WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

AGENDA

Combined Statutory Advisory Committee

Meeting date **Friday 22 March 2019**

Start time **9.30am**

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

Embargoed until Saturday 23 March 2019

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

Distribution

Board members *(full copy)*

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

External committee members *(full copy)*

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

Executive Management Team and others *(full copy)*

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

(public section only)

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

Agendas are available at www.wdhb.org.nz one week prior to the meeting.

Combined Statutory Advisory Committee member attendance schedule – 2019

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

Legend

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

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Agenda
Public session

Meeting of the Combined Statutory Advisory Committee

to be held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 22 March 2019, commencing at 9.30am

Combined Statutory Advisory Committee members

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

1 Apologies

2 Conflict and register of interests update Page 7

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

3 Late items

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

4 Minutes of the previous committee meetings Page 12

Recommendation
That the minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 30 November 2018 be approved as a true and correct record.

5 Matters arising — Page 21

Nil

6 Committee Chair's report

A verbal report may be given at the meeting

7 Whanganui DHB Annual Work Programme — Page

8 Reference and Information Section

9 Date of next meeting

Friday, 3 May 2019

10 Glossary and Terms of References *(for reference only)* — Page 55

11 Exclusion of public

Recommendation

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

Agenda item	Reason	OIA reference
Combined Statutory Advisory Committee minutes of the meeting held on 30 October 2018 (public-excluded session)	For the reasons set out in the committee's agenda of 30 November 2018	As per the committee's agenda of 30 November 2018
Annual Planning 2018/19	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations).	Section 9(2)(i) and 9(2)(j)

Persons permitted to remain during the public excluded session

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

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

WHANGANUI DISTRICT HEALTH BOARD

REGISTER OF CURRENT CONFLICTS AND DECLARATIONS OF INTEREST

Up to and including 1 February 2019

BOARD MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Graham Adams	16 December 2016	Advised that he is: ▪ A member of the executive of Grey Power Wanganui Inc. ▪ A board member of Age Concern Wanganui Inc. ▪ Treasurer of NZCE (NZ Council of Elders) ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Charlie Anderson	16 December 2016	Advised that he is an elected councillor on Whanganui District Council.
	3 November 2017	Advised that he is now a board member of Summerville Disability Support Services.
Philippa Baker-Hogan	10 March 2006	Advised that she is an elected member of the Whanganui District Council.
	8 June 2007	Partner in Hogan Osteo Plus Partnership.
	24 April 2008	Advised that her husband is an osteopath who works with some surgeons in the hospital on a non paid basis but some of those patients sometimes come to his private practice Hogan Osteo Plus and that she is a partner in that business.
	29 November 2013	Advised that she is Chair of the Future Champions Trust, which supports promising young athletes.
	7 November 2014	Philippa Baker-Hogan declared her interest as: ▪ A member of the Whanganui District Council District Licensing Committee; and ▪ Chairman of The New Zealand Masters Games Limited
	3 March 2017	Philippa Baker-Hogan declared her interest as a trustee of Four Regions Trust.
Maraea Bellamy	7 September 2017	Advised that she is: ▪ Te Runanga O Ngai Te Ohuake (TRONTO) Delegate of Nga Iwi O Mokai Patea Services Trust. ▪ Secretary of Te Runanga O Ngai Te Ohuake. ▪ Hauora A Iwi - Iwi Delegate for Mokai Patea.
	4 May 2018	Advised that she is: ▪ a director of Taihape Health Limited. ▪ a member of the Institute of Directors.
	1 February 2019	Advised that she is a trustee of Mokai Patea Waitangi Claims Trust.
Jenny Duncan	18 October 2013	Advised that she is an elected member of the Whanganui District Council
	1 August 2014	Advised that she is an appointed member of the Castlecliff Community Charitable Trust
Darren Hull	28 March 2014	Advised that he acts for clients who may be consumers of services from WDHB.
	27 May 2014	Advised that he: ▪ is a director & shareholder of Venter & Hull Chartered Accountants Ltd which has clients who have contracts with WDHB ▪ acts for some medical practitioners who are members of the Primary Health Organisation ▪ acts for some clients who own and operate a pharmacy ▪ is a director of Gonville Medical Ltd
	20 June 2014	Advised he is on the Whanganui Regional Health Network Risk & Audit Committee.
	23 May 2016	Advised he is no longer on the Whanganui Regional Health Network Risk & Audit Committee.

Stuart Hylton	4 July 2014	Advised that he is: ▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society Of New Zealand. ▪ Appointed 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	Advised that he is an executive member of the Central Districts Cancer Society.
	15 March 2017	Advised that he is appointed as Rangitikei District Licensing Commissioner.
	2 May 2018	Advised that he is: ▪ Chairman of Whanganui Education Trust ▪ Trustee of George Bolten Trust
	2 November 2018	Advised that he is District Licensing Commissioner for the Whanganui, Rangitikei and Ruapehu districts.
Judith MacDonald	22 September 2006	Advised that she is: ▪ Chief Executive Officer, Whanganui Regional Primary Health Organisation ▪ Director, Whanganui Accident and Medical
	11 April 2008	Advised that she is a director of Gonville Health Centre
	4 February 2011	Declared her interest as director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape.
	27 May 2016	Advised that she has been appointed Chair of the Children's Action Team
	21 September 2018	Declared her interest as a director of Ruapehu Health Ltd
Annette Main	18 May 2018	Advised that she a council member of UCOL.
Dot McKinnon	3 December 2013	Advised that she is: ▪ An associate of Moore Law, Lawyers, Whanganui ▪ Chair, of the the Four Regions Trust (formerly Powerco Wanganui Trust) ▪ Wife of the Chair of the Wanganui Eye & Medical Care Trust
	4 December 2013	Advised that she is Cousin of Brian Walden
	23 May 2014	Advised that she is a member of the Health Sector Relationship Agreement Committee.
	31 July 2015 and 10 August 2015	Advised that she is appointed to the NZ Health Practitioners Disciplinary Tribunal
	2 March 2016	Advised that she is a member of the Institute of Directors
	16 December 2016	Advised that she is Chair of MidCentral District Health Board
	3 February 2017	Advised that she is on the national executive of health board chairs
	8 June 2018	Advised that she is: ▪ a Director of Chardonnay Properties Limited (a property owning company) ▪ Chair of the DHB Regional Governance Group ▪ an advisory member on the Employment Relationship Strategy Group (ERSG)
Tariana Turia	16 December 2016	Declared her interests as: ▪ Pou to Te Pou Matakana (North Island) ▪ Member of independent assessment panel for South Island Commissioning Agency ▪ Life member CCS Disability Action ▪ National Hauora Coalition Trustee Chair ▪ Cultural adviser to ACC CEO ▪ Te Amokura of Te Korowai Aroha Trust (National)
	15 November 2017	Recorded that she has been appointed Te Pou Tupua o te Awa.

