Public Papers - December 2021

01 December 2021 09:30 AM - 10:30 AM

Interest Register

22 June 2021

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

28 October 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**DRAFT MINUTES** Held on Wednesday, 28 October 2021 Boardroom Level 4 Ward and Admin Building
Public Board Meeting	**Commencing at 9.30am**

Present
Ken Whelan, Chair
Annette Main, Deputy Board Chair, Chair Combined Statutory Advisory Committee
Talia Anderson-Town, Finance Risk and Audit Chair
Mary Bennett, Member
Philippa Hogan-Baker, Member
Stuart Hylton, Member
Judith MacDonald, Member
Soraya Peke-Mason, Member
Graham Adams, Member

In attendance
Graham Dyer, Acting Chief Executive and GM Strategy, Commissioning and Population
Nadine Mackintosh, Executive Officer
Andrew McKinnon, General Manager Corporate
Rowena Kui, GM Maori Health and Equity
Steve Carey, Collective Impact Strategist
Alex Kemp

1. PROCEDURAL

1.1 Karakia/reflection
M Bennett opened the meeting with a Karakia.

1.2 Apologies
The board acknowledged the recent passing of C Anderson's son with a request for acknowledgment to be passed onto the family.

The board **accepted** apologies from C Anderson, J Chandulal-Mackay.

Moved A Main **Seconded** J MacDonald **CARRIED**

1.3 Continuous Disclosure
1.3.1 Amendments to the Interest Register
Nil

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

28 October 2021 **Public**

1.4 Confirmation of minutes

1 September 2021

The minutes of the meeting held on 1 September 2021 were **approved** as a true and accurate record of the meeting.

Moved A Main **Seconded** S Hylton **CARRIED**

1.4 Matters Arising

The matters arising were received.

2. Chief Executive report

The paper was taken as read.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the paper titled 'Chief Executive Report'

b. **Note** the board appointments for both Health New Zealand and Māori Health Authority

c. **Note** that the DHB have received approval for the Whanganui DHB's 2021/22 Annual Plan

d. **Note** the planned engagements for the health sector reforms

Moved A Main **Seconded** T Anderson-Town **CARRIED**

3. Strategic Direction

3.1 Pro-Equity Report

The paper was taken as read with management covering highlights of the report.

Action:

1. Invite health providers to a meeting to understand equity of access and outcomes from their perspectives and to ensure that we are addressing equal access to achieve equitable health outcomes.
2. A paper to be provided to the board, following engagement with the health providers.
    a. **Receive** the paper Pro-Equity Report
    b. **Note** the information in the report
    c. **Note** the two appendices and progress against the Pro Equity Check Up Implementation Plan and in relation to He Hāpori Ora.
    d. **Note** the concluding comments and next steps.

CARRIED

3.2 Social Governance

The paper was taken as read with management discussing the governance framework which has two pillars of governance one for Māori and one for main stream (the board requested consideration of a new terminology for "main stream").

S Peke-Mason joined the meeting at 10:10am

The board discussion the following areas:

- Engagement of the impact collective in relation to the Covid response. Management advised that our communications team have provided some key messaging to our staff and local agencies.
- Management advised that the DHB are commencing engagement with the wider local authorities.

- Opportunities of value add to our response to the Covid outbreak.

The Board of Whanganui District Health Board:

a. **Received** the paper titled 'Social Governance Update'

b. **Noted** the updates since the last board meeting

CARRIED

3.3 Healthy at home

The paper was taken as read with management advice that there is more information that can be shared with the board.

The key discussion points were:

- Health bus
- Covid engagement and communications
- Mental health pressures

The Whanganui District Health Board:

a. **Receive** the paper Healthy at Home: Every Bed Matters

b. **Note** the information in the report

CARRIED

4. INFORMATION

4.1 Report on the deaths of pepe, tamariki and Rangatahi aged from 28 days to 24 years

The paper was taken as read and leads to somber reading. Discussion linked to Covid-19 and our engagement with agencies to assist with resilience in our communities.

The Board of Whanganui District Health Board:

a. **Received** the paper titled The 15th National Child and Youth Mortality Data reports

b. **Noted** that this brief review of data provides a link to part of the roadmap to reducing the number of deaths and disproportionate outcomes across ethnicities, age groups, sexes, and deprivation levels.

c. **Noted** that this provides evidence of the rates of deaths of pepe, tamariki and rangatahi deaths in Aotearoa.

d. **Noted** To view the full report, it is a public document and is available online at www.hqsc.govt.nz/our-programmes/mrc/cymrc

CARRIED

4.2 Planned Care Volumes and Waiting Lists post COVID-19 service interruption

The paper was taken as read with management advice on impacts being due to the lockdown period. Discussions with the MoH have been positive.

It was acknowledge that nationally there are pressures in meeting the targets and that Whanganui DHB is doing fairly well.

Action: Management to provide more information on the Urology services with MidCentral, ensuring equity of access and limit delays that would impact on a deterioration requiring provisions from Wellington.

The Board of Whanganui District Health Board:

a. **Received** the paper titled Planned Care Volumes and Waiting Lists post COVID-19 service interruption

b. **Noted** that waiting lists have increased across most areas of booked appointments following the August and September lockdowns

c. **Noted** that production forecasting across all areas of planned care is underway to inform service decisions, due in the last week of October.

CARRIED

4.3 Detailed financial report – September 2021

The paper was taken as read. Acknowledging this is a three month result.

The Whanganui District Health Board:

a. **Received** the report 'Detailed financial report – September 2021'.
b. **Noted** the September 2021 monthly result of a $27k surplus is unfavourable to budget by $108k. Including COVID-19 and the Holiday Act Compliance provision, the result is $207k unfavourable to budget.
c. **Noted** the year-to-date result of $1,903k deficit is unfavourable to budget by $100k. Including COVID-19 and the Holiday Act Compliance provision, the result is $208k unfavourable to budget.

CARRIED

5. Resolutions to exclude public

The Board of Whanganui District Health Board members:

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 3 March 2021	For reasons set out in the board's agenda of 3 March 2021	As per the board agenda of 3 March 2021
Chief executive's report	To protect the privacy of natural persons, including that of deceased natural persons	Section 9(2)(a)
Committee minutes	To avoid prejudice to measures protecting the health or safety of members of the public	Section 9(2)(c)
Committee Chair update	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)(ba)

Agenda item	Reason	OIA reference
Laboratory and Pathology services contract Allied Laundry Insurance Renewal	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)
ESPI Compliance	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

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

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 S Hylton **Seconded** S Peke-Mason **CARRIED**

The public section of the meeting concluded at 10.30am

COVID Vaccination

25 November 2021- update 4

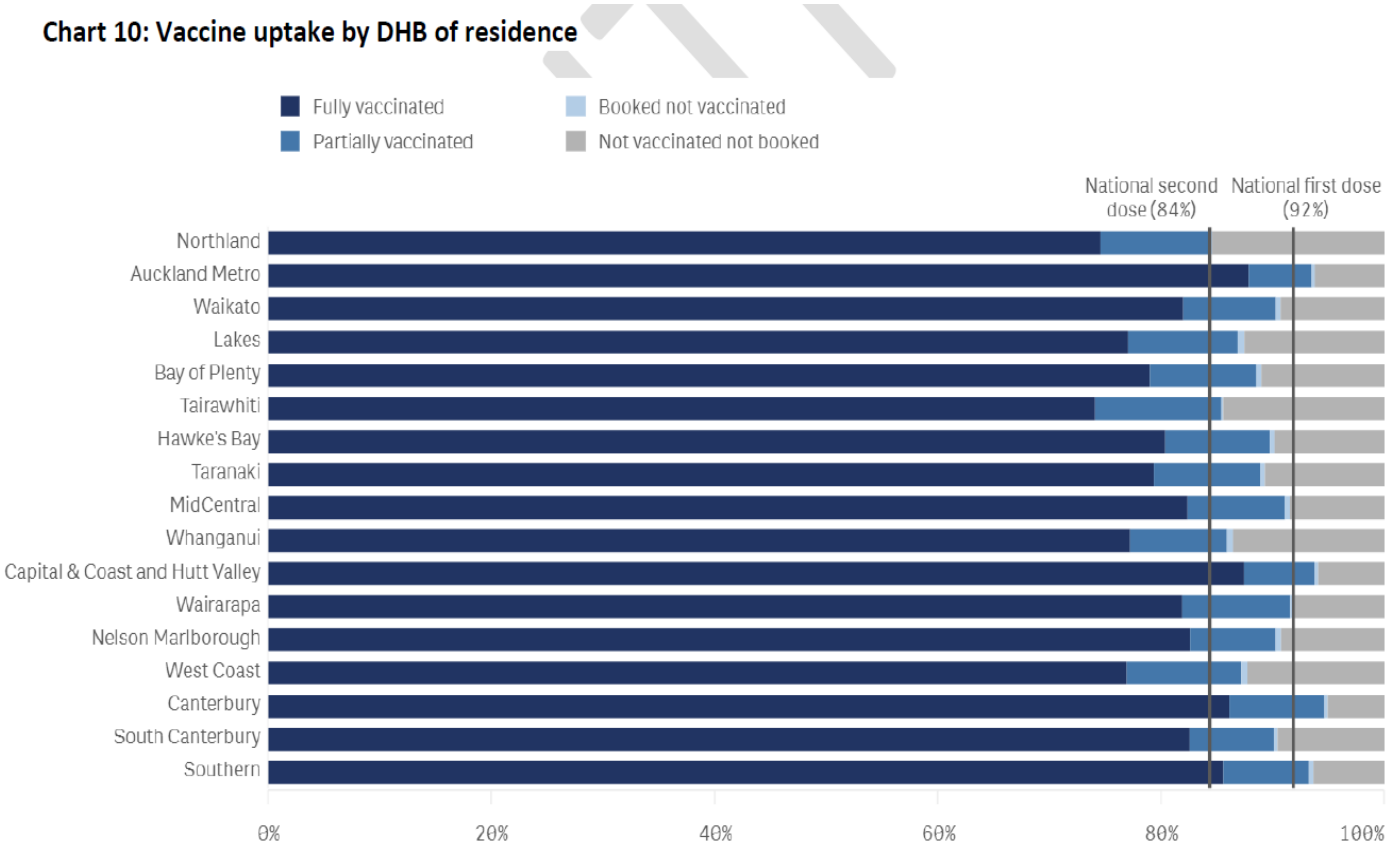
Objectives

1. 90% vaccination of population
2. Pro – equity – 90% for Maori, Pacific, disability sector etc
3. 100% staff first vaccination by 15 November 2021
4. 100% staff second vaccination by 01 January 2022

Followed by

5. 5-11 role out from Jan 22
6. Booster program from 29 November 2021 (updated- was 2022)

Progress to date of all DHB's



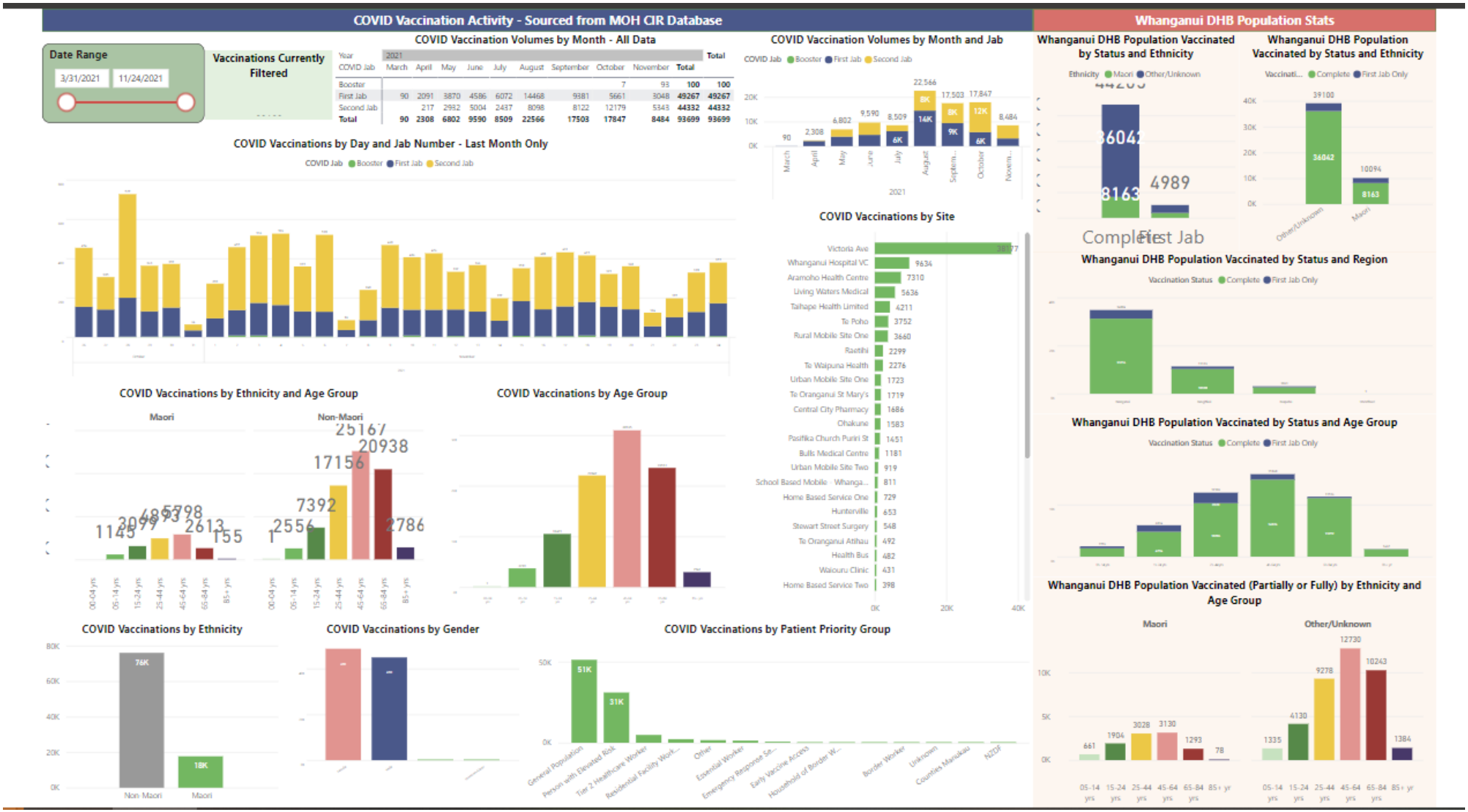
DHBs with high Maori, low socio-economic and high rural spread are slowest.

WDHB Current Position

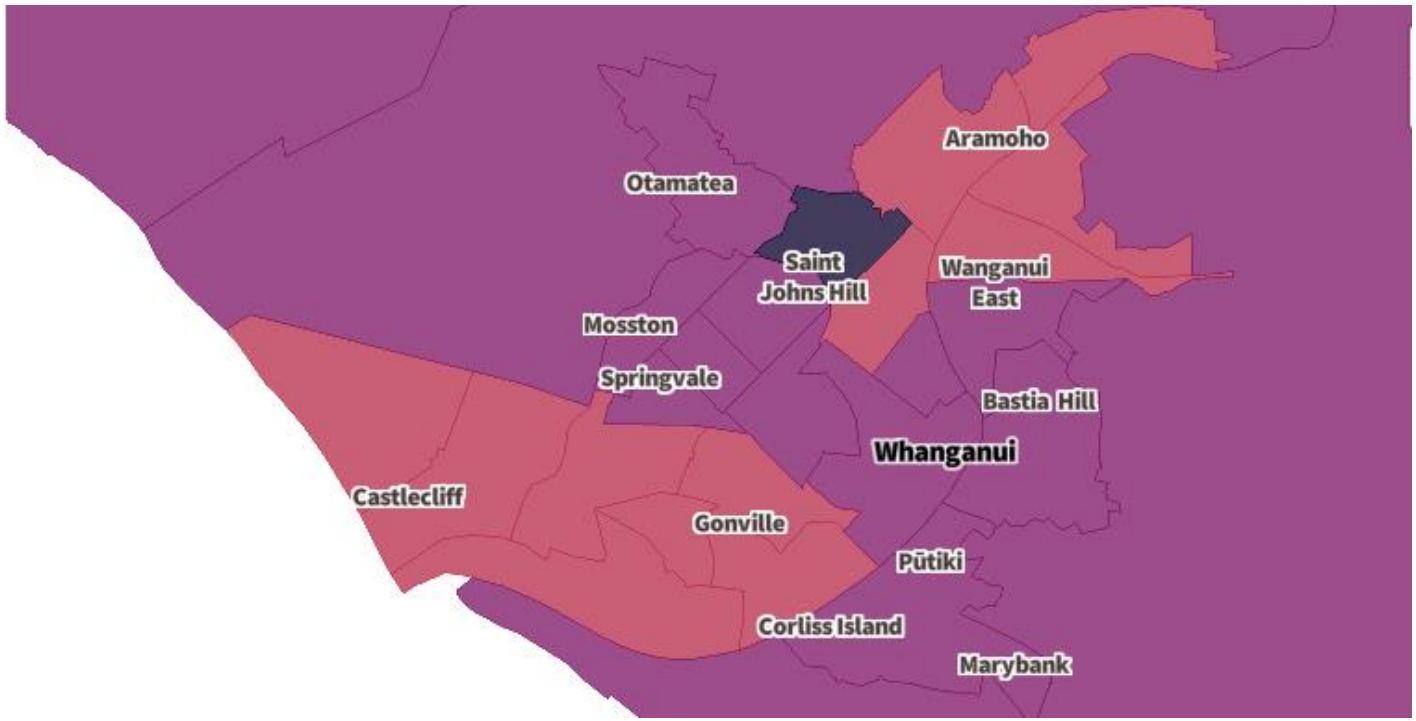
Vaccinations to 90% - 17 Nov	First doses	First doses %	First doses to 90%	Second doses	Second doses %	Second doses to 90%	Population
All Ethnicities Wanganui	49162	86%	2360	44167	77%	7355	57,247
All Ethnicities New Zealand	**3,860,356**	**92%**	**0**	**3,544,945**	**84%**	**243,206**	**4,209,057**
Maori - Wanganui	10,090	75%	2,071	8,161	60%	4,000	13,512
Maori - New Zealand	**457,894**	**80%**	**56,053**	**374,640**	**66%**	**139,307**	**571,052**
Pacific - Wanganui	1,133	82%	110	969	70%	274	1,381
Pacific - New Zealand	**257,446**	**90%**	**567**	**228,280**	**80%**	**29,733**	**286,681**

Progress since the CSAC report was written: 2360 firsts to go (down from 4078 in CSAC report 12 Nov)

2071 of the firsts are for Maori to get to 90% (was 2808 12 Nov). This is the target area


COVID Vaccination Activity - Sourced from MOH CIR Database
Whanganui DHB Population Stats
Date Range
3/31/2021
11/24/2021
Vaccinations Currently Filtered
COVID Vaccination Volumes by Month - All Data
COVID Vaccination Volumes by Month and Jab
COVID Vaccinations by Day and Jab Number - Last Month Only
COVID Vaccinations by Site
Victoria Ave
Whanganui Hospital VC
Aramoho Health Centre
Living Waters Medical
Taihape Health Limited
Te Poho
Rural Mobile Site One
Raetihi
Te Waipuna Health
Urban Mobile Site One
Te Oranganui St Mary's
Central City Pharmacy
Ohakune
Pasifika Church Puriri St
Bulls Medical Centre
Urban Mobile Site Two
School Based Mobile - Whanga...
Home Based Service One
Hunterville
Stewart Street Surgery
Te Oranganui Atihau
Health Bus
Waiouru Clinic
Home Based Service Two
COVID Vaccinations by Ethnicity and Age Group
Maori
Non-Maori
COVID Vaccinations by Age Group
COVID Vaccinations by Ethnicity
COVID Vaccinations by Gender
COVID Vaccinations by Patient Priority Group
Whanganui DHB Population Vaccinated by Status and Ethnicity
Whanganui DHB Population Vaccinated by Status and Ethnicity
Whanganui DHB Population Vaccinated by Status and Region
Whanganui DHB Population Vaccinated by Status and Age Group
Whanganui DHB Population Vaccinated (Partially or Fully) by Ethnicity and Age Group
Maori
Other/Unknown

Locations to target



We have data to a suburb and street level street level

Less than 40 | 40 - 60 | 60 - 80 | 80 - 90 | More than 90

What are we doing now?

- Last week, 18 pop ups occurred, plus three workplace vaccination sites, three mobile house to house teams (one Maori Health team), primary care, kaupapa and DHB clinics across the district.

- This week, multiple pop ups are occurring across the district, plus the house to house teams with increased vaccinations planned in primary care.

