MDHB Responses to OIAs received April to June 2022

Assaults on Staff (OIA Y22-378)
Stutter services (OIA Y22-380)
Staff assaults on patients (OIA Y22-387)
Lavender Blue funding (OIA Y22-388)
Maternal Mental Health referrals (OIA Y22-389)
Alcohol related harm (OIA Y22-474)
Risk registers (OIA Y22-479)
Board Members (OIA Y22-478)
Specialist wait times (OIA Y22-467)
Commissioned research expenditure (OIA Y22-476)
MH Services staffing (OIA Y22-484)
Gastroenterologists (OIA Y22-470)
COVID-19 therapeutics (OIA Y22-472)
Remdesivir and ventilators (OIA Y22-473)
Complaints by Doctors of Bullying (OIA Y22-480)
Enable NZ Annual report (OIA Y22-482)
Data for Breast screening wait times (OIA Y22-489)
MRT staffing levels and FTE numbers (OIA Y22-486)
ED wait times (OIA Y22-498)
Earthquake-prone buildings (OIA Y22-490)
ED visits following vaccine (OIA Y22-495)
ICPSA policies (OIA Y22-481)
Shortage of theatre nurses (OIA Y22-496)
Legal costs for inquests (OIA Y22-492)
Community Based Attachments (OIA Y22-504)
PGY1 House Officers (OIA Y22-499)
Earthquake prone buildings (OIA Y22-491)
Wait times etc for Oncology, Gynaecology, Orthopaedic, Cardiology (OIA 22-494)
Precocious puberty (OIA Y22-497)
Communications-Media (OIA Y22-500)
Terminations for COVID vaccination non-compliance (OIA Y22-501)
Health Partners Consulting (OIA Y22-506)
Ward 21 safety correspondence (OIA Y22-487, OIA Y22-488)
Seclusion rates (OIA Y22-503)
Seclusion rates 2022 (OIA Y22-503)
Outsourced procedures (OIA Y22-502)
Ward 21 new build (OIA Y22-509)
Certificates issued to local authorities (OIA Y22-511)
COVID-19 frontline staff (OIA Y22-541)
COVID Costs (OIA Y22-543)

9 May 2022

[redacted]

Dear [redacted]

I refer to your Official Information Act request received by email on 6 April 2022 with regard to assaults on staff. The responses to the bullet points below are contained in the attached pages:

- *The number of assaults on staff for years 2018,2019,2020,2021,2022 (to current date)*
- *Could I please have this broken down into minor, moderate, and serious assaults*
- *Could I please have this broken down into physical and sexual assaults*
- *For the assaults deemed moderate and serious, could I please have further details about what role the staff member holds (e.g. nurse, orderly etc), their gender, where they work, if the assault involved a weapon (please specify what the weapon was), what injuries were sustained, and what action was taken as a result (e.g. charges laid, etc).*

Could I also please have a copy of any reports or documents relating to assaults and violence towards staff published in 2020 or 2021.

We do not believe that we have published any documents on assaults and violence against staff in 2020-21.

Please note that although RiskMan is our primary incident recording application, we can only provide data on what is being reported into our system. Also, please note these incidents are where staff members reported assaults on themselves. They do not include patient incidents where a staff member may have been verbally abused.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

Incident number	Incident date	Incident type	Minor/ moderate/ major	Physical	Sexual	verbal	area	Outcome for staff member
23151	01-Jan-18	slapped and scratched	4 Minor	1		1	Mental health inpatient	
23160	02-Jan-18	punched	4 minor	1		1	Mental health inpatient	
23469	22-Jan-18	punched multiple times in head and abdomen, patient then threw equipment and returned to attack staff member again. Police apprehended patient.	2 Major	1			Emergency Department	Bruising/crushing/ Concussion/head injury
23539	29-Jan-18	hitting	4 Minor	1		1	Mental health inpatient	
24034	05-Mar-18	punched	4 Minor	1		1	rehabilitation ward	
24176	16-Mar-18	punched	4 Minor	1		1	medical ward	
24263	20-Mar-18	punched	4 minor	1		1	Mental health inpatient	
24265	19-Mar-18	pushed and hit wall	4 Minor	1			Mental health inpatient	
24617	04-Apr-18	spat and kicked	4 Minor	1		1	Mental health inpatient	
24684	23-Apr-18	hit and pushed	4 Minor	1		1	medical ward	
24858	05-May-18	slapped on face	4 minor	1		1	rehabilitation ward	
25303	04-Jun-18	punched	4 Minor	1		1	Mental health inpatient	
25627	24-Jun-18	punched	4 Minor	1		1	Mental health inpatient	
25925	16-Jun-18	verbal	4 Minor			1	Mental health inpatient	
26326	07-Aug-18	punched	4 Minor	1		1	rehabilitation ward	
26331	08-Aug-18	kicked, scratched	3 Minor	1		1	Mental health inpatient	drew blood from scratches
26344	08-Aug-18	Kicked, punched, scratched	4 Minor	1		1	Mental health inpatient	
26605	25-Aug-18	slapped	4 Minor	1			rehabilitation ward	
26705	01-Sep-18	verbal	4 Minor			1	Emergency Dept	
27137	29-Sep-18	punched	4 Minor	1			Mental health inpatient	
27227	14-Sep-18	hitting	4 Minor	1			surgical ward	
27242	06-Oct-18	slapped on face	4 minor	1			rehabilitation ward	
27250	14-Sep-18	punched	4 Minor	1			surgical ward	
27267	28-Sep-18	scratched	4 minor	1			rehabilitation ward	
27292	12-Oct-18	slapped	4 Minor	1		1	Mental health inpatient	

27311	14-Oct-18	punched	4 Minor	1		rehabilitation ward	
27337	15-Oct-18	slapping	4 Minor	1		rehabilitation ward	
27436	18-Oct-18	verbal	4 Minor		1	community mental health	
27440	21-Oct-18	strangled	3 Minor	1	1	Mental health inpatient	bruising
27445	21-Oct-18	punched	3 minor	1	1	Mental health inpatient	bruising
27535	28-Oct-18	punched	4 minor	1	1	Mental health inpatient	
27592	01-Nov-18	verbal	4 Minor		1	District nursing	
27627	04-Nov-18	punched	4 Minor	1		rehabilitation ward	
27672	07-Nov-18	kicked	4 Minor	1		Mental health inpatient	bruising
27736	11-Nov-18	poked in chest	4 Minor	1		rehabilitation ward	
27744	08-Nov-18	slapped	4 Minor	1		rehabilitation ward	
27893	22-Nov-18	hitting	4 minor	1	1	rehabilitation ward	
28001	26-Nov-18	spat and kicked	4 Minor	1	1	Emergency Dept	
28002	26-Nov-18	spat and punched	4 Minor	1	1	Emergency Dept	
28081	27-Nov-18	verbal	4 minor		1	community mental health	
28082	02-Dec-18	verbal	4 Minor		1	Emergency Dept	
28230	12-Dec-18	hitting	4 Minor	1	1	Mental health inpatient	
28288	10-Dec-18	punching	4 Minor	1	1	medical ward	
28323	16-Dec-18	hitting	4 minor	1		surgical ward	

Incident number	Incident date	Incident type	Minor/moderate/major	Physical	Sexual	verbal	area	Outcome for staff member	Designation	Gender	weapon	action taken
28529	06-Jan-19	hitting	4 minor	1			rehabilitation					
28619	02-Jan-19	head lock	3 minor	1		1	mental health inpatient					
28757	21-Jan-19	verbal	4 minor			1	rehabilitation					
28857	22-Jan-19	verbal	4 minor			1	Renal unit					
28858	24-Jan-19	verbal	4 minor			1	emergency department					
29100	16-Jan-19	verbal and pushing	4 minor	1		1	rehabilitation					
29366	01-Mar-19	verbal	4 minor			1	medical ward					
29368	01-Mar-19	hitting	4 minor	1			mental health inpatient					
29654	24-Mar-19	verbal	4 minor			1	emergency department					
29655	24-Mar	verbal	4 minor			1	emergency department					
29656	18-Mar-19	verbal	4 minor			1	mental health inpatient					
29838	07-Apr-19	hitting	4 minor	1			rehabilitation	bruising				
29937	15-Apr-19	twisted right thumb	4 minor	1			surgical ward	bruising				
30031	18-Apr-19	hitting	4 minor	1			ICU					
30032	18-Apr-19	hitting	4 minor	1			ICU					
30033	18-Apr-19	hitting	4 minor	1			ICU					
30117	29-Apr-19	verbal	4 minor			1	Renal unit					
30765	14-Jun-19	punched	4 minor	1			mental health inpatient					
30768	14-Jun-19	pushed	4 minor	1			rehabilitation					
31083	07-Jul-19	strangle and push off chair	3 moderate	1			mental health inpatient	bruising, concussion, cut	registered nurse	Female	No	time off work, psychological input
31279	19-Jul-19	scratch	4 minor	1			rehabilitation					
31389	26-Jul-19	squeezing	4 minor	1			rehabilitation					
31522	05-Aug-19	punched	3 moderate	1			mental health inpatient	cut to inside mouth/lip	health care assistant	male	no	reported to police/ no charges laid
31569	07-Aug-19	kicked	4 minor	1			rehabilitation					

31689	16-Aug-19	pushed	4 minor	1	1	community mental health
31719	16-Aug-19	pushed	4 minor	1	1	community mental health
32030	10-Sep-19	punching	4 minor	1	1	mental health inpatient
32237	24-Sep-19	punched, scratched	4 minor	1		medical ward
32289	28-Sep-19	hitting	4 minor	1	1	rehabilitation
32357	03-Oct-19	thrown hot coffee	4 minor	1	1	mental health inpatient
32818	04-Nov-19	scratch	4 minor	1	1	rehabilitation
32935	12-Nov-19	punched	4 minor	1		mental health inpatient
32943	13-Nov-19	kicked	4 minor	1		mental health inpatient
33088	24-Nov-19	kicked	4 minor	1		rehabilitation
33392	17-Dec-19	punched	4 minor	1		rehabilitation

Incident number	Incident date	Incident type	Minor/moderate/ major	Physical	Sexual	verbal	area	Outcome for staff member	Gender	weapon	action taken
Nil											

Incident number	Incident date	Incident type	Minor/moderate/major	Physical	Sexual	verbal	area	Outcome for staff member	Gender	weapon	action taken
41759	07-Jun-21	crushing of fingers	4 minor	1			mental health inpatient				
41790	05-Jun-21	pulled thumb back	4 minor	1			radiation oncology				
41958	19-Jun-21	hitting	4 minor	1			mental health inpatient				

Incident number	Incident date	Incident type	Minor/moderate/major	Physical	Sexual	verbal	area	Outcome for staff member	designation	Gender	weapon	action taken
45771	25-Jan-22	hitting	4 minor	1		1	mental health inpatient					
45846	30-Jan-22	spitting	4 minor	1		1	Rehabilitation					
45935	17-Jan-22	thrown	3 minor	1		1	mental health inpatient	time off work, psychological	Health care assistant	female	no	nil
46020	09-Feb-22	hitting	4 minor	1		1	medical ward					
46371	24-Feb-22	hitting/stricking out	4 minor	1		1	mental health inpatient					
46439	10-Mar-22	hitting	4 minor	1		1	Rehabilitation					
46477	14-Mar-22	scratched	4 minor	1			mental health inpatient					
46490	14-Mar-22	hitting/punching	4 minor	1		1	Emergency Department					
46597	23-Mar-22	hitting	4 minor	1		1	mental health inpatient					
46599	23-Mar-22	punching	4 minor	1		1	mental health inpatient					
46600	23-Mar-22	punching	4 minor	1		1	mental health inpatient					
46754	03-Apr-22	scratched	4 minor	1		1	mental health inpatient					

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

11 April 2022

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Fox (06) 355 0616

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New Zealand

[redacted]

Dear [redacted]

Official Information Act {OIA) Request Y22-380

As you are aware, your recent OIA request has been partially transferred to District Health Boards by the Ministry of Health under section 14(b)(ii) of the Official Information Act.

The following information is provided as it pertains to MidCentral District Health Board (MDHB).

1. **Whether you do provide services for people who stutter?**

   No. Ifwe were to receive a referral (rarely), we would generally recommend START or another specialist programme as a more appropriate option.

2. **If you do provide services for people who stutter, would you please advise:**
   - **How many people who stutter that you have worked with in the last year including a breakdown of their ages and ethnicities.**
   - **The type of services that you provided, e.g. individual speech therapy, group programmes.**
   - **The number of sessions of individual speech therapy you provided in the last year.**
   - **The number of any other programmes etc that you offered and the number of participants in these programmes.**

   See above.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Director

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

4 May 2022

[redacted]

[redacted]

Dear [redacted]

I refer to your Official Information Act request transferred from the Ministry of Health and received by email on 11 April 2022 with regard to your request for information relating to staff investigations of assaults on patients and respond as follows:

The timeframe for the requested information was clarified as being for:

"All DHB records and records before DHBs set-up."

The Ministry of Health have advised you to contact Archives NZ for information predating the establishment of the DHBs in 2001.

"Can ministry of health please email me aggragated staff investigations of assaults on patients ie staff fired, investigated and resigning before being fired / criminal charges being laid / withdrawn by victim?"

As far as investigations for the period 2001 – 2022, the following two instances are from information we have to hand for the period 2002-2022:

	Patient Complaint of Assault by MDHB Staff member	Outcome	Criminal Charges Laid
2016	1	Staff member resigned before investigation completed	The matter was referred to the police
	1	Staff member resigned as investigation findings were about to be completed	The matter was referred to the police

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

26 April 2022

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[redacted]

[redacted]

Dear [redacted]

Official Information Act (OIA) Request Y22-388
OIA REQUEST: Funding for home care operators

Thank you for your request for official information received on 12 April 2022 for:

Information on funding for home care operators

We have set our response to the questions that you pose below (for ease of reference we have included the text of your questions in bold).

1. **I would like to Know How many people needing personal cares have been assigned to Lavender Blue Care agency in Palmerston North between t St April 2021 and 31st March 2022. Some may be for Home management and personal care or just personal care. So everyone with personal care requirements?**

   The data that MidCentral District Health Board (MDHB) has been provided with for this period is 997 clients.

2. **How is funding paid to the care agency is it bulk funded on a defined period ie weekly, monthly, yearly or do the care agencies invoice Mid Central?**

   Home and community support providers are paid fortnightly by the Ministry of Health payment services for the hours claimed.

MDHB contracts with Lavender Blue, one of three providers to deliver home and community support services within the MDHB area. As a contracted provider MDHB can request data when required and has not provided any personal details of the requestor to Lavender Blue regarding this current request. MDHB does not have any knowledge of the employees at Lavender Blue or their employment relationships or roles within Lavender Blue.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

29 April 2022

[redacted]

Dear [redacted]

We are in receipt of your Official Information request dated 16 April 2022.

You advised that you would like the following information as stated below:

1. **The number of women referred to Maternal Mental Health to MidCentral DHB in 2021 and the number that were accepted.**

There were 108 women referred to specialist maternal mental health at MidCentral DHB in 2021. All referrals are accepted.

2. **The current wait times for Maternal Mental Health in MidCentral DHB.**

Once a referral is received it is actively managed and most women are seen within seven days. We do not have a waitlist.

For urgent and crisis maternal mental health presentations, these whānau whaiora are seen by the acute care team immediately then if necessary, followed up with the maternal mental health team.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Scott Ambridge
Operations Executive

Te Uru Rauhī - Mental Health & Addictions Services
PN Hospital, Private Mail Bag 11036, PALMERSTON NORTH
Phone: + 64 (6) 350 8354

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

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12 May 2022

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

As you are aware, your recent OJA request has been transferred to District Health Boards by the Ministry of Health under section 14 of the Official Information Act. Therefore, the following data has been provided as it pertains to MidCentral District Health Board (MDHB).

Information has been requested in regard to alcohol related inpatient admissions and alcohol related treatments. Hospital inpatient admissions were for health conditions purely attributable to alcohol and also for people who attended the Emergency Department (ED) and were then admitted as inpatients where the ED staff had marked the attendance as alcohol related.

Hospital treatments were treatments signalled by health practitioners as attributable to alcohol. They consisted of;

- ED attendances which were marked as alcohol related by ED staff.
- Outpatient appointments for medical conditions purely attributable to alcohol.
- Mental Health appointments where alcohol was mentioned as one of the diagnoses.

Limitations of the Data

Data was requested from 2012 onwards. However, some of the data couldn't be marked as alcohol related until the introduction of our new patient management system, Web PAS, in late 2017. This affected the ED data and general (non Mental Health) outpatient data.

MDHB's treatment costing system was not introduced until 2017, so for most treatments costing before 2017 was not possible.

The information requested was;

- **Please provide a yearly breakdown of how many people were treated from 2012-2022 (to date) for alcohol related harm.**
- **Please provide a yearly breakdown of age groups of those treated in your DHB between 2012-2022 for alcohol related harm.**

- **Please provide a yearly breakdown of the ethnicity of those treated in your DHB from 2012-2022 for alcohol related harm.**
- **Please provide a yearly breakdown of age groups of those admitted to your DHB from 2012-2022 for alcohol related harm.**
- **Please provide a yearly breakdown of ethnicity of those admitted to your DHB from 2012-2022 for alcohol related harm.**
- **Please provide a yearly breakdown of age groups of those admitted to your DHB from 2012-2022 for alcohol related harm.**
- **Please provide a yearly breakdown of the cost for each person treated/admitted in your DHB for alcohol related causes.**
- **Please provide a breakdown of how many patients were admitted to EDs where alcohol was determined to be a factor in their admission from 2012-2022.**

The MDHB alcohol related admissions consists of two types of admissions;

- Patients admitted for a medical condition which is directly attributable to alcohol.
- Patients who were seen at ED, admitted to hospital, and their ED attendance was recorded by ED clinical staff as alcohol involved. This would cover those patients experiencing injury because of the influence of alcohol.

The medical conditions directly attributable to alcohol were (with ICD-10 coding);

- F10 Mental and behavioural disorders due to use of alcohol.
  - .0 Acute intoxication (includes drunkenness, pathological alcohol intoxication, and hangover effects)
  - .1 Harmful use
  - .2 Dependence syndrome
  - .3 Withdrawal state
  - .4 Withdrawal state with delirium
  - .5 Psychotic disorder
  - .6 Amnesic syndrome
  - .7 Residual and late-onset psychotic disorders
  - .8 Other mental and behavioural disorders
  - .9 Unspecified mental and behavioural disorders

- G32.2 Degeneration of nervous system due to alcohol (cerebellar ataxia or degeneration, cerebral degeneration, encephalopathy, dysfunction of autonomic nervous system due to alcohol).

- G62.1 Alcoholic polyneuropathy

- G72.1 Alcoholic myopathy

- 142.6 Alcoholic cardiomyopathy

- K29.2 Alcoholic gastritis

- K70 and sub-codes Alcoholic liver disease
- KSS.2 Alcohol-induced acute pancreatitis
- K86.0 Alcohol-induced chronic pancreatitis
- Q86.0 Foetal alcohol syndrome (dysmorphic)
- P04.3 Foetus and newborn affected by maternal use of alcohol

MOHS Number of Alcohol Related Admissions by Year: 2012 to April 2022

Year	No. of Admissions
2012	66
2013	48
2014	77
2015	57
2016	67
2017	91
2018	154
2019	119
2020	123
2021	110
2022	80

MDHB Number of Alcohol Related Admissions by Age Group: 2012 to April 2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
00-04	0	0	0	0	0	1	0	0	1	0	1
10-14	1	1	1	0	0	0	0	1	0	0	0
15-19	1	1	2	4	0	2	5	5	2	2	2
20-24	0	1	0	1	2	2	8	6	9	6	1
25-29	1	4	1	2	2	0	8	7	10	8	3
30-34	2	1	3	3	4	14	11	5	7	11	4
35-39	13	3	2	2	1	10	21	10	7	9	8
40-44	7	8	18	5	10	8	16	7	11	10	2
45-49	9	7	15	12	10	12	17	9	11	9	4
50-54	8	8	12	8	12	9	15	15	19	19	6
55-59	7	2	4	11	6	11	19	28	17	16	6
60-64	1	7	8	3	11	11	11	8	13	4	4
65-69	4	2	8	3	0	5	7	7	8	4	5
70-74	6	2	2	2	6	5	9	5	6	7	1
75-79	5	0	1	1	2	1	5	3	1	3	2
80-84	1	1	0	0	1	0	1	2	0	1	1
85-89	0	0	0	0	0	0	1	1	1	1	0

MOHS Alcohol-Related Admissions by Age Group Proportions: 2012 to April 2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
00-04	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.01	0.00	0.02
10-14	0.02	0.02	0.01	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00
15-19	0.02	0.02	0.03	0.07	0.00	0.02	0.03	0.04	0.02	0.02	0.04
20-24	0.00	0.02	0.00	0.02	0.03	0.02	0.05	0.05	0.07	0.05	0.02
25-29	0.02	0.08	0.01	0.04	0.03	0.00	0.05	0.06	0.08	0.07	0.06
30-34	0.03	0.02	0.04	0.05	0.06	0.15	0.07	0.04	0.06	0.10	0.08
35-39	0.20	0.06	0.03	0.04	0.01	0.11	0.14	0.08	0.06	0.08	0.16
40-44	0.11	0.17	0.23	0.09	0.15	0.09	0.10	0.06	0.09	0.09	0.04
45-49	0.14	0.15	0.19	0.21	0.15	0.13	0.11	0.08	0.09	0.08	0.08
50-54	0.12	0.17	0.16	0.14	0.18	0.10	0.10	0.13	0.15	0.17	0.12
55-59	0.11	0.04	0.05	0.19	0.09	0.12	0.12	0.24	0.14	0.15	0.12
60-64	0.02	0.15	0.10	0.05	0.16	0.12	0.07	0.07	0.11	0.04	0.08
65-69	0.06	0.04	0.10	0.05	0.00	0.05	0.05	0.06	0.07	0.04	0.10
70-74	0.09	0.04	0.03	0.04	0.09	0.05	0.06	0.04	0.05	0.06	0.02
75-79	0.08	0.00	0.01	0.02	0.03	0.01	0.03	0.03	0.01	0.03	0.04
80-84	0.02	0.02	0.00	0.00	0.01	0.00	0.01	0.02	0.00	0.01	0.02
85-89	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.01	0.00

MOHS Number of Alcohol Related Admissions by Ethnicity: 2012 to April2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Asian	0	0	1	2	0	2	3	2	3	1	5
European	59	41	55	46	48	72	116	94	86	77	40
Maori	5	7	20	8	17	14	28	17	29	29	5
Not Stated	1	0	1	1	0	0	0	2	0	0	0
Other	0	0	0	0	0	2	6	1	2	1	0
Pacific Is.	1	0	0	0	2	1	1	3	3	2	0

MOHS Alcohol Related Admissions by Ethnicity Proportions: 2012 to April 2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Asian	0.00	0.00	0.01	0.04	0.00	0.02	0.02	0.02	0.02	0.01	0.1
European	0.89	0.85	0.71	0.81	0.72	0.79	0.75	0.79	0.70	0.70	0.8
Maori	0.08	0.15	0.26	0.14	0.25	0.15	0.18	0.14	0.24	0.26	0.1
Not Stated	0.02	0.00	0.01	0.02	0.00	0.00	0.00	0.02	0.00	0.00	0.0
Other	0.00	0.00	0.00	0.00	0.00	0.02	0.04	0.01	0.02	0.01	0.0
Pacific Is.	0.02	0.00	0.00	0.00	0.03	0.01	0.01	0.03	0.02	0.02	0.0

MDHB Alcohol Related ED Attendances

NB: The alcohol involved flag for ED attendances has only been available since our new patient management was implemented in December 2017 - therefore, previous years are not available.

MOHS Number of Alcohol-Related ED Attendances by Year, 2017 to April2022

Year	No. of Attendances
2017	75
2018	591
2019	416
2020	451
2021	493
2022	130

MOHS Number of Alcohol-Related ED Attendances by Age Group, 2017 to April 2022

	2017	2018	2019	2020	2021	2022
00-04	0	1	4	1	1	0
05-09	0	1	0	0	0	0
10-14	1	2	4	2	3	3
15-19	12	101	63	68	68	18
20-24	19	138	73	98	96	21
25-29	6	81	46	61	71	17
30-34	6	49	45	35	40	12
35-39	6	28	28	28	40	12
40-44	5	39	29	36	30	9
45-49	6	34	23	26	24	4
50-54	3	34	14	21	36	8
55-59	3	29	39	31	31	7
60-64	4	18	11	21	19	6
65-69	1	14	15	7	10	5
70-74	3	9	9	9	13	1
75-79	0	8	6	2	7	4
80-84	0	3	5	1	2	1
85-89	0	1	1	4	2	1
90+	0	1	1	0	0	0

MDHB Alcohol Related ED Attendances by Age Group Proportions: 2017 to April 2022

	2017	2018	2019	2020	2021	2022
00-04	0.00	0.00	0.01	0.00	0.00	0.00
05-09	0.00	0.00	0.00	0.00	0.00	0.00
10-14	0.01	0.00	0.01	0.00	0.01	0.02
15-19	0.16	0.17	0.15	0.15	0.14	0.14
20-24	0.25	0.23	0.18	0.22	0.19	0.16
25-29	0.08	0.14	0.11	0.14	0.14	0.13
30-34	0.08	0.08	0.11	0.08	0.08	0.09
35-39	0.08	0.05	0.07	0.06	0.08	0.09
40-44	0.07	0.07	0.07	0.08	0.06	0.07
45-49	0.08	0.06	0.06	0.06	0.05	0.03
50-54	0.04	0.06	0.03	0.05	0.07	0.06
55-59	0.04	0.05	0.09	0.07	0.06	0.05
60-64	0.05	0.03	0.03	0.05	0.04	0.05
65-69	0.01	0.02	0.04	0.02	0.02	0.04
70-74	0.04	0.02	0.02	0.02	0.03	0.01
75-79	0.00	0.01	0.01	0.00	0.01	0.03
80-84	0.00	0.01	0.01	0.00	0.00	0.01
85-89	0.00	0.00	0.00	0.01	0.00	0.01
90+	0.00	0.00	0.00	0.00	0.00	0.00

MDHB Number Alcohol Related ED Attendances by Ethnicity: 2017 to April2022

	2017	2018	2019	2020	2021	2022
Asian	1	10	7	13	10	6
European	50	376	261	276	300	80
Maori	20	172	126	140	165	41
Not Stated	0	7	3	5	2	1
Other	1	8	5	2	2	0
Pacific Is.	3	18	14	15	14	2

MDHB Alcohol Related ED Attendances by Ethnicity Proportions: 2017 to April 2022

	2017	2018	2019	2020	2021	2022
Asian	0.01	0.02	0.02	0.03	0.02	0.05
European	0.67	0.64	0.63	0.61	0.61	0.62
Maori	0.27	0.29	0.30	0.31	0.33	0.32
Not Stated	0.00	0.01	0.01	0.01	0.00	0.01
Other	0.01	0.01	0.01	0.00	0.00	0.00
Pacific Is.	0.04	0.03	0.03	0.03	0.03	0.02

MDHB Alcohol Related Outpatient (non Mental Health) Attendances

These are general hospital outpatient attendances (non Mental Health) for health conditions purely attributable to alcohol (the conditions listed earlier in the document). The recording of these reasons has only been available with our new patient management system, which was adopted in December 2017.

