Public Board Meeting - April 2022

20 April 2022 09:30 AM - 10:00 AM

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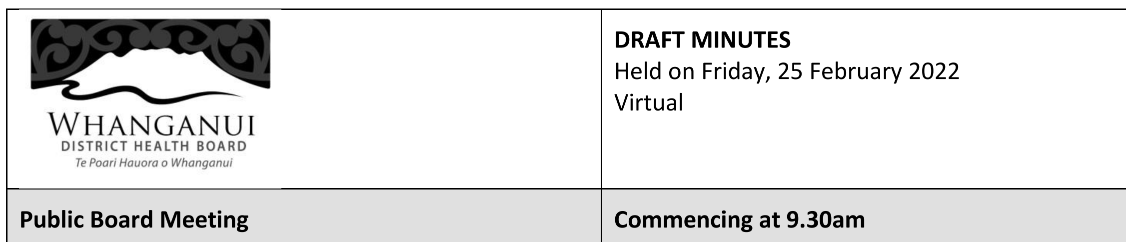
Interest Register
22 June 2021

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. ▪ A board member of Pharmac
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	▪ A member Hauora ā Iwi ▪ A member Te Oranganui Trust Board ▪ A 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

Name	Date	Interest
Peke-Mason Soraya	19 June 2021	▪ A Director, Ruapehu Health Limited ▪ A Trustee, Whanganui Community Foundation ▪ A Iwi Rep, Rangitikei District Council Standing Committee ▪ A member of Whanganui Health Network Board ▪ A member of Hauora ā Iwi

25 February 2022 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**DRAFT MINUTES** Held on Friday, 25 February 2022 Virtual
Public Board Meeting	**Commencing at 9.30am**

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

Apologies
Talia Anderson-Town, Finance Risk and Audit Chair

In attendance
Russell Simpson, Chief Executive
Nadine Mackintosh, Executive Officer
Andrew McKinnon, General Manager Corporate
Louise Allsopp, GM Patient Safety and Innovation
Ron Dunham, GM Strategy Commissioning and Population Health

1. PROCEDURAL

The board requested that whilst we are working in a virtual environment that we notify the meeting details via teams, members of the board when speaking will notify their name to identify who is speaking.

1.1 Karakia/reflection
S Peke-Mason opened the meeting with a karakia.

1.2 Apologies
The board **accepted** apologies from T Anderson-Town and noted the leave of absence from J Chandual-Mackay

Moved P Baker-Hogan **Seconded** G Adams **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
Members highlighted their interests in relation to the papers on the agenda which the board did not perceive to be a conflict of interest.

25 February 2022 **Public**

1.4 Confirmation of minutes

1 December 2021

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

Moved P Baker-Hogan **Seconded** G Adams **CARRIED**

1.5 Matters Arising

The matters arising were received.

2. PRESENTATIONS

2.1 Vaccinations

The presentation was received by the board noting that the paper is out of dates.

- COVID-19 vaccination rates were provided as at 24 February 2022 and listed in the chief executive's report.
- The numbers are frequently changing and the teams are working collectively with iwi and community groups to achieve our 90% rate.

  For Maori

  First dose we have 351 individuals to achieve 90%

  Second dose we have 881 individuals to achieve 90%

  For Pasifika

  Second does we have 36 individuals to achieve 90%

  The chair reported that learnings from northern region DHBs are hospitalisations of patients with vulnerable conditions are being reported in our COVID-19 hospital numbers when COVID is not the primary reason for their care treatment. Vaccinations still remain our best defense against the requirement for hospital level care.
- Paediatric vaccinations are challenging and the teams are working collectively to provide

CARRIED

2.2 COVID-19 Care in the Community welfare response

Hub leader details for our communities are as follows:

- Whanganui
- Rangitikei
- Taihape
- Ruapehu

The hubs provide a response to meet the needs of primary care and welfare and work as a hub and spoke model.

Where the technical systems have failed the strength in our relationships with the DHB and MSD to strenthen our local response and our willingness to work together has taught us to pivot on a daily basis.

The community hubs are comfortable with the response that we have had from our communities on our preparedness.

CARRIED

DRAFT

25 February 2022 **Public**

3. CHIEF EXECUTIVE REPORT

The paper was taken as read.

The chief executive is encouraging self determination and for board members to have a COVID-19 plan for individuals and whanau and encourage our population of five million have these in place.

The change to phase 3 will impact our stand down requirements, COVID-19 case number reporting individual rohe will cease from today. Whanganui DHB have sufficient PPE and testing stock to hand and we have assurances from the Ministry of Health that they will continue to keep the stock levels as they are.

Supervised RAT packs have been allocated to the distribution sites and self assessment tests will be circulated with distribution sites over the next few days.

A communication strategy on distribution sites will be similar to the vaccination clinics.

The Board of Whanganui District Health Board **received** the paper titled chief executive update report.

CARRIED

4. DISCUSSION

4.1 Provider Arm Report – February 2022

The paper was taken as read. The chief executive highlighted the following key points:

- High clinical presentations
- Planned care rates are behind schedule and we will continue to monitor these
  - i. ESPI 2 we are currently 252 cases behind schedule
  - ii. ESPI 5 we are currently 145 cases behind schedule
- Workforce pressures due to a number of vacancies across the health sector
- The ED presentation are triaged and Whanganui DHB has the benefit of Whanganui Accident and Medical Centre being co-located to help manage the ACC and primary care appropriate cases.

Action: The board requested a copy of the bowel screening audit report when it is released.

The Board of Whanganui District Health Board:

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

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

CARRIED

4.2 Preliminary Q2 Reporting: non-financial performance measures

The paper was taken as read noting that the performance against the report remain red as we are in the middle of a reporting cycle and this should be treated as a preliminary report.

The board will receive a final report when more accurate data is available.

The Board of Whanganui District Health Board:

a. **Received** the paper titled Preliminary Q2 Reporting; Non-financial performance measures

b. **Noted** that Quarter 2 results are preliminary.

CARRIED

25 February 2022 **Public**

5. INFORMATION PAPERS

5.1 Detailed Financial Report 2022

The paper was taken as read with acknowledgement that the finance risk and audit committee congratulated the management team for the good results.

GM Corporate advised that financial result is good whilst we are facing the pressures of COVID-19, workforce vacancies and increase costs in home care services.

The Board of Whanganui District Health Board:

a. **Received** the report 'Detailed financial report – January 2022'.

b. **Noted** the January 2022 monthly result of $25k deficit is favourable to budget by $268k. Including COVID-19 and the Holiday Act Compliance provision, the result is $254k favourable to budget.

c. **Noted** the year-to-date result of $4,020k deficit is favourable to budget by $204k. Including COVID-19 and the Holiday Act Compliance provision, the result is $99k favourable to budget.

CARRIED

5.2 COVID-19 update; 14 February 2022

The paper was taken as read.

The Board of Whanganui District Health Board:

a. **Received** the report entitled 'COVID-19 update'.

b. **Noted** the testing model changes that will occur when we move to phase II

c. **Note** the vaccination rates contained in the vaccination update

CARRIED

5.3 Health and Safety

The paper was taken as read.

The Board of Whanganui District Health Board:

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

b. **Noted** there were no notifiable events reported to WorkSafe New Zealand in the 2017/18, 2018/19, 2019/20, 2020/21 financial years. One notifiable event was sent to WorkSafe in November 2021 as a precaution (not heard back from WorkSafe yet).

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

d. **Noted** 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 decreased over the three year period.
- Slip, trip, falls injuries/incidents decreased over the three year period.
- Struck by, bumped injuries/incidents increased over the three year period.

CARRIED

DRAFT

5.4 Faster Cancer Treatment

The paper was taken as read.

The Board of Whanganui District Health Board:

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

b. **Noted** that Ministry of Health Faster Cancer Treatment Health Target reporting for Q2 indicates 86.0% compliance with the FCT Target.

CARRIED

5.5 OIA complaint report

The paper was taken as read.

The Board of Whanganui District Health Board **received** the paper titled OIA complaint report.

CARRIED

6. RESOLUTION TO EXCLUDE THE 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 28 October 2021	For reasons set out in the board's agenda of 28 October 2021	As per the board agenda of 28 October 2021
Chief executive's report Committee Chair update Covid-19 Mental Health Facilities	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
MRI Procurement WebPAS as a Service	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or	Section 9(2)(i) and 9(2)(j)

25 February 2022 **Public**

Agenda item	Reason	OIA reference
ACC High Tech Imaging Services Laboratories and Pathology	negotiations (including commercial and industrial negotiations	
Iwi Māori Relationship Boards Regional Services Plan Sustainability Initiatives.	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)

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

The public section of the meeting concluded at 11.00 am

DRAFT

April 2022 **Public**

Matters Arising

25 February 2022

Topic	Date	Action	Assigned to	Due date
Provider Arm Report	February 2022	The board requested a copy of the bowel screening audit report when it is released	R Dunham	Prior to June

April 2022 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Chief executive update**
	20 April 2022
Author	Andrew McKinnon, Acting chief executive
Subject	Chief Executive Report

Recommendations

Management recommend that the board of Whanganui DHB

a. Receive the paper titled 'Chief Executive Report'

1 COVID-19

As at 14 April 2022 there are a total of cases in our rohe:
280 in Rangitikei
70 in Ruapehu
1,011 in Whanganui

1.1 Vaccinations

All ethnicities					
Dose one	92%	Dose two	90%	Eligible Booster	72%
Māori					
Dose one	88%	Dose two	85%	Eligible Booster	58%
Pasifika					
Dose one	91%	Dose two	88%	Eligible Booster	60%
Children 5-11 years all ethnicities dose one		Children 5-11 years Māori dose one		Children 5-11 years Pasifika dose one	
41%		29%		38%	
Children 5-11 years all ethnicities dose Two 15%		Children 5-11 years Māori dose Two 7%		Children 5-11 years Pasifika dose Two 7%	

2 Proceeds of crime funding

Last year, the DHB submitted a proposal via the Ministry of Health (MOH) for funding to enable an integrated approach to mental health crisis. The submission, titled “Supporting tangata whāiora in mental health crisis through co-response” was a collaborative approach between the DHB, Te Oranganui Trust, Balance Aotearoa, and the NZ Police. The DHB has been informed that funding for the proposal has been accepted for a period of three years.

The proposal sought funding “to implement a trial of co-working, co-location, information collection and sharing in mental health crisis across health and police over three years. The model will prioritise pro equity and whānau ora approaches and have cross sector governance. The aim is to determine the best model of co working, co-location data collection and information sharing between Police and Mental Health services within the space of mental health and drug crisis. This is hoped to increase responsiveness and access to appropriate care for tangata whaiora experiencing drug and mental health crisis, within the justice and health systems.”

3 Health Reforms

3.1 New structures

The current focus is on getting the right team working through the structure of the Māori Health Authority and Health New Zealand, as well as our regional presence and identities.

Information on functions and recruiting for the first wave of leadership roles we be released by the end of April. This will include establishing national working groups to engage the teams in how parts of the operating model will work to get the best of our experience and expertise involved.

3.2 DHB chief executive roles

As the only people directly impacted in the reform, Boards will be reaching the end of their terms by 30 June and district health board chief executives received formal notification that their roles will be disestablished on 1 July. Chief executives also have an offer to extend to the end of September 2022 to provide leadership support during the transition.

Chief executives have been thanked for the role they have played in the healthcare system – many have served their communities and been in our system for decades.

3.3 DHB staff

Employment agreement and current terms and conditions will roll over on 1 July with the aim of a seamlessly transition of all current functions and people into the new Health New Zealand and Māori Health Authority organisations. by then. This means that by 1 July, you will know who your line manager or clinical leader will be. For most of it will be the same person.

3.4 Transferring some functions from the Ministry of Health to iHNZ and iMHA

It’s more important than ever that, come 1 July, we continue to deliver a high standard of care to New Zealanders without disruption.

As part of the system reforms, some of the functions that belonged to the Ministry of Health transfer to Health New Zealand and the Māori Health Authority. To make sure we have a standing start on day one, some of these functions are transitioning before then.

Earlier this month, the first group of functions transferred from the Ministry. This included around 250 people working in health infrastructure, capital and investment management, Pacific health commissioning, DHB performance and support, data and digital, and Māori health service improvement.

It is expected that the next groups of people to transfer across in May.

While new structures are being developed between now and 1 July – and will evolve beyond –focus will remain on maintaining business continuity and system stability.

3.5 Investment in Hauora Māori

15 March saw an important milestone for improving health outcomes for Māori and lifting the voice of whānau Māori across the system.

An investment of $22 million will see the Māori Health Authority commission and expand Te Ao Māori solutions and services. This is part of a broader package of investment planned over the coming years to drive the influence of Hauora Māori throughout health.

The Māori Health Authority will work with Iwi and Māori providers to deliver the budget activities over the coming months, ahead of 30 June. Specific areas to be funded include:

- $3 million for mātauranga Māori initiatives and services
- $6 million to support Māori providers within innovation and sustainability
- $5 million to support kaupapa Māori approaches to population health
- $2 million to expand existing rongoā Māori services
- $2 million to support further development of the Māori workforce

A further $3.2 million has been allocated by the Māori Health Authority and the Māori Health Directorate of the Ministry of Health to supporting the establishment of Iwi-Māori Partnership Boards this year.

More people, and not just Māori, will be able to choose to get support through a kaupapa Māori service, if that's what works best for them. And those services will be connected with other services delivered by providers such as social services, in a Te Ao Māori way.

