21 April 2021 - Public

21 April 2021 09:00 AM - 10:45 AM

Interest Register

12 April 2020

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

3 March 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**DRAFT MINUTES** Held on Wednesday, 3 March 2021 Boardroom, Level 4, Ward & Admin Block, Whanganui Hospital 100 Heads Road, Whanganui
Public Board Meeting	**Commencing at 9.30 am**

Present
Mr Ken Whelan, Board Chair
Ms Annette Main, Deputy Board Chair, Chair Combined Statutory Advisory Committee
Mr Graham Adams, Member
Mrs Talia Anderson-Town, Finance Risk and Audit Chair
Mr Charlie Anderson, Member
Mr Josh Chandulal-Mackay
Mr Stuart Hylton, Member
Mrs Judith MacDonald, Member

In attendance
Mr Russell Simpson, Chief Executive
Mrs Nadine Mackintosh, Executive Officer
Ms Alex Kemp, Allied Health Professional Lead Director
Mrs Rowena Kui, General Manager Māori Health and Equity
Mr Paul Malan, General Manager Strategy Commissioning and Population Health
Mr Andrew McKinnon, General Manager Corporate

1. Procedural

1.1 Karakia/reflection

T Anderson-Town opened the meeting with a karakia.

PUBLIC SUBMISSION
Presenter: Mrs F Donne; Supported Mrs M Lee and Mr S Lee

The board welcomed Mrs F Donne and her support people to the meeting and received a verbal submission on her reflections from both a personal and supportive position for home support services and discharge planning.

The board chair thanked Mrs F Donne for her public submission and confirmed there are a number of matters to address and the board will discuss these with the executive team and provide her a written response.

Mrs F Donne thanked the board and all the people that have supported her with this submission to the board.

Action:
1. Provide a response letter addressing the public submission concerns whilst acknowledging the direction that we are heading towards for wellness and prevention in the home and how we will see improvements.

2. Management were requested to provide a presentation to the next meeting on our over arching discharge planning to reduce readmission rates and the future health system for over 70s.
3. The board secretary will provide a letter to advise on the process that the board will be undertaking to address her concerns.

2. Insights Report

Presenters: Rebecca Davies, Lead for Healthy Families and Impact Strategist, Marguerite McGuckin, Project Manager for the Suicide Prevention Strategy

The presentation provided an overview of the work undertaken across the Whanganui District communities to enable the reporting on perspectives captured in this insights report with identified risk areas. The purpose is to prevent the system from getting overloaded and how we could mobilise the community to be aware, understand and support concerns received in the communities.

The programme of work commenced three years ago at a point when suicide sector responsibility resided with secondary care. Community involvement has been significant and highlighted the awareness and knowledge gaps across the network of supports identified.

The insight reports are being socialised with the communities and feedback has been that members of our communities feel their voices can be heard in this report.

The chief executive thanked both the staff involved in delivering the report and the board for having the courage to move this care programme out into the community through a community led solution, particularly on wellness and prevention.

The board chair thanked the presenters for their co design report from a community led perspective.

The Board of Whanganui District Health Board:

a. **Received** the paper titled 'Insights Report – approach to the prevention of suicide'

b. **Received** the presentation of the Insights Report from the Te Oranganui and Health Families Whanganui, Ruapehu and Rangitikei team.

CARRIED

Action: The Te Reo o Te Rangatahi presentation to be distributed to board members.

1.2 Apologies

The board **accepted** apologies from S Peke Mason and P Bakers-Hogan.

1.3 Continuous Disclosure

1.3.1 Amendments to the Interest Register

G Adams remove aged concern and grey power
J MacDonald remove aged concern
K Whelan remove crown monitor for Counties Manukau.

1.3.2 Declaration of conflicts in relation to business at this meeting

Nil

1.4 Confirmation of minutes

27 November 2020

The minutes of the meeting held on 27 November 2020 were **approved** as a true and accurate record of the meeting.

Moved G Adams **Seconded** C Anderson **CARRIED**

1.4 Matters Arising

Nil

1.5 Board and Committee Chair Reports

1.5.1 Chair verbal report

The board chair suggested the board to consider a board workshop prior to the next meeting in which we could discuss:

- Insights report, community led approaches
- Management overview of budget and priorities and investment
- Crown decisions.

The board **agreed** to hold a session prior to the April FRAC meeting and extend the invite to Hauora a Iwi and recommend that we amend the Joint Board meeting set for 21 April 2021 to 14 April 2021.

1.5.2 Combined Statutory Committee report

Nil

3. Chief Executive report

The chief executive highlighted the following areas of his report:

- Masters Games, particularly the health partnership role introduced at the games this year, supplemented by free balance and strength classes supported the promotion of healthy ageing and he thanked the Allied Health Profession Lead Director for leading this initiative.
- Fit for Surgery and Fit for Life presentation was held at Waitangi last Friday and J Whaanga, Ministry of Health (MoH) DDG for Māori Health was in attendance and his view was this should be rolled out across all DHBs to support prevention care. The DHB need to secure funding to continue to deliver and roll this programme across other surgeries.
- Whanganui DHB vaccination roll-out is in tranche two, NZ have purchased seven million of the current vaccine, which requires two doses per person. This will be the biggest vaccination programme for New Zealand.

The board discussed progress of the Collective Impact and Community Lived Experience Report.

The Board of Whanganui District Health Board:

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

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

CARRIED

4. Decision paper

4.1 Joint Board Meeting Dates 2021

Whanganui DHB board agreed to move the meeting of 30 June 2021 to 29 June 2021 to align with the joint board meeting dates.

There was acknowledgement that members may not be able to attend all suggested meetings.

The Board of Whanganui District Health Board:

a. **Received** the paper

b. **Noted** the dates of the Hauora A Iwi Board meetings

c. **Noted** that Hauora A Iwi have proposed the joint board meeting dates be aligned to alternatively follow set dates for the individual boards on a quarterly basis

d. **Approved** the 2021 joint meetings dates as

i. Wednesday, 14 April 2021, following the Whanganui DHB Board FRAC meeting

ii. Tuesday, 29 June 2021, following the Hauora A Iwi Board meeting

iii. Wednesday, 1 September 2021, following the Whanganui DHB Board meeting

iv. Tuesday, 14 December 2021, following the Hauora A Iwi Board meeting

e. **Approved** to move the scheduled board meeting of 30 June 2021 to 29 June 2021.

Moved C Anderson **Seconded** G Adam **CARRIED**

5. Discussion paper

5.1 Financial Report – January 2021

The paper was received with discussion on:

- FTE and workforce pressures with high acuity across the health system
- Direct COVID-19 costs will be recovered

The Board of Whanganui District Health Board:

a. **Received** the report 'Detailed financial report – January 2021'.

b. **Noted** the January 2021 monthly result of a $132k surplus is favourable to budget by $420k. When including the increase in the Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $357k favourable to budget.

c. **Noted** the year-to-date result of $3,102k deficit is unfavourable to budget by $448k. Including the increase in the Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $942k unfavourable to budget.

CARRIED

5.2 He Hapori Ora Progress Report

The report was received with management advise that this provides an oversight on activities that the DHB are undertaking to deliver on our three priority areas and will be provided to the board on a six monthly basis.

The Board of Whanganui District Health Board:

a. **Received** the paper titled He Hāpori Ora Thriving Communities Progress Report 1

b. **Noted** the progress supporting implementation and success of the strategy.

Action for Board

The board would appreciate the next report to highlight what is going well and what we are finding challenging and steps we are undertaking to address the areas.

Action for Transition Unit Presentation:

A presentation will need to be provided in June and this information can be used to frame the presentation.

CARRIED

3 March 2021 **Public**

6. Information paper

The information papers were taken as read and no questions were received.

6.1 Provider arm report

The Board of Whanganui District Health Board:

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

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

CARRIED

6.2 Status update reporting – Actions included in Annual Plans

The Board of Whanganui District Health Board **received** the paper titled Status update reporting-Actions Included in Annual Plans

CARRIED

7. Resolutions to exclude public

The Board of Whanganui District Health Board members:

a. **Agreed** that the public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table.

b. **Noted** that the grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act, believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists for withholding under the Official Information Act 1982 (OIA), as referenced in the following table.

c. **Agenda item**	**Reason**	**OIA reference**
Whanganui District Health Board minutes of meeting held on 27 November 2020	For reasons set out in the board's agenda of 27 November 2020	As per the board agenda of 27 November
Chief executive's report Committee minutes Sustainability Reporting	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)

3 March 2021 **Public**

c. **Agenda item**	**Reason**	**OIA reference**
Laboratory and Pathology services contract MOH Infrastructure Programme updates Māori Partnership Board MoU	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)
Draft Annual Plan	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

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

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

Moved G Adams **Seconded** S Hylton **CARRIED**

The public section of the meeting concluded at 10.55am

Signed K Whelan
Board Chair
Whanganui District Health Board

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 26 February 2021, commencing at 9:30am

Combined Statutory Advisory Committee (CSAC) members in attendance
Ms Annette Main (Chair)
Mr Charlie Anderson
Ms Christie Teki
Ms Debra Smith
Mr Graham Adams
Ms Heather Gifford
Mr Josh Chandulal-Mackay
Ms Te Aroha McDonnell

In attendance for Whanganui District Health Board (WDHB)

Mr Paul Malan, General Manager, Strategy Commissioning & Population Health
Ms Alex Kemp, Director Allied Health
Ms Lucy Adams, Director of Nursing, Chief Operating Officer
Mr Ian Murphy, Chief Medical Officer
Ms Deanne Holden, Secretariat

1. Procedural

1.1 Karakia & Welcome

The Chair noted a quorum was present and opened the meeting with Karakia at 9:30am.

Those present, and the wider community, were thanked for the continued support of Health lead initiatives which have enabled the community to remain COVID free.

S Peke-Mason arrived 9.35

Apologies

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

K Whelan, R Simpson, F Bristol, M Bellamy

Apologies for lateness were received from P Baker-Hogan and S Peke-Mason

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

1.3 Conflict and register of interests update

1.3.1 Amendments to the register of interests

H Gifford provided secretary with written updates to the register as below:

- Withdraw as member of Tie Tira Takimano
- Add Advisor to WALT Project – "Whanganui Primary Health Research Collaborative"

T-A McDonnell advised she will provide amendments to the secretariat following the meeting.

1.3.2 Declaration of conflicts in relation to business at this meeting

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

1.4 Minutes of the previous committee meeting

The minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 13 November 2020 were accepted as a true and correct record:

Moved: A Main **Seconded**: M Bellamy

1.5 Matters Arising

It was noted there were no outstanding matters arising.

1.6 Committee Chair's Report

There was no verbal report from the Chair.

2. Presentation : The LifeCurve
A Kemp, Chief Allied Professions Officer

The Chair welcomed the presenter, Ms A Kemp, to the meeting and noted the forthcoming presentation titled "The LifeCurve" relates to Discussion Paper Item 4.4 on the agenda which was taken as read. The Chair passed the floor to Ms Kemp.

Ms Kemp introduced herself as the WDHB Chief Allied Professions Officer and advised the presentation she was about to present was initially produced by a colleague for presentation at the recent Masters Games event. Ms Kemp noted her thanks to Kathy Everitt, Bay of Plenty DHB, for granting permission to share the presentation with Committee.

A brief overview of the key points from the presentation are captured below:

The LifeCurve is an evidence based model which supports, at its core, adding 'life to years rather than years to life'. It achieves this by capturing the hierarchical nature of function loss that occurs with age.

Initially developed in the United Kingdom by Newcastle University with over 25 years of research, the licence for New Zealand is held by the Bay of Plenty DHB who hope to release a NZ version by the end of March.

The LifeCurve provides the ability for people to map their own stage of functional decline, via a downloadable app. Positive language focus provides a platform for the user to assess functionality rather age alone as a marker for age related decline. This allows for intervention at stages along the ageing journey with the ultimate goal of providing a preventative model of care.

Discussion followed with the Committee thanking Ms Kemp for her informative and insightful presentation.

It was noted that The LifeCurve is still at the early stages of roll out in New Zealand, however the potential for positive change is immense. Possible areas of concern were raised regarding equitable access in relation to access for elderly, Māori and rural communities. It was noted the WDHB He Hāpori Ora – Thriving Communities strategy will provide a platform to identify and further develop a base to support access ie: improvement of digital capabilities throughout the region and positive use of communication models to ensure hard to reach communities are engaged.

P Baker Hogan arrived 10:05

It was agreed Ms Kemp would be invited to MOHAG (Māori Outcomes Health Advisory Group) with engagement supported by Whanau Ora Navigators. Ms Kemp thanked those present for their comments which will assist in supporting preparation of the next stage to ensure the programme is tailored to work for our communities.

Action:
Secretariat to distribute presentation to the Committee.
A Kemp be invited to present at MOHAG.

It was resolved that the committee:

- **a. Receive** the paper titled "The LifeCurve"
- **b. Note** The LifeCurve is an evidence based tool that can indicate dependence on health and care systems and economic impact
- **c. Note** the Bay of Plenty DHB have purchased the right to The LifeCurve app in New Zealand and are releasing a New Zealand version of this in Marc
- **d. Note** there is research occurring to ensure The LifeCurve is appropriate for Māori, as part of the AWESSoM study headed by Professor Ngaire Kerse at Auckland University
- **e. Note** The LifeCurve provides the potential to identify people who have not yet received support from health services
- **f. Note** The LifeCurve has the potential to be used as a functional outcome measure across the health system
- **g. Support** management to proactively promote and use the LifeCurve tool

Moved: A Main **Seconded:** C Anderson

3 Discussion Papers

3.1 Quarter 2: non-financial performance framework
K O'Gorman, SCPH & Paul Malan, GM Strategy Commissioning and Population Health

A paper titled Quarter 2: non-financial performance framework was tabled by P Malan. The paper was taken as read with feedback on information provided and/or questions welcomed.

Members were reminded that the report is produced to answer specific questions asked by the MoH.

It was noted:
- The qualitative data provided is very useful as it puts a measure into perspective.
- Where a target is not achieved, a text descriptor providing more information is shown (when available).
- A 'target' may be missed by very small numbers (ie: 1-2 persons).
- A number of targets rely on other DHBs as patients can be sent out of region (ie: cardiology). This process is well supported by the regional group so that small numbers do not result in regional restrictions.
- Inequity is still a concern with confirmation that work continues in this space. Detail is recorded where available to support identification of areas requiring further action.

The Chair noted the many successes captured in the report and highlighted a recent successful event held by the Measles immunisation team at the local markets which saw a very high uptake.

Discussion was held regarding potential perceived confusion between Influenza vaccinations, Measles Vaccinations and COVID-19 vaccination programmes. P Malan clarified that the MOH has provided very clear direction that other vaccination programmes should not lax whilst COVID vaccination programme is rolled out.

J Chandulal-Mackay referred to an item on page 144 in the following paper (Status update reporting – Actions Included in Annual Plans) relating to IDF Management noting the narrative shows elective outflow has been reduced. P Malan confirmed the reduction will be captured in financial reports which will be provided to the full Board at their next meeting.

It was resolved that the committee:

a. Receive the paper titled Preliminary Quarter Two Ratings, Non-Financial performance framework measures

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

Moved: A Main **Seconded:** G Adams

3.2 Status update reporting- Actions Included in Annual Plans
K O'Gorman / P Malan, GM Strategy Commissioning and Population Health

A paper titled Status update reporting- Actions Included in Annual Plans was tabled by P Malan and taken as read.

Committee members, through the Chair, thanked P Malan and his team for the considerable work undertaken in producing the Quarterly and Annual Plan update reports for the Committee.

It was agreed the committee:

a. **Receive** the paper titled Status update reporting- Actions Included in Annual Plans

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

Moved: A Main **Seconded:** Graham

3.3 Covid-19 planning update
P Malan, GM Strategy Commissioning and Population Health and L Allsopp, GM Patient Safety Quality and Innovation

A paper titled "Covid-19 planning update" was tabled by P Malan. Apologies were noted from L Allsopp with P Malan clarifying, in her absence, three Executive Leadership Team staff members were in attendance and available to answer any questions committee members may have.

P Malan provided a verbal summary of the key points as summarised below:

Covid-19 testing remains available onsite at the main hospital via the CBAC, however with reduced hours. Information of alternate testing sites is readily available with sites across a number of areas and venues including CBAC, General Practitioners and if/when required temporary/rural sites.

Testing criteria remains clear. Anyone feeling unwell is urged to contact Healthline (HL) for screening. If advised by HL to attend testing station they will be tested. If anyone turns up at a testing station without first contacting HL the CBAC staff will undertake screening and test if required.

It was noted the key to continuing success is the ability to remain fluid and able to react at short notice to changing requirements, based on risk.

It was confirmed there is no intention to close the onsite CBAC at this stage.

R Kui gave a brief update on the Covid-19 vaccination programme. The same approach used previously for immunisation programmes will be applied and amplified to ensure equitable uptake. Conversations are ongoing, with it being imperative communication starts both before, during and after immunisation. It is envisaged there will be a vaccinator, immunisation coordinator and Haumoana navigator onsite at vaccination centres with the use of the onsite CBAC being a possibility, however, planning is very much in initial stages.

A Main noted as there are a number of areas who welcome visitors from outside of the region (ie: Rangitiki and Ruapehu) Covid-19 where wastewater testing could be useful. It was confirmed this testing is not carried out by DHB's, however, A Main agreed to discuss further with the local council.

Action: A Main to clarify with Council the local waste water testing protocols.

It was agreed the committee:

- **a. Receive** the paper titled Covid-19 planning update
- **b. Note** Covid-19 testing continues to be available and responsive
- **c. Note** contact tracing capacity is in place
- **d. Note** Covid-19 vaccination programme planning is underway

Moved: A Main **Seconded:** H Gifford

3.4 Provider Arm Services report
L Adams, Chief Operating Officer & Director of Nursing

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

Work is ongoing to support a reduction in readmission rates. This includes the recent recruitment of an "integrated discharge navigator" who, working alongside ICT to better support data capture, will focus on removing barriers to discharge.

Discussion regarding the discharge process from ED was discussed. I Murphy clarified that where possible and appropriate positive health outcomes are achieved by a patient returning to their own home. However, the patient and family wishes are taken into account, especially if there are concerns regarding any aspect of discharge (eg: late evening).

A national shortage of midwifes across NZ continues and has impacted on recent recruitment of a midwife to a vacancy in Waimarino. In the interim I Murphy confirmed that although no permanent midwife in located in the region, there is a midwife in residence with support provided by Whanganui staff ensuring post and pre natal services are available. Emergency plans are in place which include local General Practitioner availability and air transfer via helicopter if required.

Positive feedback was received recently from a patient on the ward who was greeted warmly but the staff member serving her meals. The staff member spoke to the patient by name and went out of their way to provide an alternate meal she was aware the patient would enjoy. It was agreed thanks should be passed to the Contractor (Venitia) who provide this service.

A trend was noted with high presentation to ED and the subsequent flow on effect to the hospital. This trend is being noted throughout all DHB's with an increase in presentations, admissions and subsequent hospital flow. Work continues within our social governance programme to identify issues within the community that may be impacting on presentation. Further, although we know readmission rates are high at present, we do not have the necessary data available to establish the cause. It was noted this in an area of focus that sits under our optimisation and sustainability programme. J Chandulal-Mackay, asked that when available, further details be provided to committee on the work and learnings being identified in this space. A Main thanked the Management Team for their proactive approach to addressing the issues raised.

A brief discussion on persistence of inequities in Did Not Attend (DNA) rates was noted. Ambulatory Sensitive Hospital (ASH) rates continuing to be monitored with oversight and trend analysis reviewed at WALT.

R Kui advised a great deal of work has been undertaken in the DNA workspace, including the implementation of "text to remind". It was agreed an item be added to the agenda for the next meeting to update committee on progress.

Action: update committee on progress to improve DNA rates.

It was agreed the committee:

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

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

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

3.5 Faster Cancer Treatment targets
P Malan, GM Strategy Commissioning & Population Health

A paper titled "Faster Cancer Treatments targets" was tabled by P Malan. The paper was taken as read with a summary of the key points shown below.

Note that Quarter 2 results were not available at time of print so have not been included in paper provided, however, these are now available and show that targets continue to be met.

It was agreed the committee

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

b. **Note** that Ministry of Health Faster Cancer Treatment Health Target reporting was not available at time of print, however, is now available with results showing Q2 targets have been met.

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

4. Information papers

4.1 Final Elective Services Productivity Indicator Results for December 2020

A paper titled "Final Elective Services Productivity Indicator Results for December 2020" was tabled by P Malan with the paper taken as read.

It was noted that Covid-19 is continuing to impact on ESPI results with initial expectations of compliance in December 2020 not achieved. However, full compliance is now expected by 31 March 2021 with all procedures impacted due to Covid-19 having been completed.

It was agreed the committee

a. **Receive** the paper titled Final Elective Services Productivity Indicator Results for December 2020

b. **Note** that the results for ESPI 2 is 0.4% non-compliance and ESPI 5 is 6.2% non-compliance

c. **Note** that the Ministry of Health has devolved $7M of funding nationally to improve waiting times and WDHB's share is $1.28M

d. **Note** this paper has also been provided to the Finance, Risk & Audit Committee

Moved: A Main **Seconded:** C Anderson

4.2 Annual Plan 21/22 update

A paper titled "Annual Plan 21/22 update" was tabled by P Malan with the paper taken as read.

It was noted that the next milestone for the plan will be submission of draft 1 on 5th March 2021. Committee members will be provided with a copy of the draft following submission.

It was agreed the committee

a. **Receive** the paper titled Annual Plan 21/22 update
b. **Note** the government's planning priorities have not changed
c. **Note** the Ministry will not require a Regional Services Plan this year
d. **Note** the contents of the Minister's Letter of Expectations
e. **Note** the first draft will be submitted to the Ministry of Health on 5 March 2021

Moved: H Gifford **Seconded:** C Anderson

4.3 Public Health Covid-19 - Gatherings and Events

A paper titled "Public Health Covid-19 - Gatherings and Events" was tabled by P Malan with the paper taken as read.

The committee passed thanks to the Public Health team, via the chair, for the outstanding mahi that has been undertaken in support of our community through the summer season.

It was agreed the committee

a. **Receive** the paper titled "Public Health Covid-19 - Gatherings and Events"
b. **Note** the MoH have established a voluntary code to support lowering transmission risk
c. **Note** the Health promotion team have provided support and guidance to event organisers over the summer period in line with the MOH "make summer unstoppable" campaign

Moved: P Baker-Hogan **Seconded**: J Chandulal-Mackay

5. Date of next meeting

The next meeting will be held on, Friday 28 May 2021 from 09:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui.

6. Reasons to exclude public

It was resolved that:

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 13 November 2020 (Public – excluded session)	For the reasons set out in the committee's agenda of 13 November 2020	As per the committee's agenda of 13 November 2020

Persons permitted to remain during the public excluded session.

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

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

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

The public session of the meeting ended at 11:50am

Adopted this day of 2020

.....

Chair

April 2021 **Public**

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

Recommendations

Management recommend that Whanganui District Health Board members:

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

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

1 COVID-19 Vaccinations

We have commenced vaccinating health workers and border worker families, with 90 people being vaccinated on 31 March at Whanganui Hospital and a further 390 people by the time of writing this update (14 April). Aramoho Health Centre commenced vaccinating on 12 April, then Taihape Health on 14 April. The programme is to continuing to roll out across the district with clinics planned in Bulls, Marton, and Waimarino. The chairs of Hauora a Iwi and the Maori Health Outcomes Group are part of our planning team and our priorities include pro-equity, safety and accessibility.

We are working with local partners to identify further vaccination locations, including community centres, marae and pop-up facilities.

2 Minister Little visits new pregnancy and parenting service

Minister of Health, Andrew Little was in Whanganui to catch up on the recent launch of a new pregnancy and parenting service. This will focus on women with children under three years and pregnant women who are experiencing problems with alcohol and other drugs and are poorly connected with health and social services.

He Puna Ora has been created and is being delivered by a collective of iwi/Māori organisations under the umbrella of the Māori Health Outcomes Advisory Group.

It will focus on mothers and whānau with children under three where issues with substance use and poor connection with health and social services have been present.

The minister told the audience at Te Oranganui that it was “great to see how He Puna Ora was put together drawing on community knowledge and understanding”.

“There are many mums who are very vulnerable and they need these support services.”

Mr Little was welcomed by Te Oranganui chief executive, Wheturangi Walsh-Tapiata, who spoke of the organisation’s relationship with the DHB.

"It is a true relationship rather than something just written on paper and He Puna Ora is a reflection of that."

3 Rob Bartley

I would like to acknowledge the passing of Rob Bartley on Wednesday, 17 March 2021. Rob, a well-known local family and businessman, died at the age of 69 after being diagnosed with cancer a few years ago. I visited him on Tuesday at home to say goodbye and to thank him for what he has done for our community and the DHB. His legacy will live on through the many businesses in the Whanganui District and through the recent establishment of the Robert Bartley Foundation which supports public health services and improved health outcomes for the greater Whanganui region. Rob is survived by his wife Ann and their four children.

Rob was instrumental in supporting our bid to the Ministry of Health to bring chemotherapy services to Whanganui and his foundation gifted a bus to the community to provide mobile DHB services.

4 Paul Malan

Kātahi te rongo ka tae mai. Kua hinga tētehi pou o te Pōari Hauora o Whanganui.

E te pāpā, e te rangatira, e Paul, haere, haere, e oki. Kati!
Kua hoki tōu mauri ki te takiwā, kua hoki tōu wairua ki te pekenga wairua.
E moe!

The DHB received the tragic news that Paul Malan, a valued member of the executive leadership team, died on Stewart Island on Wednesday, 14 April 2021.

Our thoughts are with his wife and family and all those who were close to Paul.

It has been a difficult time for all of the DHB whānau.

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No.
Author	Lucy Adams, Chief Operating Officer and Director of Nursing
Endorsed by	Ian Murphy, Chief Medical Officer Alex Kemp, Chief Allied Professions Officer
Subject	**Provider Arm Services**

Recommendations

Management recommend that the Whanganui District Health Board:

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

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

Appendix 1. Whanganui DHB Performance Dashboard and definitions

1 Purpose

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

2 Service Delivery Overview

2.1 Optimisation and Efficiency Programme

Theatre Project

Processes and systems are being informally reviewed within the theatre services. This includes looking into the use of an orthopaedic planned acute theatre list with the aim to decrease the number of elective patients that are rebooked due to being displaced by acute patients. Other examples of work that are under development include implementing endoscopy processes, preoperative patient assessments and consent processes, through to cancellation reports that have been developed to improve accuracy of reporting and an automated daily theatre list.

A request has been submitted to TAS to undertake a roster review for theatre. Currently the DHB is working on an overtime model to meet acute theatre needs. The purpose of this work is to improve overall theatre efficiencies and utilisation of our theatres.

