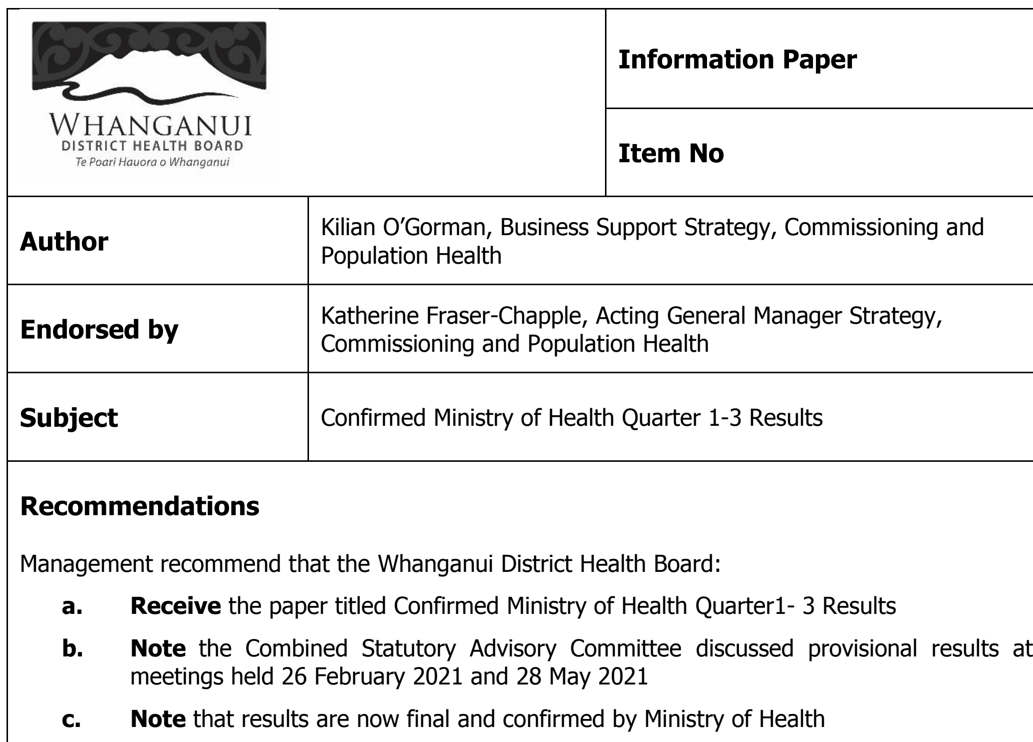
62-day indicator achievement (Health Target)

DHB	Adjusted number of records submitted *Patients within the 62-day FCT health target cohort (excluding patients breaching with a delay code of clinical consideration or patient reason), by month of first treatment*							Number of records within 62 days							Achievement 6-month quarter	Achievement 3-month quarter
	Oct	Nov	Dec	Jan	Feb	Mar	Total	Oct	Nov	Dec	Jan	Feb	Mar	Total	Oct 2020 - Mar 2021 Tracking	Jan - Mar 2021 Tracking
Auckland	27	28	44	25	20	33	177	26	28	41	22	18	31	166	93.8%	91.0%
Bay of Plenty	15	18	18	13	18	13	95	14	15	17	12	16	9	83	87.4%	84.1%
Canterbury	64	57	52	23	53	44	293	62	54	50	23	49	40	278	94.9%	93.3%
Capital and Coast	26	24	20	22	24	20	136	23	20	18	20	20	19	120	88.2%	89.4%
Counties Manukau	39	37	35	28	32	55	226	34	33	28	24	24	51	194	85.8%	86.1%
Hawkes Bay	12	13	12	4	7	15	63	10	12	10	2	5	14	53	84.1%	80.8%
Hutt Valley	26	17	14	14	7	11	89	21	16	14	11	4	11	77	86.5%	81.3%
Lakes	6	6	8	5	4	10	39	6	6	7	4	4	9	36	92.3%	89.5%
MidCentral	3	5	11	1	6	11	37	2	4	9	1	5	9	30	81.1%	83.3%
Nelson Marlborough	19	31	24	22	29	32	157	19	26	22	21	23	26	137	87.3%	84.3%
Northland	28	31	35	24	20	28	166	22	23	24	13	12	20	114	68.7%	62.5%
South Canterbury	11	9	3	5	3	5	36	9	7	3	4	3	5	31	86.1%	92.3%
Southern	33	31	33	30	19	22	168	26	24	19	15	11	14	109	64.9%	56.3%
Tairawhiti	10	8	6	7	5	5	41	8	6	6	7	4	4	35	85.4%	88.2%
Taranaki	16	24	19	19	20	18	116	13	22	17	13	14	13	92	79.3%	70.2%
Waikato	23	20	40	25	19	24	151	23	19	35	18	15	19	129	85.4%	76.5%
Wairarapa	10	8	5	11	7	8	49	8	6	5	9	6	8	42	85.7%	88.5%
Waitemata	39	41	49	35	28	46	238	34	37	47	29	24	42	213	89.5%	87.2%
West Coast	7	6	3	2	4	1	23	6	5	2	1	4	0	18	78.3%	71.4%
Whanganui	10	17	6	11	4	6	54	10	14	6	9	3	5	47	87.0%	81.0%
National total	**424**	**431**	**437**	**326**	**329**	**407**	**2354**	**376**	**377**	**380**	**258**	**264**	**349**	**2004**	85.1%	82.0%