Non-Māori are already choosing to access Māori health services, recognising the value that comes with doing things differently. If we achieve a system that works better for Māori, we'll have a better system for everyone in New Zealand.

The influence of the Māori Health Authority stretches beyond directly commissioning Māori health services.

Interim Director Service Development and Relations Mara Andrews says, "Because the MHA will also co-commission services with Health New Zealand, there will also be 'eyes' on all of HNZ's commissioning activity, whether that's with Māori or non-Māori providers. MHA can provide comment, leadership, advice and direction to HNZ on their commissioning from a Hauora Māori perspective. They are already working like this together, even in the interim environment and putting their heads together to look at how they can transform the way services are provided and delivered for Māori".

"This investment is an opportunity to build on the important mahi already underway in the health system.

3.6 Procurement and Supply Chain Project update

The transformation of the health system provides the opportunity to streamline and improve the way to procure and supply equipment, products and services.

A team of subject matter experts* from the sector have been working through ways to make it easier to navigate the procurement (sourcing and investing) and supply chain activities that support our front-line service providers. This includes removing duplication and inconsistency and promoting equitable outcomes for all New Zealanders.

The management of these activities will be led from the centre and delivered nationally, regionally, and locally. As well as allowing this to work seamlessly across the country, this approach will simplify the way we buy what the system needs and get it to where it needs to be. That means it will be easier to

see who needs it, who must approve it, and how. It will improve cost effectiveness and access to the procurement system, and allow more collaborative work with experts in the system.

Having developed a high-level operating model (ways of working), the project is now focused on delivering the plan for how it will actually work (a detailed operating model design.)

One of the issues being addressed is the current lack of focus on equity and our Te Tiriti obligations. This not only contributes to health inequities, but has also meant barriers to participation by Māori, Pasifika and other equity partners, in procurement and supply chain activities and supply.

Another area of focus is the fragmented approach to systems, policies and procedures across the different regions. A more joined-up approach will mean a well-integrated system that has the resilience to respond to unexpected or evolving challenges. We'll build public confidence by having more transparency of the decisions we make.

A third issue being addressed is the need to work more closely with clinicians in designing the best way to buy and manage supply of the things we need.

3.7 Next steps

- A dedicated project team is being established for the next phase
- A revamped steering group will oversee the development of the detailed operating model
- Eight 12-month fixed-term Day One National Procurement and Supply Chain Team positions are being established. These include the Interim Director for Procurement and Supply Chain, with most of the other appointments being project focused.
- The project team will continue to make sure the decisions being made now will support the aspirations of the health reforms and the future direction of both Health New Zealand and the Māori Health Authority.

3.8 New interim agency websites

The new websites for the Māori Health Authority and Health New Zealand are up and running.

- Health New Zealand (hnz.govt.nz)
- Māori Health Authority (mha.govt.nz)

4 Hospice Whanganui – Clinical review

The Board and Management of Hospice Whanganui have announced a series of important improvements to their service that will enable them to deliver excellent, specialist palliative care for patients and their whānau in the Whanganui community over the next 5 to 10 years.

The improvements reflect the outcomes of a review of the Hospice Whanganui service undertaken over the last 6 months. The Hospice team looked at modern palliative care models from around New Zealand, as well as the specific needs and goals of patients and whānau in our community.

HW Board Chairman Dr Andrew Zimmerman says "in looking at our service and what our patients' needs and wishes are, we are seeing that there a things that are really important to people who have received a terminal diagnosis. In most cases our patients and their whānau express a wish to remain in their own homes, where they feel safe and where they can be surrounded by the people and the things that are important to them. With some excellent advances in in technology and medicines and the availability of better care supports in the community over recent years, these goals have become entirely achievable".

In order to achieve a specialist service that is truly responsive, 24/7, that meets the needs of patients and whānau, the community will see a number of practical changes from the service. During the week there will be nurses and healthcare assistants working between the hours of 7am and 10pm, extending

support to patients and whānau in their homes well into the evening. These staff will be supported by a specialist medical and social support team during the day. After 10pm they have a 24/7 on-call nurse and doctor that can be called at any time to address any issues that may arise overnight. This wrap-around service will provide assurance that they will be safe and comfortable wherever they are, at any time of the day or night.

Despite the fact that only a small percentage of Hospice patients are ever admitted to the In-patient Unit on St Johns Hill, the 5-bed unit will continue to be available for any patients who need and want to be admitted for a short time to manage any specific complex issues, or for patients who prefer an end of life care plan managed in the unit rather than at home.

A key opportunity the review revealed is the recognition that palliative care is a community effort not just the work of Hospice. With GP teams, rest homes, Māori healthcare providers, the hospital, district nurses and a range of other care agencies, all involved in the care of a palliative patient. CEO Davene Vroon says "We will increase our focus on delivering specialist education, training and support to these agencies. We will ensure that everyone is working closely together to provide excellent care for patients and that no-one falls through the cracks".

The DHB funds half of the costs and they rely on the generous giving and donations from our community for the remainder, this allows Hospice to serve around 350 patients in our community each year.

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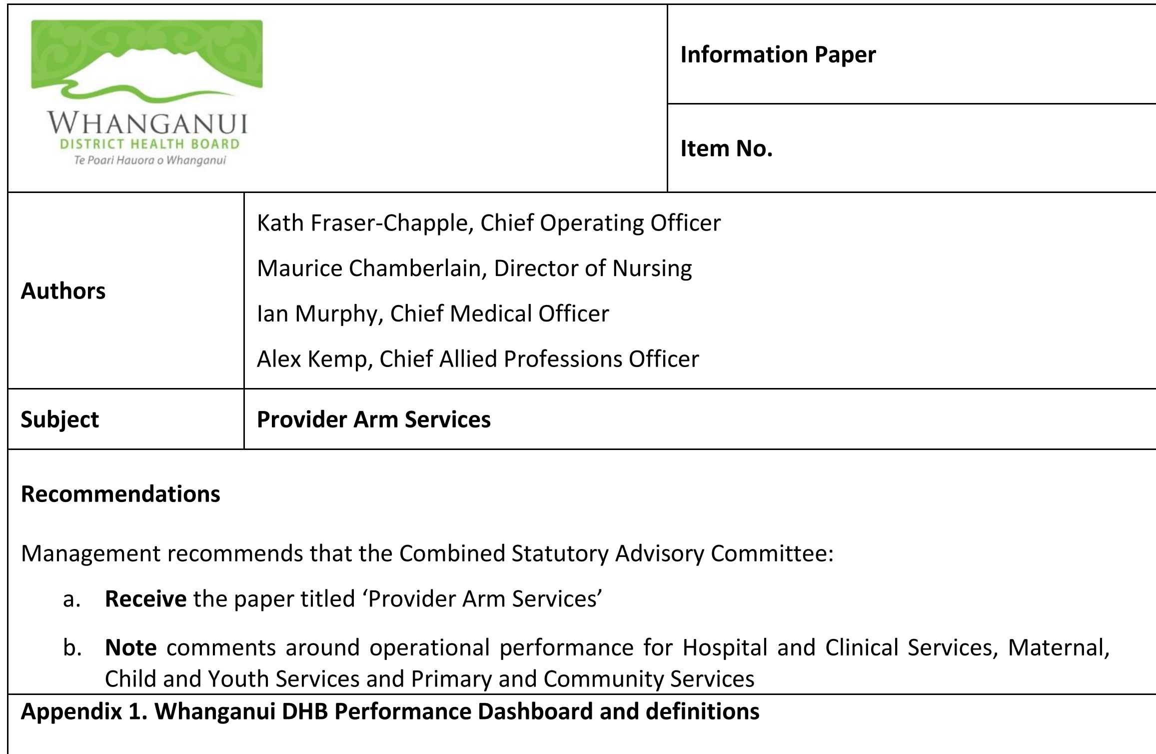


WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui		Information Paper
		Item No.
Authors	Kath Fraser-Chapple, Chief Operating Officer Maurice Chamberlain, Director of Nursing Ian Murphy, Chief Medical Officer Alex Kemp, Chief Allied Professions Officer	
Subject	**Provider Arm Services**	

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

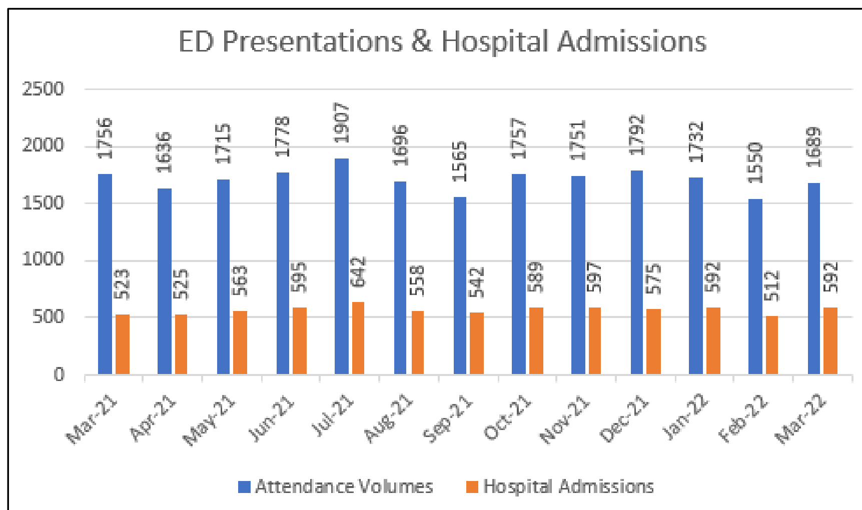
1 Purpose

To provide the Committee with a high-level overview of provider arm services; operational performance is noted for the months of February and March 2022.

2 Hospital and Clinical Services

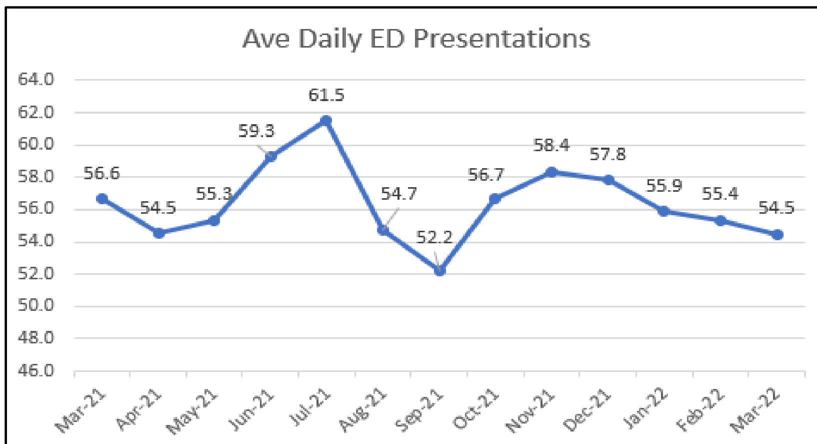
2.1 Service Delivery

Emergency Department Attendance Volumes



*Data extracted from WebPAS through PowerBI 04.04.22; Hospital Admissions are excluding 3-hr ED admits.

April 2022 **Board Public**

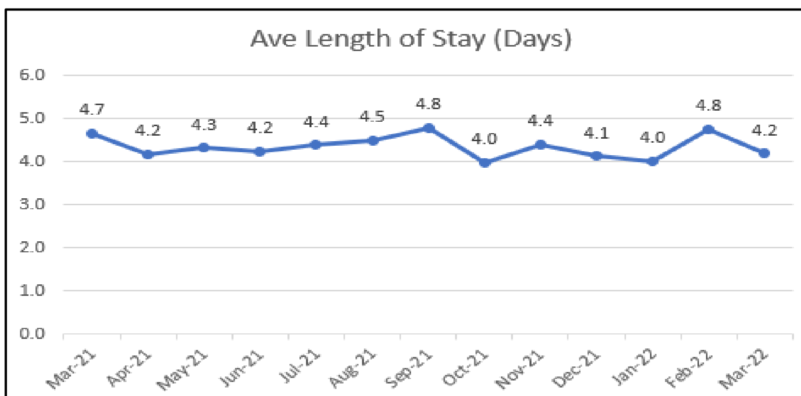


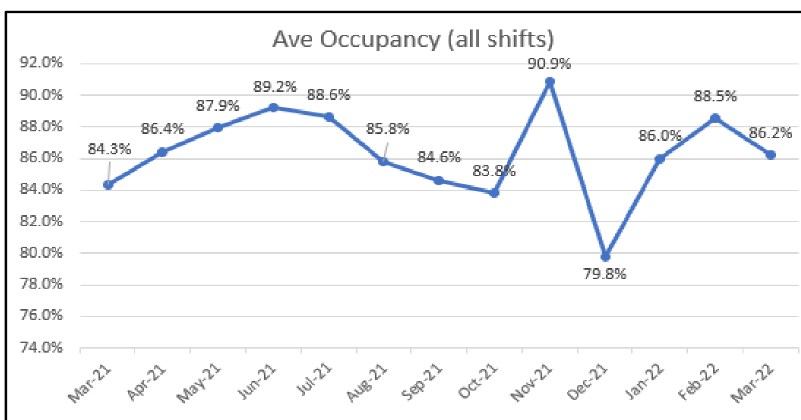
*Data extracted from WebPAS through PowerBI 04.04.22

Over the past 12 months, the percentage of presentations to ED that identify as Māori has remained steady at 25% to 28%, and Pacifica at 2% - 3%.

