WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

AGENDA

Combined Statutory Advisory Committee

Meeting date **Friday 18 October 2019**

Start time **9:30am**

Venue Board Room
Fourth Floor
Ward and Administration Building
Whanganui Hospital
100 Heads Road
Whanganui

Embargoed until Saturday 19 October 2019

Contact
Phone 06 348 3348
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Also available on website
www.wdhb.org.nz

Distribution

Board members *(full copy)*

- Ms Dot McKinnon QSM, Board Chair
- Mr Graham Adams
- Mr Charlie Anderson QSM
- Mrs Philippa Baker-Hogan MBE
- Mrs Jenny Duncan
- Mr Darren Hull
- Mr Stuart Hylton, Combined Statutory Advisory Committee Chair
- Mrs Judith MacDonald
- Ms Annette Main ONZM
- Hon Dame Tariana Turia DNZM
- Ms Maraea Bellamy

External committee members *(full copy)*

- Mr Frank Bristol
- Dr Andrew Brown
- Mr Leslie Gilsenan
- Mr Matt Rayner
- Ms Grace Taiaroa
- Ms Heather Gifford

Executive Management Team and others *(full copy)*

- Mr R Simpson, Chief Executive
- Ms L Adams, Director of Nursing
- Mr M Dawson, Communications Manager
- Mr H Cilliers, General Manager, People and Performance
- Mrs R Kui, Director Māori Health
- Mr B Walden, General Manager, Corporate Services
- Mr P Malan, General Manager, Service and Business Planning
- Mr S Carey, Funding and Contracts Manager
- Ms K Fraser-Chapple, Business Manager, Medical, Community and Allied Health
- Mrs L Torr, Business Manager, Medical Management Unit
- Mr P Wood-Bodley, Business Manager, Surgical Services
- Mrs A Bunn, Portfolio Manager, Health of Older People
- Ms C Sixtus, Portfolio Manager, Primary Care
- Mrs L Allsopp, Manager Patient Safety and Quality and Acting Director Allied Health
- Mrs J Haitana, Associate Director of Nursing
- Mrs E O'Leary, Project Manager
- Mr D Rogers, Nurse Manager Surgical Services
- Ms A Van Elswijk, Acting Nurse Manager Medical Services
- Mrs J Smith, Acting Nurse Manager, Mental Health Services
- Mrs B Charuk, Portfolio Manager, Child and Youth
- Ms D Holden, Executive Assistant, Service and Business Planning

Others *(public section only)*

- Mrs K Anderson, Chief Executive, Hospice Wanganui
- Dr B Douglas, GP, Jabulani Medical Practice
- Ms A Stewart QSO, Archivist
- Whanganui Public Library
- Whanganui Chronicle
- Ms Mary Bennett, Hauora A Iwi Chair

Agendas are available at <u>www.wdhb.org.nz</u> one week prior to the meeting

Combined Statutory Advisory Committee member attendance schedule – 2019

Name	22 February (AP workshop)	22 March	3 May	14 June	26 July	6 September	18 October	22 November
Graham Adams	✓	×	✓	×	✓	✓		
Charlie Anderson	✓	✓	×	×	✓	✓		
Maraea Bellamy	✓	✓	✓	×	✓	✓		
Frank Bristol	✓	✓	×	×	✓	✓		
Philippa Baker-Hogan	×	✓	✓	✓	×	✓		
Andrew Brown	×	✓	×	✓	×	✓		
Jenny Duncan	✓	✓	✓	✓	×	✓		
Heather Gifford	✓	×	✓	✓	×	✓		
Leslie Gilsenan	×	×	✓	✓	✓	×		
Darren Hull	✓	✓	✓	×	✓	✓		
Stuart Hylton (committee chair)	✓	✓	✓	✓	✓	✓		
Judith MacDonald	✓	×	✓	✓	✓	✓		
Annette Main	✓	✓	✓	✓	✓	✓		
Matthew Rayner	✓	✓	✓	×	✓	✓		
Grace Taiaroa	×	✓	✓	✓	✓	✓		
Tariana Turia	✓	✓	×	✓	×	✓		
Dot McKinnon (board chair)	✓	✓	×	✓	✓	✓		

Legend
- ✓ Present
- × Apologies given
- ✦ No apology received
- ✸ Attended part of the meeting only
- 👍 Absent on board business
- ⊙ Leave of absence

WHANGANUI DISTRICT HEALTH BOARD

REGISTER OF CURRENT
CONFLICTS AND DECLARATIONS OF INTEREST
Up to and including 20 September 2019

BOARD MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Graham Adams	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A board member of Age Concern Wanganui Inc. ▪ The treasurer of NZ Council of Elders (NZCE) ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Charlie Anderson	16 December 2016	An elected councillor on Whanganui District Council.
	3 November 2017	A board member of Summerville Disability Support Services.
Philippa Baker-Hogan	10 March 2006	An elected councillor on Whanganui District Council.
	8 June 2007	A partner in Hogan Osteo Plus Partnership.
	24 April 2008	Her husband is an osteopath who works with some of the hospital surgeons, on a non paid basis, on occasions hospital patients can attend the private practice, Hogan Osteo Plus, which she is a Partner at.
	29 November 2013	Chair of the Future Champions Trust, supporting promising young athletes.
	7 November 2014	A member of the Whanganui District Council District Licensing Committee.
	3 March 2017	A trustee of Four Regions Trust.
	20 September 2019	A director of The New Zealand Masters Games Limited.
Maraea Bellamy	7 September 2017	▪ Te Runanga O Ngai Te Ohuake (TRONTO) Iwi Delegate for Nga Iwi O Mokai Patea Services Trust. ▪ The secretary of Te Runanga O Ngai Te Ohuake. ▪ Hauora A Iwi - Iwi Delegate for Nga Iwi O Mokai Patea Services Trust.
	4 May 2018	▪ A director of Taihape Health Limited. ▪ A member of the Institute of Directors.
	1 February 2019	A trustee of Mokai Patea Waitangi Claims Trust.
Jenny Duncan	18 October 2013	An elected councillor on Whanganui District Council.
	1 August 2014	▪ An appointed member of the Castlecliff Community Charitable Trust. ▪ A member of the Chartered Institute of Directors.
	5 April 2019	A trustee of Four Regions Trust.
Darren Hull	28 March 2014	Acts for clients who may be consumers of services from WDHB.
	27 May 2014	▪ A director & shareholder of Venter & Hull Chartered Accountants Ltd which has clients who have contracts with WDHB. ▪ Acts for some medical practitioners who are members of the Primary Health Organisation. ▪ Acts for some clients who own and operate a pharmacy. ▪ A director of Gonville Medical Ltd
Stuart Hylton	4 July 2014	▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society of New Zealand. ▪ The Whanganui District Licensing Commissioner, which is a judicial role and in that role he receives reports from the Medical Officer of Health and others.
	13 November 2015	An executive member of the Central Districts Cancer Society.
	15 March 2017	The Rangitikei District Licensing Commissioner.
	2 May 2018	▪ The chairman of Whanganui Education Trust ▪ A trustee of George Bolten Trust
	2 November 2018	The District Licensing Commissioner for the Whanganui, Rangitikei and Ruapehu districts.

COMBINED STATUTORY ADVISORY COMMITTEE MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Frank Bristol	8 June 2017	▪ A member of the WDHB Mental Health and Addiction (MH&A) Strategic Planning Group co-leading the adult workstream. ▪ Management role with the NGO Balance Aotearoa which holds Whanganui DHB contracts for Mental health & addiction peer support, advocacy and consumer consultancy service provision. ▪ The MH&A consumer advisor to the Whanganui DHB through Balance Aotearoa as holder of a consumer consultancy service provision contract. ▪ A member of Sponsors and Reference groups of National MH KPI project. ▪ A Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders Group. ▪ Various roles in Whanganui DHB MHA WD, Quality Improvement programmes and Strategic planning ▪ A member of Whanganui DHB CCDM Council ▪ A steering group partner via Balance Aotearoa with Ministry of Health on Disability Action Plan Action 9d).This is legal and improvement work associated with MH Act, Bill of Rights and UN Convention on Rights of disabled people. ▪ A member of the Balance Aotearoa DPO Collective doing work with the Disability Action Plan representing the mental health consumers. ▪ Life member of CCS Disability Action
	14 July 2017	Consultancy work for Capital and Coast District Health Board
	1 September 2017	Appointed to the HQSC Board's Consumer Advisory Group
	22 March 2019	Appointed to Te Pou Clinical Reference group.
Andrew Brown	13 July 2017	▪ An independent general practitioner and clinical director of Jabulani Medical Centre; ▪ A member of Whanganui Hospice clinical governance committee; and ▪ Most of his patients would be accessing the services of Whanganui District Health Board.
Heather Gifford	20 November 2018	▪ Ngāti Hauiti representative on the Hauora a Iwi Board; ▪ A senior advisor and founding member of Whakauae Research for Māori Health and Development (currently engaged in research with WDHB); and ▪ A member of Te Tira Takimano partnership Board of Nga Pae o Te Maramatanga (Centre for Māori research excellence, Auckland University).
Leslie Gilsenan	11 September 2017	The Service Manager, CCS Disability Action Whanganui (formerly Whanganui Disability Resources Centre).
Matt Rayner	11 October 2012	▪ An employee of Whanganui Regional PHO – since 2006 ▪ His fiancée is an Employee of Gonville Health Limited
	26 October 2012	A member on the Diabetes Governance Group
	31 July 2015	▪ An employee of Whanganui Regional Health Network (WRHN) – formerly Whanganui Regional PHO ▪ A trustee of "Life to the Max"
	27 May 2016	A member of the Health Solutions Trust
	1 September 2017	A trustee of Whanganui Hospice
Grace Taiaroa	1 September 2017	▪ A Hauora A Iwi Board member, Iwi delegate for Ngā Wairiki Ngāti Apa ▪ The General Manager Operations – Te Runanga o Ngā Wairiki Ngati Apa (Te Kotuku Hauora, Marton) ▪ A member of the WDHB Mental Health and Addictions Strategic Planning Group ▪ A member of the Maori Health Outcomes Advisory Group.
	16 March 2018	The deputy chair of the Children's Action Team

Judith MacDonald	22 September 2006	▪ The chief executive of Whanganui Regional Primary Health Organisation ▪ A director, Whanganui Accident and Medical
	11 April 2008	A director of Gonville Health Centre
	4 February 2011	A director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape
	27 May 2016	The chair of the Children's Action Team
	21 September 2018	A director of Ruapehu Health Ltd

Annette Main	18 May 2018	A council member of UCOL.

Dot McKinnon	3 December 2013	▪ An associate of Moore Law, Lawyers, Whanganui ▪ Husband is the chair of the Wanganui Eye & Medical Care Trust
	4 December 2013	Cousin is employed by Whanganui DHB as GM Corporate
	23 May 2014	A member of the Health Sector Relationship Agreement Committee
	31 July 2015	Appointed to the NZ Health Practitioners Disciplinary Tribunal
	2 March 2016	A member of the Institute of Directors
	16 December 2016	The chair of MidCentral District Health Board
	3 February 2017	A member of the national executive of district health board chairs
	8 June 2018	▪ A director of Chardonnay Properties Limited (a property owning company) ▪ A chair of the DHB Regional Governance Group ▪ An advisory member of Employment Relationship Strategy Group (ERSG)

Tariana Turia	16 December 2016	▪ Pou to Te Pou Matakana (North Island) ▪ A member of independent assessment panel for South Island Commissioning Agency ▪ Life member CCS Disability Action ▪ National Hauora Coalition Trustee chair ▪ Cultural adviser to ACC chief executive
	15 November 2017	Appointed Te Pou Tupua o te Awa.

Agenda
Public session

Meeting of the Combined Statutory Advisory Committee

to be held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 18 October 2019, commencing at 9:30am

Combined Statutory Advisory Committee members

Mr Stuart Hylton, Committee Chair
Ms Dot McKinnon, QSM, Board Chair
Mr Graham Adams
Mr Charlie Anderson, QSM
Mrs Philippa Baker-Hogan, MBE
Ms Maraea Bellamy
Dr Andrew Brown
Mr Frank Bristol
Ms Jenny Duncan
Mr Leslie Gilsenan
Mr Darren Hull
Mrs Judith MacDonald
Ms Annette Main, ONZM
Mr Matthew Rayner
Hon Dame Tariana Turia, DNZM
Ms Grace Taiaroa
Dr Heather Gifford

Procedural

1 Apologies

2 Conflict and register of interests update — Page 4

2.1 Amendments to the register of interests
2.2 Declaration of conflicts in relation to business at this meeting

3 Late items

Registration of minor items only. No resolution, decision or recommendation may be made except to refer the item to a future meeting for further discussion.