June 2021 **Public Board**

31-day indicator (policy priority)

DHB	Expected monthly cancer registrations	Number of records submitted *Patients within the 31-day FCT health target cohort, by month of first treatment*							Number of records within 31 days							Achievement
		Oct	Nov	Dec	Jan	Feb	Mar	Total	Oct	Nov	Dec	Jan	Feb	Mar	Total	Oct 2020 - Mar 2021 Tracking
Auckland	*161*	120	91	144	76	90	124	645	106	83	128	63	76	116	572	88.7%
Bay of Plenty	*115*	102	87	92	80	77	73	511	92	74	86	70	64	65	451	88.3%
Canterbury	*246*	131	134	131	94	122	112	724	124	127	122	76	113	101	663	91.6%
Capital and Coast	*107*	98	88	118	75	79	96	554	80	75	102	60	71	84	472	85.2%
Counties Manukau	*177*	156	154	166	140	131	150	897	131	133	144	110	101	133	752	83.8%
Hawkes Bay	*76*	78	79	76	56	56	79	424	73	71	67	49	48	69	377	88.9%
Hutt Valley	*60*	75	58	54	47	47	53	334	69	54	48	39	45	46	301	90.1%
Lakes	*47*	36	37	35	35	23	26	192	31	35	31	26	22	25	170	88.5%
MidCentral	*81*	67	56	89	45	59	68	384	57	49	79	36	45	62	328	85.4%
Nelson Marlborough	*74*	62	66	79	57	59	73	396	55	60	69	52	52	67	355	89.6%
Northland	*84*	79	99	95	79	67	81	500	59	77	79	52	51	63	381	76.2%
South Canterbury	*34*	23	24	22	19	17	28	133	19	22	21	17	17	26	122	91.7%
Southern	*136*	150	131	124	110	96	119	730	127	112	107	73	73	106	598	81.9%
Tairawhiti	*20*	20	26	19	15	14	12	106	19	23	17	14	13	11	97	91.5%
Taranaki	*57*	61	50	68	42	54	59	334	49	46	59	29	44	56	283	84.7%
Waikato	*161*	139	129	161	128	109	126	792	134	120	152	107	92	100	705	89.0%
Wairarapa	*22*	17	26	25	24	30	22	144	15	25	22	22	27	19	130	90.3%
Waitemata	*222*	163	166	178	135	96	144	882	152	146	160	114	85	134	791	89.7%
West Coast	*17*	14	11	14	13	16	4	72	12	10	13	7	14	3	59	81.9%
Whanganui	*34*	41	48	41	32	22	32	216	37	40	36	28	21	29	191	88.4%
National total	***1929***	**1632**	**1560**	**1731**	**1302**	**1264**	**1481**	**8970**	**1441**	**1382**	**1542**	**1044**	**1074**	**1315**	**7798**	**86.9%**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No
Author	Kilian O'Gorman, Business Support Strategy, Commissioning and Population Health
Endorsed by	Katherine Fraser-Chapple, Acting General Manager Strategy, Commissioning and Population Health
Subject	Confirmed Ministry of Health Quarter 1-3 Results

Recommendations

Management recommend that the Whanganui District Health Board:

- **a.** **Receive** the paper titled Confirmed Ministry of Health Quarter1- 3 Results
- **b.** **Note** the Combined Statutory Advisory Committee discussed provisional results at meetings held 26 February 2021 and 28 May 2021
- **c.** **Note** that results are now final and confirmed by Ministry of Health

1. Purpose

This paper provides the Board with results, confirmed by the Ministry of Health, for Quarters 1, 2 & 3. Item 1 shows results against the Non-Financial Performance Framework and item 2, results against the 2020-21 Annual Plan.