Hospital data

The following data includes the inpatient units of AT&R, Paeds, CCU, Medical Ward, SCBU, and Surgical Ward.





** Data extracted from WebPAS through PowerBI 05.04.22 (note that due to a data glitch when compiling the
March WDHB Board report, the occupancy figures differed from 0.5% – 4% and are now corrected)

Acute Readmission Volumes **	AT&R		CCU		Medical Ward		Surgical Ward	
	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar
48-hour	0	0	1	1	5	4	3	5
7 day	3	3	1	2	11	6	13	9
14 day	0	3	1	1	10	9	7	14
28 day	5	1	2	1	9	6	10	4
Total	**8**	**7**	**5**	**5**	**35**	**25**	**33**	**32**

**Data extracted from WebPAS through PowerBI 06.04.22; March figures may not reflect the total 14 day and 28 day readmission volumes.

Māori Acute Readmission Volumes **	AT&R		CCU		Medical Ward		Surgical Ward	
	Feb	Mar	Feb	Mar	Feb	Mar	Feb	Mar
48-hour	0	0	1	0	0	0	0	1
7 day	0	0	0	0	0	2	4	2
14 day	0	0	1	0	0	2	2	3
28 day	2	0	0	0	3	3	0	1
Total	**2**	**1**	**2**	**0**	**3**	**7**	**6**	**7**
Percentage of total acute readmissions	25%	14%	40%	0%	9%	28%	18%	22%

**Data extracted from WebPAS through PowerBI 06.04.22; March figures may not reflect the total 14 day and 28 day readmission volumes.

Clinical Services and Planned Care

A project manager has been appointed for the Sterile Services Department (SSD) equipment tracking system. This T-DOC system will enable tracking of reusable clinical equipment across services and patients.

In Patient Scheduling, the implementation of new systems and processes is ongoing following the completion of the booking systems review. Staff and SMOs have sought union involvement; final processes are in progress.

A review of pre-admission processes including patient assessment has been undertaken in conjunction with Outpatients and Theatre staffing; the review will be shared with stakeholders and ELT for consideration.

CCDM

Care Capacity Demand Management (CCDM) Programme provides a set of tools and processes that help district health boards better match the capacity to care with patient demand. This is currently used across nursing areas, and there is expansion into other departments and services. FTE calculations have been completed for the calendar year January to December 2021 for inpatient clinical areas - Medical, Surgical, ATR/ASU, ED, CCU, Paediatrics, Maternity, Te Awhina and Stanford House. The outcome was used inform budgeting planning for 2022/2023 financial year, with a small increase of less than 10 FTE.

The results of the calculations have been submitted to and approved by the Whanganui DHB Executive Leadership and have been approved.

Medical Ward

Sharlene Tapa-Mosen has been appointed as the new Clinical Nurse Manager for the Medical Ward and commenced in the position on Monday 21 March 2022.

2.2 Nursing Workforce

Staff Training for COVID

There has been training for various groups of staff within the hospital to support the clinical areas with our COVID response and workforce. Dental Therapists have completed close supportive observations training, patient scheduling, accountants project team and health promotion have completed housekeeper training and clinical staff who do not work in the wards are being utilised to provide basic clinical care. They are working in teams to provide better support within the clinical areas.

There are also online learning packages to upskill and orientate those who are being deployed.

Health Workforce New Zealand

Fifty-five Health Workforce Directorate (HWNZ) funding applications were submitted for 2022. All applications were assessed on an individual basis and on past funding support received. Using the HWNZ prioritisation framework, priority was given to Maori or Pacific Islanders, new graduates and/or those working in rural setting or in key service areas. Two applicants have withdrawn their applications. This has allowed funding to be offered to a late applicant working towards the Nurse Practitioner pathway in the Acute Stroke Unit.

- Maori - 12 Applicants
- Primary Health Care - 15 Applicants
- New graduate - 3 Applicants

Priority was also given to PG study pathways in the following subjects:

- Leadership - 5
- Masters in Primary Health Care - 4
- Nurse Practitioner Pathway – 5
- PG Cert Infection Prevention and Control
- Older Adult – 2

2.3 Quality Improvement

Nurse education has been reduced to mandatory/essential education only. This is to free up staff allowing them to work clinically. The updating of the Mahi Tahi has been put on hold due to staff working clinically. Most majority of quality and patient staff have been redeployed to clinic al work or to the Incident Management Team (IMT).

Quality Audits

A DAA audit for colposcopy will be undertaken in May; the self-assessment phase has commenced. The results of the Bowel Screening Programme audit by the DAA is pending.

Hand Hygiene Results

Results are not favourable in this area and staff have been informed. Results are being presented at ward meetings. The area to focus on is moment 5 and the staff group is ‘other’.

Table 2: National compliance rates by DHB, 1 November 2021 to 28 February 2021

DHB	Correct moments	Total moments	Compliance rate	Lower 95% confidence interval	Upper 95% confidence interval
Auckland DHB	10,599	12,388	85.6%	84.9%	86.2%
Bay of Plenty DHB	763	933	81.8%	79.2%	84.1%
Canterbury DHB	3,075	3,539	86.9%	85.7%	88.0%
Capital & Coast DHB	2,245	2,593	86.6%	85.2%	87.8%
Counties Manukau DHB	11,082	12,860	86.2%	85.6%	86.8%
Hauora Tairāwhiti	552	659	83.8%	80.8%	86.4%
Hawke's Bay DHB	1,021	1,162	87.9%	85.9%	89.6%
Hutt Valley DHB	1,529	1,850	82.6%	80.9%	84.3%
Lakes DHB	765	927	82.5%	79.9%	84.8%
MidCentral DHB	324	360	90.0%	86.5%	92.7%
Nelson Marlborough DHB	1,364	1,658	82.3%	80.4%	84.0%
Northland DHB	1,326	1,550	85.5%	83.7%	87.2%
South Canterbury DHB	307	368	83.4%	79.3%	86.9%
Southern DHB	1,747	2,123	82.3%	80.6%	83.9%
Taranaki DHB	194	224	86.6%	81.5%	90.5%
Waikato DHB	2,057	2,377	86.5%	85.1%	87.9%
Wairarapa DHB	263	323	81.4%	76.8%	85.3%
Waitematā DHB	15,190	16,765	90.6%	90.2%	91.0%
West Coast DHB	204	237	86.1%	81.1%	89.9%
Whanganui DHB	618	803	77.0%	73.9%	79.7%

3 Primary and Community Services

3.1 General Overview and Highlights

The team have been placing most of their efforts in COVID-19 response, as well as continuing to provide care to the community. There continues to be increasing referrals across services, which causes challenges in those services providing input across both community and inpatient, especially with an ongoing 10% vacancy rate overall. This has increased the urgency of needing to develop integrated models of care, both across services within the DHB and with primary care, NGO and iwi health providers.

February and March have seen a reduction of work force of between 10-20% between sickness, COVID, COVID related leave and vacancies. Despite this, services have continued to provide care to the community with minimal disruption.

General Practice referrals to the community and outpatients service have increased especially in District Nurses, Community Assessment Rehabilitation Team and Radiology.

Radiology and Pharmacy have both been successful in requests for additional FTE to support increasing demands on services and meet MECA requirements.

There was also a focus within Allied Health and Scientific with preparation for the PSA Allied, Public Health and Technical Strike that was planned for 4 March. 138 DHB staff were eligible to strike with almost 100% indication of participation in the strike. Plans were established to cover essential services for this 24-hour strike, with some disruption to planned care, school dental clinics and outpatient clinics anticipated. The strike was cancelled on 3 March following a court injunction. PSA and DHBs facilitation resulted from the injunction, with no outcome from this. There has been notification of a stop work meeting on 11 April from PSA. The possibility of further industrial action continues to be a possibility.

<u>Omicron Resurgence Planning</u>

The focus on integrated care with Primary Health Services for those most likely to experience poor health outcomes from COVID-19 continues, with 3 community facing workstreams involving staff from Primary Care as well as WDHB Primary and Community services.

The workstreams are:

- A virtual hub with wraparound care for GP services, led by Whanganui Regional Health Network where DHB staff support this model of care
- Community Assessment Team to ensure integrated care for people with more complex health conditions, to avoid hospital admission.

- Supported Discharge from hospital, to enable earlier successful discharge from hospital and avoid readmission

Funding has been agreed by the MOH for 1 year to enable additional care to those with complex needs in the community with a focus on COVID-19, and work is being carried out to roll this out across the DHB and primary care.

There has been increasing work to identify critical staffing shortages, clinical areas of most need and shared agreement for workforce redeployment across services during COVID-19 surge. As such COVID-19 resurgence plans have been completed across the following areas.

- Whole of rohe Mental Health and Addictions Services across Inpatient, Community and Women and Child Health, NGOs and Iwi Health providers.
- All therapy services across the DHB (Social Work, Occupational Therapy, Speech Language Therapy, Physiotherapy, Dietetics)
- Pharmacy whole of community

Teams are also providing specialist training to other services to support specific help for patients with COVID-19, for example NG tube feeding regimes from Dietetics, positioning support from Physiotherapy, Syringe Driver training from the Specialist Nurses.

Virtual Clinics

There is an increase in use of care at a distance enabled by telehealth, which is being rolled out as hardware arrives. All the hardware to enable telehealth has been delivered, with IT support identified to support use of this.

Of note, the following services are now provided virtually:

- Dietetics is now providing virtual outpatient clinics across all areas including rurals
- Triaging for District Nursing is now virtual
- The majority of Community Mental Health has moved to virtual
- Therapy staff who normally provide care at Aged Residential Care facilities

Community Mental Health and Addictions Services

It is of note that Community Mental Health is carrying a 20% vacancy, with difficulties appointing to vacancies especially management roles. An external review of adult Community Mental Health and Addictions Service has commenced, to address pressing issues around operational structure, vacancies and the need for more integrated services across the community. This has focussed on integration with our largest NGO provider of mental health services in the Whanganui rohe, Waiora Hinengaro, Te Oranganui Trust.

The roof on Te Kopae, the building where CMHAS are currently located, needs replacing. As such the service is moving for a minimum of 4 months off site to the new Te Rito building in Wicksteed St. Staff and unions have been fully engaged in this process.

3.2 Risks/Mitigations.

Supply issues are impacting on staff time, specifically in District Nursing, Dietetics and Pharmacy, as alternate options are sorted and risk mitigation occurs. Increased resources in services is being sought to support this.

The Service continues to carry 10% vacancy, which has been relatively consistent for the last 6 months. Some vacancies are being utilised short term to target specific caseload and waiting list challenges. E.g. The Occupational Therapy manager vacancy is being covered by the Dietetics and SLT manager with part

of the vacancy being used by Dietetics to address the issues around access to enteral feeding that have arisen out of COVID-19

Some of the community staff have ongoing problems accessing cars. This is being followed up by individual managers.

The trial of personal alarms to improve staff safety in the community has been completed and the purchase of alarms is progressing.

Pharmacy has been very short staffed, with the team having to significantly prioritise. Issues across Community Pharmacies are impacting on hospital services and vice versa, so a whole of community response to this is being actioned.

Staff are tiring due to COVID, staff shortage, increase in sickness, increase in patient acuity and vacancies. The WDHB are continuing looking at ways to support staff wellness. The contract with CHNNL, the wellbeing app for staff has now been signed and should be rolled out in April.

4 Maternal, Child and Youth Services (MCYS)

4.1 General

COVID-19 Update

February and March 2022 have seen COVID-19 enter the community and infection numbers climb. Paediatric and Maternity Wards have both been working with COVID positive patients. Planned systems and processes in both wards have now been put to the test and found to work well. There are challenges with staffing rosters with many staff also impacted by COVID. Maternity has had busy periods with 81 births in March (a new record!) to navigate alongside the staffing shortages.

The Public Health team continues its valuable mahi and is working well with the Care in the Community Hubs to support our community. 'Supported isolation' or alternative accommodation has been at capacity as the case numbers rise. The team are supporting those who are unable to safely isolate at home; many of these are our homeless community or those that live in overcrowded homes. As are all services, public health has been affected by staff contracting COVID.

MICAMHAS has had some impact on staffing due to illness but service provision has been largely unaffected at this stage. MICAMHAS are contributing to the wider mental health plan and will assist adult mental health services as required.

The Oral Health team has been able to continue providing service in the schools despite the high absenteeism rates in education centres. They have not identified any staff contracting COVID whilst at work, a testament to their strong systems and procedures and use of PPE. Planning is also in place to prepare dental therapists and assistants to work in the acute wards in the hospital when required.

Teams are also assisting in the development of the all-of-DHB redeployment plan. It is challenging for all managers to keep up with the ongoing information and changes provided daily by the Ministry of Health (MOH).

General Update

The MCYS team remains focused on further establishing contact pathways between our services and the community. Unfortunately, the Whanganui Maternal, Child and Youth Community Alliance hui scheduled for March has been postponed due to the Omicron outbreak. We plan to run this hui as soon as it is safe to do so in an 'in-person' environment. The kaupapa of this hui is youth health.

Workstreams stemming from the Primary and Maternity Interface Group are progressing but have been impacted by COVID. Progressing this work is more challenging over electronic formats than in person, but is still feasible. Current projects include optimisation of the Best Start tool, the Hapū Māmā Village project, the community directory of services and the service guide for women. The community directory of services and service guide has been gifted the name 'Te Kākano' by Te Hau Ranga Ora. The whakamārama is *'Mai i te kākano, ka puawaitia ngā hua' – 'from the seed we flourish and blossom'* with the idea of 'the seed' growing capacity, increasing awareness as well as references of kākano around pregnancy, growth and development. The name and whakamārama will now help guide branding and visuals for the website.