4 Minutes of the previous committee meetings — Page 11

That the minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 6 September 2019 be approved as a true and correct record.

5 Matters arising — Page 21

6 Committee Chair's report — Page 22

A verbal report may be given at the meeting

7 Whanganui DHB Annual Work Programme — Page 23

7.1 Whanganui Alliance Leadership Team update (WALT) — Page 23

7.2 Overview of Health Protection Activity from Medical Officer of Health — Page 24

7.3 Te Huringa – Commissioning Cycle Framework (Draft) — Page 26

7.4 People and Performance update — Page 51

8 Reference and Information Section

Attachment	Description	Page
1	Te Huringa - Commissioning Cycle Framework (Draft)	29
Reference attachments – combined committee interest		
1	Glossary	55
2	Combined Statutory Advisory Committee - Terms of Reference	59

9 Date of Next Meeting

22 November 2019

10 Glossary and Terms of Reference — Page

1 Glossary — **55**

2 Combined Statutory Advisory Committee - Terms of Reference — **59**

11 Exclusion of public

Recommendation

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 6 September 2019 (public-excluded session)	For the reasons set out in the committee's agenda of 6 September 2019	As per the committee's agenda of 6 September 2019
Annual Plan 2019/2020 update	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations).	Section 9(2)(i) and 9(2)(j)

Persons permitted to remain during the public excluded session

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

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

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Unconfirmed Minutes Public session

Meeting of the Combined Statutory Advisory Committee

held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 6 September 2019, commencing at 9:40am

Combined Statutory Advisory Committee members in attendance
Mr Stuart Hylton, Committee Chair
Mrs Dot McKinnon (QSM) Board Chair
Mr Graham Adams
Mr Charlie Anderson (QSM)
Mrs Philippa Baker-Hogan (MBE)
Ms Maraea Bellamy
Dr Andrew Brown
Mr Frank Bristol
Ms Jenny Duncan
Mr Darren Hull
Mrs Judith MacDonald
Ms Annette Main (ONZM)
Mr Matthew Rayner
Hon Dame Tariana Turia (DNZM)
Ms Grace Taiaroa
Dr Heather Gifford

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive
Mr Paul Malan, General Manager, Service and Business Planning
Mrs Rowena Kui, Director, Māori Health
Ms Deanne Holden, Executive Assistant to GM Service and Business Planning, (Secretariat)
Ms Barbara Charuk, Portfolio Manager, Service and Business Planning
Mr Hentie Cilliers, General Manager, People and Performance
Ms Louise Torr, Business Manager, Medical Management Unit
Mr Karney Herewini, Acting Health Promotion Manager
Ms Eileen O'Leary, Project Manager, Service and Business Planning
Mr Steve Carey, Funding and Contracts Manager, Service and Business Planning

Presenters / In attendance
Dr Mavis Duncanson, University of Otago, NZ Child and Youth Epidemiology Service
Ms Wheturangi Walsh-Tapiata, CEO Te Oranganui Trust
Ms Jamie Proctor, Te Oranganui Trust
Helma Van Meulen, Age Concern

Karakia/reflection

M Rayner opened the meeting with a karakia/reflection

DRAFT

PROCEDURAL

1 Apologies

It was resolved that:

The apology from Mr Leslie Gilsenan be accepted and sustained

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

2 Conflict and register of interests update

2.1 Amendments to the register of interests

- J Duncan asked that an entry against her name titled "Trustee of Four Seasons Trust" be amended to read "Trustee of Four Regions Trust". It was noted this request has been made previously and apologies were given on behalf of the secretariat for the delay in acting on this request

- H Gifford has resigned as "Director of Health Solutions Trust". This information has been previously provided to the secretariat. Apologies were again provided that this amendment was not made at time of notification

2.2 Declaration of conflicts in relation to business at this meeting
Nil

3 Late items

Nil

4 Minutes of the previous committee meeting

The committee resolved

That the minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 26 July at 09:30am be **accepted** as a true and correct record, subject to the following amendments:

Attendance:
Dr A Brown be removed from attendee list with apologies noted
Mrs J Duncan be removed from attendee list with apologies noted
Mr Leslie Gilsenan to be added as an attendee
Mrs A Main to be added as an attendee

In Attendance:
Entry for Mr Steve Crew be amended to Mr Steve Carey

Apologies (Item 1.3):
Apologies be noted from Dr H Gifford, Dr A Brown, Ms J Duncan
Apologies for Mr L Gilsenan be withdrawn as he was an attendee
Apologies for Mr C Anderson be withdrawn as he was an attendee

Item 1.1
The sentence commencing "The chair acknowledged….." be deleted as it is repeated at 1.2

DRAFT

Item 1.3
As above

Item 7.2
First bullet point the word "capitative" altered to "capitation"

Item 7.2.3
First bullet point, the abbreviation "GP" altered to "PHO"

Item 7.3
Note that "D. McKinnon left the meeting" at the commencement of item 7.3

Item 7.3
Final paragraph 4 square eastside be amended to read "Four Square Eastside"

The spelling of the word(s) license/licensing be altered to licence/licencing throughout

Moved A Main **Seconded** F Bristol **CARRIED**

5 Matters arising

It was noted that hard copies of agenda and papers are sent in plastic bags and questioned whether these could be sent in paper bags. The plastic bag use is due to the policy of the Courier Company. If attendees would like to receive soft copy only to reduce plastic waste they were encouraged to speak to the committee secretary.

6 Committee Chair Report

The Chair noted the recent signing and agreement in principle of the Whanganui River land claim at Putiki Marae along with the Mōkai Pātea mandate.

The Chair highlighted to Committee that interim results of the Health and Disability Review by Heather Simpson is available and encouraged committee members to review the synopsis. Stated it is encouraging to note the strategic direction is similar to that of the Whanganui DHB Board and chief executive.

7 Whanganui DHB Annual Work Programme

7.1 Whanganui Alliance Leadership Team
Russell Simpson, Chief Executive Officer

A paper entitled "Whanganui Alliance Leadership Team Update" was tabled by the chief executive with verbal summary of the key points:

- Purpose of paper to provide an update on WALT
- The signing of an agreement around Health Pathways across the District Health Boards and PHOs is a milestone. The platform enables consistency across general practice and secondary care
- System Level Measures have been approved by Ministry of Health (MoH)
- High level of presentations to emergency department (ED) due to respiratory issues. Therefore respiratory and bowel screening pathways will receive initial focus in acute demand work
- Our region is disproportionately represented with high presentation at ED or WAM as first point of care. WALT continues to focus on investigating demand and the drivers of demand. Work programme focus on the reasons why and mitigation strategies across health sector. System wide approach is required to move towards a wellness model rather than an illness model
- Highlight the ASMS preliminary survey results to members. Clinical engagement in a District Health Board (DHB) is pivotal to making sustainable change. Whanganui DHB rated highly along most of the metrics within the survey.

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Questions taken:
- The CEO was thanked and the increase in positive results for the Whanganui DHB commended in relation to the ASMS survey
- Timeframe around the hospital front door service review discussed. Clinical pathways and changing model of care will influence change alongside culture change of both clinicians, community and engagement. Change is envisaged to be long term and not a quick fix
- MOHAG are providing cultural advice to the front door service review
- Dame Tariana Turia encouraged the review to encompass possibility of liaison point for families/whānau
- P Baker-Hogan requested an update from the Committee on car parking and outcomes of review

Action: Update committee on car park strategy, challenges and learnings

It was resolved that the Combined Statutory Advisory Committee

Receive the paper entitled Whanganui Alliance Leadership Team update
Note that HealthPathways has been approved.
Note that the respiratory and bowel screening HealthPathways were agreed as priorities for initial development
Note the agreement that as leaders WALT will demonstrate their collegial approach to ensure that the community is receiving the benefits of a joined up service that is unique to our community
Note that the results of the recent ASMS (senior doctor union) survey shows we are tracking positively in regards to clinical engagement at a national level

Moved J MacDonald **Noted** D McKinnon **CARRIED**

R Simpson left meeting 10.05

7.2 Child and youth wellbeing
Barbara Charuk, Portfolio Manager

B Charuk welcomed Dr Mavis Duncanson, Ms Wheturangi Walsh-Tapiata, and Ms Jamie Proctor to the meeting

7.2.1 Health and wellbeing of under-15 year olds in Whanganui

Dr Mavis Duncanson provided an overview to the annual report produced by the New Zealand Child & Youth Epidemiology Service (NZC&YES) which this year has focused on the wellbeing of school age tamakiri.
- The study is underpinned by a commitment to the wellbeing of children; that they imagine, explore, play and be the very best person they can be
- The service was founded in 2004 following a significant gap of access to collated information about wellbeing of tamariki being identified by DHB's for their region
- Data is designed to assist DHBs in carrying out population health planning
- Alongside annual plan reporting, a workshop is held in Wellington each year. Whanganui DHB was well represented this year with three attendees
- The full report can be access via
  - http://ourarchive.otago.ac.nz/handle/10523/9440
- A brief overview of local demographics relevant to the study was given
  - Whanganui has an over representation of children and young people living in areas of high deprivation with the subsequent increased healthcare needs

Oral health
- A child with severe dental conditions may not be able to sleep, eat and grow
- Whanganui tamariki do not have access to fluoridated water, however, Whangnaui is in line with the national average of 60% caries free

DRAFT

- Nationally there is a clear inequity between Māori (50%) and Non-Māori children (70%) caries free
- Severity of dental decay can result in hospitalisation
- Inequity in oral health has been longstanding and pervasive. Support required for social and physical environment

Dame Tariana Turia noted that Whanganui has traditionally held a strong opposition to fluoridation of the public water supply. Discussion took place around the dedicated work in oral health that has shown improved health outcomes, however, there is still more work required to achieve equity.

R Simpson returned to meeting at 10.23

Asthma and wheeze
- High prevalence of asthma in this community amongst tamariki
- Strong driver of hospitalisations for respiratory conditions
- Whanganui has seen a significant increase in last few years. Pressure on housing with overcrowding may have played a part in this
- Health providers can support change by opportunistic immunisation and actively providing smoking cessation to whānau and family members when child is hospitalised

Healthy behaviours
- Nutritional survey shows Whanganui tracking at or above national standards for 2-14 year olds in social factors such as healthy food, breakfast at home etc
- Screen time in Whanganui higher than national level
- Active transport is similar to the national pattern
- Whanganui DHB has a responsibility alongside community to provide an environment where children can enjoy opportunities for healthy behaviours
- Children in Whanganui experience health challenges consistent with inequity of health status in Aotearoa

7.2.2 Hauora Niho initiative

(Ms Chauruk introduced speakers' Ms Wheturangi Walsh-Tapiata, and Ms Jamie Proctor)

Ms Walsh-Tapiata opened with mihi and provided an overview on the initiative which has been led by Te Oranganui Trust.

Te Oranganui identified the need for ongoing community support in relation to oral health. A survey was undertaken engaging Kōhanga Reo, whānau, hapū and iwi in the Whanganui rohe to support development of kaupapa Māori oral health resources. Key findings included:
- A lack for Te Reo resources available to Kōhanga Reo and early childhood centres
- Support required to instigate nutritional health plans (ie water only, healthy kai)
- Child-friendly resources will enable child-lead change within whānau

Prototypes of Te Reo Māori waiata, video, and tamariki friendly artwork were presented to the committee for information.

Next steps:
- Honour the kōrero by moving forward with the community-based oral health approach
- Te Reo Māori resources required to support these conversations
- Funding options being explored for this and other resources as part of ongoing strategy
- Continue to develop resources using a whānau ora approach; engagement of Kōhanga Reo /ECEs
- Kaimahi be empowered as potential champions of oral health
- The use of play, kai, and waiata are key to producing productive and culturally appropriate results.

The Chair thanked Wheturangi and asked if conversations had commenced within Whanganui DHB around funding support. The speaker confirmed that a Hui with relevant parties was scheduled and that funding is also being sought from the community.

Discussion ensued with the committee congratulating Wheturangi on a presentation which showed a great example of Māori leadership and an excellent example of finding solutions that are both responsive to Māori and support addressing inequity.

P Baker-Hogan left meeting 10.57

Noted:

- The importance of Te Reo Māori resources being available to Kōhanga Reo is imperative as no written or verbal english language is used in the centres
- Tamariki focused waiata will help them to support change in their own whānau as they sing the waiata at home, whānau will listen and participate
- The project is an exciting example of what can be achieved with integration, collaboration and a collective impact
- Although work to date has been initiated by Te Oranganui, going forward it will require a community response. As such part funding has been applied for via the Whanganui Community Foundation. Wheturangi was hopeful the Whanganui DHB will also remain involved in this work stream

The CEO noted from a DHB perspective, the excellent initiative that was solution-focused and an example of what can be achieved when a community is led and empowered rather than dictated to.