BOARD ADVISORS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Peter Brown		No current declared interests.

COMBINED STATUTORY ADVISORY COMMITTEE MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Frank Bristol	8 June 2017	Advised that he is: ▪ Member of the WDHB Mental Health and Addiction (MH&A) Strategic Planning Group co-leading the adult workstream. ▪ An executive member of the National Early Intervention for Psychosis society. ▪ In a management role with the NGO Balance Aotearoa which holds Whanganui DHB contracts for Mental health & addiction peer support, advocacy and consumer consultancy service provision. ▪ Working as the MH & A Consumer Advisor to the Whanganui DHB through the Balance Aotearoa as holder of a consumer consultancy service provision contract. ▪ Working as Consumer Advisor to MidCentral DHB MHA Services. Member of MidCentral DHB MHA Executive Management team. ▪ Member of Sponsors and Reference groups of National MH KPI project. ▪ Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders Group. ▪ Member of Te Pou/Ministry of Health Information and Data reference group ▪ Member of Ministry of Health 'He Tangata" (MH Outcomes Framework) Informatics workstream ▪ Member of Whanganui DHB/WRHN Strategic IT group ▪ Has various roles in Whanganui DHB MHA WD, Quality Improvement programmes and Strategic planning ▪ Member of Whanganui DHB CCDM Council ▪ Steering group partner via Balance Aotearoa with Ministry of Health on Disability Action Plan Action 9d).This is legal and improvement work associated with MH Act, Bill of Rights and UN Convention on Rights of Disabled people. ▪ Balance Aotearoa is a Disabled Persons Organisation (DPO) and a member of the DPO Collective doing work with the Disability Action Plan representing the mental health consumers. ▪ Life member of CCS Disability Action
	14 July 2017	Advised that he is doing consultancy work for Capital and Coast District Health Board
	1 September 2017	Advised that he has been appointed to the HQSC Board's Consumer Advisory Group
Andrew Brown	13 July 2017	Advised that: ▪ he is an independent general practitioner and clinical director of Jabulani Medical Centre; ▪ he is a member of Whanganui Hospice clinical governance committee; and ▪ most of his patients would be accessing the services of Whanganui District Health Board.
Heather Gifford	20 November 2018	Advised that she is: ▪ Ngāti Hauiti representative on Hauora a Iwi; ▪ Senior Advisor and founding member of Whakauae Research for Māori Health and Development (currently engaged in research with WDHB); ▪ Member of Te Tira Takimano partnership Board of Nga Pae o Te Maramatanga (Centre for Māori research excellence, Auckland University); and ▪ Director Health Solutions Trust.
Leslie Gilsenan	11 September 2017	Advised that he is the Service Manager, CCS Disability Action Whanganui (formerly Whanganui Disability Resources Centre).

Matt Rayner	11 October 2012	Advised that: ▪ He is an employee of Whanganui Regional PHO – 2006 to present ▪ His fiancée, Karli Kaea-Norman, is an Employee of Gonville Health Limited
	26 October 2012	Advised that he is a member on the Diabetes Governance Group
	31 July 2015	Advised that he is: ▪ employed by the Whanganui Regional Health Network (WRHN) ▪ a trustee of the group "Life to the Max"
	27 May 2016	Advised that he is a member of the Health Solutions Trust
	1 September 2017	Advised that he is now a trustee of Whanganui Hospice
Grace Taiaroa	1 September 2017	Advised that she is: ▪ Hauora A Iwi (Ngā Wairiki Ngāti Apa) representative ▪ General Manager Operations – Te Runanga o Ngā Wairiki Ngati Apa (Te Kotuku Hauora, Marton) ▪ Member of the WDHB Mental Health and Addictions Strategic Planning Group ▪ Member of the Maori Health Outcomes Advisory Group.
	16 March 2018	Advised that she is deputy chair of the Children's Action Team

RISK AND AUDIT COMMITTEE MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Malcolm Inglis	12 September 2018	Advised that: ▪ He is Board member, Fire and Emergency New Zealand. ▪ He is Director/Shareholder, Inglis and Broughton Ltd. ▪ His niece works as an investigator for the Health and Disability Commissioner.