The Healthy Families Hapū Māmā Village project insight report is expected in June.

Recent declines in childhood immunisation rates in the Whanganui district places the region at risk of outbreaks of vaccine preventable disease. Over recent years the rates of opt-off and decliners for these vaccinations has increased, with vaccine hesitancy becoming more prevalent. The declining coverage rates has highlighted ethnic disparities particularly for Māori whānau. The COVID-19 vaccination programme has provided some valuable learnings, opportunities for collaboration amongst providers, new ways of working, and an enhanced vaccination workforce. Local Iwi/Māori health providers have risen to the challenge and continued to develop their workforce and systems in response to the needs of whānau and the communities they serve and are well placed to strengthen their role in immunisation. Opportunities to maximise the use of this increased vaccinator workforce and to integrate all levels of decision making is an essential next step. In light of this a Whanganui District Immunisation Governance Group is being established and the roles and responsibilities of the Immunisation Steering Group, which has an operational focus, are being reviewed. The governance group will oversee a blended programme of immunisation delivery of the National Immunisation Schedule and COVID-19 vaccinations across the age continuum as recommended by the MOH. This concomitant structure underpinned by a whānau ora approach is designed to address inequity and increase immunisation coverage rates for all vaccinations and age groups.

The Single Point of Entry Project looking at a one-point entry of all child health referrals has commenced with the appointment of the project manager. The initial project plan will be developed in the coming weeks. The Oral Health Project has also commenced with a part-time project lead appointed from within the MCY leadership team. A plan for this project will also be developed in the coming weeks.

4.2 Service Delivery

<u>Maternity</u>

The specifically designed one-day LMC Hāpai te Hoe programme arranged for 29 March has been deferred until May because of COVID.

The first Midwifery Forum for 2022 was held in February, with many LMC's attending the online platform. The main topic of conversation being COVID and the frequent changes to plans and information from the MOH.

Since the February report to the Board, Maternity FTE has improved slightly with the recruitment of one new graduate midwife and a further two nurses with previous maternity experience. However, maternity is far from staffed to budgeted FTE and recruitment plans are ongoing. A retention package for current core midwives has been approved by ELT, this is funded out of the positive variance to budget due to unfilled vacancies and the first payment will be made in the last week of March.

Recently, ELT approved an unfunded 0.6FTE administration position to support the hospital run midwifery antenatal clinic for women who can't secure an LMC. This will ensure the midwife running the clinic can focus on midwifery care. The position has been advertised but is yet to be appointed to.

A Māori midwife started in Waimarino in March. Her whakapapa links and connections to the area will be invaluable to Raetihi and the wider community. While technically fully staffed, the service has unfortunately been disrupted by COVID-19. We anticipate the service will be fully operational by the end of April.

The MOH has mandated use of an electronic maternity system. Additionally, HISO coding standards must be in place by June 2023; these standards will be impossible to meet without an electronic maternity system therefore giving us a relevant implementation timeframe to work towards. This is a large project requiring significant investment and resource. A 'business case in brief' is being prepared for Data and Digital Group endorsement, to then go on to ELT for approval to start the project.

Plans to offer a Long Acting Reversible Contraception (LARC) service to postnatal women prior to discharge are progressing. The clinical midwife manager and MQSP coordinator are developing a training plan. O&G Consultant Joanna Gheevarghese will provide practical training and credentialling.

The Newborn Early Warning score (NEWS) is being rolled out in the first calendar quarter of 2022. All maternity and neonatal staff, including LMCs, are completing NEWS online training.

<u>Paediatrics</u>

Paediatrics are starting to see some children admitted for COVID but not in significant numbers despite a high number of children in the community having COVID. There is concern nationally regarding the number of children presenting who have had COVID, recovered and then develop post-viral syndromes causing them to be extremely unwell.

Much care is taken in the paediatric ward to ensure infection control standards are extremely high as we have three children in our community who are coming in on a regular basis for chemotherapy. These children are extremely susceptible to contracting infections which may have serious consequences for them.

Paediatric community staff are continuing services as much as able but are also assisting in the wider community COVID response with some working in the virtual hub at WRHN.

STABLE Training, a combined training initiative across Maternity and Paediatric services was postponed three times last year due to COVID. We have provisional training dates for October 2022. This training will increase the understanding and confidence of paediatric and maternity clinicians in basic neonatal care.

A service development plan is progressing to undertake specific some minor Paediatric Surgery for children over two years of age who are otherwise well. This will mean some tamariki and their whānau will not need to travel for surgery. It will also allow participating general surgeons to upskill in certain areas of paediatric surgery and undertake these surgeries themselves in the future.

<u>Public Health</u>

With the arrival of the Omicron variant in the community, Public Health's primary focus is pandemic management. The team are communicating with schools about the impact of this on service delivery.

School-based services have been significantly impacted over February and March due to the Omicron outbreak. Public Health Nurses have been working with the Medical Officer of Health to manage high risk exposure events such as those in Age Residential Care and emergency housing facilities.

Contracted worked such as HEEADSSS assessments have not yet begun, this will prove challenging over the year as not all were completed in the 2021 year due to COVID. School-based immunisation programmes for Boostrix and HPV are still being rolled out. These programmes will also face challenges with high absenteeism rates and immunisation hesitancy in the schools in the early part of this year.

Mauri Ora was converted to a free-of-charge COVID-19 clinic recently to provide after-hours access to in-person assessment and intervention for those with COVID. The service is primarily for who don't currently have a GP, or their GP is overwhelmed with COVID volumes and provides increased support to our partners in primary care and community.

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

The MICAMHAS team are continuing to provide services in a COVID environment including use of Telehealth, as well as how they can support Mental Health Services across the DHB.

On 28 February MICAMHAS will be fully staffed. A nurse has been employed as an outreach clinician to engage young people who find the MICAMAHS building too formal. This is a new role and a new way of working for MICAMHAS. We hope this will allow us to connect better with young Māori rangatahi in our community.

Oral Health

Our community Oral Health service will continue to operate in the pandemic environment as directed by the Dental Council of New Zealand and the MOH. A decrease in performance is expected due to schools being less willing and able to engage, and the anticipated impacts on the oral health workforce when staff become unwell. Oral Health forms a part of the staff redeployment plan for Hospital and Clinical services; their clinical skills may be required in key areas.

The Oral Health Unit was credentialled on 25 March 2022. Results are pending and will inform aspects of the Oral Health Project which commenced on 28 March 2022. The review aims to enhance and further develop our current service to provide a modern, patient-focused dental service for our community.

Our Oral Health Service remains on track with the Dental Council Recertification programme. Dentist recertification is complete. Dental therapist recertification occurred in March 2022.

4.3 Future Focus

We will run our first Whanganui Maternal, Child and Youth Community Alliance hui focusing on Youth Health once we are through the COVID peak and able to return to BAU. This hui is interactive and best delivered in a face-to-face format.

The second of four Midwifery Forum Meetings for 2022 is scheduled for 24 May.

Options to address acute inpatient mental health service capacity issues for our rangatahi is on the workplan.

Work streams coming out of the Primary and Maternity Services Interface Group continue to progress, most of which are anticipated to take another 7-13 months to finalise.

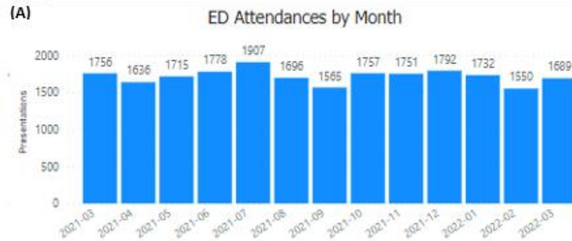
Single Point of Entry and Oral Health Projects have commenced. Regular updates will be given to the MCYS leadership team and through the regular reporting by the Project Coordinator Manager to executive leaders.

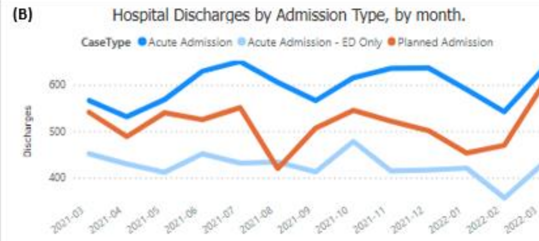
Much of our work at present has a COVID focus or has been impacted by COVID. We have adapted well so far and will continue to support our colleagues both within the MCYS and across the hospital, our patients, community providers and the community at large to through the COVID peak until we can return to our BAU, which may well be a 'new normal'.

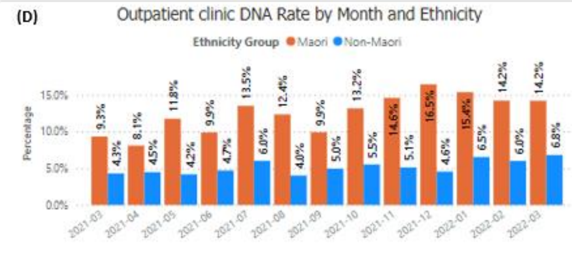
Appendix 1. Whanganui DHB Performance Dashboard

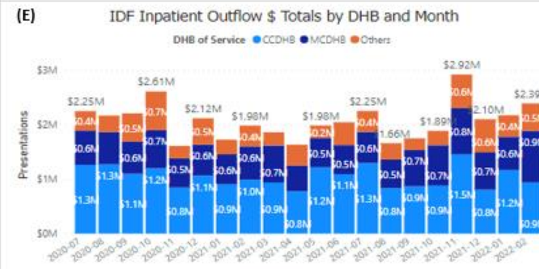
(data extracted 6 April 2022)

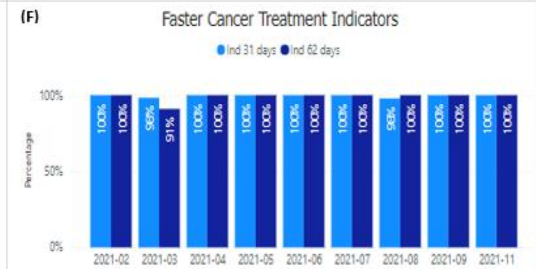
Hospital Based Care Measures



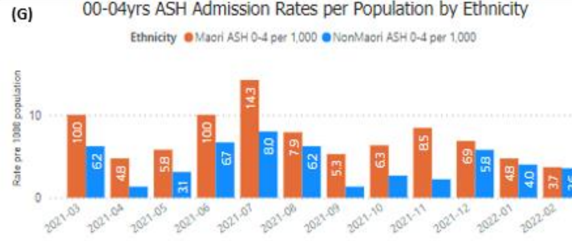


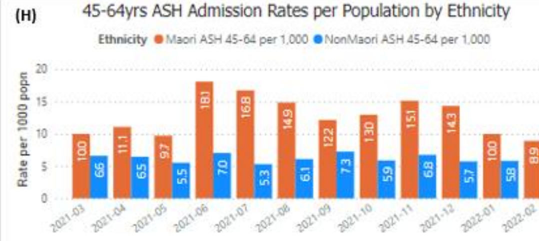


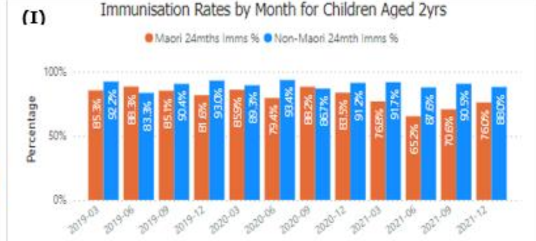




Community Based Care Measures

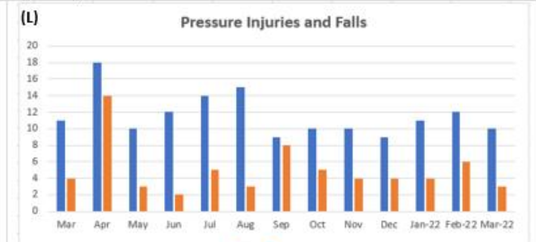






Workforce Measures

Quality

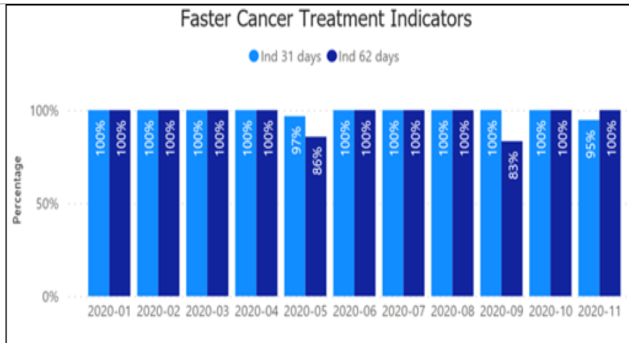


April 2022 **Board Public**

Whanganui DHB Performance Dashboard definitions.