A project manager has been engaged to review our booking systems for both outpatient appointments and surgery, with a view to ensuring they are sustainable, and patient focused. This has been funded through the Ministry of Health innovations funding.

Integrated Discharge Navigation Project

The 12-month pilot project was started on 8 March 2021. Phase one includes engaging with key stakeholders and introducing the role and scope of the project. The medical ward has introduced several initiatives to improve on estimated discharge dates, however discharges remain slow especially over weekends. For this reason, the medical ward is a part of phase one. The focus is on the daily multidisciplinary meetings and understanding what the internal barriers to timely discharges are, and the

impact this has on patient flow. Data collecting and reporting is being explored with issues and barriers being addresses or raised with the appropriate clinical leads. The project sponsor is the COO.

2.2 Emergency Department and Inpatient Services:

Emergency Department

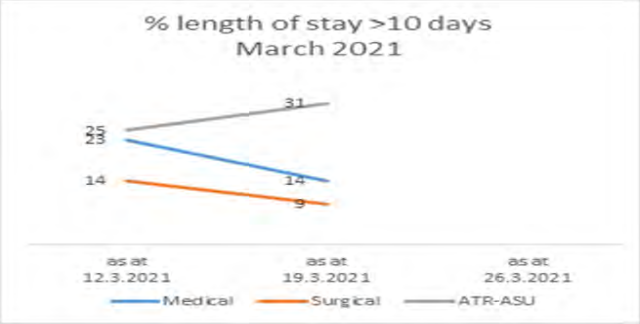
The current focus areas within the ED are on rapid assessment treatment pathways and the use of the acute assessment unit. The aim is to reduce the length of stay within ED, treat patients early and work with WAM to reduce Hospital presentations.

ED had 1756 attendances during March; of which comprised of triage 1 (10), triage 2 (206), triage 3 (1069), triage 4 (447) and triage 5 (24). This was an increase in presentations from February due to a longer month, however the daily average number of presentations has reduced from 59 to 57. 26% of presentations to ED were recorded as Māori ethnicity and 3% Pacifica.

Inpatient Wards

Work is underway to address estimated discharge times; work targeting patient flow improvement has commenced in all wards with a focus on discharge barriers, flow in ED and interdisciplinary care planning within the wards. The integrated discharge navigator role has commenced which is looking at removing blocks to discharge, improving flow. As mention within this report, this role is in an infancy stage but is showing to be very useful to understand issues.

The current patient focus for flow is medical and elderly; all patients count but this is the defined main contributor of patient flow block. The below graph illustrates a decline in number of patients whose length of stay was over 10 days. Surgical Ward utilisation remains high with discharges occurring daily.



The length of stay (LOS) is an important indicator of the efficiency of hospital management. Reduction in the number of inpatient days results in decreased risk of infection and medication side effects, improvement in the quality of treatment and increased hospital profit with more efficient bed management. Accurate understanding of the factors associating with the LOS and progressive improvements in processing and monitoring may allow more efficient management of the LOS of in-patients

Inpatient data	AAU		CCU		Medical		AT&R		Surgical	
	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar
Total monthly Admissions *	229	152	34	38	111	163	39	38	126	129
Total monthly discharges	135	111	18	15	161	210	36	34	258	262
Average Length of Stay (Days)	0.32	0.40	2.11	1.40	6.14	5.45	10.89	13.85	3.74	3.71
Average Occupancy (all shifts)	132%	80%	90%	81%	99%	94%	93%	91%	98%	86%

*Data extracted from TrendCare; note: (1) one represents an episode of care, [includes transfers between wards, theatre etc.] Total February admissions compared to discharges 503/608; Total March admissions compared to discharges 520/634. Variance will be attributed to those who cross over from end of month to beginning.

Acute Readmission Volumes **	AAU		CCU		Med		AT&R		Surg	
	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar
48-hour	6	7	1	1	4	5	0	0	3	7
7 day	7	7	1	0	14	17	4	3	14	12
14 day	5	1	0	0	11	8	0	0	6	5
28 day	10	1	1	1	18	7	4	0	6	6
Total	**28**	**16**	**3**	**2**	**47**	**37**	**8**	**3**	**29**	**30**

Māori Acute Readmission Volumes **	AAU		CCU		Med		AT&R		Surg	
	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar
48-hour	0	2	1	0	0	1	0	0	1	2
7 day	4	3	0	0	0	5	0	2	3	2
14 day	2	0	0	0	1	1	0	0	2	0
28 day	3	0	0	1	5	3	0	0	2	1
Total	**9**	**5**	**1**	**1**	**6**	**10**	**0**	**2**	**8**	**5**
Percentage of total acute readmissions	**32%**	**31%**	**33%**	**50%**	**13%**	**27%**	**0%**	**67%**	**28%**	**17%**

**Data extracted from WebPAS through PowerBI.

3 Hospital and Clinical Services (H&CS)

3.1 Workforce

Whanganui District Health Board Education and Professional Development Operational Group

A Whanganui District Health Board Education and Professional Development Operational Group has been established to provide leadership and governance regarding to education and professional development and workforce development across Whanganui District Health Board.
Currently the group are working on the development of a workforce plan for the organisation.
We are in the process of finalising membership and this will include both internal and external key stakeholders across the region. The purpose of the group is to:

- Develop a learning, education and professional development strategy and workforce development strategy to be approved by the Executive Leadership Team
- Implement the learning, education and professional development and workforce development strategies
- Develop an overarching education centre plan that includes good systems and processes regarding booking education and rooms, administration, management of resources, capex plan, financials, education delivery and provide a six-monthly report on these to the WDHB Clinical Board
- Utilise He Hāpori Ora - thriving communities as our foundation to develop and implement our professional development and workforce development strategies
- Include recommendations from the Pro-Equity report, Whanganui Alliance Leadership Team, WDHB Clinical Board to align with local, regional and national workforce initiatives
- Identify issues in service delivery and opportunities for improvement and best practice
- Provide effective engagement and delivery of national clinical education and professional development programmes
- Review and support orientation and mandatory programmes and resources that enable staff to have the skills to conduct daily activities
- Provide systems and processes that track educational activities
- Complete a workforce analysis across the region and align education and professional development to the findings
- Develop yearly education plan across the district
- Utilise audit, complaints and Cgov findings to determine education needs
- Development of policies and procedures
- Support education regarding changes in scopes of practice/models of care
- Monitor compliance of mandatory training
- Ensures findings from incidents are developed and shared as part of educational packages

Nursing and Midwifery Leadership Forum

A Nursing and Midwifery Leadership Forum (NMLF) was established in 2020 to create a connected integrated nursing and midwifery workforce that supports the development and growth of nurses and midwives across the sector.

The forum has just refreshed the Nursing and Midwifery Strategy for the region and are now in the process of developing a workforce plan to implement some of the priorities in the strategy. The membership for the nursing and midwifery forum consists of nursing/midwifery leaders across the region.

The role of this forum is to:

- Promote the development of nursing workforce development framework/initiatives that support growing nursing and midwifery healthcare workforce competence and capability sector wide
- Promote nursing shared governance, nursing clinical practice, research and education, leadership, inter sectoral collaboration, and strategic alliances
- Provide an opportunity for the voice of nurse leaders working in the healthcare sector to be heard
- Network across the region to understand barriers to care delivery with a focus on solutions
- Act as a professional nursing resource where primary health nursing advice is sought
- Share information on research, quality initiatives, consumer and community feedback, legislative changes, national and local strategies
- Inform strategic direction for nurses working across the sector
- Undertake projects/programmes of work that support an integrated approach, encompassing a population-based health focus in collaboration with consumers
- Working collaboratively with other providers to develop the sharing of information and networks
- Evaluate national nursing policies and standards of practice and how they apply locally
- Strengthen learning and development culture and opportunities
- Strengthen recruitment and retention of nurses working within the healthcare setting
- Collectively influence undergraduate programs
- Recognise and convey to the wider healthcare nursing sector the importance of maintaining quality standards of care via measured outcomes

Nurse Entry to Practice/ Nurse Entry to Specialty Practice

All new graduates have commenced in their clinical placement. They are buddied with a qualified nurse preceptor who will support them throughout the year. The new graduates also attend supervision and we will be trialling a new model to support Maori new graduates strengthening the Tuakana /Teina model that is already used.

Clinical Nurse Specialist - Renal

WDHB is working with MidCentral to strengthen the model of care for renal across the sub-region. The MidCentral team visited Whanganui to discuss ongoing local delivery of some of the renal services with the plan to consider what they would like Whanganui to deliver in the future. Locally, we have a Nurse Practitioner and Clinical Nurse Specialist for renal who are both experienced clinicians and delivering a range of care and expertise across the region.

Nurse Prescriber – Respiratory

WDHB has a Clinical Nurse Specialist who has commenced a prescribing paper at Auckland University. Her speciality is respiratory, and she is supported by a Senior Medical Officer and Nurse Practitioner at WDHB.

Nurse Practitioner – Cardiac

WDHB has a Clinical Nurse Specialist who has commenced a Nurse Practitioner pathway at Auckland University. Her speciality is cardiac, and she is supported by a Senior Medical Officer a Nurse Practitioner at WDHB and mentor from Auckland. This course finishes at the end of this year.

3.2 Mental Health Inpatient

Te Awhina

Zero seclusion target remains a key priority which has been showing significant improvement. Te Awhina is working very closely with community providers in a whole of system approach. A current test of change

is using available respite bed/s as transition beds in the community to safely (and kindly) transition tangata whaiora back into the community; early indication shows this as being very successful. Police and Te Awhina relationships are good and six-weekly formalised meetings continue. Community and inpatient relationships remain open and patient focused.

While occupancy appears high at times this does include the tangata whaiora on leave which can be up to three people at any one time as transition plans are implemented.

Stanford House

Stanford House continues to remain stable with no seclusion or significant incidents in February. Dr Short (Clinical Director of the Central Regional Forensic and Rehabilitation Mental Health Service, Wellington) has been visiting regularly and maintaining clinical oversight. Stanford house in in process of obtaining GP support for physical well-being.

Both Te Awhina and Stanford House units are waiting formal Ombudsman reports and recommendations.

3.3 Care with Dignity - Kia tu rangatira ae, kia mana te tangata review

A review has been completed on the Whanganui District Health Board's (WDHB) Care with Dignity - Kia tu rangatira ae, kia mana te tangata programme.

This model provides very close observation and preventative nursing care to reduce the incidence of patient harm occurring (Cook et al, 2020; Nadler-Moodie et al, 2009, Wood et al, 2018).

Key elements of the review included an analysis of the current literature and examined the current care with dignity model of care data, education programme, documentation and written procedure. The close care procedure, education programme and documentation will now undergo minor enhancements with a focus on measuring, monitoring, and reducing the cost of close care. The review found that clinical staff need to understand the standards that are expected for managing and supporting patients that require close care observation. Evaluating the patient at the beginning and end of each shift as to whether to continue/discontinue the close care intervention is now linked with a close care 'Request Form' that seeks approval by the charge nurse, CNM and DNM. An audit schedule will also be developed to monitor the quality and cost of the Care with Dignity - Kia tu rangatira ae, kia mana te tangata programme.

3.4 Care Capacity Demand Management (CCDM)

Safe Staffing Healthy Workplaces (SSHW) has oversight of this national programme, CCDM. Matching the capacity to patient care (hours per patient day) warrants staff, union, and management commitment. Data is entered into TrendCare at a ward level and validation of data and responses is required by those who lead these areas. WDHB does have systems and processes that support this programme, of which is embedded into our daily practice.

The CCDM programme has a set of standards and expectations. As of December 2020, WDHB was at 85% completion of the programme. The national target is for complete implementation by end for June 2021; we are on track for this.

The programme has four key areas to make compliance these are:

1. CCDM Governance
   - We achieve compliance
   - Operational and Council group in partnership with unions
   - We are currently looking at restructuring these meetings to ensure operational and strategic/governance is separated and key stakeholders are present at the appropriate meeting

2. Core Data Set
   - The Hospital have a full suite of data collection, Power BI, TrendCare, SQL and daily reporting
   - This data is used daily at the operational meeting
   - Duty managers report through a shift report every duty with VRM responses, demand needs and capacity plans/actions
   - Power BI has enhanced the available information significantly
   - Ward managers also now have a suit of information and action within 'teams' increasing accessibility

- Local (ward/unit) data is now discussed at the ward meetings with relevant data and displayed on the knowing how we are doing boards

3. FTE Calculations
   - We currently achieve compliance
   - FTE calculations are in progress and we wait meeting at council without union partners to discuss findings, it is proving difficult to get a suitable time for all parties.
   - Variable matrix agreement has been agreed and implemented (what we put in as agreed hours for non-clinical work)
   - Finance are involved in this process to align CCDM. CBS with budget setting for 21/22

4. Variance Response Management
   - We achieve compliance
   - Staff are being deployed within the hospital as indicated by demand
   - Trend care education is in place and a champion model is active with monthly meetings occurring
   - Actions are based on evidence and this is becoming more robust with reporting
   - VRM indicators are in place with hospital screen visibility
   - 'Smart 5' cards are in place for those staff who are redeployed to assist with tasks
   - Operational meetings are functioning with a 'yesterday' today' and 'tomorrow' approach

3.5 Service Delivery

Sterile Supply Department (CSSD)

Steriliser Installation Update:
Two sterilisers (autoclaves) have been purchased from Surgical and Medical Services (SMS). The initial date of install was beginning of April, but due to shipping delays from Australia the installation has been moved to the week of May 17, 2021. The installation will occur over 6 days. During this time Theatre Services will operate under a moderately reduced capacity as only one steriliser will be in operation at a time. The mix of cases will be planned in the weeks leading up to the install. During the time of installation, the use of loan surgical instrumentation will be minimised.

4 Primary and Community Services

4.1 Service Delivery Overview

Primary and Community Services have continued to progress with the vision of Healthy at Home – every bed matters, to ensure a focus on community based, preventative healthcare where possible. Work on improving the triage system to accurately identify needs of those referred to services, and where services are best delivered, has been a focus to reduce wait times and duplication. This has been a focus for Physiotherapy, Occupational Therapy, Speech Language Therapy and Dietetics, with Community Mental Health currently exploring regional triage models.

Referrals in to Allied Health services, particularly Radiology (Ultrasound and MRI), Community Assessment and Rehabilitation, and Physiotherapy, continue to rise, and this is reflected in waitlist numbers.

The radiology refurbishment is progressing, with architect plans being drawn up. It is worth noting that many pieces of major radiology equipment are at end of life and have been approved for replacement. The design of the space for equipment needs to be completed before equipment is replaced as there is significant cost involved in relocating equipment.

The loans department for equipment is also undergoing redesign, both in the space it occupies and in the electronic system to track equipment. The aim of this is to ensure a safer, cleaner, and more efficient system for loaning and delivering equipment on the wards and to the community.

The staff at Waimarino Health Centre are being regularly involved and updated with regards to the Ruapehu Wellness Transformation Project, and the proposed redesign of the Waimarino Health Centre. There is a wellness summit being held in Raetihi mid April, and staff are being actively encouraged to attend this. Workshops on future models of care that best meet the needs of the community are occurring.

4.2 Workforce

Vacancies within Social Work, Mental Health Occupational Therapy, MSK Physio, continue despite recurrent advertising. There are also ongoing rural vacancies at Waimarino Health Centre for a cleaner and a part time Co-ordinator. Work will be done with the managers to reconsider recruitment approaches to the roles. Despite this, services continue with progressing model of care work and are actively taking part in quality improvement initiatives and supporting student placements. Managers across services are also increasing the roles available for non regulated workforce (mainly assistants), as an efficient, effective and financially sustainable workforce.

The recruitment for the project lead for Telehealth will be completed mid April.

5 Maternal, Child and Youth Services (MCYS)

5.1 General

We are seeing a notable increase in the number of whānau we are caring for with complex needs in both paediatric and maternity services.

From 1 January to 22 March 2021 we have had three multi- agency case meetings (MASP) under the MOU with Police, Oranga Tamariki and WDHB. Quantitative records have not previously been kept for MASP data, but we estimate that in past years three to five MASP cases would occur in a full calendar year. There have also been 23 reports of concern in the same period completed by WDHB staff.

Oranga Tamariki are increasing the FTE of their liaison social worker from 0.5fte to full time soon which will assist the staff in this mahi. The Child Protection Coordinator will monitor and report on trends in this area in the future.

Individual service dashboards were presented by clinical managers at the MCYS all-of-service meeting for the first time in February and were well received. The report gives a snapshot view of each service in terms of quality and risk, finance, workforce and service delivery. It also highlights achievements, challenges and related service improvement actions. The Quality Marker Report has been reviewed and relevant aspects will be embedded into the dashboard on a quarterly basis.

Following feedback from Whanganui Maternal, Child and Youth Community Alliance meetings held to date, a workshop on integration with MCYS Clinical Leaders is planned for April 2021. The most recent meeting was held on the 25th March 2021 and was well attended. It was led by MCYS Kaitakitaki, Kylee Osborne, and focused on how the WDHB MCYS can partner more effectively with service providers and our community. Some big hairy audacious goals were put forward by community partners which has given the MCYS plenty to think about.

5.2 Service Delivery

Maternity

The maternity service has been steady for the last quarter. The highest birth rate being 66 in the month of December, which was as anticipated.
The nationwide midwifery shortage remains an issue.
The secondary hospital maternity service antenatal clinic established for primary clients at the start of the year is running well.
Recruitment is underway for a case-loading midwife in Waimarino. One application has been received from a highly experienced applicant. She will commence the role in October 2021 and cover will be arranged in the interim.
A new graduate midwife started in March and another graduate will commence in May. To date this year there are five new midwifery graduates within our rohe. Two are LMCs, both are Māori, one will be rurally based. Three are core midwives, and one of these is Māori.
The first Midwifery Forum held on 22 March 2021 was well received. There was good attendance by both core midwives and LMCs and some key areas of interest were discussed. We believe this engagement will provide a platform for building strong relationships between the WDHB and our LMC partners in the community.

Paediatrics

In response to capacity variance in SCBU over the last quarter, a review was undertaken and the potential for some transitional cases to be managed in the post-natal ward was identified. As a result, the paediatric and maternity teams are working together to arrange a combined STABLES training on 31 May and 1 June 2021 to be delivered by an external trainer. The training will empower paediatric and maternity staff to have confidence in managing care of these babies. This will facilitate service integration ensuring quality and continuity of care for our patients.

The Child Development Service (CDS) workforce continues to be a challenge. Reallocation of has been approved for a 0.8FTE allied health assistant until the end of the financial year.

Public Health

The public heath team have been extremely active in the community, successfully carrying out promotion and delivery of MMR and HPV immunisations at events such as UCOL Orientation week, the Whanganui River Traders Market, Pride Week, and Waka Ama.

The Public Health team is involved in supporting the national COVID resurgence response with contact tracing and were allocated 18 symptomatic contacts to follow up. We have also provided public health nurse resourcing to Central and pop-up CBACs at local events and testing of Waiouru Army cadets.

Maternal Infant Child Adolescent Mental Health and Addiction Services (MICAMHAS)

A co-design quality project is underway to design a brochure informing women entering the Maternal Mental Health service about the pathway for accessing services.

MICAMHAS staff involved with the CAMHS reception competition met with the young people engaged for the process of making changes to our reception area. Their feedback was positive, and they were pleased the changes made contributed to MICAMHAS winning the best CAMHS reception in the country.

Oral Health

Preliminary data on oral health status for 2020 shows an overall improvement for Year 8 caries free, up from 64% to 67%. Within this overall improvement, Māori have moved from 57% caries free in 2019 to 62% caries free in 2020. The situation is however static for Māori 5-year-olds who have remained the same in 2020 as they were in 2019 – 41% caries free. Consideration now must be given to how we deliver services to Māori tamariki under the age of five. It is anticipated that the Health Promotion and Public Health team joint project, Whakawhanaungatanga ki Te Kōhanga Reo, which aims to strengthen the relationship with the Te Kōhanga Reo Aotea Trust, will assist in the redevelopment of service delivery for this cohort.

5.3 Future Focus

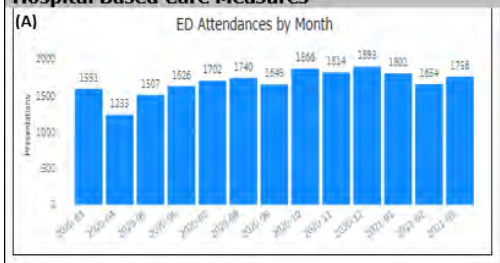
Engagement with the Whanganui Maternal, Child and Youth Community Alliance has begun to inform the review and development of current MCYS services and its future workplan. One workstream stemming from the Alliance is focused on advancing a more integrated approach for child health services within the DHB. An integration workshop with MCYS clinical leaders is planned for April 2021.

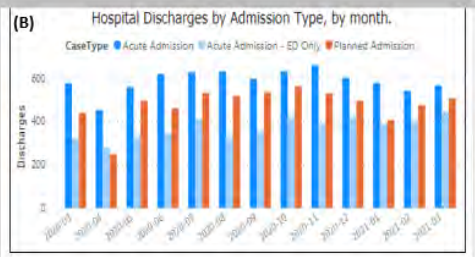
We envisage this leading to a single Child Health Referral approach where there will be a single point of entry into child health services and any redirection of referrals occurs internally rather than seeing referrals declined/ rejected and the process needing to start again. Much work is still to be done to bring this to fruition.

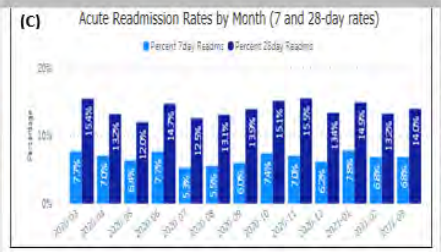
Appendix 1. Whanganui DHB Performance Dashboard

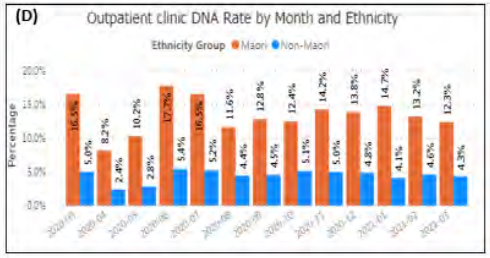
(data extracted 6 April 2021)

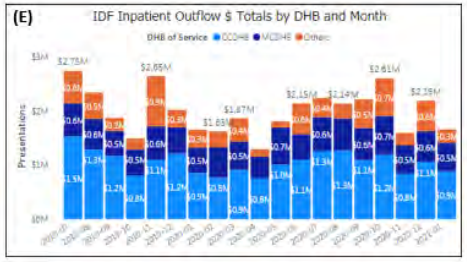
Hospital Based Care Measures

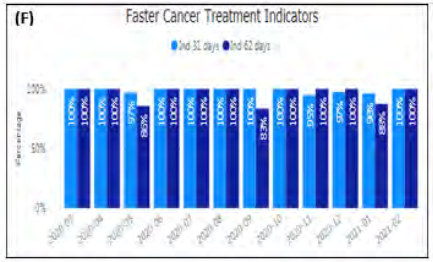












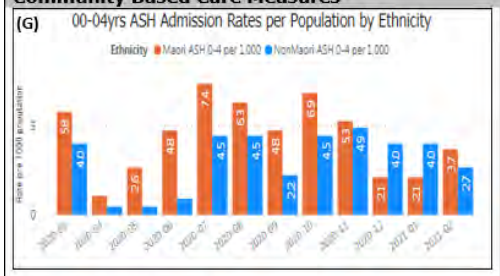
Commentary

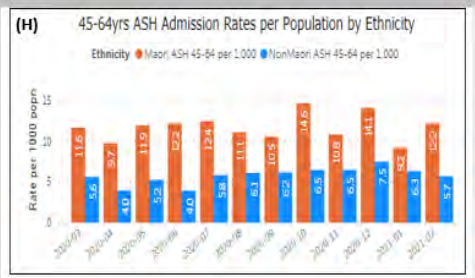
ED commentary is within the body of the report.
(B) Feburay and March data shows that for both months the numbers were similar for acute and planned admissions.
(C) However, the ED acute readmissions was 1% higher for March compared to February, of which was also reflected in (B) graph.

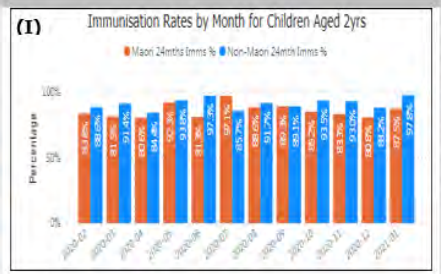
Re-admissions remain high. A one-year pilot introducing an Integrated Nurse Navigator has been introduced in March. The purpose of the role is to understanding readmission rates and barriers that are creating bottlenecks within the in-patient areas.

(D) Outpatient clinic DNA remain high for Maori but has dropped by 1 percent for each month. Whilst non Maori continues to sit around 4-5%.
(E) February and March data is not completed; however, for January we paid a total of $1.66M in IDF.
(F) Faster Cancer Treatment 6 monthly report was presented at the last Board meeting. This graph indicates during February we reach 100%. This is a good result.

Community Based Care Measures



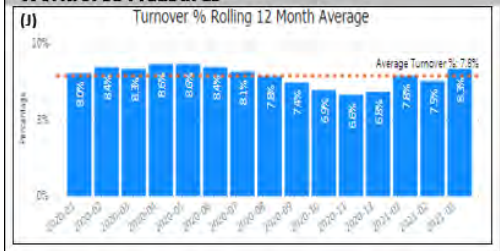




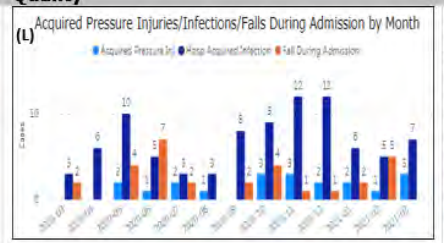
Commentary

All Ambulatory sensitive hospitalisations (ASH) rates are for Whanganui Hospital. Maori are more likely to be hospitalised for ambulatory sensitive conditions compared to non-Maori.
(G) The top themes for 0-4 years are dental, gastroenteritis and respiratory. January shows a greater gap between Maori and non-Maori; whilst February the gap was far less.
(H) The top themes for 45-64 years are chest pain, heart disease, COPD/pneumonia and cellulitis.
(I) Working with Iwi to improve the immunisation rates, January shows an improvement for both Maori and non-Maori.