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Anne Kolbe	26 August 2010	▪ Medical Council of NZ – Vocational medical registration – Pays registration fee ▪ Royal Australasian College of Surgeons – Fellow by Examination – Pays subscription fee ▪ Private Paediatric Surgical Practice (Kolbe Medical Services Limited) – Director – Joint owner ▪ Communio, NZ – Senior Consultant - Contractor ▪ Siggins Miller, Australia – Senior Consultant - Contractor ▪ Hospital Advisory Committee ADHB – Member – Receives fee for service ▪ Risk and Audit Committee Whanganui DHB – Member – Receives fee for service ▪ South Island Neurosurgical Services Expert Panel on behalf of the DGH – Chair – Receives fee for service
	18 April 2012	Advised that she is an employee of Auckland University but no longer draws a salary.
	20 June 2012	Advised that she holds an adjunct appointment at Associate Professor level to the University of Auckland and is paid a small retainer (not salary).
	17 April 2013	Advised that her husband John Kolbe is: ▪ Professor of Medicine, FMHS, University of Auckland ▪ Chair, Health Research Council of New Zealand, Clinical Trials Advisory Committee (advisory to the council) ▪ Member Australian Medical Council (AMC) Medical School Advisory Committee (advisory to the board of AMC) ▪ Lead, Australian Medical Council, Medical Specialties Advisory Committee Accreditation Team, Royal Australian College of General Practitioners ▪ Member, Executive Committee, International Society for Internal Medicine ▪ Chair, RACP (Royal Australasian College of Physicians) Re-validation Working Party ▪ Member, RACP (Royal Australasian College of Physicians) Governance Working Party

12 February 2014	Advised that she is a Member of the Australian Institute of Directors – pays membership fee
18 February 2016	Joined the inaugural board of EXCITE International, an international joint venture sponsored by the Canadian Government, to consider how to pull useful new technology into the marketplace. No fee for service, although costs would be met by EXCITE International.
13 April 2016	Advised that she: ▪ is an observer to the Medicare Benefits Schedule Review Taskforce (Australia).
10 August 2016	Advised that: ▪ Transition of the National Health Committee business functions into the NZ Ministry of Health was completed on 9 May 2016. The Director-General has since disbanded the NHC executive team. ▪ Emma Kolbe, her daughter, has taken up a position at ESR (Institute of Environmental Science and Research), Auckland as a forensic scientist working in the national drugs chemistry team. ▪ She is chair, Advisory Council, EXCITE International. ▪ She is member of MidCentral District Health Board's Finance, Risk and Audit Committee.
12 September 2018	Advised that she: ▪ Is strategic clinical lead for Communio and its consortium partners – to deliver coronial post-mortem services from Waikato, Rotorua, Nelson, Dunedin and Southland hospitals, and forensic and coronial post-mortems from Wellington Hospital. ▪ provides strategic governance and management work for Hauora Tairawhiti (Tairawhiti DHB).

Unconfirmed

Minutes

Public session

Meeting of the Combined Statutory Advisory Committee

held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 30 November 2018, commencing at 9.36am

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

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive
Mr Paul Malan, GM Service & Business Planning
Ms Kim Fry, Director Allied Health
Ms Katheryn Butters, Nurse Manager, Mental Health Services
Mr Frank Rawlinson, Chief Medical Officer
Mr Peter Wood Bodley, Business Manager Surgical Services & Procurement
Mr Declan Rogers, Nurse Manager Surgical Services
Ms Brenda Mulenga, Ophthalmologists
Mr Arvind Gupta, Ophthalmologists
Ms Eileen O'Leary, Portfolio Manager, Service & Business Planning
Mr Chester Penaflor, Health Promoter, Public Health and Community
Mr Karney Herewini, Acting Health Promotion Manager
Ms Amanda Van Elswijk, CNM/Acting Nurse Manager
Mr Matt Power, Funding and Contracts Manager
Ms Sandy Blake, Director of Nursing and General Manager Patient Safety
Ms Andrea Bunn, Portfolio Manager, Mental Health and Health of Older People
Ms Candace Sixtus, Portfolio Manager, Service and Business Planning
Ms Sue Campion, Communications Manager
Ms Jevada Haitana, Associate Director of Nursing

Ms Judie Smith, Acting Nurse Manager, Mental Health Services
Ms Michelle Tattersall, Acting Executive Assistant, Service and Business Planning *(minutes)*

In attendance at this meeting

Media
There was no media in attendance at this meeting

Public
Ms Margaret Campion, President, Whanganui Alzheimer's Society
Ms Wendy Paterson, Whanganui Alzheimer's Society
Ms Ailsa Stewart, Board Member, Whanganui Alzheimer's Society

Karakia/reflection
Matthew Rayner offered a Karakia.

1 Welcome and apologies

Apologies were received and accepted from: Ms Annette Main (NZOM)

2 Conflict and register of interests update

2.1 Updates to the register of interests

Ms Philippa Baker-Hogan and Ms Jenny Duncan reported they have both finished their appointments at the Whanganui Community Foundation.
Action: Frank Bristol to email through some changes.

2.2 Declaration of conflicts in relation to business at this meeting

There were no declarations of conflicts

3 Late items

No late items were advised.

4 Minutes of the previous meeting

It was resolved that:

The minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 19 October 2018 be approved as a true and correct record.

5 Matters arising

There were no matters arising from the previous meeting.

6 Committee Chair's report

A verbal report was given with the items of note being:

Andrew Brown and Jabulani Medical Centre have received an award for the best performance figures across the board with cervical screening, and are now meeting 100% of the target, which they have worked hard to achieve. Jabulani are the top practice of all of the NHC practices across the country.

The Chair acknowledged Grace Taiaroa stating it was lovely to see her as her presence had been missed.

The Chair thanked Paul Malan for arranging such an interesting agenda.