MDHB Number of Alcohol Related General Hospital (non Mental Health) Outpatient Attendances by Year: 2018 to April 2022

Year	No of Attendances
2018	6
2019	16
2020	20
2021	28
2022	3

MDHB Number of Alcohol Related General Hospital (non Mental Health) Outpatient Attendances by Age Group and Year: 2018 to April 2022

	2018	2019	2020	2021	2022
00-04	1	0	0	2	0
05-09	0	1	2	1	0
10-14	0	3	4	0	0
15-19	0	0	0	0	0
20-24	0	0	0	0	0
25-29	0	0	0	0	0
30-34	0	2	2	0	0
35-39	0	0	1	0	0
40-44	0	0	0	1	0
45-49	1	0	0	0	0
50-54	0	1	0	1	1
55-59	1	5	4	3	0
60-64	0	2	1	5	0
65-69	3	1	0	1	0
70-74	0	0	2	13	1
75-79	0	1	0	0	1
80-84	0	0	4	0	0
85-89	0	0	0	0	0
90+	0	0	0	0	0

MDHB Alcohol Related General Hospital /non Mental HealthJ Outpatient Attendances bv Age Group Proportions: 2018 to April 2022

	2018	2019	2020	2021	2022
00-04	0.17	0.00	0.00	0.07	0.00
05-09	0.00	0.06	0.10	0.04	0.00
10-14	0.00	0.19	0.20	0.00	0.00
15-19	0.00	0.00	0.00	0.00	0.00
20-24	0.00	0.00	0.00	0.00	0.00
25-29	0.00	0.00	0.00	0.00	0.00
30-34	0.00	0.12	0.10	0.00	0.00
35-39	0.00	0.00	0.05	0.00	0.00
40-44	0.00	0.00	0.00	0.04	0.00
45-49	0.17	0.00	0.00	0.00	0.00
50-54	0.00	0.06	0.00	0.04	0.33
55-59	0.17	0.31	0.20	0.11	0.00
60-64	0.00	0.12	0.05	0.19	0.00
65-69	0.50	0.06	0.00	0.04	0.00
70-74	0.00	0.00	0.10	0.48	0.33
75-79	0.00	0.06	0.00	0.00	0.33
80-84	0.00	0.00	0.20	0.00	0.00
85-89	0.00	0.00	0.00	0.00	0.00
90+	0.00	0.00	0.00	0.00	0.00

MDHB Number o fAlcohol Related General Hospital /non Mental HealthJ Outpatient Attendances b v Ethnicity and Year: 2018 to April 2022

	2018	2019	2020	2021	2022
European	5	12	14	26	3
Maori	1	4	6	2	0

MDHB Alcohol Related General Hospital /non Mental HealthJ Outpatient Attendances b v Ethnicity Proportions: 2018 to April 2022

	2018	2019	2020	2021	2022
European	0.83	0.75	0.7	0.93	1
Maori	0.17	0.25	0.3	0.07	0

MDHB Alcohol Related Mental Health Outpatient Attendances

These attendances are Mental Health outpatient attendances where alcohol was recorded as being a factor in their illness.

MDHB Number of Alcohol Related Mental Health Outpatient Attendances by Year: 2012 to April 2022

Year	No. of Attendances
2012	146
2013	97
2014	213
2015	249
2016	562
2017	1,343
2018	2,343
2019	1,885
2020	1,264
2021	586

MDHB Number of Alcohol Related Mental Health Outpatient Attendances by Age Group and Year: 2012 to April 2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
00-04	0	0	0	0	0	0	0	0	0	0
05-09	0	0	0	0	0	0	0	0	7	0
10-14	0	0	0	0	0	0	0	0	0	0
15-19	0	0	0	0	0	0	12	27	12	17
20-24	0	0	0	0	0	41	111	68	36	63
25-29	0	0	0	0	52	73	60	62	113	18
30-34	0	62	0	0	79	68	206	123	89	52
35-39	19	0	0	0	64	31	208	341	160	84
40-44	56	0	43	0	45	110	355	225	146	64
45-49	0	0	52	0	30	205	321	118	112	70
50-54	32	0	0	180	128	247	546	210	172	26
55-59	39	35	64	0	92	173	157	340	219	41
60-64	0	0	54	0	0	102	150	279	92	46
65-69	0	0	0	69	49	100	116	48	96	43
70-74	0	0	0	0	0	61	72	8	4	62
75-79	0	0	0	0	0	125	25	16	6	0
80-84	0	0	0	0	23	7	4	20	0	0
85-89	0	0	0	0	0	0	0	0	0	0
90+	0	0	0	0	0	0	0	0	0	0

MDHB Alcohol Related Mental Health Outpatient Attendances by Age Group Proportions: 2012 to April 2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
00-04	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
05-09	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00
10-14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
15-19	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.03
20-24	0.00	0.00	0.00	0.00	0.00	0.03	0.05	0.04	0.03	0.11
25-29	0.00	0.00	0.00	0.00	0.09	0.05	0.03	0.03	0.09	0.03
30-34	0.00	0.64	0.00	0.00	0.14	0.05	0.09	0.07	0.07	0.09
35-39	0.13	0.00	0.00	0.00	0.11	0.02	0.09	0.18	0.13	0.14
40-44	0.38	0.00	0.20	0.00	0.08	0.08	0.15	0.12	0.12	0.11
45-49	0.00	0.00	0.24	0.00	0.05	0.15	0.14	0.06	0.09	0.12
50-54	0.22	0.00	0.00	0.72	0.23	0.18	0.23	0.11	0.14	0.04
55-59	0.27	0.36	0.30	0.00	0.16	0.13	0.07	0.18	0.17	0.07
60-64	0.00	0.00	0.25	0.00	0.00	0.08	0.06	0.15	0.07	0.08
65-69	0.00	0.00	0.00	0.28	0.09	0.07	0.05	0.03	0.08	0.07
70-74	0.00	0.00	0.00	0.00	0.00	0.05	0.03	0.00	0.00	0.11
75-79	0.00	0.00	0.00	0.00	0.00	0.09	0.01	0.01	0.00	0.00
80-84	0.00	0.00	0.00	0.00	0.04	0.01	0.00	0.01	0.00	0.00
85-89	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
90+	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

MDHB Number of Alcohol Related Mental Health Outpatient Attendances by Ethnicity and Year: 2012 to April 2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Asian	0	0	0	0	52	4	12	31	10	4
European	90	97	149	182	361	1137	1743	1601	992	418
Maori	56	0	64	67	113	202	527	227	212	125
Not Stated	0	0	0	0	0	0	0	3	5	0
Other	0	0	0	0	12	0	38	15	45	18
Pacific Is.	0	0	0	0	24	0	23	8	0	21

MDHB Alcohol Related Mental Health Outpatient Attendances by Ethnicity Proportions: 2012 to April 2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Asian	0.00	0	0.0	0.00	0.09	0.00	0.01	0.02	0.01	0.01
European	0.62	1	0.7	0.73	0.64	0.85	0.74	0.85	0.78	0.71
Maori	0.38	0	0.3	0.27	0.20	0.15	0.22	0.12	0.17	0.21
Not Stated	0.00	0	0.0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	0.00	0	0.0	0.00	0.02	0.00	0.02	0.01	0.04	0.03
Pacific Is.	0.00	0	0.0	0.00	0.04	0.00	0.01	0.00	0.00	0.04

Estimated General Hospital Outpatient Costs

First Specialist Assessment Alcohol Related General Hospital Outpatient Costs On dollars}

Year	No. of Bookings	Total Cost/ Dollars
2018	3	1,506
2019	6	3,012
2020	16	8,032
2021	21	10,542
2022	2	1,004

Follow-Up Bookings Alcohol Related General Hospital Outpatient Costs fin dollars]

Year	No. of Bookinas	Total Cost/Dollars
2018	3	939
2019	10	3,130
2020	4	1,252
2021	7	2,191
2022	1	313

Estimated Inpatient Costs

The costs were estimated using the hospital's CostPro costing system, which was implemented in 2017. Costing before 2017 are not available.

MDHB Alcohol Related Inpatient Admissions Estimated Costs: 2012 to April 2022

Year	No. of Admissions	Average Cost per Admission/Dollars	Total Cost/Dollars
2012	66	NaN	NaN
2013	48	NaN	NaN
2014	77	NaN	NaN
2015	57	NaN	NaN
2016	67	NaN	NaN
2017	91	8,496.252	773,159.0
2018	154	6,844.723	1,054,087.4
2019	119	7,642.191	909,420.7
2020	123	10,015.740	1,231,936.0
2021	110	11,805.387	1,298,592.6
2022	SO	7,411.606	370,580.3

Estimated Cost of ED Attendances for Alcohol Related Reasons

MOHS Alcohol Related ED Attendance Estimated Costs: 2017 to April 2022

Year	No. of Attendances	Average Cost per Attendance/ Dollars	Total Cost/ Dollars
2017	75	129.44	9,708.00
2018	591	152.91	90,369.81
2019	416	142.68	59,354.88
2020	451	163.72	73,837.72
2021	493	168.96	83,297.28
2022	130	213.03	27,693.90

Estimated Cost of Mental Health Community *(non* inpatient) Attendances

MOHS Mental Health Outpatient Consultation Costs: 2012 to April 2022

Year	No. Patients Seen	Average Cost per Patient/ Dollars	Total Cost/Dollars
2012	4	6,991.80	27,967.20
2013	2	8,039.28	16,078.56
2014	4	13,355.80	53,423.20
2015	8	5,891.00	47,128.00
2016	20	5,413.18	108,263.68
2017	74	2,830.00	209,420.32
2018	181	1,990.60	360,298.72
2019	136	2,166.49	294,642.88
2020	98	1,842.79	180,593.12
2021	47	1,727.39	81,187.44

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

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New Zealand

13 May 2022

[redacted]

Ref: Y22-479

Dear [redacted]

In response to your Official Information Act 1982 requesting access to MidCentral District Health Board's risk register, please find attached a complete list of MidCentral DHB's recorded risk register.

If you are not satisfied with this response you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely,

Neil Wanden
General Manager, Finance & Corporate Services

Name

Service	(None Entered)
Medication error	
Patient fall	
Prescribing errors undetected	
Malfunctioning of medication fridges restricting usability	
Late presentation of HIV patients	
Misfiling of the patient file	
Failure of current PABX system	
Care of patients potentially compromised by the physical environment	
Significant system outage for considerable length of time	
Insufficient beds available on Ward 23 to meet fluctuating demand on all days	
Loss of power to organisation due to failure of substation (s)	
Non compliance	
Adverse Event resulting in poor patient outcome	
Inability to meet 'Shorter Stays in Emergency Department' key target	
Failure of computer network	
Insufficient Staff Bureau daily resource requirement	
Mislabelling of patient information	
Hospital acquired pressure injury	
Delayed access to services impacting on Patient Flow ???	
No facility for e-referrals within the current I.T infrastructure	
Misfiling of paper work in the patient file	
Faulty and/or Malfunctioning Equipment	
Undesirable/Challenging behaviour of patients/clients/and/or visitors	
Insulin prescribing and administration errors	
Safety of MCH staff working in the community	
Service loss due to failure of one or more SAN(s)	
Theft and/or Destruction/damage/loss of hospital property by patients/clients/visitors/staff/members of the public	
Insufficient clinical equipment and/or supplies throughout MCH compromises patient care	
Unprofessional conduct/attitude of staff working @ MDHB	

Name
Patient care maybe compromised due to no and/or inadequate/incomplete handover
Patient/Client care maybe compromised due to patients/clients self discharging against medical advice, attempting to abscond and/or AWOL
Delay in blood/specimen results impacts on patient care
Lack of or incomplete/inaccurate documentation may compromise patient care
Pretransfusion specimen labelling errors
Inability to meet the needs of the increasing number of 'People of Significant Size' (150kg) Bariatric
Delay in provision of treatment/patient care
Insufficient physical space within the Ambulatory Care department to accommodate individual service growth
Inability to lockdown the Facility (Horowhenua Health Centre)
Unaccounted for medications
Inappropriate use of Physical Restraint
Unsafe /adhoc storage of Mental Health clinical records
Risk of damage due to seismic activity
Infrastructure security
Loss of financial sustainability
Quality and Safety of patient care
Culture, accountabilities and escalation
Health and Safety for staff, contractors and volunteers
Relationship/Partnering
Infrastructure
Workforce pressures
Inability to meet community health needs and models of care
Capacity to support innovation
Major Incident Management
Breach of privacy
Unauthorised/compromised access of ICT systems
Infrastructure Capacity
Regional solutions stability and performance
Age and obsolescence of internal utilities /infrastructure /systems
Infrastructure configuration shortfalls

Name
Legislative Compliance
Regional Cloud Solutions
Loss of Tier 1 3rd party hosted solutions
Regional hosted systems (Disaster Recovery)
MCIS/NCIS - Electronic Clinical Record
Contractor unable to meet Contract deadline (4)
Unsafe work practices and unsafe work environment
Service deliverables not fully covered by current funding
Workforce pressures
Design and/or building works not completed to a satisfactory standard on time
Loss of market share
Dispute between the Contractor, Client and ACC
Loss of organisational reputation
Workforce Capability for the future.
Password Security
End of life application
Data and Information Security
Fire Safety Systems
Instability of the staff health Access Database held by Infection Prevention
Facility limitations to safe healthcare delivery
Inventory Control
Inability to maintain safe levels of chlorine in the water for haemodialyis in accordance with international guidelines
Variance indicator reporting
Baby/Child Abduction
Operating within agreed budget
Workforce acorss Te Uru Pa Harakeke
Oranga Tamariki responsiveness and action impacting on DHB social workers and health teams
LMC handover to secondary care
End of life - MS access applications
Data Management

Name
Inability to deliver timely psychology care within children across the district
Delivery of high quality care in Uru Pa Harakeke
Breech of Confidentiality
Product recall bed lever
Fatigue
Ability to provide ongoing operation of the Primary Birthing Centre due to midwifery staffing
Project time frame
Project scope becomes unaffordable
Loss/disruption of Business Continuum (including dust, noise and vibration)
Finished facilities fail to meet standards/operational requirements
Key person(s) dependency (retention/recruitment)
Contractor Management
Capacity to support sufficient follow up of outpatients
Existing Plant & Infrastructure
Maori Health Te Tiriti Responsiveness
Health Inequity
Care closer to home
Family Violence Intervention Programme (FVIP)
Ultrasound risk Te uru pa harakeke
Gastroenterology Service Delivery
Project Overrun
Lack of dedicated resource - key person(s) dependency (inability to retain/recruit)
Project scope becomes unaffordable
Finished facility fails to meet standards/operational requirements
Inability to recruit Radiologists
Timely access to inpatient treatment
Mosaiq Server/Storage - end of life
Introduction into Service (Mindray Anaesthetic Machine and Monitors)
Legacy Digital Infrastructure
Finished facilities fail to meet standards/operational requirements

Name
Project scope becomes unaffordable
Project time frame
Safety in Design as a PCBU
Patient care is compromised due to incomplete documentation for MCIS
Health Sector Transition
Potential for patient safety to be compromised due to current clinical layout of the rooms being used to treat patients in the Medical Oncology Day Ward

Service Acute Mental Health

Inappropriate and/or Aggressive/Assaultive threatening behaviour to staff and/or other clients
Inappropriate inpatient environment for Adolescent Mental Health clients
Patients/clients self harming or attempting to self harm on Ward 21.
Unreliability of Duress Alarms in Ward 21
Delay in triage of patients as an outcome of competing demands
Lack of communication with families of clients
Physical environment not fit for purpose for a Mental Health Inpatient Unit
Inability to staff inpatient unit (Older Adult Mental Health) with SPEC trained staff

Service Anaesthetics

Non compliance with ANZCA requirements may result in loss of training status
Unsuitable environment results in lack of patient privacy in DOSA and non compliance with Health and Disability Sector Standards
Lack of after hours echocardiography and pacemaker/ICD service

Service Breast Imaging

Inadequate succession options for specialist workforce
MRT workforce at greater than normal risk of injury due to physical requirements of mammography
Unavailability of Mobile Unit prevents timely access to screening programme/schedule
Catastrophic Network dysfunction

Service Cardiology

Lack of a dedicated Cardiac Facility for diagnostic and angiography pacemaker implantation and interventional cardiac procedure

Service Child Health

Inability to access timely paediatric echo cardiology service

Name
Inability to predict and budget for high cost transfers to Starship Hospital
Financial instability due to ongoing cost associated with patients seen in Starship
Transmission based precautions
Limited Clinicians available to provide Sexual Assault and Treatment Service (SAATS)
Environmental risk with airflow/ventilation in block c
Risk of children and young people with mental health conditions not receving appropriate therapeutic mental health care when required to be inpatient on childrens ward.

Service Child, Adolescent & Oral Health Service

Inability to recruit appropriately trained Dental Therapists
Inability to maintain communication with staff working on mobile units in remote areas
Loss of mobile dental unit(s)

Service Clinical Haematology

Access to Oncology Dayward

Service Clinical Records

Insufficient storage space for clinical records

Service Commercial Support

Increased risk of fire due to degradation of aged PVC electrical wiring system

Service Diabetes & Endocrinology Service

Demand exceeds capacity to provide safe service to our core population groups
Workload exceeds staffing resources for diabetes in pregnancy team

Service Distribution/Purchasing

Inability to access Distribution Centre and Purchasing's Computer System (JDE)

Service District Nursing

Increase in demand for community at home based care (District Nursing)
Inability to protect and monitor location of staff at all times whilst working in the community
Loss of access to an efficient electronic system

Service Emergency Medicine

Name
Workload exceeds staffing resources in Emergency Department
Insufficient seniority of junior doctors in Emergency Medicine
Failure to manage XRay reporting process in Emergency Department
Delay of specialist review of patient in Emergency Department
Emergency Department Environmental Audit
Critical staffing levels in Emergeny Department
Service Emergency Services
Risk of adverse event or poor patient outcome
Inability to staff MAPU beds (Room 9) due to insufficient resources
Inability to care for more than 2 patients requiring infectious isolation within the Emergency Department
Inability to consistently resource ED clerical needs
Service Enable New Zealand
Loss of key contestable contracts
Service Finance
Profitability and Financial Sustainability
Service Gastroenterology
Inefficient work processes in decontamination and sterilisation for Gastroenterology
Physical space of Gastroenterology no longer meeting demand
Inability to meet Endoscopy contracted volumes
Service Gynaecology
Suitable space to deliver acute gyanecological care
Service Infection Prevention & Control
Consultation with Infection Prevention and Control is not embedded in building design, alterations or changes to service delivery
Hospital associated infections
Service Information Systems
The gap between "supply and demand" increases
Lack of Disaster Recovery (DR) for single application servers

Name
Failure of aged servers
Service Intensive Care
Delayed discharge of ICU and HDU patients' decreases availability of ICU/HDU beds
Service Medical Imaging
Inappropriate radiation exposure to patient
Unnecessary radiation exposure to staff
Insufficient resources to meet demand and maintain acceptable waiting times
Failure of PACs/RIS system
Service Medical Oncology
Errors in chemotherapy prescribing
Care Plans don't match paper versions
Emergency Call Bell Location
Service Neonatal
Neonatal nursing workforce skillmix may impact on nursing care provided to neotates
Service Obstetrics
Increased numbers of pregnant patients accessing the service with high BMI's
Baby dying of asphyxia whilst in hospital
Baby falling off bed, through bedsides or parents arms
No dedicated Emergency Obstetric Operating Theatre
Insufficient numbers of trained Midwives to adequately staff maternity services at MDHB.
Insufficient numbers of trained Midwives to adequately staff maternity services at MDHB.
Service Pharmacy
Threat of "armed" hold up and/or theft of Pharmacy Department
Service Public Health
Inability to maintain business functions due to an emergency or emergent event
Lack of electronic notes system
Difficulty in maintaining Business As Usual (BAU)

Name
Public statements by staff adversely affecting the credibility of the service
Clinical incident resulting in adverse outcome for the patient/client
Breaches of confidentiality/privacy
Service Radiation Oncology
Equipment failure negatively impacting on patient flow
Waiting time for Radiation Oncologists FSA
Service Regional Cancer Treatment Service
Clinical Haematology FSA's in Regional (Peripheral) DHB's exceed available medical resource, which may impact on care being delivered in a timely manner.
In House Developed Software
Service Renal Medicine
Insufficient dedicated FTE of Nephrologists at MCH to meet increasing demand
Exposure to staff burn out
Continuity of Care
Lack of resources resulting in inability to meet demand
Functionality of the newly established Renal Unit compriomises safe patient care
Service Sterile Services
Inadequate cleaning of instruments results in unsterile equipment
Inability to locate and trace instruments
Service Therapy
Therapy Services: Physiotherapy and Occupational Therapy patients waiting longer than the targeted time
Staffing levels (difficulty to recruit and no leave cover) for Therapy staff impacts on the ability to provide service to MCH
Service Urology
Overdue and forgotten Stents

Total number of discrete items for all groups: **217**

Name

Report Criteria (If Applicable)

Risk Status

Open, Open (Not Published)

User Campus/Site Restrictions:

Palmerston North Hospital, Horowhenua Health Centre, Dannevirke Community Hospital, Dannevirke Integrated Mental Health, Clevely Health Centre, 200 Broadway, Breast Screen Coast to Coast, Enable New Zealand, Enable NZ - EASIE Living Centre, Enable NZ - Main Street (Lvl 2) PN, Enable NZ - Warehousing Christchurch, Enable NZ - Warehousing Hamilton, Enable NZ - Warehousing PN, Foxton Health Centre, Health on Main, Otaki Medical Centre, Pahiatua Medical Centre, Rongopai Street, Supportlinks, Te Papaioea Birthing Centre, Te Waiora Community Health Services, Whanganui DHB, Organisation-wide

Alerted records included (if any)

Yes

16 May 2022

[redacted]

[redacted]

MDHB Ref Y22-478

Tēnā koe

The following response is provided in relation to your Official Information Act 1982 (OIA) request received on 3 May 2022.

Your request asks that we:

Provide a list of people who have been elected to the district health board since its establishment in 2001 – including the names of members; the start and finish dates of their tenure; the position they held (whether they were a member, chair or deputy chair); whether they were an elected or appointed member; and that the information be arranged by each board term.

The information for MidCentral District Health Board from December 2001 to the current date is provided on the following pages. No changes are anticipated before district health boards are disestablished on 30 June 2022.

If you are not satisfied with this response you have the right to raise any concerns with the Ombudsman – www.ombudsman.parliament.nz or by phoning 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral District Health Board website 10 working days after your receipt of this response.