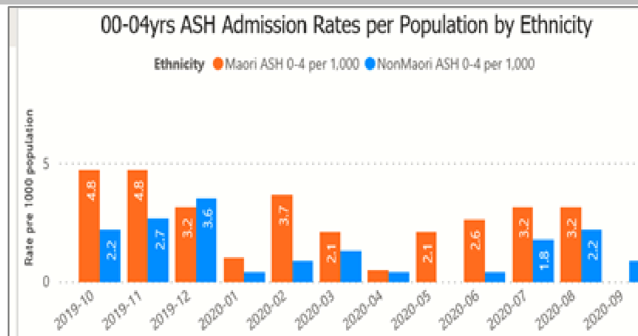
Hospital Based Care Measures	
Graph A. ED Attendances ED attendances are an indicator of acute patient demand in the system, while also identifying issues in access to primary care and potential flow issues in secondary services. **Calculation**: count of attendances.	ED Attendances by Month
Graph B.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

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

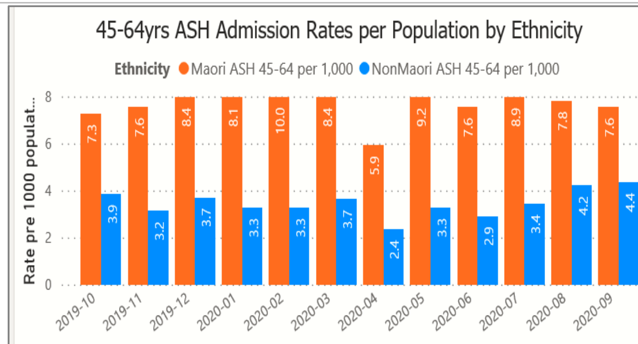


Community Based Care Measures

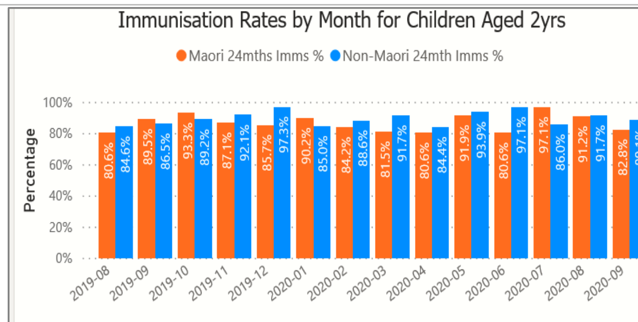
Graph G. ASH Rates 0-4 years
ASH rates are a measure of avoidable hospital admissions (Ambulatory Sensitive Hospital admissions) per 10,000 population. Significant disparities exist between rates for Māori and non-Māori indicating equity issues in access to services.
Calculation: admissions per 10,000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



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

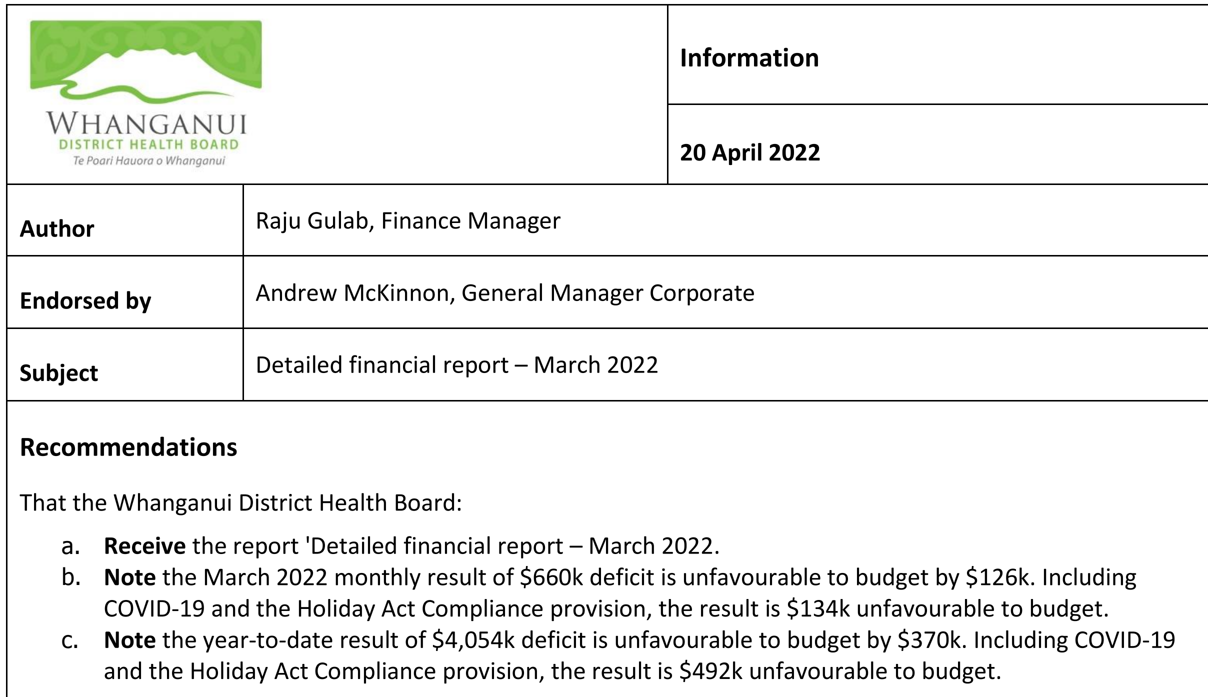


Graph I. Immunisation Rates for Children by ethnicity
Percentage of children with up to date immunisation at the age of two years
Calculation:
Denominator = total children enrolled
Numerator = total children with up to date immunisation



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

April 2022 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information**
	20 April 2022
Author	Raju Gulab, Finance Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	Detailed financial report – March 2022

Recommendations

That the Whanganui District Health Board:

a. **Receive** the report 'Detailed financial report – March 2022.
b. **Note** the March 2022 monthly result of $660k deficit is unfavourable to budget by $126k. Including COVID-19 and the Holiday Act Compliance provision, the result is $134k unfavourable to budget.
c. **Note** the year-to-date result of $4,054k deficit is unfavourable to budget by $370k. Including COVID-19 and the Holiday Act Compliance provision, the result is $492k unfavourable to budget.

Financial Overview – March 2022

YTD Performance	YTD IDF Net Flow	YTD CWDs
Actual deficit $4.1m (excluding COVID-19 and Holiday Act Compliance provision)	$37.6m expenditure	Estimated CWDs 9,259
Against budgeted deficit of $3.7m, $0.4m unfavourable to budget.	Against budgeted expenditure of $39.0m, $1.4m favourable to budget.	Against 9,026 budgeted CWDs, 2.6% ahead (IDF CWDs excluded).

YTD FTE	YTD Capital Expenditure
Actual YTD FTE 937 (Total FTE 1,004 including COVID-FTE of 67)	Actual spend $4.6m
Budgeted FTE of 948 (Full year FTE 952)	Against budgeted expenditure of $9.5m. $4.9m underspent relates to delay in IT Intangible assets and Building projects.

April 2022 **Public**

Consolidated Statement of Financial Performance for the period ended 31 March 2022

$'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
Revenue	26,378	26,423	(45)	U	240,351	235,488	4,863	F	314,675	297,522
Total Revenue	26,378	26,423	(45)	U	240,351	235,488	4,863	F	314,675	297,522
Less:										
Provider Health Service	(13,906)	(13,293)	(613)	U	(124,329)	(118,744)	(5,585)	U	(158,385)	(151,506)
Corporate Service	180	(135)	315	F	(591)	(1,220)	629	F	(1,629)	(1,818)
Governance	(125)	(103)	(22)	U	(1,089)	(947)	(142)	U	(1,266)	(1,016)
DHB Funder Division (exl IDF outflow)	(9,245)	(9,127)	(118)	U	(81,212)	(79,560)	(1,652)	U	(106,099)	(99,499)
Inter-district Outflow	(3,979)	(4,334)	355	F	(37,582)	(39,004)	1,422	F	(52,005)	(46,989)
ACC Contract (net)	37	35	2	F	398	303	95	F	408	511
Total expenditure	(27,038)	(26,957)	(81)	U	(244,405)	(239,172)	(5,233)	U	(318,976)	(300,317)
Net Surplus/(Deficit) before COVID-19 & HolidayPay	**(660)**	**(534)**	**(126)**	**U**	**(4,054)**	**(3,684)**	**(370)**	**U**	**(4,301)**	**(2,795)**
Revenue- COVID-19	1,388	-	1,388	F	8,952	-	8,952	F	-	2,367
Expenditure COVID-19	(1,390)	-	(1,390)	U	(9,040)	-	(9,040)	U	-	(2,391)
COVID-19	(2)	-	(2)	U	(88)	-	(88)	U	-	(24)
Holiday Act Costs	(59)	(53)	(6)	U	(507)	(473)	(34)	U	(644)	(2,028)
One-off	(59)	(53)	(6)	U	(507)	(473)	(34)	U	(644)	(2,028)
Net Surplus / (Deficit)	**(721)**	**(587)**	**(134)**	**U**	**(4,649)**	**(4,157)**	**(492)**	**U**	**(4,945)**	**(4,847)**

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

Overview

Month comments

The operating result for the month of March 2022 was unfavourable to budget by $126k. When including COVID-19 and Holiday Act Compliance provision, the result is $134k unfavourable to budget.

Revenue (Appendix 1)

Revenue was $45k unfavourable to budget due to a reduction in surgical elective service revenue from other DHBs and the progressing of community referrals charges to radiology for private and insurance patients did not eventuate. This lower revenue was partly offset by MoH various additional side contracts' revenue.

Revenue- COVID-19

COVID-19 expenditure was $1,388k favourable to budget with costs incurred mainly in operating the vaccination programme, development and delivery of vaccination service to engaged whanau to improve access to service, PCR and antigen testing to iwi providers, Public Health contact tracing and the local community response to people who need to isolate within the community (SIQ).

Provider health service (Appendix 2)

Inpatient estimated volumes were 111.6% to target in March 2022 with unplanned (acute) at 115.1% and planned (elective and arranged) at 102.2% of budget for the month. The value of this increased volume is approximately $750k, or 124 CWD.

Provider division was $613k unfavourable to budget due to higher nurse personnel costs resulting from the pay equity settlement and sick leave contributed by COVID, which has also impacted on additional overtime. Costs have also increased through higher acute and elective surgery volume, higher medical personnel locum costs and higher cost of clinical supplies. These unfavourable variances were partly offset by lower Allied Health personnel costs, other personnel costs and infrastructure and non-clinical supplies costs.

Corporate service (Appendix 2)

Corporate was $315k favourable to budget due to one-off wash-up for facility contract and lower personnel costs. These lower costs were partly offset by higher outsourced IT personnel costs.

Governance

Governance was $22k unfavourable due to the Impact Collective programme costs (offset by revenue) which were not budgeted.

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

Funder division was $118k unfavourable to budget due to higher pharmaceutical costs, health of older people costs and mental health costs (offset by revenue). This unfavourable variance was partly offset by personal health costs.

Inter-district flows (Appendix 4)

Inter-district flows were $355k favourable to budget due to lower inpatient activity in other DHBs.

Covid-19 expenditure

COVID-19 expenditure was $1,390k unfavourable to budget with costs incurred mainly in operating the vaccination programme, community testing, development and delivery of vaccination service to engaged whanau to improve access to service, PCR and antigen testing to iwi providers, public health contact tracing and local community response to people who need to isolate within the community (SIQ). Expenditure is expected to be fully funded by MoH (see Covid-19 revenue above).

Year-to-date comments

Year-to-date March 2022 operating result was unfavourable to budget by $370k. When including COVID-19 and Holiday Act Compliance provision, the result is $492k unfavourable to budget.

Revenue (Appendix 1)

Revenue was $4,863k favourable to budget mainly due to the Ministry of Health

Revenue was $4,906k favourable to budget mainly due to the Ministry of Health (MoH) nurses and midwives pay equity settlement funding $4,531k, MoH higher integrated mental health addiction service revenue $649k (offset by costs), and MoH addiction system collaborations design and implementation support revenue $228k (offset by costs). Other increases in revenue included:

- primary health care funding $300k
- Well child $72k
- financial sustainability improvement funding $92k
- public health funding $119k
- MoH planned care service improvement $141k
- MoH improvement action plan prior year revenue $469k
- psychology intern programme revenue $59k
- Immunisation $31k and various other funder side contract $72k
- inter-district inflow $21k
- other DHBs outpatient revenue $186k,
- ACC revenue $543k (mainly non-acute rehabilitation)
- other Government $116k mainly Ministry of Social Development Impact Collective revenue (offset by costs).

These increases in revenue were partly offset by lower planned care funding as per quarterly wash-up $322k, combined pharmaceutical revenue $553k (*Ministry of Health clawback funding for Combined Pharmaceutical Budget (CPB) $76m, Wanganui DHB's full year share is $1.3m, however $419k revenue used from last year income in advance to offset some of the increased pharmaceutical costs, last year fund is now fully utilised*), MoH local service improvement project $166k (full year impact of $237k) and MoH improvement action plan $419k, (full year impact of $599k).

Revenue- Covid-19 (Appendix 1)

Covid-19 revenue was $8,952k favourable to budget due to the ongoing support of operating CBAC facilities, vaccination programme, Maori health support, public health community testing, development, and delivery of vaccination service to engaged Whanau to improve access to service, PCR and Antigen testing to iwi provider and community response to people who need to isolate within the community (SIQ).

Provider division (Appendix 2)

Inpatient estimated volumes were 102.6% to target year to date with unplanned (acute) 104.3% and planned (elective and arranged) 97.8% of budget year-to-date. The value of this overall increased volume is $1.4 million, or 233 CWD.