Workforce Measures



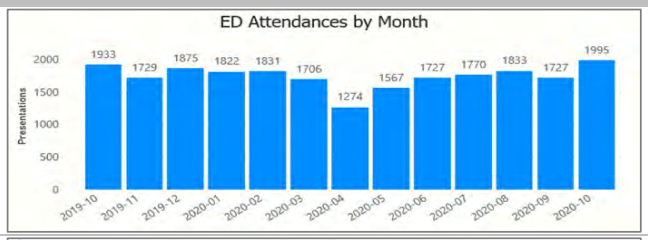
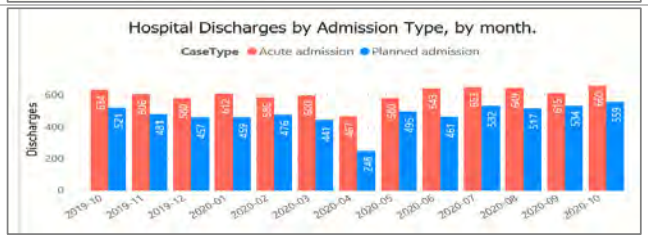
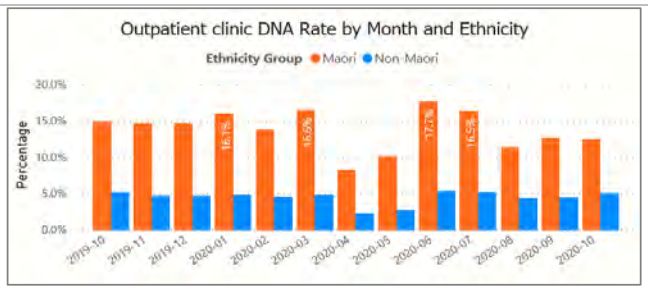
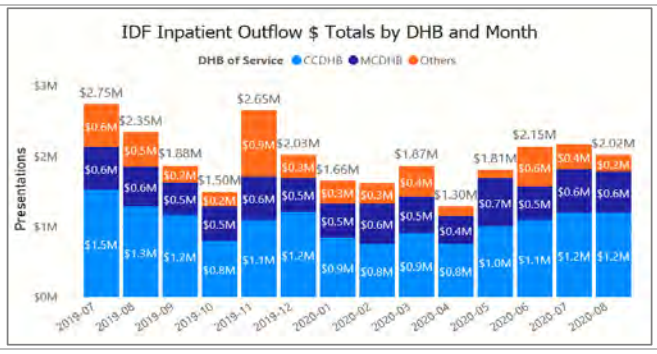
Quality



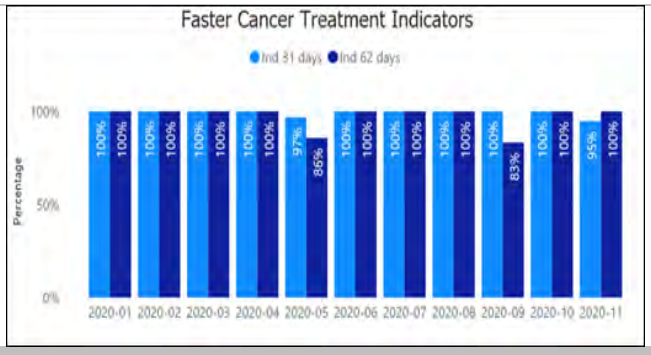
Commentary

(J) The average turnover at WDHB for February was 7.5% and this increased to 8.3% in March. WDHB average turnover is 7.8%.
(K) Prior to Xmas the sick leave was on the high side; this has decreased. The inpatient ward areas have had a lens over sick leave; this includes tightening the processes for managing absenteeism. Both January and February show a decrease in sick leave, both months were below the average percentage.
(L) Pressure injuries appear to have increased, both Hospital acquired and community. It is worth noting education, documentation and audits remain key focus areas within the wards. NB: Data comes from coded activities

Whanganui DHB Performance Dashboard definitions.

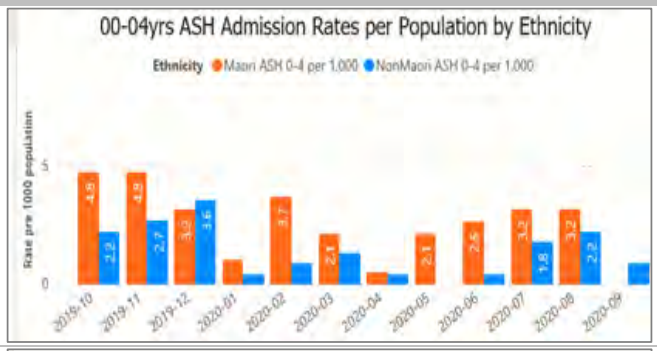
Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	
Graph B. Hospital Discharges Throughput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

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

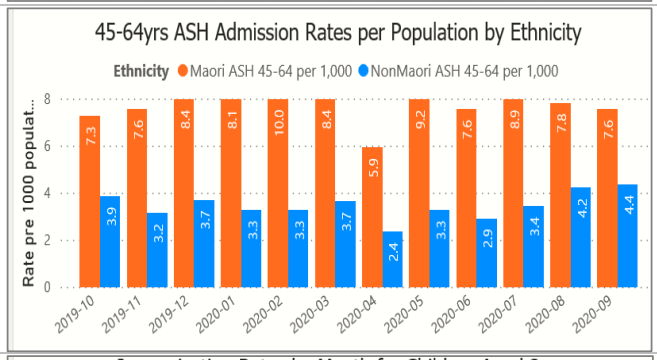


Community Based Care Measures

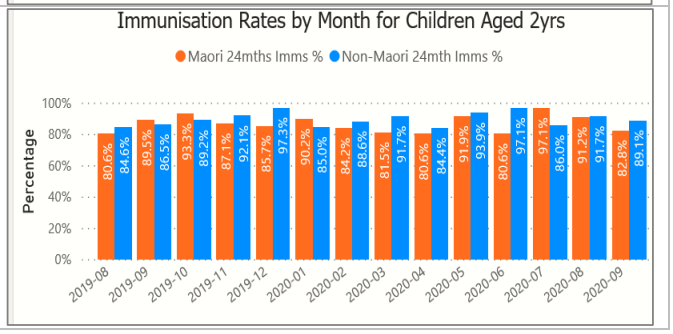
Graph G. ASH Rates 0-4 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000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



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



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

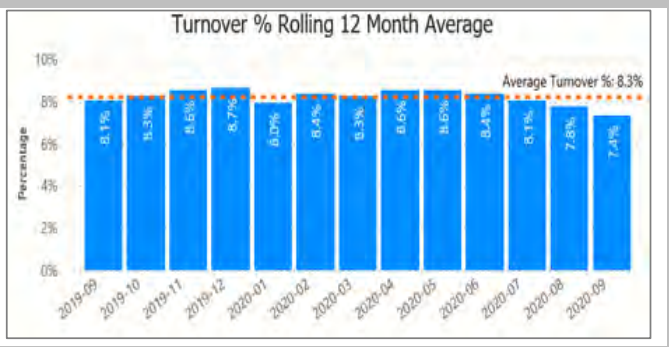


Workforce Measures

Graph J. DHB Staff Turnover

Rolling twelve month turnover rates is an indication of staff retention

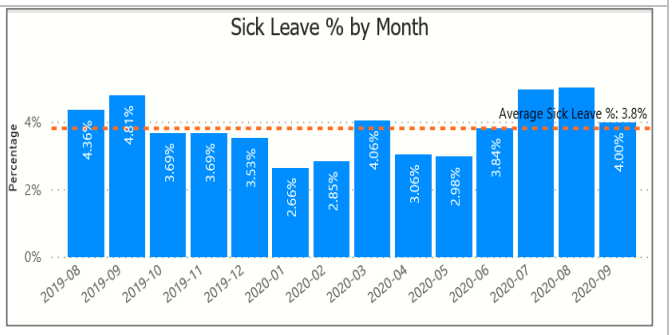
Calculation:
Denominator = total staff numbers
Numerator = new hires within the preceding twelve months



Graph K. Sick Leave %

Percentage of total paid hours taken as sick leave. This is an indication of illness levels and cost impacts when above average budgeted rates. Does not indicate where annual leave is used in place of sick leave

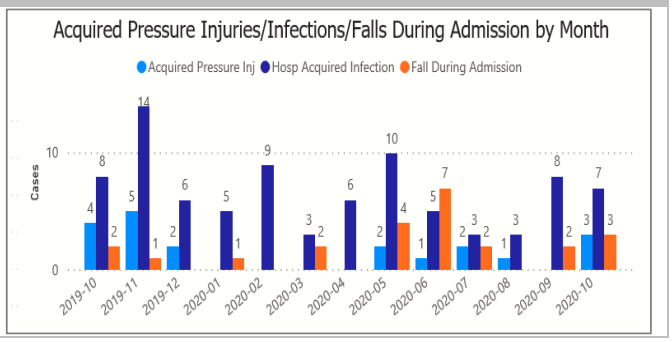
Calculation:
Denominator = total paid hours
Numerator = hours paid as sick leave



Quality

Graph L. Pressure Injuries/Infections/Falls

Patient safety and care indicators for key measures.
Calculation: count of events each month (not individual patients)



April 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora a Whanganui	**Information Paper**
	21 April 2021
Author	Raju Gulab, Finance Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	**Detailed financial report – March 2021**

Recommendations

That the Executive Leadership Team:

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

b. **Note** the March 2021 monthly result of a $601k deficit is favourable to budget by $11k. When including the increase in the COVID-19, Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $120k unfavourable to budget.

c. **Note** the year-to-date result of $2,970k deficit is unfavourable to budget by $428k. Including the increase in the COVID-19, Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $1,308k unfavourable to budget.

Financial Overview – March 2021

YTD Performance	YTD IDF Net Flow	YTD CWDs
Actual deficit $2.9m (excluding Holiday Act Compliance provision and one-off facility contract costs)	$30.0m expenditure	Estimated CWDs 9,262
Against budgeted deficit of $2.5m, $0.4m unfavourable to budget.	Against budgeted expenditure of $30.4m, $0.4m favourable to budget.	Against 9,077 budgeted CWDs; 185 CWD or 2.0% ahead of budget (IDF CWDs excluded).

YTD FTE	YTD Capital Expenditure
Actual FTE 946	Actual spend $4.6m
Budgeted FTE of 935, acuity running 1.18% above target and added pressure on nursing resource.	Against budgeted expenditure of $5.2m, $0.6m favourable, due to timing of expenditure.

April 2021 **Public**

Consolidated Statement of Financial Performance for the period ended 31 March 2021

	Month				Year to Date				Annual	Annual		Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2020-21	Forecast 2019-20	Var Forecast	Actual 2019-20
Revenue	24,676	24,586	90	F	221,520	221,168	352	F	294,806	295,008	202	272,259
Total Revenue	24,676	24,586	90	F	221,520	221,168	352	F	294,806	295,008	202	272,259
Less:												
Provider Health Service	(12,691)	(12,646)	(45)	U	(113,223)	(111,535)	(1,688)	U	(148,803)	(150,318)	(1,515)	(143,995)
Corporate Service	(108)	(77)	(31)	U	(616)	(1,004)	388	F	(1,221)	(860)	361	(1,990)
Governance	(80)	(78)	(2)	U	(682)	(707)	25	F	(950)	(903)	47	(722)
DHB Funder Division (exl IDF outflow)	(8,686)	(8,406)	(280)	U	(74,630)	(74,540)	(90)	U	(99,201)	(99,795)	(594)	(91,641)
Inter-district Outflow	(3,808)	(4,016)	208	F	(35,736)	(36,142)	406	F	(48,189)	(48,281)	(92)	(45,247)
ACC Contract (net)	96	25	71	F	397	218	179	F	309	396	87	265
Total expenditure	(25,277)	(25,198)	(79)	U	(224,490)	(223,710)	(780)	U	(298,055)	(299,761)	(1,706)	(283,330)
Net Surplus/(Deficit) before COVID-19 & HolidayPay	**(601)**	**(612)**	**11**	**F**	**(2,970)**	**(2,542)**	**(428)**	**U**	**(3,249)**	**(4,753)**	**(1,504)**	**(11,071)**
Revenue- COVID-19	(125)	-	(125)	U	2,175	-	2,175	F	-	2,718	2,718	3,931
Expenditure COVID-19	36	-	36	F	(2,399)	-	(2,399)	U	-	(2,876)	(2,876)	(5,444)
COVID-19	(89)	-	(89)		(224)	-	(224)		-	(158)	(158)	(1,513)
Holiday Act Costs	(42)	-	(42)	U	(416)	-	(416)	U	-	(542)	(542)	(2,820)
One-off Facility contract	-	-	-	F	(240)	-	(240)	U	-	(207)	(207)	-
One-off	(42)	-	(42)		(656)	-	(656)		-	(749)	(749)	(2,820)
Net Surplus / (Deficit)	**(732)**	**(612)**	**(120)**	**U**	**(3,850)**	**(2,542)**	**(1,308)**	**U**	**(3,249)**	**(5,660)**	**(2,411)**	**(15,404)**

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

Overview

The operating result for the month of March 2021 was favourable to budget by $11k. When including COVID-19 & Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $120k unfavourable to budget.

Revenue

Revenue was $90k favourable to budget due to public health funding, primary care funding (offset by costs), in-between travel funding and suicide prevention funding.

Revenue- COVID- 19

COVID-19 revenue was $125k unfavourable to budget due to $201k reduction on pharmaceutical COVID-19 funding as advised by MoH ($305k reduction in pharmaceutical COVID-19 funding, full year adverse impact is $406k), this was partly offset by $76k surveillance funding.

Provider health service (Appendix 2)

Inpatient volumes were 102.3% to target in March 2021 with unplanned (acute) at 102% and planned (elective and arranged) at 103% of budget for the month. The value of this increased volume is approximately $133k.

Provider division was $45k unfavourable to budget due to increased personnel costs mainly in nursing and medical locum, these unfavourable variances were partly offset by higher ACC radiology and ACC non-acute rehabilitation revenue, lower clinical supplies and infrastructure and non-clinical supplies cost.

Corporate service (Appendix 2)

Corporate was $31k unfavourable to budget due to IT outsourced costs.

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

Funder division was $280k unfavourable to budget due to higher pharmaceutical costs, health of older people costs and mental health costs.

Inter-district flows (Appendix 4)

Inter-district flows were $208k favourable to budget lower IDF inpatient activity.

COVID-19 expenditure

COVID-19 expenditure was $36k favourable to budget with costs incurred mainly in operating CBAC facilities and pharmaceuticals.

Year-to-date March 2021 operating result was unfavourable to budget by $428k; when including COVID-19 and Holiday Act Compliance provision and one-off facility contract mobilisation costs, the result is $1,308k unfavourable to budget.

Revenue (Appendix 1)

Revenue was $352k favourable to budget, due mainly to higher inter-district flow revenue related to service changes and higher inpatient service volume for other DHBs, student replacement revenue, ACC sexual abuse assessment and treatment service (SAAT) revenue, ACC radiology revenue, outpatient clinic revenue and non-resident patient revenue. These increases in revenue were partly offset by a reduction in capital charge funding due to the rate reduction from 6% to 5% (this reduction resulted in a lowering of the base line funding, offset by a reduction of equal amount of costs), lower ACC non-acute inpatient rehabilitation and not meeting the ACC additional revenue target.

Revenue- COVID- 19 (Appendix 1)

COVID-19 revenue was $2,175k favourable to budget due to additional funding received for ongoing support of operating CBAC facilities and COVID-19 testing. However, this funding was offset by COVID-19 related costs of $2,399k.

Provider division (Appendix 2)

Provider division was $1,688k unfavourable to budget due to increased nursing costs high acuity volumes, medical locum cost to cover vacancies, higher volume-related theatre, and ward consumable costs, increased pharmaceutical (mainly EYE drug costs), and an unmet clinical savings target. These increases were partly offset by lower outsourced service costs for radiology and unattended courses/conferences due to the COVID-19 pandemic.

Inpatient volumes were 102% to target year to date with unplanned (acute) 100.7% and planned (elective and arranged) 105.7% of budget year-to-date. The value of this increased volume is $1.02m.

Corporate (Appendix 2)

Corporate was $388k favourable to budget due to the capital charge rate reduction from 6% to 5% (offset by lower capital charge revenue). These lower costs were partly offset by higher IT-related costs, depreciation on IT capitalised projects bought into production and building depreciation costs relates to increased building valuations.

Governance

Governance was $25k favourable to budget due to lower other operating expenses, outsourced costs, and democracy.

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

Funder division was $90k unfavourable to budget due to higher primary health organisation (PHO) costs (offset by revenue), mental health additional costs (offset by revenue), this unfavourable variance was partly offset by

health of older people costs, an in-between travel refund, lower short-term home-based support, and a higher pharmaceutical rebate.

Inter-district flows (Appendix 4)

Inter-district flows were $406k favourable to budget mainly due to lower inpatient service activities, as well as closer oversight and review of IDF costs as part of savings initiatives.

COVID-19 expenditure

COVID-19 expenditure was $2,399k unfavourable to budget mainly due to other public health service operation costs of $1,410k, pharmaceutical costs of $636k (assume equal amount of expenditure occurred to offset the revenue), and personnel payroll cost of $353k.

Holiday Act provision

A provision of $416k was made to accommodate any ongoing impact on accumulated leave in the 2020-21 financial year.

Facility contract one-off

A one-off cost of $240k for new facility contract mobilisation cost, anticipated full year cost will be $280k.

April 2021 **Public**

Appendix 1 - Revenue

$'000	Month Actual	Month Budget	Month Var		Year to Date Actual	Year to Date Budget	Year to Date Var		Annual Budget 2020-21	Annual Actual 2019-20
Ministry of Health	23,501	23,449	52	F	211,441	211,052	389	F	281,284	259,121
Inter-district inflow	579	637	(58)	U	5,780	5,732	48	F	7,643	7,764
Other District Health Board (DHB)	57	50	7	F	683	421	262	F	560	612
Accident Compensation (ACC)	432	319	113	F	2,404	2,752	(348)	U	3,687	3,317
Other Government	-	6	(6)	U	198	142	56	F	197	145
Patient consumer sourced	19	30	(11)	U	232	264	(32)	U	353	371
Other income	88	95	(7)	U	782	805	(23)	U	1,082	929
COVID-19	(125)	-	(125)	U	2,175	-	2,175	F	-	3,931
Total revenue	24,551	24,586	(35)	U	223,695	221,168	2,527	F	294,806	276,190

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

Month comments

Ministry of Health

Revenue was $52k favourable to budget due to public health funding, cervical screening and suicide prevention funding.

Inter-district inflow

Inter-district inflow was $58k unfavourable to budget due to inpatient service revenue.

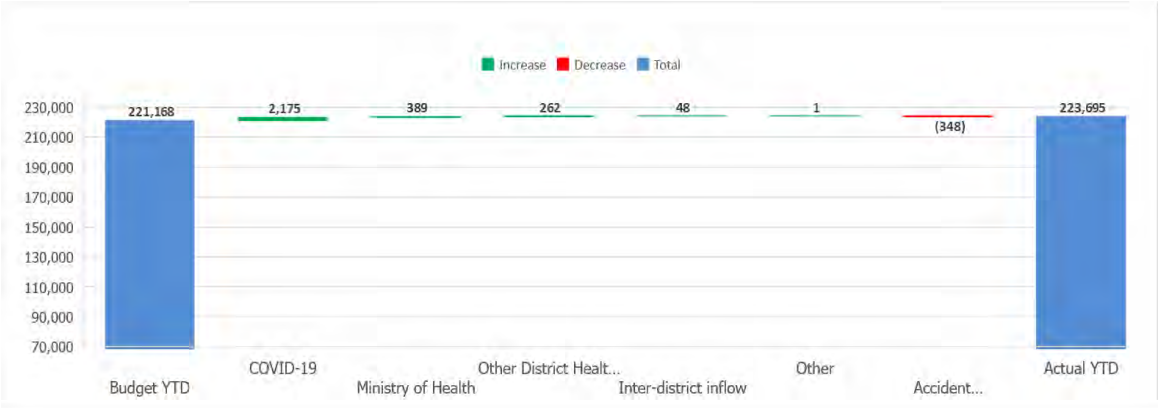
Accident Compensation (ACC)

Revenue was $113k favourable to budget due to higher ACC radiology $58k, ACC implant $33k, ACC non-acute inpatient $35k, and ACC injury prevention revenue $40k. This higher revenue was partly offset by not meeting the additional ACC revenue target $42k and lower home base nursing $11k.

COVID-19 revenue

COVID-19 revenue was $125k unfavourable to budget due to $201k reduction on pharmaceutical COVID-19 funding as advised by MoH ($305k reduction in pharmaceutical COVID-19 funding, full year adverse impact is $406k), this was partly offset by $76k surveillance funding.

Year-to-date comments



COVID-19 was $2,175k favourable to budget due to Ministry of Health funding for:

- CBAC establishment $30k
- GP based easements $62k
- Surveillance plan and testing strategy $786k
- Public health unit $450k
- HOP support $29k
- Digital enablement $182k
- Pharmaceuticals $636k

This revenue passes on to various community health providers.

Ministry of Health

Revenue was $389k favourable to budget due to an increase of primary care revenue and funder division side contract revenue (this increase in funding was passed on to PHO and other health providers), public health additional on-off funding, hospice funding (offset by costs) and suicide prevention funding. This was partly offset by a reduction in capital charge funding due to the rate reduction from 6% to 5%.

Other District Health Board (outpatient Clinics)

Other District Health Board was $262k favourable to budget due to the increase of other District Health Boards (DHBs) outpatient clinic revenue.

Inter-district inflow

Inter-district inflow was $48k favourable to budget due to service changes with other DHB's and high inpatient service revenue.

Other

Other revenue was $1k favourable to budget due to the increased patient consumable revenue.

Accident Compensation (ACC)

Revenue was $348k unfavourable to budget due to lower ACC non-acute inpatient rehabilitation $256k and not meeting the ACC revenue target of $374k. This lower funding was partly offset by additional funding from ACC radiology $88k, sexual abuse assessment and treatment service (SAAT) $80k, ACC home base nursing $11k, ACC injury prevention $65k and other ACC revenue $38k.

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Appendix 2 - Provider Health and Corporate Services

	Month					Year to Date					Annual	Annual
	Actual	Budget	Variance		Var %	Actual	Budget	Variance		Var %	Budget 2020-21	Actual 2019-20
Expenditure												
Medical Personnel	2,189	2,207	18	F		17,820	18,725	905	F		25,259	22,696
Nursing Personnel	3,712	3,596	(116)	U		33,048	31,948	(1,100)	U		42,796	42,778
Allied Personnel	1,234	1,207	(27)	U		9,582	10,131	549	F		13,545	12,346
Support Personnel	92	96	4	F		790	806	16	F		1,080	934
Management & Admin Perseonnel	1,035	1,082	47	F		8,829	9,195	366	F		12,270	12,061
Total Personnel(Exl other & outsourced)	**8,262**	**8,188**	**(74)**	**U**		**70,069**	**70,805**	**736**	**F**		**94,950**	**90,815**
Personnel Other	178	239	61	F		1,464	1,721	257	F		2,355	1,737
Outsourced Medical Personnel	377	332	(45)	U		4,484	2,902	(1,582)	U		3,883	6,433
Outsourced Allied Personnel	59	34	(25)	U		684	391	(293)	U		492	704
Outsourced Manag & Admin Personnel	88	7	(81)	U		475	59	(416)	U		78	59
Total Personnel outsourced	**702**	**612**	**(90)**	**U**		**7,107**	**5,073**	**(2,034)**	**U**		**6,808**	**8,933**
Total Personnel Expenditure	**8,964**	**8,800**	**(164)**	**U**		**77,176**	**75,878**	**(1,298)**	**U**		**101,758**	**99,748**
Outsourced Clinical Service	526	486	(40)	U		4,268	4,415	147	F		5,915	6,015
Clinical Supplies	1,440	1,517	77	F		13,474	13,044	(430)	U		17,300	16,107
Infrastructure & Non Clinical Supplies Costs	1,129	1,150	21	F		12,374	12,618	244	F		16,171	15,540
Capital Charge	187	202	15	F		1,758	1,901	143	F		2,505	2,748
Depreciation & Interest	533	550	17	F		4,656	4,565	(91)	U		6,193	5,563
Internal Allocation	20	18	(2)	U		133	118	(15)	U		182	264
Total Other Expenditure	**3,835**	**3,923**	**88**	**F**		**36,663**	**36,661**	**(2)**	**U**		**48,266**	**46,237**
Total Expenditure	**12,799**	**12,723**	**(76)**	**U**		**113,839**	**112,539**	**(1,300)**	**U**		**150,024**	**145,985**
Expenditure												
Medical personnel and Locum	2,566	2,539	(27)	U		22,304	21,627	**(677)**	U		29,142	29,129
Nursing Personnel	3,712	3,596	(116)	U		33,048	31,948	**(1,100)**	U		42,796	42,778
Allied Personnel	1,293	1,241	(52)	U		10,266	10,522	**256**	F		14,037	13,050
Othe Personnel costs	1,393	1,424	31	F		11,558	11,781	**223**	F		15,783	14,791
Clinical Supplies	1,440	1,517	77	F		13,474	13,044	**(430)**	U		17,300	16,107
Outsourced Clinical Service	526	486	(40)	U		4,268	4,415	**147**	F		5,915	6,015
Infrastructure & Non Clinical Supplies Costs	1,316	1,352	36	F		14,132	14,519	**387**	F		18,676	18,288
Depreciation & Interest	533	550	17	F		4,656	4,565	**(91)**	U		6,193	5,563
Internal Allocation	20	18	(2)	U		133	118	**(15)**	U		182	264
Total Expenditure	**12,799**	**12,723**	**(76)**	**U**		**113,839**	**112,539**	**(1,300)**	**U**		**150,024**	**145,985**
FTEs												
Medical	110.0	113.9	4	F		107.2	110.7	4	F		111.5	112.5
Nursing	462.4	454.8	(8)	U		479.7	459.7	(20)	U		460.8	462.2
Allied	167.5	161.1	(6)	U		154.7	160.3	6	F		160.3	153.4
Support	18.2	18.1	(0)	U		18.1	18.0	(0)	U		18.0	16.8
Management & Admin	166.1	170.2	4	F		169.6	169.5	(0)	U		170.5	177.9
Total FTEs	**924**	**918**	**(6.2)**	**U**		**929**	**918**	**(11.1)**	**U**		**921**	**923**
Case Weighted Discharges (CWD)												
Unplanned (Acute)	764	748	(15)	U	-2.0%	6,685	6,639	(46)	U	-0.7%	8,836	8,528
Planed (Elective & Arranged)	314	305	(9)	U	-3.0%	2,576	2,438	(138)	U	-5.7%	3,227	2,968
Total CWD	**1,077**	**1,053**	**(24)**	**U**	**-2.3%**	**9,262**	**9,077**	**(185)**	**U**	**-2.0%**	**12,063**	**11,496**
Further information												
General Medicine	353	295	(58)	U	-19.7%	3,022	2,613	(409)	U	-15.6%	3,478	3,728
General Surgery	200	220	20	U	9.1%	1,890	1,873	(17)	U	-0.9%	2,488	2,582
Orthopaedics	213	216	3	U	1.2%	1,705	1,802	97	F	5.4%	2,390	1,897
Gynaecology	30	32	2	U	5.3%	303	264	(39)	U	-15.0%	350	388
Emergency Medicine	117	114	(3)	F	-3.0%	899	1,008	109	F	10.8%	1,342	1,096
Othter	164	177	13	U	7.3%	1,441	1,517	75	F	5.0%	2,015	1,805
Total CWD	**1,077**	**1,053**	**(24)**	**U**	**-2.3%**	**9,262**	**9,077**	**(185)**	**U**	**-2.0%**	**12,063**	**11,496**

Month comments

Inpatient volumes were 102% to target year to date with unplanned (acute) 100.7% and planned (elective and arranged) 105.7% of budget year-to-date. The value of this increased volume is $1.02m.