- Clinics have been run in partnership with Balance for tangata whaiora

- The operations team are working to support Te Ranga Tupua to stand up a vaccination service (see separate slide)

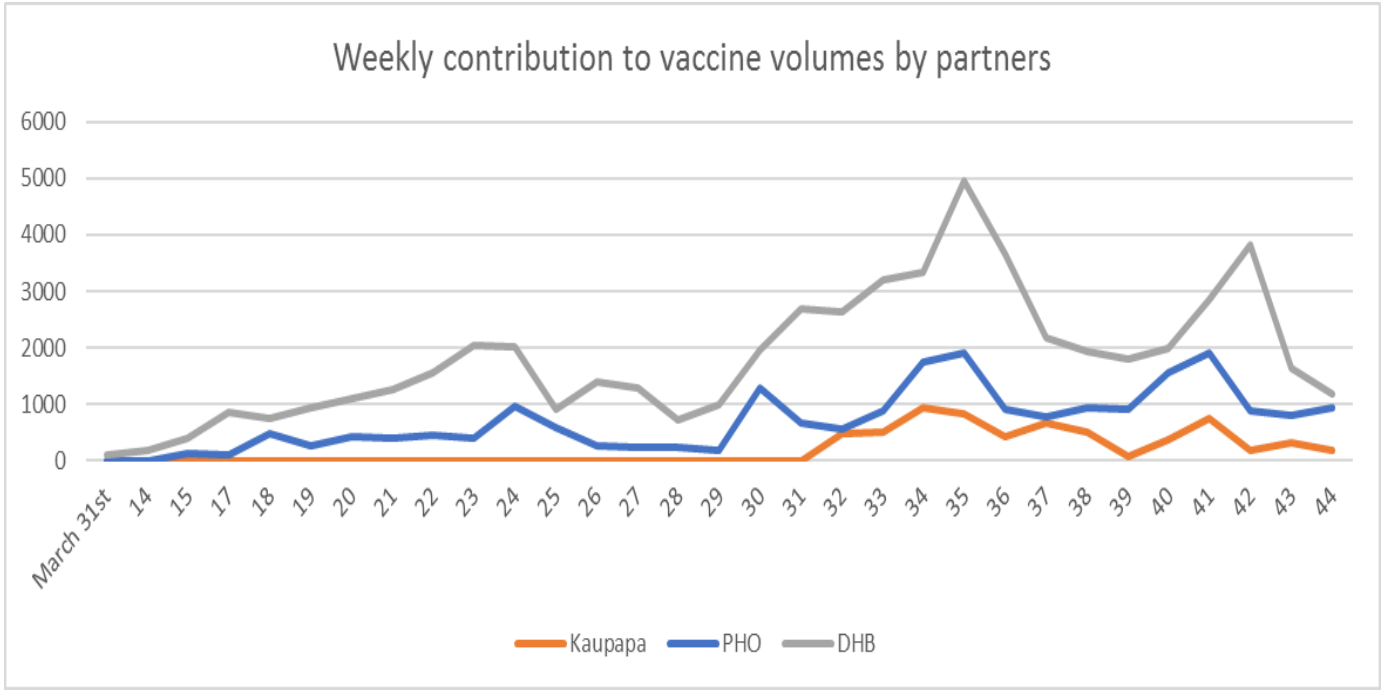
A ‘day in the life’ of the vaccination teams

- Two home based teams
- One Maori provider clinic
- Two pop ups (one Maori provider)
- Te Rito
- One vaccinating pharmacy
- Seven primary care practices
- Hospital roaming team
- One school based team

WEEK	(All)		DATE	24/11/2021
Count of NHI Number	**Column Labels**			
Row Labels	**Pfizer BioNTech COVID-19 (1)**	**Pfizer BioNTech COVID-19 (2)**	**Additional Pfizer BioNTech COVID-19 (3)**	**Grand Total**
Asian	2	4		6
European	100	133	4	237
Maori	59	58		117
Middle Eastern/Latin American/African (MELAA)		1		1
Pacific Peoples	5	9		14
Residual Categories	1	2	1	4
Grand Total	**167**	**207**	**5**	**379**

WEEK	(All)		DATE	24/11/2021
Count of NHI Number	**Column Labels**			
Row Labels	**Pfizer BioNTech COVID-19 (1)**	**Pfizer BioNTech COVID-19 (2)**	**Additional Pfizer BioNTech COVID-19 (3)**	**Grand Total**
Aramoho Health Centre	12	3	2	17
Bulls Medical Centre	5	9		14
Central City Pharmacy	13	16		29
Gonville Health	1		1	2
Home Based Service One	1	6		7
Home Based Service Two	3	3		6
Impilo Family Practice	6	9		15
Rural Mobile Site One	7	4		11
School Based Mobile - Whanganui	2	6		8
St Johns Medical Centre	2	3		5
Stewart Street Surgery	17	28		45
Taihape Health Limited	2	4		6
Te Oranganui Mobile	13	6		19
Te Poho	19	53	1	73
Victoria Ave	64	54	1	119
Whanganui Hospital VC		3		3
Grand Total	**167**	**207**	**5**	**379**

Weekly contribution by DHB and partners



Decreasing DHB input and increasing primary and kaupapa

What are we planning for the next month?

- We are continuing to engage with gang whanau, through Ned Tapa and Rangi Maniapoto (DOC) and have further pop-ups planned in locations with low uptake, including Gonville, Castlecliff, Aramoho and Whanganui East. We are planning at street level based on data provided by MoH.

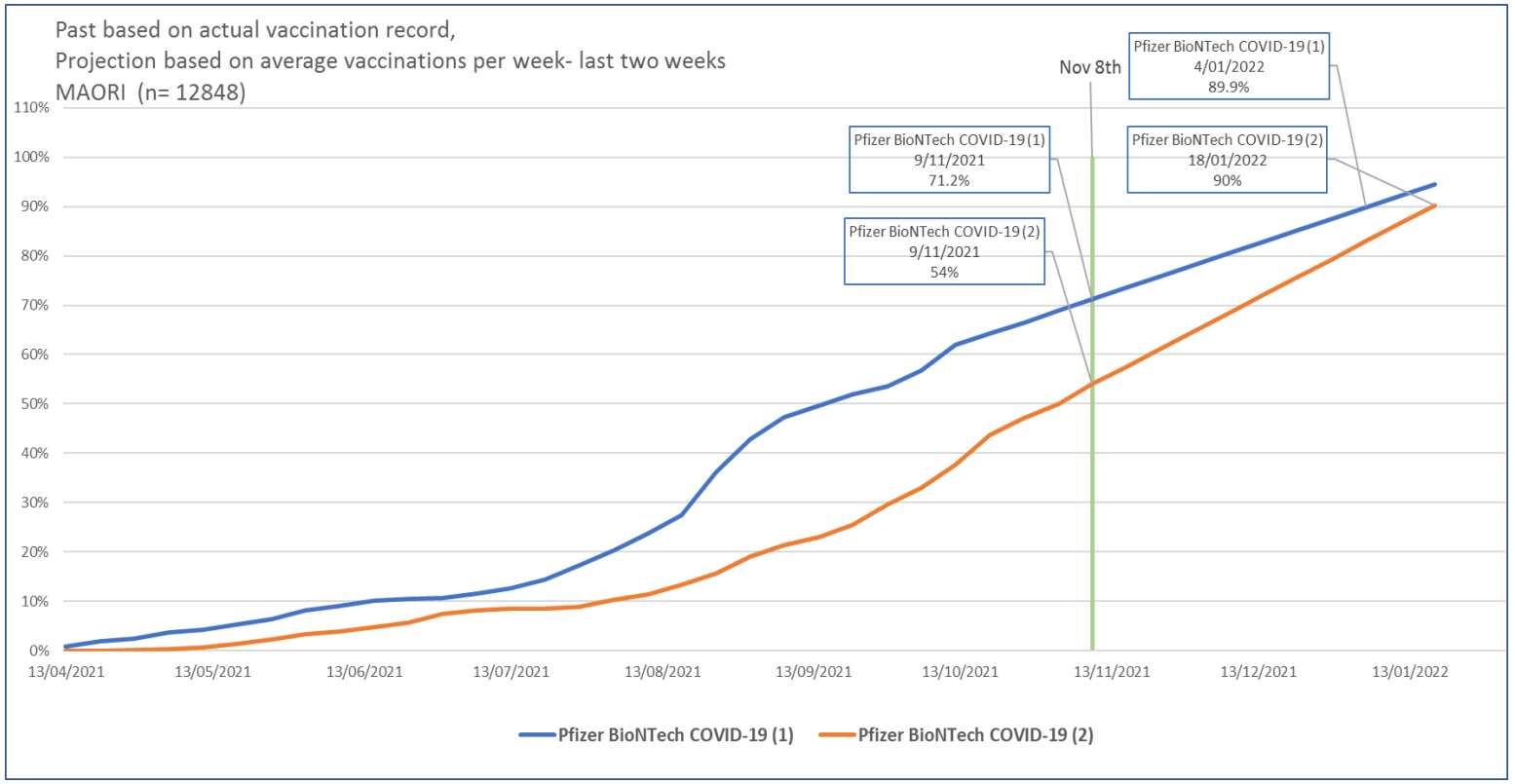
- We are running further Balance clinics

- Te Ranga Tupua and Te Oranganui mobile services hope to be up and running.

Current strategy and alternatives proposed

- We continue to plan pop ups and home visits based on suburb and street level data. The main focus is on those areas with the lowest uptake, in particular for Maori. We are increasing weekend and evening clinics.
- Gonville Health and Te Waipuna are now vaccinating and Living Waters are commencing vaccination clinics again to support boosters.
- We have one Maori Health home to home team who started on the road last week. Other Te Hau Ranga Ora team members have also mobilised to support the programme.
- CCDHB have offered vaccinator support to the Whanganui vaccination effort and these staff have been offered to primary care in the first instance. We have two CCDHB staff in the recruitment process.
- Supporting rural hubs based on the identified needs of the communities

Projection to 90% for Maori



Te Ranga Tupua proposal

- Proposal made after $120m announced to improve Maori vaccination
- WDHB asked to support proposal by minister's office
- Te Ranga Tupua successful in accessing $2.8m (02 November)
- Proposal includes vaccination and crisis management response
- Starting to work with Te Ranga Tupua to address hard to reach population. The first operational hui was held on 12 November
- They are wanting to be active ASAP

Regional Partners

- Meeting of the Impact Collective on 02 November
- Kainga Ora (Housing NZ)
- Regional Leadership Group (Horizons led)
- MoH - Information sent at street level of low levels of vaccination
- Addressing
  - Increasing overall capacity and capability
  - Planning for crisis management
  - Potential loss of care workers

Our staff situation- 16 November status

MOH Group	1st dose	2nd dose	Head Count	% First Dose	% Fully Vac
Allied	204	194	207	99%	93.7%
HCA	127	121	133	95%	91%
Midwifery	33	29	35	94%	82.9%
Nursing	468	435	478	98%	91%
Other	278	253	289	96%	87.5%
RMO	51	50	51	100%	98%
SMO	57	56	58	98%	96.6%
Total	1218	1138	1251	97%	91%

Staff who remained unvaccinated after 15 November are no longer able to work on DHB grounds.

Processes are being worked through with individuals

Questions

December 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Decision Paper**
	Item No. 3.1
Author	Nadine Mackintosh, Executive officer
Subject	**2022 Whanganui District Health Board and Committee Dates**

Recommendations

Management recommend that the Board of Whanganui District Health Board:

a. **Receive** the paper titled 2022 Whanganui District Health Board and Committee Dates.

b. **Note** that the combined statutory advisory committee dates are tentative until we receive quarterly reporting dates from the Ministry of Health for 2022.

c. **Approve** the dates listed in the paper.

1 Purpose

This paper seeks the board's support of the 2022 meeting schedule for Board and it's Committees.

2 Summary

The Board's meeting schedule is set annually and is done on a calendar year basis. Management has reviewed the meeting calendar and proposed dates that align with timelines for approving financials and production of key ministerial reporting.

It is recognised that often reports seeking a Board decision need to first receive committee endorsement. So that this can occur within the meeting cycle, it is proposed that the same report would be submitted to the committee for endorsement of the board approval. The committee chair would provide a verbal report to the Board outlining the committee findings.

A copy of the proposed meeting calendar is set out overleaf.

December 2021 **Public**

3. 2021 Proposed Meeting Schedule

Dates for the Joint Board meetings with Hauora A Iwi are to be confirmed.

2022 MEETING SCHEDULE FOR WDHB BOARD & COMMITTEES			
Meeting **Time**	**FRAC** **1pm-3pm**	**CSAC** **9.30am-1pm**	**Board** **9:30 am-1pm**
Date of meeting			19 January (virtual)
Deadline for			10 January
Published			14 January
Date of meeting	**9 February**		**16 February (F2F)**
Reporting	31 January		7 February
Published	4 February		11 February
Date of meeting		**25 March**	16 March (virtual)
Deadline for		14 March	7 March
Published		18 March	11 March
Date of meeting	**13 April**		**20 April (F2F)**
Deadline for	4 April		11 April
Published	8 April		15 April
Date of meeting			**18 May (Virtual)**
Deadline for			9 May
Published			13 May
Date of meeting	**8 June**	**24 June**	**15 June (F2F)**
Deadline for	30 May	13 June	6 June
Published	3 June	17 June	10 June
			20 July (F2F)
Deadline for			11 July
Published			15 July

December 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No. 4.1
Author	Raju Gulab, Finance Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	**Detailed financial report – October 2021**

Recommendations

That the Whanganui District Health Board:

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

b. **Note** the October 2021 monthly result of $849k deficit is favourable to budget by $6k. Including COVID-19 and the Holiday Act Compliance provision, the result is $47k unfavourable to budget.

c. **Note** the year-to-date result of $2,751k deficit is unfavourable to budget by $92k. Including COVID-19 and the Holiday Act Compliance provision, the result is $254k unfavourable to budget.

Financial Overview – October 2021

YTD Performance
Actual deficit $2.8m (excluding COVID-19 and Holiday Act Compliance provision)
Against budgeted deficit of $2.7m, $0.1m unfavourable to budget.

YTD IDF Net Flow
$16.7m expenditure
Against budgeted expenditure of $17.3m, $0.6m favourable to budget.

YTD CWDs
Estimated CWDs 4,231
Against 4,085 budgeted CWDs, 3.6% ahead (IDF CWDs excluded).

YTD FTE
Actual FTE 924 (Total FTE 991, including COVID-FTE of 67)
Budgeted FTE of 942 (Full year FTE 952)

YTD Capital Expenditure
Actual spend $2.0m
Against budgeted expenditure of $3.9m. $1.9 m underspent relates to delay in IT Intangible assets and Building projects.

December 2021 **Public**

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

	Month				Year to Date				Annual	Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2021-22	Actual 2020-21
Revenue	26,182	26,177	5	F	104,708	104,290	418	F	314,675	297,522
Total Revenue	26,182	26,177	5	F	104,708	104,290	418	F	314,675	297,522
Less:										
Provider Health Service	(13,949)	(13,968)	19	F	(53,698)	(53,947)	249	F	(158,385)	(151,506)
Corporate Service	(144)	(135)	(9)	U	(539)	(551)	12	F	(1,629)	(1,818)
Governance	(124)	(102)	(22)	U	(442)	(421)	(21)	U	(1,266)	(1,016)
DHB Funder Division (exl IDF outflow)	(8,966)	(8,530)	(436)	U	(36,236)	(34,861)	(1,375)	U	(106,099)	(99,499)
Inter-district Outflow	(3,905)	(4,334)	429	F	(16,725)	(17,335)	610	F	(52,005)	(46,989)
ACC Contract (net)	57	37	20	F	181	166	15	F	408	511
Total expenditure	(27,031)	(27,032)	1	F	(107,459)	(106,949)	(510)	U	(318,976)	(300,317)
Net Surplus/(Deficit) before COVID-19 & HolidayPay	**(849)**	**(855)**	**6**	**F**	**(2,751)**	**(2,659)**	**(92)**	**U**	**(4,301)**	**(2,795)**
Revenue- COVID-19	722	-	722	F	3,208	-	3,208	F	-	2,367
Expenditure COVID-19	(775)	-	(775)	U	(3,355)	-	(3,355)	U	-	(2,391)
COVID-19	(53)	-	(53)	U	(147)	-	(147)	U	-	(24)
Holiday Act Costs	(53)	(53)	-	F	(225)	(210)	(15)	U	(644)	(2,028)
One-off	(53)	(53)	-	F	(225)	(210)	(15)	U	(644)	(2,028)
Net Surplus / (Deficit)	**(955)**	**(908)**	**(47)**	**U**	**(3,123)**	**(2,869)**	**(254)**	**U**	**(4,945)**	**(4,847)**

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

Overview

Month comments

The operating result for the month of October 2021 was favourable to budget by $6k. When including COVID-19 and Holiday Act Compliance provision, the result is $47k unfavourable to budget.

Revenue (Appendix 1)

Revenue was $5k favourable to budget due to Ministry of Health side contract revenue (offset by costs), inter district flow revenue and ACC revenue. These increases in revenue were partly offset by Ministry of Health clawback funding for Combined Pharmaceutical Budget (CPB) (Whanganui DHB's full year share is $1.3m).

Revenue- COVID-19

Covid-19 revenue was $722k favourable due to funding for vaccination programme, Public Health contact tracing and managed isolation. These increases in revenue were offset by costs which are expected to be fully funded by the Ministry of Health.

Provider health service (Appendix 2)

Inpatient estimated volumes were 108.6% to target in October 2021 with unplanned (acute) at 115.5% and planned (elective and arranged) at 91.6% of budget for the month. The value of this increased volume is approximately $523k, 86 CWD.

Provider division was $19k favourable to budget due to favourable Allied Health, management and administration personnel costs due to vacancies, clinical supplies, non-clinical supplies and depreciation costs. These favourable variances were partly offset by higher medical personnel (including locum) cost and nursing costs.

Corporate service (Appendix 2)

Corporate was $9k unfavourable to budget due to IT related outsourced costs.

Governance

Governance was $22 unfavourable due to impact collective programme costs (offset by revenue).

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

Funder division was $436k unfavourable to budget due to health of older people and mental health service costs. Mental health increased cost was offset by higher revenue.

Inter-district flows (Appendix 4)

Inter-district flows were $429k favourable to budget due to inpatient activity.

Covid-19 expenditure

COVID-19 expenditure was $722k favourable to budget with costs incurred mainly in operating the vaccination programme, Public Health contact tracing and managed isolation management facility.

Year-to-date comments

Year-to-date October 2021 operating result was unfavourable to budget by $92k; when including COVID-19 and Holiday Act Compliance provision, the result is $254k unfavourable to budget.

Revenue (Appendix 1)

Revenue was $418k favourable to budget mainly due to higher integrated mental health addiction service revenue $394k, measles immunisation revenue $28k, primacy health care funding $157k and financial sustainability improvement funding $20k. These increases in revenue were partly offset by lower $215k combined pharmaceutical revenue (*Ministry of Health clawback funding for Combined Pharmaceutical Budget (CPB) $76m, Wanganui DHB's full year share is $1.3m, however $217k revenue used from last year income in advance to offset increased pharmaceutical cost)* and $4k various other source of revenue.

Revenue- Covid-19 (Appendix 1)

Covid-19 revenue was $3,208k favourable to budget due to ongoing support of operating CBAC facilities, community testing, managed isolation and vaccination programme.

Provider division (Appendix 2)

Inpatient estimated volumes were 103.6% to target year to date with unplanned (acute) 108.4% and planned (elective and arranged) 91.1% of budget year-to-date. The value of this overall increased volume is $886k, 145 CWD.

Provider division was $249k favourable to budget due to Allied Health, management and administration personnel costs lower due to vacancies as well as lower clinical supplies, non-clinical supplies and depreciation costs. These favourable variances were partly offset by higher medical personnel (including locum) cost and nursing costs.

Corporate (Appendix 2)

Corporate was $12k favourable to budget due to lower building insurance costs, personnel costs due to vacancies in IT and finance and lower depreciation costs. These lower costs were partly offset by higher IT outsourced costs.

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

Funder division was $1,375k unfavourable to budget due to health of older people, home base support and hospital residential care support cost (volume and price increased), higher primary health organisation (PHO) costs (offset by revenue), integrated mental health addiction service (offset by revenue), public health measles costs (offset by revenue) and pharmaceutical (partly offset by rebate).

There has been an increase in aged care beds with an additional 10 beds coming on stream this year. Also, home base support contract prices were renegotiated with a key supplier resulting in an 100% increase in cost price.

Inter-district flows (Appendix 4)

Inter-district flows were $610 favourable to budget due mainly to inpatient activities.

Covid-19 expenditure

COVID-19 expenditure was $3,355k unfavourable due to costs incurred mainly in community testing, operating CBAC facility, vaccination programme, managed isolation, and Maori health support.

Holiday Act provision

Holiday Act remediation provision of $15k unfavourable to budget due to project management consultancy costs.

December 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 2021-22	Annual Actual 2020-21
Ministry of Health	24,942	24,979	(37)	U	100,014	99,609	405	F	298,278	283,156
Inter-district inflow	660	707	(47)	U	2,810	2,829	(19)	U	8,486	8,103
Other District Health Board (DHB)	94	69	25	F	310	276	34	F	780	1,123
Accident Compensation (ACC)	373	249	124	F	1,141	1,000	141	F	3,160	3,465
Other Government	29	8	21	F	95	94	1	F	223	276
Patient consumer sourced	21	92	(71)	U	69	176	(107)	U	922	360
Other income	63	73	(10)	U	269	306	(37)	U	2,826	1,039
COVID-19	722	-	722	F	3,208	-	3,208	F	-	2,367
Total revenue	26,904	26,177	727	F	107,916	104,290	3,626	F	314,675	299,889

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

Month comments

Ministry of Health

Revenue was $37k unfavourable to budget due to Ministry of Health clawback funding for Combined Pharmaceutical Budget (CPB). This is partly offset by Ministry of Health side contract revenue (offset by corresponding costs).

Inter-district inflow

Inter-district inflow was $47k unfavourable to budget due to lower inpatient service activity.