7 Whanganui DHB Annual Plan Work Programme

7.1 Whanganui Alliance Leadership Team (WALT)

Leads: Russell Simpson, Chief Executive

A verbal update was provided by the CE.
The Service Level Agreement with the Alliance around acute demand is underway. There are three phases in this project.
The first phase of work is data collection, and collating stories from patients.
The CE reported that after ten months in the role he feels the alliance team is starting to gain momentum and is encouraged as to where the alliance is heading and the opportunities that exist in 2019.
The CE expressed his thanks to National Hauora Coalition and the Health Network for a very productive last few months.

7.2 Service Improvement Initiatives – New Primary Care Initiatives

Leads: Candace Sixtus, Portfolio Manager, Service and Business Planning

The paper was taken as read.

The paper is around the budget announcements from 2018 and Community Service Card (CSC) announcements for 1 December.
The question was asked of how many practices across the area are not taking up the option of providing low-cost access to CSC holders. There are four practices not taking up the CSC initiatives. East Care, Castlecliff, Springvale and Aramoho.
There is a charge for a child visit when the child accesses another practice and WAM during practice hours for non ACC related visits.
The next gate for opting into the CSC scheme is 1 April. The methodology for funding was based on historical information. Capacity is not available and there is a real concern in general practice around capacity. There is a lot of work going on in both PHO's to support general practice with this change.

7.3 Health of Older Persons

Lead: Andrea Bunn, Senior Portfolio Health of Older People
Wendy Paterson, Alzheimer's Whanganui

A presentation was provided on the work Alzheimer's Whanganui have been doing in one of their rural Communities Ohakune.

An audit will be done on the initiative by an accreditation committee, which is made up of the Chair of Alzheimers Northland, Manager of Alzheimers Manawatu, Manager of Alzheimers Marlbourgh, Member from Alzheimers New Zealand Board and chaired by Catherine Hall CE of Alzheimers New Zealand. An audit report will be prepared by DAA (Group health Auditors).

There are a few risks attached and one of these is financial to the community and Alzheimers Whanganui. There is great support from Andrea and the WDHB but every journey has a cost and everything done in the community has a cost. Community engagement has been good but still further work to do, however this cannot be done by an email and needs to be face to face.

A discussion was held around having communication with Ruapehu Whānau Transformation.
This would certainly be looked at after Christmas as they will be going to Ohakune as a team to see what needs to be brought together. An education programme will be run in Ohakune next year.
Action: Wendy to give Maraea who is on the steering group her card.

The service has only been going for eighteen months. There is currently seven people engaged in the service and have just received two referrals from Raetahi. There is no residential facility or respite care in Raetahi and Ohakune.

Primary measures of success when rolled out would be to be engaged with business as early as possible. Currently have New World plus two or three of the eateries and some market gardens on board and would like to see engagement with every business in the community. Essentially will be led by the community and Alzheimers will be support underneath with resources to assist when they can.

The paper is taken as read.

The powers of Ombudsman's Office have been extended to include secure dementia care and aged residential care. This is not operationalised yet, use of the word detained is a change of language and not the language that has been used to date.
The committee was informed of the NZ Human Rights Commission publication called 'This is not my home' where dementia has a more human rights aspect than it has had to date. The Age Care Residential review will have significant implications when finalised.

Note: Page 32 is showing only three facilities providing dementia care, Jane Winstone should be added to bring the total to four.
A discussion was held around cultural safety not being one of the areas of the quality improvement programme. Kowhainui and Enliven are proactive in this area and it is currently being looked at to share amongst other providers.

Feedback is due today on the National Framework for Home and Community Support Services. A short extension has been granted due to meeting with the committee today but looking for feedback if there is any.
The feedback provided was:

- A comprehensive model. Concern for dementia patients and the spouse or partner have to have a lot of social service input in these models, also, respite for the spouse is a concern going forward.
- Looks good on paper but it is not showing how it is going to be put in practice, concerns over funding being granted to residential facilities when Māori are not going into care and the cost of being looked after by family at their own cost. This has been asked before but have not seen any changes in the funding for Māori who are looking after their people at home.
- Reading it, it could be a single service provision and it talks to people over 65 where as there are a number of people under 65 who require care and this will be looked at.
- Page 79 a paragraph on the aging population, The Māori population of people aged 65 and older is projected to increase by 79% in the 10 years to 2026 and the daily care may increase by more than 200% and 75% for non-Māori. With the current capacity issues around providing care this is screaming urgency with a cultural change needing to happen around how aging is viewed.
- Feedback on the framework. We can refer to the Ministers feedback on equity as a good rational as to why there needs to be a different model of care preferences.

7.4 Disability Support Services

Lead: Eileen O'Leary, Portfolio Manager Service & Business Planning

Paper is taken as read.

Prototype Enabling Good Lives - Mana Whaikaha is just getting started in Manawatu.

Page 34 Carers Support. Carers do need support as they are not coping at home and how to steer people where to go will become a problem as people cannot keep coming back to the Doctor as they are unclear of the pathways and where to go.

The question was asked with The I Choose Programme giving the carer some respite options, when it comes to caring for someone with a higher level disability when they are on a benefit themselves is this still not part of the issue due to lack of funding?
Yes, this is about the money and how it is used as there is no more money.

A discussion was held on whānau caring for their family, on how some have had to give up full time work to care for their family member and how the disability sector does not value the care and family is unpaid. It was felt it has not been acknowledged the right of families to choose as to whether to work in care or work or as care back up and disappointment was expressed.
The final paragraph where it states: The money will not be available to pay or compensate family members who are living with the disabled person or the disabled person's parent or spouse was brought to the committee's attention.