April 2021 **Public**

The overall expenditure for the month of March was $76k unfavourable to budget.

Personnel

Total personnel costs were $90k unfavourable to budget mainly due to increase in nursing personnel and medical locum costs, outsourced allied health personnel (mainly radiology), and IT outsourced personnel costs.

Outsourced Clinical Service

Outsourced clinical service costs were $40k unfavourable to budget mainly due to high demand of radiology outsourced service costs, outsourced services for chronic disease for clients with HIV.

Clinical supplies

Clinical supplies costs were $77k favourable to budget due to lower patient travel costs, ward consumable costs, and district nursing costs. These lower costs were partly offset by higher dental supplies and pharmaceutical costs.

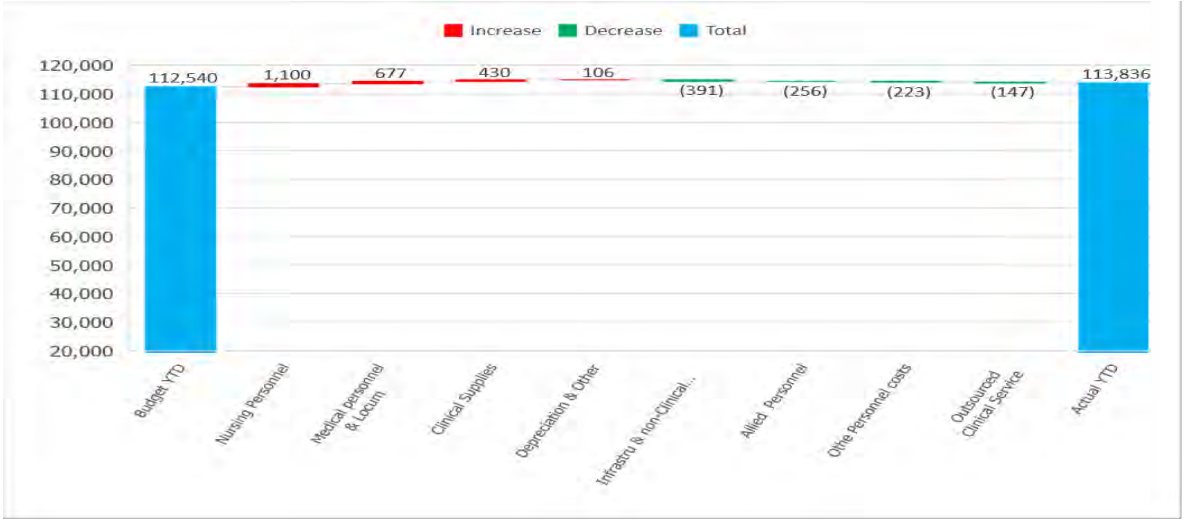
Infrastructure and Non-Clinical supplies

Infrastructure and non-clinical supplies costs were $36k favourable due lower patient meal costs.

Capital charges

Capital charges were $15k favourable to budget due to the rate reduction from 6% to 5% (offset by an equal amount of funding reduction).

Year-to-date comments



The overall year-to-date expenditure $1,300 unfavourable to budget.

Nursing personnel

Nursing personnel was $1,100k unfavourable to budget due to high nursing costs in the medical, surgical and ATR wards, mental health inpatient units (Te Awhina), ED, theatre, forensic service (Stanford House), ATR community service and community mental health. The staffing levels were particularly high due to clinical need.

Medical personnel

The medical personnel net unfavourable variance of $677k was mainly due to use of locums to cover vacancies. Unfavourable locum costs of $1,582k were partly offset by savings in payroll costs of $905k due to unfilled

vacant positions. Locum costs were made up of ophthalmology $116k, orthopaedics $24k, RMOs $353k, anaesthetics $147k, mental health $445k, gynaecology $414k, emergency $27k and dental and other units $56k.

Clinical supplies

Clinical supplies costs were $430k unfavourable to budget due to high costs in theatre consumable $299k (185, 2% CWDS above target), wards costs $100k (mainly treatment consumables and pharmaceutical drugs), orthotic and surgical footwear cost $106k. These higher costs were partly offset by lower radiology, district nursing consumable costs and patient travel.

Deprecation other costs

Deprecation costs and other costs were $106k unfavourable to budget due to clinical equipment, IT projects bought into production and the impact of deprecation for 30 June 2020 land and building valuation increases (anticipated full year unfavourable impact of $60k).

Infrastructure and Non-Clinical supplies

Infrastructure and non-clinical supplies costs were $387k favourable to budget due to building and other insurance savings of $103k, capital charge $143k, transport $44k, corporate training $22k, printing and stationary $15k, IT bureau and software licences $90k and staff travel and other $33k. These lower costs were partly offset by high security service to the mental health inpatient unit, AT&R and medical wards $32k, professional fees relating to facility contract $25k and other $6k.

Allied personnel

Allied personnel costs net favourable variance of $256k favourable to budget was mainly due to vacancies in audiology, dental, physiotherapy, speech therapy, pharmacy, community mental health and health promotion. Favourable payroll savings of $549k were partly offset by outsourced costs of $293k mainly orthotics, speech therapists and radiology locum.

Other personnel

Other personnel costs were $223k favourable to budget mainly due to unattended course and conferences as a result of the COVID-19 pandemic.

Outsourced clinical and other services

The costs of outsourced clinical and other services were $147k favourable to budget, mainly due to radiology service $116k, radiology ECHO $56k, lower CCDHB infectious disease costs $44k and various other $14k. This was partly offset by community mental health outsourced telephone service $46k and outsourced service for chronic disease service for client with HIV $37k.

Case Weighted Discharges

Year to Date estimated case weighted discharges (CWD) were 185 CWD, 2% higher than target. General medicine 409 CWD, 15.6% higher than planned.

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

April 2021 **Public**

Appendix 3 - DHB Funder Division

	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2020-21	Actual 2019-20
Expenditure by type										
Pharmaceuticals	1,711	1,524	(187)	U	12,929	12,926	(3)	U	17,173	16,052
Primary Health Organisation (PHO)	1,493	1,475	(18)	U	13,594	13,326	(268)	U	17,763	16,941
Home Based Support (short Term)	148	218	70	F	1,760	1,958	198	F	2,610	1,766
Other Personal Health	1,123	1,129	6	F	10,124	10,077	(47)	U	13,452	12,440
Health of Older People	2,749	2,672	(77)	U	23,603	23,670	67	F	31,472	30,236
Mental Health	1,023	933	(90)	U	8,697	8,414	(283)	U	11,215	9,085
Public Health	84	85	1	F	801	802	1	F	1,057	976
Maori Services	136	136	–	F	1,187	1,310	123	F	1,719	1,602
Total Other provider expenditure	**8,467**	**8,172**	**(295)**	**U**	**72,695**	**72,483**	**(212)**	**U**	**96,461**	**89,098**
Funding Admin	219	234	15	F	1,935	2,057	**122**	F	2,740	2,543
Total funder expenditure	**8,686**	**8,406**	**(280)**	**U**	**74,630**	**74,540**	**(90)**	**U**	**99,201**	**91,641**
	–	–	–		–	–	–		–	
Expenditure by service										
Personal Health	4,475	4,346	(129)	U	38,407	38,287	(120)	U	50,998	47,199
Health of Older People	2,749	2,672	(77)	U	23,603	23,670	67	F	31,472	30,236
Mental Health	1,023	933	(90)	U	8,697	8,414	(283)	U	11,215	9,085
Public Health	84	85	1	F	801	802	1	F	1,057	976
Maori Services	136	136	–	F	1,187	1,310	123	F	1,719	1,602
Funding Admin	219	234	15	F	1,935	2,057	122	F	2,740	2,543
Total Expenditure	**8,686**	**8,406**	**(280)**	**U**	**74,630**	**74,540**	**(90)**	**U**	**99,201**	**91,641**

Month comments

The overall expenditure for the month of March 2021 was $280k unfavourable to budget.

Pharmaceuticals

Pharmaceuticals was $187k unfavourable to budget due to reduction on funding adjustment costs.

Home based support (short term)

Short term home base support was $70k favourable to budget due to lower demand.

Health of older people

Health of older people was $77k unfavourable to budget, largely due to high rest home hospital care costs.

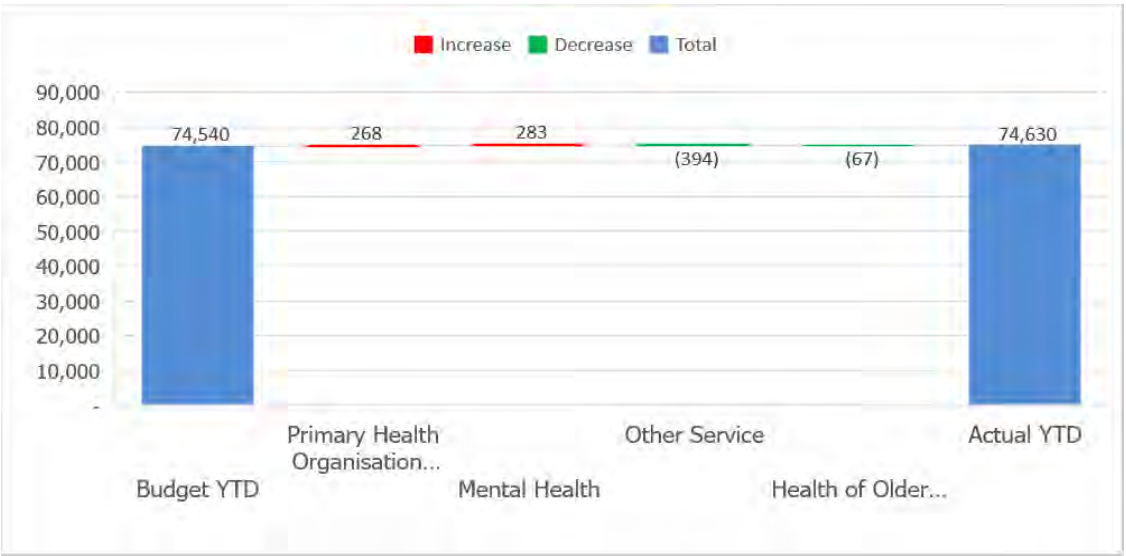
Mental Health

Mental health was $90k unfavourable to budget, largely due to an increase in the number of mental health contracts. This is partly offset by higher revenue.

April 2021 **Public**

Year-to-date comments

The overall year-to-date expenditure was $90k unfavourable to budget.



Primary Health Organisation

The Primary Health Organisation (PHO) was $268k unfavourable to budget, largely due to an increased capitation first contact service payment which indicates increases in enrolment, and the timing of the PHO system level measure capability payment. This was partly offset by increased primary care funding.

Mental Health

Mental health service was $283k unfavourable to budget largely due to an increase in the number of mental health contracts. This is partly offset by higher revenue.

Other service

Other service was $394k favourable to budget due to lower short term homebase support, lower other personal health costs and lower funding and admin management costs.

Health of older people

Health of older people was $67k favourable to budget, largely due to one-off in-between travel reimbursement related to the prior year, this was partly offset by higher rest home residential care costs.

April 2021 **Public**

Appendix 4 - Inter-district flows (IDFs)

	Month				Year to Date			Annual	Annual
	Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000	Budget 2020-21 $000	Actual 2019-20 $000
Expenditure									
Outflow inpatient	$1,878	$2,031	$153	F	$18,430	$18,278	($ 152)	$24,371	$24,073
Outflow other	$1,930	$1,985	$55	F	$17,306	$17,864	$558	$23,818	$21,174
Total outflow	**3,808**	**4,016**	**208**	**F**	**35,736**	**36,142**	**406**	**48,189**	**45,247**
Inflow inpatient	($ 224)	($ 277)	($ 53)	U	($ 2,543)	($ 2,497)	$46	($ 3,329)	($ 3,269)
Inflow other	($ 355)	($ 360)	($ 5)	U	($ 3,237)	($ 3,235)	$2	($ 4,314)	($ 4,495)
Total inflow	**(579)**	**(637)**	**(58)**	**U**	**(5,780)**	**(5,732)**	**48**	**(7,643)**	**(7,764)**
Total IDF net flow	**3,229**	**3,379**	**150**	**F**	**29,956**	**30,410**	**454**	**40,546**	**37,483**

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

Year-to-date comments

Year-to-date IDF net flow was $454k favourable to budget.

Year-to-date outflow IDF expenditure was $406k favourable to budget

Inpatient IDF outflow

Inpatient IDF outflow was $152k unfavourable to budget due to an anticipated saving target only partially achieved. Costs reflect payments made in accordance with the national plan. Specialities running over budget were acute general surgery, neurosurgery, specialist neonatal, acute cardiology, acute cardiothoracic, and acute plastic and burns.

Other IDF outflow

Other IDF outflow was $558k favourable to budget due to prior year PCT, community pharmaceutical wash-up $132k and service changes. (The IDF's for any year are set based on historical services provided and historical volumes, if there is a change in the services delivered by another DHB for Whanganui DHB population, this could be that a service is stopped, or volumes significantly change. This will only be required for IDF categories that are not washed up at the end of the year).

Year-to-date inflow IDF revenue was $48k favourable to budget.

Inpatient IDF

Inpatient IDF inflow was $46k unfavourable to budget due to a higher inpatient volume for other DHBs.

Other IDF

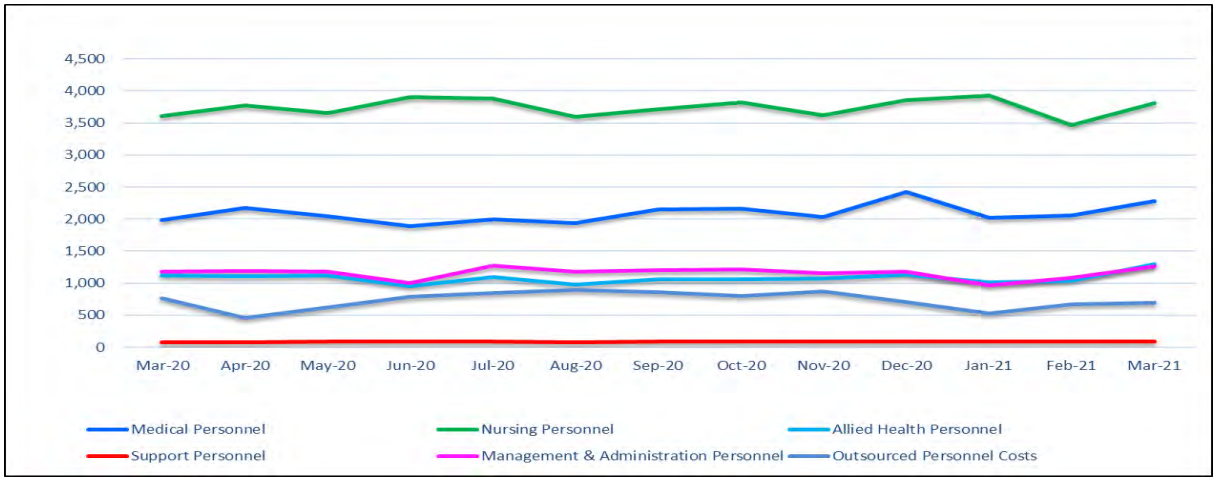
Other IDF inflow was $2k favourable to budget due to service changes. (The IDF's for any year are set based on historical services provided and historical volumes, if there is a change in the services delivered by another DHB for Whanganui DHB population i.e. if a service is stopped or volumes significantly change). This will only be required for IDF categories that are not washed up at the end of the year).

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

April 2021 **Public**

Appendix 5 - Other information

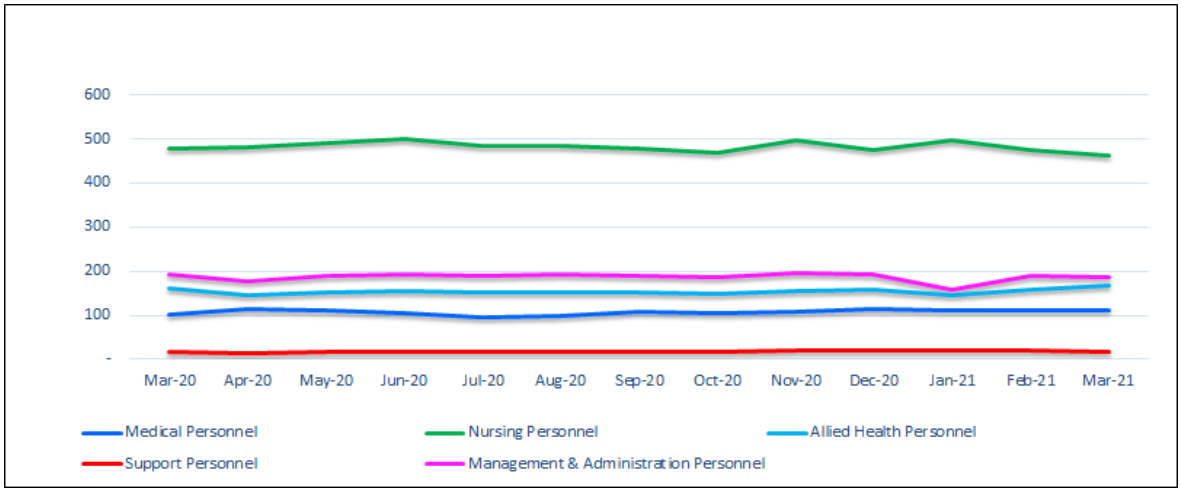
Supplementary information on costs
Personnel cost trends



Personnel costs downward trend in March compared to prior month is due to two more working days in the month.

Outsourced personnel costs slightly upward trend in March compared to prior month is due to higher ACC contract costs (offset by higher revenue)

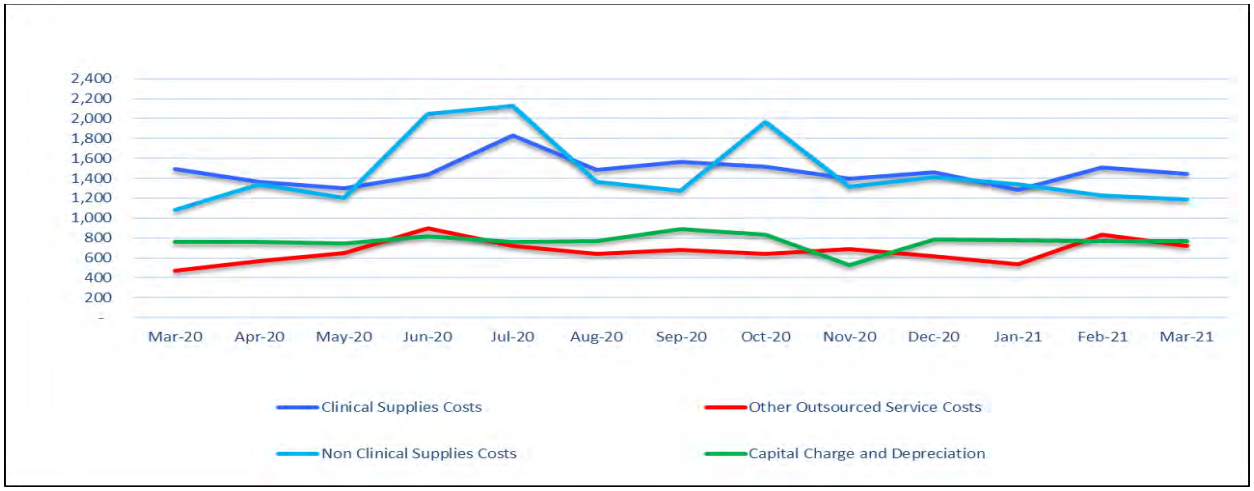
FTE trends



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

April 2021 **Public**

Other operating costs



Clinical supplies slightly downward trend in March compared to prior month is due lower patient travel and pharmaceutical costs.

Non-clinical supplies slightly downward trend in March compared to the prior month is due to telecommunication and facility costs.

Other outsourced service downward trend in March compared to prior month is due to ACC contract costs.

Capital charge and depreciation trend in March is line with prior month.

April 2021 **Public**

Appendix 6 - Statement of financial position

	Actual 2019-20 $000	Actual 2020-21 $000	Budget 2020-21 $000	Varinace to Budget	Annaul Budget 2020-21 $000
Assets					
Current assets					
Cash and cash equivalents	3,813	57	5	52	5
Receivables & Prepayments	6,275	8,070	5,613	2,457	5,492
Investments	–	–	–	–	–
Inventories	1,617	1,628	1,617	11	1,617
Trust /special funds	190	213	189	24	189
Patient and restricted trust funds	4	3	4	(1)	4
Total current assets	**11,899**	**9,971**	**7,428**	**2,543**	**7,307**
Non current assets					
Property, plant and equipment	79,602	79,881	75,918	3,963	78,310
Intangible assets	11,741	11,397	12,170	(773)	12,640
Investments in associates	1,185	1,185	1,077	108	1,102
Total non current assets	**92,528**	**92,463**	**89,165**	**3,298**	**92,052**
Total assets	**104,427**	**102,434**	**96,593**	**5,841**	**99,359**
Liabilities					
Current liabilities					
Bank Overdraft	–	(948)	(9,304)	8,356	(9,199)
Payables	(20,535)	(21,801)	(18,512)	(3,289)	(17,235)
Borrowings	(198)	(97)	(100)	3	(100)
Employee entitlements	(21,920)	(21,734)	(16,572)	(5,162)	(19,265)
Provisions	–	–	–	–	–
Total current liabilities	**(42,653)**	**(44,580)**	**(44,488)**	**(92)**	**(45,799)**
Non-current liabilities					
Borrowings	(486)	(413)	(414)	1	(385)
Employee entitlements	(839)	(831)	(855)	24	(805)
Total non current liabilities	**(1,325)**	**(1,244)**	**(1,269)**	**25**	**(1,190)**
Total liabilities	**(43,978)**	**(45,824)**	**(45,757)**	**(67)**	**(46,989)**
Net assets	**60,449**	**56,610**	**50,836**	**5,774**	**52,370**
Equity					
Contributed Capital	(112,409)	(112,409)	(112,409)	–	(114,651)
Accumulated surplus / (deficit)	82,698	86,548	85,641	907	86,349
Property revaluation reserves	(30,551)	(30,551)	(23,881)	(6,670)	(23,881)
Hospital special funds	(187)	(198)	(187)	(11)	(187)
Total equity	**(60,449)**	**(56,610)**	**(50,836)**	**(5,774)**	**(52,370)**

Total assets increased by $5.8m compared to budget due to impact of increased land and building valuation and actual 2019-20 lower capital expenditure than forecast position included for 2019-20 in annual plan 2020-21.

Total liabilities increased by $0.1m compared to budget due to accounts payable-related accrual provision and employee entitlement which was partly offset by a budgeted overdraft that was not needed.

April 2021 **Public**

Appendix 7 – Cashflow

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

	Actual 2018-19	Actual 2019-20	Actual YTD 2020-21	Budget YTD 2020-21	Variance		Annual Budget 2020-21
Net surplus / (deficit) for year	(13,654)	(15,404)	(3,850)	(2,542)	(1,308)	U	(3,250)
							–
Add back non-cash items							–
Depreciation and assets written off on PPE	5,417	**5,566**	4,658	4,570	88	F	6,201
Revaluation losses on PPE	–	–	–	–	–	F	–
							–
Total non cash movements	**5,417**	**5,566**	**4,658**	**4,570**	**88**	**F**	**6,201**
							–
Add back items classified as investment Activity							–
(loss) / gAmn on sale of PPE	15	5	3	–	3	F	–
Profit from associates	(95)	(108)	–	–	–	F	(85)
GAmn on sale of investments				–	–	F	–
Write-down on initial recognition of financial asset	1,048	–	–				–
Movements in accounts payable attributes to Ca	268	(127)	4	–	4	F	–
							–
Total Items classified as investment Activity	**1,236**	**(230)**	**7**	**–**	**7**	**F**	**(85)**
							–
Movements in working capital							–
Increase / (decrease) in trade and other payables	**4,312**	**2,301**	**1,266**	(2,630)	3,896	F	(3,907)
Increase / (decrease) employee entitlements	**3,907**	**5,173**	**(194)**	(5,332)	5,138	F	(2,689)
				–	–	F	–
(Increase) / decrease in trade and other receivable	2,555	123	(1,795)	1,069	(2,864)	U	1,275
(Increase) / decrease in inventories	(15)	(190)	(11)	–	(11)	U	–
Increase / (decrease) in provision	–	–	–	–	–	F	–
							–
Net movement in working capital	**10,759**	**7,407**	**(734)**	**(6,893)**	**6,159**	**F**	**(5,321)**
Net cash inflow / (outflow) form operating activ	**3,758**	**(2,661)**	**81**	**(4,865)**	**4,946**	**F**	**(2,455)**
	–	–	–	–			–
Net cash flow from Investing (capex)	(4,572)	(3,110)	(4,600)	(5,204)	604	F	(9,697)
Net cash flow from Investing (Other)	(65)	(48)	(11)	1	(12)	U	(24)
Net cash flow from Financing	(385)	(388)	(174)	(170)	(4)	U	2,043
Net cash flow from deficit support	–	7,000	–	–			–
							–
Net cash flow	(1,264)	793	(4,704)	(10,238)	5,534	F	(10,133)
Net cash (Opening)	4,284	3,020	3,813	939	2,874	F	939
Cash (Closing)	**3,020**	**3,813**	(891)	**(9,299)**	**8,408**	**F**	**(9,194)**

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

April 2021 **Public**

Capital Expenditure

	Actual 2019-20 000	Actual 2020-21 $000	Budget 2020-21 $000	Variance to Budget	Actual 2020-21 000
Buildings & Plant	702	1,150	1,895	745	4,825
Clinical Equipment	1,247	1,747	1,935	188	2,537
Other Equipment	46	58	90	32	210
Information Technology	239	971	183	(788)	230
Purchase of software	838	674	1,101	427	1,895
Motor Vehicles	38	–	–	–	–
Total capital expenditure	**3,110**	**4,600**	**5,204**	**604**	**9,697**

Capital expenditure is $604k lower than planned due to delay in building-related projects and timing of clinical equipment procurement. IT infrastructure variance is mainly due to PC and laptop purchases (relying on remote working and new way interacting with employees and customers). Switching IT infrastructure to cloud service would add significant new costs to WDHB.