Provider division was $5,585k unfavourable to budget due to the nurses and midwives pay equity settlement increased and higher medical personnel (including locum). These unfavourable variances were partly offset by lower Allied Health and management and administration personnel costs due to vacancies as well as lower clinical supplies and non-clinical supplies.

Corporate (Appendix 2)

Corporate was $629k favourable to budget due to lower building insurance costs, one-off wash-up for facility service, personnel costs due to vacancies in IT and finance, capitalisation of data networking costs and lower depreciation costs. These lower costs were partly offset by higher IT outsourced costs.

Governance

Governance was $142k unfavourable due to the Impact Collective programme costs (offset by revenue) which was not budgeted.

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

Funder division was $1,652k unfavourable to budget due to health of older people, home-based support and hospital residential care support costs (volume and price increased), higher primary health organisation (PHO) costs (offset by revenue), integrated mental health addiction service (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-based support contract prices were renegotiated with a key supplier resulting in a 10% increase in cost price.

Inter-district flows (Appendix 4)

Inter-district flows were $1,422k favourable to budget due mainly to reduced inpatient activities in other DHBs.

Covid-19 expenditure

COVID-19 expenditure was $9,040k unfavourable to budget due to costs incurred mainly in CBAC facilities, vaccination programme, Maori health support, public health community testing, development and delivery of

vaccination service to engaged whanau to improve access to service, PCR and antigen testing to iwi providers and community response to people who need to isolate within the community (SIQ).

Holiday Act provision

Holiday Act remediation provision was $34k unfavourable to budget due to project management consultancy costs.

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	25,087	24,892	195	F	229,061	223,758	5,303	F	298,278	283,156
Inter-district inflow	698	707	(9)	U	6,385	6,364	21	F	8,486	8,103
Other District Health Board (DHB)	71	69	2	F	753	567	186	F	780	1,123
Accident Compensation (ACC)	290	259	31	F	2,868	2,325	543	F	3,160	3,465
Other Government	19	8	11	F	315	199	116	F	223	276
Patient consumer sourced	24	92	(68)	U	230	639	(409)	U	922	360
Other income	189	396	(207)	U	739	1,636	(897)	U	2,826	1,039
COVID-19	1,388	-	1,388	F	8,952	-	8,952	F	-	2,367
Total revenue	27,766	26,423	1,343	F	249,303	235,488	13,815	F	314,675	299,889

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

Month comments

Ministry of Health

Revenue was $195k favourable to budget due to the Ministry of Health (MoH) nurses and midwives pay equity settlement funding $206k, Psychology intern programme revenue $59k and various other side contract funding $38k. These higher revenues were partly offset by removal of combined pharmaceutical revenue $108k.

Accident Compensation (ACC)

Revenue was $31k favourable to budget due non-acute inpatient revenue. This higher revenue was partly offset by lower ACC radiology revenue.

Other Government

Revenue was $11k favourable to budget due Ministry of Social Development funding for the Impact Collective project.

Patient consumer sourced

Revenue was $68k unfavourable to budget due to revenue from community referrals to radiology for private and insurance funded patients not having eventuated yet.

Other income

Revenue was $207k unfavourable to budget due to capturing surgical elective service revenue from other DHBs has not eventuated yet, and unlikely to progress.

Covid-19 revenue

COVID-19 expenditure was $1,388k favourable to budget with costs incurred mainly in operating the vaccination programme, development and delivery of the vaccination service to engaged whanau to improve access to service, PCR and antigen testing to iwi providers, Public Health contact tracing and the local community response to people who need to isolate within the community (SIQ).

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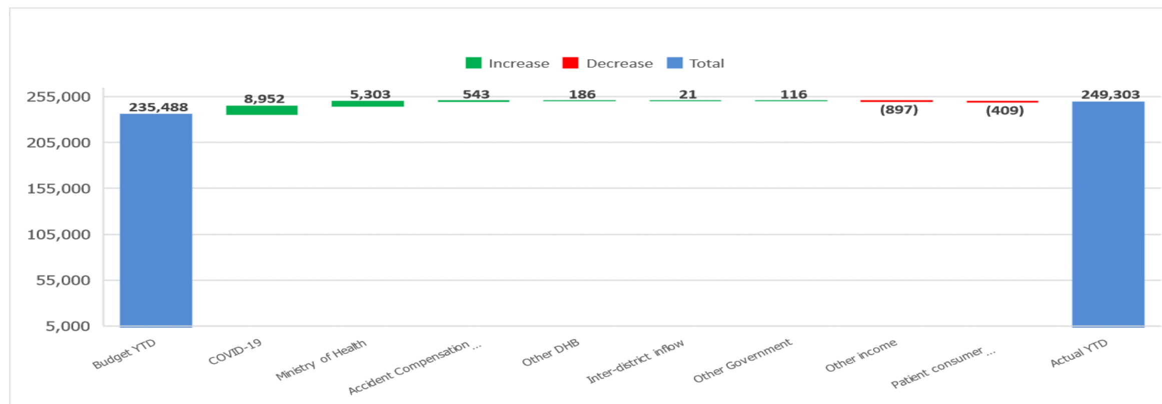
Year to date comments



Covid-19

COVID-19 was $8,952k favourable to budget due to Ministry of Health funding for:

- Vaccination estimated funding $5,573k
- Māori health support $515k (this revenue passes on to community health providers)
- Public Health community testing $396k
- GP based assessment $450k
- Community testing and other associate cost re-imbursement $706k
- SIQ $139k
- Development and delivery of vaccination service to engaged Whanau to improve access to service $593k
- PCR and Antigen testing to iwi provider $580k

Ministry of Health

Revenue was $5,303k favourable to budget mainly due to:

- Ministry of Health (MoH) nurses and midwives pay equity settlement funding $4,531k,
- MoH higher integrated mental health addiction service revenue $649k (offset by costs),
- higher MoH addiction system collaborations design and implementation support revenue $228k (offset by costs),
- Primary health care funding $300k,
- Well child $72k,
- Financial sustainability improvement funding $92k,
- Public health funding $119k,
- MoH planned care service improvement $141k,
- MoH improvement action plan prior year revenue $469k
- Psychology intern programme revenue $59k
- Immunisation $31k
- and various other $72k.

These increases in revenue were partly offset by lower planned care funding as per quarterly wash-up $322k, combined pharmaceutical revenue $553k ($419k prior year income in advance carry forward CPB funding is now full utilised), MoH local service improvement project $166k and MoH improvement action plan $419k.

Accident Compensation (ACC)

ACC revenue was $543k favourable to budget due to higher ACC home-based 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.

Other district health board

Revenue was $186k favourable to budget due to higher outpatient clinics revenue.

Inter-district inflow

Inter-district inflow was $21k favourable to budget due to higher inpatient service activity.

Other Government

Revenue was $116k favourable to budget due Ministry of Social Development funding for the Impact Collective project.

Other income

Other revenue was $897k unfavourable to budget due to capturing surgical elective service revenue from other DHBs not eventuating yet, unlikely to progress (full year budgeted $1.9m).

Patient Consumer sourced

Revenue was $409k 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.

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Appendix 2 – Provider Health and Corporate Services

	Month					Year to Date					Annual	Annual
	Actual	Budget	Variance		Var %	Actual	Budget	Variance		Var %	Budget 2021-22	Actual 2020-21
Expenditure												
Medical Personnel	2,166	2,223	57	F		19,020	18,957	(63)	U		25,622	24,261
Nursing Personnel	4,181	3,575	(606)	U		38,040	32,365	(5,675)	U		43,441	44,352
Allied Personnel	1,193	1,238	45	F		9,820	10,579	759	F		14,109	12,867
Support Personnel	98	87	(11)	U		842	741	(101)	U		989	1,054
Management & Admin Perseonnel	1,095	1,142	47	F		9,052	9,798	746	F		13,073	11,893
Total Personnel(Exl other & outsourced)	**8,733**	**8,265**	**(468)**	**U**		**76,774**	**72,440**	**(4,334)**	**U**		**97,234**	**94,427**
Personnel Other	210	263	53	F		1,744	2,004	260	F		2,778	1,754
Outsourced Medical Personnel	437	355	(82)	U		4,267	3,199	(1,068)	U		4,288	5,784
Outsourced Allied Personnel	55	37	(18)	U		474	363	(111)	U		526	888
Outsourced Manag & Admin Personnel	105	33	(72)	U		820	295	(525)	U		393	726
Total Personnel outsourced	**807**	**688**	**(119)**	**U**		**7,305**	**5,861**	**(1,444)**	**U**		**7,985**	**9,152**
Total Personnel Expenditure	**9,540**	**8,953**	**(587)**	**U**		**84,079**	**78,301**	**(5,778)**	**U**		**105,219**	**103,579**
Outsourced Clinical Service	497	537	40	F		4,537	4,639	102	F		6,196	5,915
Clinical Supplies	1,689	1,611	(78)	U		14,202	14,280	78	F		18,893	18,299
Infrastructure & Non Clinical Supplies Costs	1,190	1,471	281	F		14,962	15,392	430	F		19,762	16,546
Capital Charge	186	193	7	F		1,780	1,837	57	F		2,415	2,342
Depreciation & Interest	614	653	39	F		5,321	5,476	155	F		7,446	6,441
Internal Allocation	10	10	-	F		39	39	-	F		83	202
Total Other Expenditure	**4,186**	**4,475**	**289**	**F**		**40,841**	**41,663**	**822**	**F**		**54,795**	**49,745**
Total Expenditure	**13,726**	**13,428**	**(298)**	**U**		**124,920**	**119,964**	**(4,956)**	**U**		**160,014**	**153,324**
Expenditure												
Medical personnel and Locum	2,603	2,578	(25)	U		23,287	22,156	**(1,131)**	U		29,910	30,045
Nursing Personnel	4,181	3,575	(606)	U		38,040	32,365	**(5,675)**	U		43,441	44,352
Allied Personnel	1,248	1,275	27	F		10,294	10,942	**648**	F		14,635	13,755
Management & Admin Perseonnel	1,200	1,175	(25)	U		9,872	10,093	**221**	F		13,466	12,619
Othe Personnel costs	308	350	42	F		2,586	2,745	**159**	F		3,767	2,808
Clinical Supplies	1,689	1,611	(78)	U		14,202	14,280	**78**	F		18,893	18,299
Outsourced Clinical Service	497	537	40	F		4,537	4,639	**102**	F		6,196	5,915
Infrastructure & Non Clinical Supplies Costs	1,376	1,664	288	F		16,742	17,229	**487**	F		22,177	18,888
Depreciation & Interest	614	653	39	F		5,321	5,476	**155**	F		7,446	6,441
Internal Allocation	10	10	-	F		39	39	-	F		83	202
Total Expenditure	**13,726**	**13,428**	**(298)**	**U**		**124,920**	**119,964**	**(4,956)**	**U**		**160,014**	**153,324**
FTEs												
Medical	117.0	115.6	(1)	U		113.9	112.5	(1)	U		112.9	111.5
Nursing	477.4	458.8	(19)	U		475.0	465.1	(10)	U		467.2	460.8
Allied	152.1	167.4	15	F		150.9	166.5	16	F		166.5	160.3
Support	17.7	16.3	(1)	U		18.4	16.3	(2)	U		16.3	18.0
Management & Admin	169.3	175.2	6	F		163.8	174.5	11	F		174.5	169.5
Total FTEs	**933**	**933**	**(0.1)**	**U**		**922**	**935**	**13.0**	**F**		**937**	**920**
Case Weighted Discharges (CWD)												
Unplanned (Acute)	896	779	(117)	U	-15.1%	6,921	6,635	(286)	U	-4.3%	8,836	8,528
Planed (Elective & Arranged)	294	288	(6)	U	-2.2%	2,337	2,390	53	U	2.2%	3,227	2,968
Total CWD	**1,190**	**1,067**	**(124)**	**U**	**-11.6%**	**9,259**	**9,026**	**(233)**	**U**	**-2.6%**	**12,063**	**11,496**
Further information												
General Medicine	384	306	(78)	U	-25.4%	3,023	2,612	(411)	U	-15.7%	3,478	3,728
General Surgery	251	217	(34)	U	-15.6%	1,975	1,880	(94)	U	-5.0%	2,488	2,582
Orthopaedics	214	218	4	U	2.0%	1,556	1,764	207	F	11.8%	2,390	1,897
Gynaecology	33	32	(1)	U	-2.9%	271	258	(12)	U	-4.8%	350	388
Emergency Medicine	100	118	18	F	15.3%	907	1,008	101	F	10.0%	1,342	1,096
Othter	209	175	(34)	U	-19.2%	1,527	1,503	(23)	F	-1.6%	2,015	1,805
Total CWD	**1,190**	**1,067**	**(124)**	**U**	**-11.6%**	**9,259**	**9,026**	**(233)**	**U**	**-2.6%**	**12,063**	**11,496**

Month comments

The overall expenditure for March 2022 was $298k unfavourable to budget.

Personnel

Total personnel costs were $587k unfavourable to budget due mainly to medical locum costs, nurses and midwives pay equity settlement costs and volume pressure on wards. These unfavourable variances were partly offset by Allied Health personnel and unattended courses and conferences as a result of the Covid-19 pandemic.

Outsourced clinical and other services

Outsourced clinical service costs were $40k favourable due to dental, audiology outsourced service costs.

