Interest Register

20 March 2020

Name	Date	Interest
Ken **Whelan** *Chair*	13 December 2019	Crown monitor for Waikato DHB Crown monitor for Counties DHB Board member RDNZ (NZ) Chair Eastern Bay of Plenty PHO Contractor General Electric Healthcare Australasia
Annette **Main** *Deputy Chair* *Chair CSAC*	18 May 2019	Nil
Anderson-Town Talia *Chair FRAC*	2 June 2020	▪ A board member of Ratana Orakeinui Trust Incorporated ▪ A board member of Te Manu Atatu Whanganui Maori Business Network.
Adams Graham	16 December 2016	▪ A member of the executive of Grey Power Wanganui Inc. ▪ A board member of Age Concern 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.
	7 November 2014	A member of the Whanganui District Council District Licensing Committee.
	3 March 2017 20 September 2019	A trustee of Four Regions Trust. A director of The New Zealand Masters Games Limited.
Chandulal-Mackay Josh	10 December 2020	An elected councillor on Whanganui District Council
	21 February 2020	A council member of UCOL 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 ▪ A director, Whanganui Accident and Medical
	11 April 2008	A director of Gonville Health Centre
	4 February 2011	A director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape
	27 May 2016	The chair of the Children's Action Team
	21 September 2018	A director of Ruapehu Health Ltd
Peke-Mason Soraya	21 February 2020	▪ Chair, Te Totarahoe o Paerangi – Ngāti Rangi (Ohakune-Raetihi) ▪ Director, Ruapehu Health Limited ▪ Trustee, Whanganui Community Foundation ▪ Iwi Rep, Rangitikei District Council Standing Committee

20 March 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**DRAFT MINUTES** Held on Friday, 20 March 2020 Boardroom, Level 4, Ward & Admin Block, Whanganui Hospital 100 Heads Road, Whanganui
Public Board Meeting	**Commencing at 9.30 am**

Present
Ms Annette Main, Acting Chair
Mr Graham Adams, Member
Mr Charlie Anderson, Member
Mrs Talia Anderson-Town
Mrs Philippa Baker-Hogan, Member
Mr Josh Chandulal-Mackay
Mr Stuart Hylton, Member (via zoom)
Mrs Judith MacDonald, Member
Mrs Soraya Peke-Mason

Apologies
Mr Ken Whelan, Board Chair

In attendance
Mr Russell Simpson, Chief Executive
Mrs Nadine Mackintosh, Board Secretary
Mr Mark Dawson, Communications Manager
Mrs Rowena Kui, General Manager Māori Health and Equity
Mr Paul Malan, General Manager Strategy Commissioning and Population Health
Mr Andrew McKinnon, General Manager Corporate

Guests
Simon Ward, Emergency Management Officer
Louise Allsopp, General Manager Patient Safety, Quality and Innovation

Members of public
Nil

1. Procedural

The meeting format for the day was amended to reflect the unprecedented events impacting our global communities with the Covid-19 pandemic.

All critical matters will be addressed at the meeting today with other papers taken as read and members can direct any queries they have on the paper to management through the Board Secretary. Responses to questions received will be provided through reporting in matters arising to the next board session.

A Covid-19 presentation that was scheduled to be provided at the joint board meeting of Hauora a Iwi and Whanganui DHB Boards will be provided prior to the procedural part of the meeting.

1.1 Karakia/reflection

The meeting was opened by R Simpson with a Karakia.

20 March 2020 **Public**

1.2 Apologies

The board **accepted** the apologies from K Whelan due to self-isolation following returning from international travel in the last 14 days. P Baker-Hogan provided her apologies for lateness.

Ms A Main chaired the meeting and zoom facilities were available for absent members to join the meeting.

PRESENTATION

Covid-19 update

L Allsopp, GM Patient Safety, Quality and Innovation

As of Monday the community led Emergency Operations Centre was opened formally. The GM Patient Safety, Quality and Innovation has been appointed as an Incident Controller, the Chief Executive of Whanganui Regional Health Network is our operations lead to support our approach for a community led emergency operation centre.

Our first community based assessment centre (CBAC) has been opened on campus being led by Whanganui Regional Health Network.

There are no confirmed cases in New Zealand to date. Whanganui have had six cases swabbed in the CBAC unit and 36 attendances that did not require testing.

S Peke-Mason arrived at 9.40am

The GM Māori Health and Equity is our lead for Māori Health. She has been engaging with the Iwi leaders and representatives to ensure that our leaders are linked in with others across our boarders. We are focused on people with long term conditions. There are tikanga practices to be mindful of in particular our tangihanga.

P Baker-Hogan arrived at 9.44am

The technical advisor group has been linked in with Dr Rawiri Jenson who is leading the national guidance perspective on treatment for Māori.

Management of the pandemic will be critical based on the knowledge of overseas experiences. We may be faced with some difficult decisions and we want clear guidance for equitable access and treatment. There is a good process to ensure that everyone is involved.

The GM Corporate is our lead for logistics and we are ensuring that we have enough PPE supplies for people in our communities that require it. Indications are that the supply chain is having difficulties in meeting orders and we are continuing to focus on supply for those that need it most. Information technology has an increased workload due to looking at the requirements to assist staff to work from home if necessary.

Any guidance from the Ministry of Health (MoH) is being strictly adhered to, with public information for our communities being led by our communications team. Eileen O'Leary is working from an equity perspective in our communications team and has previous experience working at MoH during the SARS epidemic.

The technical advisory group covers a number of practices to provide expert advice into the EOC and is being led by our chief medical officer.

The chief executive reconfirmed that we are entering unprecedented times and this commenced by both Hospital and Primary care receiving texts for national updates on Saturday. It was reiterated to the board that due to the relationships that we have our DHB has been able to get up and running very quickly. The incident controller is likely to change every couple of weeks.

The protection gear training is being provided through an education programme and our infection protection team are available to train people if needed.

We have policies and protection gear and the process has been in place prior to this event. The biggest risk we are facing is person to person spread.

The country is facing a peak in cases, and evidence from other countries indicate overwhelming pressure on health services. Ventilation is required for serious cases and we currently have three ventilators at our hospital. All our cases are from other countries, if we do not follow guidelines it could create community transmission. The messages to our communities are going to be important, we need to ensure we support resilience across our communities.

Iwi are meeting daily and S Peke-Mason received support to share information from this board meeting in relevant hui.

It was recommended that we change our wording from social distancing to physical distancing. There is some concern about increased requirements for mental health services, particularly our youth with the impacts of social distancing. We will focus on the supports we have in place for engagement in preventative programmes.

There was a brief discussion on what the business as usual requirements will be for the governors during this pandemic. Management requested some flexibility for business as usual whilst we focus on the safety of our communities. Board members engaging with the communities can assist by keeping our communities calm and provide formal information to public that is being released by our communications team. Any questions received are at first directed to the public information coming out from the communications team.

Board members provided support and appreciation for staff during this time.

Covid-19@wdhb.org.nz email address can be used for staff. General questions about processes will go to Patrick O'Connor and healthline to be used for general public health concerns.

The director general of health has inspired confidence to our nation, his approach to the pandemic has been exemplary.

Action: The chief executive will provide acknowledgements to the director general of health.

1.3 Continuous Disclosure

1.3.1 Amendments to the Interest Register

The board accepted the amendments as follows:
S Hylton not a council member
A Main no longer a council member
G Adams no longer a treasurer of NZ Council of Eders (NZCE)

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

20 March 2020 **Public**

1.4 Confirmation of minutes

1.4.1 21 February 2020

The minutes of the meeting held on 21 February 2020 were **approved** as a true and accurate record of the meeting.

A discussion on the karakia/reflection was held and can include the Whakamoemiti.

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

1.5 Matters Arising

Nil

1.6 Board and Committee Chair Reports

1.6.1 Chair verbal report

Nil

2. Chief Executive Report

The national bowel screening reduction in age for Māori and Pacific from 64 to 50 will have a financial impact on our DHB of approximately $36,000 and we have agreed to underwrite this cost. This adjustment reflects our commitment to equity.

The highlights from the report were:

- Covid-19 establishment of an EOC
- 26.7% of our population is Māori which does not include the latest census data.

The Whanganui District Health Board members:

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

b. **Noted** the recent certification audit undertaken by the Designated Audit Agency (DAA)

c. **Noted** that we received an excellent audit result and this highlights the ongoing quality of work achieved at WDHB.

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

3. Decisions Papers

3.1 New Evacuation Scheme for the hospital

The paper was taken as read as a requirement to prepare and register our evacuation and we are seeking to have one evacuation plan for our site.

Management confirmed that evacuation trials are undertaken regularly.

The Whanganui District Health Board members:

a. **Receive** the paper titled New evacuation schemes for the hospital

b. **Note** that the board is deemed the hospital owner

c. **Approve** the board chair to sign the letter authorising the contractor from Fortifier Limited to act on its behalf in relation to the submission of the fire schemes with Fire and Emergency New Zealand.

Moved S Peke-Mason **Seconded** G Adams **CARRIED**

20 March 2020 **Public**

4. Information papers

4.1 February 2020 Financial Update

The paper was taken as read. Workforce management and reducing the use of locums are assisting our budget position and if we continue to manage these areas we should meet our budget deficit position.

The DHB is currently working in a business as usual environment to address planned care and will be monitored daily. Any changes to the situation will be reported to the board.

The Whanganui District Health Board members:

a. **Received** the report 'Detailed financial report – February 2020'.

b. **Noted** the February 2020 monthly result of a $343k deficit is favourable to budget by $182k.

c. **Noted** the year-to-date result of $8,851k deficit is unfavourable to budget by $501k.

Moved A Main **Seconded** C Andersen **CARRIED**

4.2 Health and Safety Update – for information only.

The report was provided for the board to receive and note the trends with the chief executive highlighting that they are flat or improving.

The Whanganui District Health Board members:

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

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

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

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

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

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

4.3 Non Financial reporting – for information only

The paper was taken as read for reporting provided to the Ministry of Health. There has been a caveat provided from the Ministry of Health that quarter three reporting will not be required.

The board requested that management continue to focus on the areas of :

- Immunisation
- Faster cancer treatment

The Whanganui District Health Board members:

a. **Received** the paper titled "Non-Financial Performance Reporting (NFPR)"

b. **Noted** Q2 results for the Ministry of Health

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

20 March 2020 **Public**

5 Resolution to exclude the public

The 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 1 November 2019	For reasons set out in the board's agenda of 1 November 2019	As per the board agenda of 1 November 2019
Chief executive's report Board & committee chair reports HDC Complaints	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations) 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)(i) and 9(2)(j) Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Integrated Facilities Contract Extension Dental Digital Image Capture Unit Procurement	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)
Board Committee Membership Delegations Policy	To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty	Section 9 (2) (g) (i)

Persons permitted to remain during the public excluded session

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

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

Moved A Main **Seconded** J Chandulal-McKay **CARRIED**

20 March 2020 **Public**

The public section of the meeting concluded at 10.35 am

Signed A Main
Deputy Chair
Whanganui District Health Board

June 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Chief Executive Paper**
	Item 2
Author	Russell Simpson, Chief Executive
Subject	**Chief Executive Report**

Recommendations

Management recommend that Whanganui District Health Board members:

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

b. **Notes** the new legislation passed on 30 April 2020 allowing Ministers to extend the time for meeting planning requirements under the Crown Entities Act 2004 by up to three months

c. **Note** the Minister of Health has agreed to expand the timeline for finalising and publishing the 2020/21 statement of performance expectation (SPE) to 15 August 2020, this also applies to the statement of intent (SOI) for those DHB choosing to produce one

d. **Note** the reason the extension has been granted is to reflect the revised timelines agreed for finalising 2020/21 DHB annual plans due to COVID-19 impacts, and to ensure quality SPE/SOI documents are produced that align with DHB annual plans and appropriately reflect COVID-19 recovery.

1. Extension to the date DHBs are required to finalise and publish 2020/21 Statements of Intent

New legislation was passed on 30 April 2020 allowing Ministers to extend the time for meeting planning requirements that apply under the Crown Entities Act 2004 by up to three months due to the impacts of Covid-19. The relevant extension will be repealed on 1 October 2020.

The Minister of Health has agreed to extend the timeline for finalising and publishing the 2020/21 statement of performance expectation (SPE) to 15 August 2020. The extension also applies to the statement of intent (SOI) for those DHB choosing to produce one (noting the Minster of Health did not ask DHBs to produce updated SOIs for 2020/21).

The reason the extension has been granted is to reflect the revised timelines agreed for finalising 2020/21 DHB annual plans due to COVID-19 impacts, and to ensure quality SPE/SOI documents are produced that align with DHB annual plans and appropriately reflect COVID-19 recovery.

The legislation requires DHBs to publish a notice of the extension on their website, and the Minister's reasons for granting it. A statement of the notice and the reasons for granting it will also need to be included in the annual report.

2. Flu Vaccinations

The latest figures from the Ministry of Health show the collective efforts of Whanganui health providers achieved the highest rate of vaccination in the country. As of 15 May 2020, 83 percent of the Māori population aged 65 and over had been vaccinated and 77 percent of this age group for other ethnicities had been vaccinated. Out of the country's twenty district health boards, Whanganui had the best result of total population vaccinated with 24%.

3. International Nurses Day

International Nurses Day was celebrated across the district this year although with some limitations due to COVID-19. DHB senior nursing leaders walked about in the hospital with treats and went out to our community partners to acknowledge the day. Photos and statements from nurses were sent to communications for publishing in the Chronicle and the WDHB website to celebrate the contribution of nurses and midwives. Our community partners acknowledged and welcomed the visit.

4. Whanganui DHB COVID-19 Response

The WDHB COVID-19 response commenced with the opening of the emergency operations centre (EOC) on 16 March 2020.

The readiness phase was aligned with the national response framework which guided actions and responses for each level [green, yellow, orange and red]. Whanganui DHB was connected to the national forums for chief executives, chief operating officers, directors of nursing, human resources general managers, chief medical officers and directors of allied health services. This was of great benefit as it enabled sharing of issues, solutions and resources. It also enabled each discipline to benchmark our internal responses with other DHBs.

WDHB moved the EOC off site to the Whanganui Council whilst the provider arm formed an incident management team (IMT) at Whanganui Hospital. Daily monitoring for COVID probable and confirmed cases, along with workforce and service delivery data was provided through IMT to the EOC. Whanganui DHB has had no confirmed patients within the hospital setting. The IMT action plan was aligned to readiness, reset and redesign. This system has followed through into level two (2), however the EOC and IMT have now been amalgamated.

5. ED SMO Passing

We received devastating news on 9 May 2020 about a plane crash that led to the passing of one of our past ED SMO's Scott Piotrowsky, he was the only fatality in the crash. Scott was survived by his wife Aimee and his two children.

Scott worked at Whanganui DHB since October 2018 and had recently moved home to the US, working at Huguley Medical Centre in Ft. We had been in discussions with him returning to New Zealand.

A memorial service was held Saturday, the 16 May 2020. Tributes from the DHB were sent to the family. Additionally, there's a GoFundMe page established for his family. https://www.gofundme.com/f/doctor-p?utm_source=facebook&utm_medium=social&utm_campaign=p_cp+share-sheet

Dustin Corgan past ED SMO who resides in Texas, advised the DHB of the tragedy and attended the funeral as a friend, colleague and a representation for DHB staff that were unable to be there for Scott and his family.

June 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Board Decision paper**
	Item 3.1
Author	Mark Dawson, Communications Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	**Whanganui DHB Communication Procedure**

Recommendations

Management recommend that the Whanganui District Health Board members:

a. **Receive** the report titled 'Whanganui DHB Communication Procedure'

b. **Note** the suggested tracked changes to the procedure

c. **Approve** the WDHB Communication Procedure for a further three-year term

1 Purpose

To enable the Board to review the Whanganui DHB Communication Procedure and advise of any changes required before it is approved for a further three-year term.

The WDHB Fraud Policy (WDHB-5795) was reviewed and approved by the board in June 2017 for a three-year term.

Procedure

Communications Procedure	
Applicable to: Whanganui District Health Board	**Authorised by:** Chief executive
	Contact person: Communications Manager, Communications

1. Purpose

This procedure outlines the processes to be followed in the implementation of the WDHB's Communications Policy.

2. Scope

It applies to all board and committee members, all Whanganui District Health Board (WDHB) employees (permanent, temporary and casual), visiting medical officers, contractors, consultants and volunteers.

3. Prerequisites

- WDHB Communications Policy
- WDHB's Privacy Strategy

4. Definitions

Communications - the imparting or exchanging of information by speaking, writing or using other medium such as social media (Facebook and Twitter) and videos.

Delegated managers – senior managers authorised by the CE and EMT ELT to speak to the media. This also includes the Director of Area Mental Health Services (DAMHS)/Area Director - Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

5. Roles and responsibilities

Roles	Responsibilities
Board members	Endorse the policy Adhere to the policy
Chief executive	Adhere to the policy Approve delegations within the policy as required
WDHB kaumatua and kuia	Provide advice regarding te reo Māori to enable

	implementation of the policy
~~Executive management team~~ Executive Leadership Team	Adhere to the policy Enable implementation of the policy
Board, committees and staff with delegated authority	Adhere to the policy Enable implementation of the policy
Operational management team	Adhere to the policy Ensure all staff are informed and apply the policy effectively
Communications manager	Leads operation of the policy Monitors use of the policy
Communications team	Enable operation of the policy
Te Hau Ranga Ora	Provide advice to enable effective and accurate use of te reo Māori and Whanganui mita
Staff	Understand their responsibilities and adhere to the policy and associated procedures.

6. Equipment and resources

The Communications Procedure applies to all equipment and resources used by the Communications Department and anyone else within, and external to, the organisation covered by the procedure.

7. Procedure

An official set of actions put in place to support the Whanganui DHB's ability to meet its obligations as set out in the Whanganui DHB's Communications Policy. Please refer No 13 Procedures in detail.

8. Measurement criteria

Media monitoring (Isentia), website and social media analytics, project evaluation, feedback from Ministry of Health, Minister's office, Board, DHB staff and stakeholders.

9. References

MidCentral DHB's Communications Policy
Māori Translation Policy

10. Related Whanganui District Health Board documents

Publications

- WDHB Writing Style Guide and Writing Style Companion Guide
- Communications Policy
- Information Communications and Technology Security Policy
- Publications Management Procedure
- Hauora A Iwi and WDHB Memorandum of Understanding

11. Appendices

Communications Policy
Translations Policy

12. Key words

Communication, Communications, Communications Policy, Communications Procedure, media, permission, publications, sign-offs, social media, submissions.

13. Procedures in detail

13.1 General

All communication with external parties will be performed within the employee's scope of practice and delegated authority and shall represent the organisation's views in an accurate and professional manner. The employee will be mindful of the organisation's image as a planner, funder and provider of health and disability services. The onus is on the employee to establish the credentials of the enquirer.

All communication will be undertaken with the target audience in mind. The language used will be readily understandable, and respectful.

Where appropriate and relevant, messages ~~-~~and statements issued by the WDHB will acknowledge and reflect the cooperative and collaborative nature of relationships between Whanganui DHB and Whanganui's other health and social sector providers.

All written communication, whether electronic, handwritten or graphic will be in accordance with the WDHB's Writing Style Guide and Writing Style Companion Guide, using approved templates where applicable.

All communication sent by email must adhere to the WDHB's Information Communication & Technology Policy.

13.2 Media and public comment

Media enquiries are to be coordinated through the Communications Department and dealt with in a timely, helpful manner, while maintaining patient, client, resident, and employee confidentiality.

All media statements whether written or verbal are to be coordinated by the Communications Department and approved by the chief executive (CE), manager or clinical leader in accordance with WDHB's Delegations Policy. An embargoed copy of all media releases is to be circulated to WDHB Board members and the ~~Executive Management Team~~ Executive Leadership Team prior to release.

At the time of release, the communications manager or communications adviser will send a copy to the following:

- Ministry of Health
- Local media
- ~~MPs and Mayors~~
- WDHB staff requesting press releases
- National media when applicable
- Health and nursing magazines.

Employees may not make unauthorised statements to the media on matters relating to their work with WDHB. Employees may discuss with the media, matters affecting their professional activities which do not impinge (by implication or otherwise) on WDHB policy or operational activities. In such cases, employees are to advise the Communications Department or an ~~Executive Management Team~~ Executive Leadership Team member of their involvement.

However, this Communications Policy and Communications Procedure, does not take away the right for health professionals to invoke the protections of the Protected Disclosures Act 2000 commonly referred to as the Whistleblower protection in bringing to light any unsafe practise.

The board's chair is the official spokesperson for matters of governance and policy.

Committee chairs may speak on behalf of their committees and on governance matters falling within the ambit of their committee's terms of reference.

Board and committee members have the right to express their views in the media and public arena, but must make it clear the views are their personal views, and they are not speaking for, or on behalf of, the board in respect of current or future policy or decisions.

As a courtesy, board members will inform the Board chair when they plan to express their personal opinion on Board matters to the media.

For policy, and issues defined as critical by the board's chair or the CE, the media spokespersons shall be the board's chair and/or CE as mutually agreed.

For operational issues, an ~~Executive Management Team~~ Executive Leadership Team member may respond to the media, in consultation with the Communications Department. For special projects or incidents a media spokesperson may be appointed by the general manager or CE.

Issues which may cause significant public concern must be referred to the CE and the Communications Department. Where the issue involves a threat to public health, any response is to be developed in consultation with the Medical Officer of Health or designate.

Staff shall not publicly comment on the work, policy, actions, or efficiency of external organisations without agreement from the organisation concerned and without having the appropriate delegated authority.