The Chair encouraged the korero around funding to continue.

7.2.3 B4 School Check

B Charuk presented a paper on behalf of Nicola Metcalf, the B4 School Coordinator, Whanganui Regional Health Network. Key points were noted as follows:

- The check, completed at age 4, is the final core contact delivered under the Well Child Tamariki Ora schedule
- The MoH target is 90% engagement. Last year Whanganui overachieved at 102% engagement. Over-delivery as total number of eligible tamariki in the region is higher than the provisional estimate
- Check includes; oral health, height, weight, vaccinations, developmental/behavioural concerns, hearing and vision
- Completed by practice nurse and/or outreach team with strong community networks
- Target of 95% for children identified as overweight and referred for support
- Whanganui DHB achieved second in New Zealand for the B4 School target

Questions taken

- Clarification was sought around information obtained at the B4 School Check being shared with schools for example: transitional support. Ms Charuk advised that where possible this information is shared for referral, however, it was appreciated more can be achieved in this area particularly in relation to behavioural needs

It was noted that the next steps include implementation of key strategies and initiatives outlined in the 2019/20 annual plan with development of a 3-5 year strategic plan for maternal, child and youth health.

Ms Charuk ended by acknowledging the mahi by all organisations represented and again thanked speakers for their time.

It was resolved that the Combined Statutory Advisory Committee

Receive the paper entitled "Child youth and wellbeing"
Receive the presentations
Note excellent presentation and work from Te Oranganui Trust relating to the Hauora Niho initiative
Note the excellent result in the B4 School Checks

Moved S Hylton **Seconded** J MacDonald **CARRIED**

7.3 Children's worker safety checks within Whanganui DHB
Lead: Henti Cilliers, GM People and Performance

P Malan advised, for a trial period, papers to the committee for the workforce-related agenda item had been aligned with the theme of the presentations in section 7.2. This replaces general human resources information previously provided. It is intended to continue with this approach and any feedback from the committee is welcome.

H Cillers advised that children's worker safety checks is not compliance focused, it is core to what we do in ensuring we provide safe staff to our children and whānau. Safety vetting is one element of this supported by the interview process, reference checking and ongoing performance reviews.

Questions:
There were no questions posed

Comments:
The Chair thanked the team for its work, and for the reassurance it is being carried out and compliance met.

It was resolved that the Combined Statutory Advisory Committee

Receive the report entitled "Children's worker safety checks within Whanganui DHB"
Note compliance of the Whanganui DHB in relation to the Children's worker safety checks within Whanganui DHB

Moved S Hylton **Seconded** J MacDonald **CARRIED**

7.4 Non-financial performance measures
Lead: Paul Malan, GM Service & Business Planning

P Malan tabled the quarterly report for Q4 2019/20 and advised committee that the MoH provides a rating to the Whanganui DHB reporting for each quarter.

Rating is not solely defined by achievement of the target, also takes into account mitigation and information provided alongside numerical data.

Items in red indicating not achieved were discussed by committee.

Questions / Comment:
Oral health: engagement of young people post primary school age was an area of risk. In part due to barriers such as responsibility shifting from the school to parent/whānau and unwillingness of young people to proactively attend dental appointments. Work continues on finding ways to support engagement and participation from young people.

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Mental health: it was noted that there is sustained high utilisation of s29 of the Mental Health Act for Māori. The Chair was advised that substantial work continues through the DHB, to further support the community in this area. Further, guidelines from the MoH are due early 2020 to assist psychiatrists with supported decision making around s29 of the Act.

Faster Cancer Treatment: clarification of the target and information captured regarding this target was sought by the committee. It was clarified that against measure PP30 "Faster Cancer Treatment" targets have been achieved across all four quarters. ie: "patients receive their first cancer treatment (or other management) within 31 days of the decision to treat".

It was resolved that the Combined Statutory Advisory Committee
Receive the non-financial performance report
Accept the non-financial performance report

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

7.5 Public Health Annual Plan 2019/2020
Paul Malan, GM Service & Business Planning

The Public Health Annual Plan 2019/2020 has been approved by the MoH Health and is available on the Whanganui DHB website.

It was noted that from the next financial year it is expected the way public health will be funded will change including the integration of public health priorities and planning into DHB Annual Plans.

Clarification was sought around how equitable access to integrated service is assured across key focus areas. In particular it was felt detailed information on primary health care for kaumatua in the community would assist.

Planning for epidemics and public health in the regions was discussed at length. It was agreed any communication strategy should be robust and formed in conjunction with the local Medical Officer of Health.

The Chair directed the committee to detail provided in the tabled plan which provided further information around this strategy. It was noted that a change from a 1 year to a 3 year funding model may be included in ongoing Governmental review.

Action: P Malan to arrange for the local Medical Officer of Health to provide an outline of the planning and process for such an event.

It was resolved that the Combined Statutory Advisory Committee
Receive the report entitled "Whanganui DHB Public Health Annual Plan 2019/2020"
Support that the Board endorse the Whanganui DHB Public Health Annual Plan 2019/20
Note that the plan has been approved by the Ministry

Moved S Hylton **Seconded** J MacDonald **CARRIED**

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8 Reference and Information

1. The information papers noted below were taken as read:
   - ASMS survey

9 Date of next meeting

The date for the next meeting was confirmed as Friday 18 October 2019 from 9:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui.

10 Glossary & Terms of references (for reference only)

11 Exclusion of public

Moved S Hylton **Seconded** D McKinnon **CARRIED**

It was resolved that:

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 6 September 2019 (public-excluded session)	For the reasons set out in the board's agenda of 6 September 2019	As per the board's agenda of 6 September 2019
Emerging issues and alerts	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Multi-employer collective agreement or negotiations	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations)	Section 9(2)(i) and 9(2)(j)
Staff matters	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)

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Agenda item	Reason	OIA reference
	information should continue to be supplied; or would be likely otherwise to damage the public interest	
Adverse events	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)

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

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

The public session of the meeting ended at 11:53am

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5 Matters arising from previous meetings

Meeting Date	Detail	Response	Status
09/19-01	Update committee on car park strategy, challenges and learnings	As requested at the board meeting in April 2019 a consultation and implementation plan has been developed by management. This is expected to be in place by December 2019	Complete
09/19-02	Local Medical Officer of Health to provide an outline of the planning and process for such an event [epidemic management/public health in regions]	To be addressed: Item 7.2 on agenda 10/19	Complete

6. Committee Chair Report

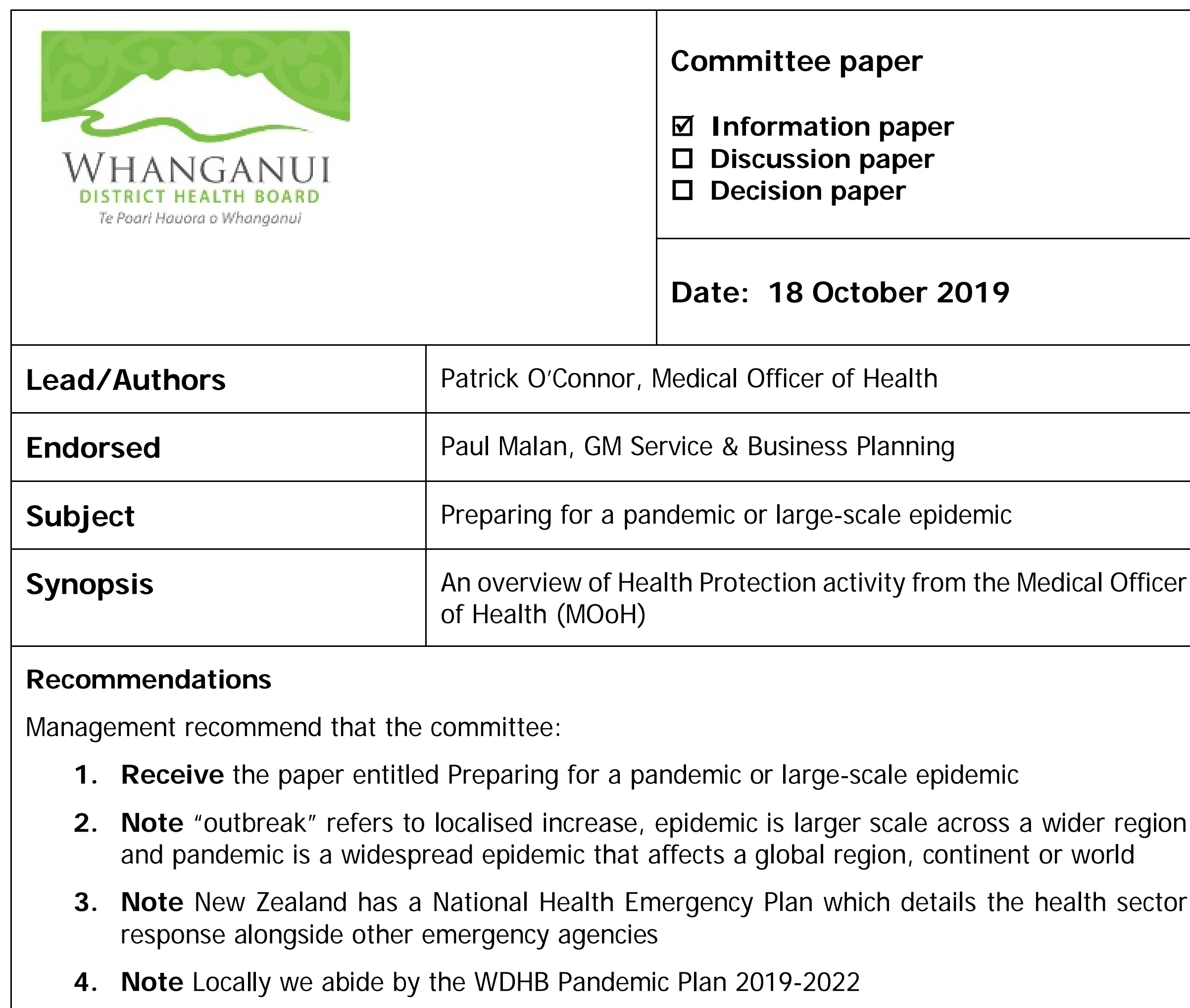
The Chair will provide a verbal report at the meeting.

7 Whanganui DHB annual work programme

7.1 Whanganui Alliance Leadership Team

Russell Simpson, Chief Executive Officer will provide a verbal update at the meeting.

7.2 Overview of Health Protection Activity from Medical Officer of Health



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Committee paper** ☑ **Information paper** ☐ **Discussion paper** ☐ **Decision paper** **Date: 18 October 2019**
Lead/Authors	Patrick O'Connor, Medical Officer of Health
Endorsed	Paul Malan, GM Service & Business Planning
Subject	Preparing for a pandemic or large-scale epidemic
Synopsis	An overview of Health Protection activity from the Medical Officer of Health (MOoH)

Recommendations

Management recommend that the committee:

1. **Receive** the paper entitled Preparing for a pandemic or large-scale epidemic
2. **Note** "outbreak" refers to localised increase, epidemic is larger scale across a wider region and pandemic is a widespread epidemic that affects a global region, continent or world
3. **Note** New Zealand has a National Health Emergency Plan which details the health sector response alongside other emergency agencies
4. **Note** Locally we abide by the WDHB Pandemic Plan 2019-2022

1. Purpose

To provide committee with an outline of the planning and process for a large scale outbreak or epidemic as requested in the meeting held 6 September 2019.

2. Overview

The term outbreak refers to a localised increase in the number of cases of a particular disease. An epidemic is a larger scale event generally across a wider region or population. A pandemic is an epidemic that becomes very widespread and affects a whole global region, a continent or the world. The most likely agent to cause this is influenza.

The overarching planning document for dealing with an epidemic or pandemic in New Zealand is the National Health Emergency Plan. This describes how the health sector response fits in with other emergency agencies, and specifies roles in relation to risk reduction, readiness, response and recovery. It

outlines a framework of plans – national, regional and at DHB level. The plan identifies 17 types of hazard, including "infectious human disease pandemics". It contains the statement "The Ministry of Health has the role of lead agency in an all-of-government response to a health emergency such as an epidemic or pandemic".

Beneath this document sits the National Influenza Pandemic Plan. This identifies six phases of response: planning, border management, cluster control, peak then post-peak management, and recovery. A Pandemic Influenza Technical Advisory Group (PITAG) will be convened as required. A number of roles and responsibilities are identified for DHBs, including: coordinating with the local MOoH and Civil Defence Emergency Management Controller; preparing and implementing appropriate local plans, ensuring ongoing health service provision including, where necessary, community based assessment centres (CBACs); and provision of immunisation programmes.