Yours sincerely

kg Cook

Kathryn Cook**Chief Executive**

MidCentral DHB – December 2001 to December 2004

Name	Position	Status	Term
Ian Wilson	Chair	Appointed	Complete
Piers Hamid	Deputy Chair	Appointed	From 10 January 2002
Diane Anderson	Member	Elected	Complete
Lindsay Burnell	Member	Elected	Complete
Ann Chapman	Member	Elected	Complete
Dr Jack Drummond	Member	Elected	Complete
Dennis Emery	Member	Appointed	Complete
Danielle Harris	Member	Appointed	Complete
Janet Olliver	Member	Elected	Complete
Barbara Robson	Member	Elected	Complete
Dr Ralph Saxe	Member	Elected	Complete

MidCentral DHB – December 2004 to December 2007

Name	Position	Status	Term
Ian Wilson	Chair	Appointed	Complete
Ann Chapman	Deputy Chair	Elected	Complete
Diane Anderson	Member	Elected	Complete
Lindsay Burnell	Member	Elected	Complete
Dr Jack Drummond	Member	Elected	Complete
Dennis Emery	Member	Appointed	Complete
Danielle Harris	Member	Appointed	Complete
Pat Kelly	Member	Elected	Complete
Jim Jefferies	Member	Elected	Complete
Barbara Robson	Member	Elected	Complete
Dr Cynric Temple Camp	Member	Appointed	Complete

MidCentral DHB – December 2007 to December 2010

Name	Position	Status	Term
Ian Wilson	Chair	Appointed	Until 31 December 2009
Phil Sunderland	Member Chair	Appointed	From 2 November 2009 From 1 January 2010
Ann Chapman	Deputy Chair	Elected	Complete
Diane Anderson	Member	Elected	Complete
Lindsay Burnell	Member	Elected	Complete
Dr Graeme Campbell	Member	Elected	Complete
Dr Jack Drummond	Member	Elected	Complete
Dennis Emery	Member	Appointed	Complete
Jim Jefferies	Member	Elected	Complete
Barbara Robson	Member	Elected	Complete
Stephen Paewai	Member	Appointed	From 28 April 2008
Ormond Stock	Member	Appointed	Until 11 September 2009
David Warburton	Member	Appointed	From January 2010

MidCentral DHB – December 2010 to December 2013

Name	Position	Status	Term
Phil Sunderland	Chair	Appointed	Complete
Kate Joblin	Deputy Chair	Appointed	Complete
Diane Anderson	Member	Elected	Complete
Lindsay Burnell	Member	Elected	Complete
Barbara Cameron	Member	Appointed	From 25 April 2013
Ann Chapman	Member	Elected	Complete
Dr Jack Drummond	Member	Elected	Complete
Pat Kelly	Member	Elected	Complete
Mavis Mullins	Member	Appointed	Until July 2011
Karen Naylor	Member	Elected	Complete
Richard Orzecki	Member	Appointed	Complete
Barbara Robson	Member	Elected	Complete

MidCentral DHB – December 2013 to December 2016

Name	Position	Status	Term
Phil Sunderland	Chair	Appointed	Complete
Kate Joblin	Deputy Chair	Appointed	Complete
Diane Anderson	Member	Elected	Complete
Adrian Broad	Member	Elected	Complete
Lindsay Burnell	Member	Elected	Complete
Barbara Cameron	Member	Appointed	Complete
Ann Chapman	Member	Elected	Complete
Nadarajah Manoharan	Member	Elected	Complete
Karen Naylor	Member	Elected	Complete
Richard Orzecki	Member	Appointed	Died June 2015 (in office)
Oriana Paewai	Member	Appointed	From 3 December 2015
Barbara Robson	Member	Elected	Complete

* Phil Sunderland died two days after his term ended

MidCentral DHB – December 2016 to December 2019

Name	Position	Status	Term
Dot McKinnon	Chair	Appointed	Complete
Brendan Duffy	Deputy Chair	Appointed	Complete
Diane Anderson	Member	Elected	Complete
Adrian Broad	Member	Elected	Complete
Barbara Cameron	Member	Appointed	Complete
Ann Chapman	Member	Elected	Complete
Michael Feyen	Member	Elected	Complete
Nadarajah Manoharan	Member	Elected	Complete
Karen Naylor	Member	Elected	Complete
Oriana Paewai	Member	Appointed	Complete
Barbara Robson	Member	Elected	Complete

MidCentral DHB – December 2019 to 30 June 2022

Name	Position	Status	Term
Brendan Duffy	Chair	Appointed	Complete
Oriana Paewai	Deputy Chair	Appointed	Complete
Heather Browning	Member	Elected	Complete
Vaughan Dennison	Member	Elected	Complete
Lew Findlay	Member	Elected	Complete
Norman Gray	Member	Appointed	Complete
Muriel Hancock	Member	Elected	Complete
Materoa Mar	Member	Appointed	Complete
Karen Naylor	Member	Elected	Complete
John Waldon	Member	Elected	Complete
Jenny Warren	Member	Elected	Complete

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

23 May 2022

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

Your recent OIA request of 27 April 2022 to MidCentral District Health Board (MDHB) is acknowledged.

The information you have requested for the 2021 calendar year follows.

1. Please provide the length of time for patients on the waiting list who were referred by their GP to Specialist in your district (incl. count of events and average wait days) for the following;

a. Hip replacement
b. Knee replacement
c. Hysterectomy (or general gynae)
d. Breast reconstruction
e. Gall bladder
f. CT/MRI/PET scan
g. Colonoscopy

(i) Covering a 12 month period from 1 March 2021 to 28 February 2022.
(ii) Covering a 12 month period from 1 March 2016 to 28 February 2017.

	01.03.16 – 28.02.17		01.03.21 – 28.02.22	
	Count Events	Avg. Days Wait	Count Events	Avg. Days Wait
Hip replacement	189	46.1	145	71.9
Knee replacement	152	46.5	162	69.4
Hysterectomy	101	52.6	36	54.7
Breast Reconstruction	0	0	1	15.0
Gall Bladder	97	48.3	78	76.6

	01.03.16 – 28.02.17			01.03.21 – 28.02.22	
	Count Events	Avg. Days Wait		Count Events	Avg. Days Wait
CT	254	24.6		443	11.1

Referrals to MRI are managed in a separate patient management system and are not received from GP to Medical Imaging Specialist directly. This information is unobtainable. Patients requiring PET scans from the MDHB region are referred to Wellington for this diagnostic procedure.

	01.03.18 – 28.02.19			01.03.21 – 28.02.22	
	Count Events	Avg. Days Wait		Count Events	Avg. Days Wait
Colonoscopy					
- Non Urgent	1,128	48.8		1,004	75.3
- Surveillance	352	73.6		209	126.2
- Urgent	149	11.1		166	9.5

A change in administration systems means we cannot consistently measure prior to 2018.

2. Please provide the length of time for patients on the waiting list, who are awaiting surgery in your district (incl. count of events and average wait days) for the following;

a. Hip replacement
b. Knee replacement
c. Hysterectomy
d. Breast reconstruction
e. Gall bladder
f. CT/MRI/PET scan

(i) Covering a 12 month period from 1 March 2021 to 28 February 2022.
(ii) Covering a 12 month period from 1 March 2016 to 28 February 2017.

	01.03.16 – 28.02.17			01.03.21 – 28.02.22	
	Count Events	Avg. Days Wait		Count Events	Avg. Days Wait
Hip replacement	238	86.6		122	141.6
Knee replacement	168	86.6		149	144.6
Hysterectomy	117	85.3		21	96
Breast Reconstruction	0	0		0	0
Gall Bladder	147	66.9		71	83.8

The pathways for scans is from appointment to scan. Therefore, the response for CT/MRI/PET is as above.

3. Could you please provide the average wait time for patients being treated with the following cancers (include count of events and average days);

a. Lung
b. Breast
c. Cervical
d. Bowel
e. Prostate
f. Skin

(i) Covering a 12 month period from 1 March 2021 to 28 February 2022.
(ii) Covering a 12 month period from 1 March 2016 to 28 February 2017.

FSA to Treatment

	01.03.16 – 28.02.17		01.03.21 – 28.02.22	
	Count Events	Avg. Days Wait	Count Events	Avg. Days Wait
Lung	166	32.2	182	20.6
Breast	279	52.7	367	44.8
Cervical	4	24.5	3	11.0
Bowel	18	37.9	20	22.0
Prostate	151	78.6	277	60.2
Skin	166	46.0	189	26.0

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Sarah Fenwick
Operations Executive
Healthy Women Child & Youth

24 May 2022

[redacted]

[redacted]

MDHB Ref: Y22-476

Dear [redacted]

The following response is provided in relation to your Official Information Act 1982 (OIA) request received on 2 May 2022.

Your request asks that we:

Provide details related to the expenditure of commissioned research the DHB has awarded to external organisations over the last three years. Specifically, how many external commissioned research contracts there have been, who they went to and how much it cost.

A review of MidCentral District Health Board's (MDHB) contracts has not identified any third party research projects commissioned over the past three years.

If you are not satisfied with this response you have the right to raise any concerns with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance and Corporate Services

Finance and Corporate Services
MidCentralDHB, PO Box 2056, Palmerston North Central, 4440.
Tel: 06 350 8800 Fax: 06 350 8080

19 May 2022

[redacted]

Via email: [redacted]

Dear [redacted]

I refer to your Official Information Act request received by email on 6 May 2022 with regard to complaints raised by doctors regarding bullying over the past five years and respond as follows:

Year	Number	Disciplinary Action
2022	0	
2021	0	
2020	1	No – complaint not upheld
2019	0	
2018	0	
2017	0	

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

26 May 2022

[redacted]

Dear [redacted]

We are in receipt of your Official Information request dated 11 May 2022.

You advised that you would like the following information as stated below:

- **Copies of key documents held by senior management created in the last two years that were substantially about the challenges in recruitment and or the impact of staff pressures in mental health services.**

- **Copies of any documents pertaining mental health staffing risk reports conducted in the last two years that highlights what the staff pressures in mental health services are?**

The following documents are attached which are covered by your request:

- Agenda and minutes of Skill Mix/Workforce Composition Review meeting, November 2020
- Ward 21 Increase in staffing, April 2021
- Ward 21 Action Plan which was developed specifically around mitigating risks associated with violent and aggressive behaviour, August 2021
- Business case: Increase in Child and Adolescent Mental Health Service FTE, September 2021
- Acute Mental Health and Addiction Inpatient Unit leadership decision document, December 2021
- Acute Mental Health Unit Leadership, December 2021
- Medical Leadership of the Mental Health and Addiction Services Cluster, December 2021.

Workforce reporting is presented to the Board of MidCentral District Health Board. These documents are publicly available and can be found at the following address:
http://www.midcentraldhb.govt.nz/AboutMDHB/BoardandCommittees/Pages/default.aspx

Te Uru Rauhī - Mental Health & Addictions Services
PN Hospital, Private Mail Bag 11036, PALMERSTON NORTH
Phone: + 64 (6) 350 8354

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Scott Ambridge
Operations Executive

Te Uru Rauhī - Mental Health & Addictions Services
PN Hospital, Private Mail Bag 11036, PALMERSTON NORTH
Phone: + 64 (6) 350 8354

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

SKILL MIX / WORKFORCE COMPOSITION REIVEW – Mental Health & Addictions Services (MHAS)

Agenda Tuesday 17 November 2020

8.15am – 9.30am Large Admin Meeting Room

Attendees	Title
[redacted]	Executive Director of Nursing & Midwifery
[redacted]	Chief Medical Officer
[redacted]	Executive Director, Allied Health
[redacted]	Manager, Human Resources
[redacted]	Programme Director, EPMO
[redacted]	Clinical Executive – Mental Health & Additions
[redacted]	Operations Executive - Mental Health & Addictions
[redacted]	Associate Director of Nursing – Mental Health & Additions
[redacted]	Business Advisor P & I Lead
[redacted]	Finance Business Partner
[redacted]	Human Resources Business Partner

Item	Details	
1.	**Karakia (over page)**	[redacted]
2.	**Welcome & Apologies**	[redacted]
3.	**MOLM (Minutes of last meeting) – Matters arising**	All
4.	**Leadership Structure** • Nursing • Allied • Medicine	
5.	**Nursing** i) Clinical Nurse Specialist Team – transfer new JDs ii) Nurse Practitioners – Strategy	[redacted]
6.	**Allied** i) Activity Logs – use of non-regulated workforce ii) Skill mix of NGOs	
7.	**Medicine** i) Junior medical staff ii) Locum Usage iii) Medical model of care	
8.	**FACT – workforce required for model of care** • Plan	[redacted]
9.	**Training for undergraduates** • Numbers	
10.	**Workforce Strategy Progress – Template** i) Nursing ii) Allied iii) Medical	[redacted]
11.	**Workforce Budgets and Establishments (attached** • Overtime usage • Locum Usage • Vacancy Management	[redacted]
12.	**AoB**	

He karakia huakina huinga

Pou hihiri
Pou rarama
Te Pou o te whakaaro
Te Pou o te tangata, te Pou o te Aroha

Te Pou e here nei I a tātou
Mauri ora ki a tātou
Haumi e, hui e, tāiki e

May Clarity be yours
May understanding be yours
Through reflection
Through personal endeavour
Through respect
The virtues which bind us as one
May we be filled with wellbeing

DRAFT

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

SKILL MIX / WORKFORCE COMPOSITION REIVEW – Mental Health & Addictions Services (MHAS)

Minutes from meeting Tuesday 17 November 2020

8.00-9.30am Large Admin Meeting Room

Attendees	Title	Attended	Apologies
[redacted]	Executive Director of Nursing & Midwifery	√	
[redacted]	Chief Medical Officer	√	
[redacted]	Executive Director, Allied Health	√	
[redacted]	Manager, Human Resources	√	
[redacted]	Programme Director, EPMO		√
[redacted]	Clinical Executive – Mental Health & Additions	√	
[redacted]	Operations Executive - Mental Health & Addictions	√	
[redacted]	Associate Director of Nursing – Mental Health & Additions	√	
[redacted]	Business Advisor P & I Lead	√	
[redacted]	Finance Business Partner	√	
[redacted]	Human Resources Business Partner	√	

Item	Details	
1.	**Minutes of Last Meeting** - approved **Terms of Reference** – agreed **Invite** – admin [redacted] (when Administration is on the agenda)	
2.	**FACT Plan** Core group has been meeting for some time (professional leads/ operational lead/ clinical lead) Divided the programme of work into different work streams. [redacted] is heading the workforce work stream - mapping the workforce requirements moving forward. There is still work to be done in this space. Modelling is by locality and is based on how many clients each FACT team will manage. FACT team workforce has been determined by population. Although the size of teams has been weighed, based on high health needs and rurality. Due to this we will have 6 FACT teams. <u>Current modelling is 6 FACT teams</u> 3 in Palmerston North 2 in Horowhenua 1 in Tararua. <u>These are inclusive of two dedicated Kaupapa Maori FACT teams</u> 1 in Palmerston North 1 in Horowhenua <u>An example of a FACT team would be as follows</u> - made up of clinical and non-clinical staff. 1 x FTE psychiatrist 0.5 FTE clinical team leader, (1 FTE and carry a .5 FTE clinical case load). Four registered nurses at full FTE. (4.5 .5 is team leader role) 1 FTE social worker 0.8 FTE phycologist 2 FTE addictions specialists, 2 FTE administration support 1 FTE peer support worker/cultural support 0.5 FTE employment support. Last 2 non clinical roles and will be contracted to NGOs. FACT team is one part of the overall integrated model of care that is being proposed. <u>In addition – the Kaupapa Maori teams will have</u>	

1 FTE Kaumātua / cultural advisor
1 FTE Whānau Ora link role

Two broad functions
Long-term services and acute and specialist care.
FACT team supports overall model of care around long-term services and supports people with long and enduring mental illness.

Phase one of the transformation of MHAS is increasing capability and capacity of primary mental health through Te Aroha access and Choice. We are in year one of a four year programme.

Specialist liaison assessment and treatment service – this is a specialist service that provides comprehensive liaison assessment and treatment. Proactive outreach and in reach service. This service is providing time limited interventions both individual and group based.

The new pathway would be GP makes contact with Te Aroha – first appointment for person, clinician then decides if we need specialist intervention – liaison team actively reaches into primary practice and provides support. An in reach out reach service. There will be functions for un-planned care ie a person who is not in crisis, but walks into community mental health service and needs some support.

In Palmerston North we have a new community mental health centre – part of funding. Within this centre there are different functions, FACT team providing the long term rehabilitation. Specialist liaison service, a function that is providing both planned and unplanned care and a duty team within the FACT team that are looking at how best to support the people coming into the service.

These services are predominantly dividing the care and support for people who need specialist interventions.

Broad modelling comes from FACT model itself. Modelling methodology was also used based on rurality, locality and high health needs. High health needs are evidence based. Core skill mix come from FACT – which is from Australia.

Now trying to understand the actual workforce mix verses the proposed workforce mix. Where there may be challenges and opportunities. What are the options available? Interested in thinking about this creatively, bring the unions on board early.

What is the relationship with government departments that are working with mental health eg Justice Department/Corrections – how do they fit in with the model? How do we get the flow?

[redacted] explained that we have direct relationships in to the ward, and other community based services that we fund. We fund a single point of entry addiction service into the community.

MSD – MHAS working closely with them, wanting to set up an MOU with the DHB in regards to streamlining processes for people who enter the ward – to ensure they are getting the right benefits.
MHAS keen to work in partnership with Kāinga Ora in a more planned way around housing opportunities. To have sustained housing for those with high and complex needs.

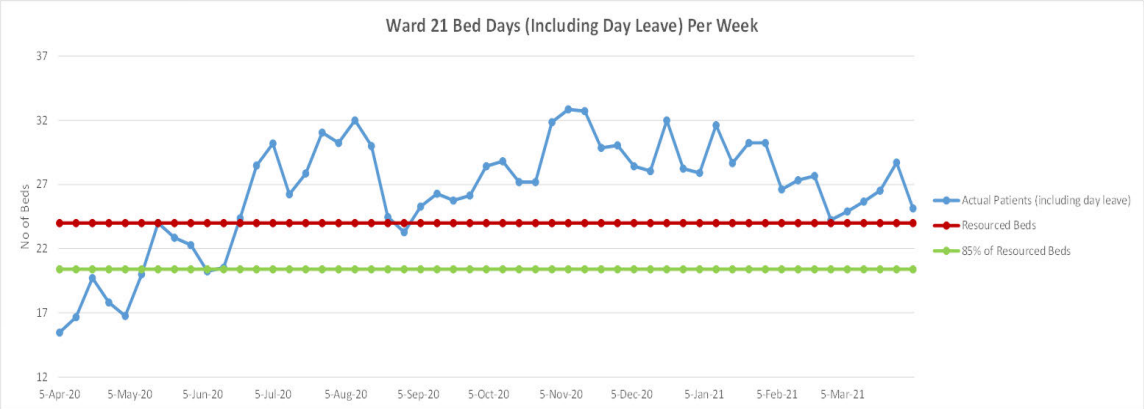
Next key piece of work
What does the analysis of virtual verses proposed, look like?
Consultation process and plan – agreed that this group would be used as a forum for discussion.
Conversations have been started with the medical workforce - Creating a sustainable

	workforce. Crisis team (24/7) – this workforce has not been worked through at this stage. OST is out of scope, may integrate at a later stage. CAFS is out of scope. Workforce remains unchanged. To give some thought on what the group would like to see – the updates would come through the Workforce Working Group. [redacted] has been looking into pathways for nursing – how do we create a pathway through to a NP, or CNS. In terms of nursing, MHAS are looking at developing these pathways. To identify the current nurse workforce that can develop onto the pathways. NGOs have a second line of funding through the ministry, that they currently don't access. Suggested that this is discussed with NGOs from a contractual basis. *What is the learning model for medical team within this? How do they get their experience?* Do you need nurses or more Allied? What is your treatment model? Vanessa is leading a piece of work on this - model focussed on effective interventions, ensuring that we have strong cohort of therapists or people trained in talking therapies. The OT components of the model are more around the functional employment. <u>Establishments</u> – they are underway and will be send to all managers for any changes. Work underway to get this into the HR system. First team up and running – phase implementation is from June/July 2021. Horowhenua and Tararua are almost there. Mostly will effect central Palmerston North. Noted that the limiting factor is the infrastructure/digital work that needs to come on string as this is all very dependent on this, to enable collaboration of information across teams. Workforce strategy will be a work in progress and it rolls out. *Leadership – is 0.5 FTE enough*? There is a consideration for what the operations leadership looks like – strengthening the tier three roles. Will still have CAFS and the ward to work through, with regards to Locum and high usage of overtime. <u>Summary</u> MHAS would like the planned pathways completed before Christmas. Agreed Business case going to board on 15 December. Book another meeting for early December – present at this meeting.	

Ward 21 Action Plan

Item	Action	Responsible Person	Date	Complete	Comment
Communication	Follow up meeting to be arranged	[redacted]	20/08/2021	Yes	Date proposed as 03/09/2021 - Will close once confirmed attendance. Closing as agreeing follow up meetings at each meeting.
Communication	Weekly update against action plan to be sent out	[redacted]	Ongoing	Yes	Updated on 03/09/2021. Some outstanding information - will continue to chase and update. Closing as on going and occuring.
Communication	Organise regular meetings with NZNO delegates and the ward CN/ACN team	[redacted]		Yes	To try to identify issues early - 6 weekly
Community Care Facilities	Establish and operationalise step-down/crisis respite in Horowhenua	[redacted]	Late 2021/ Early 2022	Closed	Closing as on track and tracked elsewhere.
Community Care Facilities	Establish and operationalise Emerge facility	[redacted]	13/12/2021	Closed	Draft contract to go out mid next week, recruitment and works will commence immediately and to be operationalised by 13 December at the latest.
Community Care Facilities	Establish and operationalise Community-based bed facilities	[redacted]		Yes	Emerge Operational Since December 2021
Safety on the Ward	Arrange for trial of security guards to be present 08:00-20:00 7/days	[redacted]	2/08/2021	Closed	Arranged for 4 weeks and then to review effectiveness in reducing incidents
Community Care Facilities	Establish and operationalise Community-based bed facilities	[redacted]			Horowhenua Crisis Respite/Step down RFP out currently. Estimated to be operational by June 2022
Safety on the Ward	Review the effectiveness of the use of security in relation to visitors	[redacted]		Yes	To be reviewed during trial and after trial. Small group to be gathered to review
Community Care Facilities	Agree working group and review St Dominics crisis respite to ensure is meeting the needs of service users	[redacted]			Include CNS & SW from ward in group. Meeting to occur in next 2-3 weeks.
Safety on the Ward	Review the use of security on the ward	[redacted]	23/08/2021	Closed	Security is currently being used to be in HNU and not to address drugs. CN advised that there is no need for this security as drugs are coming through the windows. Security presence
Facilities	Door in HNU to repair	[redacted]	TBC	Yes	Confirmed parts ordered. Will update timeframe as information available Meeting with [redacted] arranged to discuss further
Facilities	Install security "guards" on external windows.	[redacted]		Yes	Proposed solution is to fence around the building. Costings received and reviewing next steps
Facilities	Remove raised courtyard area	[redacted]	TBC		PO raised to have this removed. Artifical grass or similar to be explored. Request options from Ventia [redacted] to get estimated timeframe from [redacted]
Facilities	Establishment of Sensory Modulation room in HNU	[redacted]	TBC		Design proposed and agreed with facilities. Awaiting costing and srtuctural confirmation
Facilities	Extend cameras to provide full coverage of female and male wings	[redacted]	TBC		On order - Capex approved
Illicit Drugs on the Ward	Review illicit drugs policy and update as required	[redacted]	27/08/2021	Yes	Drug policy in date. Implementation is the issue. [redacted] to discuss with the Associate CNs Had an initial discussion but needs further discussion around how other services respond e.g. police
Illicit Drugs on the Ward	Ensure illicit drugs policy is adhered to	[redacted]	18/03/2022		An audit of use of the patient confirmation form may be appropriate
Illicit Drugs on the Ward	Discuss jurisdiction and options with NZ Police (local contact number and drug dogs)	[redacted]	30/08/2021	Yes	Police have confirmed they do not have jurisdiction to bring police dogs on to ward. Police are liaising with colleagues nationally to identify what is being done. Currently in discussions with an organisation that provide this to a number of DHBs in lieu of the police [redacted] to discuss with Buddle Findlay re: legal stance of searching property
Safety In the Ward	All inpatients to have current care plans	[redacted]	Ongoing	Yes	Confirmed that this is not an issue at previous meeting - all paitents have care plans
Safety on the Ward	Review staffing practices around observations i.e. do staff need to be stationed down each corridor in the lounge areas to detect early signs of escalation	[redacted]	[redacted]/08/2021	Yes	Closed and replaced by camera action
Staff wellbeing	Staff to be invited to first roll out of wellbeing leaders training in two weeks	[redacted]	6/08/2021	Closed	Staff invited - declined, invited to later session
Safety on the Ward	Arrange for some lockers for visitor belongings	[redacted]	30/08/2021	Yes	These are in situ and being utilised
Community Care Facilities	Agree service specification for Emerge facility	[redacted]	20/08/2021	Closed	Service Specifications agreed between MDHB and Emerge
Safety on the Ward	Policy and signage to reflect that visitors will be required to deposit all belongings in lockers provided and that they may be searched	[redacted]	18/03/2022		[redacted] to follow up with Kylee & Matt [redacted] to review W21 visiting policy, work with [redacted] DAMHS and DI Te Ahomai policy shared
Safety on the Ward	Recruit to vacant RN positions	[redacted]	Ongoing		1.8 FTE offered. Leaving 2.2 FTE Vacant once these are taken up (Plus 3.2 FTE (Mat leave, sickness and temp appointments). Advert to out currently. To review progress with [redacted] 3-4 weekly
Safety on the Ward	Recruit to vacant HCA positions	[redacted]	Ongoing		2.0 FTE to be offered and 4 casual contracts offered & accepted. Leaving 7.9 FTE. Casual HCA pool increased (e.g. Nursing Students) Recruitment challenging. To review progress with Jon 3-4 weekly
Safety on the Ward	Sensory room to be converted back to sensory room and bedroom furniture removed	[redacted]	Underway	Yes	Working group organised.
Safety on the Ward	Trial of security guards to be present 08:00-20:00 7/days	[redacted]		Yes	Trial concluded - review group to be established
Operational	To reconfirm with Integrated Operations Centre and Duty Nurse Managers that admission in to non-purpose bedrooms requires escalation to the on call manager	[redacted]	24/08/2021	Closed	Email sent to confirm this and has been disseminated to on-call managers and DNMs. This will also be incorporated in the escalation plan.
Operational	VRM indicators - identify why change to 28 and revert back to 24 until recruitment situation closer to FTE requirements	[redacted]	27/08/2021	Closed	[redacted] not sure why has changed. Contact given to follow up. Email sent to chase [redacted] on 20/08/2021
Smoking	Review current policy and practices regarding this and discuss proposal with District Inspector and DAMHS	[redacted]		Yes	[redacted] liaising with [redacted] ACNs to look at working group. On hold due to COVID Following on from COVID restrictions, escorted smoke leave has remained restricted.
Smoking	Establish a small working group to take forward proposed changes regarding escorted leave for the purpose of smoking	[redacted]		Yes	To include [redacted] On hold due to COVID This has been discussed with community teams. Small team on ward will look at how to manage challenges with
Staff wellbeing	Use of cultural / pastoral care - promote and encourage for individual & team	[redacted]		Closed	Start conversation with [redacted] and [redacted] around possible options
Staff wellbeing	Increase availability of psychology on the ward for staff	[redacted]		Closed	Psychologist FTE increasing by 0.2 FTE (1/day/week) to focus on supporting staff

To	[redacted], Operations Executive
Author	[redacted], Associate Director of Nursing and Operations Lead
Date	24 April 2021
Subject	**Ward 21 – Increase of Staffing**

SECTION	**DETAIL**
Background *Describe the current state and the case for change*	Ward 21 is currently resourced and staffed to provide care for 24 patients. We are seeing increased and sustained demand for inpatient care that is leading to the ward running above 24 beds. The proposed integrated model of care that is out for consultation aims to address admissions that could be supported at home by way of providing the ability in the system to more intensively and proactive visit patients, however this is unlikely to address the underlying demand on acute services Initial CCDM data suggests that 95% of shifts on Ward 21 are short of available nursing care hours; some of this is due to the staffing model not being sufficient to meet patient needs and some of this is due to running over 24 beds. Additionally, Ward 21 has been running at 143.4% bed day usage (average occupany of 28 beds against resourced of 24 beds). The average bed days by month are shown in the graph below. The lower bed utilisation in April and May is attributed to Covid-19 alert levels and restrictions, which saw a significant decline in presentations throughout this period.  Conversely, the average length of stay remains within target at 15.2 days (Target 14 – 21days) noting however there are four long-stay patients with a length of stay > 100 days. Managing this increased demand is currently achieved by increasing staffing by 1 Registered Nurse (RN) on each shift; currently, this comes out of existing resources and leads to overtime. Overtime currently for Nursing on Ward 21 averages 300 hours/fortnight, with peaks in excess of 400 hours. Double shifts account for 75% of the overtime worked, 321 hours per month. The use of double shifts is an unsafe practice and whilst procedures are in place to reduce its use it remains the dominant practice for covering RN roster gaps.