The committee was informed it is a fundamental change to the way people ideologically can get services, instead of funding going to services it does enable self-determination for whānau on what services they get provided. I Choose is in early stage of pilots in Waikato and Canterbury with the rollout close by. The good operators who have good services are working closely with whānau to change their services and there has not been any evaluation as yet or time line to roll out wider, people with disabilities are excited on how the decision comes to them rather than to providers which is the fundamental change, how it gets rolled out or how it is funded is the next step. Potentially it will allow self-determination so families get what they need. It won't necessarily be delivered by big providers and it could potentially cut out big providers.
It was discussed how the DHB could look at how does enabling good lives impact on healthy aging in the future?

Dame Tariana left the meeting 10.46

7.5 Ophthalmology Service Developments

Leads: *Peter Wood Bodley, Business Manager Surgical Services & Procurement*
Declan Rogers, Nurse Manager Surgical Services
Brenda Mulenga, Opthalmologist
Arvind Gupta, Ophthalmologist

The committee thanked Brenda and Arvind for making the time to attend the meeting, while acknowledging Judie Smith who has worked closely with Brenda and Arvind.

Paper was taken as read

A WDHB nurse has been accepted for training at MidCentral DHB next February, and there is the possibility of another nurse joining the team. The committee thanked the team for the relationship with the primary care providers and for the nurses receiving training.

The Committee commented:

- Would like to see Māori and Non Māori in the patient discharge and case weight information come to the Board. Refer table on page 38.
- Support to maintain best practice model in a provincial model.
- Support page 36 the equity considerations, urged to look deeper at what is unidentified need and have a think about other explanations for underrepresentation.
- Shared care - do opticians have shared access through clinical portal? – yes they do, the form has just undergone a redraft and will sent out shortly.

The Committee was informed that in the past two days notification has been received that the period of Brenda's vocational supervision has been shortened to 6 months which is unheard of and an incredible feather in Brenda's cap.
Mr John Ah-Chan is acknowledged and his team from MidCentral for how they have embraced the regional alliance and central alliance and have given a hand up in ensuring there is a vibrant sub

regional and regional service. Part of that is there are now six weekly central alliance and two monthly regional ophthalmology network meetings.

7.6 Service Improvement Initiatives – Position Statement on Alcohol

Lead: Chester Penaflor, Health Promoter, Public Health and Community
Karney Herewini, Acting Health Promotion Manager

The position statement is written from a Public Health stance and we are looking for endorsement and adoption by the WDHB.

Feedback on the position statement was:

- In terms of a presentation for the Board supporting the draft position statement on alcohol, where is the how?
- From the position statement there is nothing in there which is not already being done.
- In terms of structure we don't have the position with the how not being listed underneath and getting lost, the position statement does include some of the detail. It is there but just needs to be drawn out.
- Good initiative to put a position statement to the WDHB, and would like to see much more deliberate strategy objectives. See some statements, in relation to education, integrated strategy, see some statements how we intend to work as a collective impact, around working with employers and high risk industries.
- Critical for the WDHB to show leadership and to say exactly what they think. Need to be brave about a really specific targeted response.
- To emphasize alcohol is not only about self-harm but harm to others, domestic violence is probably fueled 95% by alcohol.
- Support targeting suppliers.

It was recommended the Combined Committee Statutory Committee:
Endorses the draft Position Statement on Alcohol; and
Supports presentation of the Position Statement on Alcohol being made to the Whanganui District health Board for official adoption by the organisation.

Dot McKinnon abstained due to a conflict of interest.

7.7 Service Improvement Initiatives – Mental Health and Addictions

Leads: Jeff Hammond, Associate Director of Nursing (ADoN), Director Area Mental Health Services (DAMHS), Area Director, Mental Health and Addictions Services
Jo Stephens, Acting Medical Director, Mental Health and Addictions Services
Katheryn Butters, Nurse Manager, Mental Health and Addictions Services

Apologies were received for Jo Stephens and Jeff Hammond

With the changes in electronic platforms the service is struggling to get good reporting and the thought is to do some more validating checking in the system and how it is capturing ethnicity. Manually does give a picture. In the rural space are sending an entire team and are surprised by the low numbers.

Now have Zoom into rural areas and can now Zoom across the campuses and across the community providers.

Scale and proximity helps in some ways and not in others. The 12 bedded unit is across the age continuum and the past weekend had two people over 65 with three youth which raises challenges, the use continues to be high.

A large scale change that has been concentrated on over the last two years is reviewing the entire adult community model and have come up with what is termed the network model of care. This is a structure and a model based on integration of communities of practice rather than geographical locations. Very much premised on relationships and working together.

Have met with MHOAG and Te Oranganui who are keen to use the infrastructure to work together. Feedback given on the Network Model of Care is that it is working well across the hubs, with a rapport going and looks good going forward. Patients are also commenting it is good, as they are not seeing different people each time.

Primary care credentialing programme is in its first year. There has been one dozen people go through the programme which is credentialed by the College of Mental Health Nurses.

On her last day after 24 years Katheryn believes there have been some great things achieved within the service. Katheryn thanked Russell and Paul, and Sandy Blake for being a fantastic mentor and supporter of her and the nursing and patient safety and mental health nurses.

Stuart thanked Katheryn on behalf of the committee and wished her all the best for her future. Grace thanked Katheryn on behalf of her own family and community.

The committee was informed that Judie Smith will be acting in the role.

Russell publicly acknowledged Katheryn's work and on behalf of the DHB thanked her for her service and the changes that have been made.

The Committee was urged by Paul to read the Te Pou evaluation, the link having been provided in the papers.