At the regional level there is a Central Region Health Emergency Plan. This would be actioned where individual DHBs require support from neighbours. There is a regional emergency health advisor with the Ministry of Health who can assist with the process.

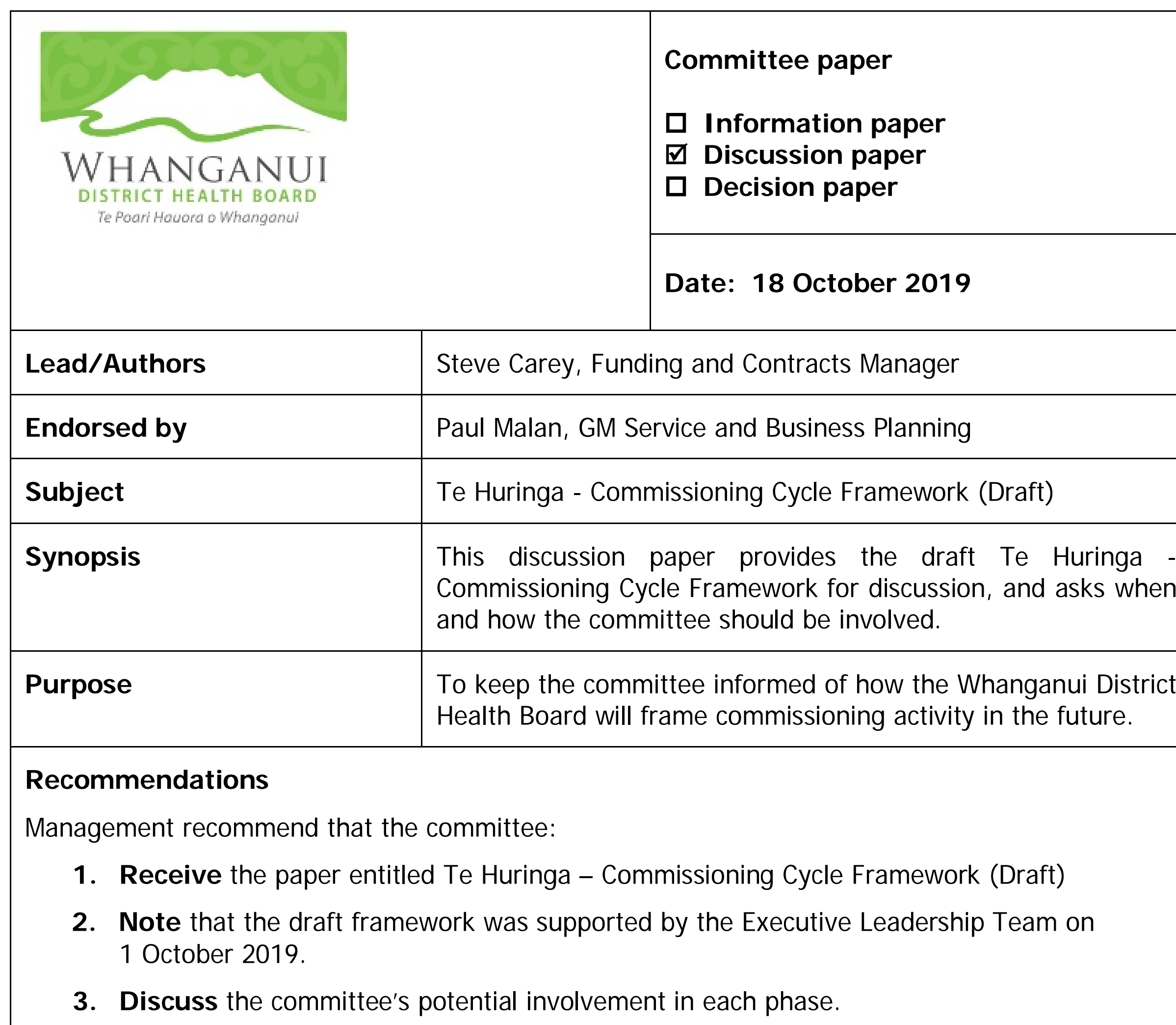
Locally we have the WDHB Pandemic Plan 2019-2022. It defines the relationship the DHB has with the PHOs and with Public Health in any response. An advisory committee can be convened to provide advice for planning or in the event of a response. For the actual response an incident management team will be set up, with CEO or delegate as Incident Controller. As the incident escalates, general practices can stream relevant patients by for example setting aside specific clinic time within the practice. With yet further escalation a Community Based Assessment Centre can be set up. Gonville Health is the first site. Whanganui Central Baptist Church may be used if needed. Due to lower population numbers in rural areas it is unlikely that a formal CBAC structure will be required. Local solutions will be considered and activated by the WDHB EOC in accordance with needs.

3. Conclusion

In any declared emergency the relationship between the Incident Management Team and the MOoH will be important. The Health Act defines powers of the MOH where a state of emergency has been declared because of infectious disease. The local MOH is employed by MidCentral DHB rather than Whanganui DHB, but primary responsibility is for the population of Whanganui DHB. The Pandemic Plan states that "The MOoH will be a member of the Advisory Committee advising the Incident Controller, and any actions taken pursuant to ss70&71 of the Health Act will be taken with the agreement of the Incident Controller." Within the Incident Management Team, it is anticipated that the MOH would be part of the Planning & Intelligence Team.

There may be situations where an epidemic requires a coordinated DHB response, but not within the context of a declared emergency. An example was the response to the influenza event of 2009. A formal Incident Management Team was not established, but an advisory group met regularly to monitor and manage the response. This is the likely response if we were to experience a significant number of measles cases locally. If the situation reached a stage where there was considerable strain on local health resources, then a formal Incident Management Team could be established.

7.3 Te Huringa - Commissioning Cycle Framework (DRAFT)



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Committee paper** ☐ **Information paper** ☑ **Discussion paper** ☐ **Decision paper** **Date: 18 October 2019**
Lead/Authors	Steve Carey, Funding and Contracts Manager
Endorsed by	Paul Malan, GM Service and Business Planning
Subject	Te Huringa - Commissioning Cycle Framework (Draft)
Synopsis	This discussion paper provides the draft Te Huringa - Commissioning Cycle Framework for discussion, and asks when and how the committee should be involved.
Purpose	To keep the committee informed of how the Whanganui District Health Board will frame commissioning activity in the future.

Recommendations

Management recommend that the committee:

1. **Receive** the paper entitled Te Huringa – Commissioning Cycle Framework (Draft)
2. **Note** that the draft framework was supported by the Executive Leadership Team on 1 October 2019.
3. **Discuss** the committee's potential involvement in each phase.

1. Purpose

The Te Huringa - Commissioning Cycle Framework has been developed in order to provide an operational structure to the way that as an organisation, the Whanganui District Health Board (WDHB) commissions for the goods and services it purchases – both externally and internally (including under the Operational Policy Framework/Service Coverage Schedules/Crown Funding Agreements). This framework will provide structure for the strategic, ministry requirements and service planning methods and is an important part of developing and implementing prioritisation and strategic directives of the organisation.

The Framework outlines six phases to provide structure and consistency for how we commission to enable the organisation to achieve its vision of He Hāpori Ora – Thriving Communities. These phases include:

- Kōtahitanga - Analyse
- Tikanga - Plan
- Whanaungatanga - Design
- Kaitiakitanga - Implement
- Mana Tangata - Maintain and Support
- Tino Rangatiratanga - Evaluate

Each phase has a particular set of reference points and operational tasks to undertake to ensure that we are making the correct commissioning decisions for the organisation. Throughout the framework, there are reference to documents which link into the Commissioning Cycle, some of these documents need to be developed – such as the prioritisation framework. The Commissioning Cycle Framework will support the development of workforce, workflow, procurement, contracting, analytic, project management and service planning and provide a consistent approach to how the organisation operate in this specialist field.

The Commissioning Cycle Framework will provide consistency to procurement, contracting and strategic project management enabler functions. Through this, the organisation will be supported in focusing resources on delivering outcomes which align to our strategic direction in a financially responsible and methodical manner. The Commissioning Cycle Framework supports the broader outcomes procurement responsibilities, WAI2575 report, and the centralisation of functions as outlined in the Health & Disability System Review interim report. It enables the social procurement and enterprise expectations of WDHB and is explicit in its requirement around the inclusion of Māori and equity in all phases.

The Commissioning Cycle Framework has been supported by input from the Te Hau Ranga Ora team, including assistance with the development of the Cycle logo, the name of the framework and the attribution of values to each of the phases. The Commissioning Cycle Framework has been supported to be presented at the Joint Board meeting as an example of how we as an organisation will be implementing the pro-equity implementation plan – in particular, recommendation three – "improve transparency in data and decision making".

2. Discussion

The Commissioning Cycle Framework will be enabled through the Commissioning Team, who will be a team of specialists in contracting, project management, procurement and planning and accountabilities (Ministry mandated planning and reporting). This team will lead the commissioning and strategic project management operations for the organisation and each role will be supported by a Kaitakitaki. At this stage, the team will operate collectively, however, in a virtual situation.

At each phase, there are a number of people who will need to be involved, from consumers, to clinicians, to iwi/hapu and Business, Service and Portfolio Managers. We are now seeking input, as to when the Committee should be involved in the cycle. Although the Committee will not be the decision makers of who or how we should contract, it is important that these decisions are not made in isolation.

3. Points for discussion

a. Is the commissioning cycle framework a robust enough process to provide certainty and clarity to our governors (Board and Committees) that the way we will approach commissioning and strategic project management is methodical and sets the organisation up for success?

b. Identify the phase(s) in which the Committee should be involved.

c. What level of Committee involvement is appropriate in each phase?

d. How should the Committee be engaged in the Commissioning Cycle Framework?

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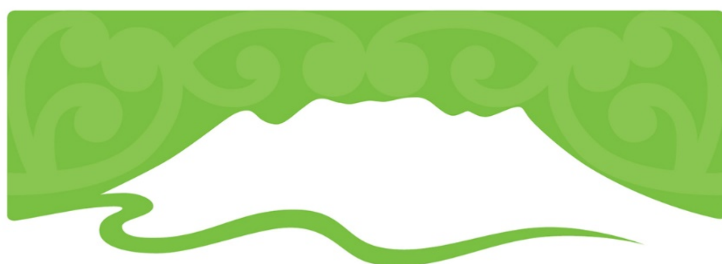
Kōtahitanga
ANALYSE
Tikanga
PLAN
Whanaungatanga
DESIGN
IMPLEMENT
Kaitiakitanga
Mana Tangata
MAINTAIN & SUPPORT
EVALUATE
Tino Rangatiratanga
WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui
COMMISSIONING CYCLE
TE HURINGA



Te Huringa
Commissioning Cycle Framework

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1.0 PURPOSE

Commissioning is more than just planning, funding and procurement. Planning takes identified needs of the community and maps the best ways to meet those needs. Funding relates to budgeting for goods and services based on those plans and seeks to allocate funding through a process of procurement and contracting. Procurement provides a way to select providers to contract with for goods or services, making use of the plans and tasks to identify goods or service providers to meet those needs.

As a result, the process of commissioning covers a range of activities from identifying and establishing need, budgeting and resource allocation, to the provision and evaluation of the services contracted to address that need. Commissioning is informed by a process of engagement and consultation with the people who will be impacted by the services, either as clients, whānau, carers, community members or service providers, and other stakeholders (e.g. experts in the field, etc.). It "is an opportunity to rethink the model of delivery by assessing 'what is possible' unconstrained by historical practice, funding and policy." (NSW Treasury, 2016). The overall purpose of commissioning is to provide specific, equitable and cost-effective services that meet the needs of our community, where the focus is on innovation to achieve outcomes that address need rather than service activities.

Commissioning is sometimes used as a synonym for procurement or contracting. These can be part of the process but not the process itself. Part of commissioning's aim is to purchase services and utilise competition mechanisms, such as contestability, however its remit is broader. Commissioning health and community services in WDHB includes making informed, deliberate choices about diverse issues including objectives, needs, cost-effectiveness, funding, pricing, risk management, quality, eligibility, performance management, information flows, provider-market sustainability, and interactions with other services (New Zealand Productivity Commission, 2015). It also assesses the most effective way of achieving outcomes including procurement, contracting, delivery and evaluation. Its intention is to be strategic, focussing on /services that meet the needs of whānau and their communities throughout the process.