Accident Compensation (ACC)

Revenue was $124k favourable to budget due to ACC non-acute inpatient rehabilitation, ACC sexual abuse assessment and treatment and ACC radiology revenue.

Patient Consumer sourced

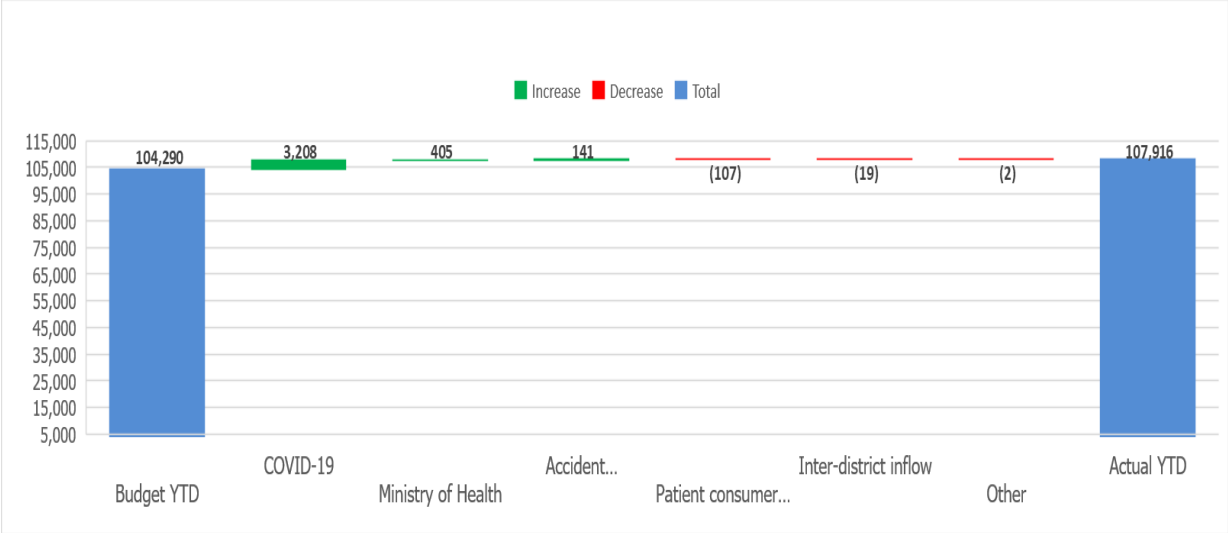
Revenue was $71k unfavourable to budget due to revenue from community referrals to radiology for private and insurance funded patients having not eventuated yet.

Covid-19 revenue

COVID-19 expenditure was $722k favourable to budget with costs incurred mainly in operating the vaccination programme, Public Health contact tracing and managed isolation management facility.

December 2021 **Public**

Year to date comments



Covid-19

COVID-19 was $3,208 favourable to budget due to Ministry of Health funding for:

- Community testing $62k
- Vaccination estimated funding $2,573k.
- Maori health support $410k (this revenue passes on to community health providers)
- Public Health community testing $120k
- Managed isolation $43k

Ministry of Health

Revenue was $405k favourable to budget, mainly due to an increase of integrated mental health addiction service revenue $394k (offset by costs), measles immunisation revenue $28k (offset by costs), primary health care funding $157k (offset by costs), financial sustainability improvement revenue $20k (offset by costs), and various other $21k. These increases in revenue were partly offset by lower combined pharmaceutical revenue of $215k.

Accident Compensation (ACC)

ACC revenue was $141k favourable to budget due to higher ACC home base nursing revenue, ACC non-acute inpatient rehabilitation revenue and ACC sexual abuse assessment and treatment revenue. These increases in revenue were partly offset by lower ACC radiology revenue.

Patient Consumer sourced

Revenue was $107k unfavourable to budget due to dental revenue, non-resident revenue and capturing revenue from community referrals to radiology for private and insurance funded patients having not eventuated yet.

Inter-district inflow

Inter-district inflow was $19k unfavourable to budget due to lower inpatient service activity.

December 2021 **Public**

Appendix 2 – Provider Health and Corporate Services

	Month					Year to Date					Annual Budget 2021-22	Annual Actual 2020-21
	Actual	Budget	Variance	Var %		Actual	Budget	Variance	Var %			
Expenditure												
Medical Personnel	2,013	2,032	19	F		8,222	8,323	101	F		25,622	24,261
Nursing Personnel	3,693	3,573	(120)	U		14,454	14,214	(240)	U		43,441	44,352
Allied Personnel	1,061	1,149	88	F		4,397	4,714	317	F		14,109	12,867
Support Personnel	85	81	(4)	U		354	333	(21)	U		989	1,054
Management & Admin Perseonnel	976	1,065	89	F		3,958	4,387	429	F		13,073	11,893
Total Personnel(Exl other & outsourced)	**7,828**	**7,900**	**72**	**F**		**31,385**	**31,971**	**586**	**F**		**97,234**	**94,427**
Personnel Other	213	233	20	F		722	846	124	F		2,778	1,754
Outsourced Medical Personnel	479	351	(128)	U		2,014	1,442	(572)	U		4,288	5,784
Outsourced Allied Personnel	68	42	(26)	U		201	168	(33)	U		526	888
Outsourced Manag & Admin Personnel	64	33	(31)	U		362	131	(231)	U		393	726
Total Personnel outsourced	**824**	**659**	**(165)**	**U**		**3,299**	**2,587**	**(712)**	**U**		**7,985**	**9,152**
Total Personnel Expenditure	**8,652**	**8,559**	**(93)**	**U**		**34,684**	**34,558**	**(126)**	**U**		**105,219**	**103,579**
Outsourced Clinical Service	538	533	(5)	U		2,055	2,100	45	F		6,196	5,915
Clinical Supplies	1,419	1,597	178	F		6,370	6,743	373	F		18,893	18,299
Infrastructure & Non Clinical Supplies Costs	2,733	2,633	(100)	U		8,020	7,920	(100)	U		19,762	16,546
Capital Charge	202	210	8	F		814	840	26	F		2,415	2,342
Depreciation & Interest	578	600	22	F		2,308	2,351	43	F		7,446	6,441
Internal Allocation	(29)	(29)	-	F		(14)	(14)	-	F		83	202
Total Other Expenditure	**5,441**	**5,544**	**103**	**F**		**19,553**	**19,940**	**387**	**F**		**54,795**	**49,745**
Total Expenditure	**14,093**	**14,103**	**10**	**F**		**54,237**	**54,498**	**261**	**F**		**160,014**	**153,324**
Expenditure												
Medical personnel and Locum	2,492	2,383	(109)	U		10,236	9,765	**(471)**	U		29,910	30,045
Nursing Personnel	3,693	3,573	(120)	U		14,454	14,214	**(240)**	U		43,441	44,352
Allied Personnel	1,129	1,191	62	F		4,598	4,882	**284**	F		14,635	13,755
Management & Admin Perseonnel	1,040	1,098	58	F		4,320	4,518	**198**	F		13,466	12,619
Othe Personnel costs	298	314	16	F		1,076	1,179	**103**	F		3,767	2,808
Clinical Supplies	1,419	1,597	178	F		6,370	6,743	**373**	F		18,893	18,299
Outsourced Clinical Service	538	533	(5)	U		2,055	2,100	**45**	F		6,196	5,915
Infrastructure & Non Clinical Supplies Costs	2,935	2,843	(92)	U		8,834	8,760	**(74)**	U		22,177	18,888
Depreciation & Interest	578	600	22	F		2,308	2,351	**43**	F		7,446	6,441
Internal Allocation	(29)	(29)	-	F		(14)	(14)	-	F		83	202
Total Expenditure	**14,093**	**14,103**	**10**	**F**		**54,237**	**54,498**	**261**	**F**		**160,014**	**153,324**
FTEs												
Medical	112.4	111.8	(1)	U		112.7	111.8	(1)	U		112.9	111.5
Nursing	470.1	458.9	(11)	U		464.6	458.2	(6)	U		467.2	460.8
Allied	153.8	166.8	13	F		152.2	166.6	14	F		166.5	160.3
Support	17.6	16.3	(1)	U		17.6	16.3	(1)	U		16.3	18.0
Management & Admin	166.0	174.5	9	F		161.8	174.6	13	F		174.5	169.5
Total FTEs	**920**	**928**	**8.5**	**F**		**909**	**928**	**18.6**	**F**		**937**	**920**
Case Weighted Discharges (CWD)												
Unplanned (Acute)	821	711	(110)	U	-15.5%	3,192	2,945	(246)	U	-8.4%	8,836	8,528
Planed (Elective & Arranged)	265	289	24	U	8.4%	1,039	1,140	101	U	8.9%	3,227	2,968
Total CWD	**1,086**	**1,000**	**(86)**	**U**	**-8.6%**	**4,231**	**4,085**	**(145)**	**U**	**-3.6%**	**12,063**	**11,496**
Further information												
General Medicine	386	280	(106)	U	-38.0%	1,496	1,159	(337)	U	-29.0%	3,478	3,728
General Surgery	215	213	(3)	U	-12%	891	869	(22)	U	-2.5%	2,488	2,582
Orthopaedics	172	210	38	U	18.1%	635	807	172	F	21.4%	2,390	1,897
Gynaecology	41	29	(12)	U	-40.3%	125	120	(5)	U	-4.3%	350	388
Emergency Medicine	120	108	(12)	F	-11.5%	426	447	21	F	4.8%	1,342	1,096
Othter	151	160	9	U	5.6%	658	683	25	F	3.7%	2,015	1,805
Total CWD	**1,086**	**1,000**	**(86)**	**U**	**-8.6%**	**4,231**	**4,085**	**(145)**	**U**	**-3.6%**	**12,063**	**11,496**

Month comments

The overall expenditure for October 2021 was $10k favourable to budget.

Personnel

Total personnel costs were $93k unfavourable to budget due mainly to an increase in nursing personnel and medical locum costs. These unfavourable variances were partly offset by Allied Health personnel, management personnel and unattended courses and conferences as a result of the Covid-19 pandemic.

Outsourced clinical service

Outsourced clinical service costs were $5k unfavourable to budget due mainly to radiology outsourced service costs and after hours mental health telephone service.

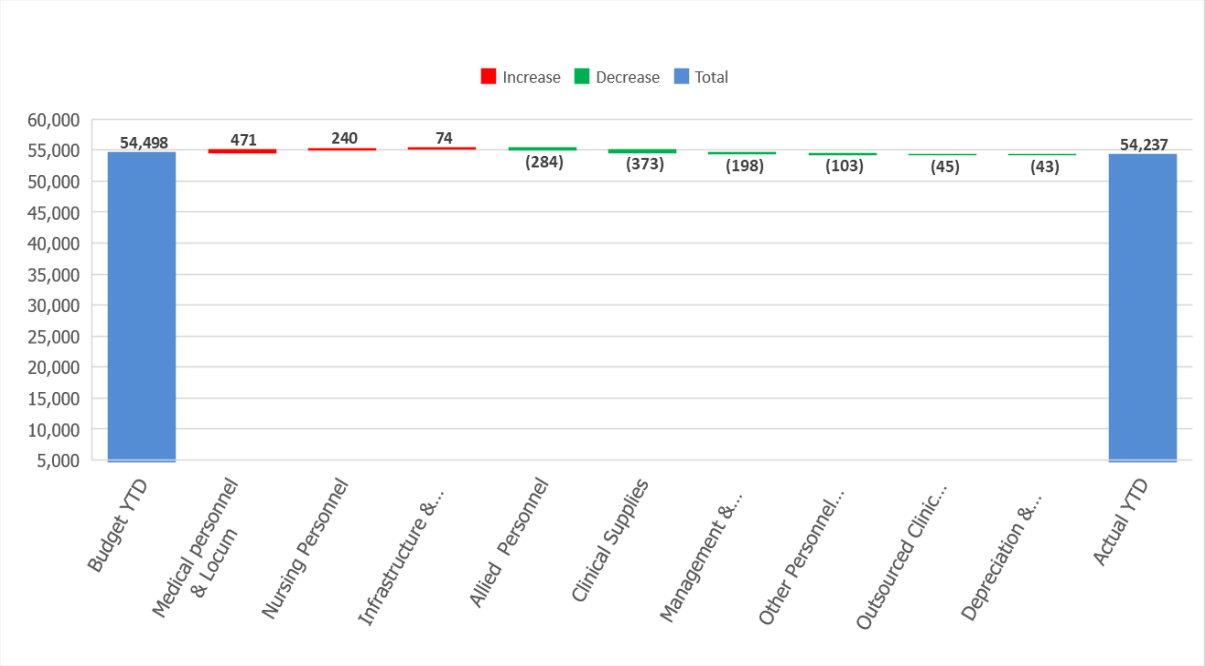
Clinical supplies

Clinical supplies costs were $178k favourable to budget due to lower theatre consumables (orthopaedic surgery 18.1% lower than target) and district nursing consumables costs.

Infrastructure and non-clinical supplies

Infrastructure and non-clinical supplies costs were $100k unfavourable due to data networking and IT bureau costs.

Year-to-date comments



The overall year-to-date expenditure $261k favourable to budget.

Medical personnel

The medical personnel net unfavourable variance of $471k was mainly due to use of locums to cover vacancies. Unfavourable locum costs of $572k were partly offset by savings in payroll costs of $101k due to unfilled vacant positions. Locum costs were made up of ophthalmology $84k, general medicine $124k, RMOs $51k, mental health SMO $150k, gynaecology $163k.

Nursing personnel

Nursing personnel was $240k unfavourable to budget due high acute demand (inpatient activity 3.6% above target).

Infrastructure and non-clinical supplies (including capital charge)

Infrastructure and non-clinical supplies costs were $74k unfavourable to budget due to data networking upgrade IT bureau, outsourced and non-capitalised hardware costs. These higher costs were partly offset by lower facility maintenance costs, transport costs and building and other insurance costs.

Allied personnel

Allied personnel costs net favourable variance of $284k favourable to budget was mainly due to vacancies in audiology, radiology, occupational therapies, dental, physiotherapy, pharmacy, community mental health and health promotion. Favourable payroll savings of $317k were partly offset by outsourced costs of $33k mainly in the areas of radiology and physiotherapy.

Clinical supplies

Clinical supplies costs were $373k favourable to budget due to lower theatre consumables (orthopaedic surgery 21.4% lower than target), district nursing consumables and dental supplies. These lower costs were partly offset by higher infliximab drug costs and radiology costs.

Management and administration

Management and administration personnel costs net favourable variance of $198k favourable to budget was mainly due to vacancies IT, finance and patient safety and various other areas. Favourable payroll savings of $429k were partly offset by outsourced costs of $231k mainly in IT, business manager and communication areas.

Other personnel

Other personnel costs were $103k favourable to budget due mainly to unattended courses and conferences as a result of the Covid-19 pandemic.

Outsourced clinical and other services

Outsourced clinical service costs were $45k favourable to budget mainly due to lower radiology, dental, ophthalmology, audiology outsourced service costs. This is partly offset by higher after hours mental health telephone service costs.

Depreciation and interest costs

Depreciation and interest costs were $43k favourable to budget due to timing of clinical and IT equipment purchase and interest costs.

Case weighted discharges

Year to Date estimated case weighted discharges (CWD) were 145 CWD, 3.6% higher than target. General medicine 337 CWD, was 29% 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.

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Appendix 3 – DHB Funder Division

	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2021-22	Actual 2020-21
Expenditure by type										
Pharmaceuticals	(1,419)	(1,495)	76	F	(6,315)	(6,000)	(315)	U	(17,723)	(17,355)
Primary Health Organisation (PHO)	(1,598)	(1,565)	(33)	U	(6,587)	(6,449)	(138)	U	(18,909)	(18,015)
Home Based Support (short Term)	(203)	(203)	-	F	(819)	(811)	(8)	U	(2,431)	(2,452)
Other Personal Health	(1,121)	(1,133)	12	F	(4,657)	(4,656)	(1)	U	(14,273)	(13,398)
Health of Older People	(2,958)	(2,563)	(395)	U	(11,093)	(10,649)	(444)	U	(34,187)	(31,490)
Mental Health	(1,138)	(1,087)	(51)	U	(4,734)	(4,342)	(392)	U	(12,981)	(11,436)
Public Health	(93)	(93)	-	F	(406)	(374)	(32)	U	(1,140)	(1,184)
Maori Services	(139)	(139)	-	F	(642)	(642)	-	F	(1,757)	(1,713)
Total Other provider expenditure	**(8,669)**	**(8,278)**	**(391)**	**U**	**(35,253)**	**(33,923)**	**(1,330)**	**U**	**(103,401)**	**(97,043)**
Funding Admin	(299)	(253)	(46)	U	(984)	(938)	(46)	U	(2,698)	(2,457)
Total funder expenditure	**(8,968)**	**(8,531)**	**(437)**	**U**	**(36,237)**	**(34,861)**	**(1,376)**	**U**	**(106,099)**	**(99,500)**
	-	-	-		-	-	-		-	1
Expenditure by service										
Personal Health	(4,341)	(4,396)	55	F	(18,378)	(17,916)	(462)	U	(53,336)	(51,220)
Health of Older People	(2,958)	(2,563)	(395)	U	(11,093)	(10,649)	(444)	U	(34,187)	(31,490)
Mental Health	(1,138)	(1,087)	(51)	U	(4,734)	(4,342)	(392)	U	(12,981)	(11,436)
Public Health	(93)	(93)	-	F	(406)	(374)	(32)	U	(1,140)	(1,184)
Maori Services	(139)	(139)	-	F	(642)	(642)	-	F	(1,757)	(1,713)
Funding Admin	(299)	(253)	(46)	U	(984)	(938)	(46)	U	(2,698)	(2,457)
Total Expenditure	**(8,968)**	**(8,531)**	**(437)**	**U**	**(36,237)**	**(34,861)**	**(1,376)**	**U**	**(106,099)**	**(99,500)**
	-	-	-		-	-	-		-	-

Month comments

The overall expenditure for the month of October was $437k unfavourable to budget.

Pharmaceuticals

Pharmaceutical was $76k favourable to due to reversal of prior year final accrual adjustment.

Primary Health Organisation

The Primary Health Organisation (PHO) was $33k unfavourable to budget. This was offset by increased primary care funding.

Health of Older People (HOP)

Health of older people was $395k unfavourable to budget due to home base support and residential care hospital demand and a price increase.

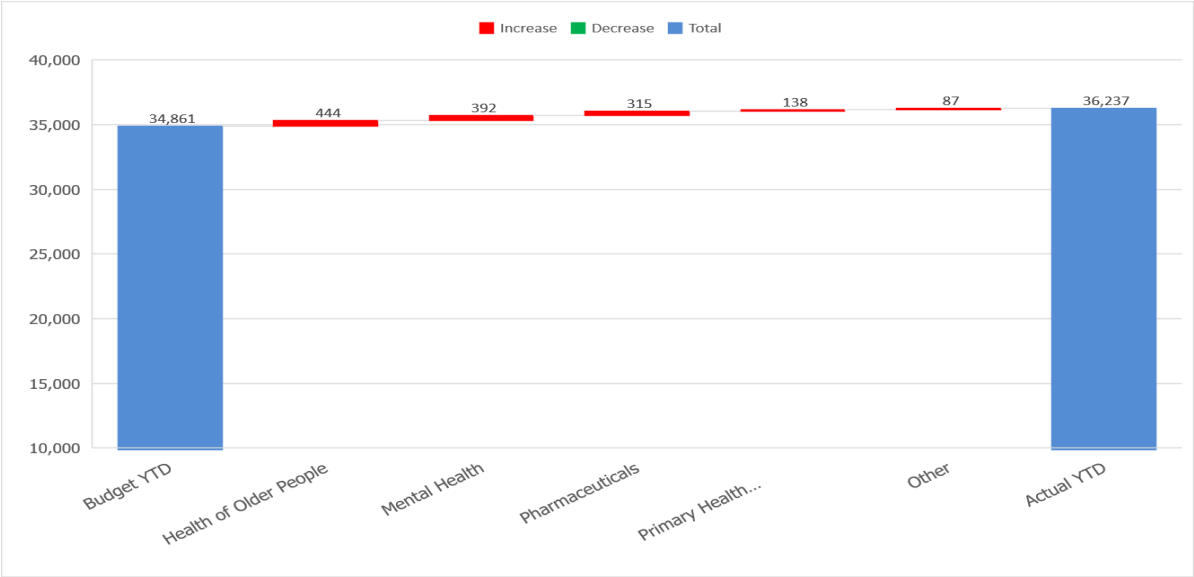
Mental health

Mental health service was $51k unfavourable to budget largely due to an increase in the integrated primary mental health and addiction service costs. This was offset by higher revenue.

December 2021 **Public**

Year-to-date comments

The overall year-to-date expenditure was $1376k unfavourable to budget.



Health of Older People (HOP)

Health of older people was $444k unfavourable to budget due to home base support and residential care hospital demand and a price increase.

Mental health

Mental health service was $392k unfavourable to budget largely due to an increase in the integrated primary mental health and addiction service costs. This was offset by higher revenue.

Pharmaceuticals

Pharmaceutical was $315k unfavourable to budget due to likely impact of Covid-19.

Primary Health Organisation

The Primary Health Organisation (PHO) was $138k 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.

Other

Other cost was $87k unfavourable to budget due to measles immunisation costs and funding admin mainly vacancy costs.