Media are welcome to attend WDHB public board and committee meetings. Since filming or photographing the meeting can be disruptive to the conduct of the meeting, media are expected to contact the Board or committee chair as early as possible prior to the meeting, (but no later than a working day) so that agreement can be reached as to how the need of both parties can be met.

13.3 Protecting confidentiality

Media or other external parties seeking comment relating to patients/clients/residents and/or their welfare, including access for interviews and photographs, are to be handled within the organisation's policy on patient confidentiality. This states that the only information that may be released without the patient/client/resident's prior consent is:

- Brief general information concerning the nature of injuries to a person involved in an accident, provided this is within 24 hours of their admission.
- General information concerning the condition of the patient on the day of enquiry, unless the patient/client or their family/representative has expressly requested no information be given.

Where the media or other external parties are seeking comments on individual staff members concerning personal information, disciplinary and/or industrial relations procedures, including access for interviews and photographs, the response must take into account the need to protect employee privacy. The only information that may be released without the individual employee's prior consent is general information pertaining to the issue in question only (without divulging individual or personal details).

Where the media or other external parties are seeking comments on contract holders concerning contract arrangements, the response must take into account the need to protect information where the making available of such information would unreasonably prejudice the commercial position of the contractor, or, disclose a trade secret.

Patients/clients who are resident at WDHB's facilities and wish to be interviewed by the media have that right. All such requests should be referred to the Communications Department and must be approved by the CE or appropriate general manager.

Media on WDHB property without permission should be asked to leave, and, if necessary escorted from the premises by security.

13.4 Patient condition guidelines for media

To protect patient confidentiality, WDHB Communications staff, duty nurse managers and other staff permitted to speak to the media can release the following information only, to describe a patient's condition:

1. A patient's gender.
2. A patient's age described as child, teenager, in their 20s, 30s, 40s, etc.
3. A person's condition described as critical, serious, serious but stable or stable.

13.5 External publications

External publications, including newsletters, brochures, multimedia material (eg DVD/CD) must be consistent with the Writing Style Guide, and include the WDHB logo. External publications are to be approved by the Communications Department prior to completion.

External communication for mass distribution is to be approved by the Chief Executive.

13.6 Public meetings

When representing the organisation at public meetings, employees must inform their line manager and seek approval prior to the event.

13.7 Submissions

Submissions on policy and/or legislative matters, shall be made on behalf of the organisation as a whole and must be approved and signed by the appropriate ~~EMT~~ ELT member. A copy of the final submission will be filed as a PDF in **Shared Drive/EMT/Submissions/Month and Year/Name of the Submission.** A hard copy is to be supplied to, and filed by the Board office.

Staff who wish to contribute to a submission on policy and/or legislative matters, in their role as a Whanganui DHB employee, shall forward their views to the relevant ~~EMT~~ ELT member or the person leading the submission's development.

The submission lead's name is stated in the Submissions Register found in the external submissions folder in **Shared/third tier managers & PAs/external submissions folder.**

All other staff (below third tier managers) can check the submissions register on the WDHB intranet.

Staff are advised to read the Whanganui District Health Board's Submissions Policy before making a submission.

13.8 Official Information Act requests

Responses to Official Information Act requests (made in accordance with the terms of the Act and for other than clinical records) shall be made on behalf of the organisation and must be approved and signed by the CE or appropriate general manager, and filed with the OIA co-ordinator.

13.9 Political correspondence

All correspondence to Ministers of the Crown or Members of Parliament, on behalf of the district health board or on Whanganui District Health Board letterhead, must be approved by the CE or appropriate general manager prior to being issued, and a copy provided to the board chair.

13.10 Filming

Media requests for permission to film/take photographs on WDHB premises should be directed to the Communications Department. Consents and a specific filming agreement should be signed with the film company and patient/client or next of kin prior to filming.

13.11 Intranet and website

Management of the intranet and website is the responsibility of the Communications Department.

The Communications Department approves what information is placed on the intranet and website. The Information Technology Department provides technical support to maintain the sites, as required.

All staff are to have access to, and be trained in the use of, the intranet.

13.12 Social media

For the purposes of this policy, social media refers to web and mobile-based technologies used to allow communication to become interactive dialogue between organisations, communities and individuals. It includes, but is not limited to, webzines, weblogs, social blogs, microblogging, wikis, social networks, podcasts, photographs or pictures, video, rating and social bookmarking, eg Facebook, Twitter, Flickr, YouTube, etc.

Board members and everyone covered by the scope using social media in their personal capacity, are reminded to adhere to the WDHB's and their professional bodies' Code of Conduct, ethics and standards and to not make comments/postings on behalf of WDHB, or in their role as a DHB employee unless delegated as part of their role. The privacy of WDHB's patients, staff and clients must not be breached or the DHB be brought into disrepute. Staff should always be mindful of the impact of any statements they make on their own and/or WDHB's reputation.

If an employee does communicate about WDHB-related issues they should include a disclaimer which makes it clear they are commenting in a personal capacity, e.g. *'the opinions and positions expressed are my own and do not necessarily reflect those of the WDHB'.*

13.13 Publications

Refer to the Publications Management Procedure

Refer to the Submissions Policy

13.14 Authority to speak to the media and sign-offs

Authority to speak to the media

- ~~Executive Management Team~~ Executive Leadership Team members are authorised to speak to the media.
- If granted authority to do so by their line manager and/or the CE, other senior staff members may speak to the media.

Sign-offs

- Any letters, memorandums or documents written by the chief executive officer (CE) must not be released without his/her sign-off and permission to do so.
- In the CE's absence, the acting CE will be responsible for sign-offs.

- All media releases and media responses must be signed off by the person interviewed, ~~their direct manager,~~ the appropriate EMT member where required and the chief executive officer.
- As a courtesy, all media releases and media responses are sent to the Board on an FYI basis.
- All community updates and official documents must not be released without the CE's sign-off.
- ~~New and updated brochures and booklets developed for patients must be signed by Tier Three managers at a minimum.~~
- ~~All stories written about, or for, staff for the Staff Newsletter must be signed off by the person/ people interviewed and their manager.~~
- The Staff Newsletter must be signed off by the CE before publication and distribution.
- Posters produced and printed onsite for public and staff viewing within the DHB campus must be signed off by the appropriate line manager.
- Posters printed by offsite providers for public viewing must be signed off through the Approval Plus delegation system.
- Sign-offs can be obtained by email or where appropriate, verbally.

13.15 Translations

Refer to the Māori Translation Policy to ensure that Māori translated material is of a high quality and that translations are consistent across the organisation. To protect and promote te reo Māori in a manner consistent with Māori cultural aspirations and preferences.

13.16 Time limits for responses

Urgent – within two hours
Medium – by the end of the day
Non-urgent – within a week

14. Legislation guiding communication

Communication shall comply with all relevant legislation which includes, but is not limited to:

- Privacy Act 1993
- Health Information Privacy Code 1994
- Code of Health and Disability Services Consumers' Rights 1996
- Employment Relations Act 2000
- Official Information Act 1982
- Protected Disclosures Act 2000
- Defamation Act 1992
- Electoral Finance Act 2007
- NZ Public Health & Disability Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989

15. Related WDHB documents

WDHB Delegations Policy
WDHB Code of Conduct
WDHB Style Guide
WDHB Patient Confidentiality Policy
WDHB Information Communication & Technology Security Policy
WDHB Submissions to External Agencies Policy

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Discussion paper**
	Item No. 4.1
Author	Harriet McKenzie, Commissioning officer
Endorsed by	Louise Allsopp, Health Recovery Manager
Subject	**COVID-19 Recovery – Reset and Redesign**

Recommendations

It is recommended that the Whanganui District Health Board:

a. **Receive** the paper 'COVID-19 Recovery – Reset and Redesign'
b. **Note** the principles and structure of the Whanganui Regional Recovery Team
c. **Note** the role of the Whanganui DHB Recovery Health-taskforce
d. **Discuss** the direction and degree of change WDHB board wishes to see for our rohe.

Appendix 1: Whanganui DHB Recovery Health-taskforce draft Terms of Reference

Appendix 2: Whanganui Regional Recovery Team Strategy

1 Purpose

The purpose of this paper is to provide an update on the recovery phase for the Whanganui Region post COVID-19. It intends to provide information on what recovery entails, the Whanganui Regional Recovery Team and initial stakeholder engagement. In doing so, the Whanganui Regional Recovery Team seeks to elicit some understanding as to what the Whanganui DHB Board perceive to be the direction and degree of change for our rohe.

2 Background

The Whanganui DHB Recovery Health-taskforce are working as part of a socially governed, integrated team consisting of health, economic and social/welfare recovery teams and iwi liaison to oversee recovery activities for the Whanganui DHB rohe.

The COVID-19 crisis has tested the health system in a once in a generation manner, exposing weaknesses and capacity issues that have been ongoing for many years. Recovery is not about returning to normality. The opportunity presented is a burning platform from which to reset and redesign the health, social, and economic systems in the Whanganui DHB rohe to achieve 'thriving communities'.

2.1 Whanganui DHB Regional COVID-19 Recovery

The arrangements for recovery, which we have called Reset, Redesign - Recovery, involve the coordinated efforts and processes used to bring about the immediate, medium-term and long-term holistic regeneration and enhancement of our communities following the COVID-19 pandemic.

We recognise that the scale and complexity of issues that we face as a rohe following the COVID-19 crisis are beyond the scope of health alone. Furthermore, that many of the influences on health and wellbeing are outside of the health sector. Social, Economic and Health/wellness recovery will only

succeed with a shared vision for a thriving and equitable Whanganui DHB rohe and a willingness for collective action to support the communities we serve.

We will ensure our regional recovery team places people and their whānau at the centre of everything we do, with and for them. We will support and empower individuals and whānau to determine their own wellbeing. We are committed to working in authentic partnership with other providers, iwi, government, social and community agencies to build strong, resilient, connected people and whānau. As part of our commitment to Whānau Ora, we recognise that to achieve thriving communities, all people, regardless of income or social status, need to live in healthy homes and environments, where people feel safe, connected, resilient and able to determine their own needs and the needs of their whānau.

2.2 Definitions

It is important that we clearly define the different stages for the Reset, Redesign - Recovery:

Reset: Reset is about acknowledging the services and systems that are in place and existing that are working well and are strategically aligned; enabling them to reset as quickly as possible.

Redesign: Redesign is about identifying opportunities to deliver services and systems differently. This may include redeveloping, redesigning or ceasing existing services, or developing and designing new services which are more aligned to our communities' needs. It is about working closely with our communities to identify their social, economic and health/wellness goals and aspirations, and supporting and enabling thriving communities.

Recovery: Recovery means the coordinated efforts and processes to bring about the immediate, medium and long term holistic regeneration and enhancement of our community following this COVID-19 pandemic. It is composite of all systems and services under Reset and Redesign. Recovery is about the community; the community is our future.

2.3 Recovery Principles

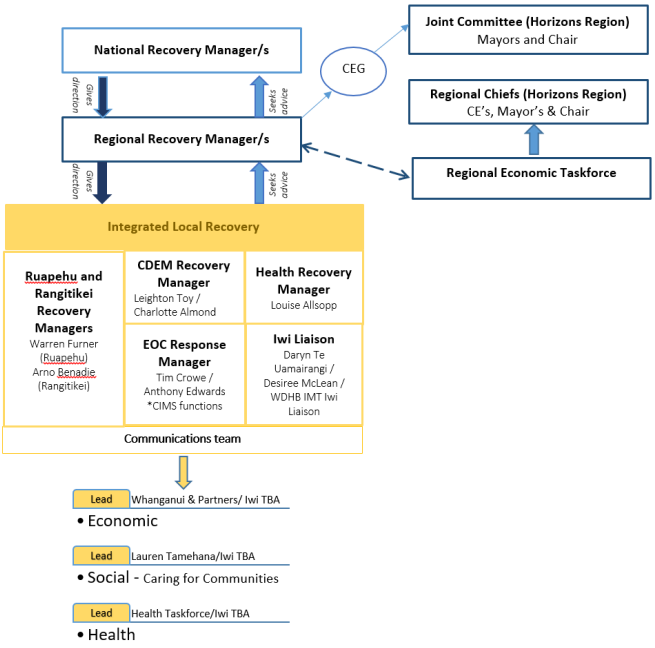
Our strategy for recovery is principles-based. Rather than a service or model, Reset, Redesign – Recovery is a way of thinking and working that is underpinned by six guiding principles which are built upon the Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Recovery Plan (2020):

1. People and whānau centred,
2. Community-led,
3. Uphold Te Tiriti o Waitangi,
4. Achieve pro-equity,
5. Protect human rights, and
6. Work together.

These principles guide five focus areas for action, which are to:

1. Collectively build the health, social and economic foundations for holistic wellbeing
2. Enable community-led solutions
3. Equip people to look after themselves, their whānau, hapu and communities
4. Strengthen social, economic and health supports in communities
5. Support community led services.

2.4 Whanganui region recovery structure



Leadership and direction will sit with a social governance leadership group, including the WDHB and Territorial Local Authority (TLA) representatives, mayors, local iwi representatives and the area police commander. Recovery managers will also report through to their respective regional and national structures. In the response phase, health has been the lead agency; at this stage, it is not anticipated this will change, however this is no known at the time of writing this report. A social governance framework has been established to lead the reset, redesign and recovery planning.

2.5 Whanganui DHB health recovery manager and taskforce

The role of the recovery manager is to coordinate the recovery activities within the local authority (DHB) area with the local integrated recovery team and the social governance advisory group. To be able to perform the role, key competencies from health will be provided through the recovery taskforce members (Civil Defence Emergency Management: Competency Framework Role Map – Recovery Manager[1]).

The recovery manager ensures:

- planning, prioritisation, and management functions are undertaken
- effective reporting mechanisms are in place
- government is informed of local and regional issues
- recovery resources are identified and obtained as required
- information is provided on the impact of the event on the affected area
- emerging issues are identified and solutions sought.

3 Stakeholder Engagement

A crucial first step in the recovery phase is to *understand* the consequences of a crisis on groups and communities in order to meet the needs of communities. Understanding involves developing relationships, listening, gathering information and identifying needs. In the first instance, some groups are more prone to loss and suffering in the wake of crisis. Following the COVID-19 pandemic, such groups may include isolated older persons, newly unemployed and school students who have missed important educational achievements. It is important that vulnerable groups are identified and we

[1] Ministry of Civil Defence & Emergency Management. (2020). *Civil Defence Emergency Management: Competency Framework Role Map – Recovery Manager.* Author.

understand their needs early to ensure they have access to resources and support needed to facilitate their recovery.

In the second instance, understanding is about engaging with groups and communities to understand their short, medium and long-term needs, goals and aspirations, and continued engagement in planning and decision-making. This is an important means of empowering communities to manage their own recovery, and facilitate communities planning together for the 'next normal'. The dramatic nature of crises and the need to recover from its impacts, provides an opportunity to improve the sustainability of communities in a manner that rarely presents itself otherwise.

Therefore, the initial focus of the Whanganui DHB Recovery Health-taskforce is engaging with stakeholders and communities across the rohe.

To date, 20 interviews have been held with key strategic leads across the rohe, identifying opportunities resulting from the crisis. A survey has been widely distributed to understand the scope of organisational vulnerability across the region as well as identifying opportunities to improve the way we operate and deliver services. Focus groups are being planned with groups and communities to further understand needs and opportunities for health. Beyond this, stakeholder groups will continue to emerge as we listen to what is already occurring, build relationships, and draw on existing networks.

3.1 Initial indications - the local landscape

The COVID-19 pandemic has thrust upon us an extreme range of experiences, the impacts of which are being felt worldwide, including here in our Whanganui DHB rohe. As well as creating a global health crisis with widespread suffering and health service disruption, the pandemic is having far-reaching societal and economic impacts that will affect each and every one of us. It has upended people's lives, disrupted services and required social distancing that goes against what is inherently human.

However, alongside these challenges there have been numerous positives. Strong themes emerging from our engagement are that the crisis has accentuated and consolidated the existing strong networks across our rohe, and we saw a huge willingness for iwi and our communities to collaborate on difficult issues. These collaborative ways of working softened our collective experience of the crisis and contributed to our successful COVID-19 testing strategy. The crisis has also given space for a community ground-swell of initiatives and innovation, for example, the holistic pop-up clinics in remote communities, hundreds joining morning karakia, new ways of preparing food and social media use for positive outreach. Another positive was the 'black-market response of generosity', with numerous stories of the crisis drawing communities closer together, sharing and caring for friends, family and strangers alike, and businesses joining forces to help each other get through.

The willingness for transformation and community-led change is apparent, and Whanganui is the perfect incubator for community innovation and collective approaches. Our size supports initiatives to get off the ground relatively easily. We have innovators who are already moving. We attract people who think and live outside the box, creative-thinkers and environmental advocates. Our unique bi-cultural heritage provides a rich resource of wisdom and insight that informs collective leadership, and we have existing strong networks and collaborative ways of working that are the norm. We can also glean some indication of an appetite for change at a national health system level through the Governments recent priorities and actions in Health, and publications such as the Waitangi Tribunal's Hauora Report (Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry, Wai 2575) and the NZ health and disability review. The recovery health-taskforce recognise that the recovery approach will also require an understanding wider regional and national level directions and opportunities as well as local.

This community engagement and self-organised interaction has a vital role to play in the recovery. Important questions to ask are 'how do we keep the momentum of change?' And 'how do we make the most of this opportunity recovery presents us to us ensure our 'next normal' is a better normal for our communities?'

COVID-19

Integrated Recovery Strategy

Reset, Redesign - Recovery

Supporting Organisations

Whanganui Regional Health Network

National Hauora Coalition

WHANGANUI & PARTNERS

TE ORANGANUI

NEW ZEALAND POLICE Ngā Pirihimana o Aotearoa

MINISTRY OF SOCIAL DEVELOPMENT TE MANATŪ WHAKAHIATO ORA

MINISTRY OF HEALTH MANATŪ HAUORA

DOCUMENT CONTROL	
Authorised by:	Version Number: 1.0
Document Author	Health Recovery Taskforce
Health Recovery Manager	Louise Allsopp
Te Ranga Tupua	Gerard Albert
WDC Recovery Manager	Leighton Toy
Whanganui Civil Defence	Timothy Crowe
Ruapehu DC Recovery Manager	Warren Furner
Rangitikei DC Recovery Manager	Arno Benadie
Date Authorised: 25 May 2020	Next Review Date: 25 June 2020

Contents

Acronyms

The following acronyms are used in this document.

Acronym	Term
ARC	Aged Residential Care
CBAC	Community Based Assessment Centre
CEG	Chief Executive Group
CDEM	Civil Defence Emergency Management
CIMS	Coordinated Incident Management System
COVID-19	Novel strain of coronavirus
DC	District Council
DHB	District Health Board
ECC	Emergency Coordination Centre
NGO	Non-Government Organisation
RRT	Regional Recovery Team
RDP	Recovery Development Plan
SLG	Strategic Leadership Group
TAS	Technical Advisory Services
TLA	Territorial Local Authority
WDC	Whanganui District Council

Te Poari Hauora O Whanganui

1. Whanganui District Health Board Rohe

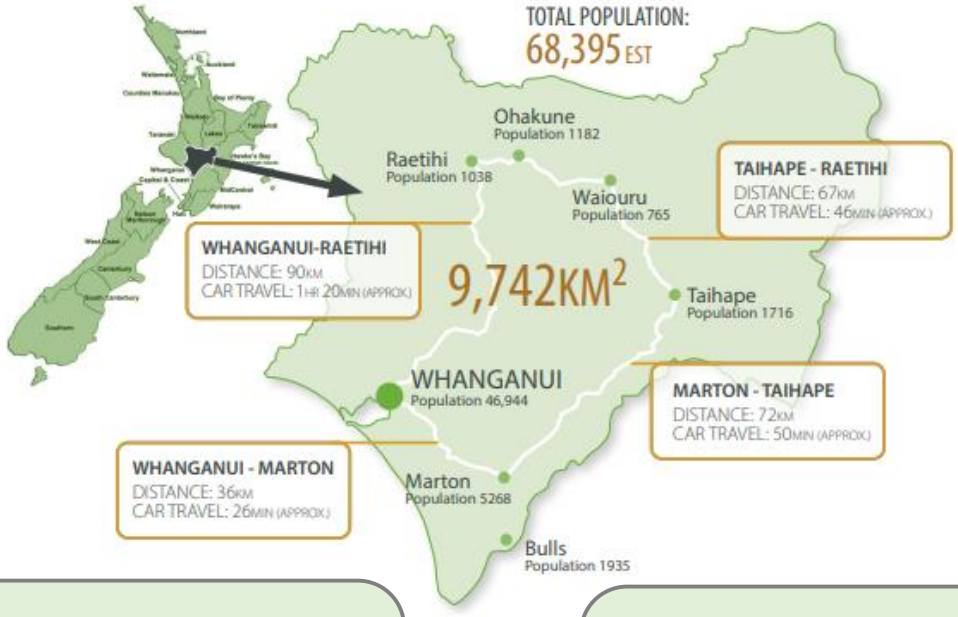
The Whanganui District Health Board rohe covers a total land area of 9742 square kilometres, much of which is sparsely populated. The terrain is mountainous with two major centres - Whanganui city with a population of 46,944 and Marton with a population of 5268. The major centres are supported by five smaller towns with a population less than 2000 - Waiouru 765, Taihape 1716, Bulls 1935, Ohakune 1182 and Raetihi 1038.

The population of Whanganui is characterised by a large percentage of Māori at 27 percent of our population (compared to the New Zealand average of 15.7 percent) and small but growing populations of Pasifika and Asian people at 4 and 5 percent respectively.