The Te Huringa - Commissioning Cycle Framework has been developed to guide the Whanganui District Health Board (WDHB) in its commissioning practices for the goods and services it purchases for all aspects of the organisation. This framework will provide the structure for the strategic, ministry requirements and service planning methods and is an important part of developing the prioritisation framework that will enable the priorities and strategic direction of the organisation.

2.0 BACKGROUND

WDHB contracts with a more than 92 providers, equating to 302 active contracts, for the delivery of health and disability services for the population of the district. This represents a significant proportion of the DHB's annual budget. Some of these contracts are set locally while others are negotiated and determined at the national level. This is an annual process undertaken in accordance with requirements of the national service framework and in line with the DHB's annual planning and budgeting process.

The Strategy, Commissioning and Population Health enablers are responsible for providing strategy, planning and commissioning frameworks for WDHB, with the intention of ensuring the DHB functions as a consistent, purposeful and well-managed organisation. Given the wide range of people who contribute to the integrated and collaborative commissioning process, it

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is important for there to be a shared understanding of what is meant by "commissioning". At its most basic, commissioning involves understanding need and then ensuring there is a supply of goods and services to meet that need.

The Te Huringa - Commissioning Cycle Framework is a strategy and equity led process which considers the needs of communities and population groupings, the goals and desired outcomes of the DHB, and the strategies and actions necessary to give them effect. In this context, actions include both make and buy decisions with consistent prioritisation across both.

From a practical perspective, the commissioning framework involves six phases as follows:

1. Kōtahitanga - Analyse
2. Tikanga - Plan
3. Whanaungatanga - Design
4. Kaitiakitanga - Implement
5. Mana Tangata - Maintain and Support
6. Tino Rangatiratanga - Evaluate

An important part of this, is the management of internal and external health goods and service provider contracts. Responsibility for managing these contracts lies with the Business, Service or Portfolio Managers, with the Commissioning Team (CT) providing the support, frameworks and coordination of the contracting process.

The CT will be a team of specialists in contracting, project management, procurement and planning and accountabilities (Ministry mandated planning and reporting). This team will lead the commissioning and strategic project management operations for the organisation and each role will be supported by a Kaitakitaki. Where CT is mentioned in the phases in this framework, the CT member will be the appropriate team member with the required specialist skills for the task.

3.0 LOCAL CONTEXT

The New Zealand Public Health and Disability Act 2000 mandates DHBs to improve and protect the health of people and communities and meet it responsibilities under Te Tiriti o Waitangi through funding and delivering services to meet the equitable needs of the population.

The Te Huringa - Commissioning Cycle Framework for goods and services funded by the Whanganui DHB is a mechanism to support this mandate and ensures that it is done so in a financially responsible manner.

The Te Huringa - Commissioning Cycle Framework will be applied to all Business Streams across WDHB. Whilst traditionally each business unit has commissioned for goods and services to meet the individual needs of the service groups, the Te Huringa - Commissioning Cycle Framework takes a higher level approach and ensures that all goods and services purchased align to the WDHB strategic direction of equitable health procurement and contracting. For lower value, low risk commissioning, the time spent in each phase of the Te Huringa - Commissioning Cycle Framework will be reduced in contrast to high risk, high value commissioning.

It is important to note that although as a DHB we are required to provide services under the Operational Policy Framework, Crown Funding Agreements, Price Volume Schedule and

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Service Coverage Schedules, how these are designed and implemented and the monitoring and reporting will be in line with the Te Huringa - Commissioning Cycle Framework.

4.0 GUIDING PRINCIPLES

The Te Huringa - Commissioning Cycle Framework principles for commissioning for goods and services are:

- The Te Huringa - Commissioning Cycle Framework will support the Regionally Supported and Locally Required document planning process;
- All goods and services must align to the New Zealand Health, He Korowai Oranga and WDHB strategies;
- Consider cross sector partnerships, the value add of local community partners and community facing service development and provision (Broader Outcomes);
- All goods and services shall take a regionally consistent approach where appropriate;
- Public Value (Cultural, Environmental, Social and Economic) be a driver for decisions;
- Robust analysis of the health environment will enable WDHB to commission for goods and services purposefully and equitably;
- The Te Huringa - Commissioning Cycle Framework will ensure that Māori voices and influence is end to end across the phases;
- Kaupapa Māori service commissioning processes will be sponsored by General Manager Māori health and Equity; and
- Each phase of the Te Huringa - Commissioning Cycle Framework must be completed for all services, and reviewed on a regular basis.

5.0 THE FRAMEWORK

The Te Huringa - Commissioning Cycle Framework comprises of six phases:

1. Kōtahitanga - Analyse
2. Tikanga - Plan
3. Whanaungatanga - Design
4. Kaitiakitanga - Implement
5. Mana Tangata - Maintain and Support
6. Tino Rangatiratanga - Evaluate

The values attributed to these phases are:

- Kōtahitanga – Working together, bringing achievements together.
- Tikanga – Procedure, planning, methods.
- Whanaungatanga – Value and understand each other's perspectives – strengths, weaknesses, relationships and value set. Development and establishment.
- Kaitiakitanga – Demonstrating behaviours, implementations that reflect responsibilities.
- Mana Tangata – Respect, recognising rights.
- Tino Rangatiratanga – Taking ownership.

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5.1 Kōtahitanga

Understand the delivery environment you HAVE, then CREATE the one you need.

Commissioning for equitable health is not preventative healthcare by another name. It requires a particular form of approach and understanding of how to promote health as opposed to treating or preventing disease or illness – moving from an illness model to a wellness model.

The analysis of systemic problems which may be creating inequitable outcomes, areas of unmet need and the identification of contracts that will benefit from recalibration, termination or innovation, is imperative to the Te Huringa - Commissioning Cycle Framework. Through analysing the health, social and commercial factors of the current health environment, quality intelligence will be embedded into the Te Huringa - Commissioning Cycle Framework. In the Analysis phase, information will be scrutinised from the following sources:

- Health Needs Assessments
- WDHB Pro Equity Check-up Report 2018
- Quality Accounts
- Locality Planning/Information
- Iwi, consumer and provider surveys – Whānau Ora Health Impact Reports and Health Impact Reports
- Whanau voice – qualitative hui and feedback
- WDHB Māori Health Profile 2015
- Health of Children and Young People in Whanganui. Child and Youth Epidemiology Service
- Whanau Ora Policy Framework
- Health Informatics – (i.e. Health Roundtable, Atlas of Healthcare Variation)
- Health Sector and Market Analysis
- Inter-sectoral Collaboration Assessments (Determinants of Health Status Reports)

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Social determinants of health are the conditions in which people live, learn, work, and play[1]. These conditions include a broad range of socioeconomic and environmental factors, such as air and water quality, the quality of the built environment (e.g., housing quality; land use; transportation access and availability; street, parks and playground safety; workplace safety; etc.), opportunities for employment, income, early childhood development and education, access to healthy foods, health insurance coverage and access to health care services, safety from crime and violence, culturally and linguistically appropriate services in all sectors, protection against institutionalised forms of racism and discrimination, and public and private policies and programs that prioritize individual and community health in all actions.

When a society's philosophies and policies work to improve these social determinants of health to promote justice and equity for everyone, health is created at the levels of the individual, the whānau, communities, the environment, and society at large. When any combination of these conditions is lacking, the engine that powers total health can break down, resulting in significant health inequities and disparities in health outcomes. In the WDHB district inequities in health outcomes is highest in Māori population groups across all age bands.

Addressing the social determinants of health will promote a culture that empowers everyone to live the healthiest lives that they can, even when they are dealing with chronic illness or other constraints. This includes developing a health care system that extends beyond the walls of hospitals or GP Clinics, and couples treatment with care, to consider the life needs of patients, families, and whānau.

Understanding what creates or limits the opportunity for health is essential to understanding what creates health inequity of outcomes and what needs to be done to prevent them. Among other things, the solutions need to involve changes at the policy level by a broad set of public, community and private partners representing sectors that impact public health but may not have health at the centre of their decision making, such as transportation, economic development, education, justice, social housing, chambers of commerce, and Local Government.

[1] https://letsgethealthy.ca.gov/sdoh/

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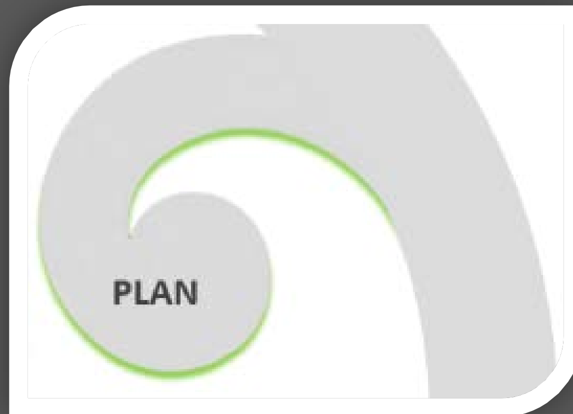
5.2 Tikanga



In the Planning phase of the Te Huringa - Commissioning Cycle Framework, WDHB is trying to answer two important questions:

1. *What are we trying to accomplish (our aim)? and*
2. *What health need will we be serving (or unmet need)?*

WDHB seeks to answer these broad questions at a high level in our strategy and staff values. Furthermore, through the development of our foundational documents; the supporting documents of the annual plans, service plans, and annual budget will be guided to align with WDHB strategy. WDHB will be able to identify areas, which based on the analysis phase, will provide the most beneficial and equitable health outcomes. Foundational documents are:

- Statement of intent;
- A Capital Investment Plan; and
- A prioritisation framework.

Supporting Documents:

- The Annual Budget;
- Annual Plan;
  - Including Statement of Performance Expectations
  - WDHB Planning Priorities,
  - Service Change and Coverage Schedules
- Local, Regional and National Strategies, He Korowai Oranga and Service Plans;
- A Production Plan.

Key Priorities:

- WDHBs Strategic Direction;
- Focus on Equity;
- Public Value – Economic, Cultural, Environmental and Social;
- Access to kaupapa Māori services; and
- Building Māori workforce capacity and capability across the system.

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5.3 Whanaungatanga

In the Design phase of the Te Huringa - Commissioning Cycle Framework, utilisation of the information and data gained from the Analysis phase and the documents developed in the Planning phase occurs. With these, the CT support WDHB and other external agencies to design procurement plans and business cases for goods and services. The CT ensure that services are aligned to budget, funding and appropriate delegation levels.

The tools that support the formation of procurement plans and business cases include:

- Information from the Analysis and Planning Phases;
- Design and Development of Business Cases, Reporting and Monitoring;
- HEAT equity tool and methodologies;
- Utilisation of the Māori Engagement Framework;
- Strategic and Equity Alignment assessment;
- Decision Support Tool;
- Risk Analysis;
- Project Initiation Support;
- Government Procurement Rules;
- Probity assessments;
- Service design plans and templates;
- Legal opinions/expertise; and
- Procurement and Contracting Expertise.

It is important that the CT is approached at the very beginning of commissioning to provide advice, oversight, ensure that all legal requirements are met and that all the necessary stakeholders are informed – this is regardless of the Service Group. Some processes may need to be completed annually to match the Annual Plan requirements which includes the service change notifications. Depending on the level of change, the CT will liaise with the Ministry and/or the Minister of Health as required under the Service Change Schedule and notification process.

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All contracts and variations will be reviewed and approved in accordance with the CTs contract approval procedures and processes. Additionally, all contracts will be approved and signed in accordance with the WDHB Delegated Authority Policy and involve Responsibility Area delegates. All applications, sign offs and contracts will be designed and stored electronically. Once signed and activated, all contracts will be held by the CT.

It is important that a robust service specification and business case is developed to support the design of the service. This includes the formulation of reporting requirements in line with our identified outcomes frameworks from the Analysis and Planning Phases. This will help to ensure that WDHB only collects the information that is of value and can help show outcomes – these metrics need to be both qualitative and quantitative. The CT can help with the development of these documents and metrics if required.

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5.4 Kaitiakitanga

Once the Analysis of the current health environment has occurred, the Planning phase identifies the areas for focus and a business case is produced in the Design Phase. In order to implement or commission a service, the CT will formulate the contracts and/or procurement plan. The CT will work with you to ensure that the correct approvals have been sought, the request forms are filled out and that the service specifications are attached.

There are two types of implementation:

- Procurement and commissioning of new goods and Services; and
- Contracting for new or existing goods and services.

5.4.1 Procurement

Procurement is a specialised field that involves a complex set of rules, legal requirements, processes, notifications and paperwork. As a result, the CT will guide procurement process.

5.4.2 Contracting

Contracting involves formulating the Terms and Conditions, service specifications, Agreement Request Forms, PERORG forms, creating the appropriate contract and liaising with providers and the Ministry of Health. The CT will work with business units to initiate the contracts and support the Performance Management Reporting (PMR) process.