December 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 2020-21 $000
Expenditure										
Outflow inpatient	($ 1,789)	($ 2,239)	450	F	($ 8,407)	($ 8,955)	548	F	($ 26,864)	($ 24,045)
Outflow other	($ 2,116)	($ 2,095)	(21)	U	($ 8,318)	($ 8,380)	62	F	($ 25,141)	($ 22,944)
Total outflow	**(3,905)**	**(4,334)**	**429**	**F**	**(16,725)**	**(17,335)**	**610**	**F**	**(52,005)**	**(46,989)**
Inflow inpatient	$241	$308	(67)	U	$1,201	$1,232	(31)	U	$3,694	$3,269
Inflow other	$419	$399	20	F	$1,609	$1,597	12	F	$4,792	$4,834
Total inflow	**660**	**707**	**(47)**	**U**	**2,810**	**2,829**	**(19)**	**U**	**8,486**	**8,103**
Total IDF net flow	**(3,245)**	**(3,627)**	**382**	**F**	**(13,915)**	**(14,506)**	**591**	**F**	**(43,519)**	**(38,886)**

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

Year-to-date comments

Year-to-date IDF net flow was $591k favourable to budget.

Year-to-date outflow IDF revenue was $610k favourable to budget.

- Inpatient IDF outflow was $548k favourable to budget due to lower inpatient activity at Capital and Coast DHB and Midcentral DHB. Anticipated saving of $1.8m is included in budget.
- Other IDF outflow was $62k favourable to budget due to service changes and Mental Health additional IDF budget not eventuate.

Year-to-date inflow IDF revenue was $19k unfavourable to budget.

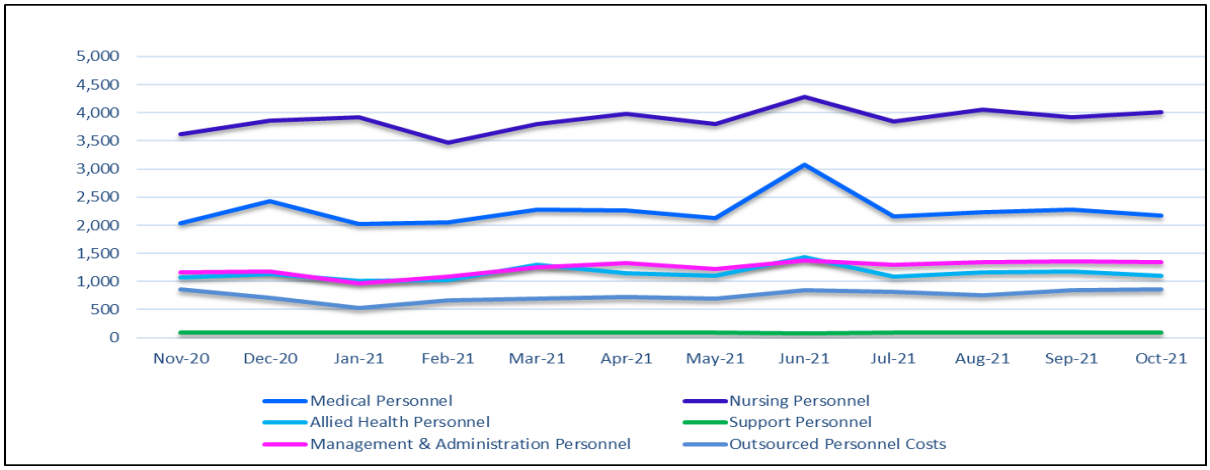
- Inter-district inpatient inflow $31k unfavourable relates to inpatient service.
- Inter-district other inflow $12k favourable due to service changes.

December 2021 **Public**

Appendix 5 – Other information

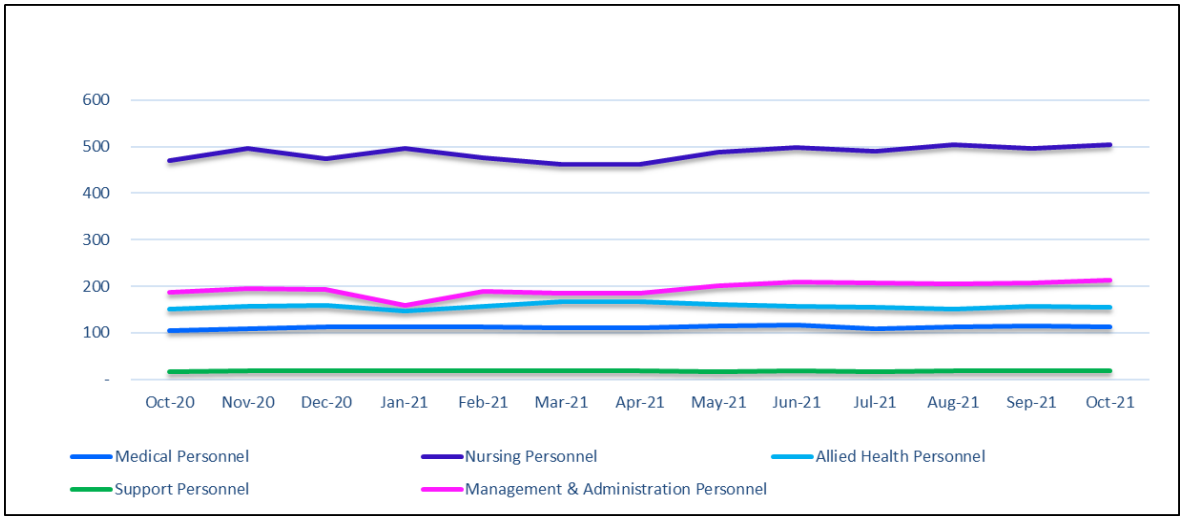
Supplementary information on costs

Personnel cost trends



- Over all personnel costs in October comparable to prior month.
- Outsourced personnel costs October comparable to prior month.

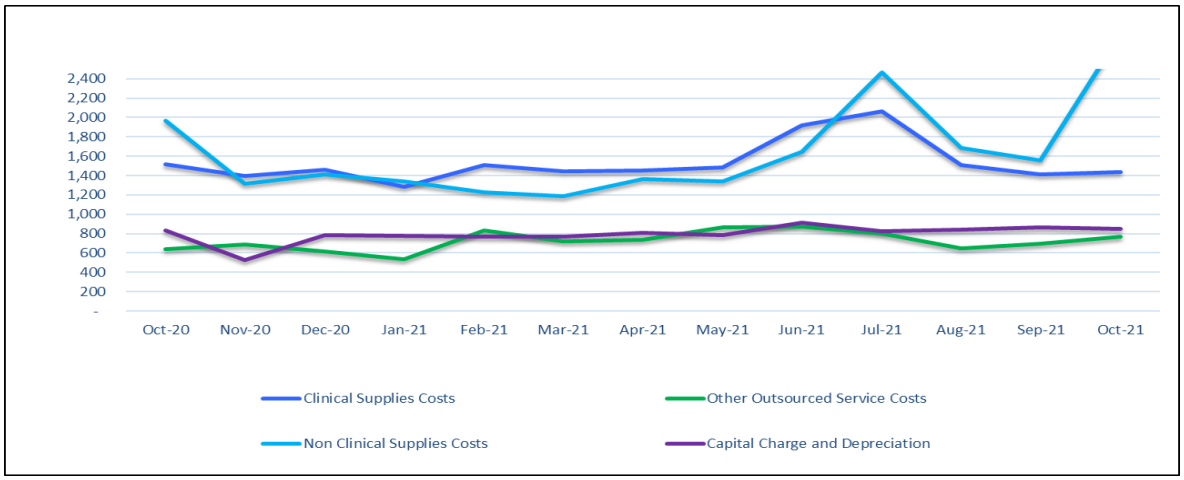
FTE trends



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

December 2021 **Public**

Other operating costs



- Clinical supplies trend in October comparable to the prior month.
- Non-clinical supplies upward trend in October compared to the prior month is due to phasing software license fees.
- Other outsourced service upward trend in October compared to prior month is due to ACC contract and radiology costs.
- Capital charge and depreciation comparable to prior month.

December 2021 **Public**

Appendix 6 – Statement of financial position

	Actual 2020-21 $000	Actual 2021-22 $000	Budget 2021-22 $000	Varinace to Budget	Annaul Budget 2021-22 $000
Assets					
Current assets					
Cash and cash equivalents	–	1,831	5	1,826	5
Receivables & Prepayments	10,888	9,527	7,825	1,702	6,575
Investments	–	–	–	–	–
Inventories	1,495	1,479	1,617	(138)	1,617
Trust /special funds	200	207	190	17	189
Patient and restricted trust funds	4	3	3	–	4
Total current assets	**12,587**	**13,047**	**9,640**	**3,407**	**8,390**
Non current assets					
Property, plant and equipment	88,806	88,960	91,776	(2,816)	96,445
Intangible assets	11,255	10,815	12,232	(1,417)	13,422
Investments in associates	1,173	1,173	1,220	(47)	1,255
Total non current assets	**101,234**	**100,948**	**105,228**	**(4,280)**	**111,122**
Total assets	**113,821**	**113,995**	**114,868**	**(873)**	**119,512**
Liabilities					
Current liabilities					
Bank Overdraft	(1,355)	–	(7,504)	7,504	(8,577)
Payables	(20,655)	(25,130)	(20,273)	(4,857)	(21,526)
Borrowings	(100)	(100)	(103)	3	(103)
Employee entitlements	(26,435)	(26,646)	(23,931)	(2,715)	(27,299)
Provisions	–	–	–	–	–
Total current liabilities	**(48,545)**	**(51,876)**	**(51,811)**	**(65)**	**(57,505)**
Non-current liabilities					
Borrowings	(385)	(352)	(353)	1	(282)
Employee entitlements	(768)	(769)	(774)	5	(729)
Total non current liabilities	**(1,153)**	**(1,121)**	**(1,127)**	**6**	**(1,011)**
Total liabilities	**(49,698)**	**(52,997)**	**(52,938)**	**(59)**	**(58,516)**
Net assets	**64,123**	**60,998**	**61,930**	**(932)**	**60,996**
Equity					
Contributed Capital	(112,251)	(112,251)	(112,251)	–	(113,393)
Accumulated surplus / (deficit)	87,556	90,683	90,093	590	92,169
Property revaluation reserves	(39,230)	(39,230)	(39,577)	347	(39,577)
Hospital special funds	(198)	(200)	(195)	(5)	(195)
Total equity	**(64,123)**	**(60,998)**	**(61,930)**	**932**	**(60,996)**

- Total assets $873k lower than budget. Property, plant and equipment lower expenditure due to the impact of actual 2020-21 capital expenditure was less than originally included in 2021-22 Annual Plan forecast for 2020-21.
- Total liabilities closed to budget due to improvement in budged overdraft (better cash position relates to favourable prior year IDF wash-up and Planned care funding), offset by increased payables and employee entitlement provision.

December 2021 **Public**

Appendix 7 – Cash flow

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

	Actual 2019-20	Actual 2020-21	Actual YTD 2021-22	Budget YTD 2021-22	Variance		Annual Budget 2021-22
Net surplus / (deficit) for year	(15,404)	(4,847)	(3,123)	(2,869)	(254)	U	(4,945)
							–
Add back non-cash items							–
Depreciation and assets written off on PPE	5,565	6,366	2,299	2,327	(28)	U	7,349
Revaluation losses on PPE	–	–	–	–	–	F	–
							–
Total non cash movements	5,565	6,366	2,299	2,327	(28)	U	7,349
							–
Add back items classified as investment Activity							–
(loss) / gAmn on sale of PPE	5	80	14	–	14	F	–
Profit from associates	(108)	(126)	–	–	–	F	(85)
GAmn on sale of investments				–	–	F	–
Write-down on initial recognition of financial asset	–	–	–				–
Movements in accounts payable attributes to Ca	(127)	271	–	–	–	F	–
							–
Total Items classified as investment Activity	(230)	225	14	–	14	F	(85)
							–
Movements in working capital							–
Increase / (decrease) in trade and other payables	2,301	120	4,475	242	4,233	F	1,495
Increase / (decrease) employee entitlements	5,173	4,444	212	(683)	895	F	2,640
				–	–	F	–
(Increase) / decrease in trade and other receivable	123	(4,487)	1,361	(1,380)	2,741	F	(45)
(Increase) / decrease in inventories	(190)	122	16	–	16	F	–
Increase / (decrease) in provision	–	–	–	–	–	F	–
							–
Net movement in working capital	7,407	199	6,064	(1,821)	7,885	F	4,090
Net cash inflow / (outflow) form operating activ	(2,662)	1,943	5,254	(2,363)	7,617	F	6,409
	–	–	–	–			–
Net cash flow from Investing (capex)	(3,109)	(6,756)	(2,027)	(3,881)	1,854	F	(14,762)
Net cash flow from Investing (Other)	(48)	2	(8)	1	(9)	U	(34)
Net cash flow from Financing	(388)	(357)	(33)	(29)	(4)	U	1,042
Net cash flow from deficit support	7,000	–	–	–			–
							–
Net cash flow	793	(5,168)	3,186	(6,272)	9,458	F	(7,345)
Net cash (Opening)	3,020	3,813	(1,355)	(1,227)	(128)	U	(1,227)
Cash (Closing)	**3,813**	**(1,355)**	**1,831**	**(7,499)**	**9,330**	**F**	**(8,572)**

Closing cash is better than budget due to a timing of receivables and payables working capital movements, reduced capital expenditure and receipt of the prior year IDF washup.

December 2021 **Public**

Capital Expenditure

	Actual 2020-21 000	Actual 2021-22 $000	Budget 2021-22 $000	Variance to Budget	Actual 2021-22 000
Buildings & Plant	1,885	600	1,450	850	5,550
Clinical Equipment	2,400	919	863	(56)	4,474
Other Equipment	138	12	40	28	210
Information Technology	1,147	430	340	(90)	1,015
Purchase of software	1,186	67	1,088	1,021	3,273
Motor Vehicles	–	(1)	100	101	240
Total capital expenditure	**6,756**	**2,027**	**3,881**	**1,854**	**14,762**

Capital expenditure is $1.9m lower than planned due to a delay in building-related projects. Building project and IT projects are also running behind schedule.

Andrew McKinnon
General Manager Corporate

November 2021

December 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No
Author	Lucy Adams, Chief Operating Officer and Director of Nursing
Subject	**Whanganui DHB IMT and EOC**

Recommendations

Management recommends that the Whanganui District Health Board:

a. **Receive** the paper titled 'Whanganui DHB IMT and EOC'
b. **Note** the resurgence emergency management function.
c. **Note** the Whanganui DHB EOC and IMT.

Appendix 1. Emergency Management and COVID Directorate

1 Background

COVID-19 warranted a National Public Health response. This paper is to provide an understanding regarding where WDHB is within activating an Emergency Operation Centre. At note this term is used at the time of reporting as Whanganui does not have Delta positive case within the community.

1.1 Resurgence

MoH Emergency Management Team

- The health emergency management function is a relevant and crucial component of health security system for contending with emergencies (regardless of cause) as a threat to the provision of equitable health and wellbeing.
- Emergency management framework covers:
  - Systems and all of government engagement
    - Cohesion; develop and align EM responsibilities.
  - Readiness and response
    - Common operating systems, delivery of response plans, improved coordination and improved agility and scalability.
  - Resilience and recovery
    - Strengthen continuity strategies.
    - Improve disaster risk reduction and preparedness.
  - Information and integration
    - Common operating picture: lessons learned, innovation and adaptability
- Appendix 1 illustrates how Emergency Management and the COVID directorate interconnect. Emergency Management is focusing on strengthening regional coordination centres that would be supported by the National Health Coordination Centre. Currently, the Northern Regional Coordination Centre has been activated since COVID hit our shores.

1.2 Central Regional Health Coordination Centre

TAS is supporting the Central Region in developing resurgence and resilience plans. A central region coordination centre and supporting processes are being finalised; this includes how to operationalise a virtual coordination centre.

1.3 WDHB Emergency Operation Centre (EOC) and Incident Management Team (IMT)

Based on the Coordinated Incident Management System (CIMS) a DHB IMT can be activated. Currently, the DHB has applied the doctrine to the readiness phase and have stood up a notional IMT that has a workplan aligned to themes. This approach will easily interface with activation of an IMT.

The roles and activities align to Planning and Intelligence; Logistics; Operations and Communications; supported by Welfare and Technical Advisory Group (TAG), including Māori Health; note the Regional EOC would have Iwi.

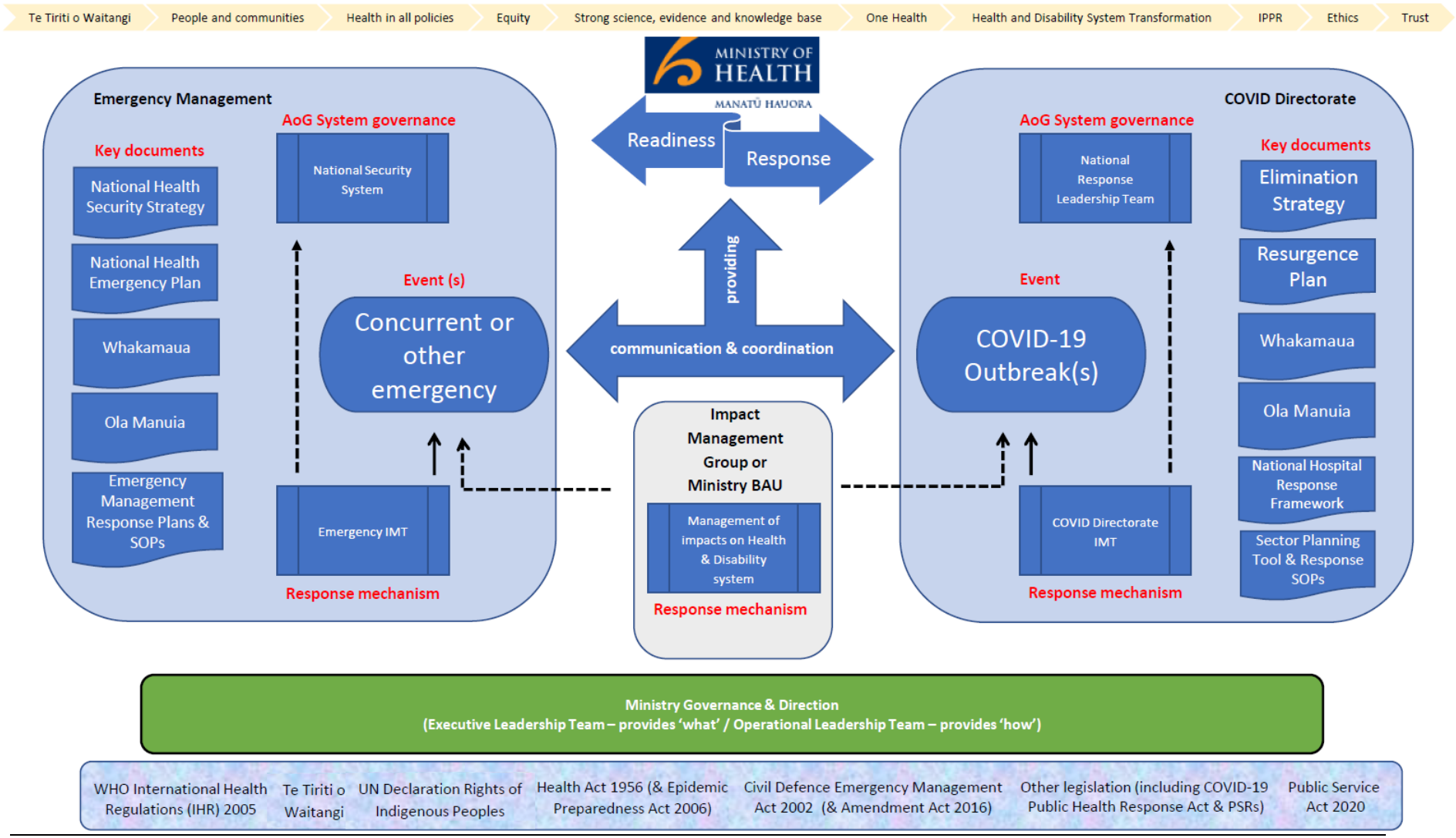
Whanganui Region activated a collective EOC last year, the DHB IMT reported through the operations Function. It is still a feasible this maybe an option should the region be overwhelmed and warrant a whole of system approach.

1.4 Resilience

Central Region Resilience Plan has been updated and defines resilience projects which aim to support the delivery of healthcare. Several of the initiatives, if implemented, will also strengthen the healthcare position prior to transitioning to tier one and two.

December 2021 **Public excluded**

Appendix 1



November 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information**
	Item 4.3

Author	Barry Morris, CIO
Endorsed by	Andrew McKinnon, GM Corporate
Subject	**ICT Security update on workplan progress**

Recommendations

It is recommended that the WDHB Board:

- **a. Receive** the ICT Security Assurance Plan as an update on progress towards enhancing security controls across the WDHB network.
- **b. Note** the plan is an annual requirement by the Ministry of Health.
- **c. Note** an independent assessment of security across the WDHB network found no cyber threats. A number of potential vulnerabilities in software and configurations were identified and these have formed the WDHB security workplan.
- **d. Note** that a number of actions have been completed (Critical and High priority) and ongoing work is occurring to progress the security workplan.

1 Background

The Ministry of Health require DHBs to provide an annual security assurance plan to demonstrate that actions are underway to ensure effective security controls are in place. The WDHB plan is presented to the board as an update on cyber security activity.