Compared to New Zealand's 19.6 percent, our district is home to a higher percentage of children and young people, with 20.2 percent under 15 years of age, of which 43 percent are of Māori ethnicity. This reflects the younger Māori population of our rohe compared to the rest of the country.

Whanganui has a higher than average population of older aged citizens – with 19.7 percent older than 65 years of age (compared to 15.4 percent for the rest of the country in 2018). As older people, like young people, are high healthcare users, this demographic change has significant implications for future provision of health services.

Population profile within the Whanganui DHB rohe



Iwi

- Whanganui
- Ngāti Rangi
- Ngāti Hauiti
- Ngāti Uenuku
- Ngāti Rauru Kītahi
- Mōkai Patea
- Ngāti Wairiki Ngāti Apa

Territorial Authority Partners

- Whanganui District Council
- Rangitikei District Council
- Ruapehu District Council

Whanganui Regional COVID-19 Recovery

2. Background

The impact of COVID-19 on New Zealand is far-reaching and profound. As at 25 May 2020, 1,504 people have contracted the virus and 21 people have died. Across the globe, over 5.38 million people have contracted the virus and over 344,000 people have died. Health systems have been overwhelmed in many countries and the economic impact is huge and unfolding. The global pandemic and the measures taken to control it have disrupted the lives of all New Zealanders. This has created the need to support the wellbeing of the whole population and also ensure we support and address the needs of those most severely impacted, whether that be health and wellness, socially or economically.

The COVID-19 pandemic has tested all aspects of New Zealand society, but with every emergency new opportunities are created. An emergency operations centre was opened on the 16th of March 2020 in response to the pandemic. As this response now moves towards recovery, an integrated Regional Recovery Team (RRT) has been established to lead the recovery phase of the COVID-19 pandemic. The intention is to plan for recovery from COVID-19 by thinking strategically about 'reset and re-design'. This is best achieved through key strategic leaders working collaboratively and planning together for the 'next normal'. Integrated planning, redesign and ultimately provision of services will provide our community with the best opportunity to increase its economic and social capital and wellbeing.

3. Who are the regional recovery team?

The RRT are a collective group of public service organisations across the Whanganui DHB rohe that were formed as a result of the response to the COVID 19 pandemic. The primary organisations that are represented are:

- Whanganui District Health Board
- Te Ranga Tupua
- Whanganui District Council
- Whanganui Civil Defence
- Ruapehu District Council
- Rangitikei District Council

These organisations are supported by representation from our iwi partners, Government liaisons, partners in care and public service partners. As we transition from the response phase into the recovery phase of the COVID-19 pandemic, this collective group of organisations have recommitted to working together to collectively enable and support thriving communities.

Working together, we can foster protective factors that build the resilience of whānau and communities and grow all communities with the Whanganui District Health Board rohe ability to strengthen their responses to distressing times.

He waka eke noa – We're all in this together.

Our Recovery – Reset, Redesign - Recovery

This document sets out the socially governed Reset, Redesign - Recovery strategy. It identifies the elements to our recovery and outlines the importance of working in an interconnected manner with our community partners in care. Through this, we will begin to address the wider social determinants of health which will lead to thriving communities.

4. Definitions

It is important that we clearly define the different stages for the Reset, Redesign - Recovery:

Reset: Reset is about acknowledging the services and systems that are in place and existing that are working well and are strategically aligned; enabling them to reset as quickly as possible.

Redesign: Redesign is about identifying opportunities to deliver services and systems differently. This may include redeveloping, redesigning or ceasing existing services, or developing and designing new services which are more aligned to our communities' needs. It is about working closely with our communities to identify their social, economic and health/wellness goals and aspirations, and supporting and enabling thriving communities.

Recovery: Recovery means the coordinated efforts and processes to bring about the immediate, medium and long term holistic regeneration and enhancement of our community following this COVID-19 pandemic. It is composite of all systems and services under Reset and Redesign. Recovery is about the community; the community is our future.

5. Enabling and supporting Thriving Communities

The regional recovery team understand that collectively we are required to enable and support our communities to live their healthiest lives possible in thriving communities. The arrangements for recovery, which we have called reset, redesign and recovery, involves the coordinated efforts and processes used to bring about the immediate, medium-term and long-term holistic regeneration and enhancement of our communities following this COVID-19 pandemic.

We recognise, however, that many of the influences on health and wellbeing are outside of the health sector. This strategy will only succeed with a shared vision for a thriving and equitable Whanganui DHB rohe and a willingness for collective action to support the communities we serve. The recovery team is committed to fostering and developing partnerships that aim to prevent and minimise the wide-reaching impacts that COVID-19 and related stressors may have on our physical, environmental, economic, health and mental and social wellbeing.

We will ensure our recovery team places people and their whānau at the centre of everything we do with and for them. We will support and empower individuals and whānau to determine their own wellbeing. We are committed to working in authentic partnership with other providers, iwi, government, social and community agencies to build strong, resilient, connected people and whānau.

As part of our commitment to Whānau Ora, we recognise that to achieve thriving communities, all people, regardless of income or social status, need to live in healthy homes and environments, where people feel safe, connected, resilient and able to determine their own needs and the needs of their whānau.

6. The Elements to Recovery

Three elements for recovery have been identified; economic, social and health. These are underpinned by our values and cultural and environmental foundations.

6.1. Economic

Economic recovery is about enabling and supporting individuals, organisations and industry to recover from the effects of the COVID-19 pandemic. It will support the protection of jobs, redeployment, incomes and businesses, bringing about a sustained period of improved business activity and opportunity within the Whanganui DHB rohe.

6.2. Health

Health recovery is about more than returning to the way that we delivered services pre-COVID. It is about learning from the experiences of our clinicians and communities during the pandemic. The way that we delivered services, utilised technologies and enabled rapid decision making throughout our response must continue to inform our reset and redesign strategy for our future health system.

6.3. Social

Social recovery focuses on ensuring that the social wellbeing needs of whānau and communities are met, and they are supported to recover, adapt and thrive despite challenges and disruption. Social recovery spans a wide range of both mental health and social interventions. This includes ensuring whānau and communities have clear information, basic needs and community connection, through to supporting the delivery of mental health services for people who have or develop significant mental distress, or social issues.

Our Recovery - Vision

The vision is the anchor point of this Reset, Redesign - Recovery strategy. It outlines where the Whanganui DHB rohe COVID-19 recovery is headed and how we will know when we get there. The vision focuses every goal and future actions in the strategy to ultimately contribute towards achieving thriving communities.

Kia tāea e te whānau me te hāpori i tōna ake tino rangatiratanga

Together we will support our region to build resilient communities, empowering whānau and individuals to determine their own wellbeing.

Our Recovery - Values

For this Reset, Redesign - Recovery strategy we will be led by the following collective values:

Aroha
The value of love, respect and empathy, demonstrating compassionate and non-judgemental relationships.

Kōtahitanga
The value of unity and vision sharing where we demonstrate trust and collaboration.

Manaakitanga
The value of respect, support and caring where we demonstrate doing our very best for others.

Tino Rangatiratanga
The value of self-determination where we empower individual/whānau choice.

Our Recovery - Principles

Our strategy is principles-based. Rather than a service or model, Reset, Redesign – Recovery is a way of thinking and working that is underpinned by six guiding principles which are built upon the Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Recovery Plan[1] :

1. People and whānau centred,
2. Community-led,
3. Uphold Te Tiriti o Waitangi,
4. Achieve pro-equity,
5. Protect human rights, and
6. Work together.

These principles guide five focus areas for action, which are to:

1. Collectively build the health, social and economic foundations for holistic wellbeing
2. Enable community-led solutions
3. Equip people to look after themselves, their whanau, hapu and communities
4. Strengthen social, economic and health supports in communities
5. Support community led services.

This strategy is intended to guide actions for the next 12–18 months, but we recognise that recovery and adapting to '*the next normal'* is likely to take several years. The strategy has been developed on an understanding that our response to recovery and actions must evolve to reflect emerging community needs and evidence, but that our overarching values and guiding principles will remain constant. Through these principles, we will ensure that we are working on the system and not 'in' the system. It is important that we continue to have links back to the Whanganui DHB Thriving Communities strategy and the three priority areas contained within it – Pro-Equity, 69,000 Beds and Social Governance. Each principle will clear identify the links and to which focus area.

7. Principles

7.1. Principle 1: People- and whānau- centred

DHB Focus Area Links – 69,000 Beds, Pro-Equity

Placing people at the centre means ensuring support is easily available and appropriate to each person's and whānau needs. It means listening to people of all age groups and different backgrounds and recognising whānau as a crucial part of the support network for family members experiencing challenges.

[1]Ministry of Health (2020). *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Recovery Plan*. Wellington: Ministry of Health.

Being people- and whānau- centred ensures that personal, whānau, community and cultural values are respected and integrated into how support and services designed and delivered.

How this principle will be demonstrated

- Ensure a range of actions that meets the needs of everyone, where people and families are equal partners in their physical, environmental, economic, health and mental and social wellbeing.
- Provide support appropriate to people's culture, age, background and circumstances.
- Protect from further harm and promote a sense of safety; self-efficacy; connectedness; calm and hope.
- Acknowledge and build on the strengths and assets of people and whānau.
- Adopt a Whānau Ora approach.

7.2. Principle 2: Community-led

DHB Focus Area Links – 69,000 Beds, Pro-Equity and Social Governance

Recovery is best achieved when communities can exercise a high degree of self-efficacy, self-determination, and agency. Communities have strengths, resourcefulness and already implement solutions to community needs. These solutions should be built on and supported to thrive.

Grass-roots approaches to identify needs is vital to understanding the reality of people's lives and meet their wellbeing needs. Supporting community-led approaches means applying bottom-up decision making and building on the social capital of communities.

There is an opportunity for support services to move to community-based delivery models, in which integrated services and supports are provided according to need and matched to population diversity.

How this principle will be demonstrated

- Promote strengths-based recovery, focused on prevention by enhancing protective factors and reducing risk factors (the wider social determinants of health).
- Create conditions for community-led solutions, eg, ensure communities guide decision-making.
- Build on the existing networks, self-determined communities and their strengths and social capital that are underpinned by trusting relationships.
- Encourage social cohesion, sense of belonging, wairua, and kotahitanga.

7.3. Principle 3: Uphold Te Tiriti O Waitangi

DHB Focus Area Links –Pro-Equity and Social Governance

The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal, underpin the Ministry's commitment to Te Tiriti and guide the actions outlined in this strategy. The principles that apply to work across the recovery are: – tino rangatiratanga, equitable outcomes, active protection, options and partnership. In responding to the pandemic, these principles need to be understood and upheld, to ensure Māori rights are recognised and the health and wellbeing of whānau, hapū, iwi and Māori communities is supported.

How this principle will be demonstrated

- Ensuring iwi, hapū, whānau and Māori organisations are supported to respond directly to the increasing health, social and economic needs of their people due to COVID-19.
- Enabling iwi, hapū, whānau and Māori organisations to utilise mātauranga Māori approaches in the design and delivery of appropriate services for their people in response to COVID-19[2].
- Adopt a holistic wellbeing approach that incorporates mental, physical, spiritual, whānau, and environmental wellbeing.
- Monitor delivery and outcomes for Māori and ensure accountability to whānau, hapū and iwi.
- Ensuring that local iwi and Māori representation and partnerships are at all levels of the Reset, Redesign – Recovery.

7.4. Principle 4: Achieve Pro-equity

DHB Focus Area Links – Pro-Equity and Social Governance

Equity recognises different people with different levels of advantage and experience require different approaches and resources to get equitable outcomes. We are going beyond the language of 'equity', to be 'pro-equity'. Differential access to power and decision making, resources, and service access and quality on the basis of social identity (eg, ethnicity, age, gender, disability) are key drivers of inequities.

All New Zealanders should experience the best support and care, regardless of where they live or who they are.

How this principle will be demonstrated

- Acknowledge the cumulative impact of pre-existing, historic and generational inequities.
- Show fairness and respect by directing resources and effort in a timely manner to populations and groups that most need it.
- Support tailored delivery to different groups to achieve equitable outcomes, eg, for Māori, Pacific, people with disabilities, children and young people, and older people.
- Empower disadvantaged groups to make their own decisions.
- Address institutional racism and discrimination in services and policy design.

7.5. Principle 5: Protect human rights

DHB Focus Area Links – 69,000 Beds, Pro-Equity

Human rights place responsibilities on government and others holding public power, and they also place responsibilities on individuals to their communities. The human rights values – partnership, participation, protection, safety, dignity, decency, fairness, freedom, equality, respect, wellbeing, community and responsibility – are central to implementing an effective, equitable and balanced way forward as we recover from COVID-19.

[2] Ministry of Health. 2020. *Initial COVID-19 Māori Response Action Plan*. Wellington: Ministry of Health.

How this principle will be demonstrated

- Ensure actions adhere to human rights values – partnership, participation, protection, safety, dignity, decency, fairness, freedom, equality, respect, wellbeing, community and responsibility.
- Abide by international conventions (Universal Declaration of Human Rights Convention on the Rights of Indigenous Peoples, Convention on the Rights of Persons with Disabilities, Convention on the Rights of the Child).

7.6. Principle 6: Work together

DHB Focus Area Links – 69,000 Beds, Pro-Equity and Social Governance

Strong leadership at all levels is at the heart of working together. Central and local government, DHBs, NGOs, community groups, rural communities, businesses, families, whānau, hapū and iwi all have leadership roles to play in responding to COVID-19 and supporting social, economic and health wellbeing for recovery. We are in this together. Issues led by different government agencies cannot be dealt with in isolation, as they are interlinked. Coordination, clarity of roles and governance, and communication are essential to achieve locally-relevant and effective responses, within a coherent national framework.

Lessons learned from previous local disasters highlight that pre-existing, established trusting relationships between and within agencies and communities are a protective factor and stabilising influence during psychosocial recovery.

How this principle will be demonstrated

- A shared vision, cooperative relationships and collaboration between government, DHBs, NGOs and communities in the ongoing planning and recovery.
- People, whānau and communities are empowered by all partners and stakeholders to recover, adapt and thrive.
- Stay connected, share information and keep checking activities are aligned.

8. Focus Areas

8.1. Focus Area 1: Collectively build the health, social and economic foundations for holistic wellbeing

Positive holistic wellbeing, healthy families and thriving communities cannot be achieved by the health sector alone. We are all shaped by our environments and circumstances. Income, employment, housing, education, recreation, social connection, cultural identity, safe and healthy relationships, and many other factors impact on our wellbeing (the social determinants of health). Negative impacts in these areas can have deep impacts on the health and wellbeing of individuals, hapū, whānau and communities.

This focus area is based on working together to ensure that whānau and communities have the resources they need to recover and adapt from this pandemic. We also want to support and create environments in which whānau and communities thrive. This includes supportive schools and workplaces that prioritise holistic wellbeing, green spaces in our neighbourhoods that are safe and accessible, affordable and connected housing and connection with marae and places of significance.

Initiatives that actively reduce the extent of harm caused directly or indirectly by COVID-19 and/or address the foundations on which holistic wellbeing is built are crucial for the COVID-19 recovery. Whānau and

communities which experience the most disadvantage and hardship will require particular attention. This will require joined-up policy-making and social governance as the issues impacting on people's lives are interlinked. The role of central and local government, iwi/hapū, NGOs and businesses are crucial to the success of this focus area.

8.2. Focus Area 2: Enable community-led solutions

Communities are the heart of recovery. Wellness often starts with family and friends. However, the networks and groups we belong to (such as marae, sport and recreation clubs, arts groups, playcentres, churches and peer support groups) play a vital role in helping us find a positive path through challenging times. These social connections are a key protective factor for the wellbeing of communities.

This strategy recognises that communities have a wealth of knowledge, skills and resourcefulness to support one another. However, sometimes additional support, resources or coordination is required for community solutions. Focus area two aims to strengthen community-led solutions. In particular, solutions led by iwi/hapū, community organisations, and people who live in our communities.

8.3. Focus Area 3: Equip people to look after themselves, their whānau, hapū and communities

Supporting people, whānau and communities to nurture and look after their own and each other's wellbeing can reduce the impact of stress on whānau, prevent and protect from developing long-lasting or more severe mental distress, and enhance overall wellbeing of communities.

This focus area recognises the need for promotion of public messages as well as access to evidence-informed self-help tools and educational resources. Design and delivery of tools, services, resources and messaging should be accessible and tailored to meet diverse needs, such as for older people, Māori, Pacific, young people, and people with disabilities.

8.4. Focus Area 4: Strengthen social, economic and health supports in communities

This focus area seeks to address the need to strengthen the social, economic and health/wellness supports in our communities.

An increased and diversified range of community identified services will be provided across the rohe. Good information will help people find support that works for them, and there will be clear links between services. There will be more choice of services and increased accessibility, where there is no right or wrong door – there is no door. People of different ages, ethnicities and identities will easily find support that is appropriate for them, no matter where they live. Kaupapa Māori services, designed by and for Māori, will be expanded.

Effective evaluation and workforce support will supplement this focus area. Services will be designed collaboratively, including input from our communities.

8.5. Focus Area 5: Support community led services.

Community led services are essential for the wellness of people living within our rohe.

The need for specialist social, economic and health/wellness services may increase over the COVID-19 recovery period. This will put pressure on these services, and some services will need to change the way they meet the needs of clients and whānau. More access and greater choice of services will be provided to people needing specialist services. This will involve determining how to best use alternative forms of

support if possible. It will require increased support from the regional recovery team to support community based services to provide to our population.

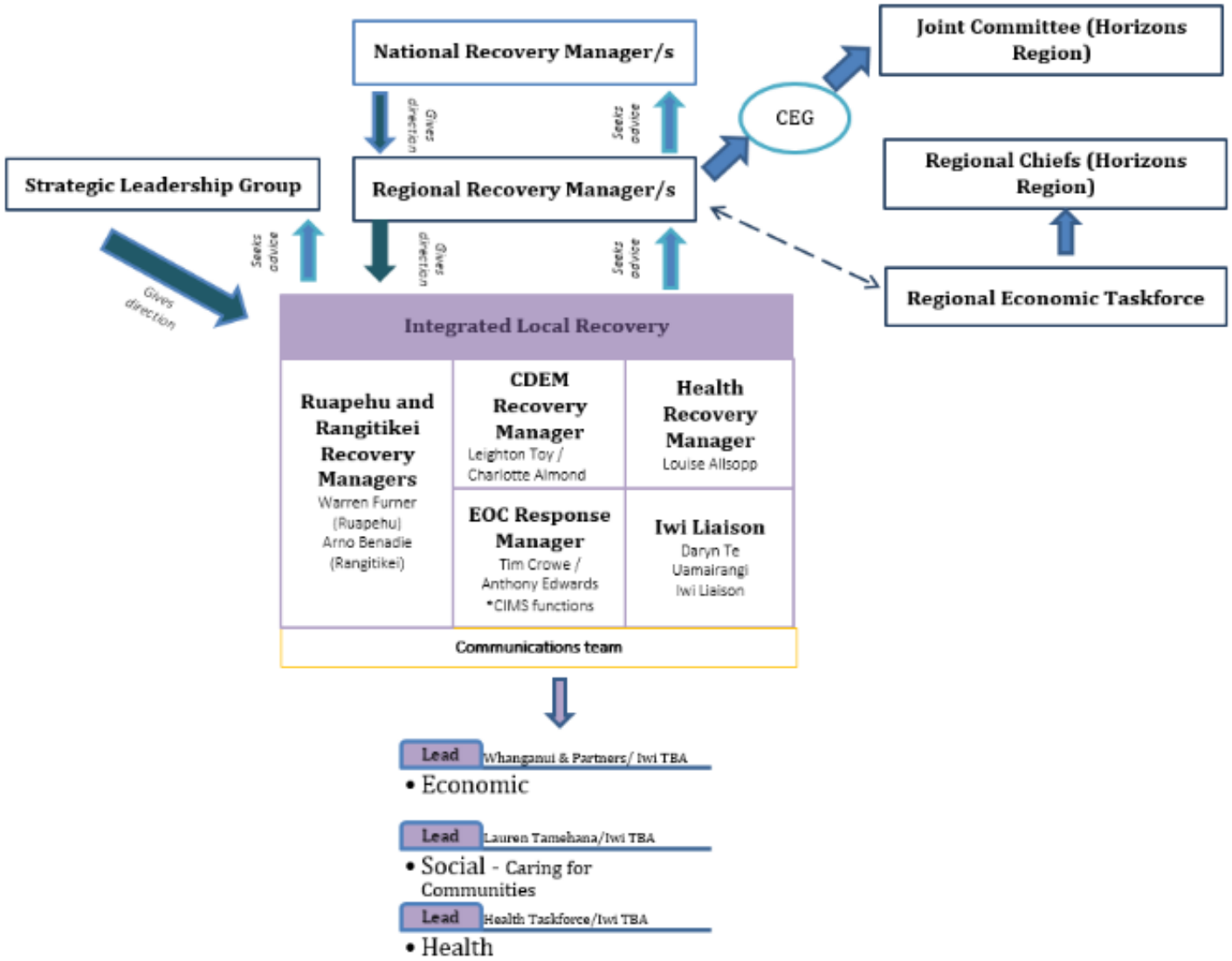
Decision-making to prioritise and implement changes in our services will continue to involve our communities and whānau.

Our Recovery – Social Governance Led

Leadership and direction will sit with a sub group of the Coordinated Executives Group (CEG) called the Strategic Leadership Group (SLG), including the WDHB and Territorial Local Authority (TLA) chief executives, mayors, board chair, local iwi representatives and the area police commander. Recovery Managers will also report through to their respective local, regional and national structures.