Item 1: Confirmed ratings for Quarter 1-3: Actions included in the Annual Plan 2020-21

Not applicable	Other / Note	Achieved overall	Partially achieved	Not achieved

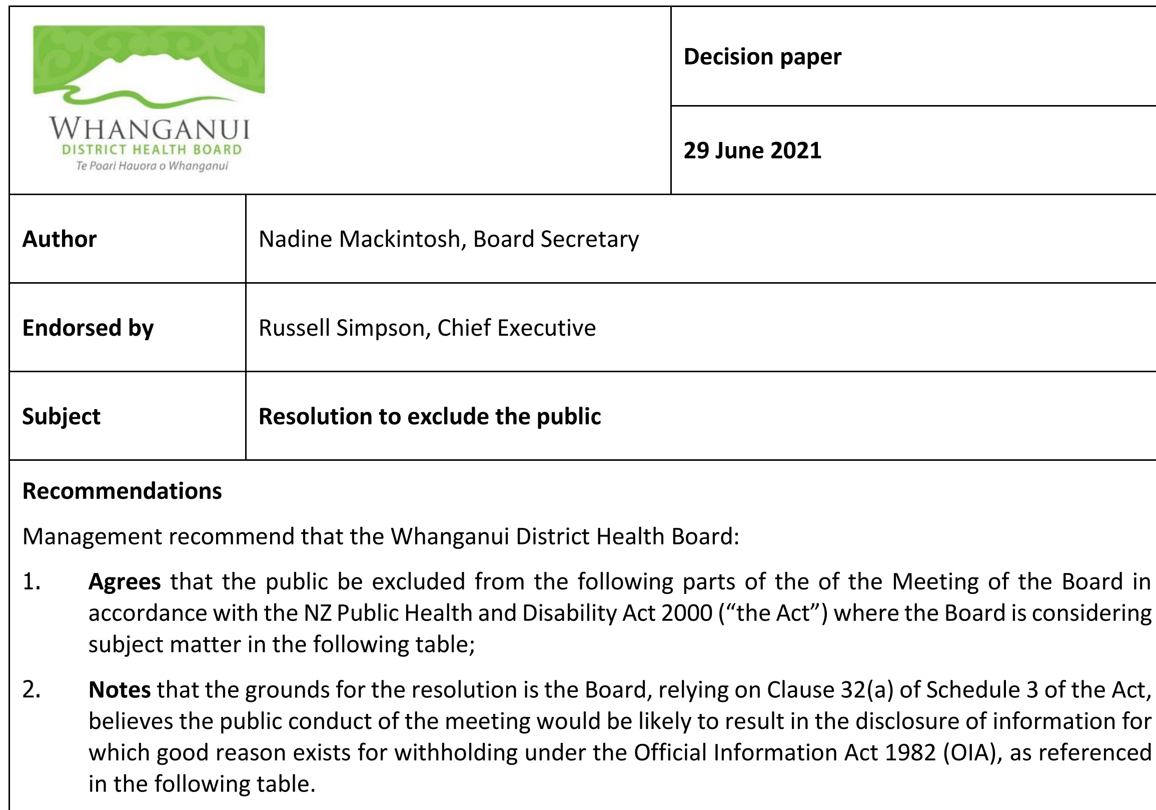
Status update reporting- Actions Included in Annual Plans	Quarter 1 MoH Ratings	Quarter 2 MoH ratings	Quarter 3 MoH ratings
Better population health outcomes supported by primary health care			
Better population health outcomes supported by strong and equitable public health services			
Give practical effect to He Korowai Oranga – the Māori Health Strategy			
Improving Child wellbeing			
Improving Mental wellbeing			
Improving Sustainability			
Improving wellbeing through Prevention			

Item 2: Confirmed Ratings Quarters 1-3 : Non-Financial performance framework measures