2 The security assurance plan

The attached plan documents actions taken by WDHB (especially following the Waikato DHB cyber incident) and a plan of remedial work following recommendations from internal and external assessments of the WDHB security posture, aligning to security standards and best practice.

The plan shows that the Whanganui District Health Board commenced action to implement new recommendations coming from the Waikato DHB incident via the Ministry of Health and NZ National Cyber Security Centre and work on security projects already underway was accelerated in response.

To provide further assurance to the DHB an external assessment was undertaken using an MoH recommended vendor and process – Inphysec.

Inphysec undertook a deep inspection and analysis of the WDHB network including servers and desktops over a period of one month. No cyber threats were found within the WDHB network. Recommendations from the Inphysec report to protect against known software vulnerabilities and configurations have formed the security workplan shown within the assurance plan.

Progress against the security workplan has seen the most critical and high risk recommendations implemented and work continues.

December 2021 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item #
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 recommends that the Combined Statutory Advisory 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

Appendix 1. Whanganui DHB Performance Dashboard and definitions

1 Purpose

To provide the Committee with a high-level overview of provider arm services; operational performance is noted for the months of August, September and October 2021.

2 Service Delivery Overview

2.1 Industrial Action

The DHB NZNO Nursing and Midwifery MECA has been ratified. Members have received a revised offer.

2.2 COVID-19

At all levels, National, Regional and Local, DHBs are reviewing and strengthening plans. WDHB has executed exercises whereby a notional infected patient journey is created, and staff play out their responses. An external lens is critiquing and intervening so that participates are aware of the appropriate healthcare practices and staff are aware of plans. WDHB is contributing to workstreams that are regional and national focusing both on resilience and resurgence.

<u>COVID-19 Exercise</u>

On Wednesday, 8 September 2021, some of our clinical team simulated a person with COVID (Delta) coming in by ambulance right through to admission in the Medical Ward. This tested our COVID plans, infection control techniques in practice and gave us some opportunities to improve.

A second exercise was held on 6 October 2021 which followed a COVID patient from ED to CCU; this provided a chance to build on learnings from the first exercise and further test our plans. The staff involved were very engaged and enjoyed the exercises. There are more simulations planned over the month of November to test other areas such as Paediatrics and Maternity.

Planning for an Emergo Train System (ETS) pandemic simulation exercise is also underway. The simulation will take place on 14 December 2021 and will involve hospital, primary and community, and public health.

Covid vaccinations

As of 9 November 2021, vaccinations given to the Whanganui region population totalled 88,152; of that, there were 47,156 first doses and 40,996 final doses. This is good progress from 10 August, where vaccinations given totalled 31,644.

As of 8 November 2021, Whanganui DHB staff vaccination rates (in percentages):

	1st dose	2nd dose	Fully Vac.	Head Count	% Fully Vac.
Allied	201	190	190	208	91.3%
HCA	123	120	120	134	89.6%
Midwifery	31	29	29	35	82.9%
Nursing	459	428	428	478	89.5%
Other	270	251	251	292	86.0%
RMO	50	49	49	51	96.1%
SMO	57	56	56	58	96.6%
Total	1191	1123	1123	1256	89.4%

In summary, 95% of all staff have had their first dose; 89.4% have had their second dose and are fully vaccinated.

2.3 Optimisation and Efficiency Programme

Scheduling

A formal roster review of theatre and SSD has been done by TAS; results are pending.

Excellent progress is being made on the booking project that was funded through the sustainability funding from the Ministry of Health. The report and recommendations have been presented to ELT and accepted. Planning for the implementation of recommendations is underway.

Bowel screening

An audit of the bowel screening programme and endoscopy will be done by the DAA Group on 27 and 28 October 2021. Whanganui DHB is working to standards and looking into optimising the current space and maintaining safety for patients and staff. Overall comments from the audit team were positive and we await the draft audit report.

Theatre utilisation

Some gains are being made on the theatre optimisation workplan this is due partially to not having a dedicated project resource within the department. The continuous improvement cycle will become a focus area once COVID planning and agreed projects are completed.

T-Doc is currently going through the business case process and will require project management and investment into technology. Roster review findings are being collated by TAS the report has yet to be received.

2.4 Emergency Department and Inpatient Services

Emergency Department triage data

ED Data	Total Attendances	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5	% Maori	% Pacifica	Did not waits	Ave daily attendances
Aug	1861	10	239	1047	490	75	26%	2%	162	60.0
Sept	1671	5	193	1007	423	43	24%	1%	106	55.7
Oct	1914	5	200	1149	498	62	25%	2%	156	61.7

*Data extracted from WebPAS through SQL Server Reporting Services 4.11.21

During the months of August, September and October 2021, the average daily ED attendances have trended downward from the July 2021 figure of 66.9.

Hospital data

	AAU			AT&R			CCU			Medical Ward			Surgical Ward		
	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct
Total monthly admissions *	193	188	208	30	39	33	43	38	54	134	138	171	147	154	128
Total monthly discharges **	133	125	143	23	31	24	27	21	31	191	186	223	232	257	256
Average Length of Stay (Days) **	0.43	0.32	0.29	16.57	16.23	15.13	2.6	2.9	1.7	5.54	5.53	4.2	3.55	3.82	3.51
Average Occupancy (all shifts) **	105%	91%	91%	94%	91%	96%	80%	89%	80%	92%	91%	93%	92%	92%	86%
Average Occupancy (YTD from 1 July 2021)	101.8%			92.0%			83.1%			93.4%			90.4%		

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

Total admissions compared to discharges: August 547/606; September 557/620; October 594/677. Variance will be attributed to those who cross over from end of month to beginning.

** Data extracted from WebPAS through PowerBI 5.11.21

Acute Readmission Volumes **	AAU			AT&R			CCU			Medical Ward			Surgical Ward		
	Aug	Sept	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct
48-hour	9	6	7	1	2	0	2	1	3	4	5	6	3	8	9
7 day	8	6	7	0	0	2	1	0	3	11	8	20	18	10	20
14 day	1	4	5	0	2	0	0	0	4	6	13	13	9	9	8
28 day	10	6	6	1	1	0	1	0	1	20	16	10	17	17	7
Total	**28**	**22**	**25**	**2**	**5**	**2**	**4**	**1**	**11**	**41**	**42**	**49**	**47**	**44**	**44**

** Data extracted from WebPAS through PowerBI 8.11.21; October figures may not reflect the total 14 day and 28 day readmission volumes.

Māori Acute Readmission Volumes **	AAU			AT&R			CCU			Medical Ward			Surgical Ward		
	Aug	Sept	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct	Aug	Sep	Oct
48-hour	1	2	0	0	0	0	0	0	1	1	2	0	1	1	2
7 day	3	1	0	0	0	0	1	0	0	4	2	3	3	4	5
14 day	1	0	0	0	0	0	0	0	1	4	0	3	2	1	1
28 day	4	2	1	0	0	0	0	0	0	4	4	4	5	3	3
Total	**9**	**5**	**1**	**0**	**0**	0	**1**	**0**	**2**	**13**	**8**	**10**	**11**	**9**	11
Percentage of total acute readmissions	32%	23%	4%	0%	0%	0%	25%	0%	18%	32%	19%	20%	23%	20%	25%

** Data extracted from WebPAS through PowerBI 8.11.21; October figures may not reflect the total 14 day and 28 day readmission volumes.

3 Hospital and Clinical Services (H&CS)

3.1 Workforce

Nurse Entry to Practice (NETP)/ Nurse Entry to Specialty Practice (NESP)

We employed eleven (11) NETP/NESP for January 2021. Of these, seven (7) identified as Māori, and all of these NETP/NESP were employed in the hospital, two (2) were employed in General Practice and two (2) in Te Awhina. The NETP nurses will complete a post graduate paper at the end of October through Victoria University. The NESP nurses have completed their post Graduate study via Whitireia.

This year WDHB also had a midyear intake for NETP. Six (6) NETP nurses were employed, of these one identified as Māori. Two (2) have positions in the hospital and the rest are based in the community. They will commence work in October and begin their paper with Victoria University on 1 December 2021.

Return to Nursing Programme

WDHB is partnering with MidCentral DHB to promote a return to nursing programme. These additional nurses will support the DHB nursing workforce plan. This programme is open to all nursing staff who have been out of the profession for more than five years who are wanting to come back to the workforce. There will be open days to discuss the programme and what it entails. The programme consists of 200 hrs practicum (supported by a preceptor) and 20 hours theory. MidCentral is hosting their day in early November and ours will be later in November.

Health Workforce New Zealand

Funding is available for nurses within the hospital and community to commence study in 2022. A group of senior nurse leaders have met to review a pro-equity framework for funding, and this has a focus on Māori Nurses, long term conditions, child and adolescent and older adult. A group will be meeting to discuss this funding and to approve who will receive this.

Te Whare Toi

Te Whare Toi is the new education centre based in the old theatre suite at WDHB. This space has six classrooms and is available to be utilised for teaching purposes by hospital groups and our community healthcare partners. Te Whare Toi officially opened on the 12 October 2021.

3.2 Care Capacity Demand Management (CCDM)

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

The CCDM programme has a set of standards. To meet the standards programme implementation needs to be prioritised, appropriately resourced and sequenced.
(TAS, www.ccdm.health.nz)

WDHB continues to successfully implement the CCDM programme. We have improved to 88% implementation with the last barrier being total implementation of all local data councils.

WDHB has had a full evaluation of the programme by TAS. TAS believe areas for improvement are in the governance domain and core data set. This audit is in draft as discussions continue around the findings.

Items	Progress	Action required
Core Data Set	**Partially**	• Power BI and formal local data tools are all developed with transparency to staff. • Local data councils have now progressed (and require full embedding) • Staff discuss the data at ward meetings in partnership with union delegates
FTE Calculation	**Completed**	• ED FTE calcs have been completed
Variance Response Management	**Completed**	• VRM is used daily with good response. • Reporting is daily/weekly/monthly and feeds into the local data councils. • Response is analysed monthly at the CCDM operational group.

3.3 Variance Response Management (VRM) response

Daily Integrated Operations Centre used live data that is illustrated through PowerBI to inform decisions along with the 1100 and 1600 CNM/CNC meetings that confirms staffing and bed management needs.

In-patient information is entered into TrendCare, as in predicted hours of care, and then actualised at the end of the shift. This data is visible throughout the Hospital; any DHB computer has the capability to see the Hospital at a Glance (HAAG) and the in-patient areas have large screens.

Variance response management is required when there is a deficit of hours to provide care; this can be due to staffing gaps i.e. sick calls; or potentially an increase in predicted hours of care (acuity), bed utilisation (increase of admissions and discharges). This is when an in-patient area warrants tasking to support delivery of care. WDHB is currently in the process of recruiting 4.05 FTE (identified through the CCDM calculations) to work on as a variance response resource. The role will be to task, as identified above and cover breaks. The hours of work will cross over the normal shift pattern.

3.4 Mental Health Inpatient

Stanford House

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

No seclusion has occurred in Stanford House. No restraints have occurred in Stanford house. Rehabilitation activities with Stanford house continue with significant success, and all involved continue to give exemplary feedback.

Stanford House has had approval to hire a coordinate registered nurse Monday to Friday; this role is being advertised. This is within FTE and aligns with Nga Tapawae project and allows leadership succession planning.

3.5 Quality

Person & Whānau Centred Care Service Improvement Initiative

Hospital and Clinical Services has had a lens over nurse sensitive indicators and service improvement initiatives. Audits, education and a proof-of-concept change to the Mahi Tahi form have all been undertaken. Findings indicate that additional support is required in the clinical setting to continuously monitor, coach and mentor staff.

An opportunity has presented whereby clinical coach positions on the wards have become vacant and this has provided an opportunity to merge three wards clinical coaches into one role, and then align this to an existing position, supervision of students. The incumbent that supervisors the students is available to fill the merged role for a year starting on Monday 27 September 2021.

Benefits for the DHB are having an undergraduate tutor to work within our hospital to provide support to RN and students. This opportunity would allow us to understand where gaps from theory to practice may be evolving from.

Review of clinical audit schedule

Early this year, a review of the clinical audit schedule commenced as one approach to improving the quality of patient care. The aim is to use the clinical audits as a tool to discover how well clinical care is being provided and to learn if there are opportunities for improvement.

Audits in this review focus on falls, pressure injuries, fluid balance charts, early warning scores, Know Your IV Lines (KYIVL), and the newly introduced Mahi Tahi nursing assessment and patient care plan and goals. Each of the clinical nurse managers ensures the audits are completed and uploaded onto an electronic template, and results are pulled through into their monthly reports. The next step is to develop an audit summary with involvement of the key stakeholders so that the information can be presented in a meaningful manner and in a way to ensure the best outcomes for our patients.

Know Your IV Lines (KYIVL)

The 6-month KYIVL Point Prevalence audit was completed on the 3rd August, where 50 peripheral intravenous cannulas (PIVCs) were audited and patients interviewed. The ACC Know Your IV Lines (KYIVL) programme was launched earlier this year. The ACC funded programme is designed to reduce complications from peripheral intravenous cannulas.

Our project objectives:

- The proportion of patients with a PIVC for no clear ongoing reason <10%.
- The proportion of patients with a PIVC that is unused for >24 hrs <15%.
- Improved documentation of Phlebitis score monitoring by nursing staff to >90%.
- Improved patient experience as a result of education, where patients and whānau would speak up if their cannula has not been used in the past 24 hours >70%.

- Monitor to Staphylococcus aureus bacteraemia (SAB)

Audit results showed we are on track, but improvements could be made in the documentation and unnecessary insertions. Compared with the baseline data collected pre-project, the number of PIVCs with no clinical reason for being in place has dropped from 23% to 10%, meeting our target of <10%. All PIVC insertions should be clinically indicated. Staff are asked to question is an IV access necessary and is there an alternative?

The proportion of PIVCs unused for >24hours reduced from 32% to 20%. Staff are required to check every shift, that there a clear ongoing reason for the IV access, if not it should be removed.

There is room for improvement with our documentation. The audit showed the Visual Infusion Phlebitis (VIP) score was only documented for 149 shifts of the 309 (48%) 8 hour shifts the patients were in hospital. Staff are asked to document the VIP score, site condition, cannula patency and clinical indication each shift.

More of our patients were aware of why they have an IV access, with an increase from 66% to 88% knowing its purpose. Staff are encouraged to involve their patient and increase their awareness of PIVC complications. 50% of patients had received written information; however, not all felt comfortable about speaking up if there was a problem. 88% would speak up about a red insertion site, 90% would voice it was painful and only 72% felt comfortable questioning the need for the cannula, if not used for >24hrs.

3.6 Service Delivery

Service delivery has been significantly impacted across all areas of planned care during the COVID lockdowns at level 3 and 4. All services developed a prioritisation system to ensure that patients whose treatment could not be deferred were seen. This included those patients with cancer or high suspicion of cancer, and those where their condition would deteriorate if treatment was delayed.

A total of 89 Elective Surgeries were deferred across all services up to the week ending 5 September 2021. This included those surgeries that were not safe under COVID restrictions (for example aerosol generating procedures) and some that required complex post-operative care in HDU/CCU or long stays.

Patient prioritisation over this time followed a formula that linked clinical priority with procedure safety and maintained acute capacity for potential COVID patients. Patients were also screened to ensure they had post-operative support in their "bubble" and were willing to attend hospital in levels 3 and 4 lockdowns.

We are now working to clear the backlog created by this event. Patients are being seen in order of clinical priority, ensuring that there is no undue deterioration of conditions. This is having an impact on waiting lists; however, they are trending down.

The provider services have undertaken production planning across all services to determine the impacts of COVID and holiday period service reduction on waiting lists over the next six months. Initial findings were positive, with no un-expected increase in waiting list volumes. Further work on the detail behind each services continues.

4 Primary and Community Services

4.1 General Overview and Highlights

Primary and Community Services has twelve service areas. Overall positive
Gains have been made, whilst the team balance working on achieving the DHB strategy whilst dealing with the challenges of the recent COVID-19 level 3 lockdown and resurgence planning.

Primary and Community staff has been following and updating their COVID operational plans during the lockdowns. Several of the services split into workstreams to avoid possible cross transmission of COVID-19. The vulnerability of smaller services was highlighted during this time, and work within the region and across regions has commenced to ensure sustainability of service in readiness for the presence of COVID-19 in the community. There has been targeted work with primary care, specifically in the space of Aged Residential Care facilities, to support care within the facilities, avoid hospital admissions where possible, and provide streamlined care back into facilities when there is a need to attend hospital. This work is continuing with a joint community response to COVID-19 resurgence being developed as a priority.

With the lockdown there has been an increase in the offer of telehealth for patients and whanau with positive uptake. There has been a noticeable pattern of more people in the community declining telehealth this lockdown, with data suggesting a preference to defer waiting for in-person new appointments.

Many of the services noted there was a decrease in referrals during August, but are anticipating an increase as the COVID-19 lockdown levels change (this occurred in 2020).

We are currently in the process of recruiting for Clinical Manager District Nurse and Occupational Therapy.

District Nurses are currently recruiting to vacancies which will assist with the staffing as they are often short staffed and there are no casual registered nurses to fill in for sick calls etc.

4.2 Service Delivery

COVID-19 Resurgence Planning

Senior Leadership have been heavily involved in COVID-19 resurgence planning, noting that many of the teams are working across the hospital and the community. The teams have been working with WRHN, NHC, SIQ Lead, for care of COVID-19 in the community, as well as increasing ability to support more complex patients at home to avoid hospitalisations and ensure early supported discharge from hospital where needed. Work has also been progressing in the area of mental health, with plans to support both COVID-19 positive tangata whaiora and increasing complexity of acuity of tangata whaiora in the community. The Primary and Community space is complex, with over 160 different DHB contracted providers in health, as well as social providers, who will need to wrap services together to provide seamless care in our community.

Community Mental Health and Addictions Services (CMHAS)

CMHAS provided a large amount of care via telephone with success during the recent level 3 lockdown. From this, a trial of group addiction services held virtually has started.

Two psychologists have resigned recently to pursue private practise. This follows national trends for shortages of psychologists. Funding from the Ministry of Health to support an intern position has been agreed, to support growth into psychology roles.

A mental health crisis worked has been located with police two days a week, in response to concerns raised about the quality of shared working between the two services. There has also been a reduction in people presenting to the emergency department using this co-response model, and it has been decided this will continue two days a week for an extended trial.

The Mental Health Crisis team have been working closely with the Whanganui police to improve working relationships and provide coaching and training to front line officers dealing with people in distress. This has been received positively, with a significant reduction in complaints from police in the joint working space, and an increase in shared understanding of roles. A recent collaborative bid for Proceeds of Crime funding to support new models of crisis working has been shortlisted. This bid is supported by MOH and involves Te Oranganui, Balance, and Police as well as CMHAS.

Community Assessment and Rehabilitation Team (CART)

There has been a decrease in people on the short-term services caseload by approximately 30%. This would indicate a more efficient process for people in the community, as services are reviewed more frequently and have less time waiting for assessment.

There has been an informal consultation process sent to the community, reviewing the services provided for Falls and Pressure Injuries. The outcomes of this have indicated the need to move to formal change consultation to consider a more primary focussed and equity focussed approach to prevention of falls and pressure injuries. Formal change consultation process is expected to start this month.

Therapies

Waitlists continue to decrease in some services, such as physiotherapy outpatients and Speech and Language Therapy. The service for wheelchair assessments has shown a significant improvement, with the waiting time at 18 months one year ago, now at less than two months.

The Dietitians waiting lists continue to increase mainly due to a vacancy which has been recruited to, and the waiting lists are currently being addressed. Outpatient Clinics DNAs continue to be high and the dietitians are looking at different ways of engaging with patients/whanau from a service and organisation perspective.

Inpatient pressure and complexity of inpatient presentations continues to challenge the ability for therapy services to deliver community-based care, with the risk of increasing fragility in the community leading to admissions that are potentially preventable. This is being reviewed as a priority.

The Physiotherapy team are delighted that they have offered employment to a musculoskeletal Physiotherapist, which fills a vacancy that has been present for almost two years. This role is vital for many of the services that offer a preventative model of care, such as specialist assessment prior to joint replacement, and assessment of back pain in ED and primary care.

There is shortage of administration cover across therapy services and clinicians continue to complete administration tasks which reduces patient intervention contact. The expectation is that this will be addressed with the administration review.

There are ongoing issues with home care providers unable to provide community home based support services for current and new patients and there have been episodes that the services have not commenced following the patient being discharged into the community. The clinician staff continue following up patients and the home care agencies.

Radiology

The radiology service is in the process of purchasing a large amount of equipment, including four x-ray machines (two for the hospital, and one for the Taihape, one in Waimarino), a fluoroscopy machine, and ultrasound, and an MRI machine. There are increasing issues with x-ray machines breaking down and a lack of replaceable parts for machines, so these purchases are a priority for ongoing clinical care. The service is also looking at options and process for locating one of the ultrasound machines off site.

Pharmacy

Pharmacy continue to be part of the logistics team to help distribute the vaccine and ensure the smooth implementation and roll out across the DHB. Staff shortages are placing increasing pressure on this service, which is seeing itself challenged by increasing time accessing drug alternatives and ensuring that there is no adverse effects in drug reactions for those taking these; working to replace the Pyxis machines on the wards that dispense medications and have reached end of life, and responding to increasing inpatient surges.