It is important to follow the flowcharts to understand what document are require and what supporting documentation needs to be provided.

Base Agreements

If a provider has a number of contracts, then where possible, a base agreement will be created that includes all contract lines. If variations are required, the end date will be the same as the end date as the base agreement.

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End Dates

Unless there is a specific reason, all Nationally Specified contracts will have an end date as the 30/06/20XX and all Local contracts as the 30/09/20XX.

Length of Term

With the exception of Nationally Specified contracts and major procurement (High Risk, High Value), all new providers will be put on an initial 12 month term (pilot). Following the 12 months of satisfactory provider performance and continued strategic and equity focus, the next contract will be for 24 months. Following the 24month term of satisfactory provider performance and continued strategic and equity focus, all future contracts will be on 36 month terms. This will enable providers to invest sustainably into the future with surety of contract.

Outcomes Based Contracting

Where providers are identified as being sustainable, and partners in high trust agreements, WDHB will seek to move toward less rigid outcomes based contracts where the provider either co-design, or lead the design in services to address the needs of identified population groups. This is important to develop this down to an iwi/hapu level, where they can be participants in their own healthcare journeys.

Cost Price Pressure Adjustment

Whilst WDHB will make every endeavour to pass on CPP to all providers, it may not always be possible.

- Nationally Mandated CPP will be passed through;
- Providers who provide exceptional service (as determined by the outcomes of the desktop reviews and annual evaluation [Performance Monitoring Framework]) will have CPP increase;
- If a provider is not performing (as determined by the outcomes of the desktop reviews and annual evaluation), then CPP will be reduced or not passed onto the provider (as per the Performance Monitoring Framework);
- Where possible, if a provider has multiple contract lines, the CPP is to be consistent across all contract lines;
- Where possible, 'similar' service providers are to receive the same CPP (i.e. Mental health beds, LTC beds etc) in order to provide surety of a longer term contract, the first year will have a higher CPP increase than out years.

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5.5 Mana Tangata

Throughout the Maintain and Support Phase, the expected values of WDHB employees, and by extension, through to how the DHB treat and interact with providers is woven. These include our values of:

- ~ **Kotahitanga** - Unity, cohesion, sharing vision, working together, trust, relationships, collaboration, integration.
- ~ **Kaitiakitanga** - Protection, taking care of people, things, conflict resolution, environmental, awa, maintain values, vision, understanding, absolute protection, keeping yourself and each other safe.
- ~ **Rangimarie** - Humility, maintaining one's composure, peace, accountability, responsibility, respect;
- ~ **Mana tangata** - Dignity, relationships, protection, safety, patient and whānau involvement, respect, acceptance; and
- ~ **Manaakitanga** - Respect, support, helping, caring, non-judgmental, do absolute best to support, be of service to others, no expectation of receiving back, kaupapa.

It is important that as the WDHB we take our role as stewards seriously. Business, Service and Portfolio Managers are responsible for maintaining positive relationships with their identified providers and work collaboratively with them to ensure success. Some of the ways that can demonstrate our manaaki towards providers is through:

- Ensuring that providers have sufficient time to respond to requests for information – proactive rather than reactive.
- Work with providers to ensure that they are up-to-date with all reporting and monitoring requirements.
- Make sure that Notification of Contract Intent is issued to all providers to whom the WDHB are unable to have a formal contract signed with prior to contract expiration dates – it is hoped with the new systems in place that this will not occur often.
- Undertake desktop reviews of strategic, public value and equity alignment with WDHB throughout the year and work with the providers to identify remedial actions if required.

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- The CT and finance department will ensure that invoices are received and actioned within 10 business days. This will mean that with assistance from the Management Accountants, the Business, Service and Portfolio Managers will be required to understand when invoices are expected from providers and ensure they are followed up if not received where appropriate – we want to pay for the services we contract for. The expectation is that the Business, Service or Portfolio Managers will follow up with providers on exceptions only and not for day-to-day invoicing concerns.
- In conjunction with the Management Accountants, the Business, Service and Portfolio Managers will be responsible for checking that provider invoicing is aligned to the budget allocated. This will enable providers to be aware if they are at risk of over (or under) spending for goods and service provision. The Business, Service and Portfolio Managers can then work collaboratively to help providers to work to budget, or gain an understanding of the causes and identify potential solutions. As a proxy of this, Business, Service and Portfolio Managers will co-ordinate the monthly and end of year accrual processes with the Management Accountants to ensure that money that is 'tagged' or required to be accrued, is accrued.
- Business, Service and Portfolio Managers will be responsible for reviewing all PMRs and provide narrative where required to provide context to the reporting. Many providers put time and effort into producing these reports, so it is important that we not only acknowledge their receipt, but also provide them with feedback. *It is therefore important in the Design Phase that we develop meaningful reporting to enable us to show value and outcomes as a result of the goods or services provided.* In essence, this is about monitoring and maintaining the contacts with the providers to ensure they can fulfill the requirements.
- The CT will be responsible for maintaining and supporting the renewal, review or termination of contracts. In conjunction with the Funding Management Group, the CT will develop a three year workflow document to identify high risk contracts, and formulate an annual work plan to support early notification through to Business, Service and Portfolio Managers. This will enable contracts to be formed and actioned in a timely and coordinated manner.
- For minor contracts, the CT will ensure that contracts due to expire are sent through to Business, Service and Portfolio Managers for review 2 months prior to expiration and co-ordinate Notification of Contract Intent letters to providers (if required).
- If required, the CT will liaise with MOH to stop or halt provider payments in the event of provider non-performance. In the unlikely event of serious misconduct or non-performance, the CT will co-ordinate the termination of contracts with the Business, Service and Portfolio Managers. If claw backs are required as a result of Audit or non-compliance, the CT will co-ordinate with the providers to ensure this is completed.
- In essence, in the Maintain and Support phase, the CT will ensure correctness of documentation, and enforce the contract when required. This will enable the Business, Service and Portfolio Managers to focus on the development and maintenance of the relationships with their providers. It is acknowledged that many aspects of the maintain and support phase are tailored more towards the responsibilities of the Portfolio Managers, however this is not exclusive and therefore Business and Service Managers are included.

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5.6 Tino Rangatiratanga

WDHB wants to be more responsive, more transparent and better engaged with the communities we serve. We want to demonstrate value and be able to learn and adapt to changing needs, constraints and opportunities.

As a consequence, it is important that we invest in strengthening the knowledge, skills and processes needed for the effective use of evidence and evaluation, creating opportunities to apply tried-and-tested methods, explore new approaches and collaboratively build effective systems. Capacity to choose the right methods and processes to gather evidence and to monitor, report and reflect on the results, are imperative.

We all want to make a positive difference. We all want our services to improve people's lives. But how do we know if what we're doing achieving this? How do we know if it's the best use of our resources?

Evaluation is fundamentally about knowing if service delivery is working. Every evaluation adds to our understanding of what families/whānau and communities need, access and use of services.

Evaluation is not just a retrospective review – it includes integrated monitoring at all stages of implementation, and forms the basis for continuous improvement (Design and Maintain and Support Phases). It's not just about knowing if service delivery is working, but also about improving our understanding of what is needed, and what changes could be made to make things work better.

Evaluation provides a systematic method to study a service to understand how well it achieves its goals and helps determine what works well or what could be improved in a service. Program evaluations can be used to:

- Demonstrate strategic and equity focus alignment;
- Should help to identify where resources are not being put to the best use and could be redirected.
- Provide both qualitative and quantitative data to support continuation or discontinuation of a service; and
- Identify services that would benefit from volume or price increase or decrease.

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At WDHB, evaluations of provider performance will be undertaken:

- Annually as part of the CPP adjustment review;
- Nearing the completion of a contract to consider renewal, review or termination;
- At the end of a pilot program; and/or
- To collate the quarterly reports and desktop reviews to formulate provider performance evaluations.

Providers will be evaluated against:

- Their achievements against the requirements of the service specification;
- Their alignment with the DHB strategic direction;
- Their alignment with the DHB values;
- Their focus on equitable outcomes – including a link to the Hauora Report 2019 recommendations;
- Their alignment to the MOH/Maori health and Government priorities, including 'broader outcomes';
- Their community focus and social enterprise – employing local solutions that reduce social, environmental and family/whānau harms (Kaitiakitanga);
- Their performance of expenditure against budget;
- Their performance in audit programmes;
- Their quality and timeliness invoicing;
- Their quality and timeliness of reporting – both qualitative and quantitative;
- Their performance in customer evaluations;
- Their performance in managing complaints; and
- Their overall performance based on Business, Service and Portfolio Manager desktop reviews throughout the year.

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6.0 REFERENCE DOCUMENTS

- WDHB Procurement Guide
- Māori engagement/consultation document
- WDHB Pro Equity Check–up Report and Implementation Plan
- WDHB Strategy He Hāpori Ora – Thriving Communities

WDHB Policies

- Tiriti o Waitangi – Treaty of Waitangi Policy
- Capital Investment Policy
- Procurement Policy
- Delegation Policy
- Security Policy
- Sensitive Expenditure Policy
- Consultation Policy

WDHB Terms of Reference

- CAPEX Committee
- Procurement Working Group
- Product Evaluation Committee

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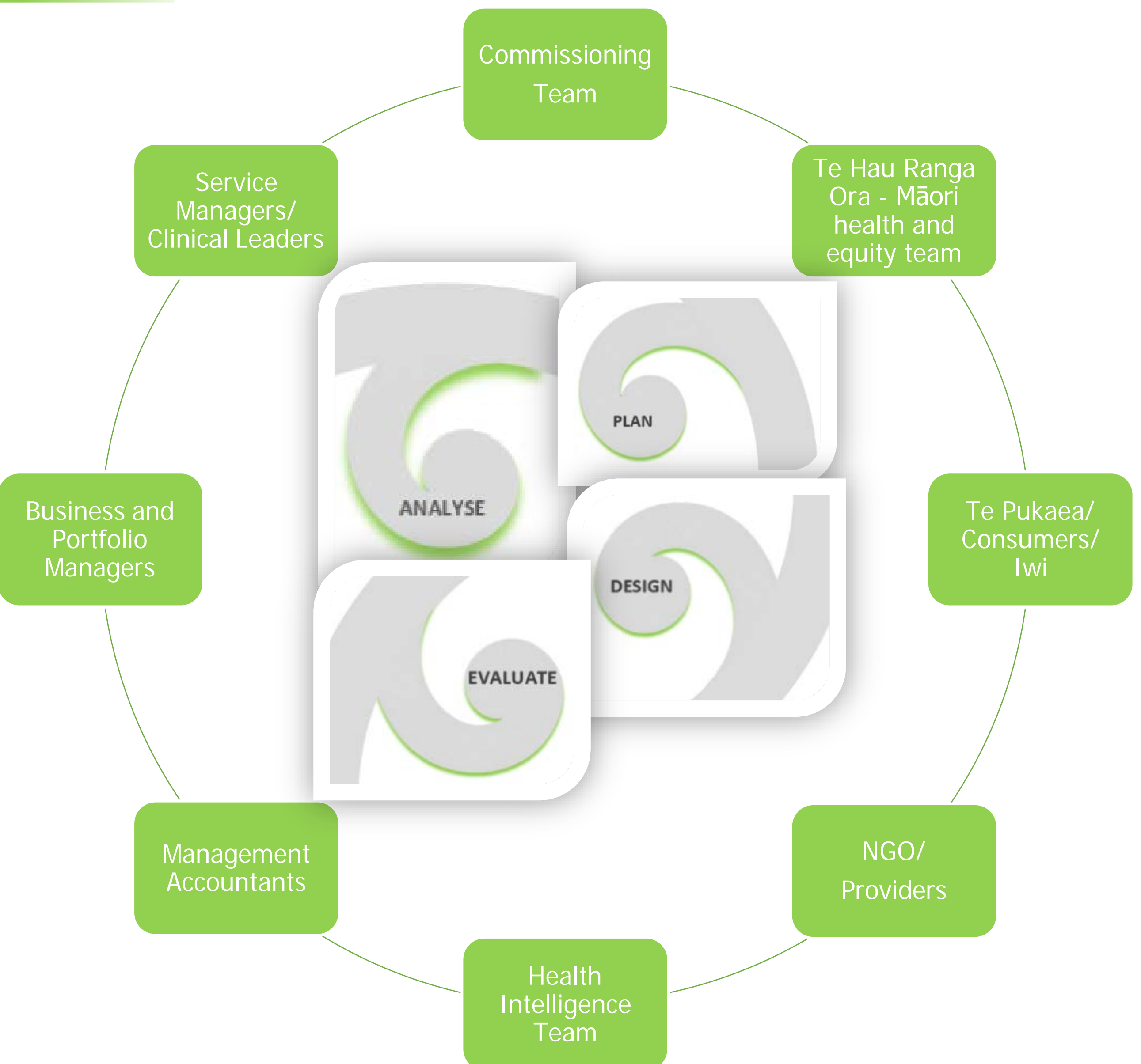
7.0 KEY FUNCTIONS PER PHASE