A social governance framework has been established to lead the reset, redesign and recovery implementation. The Regional Recovery Team (RRT) will foster a social governance led model to enable and support our communities to transition to the next normal post COVID-19.

9. Whanganui Regional Recovery Structure



10. Functions of the Regional Recovery Team (RRT)

The functions of the RRT shall be to:

- Ensure the timely and proper implementation and execution of an agreed Recovery to Development Plan (RDP),
- Conduct robust community engagement to inform the RDP and identify the actions that will support and enable thriving communities,
- Review options and business cases for all potential investments in the RDP and in so doing, the RRT will seek to incorporate all available evidence and where necessary commission research to inform its submissions to the SLG,
- Implement projects under the RDP to ensure that projects under the Plan are implemented in a manner that provides the greatest public value,
- Prepare and publish monthly progress and performance reports and submit same to the SLG,
- Provide policy advice, research, analysis and technical assistance to the SLG and other partners when requested,
- Monitor and report, including establishing performance monitoring framework, on individual project implementation and procurement,
- Coordinate and provide support and advice to technical advisors and contractors, and
- Recommend recovery timeframes for all activities.

11. RRT Powers

The RRT shall have all such powers as are reasonably necessary to enable it in the performance of its functions. This includes the power to request information, if it is the public interest.

12. Transparency and Accountability

For the RRT to be accountable to the people across the region requires the RRT to publish and distribute its information as widely as possible. It is the intention of the RRT to publish regularly on the WDC, Ruapehu DC, Rangitikei DC and WDHB websites and social media channels information pertaining to all recovery to development plans, policies and activities.

Engagement Strategy

13. Engagement

The Civil Defence Emergency Management (CDEM) Best Practice Guide to Community Engagement defines engagement as a process where people come together to participate in decision making on an issue that affects them and their community.

Engagement can be thought of as two-way communication, or an ongoing conversation between groups of stakeholders. The engagement 'conversation' can happen at a number of different levels, depending on the objectives of the engagement. Basic information sharing can be considered to be the lowest level of engagement as it requires the least amount of commitment from all parties. The highest level of engagement is a situation where final decision-making power is placed with the community. In terms of outcomes, high level engagement is the most effective because parties work in partnership with each other, but it is the hardest to achieve due to the time and effort required (CDEM).

In this plan, 'engagement' will be used to denote the full spectrum of engagement activities with stakeholders, whether individuals, groups or communities. 'Communities' may be communities of interest and communities of place. It is acknowledged that 'Māori' specifically will be a primary stakeholder and will therefore be engaged throughout the spectrum of engagement where 'stakeholder' is mentioned.

13.1. Principles of engagement

Community engagement plays a crucial role in creating resilient communities. The following principles are based on engaging early, being inclusive and thinking broadly.

Effective and genuine engagement supports relationships that are based on trust and confidence.

Engagement that is early, inclusive and broad will lead to the following:

- A greater understanding of one another's expectations and aspirations
- Increased opportunities to co-design processes and systems
- Increased opportunities to establish shared projects and programmes
- Improved process based on understanding of one another's priorities, expectations and available resources
- More efficient use of resources
- Supporting expectations and aspirations

If engagement is not early, inclusive or broad there may be reduced opportunities to develop meaningful future relationships and the development of effective policy options may be compromised. The effort and costs of engagement will be reduced if the Regional Recovery Team utilises its established networks and ongoing relationships with Māori through which ideas can be tested as part of our regular work routine.

13.2. Planning for Engagement

Before engaging members of the community and stakeholders it is important that a plan is in place prior to ensure that engagement is effective. Three steps to planning engagement as follows:

1. Know the community
2. Identify communities of interest
3. Develop an engagement programme in partnership with community leaders

Some key questions that should be considered in planning our engagement include:

- What are the key messages?
- Who can you talk to within your organisation (or in another agency) to determine the potential significance of your kaupapa?
- Are there legal requirements, Treaty settlement commitments or a policy/Ministerial directive driving your engagement?
- What relevance does this have in the social, cultural, economic and environmental sectors?
- Have you determined what Māori protocols may need to be organised and do you have the appropriate staff?
- How will Māori perceptions and expectations be identified and managed before, during and after engagement?
- How will stakeholder perceptions and expectations be identified and managed before, during and after engagement?
- How can we maximise this opportunity for involvement and meaningful engagement?
- Are you providing a range of opportunities for stakeholders to provide input in the circumstance they are not available to attend hui or meetings (ie. electronic feedback options)?
- Have you included resource to record the discussions at the engagement so you can disseminate this back to participants and inform your feedback/evaluation?

13.3. Who to engage with

Local
The issue affects stakeholders in a local area.
e.g. Individuals, Whānau, Hāpu, Iwi, and Local Providers

Regional
The issue affects stakeholders in a regional/central/lower North Island area.
e.g. Iwi organisations, Collectives, regional service providers, TAS, CentralAlliance

National
The issue affects stakeholders across Aotearoa/New Zealand
e.g. Government, national organisations dedicated to Social, Economic, Environmental or Cultural issues, or national providers.

For the Regional Recovery Team, we acknowledge that although the number of people that are required to be engaged with for National Issues is much larger, we are committed to imbedding the importance of local engagement to support the direction of our Reset, Redesign – Recovery work.

13.4. Method of Engagement

These methods of engagement provide a sliding scale assessment to help us consider the impact and engagement methods based on the IAP2 Public Participation Spectrum. There will be times where different methods of engagement are appropriate for different audiences and for different stages of our process, and we will remain open and flexible to these situations, engagement is not a one size fits all model. This is based on the Guidelines for engagement with Māori (Te Arawhiti, 2018) and has been tailored to fit all stakeholder engagement.

Table 1: The spectrum of engagement methods that are provided in the engagement framework:

Inform	The regional recovery team will keep stakeholders informed about what is happening. Stakeholders will be provided with balanced and objective information to assist them to understand the problem, alternatives, opportunities and/or solutions.
Consult	The regional recovery team will seek feedback on drafts and proposals, and will keep stakeholders informed, listen and acknowledge concerns and aspirations, and provide feedback on how their input influenced the decision.
Collaborate	The regional recovery team and stakeholders will work together to determine the issues/problems and develop solutions together that are reflected in proposals. The recovery team will involve stakeholders in the decision-making process but will ultimately decide.
Partner	The regional recovery team and stakeholders will partner to determine the issue/problem, to design the process and develop solutions. The regional recovery team and stakeholders will make joint decisions.
Empowerment for Māori	Māori will decide. The regional recovery team will implement the decision made by Māori.

13.5. Approach to Engagement

There is no blueprint approach for community engagement. Each community is unique, with its own characteristics, strengths, vulnerabilities, needs and aspirations. Communities and groups are affected by crisis in different ways and levels of severity.

No one person or group will know everything about their community. Therefore it is essential to identify key community representatives and leaders and utilise networks to ensure that different perspectives are gained to bring together a more complete picture.

Furthermore, issues can be complex, multi-faceted and overlap sectors/communities/services etc. It is important to think broadly and consider any intersects as early as possible in your planning - it is easy to remove interests once the process has started, but it is difficult to introduce interests once a process is underway.

The Regional Recovery Team will consider the most appropriate method of engaging with individuals, groups and communities. Choice of time and location will be determined by the stakeholders themselves, their communities and groups.

Our approach draws heavily on the Consumer Engagement Quality and Safety Marker (QSM) SURE Framework (Supporting, Understanding, Responding and Evaluating), seeking 'partnership & shared leadership' in each of the frameworks' three areas: Engagement; Responsiveness; and Experience.

Table 2: Consumer Engagement Quality and Safety Marker (QSM) SURE Framework

Area	What 'partnership & shared leadership' looks like
Engagement The environment created to support community engagement.	▪ Consumers are involved at all levels of the organisation: direct care, service delivery, policy, and governance. The representation and input reflect the broader population served (e.g. clubs and associations, educational institutions, cultural and social groups, churches and marae), and there is a transparent process for recruiting membership at all levels. Representation is equitable and covers a broader understanding of health care and the wider determinants of health. ▪ Equity is a well understood principle throughout the organisation and achieving equity for the population served is acted upon. ▪ The consumer council is well established, resourced, and regularly evaluated. ▪ Co-design is a method used and applied within the service. This means using co-design to improve the system for staff and consumers. ▪ The organisation encourages a diverse workforce through its recruitment strategy, reflecting the broader population served. Consumers are included on interview panels where appropriate. Equity is incorporated as part of the recruitment strategy.
Responsiveness Responding to and acting on what consumers are saying about the service and having	▪ There are established systems to a) capture and understand the experiences and views of consumers and whānau, b) respond to them, c) share the results and themes with participants and the wider organisation and, d) involve consumers as partners in any resulting improvement activity. These systems involve broad representation, and allow for diverse feedback (e.g. different cultures including Māori and Pacific, younger and older, different socioeconomic groups, LGBTQI+)

the right information at the right time for consumers accessing services.	▪ Community voices are brought to the attention of senior leaders within the organisation and always acted upon (i.e. the loop is closed). ▪ The input of the consumer council is heard, documented, and sufficiently linked to be acted upon. ▪ Most consumers and staff have the skills required to make sure consumers are involved in the development and implementation of services (e.g. co-design, listening, behavioural science). ▪ Everyone can find and access what they need, at the right time (e.g. websites are up-to-date and easy to follow, signage is clear for all groups). Every interaction builds understanding between patients, whānau, and staff and co-designed health education resources and information are used when needed to support understanding.
Experience The systems in place to capture consumer experience, and act upon the results.	▪ There are specific metrics in place to support the monitoring of patient experience surveys and patient feedback. ▪ These metrics are reported on and shared with relevant stakeholder groups, including consumers involved with the work. Reporting is timely, and feedback loops are closed. ▪ There are a range of options for consumers to provide feedback. (e.g. online, face-to-face, meeting). No matter what form the feedback takes it is acknowledged and responded to.

13.6. Communication strategy and key messages

A clear communications strategy will be developed with the Communications Team early and will contribute to the success of our engagement process. The communications strategy will include the key messages we intend to deliver to our audience that are tailored to suit the audience we are engaging with. Our key messages will acknowledge the value that stakeholder perspectives can bring to our kaupapa.

Included in our communications strategy will be the consideration of the relevant information that we are going to share with our audiences. This material will be developed with the Communications Team as early as possible so that it can be distributed to our audiences as early as possible so informed input can be provided.

Any engagement material that we produce will be easily accessible to our audiences, their accessibility to different forms of media will be considered. The form of communication used will be suitable for our audiences and we will always offer more than one way.

Finally, our strategy will include how we will manage any media interest in engagement.

14. Stakeholder Groups

Stakeholder groups across the Whanganui DHB rohe identified at this point in time as being important in terms of reset and redesign are as follows:

- Iwi
- Strategic leaders in the COVID-19 response (across health, economic and social)
- Health providers
- Social sector services

- Businesses and business sector groups
- Whanganui, Ruapehu and Rangitikei communities
- Te Manu Atatu
- Whanganui Chamber of Commerce
- Mainstreet Whanganui
- Tamaupoko River Valley Community Led Development
- Ruapehu Whanau Transformation
- Education providers

Each of these groups and communities have multiple groups within them. Furthermore, stakeholder groups will continue to emerge as we listen to what is already occurring in communities, build relationships, and draw on existing networks. Community engagement in particular will be through self-nominated groups/individuals therefore is not yet entirely known.

15. Government agencies

Central Government remain a critical partner for National and Regional recovery, with the following agencies identified that will provide support:

- Ministry of Business, Innovation and Employment
- Inland Revenue Department
- Ministry of Primary Industry
- Ministry of Social Development
- Department of Corrections
- Ministry of Education
- Te Arawhiti
- Oranga Tamariki
- Te Puni Kokiri
- Kaianga Ora

16. Iwi within the Whanganui Rohe

We are committed to meeting our obligations under Te Tiriti o Waitangi and therefore to ensuring iwi, hapū, whānau, and Māori communities and organisations are supported and active partners in preventing and addressing the potential impacts of COVID-19 and the response to it. This is crucial to realising the overall aim of Pae Ora (healthy futures for Māori) under He Korowai Oranga (the Māori Health Strategy).

- Te Ranga Tupua
- Iwi within the Whanganui DHB rohe
    - Whanganui
    - Ngāti Rangi
    - Ngāti Hauiti
    - Ngāti Uenuku
    - Ngāti Rauru KĪtahi
    - Mōkai Patea
    - Ngāti Wairiki Ngāti Apa
- Hapū
- Whānau

Note: There may be many organisations or groups that represent an iwi, for example there may be a rūnanga, a post settlement governance entity and/ or a mandated iwi organisation. In the first instance, we will talk to as many representative entities as possible. If the kaupapa is not relevant to one of them we expect that they will be able to tell us who we need to engage with. The Regional Recovery Team members may already have existing relationships with Māori stakeholders or a specific Māori advisory team who may be a good first point of contact. Treaty settlement commitments and/or statutory requirements may also require that we engage with particular people or groups - the Settlement Commitments Units will be able to advise whether there are settlement commitments.

Supporting Documents

17. National Documents

Health Quality and Safety Commission. (2019). *Consumer engagement quality and safety marker (QSM) SURE Framework*. Health Quality & Safety Commission.

International Association for Public Participation. (2018). *IAP2 Spectrum of Public Participation.* International Association for Public Participation.

Ministry of Health. (2008). *Guidance on Community-Based Assessment Centres and Other Support Services.* Wellington: Ministry of Health.

Ministry of Health. (2020). *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Recovery Plan.* Wellington: Ministry of Health.

New Zealand Government. (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.* Wellington, New Zealand.

Ministry of Health. (2020). *Initial COVID-19 Māori Response Action Plan.* Wellington: Ministry of Health.

Ministry of Civil Defence & Emergency Management. (2002). *CDEM Best practice guide: Community Engagement in the CDEM context.* Wellington: Ministry of Civil Defence & Emergency Management.

Ministry of Health. (2002). *He Korowai Oranga: Māori Health Strategy.* Wellington: Ministry of Health

New Zealand government Office for Maori Crown Relations (Te Aawhiti). *Guidelines for engagement with Māori.* Wellington: Te Arawhiti

18. Local Documents

Whanganui DHB. (2020). *Community Engagement Policy*. Whanganui: Whanganui DHB


WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui
HE AHA TE MEA NUI O TE AO
HE TANGATA, HE TANGATA
WHAT IS THE GREATEST THING IN THE WORLD
IT IS PEOPLE, IT IS PEOPLE
VISION
WHĀNAU ORA - EQUITY
THE PEOPLE - COMMUNITY
PAE ORA - HEALTHY FUTURES
MAURI ORA – HEALTHY INDIVIDUALS
WHĀNAU ORA – HEALTHY FAMILIES
WAI ORA – HEALTHY ENVIRONMENTS
2019
2020
2021
2022
2023
SOCIAL GOVERNANCE
EQUITABLE OUTCOMES
INTEGRATED CARE
WHĀNAU AND PERSON-CENTRED CARE
COLLABORATIVE LEADERSHIP & CROSS-AGENCY PARTNERING
INTEGRATED PROCESSES &TECHNOLOGY
CULTURE & PERFORMANCE
FINANCIAL STEWARDSHIP
STAKEHOLDER CRITERIA
IMMEDIATE HEALTH NEEDS MET
PATIENT SAFETY AND QUALITY OF CARE
THRIVING HEALTHY COMMUNITIES
STAFF ENGAGEMENT & WELLBEING
STAKEHOLDER TRUST AND CONFIDENCE
ALL UNDERPINNED BY THE
WDHB ORGANISATIONAL & WAKA VALUES

Author	Raju Gulab, Finance Manager
Endorsed by	Andrew McKinnon, General Manager Corporate
Subject	**Detailed financial report – April 2020**

Recommendations

That the Whanganui District Health Board:

1 **Receive** the report 'Detailed financial report – April 2020'.

2 **Note** the April 2020 monthly result of a $926k deficit is favourable to budget by $183k.

3 **Note** the year-to-date result of $10,404k deficit is unfavourable to budget by $113k.

Consolidated Statement of Financial Performance for the period ended 30 April 2020

	Month				Year to Date				Annual	Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2019-20	Actual 2018-19
Revenue	22,586	22,663	(77)	U	226,985	226,550	435	F	271,775	262,211
Revenue- COVID-19	287	-	287	F	1,542	-	1,542	F	-	-
Total Revenue	22,873	22,663	210	F	228,527	226,550	1,977	F	271,775	262,211
Less:										
Provider Health Service	(11,433)	(12,103)	670	F	(119,984)	(120,694)	710	F	(144,784)	(138,617)
Corporate Service	(56)	(111)	55	F	(1,209)	(1,494)	285	F	(1,716)	(300)
Governance	(66)	(79)	13	F	(713)	(807)	94	F	(961)	(718)
DHB Funder Division (exl IDF outflow)	(7,345)	(7,892)	547	F	(77,315)	(77,989)	674	F	(93,901)	(88,113)
Inter-district Outflow	(3,604)	(3,607)	3	F	(37,115)	(36,075)	(1,040)	U	(43,290)	(43,778)
ACC Contract (net)	10	20	(10)	U	207	218	(11)	U	280	317
COVID-19	(1,305)	-	(1,305)	U	(2,802)	-	(2,802)	U	-	-
Total expenditure	(23,799)	(23,772)	(27)	U	(238,931)	(236,841)	(2,090)	U	(284,372)	(271,209)
Net Surplus/(Deficit) after IDF net Flow	**(926)**	**(1,109)**	**183**	**F**	**(10,404)**	**(10,291)**	**(113)**	**U**	**(12,597)**	**(8,998)**
NoS Impairment	-	-	-		-	-	-		-	(1,048)
Holiday Pay Provision	-	-	-		-	-	-		-	(3,608)
One-off	-	-	-		-	-	-		-	(4,656)
Net Surplus / (Deficit)	**(926)**	**(1,109)**	**183**	**F**	**(10,404)**	**(10,291)**	**(113)**	**U**	**(12,597)**	**(13,654)**

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

Overview

Result for the month of April 2020 is favourable to budget by $183k.

- ***Revenue (Appendix 1)***
  Revenue is $77k unfavorable to budget due mainly to a decrease in ACC revenue and inter-district outflow revenue based on reduced activity. This decrease is partly offset by an increase bowel screening revenue, health workforce revenue and integrated primary mental health and addiction revenue, largely offset by corresponding expense.
- ***Revenue- COVID- 19 (Appendix 1)***
  Covid-19 related revenue $287k favourable is due to funding received from the Ministry of Health for GP based covid-19 assessments (offset by corresponding expense).

- ***Provider health service (Appendix 2)***
  Provider division is $670k favourable due to savings in clinical supplies as result of decreased activity in theater, wards, district nursing and dental relating to reducing services during Covid-19 level 4. These decreases were partly offset by higher nursing resources due to lower annual leave taken than budget and higher outsourced clinical service costs.

  Corporate service (Appendix 2)
  Corporate is $55k favourable due to lower non-clinical supplies and IT deprecation cost lower than budgeted due timing delay of IT equipment purchase and RHIP project.

- ***Governance***
  Governance is $13k favourable due to lower personnel costs through delays in recruitment and lower other operating expenses.

- ***DHB Funder division (exl IDF outflow) (Appendix 3)***
  Funder division is $547k favourable due to receiving a larger pharmaceutical rebate than expected, plus lower health of older people and aged residential and home based support costs. Also various other contracts were budgeted but no actual commitment to-date.

- ***Inter-district flows (Appendix 4)***
  Inter-district flows are in line with budget for the month.

- ***COVID -19***

  These Covid-19 costs of $1,305K are the direct incremental costs the WDHB has incurred in responding to Covid-19. They are reported on to the Ministry of Health. They do not include all the costs of all staff that were involved in responding to Covid-19 (i.e. do not include the hospital staff cost). The costs are made up of:
  - GP based assessments $265k
  - Clinical supplies $399k
  - Non-clinical and infrastructure $102k
  - Other $15k
  - Provider arm payroll costs for staff of $523k (requires further validation of true incremental cost increase as it includes payroll costs for staff who were sent home and were not required to work)

Year-to-date April 2020 result is unfavourable to budget by $113k

- ***Revenue (Appendix 1)***
  $435k favorable mainly due to additional revenue for funder division side contract (offset by corresponding expense), MECA settlement, bowel screening, cost recovery from other DHB, interest and patient consumables, partly offset by IDF inflow revenue.

- ***Revenue- COVID- 19 (Appendix 1)***
  $1,542k favourable- Ministry of health funding for CBAC establishment, GP sustainability funding, GP based assessments, primary response and virtual consolation and public health unit funding (offset by corresponding expense).

- ***Provider division (Appendix 2)***
  Provider division is $710k favourable due to savings in clinical supplies in theater, wards, district nursing and dental, and allied health vacancies. These were partly offset higher medical personnel, locums and nursing resource to meet patient demand.

- ***Corporate (Appendix 2)***
  Corporate is $285k favourable due to lower personnel costs (vacancies), increases in other income and a reduction in building insurance costs. These are partially offset by higher reactive building maintenance costs.

- ***Governance***
  Governance is $94k favourable due to lower personnel costs and other operating expenses.

- ***DHB Funder division (exl IDF outflow) (Appendix 3)***
  Funder division is $674k favourable due to a larger than expected pharmaceutical rebate in April, as well as lower health of older people, aged residential and home based support costs. Also various other contracts were budgeted but no actual commitment to-date. This was partly offset by personal health domiciliary and district nursing costs.