Rural Centres

A new leadership role in Raetihi has been developed, led by the Integrated Directors Ruapehu limited, which will provide operational management for the Primary Care Practise in Waimarino, and facilitate closer working relationships between the DHB and other health partners in the region. The role will also work closely on developing proposed models of care for health services in the region, following on from the co-design process as part of the Ruapehu Whanau transformation plan. The new role has been welcomed by DHB staff based in Waimarino, who have been engaged regarding the formal relationship with this role. Although the role no formal operational role with staff, there is positive feedback that this will lead to closer and more seamless working relationships within the region.

4.3 Risks/Mitigations

The implementation of security tracking devices is a priority for this year for all staff working in the community, to meet legislative requirements.

Vacancies in services continue to be a challenge, and this is being addressed short term through outsourcing, with more sustainable models of care and clinical pathways being developed regionally.

There has been a surge of presentations in mental health, both in acuity and complexity, with increasing pressure for mental health crisis teams to find alternative models of care when there are shortages of beds both locally and regionally. This is progressing as a priority piece of work with inpatient services and will involve community partners in mental health as well.

4.4 Quality and Performance

Work continues with CCDM, with work identified to ensure all services have moved to TrendCare and are able to capture all data across services.

'Sit up, get dressed, keep moving', designed to encourage patients to be active when in hospital to prevent deconditioning and associated health risks. There will be a trial started soon of an exercise class, led by the Allied health assistant on medical ward.

The Joint assessment form for allied health is in the process of being upgraded and then will be sent to all teams to review**.**

5 Maternal, Child and Youth Services (MCYS)

5.1 General

The Covid-19 resurgence (Delta variant) has impacted on Maternal, Child and Youth Services business as usual and service delivery particularly for our Public Health team with their involvement in contract tracing, CBAC testing, COVID immunisations and assisting with MIQ facilities in Auckland. Anti-vaccination presence is an ongoing issue facing our public health staff. On a positive note, Covid lockdowns have also stifled the spread of Respiratory Syncytial Virus (RSV) in the community.

Planning of Red (Covid) and Green (non-Covid) pathways within our Paediatric and Maternity Wards is well advanced. The Covid simulation scenario exercise focusing on Maternity and SCBU scheduled for 16 November will inform plan finalisation.

The MCYS team is working to further establish contact pathways between our services and the community. Workstreams stemming from the Primary and Maternity Services Interface Group are progressing including the service guide for women, community directory of services and optimisation of the Best Start tool. The Hapū Māmā Village project is gathering momentum with Project Lead Pania Millar gathering information and arranging Wānanga with māmā, providers and other stakeholders over the coming months. An oversight group has been formed to support Pania in this important work. The insights of this system-wide review of maternity services will inform future maternity service provision.

Recruitment for project managers for both the Oral Health Project and Single Point of Entry Project is progressing. The development of a single point of entry into child health services is a key project for our service and some funding has been provided by the MOH. Objectives include development of clear referral and acceptance guidelines for child health services, reducing DNA rates, and identification of high risk tamariki and whānau so holistic health plans can be developed.

The childhood immunisation plan requested by the Ministry of Health (MOH) has been submitted, and provisionally accepted subject to review by the Immunisation Implementation Advisory Group (IIAG). The Health Promotion team are developing on a localised communications plan. There is some discussion about how we can approach immunisation differently; a whānau-centred approach that looks to engage with whānau as a whole rather in age-group silos.

The Whanganui Maternal, Child and Youth Community Alliance held a hui on 30 September 2021 at Keith Street School focused on the impact of toxic stress on children and gathering feedback on the Single Point of Entry Project. It was another valuable hui with active engagement from our community partners, including representation from local Te Kōhanga Reo.

Two of our five MCYS services have 100% of staff completed He Waka Hourua and the other services are well on the way to achieving this, with a goal of completion within six months.

5.2 Service Delivery

Maternity

We have successful recruited 1.2FTE and recruited staff will be clinically on the floor by December 2021. Interviews are planned for the Midwife Clinical Coach, and if successful, this role will commence in January 2022. This role supports staff undergoing return-to-practice requirements, new graduates and internationally qualified midwives into practice. Maternity is still not staffed to our budgeted FTE; recruitment plans are ongoing.

The unit caseload numbers for December/January/February has reached 58 and has the potential to increase further with an LMC signalling her intention not to be vaccinated and hand over her caseload of 20 women in this time period. Plans are being put in place to increase antenatal clinic FTE to accommodate the current unit clients and potential increase.

Our Primary and Maternity Services Interface Group workstreams are progressing well including the Hapū Māmā Village project facilitated by Healthy Families, service guide for women, community directory of services and optimisation of the Best Start tool.

Patient Safety Day on 17 November 2021 has a Maternity focus this year about "increasing culturally responsive care". There is a significant focus on staff education. The main promotion event will be held at Women's Network Whanganui where the HQSC videos will be showcased.
Plans to offer a Long Acting Reversible Contraception (LARC) service to postnatal women prior to discharge are progressing. We are in discussion with Family Planning and our new O&G consultant regarding the education and credentialing process.

The Maternity Early Warning Scores (MEWS) project is now business as usual. We anticipate the Newborn Early Warning Score (NEWS) will be rolled out in the first calendar quarter of the new year. All maternity and neonatal staff including LMCs will complete NEWS online training.

The Midwifery Forum held on 12 October 2021 was another valuable hui. Covid-19 readiness and vaccination were significant areas of discussion and other issues that are top-of-mind for our LMCs and core midwives were able to be raised and discussed. Next year four Midwifery Forum's will be held, with the first scheduled for 22 February 2022.

A one-day Hāpai te Hoe programme has been offered to LMCs this year. One session has been run and the second session scheduled for September was postponed but the aim is to run before year end. Going forward all new LMC's to our rohe who have not trained in our DHB will be offered attendance at Hāpai Te Hoe during orientation week.

Two of our staff, a midwife and the CNM of paediatrics, are enrolled in Ngā Manukura o Apopo Clinical Leadership training and will complete this by the end of the year (Covid permitting).

Paediatrics

The Paediatrics and SCBU Covid-19 response procedure is complete. Plans include establishing a second SCBU in the red zone of the children's ward, doors/plastic barriers between rooms two and three on the ward, rostering plans for both green and red zones and plans for Oncology patients to be seen at a different location.

The new paediatrician is on track to commence work before the end of the year. Plans to recruit another paediatrician are underway. The child health nurse practitioner is now working four days per week in child health and a clinical nurse specialist paediatrics role has been developed and recruited to.

Recruitment of a psychologist to MICAMHAS and CDS has been successful with the commencement date in early December. This appointment will allow us to develop an improved pathway for Autism diagnosis.

Renovations to the CDS gym are complete, following significant Covid-19 related delays. The team are ecstatic, and our gym is now a safer, fit-for-purpose space to serve our tamariki and their whānau.

Regional CDS leaders continue to meet regularly, and work is progressing on two innovation projects:
1. Regional feeding service project - led by Capital and Coast DHB - is making progress with initial data collection complete. This is being led by an experienced speech language therapist.

2. Regional neurodevelopmental therapy expert project – led by Hawkes Bay DHB. This has been successful to date with regional Neurodevelopmental Therapists (NVDT's) developing clear assessment guidelines and practice to follow. There has been excellent collaboration amongst Regional NVDT's. The MOH have just announced funding for one further year. This project has identified a service gap in WDHB SCBU as there is currently no allocated FTE for inpatient developmental therapy. This is initiated in the Newborn Intensive Care Unit (NICU) and requires follow-up in SCBU; however, this is not available until discharge into the community.

Funding for a quality coordinator across the central region child development services has been approved by the Ministry of Health.

STABLE Training, a combined training initiative across Maternity and Paediatric services, has been postponed for the third time due to Covid-19 and will be rescheduled for the new year.

Opportunistic immunisations and distribution of safe sleep devices to tamariki and whānau who need them remain a strong focus of our paediatric team on the ward.

Public Health

Our public health team continue to do a great job despite the sustained pressure of the Covid-19 environment and their work profile. Our public health staff are being recognised and receiving thanks and acknowledgement from fellow DHB colleagues for their hard work during the Covid response. Compliments are also being received from our community, including schools and individuals from the public that our PHN's are in contact with as part of the Covid response.

In October, the Ministry of Health requested Public Health Units decrease their BAU by 50% to assist with the nationwide surge in contact tracing. The public health nursing team are running a seven-day-a-week roster to assist with Covid-19 case investigation for the Auckland Regional Public Health Centre. Public health leadership have contacted all schools in the rohe outlining the prioritisation of contact tracing and the impact this will have on service delivery.

Our immunisation coordinator, in conjunction with the Covid-19 vaccination team, is working on the opportunity for students over the age of 12 to have their Covid-19 immunisation in an education setting.

School-based COVID-19 immunisation roll-out for 16 to 18-year-old secondary school students has commenced and work is being done to extend the service to other age groups. An electronic consent form is being developed for parents wanting their child to have access to Covid-19 vaccinations through the school-based immunisation programme. There is continued anti-vacs challenging school-based vaccination consenting and school sites as venues for vaccinations. The engagement and rapport with schools and students and the education imparted around vaccination has helped in these situations. National radio has covered this topic with a positive mention of Whanganui DHB.
(Link: https://www.rnz.co.nz/news/national/449256/students-told-anti-vaccine-campaigners-to-go-away-deputy-principal.

The school-based health service reports just over 50 percent completion rate of HEEADSSS assessments for eligible students. Assessments for lower decile schools and high-risk youth have been prioritised and are 100 percent complete. The impact of Covid-19 means we are unlikely to finish the remaining assessments by the end of the year.

The resignation of the public nurse who worked in the Te Kōhanga Reo space has created an opportunity to review whether the Te Kōhanga Reo service is best provided by kaupapa Māori services. A discussion paper was submitted to MHOAG for their consideration and following their feedback, further avenues are being explored to put an effective service in place that will enhance the benefit to the community.

A 'one-point' entry point has been formed for our under-25-year-old transgender population within the community. Referrals would be received by the Public Health Sexual Health Clinic and triaged. For clients under 25 years, we work collaboratively with Youth Services Trust (YST) who provide us with a space to conduct assessments. For clients over the age of 25 years, information, support and resources will be provided and recommendations made to the general practitioner around treatment, maintenance and screening as per the Guidelines for Gender Affirming Healthcare.

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

Staff anecdotally report that youth required an increased level of support when compared to the COVID-19 lockdown in 2020.

Access to acute inpatient services for youth remains a key issue. There are no funded acute inpatient beds within the Whanganui rohe and the central region's Regional Rangatahi Adolescent Inpatient Service (RRAIS) is often at capacity. With no planned improvement to the regional Rangatahi Unit consideration needs to be given to providing care closer to home for our rangatahi. The central region funding and planning managers group are pursuing alternative solutions closer to home.

In response to increases in serious self-harm incidents the MICAMHAS team, Community Mental Health team and community agencies have increased clinical input and risk planning which has had a notable impact on the number of incidents.

One of the MICAMHAS quality improvement groups has been meeting to investigate how to best capture the voice of young people and their whānau in service development. This includes inviting young people and their whānau to attend a hui as MICAMHAS has previously done with our reception/waiting area. The development of specific questions or an open forum is being considered as well as how to maintain the youth/whānau voice.

Oral Health

The Oral Health team (along with many other staff and groups within our DHB) exhibited the WDHB values of kōtahitanga and manaakitanga during COVID-19 lockdown – oral health staff manning the main reception entry and assisting with CBAC swabbing and administration. Telehealth appointments were initiated for the preschool group during this lockdown.

The Executive Leadership Team (ELT) have approved the business case for an Oral Health Service Review which aims to enhance and further develop our current service to provide a modern, patient focussed dental service for our community.

Our Oral Health Service is on track with the Dental Council Recertification programme. All dentist recertification is complete and dental therapist recertification occurs in March 2022.

Our preschool, school-age and adolescent arrears started to reduce in September. Our arrears rates remain one of the lowest in the country, but our team remains focused on reducing these as much as possible. Inequity of access for the 0-4 age group remains a key concern and area of focus for improvement for our oral health service.

5.3 Future Focus

Planning for engagement with our Whanganui Maternal, Child and Youth Community Alliance hui in the new year is underway. Youth Health will be the focus of our first meeting in 2022. In the interim a communication will be sent to Alliance members to summarise the content of hui held this year, achievements, and our future focus points.

The first of four Midwifery Forum meetings for 2022 will be held at the end of February 2022.

Options are being explored to address acute inpatient mental health service capacity issues for our rangatahi. It is hoped this will be recognised in the local mental health service review being undertaken by Healthy Families.

Work streams coming out of the Primary and Maternity Services Interface Group continue, most of which are anticipated to take another 12-18 months to finalise.

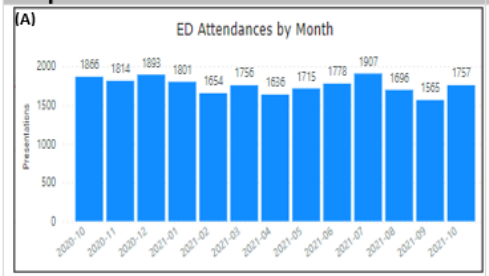
Covid-19 planning and BAU take precedence in many areas as we prepare for Covid-19 in our community.

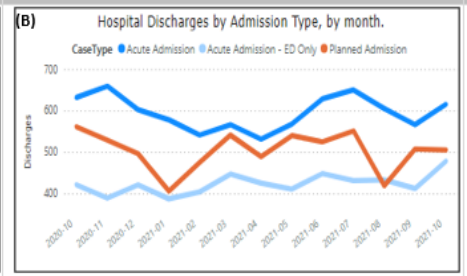
December 2021 **Public**

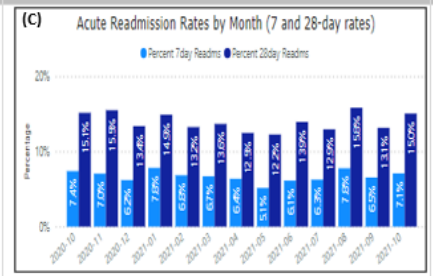
Appendix 1. Whanganui DHB Performance Dashboard

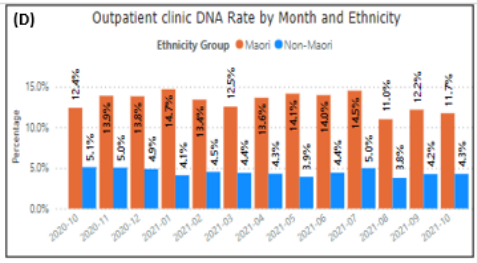
(data extracted 8 Nov 2021)

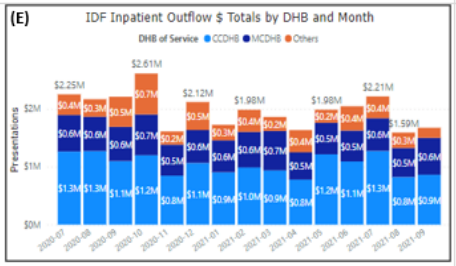
Hospital Based Care Measures

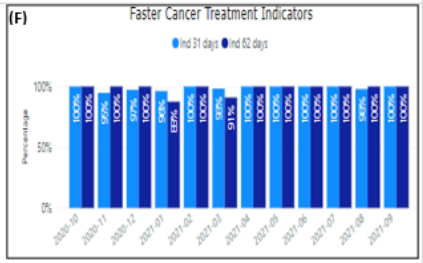










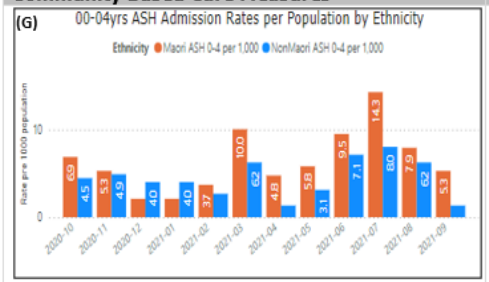


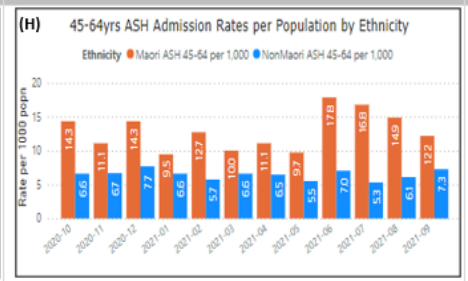
Commentary

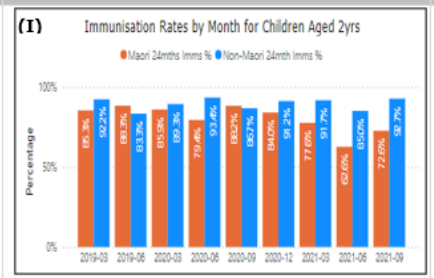
ED commentary is within the body of the report.
(A) ED attendances were slightly down for August and September and raised slightly in October.
(B) Hospital discharges by acute admissions and planned admissions were down for August, September and October whilst the 'hospital discharges acute admission - ED only' rose slightly in October.
(C) Readmission rates, 7 and 28 days, slightly increased in August, returned to previous levels in September and slightly increased again in October. The DHB is continiuing to explore ways to capture relevant information and better understand these rates; however, hope that initiatives that are being introduced into the primary and community settings will help reduce these numbers.

(D) Outpatient clinic DNA decreased slightly in August and remained steady over September and October. Work continues to improve DNAs, of which will be referred to as missed scheduled appointments. Acitivities to improve appointment attendance rates include, text to remind, review of booking processes, improved data to reflect DNA information, telehealth.
(E) October data is not complete; September outflow was $1.67M.
(F) Faster Cancer Treatment Indicators remain steady.

Community Based Care Measures



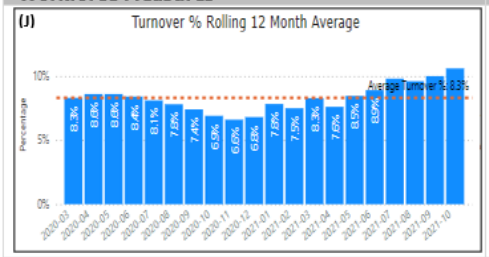


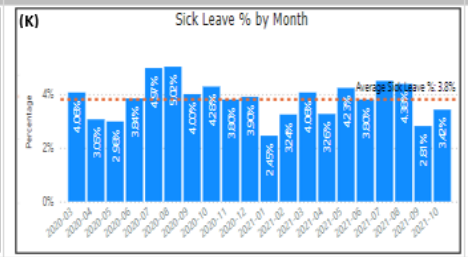


Commentary

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 respiratory and others [nausea, wheezing]. **NB:** Commentary is correct for August, September and October; however, final October data is not available at time of report and is not included on the attached graph.
(H) The top themes for 45-64 years are respiratory, other [i.e. chest pain], and circulatory [heart disease]. **NB:** Commentary is correct for August, September and October; however, final October data is not available at time of report and is not included on the attached graph.
(I) Immunisation rates for Māori and non-Māori children increased last quarter.

Workforce Measures





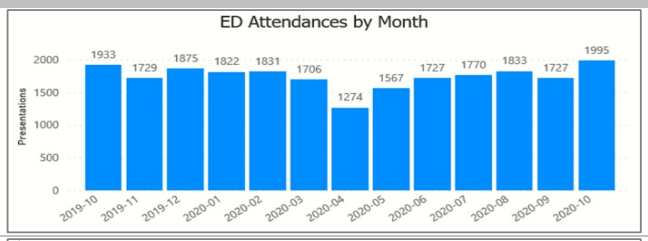
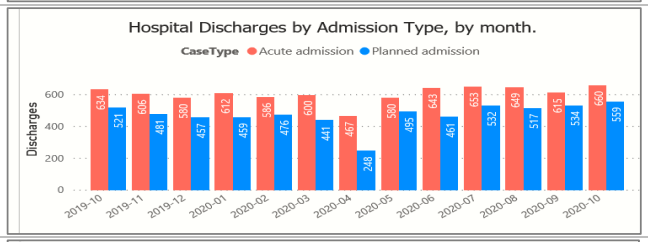
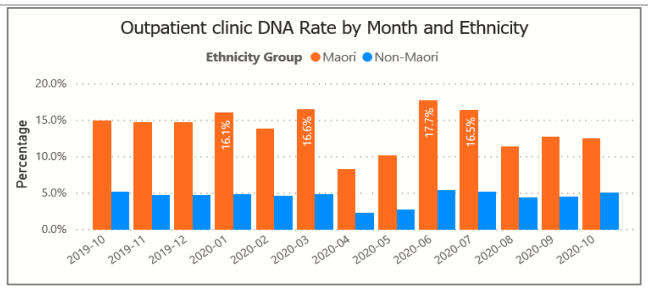
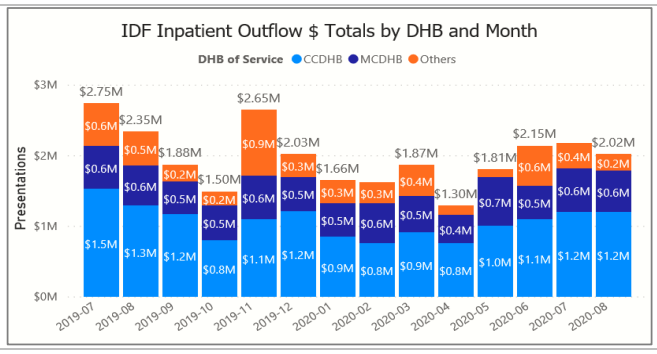
Quality

Commentary

(J) The average turnover at WDHB has risen over the last three months. WDHB average turnover has risen 0.3% since July to 8.3%. Staff have moved within the Hospital or have left the DHB, i.e. left Whanganui, retired or have employment within the community.
(K) Sick leave was 4.38% in August but decreased over September and October. The rolling average remains at 3.8%.
(L) Falls and pressure injuries in care remain a focus of the quality team. (Note: This quality indicator information is gathered from Cgov.)