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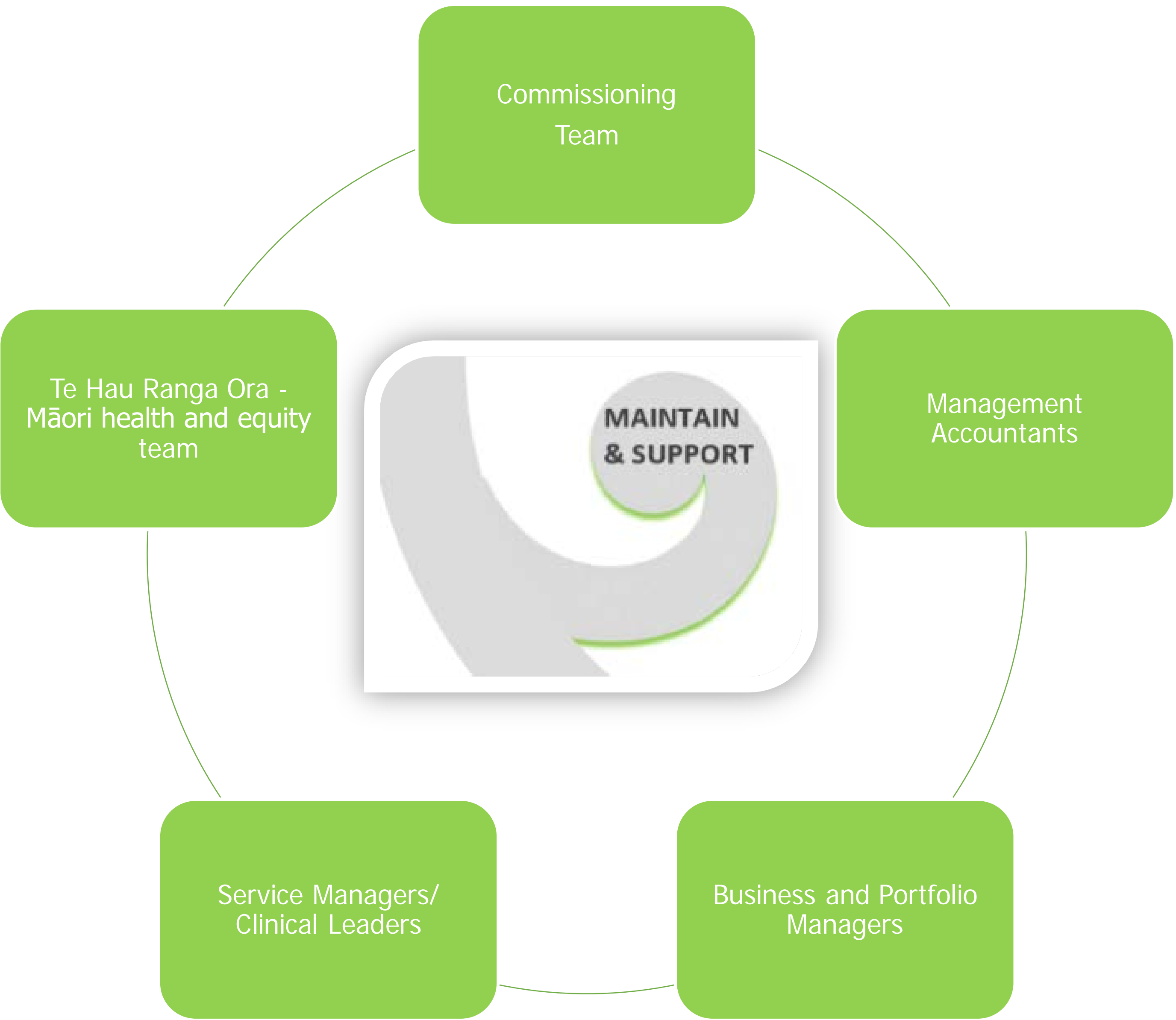

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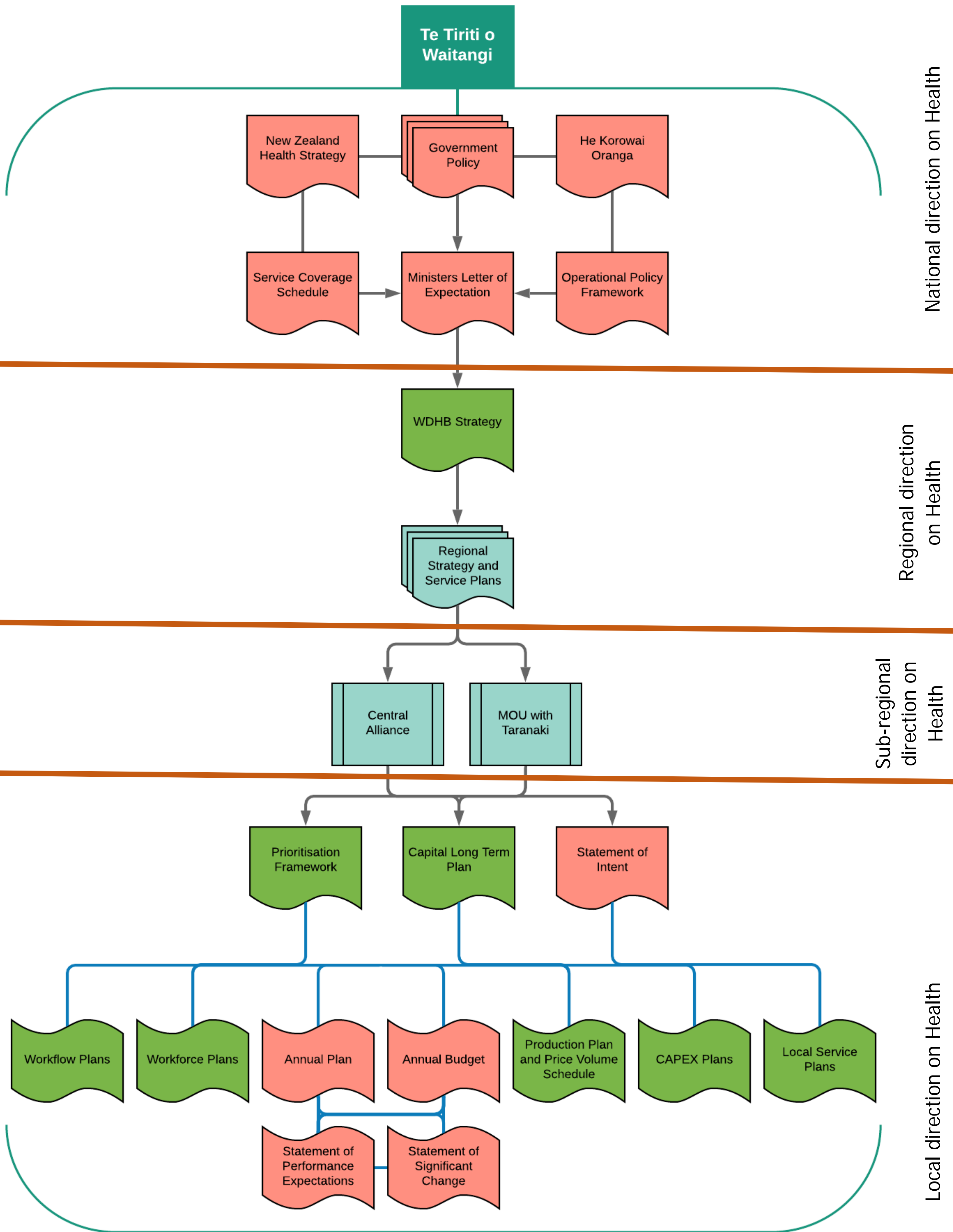

Nationally Mandated Documents

Regionally Supported Documents

Locally Required Documents

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7.4 People and performance update

WHANGANUI DISTRICT HEALTH BOARD *Te Poari Hauora o Whanganui*	**Committee paper** ☑ **Information paper** ☐ **Discussion paper** ☐ **Decision paper** **Date: 18 October 2019**
Lead/Authors	Hentie Cilliers, GM People and Performance
Subject	People and Performance update
Synopsis	To update the committee on activities of the People and Performance team

Recommendations

Management recommend that the committee:

1. **Receive** the paper entitled People and performance update
2. **Note** WDHB has low staff turnover compared with other DHB's
3. **Note** There were no notifiable injuries or events notified by WDHB, to WorkSafe New Zealand, between July and September

1. Staffing status

The WDHB turnover for 2018/19 was 8.8%, slightly higher than 7% in 2017/18. The current year to date turnover is 2.4%. WDHB has one of the lowest turnover percentages compared with other DHBs.

Sick leave taken trends continue to be similar to previous years. The year to date sick leave (paid and unpaid) for 2019/20 as a percentage of total hours paid is 4.31%.

The year to date 2019/20 excessive annual leave balance as a percentage of employees whom have an annual leave balance in excess of two times their annual leave balance is 4.2%. This is slightly higher than the 2018/19 year to date balance of 3.79%.

2. Recruitment / resignation issues

Current medical vacancies include a consultant psychiatrist, ophthalmologist, O&G, emergency consultant and senior house officers.

Other clinical vacancies include a registered nurse CCU, clinical pharmacist, occupational therapist, audiologist, physiotherapist, cardiac sonographer and casual midwives.

3. Employee Relations

Bargaining continues for the Medical Radiation Technologist and Psychologist MECAs. Initiation for bargaining for the Sonographer MECA was received on 3 October.

During 2020 bargaining for the following MECAs will take place:

- Senior Medical Officers
- Nursing and Midwifery
- Mental Health and Public Health Nursing
- Allied, Public Health and Technical
- Specialty Trainees of New Zealand (RMOs)

In addition to the above bargaining, 2020 will potentially include pay equity bargaining for nursing (NZNO and PSA), midwifery (MERAS) and clerical / administrative (PSA) employees.

4. Health and Safety

Forty one injuries were reported between July and September, fourteen of which are an ACC claim. There were five lost time injuries recorded between July and September.

From July to September, one employee with a work related injury, twelve employees with a non-work related injury and five with a medical condition were on return work plans.

There were no notifiable injuries or events notified to WorkSafe New Zealand between July and September.

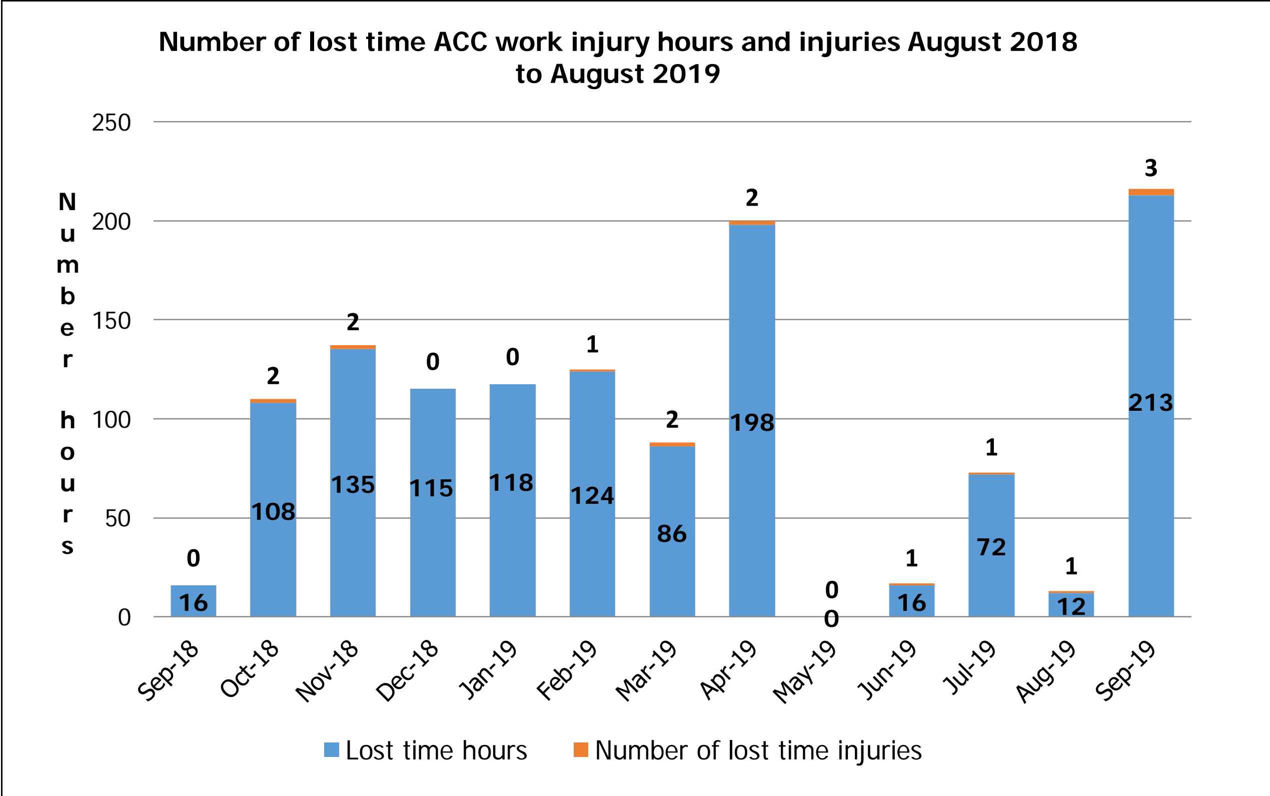
The graph below details lost time ACC work injury hours from August 2018 to August 2019.