Measure	Q-1	Q-2	Q-3	Q-4
Ratings confirmed?	✓	✓	✓	
Key: Achieved / Partial / Not achieved / Not req'd / Update due				
Child-wellbeing				
CW01: Children caries-free at five years of age			Achieved	
CW02: Oral Health- Mean DMFT score at school Year 8			Achieved	
CW03: Improving the number of children enrolled in and accessing the Community Oral Health Service.			Partial	
CW04: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years				Update due
CW05: Immunisation coverage 8 month	Not achieved	Partial	Not achieved	Update due
CW05: Immunisation coverage 5 year	Not achieved	Partial	Not achieved	Update due
CW05: Immunisation coverage HPV				Update due
CW05: Immunisation coverage influenza	Achieved			
CW06: Improving breast- feeding rates	Achieved		Not achieved	
CW07: Improving newborn enrolment in General Practice	Partial	Partial	Achieved	Update due
CW08: Increased Immunisation 2 years	Partial	Partial	Not achieved	Update due
CW09 Better help for smokers to quit (Maternity)		Achieved	Achieved	Update due
CW10: Raising healthy kids	Achieved	Achieved	Achieved	Update due
CW12: Youth mental health	Achieved	Achieved	Achieved	Update due
Mental wellbeing				
MH01: Improving the health status of people with severe mental illness through improved access		Not achieved		Update due
MH02: Improving mental health services using wellness and transition (discharge) planning	Partial	Not achieved	Partial	Update due
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Partial	Achieved	Achieved	Update due
MH04: Mental Health and Addiction Service Development PRIMARY	Achieved	Achieved	Achieved	Update due
MH04: Mental Health and Addiction Service Development SUICIDE PREVENTION	Achieved	Achieved	Achieved	Update due
MH04: Mental Health and Addiction Service Development CRISIS RESPONSE	Partial	Partial	Not achieved	Update due
MH04: Mental Health and Addiction Service Development OUTCOMES FOR CHILDREN	Achieved	Achieved	Achieved	Update due
MH04: Mental Health and Addiction Service Development EMPLOYMENT & PHYSICAL NEEDS	Achieved	Achieved	Achieved	Update due
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Partial	Partial	Partial	Update due
MH06: Output delivery against plan	Partial	Achieved	Achieved	Update due
MH07: Improving mental health services by improving inpatient post discharge follow-up rates	Achieved	Achieved	Achieved	Update due

Measure	Q-1	Q-2	Q-3	Q-4
Primary health care				
PH01: Improving System Integration & SLMs				
PH02: Improving the quality of data collection in PHO and NHI registers		No/report		
PH03: Improving Maori enrolment in PHOs to meet the national average of 90%				
PH04 :Better help for smokers to quit (primary care)			No rating	
Improving wellbeing through prevention				
PV01: Improving breast screening coverage and equity for priority women.				
PV02: Improving cervical screening coverage and equity for priority women.				
Strong and equitable public health and disability system				
SS01: Faster cancer treatment (31 days)				
SS02: Delivery of Regional Service Plans				
SS03: Ensuring delivery of service coverage				
SS04: Implementing the Healthy Ageing Strategy				
SS05: Ambulatory sensitive hospitalisations (ASH adult)		No/report		
SS06: Better help for smokers to quit in public hospitals				
SS07: Planned Care Measures				
SS09: Improving the quality of identity data NHI				
SS09: Improving the quality of identity data NATIONAL COLLECTIONS				
SS09: Improving the quality of identity data PRIMHD				
SS10: Shorter stays in Emergency Departments				
SS11: Faster cancer treatment (62 days)				
SS12: Engagement and obligations as a Treaty partner				
SS13: FA1 Long Term Conditions				
SS13: FA2 Diabetes services				
SS13: FA3 Cardiovascular health				
SS13: FA4 Acute heart services				
SS13: FA5 Stroke services				
SS15: Improving waiting times for colonoscopies				
SS17: Delivery of Whānau Ora				

June 2021 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	Decision paper
	29 June 2021
Author	Nadine Mackintosh, Board Secretary
Endorsed by	Russell Simpson, Chief Executive
Subject	**Resolution to exclude the public**

Recommendations

Management recommend that the Whanganui District Health Board:

1. **Agrees** that the public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table;
2. **Notes** that the grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act, believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists for withholding under the Official Information Act 1982 (OIA), as referenced in the following table.

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 21 April 2021	For reasons set out in the board's agenda of 21 April 2021	As per the board agenda of 21 April 2021
Chief executive's report Committee minutes Committee Chair update Sustainability Initiatives Theatre productivity	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Laboratory and Pathology services Allied Laundry Fair Value Impairment Insurance Renewal Flight procurement	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)

Operating theatres and surgical flow HSC services agreement IPMHA HDC complaint report	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

That the following person(s) may be permitted to remain after the public has been excluded because the board considers that they have knowledge that will help it. The knowledge is possessed by the following persons and relevance of that knowledge to the matters to be discussed follows:

Person(s)	Knowledge possessed	Relevance to discussion
Chief executive, senior managers and clinicians present	Management and operational information about Whanganui District Health Board	Management and operational reporting and advice to the board
Executive Officer	Minute taking, procedural and legal advice and information	Recording minutes of board meetings, advice and information as requested by the board