7.8 Service Improvement Initiatives – Workforce and Organisational Development

Leads: Hentie Cillers, General Manager People and Performance

Apologies were given for Hentie Cillers

Paper taken as read with Paul to take back to Hentie any questions people may have. The questions were:

- Current four vacancies and how long they will be vacant.
- 36 % of staff having performance agreements, is this acceptable and if not what is being done about it. It is unacceptable and acknowledged as such.
- Do we have any members of STONZ. Yes the STONZ meca has been ratified and WDHB has one member. STONZ (Specialty Training of New Zealand Union). 100 members nationwide and an alternative for training medical practitioners from the RDA

7.9 Financial Performance

Leads: Matt Power, Funding and Contracts Manager
Kath Fraser-Chapple, Business Manager Medical, Community & Allied Health
Peter Wood-Bodley, Business Manager Surgical Services and Procurement

Apologies were given for Kath Fraser-Chapple

Paper was taken as read.

Page 60: the financial results for the first month – should read first quarter

Trend in Nursing FTE - is that going to be sustainable? Medical services unfavourable and is likely this is going to continue. This is consistent with the case weighted discharges and volumes which are most under pressure.
No update from the Ministry on the revised budget has been received.
The level of financial detail provided in these papers was due to timing and it was agreed if financial information was available for this committee prior to the Board meeting and there is no duplication of effort to prepare it, then it is acceptable to show this level of detail in these papers.

7.10 National & Regional Strategic Reviews

Lead: Paul Malan, General Manager, Service and Business Planning

Omitted from the list - the Office for Disability Issues is currently reviewing the disability action plan and have held some meetings around the country, with the workshops continuing on to February of next year. The Office for Disability Issues and the Disabled Peoples Coalition have jointly facilitated this work.

It was noted that Whanau Ora is undergoing a review by Te Puni Kokiri. The review is almost completed and there will be some recommendations being made to the new Government.

It **was recommended** that the Combined Statutory Advisory Committee:

NOTE the key national and regional reviews that are currently underway; and
NOTE the need for Whanganui DHB to include the direction from these reviews into our own strategic and operational planning

8 Date of next meeting

Friday, 22 February 2019 – Annual Planning Day

9 Glossary and terms of reference

For information only.

10 Exclusion of public

It was resolved that:

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

Agenda item	Reason	OIA reference
Minutes of meeting held on 19 October 2018 (public excluded session)	For the reasons set out in the committee's agenda of 19 October 2018	As per the committee's 19 October 2018

Persons permitted to remain during the public excluded session

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

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

General

A discussion was held around disability being added to the work programme and it was noted it would come up as there is a section in the Annual Plan around disability.

The public session of the meeting ended at 12.10pm

5 Matters arising from previous meetings Page

There were no matters arising from the previous meetings.

6 Committee Chair's report Page

A verbal report may be provided at the meeting.

7. Whanganui DHB Annual Plan work programme

7.1 Whanganui Alliance Leadership Team

Leads: Russell Simpson, Chief Executive Officer

Purpose
To update the committee on activities of the Whanganui Alliance Leadership Team (WALT)

The chief executive will provide a verbal update.

7.2 Service Improvement Initiatives – Acute Demand Information and Work Programme

Leads: Judith McDonald WRHN, Sub-alliance Acute Demand Working Group

Purpose
To provide the Combined Statutory Advisory Committee with an update on the Whanganui acute demand service level alliance (SLA) examining the significant increase in acute demand presentations to the hospital front door, and co-constructing a system wide response to reduce avoidable presentations.

Background
This report outlines the findings from phase one (understanding patient flow) of the Acute Demand SLA. The report includes system data from WDHB Emergency Department (ED), Whanganui Accident and Medical (WAM), WRHN General Practice members and St John Ambulance, two Health Roundtable reports, a number of case reviews and a survey. The report also outlines a work stream proposal to progress to phase two (undertake a work programme to address avoidable presentations) of the acute demand SLA.

Content
- data themes and learnings from phase one
- work stream proposal to progress to phase two.

Appendices (refer to information section)
St John Ambulance service data for WDHB region 2018, analysed by:
1. patients seen and not transported to ED
2. patients seen and transported to ED.

The committee is asked to note
a. the research undertaken to date in phase one
b. the work stream proposal to progress phase two.

7.2.1 Data themes and learnings from phase one

Background
WALT agreed the terms of reference for the establishment of a working group to examine the significant increase in acute demand presentations to the hospital front door. A sub-group was formed and this group have analysed system data generated from WRHN general practice members (unable to access NHC practice member data as yet), Whanganui Accident and Medical (WAM urgent care clinic), Whanganui District Health Board (WDHB) Emergency Department data, admission data, reviewed two reports from the Health Roundtable (which benchmarks individual DHBs with some Australian health provider data) and received data and information from the St John Ambulance service for the WDHB region.

In addition, a number of case studies and a survey were undertaken, and while the volume and approach would not be considered statistically relevant, drilling down was a useful exercise that clarified some assumptions and created greater context in some instances.

Phase one of the programme of work

1. Formulate a data collection that understands and describes patient flow
2. Identify any lessons learned to Whanganui Alliance Leadership Team (WALT) and develop themes and work streams that are considered essential priorities for solution work streams:
   - Examine and analyse quantitative data with an equity focus
   - Examine case reviews, note audits and presentation records.
3. Present findings to the Whanganui Alliance Leadership Team on 19 February 2019.

Sub-group members

Michael Caruso, Bernd Kraus, Harriet McKenzie, Phil Murphy, John McMenamin, Amanda Van Elswijk.

Co-sponsors

Jude MacDonald and Declan Rogers

Process

The sub-alliance facilitated two hui to test the data assumptions and qualitative information with a wider audience. The first hui was an invited group of clinical leaders who worked in relevant settings such as WAM/ED, the hospital and general practice as well as two DHB consumer representatives. Eighteen people attended this hui and excellent contributions and collaborative thinking emerged.