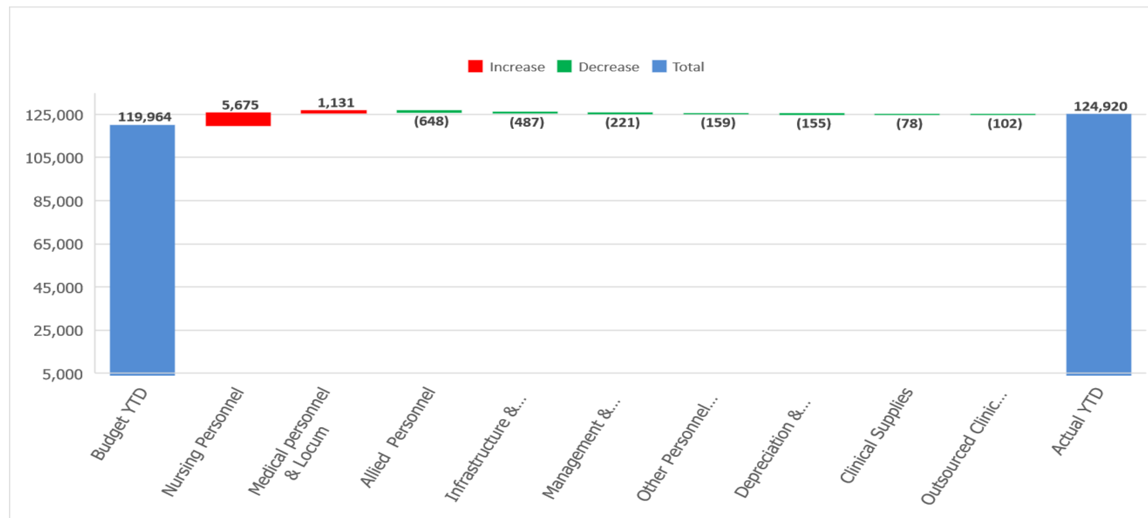
Clinical supplies

Clinical supplies costs were $78k unfavourable to budget due to wards consumable costs and orthotics costs. These unfavourable variances were partly offset by lower pharmaceutical costs.

Infrastructure and non-clinical supplies (including capital charge)

Infrastructure and non-clinical supplies costs were $281k favourable to budget due to lower facility service costs and one-off favourable wash-up for facility service contract.

Year-to-date comments



The overall year-to-date expenditure $4,956k unfavourable to budget.

Nursing personnel

Nursing personnel was $5,675k unfavourable to budget due to the nurses and midwives pay equity settlement, high acute demand (inpatient activity 2.6% above target), higher sick leave $153k, high other leave $176k and overtime $520k.

Medical personnel

The medical personnel net unfavourable variance of $1,131k was mainly due to the use of locums to cover vacancies. Unfavourable payroll costs of $63k are mainly due to radiology and RMOs personnel and outsourced $1,068k locum costs made up of ophthalmology $169k, general medicine $180k, RMOs $71k, mental health SMO 381k, gynaecology $267k.

Allied personnel

Allied personnel costs net favourable variance of $648k 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 $759k were partly offset by outsourced costs of $111k mainly in the areas of radiology, orthotics, and physiotherapy.

Infrastructure and non-clinical supplies (including capital charge)

Infrastructure and non-clinical supplies costs were $487k favourable to budget due to lower facility maintenance costs, transport costs, building and other insurance costs. These lower costs were partly offset by IT bureau, outsourced and costs and wards security costs.

Management and administration

Management and administration personnel costs net favourable variance of $221k favourable to budget was mainly due to vacancies in IT, finance, patient safety and other areas. Favourable payroll savings of $746k were partly offset by outsourced costs of $525k mainly in IT, business manager and communication roles.

Other personnel

Other personnel costs were $159k favourable to budget due mainly to unattended courses and conferences because of the Covid-19 pandemic.

Depreciation and interest costs

Depreciation and interest costs were $155k favourable to budget due to timing of IT software purchasing and interest costs for expected overdraft.

Clinical supplies

Clinical supplies costs were $78k favourable to budget due to lower theatre consumables (orthopaedic surgery YTD 11.8% lower than target), pharmaceuticals, dental and district nursing consumables. These lower costs were partly offset by ward (mainly treatment and pharmaceutical) and radiology consumables costs.

Outsourced clinical and other services

Outsourced clinical service costs were $102k favourable to budget mainly due dental, ophthalmology and audiology outsourced service costs. These lower costs were partly offset by higher after-hours mental health telephone service costs and radiology costs.

Case weighted discharges

Year to Date estimated case weighted discharges (CWD) were 233 CWD, 2.6% higher than target. General medicine 411 CWD, was 15.7% higher than planned and Orthopaedics is 207 CWD 11.8% lower 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	(1,771)	(1,583)	(188)	U	(14,241)	(13,342)	(899)	U	(17,723)	(17,355)
Primary Health Organisation (PHO)	(1,578)	(1,536)	(42)	U	(14,545)	(14,190)	(355)	U	(18,909)	(18,015)
Home Based Support (short Term)	(203)	(203)	-	F	(1,495)	(1,824)	329	F	(2,431)	(2,452)
Other Personal Health	(1,072)	(1,370)	298	F	(10,269)	(10,528)	259	F	(14,273)	(13,397)
Health of Older People	(2,981)	(2,897)	(84)	U	(25,958)	(25,698)	(260)	U	(34,187)	(31,490)
Mental Health	(1,109)	(1,080)	(29)	U	(10,166)	(9,739)	(427)	U	(12,981)	(11,436)
Public Health	(102)	(93)	(9)	U	(880)	(860)	(20)	U	(1,140)	(1,184)
Maori Services	(155)	(139)	(16)	U	(1,467)	(1,339)	(128)	U	(1,757)	(1,713)
Total Other provider expenditure	**(8,971)**	**(8,901)**	**(70)**	**U**	**(79,021)**	**(77,520)**	**(1,501)**	**U**	**(103,401)**	**(97,042)**
Funding Admin	(274)	(226)	(48)	U	(2,191)	(2,040)	(151)	U	(2,698)	(2,457)
Total funder expenditure	**(9,245)**	**(9,127)**	**(118)**	**U**	**(81,212)**	**(79,560)**	**(1,652)**	**U**	**(106,099)**	**(99,499)**
	-	-	-		-	-	-		-	-
Expenditure by service										
Personal Health	(4,624)	(4,692)	68	F	(40,550)	(39,884)	(666)	U	(53,336)	(51,219)
Health of Older People	(2,981)	(2,897)	(84)	U	(25,958)	(25,698)	(260)	U	(34,187)	(31,490)
Mental Health	(1,109)	(1,080)	(29)	U	(10,166)	(9,739)	(427)	U	(12,981)	(11,436)
Public Health	(102)	(93)	(9)	U	(880)	(860)	(20)	U	(1,140)	(1,184)
Maori Services	(155)	(139)	(16)	U	(1,467)	(1,339)	(128)	U	(1,757)	(1,713)
Funding Admin	(274)	(226)	(48)	U	(2,191)	(2,040)	(151)	U	(2,698)	(2,457)
Total Expenditure	**(9,245)**	**(9,127)**	**(118)**	**U**	**(81,212)**	**(79,560)**	**(1,652)**	**U**	**(106,099)**	**(99,499)**
	-	-	-		-	-	-		-	-

Month comments

The overall expenditure for the month of March was $118k unfavourable to budget.

Pharmaceuticals

Pharmaceutical was $188k unfavourable to budget due to the likely impact of Covid-19 on supply chain.

Primary Health Organisation

The Primary Health Organisation (PHO) was $42k unfavourable to budget. This was offset by increased primary care funding.

Other personnel Health

Other personnel health $298k favourable mainly due to lower demand driven cost reversal of addition costs budgeted for various workstream not eventuate.

Health of Older People (HOP)

Health of older people was $84k unfavourable to budget due to increased costs for ageing in place, respite and transition care.

Mental health

The mental health service was $29k unfavourable to budget largely due to an increase in the integrated primary mental health and addiction service costs and addiction system collaborations design and implementation support costs. This was offset by higher revenue.

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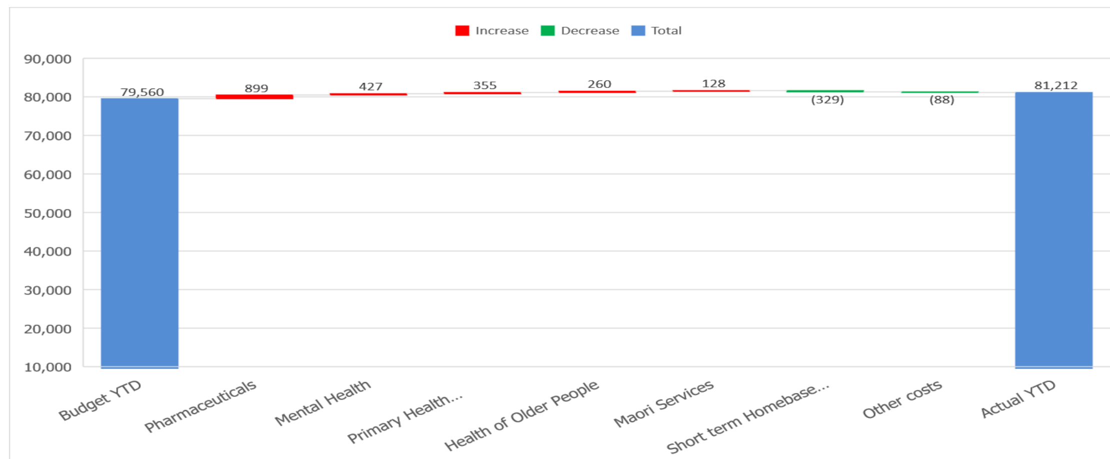


Year-to-date comments

The overall year-to-date expenditure was $1,652k unfavourable to budget.

Pharmaceuticals

Pharmaceutical was $899k unfavourable to budget due to likely impact of Covid-19. ($419k prior year income in advance carry forward CPB funding is now full utilised).

Mental health

Mental health service was $427k unfavourable to budget largely due to an increase in the integrated primary mental health and addiction service costs and addiction system collaborations design and implementation support costs. This was offset by higher revenue.

Primary Health Organisation

The Primary Health Organisation (PHO) was $355k unfavourable to budget, due largely 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 unfavourable cost variance was partly offset by increased primary care funding.

Health of Older People (HOP)

Health of older people was $260k unfavourable to budget due to high demand of home-based support and residential care hospital.

Māori Health

Māori Health $128k unfavourable to budget mainly due to equity costs initially budgeted in mental health costs and transferred to Māori Health.

Home base support (short Term)

Home based support short term $329k favourable to budget due to the lower demand of short-term home-based and community service support. This favourable cost variance was partly offset by the health of older people unfavourable variance.

Other Costs

Other costs were $88k favourable mainly due to lower demand driven cost and addition costs budgeted for various workstream not eventuate. These lower costs were partly offset by funding and administration operation costs and public health costs (offset by revenue).

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 $000
Expenditure										
Outflow inpatient	($ 1,906)	($ 2,239)	333	F	($ 18,891)	($ 20,148)	1,257	F	($ 26,864)	($ 24,045)
Outflow other	($ 2,073)	($ 2,095)	22	F	($ 18,691)	($ 18,856)	165	F	($ 25,141)	($ 22,944)
Total outflow	**(3,979)**	**(4,334)**	**355**	**F**	**(37,582)**	**(39,004)**	**1,422**	**F**	**(52,005)**	**(46,989)**
Inflow inpatient	$298	$308	(10)	U	$2,772	$2,771	1	F	$3,694	$3,269
Inflow other	$400	$399	1	F	$3,613	$3,593	20	F	$4,792	$4,834
Total inflow	**698**	**707**	**(9)**	**U**	**6,385**	**6,364**	**21**	**F**	**8,486**	**8,103**
Total IDF net flow	**(3,281)**	**(3,627)**	**346**	**F**	**(31,197)**	**(32,640)**	**1,443**	**F**	**(43,519)**	**(38,886)**

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

Year-to-date comments

Year-to-date IDF net flow was $1,443k favourable to budget.

Year-to-date outflow IDF cost was $1,422k favourable to budget.

- Inpatient IDF outflow was $1,257k favourable to budget due to lower inpatient activity at Capital and Coast and Midcentral DHBs. Anticipated savings of $1.8m are included in the budget.
- Other IDF outflow was $165k favourable to budget due to service changes and mental health additional IDF budget which did not eventuate.

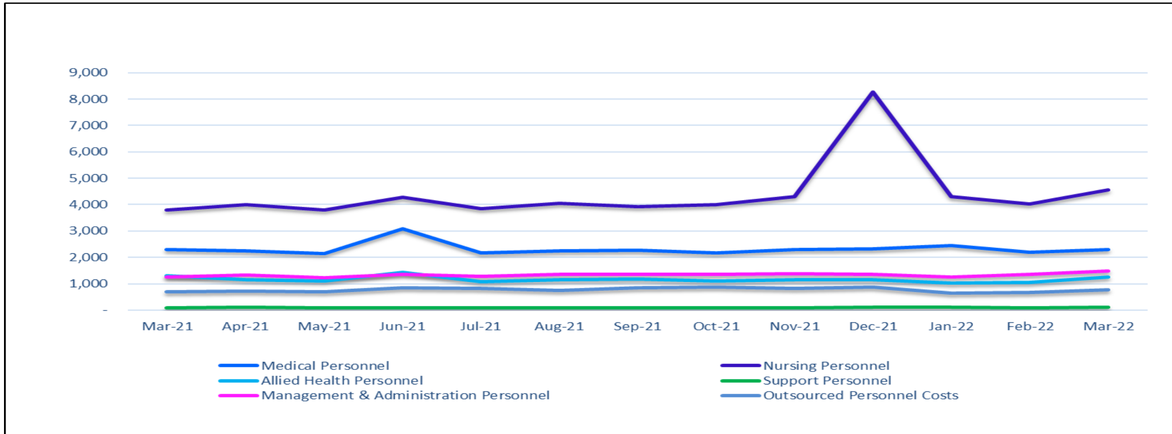
Year-to-date inflow IDF revenue was $21k favourable to budget.