	In addition to nursing hours, specialling causes a significant pull on existing resources where the IOC staffing pool are unable to meet demand. Whilst the use of bureau staff has reduced (down [redacted] year on year) double shifts for HCAs have increased by 50% during the same period. The data from CCDM shows that there is an average requirement of 1.79 requests per shift above existing staffing to provide Level 3 specialling. The proposal seeks to employ additional HCAs to reduce the level of overtime work, and bureau costs. It is anticipated that the ward would provide specialling for up to 3 patients within this proposed staffing; they currently do this for up to one patient requiring specialling. The HQSC zero seclusion project that has been running since 2017, aims to reduce the use of seclusion and restrictive practices. The ward has enjoyed some significant successes around the reduction of restrictive practices. One of the consequences of this has been an increase in the use of specialling to maintain patient/staff safety and to provide early de-escalation of behaviours that, unmanaged, may escalate and require restraint and/or seclusion. Note: the 2019/20 proposal to increase HCA by one/shift (5.3 in total) aimed to reduce the use of security. Security costs for the current year compared to the same period the year before have reduced by [redacted]. Finally, there is a large and consistent body of evidence around staff wellbeing and morale being a clear indicator of the quality of patient care. It is anticipated that appropriately staffing the ward and resetting the culture around overtime being the exception not the norm that this will positively impact staff wellbeing and morale.

	Average	Min	Max
Requests/Month	160.67	152	172
Average Requests/Shift	1.79	1.69	1.91
Multiplied * 5.2 for FTE Calculation	9.28	8.78	9.94

Description and objective of Proposal	This proposal seeks to increase nursing and HCA staffing ahead of the formal recommendations via CCDM (anticipated to be June 2021). The primary objectives are to:
	1. Provide the right staff at the right time to meet patient needs and patient flow demand.
	2. To reduce the level of overtime, specifically double shifts being utilised on the ward.
	3. Provide resources for up to 28 beds.
	4. improve the quality of care provided to patients at their most vulnerable time.
	5. improve staff wellbeing and morale.
	
	Note on 21/22 budget:
	A discussion is needed on agreeing the bed numbers for the 21/22 budget. Currently the ward is set at 24 beds (85% occupancy) versus a current average occupancy of 28 beds.
	
	Changes proposed to meet the above objectives:
	• Increase Registered Nurses by 5.3 FTE
	• Increase Healthcare Assistants 9.3 FTE, recruited in two phases:
	  ○ May 2021 - Recruit 5.3 HCA, once recruited monitor and review in three months
	  ○ Subject to validation of outcomes, recruit the additional HCA's or implement CCDM recommendations (whichever occur first).

Key Performance Indicators (KPI's)

KPI	Current Measure	Target Measure	Date to be achieved by
1. Double shifts for RNs is reduced by 50% by December 2021	320 hrs / fortnight	< 160 hrs / fortnight	To be reviewed monthly
2. Double shifts for HCAs is reduced by 50% by December 2021	209 hrs / fortnight	< 100 hrs / fortnight	To be reviewed monthly
3. The use of security stops (unless there is a specific safety need)	N/A	100%	To be reviewed weekly
4. The use of bureau and duty calls reduces	$17k per month	25% reduction	To be reviewed monthly

The measures used to validate staff wellbeing will be a combination of qualitative (feedback from staff) and quantitative (planned and unplanned leave, leave in excess of 2 years).

All the above measures have an impact on the ward budget, patient experience and safety, and staff morale. The Charge Nurse will report monthly to the Operations Lead. Anything outside of agreed parameters, the Operations Lead will report to the Operations Executive.

Risks associated with implementing the business case

Risk	Mitigating Action	RAG
Expected KPIs are not met	Weekly review by Charge Nurse and escalation as required. This will help identify any patterns and/or avoidable practices.	High (9)
KPIs 1 and 2 are not met	A protocol will be developed for overtime with consideration for alternative options.	Moderate (6)
KPI 3 will not be met	The use of security will require authorisation by the Charge Nurse during working hours and the on-call manager out of hours.	Low (3)
KPI 4 will not be met	The use of bureau and duty calls staff will be reviewed weekly to identify the reason for use. All requests are also currently discussed through the IOC meetings.	Low (3)
CCDM FTE calculations will not match the proposed staffing	The data is based on initial CCDM data and calculations and are conservative. Where there is a variation I have opted for the low end (or average where the difference is small). Staff turnover would also support any corrections required of over-estimation.	Low (3)

QIPP Benefit

This initiative will ensure:

- A workforce that is the right size, skill mix and in the right place.
- A diverse workforce that is competent and capable.
- A workforce that is focused on people and improved outcomes.
- A reduction in the level of overtime being utilised on the ward.
- Improvement in the quality of care provided to patients at their most vulnerable time.
- Improvement to staff wellbeing and morale.
- Adherence to RCA recommendations for staffing ratios

Appendices Attached

Finance

Finance Review of Proposal

Roster budget 2020/21 is based on

	Mon			Tues			Wed			Thur			Fri			Sat			Sun			$
	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	
RN	8	7	5	8	7	5	8	7	5	8	7	5	8	7	5	7	7	5	7	7	5	[redacted]
HCA	4	4	3	4	4	3	4	4	3	4	4	3	4	4	3	4	4	3	4	4	3	[redacted]
Total	**12**	**11**	**8**	**12**	**11**	**8**	**12**	**11**	**8**	**12**	**11**	**8**	**12**	**11**	**8**	**11**	**11**	**8**	**11**	**11**	**8**	[redacted]

Proposed Roster

	Mon			Tues			Wed			Thur			Fri			Sat			Sun			$
	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night	
RN	9	8	6	9	8	6	9	8	6	9	8	6	9	8	6	8	8	6	8	8	6	[redacted]
HCA	5.3	6	5	5.3	6	5	5.3	6	5	5.3	6	5	5.3	6	5	5.3	6	5	5.3	6	5	[redacted]
Total	**14**	**14**	**11**	**14**	**14**	**11**	**14**	**14**	**11**	**14**	**14**	**11**	**14**	**14**	**11**	**13**	**14**	**11**	**13**	**14**	**11**	[redacted]

The proposed roster will cost [redacted] more than the current roster.

We have then analysed the current overruns within personnel costs for both Registered Nurses and Health Care Assistants.
On our review of this we have found that the significant overrun for the ward is within overtime which Registered Nurses have minimal overtime budgeted and Health Care Assistants have no overtime budgeted. We also noted overruns in ordinary time but on a smaller scale than overtime. We have extrapolated the current run rate to get our expected overrun for 2020/21. See tables below for breakdown:

RN cost pressure overrun against budget

	FY 2019	YTD 2020	Extrap. 2020
Ordinary Time	[redacted]	[redacted]	[redacted]
Annual Leave	[redacted]	[redacted]	[redacted]
Other Leave	[redacted]	[redacted]	[redacted]
Study Leave	[redacted]	[redacted]	[redacted]
Allowances	[redacted]	[redacted]	[redacted]
Overtime	[redacted]	[redacted]	[redacted]
Penal	[redacted]	[redacted]	[redacted]
Superannuation	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]

HCA cost pressure overrun against budget

	FY 2019	YTD 2020	Extrap. 2020
Ordinary Time	[redacted]	[redacted]	[redacted]
Annual Leave	[redacted]	[redacted]	[redacted]
Other Leave	[redacted]	[redacted]	[redacted]
Study Leave	[redacted]	[redacted]	[redacted]
Allowances	[redacted]	[redacted]	[redacted]
Overtime	[redacted]	[redacted]	[redacted]
Penal	[redacted]	[redacted]	[redacted]
Superannuation	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]

Total anticipated overruns for 2020/21 is [redacted], we do note this is down on the overrun in 2019/20 of [redacted] which shows the positive impact of the previous business case for increasing HCAs that was mentioned above has had on the overrun cost. With the proposed roster we anticipate that there would be no overrun to budget and therefore this cost would offset against the increased new proposed roster costs.

Specialing is another area that the new proposed roster will eliminate.
We have analysed the agency hours across the full 2019/20 and and up to April for the 2020/21 year.
Obtaining an average cost per hour from the last year and current year YTD we have been able to use this to put a cost against the expected savings for this area and average hours used per day. The average cost per hour is around [redacted] for the outsourced Specialing and the average hours used per day is around **15.38**.

We have then obtained the average salary for a HCA (from our budgeting model upload Oct 2020) which is [redacted] and have divided this by a 2,080 hours working year (40 hours per week across 52 weeks). To give a cost per hour of [redacted] for a HCA.

We have then worked out the following:

Each shift for HCAs is 8 hours		
So originally there is a total of	88	HCA hours per day
So now there is a total of	130	HCA hours per day
Increase of	**42**	HCA hours per day
	15	Remove the avg. specialing hours per day currently
	27	Remaining HCA hours per day extra to previous roster
	3	***Avg. hours spare per shift***

Cost difference between specialing outsourced and HCAs internal	[redacted]
Extrapolated 2020 specialing hours	[redacted]
Cost savings from not using outsourced specialing costs	[redacted]

Therefore we expect the following:

[redacted]	Increase to cost
[redacted]	Anticipated overruns 2020 (extrapolated)
[redacted]	Increase to roster not covered by overruns in 2020 personnel budget
[redacted]	Anticipated specialing savings
[redacted]	**Increase to roster not covered by savings**

In conclusion we note the following:

- With the proposed roster there would be **no budget** for **overtime** or **Specialing** costs; and
- The roster costs a further [redacted] to run than the current anticipated overrun costs.

	**For:** √ Decision Endorsement Noting

To	Chief Executive Officer
Author	[redacted], Clinical Manager Child, Adolescent and Family Mental Health and Coexisting Disorder Service
Endorsed by	Operations Executive Mental Health and Addictions
Date	22nd September 2021
Subject	**Business Case: Increase in Child and Adolescent Mental Health Service FTE**

RECOMMENDATION

It is recommended that the CEO:

- Approves an increase of 5.4 x FTE in the Child, Adolescent and Family Mental Health and Co-existing Disorder Service**.** These FTE would be made up of a range of professionals (Psychology, Allied support Worker, Case manager (RN, SW or OT a dietician and Child Psychiatrist). This would add much needed capacity and a richer flavour and flexibility of support to our existing multi-disciplinary team and to the community

PURPOSE

The purpose of this proposal is to present the case for an increase of 5.4 FTE in the Regional Child, Adolescent and Family Mental Health and Co-existing Disorder Service (CAFS). This is to:

- Bring staffing levels more in line with demand (current stats (Aug 2021) indicate a 40% rise in referrals over the last 12 months)
- Enable CAFS to have the capacity to have a more supportive community presence (for instance help community agencies like the PHO and interested schools and NGO's set up and run emotional regulation groups i.e ALERT).

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- Enable CAFS to be more responsive to the increased demand for service (particularly since post Covid 19).
- Provide a more focussed and consistent approach to the support of our community partner agencies, in their provision of earlier intervention. This would include our assistance with support for prevention of escalation into acute MH services and help with increasing their capacity/skills to work with children and young people with mild to moderate mental health issues.
- Address gaps in service provision; for instance, more group work, increase in assessment and therapy focussed staff (particularly around trauma focussed care).
- Enable us to eliminate the waitlist.
- Enable CAFS to reduce stress and overload of clinical staff.
- Enable CAFS to explore setting up a day program in collaboration with MASH Trust (at Te Matai)

BACKGROUND

Ministry of Health Priority Areas

Child & Adolescent Mental Health Services continues to be a priority area of mental health at a national level, highlighted by the Prime Ministers Youth mental health project from March 2015. There are 26 youth related projects, one of which continues to be to improve wait times and follow up care in CAMHS (DHB). As a result of the Mental Health review conducted in 2018, it has also been recommended that CAFS (Nationally) assists in supporting community services to up skill and develop more meaningful partnerships with NGO providers and schools.

Access for Maori continues to be a high priority for the MOH. Currently our Horowhenua team (based in Levin) have 52% Maori on their caseloads, partially representative of the fact that for the last 2 years Oranga Hinengaro have had no presence in the child and youth area. A large proportion of the group we have in our service have requested mainstream services.

Previous Service Capacity and Staffing reductions

Throughout 2018/19 CAFS recruited to back-fill positions that we lost between 2014-16 and were successful in getting the funding back for these in 2018. This brought us back to where we should have been but there has been no growth in CAFS FTE for some years.

Service Demand

Child and Adolescent Mental Health Services, both nationally and internationally, have experienced a significant increase in demand and acuity over the past several years but particularly so since the end of Covid 19 Lockdown. Recent statistical data shows a 40% increase in referrals across the Midcentral district since August 2020, on the back of a steadily rising referral number for several years. We currently have a waitlist. Crisis presentations and young people presenting with an Eating Disorder are very high now and are usually prioritised for follow up by the clinical team.

CAFS Midcentral has managed to keep waitlists to an absolute minimum (far below the national average through very active management of all referrals, use of brief intervention by our newly reconfigured Intake team and willingness of staff to push themselves). The increased Average Length of stay (ALOS) reflects the increasing

complexity of cases and stretches the capability of some of our staff, who need ongoing further mental health training. We have also centralised our referrals in-to Palmerston North so that our rural teams have more capacity for assessments and therapy.

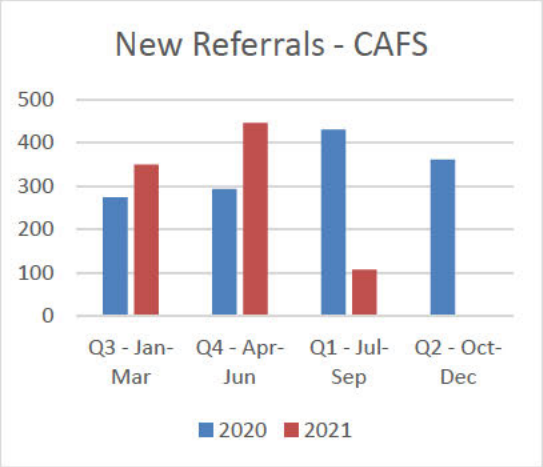


Diagram 1

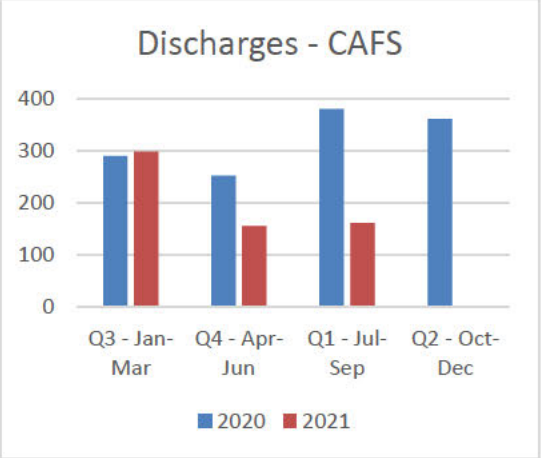


Diagram 2

Diagram 1 shows a referral increase of 40%. The 2nd diagram shows a reduction in discharges, showing increased complexity and hence longer-term involvement by CAFS.

Acuity and capacity

We use an acuity tool (adapted from CMHT tool) in order to capture the complexity of cases and to give a truer picture of a clinician's workload and capacity. This is also an essential tool for capturing work of clinicians who are not the primary clinician but completing a piece of work that is often more specialist (for instance Psychometrics, or specific therapies ie sensory profiles or Psychotherapy). One of the pieces of work we have so far been unable to capture adequately is the work involved with young people with an eating disorder as this exceeds the tools maximum capacity for client contact in a week (especially for those requiring multiple staff in daily contact i.e when admitted to medical or paediatric ward). Overall clinicians can be seen to be working at or above capacity, this is also congruent with our monthly KPI statistics, which shows consistently high-performance levels.

In terms of benchmarking caseloads against other CAF Services I was recently part of a small team of CAFS leaders asked to assist in the external review of Hawkes Bay CAMHS. I worked alongside Taranaki DHB, Hawkes Bay DHB and Waitemata DHB and was informed that the expectation for caseloads of CAFS Case managers/Clinicians was 15-20 dependent upon complexity. CAFS Midcentral is 20-25

Typical Clinical Vignettes:
15-year-old with symptoms of depression, anxiety, suicidal ideation and deliberate self-harm in the context of parental separation, history of family violence and recent social media bullying. Will often have tried PHO, school or NGO services first. The clinician requires skills in not only completing a very comprehensive assessment but then skills in working with the young person individually, psychological interventions such as (CBT -Cognitive Behavioural Therapy and DBT -

Dialectical Behavioural Therapy), and family therapy in the context of trauma AND how to liaise with schools, non-government agencies and Oranga Tamariki.

A typical referral for a child would be for query ADHD and behavioural issues, with a question around Autism Spectrum or learning difficulties (not explored by MOE), in the context of attachment issues and parental conflict with low threshold child protection concerns. Our initial assessment would include family but need information from school and Oranga Tamariki. It would involve a case manager and CAFS Paediatrician and possibly a Psychologist as well as input from our wider MDT meeting. It may also need the involvement of an Occupational therapist in terms of a sensory profile. Although CDS and Paediatrics are responsible for the assessment of a child for ASD, their waitlist has been 3 years and unfortunately children are developing significant behavioural and/or mental health issues whilst awaiting support. This then comes to CAFS.

Young people being referred regarding a probable eating disorder would be aged typically between 12 and 17yrs and at the point of referral would be very physically compromised. We have recently had at least 2 young people admitted into the Paediatric ward at any one time. These young people often present with very complex family dynamics and require us to utilise (wherever possible) the Maudsley Family Based Model of care. We had a full time RN and Specialist Paediatrician, plus a couple of hours of Psychology and some dietician hours, currently we are using a 1.2 fte RN, 0.8 fte Social Worker, dietician hours (not carved out time) and both Paediatric and Psychiatry time plus use of the CAFS duty/crisis service.

The cases we see at CAFS are varied but ultimately increasingly complex, some families will engage readily and be keen for change, others will need a lot of chasing up and encouragement (we do this because we hold the child at the centre of everything we do).

Current Service

The CAFS Team currently employs 32 clinical FTE (2.2 of these being for a MOH project with MOE for children with early signs of Conduct Disorder). We have also just seconded an Occupational Therapist 0.5 fte to MOE to run their funded pilot project regarding establishing the ALERT group in Early Childhood Centres (there are 5 pilot sites across the country).

The average keyworker caseload for a CAFS clinician is 20 – 25 clients, dependent upon acuity. This number is high and presents a risk to the service as the majority of our cases present with multiple diagnosis and sometimes extreme levels of acuity (risk of harm to self or others, domestic violence, out of school, parents with AoD use or severe MH issues). CAMH/CAF Service provision differs greatly from adult MH in 3 ways:

1. All CAFS staff are trained in therapy; we don't operate a case manager only system
2. CAFS work not only with the child/teen but also with their family, school and other services, such as Oranga Tamariki and MOE. This increases the amount of 'running around' to ensure a collaborative approach to a child's care.
3. We offer a wide range of best practice, evidence-based groups and several functional groups (10 in total).
    - Art Therapy (with community-based art therapist and CAFS staff member)
    - ALERT group (emotional/behavioural regulation group) which we run in a community hall, have also taught and help set up this in several schools.

- Box fit (we co-run a group for mixed sex and also recently started a girls only group)
- DBT, we have a full rolling program (this is for young people with self-harming behaviours and their parents and involves individual and groupwork)
- Skills group for parents of children in the Te Ohu conduct disorder service (teaches emotional regulation for parents)
- Parenting with Confidence, specifically for parents of children in the CAF Service
- Coping Kiwi, a specialist intervention for children with anxiety (with parent intervention)
- Family Therapy, we have a small specialist team who offer a family consult with brief intervention (this also involves the case manager)
- The Body Project, run on an as needs basis for young people experiencing some early body image issues (also have been approached to deliver the training to other DHB's)
- Smashed and Stoned, just about to re-start this with young people mis-using drugs & alcohol on a regular basis
- We have just developed an emotional regulation program that is not as intense as DBT that we will hopefully trial with an interested High School.
- Parent support and education groups (to be announced)
- Father support group (currently in discussion with a local NGO to co-run this group aiming to elevate the role of a father within our families and in our service)

The CAFS team is a truly Multi-disciplinary team with a range of professionals including Psychiatry, Social work, Nursing, Occupational therapy, Psychology, AoD and Admin as well as students/interns from Psychology, Social Work, Nursing and Occupational Therapy. Many of these professionals link well with schools, NGO's and community groups. However, the sheer demand on the service has limited our opportunity for outreach.

We have created a Single point of entry for all CAFS referrals which now go through our Palmerston Team. This team has been increased in size in the last 12 months from 2.8 FTE (1.0 Coordinator) to 4.5 FTE from within current resource, this is barely enough to handle the increase in referrals which need triaging. We run an acute service during hours of 8.30 to 3.30 (for crisis presentations to ED, Police, GP etc). Reflective of the acuity is our increase in admissions to Ward 21, the Rangitahi Adolescent unit and Paediatric ward.

PROPOSAL

The Ministry of Health via the CAMHS Sector meetings has been encouraging CAMHS to think about employing personnel outside of the usual registered professional groups to increase the breadth of services and the support offered to young people and their families. Examples are of Youth Workers and community support workers. The MOH has also placed emphasis on CAMHS helping to upskill Community partners and so sharing more of the load (in a safe and supportive way)

It is proposed that a further 5.4 FTE for CAFS be approved from new funding. This number would be enough to help meet current demands of the service and reduce the risk currently held by the team. It will also ensure we are able to give critical time to the up skilling of our more junior staff (essential if we are to continue to offer a sub-speciality service) and community partners. Two of the roles we have

prioritised (Allied Support worker and Psychologist in Horowhenua) all have a supportive function both in terms of the clinical team and our partners in the community.

Briefly:
Allied Support Worker (1 FTE). This is an innovative new role to provide support for CAFS clinicians by undertaking lower threshold clinical and some administrative tasks under a delegation model as per the MDHB Direction Delegation and Supervision of Therapy Assistants / Therapy Support staff. This would involve provision of training – Career Force and a competency framework to ensure safe practice. The role will support clinicians by assisting with more assertive outreach with youth: ensuring they get to appointments, support in completing CAFS treatment homework and enabling us to contain more complex situations without needing to resort to an admission.
The role would support the continuation of the numerous groups (currently 10) offered by CAFS by freeing up the second clinician, enabling them to undertake more clinical work. Best practice Group work currently increases our access and through put of clients.

Clinical Psychologist (1 FTE) to increase the assessment of children and young people with complexity, to fully understand what is going on to guide interventions. Although most of the CAFS team have substantial clinical/therapy skills and training, only a Psychologist can do Psychometric testing and more specialised interventions. This role would be based in Palmerston and Otaki where there is a greater need for this with an increasing wait list. Psychometric assessments are time consuming and an additional Psychology FTE would make a huge difference to helping meet this need.

CAFS Practitioner (2.0 FTE) must be multi-skilled and adaptable to adjust their interventions for the individual client and family. They are trained in CBT and all the team recently completed DBT training. Several case managers have experience in running groups. Now, running to maximum capacity we still have a waiting time of 8 weeks for an initial comprehensive assessment appointment, and are establishing a waitlist in Palmerston for the first time in a long time as demand is increasing each year. We need more case managers to meet the demand.

Dietician (0.4fte) This is to support our huge increase in demand for services for young people with a severe Eating disorder. This work is complex, time consuming and ultimately working with young people who have a life-threatening condition. We currently have no funded fte for a dietician. Although our dietetics dept are wonderful they are very stretched so the funding would go directly to them.

Community Liaison (1.0fte) the ongoing increase in referrals and acuity has meant that we have had to reduce the amount of liaison with our community providers (except where specific families). The opportunity to assist with upskilling and support is very limited. The role of community liaison would be to identify where we can be useful in preventing families falling between cracks in service, creating opportunities for upskilling/joined up working and myth busting between services. It is critical that we keep good channels of communication. We recently embarked upon a joined up working situation with Youthline because we sent out an email asking for help, we are hoping this will have great benefit not only for our young people but for the staff across both agencies.

BENEFITS OF PROPOSAL

If approved, the addition of FTE will allow CAFS to keep up with the current increased demand of the increasingly complex referrals while helping to maintain and support workforce development both within the CAFS team and in the community. It will assist in meeting the Key Performance Indicators, 'flexing' of some of our interventions (particularly group work) whilst ensuring we don't have high staff turnover because of 'burn out'.

A huge benefit will be supporting our NGO, PHO and school partners in increasing/stretching their skills as they increase their FTE and range of services. The bulk of this fte will be for CAFS FTE, we have been quite deliberate in this – we are a specialist, sub-specialty for mental health and in dire need of resource within.