The second hui included 23 Māori leaders who represented community/NGO/general practice/iwi provider leadership/Public Health/DHB Haumoana team members and WRHN Māori clinicians. The participants were actively engaged and demonstrated genuine desire to create solutions as 'one team' to drive tangible change that would make real difference for Māori through addressing apparent and emerging inequities.

Data themes and learnings

1. **Emergency Department data**
   Key learning: Elderly are increasing and driving ED patient flow.

2. **Whanganui Accident and Medical data**
   Key learnings: The older you are the less likely your medical presentation will be managed in WAM, but it is very likely you will receive care in ED. The increased burden of older populations is evident in all services.

3. **WAM/ED triage**
   Key learning: WDHB is an outlier for triage 3 presentations, which merits further investigation and solutions given a primary service is located next to ED.

4. **General Practice (WRHN data only)**
   Key learning: There is no evidence of a disproportionate utilisation of GP services by any specific or particular population group, and general practice have been experiencing year-on-year growth in presentations.

5. **Inpatient admissions**
   Key learning: 65-84 year olds are occupying twice as many bed day hours than others and are predominantly non-Māori/PI, however there is substantial growth in demand for Māori/Pacific Island populations.

6. **Community Care Conditions**
   - Community Care Conditions (CCC) Roundtable data is questionable due to methodology, however it is showing that 30% of the inpatient volume falls within this group, which points to WDHB as being a significant outlier.

- Assertive models of community treatment and management such as Primary Options Acute Care/assertive outreach treatment and mobile clinical services are not sufficiently visible and evident across the city. This is driving acute volume that is appropriate to be managed by primary care into the inpatient and ED service such as cellulitis IV management.

7.2.2 Work stream proposal to progress to phase two

Fragmented health system driving episodic care	Create interconnected relationships – Kotahitanga – 'one team' across the system despite who we work for to create the basics of good care (acceptable, affordable and accessible). Take learnings from rural models around how various providers work together and apply in the city. Develop a connected clinical record and e-referral capability to improve transfer of information from all perspectives.
Reframe our response to elderly living at home and at Aged Residential Care	Develop a system response to the growing frail and older population, and agree on collaborative strategies that will be adopted and invested in to maintain elderly out of the hospital and being cared and managed where possible in their homes, Aged Residential Care (ARC) and in their communities.
Reduce WAM and ED volumes	Explore messaging/health literacy/better navigation through creating a connected health and social response with improved wrap around care for people. Improve self-management and self-navigation in accessing right health care choices at the right time across general practice/WAM and hospital. Review with St John Ambulance service the response of going direct to ED, and develop other clinical pathways and models of care. Remove ED as the sorting place for specialist pre-admission and follow up activity. Develop a collaborative health promotion messaging response for children and young families for common conditions, and improve education and capability. Fully implement 'Choosing Wisely' in ED.
Threshold and access to services represents right place right time	Review WAM/ED triage process. Explore establishment of a general practice nurse-led type service in WAM, providing education, advice, navigation and connection to a general practice home. Revisit POAC options of care and move some clinical service access to primary care. Review GP referrals for admission to ED/hospital and create other options and pathways for treatment and support.
The system workforce is culturally responsive and competent to the population it is serving	Agree on standards and develop a training and education framework that crosses the entire system. Co-design a programme with rangatahi.
General practice has capacity and capability to operate a whanau centred model of practice	Whanau Ora operating in general practice through re alignment and development of healthcare home models to drive workforce mix, and use of technological options to enhance communication and care.

Enablers to change	Contract definition and expectations provides a system lens approach rather than silo approach to investment. Invest in technology capability. Invest in communication capability. Community is our active partner and are engaged, informed and participate in and understand change process.

7.3 Health of Older Persons – Falls Prevention

Lead: Andrea Bunn, Senior Portfolio Health of Older People

Purpose
The purpose of this paper is to update the committee on falls prevention and fracture management.

The Whanganui District Health Board (WDHB) has an injury prevention partnership agreement with ACC who are cross-agency partners with Ministry of Health and the Health Quality and Safety Commission.

The partnership agreement has been in place since 1 July 2017. The expectation of the partnership agreement is that district health boards take a system wide approach to falls and fractures.

The approach is supported by ACC's 'Live Stronger for Longer' national campaign aimed at reducing falls and fractures and their impacts for older people. It's an integral part of New Zealand's healthy ageing strategy and it contributes to system level measures, both acute demand and acute bed days.