April 2021 **Public Board**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	21 April 2021
Author	Kath Fraser-Chapple. Business Manager Hospital and Clinical Services
Subject	**Faster Cancer Treatment Targets**

Recommendations

Management recommend that the Combined Statutory Advisory Committee:

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

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

Appendix

1. Ministry of Health Faster Cancer Treatment Report for Q2 20-21

1 Purpose

This paper provides an update on Faster Cancer Treatment (FCT) Health Target Results for Q2 2020-21.

2 Summary

Results for the Faster Cancer Treatment target for quarter two 20-21 are 92.6% of patients referred with high suspicion of cancer starting their treatment within 62 days of their referral.

3 Background

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

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

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

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

Results received from Te Aho o te Kahu for quarter two 20-21 show that 92.6% of patients referred with high suspicion of cancer received their first treatment within 62 days of referral. A total of 50 referrals were within the 62-day target cohort. Of these 50 received their treatment within the timeframe.

Of the delayed patients two were delayed for clinical staging and multi-disciplinary team requirements. The third patient was delayed for multiple reasons and this is being investigated for contributing system failures. A fourth patient was delayed due to clinical capacity.

These results reflect our previously reported internal calculation of 92% compliance. Due to the different collection methods of the MoH data (submitted nationally and calculated as a rolling 6-month quarter) and the local data collected by our cancer nursing team there are variances in final numbers. For clarity we use the Ministry of Health reporting as our definitive results.

5 Faster Cancer Treatment (31-day target)

The results for Q2 have been received from the Ministry, for data collected up to 31 December 2020. We had a total of 207 patients in the FCT cohort for the reported timeframe with 178 receiving their treatment within 31 days of decision to treat, with a result of 86% against the target of 85%.

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Appendix 1.

Faster Cancer Treatment

Data submitted to the Ministry of Health as at 22 Jan 2021

This report provides preliminary achievement data for quarter two 2020/21 (which is based on patients who received their first cancer treatment or other management) between 1 Oct 2020 and 31 Dec 2020).

62-day indicator achievement (Health Target)

DHB		Adjusted number of records submitted Patients within the 62-day FCT health target cohort (excluding							Number of records within 62 days							Achievement 6-month quarter	Achievement 3-month quarter
		Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul 2020 - Dec 2020 Tracking	Oct - Dec 2020 Tracking
Auckland		24	32	27	27	27	40	177	24	31	24	26	27	39	171	96.6%	97.9%
Bay of Plenty		11	14	16	13	19	16	89	11	14	16	12	14	13	80	89.9%	81.3%
Canterbury		54	45	69	61	56	36	321	53	43	67	59	53	34	309	96.3%	95.4%
Capital and Coast		18	29	16	26	24	19	132	17	24	14	23	20	17	115	87.1%	87.0%
Counties Manukau		34	32	33	38	37	32	206	31	31	31	33	33	26	185	89.8%	86.0%
Hawkes Bay		15	14	17	12	13	12	83	15	11	15	10	12	10	73	88.0%	86.5%
Hutt Valley		10	16	15	24	15	10	90	10	16	13	19	14	10	82	91.1%	87.8%
Lakes		6	2	10	6	7	6	37	6	2	10	6	6	6	36	97.3%	94.7%
MidCentral		4	10	8	3	5	10	40	4	10	8	2	4	8	36	90.0%	77.8%
Nelson Marlborough		32	28	21	18	31	26	156	31	25	21	18	26	21	142	91.0%	86.7%
Northland		22	31	30	25	27	26	161	18	23	20	21	19	16	117	72.7%	71.8%
South Canterbury		6	6	5	11	9	2	39	5	6	3	9	7	2	32	82.1%	81.8%
Southern		32	31	31	32	30	32	188	23	25	22	26	24	18	138	73.4%	72.3%
Tairawhiti		7	1	5	9	9	3	34	5	1	4	7	7	3	27	79.4%	81.0%
Taranaki		3	2	22	16	24	21	88	3	2	22	13	22	17	79	89.8%	85.2%
Waikato		22	22	30	22	20	32	148	22	22	30	22	19	27	142	95.9%	91.9%
Wairarapa		4	13	8	10	8	3	46	4	10	8	8	5	3	38	82.6%	76.2%
Waitemata		47	41	49	39	40	46	262	43	36	44	34	37	44	238	90.8%	92.0%
West Coast		4	1	6	7	6	2	26	4	1	4	6	5	1	21	80.8%	80.0%
Whanganui		10	6	6	10	17	5	54	10	6	5	10	14	5	50	92.6%	90.6%
National total		**365**	**376**	**424**	**409**	**424**	**379**	**2377**	**339**	**339**	**381**	**364**	**368**	**320**	**2111**	**88.8%**	86.8%

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31-day indicator (policy priority)

DHB	Expected monthly cancer	Number of records submitted							Number of records within 31 days							Achievement
		Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul	Aug	Sep	Oct	Nov	Dec	Total	Jul 2020 - Dec 2020 Tracking
Auckland	*161*	90	116	102	118	85	127	638	83	99	93	104	77	112	568	89.0%
Bay of Plenty	*115*	91	100	97	95	82	72	537	84	94	87	86	68	66	485	90.3%
Canterbury	*246*	129	132	158	121	123	77	740	121	126	149	114	116	73	699	94.5%
Capital and Coast	*107*	82	111	82	97	82	98	552	76	94	71	79	69	86	475	86.1%
Counties Manukau	*177*	144	140	172	153	152	145	906	130	125	147	128	131	124	785	86.6%
Hawkes Bay	*76*	94	67	64	76	65	51	417	87	63	57	71	58	43	379	90.9%
Hutt Valley	*60*	49	53	63	73	51	39	328	42	50	57	67	47	35	298	90.9%
Lakes	*47*	29	30	34	34	31	19	177	28	29	31	29	29	18	164	92.7%
MidCentral	*81*	72	85	76	66	55	84	438	68	78	66	57	48	75	392	89.5%
Nelson Marlborough	*74*	78	79	58	60	66	77	418	75	74	49	53	60	67	378	90.4%
Northland	*84*	63	78	76	60	70	56	403	56	69	62	42	57	49	335	83.1%
South Canterbury	*34*	24	22	22	22	22	15	127	22	21	20	18	20	14	115	90.6%
Southern	*136*	117	134	126	148	112	111	748	104	111	106	126	98	94	639	85.4%
Tairawhiti	*20*	18	11	13	21	26	13	102	17	11	13	20	23	13	97	95.1%
Taranaki	*57*	16	19	58	62	50	63	268	16	18	54	50	46	54	238	88.8%
Waikato	*161*	128	116	161	137	107	106	755	127	110	154	131	97	100	719	95.2%
Wairarapa	*22*	14	33	25	17	24	21	134	12	33	23	15	23	18	124	92.5%
Waitemata	*222*	161	174	180	148	137	131	931	149	157	160	137	122	115	840	90.2%
West Coast	*17*	19	16	17	14	11	11	88	18	16	15	12	10	10	81	92.0%
Whanganui	*34*	37	24	40	39	46	21	207	32	21	33	37	38	17	178	86.0%
National total	***1929***	**1455**	**1540**	**1624**	**1561**	**1397**	**1337**	**8914**	**1347**	**1399**	**1447**	**1376**	**1237**	**1183**	**7989**	**89.6%**

April 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	21 April 2021
Author	Dr David Montgomery, Paediatrician
Subject	**Six-monthly paediatrics update**

Equity Consideration

The update points to improvements that have overcome some key equity gaps in terms of rurality and disability. Waiting times for assessments and rural clinics have been eliminated and there is now 100% completion of ADHD and behaviour assessments within 2 months.

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled 'Six-monthly paediatrics update'

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

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

d. **Note** the current service projects

1. Purpose

The purpose of this item is to provide the Board with an update on the paediatric service. The report highlights some key service factors – achievements, results, challenges – and reflects on the status of those factors over the last six months.

2. Key service factor highlights

Since the last in-person update to the Board, the service has continued to evolve and develop. These are some of the highlights:

Development of the Maternity, Child and Youth Community Alliance:

This is a Service Level Alliance (SLA) initiative which brings together and connects perspectives from across the system, applying those perspectives to resolving service design challenges so that the service is better able to meet the needs of health consumers, with an emphasis on effectiveness and quality. Two huis have been held so far, and emerging themes which were identified at the conclusion of the last meeting were: Co-location of services and providing services in the community where possible, better integration of services, improvements in parenting support, further development of Iwi-led and Maori-specific services and approaches, promoting a higher proportion of Maori workers in the health workforce, improving health literacy, and improving access to services in general.

Nurse Practitioner role for Gateway Assessments:
Gateway assessments are mandatory Health and Education assessments for children and young people in Oranga Tamariki care. We have provided these assessments at Whanganui hospital for many years. Our Nurse Practitioner takes a leading role in providing these assessments. These assessments and the associated Multi-Disciplinary Team meetings continue to provide a valuable service to our most vulnerable children. There is no waiting list for these assessments.

Paediatric SMO staffing:
We continue to have a fully staffed specialist paediatrician roster. Our complement of permanent SMOs is low at present, and we continue to require additional part-time doctors and locums. Fortunately, we have an established pool of experienced part-time paediatricians and locum paediatricians. There is good news on the recruitment front, and we expect to announce the appointment of a new paediatrician within the next few weeks, with further announcements likely to follow in the coming few months.

Rural Clinics:
Rural clinics restarted following the lockdown. We supply a fully qualified Nurse Practitioner who performs the clinics in Taihape, Bulls, Marton and Waimarino, with specialist Paediatrician support via Microsoft Teams. There is no waiting list for the rural clinics.

Taihape Paediatric Outreach clinic being performed by nurse practitioner Loren Mooney with support on Teams by Dr Montgomery.

Paediatric Registrar:
We have trialled having a paediatric registrar for six months, and this was very successful. The advantages were improved continuity with our ward patients, a reduction in workload for the consultants, and improved teaching and support for junior doctors. The paediatric registrar role was very beneficial for the registrars training objectives. We are pursuing Royal Australasian College Approval to provide accredited advanced training for senior paediatric registrars needing to complete provincial or community placements for the completion of their specialist training. This would make it possible for us to employ a senior paediatric fellow on a 12 month contract, which would provide us with a senior paediatric registrar-equivalent for a year at a time, and would increase our opportunities to recruit New Zealand medical graduates as paediatricians in the future.

Specialist Outreach Services:
Specialist outreach clinics resumed post lock-down for Paediatric Cardiology, Neurology, Renal, Oncology, Renal, Paediatric Surgery and Urology, Endocrine and Diabetes, Developmental, Clinical Genetics, Dermatology, Plastic Surgery and Neurosurgery. We also make use of Zoom for ad hoc clinics for other specialties, such as Paediatric Gastroenterology.

3. Service shortfalls and deficiencies:

All necessary and expected services are being provided, either within the DHB, or through arrangements with other providers. Some areas of concern are:

- **a.** MRI under general anaesthesia – patients need to be sent to other DHBs for this because specialised anaesthetic equipment not available for use in MRI, and because of deficiencies in the ventilation system in the MRI room.
- **b.** Paediatric surgery: we are still working on establishing day lists by the paediatric surgeons from Wellington. For decades, children have been travelling to Wellington for three days/two nights to have day surgery performed. The paediatric surgeons from Wellington are keen to perform the low-risk day surgery cases in Whanganui, and work is being done to make this possible.
- **c.** Child psychology services are in short supply in all DHBs, and currently we have very little access to child psychology for the purposes of cognitive testing, autism assessment, and ADHD assessment. A series of ad hoc contracts with Massey University are being applied to obtaining cognitive assessments, which are necessary for children and young people who require a diagnosis of intellectual disability, without which they are unable to access respite and other services through the Needs Assessment Agency. The waiting list for these assessments is approximately 18-24 months.
- **d.** We are short of occupational therapists and there have been delays in a therapist recruited from overseas being able to start due to various factors such as COVID-19 and immigration formalities.

4. Projects/Initiatives/Opportunities:

ADHD and behaviour assessments:
We are continuing with our nurse-specialist led ADHD assessments and we are finding that we have 100% completion of these assessments within two months of referral. This is a considerable improvement on the pre-implementation rate of non-attendances, non-completion of the full assessment, and the time taken from referral to assessment and treatment. The feedback from families has been excellent. Patients are being navigated through the specialist assessment process and back into primary care, with options following this transition for the primary practitioner to obtain instant telephone or telemedicine support from a specialist for problem-solving, medication reviews, and renewal of special authority forms.

We are continuing to develop improved pre-referral processes in partnership with primary care practices in order to upskill the primary care teams and to improve the efficiency of the assessment process.

Remote clinics via Teams/Zoom:
We are increasingly using telemedicine for clinical consultations, particularly with rural practices. For example, we recently performed a combined clinical assessment with a GP at a clinic in Waiouru and with a specialist paediatrician in Whanganui. The outcome was that there was no delay in making a diagnosis and formulating a treatment plan for an infant. Another example: A consultation held in Whanganui with the local paediatrician, and participation by a specialist paediatric gastroenterologist at Starship. This greatly reduced the time to assessment and treatment for the young person, and saved the costs of the patient and her caregiver travelling to Auckland for a specialist consultation.

Virtual FSAs:
We continue to do many Virtual First Specialist Assessments (FSAs) by written letter, email, telephone, text message and telemedicine. This means outpatient waiting times are short, and primary care practitioners are well supported and are receiving feedback and continuing professional development through the process.

Pathways: We have participated in developing primary and secondary integrated pathways for eczema, asthma and gastroenteritis.

April 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora a Whanganui	**Information paper**
	21 April 2021
Author:	Karmin Erueti, Health Promotion Manager
Subject:	**Smokefree Environments Regulated Products Act 1990 Proposal for Regulation Submission.**

Recommendations:

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

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

c. **Note** the submission was submitted through the Parliamentary process on 15th March 2021

Appendix:

WDHB Smokefree Environments Regulated Products Act 1990 Proposals Regulation Submission:

1. Purpose

The purpose of this paper is to provide the board with a brief update regarding the Smokefree Environments Regulated Products Act 1990 Regulations Proposals Submission.

2. The Background - Submission Proposal

The Smokefree Environments Regulated Products Act 1990 Proposal for Regulation Submission is a supporting document of the Smokefree Environments Regulated Products Amendment Bill that was passed by Parliament on August 11th, 2020. There were 46 proposals which will provide Ministry of Health more detailed feedback and recommendations on the proposed regulations of the Smokefree Environments and Regulated Products (Vaping) Amendment Bill. Consultation

The Ministry of Health was seeking comments on the following:

- Regulatory Proposal 1: Defining internal Areas
- Regulatory Proposal 2: Specialist vape retailer approvals
- Regulatory Proposal 3: Promotion, Information and advice
  - Display of vaping products in retail settings
  - Price lists give to retailers for tobacco only
  - Public Health messages
  - Vaping product information in retail settings

- Regulatory Proposal 4: Packaging
- Regulatory Proposal 5: Packaging Product notification and safety
- Regulatory Proposal 6: Annual reporting and returns
- Regulatory Proposal 7: Annual Fees

3. WDHB Position

As research of the impacts of vaping are still unclear, there is a need to ensure Tamariki/Rangatahi grow up free from any potential risks of addiction or negative health implications that may be associated with vaping. The WDHB has therefore taken a clear yet balanced stance supporting vaping specific products as one of a number of aids provided by stop smoking services working with our whanau who are determining a plan to quit smoking.

April 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	21 April 2021
Author	Steve Carey – Integrated Community Impact Strategist
Endorsed by	Russell Simpson – Kaihautū Hauora Chief Executive
Subject	**Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui (Update)**

Equity Consideration - The broader Impact Collective supports the values of the Whanganui District Health Board of Aroha, Kōtahitanga, Manaakitanga and Tino Rangatiratanga. This work seeks to remove organisational silos and territories which have historically led to inequities in holistic wellbeing.

Recommendations

Management recommend that the board members of Whanganui District Health Board:

a. **Receive** the paper titled Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui (Update)

b. **Note** the key messaging for the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui

c. **Note** the update for the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui

1 Purpose

The paper is provided to the members of the Whanganui District Health Board to provide them with an update of the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui.

2 Summary

The Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui is a collective of Iwi, local council, DHB, Police, Ministry of Social Development Te Puni Kōkiri representatives, formed in the immediate aftermath of the nationwide level 4 lockdown response to the COVID-19 pandemic. Since then, through an integrated social governance model, the impact collective has continued with the renewed purpose to nurture a regenerative economy within a thriving community that creates wellbeing for all people, our whenua and the planet.

Across the Whanganui Rohe (Ruapehu, Rangitikei, Whanganui and South Taranaki) there are a number of organisations and government agencies working towards outcomes and delivering services to our communities. Traditionally in a pre-COVID environment however, these organisations operated in institutional and territorial silos. However, throughout the response and recovery to the Covid-19 pandemic, the organisational and territorial boundaries were removed, and our communities were placed at the centre. The coming together of organisations to address social (health, housing etc), economic and environmental factors ensures that all of the community, all of a whānau, and all of an individual are considered as part of the decision making process – no one element is to be perceived in isolation.

The Impact Collective are seeking to keep this sense of integrated social cohesion and governance and ensure that this becomes the 'new-normal' in response to the impacts of Covid-19 in Aotearoa New Zealand. To enable this, we are creating a 'Impact Collective Operational Team' to work with our communities, to baseline a rohe wide 'Community Wellbeing and Equity Profile'. This baselining will bring together the organisational statistics which are aligned to the 17 United Nations Sustainable Development Goals (thinking Global), Treasury's Living Standards Framework (aligning Nationally) and to a localised Whānau Ora framework (acting regionally/locally), alongside the 'stories and narratives'

which are collated during community wide engagement. By collating the 'Stats and the Stories' for the communities, we are able to present a holistic wellness picture of our communities to the membership of the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui, the New Zealand Government, and most importantly, our communities. Through initial scoping of this mahi, we have identified those that have gone before us in community co-design for wellbeing. We have engaged with the Southern Initiative, the Waikato Wellbeing Project and the Ruapehu Whānau Transformation programme. Each one of these initiatives identified a 'lynchpin organisation' who sponsored the mahi in terms of driving the movement for change. The Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui, whist in this initial phase has been sponsored to date by the Whanganui DHB, this mahi is not about a person, or organisation, it is about enabling our communities to thrive – to better plan and organise – in a partnered, all of government, iwi and community tailored, localised approach to meet the needs of the communities.

Following baselining, in phase two, we will be able to work alongside our communities to co-design local services and supplies, which enable them to live more meaningful and healthy lives in our thriving communities – this maybe supporting a strength based approach to design, or supporting addressing community concerns/issues.

3 Purpose and Service – Key Messaging

It has been important to formalise the key messaging for the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui – this work programme is for the betterment of the whanau, hapū, iwi and communities within our rohe. The Impact Collective Governance Leadership Team have agreed that organisational and territorial boundaries are required to be removed in order to work for the communities we serve – in essence, creating a series of porous boundaries which enables communities to participate should they align to the purpose of the Impact Collective, tūrangawaewae to the rohe, or are tangata whenua.

3.1 Where did the Impact Collective come from?

The Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui is a collective of Iwi, local council, DHB, Police, Ministry of Social Development and private and social enterprise representatives, formed in the immediate aftermath of the nationwide level 4 lockdown response to the COVID-19 pandemic. The formation was a continuation of the work being conducted in the Integrated Response Team and then the Integrated Recovery Team. The Integrated Recovery Team's final report was released in January 2021, with some of its membership now focused on resurgence and vaccination rollout planning. Whilst the membership has changed since its initial conception, the purpose has remained the same.

3.2 What is the purpose of the Impact Collective?

The purpose of the impact collective is to nurture a regenerative economy within a thriving community that creates wellbeing for all people, our whenua and the planet. This will be achieved by breaking down organisational and territorial boundaries and focusing on our communities holistically – through economic, social and environmental determinants. It is not about viewing our communities solely in terms of health, or wealth, or access, or vulnerability, but rather in terms of the whole person – a whānau ora approach. This will ensure that our resources, our services and our collective wellbeing is equitably shared across our rohe, founded in the principles of Mātauranga Māori.

3.3 Who does the Impact Collective serve?

The Impact Collective serves all people within the porous boundaries of wider rohe of Whanganui, Rangitikei, Ruapehu and South Taranaki. This enables communities to participate should they align to the purpose of the Impact Collective, tūrangawaewae to the rohe, or are tangata whenua. It serves to address inequities in service provisions, resources, capability and capacity, through a collaborative approach operationalised through a community codesign methodology[1].

[1] Beyond Sticky Notes – Kelly Ann McKercher (2020).

3.4 Initially Private and Social Enterprise were part of the Collective, where are their representatives?

Post the nationwide level 4 lockdown, a hui was called between the Integrated Social Governance Members, iwi and private and social enterprise (the build back better network). Throughout the course of the hui, the build back better network were supportive of the Impact Collectives mahi, but indicated that they were in the best position to support this once the initial baselining had occurred, and they were able to contribute in terms of expertise and resource once the community strengths and concerns were identified. They remain informed of the happenings within the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui but are not currently represented as members on the Impact Collective Governance Leadership Team during phase 1 of this mahi. This may change at the discretion of the Impact Collective Governance Leadership Team.

3.5 How will this help your community?

The initial baselining work will enable the Impact Collective Operational Team to present a holistic wellness picture of our communities to the membership of the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui, the New Zealand Government, and most importantly, our communities. Traditionally, we have worked on anecdotal evidence or statistics to drive change delivery. In order to all work from the same starting point, the baseline is imperative. We need to try something different. It is time to go "with our community" to find the next generation of solutions and stop "doing it to our community". Our wider region has the depth of collaborative relationships and connection needed for this to succeed. The team's focus will be research, community engagement and identification of pivotal regenerative projects/initiatives. This will create opportunities for phase two which has similar links to the Southern Initiative, the Waikato Wellbeing Project and the Ruapehu Whānau Transformation Plan.

3.6 How is this initiative a response to the ongoing impact of Covid-19?

The harms arising from social and economic inequities, and environmental harm considerations are increasingly recognised as interconnected crises – these have been amplified through the Covid-19 Pandemic. The COVID-19 outbreak affects all segments of the population and is particularly detrimental to members of those social groups in the most vulnerable situations, continues to affect populations, including iwi and our communities, people living in poverty situations, older persons, persons with disabilities and youth. Local and global momentum is building for systemic change. Covid-19 has accelerated both desire for and funding to progress change towards wellbeing for our people, our whenua and the planet. Our rohe Covid-19 response has proven we can collaborate and work together. Communities want to drive their own solutions, public organisations and private businesses want to play their part; co-designed innovation offers the answers.

4 Iwi at all levels

It is important for the Impact Collective to have the support, representation and leadership from Iwi at all levels of the team. At the Governance Level, we have the Chair from Te Ranga Tupua represented, to enable them to be able to disseminate information or support engagement directly with the Iwi Chairs and Chief Executives. An operational Co-Lead role (the Integrated Iwi Impact Strategist) is currently being sort to be one of the two co-leaders for the Impact Collective Operational Team – the purpose of this role is to manaaki and increase whānau, hapū and iwi engagement in the mahi, while developing long term partnerships and relationships. By doing so will ensure the voice of whānau, hapū and iwi is represented in the Community Equity and Wellness Profiles which will led to any concerns or strengths identified to be supported in phase 2 of this mahi.

5 Update

The first hui of 2021 of the Impact Collective Governance Leadership Team was held on the 29th of April 2021. In this hui, financial contributions from the Whanganui District Health Board and the Ministry of Social Development (MSD) were confirmed, with the representatives from the remaining members seeking leave to work through the commitment that they are able to contribute. All members who attended the hui recommitted to the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui. In this meeting, it was identified that a representative from Te Puni Kōkiri should also be

added as a member of the Impact Collective Governance Leadership Team – initial contact has been made to enable this.

Immediately following the hui with the Impact Collective Governance Leadership Team, the Chief Executive of the Whanganui District Health Board and the Integrated Community Impact Strategist presented the mahi to the Regional Public Sector Leads. This presentation was well received, and on-going conversations are being held to enable this mahi to have regionally supported funding through the RPSL priorities programmes, and national funding through the Place Based Initiative funding.

Since the meetings, a MoU has been signed between Whanganui District Health Board and MSD, with the initial funding coming through from MSD to enable the creation of the Charitable Trust, the website, the initial data and analytics draw, and the formation and initial employment of the Integrated Iwi Impact Strategist, the Visual Storyteller and part time administration support (for the team and the Governance Leadership Secretariat).

A local legal firm has been engaged to support the creation of the Charitable Trust and this will be completed by the end of April 2021. Following the Trust's formulation, this will then be incorporated, and the Impact Collective Governance Leadership Team will become the Trust Board.

5.1 2021 Action Plan

The following table outlines the action plan for the Impact Collective - Rangitīkei, Ruapehu, South Taranaki and Whanganui over the next 10 months. In all reports hereafter, this action plan will be presented with an appropriate Red, Amber Green (RAG) status indicating progress to date.

Objectives	Who	When
Formalise the commitment to the Impact Collective through the creation of the Charitable Foundation	Governance Team and Legal Support	April 2021
Creation of an Impact Collective Logo that can be used in communications – this will separate the organisations from the Impact Collective	External creation – Governance Team endorsement	April 2021
Creation of the Impact Collective Operational team once funding is released	Impact Collective Operational Team - Governance Team endorsement	April - June 2021
Creation of a 'one pager' of talking points with key themes from the Impact Collective's purpose: • Used as basis of web page • Used for consistent communication about the Impact Collective	Impact Collective Operational Team - Governance Team endorsement	May 2021
Creation of the Impact Collectives website	Impact Collective Operational Team	May 2021
Creation of the Impact Collectives community/iwi engagement plan	Impact Collective Operational Team - Governance Team endorsement	May 2021
Development of the Whānau Ora Framework	Impact Collective Operational Team	May 2021 - ongoing
17SDG Workshop	Led by 'Bead and Proceed' – Impact Collective	April/May 2021

Data collation for the 17 SDGs, Treasury's Living Standards Framework and Whānau Ora	External Company – Dot Loves Data	20 weeks – Start May 2021
Community/Iwi engagement	Impact Collective Operational Team	Start May/June - Ongoing
Increased community engagement through multimedia	Impact Collective Operational Team	Start May/June - Ongoing
Treasury Presentation	Led by Treasury – Impact Collective	June 2021
Whānau Ora Presentation	Led by Whanau Ora local experts – Impact Collective	July 2021
First Draft of Community Equity and Wellbeing Report	Impact Collective Operational Team	November 2021
Final Report of Community Equity and Wellbeing	Impact Collective Operational Team - Governance Team endorsement	December 2021
Phase 2 Engagement Plan developed	Impact Collective Operational Team - Governance Team endorsement	February 2022

April 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	21 April 2021
Author	Rihi Karena, Kaitakitaki Clinical and Haumoana services
Endorsed by	**Rowena Kui, Kaiuringi GM Māori & Equity**
Subject	**Haumoana Service - Te Hau Ranga Ora Māori Health**
Equity Consideration – improving health outcomes for patients and whanau reducing inequities in health experience , patient journey and outcomes or Māori	
Recommendations Management recommend that the Whanganui District Health Board: a. **Receive** the paper titled 'Haumoana service - Te Hau Ranga Ora Māori Health' b. **Note** the work of the Haumoana Health service c. **Note** the Te Waka guiding principles and model	
Appendices **Appendix 1.** Te Waka Guiding Principles and Model **Appendix 2.** Haumoana Service Allocation	

1 Purpose

To provide the Board with an overview of the Haumoana service, role and operational functions.