Risks

There are several risks associated with not increasing CAFS FTE.

- Increased waitlists and inability to meet KPI's
- Young people deteriorating whilst on waitlist then needing crisis intervention.
- Clinician 'burn out', especially Child Psychiatry
- Inability to develop service to meet the needs of local population (for instance more group work, community pilot project)
- Inability to support the growing primary mental health sector.

COST

1 x Clinical Psychologist (Horowhenua, 0.5 cover Otaki)	[redacted]
1 x Allied support worker	
2 x Case manager (1x Horowhenua and 1 x CM) RN or OT	
1 x Community Liaison worker (RN or SW)	
1 x 0.4 Dietician	
Total	

NB: Not expanded on in this proposal is the possibility of a day program in the Palmerston North region. This would alleviate some of the need to refer into the Rangitahi Unit or CREDS service and will be presented for discussion at a later point.

7. RECOMMENDATION

It is recommended:

- That the Chief Executive Officer approves an increase of 5.4 FTE in the Child, Adolescent and Family Mental Health and Coexisting Disorder Service.

CAFS Leadership Team

[redacted]	[redacted]	[redacted]
CAFS Clinical Manager	Child Psychiatrist	Specialist Paediatrician
[redacted]	[redacted]	[redacted]
Clinical Co-ordinator	Clinical Co-ordinator	Clinical Co-ordinator

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

To	[redacted] Chief Executive Officer [redacted]
Author	[redacted] Associate Director of Nursing and Operations Lead, Mental Health and Addiction Services
Endorsed By	[redacted] Operations Executive, Mental Health and Addiction Services
Date	21 December 2021
Subject	**Acute Mental Health Unit - Leadership**

Background
Describe the current state and the case for change

Over the past two years the Acute Inpatient Unit (Ward 21) has seen increased and sustained demand for inpatient care. In response to this. staffing numbers have been progressively increased, the total budgeted FTE for the unit is currently at 83 with a further increase of 8.2 FTE proposed from the recently completed CCDM process. This would make Ward 21 the most highly resourced department in the hospital.

The DHB has also had difficulties recruiting and retaining senior clinical leadership (Charge Nurse) over the past two years. Whilst previous candidates brought there own challenges the role is large and complex and there is a view that we could be setting people up to fail. Current recent recruitment rounds that replace the vacant Charge Nurse roles have yielded no suitable candidates.

Additionally, the implementation of the acute model of care (to support the development of the new acute MH&A facility) requires a significant change effort across the unit whilst maintaining "business as usual" activities.

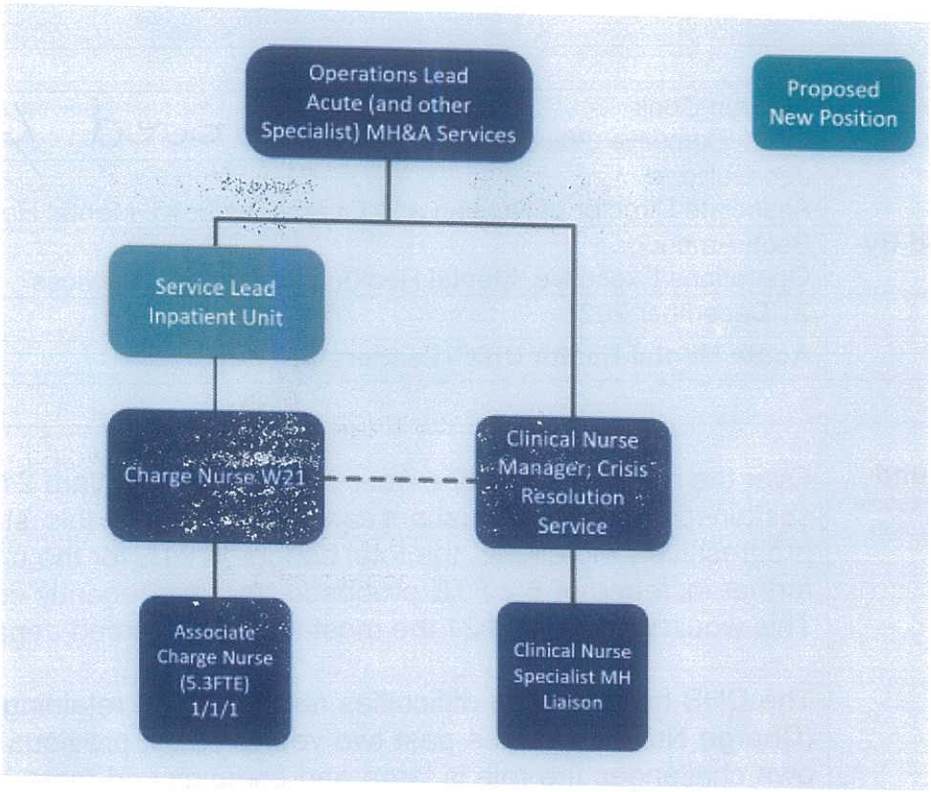
Late last year we consulted on a range of leadership options, there was strong support for the introduction of a new role, Service Lead, Acute MHA Services. The role would work in partnership with the Charge Nurse to provide operational service delivery and clinical care. Importantly the role would be responsible for leading the transformational change program within the ward.

Benchmarking with other similar size DHBs was also undertaken. As a comparison Taranaki and Hawkes Bay DHB have a hierarchical structure that include a Clinical Nurse Manager, Associate Clinical Nurse Manager and Clinical Coordinator on each shift. A recent review undertaken by Women and Children confirmed a similar structure of Midwife Manager and Charge Midwife for the Maternity suite.

Proposal

This proposal seeks approval for a **1.0 FTE increase** for a **Service Lead, Inpatient Unit**. The Service Lead and Charge Nurse will work in partnership to lead the effective and efficient clinical delivery of inpatient services. Combined with the

Clinical Nurse Manager, the three roles have overall responsibility for Acute Services within Te Uru Rauhi as shown in the diagram below:



The Service Lead is responsible for continually optimising care and pathways across the acute continuum of care, not just inpatient services with a strong focus on integration and transformation (NB: the role has been positioned such that it is available to all professional groups).

The structure creates a more sustainable leadership model with additional capacity and capability to transform services that align with the acute model of care whilst maintaining and improving the current clinical environment.

There is a shared accountability approach with responsibilities allocated across both roles See below:

Service Lead	Charge Nurse
• Operational leadership of workforces, including Human Resources metrics and management • Financial sustainability and accountability • Planning and management of facility and equipment • Workforce health, safety, and wellbeing • Workforce modelling • Performance management and meeting KPIs	• Clinical Governance • Safety and adverse events • Clinical Risk Management and Leadership • Consumer participation/engagement • Clinical effectiveness of service • Quality assurance of clinical service • Quality and service improvement • Model of care • Population health needs analysis • Clinical workforce leadership • Clinical vision and strategy

	• Project or programme management • Non-clinical risk management and leadership • Stakeholder engagement and intersectoral relationship building	• Professional accountability
	The pros and cons of a flatter structure were discussed, however given where the unit is at now, it was more important to ensure that the lines of accountability were very clear and transparent. A hierarchical structure provides this (NB: feedback from the consultation process also supported this approach).	
Funding Implications	This is a new position and would be an increase of FTE by 1.0 against budget. There is unlikely to be a cost impact in this financial year, due to the timing of recruitment and the current vacancies that are being carried across MHA services (NB: of the 270 positions, there are currently 57 vacancies across Nursing, Allied and Administration).	

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Decision Document

Acute Mental Health & Addiction Inpatient Unit Leadership

Te Uru Rauhī

December 2021

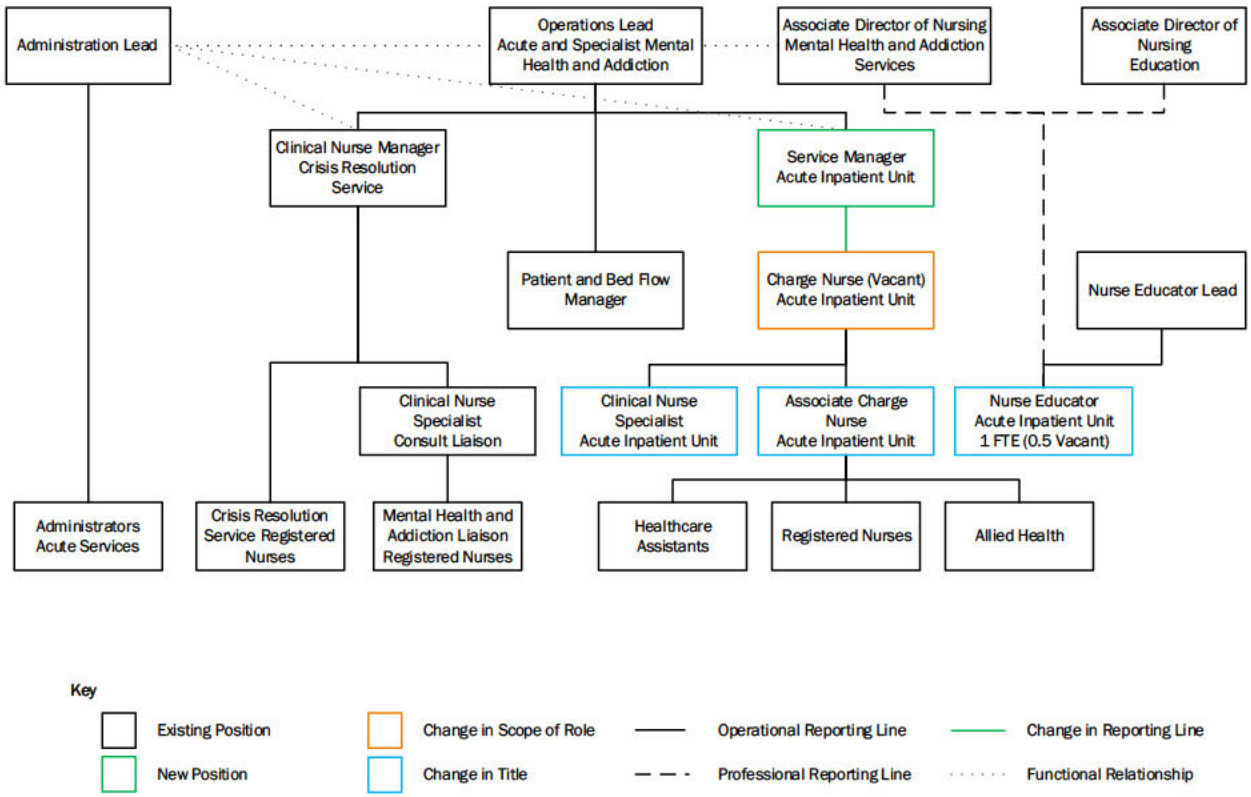
1. Background

Over the past two years the Acute Inpatient Unit (Ward 21) has seen increased and sustained demand for inpatient care. In response to this. staffing numbers have been progressively increased, the latest proposal identified the requirement to ensure the unit was able to safely operate up to 28 beds (up from 24-beds).

These increased resources (the majority of which are Registered Nurses and Healthcare Assistants), whilst positive have placed increased demands on the senior nursing staff. The DHB has also had difficulties recruiting and retaining senior clinical leadership (Charge Nurse) over the past two years. This lack of leadership creates instability, limits sustainable improvement and can adversely impact on clinical care.

Additionally, the development of the new acute MH&A facility supported by the acute model of care highlighted the need to change. The focus of the latter is to provide effective and efficient person- and whānau-centred care consistent with the principles of recovery to all experiencing acute mental (hinengaro) illness and/or addiction.

Consequently, a consultation process commenced, with a change paper released to staff on 19 November 2021. This proposed a new role, Service Manager. The Service Manager, Charge Nurse (CN) and Associate (CNs) work collectively to lead the Acute Inpatient Unit. The structure aims to provide additional capacity and capability to transform services to align to the acute model of care whilst maintaining and improving the current clinical environment. The following structure was proposed:



Note: Not all professional reporting lines are shown here. However, all Nurses and Healthcare Assistants have a professional reporting line to the Associate Director of Nursing, and all Allied Health have a professional reporting line to the appropriate professional leader. The Service Manager, if holding an annual practicing certificate, will have a professional reporting line to the relevant discipline professional leader.

2. Change Drivers

As outlined in the previous paper, to support the effective and safe functioning of the Acute Inpatient Unit, the key change drivers are:

- A sustainable leadership model that allows a supportive leadership environment with appropriate scopes of responsibility.
- An accountability approach that ensures all leaders are responsible for and committed to delivery of excellent care that is sustainable.
- Leadership that reflects benchmarked links between outcome expectations and leadership capacity
- Adequate resources are in place to support the implementation and normalisation of a new model of care.

3. Summary of Feedback

Thank you to everyone who took the time and effort to provide their views on the change proposal which were well considered. The following themes were identified:

- Support for the need to increase clinical and professional leadership
  This is supported and the introduction of a role that focusses on the operational components of leading and inpatient unit, will allow the Charge Nurse to focus on this.
- Support for increased operations management capacity
  This is supported – as above.
- This role to be a Nurse Manager rather than Service Manager
  This was not supported. Changing this to a nursing role limits the recruitment pool and doesn't acknowledge the expertise that Allied Health bring. There is also strong Nursing leadership in the inpatient unit, and across the directorate.

4. Summary of Changes

The following decisions were outlined in the paper:

Workforce Group	Change	Decision
Charge Nurse Ward 21	Minor change - Change of title to Charge Nurse – Acute Inpatient Unit and change of reporting line	Proposal Adopted
Associate Charge Nurse Ward 21	Minor change - Change of title to Associate Charge Nurse – Acute Inpatient Unit	Proposal Adopted
Clinical Nurse Specialist Ward 21	Minor change - Change of title to Clinical Nurse Specialist – Acute Inpatient Unit	Proposal Adopted
Nurse Educator Ward 21	Minor change - Change of title to Nurse Educator – Acute Inpatient Unit	Proposal Adopted

The following new role was outlined in the paper:

Workforce Group	Change	Decision
Service Manager Acute Inpatient Unit	New Role	Proposal Adopted

5. Support

It is recognised that this decision has some impact for staff. We ask and thank all colleagues in advance for being respectful and understanding during this time. The proposal may create uncertainty and concern for affected individuals. The employee assistance programme (EAP) provides is available for staff providing free, independent, and confidential counselling services. Support can be sought by contacting 0800 327 669.

Staff impacted by change are entitled to have the representation or support of a union, legal or employment advocate, whānau support or other person of their choice. NZNO and PSA have been informed of the proposal. Any staff who are not part of a union are entitled to seek independent advice and representation if they wish.

Free, independent, and confidential counselling services can be sought from EAP Services by contacting them on 0800 327 669. If staff have any questions related to their employment conditions, [redacted] [redacted] Senior HR Business Partner is available to be contacted on [redacted].

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Medical Leadership of the Mental Health & Addictions Services Cluster
Te Uru Rauhī
13 December 2021

MidCentral District Health Board | Te Pae Hauora o Ruahine o Tararua

Table of Contents

1. Purpose

This paper sets out changes aimed at strengthening medical leadership within Te Uru Rauhi - the Mental Health and Addictions Services (MHA) directorate. The relevant background, rationale for change and the impacts of the changes, are outlined for consideration. Information on the consultation process has been included. The input provided by medical staff in confirming this paper is appreciated and has been duly considered in confirming these decisions.

2. Background and Rationale for change

In April 2017 following wide consultation, MidCentral District Health Board (MDHB) confirmed that it would be moving to an Integrated Service Model and to support this, a directorate structure with 'cluster' and 'enabler' functions was developed.

It was agreed that each cluster would be led jointly by an Operations Executive and a Clinical Executive.

The Operations Executive would have overall accountability for the operational leadership and management of the service cluster, spanning primary, community and specialist services. The Clinical Executive would have overall accountability for the clinical leadership and management of the service cluster, spanning primary, community and specialist services. Collectively, the Operations and Clinical Executives for a service cluster would be jointly accountable for service and clinical performance, and patient outcomes for the services under their leadership. Together they would lead the planning, procurement, delivery, monitoring and evaluation of their services, regardless of the delivery model for those services, whether that be in the home, in a primary or community setting, or in a hospital environment. This structure has been in place across most clusters.

At this time, in September 2019, a Medical Lead role was established to support the Clinical Executive and to strengthen the medical leadership of the MHA directorate. However, as this role remained unfilled, despite recruitment attempts, the role morphed into a Medical Director role and an appointment was made to this role in February 2020.

The **Medical Director** is part of the senior leadership team within Te Uru Rauhī and works in partnership with the Operations Executive, Clinical Executive and Operations Leads to deliver safe, efficient, and comprehensive delivery of contemporary high quality, person/whānau centered clinical services across the continuum of care. The Medical Director is responsible for:

1. Providing clinical leadership, advice and support for the MHAS in the areas of Clinical Governance, Quality Improvement and Strategic Planning.
2. Providing clinical oversight of the MHAS and resolving clinical situations, where significant differences of clinical opinion and patient management exist between clinicians, teams and/or other DHB services. To achieve positive clinical and well-being outcomes, this may variously involve liaising and collaborating with Operational Leads, Locality Managers, Lead facilitators, Care Coordinators and SMOS, the DAMHS, Professional Leads and where necessary the MHAS Operational Executive, the CMO and other MDHB Clinical Executives
3. Liaising with other DHB Clinical and Medical Directors and the Ministry of Health and representing the Service at key National, Regional and Community Mental Health and Addiction forums.
4. The recruitment, deployment, retention and performance management of SMOs and RMOs.

Since the departure of the Clinical Executive (in August 2021) the Medical Director has taken on additional responsibilities that include several clinical executive functions as outlined below:

1. Acts as the representative for Te Uru Rauhi on the Medical Reference Group.
2. Chairs Te Uru Ruahī Clinical Governance Committee
3. Represents Te Uru Ruahī on the SEARGG.
4. Is the clinical contact for Te Uru Rauhi with the Ministry of Health.
5. Clinical Director representative for the Central Region DHBs on national Mental Health and Addictions Reference Group

In addition, Te Uru Ruahī has embarked a significant change management programme, te Matapuna o te Ora and the rebuild of the Mental Health facility that require increased medical leadership, the majority of which is falling to the Medical Director.

3. Confirmed Changes

Key changes confirmed as a result of the review are outlined below.

To ensure continued joint accountability for clinical and operational leadership the **Clinical Executive role is reinstated.** Recruitment to this role will begin as soon as practicable. It is intended that the incumbent recruited to this role is a Psychiatrist so that reporting for other Medical roles is simplified.

Once the CE role has been recruited and after an agreed transition period (and subject to that role being a psychiatrist), it is intended that the Medical director role (currently contracted) will be disestablished. Recruitment to the CE role will therefore commence.

To support the Clinical Executive, it is appropriate that the medical leadership structure of the directorate be reviewed to ensure there is sufficient medical leadership in place as Te Uru Ruahī and the DHB transitions into the new health system. The medical leadership model aligns with the direction of the Te Mātāpuna o te Ora and recognises the importance of the medical workforce as a critical success factor in leading the change. It also provides opportunities for elevating medical leadership with Te Uru Rauhī.

It is therefore decided that a Medical Lead for **Acute and Specialist Services** and a Medical Lead for **Specialist Community & Primary Services**, within the directorate be appointed.

The two **Medical Lead** roles report to the Clinical Executive (subject to the Clinical Executive being a Psychiatrist) and work in partnership with the Operations Leads to provide effective medical/leadership within each of their specialty area - Acute and Specialist Services and Specialist Community & Primary Services.

The Medical Leads are responsible for:

1. Providing medical leadership, oversight and guidance of clinical care, within their service cluster, to support person/whanau focused systems of integrated care that deliver high-quality, safe mental health and addiction services and positive health and well-being outcomes. This may variously involve liaising, advising and collaborating with their Operational Lead, Locality Managers, Lead facilitators, Care Coordinators, SMOS and the Medical Director.
2. Contributing to the growth and development of front-line clinical leadership, facilitating clinicians and teams within their cluster to undertake good clinical decision making and patient care and where necessary resolving clinical differences of opinion and approaches relating to care of patients presenting service challenges.
3. The clinical leadership and deployment of SMOs and RMOs within their service area and ensuring excellence in professional and practice standards.
4. Acting as a medical representative for their cluster and contributing to strategic and operational service planning relevant to the specialty and the medical workforce.

5. Reporting regularly to the Clinical Executive about the functioning and quality of services within their cluster and advising him/her of serious incidents occurring within the services.

The Medical Leads will work up to 0.3 FTE exclusive of maintaining clinical practice in their area of specialty.

To ensure stability and continuity of medical leadership the position of **Medical Director** will continue to provide medical leadership. The Medical Lead roles will report to the Medical Director until such time as a Clinical Executive, is in place. Once the CE role has been recruited and the CE is a psychiatrist, the Medical Leads will report to the CE and the Medical Director role will be disestablished.

Change impacts if this proposal is adopted:

- Clinical Executive role is reinstated and recruited to
- Two new roles of Medical Leads are created and recruited (internally)
- The Medical Director role is disestablished once the Clinical Executive is in place (subject to the Clinical Executive being a psychiatrist).

4. Consultation Process

The decisions contained in this paper were following a consultation process, encompassing directly and indirectly affected medical staff within the DHB and the unions.

All feedback has been carefully and fully considered in confirming these decisions. The final decision will be implemented as soon as practicable, following due process. A summary of feedback received is attached as Appendix A.

5. Support

Through this process, MDHB is committed to taking care of our people, preserving their mana, and ensuring their employment rights are met. This means acting according to our organisational values, engaging in genuine and meaningful consultation, and meeting our obligations as a fair and reasonable employer under the applicable legislation and in accordance with employment agreements.

Those staff who may be affected by change are entitled to have the representation or support of a union, legal or employment advocate, whānau support or other person of their choice.

Free and confidential counselling support through EAP Services will be available to all staff as consultation is progressed. EAP can be contacted by phone at 0800 327 669.

6. Recruitment process

Selection process

Recruitment process that is consistent with the requirements of the ASMS MECA will be followed.

Recruitment for the Clinical Executive and Medical Lead roles will be sequenced to allow staff to be able to apply for them.

Summary of Feedback

From	Feedback Theme	MDHB Response
ASMS Industrial Officer	Suggested minor changes to document Extension of timeline for feedback Clarity around certain aspects of the paper	All amendments noted and accepted
Senior Medical staff MHAS directorate	Amendments to the Medical Lead position description	All changes accepted and PD amended
All Senior Medical officers of the directorate	Emphasised that the Clinical Executive role must be a psychiatrist	Noted and accepted. The current recruitment market is hard enough to get psychiatrists. While getting a psychiatrist into this role will be our preference, we will continue to inform SMOs of the progress on this recruitment – any change of direction will be agreed with the SMOs in advance.

26 May 2022

[redacted]

Via email: [redacted]

Dear [redacted]

I refer to your Official Information Act request received by email on 28 April 2022 with regard to your request for information relating to the number of Gastroenterologists employed at MDHB and respond as follows:

- *How many Gastroenterologists have been appointed to your DHB between the dates 1st April 2020 – 1st April 2022?*

  Three

- *Were they employed in a sole Gastroenterology or dual Gastroenterology and General Medicine role?*

  One is Gastroenterology only. The remaining two have a Gastroenterology and General Medicine mixed role.

- *For those employed in dual Gastro/Gen Med roles:*
  - *What was the full time equivalent (FTE) for each role?*

    There is currently no defined FTE split between Gastroenterology and General Medicine components. However, demand dictates that Gastroenterology is the majority of the role.

  - *Did the General Medicine role include General Medicine ward cover?*

    General Medicine patients under their care are admitted to the General Medicine ward.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

25 May 2022

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Physical Address:
Gate 2
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Palmerston North
New Zealand

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

Your recent OIA request of 2927 April 2022 to MidCentral District Health Board (MDHB) is acknowledged.

The information you have requested follows.

Can you please advise how many courses of the following COVID-19 treatments have been dispensed to both inpatients and outpatients between 1 January and 28 April;

- **Baricitinib (Olumiant)**
  0 (seen by hospital clinicians)
- **Casirivimab with imdevimab (Ronaprever)**
  0 (seen by hospital clinicians)
- **Nirmatrelvir and Ritonavir (Paxlovid)**
  0 (seen by hospital clinicians)
  11 courses (outpatients – dispensed by community pharmacies)
- **Remdesivir (Veklury)**
  59 (seen by hospital clinicians)
- **Tocilizumab (Actemra)**
  3 (seen by hospital clinicians)

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

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Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

26 May 2022

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

As you are aware, your recent OIA request has been transferred to District Health Boards by the Ministry of Health under section 14 of the Official Information Act. Therefore, the following data has been provided as it pertains to MidCentral District Health Board (MDHB).

Can I please ask if the treatment of Remdesivir and ventilators has been or are being used as a treatment for COVID patients in hospital?

MDHB confirms that Remdesivir and ventilators have been used to treat patients with COVID-19 at Palmerston North Hospital.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

19 May 2022

[redacted]

Via email: [redacted]

Dear [redacted]

I refer to your Official Information Act request received by email on 6 May 2022 with regard to complaints raised by doctors regarding bullying over the past five years and respond as follows:

Year	Number	Disciplinary Action
2022	0	
2021	0	
2020	1	No – complaint not upheld
2019	0	
2018	0	
2017	0	

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

email **enable@enable.co.nz**
web **enable.co.nz**

1 June 2022

[redacted]

Dear [redacted]

Official Information Act request response

Please see enclosed information in response to your request on 6 May 2022 for the following information under the Official information act.

1) Copy of Enable New Zealand annual report and financials.

Enable New Zealand has referred the other information requests on to the Ministry of Health. Enable New Zealand are contracted to provide hearing services on behalf of the Ministry of health.

The Ministry of Health are going to provide the following information to you:

2) Information on the hearing services annual spend for subsidies and funding; and
3) Information on past hearing services and why and when adjustments to the subsidy will occur.

Enable New Zealand is part of Midcentral District Health Board (DHB), so we have attached a copy of Midcentral DHB financials.