The numbers above the columns represent the number of lost time injuries. The lost time hours include all hours lost following an accident.

The spike in lost time work injury hours in September 2019 relates to one work related injury claim where the cover decision was only made after a full investigation. This resulted in lost time hours from previous months recorded in September.

There were five ACC lost time injuries registered through payroll in July, August and September 2019. Incidents/accidents included:

- Lost balance and fell onto knees.
- Strained shoulder from lifting and throwing bags of dirty linen into linen bag.
- Hit in the face during a restraint.
- Lost balance and fell onto stomach.
- Pain in lower back whilst turning in a swivel chair.



Number of lost time ACC work injury hours and injuries August 2018 to August 2019
Number hours
250
200
150
100
50
0
0
16
2
108
2
135
0
115
0
118
1
124
2
86
2
198
0
0
1
16
1
72
1
12
3
213
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Lost time hours
Number of lost time injuries

8 Information papers

Attachment	Description	Page
1	Te Huringa - Commissioning Cycle Framework (Draft)	29
Reference attachments – combined committee interest		
1	Glossary	55
2	Combined Statutory Advisory Committee - Terms of Reference	59

9 Date of next meeting

Friday 22 November 2019

Glossary and terms of reference *(for information and reference)*

AAU	Acute Assessment Unit
ACE	Advanced Choice of Employment
AH	Allied Health
AOD	Alcohol and Other Drugs
AoG	All of Government
APEX	Association of Professional and Executive employees
APC	Annual Practising Certificate
ASD	Autism Spectrum Disorder
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation
Capex	Capital expenditure
CAR	Corrective Action Request
CCU	Critical Care Unit
CMO	Chief Medical Officer
CSAC	Combined Statutory Advisory Committee
CSA	Critical Systems Analysis
CTA	Clinical Training Agency
CWD	Case Weighted Discharge
DNA	Did Not Attend
DSS	Disability Support Services
ED	Emergency Department
EN	Enrolled Nurse
ESPI	Elective Services Performance Indicator
FTE	Full Time Equivalent
GP	General Practitioner
HAI	Hauora a Iwi
HDC	Health and Disability Commission(er)
HPPPD	Hours Per Patient Per Day
HQPP	Hospital Quality and Productivity Programme
HQSC	Health Quality and Safety Commission
HRT	Health Round Table
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
InterRAI	International Resident Assessment Instrument
LMC	Lead Maternity Carer
MERAS	Midwifery Employee Representation and Advisory Services
MERT	Medication Error Review Team
MHAHT	Mental Health Assessment Home Treatment
MHOAG	Maori Health Outcomes Advisory Group
MoH	Ministry of Health
MOoH	Medical Officer of Health
NASC	Needs Assessment Service Coordination Agency
NETP	Nurse Entry To Practice (Nursing)
NHC	National Hauora Coalition
NRT	Nicotine Replacement Therapy
NZHP	New Zealand Health Partnerships
NZNO	New Zealand Nurses Organisation
NZPHDA	New Zealand Public Health and Disability Act, 2000
NZRDA	New Zealand Resident Doctors' Association
OAG	Office of the Auditor-General
Opex	Operational expenditure
PACS	Picture Archive Communication System

PATHS	Providing Access To Health Solutions
PDRP	Professional Development and Recognition Programme (Nursing)
RAC	Risk and Audit Committee
RCA	Root Cause Analysis
RIS	Radiology Information System
RFI	Request for Interest
RFP	Request for Proposal
RMO	Resident Medical Officer
RN	Registered Nurse
RSP	Regional Service Plan
SAR	Severity Assessment Rating
SCBU	Special Care Baby Unit
SLT	Speech Language Therapist
SWIS	Social Workers In Schools
TAS	(Central Region) Technical Advisory Services
TOT (formally TOIHA)	Te Oranganui Trust (formally Te Oranganui Iwi Health Authority)
TOR	Terms Of Reference
VIP	Violence Intervention Prevention
WDHB	Whanganui District Health Board
webPAS	Web-based Patient Administration System
WRHN	Whanganui Regional Health Network

Kupu Māori	**English**
Aotearoa	Land of the long white cloud – New Zealand
Aroha	Love
Hapai te Hoe	Name of WDHB Education Programme
Hapū	Sub-tribe of a large tribe. It also means pregnancy or to be pregnant
Hariru/Hongi	Acknowledge (Pressing noses x2)
Haumoana	Family/whanau navigator
Hinengaro	Psychological realm, mental well-being
Hui	Meeting, gathering
Ipu Whenua	Container for placenta
Iwi	Tribe
Kai	Food
Kaiarahi	Clinical Management - Te Hau Ranga Ora Framework
Kaihoe	Frontline Staff - Te Hau Ranga Ora Framework
Kaikorero	Speaker (on behalf of group)
Kaitakitaki	Operational Management - Te Hau Ranga Ora Framework
Kaitiaki	Protector, caretaker
Kaitiakitanga	Protection, Guardianship
Kaihautu Hauora	CEO - Te Hau Ranga Ora Framework
Kaiuringi	Executive Management Team - Te Hau Ranga Ora Framework
Karakia	Blessings, incantations, prayer
Karakia tuku i te wairua	A prayer/incantation for the safe departure of the spirit from the deceased
Karanga	Calling (done by women)
kāumatua	Elder (usually male)
Kaupapa	Policy, protocol, theme, rule, topic. It also means a fleet (of ships)
Kia ora	Greetings
Kia piki te ora	Get well/May you be well

Kupu Māori	English
Koha	Gift
Koroheke	Elder (male)
Kotahitanga	Unity, cohesion, sharing vision, working together, trust, relationships
Kuia	Elder (female)
Kupu	Words
Mana	Status, standing, power, influence. The spiritual power/authority to enhance and restore tapu
Manakitanga	Ultimate respect and care
Manatangata	Dignity of relationships
Māoridom	Plural of Māori world
Māoritanga	Maori culture and perspective
Marae	Traditional meeting place
Mātua	Parents
Mauri	Life essence
Mauri Ora	Emergency Housing of families on WDHB Campus (Name of building)
Mihi or Mihimihi	Greeting/welcome, acknowledgement
Mihi Whakatau	Informal welcome
Noa	Free from tapu. Tapu and noa are terms used to describe a state or condition affecting both the animate and inanimate. Tapu denotes a state of restriction or sacredness. Noa is free from tapu
Pae Ora	Healthy Futures – Aim of the Ministry of Health Maori Health Strategy – He Korowai Oranga.
Pēpē	Baby infant
Pou tuara	Back bone
Pōwhiri	Formal Māori welcoming ceremony
Rangaimārie	Humility, peace
Rangatahi	Youth
Rongoa	Traditional Māori methods of healing
Take	Subject, topic, purpose
Tamariki	Children
Tāngata Whaiora	Māori mental health service user
Tangata Whenua	Local people Māori
Tangihanga	The mourning process before burial. Funeral
Tāonga	Treasure, valuables. Tāonga is interpreted to mean in its broadest sense an object or resource which is highly valued. Children and future generations are also regarded as tāonga
Tapu	Sacred. Tapu and noa are terms used to describe a state or condition, affecting the animate and inanimate. Tapu denotes a state of restriction or sacredness. Noa is free from tapu
Tapu o te Tinana	Respect for people
Te Hau Ranga Ora	WDHB Māori Health Services
Te Piringa Whanau	Building on WDHB campus under Tikanga of the Whanganui Iwi.
Te Puawai Arahi	Māori Mental Health Cultural Advisor
Te Reo Māori	Māori Language
Te Whare Whakatau Mate	Building on WDHB campus under Tikanga of the Whanganui Iwi – Temporary resting place for the deceased.
Tena koutau/koutou katoa	Greetings/to all

Kupu Māori	**English**
Tikanga	Customs, protocols or policies. Tikanga is used as a guide to moral behaviour and within a health context indicates the way resources, guardianship, responsibilities, obligations and future generations will be protected
Timatanga	Beginning
Tinana	The physical body
Tino Rangatiratanga	Māori chieftainship, self-determination, and absolute sovereignty
Toihau	Board/Chairperson – Te Hau Ranga Ora Framework
Tūpāpaku	Deceased person
Waiata	Song
Waiora	Health
Wairua	Spirit. Wairua refers to the spiritual element, an integral part of tapu and noa
Wairuatanga	Spirituality
Wananga	Place of learning
Whakamutunga	End
Whakanoa	Ceremony to make an area safe to use again
Whakapapa	Genealogy
Whakatauki	Proverb
Whakawhanaungatanga	Family/make connections
Whānau	Family. It also means to be born/give birth. Whānau in this document refers to Māori patients and their families and can include groups regarded as extended family as well as groups outside the traditional family structure
Whanaungatanga	Relationship
Whare	House, Building
Whenua	Placenta. Also means land

*The English definitions for Kupu Māori are reflective of the WDHB context.

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Terms of Reference

<table>
<tr><th colspan="2">Combined Statutory Committee</th></tr>
<tr><td rowspan="2">Applicable To:
Whanganui District Health Board</td><td>Authorised By:
Whanganui District Health Board</td></tr>
<tr><td>Contact Person: Chief Executive</td></tr>
</table>

1. Committee of the board

The Combined Community and Public Health, Disability Support and Hospital Advisory Committee is a standing committee of the board, established in accordance with Section 34 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act and Schedule 4 of the Act.

2. Functions of the committee

- To provide advice to the board on the needs, and any factors that the committee believes may adversely affect the health status of the resident population of the district health board.
- To provide advice to the board on the disability support needs of the resident population of the district health board.
- To provide advice to the board on policy and priorities for use of the health and disability support funding provided.
- To ensure that all service interventions the district health board has provided or funded, or could provide or fund for the population, maximise the overall health and independence of the population whilst contributing to improving equity of outcomes for all people.
- To promote, through its services and policies, the inclusion and participation in society, and maximise the independence of people with disabilities within the district health board's resident population.
- To advocate to external parties and organisations on the means by which their practices may be modified so as to assist those experiencing disability.
- To monitor and advise the board on the financial and operational performance of the hospitals (and related services) of the district health board.
- To assess strategic issues relating to the provision of hospital services by or through the district health board.
- To recommend policies relative to the good governance of hospital services.
- To report regularly to the board on the committee's findings (generally the minutes of each meeting will be placed on the agenda of the next board meeting).

3. Delegated authority

The advisory committee shall not have any powers except as specifically delegated by the board from time to time. The following authorities are delegated to the Combined Statutory Committee.

- To require the chief executive officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request.
- To interface with any other committee(s) that may be formed from time to time.

4. Membership and procedure

Membership of the Committee shall be as directed by the board from time to time. All matters of procedure are provided in Schedule 4 of the Act, together with board and committee Standing Orders.

Membership will consist of:

- All board members, one of which will be appointed to chair the committee
- External (non-board member) appointments:
  - Up to two members following nomination from Hauora A Iwi
  - Up to five members able to advise on matters relating to the DHB's functions and objectives.

5. Meetings

The Advisory Committee shall hold meetings as frequently as it considers necessary or upon the instruction of the board. It is anticipated that 8-10 meetings will be held annually, including the annual planning workshop.

Note

For the purposes of this document, the definitions of 'public health and disability support services' is incorporated in the Act, which means the health and disability support of all of the community in the district health board's region.

'Hospital' means all public health services owned by the Crown and previously known as 'Hospital and Health Services'.