- ***Inter-district flows (Appendix 4)***
  Inter-district flows is $1,040k unfavourable to budget mainly due to significant increase in payments to Capital and Coast DHB of $1,086k (208 CWD higher than budget) related to high acute demand for cardiothoracic, vascular surgery and respiratory inpatient services. MidCentral DHB variance of $98k relates to acute demand for haematology, maternity inpatients and elective demand for the urology inpatient service. Favorable inter-district inflows for various DHBs resulted in a positive variance of $24k, as well as service changes and reduction in inter-district outflows giving rise to favourable variance of $120k.

- ***COVID -19 (Appendix 5)***
  These Covid-19 costs of $2,802K are the direct incremental costs the WDHB has incurred in responding to Covid-19. They are reported on to the Ministry of Health. They do not include all the costs of all staff that were involved in responding to Covid-19 (i.e. do not include the hospital staff cost). The costs are made up of:
  - CBAC establishment $439k
  - GP based easements $393k
  - Primary care response and virtual consultation $253k
  - Community pharmaceutical $232k
  - Public health unit funding $225k
  - Clinical supplies $570k
  - Non-clinical and infrastructure $135k
  - Other $21k

  Payroll cost (further validation of these cost required)
  - Incident management team and planning $5k
  - Provider arm service response $524k (includes payroll costs for some staff who were sent home and were not required to work)
  - Payroll, including overtime and additional leave.

1. Revenue- Appendix -1

	Month				Year to Date				Annual	Annual
$'000	Actual	Budget	Var		Actual	Budget	Var		Budget 2019–20	Actual 2018–19
Ministry of Health	21,853	21,580	273	F	216,508	215,743	765	F	258,783	248,274
Inter–district inflow	477	661	(184)	U	5,974	6,607	(633)	U	7,928	6,984
Other District Health Board (DHB)	41	44	(3)	U	488	458	30	F	549	653
Accident Compensation (ACC)	142	289	(147)	U	2,746	2,758	(12)	U	3,332	4,109
Other Government	–	3	(3)	U	124	108	16	F	147	269
Patient consumer sourced	32	25	7	F	333	247	86	F	298	359
Other income	41	61	(20)	U	812	631	181	F	738	1,563
COVID–19	287	–	287	F	1,542	–	1,542	F	–	–
Total revenue	22,873	22,663	210	F	228,527	226,552	1,975	F	271,775	262,211

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

Month comments

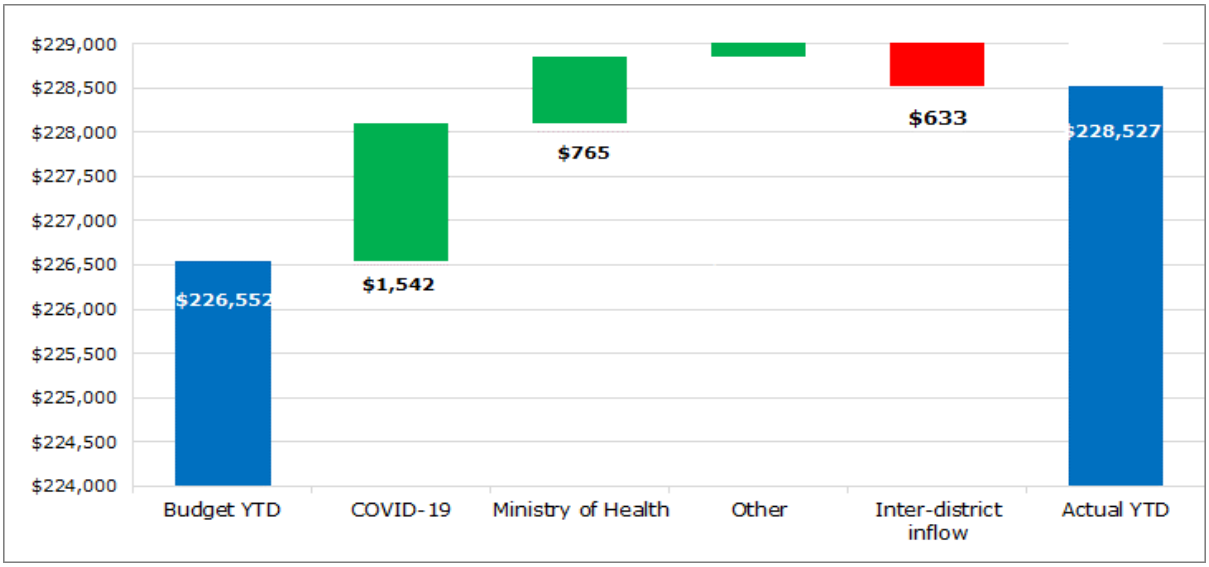
Ministry of Health
Revenue favourable to budget by $273k mainly due to timing of the bowel screening funding and integrated primary mental health and addiction service (offset by corresponding expense) and health workforce revenue.

Inter-district inflow
$184k unfavourable to budget due to unfavorable wash-up with various DHB and also impact of closure of theatre service due to COVID-19.

ACC Compensation (ACC)
$147k unfavourable to budget due to indirect impact of COVID-19 on radiology and non–acute inpatient rehabilitation, through reduced volumes.

COVID- 19
$287k favourable due to Ministry of Health funding for GP based easements.

Year-to-date comments



COVID- 19

$1,542k favourable due to Ministry of health funding for:

- CBAC establishment $439
- GP based easements $393
- Primary care response and virtual consultation $253
- Community pharmaceutical $232k
- Public health unit funding $225k

This revenue passes on to various community health providers.

Ministry of Health

Revenue favourable to budget by $765k due to:

- Addition revenue for funder division number of side contract (well child,B4 school, school base health, ,gateway assessment, pay equity etc.) largely offset by increased cost $265k
- New service establishment funding for pregnancy and parenting support , offset by cost $200k
- Youth AOD Exemplar services funding from income in advance $50k.
- Prior year one-off pay equity favourable wash-up $125k.
- Prior year one-off In-between-travel (IBT) favourable wash-up $114k.
- new contract for health activity learning, replaced Health promoting in school $32k

This is partly offset by

- Health workforce training revenue decrease of $21k, relating to lower uptake and also non-resident RMOs training not funded.

Inter-district inflow

$633k unfavourable to budget due to unfavorable wash-up with various DHB $394k and $239 relates additional IDF budgeted for Taranaki DHB not eventuate. Also the unfavourable variance reflects the impact of the closure of theatre services due to COVID-19.

Patient Consumer sourced

$86k favourable to budget due to revenue from an increase in non-resident patients and also an increase in dental and pharmaceutical co-payment.

Other Income

$181k favourable to budget due to:

- Ophthalmology staff cost recovery from other MidCentral DHB $54k,
- Flight nurses cost recovery for various DHB $47k (usage driven)
- Interest income due to better than plan cash position relates lower capital expenditure $43k.
- Number of various other income $37k.

2. Provider Health and Corporate Services - Appendix 2

	Month					Year to Date					Annual	Annual
	Actual	Budget	Variance			Actual	Budget	Variance			Budget 2019-20	Actual 2018-19
Expenditure												
Medical Personnel	2,123	2,154	31	F		18,687	20,467	1,780	F		24,714	22,080
Nursing Personnel	3,539	3,589	50	F		35,350	34,914	(436)	U		41,956	39,994
Allied Personnel	942	1,071	129	F		10,233	10,505	272	F		12,601	11,727
Support Personnel	72	82	10	F		765	805	40	F		965	852
Management & Admin Perseonnel	869	1,041	172	F		9,996	10,368	372	F		12,406	11,464
Total Personnel(Exl other & outsourced)	**7,545**	**7,937**	**392**	**F**		**75,031**	**77,059**	**2,028**	**F**		**92,642**	**86,117**
Personnel Other	143	158	15	F		2,046	2,107	61	F		2,560	2,319
Outsourced Medical Personnel	366	322	(44)	U		5,400	3,257	(2,143)	U		3,904	5,076
Outsourced Allied Personnel	59	51	(8)	U		565	512	(53)	U		611	610
Outsourced Manag & Admin Personnel	–	10	10	F		79	80	1	F		100	59
Total Personnel outsourced)	**568**	**541**	**(27)**	**U**		**8,090**	**5,956**	**(2,134)**	**U**		**7,175**	**8,064**
Total Personnel Expenditure	**8,113**	**8,478**	**365**	**F**		**83,121**	**83,015**	**(106)**	**U**		**99,817**	**94,181**
Outsourced Clinical Service	513	487	(26)	U		4,912	4,815	(97)	U		5,815	5,810
Clinical Supplies	953	1,374	421	F		13,439	14,464	1,025	F		17,348	16,564
Infrastructure & Non Clinical Supplies Costs	1,182	1,099	(83)	U		12,580	12,499	(81)	U		14,629	13,097
Capital Charge	217	217	–	F		2,314	2,315	1	F		2,749	3,521
Depreciation & Interest	483	530	47	F		4,546	4,803	257	F		5,882	5,428
Internal Allocation	28	29	1	F		281	277	(4)	U		260	316
Total Other Expenditure	**3,376**	**3,736**	**360**	**F**		**38,072**	**39,173**	**1,101**	**F**		**46,683**	**44,736**
Total Expenditure	**11,489**	**12,214**	**725**	**F**		**121,193**	**122,188**	**995**	**F**		**146,500**	**138,917**
NoS Impairment	–	–	–			–	–	–			–	1,048
Holiday pay provision	–	–	–			–	–	–			–	3,608
Total one-off	–	–	–			–	–	–			–	**4,656**
Total Expenditure	**11,489**	**12,214**	**725**	**F**		**121,193**	**122,188**	**995**	**F**		**146,500**	**143,573**
Expenditure												
Medical personnel and Locum	2,489	2,476	(13)	U		24,087	23,724	**(363)**	U		28,618	
Nursing Personnel	3,539	3,589	50	F		35,350	34,914	**(436)**	U		41,956	
Allied Personnel	1,001	1,122	121	F		10,798	11,017	**219**	F		13,212	
Othe Personnel costs	1,084	1,291	207	F		12,886	13,360	**474**	F		16,031	
Clinical Supplies	953	1,374	421	F		13,439	14,464	**1,025**	F		17,348	
Outsourced Clinical Service	513	487	(26)	U		4,912	4,815	**(97)**	U		5,815	
Other Costs	1,910	1,875	(35)	U		19,721	19,894	**173**	F		23,520	
									F			
Total Expenditure	**11,489**	**12,214**	**725**	**F**		**121,193**	**122,188**	**995**	**F**		**146,500**	–
FTEs												
Medical	113.6	110.2	(3.4)	U		102.4	112.4	10.0	F		112.5	112.3
Nursing	480.2	468.4	(11.9)	U		474.7	462.6	(12.1)	U		462.2	455.0
Allied	147.2	152.7	5.5	F		152.6	153.4	0.8	F		153.4	160.7
Support	15.5	16.8	1.3	F		15.9	16.8	0.9	F		16.8	16.0
Management & Admin	162.9	176.7	13.9	F		172.3	176.8	4.5	F		177.9	175.9
Total FTEs	**919**	**925**	**5**	**F**		**918**	**922**	**4**	**F**		**923**	**920**
Case Weighted Discharges												
Unplanned (Acute)	134	223	89	F	40%	1,962	2,267	305	F	13%	2,721	2,383
Planed (Elective & Arranged)	12	41	29	F	72%	484	522	38	F	7%	637	594
General Medecine	317	285	(32)	U	-11%	3,104	2,898	(206)	U	-7%	3,478	3,703
General Surgical	145	187	42	F	23%	2,106	2,061	(45)	U	-2%	2,488	2,595
Orthopedics	37	171	134	F	78%	1,551	1,973	422	F	21%	2,390	1,915
Gynaecolgy	5	24	19	F	77%	332	288	(44)	U	-15%	350	408
Total FTEs	**651**	**932**	**281**	**F**	**30%**	**9,539**	**10,009**	**470**	**F**	**5%**	**12,063**	**11,598**

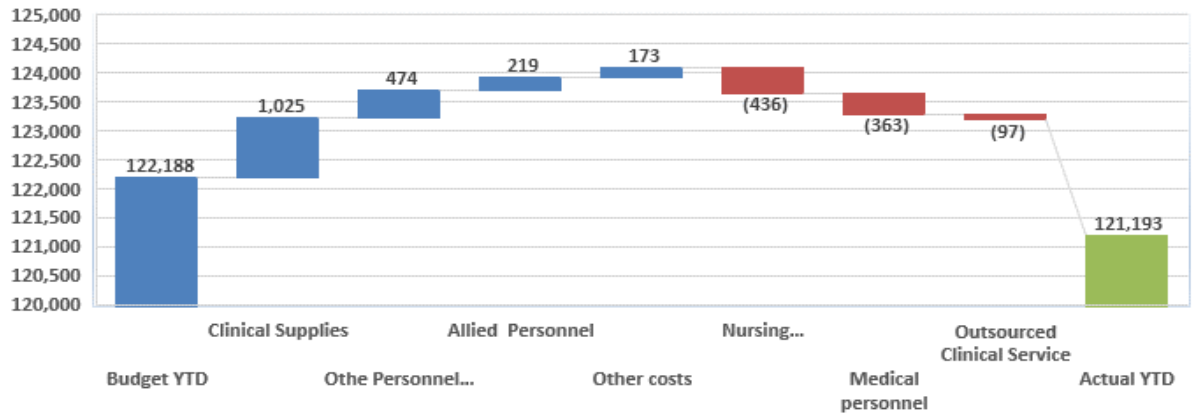
Month comments

Inpatient volumes were 69.9% to target in April 2020 with unplanned (acute) being 78.9% and planned (elective and arranged) being 38.2% of budget for the month. This is due to the WDHB reducing non-essential services (including, outpatients and elective surgery) in response to Covid-19 pandemic.

The overall expenditure for the month of April was $725k favourable to budget

- **Total personnel costs $365k favourable to budget** mainly due to payroll costs allocated to COVID-19 for staff who were sent home and were not required to work $399k, payment to casual employee $8k (further validation of true cost required)
- **Clinical supplies $421k favourable to budget** due to lower theatre consumables cost relates to lower activity, especially implant and prostheses.
- **Infrastructure and non-clinical supplies $83k unfavourable** due to reactive facility maintenance cost and additional license for Microsoft office 365.

Year-to-date comments



Inpatient volumes were 95.3% to target year to date with unplanned (acute) 96.4% and planned (elective and arranged) 92.3% of budget year-to-date.

The overall year-to-date expenditure $995k favourable to budget.

Total personnel costs $106k unfavourable to budget – mainly due to:

- **Medical personnel net unfavourable variance of $363k mainly due to use of locums to cover vacancies.** Unfavourable locum costs of $2,143k are partly offset by savings in payroll costs of $1,780k due to vacant positions not filled or parental leave. Locum costs made up of ophthalmology $259k, orthopaedics $21k, RMOs $295k, ED $473k, anaesthetics $338k, mental health $390k, gynaecology $484k, dental $48k and ENT $5k. This was partly offset by urology $170k.
- **Nursing personnel $436k unfavourable** due to high nursing costs in the Medical Ward, CCU, ED, Maternity Ward, ATR community service, community mental health, and patient safety unit. The staffing levels were particularly high at the beginning of the year, but the staff levels have been reviewed and proactive staff management practices have been implemented to better utilize staff.
- **Allied personnel costs $219k favourable mainly due to vacancies** in audiology, physiotherapy, Pharmacists, health promotion. Favourable payroll savings of $272k were partly offset by outsourced costs of $53k mainly orthotics and radiology locum.
- Support personnel $40k favourable.
- Management personnel had a net favourable variance of $273k mainly resulting from vacant positions not being filled.
- Personnel other costs were $61k favourable to budget mainly due to course and conferences not being attended as a result of COVID 19. These savings were partly offset by RMO recruitment costs, parental leave and gratuities.

- **Outsourced clinical and other services $97k unfavourable to budget** with radiology services $170k, ophthalmology $55k (offset by saving in personnel cost), medical and surgical terminations $90k, dental patient treatment $51k ($46k one-off) and laboratory $19k (offset by funder savings), these were partly offset rest home convalescence $203k (paid by funder), CCDHB infectious disease $15k, ECO service $30k and various other $21k.
- **Clinical supplies $1,025k favourable to budget** due to:
  - Theatre consumables $674k favourable mainly related to reduced orthopaedics volumes (overall volume 422 CWD lower than planned, planned volumes 65.3% and unplanned volumes $96.9% lower than target).
  - District nursing consumables $159k favourable mainly related to reduced treatment and disposables costs directly related to volumes (mainly dressings).
  - Ward consumables $115k favourable mainly related to lower pharmaceutical costs as a result of patient mix and COVID-19 impacted on wards activity.
  - Dental costs $37k favourable mainly related to dental consumables mainly due to COVID-19 impacted on activity of dental units

- Blood costs $148k favourable (demand and volume driven).

These favourable variances are partly offset by:

- Radiology $56k unfavourable mainly related to higher clinical equipment repairs and maintenance, minor purchases, IV supplies, repairs and maintenance.
- Patient travel $94k unfavourable (a higher number of transfers to Starship which are particular expensive).
- Orthotics and surgical footwear $72k unfavourable.

- **Infrastructure and non-clinical supplies $81k unfavourable to budget** due to facilities reactive building maintenance costs $106k, books and journals $75k, partly offset-by building insurance costs due to a change in the premium allocation method $78k and telecommunication and various other costs $22k.
- **Depreciation and interest favourable to budget by $257k**, deprecation $244k (mainly related to IT, buildings and clinical equipment, capital spend not occurring as quickly as budgeted) and interest $13k.

Case Weighted Discharges

Year to date case weighted discharges (CWD) are 5% lower than plan. Year to date 470 CWD lower than plan, out of 470 CWD, 441 (93.86%) favourable CWD attribute to March and April due to impact of COVID-19.

General medicine CWD 7% and Gynaecology CWD 15% higher than plan.

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

3. DHB Funder Division - Appendix 3

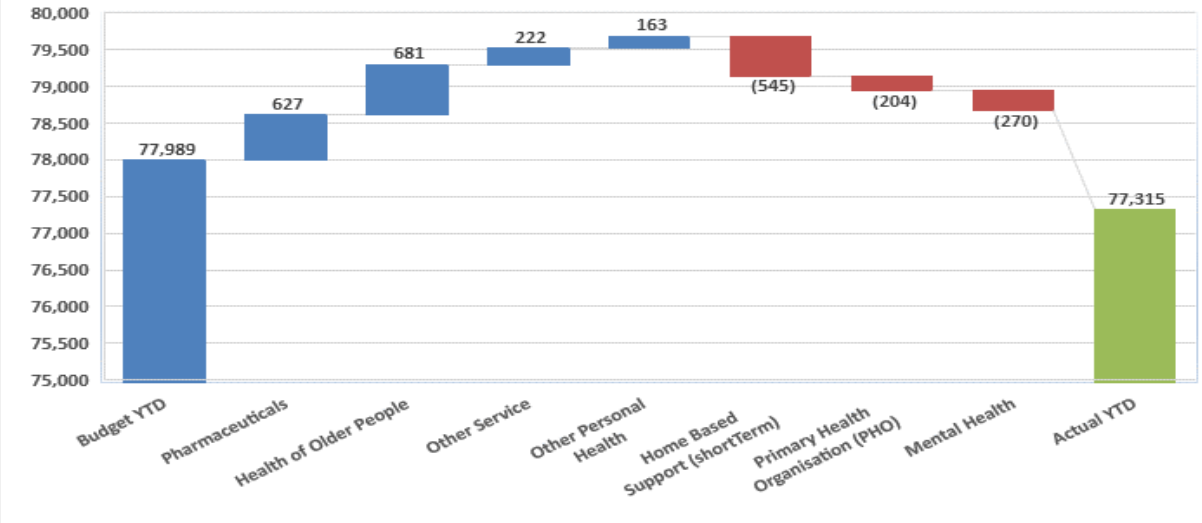
	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2019-20	Actual 2018-19
Expenditure by type										
Pharmaceuticals	1,038	1,404	366	F	13,646	14,273	627	F	17,140	15,986
Primary Health Organisation (PHO)	1,377	1,381	4	F	14,234	14,030	(204)	U	16,870	15,037
Home Based Support (short Term)	89	112	23	F	1,662	1,117	(545)	U	1,340	1,486
Other Personal Health	1,200	1,246	46	F	10,507	10,670	163	F	13,013	12,511
Health of Older People	2,465	2,557	92	F	25,152	25,833	681	F	31,013	29,118
Mental Health	857	750	(107)	U	7,748	7,478	(270)	U	8,978	8,882
Public Health	47	82	35	F	809	822	13	F	986	855
Maori Services	65	134	69	F	1,356	1,427	71	F	1,695	1,595
Total Other provider expenditure	**7,138**	**7,666**	**528**	**F**	**75,114**	**75,650**	**536**	**F**	**91,035**	**85,470**
Funding Admin	207	226	19	F	2,201	2,339	138	F	2,866	2,644
Total funder expenditure	**7,345**	**7,892**	**547**	**F**	**77,315**	**77,989**	**674**	**F**	**93,901**	**88,114**
Expenditure by service										
Personal Health	3,704	4,143	439	F	40,049	40,090	41	F	48,363	45,020
Health of Older People	2,465	2,557	92	F	25,152	25,833	681	F	31,013	29,118
Mental Health	857	750	(107)	U	7,748	7,478	(270)	U	8,978	8,882
Public Health	47	82	35	F	809	822	13	F	986	855
Maori Services	65	134	69	F	1,356	1,427	71	F	1,695	1,595
Funding Admin	207	226	19	F	2,201	2,339	138	F	2,866	2,643
Total Expenditure	**7,345**	**7,892**	**547**	**F**	**77,315**	**77,989**	**674**	**F**	**93,901**	**88,113**

Month comments

The overall expenditure for the month of April is $547k favourable to budget

- **Pharmaceuticals favourable to budget** is due to receiving a larger pharmaceutical rebate than budget and lower pharmaceuticals expenditure.
- **Health of older people favourable to budget** is due to lower demand of home based support.
- **Mental Health unfavourable to budget** is due to costs relating to integrated primary mental health and addiction service new contract, offset by equal amount of revenue

Year-to-date comments



The overall year-to-date expenditure is $674k favourable to budget.