If you have any queries, please contact me on 0800 362 253 or 06 3535811.

Yours sincerely

Rachel Tatham
Service Manager, Professional Services

Palmerston North Head Office
1st Floor, 585 Main St, Palmerston North
PO Box 4547, Palmerston North 4442
06 353 5800

Christchurch Locality Office
78A Hammersmith Drive, Wigram, Christchurch
PO Box 33054, Christchurch 8244
03 343 8900

Hamilton Locality Office
8 Clow Place, Melville, Hamilton
PO Box 5744, Frankton, Hamilton 3242
07 843 9170

Tena koe [redacted]

Official Information Act (OIA) request - OIA Y22-489 - Breast Screening Wait Time Data

Your request sent through to the Ministry of Health dated 28 April 2022 to Jan Torres, Acting Manager, OIA, Service Office of the Director-General has been transferred to our DHB to answer the following questions as it relates to Breast Screen Coast to Coast:

1. Average wait time

	Rescreen	New Enrolment – fixed site	New Enrolment – mobile sites
MidCentral	22.5 months	0 – 2 months	6 – 8 months
Whanganui	23.7 months	0 – 2 months	6 – 8 months
Taranaki	23.3 months	0 – 2 months	6 – 8 months
Hawke's Bay	22.4 months	0 – 2 months	0 – 2 months
Tairawhiti	25 months	0 – 2 months	4 months

2. Median wait time

	Rescreen	New Enrolment – fixed site	New Enrolment – mobile sites
MidCentral	23 months	0 – 2 months	4 – 6 months
Whanganui	23 months	0 – 2 months	6 – 8 months
Taranaki	22 months	0 – 2 months	4 – 6 months
Hawke's Bay	23 months	0 – 2 months	0 - 2 months
Tairawhiti	24 months	0 – 2 months	4 months

3. Longest wait time

	Rescreen	New Enrolment – fixed site	New Enrolment – mobile sites
MidCentral	24 months	0 – 2 months	12 months
Whanganui	24 months	0 – 2 months	12 months
Taranaki	24 months	0 – 2 months	12 months
Hawke's Bay	24 months	0 – 2 months	2 – 4 months
Tairawhiti	28 months	0 – 2 months	4 – 6 months

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Mātai Matengau
Cancer Treatment, Screening and Support

CC [redacted], OIA Services, Office of the Director-General, Minisry of [redacted]

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

10 June 2022

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[redacted]

Dear [redacted]

Official Information Act (OIA) Request

I am responding on behalf of MidCentral District Health Board to your OIA request of 13 May 2022 in which you have requested the following information.

1. **Data about MRT staffing levels. We required the budgeted and the current FTE figures for each DHB site, for the following years;**
   a. **The financial year ended 30 June 2020.**
   b. **The financial year ended 30 June 2021.**
   c. **The year to date, ending 14 April 2022.**

2. **Figures for the total number of examinations (i.e. examinations, not patient numbers) performed for the following years;**
   a. **The financial year ended 30 June 2020.**
   b. **The financial year ended 30 June 2021.**
   c. **The year to date, ending 14 April 2022.**

3. **Wait list times for the following years;**
   a. **The financial year ended 30 June 2020.**
   b. **The financial year ended 30 June 2021.**
   c. **The year to date, ending 14 April 2022.**

4. **Current Radiology services and hours of work.**

The information you have requested follows.

Name of DHB:	**MidCentral DHB**					
Name of Hospital Site:	**Palmerston North Hospital**					
	30 June 2020		**30 June 2021**		**14 April 2022**	
	MIT Budgeted FTE	**MIT Actual FTE**	**MIT Budgeted FTE**	**MIT Actual FTE**	**MIT Budgeted FTE**	**MIT Actual FTE**
TOTAL	38	43.625	52	44.125	53	40.8

Name of DHB:	MidCentral DHB		
Name of Hospital Site:	Palmerston North Hospital		
	Year ended 30 June 2020	Year ended 30 June 2021	Year to Date, Ending 14 April 2022
	Total Number of Examinations Completed	Total Number of Examinations Completed	Total Number of Examinations Completed
MRI	5,155	6,461	4,371
Nuclear Medicine	3,134	3,774	3,007
Mammography	2,302	2,147	1,726
CT	14,842	20,741	14,865
Angiography	221	209	230
Angiography – Cardiology	397	414	310
Fluoroscopy	556	550	427
Theatre	1,300	1,427	1,110
Emergency – General	34,922	37,115	25,613
General – Other	19,408	22,027	16,728
TOTALS	**82,237**	**94,865**	**67,937**

Name of DHB:	MidCentral DHB			
Name of Hospital Site:	Palmerston North Hospital			
Average Patient Wait Times by Urgency as at June 2020				
Exam Dept	Urgent	High Suspicion of Cancer	Semi-urgent	Non-urgent
MRI				
Nuclear Medicine	Within 2 days	Within 1 week	Within 2 weeks	Within 3 weeks
Mammography				
CT				
Angiography/Cardiology				
Fluoroscopy				
Theatre				
Emergency – General				
General – Other				

Average Patient Wait Times by Urgency as at June 2021				
Exam Dept	Urgent	High Suspicion of Cancer	Semi-urgent	Non-urgent
MRI				
Nuclear Medicine	Within 2 days	Within 2 weeks	Within 3 weeks	Within 3 weeks
Mammography	N/A	N/A	N/A	N/A
CT	1 hour	10 days	40 days	60 days
Angiography/Cardiology	4 hours	7 days	3 weeks	4 months
Fluoroscopy	N/A	N/A	N/A	N/A
Theatre	Nil	N/A	N/A	N/A
Emergency – General	Nil	Nil	Nil	Nil
General – Other	Nil	Nil	Nil	Nil

Average Patient Wait Times by Urgency as at June 2022				
Exam Dept	**Urgent**	**High Suspicion of Cancer**	**Semi-urgent**	**Non-urgent**
MRI				
Nuclear Medicine	Within 2 days	Within 3 weeks	Within 4 weeks	Within 6 weeks
Mammography	N/A	N/A	N/A	N/A
CT	1 hour	10 days	40 days	60 days
Angiography/Cardiology	4 hours	7 days	3 weeks	4 months
Fluoroscopy	N/A	N/A	N/A	N/A
Theatre	Nil	N/A	N/A	N/A
Emergency – General	Nil	Nil	Nil	Nil
General – Other	Nil	Nil	Nil	Nil

Name of DHB:	**MidCentral DHB**		
Name of Hospital Site:	**Palmerston North Hospital**		
Current Services & Hours of Work as at 14 April 2022			
Mondays to Friday			
Modality (if more than one room, document each room)	**Location**	**MITs on Duty/Shift**	**On-call**
CT	PN Hospital	0730 – 2400 hrs	2330 – 0730 hrs
MRI	PN Hospital	0600 – 1900 hrs	
Nuclear Medicine	PN Hospital	0800 – 1630 hrs	
General 2	PN Hospital	0800 – 1630 hrs	
General 3	PN Hospital	0800 – 1630 hrs	
General 6	PN Hospital	0800 – 1630 hrs	
General 10	PN Hospital	As required	
General ED 1	PN Hospital	0000 – 2400 hrs	1630 – 0800 hrs
General ED 2	PN Hospital	0800 – 2230 hrs	
Mobiles	PN Hospital	0800 – 1630 hrs	
Fluoro/DSA	PN Hospital	0730 – 1630 hrs	1630 – 0730 hrs
Weekends & Public Holidays			
Modality (if more than one room, document each room)	**Location**	**MITs on Duty/Shift**	**On-call**
CT	PN Hospital	0800 – 2400 hrs	2330 – 0800 hrs
MRI	PN Hospital	0800 – 1400 hrs (Sat)	
General ED 1	PN Hospital	0000 – 2400 hrs	0000 – 2400 hrs
Fluoro/DSA	PN Hospital		0000 – 2400 hrs

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

13 June 2022

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

Your OIA request of 31 April 2022 to MidCentral District Health Board (MDHB) is acknowledged.

The information you have requested follows.

1. **What is the current shortest, longest, median and average ED waiting time over the month of May 2022?**

Shortest	0.0 hours
Longest	48.2 hours
Median	6.0 hours
Average	8.1 hours

2. **How many people arriving at ED were managed (as per previous ED wait time national target definitions) within six hours in the last month?**

   2,063 out of 3,917

3. **What is the performance against an ED wait time target of 95% managed within six hours (as per previous ED wait time national target definitions) for every quarter in the past year, listed per quarters?**

2021	Quarter 1	77%
2021	Quarter 2	73%
2021	Quarter 3	68%
2021	Quarter 4	64%
2022	Quarter 1	64%

4. What are the ED presentation numbers per quarter for the past five years listed per quarter as an absolute number and as a per capita percentage and totalled as an absolute number per year and as total presentations per capital per year?

Year	Quarter	No.	%	Annual	%
2017	1	10,425	5.8%		
	2	10,435	5.8%		
	3	11,290	6.3%		
	4	10,762	6.0%	42,912	24%
2018	1	11,088	6.1%		
	2	11,126	6.1%		
	3	11,984	6.5%		
	4	11,430	6.2%	45,628	25%
2019	1	11,694	6.3%		
	2	11,795	6.3%		
	3	12,142	6.5%		
	4	11,597	6.2%	47,228	25%
2020	1	11,158	5.9%		
	2	9,688	5.2%		
	3	11,561	6.2%		
	4	12,216	6.5%	44,623	24%
2021	1	11,910	6.3%		
	2	12,281	6.5%		
	3	11,649	6.2%		
	4	11,982	6.3%	47,822	25%
2022	1	10,895	5.7%		

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

[redacted]

Tēna koe

The following response is provided in relation to your Official Information Act 1982 (OIA) request received on 23 May 2022.

1 *Which buildings or structures are at 34% NBS or less listed by building, NBS, date assessed and assessing agency?*

Building	NBS	Date assessed	Assessing agency
B Block – Main corridor	34%	18.1.2020	Calibre
B Block – Roof plant space	<34%	18.1.2020	Calibre

2 *Which buildings or structures are at 15% NBS or less, listed by building, NBS, date assessed and assessing agency?*

There are no buildings or structures at 15% NBS or less.

3 *When was the last enterprise wide seismic assessment? We request a copy of that assessment.*

Seismic assessments are conducted on a building by building basis over time. The volume of buildings involved requires a staggered approach rather than a single enterprise-wide seismic assessment.

4 *When was the last time seismic risks were shared with the Ministry of Health, Minister or his Office listed by date and type of communication?*

The Ministry of Health required seismic reports to be submitted every six months. The last report was submitted in late 2019.

Finance and Corporate Services
MidCentralDHB, PO Box 2056, Palmerston North Central, 4440.
Tel: 06 350 8800 Fax: 06 350 8080

5 *Does your risk register fully describe seismic risk to the same degree as seismic briefings to risk and audit committees; if not, why not?*

The Finance, Risk and Audit Committee receives quarterly updates on all risks and mitigations, including any seismic or infrastructure risks. The Committee also receives an annual report on the DHB's seismic programme.

6 *When was the last time the risk register was sent to the Ministry of Health, Minister or his office?*

The papers for every Finance, Risk and Audit Committee meeting were sent to the Ministry of Health's Account Manager. These papers included regular updates on the risk register. This practice ceased early 2020.

7 *When was the last time the DHB sent a letter or email of concern around seismic risk to the Ministry of Health or the Minister or his office? We request a copy of that communication.*

To the best of my knowledge, no letters or emails of concern around seismic risk have been sent to the Ministry of Health or the Minister or his office.

8 *When was the last time seismic risk was discussed at a board level and what was the nature of that discussion?*

As noted above, the Finance, Risk and Audit Committee (a subcommittee of the board) receives a full report each year on the DHB's seismic programme. The last report was in June 2021. This report provided an update on the seismic remedial work programme including progress made, actions undertaken and planned future work. It was noted that regular seismic reviews ensure the DHB's seismic risk assessments and mitigation strategies remain relevant.

9 *When was the last time communication was had with seismic insurance or indemnifiers around seismic risk concerns? I request a copy of that communication.*

To the best of my knowledge, MidCentral District Health Board has not had any communication with seismic insurance or indemnifiers around seismic risk concerns.

If you are not satisfied with this response you have the right to raise any concerns with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance and Corporate Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

15 June 2022

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

As you have been advised by the Ministry of Health (MoH), your OIA request of 17 April 2022 has been partially transferred (questions 1, 2 and 8) to MidCentral District Health Board (MDHB).

The information requested as it pertains to MDHB follows.

1. **All hospital Emergency room visits in the last 24 months with a patient complaining of heart issues where the patient has claimed, as written in their notes, that their issues are related to the vaccine.**

   We are unable to provide this data as;

   (i) The patient would have to specifically state this and it would have to be recorded in the clinical notes.

   (ii) This information cannot be extracted electronically. This would require every possible case to be pulled manually and the clinical records reviewed.

2. **All acute myocarditis, pericarditis and tachycardia admissions post COVID diagnosis.**

   We are unable to provide this data as we do not have access to the central COVID database that records all positive case, as reported to the MoH, and therefore cannot cross reference that data with a patient list for the conditions mentioned.

8. **The number of ambulance admissions to emergency departments for heart and breathing or neurological issues that have been referred to in any hospital notes as anxiety since the rollout began and the comparative figures for the last five years.**

   We are unable to provide this data as;

   (i) The patient would have to specifically state this and it would have to be recorded in the clinical notes.

(ii) This information cannot be extracted electronically. This would require every possible case to be pulled manually and the clinical records reviewed.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

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Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

28 June 2022

[redacted]

Dear [redacted]

We are in receipt of your Official Information request dated 6 May 2022.

You advised that you would like copies of the following documents under the Official Information Act 1982:

- **Any policy document the DHB has in place addressing the risk that an Integrated Pharmacy Services Agreement (ICPSA) is granted to a pharmacy in which medicines are co-located (i.e., offered for sale within the same physical premises) as alcohol, cigarettes.**

  MDHB has a policy document highlighting criteria required for an ICPSA application. Under paragraph 6.1 a criterion details "The applicant will demonstrate how it will increase the impact of co-located and nearby services and facilities with positive health outcomes and how it will minimise and mitigate the impact of those with negative health outcomes".

  The policy document is attached as Appendix 1.

- **To the extent your DHB has such a policy document, documents recording any discussion about the potential issues raised by co-location of pharmacies and alcohol and/or cigarettes during the development of the DHB's pharmacy contracting policy.**

  MDHB has feedback that is recorded in the form of submissions received as part of process for MDHB's Community Pharmacy Commissioning Policy that went out for submission. Two submissions were received in relation to the OIA.

Issue	Number of submissions	Proposed change
Pharmacies should not sell tobacco and alcohol	2	Needs careful consideration, would exclude supermarkets from obtaining an agreement. May negate improved access opportunities. Can be easily circumvented. Also issue of other products contributing to burden of disease.

MDHB has written information from the Community Pharmacy Commissioning Policy Workshop which is detailed in Appendix 2.

- **Any documents showing that the DHB and its personnel took into account and/or addressed the fact that alcohol and/or cigarettes are available for sale within the same premises as a pharmacy when considering the application for an ICPSA by a Countdown Pharmacy. This request is limited to ICPSA applications submitted to the DHB by a Countdown Pharmacy after 1 May 2020.**

  MDHB has one ICPSA application entrain, and the process is still ongoing. The comment presented by MDHB is presented below:

  > *"The sale of tobacco and alcohol products from the premises is of concern to the DHB. The Panel members expect the identification of specific actions to promote smoking cessation and reduce alcohol related harm".*

- **Any policy document the DHB has in place to monitor the operation of an ICPSA (or, if no such specific policy exists, any policy document the DHB has in place to monitor the operation of service agreements it has entered into pursuant to section 25 of the New Zealand Public Health and Disability Act 2000).**

  MDHB does not have such a policy, for either the ICPSA or agreements more generally. MDHB relies on the provisions contained in the ICPSA and the reporting requirements for the various service specifications attached to the ICPSA to monitor the service delivery of the agreement holders.

- **Any policy document the DHB has in place addressing how it should respond to a failure to comply with the terms of an ICPSA (or, if no such specific policy exists, any policy document the DHB has in place to address a failure to comply with a service agreement it has entered into pursuant to section 25 of the New Zealand Public Health and Disability Act 2000).**

MDHB does not have such a policy. MDHB relies on the provisions of the ICPSA to enable it to respond to failures to comply with the terms of the ICPSA.

- **Documents recording the DHB's response to any failure by a pharmacy to comply with the terms of its ICPSA. This request is limited to failures since 1 January 2021.**

  MDHB does not have any documents since 1 January 2021, recording MDHB's response to any failure by a pharmacy to comply with the terms of its ICPSA.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Deborah Davies
Operations Executive
Primary Public & Community Health

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Appendix 1

POLICY

COMMUNITY PHARMACY SERVICES COMMISSIONING	
Applicable to: **Community Pharmacy Services Providers and persons wanting to provide Community Pharmacy Services**	Issued by: **Strategy, Planning and Performance**
	Contact: **Advisor Commissioning and Contracts**

1. PURPOSE

The purpose of this policy is to outline an equitable and quality approach by which MidCentral District Health Board (MDHB) will commission Community Pharmacy Services that achieve its statutory objectives and the national and MDHB visions for those services in an equitable manner that best meets the needs of MDHB's district community.

Commissioning is a continual and iterative cycle involving the development and implementation of services based on strategic planning, procurement, monitoring/reporting and evaluation. Commissioning describes a broad set of linked activities, including service overviews, priority setting, procurement and purchase through contracts, monitoring of service delivery and review and evaluation.

2. CONTEXT

MDHB has a statutory objective under the New Zealand Public Health and Disability Act 2000:

'....to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local... needs' (section 22(1)(ba)).

The Integrated Community Pharmacy Services Agreement (ICPSA) came into effect on 1 October 2018. The purpose of this contract is to implement the objectives relating to the delivery of Community Pharmacy Services that are set out in clause A.1 of the ICPSA. These include:

- delivering Community Pharmacy Services in an innovative way so that all New Zealanders have equitable access to medicines and health care services;
- fully utilising the unique and complementary skill set of pharmacists as healthcare providers to enhance patient safety; and
- flexible delivery of Community Pharmacy Services to enable DHBs to commission population services to meet the needs of the people living in the DHB's geographical area.

A variation to ICPSA that came into force in 2019 provides that a DHB may control the location of contract holders if it has a policy relating to population access to Community Pharmacy Services. This policy serves that purpose.

This policy guides how MDHB will achieve the intent of the Ministry of Health's *Pharmacy Action Plan 2016-2020* and MDHB's *Pharmacy in MidCentral Strategy*.

3. POLICY STATEMENT

This policy provides the opportunity to configure and shape MDHB's pharmacy services to ensure greater emphasis on access, target inequities and generate better health outcomes for MDHB's district community. The policy provides greater influence on where new pharmacist services are located, and ensures that providers demonstrate a collaborative partnership with primary care. It will ensure Community Pharmacy Services best address MDHB's vision for quality pharmacist services. Providers must be capable of complying with the ICPSA and support the Pharmacy Action Plan and Pharmacy in MidCentral Strategy.

MDHB will continue to investigate and develop opportunities to commission services through Community Pharmacies that support the following:

- MDHB Strategic Imperatives, including:
  - Achieving quality and excellence by design;
  - Connecting and transforming primary, community and specialist care;
  - Partnering with people and whānau to support health and wellbeing; and
  - Achieving equity of outcomes across communities.
- Pharmacy Action Plan 2016-2020, in relation to:
  - Population and personal health;
  - Medicines management services;
  - Minor ailments and referral; and
  - Dispensing and supply services.
- Pharmacy in MidCentral Strategy, in relation to:
  - Systems;
  - Services; and
  - Workforce.

This approach will take a quality improvement approach, with a focus on:

- Delivery of services based on health need;
- Equitable access to Community Pharmacy Services;
- Fully informed patient self-care;
- Integrated, multi-disciplinary co-ordination to patient services;
- A focus on people centric collaboration between pharmacists, from the hospital to the community; and
- Increasing primary care capacity

4. SCOPE

To achieve the policy statement set out above, this policy will guide MDHB's decision-making relating to Community Pharmacy Services in MDHB's district including:

- All requests received for a new ICPSA;
- When existing ICPSA holders seek to transfer their pharmacy contract, which results from the partial or complete sale of a pharmacy or because there is a change in control of the pharmacy
- When an existing ICPSA holder:
  - Seeks to relocate the pharmacy;
  - Seeks to provide services from an additional premise (including through a satellite pharmacy) or location;

- Seeks to amalgamate with one or more providers; or
- Seeks to provide a new Community Pharmacy Service within an existing contract.

This policy applies to:

- All employees and Board Members of MDHB;
- All external personnel of MDHB; and
- Any other designated person or organisation dealing with the commissioning of Community Pharmacy Services for, or on behalf of, MDHB.

5. PROCESS

The process for assessing applications will be as follows:

a. Applicants must complete the relevant application form and send it to: Advisor Commissioning and Contracts, Strategy, Planning and Performance, MidCentral DHB, Gate 2, Heretaunga St, Palmerston North 4414 or emailed to contracts.department@midcentraldhb.govt.nz
b. An email acknowledging your application will be sent within 5 working days of receipt.
c. MDHB will convene the MidCentral DHB Community Pharmacy Commissioning Panel (the Panel) to consider the information provided in the application form, having regard to current access and quality of pharmacist services for the population in the proposed location.
d. The Panel will make a recommendation to the Chief Executive Officer's delegate who will make a decision on the application.

5.1 Applications for new ICPSA

The applicant will be advised of the outcome of the application within 20 working days of making the application, unless a request for additional information is made.

Applications relating to new pharmacy contracts will be considered against the criteria outlined in clause 6.1 of this policy.

Applications that are granted will be subject to the pharmacy subsequently obtaining and maintaining a pharmacy licence through the Ministry of Health where required.

5.2 Applications for transfer of existing ICPSA

The applicant will be advised of the outcome of the application within 20 working days of making the application, unless a request for additional information is made.

Applications relating to existing pharmacies will be considered against the criteria outlined in clause 6.2 of this policy, consistent with the requirements of clause C.45 of the ICPSA.

5.3 Applications to provide services from a new location, additional premises, or new services within an existing ICPSA, including delivery of existing national service not currently provided by the provider

The applicant will be advised of the outcome of the application within three months of making the application. MDHB will notify the applicant for a change of location of its decision within 20 working days from receipt of the notification given under subclause (1)(a) of clause B.20 of the ICPSA.

If approved, the service may be initially tested through a short-term pilot programme with funding support (up to 12 months). Extensions after that period will be dependent on the performance of the pilot programme.

Applications relating to the change of location, additional premises, or new funded national services within existing Pharmacy Contracts will be considered against the criteria outlined in clause 6.3 of this policy, and in accordance with the requirements of clause B.20 of the ICPSA.

5.4 Applications not received

MidCentral DHB is not responsible for applications that are not received.

5.5 Requests for additional information

During the application process, the Panel may require further information from an applicant additional to that contained in the application, for example in regard to:

- determining the nature of the interest held by any person in the pharmacy;
- the requirement for a person to be a 'fit and proper' person or a body corporate to be of 'good repute'; or
- the ownership structure of the pharmacy.

The applicant will be advised of the outcome of the application within 20 working days of providing the additional information.

If the applicant fails to supply the information within 30 days of the date of the request (or within any additional time given by the Panel) the application will lapse. This requires the applicant to submit a new application.

5.6 Once an application is approved

Applications for new Pharmacy Contracts, relocations, additional premises or locations, transfer of existing pharmacy contracts.

Subject to the application being approved, the applicant will have 90 days to begin the process of purchasing/leasing the pharmacy building and submit the application for a Ministry of Health Pharmacy Licence. If the applicant fails to begin the process within 90 days, the approval may be revoked and a new application may be required. New pharmacy operations must be completed within 12 months of approval. If the applicant fails to begin to complete the process within 12 months from approval, the approval may be revoked and a new application may be required.

Applications for new Community Pharmacy Services within existing Pharmacy Contracts

Subject to the application being approved, the applicant will have 90 days to begin the provision of service through a new pharmacy or existing pharmacy. If the applicant fails to complete providing the service within 90 days, the approval may be revoked and a new application may be required.

5.7 If an application is declined

In the event of the application being declined, the applicant may request that the decision be reviewed by the Chief Executive Officer within 30 days of notification of the decision, by providing additional information to support the original application. The decision of the Chief Executive Officer will be final.

If any information provided in relation to an application is found to be untrue, incomplete or misleading in anyway the application will be declined.

6. APPLICATION CRITERIA AND DECISION MAKING

6.1 New ICPSA

Consideration of applications for a new ICPSA will be guided by the criteria set out in the table below. The associated information requirements are also set out in the table below.

Criteria	Information requirement
The applicant has demonstrated it is of good character and there are no unresolved issues concerning the pharmacist/s current or past Annual Practicing Certificate/s (APC) or Ministry of Health licence/s or conditions.	• Provide the following Applicant information – APC (including any conditions), police check and good character information. • Details of community pharmacy experience • Details of any conditions imposed on an APC • Details if an APC has ever been cancelled • If the applicant has been a pharmacy owner previously, provide details if a Ministry of Health licence has had conditions applied or cancelled.
The applicant has demonstrated that the proposed services are consistent with relevant national and local strategic priorities, including Ti Tiriti o Waitangi commitments, for pharmacy and pharmacy services. The applicant will contribute to providing best practice advice and service so that the people of MidCentral achieve better health outcomes – People Centric, Best Practice, Better Health Outcomes.	• Explain how the proposed services will meet the relevant national and local strategic priorities for pharmacy and pharmacy services outlined in the Clause 3 Policy Statement and Pharmacy in MidCentral Strategy. • Provide details of how the applicant will support the introduction of appropriate Maori principles/tikanga within its organisation to promote the holistic approach of Maori health care. • Provide a Quality Improvement Plan that includes details of how the applicant will take into account the needs of Maori service users. • Provide a plan on how the proposed services will address inequity. • Provide details about how the applicant will contribute to providing best practice advice and service so that the people of MidCentral achieve better health outcomes – People Centric, Best Practice, Better Health Outcomes.