2 Overview of Te Hau Ranga Ora – Māori Health service

The Haumoana service is part of the overall service of Te Hau Ranga Ora. Te Hau Ranga Ora refers to the four winds that work together representing all health services within our rohe/region working collectively to improve health outcomes for our community. This name was given by John Maihi, WDHB Kaumatua. Te Hau Ranga Ora has been on a journey over the past seven years and has led and influenced big changes in culture and service delivery within the WDHB service and operational teams with a clear focus on improving the health and wellbeing of Māori whānau and equity.

As a service model, the team use the analogy of the waka, which refers to everyone being in the waka working together and reflects the waka values in the hoe. (See **Appendix 1.)** There are different positions or support mechanism's such as the Haumoana that are used to identify the roles within Te Hau Ranga Ora. These are the Kaiuringi, Kaitakitaki and Haumoana.

The leader of Te Hau Ranga Ora is the Kaiuringi GM Māori & Equity who works at a strategic level and is part of the Executive Leadership Team. There are six Kaitakitaki leads responsible for different work streams to support the organisations commitment to whānau ora, equity and values based principles at an operational management level.

2.1 Kaitakitaki

The Kaitakitaki are allocated to work alongside the organisation's hubs as enablers to support and advise each hub around their mahi. A small snapshot of their work may include:

- working in the Corporate hub with People and Culture on the revised WDHB Recruitment Policy, administrating the Māori Workforce Development Fund for WDHB region;
- in the Maternal Child and Youth services to interview new staff;
- with the Hospital Services hub leading Te Uru Pounamu, Māori nursing workforce development programme;
- in the Planning Commissioning and Population Health hub on education and support to build capability in the use of the Health Equity Assessment Tool in the team and across the organisation;
- cultural leadership and support across the organisation.

2.2 Haumoana service

Haumoana refers to the wind's that come off the sea to wrap around and support the waka and is a unique name given to this position in our DHB. In the hospital services, there are five Haumoana who work operationally on the ground to support patients/tangata whaiora, whānau/families and staff. The common term for this role that is more familiar is whānau ora navigator or family support worker.

The Haumoana are whānau ora practitioners and their expertise is working from a whānau/family centred approach. Their role is to work in a pro-active manner by working alongside the multidisciplinary care team involved in whānau/family hui, supporting doctor's round's, working alongside patients, whānau/family to help them understand their care plan and connecting them to community based health and social services and kaupapa Māori health provider services as needed on discharge.

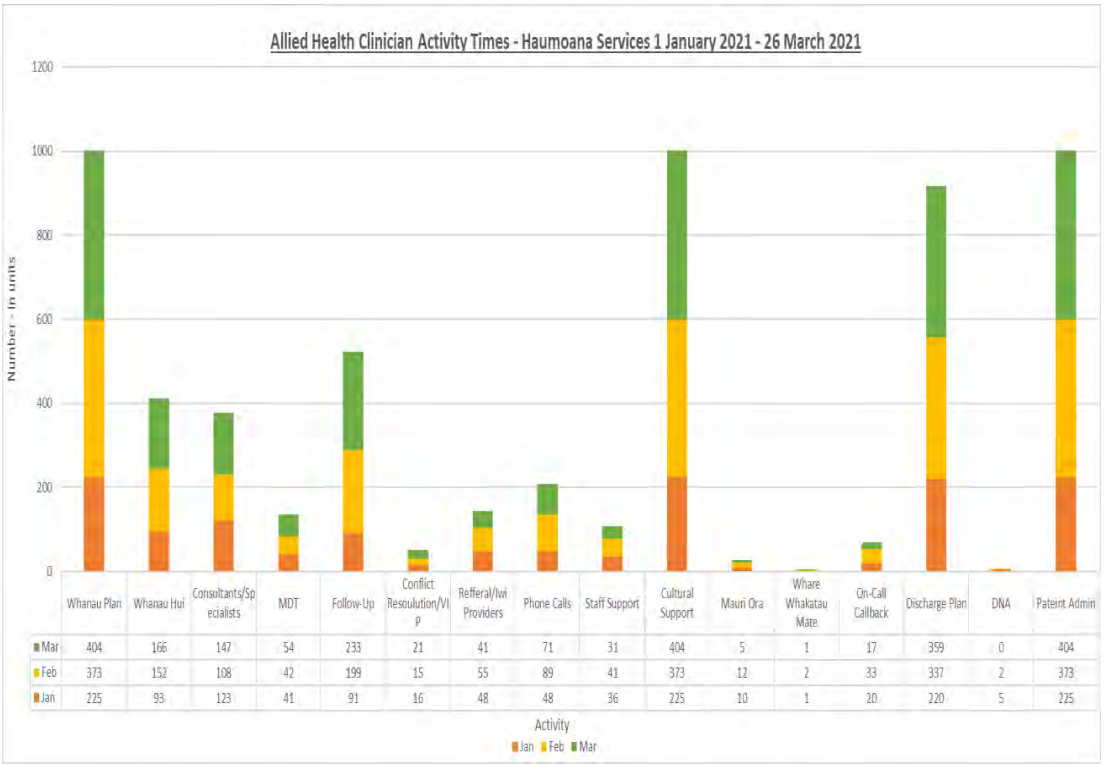
The Haumoana service is managed by the Kaitakitaki Clinical and Haumoana services, who is the clinician and is supported by the Kaitakitaki educator/cultural advisor to lead, advise and support the team. The Haumoana are an essential enabler to high quality care and whānau ora. As part of Te Hau Ranga Ora Haumoana are allocated to WDHB services within the hospital from Monday-Friday and have different portfolio's that they are responsible for within their roles as well as overall performance objectives and responsibilities as described in **Appendix 2.**

2.3 Haumoana administrator

An important member of the team is the Haumoana administrator who is employed at 20 hours a week. Supporting the team, the Hāpai te Hoe education programme and monitoring of stocks at the whare. The administrator is also responsible for organising and informing the WDHB Kaumatua of any WDHB events that they need to attend, such as the organisation orientation. The Haumoana administrator carries out the day-to-day tasks to support the Kaitakitaki Clinical and Haumoana services regarding administrative functions.

2.4 Haumoana records and data activity

The Haumoana record their patient, whānau activity into the patient's written notes and/or WebPas depending on ward/area. They then record the number of activities (or interventions) by units per activity in Trendcare. As a clinical tool, Trendcare is not fit for purpose and is indicative. It has been adapted as a reporting tool to collect and reflect the type of activity that the Haumoana engage in daily and after hours (on-call), that best reflects daily activities within a DHB setting. These functions are identified under the following activities from the 1 January-26 March 2021.



2.5 Support afterhours

After hours and in the weekends the Haumoana service operates an on-call service to support patients/tangata whaiora, whānau/families and staff out of hours 24/7. The Haumoana triage the phone calls and will actively come in to support after hours based on need and on a case-by-case basis. They are part of an on-call roster that is supported by the Kaitakitaki Clinical and Haumoana service and the Kaitakitaki educator cultural advisor.

2.6 Management of Whare

The Haumoana service is also responsible for the management of Mauri Ora Emergency/Temporary accommodation and the Whare Whakataumate that supports whānau/family at a time of the sudden death of a loved one in the community. Mauri Ora Emergency/Temporary accommodation is for whānau who are from out of town or city limits who have nowhere to stay and/or cannot afford accommodation. Both whare are available 24/7 via the Haumoana on-call service through the hospital operator.

COVID Alert levels have determined if these whare are open for use or not. Under Level one both whare are open with business as usual. Under level two, it has been dependant on the case with one whānau within the same bubble approved to stay in Mauri Ora. At Alert level three & four both Mauri Ora and the Wharewhakataumate are closed as social distancing, and other COVID guidelines cannot be monitored 24/7. During this time, all requests for Emergency accommodation are referred to the Duty Nurse Manager. The on-call Haumoana continues to work alongside whānau and our staff to understand the reasons why the whare are unavailable and what the options are. Alert levels for the time that affected occupancy were:

- 4 -17 February 2021 – Alert Level 2
- 28 February – 6 March 2021 – Alert Level 2

Below are the number of whānau who have occupied Mauri Ora and the Whare Whakataumate during the period of 1 January - 26 March 2021.

Mauri Ora January 2021 – March 2021

	Number of Whanau	Ethnicity		
		Māori	Pasifika	Other
Jan 21 (31 days)	10	6	2	2
Feb 21 (28 days)	12	7	0	5
Mar 21 (31 days)	5	5	0	0
Total	**27**	**18**	**2**	**7**

Whare Whakatau Mate January 2021 – March 2021

	Number of Whanau	Ethnicity		
		Maori	Pasifika	Other
Jan 21 (31 days)	1	1	0	0
Feb 21 (28 days)	2	2	0	0
Mar 21 (31 days)	1	0	0	1
Total	**4**	**3**	**0**	**1**

2.7 Tracer Audit

As part of the overall organisation preparation for Auditing, the WDHB carries out regular Tracer audits of wards/services throughout the year. All Haumoana including the Kaitakitaki Clinical and Haumoana services and Kaitakitaki educator cultural advisor, are trained in Tracer audit. The Haumoana are rostered throughout the year as part of this process. A key area of focus is around whānau experience as well as other factors that are included in the tracer. The Haumoana enjoy being part of the wider team and contributing to a quality imporvement process

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APPENDIX 1

"Kaua e rangiruatia te hāpai o te hoe, e kore to tātou waka e u ki uta"

Do not lift the paddle out of unison or our canoe will never reach the shore.

The whakataukī or proverb above refers to everyone being in the same waka or canoe working together to get positive outcomes for patients, families/whānau and our community.

We recognise and respect the principles of Te Tiriti O Waitangi/Treaty of Waitangi and ensure Māori have the opportunity to contribute to decision-making and participate in the delivery of health and disability services.

Te Waka - guiding principles and values

Te Waka describes the principles and values, which guide the health care team in their decision-making and service delivery. Their aim is to improve the health outcomes of Māori populations and reduce health disparities for all families/whānau.

Kotahitanga	Unity, cohesion, sharing vision, working together, trust, relationships, collaboration, and integration.
Whanaungatanga	Spiritual wellness, relationships, beliefs, karakia, knowing who you are, what you do, identity, family, whānau, whānau whakapapa, whānau kaupapa, social equity.
Wairuatanga	Spiritual wellness, relationships, beliefs, karakia, whakamoemiti, ruruku, tōhunga rongoā, awa, wātea/blessings, blessings.
Aroha	Love, respect, empathy, protections, foundation, relationships, non-judgmental, unconditional, passion, determinants of health.
Tinorangatiratanga	Self-determining, empowering, respectful, proactive, solution focused, choice, adaptability.
Kaitiakitanga	Protection, taking care of people, things, conflict resolution, environmental, awa, maintain values, vision, understanding, and absolute protection, keeping yourself and each other safe.
Rangimārie	Humility, maintaining ones composure, peace, accountability, responsibility, humble, respect.
Mauri	Life essence, animate and inanimate objects have a mauri, tika, pono, balance and universe.
Tikanga	Māori Rights, honest, guiding principles, protocols, guidelines, how we do it, actions tapu, noa, tika, pono, accountability, as individuals being able to be flexible.
Whakapapa	Whanau centre, Improving Māori health outcomes, reducing inequalities for Māori, Māori cultural foundation, service approach with a wider relevance and value for all people.
Mana tangata	Dignity, relationships, protection, safety, patient and whānau involvement, respect, acceptance.
Manaakitanga	Respect, support, helping, caring, non-judgemental, do absolute best to suppo

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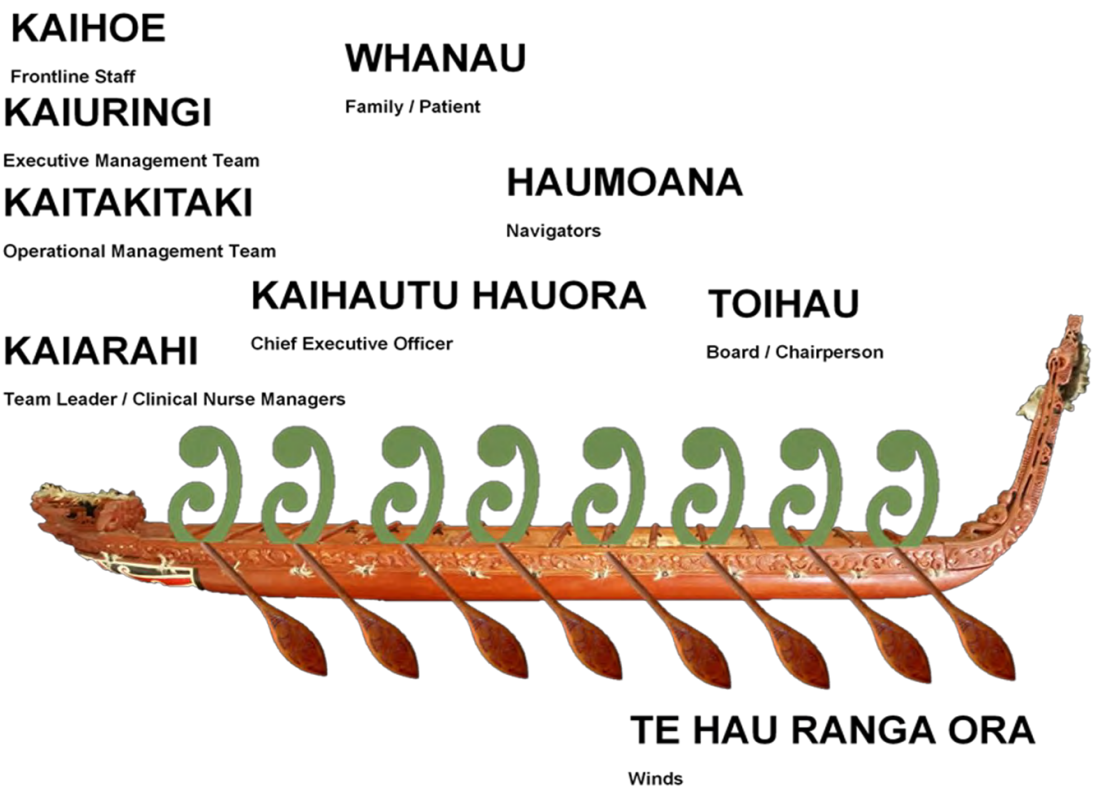
TE WAKA MODEL



APPENDIX 2

Haumoana service allocation

Haumoana	Allocated service/area	Portfolio
Brenda Nelson	Medical ward ATR ward Co-share CCU On-call roster	Smoke free Champion Falls Prevention Group ACC Live Longer AT&R - Cultural responsive goal setting rehabilitation Integrated Discharge Navigation Working Group
Aria Reweti	Maternity SCBU Paediatrics CCU lead On-call roster	Hāpu Mama Wānanga Te Rerenga Tahi VIP Champion Care & protection
Kiri Thompson	Surgical ward Day unit/Theatre services Outpatient department Dental unit On-call roster	DNA project Audiology Dental New-born hearing Ophthalmology Orthopaedics
Pip Thompson	**WDHB Community services:** District Nurses, Oncology, Allied Health, Public Health, Renal services On-call roster	Stroke Circuit Class AT&R Faster Cancer Treatment Team DNA – Patients who have not attended their Outpatient appointments
Reneti Tapa	**WDHB Mental Health services:** Te Awhina Community Mental Health service ED lead On-call roster	Hapai Te Hoe Trendcare Webpass/ Clinical Portal Connecting care program. Restraint hui Transitional Nurse hui Zero seclusion hui Te Awhina IPC hui MYCAMSHASS ward

Please note that Stanford House have a different model and employ a cultural advisor to accommodate the needs of the tangata whaiora and the service model there

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HAUMOANA ROLE RESPONSIBILITY & KPI'S

*"**Kaua e rangiruatia te Hapai o te hoe, e kore to tatou waka e u ki uta**"*
Do not lift the paddle out of unison or our canoe will never reach the shore

Role responsibility	This role is primarily accountable for: Assisting and supporting whānau/patients and their families Engaging, guiding and supporting staff as a member of the service teams Role modeling the WDHB and Te Waka values. Role modeling the kaupapa of Whānau Ora and the world of Te Ao Māori. Engage and work with community providers Participating in quality improvement activities, health promotion and community awareness raising activities Works confidentially across Te Ao Māori and Te Ao Pākehā within the WDHB services. A set of performance objectives will be agreed annually between your manager and you reflecting applicable strategic and operational ambitions.

Key Performance Indicators

Key Accountabilities (Key areas of your focus)	Tasks (How you achieve)	Performance Indicators (How you will be measured)
To support staff to provide family, whānau centered care and work in a way that respects Māori values and beliefs by upholding the WDHB values.	Establish strong relationships across all services Work as part of the service team Contribute to or lead project/ service portfolios that provide: cultural advice mentorship and supervision to staff advice and participation in the development of service area policies and procedures, project reports and the facility environment participation in complaints resolution (as agreed with Kaitakitaki Clinical)	Patient/whānau and staff feedback Service utilisation statistics Audit of service policies and guidelines Annual performance review Health literacy methodology – check back that messages are understood by whānau
Family/whānau centered care	Work in partnership with whānau, patients and their family through: daily visits active listening to the stories of patients, whānau and treating the information with respect whānau are supported to take the lead role in making change, and improved progress for themselves	▪ Patient/whānau and staff feedback ▪ Attendance and active participation in multidisciplinary team ▪ Audit of clinical notes and electronic files

	whānau actively encouraged and supported to meet with clinicians, multidisciplinary team to understand and participate in the care of their whānau regularly meets/communicates with clinical staff/MDT team to reflect on progress. Attend, participate and contribute to multidisciplinary team meetings Evaluate patient progress and update patient notes, including multidisciplinary meetings and whānau hui Referrals to internal/external agencies/providers Provide patient/whānau information and advice	▪ Trendcare data
Support proactive discharge planning	Actively work with clinical teams and patient and whānau to achieve effective discharge plans and referral Patients and whānau are linked to services, agencies as determined by their needs e.g. referrals to other services (internal and external), to ensure that timely services and support are available on discharge	▪ Patient records ▪ Audit of clinical notes and electronic files ▪ Trendcare data
Team member	Work as part of the Te Hau Ranga Ora team to support increased cultural awareness and confidence across the whole organisation Active participation in orientation (monthly) and any other pōwhiri or mihi whakatau Support Kaumātua and Kuia in cultural activities, blessings, pōwhiri and mihi whakatau Work with the Kaitakitaki Clinical and Kaitakitaki educator/cultural support to: support and promote the 'Te Waka' service model audit and review Māori health policies and guidelines	▪ Performance review ▪ Attendance at pōwhiri and cultural activities ▪ Feedback from staff and service leaders ▪ Staff roster on Trendcare

	Support and/or participate in the delivery of 'Hāpai te Hoe' workforce development training Coordinate the Mauri Ora and Whare Whakatau Mate services Participate in 24 hour seven day week service roster	
Development of a plan to assist whānau in their journey towards self-determining and achieving health and well being	Using tools such as Whānau ora, Te Whare Tapa Wha to facilitate a whānau plan in partnership with patients and whānau building on whānau/individual strengths Provide health information and facilitate health education appropriate to the request/needs of the patient and their whānau (in conjunction with clinical team) Refer patient and whānau for follow up to relevant support as determined by request/needs of patient/whānau Facilitate whānau/multidisciplinary hui	▪ Patient/whānau feedback ▪ Trendcare ▪ Patient notes and plan ▪ Audit of clinical notes and electronic files
Contributes to quality improvement initiatives	Participate in continuous quality improvement initiatives as part of the Te Hau Ranga Ora service	▪ Audits and surveys
Professionalism	Accepts responsibility for ensuring that his, her practice and conduct meet the organisational standards policies and procedures, values 'Te Waka' values and service model and relevant legislation Practices under tikanga best practice maintaining the mana of the organisation, service and individual Role model WDHB Speaking Up for Safety and Professional Accountability Communication style demonstrates empathy and respect of others views when working with patient/whānau and staff	▪ Annual performance review ▪ Audits and surveys ▪ Patient/whānau, staff feedback

NB: Adapted from Haumoana Job description

April 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information paper** **21 April 2021**
Author	Glenys Fitzpatrick, Health and Safety Advisor, Patient Safety, Quality and Innovation
Endorsed by	Louise Allsopp, General Manager, Patient Safety, Quality and Innovation
Subject	**Health and safety update**

Recommendations

Management recommend that the board:

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

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

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

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

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

1 Purpose

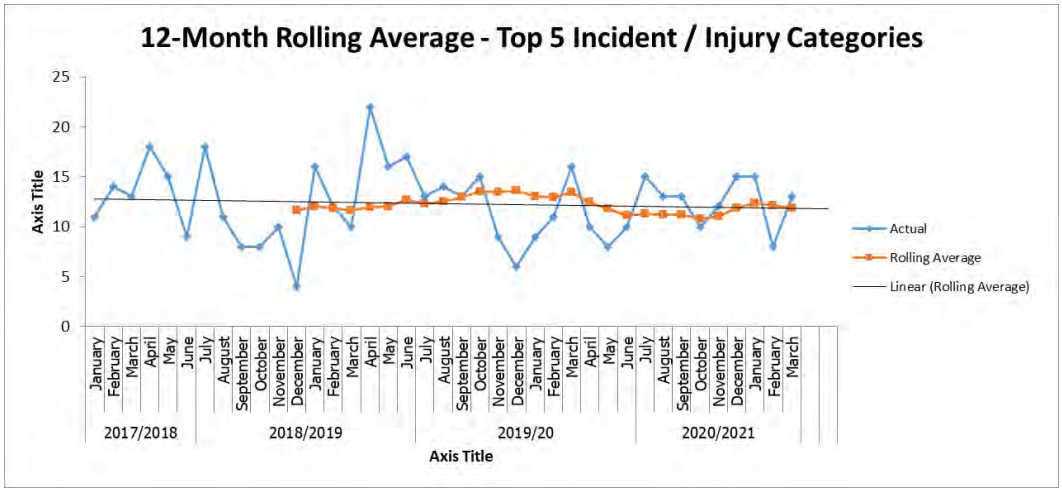
To enable the board to exercise due diligence on health and safety matters. This report on key health and safety system risks covers:

- incident/injury trends.
- incident/injury details.
- employee participation.
- contractor management.

2 Incident/injury trends

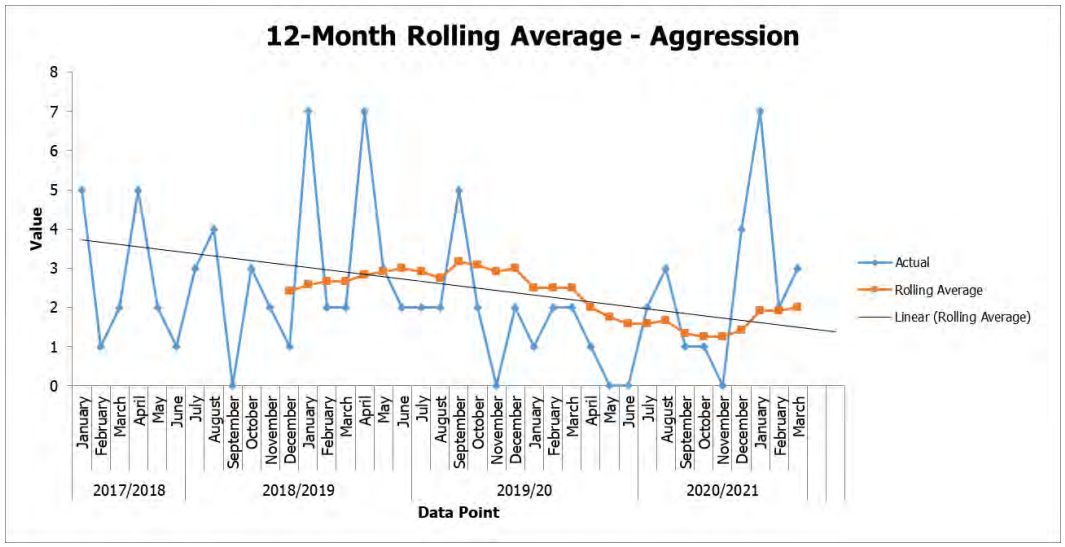
The graph below provides a rolling average, actual summary and trend line of the last three years' top five injury/incident trends.

The trend line (based on the rolling average) indicates a slight decline in the overall number of incidents/injuries (top five) over the three year period.



The following graphs provide a rolling average, actual three year breakdown of monthly incidents and trend line for each of the top five incident/injury categories.

Aggression



The trend line (based on the rolling average) shows a decline in the number of incidents/injuries over the three year period.

From November 2020 and March 2021 there were eleven physical, four verbal and one sexual aggression injuries/incidents recorded on RiskMan and C-gov – Physical Te Awhina (6) Medical (2), Emergency (1) Surgical (1), CMH (1). Verbal – Emergency (2), CMH (1), Public Health (1) and Emergency had one sexual assault.

Issues identified

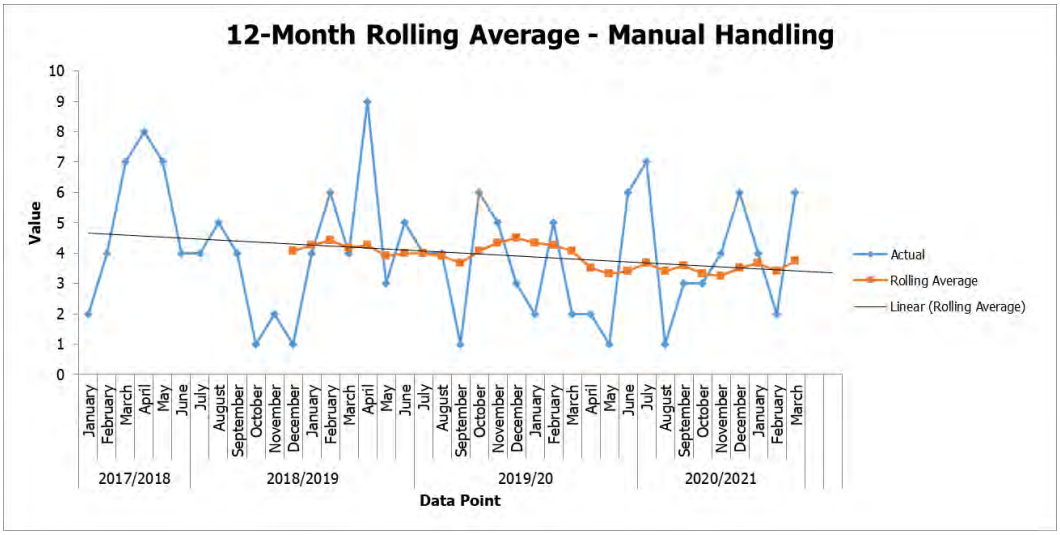
1. Nursing plan to encourage adherence to a prescribed LAI in the tangata whaiora's own time was overruled
2. Threats to kill a SMO and family thwarted during a weekly hui.