- **Pharmaceuticals $627k favourable to budget -** due to receiving a larger pharmaceutical rebate than budgeted and lower than budgeted pharmaceuticals expenditure.
- **Primary Health Organization (PHO) $204k unfavorable to budget-** largely due to increased capitation first contact service payment which indicates increase in enrollment.
- **Home based support (short term) $545k unfavorable to budget -** largely due to increased demand in short term home based and community service support costs, offset by health of older people favorable variance.
- **Other personal health favorable to budget $163k -** largely due to general medicine subsidy (partly offset by PHO cost), and lower expenditure in surgical outpatient, palliative care and other expenditure.
- **Health of Order People $681k favourable to budget-** largely due to residential care service relating to demand, partly offset by short term home based support.
- **Mental Health $270k unfavourable to budget- -** largely due to two new service contract, integrated primary mental health and addiction service and pregnancy and parenting support service, offset by equal amount of funding.

4. Inter-district flows (IDFs) Appendix 4

	Month				Year to Date				Annual	Annual
	Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000		Budget 2019-20 $000	Actual 2018-19 $000
Expenditure										
Outflow inpatient	1,862	1,871	9	F	$19,870	$18,708	($ 1,162)	U	$22,450	$22,624
Outflow other	1,742	1,736	6	F	$17,245	$17,367	$122	F	$20,840	$21,154
Total Outflow	**3,604**	**3,607**	**6**	**F**	**37,115**	**36,075**	**(1,040)**	**U**	**43,290**	**43,778**

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

Year-to-date comments

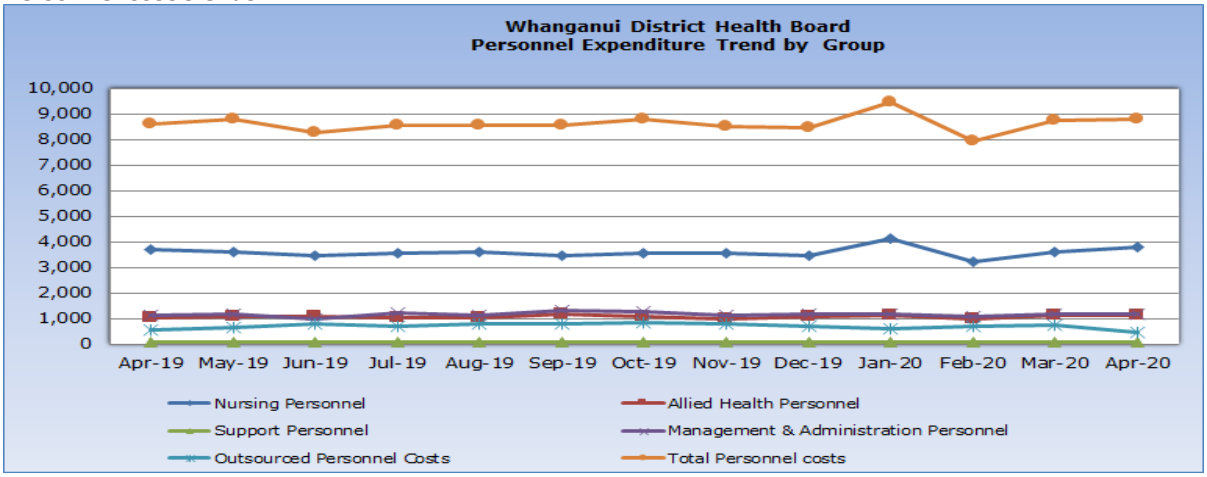
The overall year-to-date inflow IDF expenditure is $1,040k unfavourable to budget.

- Capital and Coast DHB unfavourable variance of $1,086k (208 CWD higher than budget). This is related to acute demand for cardiothoracic, vascular surgery and respiratory inpatient.
- MidCentral DHB unfavourable variance of $98k relates to acute demand for haematology, maternity inpatients and elective demand for urology inpatient services
- Reduction in inter-district outflows $235k.
  This is partly offset by
- Various DHB favourable inpatient wash-up $257k
- Other DHB favorable IDF $122k.

5. Other information Appendix 5

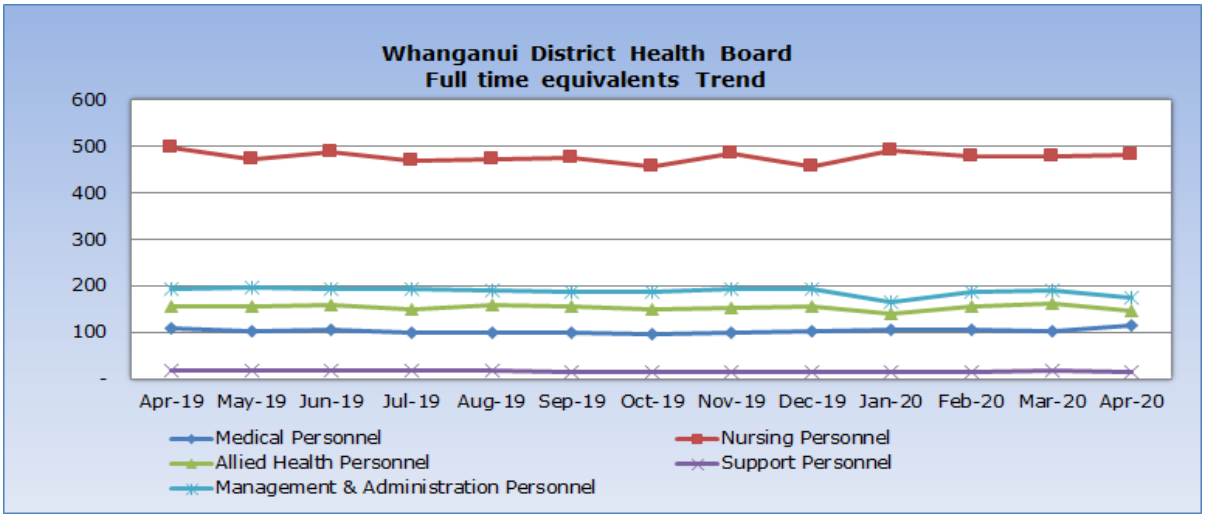
Supplementary information on costs

Personnel cost trends



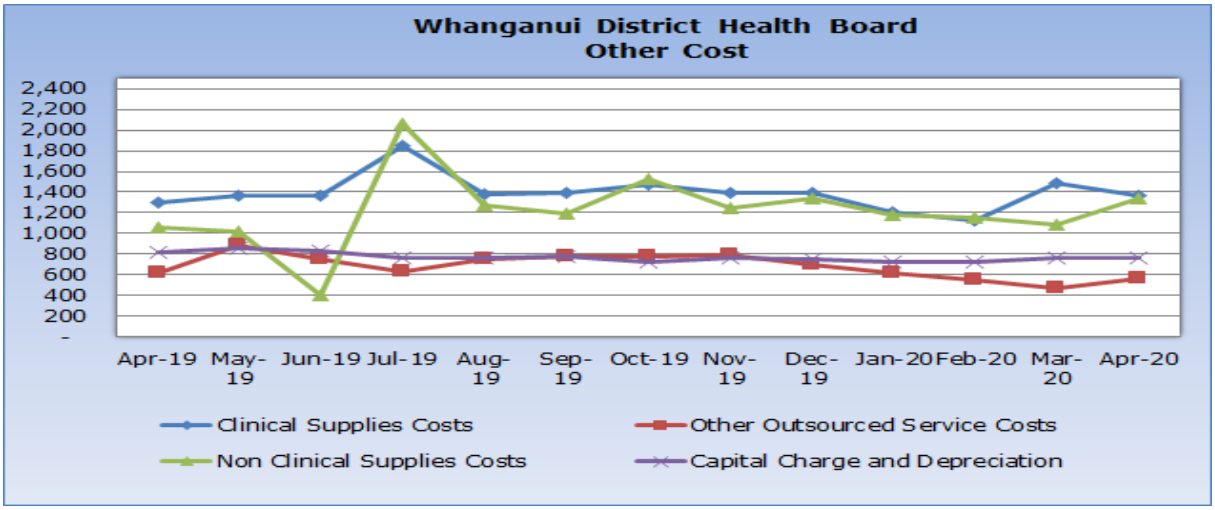
- Overall personnel cost upward trend in April reflects the impact of two statuary holiday compared to prior month and the effect of COVID 19.
- Outsourced personnel costs downward trend in April compared to prior month is due to mental health locum and ACC contract (Belverdale facility closed all of April due to COVID-19).

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 downward trend in April compared to the prior month is due to lower theatre consumables, district nursing and wards. These are partly offset by an increase in COVID 19 consumables.
- Non-clinical supplies upwards trend in April compared to the prior month is due to increased IT costs (MS office 365) and health workforce training cost (offset by corresponding revenue).
- Other outsourced service upward trend in April compared to prior month is due to increased radiology service costs.
- Capital charge and depreciation upward trend compared to prior month is due to the capitalisation of regional WEBPAS and radiology informative system.

Rolling trend of financial performance

Consolidated Statements of Financial Performance 12 Month Rolling ($000s)

	Apr-19	Apr-20	1 month Average	Last 12 Month Rolling Total	Budget 2019-20	12mth rolling total Vs Budget 2019-20		Actual 2018-19	Actual 2017-18
REVENUE									
MoH - Government And Crown Agency	22,479	22,828	22,929	275,150	274,598	552	F	263,822	251,767
Other Income Revenue	104	75	154	1,848	1,168	680	F	2,072	2,439
Total Revenue	**22,583**	**22,903**	**23,083**	**276,998**	**275,766**	**1,232**	**F**	**265,894**	**254,206**
EXPENDITURE									
Medical Personnel	2,063	2,176	1,998	23,973	26,334	(2,361)	U	23,598	22,100
Nursing Personnel	3,701	3,777	3,582	42,986	42,497	489	F	40,633	37,029
Allied Health Personnel	1,055	1,112	1,071	12,851	12,953	(102)	U	12,040	11,072
Support Personnel	85	83	78	935	969	(34)	U	855	726
Management & Administration Personnel	1,139	1,192	1,172	14,066	14,656	(590)	U	13,357	12,529
Outsourced Personnel Costs	563	454	718	8,611	6,145	2,466	F	7,123	7,115
Total Personnel Expenditure	**8,606**	**8,794**	**8,619**	**103,422**	**103,554**	**(132)**	**U**	**97,606**	**90,571**
				-					
Other Outsourced Service Costs	621	566	688	8,251	8,215	36	F	7,999	7,282
Clinical Supplies Costs	1,303	1,364	1,397	16,760	17,362	(602)	U	16,579	15,935
Infrastructure & Non Clinical Supplies Costs	1,052	1,341	1,233	14,794	15,483	(689)	U	13,628	13,636
Other Provider Payments	6,842	7,402	7,637	91,638	91,034	604	F	85,469	80,733
Inter-district-outflow	3,953	3,605	3,725	44,696	43,290	1,406	F	43,778	41,134
Total Other Expenditure	**13,771**	**14,278**	**14,678**	**176,139**	**175,384**	**755**	**F**	**167,453**	**158,720**
Net Surplus / (Deficit) before Int, Depr &	**206**	**(169)**	**(214)**	**(2,563)**	**(3,172)**	**1,855**	**F**	**835**	**4,915**
Capital Charges	353	273	305	3,665	3,535	130	F	4,401	4,357
Depreciation	464	484	461	5,534	5,858	(324)	U	5,432	4,737
Interest Costs	-	-	-	-	32	(32)	U	-	-
Total Interest Depreciation and Capital E	**817**	**757**	**767**	**9,199**	**9,425**	**(226)**	**U**	**9,833**	**9,094**
Total Expenditure	**23,194**	**23,829**	**24,063**	**288,760**	**288,363**	**397**	**F**	**274,892**	**258,385**
Net Surplus/ (Deficit)	**(611)**	**(926)**	**(980)**	**(11,762)**	**(12,597)**	**835**	**F**	**(8,998)**	**(4,179)**
NOS impairment	-	-	-	-	-	-	F	1,048	-
Holiday pay provision	-	-	-	-	-	-	F	3,608	-
Total One-off	**-**	**-**	**-**	**-**	**-**	**-**	**F**	**4,656**	**-**
Net Surplus/ (Deficit)	**(611)**	**(926)**	**(980)**	**(11,762)**	**(12,597)**	**835**	**F**	**(13,654)**	**(4,179)**

The 12-month rolling average of $11.8 million looks better than when compared to the 2019/20 budget of $12.6 million. The rolling average does not reflect price increases and MECA increases during the year, or increased demand expenditure and inter-district outflows.

6. Statement of financial position

	Actual 2019 $000	Actual 2020 $000	Budget 2020 $000	Varinace to Budget	Annaul Budget 2019 $000
Assets					
Current assets					
Cash and cash equivalents	3,020	489	5	484	5
Receivables & Prepayments	6,290	9,218	6,581	2,637	6,914
Investments	–	–	–	–	–
Inventories	1,427	1,555	1,437	118	1,437
Trust /special funds	181	184	180	4	180
Patient and restricted trust funds	4	3	4	(1)	4
Total current assets	**10,922**	**11,449**	**8,207**	**3,242**	**8,540**
Non current assets					
Property, plant and equipment	75,230	73,280	76,148	(2,868)	76,138
Intangible assets	11,777	11,651	12,384	(733)	12,366
Investments in associates	1,146	1,077	1,146	(69)	1,171
Total non current assets	**88,153**	**86,008**	**89,678**	**(3,670)**	**89,675**
Total assets	**99,075**	**97,457**	**97,885**	**(428)**	**98,215**
Liabilities					
Current liabilities					
Bank Overdraft	–	–	(4,761)	4,761	(6,918)
Payables	(18,234)	(19,392)	(16,928)	(2,464)	(15,904)
Borrowings	(230)	(232)	(232)	–	(198)
Employee entitlements	(16,713)	(17,501)	(16,522)	(979)	(18,181)
Provisions	–	–	–	–	–
Total current liabilities	**(35,177)**	**(37,125)**	**(38,443)**	**1,318**	**(41,201)**
Non-current liabilities					
Borrowings	(684)	(502)	(501)	(1)	(486)
Employee entitlements	(873)	(889)	(892)	3	(942)
Total non current liabilities	**(1,557)**	**(1,391)**	**(1,393)**	**2**	**(1,428)**
Total liabilities	**(36,734)**	**(38,516)**	**(39,836)**	**1,320**	**(42,629)**
Net assets	**62,341**	**58,941**	**58,049**	**892**	**55,586**
Equity					
Contributed Capital	(105,567)	(112,567)	(111,567)	(1,000)	(111,409)
Accumulated surplus / (deficit)	67,287	77,694	77,579	115	79,884
Property revaluation reserves	(23,881)	(23,881)	(23,881)	–	(23,881)
Hospital special funds	(180)	(187)	(180)	(7)	(180)
Total equity	**(62,341)**	**(58,941)**	**(58,049)**	**(892)**	**(55,586)**

Current asset increased by $3,242k compared to budget mainly in receivables and prepayment variance reflect difference mainly due to the Ministry of Health outstanding payment, Pharmac rebate, pay-equity, in-between travel (IBT) and various other.

Non-current asset decreased by $3,670k compared to budget due to Capital expenditure Programme running behind schedule, mainly clinical equipment, facility IT and RHIP.

Current liabilities decreased by $1,318k compared to budget due to Bank over draft better than budget due to Capital expenditure Programme running behind schedule, partly offset by increased in payables relates to IDF wash-up provision and funder demand driven expenditure and employee leave entitlements impact of staff not taking annual leave due to COVID -19 and timing accruals.

Equity increased by $892k compared to budget due to receipt of additional $1m deficit support (budgeted $6m and received $7m)

7. Cash Flow

Consolidated Summary Statement of Cash Flows for the period ended 30 Apr 2020 ($000)

	Actual 2017–18	Actual 2018–19	Actual YTD 2019–20	Budget YTD 2019–20	Variance	
Net surplus / (deficit) for year	(4,179)	(13,654)	(10,404)	(10,292)	(112)	U
Add back non–cash items						
Depreciation and assets written off on PPE	4,720	**5,417**	4,545	4,796	(251)	U
Revaluation losses on PPE	–	–	–	–	–	F
Total non cash movements	**4,720**	**5,417**	**4,545**	**4,796**	**(251)**	**U**
Add back items classified as investment Activity						
(loss) / gAmn on sale of PPE	16	15	5	–	5	F
Profit from associates	(129)	(95)	–	–	–	F
GAmn on sale of investments				–	–	F
Write–down on initial recognition of financial asset	83	1,048	–			
Movements in accounts payable attributes to Ca	64	268	102	144	(42)	U
Total Items classified as investment Activity	**34**	**1,236**	**107**	**144**	**(37)**	**U**
Movements in working capital						
Increase / (decrease) in trade and other payables	**(873)**	**4,312**	**1,158**	(1,306)	2,464	F
Increase / (decrease) employee entitlements	**2,112**	**3,907**	**804**	(172)	976	F
				–	–	F
(Increase) / decrease in trade and other receivable	(1,091)	2,555	(2,928)	(291)	(2,637)	U
(Increase) / decrease in inventories	(85)	(15)	(128)	(10)	(118)	U
Increase / (decrease) in provision	–	–	–	–	–	F
Net movement in working capital	**63**	**10,759**	**(1,094)**	**(1,779)**	**685**	**F**
Net cash inflow / (outflow) form operating activ	**638**	**3,758**	**(6,846)**	**(7,131)**	**285**	**F**
	–	–	–	–		
Net cash flow from Investing (capex)	(6,402)	(4,572)	(2,576)	(6,465)	3,889	F
Net cash flow from Investing (Other)	(7)	(65)	71	1	70	F
Net cash flow from Financing	(351)	(385)	(180)	(181)	1	F
Net cash flow from deficit support	–	–	7,000	6,000		
Net cash flow	(6,122)	(1,264)	(2,531)	(7,776)	5,245	F
Net cash (Opening)	10,406	4,284	3,020	3,020	–	F
Cash (Closing)	**4,284**	**3,020**	489	**(4,756)**	**5,245**	**F**

Closing cash is better than budget due to Capital expenditure Programme running behind schedule and received additional $1m deficit support

Andrew McKinnon
General Manager Corporate

Xxx May 2020

Colour coding description	**Strong positive impact with high probability that gain can be extrapolated**
	One-off impact – trend uncertain
	Neutral
	Strong negative impact with high probability that loss can be extrapolated

June 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No 5.2
Author	Hentie Cilliers, Manager People and Culture
Endorsed by	Andrew McKinnon, General Manager Corporate Services
Subject	Pay Restraint in the Public Service

RECOMMENDATIONS

Management recommend that the Whanganui District Health Board:

a. **Receives** the paper

b. **Notes** that all executive leaders will forego remuneration reviews until June 2021

c. **Notes** that DHB GM Human Resources have requested further guidance on pay restraint from State Services Commission to ensure our alignment

d. **Notes** that staff employed on an individual employment agreement (IEA) will comply with the guidance and principles for pay restraint

1. PAY RESTRAINT

1.1 Background

Following the Prime Minister's announcement of a pay reduction for senior leaders in Government and the Public Service, Cabinet has agreed that visible pay restraint in the public sector is an appropriate response to the COVID-19 context.

The Prime Minister and Ministers are taking a 20 percent pay reduction for six months. Public Service chief executives are voluntarily agreeing to the same reduction, as well as agreeing to forego any remuneration reviews that might usually occur before 30 June 2021.

The State Service Commissioner encouraged chief executives to consider taking a similar reduction to their colleagues in the Public Service and provided guidance for a nil remuneration increase for chief executive remuneration reviews due from now until 30 June 2021.

1.2 Impact on Chief Executives and Board Chairs

The DHB Chairs have agreed to a proposal from all the Chief Executives to cut their remuneration by 20 percent for the next three months, as well as forgoing any pay increases until 2021.

The Chairs of the DHBs have also chosen to take a 20 percent reduction in all fees and payments for their Board work.

1.3 Impact on workforce

The State Service Commissioner provided Public Service chief executives with the following key principles on how to apply pay restraint for their workforces:

- the voluntary pay reductions agreed by chief executives will not be extended beyond the chief executive level
- the approach to restraint applies through to June 2021
- retaining people in jobs is a priority
- no pay increases for senior leaders and higher paid staff and no or minimal increases below that level
- current employment agreement obligations to be complied with where they require an increase to pay
- any discretionary provisions should be operated to target low paid and frontline roles, and continue to address gender and ethnic pay inequities
- exceptional and urgent recruitment and retention pressures may need to be addressed
- outcomes across individual employment agreements and collective agreements covering the same roles should be equitable.

The following actions are underway in support of the guidance and key principles provided:

- WDHB executive leaders will forego any remuneration reviews for the 2020/21 financial year
- the 20 DHB's General Managers Human Resources have requested further guidance regarding pay restraint from the State Services Commission to guide alignment
- the 2020/21 WDHB remuneration strategy for staff employed on an individual employment agreement (IEA) will comply with the guidance and principles for pay restraint.