Criteria	**Information requirement**
The applicant has demonstrated that it will provide services required by MDHB in an area or for a population in need of pharmacy services. Assessment of this criterion will include: • location • population served • proposed services • opening days/hours	• Pharmacy Information – location, proposed services, opening hours. • Confirmation that the applicant will provide all PHARMAC Schedule section B, C and D medications to patients if requested and required; including high cost medications (exemptions may apply as directed by MidCentral DHB or PHARMAC). • Provide information about existing pharmacy services in the proposed location and the different services that will be supplied from the existing services. • Distance to nearest existing pharmacies. • Proximity to primary care services and populations with special needs. • Explanation of what the population needs are of the proposed pharmacy location, how are they currently being met and how the services provided by the applicant will meet the unmet population health needs.
The applicant demonstrates that it has sufficient staff with relevant qualifications and accreditations to deliver the proposed services.	• Provision of staffing plan and profile. • Information on contingency planning to ensure maintenance of acceptable minimum staffing levels.
The applicant will demonstrate how it will increase the impact of co-located and nearby services and facilities with positive health outcomes and how it will minimise and mitigate the impact of those with negative health outcomes.	• Information on where the proposed pharmacy will be located, including information on co-located and nearby services and facilities relating to better population health outcomes, such as healthy eating, healthy exercise, social inclusion, etc. and how the pharmacy will leverage these to improve health outcomes. • Information on any co-located and nearby services and facilities relating to alcohol and tobacco sales, gambling facilities, or other services that contribute to poorer population health outcomes and how the pharmacy will reduce or eliminate their adverse impact on health outcomes.
The applicant has demonstrated that it will work in an integrated manner with primary care providers to ensure continuity of care to patients resulting in better health outcomes.	• Explanation of how the applicant will work with primary care providers to support better health outcomes. • Evidence of engagement plan with primary care providers in the proposed location.

Criteria	Information requirement
	• Information on how the applicant will engage with population groups with greater needs, including the elderly and those receiving mental health and addiction services. • Information on how the applicant will address the physical, emotional, social, spiritual and intellectual aspects of health in providing holistic services
The applicant has demonstrated it has suitable systems and processes in place to meet the Pharmacy in MidCentral Strategy and the Community Pharmacy Quality Standards.	• Provide evidence of systems and processes relevant to meeting the Pharmacy in MidCentral Strategy and the Community Pharmacy Quality Standards.

6.2 Transfer of existing ICPSA

Consideration of applications for a transfer of an existing pharmacy contract will be guided by the criteria set out in the table in clause 6.1 as relevant and decisions about applications will be made in accordance with C.45 of the ICPSA. MDHB must be satisfied of the proposed transferee's ability to perform its obligations under the ICPSA and request reasonable details to inform any consent. The MDHB seeks to gain maximum quality improvement through any change.

6.3 Services from a new location, additional premises or for new services within existing ICPSA, including delivery of existing national service not currently provided by the provider

Consideration of applications for services from a new location, additional premises or new funded national services within an existing ICPSA, including delivery of existing national service not currently provided by the provider, will be guided by the criteria set out in the table in clause 6.1 as relevant. Consideration of applications for a change in location of premises will be consistent with clause B.20 of the ICPSA. MDHB will have regard to the proximity of other community pharmacies to the proposed location, needs of the providers current service users and the likely needs of the population that may be served at the proposed location. MDHB seeks to gain maximum quality improvement through any change.

7. MIDCENTRAL DHB COMMUNITY PHARMACY COMMISSIONING PANEL

The Panel will assess applications against the criteria and provide an assessment on the extent an application meet the criteria.

The Panel will include the following roles:

- Community Pharmacy Experience nominated by the MidCentral Community Pharmacy Group;
- Pae Ora Maori Health Directorate representative;
- Primary Care Representative nominated by THINK Hauora;
- Consumer or Community Representative nominated by the Consumer Council;

- Chief Pharmacist; and
- Business Accountant.

The Panel may seek additional information or advice, and/or co-opt additional members as required.

Panel members will be required to declare any conflicts of interest in respect to each application considered. MDHB will determine whether the conflict excludes the member from the Panel, or the conflict can be satisfactorily managed.

8. POLICY REVIEW

This policy will be reviewed as and when required, and may be updated by MDHB at any time.

9. REFERENCES

This policy acknowledges MDHB's responsibilities under legislation, such as:

- New Zealand Public Health and Disability Act 2000;
- Commerce Act 1986;
- Employment Relations Act 2000;
- Fair Trading Act 1986;
- Health and Safety at Work Act 2015;
- Human Rights Act 1993;
- Medicines (Database of Medical Devices) Regulations 2003;
- Official Information Act 1982;
- Privacy Act 1993;
- Contract and Commercial Law Act 2017;
- Treaty of Waitangi Act 1975;
- Resource Management Act 1991;
- Ministry of Health, Health and Disability Services, Pharmacy Service Standards 2010.

10. DEFINITIONS

APC	The principal purpose of the Health Practitioners Competence Assurance (HPCA) Act 2003 is to protect the health and safety of members of the public by providing for mechanisms to ensure that pharmacists are competent and fit to practise. It requires pharmacists to be registered and hold a current Annual Practising Certificate (APC) to be able to practice, even if practising under supervision.
Community Pharmacy Services	Means the services provided by the Provider under the ICPSA, including services provided in relation to the dispensing of pharmaceuticals
Contract	An agreement between two or more persons or legal entities which is intended to be enforceable. Both parties must have capacity to contract. The essential elements of a contract are: • agreement between the parties as to the essential terms of their bargain; • an intention by the parties to create a legally binding relationship; and

- the existence of consideration which means that each party gives the other something and each party gets something in return.

External Personnel

Means:

- authorised paid individuals or individuals from paid companies or other entities (non-employees) working within MidCentral DHB to meet staffing/service/project needs, e.g. external agency staff, locums, consultants and contractors; and
- authorised unpaid individuals or groups to observe (including clinical observers), gain experience, teach or provide support within agreed boundaries.

PHARMAC

The Pharmaceutical Management Agency (PHARMAC) is the New Zealand Crown agency that decides, on behalf of District Health Boards, which medicines and related products are subsidised for use.

More recently, PHARMAC been appointed by Cabinet to be the future national shared procurement service for Medical Devices and will gradually begin to work on national contracts. The national contracts are optional for DHBs to use, but may offer significant benefits to the DHBs and where appropriate should be applied.

Procurement

All of the business processes associated with acquisition of goods and services, spanning the whole cycle from the identification of needs to the end of a service contract or the end of the useful life and subsequent disposal of an asset.

Purchase

A transaction in which goods or services are acquired in exchange for payment.

Staff

Means generally all people to whom this policy applies and who are involved in some capacity during a procurement process; and also

Means the person nominated to directly manage and be accountable for a particular procurement. Responsibilities include:

- planning and documenting the procurement activity adequately;
- engaging key stakeholders (including Procurement Services, Contract Services, Infection Control, Local and Regional Information Services, Health and Safety Services, where necessary);
- development of requirements and specifications;
- obtaining necessary approvals and authorisation;
- providing originals of signed contracts to Contract Services; and
- complying with regulatory requirements and relevant MidCentral DHB policies.

11. RELATED MDHB DOCUMENTS

MDHB Policies:

MDHB-1892	Health and Safety [Policy] [HR H3]
MDHB-7376	Contracts Policy
MDHB-2018	Conflict of Interest Policy
MDHB-2022	Delegations Policy
MDHB-5705	Procurement Policy

MDHB Guides:

Panel Assessment Template – New Pharmacy, Amalgamations or Sale and Purchase of existing Pharmacy
Panel Assessment Template – New Pharmacy Services within existing Pharmacy Contracts

MDHB Manuals:

Board Policies Manual
Health and Safety Manual
Procurement Manual

MDHB Strategy Documents:

MidCentral DHB Strategy
Pharmacy in MidCentral Strategy

12. KEYWORDS

Contracts
Government Rules of Sourcing
Pricing / price reviews
Procurement
Community Pharmacy

ISSUES

- Application to sales and transfers – consistency with ICPSA
- Commissioning Panel membership
- Formatting and terminology
- Lack of definition/metrics for assessing
- Ongoing monitoring of performance
- Need for financial information
- Sale of tobacco and alcohol
- Disaster mitigation – security of supply
- Disputes, complaints and review
- Equity plan

CHANGES

- Need for financial information: Requirement met by Letter of Solvency
- Sale of tobacco and alcohol: Could exclude providers with access benefits from obtaining agreements. Can be easily circumvented. Issue of other products contributing to burden of disease
- Disaster mitigation – security of supply: have 32 Pharmacies and wholesaler in district. Could exclude providers with access benefits from obtaining agreements
- Disputes, complaints and review: Administrative law more appropriate

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

1 June 2022

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

I am responding on behalf of MidCentral District Health Board to your OIA request of 25 May 2022 in which you have requested the following information.

- **Can you please tell me how many theatre nurses you are currently short? I am referring to vacancies, rather than COVID absences.**

  MDHB is fully recruited with theatre nurses.

- **What impact is this having on Planned Care, e.g. are theatres sometimes not able to be used because there are not enough nurses?**

  Not applicable as MDHB is fully recruited.

- **If there is an impact, can you please estimate what percentage of operations are not able to go ahead, or how many hours theatre time cannot be used, or any other tangible measure the impact is having. What are you doing to resolve the problem?**

  Not applicable as no theatre nurse vacancies.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

[redacted]

MDHB Ref: Y22-492

Tēna koe

The following response is provided in relation to your Official Information Act 1982 (OIA) request received on 23 May 2022.

Your request asks that we provide MidCentral District Health Board's (MDHB) legal costs for the inquest into Simon Oakley's death; the costs incurred so far for the inquests into the deaths of Shaun Gray and Erica Hume; and for all of these, the name of the law firm and the hourly charge-out rate.

Simon Oakley inquest
MDHB's legal costs total $17,028.00

Shaun Gray inquest
MDHB's legal costs so far total $69,880.13

Erica Hume inquest
MDHB's legal costs so far total $39,775.48

Buddle Findlay have acted for MDHB in all three inquests. Their hourly charge out rate varies between $370 and $460, GST excl.

If you are not satisfied with this response you have the right to raise any concerns with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Finance and Corporate Services
MidCentralDHB, PO Box 2056, Palmerston North Central, 4440.
Tel: 06 350 8800 Fax: 06 350 8080

Please note that this response, or an edited version, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance and Corporate Services

[redacted]

From: OIA <OIA@midcentraldhb.govt.nz>
Sent: Friday, 17 June 2022 9:01 AM
To: [redacted]
Subject:

Hi [redacted]
Below is a response to Our OIA request from Janine Stevens. Regards, [redacted]

Kia ora koutou,

Answers to the OIA request as below ☺

1. The total number of Community-based attachments (CBAs) currently accredited at your DHB
   As at 17/06/2022, Mid Central DHB has five accredited sites for CBAs. Some sites are able to take more than one intern per quarter so this equates to 7 CBA placements available per quarter.
2. A breakdown of the types of CBA these are (e.g. Urban GP, rural GP, sexual health clinic, public medicine, urgent care, etc.)
   Three of these sites are urban general practices (offering up to 5 placements per quarter), one is a Hospice and one is a first responder organisation (St John Ambulance).

Cheers
Janine

[redacted]
Quality Assurance	Northside Building
MidCentral District Health Board	Private Bag 11036	Palmerston North 4442
P: +64 (6)[redacted]	F: +64 (6) 350 8544	www.midcentraldhb.govt.nz

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From: [redacted]
Sent: Thursday, 16 June 2022 13:47 PM
Subject: Accredited community based attachments for house officers

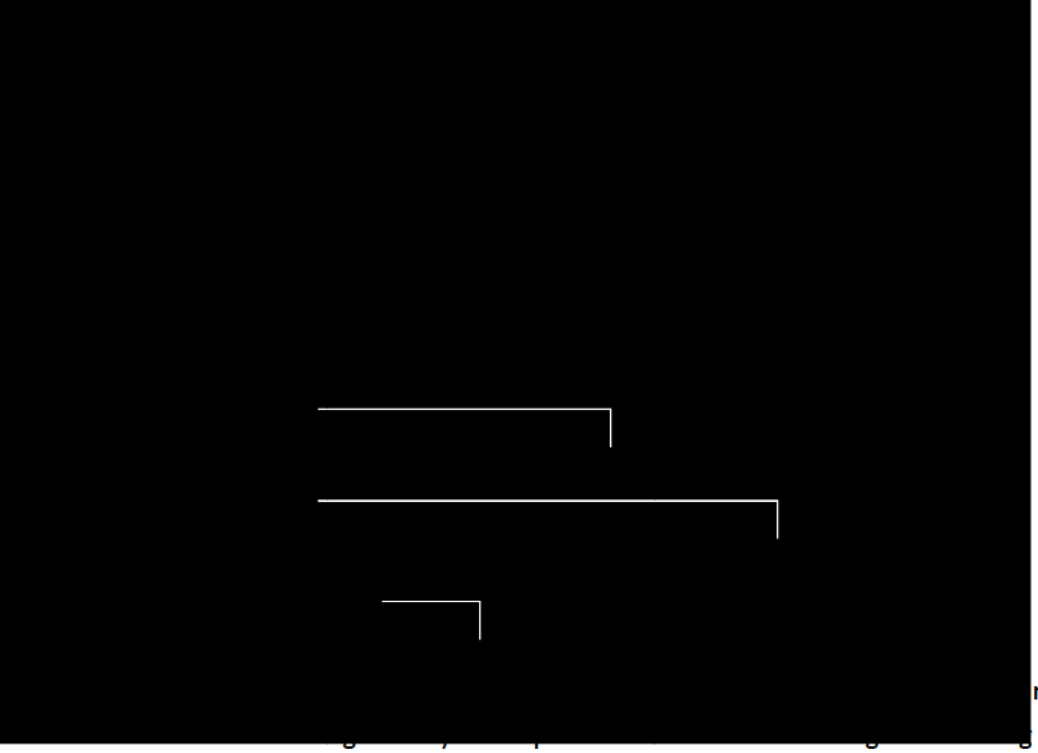
Tēnā koe,

I would like to make a request under the Official Information Act (1982) for the following data.

1. The total number of Community-based attachments (CBAs) currently accredited at your DHB
2. A breakdown of the types of CBA these are (e.g. Urban GP, rural GP, sexual health clinic, public medicine, urgent care, etc.)

Ngā mihi nui,

[redacted]



mail on 1 June 2022 with
data for PGY1 House Officers at MidCentral DHB (MDHB) and respond as follows:

1. *The total number of PGY1 House Officer positions filled by the ACE matching system for each year between 2018 and 2022, and a breakdown of these by country of training of the candidates (e.g. New Zealand, Australia).*

   Please see table below.

2. *The total number of PGY1 House Officer positions filled in by NZREX graduates for each year between 2018 and 2022.*

   Please see table below.

3. *The total number of PGY1 House Officer positions filled in by candidates from a Comparable Health System (e.g. U.K., Ireland, U.S.A., Canada etc.) for each year between 2018 and 2022.*

   Please see table below.

Year	ACE hires	Country of training	NZREX hires	Competent/ Comparable authority hires
2018	19	All NZ	2	0
2019	19	All NZ	1	0
2020	19	All NZ	4	0
2021	19	All NZ	2	0
2022	21	All NZ	5	0

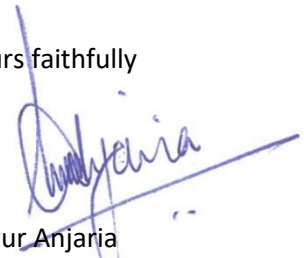
4. *The total number of PGY1 House Officer positions that were available and advertised outside of the ACE matching system for each year between 2014 and 2022 (please note this is a wider time range than the three requests above).*

   MDHB does not specifically advertise for PGY1 positions as its allocated PGY1 positions are filled via the ACE allocation process.

When vacancies arise during the year, MDHB assesses whether the vacancy is suitable for a PGY1 and then look at NZREX applicants if it determines the position could be filled by a PGY1.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully



Keyur Anjaria
General Manager
People & Culture

[redacted]

Dear [redacted]

The following response is provided in relation to your Official Information Act 1982 (OIA) request received on 19 May 2022.

1 *A count and list of all buildings owned, occupied, rented, leased or in use*

There is a total of 73 buildings (55 owned and 18 leased) as listed below.

City/Campus	Building name	Status
Palmerston North	B Block	Owned
Palmerston North	A Block	Owned
Palmerston North	C Block	Owned
Palmerston North	Linear Accelerator	Owned
Palmerston North	Blood Donors	Owned
Palmerston North	Link Block	Owned
Palmerston North	Rehab	Owned
Palmerston North	H Block	Owned
Palmerston North	Boiler House	Owned
Palmerston North	Chimney Stack	Owned
Palmerston North	Hospital Admin Block	Owned
Palmerston North	Education Block	Owned
Palmerston North	Chapel	Owned
Palmerston North	Community Village (seven buildings)	Owned
Palmerston North	Northside	Owned
Palmerston North	Laundry	Owned
Palmerston North	Laundry Extension	Owned
Palmerston North	Ambulance Station	Owned
Palmerston North	Workshops	Owned
Palmerston North	Contractors Office	Owned
Palmerston North	Rapuora	Owned
Palmerston North	Garage	Owned
Palmerston North	Dangerous Goods Store	Owned
Palmerston North	Board and Admin offices	Owned
Palmerston North	Board and Admin Extension 1	Owned
Palmerston North	Board and Admin Extension 2	Owned
Palmerston North	D Block	Owned

Finance and Corporate Services
MidCentralDHB, PO Box 2056, Palmerston North Central, 4440.
Tel: 06 350 8800 Fax: 06 350 8080

City/Campus	Building name	Status
Palmerston North	Transitory Care	Owned
Palmerston North	Clinical Records Block	Owned
Palmerston North	Medical Museum	Owned
Palmerston North	Ruahine House	Owned
Palmerston North	Digital Services	Owned
Palmerston North	Pullar Cottage	Owned
Palmerston North	4 Rongapai Street	Owned
Palmerston North	Junior Drs Residences (eight buildings)	Owned
Palmerston North	73 Heretaunga Street (two buildings)	Owned
Palmerston North	Water Tower	Owned
Palmerston North	Medical Gas Room	Owned
Palmerston North	Truck Bay	Owned
Palmerston North	Office Building	Owned
Levin	Horowhenua Health Centre	Owned
Dannevirke	Barraud Street	Leased
Dannevirke	Allardice Street	Leased
Pahiatua	Main and Centre Streets	Leased
Foxton	Lady's Mile	Leased
Otaki	Cnr Aotaki and Raukawa Streets	Leased
Palmerston North	Amesbury Street	Leased
Palmerston North	200 Broadway Avenue	Leased
Palmerston North	619 Featherston Street	Leased
Palmerston North	Ferguson Street	Leased
Palmerston North	Ruahine Street	Leased
Palmerston North	38 Fitzherbert Avenue	Leased
Feilding	Duke Street	Leased
Whanganui	Wicksteed Street	Leased
Palmerston North	585 Main Street	Leased
Palmerston North	291 Tremaine Avenue	Leased
Hamilton	Clow Place	Leased
Hamilton	Collins Road	Leased
Christchurch	Hammersmith Drive	Leased

2 *The count and list of buildings from question 1 that have had a seismic assessment since 1 July 2017*

Since 1 July 2017, a seismic assessment has been carried out on 13 buildings owned by MidCentral District Health Board, as listed below.

City/Campus	Building name
Palmerston North	B Block
Palmerston North	A Block
Palmerston North	C Block
Palmerston North	Link Block
Palmerston North	Northside
Palmerston North	Board and Admin offices
Palmerston North	Board and Admin Extension 1
Palmerston North	Board and Admin Extension 2
Palmerston North	D Block
Palmerston North	Water Tower
Palmerston North	Medical Gas Room
Palmerston North	Truck Bay
Levin	Horowhenua Health Centre

3 *The count and list of buildings from question 1 that have not had a seismic assessment since 1 July 2017*

Since 1 July 2017, a seismic assessment has not been carried out on 42 buildings owned by MidCentral District Health Board, as listed below.

City/Campus	Building name
Palmerston North	Linear Accelerator
Palmerston North	Blood Donors
Palmerston North	Rehab
Palmerston North	H Block
Palmerston North	Boiler House
Palmerston North	Chimney Stack
Palmerston North	Hospital Admin Block
Palmerston North	Education Block
Palmerston North	Chapel
Palmerston North	Community Village (seven buildings)
Palmerston North	Laundry
Palmerston North	Laundry Extension
Palmerston North	Ambulance Station
Palmerston North	Workshops
Palmerston North	Contractors Office
Palmerston North	Rapuora
Palmerston North	Garage
Palmerston North	Dangerous Goods Store
Palmerston North	Transitory Care
Palmerston North	Clinical Records Block
Palmerston North	Medical Museum
Palmerston North	Ruahine House
Palmerston North	Digital Services
Palmerston North	Pullar Cottage
Palmerston North	4 Rongapai Street
Palmerston North	Junior Drs Residences (eight buildings)
Palmerston North	73 Heretaunga Street (two buildings)
Palmerston North	Office Building

4 *The count and list of those from question 1 that are currently earthquake prone*

The only building owned by MidCentral District Health Board considered to be earthquake-prone is the B Block Roof Plant Space.

To the best of our knowledge, none of the buildings leased by MidCentral District Health Board are earthquake prone.

5 *The count and list of those from question 4 that are between 20 percent and less than 34 percent of the New Building Standard (NBS)*

The only building between 20 and 34 percent of NBS is the B Block Roof Plant Space.

6 *The count and list of those from question 4 that are less than 20 percent of the New Building Standard (NBS)*

No buildings owned by MidCentral District Health Board are less than 20 percent of NBS.

If you are not satisfied with this response you have the right to raise any concerns with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance and Corporate Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

22 June 2022

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Physical Address:
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Heretaunga Street
Palmerston North
New Zealand

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

Your OIA request of 25 May 2022 to MidCentral District Health Board (MDHB) is acknowledged. The information you have requested follows.

1. **The average wait time to see an Oncologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.**

   The average wait time in days is provided below. It should be noted that a direct referral from a GP to an Oncologist is not a common pathway for cancer patients after their diagnosis and these referrals can often be a request to provide ongoing follow up after a patient has transferred from another district or country. Most cancer patients are referred to Oncologists by secondary care specialties.

2018	2019	2020	2021	2022
19	20	18	21	21

2. **The longest and shortest wait time to see an Oncologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.**

   The wait times in days are provided below. It should be noted that a direct referral from a GP to an Oncologist is not a common pathway for cancer patients after their diagnosis and these referrals can often be a request to provide ongoing follow up after a patient has transferred from another district or country. Most cancer patients are referred to Oncologists by secondary care specialties.

	2018	2019	2020	2021	2022
Longest	345	364	357	337	314
Shortest	0	0	0	0	0

3. The average wait time for cancer surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date.

The average wait time in days is provided below. It should be noted that for certain cancers patients will undergo pre-operative radiation and/or chemotherapy or it may have been determined to have a period of active surveillance prior to cancer surgery.

2018	2019	2020	2021	2022
14	27	36	29	39

4. The longest and shortest wait time for cancer surgery after a patient's FSA, for the last five years between 2018 and this year to date.

The wait times in days are provided below. It should be noted that for certain cancers patients will undergo pre-operative radiation and/or chemotherapy or it may have been determined to have a period of active surveillance prior to cancer surgery.

	2018	2019	2020	2021	2022
Longest	156	290	264	281	196
Shortest	0	0	1	2	1

5. The average wait time to see a Cardiologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

Year	Cardiology average days waiting
2018	120
2019	90
2020	103
2021	86
2022	119

6. The longest and shortest wait time to see a Cardiologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

Year	Cardiology longest days waiting	Cardiology shortest days waiting
2018	440	0
2019	407	0
2020	437	0
2021	432	0
2022	428	3

7. The average wait time for heart surgery after a patient's FSA, for the last five years between 2018 to this year to date.

Not available. These services are provided by Capital & Coast DHB and MDHB does not hold the information that would allow us to comment.

8. The longest and shortest wait time for heart surgery after a patient's FSA, for the last five years between 2018 to this year to date.

Not available. These services are provided by Capital & Coast DHB and MDHB does not hold the information that would allow us to comment.

9. The average wait time to see an Orthopaedic Surgeon after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

Year	Orthopaedic average days waiting
2018	57
2019	37
2020	41
2021	41
2022	39

10. The longest and shortest wait time to see an Orthopaedic Surgeon after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

Year	Orthopaedic longest days waiting	Orthopaedic shortest days waiting
2018	434	0
2019	440	0
2020	424	0
2021	437	0
2022	406	0

11. The average wait time for Orthopaedic surgery after a patient's FSA, for the last five years between 2018 to this year to date.

Year	Orthopaedic average days waiting
2018	128
2019	177
2020	191
2021	164
2022	202

12. The longest and shortest wait time for Orthopaedic surgery after a patient's FSA, for the last five years between 2018 to this year to date.

Year	Orthopaedic longest days waiting	Orthopaedic shortest days waiting
2018	377	2
2019	436	0
2020	438	0
2021	440	0
2022	440	2

13. The average wait time for a Gynaecologist appointment after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

2018	2019	2020	2021	2022
78	84	53	59	59

14. The longest and shortest wait time for a Gynaecologist appointment after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

	2018	2019	2020	2021	2022
Longest	361	362	363	314	343
Shortest	0	0	0	0	0

15. The average wait time for gynaecological surgery after a patient's FSA, for the last five years between 2018 to this year to date.

2018	2019	2020	2021	2022
82	115	116	85	98

16. The longest and shortest wait time for gynaecological surgery after a patient's FSA, for the last five years between 2018 to this year to date.

	2018	2019	2020	2021	2022
Longest	339	363	364	362	362
Shortest	0	0	0	0	1

17. The average wait time for a Urologist appointment after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

Year	Urology average days waiting
2018	87
2019	72
2020	59
2021	67
2022	86

18. The longest and shortest wait time for a Urologist appointment after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date.