December 2021 **Public**

Whanganui DHB Performance Dashboard definitions.

Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	
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.	

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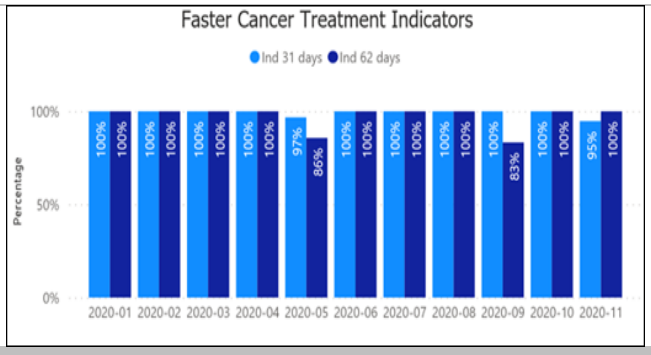
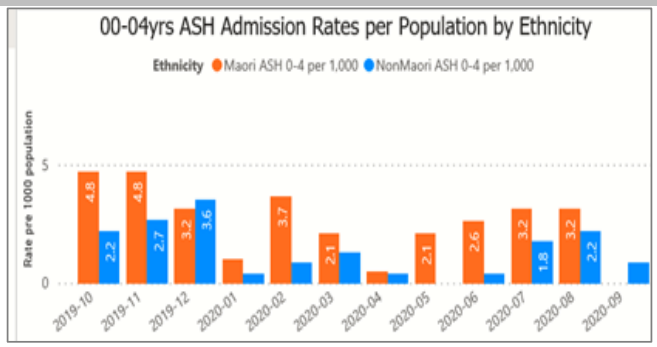
Graph F. Faster Cancer Treatment
Patients identified as high suspicion of cancer on referral receiving treatment within 62 days (further information provided within the paper).

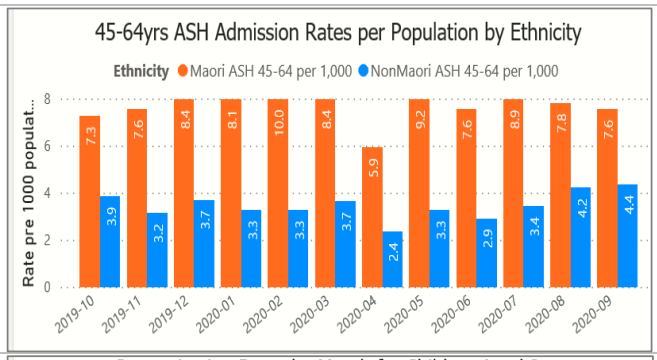


Community Based Care Measures

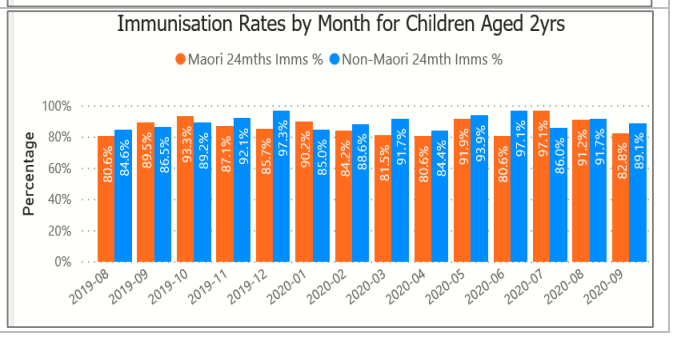
Graph G. ASH Rates 0-4 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000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



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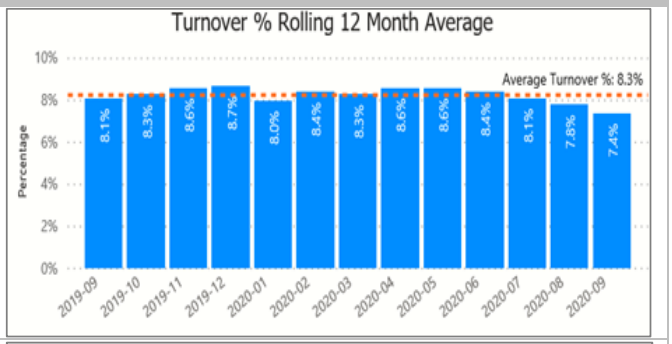
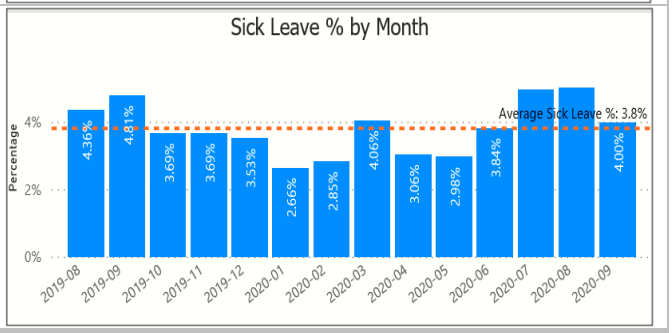
Workforce Measures

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

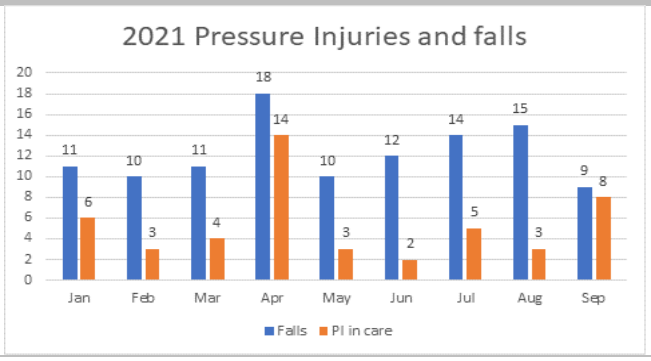


Graph K. Sick Leave %
Percentage of total paid hours taken as sick leave. This is an indication of illness levels and cost impacts when above average budgeted rates. Does not indicate where annual leave is used in place of sick leave
Calculation:
Denominator = total paid hours
Numerator = hours paid as sick leave



Quality

Graph L. Pressure Injuries/Falls
Patient safety and care indicators for key measures.
Calculation: count of events each month (not individual patients)



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WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information**
	Item #
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, 2020/21 financial years or 2021/22 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 increased 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 decreased over the three year period.
- Struck by, bumped injuries/incidents decreased over the three year period.

1 Purpose

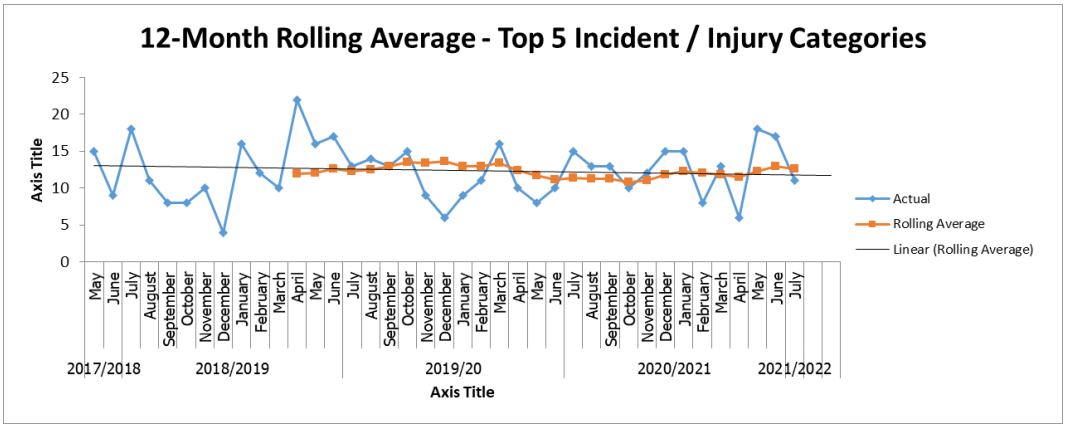
To enable the board to exercise due diligence on health and safety matters. This report on key health and safety system risks covers:

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

2 Incident/injury trends

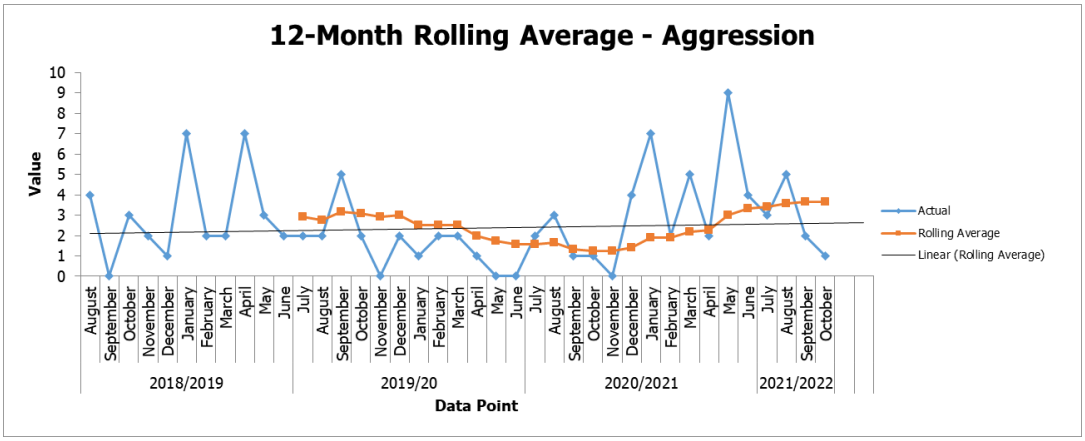
The graph below provides a rolling average, actual summary and trend line of the last three years' top five injury/incident trends.

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.

2.1 Aggression



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

From August 2021 to October 2021 there were six physical aggression injuries/incidents recorded on C-gov Te Awhina (5), CMH (1) and two verbal in Emergency and Te Awhina.

3 Issues identified:

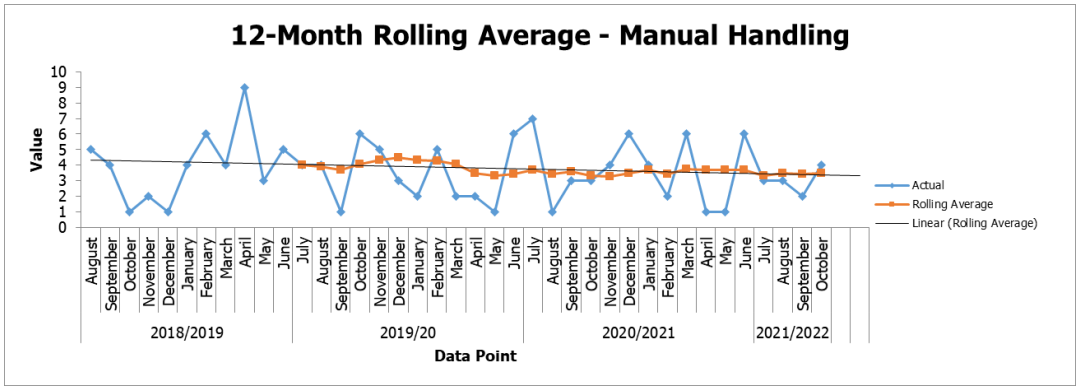
1. Increase in the number of patients on the general wards requiring close supportive observation (CSO). Some staff are not familiar with the risks when monitoring these patients.
2. Some clients (allegedly) deliberately assaulting staff as a means to exercise their angst, dismay and distress at their circumstances e.g. not being allowed leave
3. All IPC rooms being used
4. Staff have high tolerance to the behaviour and under report the number of incidents

3.1 Improved risk mitigations include:

1. Education for staff to remind them to be aware the unpredictability of patients requiring close observation and to follow the managing escalating situations procedure which includes completing the patient risk assessment escalating situations form.
2. Increased security in some situations
3. Staff offered supervision
4. A client charged by police and under investigation

5. IPC protocols reviewed
6. In ED daily updates of WDHB visitor policy.
7. A group comprising of a SPEC trainer, a CNC and CNM are developing a training package to assist with more deliberate violence in Te Awhina.
8. The Workplace Aggression Steering group has been re-established to monitor the incidents of aggression.

3.2 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 August 2021 to October 2021, there were five patient staff incidents; CCU, Emergency, Surgical, Theatre and Community Nursing, 2 object related; Clinical Records and Stores, 1 OOS injuries in Clinical Records and 1 other in Theatre (supporting a colleague who had fainted to the floor).

3.3 Issues identified:

- Incorrect moving and handling techniques used when transferring patients and equipment
- Occupational Overuse Syndrome – staff sitting for long periods of time typing notes instead of rotating tasks and taking regular breaks.

3.4 Improved risk mitigations include:

- Specific moving and handling training by manual handling training co-ordinator and the ward champions
- Reminding staff to take regular breaks and rotate tasks so not to sit in one position for extended periods of time.
- Workstation evaluations to ensure a good fit between staff and their workstation.

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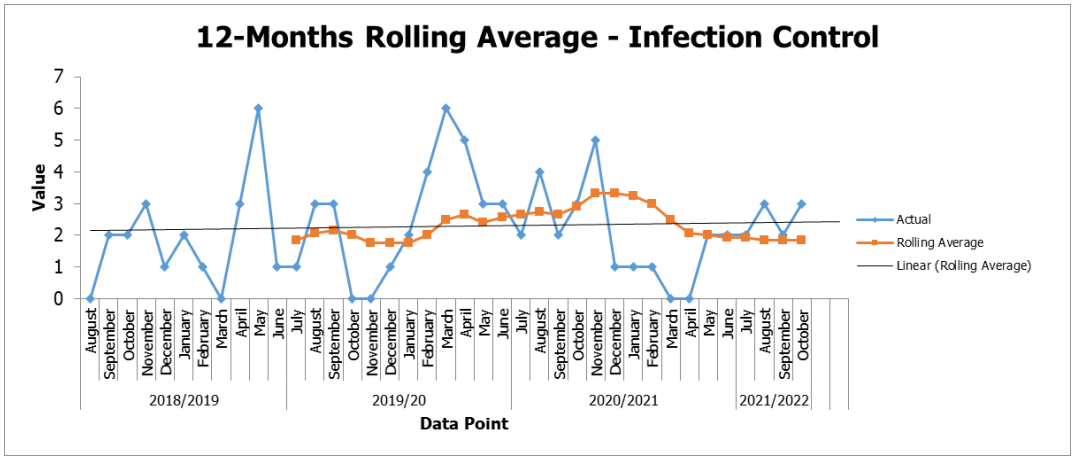
3.5 Infection prevention



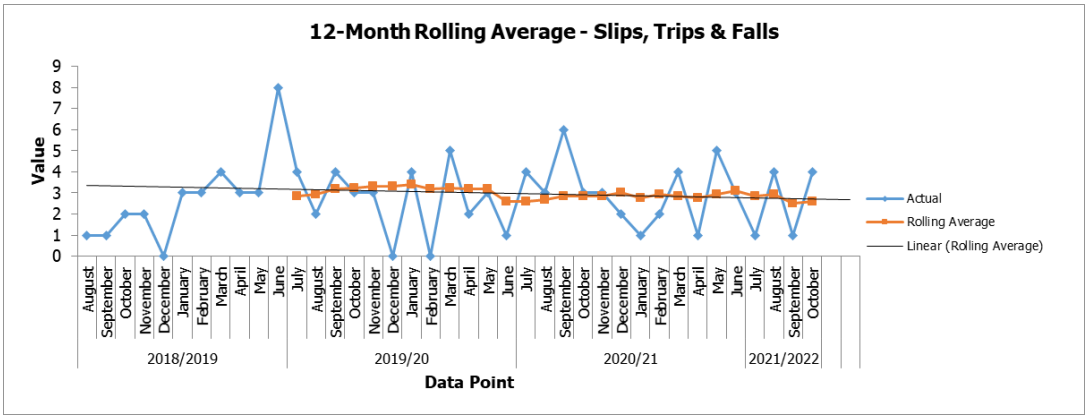
The trend line (based on the rolling average) shows an increase in the number of infection control incidents/injuries over the three year period.

From August 2021 to October 2021 there were eight needle-stick injuries

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

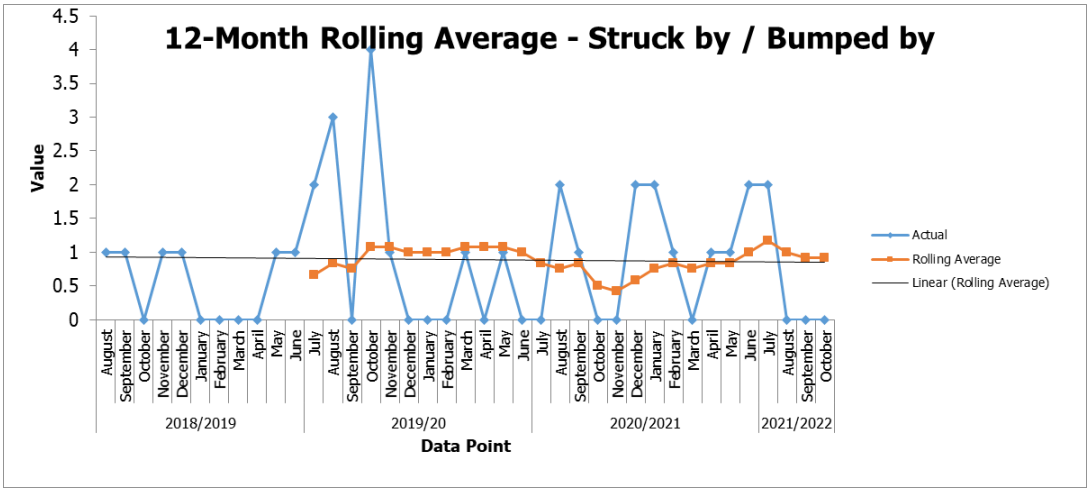
3.6 Slips, trips and falls



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

From August 2021 to October 2021 nine slips, trips and falls incidents/injuries were reported. Injuries/incidents included: wet surface (2) stairs (2), over a barrier in the car park, during de-escalation training, catching a patient as they fell, over a linen bag and another staff member

3.7 Struck by or bumped by



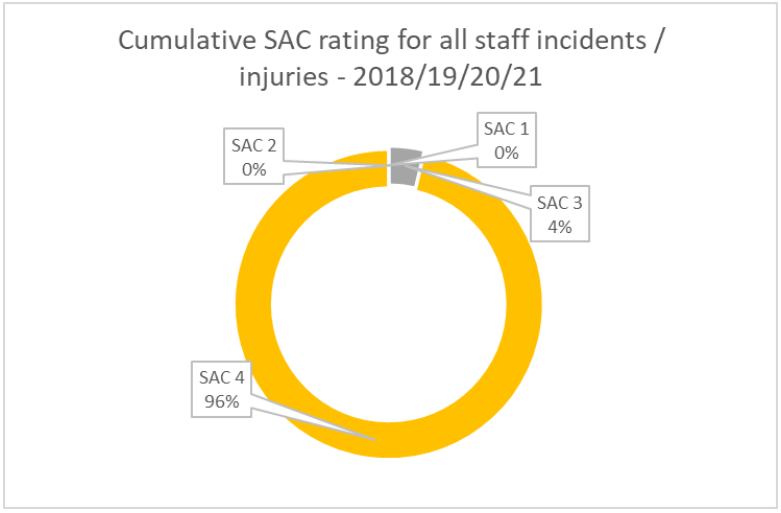
The trend line (based on the rolling average) shows a decrease in the number of struck by or bumped by incidents/injuries over the three year period.

From August 2021 to October 2021 no stuck bumped by incident/injuries were reported.

4 Incident/injury details

There were 40 staff incidents (injuries/potential injuries) recorded by staff on C-gov from August 2021 to October 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.

5 Health and safety representative training

The health and safety representative training (NZQA 29315) with Coachio Group is scheduled for 23 & 24 November 2021 and 30 November & 1 December 2021. Currently there are seven WDHB workgroups who do not have a health and safety representative.

6 Employee participation

The WDHB Health and Safety Committee met in August, September and October.

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

- Review of monthly incident trends
- Rolling average trends and graphs for board report
- Monitor and update of health and safety objectives for 2020/2021
- Manual handling – trial ceiling hoists in medical ward
- EMERGO exercise with other emergency management agencies scheduled for December 2021
- COVID-19 vaccination programme
- Mask fit testing
- Provisional Improvement Notices (PIN)
- WorkSafe court cases
- Excellence and innovation in health and safety
- TAS audit "Violence and aggression towards staff"
- Re-activation of the violence in the workplace workgroup
- Health and safety representatives training

7 Contractor management update

Ventia and MedLab have representatives on the WDHB Health and Safety Committee meeting.

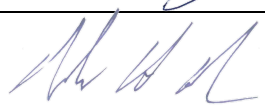
The investigation of MedLab Xylene exposure is continuing. WorkSafe are meeting with MedLab on 25 November to discuss the incident that MedLab reported to them. MedLab will be advised if any action will be taken by WorkSafe.