June 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information paper**
	Item 5.3
Author	Glenys Fitzpatrick, Health and Safety Advisor, Patient Safety, Quality and Innovation
Endorsed by	Louise Allsopp, General Manager, Patient Safety, Quality and Innovation
Subject	**Health and safety update**

Recommendations

Management recommend that the board:

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

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

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

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

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

1 Purpose

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

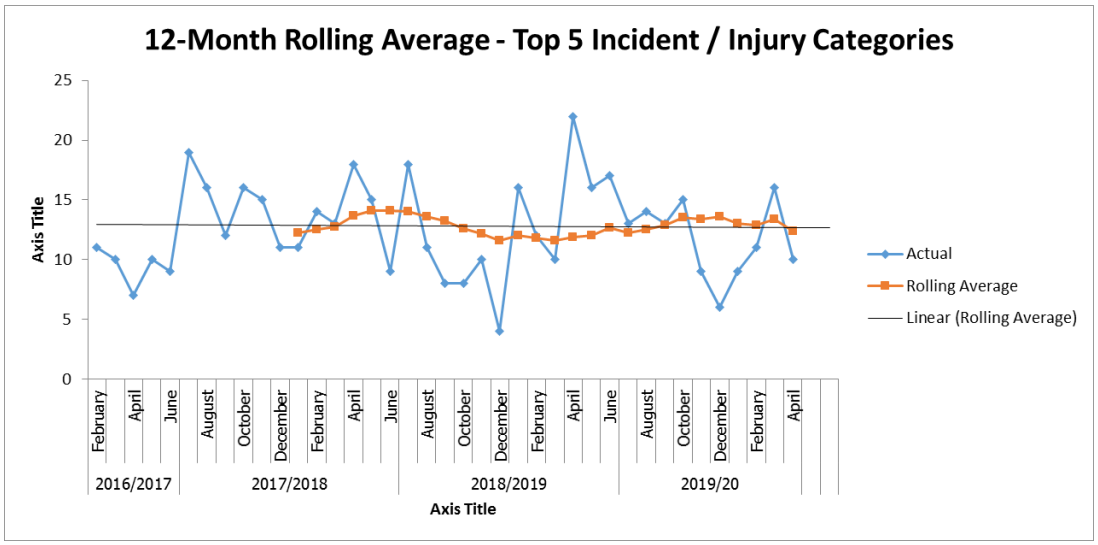
- incident/injury trends.
- incident/injury details.
- employee participation.
- contractor management.

2 Incident/injury trends

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

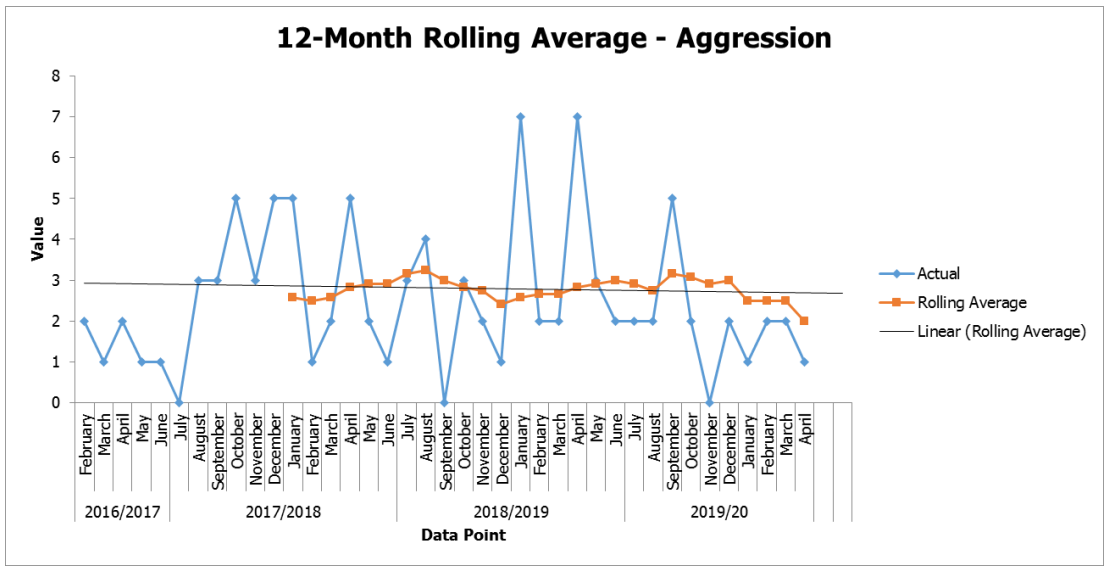
The trend line (based on the rolling average) indicates a slight decline in the overall number of incidents/injuries (top five) over the three year period.

June 2020 **Public**



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

Aggression



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

During February, March and April 2020 there were five physical aggression injuries/incidents – Te Awhina (4) and Medical Ward (1).

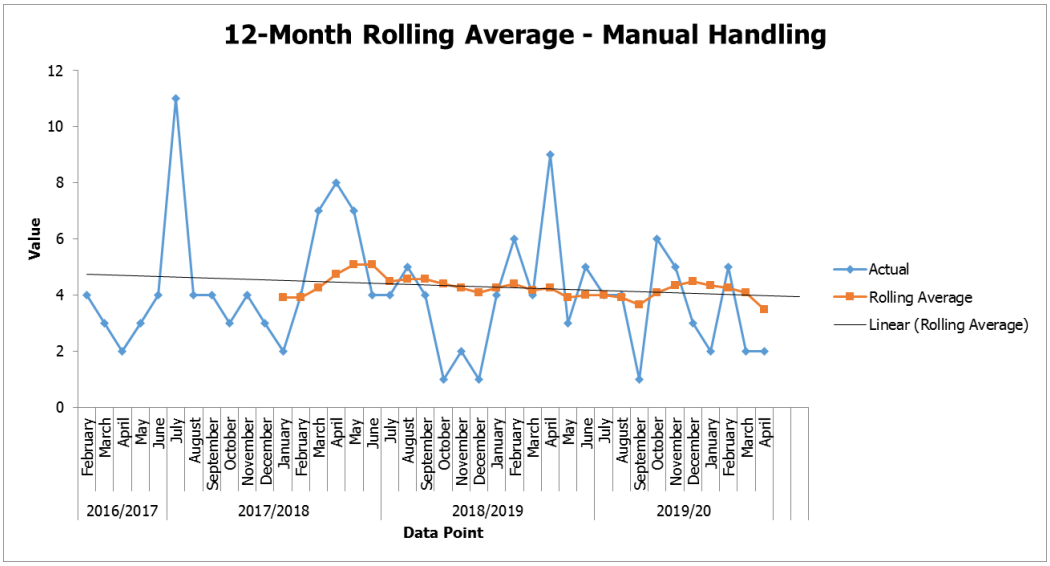
Improved risk mitigations include:

- All police staff who come to assist with aggressive patients are informed of the total plan. This ensures that everyone is on the same page.
- Commenced "hub" nursing to ensure the patients in intensive care areas are better covered with a team of staff.

- Trying to have consistency with the same staff caring for the same person for a few days in a row.
- This ensures the patient has the appropriate number of staff caring for them and there is cover for breaks

- Huddles continue throughout the day to manage the workload, picking up changes of the patient and to ensure better communication
- Broset scoring continues

Manual handling



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

During February, March and April 2020, there were three patient (Radiology (2) and Surgical) and six object related manual handling injuries in Therapies, Health Records, Lambie, Surgical, Outpatients and Waimarino.

Issues identified:

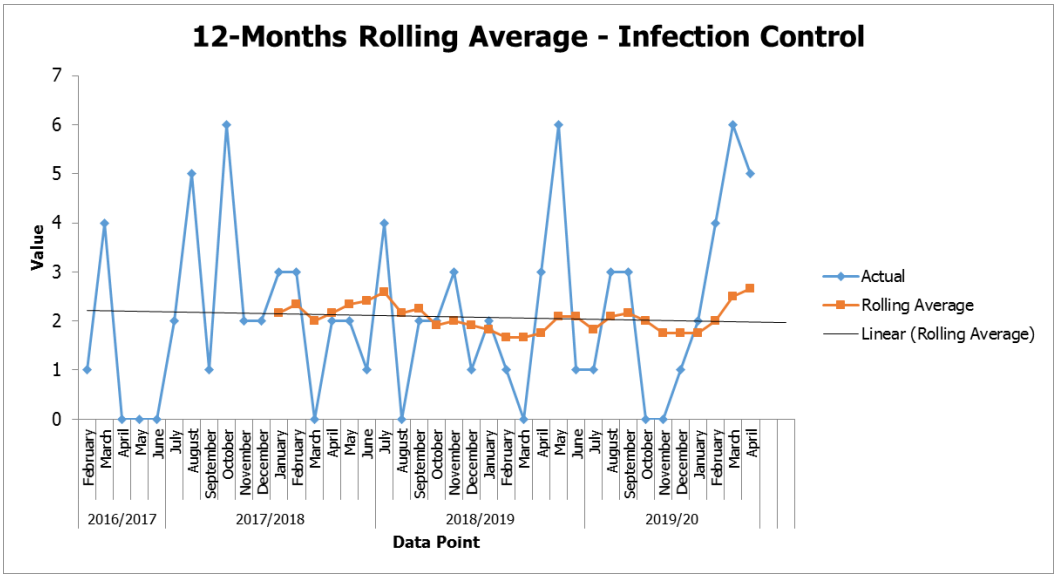
- Lack of communication and critical thinking between staff
- Lack of suitable equipment and insufficient staff during patient transfer
- Run out of storage space due being unable to carry out destruction. Archivist has placed a moratorium on destruction of medical records

Improved risk mitigations include:

- Book staff onto manual handling training to refresh knowledge
- Debriefing and one on one conversation with staff involved in the incidents
- Staff on return to work plans to wear a badge to let their colleagues know and be aware of restrictions
- Reminder at monthly staff meetings

June 2020 **Public**

Infection prevention



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

During February, March and April 2020 there were fifteen infection control (needle-stick and blood body fluid splash) incidents.

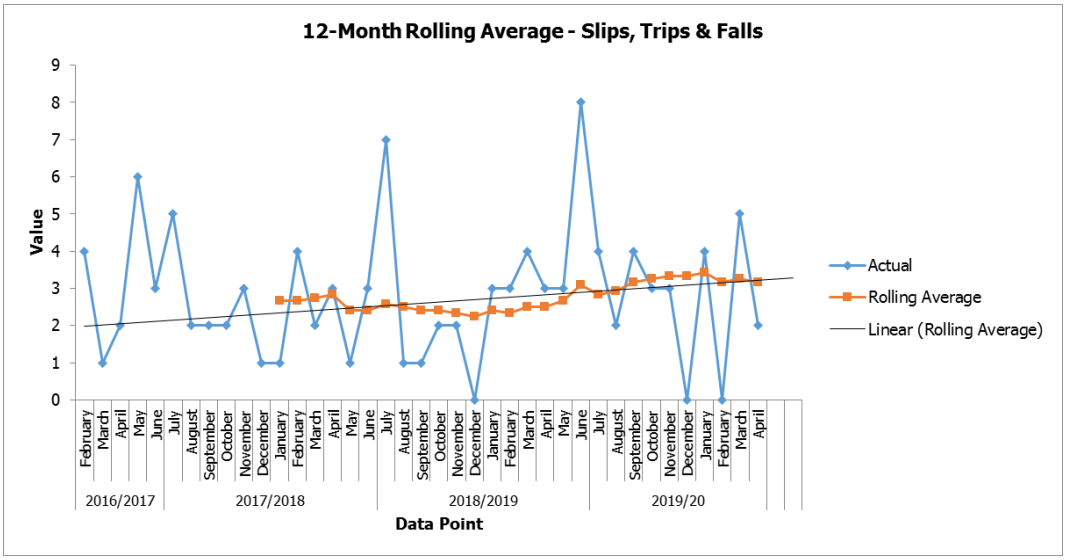
Issues identified:

- Staff members not wearing appropriate personal protective equipment.
- Generally more care needs to be taken to think it through

Improved risk mitigations include:

- Infection prevention clinical nurse specialist discussing the incident with each staff member

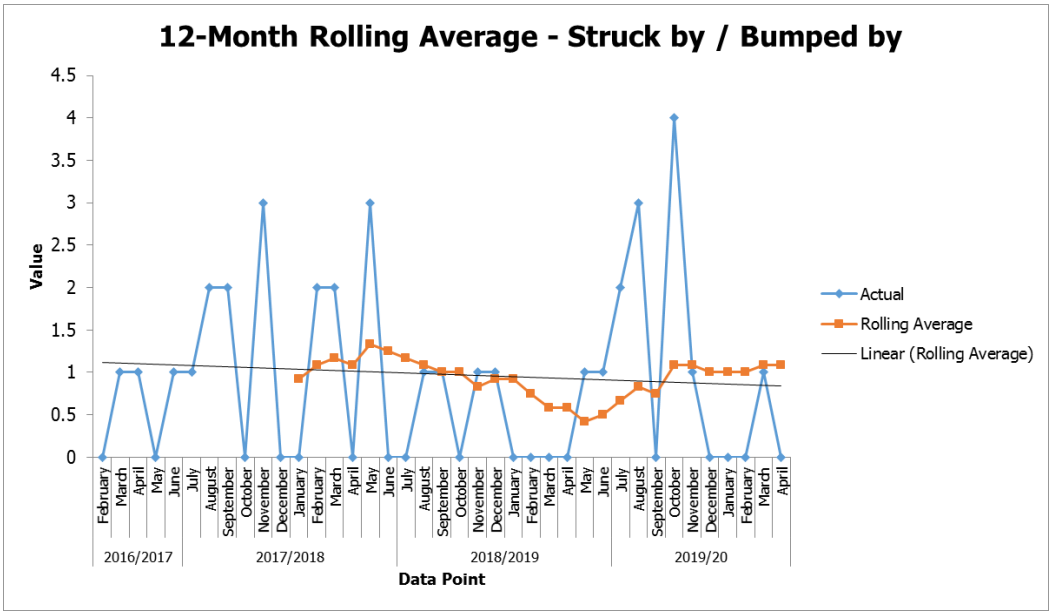
Slips, trips and falls



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

During February, March and April 2020 seven slips, trips and falls incidents/injuries were reported. Injuries/incidents included: slipped on a wet floor (2), lost footing and fell, tripped and fell when backing through a door, and tripped up stairs.

Struck by or bumped by



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

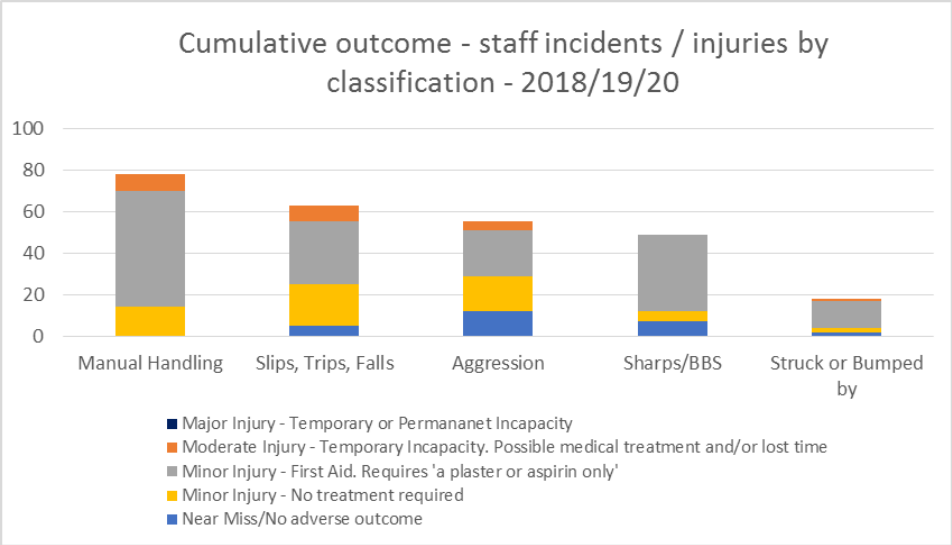
During January 2020 one bumped by incident/injuries was reported.

June 2020 **Public**

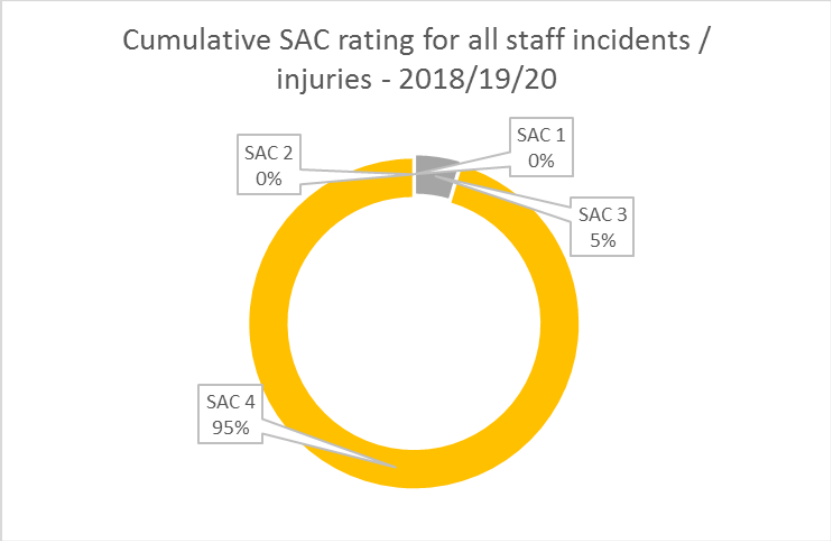
3 Incident/injury details

There were 39 staff incidents (injuries/potential injuries) recorded by staff on RiskMan in February, March and April 2020.

The graph below provides a cumulative view of outcomes classifications for 2018/19/20.



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



Definitions used in the graph:

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

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

4 Employee participation

The WDHB Health and Safety Committee met in February and March.

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

- WorkWell wellness programme
- Review of monthly incident trends
- Rolling average trends and graphs for board report
- Monitor and update of health and safety objectives for 2019/2020
- Aggression workgroup
- Excellence and innovation in health and safety
- Manual handling
- Cgov
- Security monitoring tags

5 Contractor management

Spotless Services, as our key on-site contractor, provided the following health and safety report, which is evidence of having active health and safety systems in place.

Spotless H&S	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec 19	Jan 20	Feb-20
Category A: Fatality / Disabling	0	0	0	0	0	0	0	0	0	0	0	0	0
Category B: Lost Time Injury	0	0	0	0	0	0	0	0	0	0	0	0	0
Category C: Medical Treatment	0	0	0	0	0	0	0	0	0	0	0	0	0
Category D: First Aid / Allied Health	0	0	0	0	0	0	0	0	0	0	0	0	0
Category E: Injury with no treatment	0	0	0	0	0	1	0	0	0	0	0	0	0
Category G: Non-work	0	0	0	0	0	0	0	0	0	0	0	0	0
Near Miss	0	0	0	0	0	0	0	1	0	0	0	0	0
Spotless H&S	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec 19**	**Jan 20**	**Feb 20**
Hazard	10	10	10	9	8	10	12	11	9	10	10	10	8
Safety Observations	17	18	17	11	15	17	17	14	15	15	15	17	14
Sub-Contracted to Spotless	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec 19**	**Jan 20**	**Feb 20**
Contractor Safety Interactions	11	8	9	12	8	6	4	5	3	0	0	4	2
Contractor Hazard	0	0	0	0	0	0	0	0	0	0	0	0	0
Contractor Injury	0	0	0	0	0	0	0	0	0	0	0	0	0
Contractor Near Miss	0	0	0	0	0	0	0	0	0	0	0	0	0

June 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No 5.4
Author	Andrea Bunn, Portfolio Manager
Endorsed by	Paul Malan, GM Strategy Commissioning and Population Health
Subject	Suicide Prevention Strategy

RECOMMENDATIONS

Management recommend that the Whanganui District Health Board members:

a. **Receives** the paper

b. **Notes** that the programme has moved to the second phase

c. **Notes** that the membership will be decided by both WALT and Hauroa A Iwi

1. Purpose

The purpose of this document is to provide a progress update on the Whanganui District Suicide Prevention strategy and the development of an action plan.

The Suicide Prevention Strategic Framework is an enabling framework with whānau and community wellbeing at the centre of its intention. An enabling framework means the strategy is dynamic (living), evolving as the project team gathers external contribution and unifies people to the mission.

2. Phase Two, Designing for Action

The project team moved into Phase two, Designing for Action, in February 2020. In this phase we are focused on concurrent engagements to:

- Gather external contributions to the strategic framework and enroll partners
- Share the key insights and gather further actionable intelligence
- Convene groups to solidify their commitment for collective action. This includes:
  - Capturing and progressing the proposed contributions to the regional action plan from the different collaborations
  - Leverage existing initiatives to integrate with the framework
  - Identify what is already working well, then recommend which successful initiatives should be scaled
- Facilitate a strategic working group, championed by the WDHB, to agree the backbone (operating model), building blocks, and the measurement framework.

3. Extension

This phase, which was due 30 June 2020, has been extended to 30 September 2020 in response to COVID-19.

4. Project Team Oversight

Rebecca Davis, Impact Strategist (The Change & Innovation Agency) has come in to Te Oranganui to provide interim leadership in Healthy Families Whanganui,

Ruapehu, Rangitīkei. This means Rebecca has oversight of the Suicide Prevention strategy, working alongside the Project Manager and Advisory Group.

5. Emerging Priority Focus Areas for the Start Up Phase

We refer to the first two years of the action plan as the *Start Up Phase*. As a result of the engagements there are several collaborations beginning to form – each aligned to a specific focus area. The focus areas for the Start Up phase are:

1. Child health & wellbeing – earlier intervention and protection for whānau
2. Māori Tane – Māori-led systems design
3. Rural Community, Farming - Community Regeneration
4. An interconnecting health system
5. Community capacity for community-led wellbeing solutions

6. Whānau wellbeing during COVID-19

During COVID-19 Whanganui district did not have any suicides. We heard the positive benefits of rāhui, lockdown for many. Such as: people experiencing increased connection, different forms of community-led wellbeing practices (meditation, yoga, indigenous traditions), quality time with parents and their children, shift in what people value as important (shift in priorities), people taking the time to reflect and make positive changes, quality outreach by Iwi, case managers, support workers, volunteers.