- Inter-district inpatient inflow in line with budget.
- Inter-district other inflow $20k favourable to budget due to service changes.

Appendix 5 – Other information

Supplementary information on costs

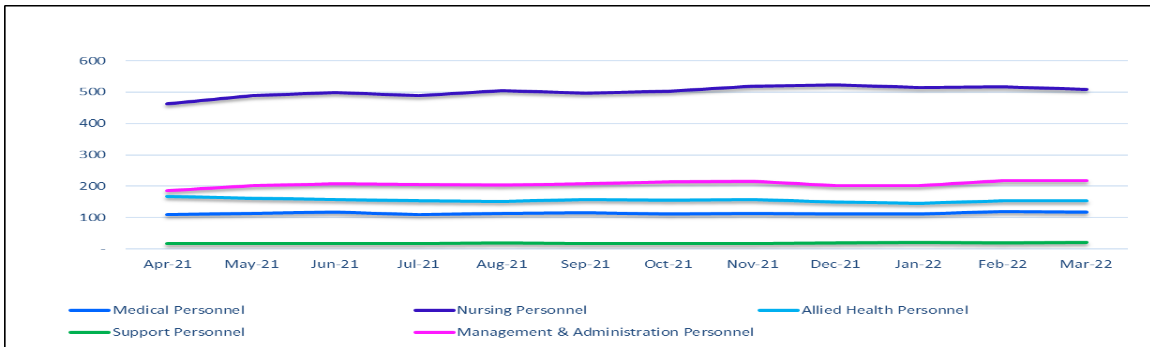
Personnel cost trends



Over all personnel costs upward trend in March compared to the prior month is due to three more working days in the month.

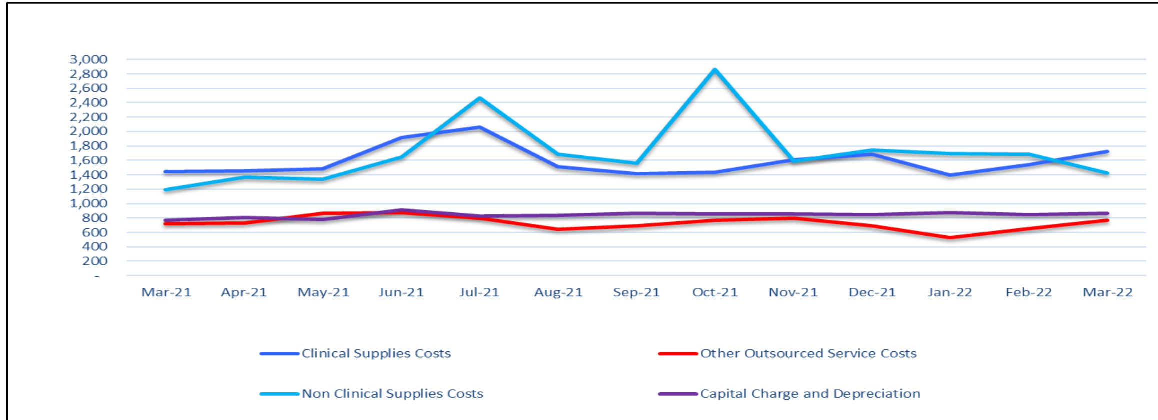
Outsourced personnel costs slightly upward trend in March compared to prior month is due to ACC contract costs.

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.

Other operating costs



- Clinical supplies upward trend in March 2022 compared to prior month is due higher theatre, wards, and radiology consumable costs.
- Non-clinical supplies downward trend in March 2022 compared to the prior month is due lower facility and other operating costs.
- Other outsourced service upward trend in March 2022 compared to the prior month is due to higher ACC contract and radiology costs.
- Capital charge and depreciation is comparable to the prior month.

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	-	4,982	5	4,977	5
Receivables & Prepayments	10,888	12,478	6,985	5,493	6,575
Investments	-	-	-	-	-
Inventories	1,495	1,615	1,617	(2)	1,617
Trust / special funds	200	212	190	22	189
Patient and restricted trust funds	4	3	3	-	4
Total current assets	**12,587**	**19,290**	**8,800**	**10,490**	**8,390**
Non current assets					
Property, plant and equipment	88,806	89,025	93,741	(4,716)	96,445
Intangible assets	11,255	10,361	12,833	(2,472)	13,422
Investments in associates	1,173	1,173	1,220	(47)	1,255
Total non current assets	**101,234**	**100,559**	**107,794**	**(7,235)**	**111,122**
Total assets	**113,821**	**119,849**	**116,594**	**3,255**	**119,512**
Liabilities					
Current liabilities					
Bank Overdraft	(1,355)	-	(9,397)	9,397	(8,577)
Payables	(20,655)	(32,437)	(21,344)	(11,093)	(21,526)
Borrowings	(100)	(100)	(103)	3	(103)
Employee entitlements	(26,435)	(26,770)	(24,017)	(2,753)	(27,299)
Provisions	-	-	-	-	-
Total current liabilities	**(48,545)**	**(59,307)**	**(54,861)**	**(4,446)**	**(57,505)**
Non-current liabilities					
Borrowings	(385)	(310)	(313)	3	(282)
Employee entitlements	(768)	(763)	(779)	16	(729)
Total non current liabilities	**(1,153)**	**(1,073)**	**(1,092)**	**19**	**(1,011)**
Total liabilities	**(49,698)**	**(60,380)**	**(55,953)**	**(4,427)**	**(58,516)**
Net assets	**64,123**	**59,469**	**60,641**	**(1,172)**	**60,996**

Total assets are $3,256k higher than budget mainly due to a better cash position than forecasted overdraft. Property, plant, and equipment lower expenditure is due to the impact of actual 2020-21 capital expenditure being less than originally included in the 2021-22 Annual Plan forecast for 2020-21.

Total liabilities are $4,428k higher than budget due to improvement in budgeted overdraft (better cash position relates to favourable prior year IDF wash-up and planned care funding), offset by increased payables and employee entitlement provisions.

Appendix 7 – Cash flow

Consolidated Summary Statement of Cash Flows for the period ended 31 Mar 2022 ($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)	(4,649)	(4,158)	(491)	U	(4,945)
							-
Add back non-cash items							-
Depreciation and assets written off on PPE	5,565	6,366	5,298	5,407	(109)	U	7,349
Revaluation losses on PPE	-	-	-	-	-	F	-
							-
Total non cash movements	5,565	6,366	5,298	5,407	(109)	U	7,349
							-
Add back items classified as investment Activity							-
(loss) / gAmn on sale of PPE	5	80	43	-	43	F	-
Profit from associates	(108)	(126)	-	-	-	F	(85)
GAmn on sale of investments				-	-	F	-
Write-down on initial recognition of financial assets	-	-	-				-
Movements in accounts payable attributes to Capital purchase	(127)	271	-	-	-	F	-
							-
Total Items classified as investment Activity	(230)	225	43	-	43	F	(85)
							-
Movements in working capital							-
Increase / (decrease) in trade and other payables	2,301	120	11,782	1,313	10,469	F	1,495
Increase / (decrease) employee entitlements	5,173	4,444	330	(592)	922	F	2,640
				-	-	F	-
(Increase) / decrease in trade and other receivables	123	(4,487)	(1,590)	(540)	(1,050)	U	(45)
(Increase) / decrease in inventories	(190)	122	(120)	-	(120)	U	-
Increase / (decrease) in provision	-	-	-	-	-	F	-
							-
Net movement in working capital	7,407	199	10,402	181	10,221	F	4,090
Net cash inflow / (outflow) form operating activities	(2,662)	1,943	11,094	1,430	9,664	F	6,409
	-	-	-	-			-
Net cash flow from Investing (capex)	(3,109)	(6,756)	(4,666)	(9,527)	4,861	F	(14,762)
Net cash flow from Investing (Other)	(48)	2	(16)	1	(17)	U	(34)
Net cash flow from Financing	(388)	(357)	(75)	(69)	(6)	U	1,042
Net cash flow from deficit support	7,000	-	-	-			-
							-
Net cash flow	793	(5,168)	6,337	(8,165)	14,502	F	(7,345)
Net cash (Opening)	3,020	3,813	(1,355)	(1,227)	(128)	U	(1,227)
Cash (Closing)	**3,813**	**(1,355)**	**4,982**	**(9,392)**	**14,374**	**F**	**(8,572)**

Closing cash is ahead of budget due to the timing of receivables and payables working capital movements, reduced capital expenditure and receipt of the prior year’s IDF wash-up.

April 2022 **Public**

Capital Expenditure - 31 March 2022

	Actual 2020-21 000	Actual YTD 2021-22 $000	Budget YTD 2021-22 $000	Variance to Budget	Budget 2021-22 $000
Buildings & Plant	1,885	1,285	4,354	3,069	5,550
Clinical Equipment	2,400	1,831	1,892	61	4,474
Other Equipment	138	142	90	(52)	210
Information Technology	1,147	1,116	680	(436)	1,015
Purchase of software	1,186	190	2,311	2,121	3,273
Motor Vehicles	-	102	200	98	240
Total capital expenditure	**6,756**	**4,666**	**9,527**	**4,861**	**14,762**

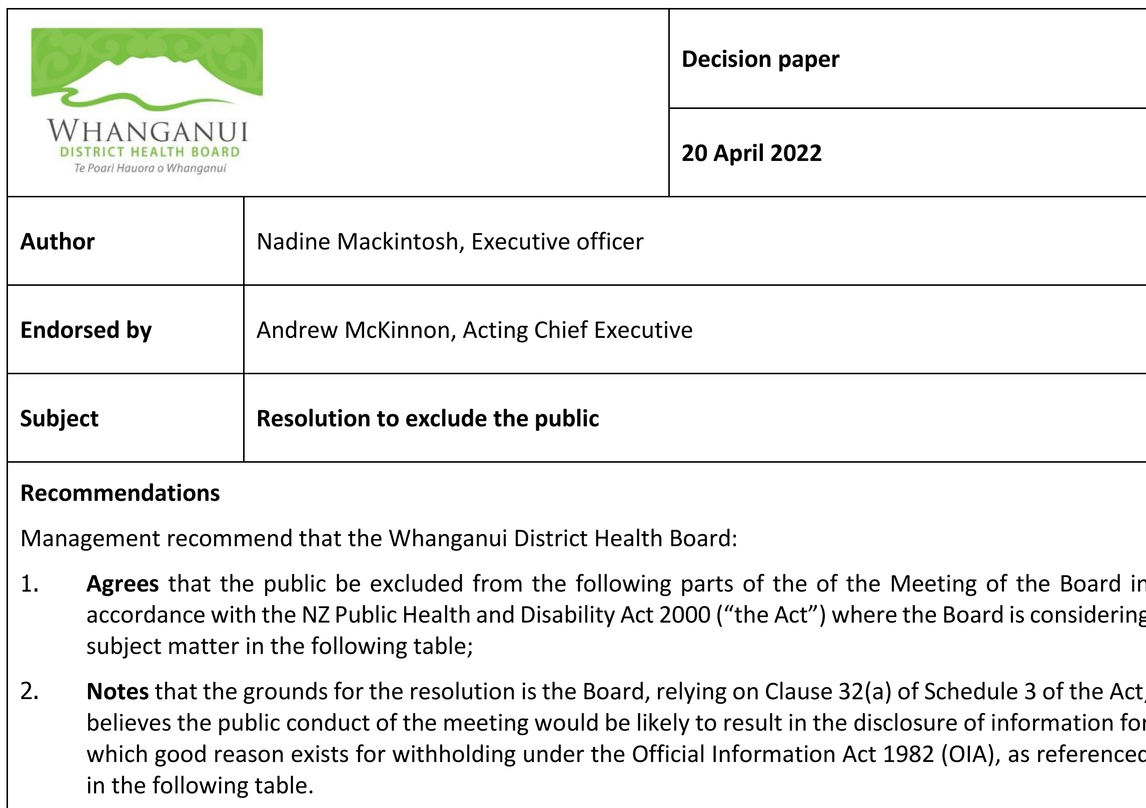
Capital expenditure is $4.9m lower than planned due to a delay in building-related projects. Building project and IT projects are also running behind schedule.

Andrew McKinnon

General Manager Corporate

April 2022

April 2022 **Public**



WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Decision paper** **20 April 2022**
Author	Nadine Mackintosh, Executive officer
Endorsed by	Andrew McKinnon, Acting Chief Executive
Subject	**Resolution to exclude the public**

Recommendations

Management recommend that the Whanganui District Health Board:

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting	For reasons set out in the board's agenda of 25 February 2022	As per the board agenda of 25 February 2022
Chief executive's report Committee Chair updates Clarification of Board Annual Reporting and Audit Obligations Planned care Provider Arm	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Contracts approval in excess of one million dollars	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)

April 2022 **Public**

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