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

ICT Security Assurance Plan
2021/22

Document Control

Document Approval

	Name	Signature	Date
Recommended by Chief Information Officer	Barry Morris		5/11/2021
Endorsed by GM Corporate	Andrew McKinnon		5/11/2021
Approved by acting CEO	Graham Dyer		8/11/2021

Version Control

Version	Issue Date	Author	Description of Changes
0.1	1/10/21	Barry Morris	Initial draft
0.2	28/10/21	Barry Morris	updates

Key Contacts

Name	Title	Contact Details
Barry Morris	Chief Information Officer	barry.morris@wdhb.org.nz

Contents

1. Context

1.1 Key Objectives and Outcomes

The objective of this document is to outline how over the course of the 2021/2022 financial year Whanganui District Health Board (WDHB) will undertake assurance activities regarding ICT security, to provide confidence that risks are being managed appropriately and securely to enable our agency's key business objectives.

1.1.1. Security risks are business risks

In fulfilling our mandate to deliver services to the public, we depend on the effective, secure, and reliable operation of our ICT systems. In addition, opportunities frequently arise to leverage technology which improve our business outcomes. We must be able to both maintain the security of our existing ICT systems and be in a position that ensures our agency's leaders can confidently take advantage of secure technology-enabled opportunities.

This ICT Security Assurance Plan outlines the assurance activities planned for FY 21/22 to develop and implement controls which will provide objective evidence that these controls and other mitigations are successfully working. These activities may include; analysis of information obtained through monitoring, routine or special reviews by management or governance bodies, and audits/reviews carried out by internal or external parties.

This plan will fulfil our commitment to providing a structured programme of assurance strategy.

1.2 Scope and Approach

The assurance plan is part of the agency's overall risk management and assurance approach, and specifically covers ICT security risk areas i.e. business-as-usual (non-project) risks related to the security of data and technology.

CERT NZ has informed us in 2020 of the 10 Critical Security Controls that should be in place. These are:

1. Patch software and systems - keeping software such as operating systems and applications, up to-date.
2. Disable unused services and protocols - keeping unused and unnecessary services running on a system can leave it vulnerable, especially if the host is exposed to the internet.
3. Implement and test backups - backing up data is a critical corrective control if a security incident occurs.
4. Implement application whitelisting - application whitelisting is a control that can prevent unauthorised files from executing on computers.
5. Enforce the principle of least privilege - the principle of least privilege means granting users the minimum level of access they need to perform their job.
6. Configure centralised logging and analysis - logging is an important control for understanding what is happening in the network. It can help detect when a security incident has occurred and prevent them from happening again.
7. Implement network segmentation - network segmentation means breaking down the network into smaller networks and setting access controls to manage connections across them.
8. Manage Authentication - this control is aimed at protecting authentication to the organisation's systems. It recommends changing default credentials and making sure each account has a strong, unique password.
9. Follow an asset management life cycle - an asset management framework allows the organisation to track assets throughout their life, including purchase, development, maintenance, and disposal
10. Set secure defaults for macros - macros are small programs that can be run in office productivity software, like Microsoft Office. Attackers often use macros for hiding malicious programs.

Further security controls that have been recommended following recent health sector security breaches or through external assessment are:

1. Encryption - ensure that portable endpoints such as mobiles, laptops and tablets are encrypted, due to the potential of loss or theft.
2. Data classification – documented data classification and protection requirements, monitoring and alerting of data movement – DLP (Data Loss Prevention).
3. User education – documented cyber education and awareness programme, regular cyber training and education given to the organisation including new user onboarding cyber security training.
4. Internet facing applications – ensure that internet facing applications are securely configured to protect from external breach.
5. Disable and replace vulnerable software – software with known vulnerabilities should be patched or replaced to ensure they are not compromised.
6. Email controls – controls to protect the spread of malware, spam and phishing attacks via email.

The WDHB has over 30 major operational systems (both clinical and business). Our reputation and ability to deliver services depends on these systems being secure and available.

Following a recommendation from the Ministry of Health Information Technology Security Manager in August 2021, independent ICT security specialists, Inphysec, were engaged to undertake an assessment of the WDHB network and endpoints using Crowdstrike software.

Inphysec did not find any serious active malware infections within the WDHB environment and reported on vulnerabilities that could be potentially compromised.

1.3 Key Risks

As a result of the Inphysec assessments the following risks were identified:

Key Risks
Compromised credentials
Dmarc not configured
General vulnerabilities
High risk port in use
Open source intelligence and Reconnaissance findings
Patch management
Removable media activity
SPF not configured
Suspicious activity
User account management
User breaches
Volume encryption
Vulnerable applications
Vulnerable windows operating systems
Weak encryption
Website Component Exposures
Website header security

Mitigation of these risks are included in the schedule of assurance activities (see section 3)

1.4 Roles, Accountability and Responsibilities – Overall Plan

The table below outlines the key roles and responsibilities in developing and managing this plan.

1. Accountability	
Overall accountability for the assurance plan. Acceptance of the residual business risk.	Chief Executive Russell Simpson
2. Responsibility	
2a Preparation	
Preparation /sign-off of the assurance plan (annually).	Chief Information Officer Barry Morris
Recommendation of the assurance plan to the Chief Executive.	Chief Information Officer Barry Morris GM Corporate Andrew McKinnon
2b Monitoring	
Ongoing monitoring of progress against this plan, and the consolidated results of the assurance activities.	Chief Information Officer Barry Morris
Updating the plan mid-cycle in response to changing priorities.	Chief Information Officer Barry Morris
Tracking of action items (such as control improvement initiatives and remediations).	Chief Information Officer Barry Morris
2c Reporting	
Preparation and distribution of the annual security assurance report Due: 1 September	Chief Information Officer Barry Morris
Approval of security assurance report	GM Corporate Andrew McKinnon
Reporting of assurance results to the Risk and Audit Committee.	GM Corporate Andrew McKinnon
2d Quality	
Quality and adequacy of plan. Monthly review of risks and addition of any new assurance activities.	Chief Information Officer Barry Morris
3. Contributing	
Contributing to the plan, confirming the scope / timing of assurance activities they sponsor.	Chief Information Officer Barry Morris GM Corporate Andrew McKinnon

1.5 Monitoring and Reporting Process

The results of each assurance activity will be reported through to the key stakeholders:

- GM Corporate
- Finance, Risk and Audit Committee
- Digital and Data Governance Committee
- Executive Leadership Team
- CEO

On a four-monthly basis, the CIO will compile progress results into an ICT Security Assurance Summary.

The ICT Security Assurance Summary will include:

- Progress against the plan (are the assurance activities on schedule and on budget)
- Key results from the previous period (summary)
- Indication of increasing or decreasing confidence in controls over each key risk from Section 1.3 (key risk dashboard)
- Any new risks identified (with a summary of how these were escalated/recorded)
- Any new adjustments needed to assurance or controls (with action plans)
- Challenges and successes.

The CIO and GM Corporate will review and approve the ICT Security Assurance Summary**,** directing where necessary, any new risks or adjustments to the plan. Copies will then be made available to the Executive Management Team and the Chief Executive.

The GM Corporate will report to the Risk and Audit Committee on the progress of the ICT Security Assurance plan and escalate to the Risk and Audit Committee any critical risks.

Notwithstanding the above process, any significant new risks or assurance information will be escalated immediately to the appropriate level. In some cases, it will be appropriate to communicate assurance results and/or key risks (including opportunities) to the MoH to support its system-wide view.

The results of the assurance activities, and lessons learned from the process, will be used to inform the development of the FY 22/23 lCT Security Assurance Plan, which will be developed beginning in July 2022 and completed by 30 August 2022.

2. Assurance Schedule Overview

2.1 Assurance Approach

To develop the assurance schedule for FY 21/22, we first sought to understand the relevant risks within the CERT NZ critical security controls. We evaluated the risks, with due consideration of the likely “risk appetite” of our agency, and the effectiveness of existing controls.

Next, we sought to determine what activities were already planned or underway to give us assurance the controls are managing the risks. Through this process, we identified some areas where we felt our effort may best be focussed.

To provide further insight into our security capability and to provide further confidence to our executive we engaged Inphysec to undertake a security assessment of our environment and report back the findings and recommendations. Inphysec provided advice on risks we face, as well as identified gaps and/or deficiencies in our security advice.

From security advice given and recommendations from the Inphysec reports we then created a schedule of assurance activities for FY 21/22 (see section 3)

2.2 Lessons Learned

There has been a wealth of information and learnings shared across the sector from the Waikato DHB incident which has been a wake-up call to improve our security posture.

2.3 Decisions / Assumptions

In many areas of ICT, new controls are being embedded to mitigate risk e.g. learnings from the experience of other agencies, best practice recommendations from audits, advice from the National Cyber Security Centre. Implementing these controls has a cost, as does providing for continued assurance over them. Some of this cost can be recovered through efficiencies identified through the assurance activities themselves (e.g. some assurance activities pay for themselves).

2.4 Roles, Accountability and Responsibilities – Individual Activities

As discussed above, many parties will be involved in providing the required assurance, including:

- ICT Staff – routine checks.
- ICT Management – monitoring and upward reporting of risks and issues
- Service desk – aggregate reporting on events, incidents, and problems.
- Infrastructure Team – oversight on patch levels, vulnerabilities, security incidents, and other areas.

Breach reporting and analysis by which privacy controls can be assessed.

Risk registers, operational monitoring reports and deep-dive reviews to help manage risk.

- Applications Support Team – application enhancements and patches. Data quality, user support, identify training needs, privacy.
- External audit – external audit procedures which may provide assurance.
- Security contractor –services such as independent controls testing and penetration testing to help identify exposures.
- External agencies/regulators – views on compliance and risk within the context of their mandates.
- GCIO – shared information on system-wide risks, lessons learned, assurance guidance.

Specific activities and deliverables are listed in the Assurance Schedule (Section 3).

2.5 Assurance Budget

Assurance activities will be undertaken using both DHB and contracted resources. The estimated cost of the FY21/22 for external resources is $ 50,000.

2.6 Assurance Schedule

Refer to Section 3 for the schedule of assurance activities planned for FY 21/22.

3. Detailed Assurance Schedule

Below are the assurance activities that will occur in FY21/22 over Security:

* Refer to list of controls in Appendix 1

Risk Area	Source	Key Control	Specific Activity and deliverable	Owner	Existing security management activity	Critical/High/Medium /Low	Key risk
Open source intelligence and Reconnaisence findings	Inphysec - Threat Hunting report	8	Implement two factor authentication 2FA for the Remote Access Gateway and for Fortigate VPNs	CIO	Duo 2FA has been added to the remote access gateway. All external users now are protected with 2FA - Microsoft e5 licensed users through Azure and RAG users (Duo).	COMPLETED	Without 2FA threat actors will be able to access the WDHB network via a successful phishing attack or if staff credentials are compromised via a breach of a separate service
Immediately deploy critical OS security patches	Security advice	1	Install security updates as soon as they become available, to fix exploitable bugs in relevant products	CIO		COMPLETED	
Scripting environments	Security advice		Disable or restrict other scripting environments (e.g. PowerShell) if possible.	CIO		COMPLETED	
Antivirus	Security advice		Ensure antivirus products are required to be enabled and up to date.	CIO		COMPLETED	
Separate and protect privileged accounts users/workstations	Security advice	5	Apply controls to privileged accounts: - MFA enforced - Separate user accounts for Privileged actions - Restriction on workstation access	CIO	Reviewed and reduced the number of domain admins	COMPLETED	Administrator accounts have higher privileges which could be used by threat actors if compromised to easily propagate malware across the network.
General vulnerabilities	Inphysec - Threat Hunting report	15	Prioritise highlighted vulnerabilities	CIO	The majority of the vulnerabilities exist in remaining windows 7 devices which will be gone by end of November 2021. Others have been prioritised and reviewed	Critical	Common vulnerabilities were found in the WDHB environment which may lead to a threat actor being able to compromise the network once gaining an initial foothold.

Risk Area	Source	Key Control	Specific Activity and deliverable	Owner	Existing security management activity	Critical/High/Medium /Low	Key risk
Implement unique local administrator passwords on all systems	Security advice	5	Disable local administrator accounts or assign random and unique passwords for each computer's local administrator account.	CIO	LAPS to be implemented	Critical	Administrator accounts have higher privileges which could be used by threat actors if compromised to easily propagate malware across the network.
Patch management	Inphysec - Endpoint baseline report	1	Confirm a regular patch management process with urgent focus on critical vulnerabilities	CIO	Patch management is in place	COMPLETED	Unpatched systems are open to vulnerabilities being compromised
Office Macros Disabled	Security advice	10	Ensure all office macros have been disabled by default for all users with exceptions granted on a need and case by case basis.	CIO	Actioned blocked at email gateway	COMPLETED	Macros may contain mischievous code
Suspicious activity	Inphysec Threat Hunting report	15	Remove “anydesk” application	CIO	Application was removed immediately following receipt of the Inphysec report on 21st September 2021	COMPLETED	Allows for remote desktop connections bypassing security controls and such software is often used by hackers to compromise existing remote access channels.
Vulnerable applications	Inphysec - Endpoint baseline report	15	Review list of applications with a view to consolidation and prioritise and update vulnerable apps	CIO	Under action	High	Applications that have been commonly exploited
User account management	Inphysec - Endpoint baseline report	8	Ensure a password policy is in place with complex passwords enabled and review the list of accounts with administrative privileges	CIO	Policy in place, still working through implications of complex passwords with the business	High	Ability for a users password to be guessed or for the user to be a victim of a brute force attack
Volume encryption	Inphysec - Endpoint baseline report	11	Encrypt unprotected volumes and develop an encryption policy	CIO	Replacement of windows 7 with windows 10 by end of november 2021 will enforce bit locker to encrypt all volumes	High	Data being accessed if the device is lost or stolen

Risk Area	Source	Key Control	Specific Activity and deliverable	Owner	Existing security management activity	Critical/High/Medium /Low	Key risk
Vulnerable windows operating systems	Inphysec - Endpoint baseline report	15	Update endpoints that are using out of date operating systems	CIO	Replacement of windows 7 with windows 10 by end of November 2021 and upgrade of older versions of windows 10 by 31 December 2021	High	Ability for an adversary to exploit and gain system access
Website Component Exposures	Inphysec - Internet Footprint report	14	Limit access to source IP addresses or relevant geo locations and ensure all hostnames are intended to be publicly internet accessible and that webservers are not set to display the webserver version	CIO	Under action	High	Servers exposed to the internet increase WDHBs external footprint and if a server is left unpatched a vulnerable component may be exploited.
High risk port in use	Inphysec - Internet Footprint report	2	Ensure firewall rules are at least permissive and consider restricting access to management services such as SSH to trusted and hardened hosts. Use of a second factor of authentication for remote access	CIO	Under action	High	Access to remote server administration ports such as 22 increase the resource attack surface
Cyber Security response plan	Security advice		Develop a cyber security response plan	CIO	Under action	High	Unprepared to manage a cyber security incident
Discover and reduce broad permissions on file repositories	Security advice	5	Complete an assessment and remediate permissions issues for the following services based on least privilege principles: ▪ Fileshares ▪ Sharepoint ▪ Service Accounts ▪ Machine users ▪ NFS mounts	CIO	Will be actioned with pending upgrade of main file server.	High	Broad permissions could be used by threat actors if compromised to easily propagate malware across the network.
Centralised logging - security alerting	Security advice	6	Documented logging and alerting strategy for organisation ▪ Monitoring of all Critical services ▪ Basic SIEM deployed with initial playbook responses	CIO	PRTG for monitoring of critical services, Further security monitoring to be investigated. National / Regional activity to look at SOC and SIEM. It will be a significant cost.	High	Information may be accessed / accessible by unauthorised person

Risk Area	Source	Key Control	Specific Activity and deliverable	Owner	Existing security management activity	Critical/High/Medium /Low	Key risk
			▪ SIEM tools integrated with most areas. ▪ Active testing on a regular basis for specific attacks				
User Education and Training	Security advice	5	Inform end users about security best practices and credential hygiene. Review orientation network training material to stress importance of end user behaviour	CIO	On going	High	End users are the last line of security defence and need to know what is expected of them.
Information Classification and Protection	Security advice	12	Documented data classification and protection requirements ▪ Identity protection capability ▪ Monitoring and alerting of data movement	CIO	To be planned	High	Data classification provides a clear picture of all data within an organization's control and an understanding of where data is stored, how to easily access it, and the best way to protect it from potential security risks.
Disable unneeded legacy protocols	Security advice	2	Legacy protocols have been disabled? ▪ SMB1 ▪ LanMan and NTLMv1 ▪ LDAP	CIO	Under action	High	Vulnerable protocols may be used by threat actors to compromise the network.
Implement network segmentation	Security advice	7	Ensure network is segmented to improve performance and security	CIO	Under action	High	Open flat networks
Identity & Access Management	Security advice	8	Centralised user management, documented onboarding/offboarding process ▪ All services are SSO integrated (single sign on), sub organisations are effectively federated. ▪ User access and privilege access reviews conducted every 90 days	CIO	To be planned	High	Information may be accessed/accessible by unauthorised person

Risk Area	Source	Key Control	Specific Activity and deliverable	Owner	Existing security management activity	Critical/High/Medium /Low	Key risk
			▪ Privileged access management implemented				
User Education and Training	Security advice	13	Documented Cyber education and awareness programme ▪ Regular cyber training and education given org wide ▪ New user onboarding cyber security training	CIO	Ongoing - Informing end users about security best practices and credential hygiene. Review orientation network training material to stress importance of end user behaviour	High	End users are the last line of security defense and they need to understand their responsibilites
Backups	Security advice	3	Validate your backups using standard restore procedures and tools	CIO	Regular - backup validations	High	Backups can be used to restore service
Application whitelisting	Security advice	4	Only allow applications trusted by the enterprise to run on devices	CIO	Windows 10 image restricts applications to those approved and prevents installation by end users.	High	Vulnerable apps installed by end users may be used to compromise the WDHB network
User breaches	Inphysec - Internet Footprint report	8	Ensure 10 users whose credentials have been exposed through public data breaches are changed and multi factor authentication is enabled where possible	CIO	All current users have changed their passwords several times since the public data breaches.	COMPLETED	Users whose credentials have been exposed through public data breaches are susceptible to authentication-based attacks.
Removable media activity	Inphysec - Endpoint baseline report	11	Ensure a device control policy is in place and USB drives are encrypted	CIO	Under action	Medium	Removable media devices can pose a high risk due to the number of files they can hold, are easy to steal or lose and are rarely encrypted
Weak encryption	Inphysec - Internet Footprint report	11	Review all hosts identified as at risk and remove support for old non-secure TLS versions	CIO	Under action	Medium	Weak encryption increases the likelihood of WDHB being subject to a brute force attack
Dmarc not configured	Inphysec - Internet Footprint report	16	Configure Domain Based Message Authentication DMARC is configured on wdhb.org.nz and wdhb.health.nz domains	CIO	Awaiting Midcentral DHB to implement before we can complete as they send emails from hosted JDE system on behalf of WDHB.	Medium	Without Dmarc unauthorised use of the WDHB email domain is possible by spoofing .

Risk Area	Source	Key Control	Specific Activity and deliverable	Owner	Existing security management activity	Critical/High/Medium /Low	Key risk
SPF not configured	Inphysec - Internet Footprint report	16	Configure SPF on the wdhb.health.nz domain	CIO	Not currently using this domain	Medium	SPF detects forged sender addresses in email (spoofing) which is commonly used in email phishing and spam.
Asset management	Security advice	9	Documented lists of critical services/applications ▪ Accurate list/register of all servers/workstations ▪ Asset discovery and reporting Configuration change management solution deployed across all environments ▪ Isolate or retire computers that cannot be updated and patched	CIO	Asset lists in place Configuration change reporting to be implemented Isolating computers that can't be upgraded or patched	Medium	Vulnerable equipment can be used to compromise network security
Suspicious activity	Inphysec - Threat Hunting report	16	Investigate the use of network scanner on WDHB-SVR-UTIL4	CIO	Used legitimately by Spark support staff to troubleshoot network issues	COMPLETED	Threat actors will perform network reconnaissance to gather information about a network topology or active directory.
Compromised credentials	Inphysec - Threat Hunting report	8	Ensure passwords have been changed for 22 WDHB accounts that have passwords available on the web due to known compromises of web sites	CIO	All current users of the 22 have changed their passwords recently.	COMPLETED	Threat actors may use these credentials to access the WDHB network
Suspicious activity	Inphysec - Threat Hunting report	16	Investigate use of team viewer app and remove where not necessary	CIO	Under action	Low	Allows for remote desktop connections bypassing security controls and such software is often used by hackers to compromise existing remote access channels.

Risk Area	Source	Key Control	Specific Activity and deliverable	Owner	Existing security management activity	Critical/High/Medium /Low	Key risk
Website header security	Inphysec - Internet Footprint report	14	Ensure non secure items are reconfigured to ensure browser compliance	CIO	To be planned	Low	Malicious actors may use poorly configured website headers to attack the WDHB website.

Appendix 1

Key Controls

1. Patch software and systems
2. Disable unused services and protocols
3. Implement and test backups
4. Implement application whitelisting
5. Enforce the principle of least privilege
6. Configure centralised logging and analysis
7. Implement network segmentation
8. Manage Authentication
9. Follow an asset management life cycle
10. Set secure defaults for macros
11. Encryption
12. Data Classification
13. User education
14. Internet facing applications
15. Vulnerable software
16. Email controls