Practitioners and services are preparing for the predicted economic impacts on communities that may trigger diminished wellbeing.

7. Next steps

1. Convene WALT and Hauora A Iwi to agree the membership of the strategic working group who will develop the backbone structure and measurement framework, and prioritise and define the building blocks for the start up phase.

2. Continue with existing engagements and tasks

Progress Update

For the Whanganui **District Health Board**

Prepared for	Russell Simpson, CEO WDHB Wheturangi Walsh-Tapiata, CEO Te Oranganui and Healthy Families Whanganui, Ruapehu, Rangitīkei
CC	Judith MacDonald, CEO Whanganui Regional Health Network
Prepared by	Rebecca Davis, Impact Strategist Marguerite McGuckin, Project Manager
Date	19 May 2020

The purpose of this document is to provide a progress update on the Whanganui District Suicide Prevention strategy and the development of an action plan.

The Suicide Prevention Strategic Framework is an enabling framework with whānau and community wellbeing at the centre of its intention. An enabling framework means the strategy is dynamic (living), evolving as the project team gathers external contribution and unifies people to the mission.

Phase Two, Designing for Action

The project team moved into Phase two, Designing for Action, in February 2020. In this phase we are focused on concurrent engagements to:

- Gather external contributions to the strategic framework and enroll partners
- Share the key insights and gather further actionable intelligence
- Convene groups to solidify their commitment for collective action. This includes:
    - Capturing and progressing the proposed contributions to the regional action plan from the different collaborations
    - Leverage existing initiatives to integrate with the framework
    - Identify what is already working well, then recommend which successful initiatives should be scaled
- Facilitate a strategic working group, championed by the WDHB, to agree the backbone (operating model), building blocks, and the measurement framework.

Extension

- This phase, which was due 30 June 2020, has been extended to 30 September 2020 in response to COVID-19.

Project Team Oversight

- Rebecca Davis, Impact Strategist (The Change & Innovation Agency) has come in to Te Oranganui to provide interim leadership in Healthy Families Whanganui, Ruapehu, Rangitīkei. This means Rebecca has oversight of the Suicide Prevention strategy, working alongside the Project Manager and Advisory Group.

Emerging Priority Focus Areas for the Start Up Phase

We refer to the first two years of the action plan as the *Start Up Phase*. As a result of the engagements there are several collaborations beginning to form – each aligned to a specific focus area. The focus areas for the Start Up phase are:

1. Child health & wellbeing – earlier intervention and protection for whānau
2. Māori Tane – Māori-led systems design
3. Rural Community, Farming - Community Regeneration
4. An interconnecting health system
5. Community capacity for community-led wellbeing solutions

Whānau wellbeing during COVID-19

During COVID-19 Whanganui district did not have any suicides. We heard the positive benefits of rāhui, lockdown for many. Such as: people experiencing increased connection, different forms of community-led wellbeing practices (meditation, yoga, indigenous traditions), quality time with parents and their children, shift in what people value as important (shift in priorities), people taking the time to reflect and make positive changes, quality outreach by Iwi, case managers, support workers, volunteers.

Practitioners and services are preparing for the predicted economic impacts on communities that may trigger diminished wellbeing.

Next steps

1. Convene WALT and Hauora A Iwi to agree the membership of the strategic working group who will develop the backbone structure and measurement framework, and prioritise and define the building blocks for the start up phase.

2. Continue with existing engagements and tasks

June 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Information Paper**
	Item No. 5.5
Author/s	Lucy Adams, Chief Operating Officer/Director of Nursing Alex Forsyth, Director of Allied Health Scientific and Technical Ian Murphy, Chief Medical Officer
Subject	Provider Arm Services (excludes financials)

Recommendations

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper entitled Provider Arm Services

b. **Note** comments around operational performance

1 Purpose

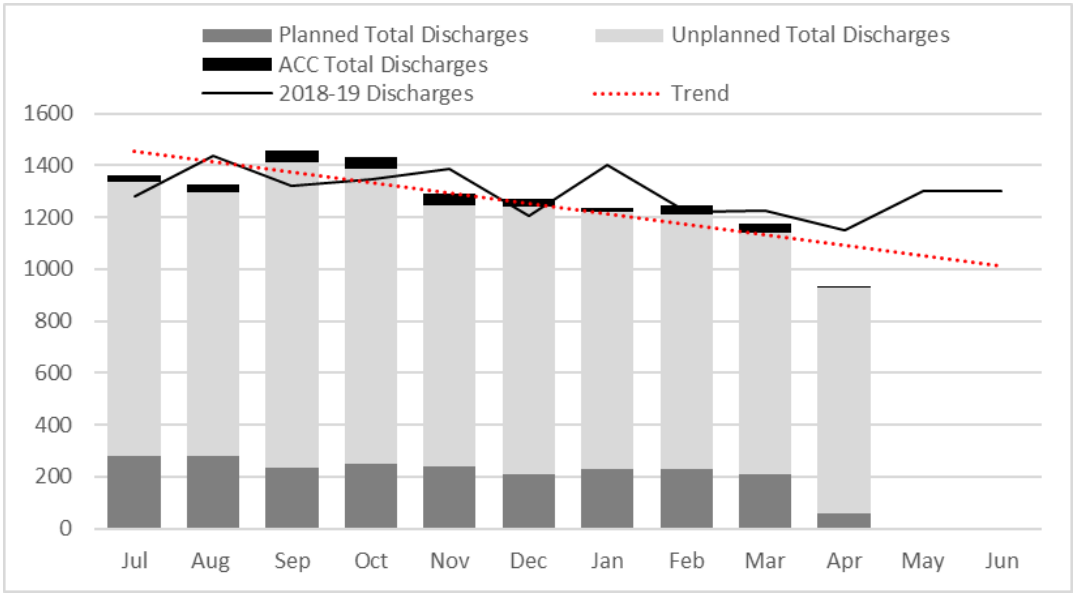
To provide the Board with a high level overview of WDHB Provider Arm: Hospital and Clinical Services; Maternal, Child and Youth Services; Primary and Community Services. The reporting period is for the two months March and April 2020.

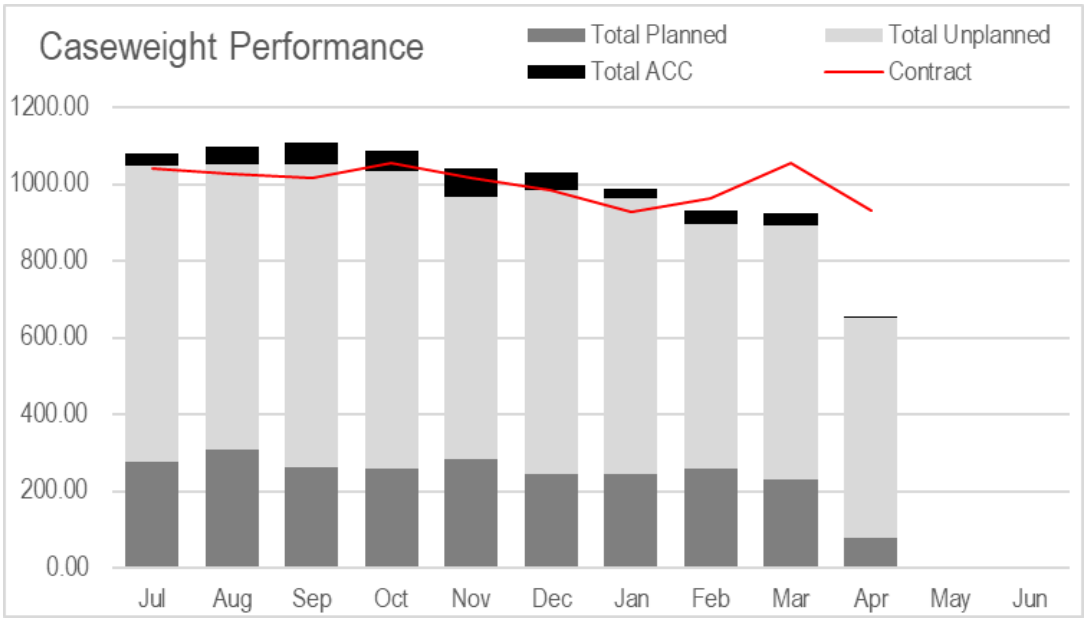
2 Service Delivery Overview

2.1 Discharges and Caseweight delivered against contract

Patient throughput for the months of March and April has been disrupted by preparation and readiness for COVID-19. Elective services were reduced, and only urgent and non-deferrable patients were seen. April throughput reduced by 70% against previous monthly average and YTD caseweight volumes are 8% less than contracted. A reset plan to recover volumes is in place with a number of strategies. Elective/Planned Care makes up 26% of our total budgeted inpatient volumes.

Patient discharges for the period to April 2020 were 12,732 across personal health inpatient areas, with significant reductions in April.





2.2 Occupancy

Inpatient occupancy was also impacted by COVID preparation and averaged 55% across all inpatient units excluding mental health. Occupancy in acute mental health inpatient facility averaged 92%. As part of the response medical and surgical wards were reconfigured to accommodate infectious/non-infectious patients.

2.3 ED attendances

ED presentations also reduced significantly with a total of 1274 patients presenting in April. This is 68% of the pre-COVID average, and there were days with as few as 27 patients presenting. The average daily number of patients acutely admitted was 11, marginally lower than pre COVID volumes.

3 Workforce Overview

3.1 Medical Staff

There are currently 2.5 FTE active vacancies for senior medical staff; psychiatry 1.5 FTE and obstetrics and gynaecology 1 FTE. We are awaiting the arrival of a new ophthalmologist, which has been delayed due to COVID-19 and lock-downs in the UK and India. A newly recruited anaesthetist is expected to arrive in June or July depending on travel from South Africa.

There are no RMO vacancies for Q3 with 4 vacancies in quarter 4. Q3 staffing includes locums due to a number of RMOs returning at short notice to the UK due to the COVID-19 situation. There is an opportunity to align the 2021 RMO start dates with the Australasian Colleges which is currently under consideration nationally by the CMOs.

The actions arising from the medical department credentialing are being assigned leads and timeframes. Work has commenced on implementing these actions.

3.2 Nursing Staff

During this reporting period staffing numbers fluctuated; a vulnerable workers assessment tool had indicated some staff were not able to work during the level 3 and 4 Pandemic response period, and with low occupancy staff were either deployed to cover gaps or offered annual leave. The integrated operations centre had oversight of this process and modified their daily operational meetings to have a "yesterday/today/tomorrow" approach. This has proved extremely useful information sharing during preparedness for COVID-19. This practice will continue.

In late 2019 the Technical Advisory Services undertook an external audit of the Nurse Roster, Budgeting and Payroll and their findings were released in February 2020. In accordance with the report findings several steps have been taken to improve staffing systems and create workforce efficiencies. A centralised rostering position will be implemented, with a purpose to ensure rosters are aligned to our MECA guidelines and reduce the time spent building rosters by clinical managers. All nursing rosters will be in TrendCare.

Using vacant FTE, another position has been created, the patient flow and discharge facilitator. This role will assist with complex discharges and repatriation of patients from other hospitals.

Care Capacity Demand Management (CCDM) is tracking to agreed timelines. CCDM has continued during our COVID-19 response and the Variance Response Management (VRM) tool fully utilised. CCDM FTE calculations have been completed and would appear that no further FTE is required within the wards; note, this process is not finalised as the unions and safe staffing are required to sign off on this process.

The 14 Nursing Entry to Practice (NETP) and 3 New Entry to Specialist Practice (NESP) nursing graduates are doing well within the organisation. Fourteen of the NETP have not yet commenced their post-graduate study with Victoria University due to universities closing during COVID-19. The three NESP commenced post graduate study via Whitirea Polytechnic in February.

The new WDHB nursing uniforms are due to arrive in August 2020. This has been a regional project with all central region DHBs participating. This has resulted in a change of uniform that is fit for purpose and costs less due to the high volume of uniforms that will be purchased. All DHBs are swapping the scrubs for new uniforms as the cost of scrubs is expensive and the amount used is much higher than the allocation of uniforms (exclusion theatre). A roll out plan will commence within the next 2-3 weeks once the final communications come from Deane Apparel, the uniform manufacturer.

4 Hospital and Clinical Services

4.1 Health Target achievement

Faster Cancer Treatment 62 Day target

The latest Faster Cancer Treatment results for quarter three have been received by the Ministry of Health. For the quarter we achieved 96.5% of patients receiving their treatment within 62 days of referral; this result is a good outcome for patients. This is taken as an average over six months, when broken down to monthly figures our achievement was as follows:

Month	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Result	100%	83%	100%	100%	100%	100%

Emergency Department 6-hour target

Emergency department has met the 6-hour target for April with 96% of patients seen, treated and discharged from the Emergency Department within 6 hours of presentation. ED presentations were significantly disrupted through March and April, so maintaining target achievement has been a significant effort across the team.

Elective Services Performance Indicators

Whanganui DHB has been one of few DHBs to maintain ESPI compliance throughout the 2019-20 year. Final results have been received for the month of March and we have become non-compliant for ESPI 2 and ESPI 5 overall, with variance in the two largest surgical specialties (orthopaedics and general surgery) strongly influencing the results. This means that we have a number of patients waiting longer than 120 days for fist specialist assessments (16 in total) and elective surgery (38 in total). April results are expected to be a deterioration on this, as very limited planned care took place. We will be working with the Ministry to ensure we return to normal production and see patients in the order of clinical priority.

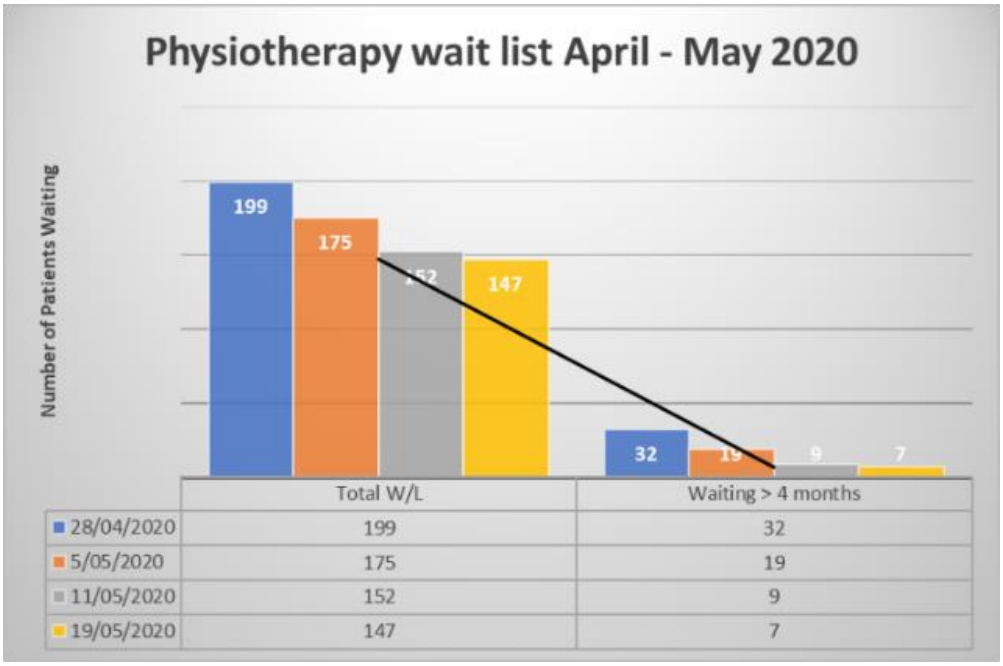
5 Primary and Community Services

5.1 Service Delivery and Performance

The vision of 69,000 beds (the best bed for a person is their own bed) is well established with staff. The events of the COVID-19 pandemic has led to the need to expedite the vision for 69,000 beds in order to ensure hospital capacity was at its lowest, and that as much proactive and preventative care occurred within a person's bubble, with as few breaches of this as possible.

This led to multiple instances of teams working more responsively, in more collaborative ways both within the DHB and with the wider health community, and in a more proactive and preventative manner. Examples of this include District Nurses supporting Aged Residential Care facilities to undertake greater scope in wound care management, the merging of Allied Health, needs assessment and rehabilitation services to provide a one stop, open referral system for people living in the community with physical frailty, and the placing of a physiotherapist in one of the Aged Residential Care facilities to support patients who would otherwise be at high risk of readmission to hospital. All services also moved to telehealth, using mainly telephone and video for assessment and intervention where appropriate.

Informal patient feedback was especially positive in Community Mental Health and Addiction services, and Sexual Health services. The use of telehealth also enabled a 26% reduction in Physiotherapy waitlist, with a 78% reduction in those waiting over four (4) months, and a 40% overall reduction in the Occupational Therapy waitlist, with a 50% reduction in those waiting for wheelchair assessments.



	Total W/L	Waiting > 4 months
28/04/2020	199	32
5/05/2020	175	19
11/05/2020	152	9
19/05/2020	147	7

	0-3 months	3-6 months	6-9 months	9-12 months	>12 months	Total
20/04/2020						186
28/04/2020	60	25	32	22	31	170
4/05/2020	50	29	22	14	22	137
11/05/2020	56	16	13	11	22	118
19/05/2020	54	13	17	9	20	113

5.2 Workforce

The final two (2) Clinical Managers to complete the Primary and Community leadership team started in March. Recruitment of traditional hard to recruit posts has been positive, with two (2) Speech and Language Therapy vacancies filled after seven (7) applicants for the roles. A longstanding Musculoskeletal Physiotherapy role has been recruited to, and there is interest from an Audiologist with a promising CV.

The Sexual Health service is now led by a Clinical Nurse Practitioner after the retirement of the previous doctor who led this service. The move of Dietetic services from Spotless to the DHB is in progress. Longstanding recruitment challenges in Pharmacy are being reviewed with the potential of the development of specialist Pharmacy roles.

5.3 Service Change

Partnership Agreement between WDHB and WRHN is under development which will outline a partnership approach to strengthening connected health services across our community. This agreement will be support transition for DHB staff in to community working, and identifying areas for opportunity and priority.

A Clinical Informatics Lead role has been approved and will be advertised. This is seen as a pivotal role to support Primary and Community services with the measuring value adding interventions provided by Allied clinicians across the organisation and wider community. The case for change is supported by the readiness of Allied Health services to better collect and understand information to improve healthcare, redesign models of care to improve patient outcomes, across the wider Whanganui district.

6 Maternal, Child and Youth Services

6.1 General

It has been a slower than anticipated commencement to the delivery of the new model for Maternal, Child and Youth Services (MCYS) within the DHB due to both a delay in completing recruitment for leadership roles and the COVID-19 pandemic. Pleasingly, on both counts this appears to largely be behind us and it is expected that considerable progress can now be made with establishing the service.

6.2 Staff

The service leadership team has begun to take shape with the recent appointment of a permanent Child Health Manager.

Trish Silk has taken the step up from her role as Clinical Nurse Manger Paediatrics to operational lead for all child health services provided within the provider arm of the DHB including Oral Health, MICAMHAS, Paediatrics and Public Health. She is joined by Barbara Charuk (Strategic Lead) and Anthea Stynder (Executive Assistant) in the leadership team.

The group will be completed with the anticipated appointment of a Director of Midwifery, responsible for maternity services. Applications have recently closed with a satisfying amount of interest being received. Our sincere thanks to Barbara Charuk for her excellent work as acting Child Health Manager over the last four months.

6.3 Services

As with many DHB services considerable disruption has occurred as a consequence of COVID-19. Non-financial data reporting reflects this with reduced immunisation rates being achieved as an example. It is expected that these challenges will again be borne out in Q4 reporting.

Current activity is focussed on a resumption of normal service as quickly as possible within what is permissible under the current Alert Level (social distancing, PPE use, additional cleaning requirements). Additional challenges exist with access to external environments such as schools still an issue as organisations occur to take a conservative approach to the resumption of normal activity.

6.4 Future focus

There are several tasks underway within MCYS:

<u>Service Level Alliance</u>

A Terms of Reference for this group is being developed at present with a desire to establish a diverse group to represent the interests of the community and sector that the service seeks to support. It is anticipated that this group will provide guidance and perspective to the leadership team around where its focus should be particularly in relation to the stated Government expectations of improving child well-being and mental well-being.

Annual Planning

Business support staff are providing input into this document to again ensure that our programme of work is aligned to expectations and appropriately reflect COVID-19 recovery.

Contract renewals

These are currently underway with external providers for 2020/21. In light of COVID-19 these are largely being rolled over under the same terms as for 2019/20.

June 2020 **Public**

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**Decision paper**
	Item. 7
Author	Nadine Mackintosh, Board Secretary
Endorsed by	Russell Simpson, Chief Executive
Subject	**Resolution to exclude the public**

Recommendations

Management recommend that the Whanganui District Health Board:

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 21 February 2020	For reasons set out in the board's agenda of 20 March 2020	As per the board agenda of 20 February 2020
Chief executive's report Board & committee chair reports Smokefree Policy Submission	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations) 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)(i) and 9(2)(j) Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Integrated Facilities Update Pathology and Laboratory Services	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)
Draft Annual Plan Covid-19 Opportunities Consumer Engagement	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)

June 2020 **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
Board secretariat or board's executive assistant	Minute taking, procedural and legal advice and information	Recording minutes of board meetings, advice and information as requested by the board