3. MHAHT staff and Tangata whaiora's whanau assaulted whilst awaiting assessment. Safely managed to a secure area and supported.
4. Tangata whai ora took exception to his room being searched in his absence and lost his ability to self-regulate.
5. Patients in Close Supportive Observation (CSO) rooms can be unpredictable
6. Patients sometimes arrive in Emergency who are aggressive. Staff have high tolerance to the behaviour and under report the number of incidents

Improved risk mitigations include:

1. Used as learning experience to adhere to stated plans
2. Choose rooms with multiple exits, preparation of Tangata whai ora prior and traversing management of patients with this diagnosis via the regional team, education for staff and specific plan for the future
3. MHAT approach and management of risk and aggression and review by CMH service prior to being assaulted
4. Contraband policy reviewed. Need to avoid confrontational or aversive approaches discussed
5. CSO procedure reviewed. Education to staff to ensure own safety boundaries.
6. Re-establishment of the Workplace Aggression Steering and a wider group from areas throughout the DHB. The group will monitor the incidents of aggression.

Manual handling



The trend line (based on the rolling average) shows a decrease in the number of incidents/injuries over the three year period.

From November 2020 to March 2021, there were seventeen patient staff incidents; Medical (6), CCU (3), ATR (2), Emergency (2), ASU, Maternity, Surgical and Radiology, two relating to objects in Emergency and District Nursing and 3 OOS injuries in CMH, Emergency and Health Records.

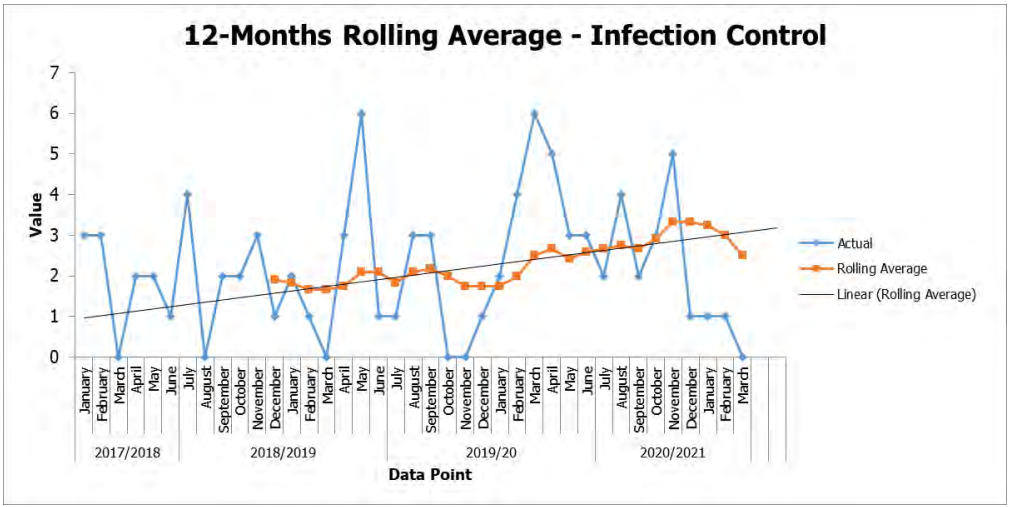
Issues identified:

- Staff not familiar with a specific manual handling techniques
- Suitable bed not available

Improved risk mitigations include:

- Specific manual handling training by manual handling training co-ordinator and the ward champions
- Remind staff to be aware of their surroundings and the position they put themselves in to keep safe
- Ward champions to provide refresher training
- High low bed now in place

Infection prevention



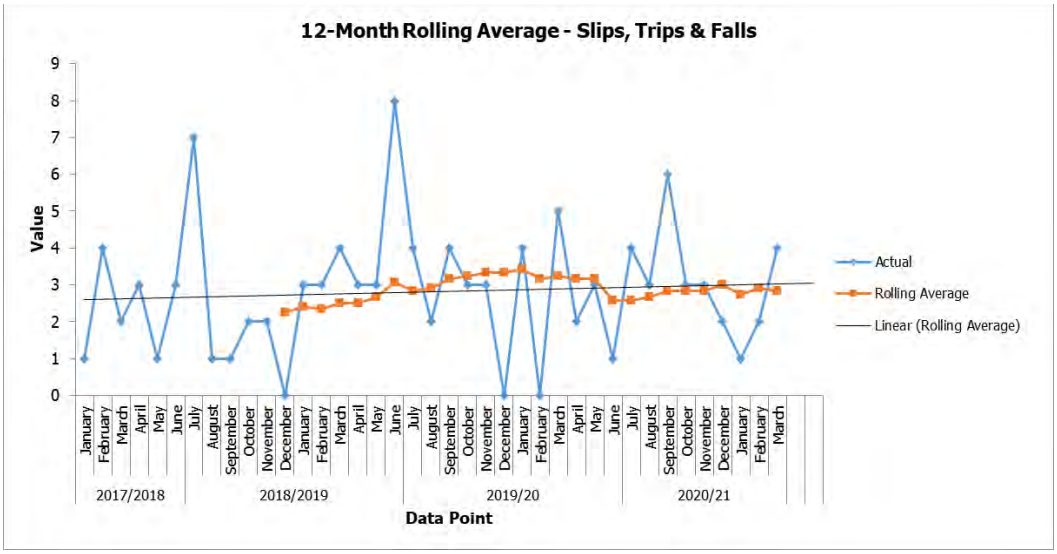
The trend line (based on the rolling average) shows an increase in the number of infection control incidents/injuries over the three year period.

From November 2020 to March 2021 there were eight infection prevention incidents (4 needle-stick, 2 blood body fluid splash, cut from a scalpel and cut from a craft knife).

Each incident is reviewed and staff are followed up over the six months post needle stick event. To date no staff member has contracted a blood borne virus from any injury. Nor has a link between event been identified.

Reporting of any incidence is also routine, and this increase in incidence may be as a result of better reporting

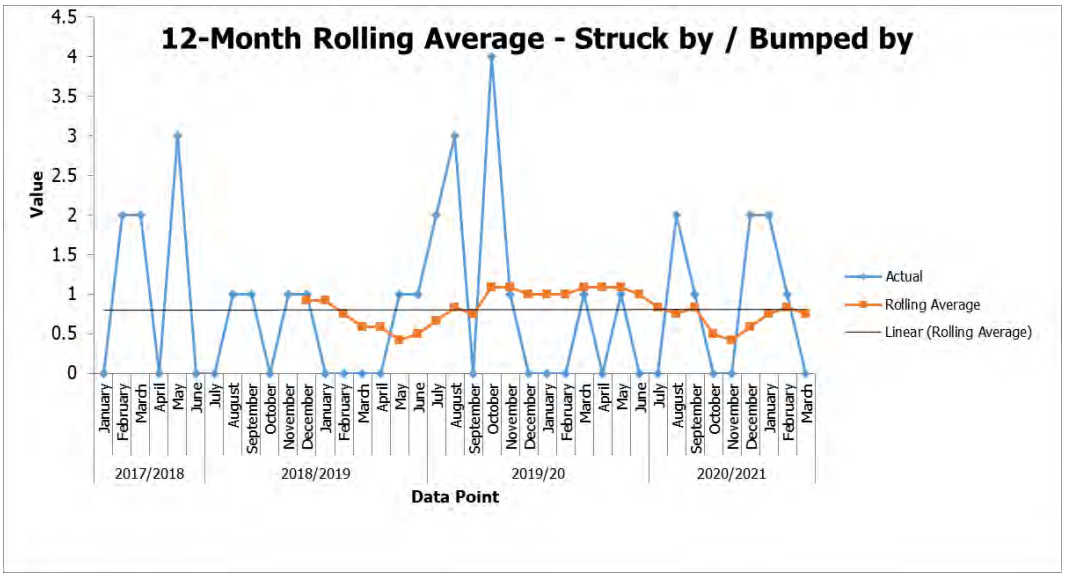
Slips, trips and falls



The trend line (based on the rolling average) shows an increase in the number of slips, trips and falls incidents/injuries over the three year period.

From November 2020 to March 2021 twelve slips, trips and falls incidents/injuries were reported. Injuries/incidents included: over chairs (3), on wet floor (2), stairs (2) uneven ground, on concrete grate, carrying a sign, out of the lift, and moving a filing cabinet.

Struck by or bumped by



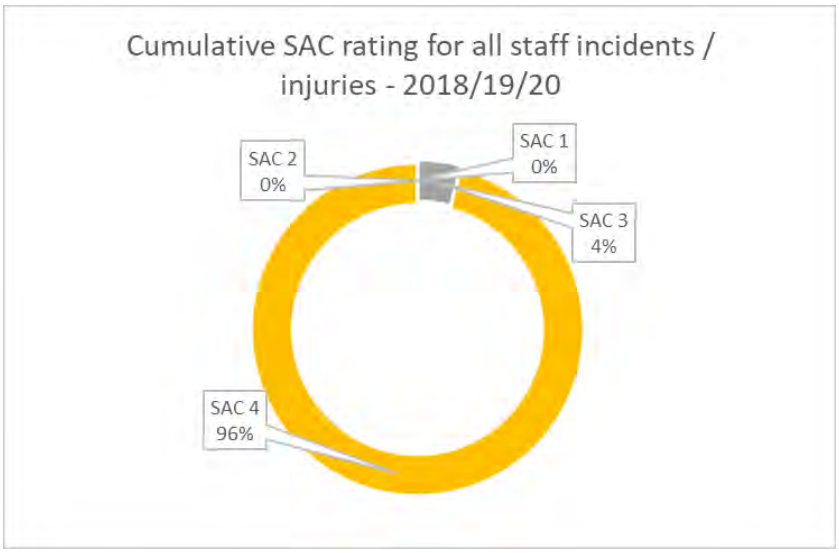
The trend line (based on the rolling average) shows a slight decline in the number of struck by or bumped by incidents/injuries over the three year period.

From November 2020 to March 2021 five stuck bumped by incident/injuries was reported.

3 Incident/injury details

There were 63 staff incidents (injuries/potential injuries) recorded by staff on RiskMan and Cgov from November 2020 to March 2021.

The graph below provides a cumulative SAC rating (Likelihood x Consequence) for all staff incidents/injuries for 2018/19/20/21.



Definitions used in the graph:

SAC 4 Minor/minimal – no injury
SAC 3 Moderate – permanent moderate or temporary loss of function
SAC 2 Major – permanent major or temporary severe loss of function
SAC 1 Severe – death or permanent severe loss of function.

SAC 1 incidents/injuries (and potentially SAC 2 incidents/injuries) require WorkSafe notification. No notifiable events were reported to WorkSafe New Zealand in the 2017/18 or 2018/19 financial years. For all SAC 1 and 2 incidents/injuries, a Critical Systems Analysis (CSA) is undertaken. All injuries reported to Wellnz (tertiary ACC provider) are investigated.

4 Employee participation

The WDHB Health and Safety Committee met in November, December, February and March.

The following issues were discussed at the WDHB Health and Safety Committee meeting.

- WorkWell wellness programme
- Review of monthly incident trends
- Rolling average trends and graphs for board report
- Monitor and update of health and safety objectives for 2019/2020
- Manual handling – discussion ward champions being given time to train and bariatric training day
- Manual handling – bed and equipment trials
- COVID-19 response plans and exercises

- WorkSafe court cases
- Excellence and innovation in health and safety
- Pandemic exercises
- Safe365 audit
- Re-activating the violence in the workplace workgroup
- WDHB Health and Safety Committee TOR

5 Contractor management update

Ventia is the new contractor replacing Spotless and have representatives on the WDHB health and safety committee. Ventia is in the process of creating a health and safety report for the committee.

April 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	21 April 2021
Author	Rachel Taylor, MQSP Coordinator
Endorsed by	**Ian Murphy, Chief Medical Officer**
Subject	**Maternity Service Annual Report**
Equity Consideration – improving health outcomes for patients and whanau reducing inequities in health experience , patient journey and outcomes or Māori	
Recommendations Management recommend that the Whanganui District Health Board **receive** the paper titled Maternity Service Annual Report	
Appendix 1. Maternity Service Annual Report	

1 Purpose

To provide the Board with a copy of the maternity services annual report for their information.

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Poipoia tō pēpē whānau ma

FAMILIES CHERISHING, EMBRACING & NURTURING OUR BABIES

Ko au ko tōku whānau, ko tōku whānau ko au

Nothing about me without me and my whānau/family

Acknowledgment goes to the mothers and their whānau/families who have experienced a loss of their pēpē/babies during their childbearing journey.

Tēnā ko te tuatahi me mihi ki a koutou tāonga kua ngaro nei i a tātou. Haere, haere, e moe koutou i te manaakitanga a o tātou tūpuna – kati! Tēnā tātou katoa.

Kia ora, talofa, namaste, bula, ni hao and hello from Whanganui District Health Board's maternity services team. This is our sixth annual Whanganui District Health Board (WDHB) maternity service/maternity quality and safety (MQSP) combined report in which we provide an overview of maternity services and outcomes during the 2019 calendar year.

Kia ora mai tātou me ngā mihi harikoa o te wā. Nei rā mātou ko te Ratonga Whānau Pēpē o te Pōari Hauora o Whanganui e mihi ana. Ko tēnei te ripoata tuaono mo te tau 2019 me ōna pūtanga hei kitenga mō te Hāpori.

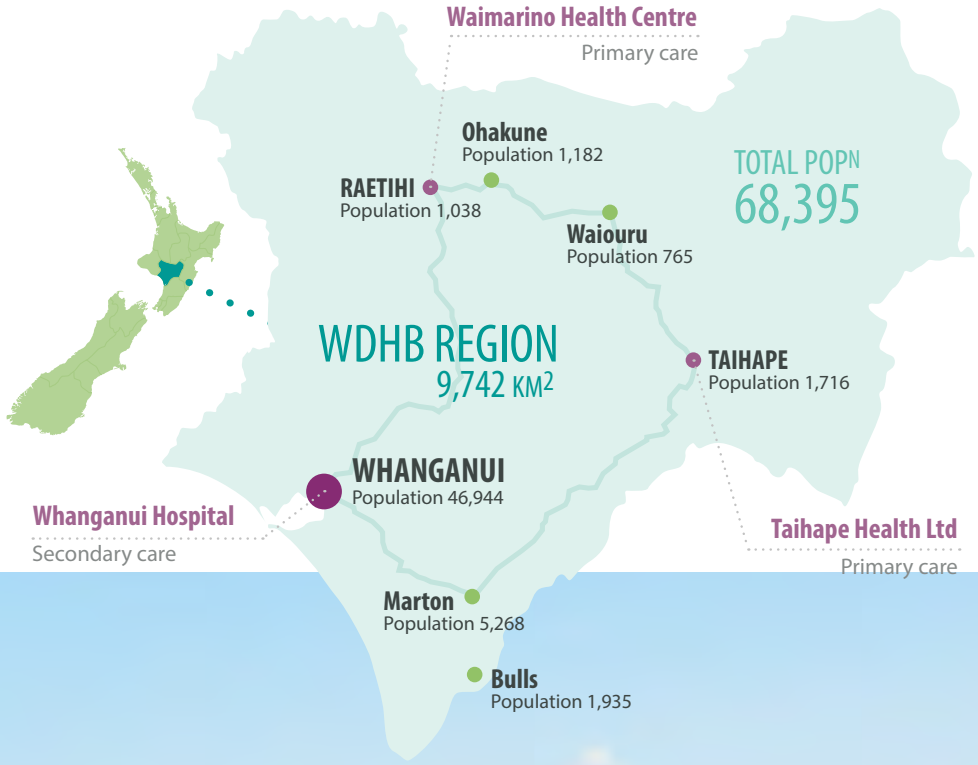
WHITI
SECTIONS

Data note: *The data in this report comes from a variety of sources including the Ministry of Health maternity data collection, WDHB WebPAS data and manually collected spreadsheets. Because of the variety of collection methods we have chosen to focus this report on the 2019 calendar year to ensure the information is as consistent as possible.*

OUR ROHE

OUR REGION (JAN-DEC 2019)

MATERNITY SERVICES IN THE WDHB REGION



IWI IN THE ROHE*


Whanganui


Ngā Rauru Kītahi


Ngāti Hauiti


Ngā Wairiki Ngāti Apa


Mōkai Pātea


Ngāti Rangi

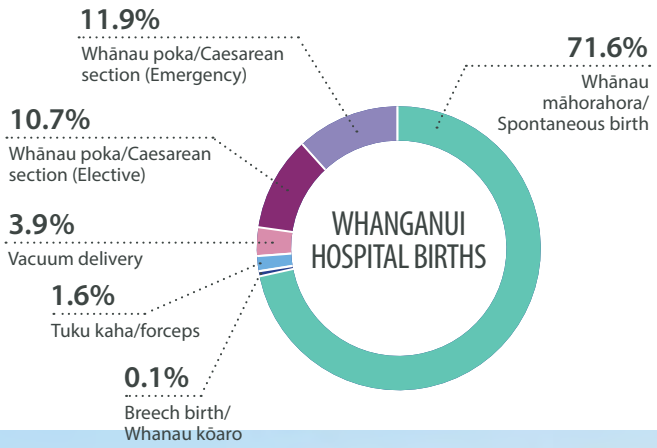
* NB: Iwi and DHB boundaries are different so an Iwi can cross over more than one DHB rohe

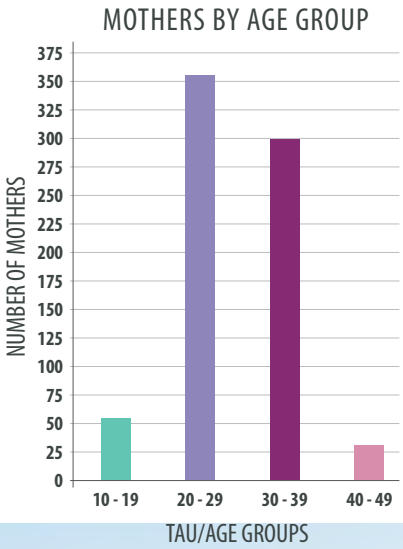
Visit our maternity unit following this link:
wdhb.org.nz/patients-and-visitors/our-departments-and-wards/whanganui-hospitals-maternity-unit/

732
LIVE BIRTHS
IN WHANGANUI HOSPITAL/
RURAL HEALTH SERVICE

26
HOME BIRTHS
IN WHANGANUI HOSPITAL/
RURAL HEALTH SERVICE

"All the midwives at the Whanganui maternity unit are doing an amazing job and made our birth experience very positive."





152
WAHINE/FAFINA
SMOKING AT BOOKING

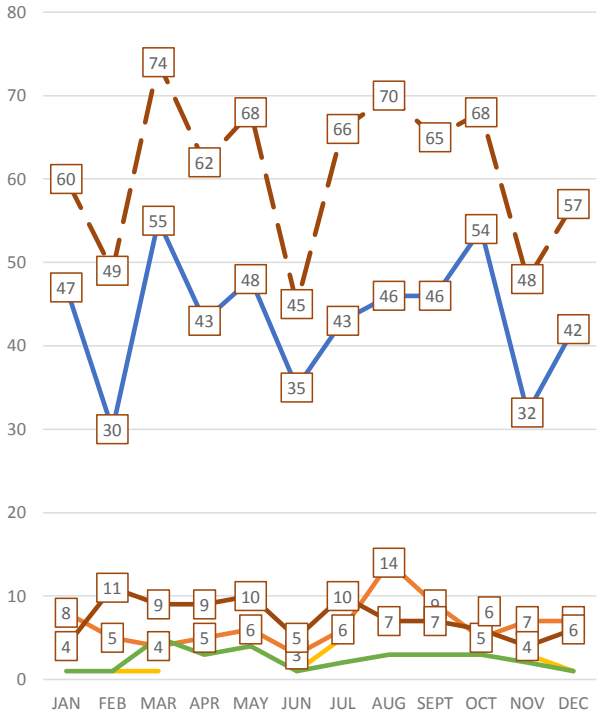
283
WAHINE
MĀORI

28
FAFINA
PACIFIKA

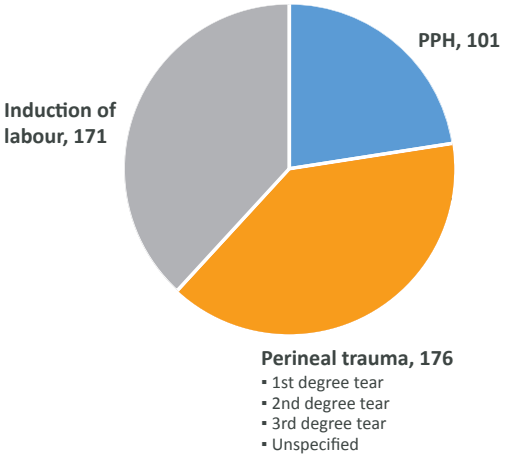
RARAUNGA

DATA - 2019

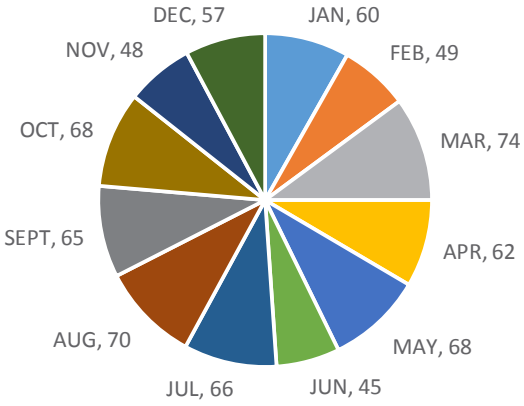
Type of birth by month in the Whanganui rohe (2019)



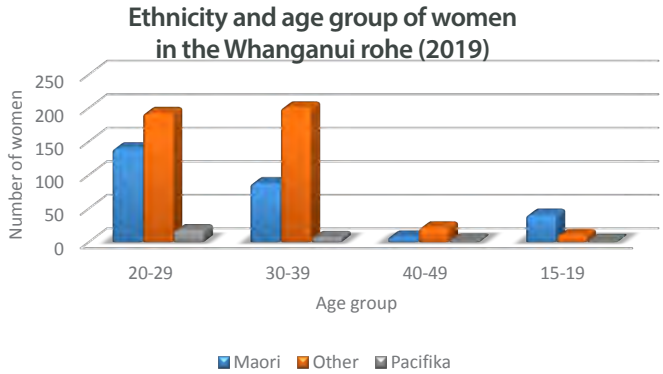
Clinical maternity related events in the Whanganui rohe (2019)



Live births by month in in the Whanganui rohe (2019)



Ethnicity and age group of women in the Whanganui rohe (2019)



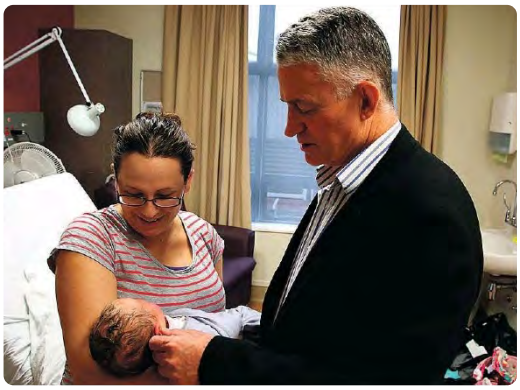
"Feeding/latch help at all hours, helped put our baby to sleep on the first night, husband stayed in the room for all night - a huge thank you."

Registered midwife Lenna Young and core midwife Laura Dean

KAIMAHI
OUR STAFF

MAITAI WHAKAWHĀNAU/OBSTETRICS
Whanganui District Health Board has a group of specialist obstetrician/gynecologists who provide rostered cover 24 hours a day, seven days a week.

Maintaining specialist cover, ensuring clinical competency with relatively low numbers of women requiring secondary services and retaining resources given the increasing trend of sub-specialisation remains a concern, as it is for all small and medium sized district health boards.



Proud mum Shonelle Reilly shows her daughter to Obstetrics and Gynaecology consultant Mark Stegmann
- Photo: Stuart Munro, Whanganui Chronicle

ANAESTHETISTS
Whanganui DHB provides a 24-hour anaesthetic service for labour and delivery.

MĀTANGA TIAKI HAPŪTANGA (Lead Maternity Carer)/MIDWIFERY
Historically Whanganui has had a stable midwifery workforce however since 2018 we have seen a number of retirements, resignations and midwives moving areas which has impacted on service delivery. WDHB is working with the Whanganui Regional Health Network to ensure local wahine/fafina have access to care via a primary care team of midwives.

Director of midwifery Lucy Pettit and obstetrics and gynaecology consultant Mark Stegmann in a Whanganui Hospital delivery suite

SUPPORT SERVICES

MedLab tests samples from patients referred by general practitioners, specialists, midwives and other medical referrers. Collection sites are based at four locations around the Whanganui rohe; Whanganui Hospital, Bulls Medical centre, Marton and Wicksteed Street (Whanganui).

PREGNANCY ULTRASOUND

Rivercity Ultrasound is based in Bell Street. The company provides a number of pregnancy services including dating, nuchal translucency, morphology and growth scan.

Phone: **06 281 3182** email: **reception@rivercityultrasound.co.nz**.

Whanganui Hospital's Radiology Department also provides ultrasound services especially for women who have complex pregnancies.