Year	Urology longest days waiting	Urology shortest days waiting
2018	440	0
2019	408	0
2020	419	0
2021	440	0
2022	437	0

19. The average wait time for Urology surgery after a patient's FSA, for the last five years between 2018 to this year to date.

Year	Urology average days waiting
2018	82
2019	107
2020	97
2021	84
2022	84

20. The longest and shortest wait time for Urology surgery after a patient's FSA, for the last five years between 2018 to this year to date.

Year	Urology longest days waiting	Urology shortest days waiting
2018	335	1
2019	440	0
2020	438	1
2021	424	1
2022	412	1

21. The average wait time for a Respiratory specialist appointment/or General Medicine specialist for respiratory problems after a referral from a GP, for the last five years between 2018 to this year to date.

Year	Respiratory average days waiting
2018	77
2019	55
2020	48
2021	42
2022	63

22. The longest and shortest wait time for a Respiratory specialist appointment/or General medicine specialist for respiratory problems after a referral from a GP, for the last five years between 2018 to this year to date.

Year	Respiratory longest days waiting	Respiratory shortest days waiting
2018	436	0
2019	420	0
2020	416	0
2021	372	0
2022	273	1

23. The average wait time for Respiratory surgery after a FSA, for the last five years between 2018 to this year to date.

Not available. These services are provided by Capital & Coast DHB and MDHB does not hold the information that would allow us to comment.

24. The longest and shortest wait time for Respiratory surgery after a FSA, for the last five years between 2018 to this year to date.

Not available. These services are provided by Capital & Coast DHB and MDHB does not hold the information that would allow us to comment.

25. The average wait time for a patient visiting the Emergency Department, for the last five years from 2018 to this year to date.

Year	Average of Time To First Seen
2018	1 hours 47 minutes
2019	1 hours 54 minutes
2020	1 hours 52 minutes
2021	2 hours 2 minutes
2022	2 hours 16 minutes

26. The longest and shortest wait time for a patient visiting the Emergency Department, for the last five years from 2018 to this year to date.

Year	Maximum of Time To First Seen	Minimum of Time To First Seen
2018	14 hours 15 minutes	0 hours 0 minutes
2019	18 hours 15 minutes	0 hours 0 minutes
2020	16 hours 52 minutes	0 hours 0 minutes
2021	15 hours 17 minutes	0 hours 0 minutes
2022	18 hours 46 minutes	0 hours 0 minutes

27. All reports discussing hospital wait times and Emergency Department delays, dated between January 2021 to date, held by the DHB.

These reports can be found on the MDHB website via the following link;

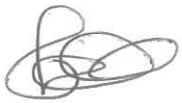
http://www.midcentraldhb.govt.nz/AboutMDHB/BoardandCommittees/Pages/Health-and-Disability-Services-Advisory-Committee.aspx

28 All reports discussing increasing patient transfers between hospitals under the new Health New Zealand model, between January 2021 to date, held by the DHB.

There are no reports specifically on or related to this subject.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely



Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women, Children & Youth

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

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Fax (06) 355 0616

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Palmerston North
New Zealand

23 June 2022

[redacted]

Dear [redacted]

Official Information Act (OIA) request – OIA Y22-497

Thank you for your request for information dated 30 May 2022. Your request is acknowledged and has been passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information regarding precocious puberty. Please note MDHB's results only go back to 2013, the 2013 data is generally less robust than more recent data as MDHB was on a different Patient Management system at that time.

1. How many children were referred for precocious puberty in each calendar year from 2006 until the most recent available year (presumably 2021)?

Year	Total
2013	1
2014	4
2015	0
2016	2
2017	5
2018	6
2019	5
2020	5
2021	8

2. How many children were being treated (i.e. total ongoing treatments) for precocious puberty in each calendar year from 2006 until the most recent available year?

Year	Total
2013	1
2014	7
2015	0
2016	4
2017	9
2018	6
2019	11
2020	15
2021	11

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth

Refer to your Official Information Act request received by email on 7 June 2022 with regard to your request for information relating to communications/media at Midcentral DHB now Te Pae Hauora o Ruahine o Tararua | MidCentral and respond as follows:

I would like to request the following information from your organisation, for each financial year: 2017, 2018, 2019, 2020, 2021 and for the partial year of 2022 to date:

1. *Number of FTE communications/media staff employed in each year (this includes all internal and external communications staff/content producers and social media staff)*

   See table 1 below.

2. *The salary range paid to communications staff in each year.*

   See table 1 below.

3. *Number of communications/media contractors used in each year.*

   See table 1 below.

4. *Total sum paid to communications contractors in each year*

   See table 1 below.

5. *A breakdown of positions and numbers employed in each role (ie how many media advisors, senior media advisors, internal communications, managers, social media producers/managers)*

   The Communications team has varied over the years, but is usually made up of one manager, one senior communications advisor, one communications advisor, two digital specialists (managing the website, intranet and digital platforms), and one graphic designer (who is included within the communications team and budget and supports all Te Pae Hauora o Ruahine o Tararua | MidCentral graphic design needs). Two communications advisors work independently for Enable New Zealand Limited (a subsidiary of Te Pae Hauora o Ruahine o Tararua).

   Internal, external and media communications responsibilities are shared amongst the Communications team.

6. *How many media queries received in each year*

See table 2 below.

Please note that responding to media is a crucial part of the Communications role, but it is only one task out of many that the team is responsible for. The team:

- helps manage and provide content for many internal channels, to help support staff and keep them informed on critical issues
- provides advice and guidance on key projects and working groups, so they understand how they can better interact and reach key community groups
- leads numerous initiatives to help the community, and rohe, understand what is happening with their healthcare – from managing the Te Pae Hauora o Ruahine o Tararua website and multiple social media platforms, to producing stakeholder newsletters, informative billboards and collateral, to name just some of the work carried out.

7. *How many interview requests received in each year*

See table 2 below.

8. *How many media interviews given, and to which media organisations and when.*

See table 2 below.

Media interviews are usually given to local and national radio organisations and the Manawatū Standard. Where interviews couldn't occur due to time restraints, detailed, written responses have been provided to support journalists.

9. *Total salary costs for communications staff each year (rounded to the nearest $1000)*

2017	2018	2019	2020	2021
$359,000	$460,000	$478,000	$476,000	$422,000

10. *In each year, how many communications staff paid a salary more than $100,000 per annum and $200,000 per annum*

See table 1 below.

Table 1 – Salary and Staffing

		Salary Band						
Financial Year	FTE Employed each year	<$50,000	$50,000 - $100,000	>$100,000	Contractors	Sum paid to Contractors	Communications staff paid more than $100,000 pa	Communications staff paid more than $200,000 pa
2017-18	7	4	3	0	0	0	1	0
2018-19	8	0	8	0	0	0	1	0
2019-20	9	0	8	1	0	0	1	0
2020-21	8	0	7	1	0	0	1	0
2021-22	6	0	5	1	1	$65,000	1	0

*Includes Enable New Zealand Limited, who employ two Marketing and Communications Specialists.

Table 2 – Media Responses

Year	Media enquiries	Interview requests	Media interviews given
2017	Information on media responses for 2017 and 2018 were unavailable.		
2018			
2019	218	36	36
2020	253	39	36
2021	337	25	17
Partial 2022	Can range from one enquiry to 22 per week. Currently approx. 134 enquiries have been received.	Approx. 14	Approx. 8

Media interviews are usually given to local and national radio organisations and the Manawatū Standard. Where interviews couldn't occur due to time restraints, detailed, written responses have been provided to support journalists.

Please note that this response, or an edited version of it, may be published on the Te Pae Hauora o Ruahine o Tararua | MidCentral website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

11 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Dear [redacted]

I refer to your Official Information Act request received by email on 12 June 2022 with regard to your request for information relating to terminations due to non-compliance of the COVID Vaccination mandate for MidCentral DHB (MDHB) and respond as follows:

Number of people issued with a notice of termination for COVID vaccination non compliance for failure to produce evidence of having received

- a first or second COVID vaccination
- the 3rd COVID vaccination shot, commonly referred to as the COVID booster

See table below.

The numbers of those people that

- were terminated during their COVID vaccination non compliance notice period
- were terminated at the end of their COVID vaccination non compliance notice period
- resigned within the COVID vaccination non compliance notice period

See table below.

Were possible, break down these terminations and resignations by occupational department and a summary of the years experience of each terminated person and person whom resigned.

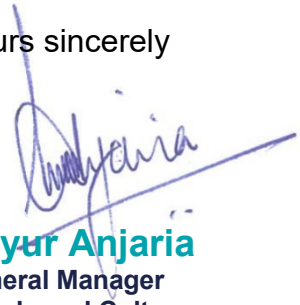
See table below.

Question	Number	Department
Number of people issued with a notice of termination for COVID vaccination non-compliance for failure to produce evidence of having received:		
- A first or second COVID vaccination	37	See Below
- The third COVID vaccination/booster	2	
The numbers of those people that:		
- were terminated during their COVID vaccination non-compliance notice period	0	
- were terminated at the end of their COVID vaccination non-compliance notice period	32	15 x Nursing/Midwifery/ Health Care Assistants 10 x Admin 6 x Allied Health 1 x Doctor
- resigned within the COVID vaccination non-compliance notice period	3	3 x Allied Health

(3 notices of termination were rescinded, 1 temp medical exemption).

Please note that this response, or an edited version of it, may be published on the Te Pae Hauora o Ruahine o Tararua | MidCentral website ten working days after your receipt of this letter.

Yours sincerely



Keyur Anjaria
General Manager
People and Culture
Te Pae Hauora o Ruahine o Tararua | MidCentral

12 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Ref: OIA Y22-0506

Dear [redacted]

In response to your Official Information Act 1982 requesting:

"*in each of the financial years ended June 30 2010, 2011, 2012, 2013, 2014 and 2015 were Health Partners Consulting engaged by the DHB to undertake any reviews, projects or other activities or work, what was the purpose of each review, project, or other activity or work, and how much was paid to Health Partners Consulting for each review, project, or other activity or work*" we advise for MidCentral as follows:

Health Partners Consulting have not been engaged by MidCentral DHB and thereby have not been paid, in any of the years requested.

If you are not satisfied with this response, you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral website ten working days after your receipt of this response.

Yours sincerely,

Neil Wanden
General Manager, Finance & Corporate Services

TeWhatuOra.govt.nz
PO Box 2056, Palmerston North, 4440
06 350 8061

15 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Tēnā koe [redacted]

OIA request
Our Reference: Y22-487 and Y22-488

We are in receipt of your Official Information Act requests dated 16 May 2022. On 15 June 2022 we wrote to you extending the deadline for responding to your requests, due to the large number of documents captured within the scope of your requests, and the substantial amount of staff time required to collate and review those documents.

You requested the following information:

OIA Y22-487
Please provide all official information as defined in the Official Information Act, not limited to but including emails re MidCentral District Health Board Palmerston North Hospital Mental Health Services and Ward 21 where concerns/issues relating to or discussing Patient Safety or Staff Safety were raised between 1st February 2020 and 31st March 2020.

The response should include but not limited to include persons:

1. Gemma Turner
2. Kathryn Cook
3. Dr Jeff Brown
4. Celina Eves
5. Dr Joanna Jestrezebska
6. Dr Neelima Pradhan
7. MidCentral District Health Board Members and Board Chair
8. Vanessa Caldwell
9. Scott Ambridge
10. Ministry of Health

OIA Y22-488
Please provide all official information as defined in the Official Information Act, not limited to but including emails re MidCentral District Health Board Palmerston North Hospital Mental Health Services and Ward 21 where concerns/issues relating to or discussing Patient Safety or Staff Safety were raised between 1 April 2020 and 31 December 2020.

The response should include but not limited to include persons:

1. Scott Ambridge
2. Vanessa Caldwell
3. Jon Gullidge
4. Richard Barrass
5. Stacey Wilson
6. Kathryn Cook
7. Dr Jeff Brown
8. Judith Catherwood
9. MidCentral District Health Board Members and Board Chair

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Health New Zealand

Te Pae Hauora o Ruahine o Tararua | MidCentral (MidCentral) has now completed a search for the information you have requested. This has involved searching MidCentral's common directories, as well as the email accounts of each of the individuals named in your OIA request for the time periods stipulated, using relevant search criteria.

We enclose the relevant information. However, we have withheld some information (by way of redaction) under section 9(2)(a) of the Official Information Act, where doing so was necessary to protect the privacy of individuals, and where we did not consider that a public interest existed that outweighed that privacy consideration. We have also withheld a small amount of information under section 9(2)(i) of the Official Information Act, which allows information to be withheld in order to enable Te Pae Hauora o Ruahine o Tararua | MidCentral (MidCentral) to carry out commercial activities without prejudice.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Ngā mihi

Scott Ambridge
Operations Executive
Te Uru Rauhī - Mental Health & Addictions Services Te Pae Hauora o Ruahine o Tararua | MidCentral

Te Whatu Ora
Health New Zealand

15 July 2022

[redacted]

Tēnā koe [redacted]

OIA request
Our Reference: Y22-503

We are in receipt of your Official Information request which was transferred from the Health Quality and Safety Commission New Zealand to Te Pae Hauora o Ruahine o Tararua |MicCentral on 13 June 2022.

We apologise for the delay in getting this information to you.

The breakdown in seclusion data from Te Pae Hauora o Ruahine o Tararua | MidCentral from January 2016 to December 2021 is attached.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Ngā mihi

Scott Ambridge
Operations Executive
Te Uru Rauhī - Mental Health & Addictions Services
Te Pae Hauora o Ruahine o Tararua | MidCentral

Seclusion rates - Te Pae Hauora o Ruahine o Tararua | MidCentral

	Māori	Non-Māori	TOTAL
Jan-16	9	9	18
Feb-16	3	2	5
Mar-16	1	2	3
Apr-16	4	4	8
May-16	5	9	14
Jun-16	8	11	19
Jul-16	5	18	23
Aug-16	2	5	7
Sep-16	7	4	11
Oct-16	5	5	10
Nov-16	4	9	13
Dec-16	1	8	9
Jan-17	5	2	7
Feb-17	6	4	10
Mar-17	3	2	5
Apr-17	2	2	4
May-17	13	9	22
Jun-17	2	3	5
Jul-17	8	12	20
Aug-17	15	10	25
Sep-17	4	6	10
Oct-17	9	5	14
Nov-17	10	12	22
Dec-17	14	7	21
Jan-18	9	9	18
Feb-18	6	3	9
Mar-18	5	3	8
Apr-18	4	9	13
May-18	9	6	15
Jun-18	1	1	2
Jul-18	7	2	9
Aug-18	1	4	5
Sep-18	14	3	17
Oct-18	9	6	15
Nov-18	12	3	15
Dec-18	8	3	11
Jan-19	7	5	12
Feb-19	4	6	10
Mar-19	3		3
Apr-19	2	3	5
May-19	9		9
Jun-19	16	1	17
Jul-19	2	4	6
Aug-19	6		6

Sep-19	16	4	20
Oct-19	6	6	12
Nov-19	3		3
Dec-19	2	3	5
Jan-20	12	1	13
Feb-20	5	3	8
Mar-20	6	1	7
Apr-20	2	6	8
May-20	4	4	8
Jun-20	6	3	9
Jul-20	15	4	19
Aug-20	5		5
Sep-20	2	1	3
Oct-20	1	1	2
Nov-20	1	1	2
Dec-20	4	2	6
Jan-21	1	2	3
Feb-21	4	1	5
Mar-21	1	1	2
Apr-21	2		2
May-21	5	2	7
Jun-21	10	5	15
Jul-21	7	1	8
Aug-21	7	2	9
Sep-21	5		5
Oct-21	7		7
Nov-21	9	3	12
Dec-21	1	4	5

18 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Tēnā koe [redacted]

OIA request
Our Reference: Y22-503

Further to our OIA response to you on 15 July 2022 and your email dated 18 July 2022 requesting seclusion figures to date.

Seclusion data from Te Pae Hauora o Ruahine o Tararua | MidCentral from January to June 2022 is detailed below.

	Māori	Non-Māori	Grand Total
Jan-22	1	6	7
Feb-22	6	6	12
Mar-22	15	2	17
Apr-22	1		1
May-22	1		1
Jun-22	4	2	6

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Ngā mihi

Scott Ambridge
Operations Executive
Te Uru Rauhī - Mental Health & Addictions Services
Te Pae Hauora o Ruahine o Tararua | MidCentral

TeWhatuOra.govt.nz
PO Box 2056, Palmerston North, 4400

Te Whatu Ora
Health New Zealand

12 July 2022

[redacted]

Dear [redacted]

Official Information Act (OIA) Request

As you are aware, your recent OIA request has been transferred to District Health Boards by the Ministry of Health under section 14 of the Official Information Act. Therefore, the following data has been provided as it pertains to Te Pae Hauora o Ruahine o Tararua | MidCentral (previously MidCentral District Health Board).

You have requested the following information:

1. **The total number of procedures outsourced by year (including the year to date) for the past five years.**

Year	Procedures
2017/18	80
2018/19	380
2019/20	625
2020/21	1,119
2021/22	982
Total	**3,186**

YTD – 27.06.22

2. **For each year, provide a breakdown of the type of procedure.**

Procedure Type	2017/18	2018/19	2019/20	2020/21	2021/22
Dental		58	106	136	126
Ear Nose Throat	27	63	117	218	156
Gastro Surgery				188	172
General Surgery	17	62	131	270	116
Gynaecology		50	10	42	144
Maxillo-Facial Surgery		1	2	9	16
Ophthalmology	31	98	73	213	158
Orthopaedics		32	164	176	213
Urology	5	16	22	54	53
Total	**80**	**380**	**625**	**1,306**	**1,154**

Note: Procedure type was summarised by health speciality.

3. **For each year, provide the total spend on outsourced elective surgeries.**

Year	Spend
2017/18	$137,665.24
2018/19	$1,182,393.27
2019/20	$3,470,568.43
2020/21	$5,874,785.65
2021/22	$5,745,074.50
Total	**$16,410,487.10**

Note: Total spend is based on the invoices paid to outsourced providers.

4. **For each year, provide the amount that these surgeries would have cost the DHB if they had not been outsourced."**

Year	Spend
2017/18	$424,035.45
2018/19	$2,039,079.00
2019/20	$3,466,120.18
2020/21	$6,135,741.45
2021/22	$5,884,906.82
Total	**$17,949,882.91**

Note: The costs are an estimate based on the volume of outsourced surgeries (Question 2) and the average cost of procedures if not outsourced. Average cost was calculated based on surgeries completed at MidCentral (not outsourced) during the 2021/22 financial year.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Te Uru Arotau – Acute & Elective Specialist Services
Te Pae Hauora o Ruahine o Tararua | MidCentral

18 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Ref: OIA Y22-0509

Dear [redacted]

In response to your Official Information Act 1982 requesting:

Ward 21 New Build Project information, we advise for MidCentral as follows:

"Understand the new ward will have 28 beds, plus 2 low stimulus suites. Also understand the ward has also been designed so that it can be expanded with an addition in future which would allow for a further 8 beds" Scott Ambridge.

1. *Could we please have confirmation of the following in regard to the above statement.*
   i. *How many of those 28 beds, are HNU* beds? The 2 low stimulus suites – are they on Open Side* or HNU*?*

The unit includes 28 beds plus a further 2 beds in low stimulus rooms (being larger rooms each with own lounge and courtyard), making a total of 30 rooms when needed.

The 28 are configured into pods of between 2 and 5 beds each which allow for patients to manage levels of interaction within smaller, appropriate, cohorts as needed.

Of these, 6 are configured as HNU beds with the ability to flex 2 or 4 of those to lesser acuity cohorts as best supports the range of patients occupying the unit on any day.

ii. *Will the 2 low stimulus suites be used as patient bedrooms? Are the counted as part of the 28 beds?*

Please see above response.

iii. *"designed so that it can be expanded with an addition in future which would allow for a further 8 beds" Scott Ambridge*
a) Are the plans already fully completed for this expanded area?

The space for future expansion has been designed so that it would work as an integral part of the unit rather than an afterthought, ie its location and interface will already be there. However, the specific layout within that space will not be refined until some future date when the demand becomes evident and the best bed configuration to support that can be decided with experience of delivering care in the new therapeutic environment.

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Health New Zealand

b) Are the plans at a stage whereby they are signed off by Architects and all other relevant parties to ensure building could start as soon as funding is approved? If no, then what would be the expected timeframes for this to be achieved?

No, they are not needed at this time and the unit has been sized within an overall model of care to support forecast needs well into the next decade.

c) What is the predicted cost for the 'expansion for further 8 beds' design component?

Unknown.

d) Is funding already pre-approved for this further expansion or does MDHB (or the new Health Entity that will be operating after 30 June 2022) have to apply for funding?

Funding will be requested at a future time when it is needed.

e) If funding needs to be applied for, what are the processes to be gone through to obtain funding? And whom would those entities be (list please) to gain full approval to go ahead with the expansion? What would the timeframes be for each step please?

Future capital funding processes are not yet known, but it is anticipated that the cost would fit within the delegation of either the Te Whatu Ora Health New Zealand Chief Executive or Board.

f) When would MDHB (or the new Health Entity) be expecting to have to utilise the expanded 8 bed area for Ward 21 New Build?
**(note or whatever the equivalent name for High Needs Unit and Open Side will be if name has been changed.)*

The probability of requiring these beds earlier than 2038 is low.

2. *The approved cost for the new ward was $35 million.*
   a) Can you please confirm if additional funding has been approved (or has been or is being) applied for? If so, how much is the additional funding approved/applied for/being applied for?

   No additional funding has been applied for at this stage.

   b) If no additional funding has been applied for or approved, then are modifications / cuts being made to the design plan to reduce the construction costs?

   The design and construction methodology of our building projects are continually reviewed through the design process to ensure they are fit for purpose and good value for money.

Te Whatu Ora
Health New Zealand

3. *With regard to the stages for the building of New Ward 21 Mental Health Ward. Would you please provide a detailed Project Schedule of each of the Projects Stages – Define/Design/Delivery from 1 January 2022 to the Construction Completion Stage and Go Live Stage.*
This information to include Actual or Forecast Start and Completion Dates, as well as the current status of each stage.

Phase	Start	Finish	Status
Preliminary Design	December 20	October 21	Complete
Developed Design	November 21	May 22	Complete
Detailed Design	June 22	September 22	50% Complete
Procurement	April 22	November 22	Site clearance awarded Structural Timber awarded Main contractor in tender
Site Clearance	July 22	September 22	Commencing
Main Construction	September 22	March 24	

If you are not satisfied with this response, you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral website ten working days after your receipt of this response.

Yours sincerely,

Neil Wanden
General Manager, Finance & Corporate Services

18 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Dear [redacted]

Official Information Act Request: OIA Y22-511 Certificates to Local Health Authorities

This letter is in response to your Official Information Act 1982 (the Act) request which was received by the Ministry of Health on 8 April 2022.

The request was partially transferred to Te Whatu Ora Te Pae Hauora o Ruahine o Tararua | MidCentral, under section 14(b)(i) of the Act on 21 June 2022.

The information that you were seeking was:

":..information about the provision of any certificates to local authorities under s42(1)(e) by medical officers of health, and the issue of any repair notices under s44(1). Specifically, I would like to request the dates and local authorities for any such certificates or repair notices since, say, 2000.

If it would help in keeping this request reasonably bounded, I am quite happy to limit this to within a lesser reasonable period --- say ten years --- but would prefer as broad a time range as possible. If no certificates or notices have been issued, or few such, I would also like to expand my request for information to encompass policy directions, legal advice, practice manuals and/or training etc around medical officers' of health ability to take action on non-compliance with housing regulations, if any such records exist."

I have checked with our two Medical Officers of Health and can confirm that since February 2011, neither has issued any certificates to local authorities under section 42(1)(e), or any repair notices under section 44(1) of the Act.

I understand that the Ministry of Health has responded to the second part of your request, noting that their Border Health Team has provided no training, policy directions, legal advice, practice manuals relating to Medical Officers' of Health ability to take action on non-compliance with housing regulations.

Please note that this response, or an edited version of this response, may be published on the Te Whatu Ora MidCentral website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at ww.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Te Whatu Ora
Health New Zealand

Deborah Davies
General Manager Communities, Localities & Commissioning
Te Pae Hauora o Ruahine o Tararua | MidCentral

[redacted]

I refer to your Official Information Act request transferred from the Ministry of Health and received by email on 29 June 2022 with regard to your request for information relating to COVID positive employees currently working and respond as follows:

"I am lodging an OIA request for the number of front line medical staff including nurses, doctors and all hospital staff that the Ministry has in circulation who are currently working and knowingly have Covid-19 by the Ministry.

I would like this data for the months of Jan, Feb, March, April, May 2022."

	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Number of front-line medical staff who are currently working and knowingly have Covid-19 by the Ministry	0	0	0	0	0

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

27 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Dear [redacted]

Official Information Act Request: OIA Y22-543 COVID Costs Since March 2020

This letter is in response to your Official Information Act 1982 (the Act) request which was received on 30 June 2022.

The information that you were seeking was:

"Since the beginning of the Covid-19 pandemic [March 2020] to date, how much money has Mid Central DHB spent on giving free items to the public to encourage them to get vaccinated.

This includes food, coffee, gift cards, prizes such as local and overseas trips, mobile phones, fuel vouchers, Christmas hams and any other such prizes to entice people to get vaccinated."

After liaising with our COVID-19 Vaccination Team and Finance Team I can advise $34,372 has been spent by Te Pae Hauora o Ruahine o Tararua | MidCentral since March 2020. Included in this expenditure are Petrol, Grocery, Book and Gift Vouchers along with a variety of children's items.

Please note that this response, or an edited version of this response, may be published on the Te Whatu Ora MidCentral website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at ww.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Deborah Davies
General Manager Communities, Localities & Commissioning
Te Pae Hauora o Ruahine o Tararua | MidCentral

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