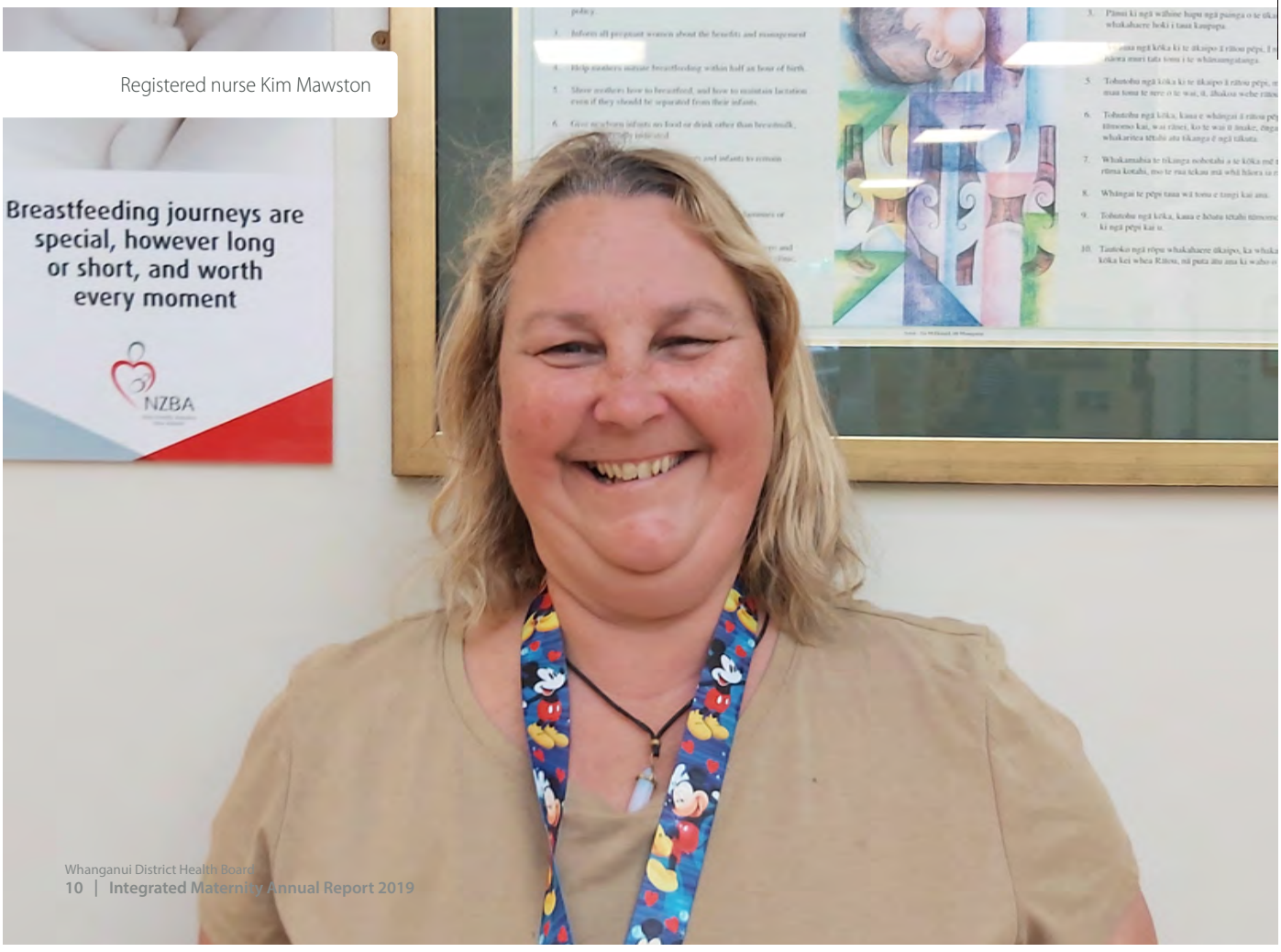
Phone: **06 348 3224**

ROOPU HOHIPERA (HOSPITAL TEAM)

The hospital's secondary service team includes an obstetric registrar, house officer, midwifery educator, charge midwife, lactation consultant, kaiwhakawhānau (core midwives), nēhi (registered nurse), kaimahi (administrator) and health care assistants.

Workforce challenges

In 2019 strike notices were issued by MERAS (the midwives union) and the New Zealand Registered Doctors union which represents the junior doctors. We also faced an increasing shortage of community midwives with midwives retiring or moving out of the area. In order to provide care to the hapu wahine/pregnant women in Whanganui the hospital began providing antenatal care in a midwifery run clinic.



Registered nurse Kim Mawston

WHĀNAUTANGA TUATAHI/PRIMARY BIRTHING

OTAIHAPE HEALTH - 2019

Otaihape is a midwifery led unit where women can birth their babies and stay postnatally. The maternity services are led by a small team of rural midwives who offer antenatal, labour and birth and postal services.

During the 2019 year the midwives report 20 women birthing at the health centre.

WAIMARINO MIDWIFERY SERVICES (WMS) - 2019

Waimarino Health was been fully staffed from April 2019 when Jess White joined Kate Brewis.

There has been a steady decline in the numbers of women registering with WMS and birthing locally. Reasons may include complexity of obstetric and/or social circumstances, personal choice and an increase in transfers during labour.


M6C/OB
9.8cm / 1.2 / 14Hz
MI 0.6
Non Diagnostic Image

RATONGA
OUR SERVICES

PIRIPOHO/LACTATION CONSULTANTS
Whanganui DHB has one International Board of Lactation Consultants (IBLC) practitioner and a trainee practitioner.

2019 ACTIVITIES
The consultant reports that they have seen fewer women on the postnatal ward in the past year but they have seen more in clinics and outside of clinic hours.

The introduction of a guideline for administration of 40% dextrose (gel) for neonatal hypoglycaemia appears to have reduced the number of babies being separated from their mothers and admitted to Special Baby Care Unit (SCBU). In the first six months of 2019 there were 26 babies treated and only six required admission to the SCBU).

TE RERENGA TAHI
This group seeks to enable the best possible outcomes for women and their whānau with complex needs during the maternity care period (antenatal to six weeks post-partum). Complex needs could include health, social, cultural and economic needs. By working in partnership with the women our primary aim is to strengthen families by facilitating a seamless transition between primary and secondary providers. The groups uses a multi-agency approach. Our secondary aim is to strengthen the support to maternity/health professionals throughout the continuum of maternity care up until six weeks postpartum.

ACTIVITIES
There have been 112 completed referrals since commencement. Primary reasons for referral were:
- family violence (34%)
- identified support needs (social, financial or educational) (31%).
- Referrals predominantly come from LMC's or social workers (26% and 22% respectively).
- 14 reports of concern
- 48% of women referred to Te Rerenga Tahi identify as Māori, 32% NZ European and 12% Māori/NZ European.

Since the start of the group there have been four cases where an infant has been uplifted from their mother's care while in the hospital.

Forum members have offered positive feedback around the benefits of the Te Rerenga Tahi weekly hui.

UNIVERSAL NEWBORN HEARING SCREENING AND EARLY INTERVENTION PROGRAMME (UNHSEIP)
Newborn hearing screening is a safe and simple check to find out if a baby hears well. The screen is designed to pick up moderate to profound hearing loss. It may not pick up mild hearing loss.

The four screeners carry out screening primarily within the Maternity unit, but hold outreach clinics at Whanganui, Marton, Taihape and Raetihi. Home visits may also be offered on a case by case basis.

1–3–6 outcomes - 2019
- 85% of infants were screened by one month of age.
- A further 8% were completed after one month of age
- Overall, 92% of all infants were screened with five cases of hearing loss identified.

WHAKAWHANAKE (IMPROVEMENT) 2019
- Use of the clinical portal to complete GP notification of clinic appointment outcomes. This has decreased the paperwork required by screeners at clinic and in turn increased efficiency and time management at clinic.
- Involving the Haumoana Navigator team to improve attendance at clinic appointments. The navigator contacts whānau who do not attend, establishes reasons for non-attendance and follows up on whānau who are difficult to contact. This will improve screening rates and enable early identification of hearing loss in an at-risk population.

HAPAI TE HOE

NGĀ HOE (VALUES): Aroha | Whakapapa | Mana Tangata | Tino Rangatiratanga | Kaitiakitanga | Kotahitanga | Wairuatanga | Tikanga Maori | Manaakitanga | Whanaungatanga | Rangimārie | Mauri

WDHB staff attend Hāpai te Hoe training in the first week of employment. The training has also been delivered to all existing staff and has been offered to our LM's. Hāpai te Hoe is the WDHB cultural awareness training programme which aims to educate health professionals so the way they deliver services to our community contributes to:

- improved health and wellbeing of all whānau who access WDHB hospital services
- increased knowledge, skill and confidence
- reduced inequalities for Māori
- embedding the Whānau Ora philosophy and partnering with patients and their whānau services
- integrated service models developed across Primary care and NGO services
- improved access to services for whānau Māori
- increased ability for whānau to self-determine their health services.

PREGNANCY AND PARENTING PROGRAMMES - HAPŪ ME TE WHĀNAU TAMARIKI

MĀTAURANGA/EDUCATION

- 190 wahine accessed antenatal classes
- 95% first time hapū wahine.
- Fifty-six classes - sixteen in rural areas.

Class options range from six-weekly to two-hour, one-on-one sessions and are tailored to meet each client's needs.

Rā Hapū Wahine
One stop shop aimed at young wahine Māori. Incorporates cultural aspects of pregnancy, labour and birth.
Five days held in 2019.

Safe sleep (pepi pods)
Safe sleep spaces are distributed to any baby with increased risk of SUDI which includes, pre-term or small for dates, co-sleeping, addiction, mental health issues and smoking whānau or mama.

268 safe sleep spaces distributed:

- 53% Māori
- 6% Pacifika
- 35% locally woven harakeke wahakura
- 44% of mothers were smokers.

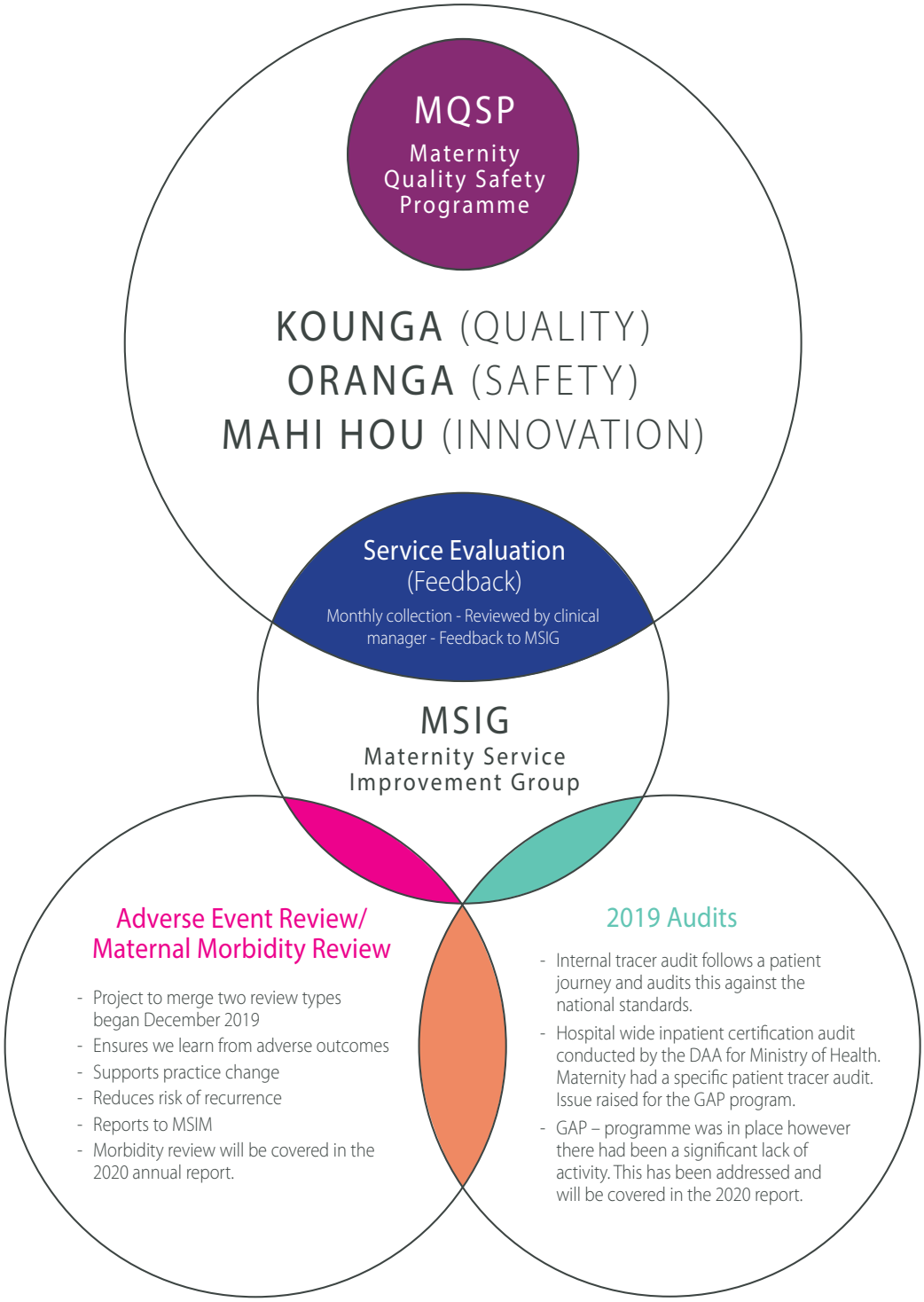
WRHN Wāhine Whakawhānau
Established in September 2019 to meet the demands caused by a LMC shortage. The team has provided antenatal and postnatal care.

- Late booking women
- 77% from high deprivation areas
- 68% are not of NZ European ethnicity.

Whanganui Regional Health Network

GETTING IT RIGHT - QUALITY SAFETY INNOVATION

There are a number of things we do to make sure we are delivering a quality, safe service to our wāhine/women and their whānau.



MATERNITY SERVICE IMPROVEMENT GROUP WHAKATŪTUKI (ACHIEVEMENTS)

MATERNITY QUALITY AND SAFETY PROGRAMME

The 2019 year saw some changes across the Whanganui District Health Board 's Maternity Quality and Safety Programme. A review of the make-up of the governance group and MQSP activities was undertaken. The review included discussion with members of the governance group and the consumer advisor.

A number of issues were identified including:

- the need to refresh terms of reference
- a lack of clarity between the activity of governance and the operation/project management role
- gaps where locally the programme was not fully delivering against the six core components or the crown funding engagement agreement.

In addition to issues raised regarding the programme, the DHB was undergoing a process of transformation at executive level. The role of MQSP coordinator would no longer sit within the Patient Safety Centre but was instead to report to the director of midwifery. While this was undoubtedly a positive change of reporting line, there was no director in position. As a result towards the end of 2019 the role was reporting by default to the clinical midwifery manager and chief medical officer.

In view of the changes occurring within the DHB it was agreed that the MQSP programme would focus on the roll-out of national projects. Once a director of midwifery was in place the programme would be re-evaluated and a refreshed work plan designed.

PROJECT UPDATES

MATERNITY EARLY WARNING SCORE (MEWS)

Rationale
National HQSC project to introduce national maternal early warning system (MEWS) to help clinicians identify when a pregnant or recently pregnant woman's condition starts to get worse, so they can respond quickly.

Actions

- Project plan developed.
- Midwifery educator and MQSP coordinator formed the WDHB MEWS team.
- Team attended HQSC teleconferences (Oct/Nov)

Measures
Random auditing following roll-out

Outcomes
Roll-out to be complete by end February 2020

Future
MEWS will be used across Whanganui DHB for all pregnant and postpartum women.

MATERNAL MORTALITY REVIEW TOOLKIT

Rationale
National HQSC project.

Actions

- The maternity reviewer was assigned to develop this project.
- Pilot and roll out to be completed in the first quarter of 2020.

Whanganui District Health Board MQSP Governance Group:
Front row from left: Director of midwifery Lucy Pettit and MQSP coordinator Rachel Taylor
Back row from left: WRHN child health manager Janine Spence, consumer representative Carla Donson and lead maternity carer Katherine Hall

NGĀ PŪRONGO A MOTU
NATIONAL REPORTS

Whakatūpato (alert)
In previous reports we have presented raraunga/data both by financial and calendar year. In order to align with the Ministry of Health's data timeframes and the national reports we have chosen to present this year's data by calendar year only. This does mean a slight overlap with data presented in last year's report. Our maternity specific COVID-19 response information will be presented in the 2020 report.

USING RARAUNGA/DATA TO INFORM LOCAL PRACTICE

CLINICAL INDICATORS (2018)

Manatū Hauora (Ministry of Health) has been releasing the annual New Zealand Maternity Clinical Indicators for ten years. The indicators present comparative maternity interventions and outcomes data across a set of 20 indicators for pregnant women and their babies by maternity facility and district health board region.

Maternity service delivery and outcomes for women and babies vary between district health boards (DHBs) and between individual secondary and tertiary facilities. Manatū Hauora cautions that these findings merit further investigation of data quality and integrity as well as variations in local clinical practice management.

Why does this matter to us?
Although there is an almost two year lag in the data released we can use this raraunga in our local maternity quality and safety programmes to identify areas that we may wish to focus on. Our note of caution is that the Ministry's data is from 2018 and often we will have seen and addressed these concerns before the indicator report is released.

Really impressed with the respect and care baby, whānau and I were shown. Huge improvement since our last stay in 2012.

Communicating with myself and partner during birth, respecting my wishes, supporting myself and partner and baby. Always happy to help.

Lactation consultant Margaret Colway talks with proud new mum of twins

WHERE DID WE DO WELL IN THE 2018 INDICATORS?

71.9%

Mothers registering with an LMC before 12 weeks of pregnancy

The clinical indicator data shows a continuing slight increase year on year since 2015.

We identified workforce challenges due to retirement/resignation in the previous report. Workforce remains an issue both locally and nationally.

Locally women are struggling to find a midwife to care for them and, despite the creation of the Whanganui Regional network (PHO) midwifery team, the core service is continuing to provide primary care to women without an LMC.

www.findyourmidwife.co.nz
www.wdhb.org.nz/your-heath/find-a-gp-or-midwife

7.1%

Standard first time mothers who underwent an instrumental birth

In 2018 Whanganui significantly outperformed against a national rate of 17.

5.4%

Standard first time mothers who undergo induction of labour

While less mothers were reported as having an induction of labour when compared to 2017, this should be treated with caution. It may be the reduction in induction can be explained in part by the increase in caesarean sections.

Our local 2019 data suggests an overall induction rate of 23% for all mothers.

Kawenga whakawhānau | Induction of labour

The process of using drugs or other methods to encourage labour to start artificially rather than waiting for labour to start naturally.

www.nationalwomenshealth.adhb.govt.nz/womens-health-information/maternity-2/labourandbirth/induction-of-labour/

38.1%

Standard first time mothers with an intact lower genital tract (no first to fourth degree tear or episiotomy)

Our rates are high compared to the national average however this may not be accurate as we know that genital trauma is extremely common. It has been suggested that midwives completing forms may record 'intact' for small grazes and tears that don't need repair.

Women with an intact perineum are more likely to resume intercourse earlier, report less pain with first and subsequent sexual intercourse. Perineal massage from 34 weeks of pregnancy can reduce the chances of tears.

https://nationalwomenshealth.adhb.govt.nz/assets/Uploads/Perineal-Massage.pdf

WHERE CAN WE IMPROVE?

13.4%

Standard first time mothers who undergo a caesarean section

Whilst our caesarean section rate for first time mothers was lower than the national rate of 17.2% there was a significant increase in first time mothers having caesareans when compare to the 2017 report (7.4%)

In 2019 our overall caesarean rate was 23%. This includes women have elective caesarean sections and women who have had at least one baby before.

The World Health Organization recommends a Caesarean section rate of between 10-15% as optimal – higher rates are not associate with reductions in maternal and newborn mortality rates.

www.midwife.org.nz/news/caesarean-section-and-health-of-baby

17.4%

Women having a general anaesthetic for caesarean section

4.1%

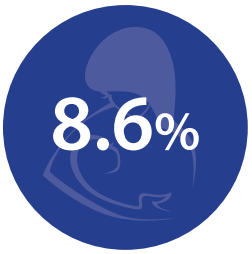
Women requiring a blood transfusion with caesarean section.

2.5%

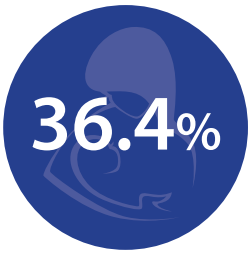
Women requiring a blood transfusion with vaginal birth.

The Whanganui 2018 general anaesthesia rates were double those of the national average. There has historically been a difference between the Ministry of health data and the local birthing data. Regardless this rate increase flags a potential concern. The GA caesarean section cases for 2018 are being audited by a member of the obstetric team and our maternity anaesthetic specialist.

Blood transfusions post-caesarean and vaginal birth are slightly higher than the national average however this may be due to consultant preference to not give iron infusions rather than reflecting a genuine issue with anaemia.



Pre-term birth



Small babies at term born at 40-42 weeks gestation

The 2018 rate of pre-term birth remained slightly above the national average. This is likely to be a reflection of the demographics of the local birthing women.

Locally our small term babies rate is higher than the national average. We have an actively run GAP program which is intended to identify at-risk babies early and enable management of the pregnancy.

Momi tupeka/maternal tobacco use/during the postnatal period

Whanganui has ongoing problem with smoking. Our rates for postnatal smoking in the 2018 dataset were twice the national average. Our 2019 data suggest about 20% of women are identified as smoking and we are aware this rate has further increased for 2020.

When women smoke, harmful toxins (poisons) enter the bloodstream and pass through the placenta to their pēpē baby. These poisons harm your baby's health, putting them at risk of problems including glue ear, asthma, pre-term birth and low birth weight. Smoking can also increase the risk of miscarriage and Sudden Unexplained Death in Infancy (SUDI).Stopping smoking has huge benefits for mother and baby and, even if women have smoked for a part of their pregnancy, quitting will still have significant benefits for them.

TE RŌPŪ O NMMG (National Maternity Monitoring Group) 2019 PŪRONGO-Ā-TAU (Annual Report)

The NMMG acts as a strategic advisor to the Ministry on areas for improvement in the maternity sector, provides advice to district health boards (DHBs) on priorities for local improvement, and provides a national overview of the quality and safety of New Zealand's maternity service. The 2019 report was released to the health sector on 8 December 2020 and includes recommendations for DHB and primary care activities as well as to actions for the Ministry of Health.

The report introduction highlights concern that:
The New Zealand Maternity Standards (2011) strategic statement in relation to "all women having access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women" is not being achieved in a number of areas in New Zealand.

NMMG RECOMMENDATIONS TO SERVICE PROVIDERS	WHANGANUI DHB RESPONSE/ACTIVITIES
Place of birth DHB and PHO to report on how women are informed of the full range of birth options; and outline methods used to promote primary birthing facilities for appropriate women.	As a smaller DHB we have a secondary birthing facility at the hospital which includes a primary care approach and a primary care unit at Waimarino. We have a high rate of normal birth and decisions regarding whether to birth at home or in hospital are made between a woman and her midwife.
Equitable access to contraception DHB to report on access to postnatal contraception for women, processes in place for supporting women to make informed choices, and services available that support women to obtain their choice of contraception.	This has been identified as an area for us to work on in 2021.
Maternal Mental Health The NMMG would 'like to see' a DHB report on mental health referral and treatment pathways for women.	This will be discussed at the Maternity Service Improvement Group meetings.
MQSP Areas of improvement for all DHBs included: ▪ Evidence of DHB audit and progress on achieving the New Zealand Maternity Standards. ▪ The analysis, interpretation and application of DHB data/statistics into quality improvement projects that improve outcomes. ▪ undertake an audit of DHB LARC services to include the age and ethnicity of women receiving them and the number of LARCs removed in each 12 month period, so trends can be shown. ▪ Data in relation to DHB specialist maternal and infant mental health referrals, declines and access issues. ▪ Evidence of consumer feedback being incorporated into quality improvement projects and the impact on outcomes.	Consumer feedback is reviewed at the monthly Maternity Service improvement Group meeting. LARC activity will be reported to the Ministry of Health quarterly. The NMMG reviewed the WDHB report and noted that we were "an exemplar of good practice in their adoption of kupu Māori (Māori words) and commitment to embracing mātauranga Māori (Māori knowledge and understanding)".

KUPUTAKA
GLOSSARY

Caesarean Section	An operative birth through an abdominal incision.
Episiotomy	An incision of the perineal tissue surrounding the vagina to facilitate or expedite birth.
Gravida	A pregnant woman.
Maternity Facilities	A maternity facility is a place that women attend, or are resident in, for the primary purpose of receiving maternity care, usually during labour and birth. It may be classed as primary, secondary or tertiary depending on the availability of specialist services (Ministry of Health 2012). This section describes women giving birth at a maternity facility.
Multiparous	Multiparous is a woman who has given birth two or more times.
Neonatal Death	Death of a baby within 28 days of life.
Parity	Number of previous births a woman has had.
Primiparous	A woman who is pregnant for the first time.
Primary Facility	Refers to a maternity unit that provides care for women expected to experience normal birth with care provision from midwives. It is usually community-based and specifically for women assessed as being at low risk of complications for labour and birth care. Access to specialist secondary maternity services and care will require transfer to a secondary/tertiary facility. Primary facilities do not provide epidural analgesia or operative birth services. Birthing units are considered to be primary facilities. Primary maternity facilities provide inpatient services for labour and birth and the immediate postnatal period.
Postpartum Haemorrhage	Excessive bleeding after birth that causes a woman to become unwell.
Primary Maternity Services	Primary maternity services are provided to women and their babies for an uncomplicated pregnancy, labour and birth, and postnatal period. They are based on continuity of care. The majority of these maternity services are provided by Lead Maternity Carers (LMCs).
Secondary Facility	Refers to a hospital that can provide care for normal births, complicated pregnancies and births including operative births and Caesarean Sections plus specialist adjunct services including anaesthetics and paediatrics. As a minimum, secondary facilities include an obstetrician rostered on site during working hours and on call after hours, with access to support from an anaesthetist, paediatrician, radiological, laboratory and neonatal services.
Standard Primiparae	A group of mothers considered to be clinically comparable and expected to require low levels of obstetric intervention. Standard primiparae are defined in this report as women recorded in the National Maternity Collection (MAT) who meet all of the following inclusions: ▪ delivered at a maternity facility ▪ are aged between 20 and 34 years (inclusive) at delivery ▪ are pregnant with a single baby presenting in labour in cephalic position ▪ have no known prior pregnancy of 20 weeks and over gestation ▪ deliver a live or stillborn baby at term gestation: between 37 and 41 weeks inclusive ▪ have no recorded obstetric complications in the present pregnancy that are indications for specific obstetric interventions. Intervention and complication rates for such women should be low and consistent across hospitals. Compiling data from only standard primiparae (rather than all women giving birth) controls for differences in case mix and increases the validity of inter-hospital comparisons of maternity care (adapted from Australian Council on Healthcare Standards 2008, p 29).

Stillbirth	The birth of an infant after 20 weeks gestation, which has died in the womb and weighed more than 400 grams.
Tertiary Facility	Refers to a hospital that can provide care for women with high-risk, complex pregnancies by specialised multidisciplinary teams. Tertiary maternity care includes an obstetric specialist or registrar immediately available on site 24 hours a day. Tertiary maternity care includes an on-site, level 3, neonatal service.
Weeks' Gestation	The term used to describe how far along the pregnancy is. It is measured from the first day of the woman's last period.

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April 2021 **Public**

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

Recommendations

Management recommend that the Whanganui District Health Board:

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 3 March 2021	For reasons set out in the board's agenda of 3 March 2021	As per the board agenda of 3 March 2021
Chief executive's report Committee minutes Committee Chair update	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Laboratory and Pathology services contract Allied Laundry	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)

Insurance Renewal		
ESPI Compliance	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

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

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