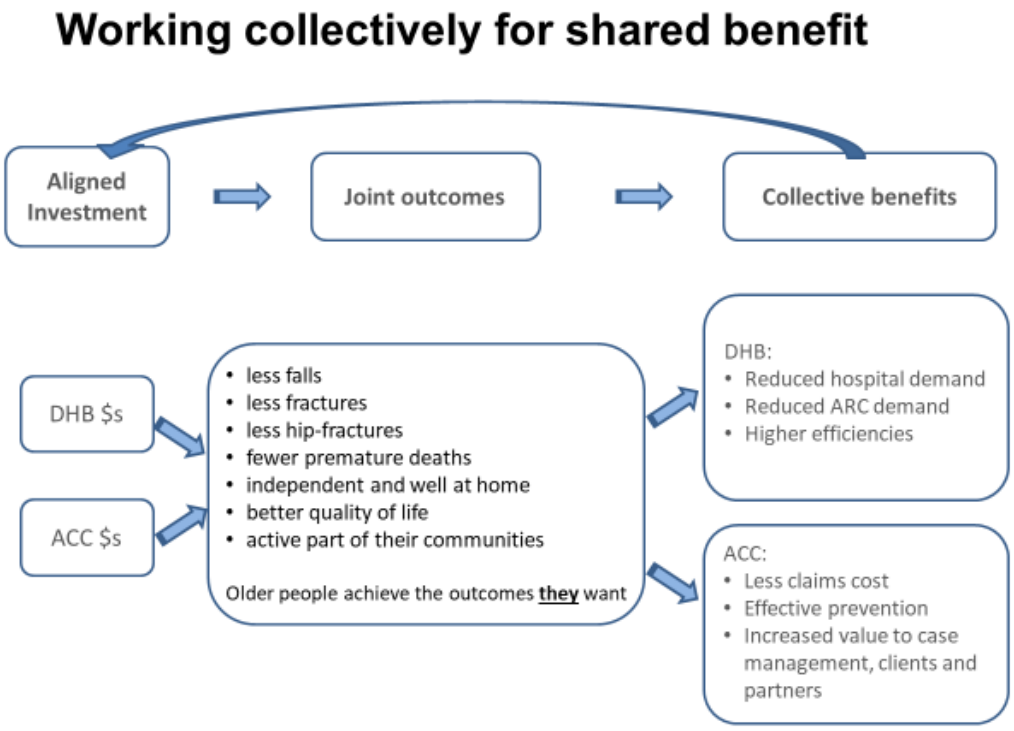
The approach requires all health systems to work towards a common vision of keeping older people well and independent at home and focussing on delivering agreed shared outcomes - reduced falls, reduced serious harm falls, improved recovery (at hospital or at home) and better system integration.

Key components include: Fracture liaison services (FLS), in-home strength and balance (S&B), community strength and balance classes (CS&B).

Falls are the most common and costly cause of injury in people 65 years and over. There is compelling evidence of effective interventions to reduce falls and prevent fractures in this population group. Injury prevention, particularly fracture prevention, cannot be significantly reduced without preventing falls.

A fall for ACC is an injury. For the health system, a fall is often a marker of frailty and an indicator of a number of health care issues often translating into acute service demand. For the older person, a fall often means a loss of independence.

The diagram below demonstrated the benefit of a partnership approach:



Reach targets have been set for local DHBs from a population at risk perspective. WDHB reach targets are outlined below.

Note the templates below also include the WDHB's results ending quarter two (ending December 2018) and as reported to ACC and the Ministry of Health.

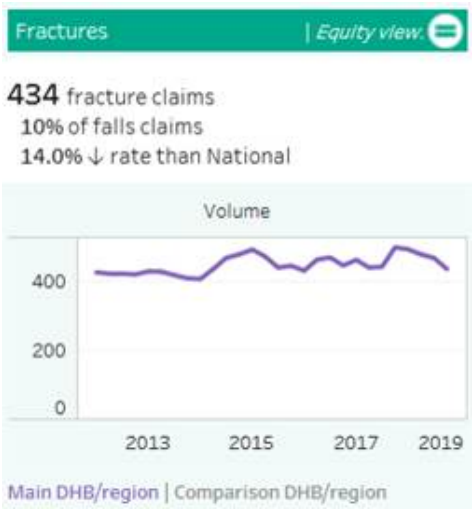
Component	Classification	# of people (Quarter)	# of people (YTD)	Annual ACC/MOH target
Report the number of older people (65 and over, or younger if identified as a falls risk) that have received in-home strength and balance retraining services:	Number of people that received in-home strength and balance retraining (aged 65+):	56	129	199

Component	Classification	# of people (Quarter)	# of people (YTD)	Annual ACC/MOH target
Report the number of older people (65 and over, or younger if identified as a falls risk) that have received community / group strength and balance retraining services	Number of people that received community / group strength and balance retraining (aged 65+):	606	1101	880

Component	Classification	# of people (Oct-Dec 2018)	# of people (YTD)	Annual ACC/MOH target
Report the number of older people (65 and over, or younger if identified as a falls risk) that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service:	Number of people that have been seen by the FLS or similar fracture prevention service (aged 65+):	58	115	221

From the WDHB's InterRAI (a comprehensive clinical assessment) data for 2017/18, we know that nearly 50% of the people that had this assessment had had a fall within the previous 90 days. This equates to 19% of the DHB's older population who had at least one interRAI assessment during that period. Note that all these people would have been referred to the falls service.

While 'Live Stronger for Longer' is taking a longer term population health view, the graph below from the HQSC Atlas of Health Care Variation looking at a twelve month rolling average for WDHB does indicate a trend in the right direction.



The partnership agreement is for three years, however ACC recognise the 'sustainability challenges' and have signalled that they will be developing an internal business case in early 2019 based on National outcomes and benefits realisation to date.

They have also indicated they will be able to notify of potential ongoing funding by July 2019. Note the partnership agreement for the DHB ends 30 June 2020.

7.4 Service Improvement Initiatives – Advance Care Planning

Lead: Rebecca Casey, Whanganui Regional Health Network

Purpose
The purpose of this report is to update the Combined Statutory Advisory Committee on advanced care planning.

A verbal update will be provided.

7.5 Service Improvement Initiatives – Mental Health and Addictions – Acute Demand

Leads: Jeff Hammond, Associate Director of Nursing (Acting Director of Nursing), Director Area Mental Health Services (DAMHS), Area Director, Mental Health and Addictions Services
Jo Stephens, Acting Medical Director, Mental Health and Addictions Services
Judie Smith, Acting Nurse Manager, Mental Health and Addictions Services

Purpose
The purpose of this report is to provide information to the committee about acute demand in the context of specialist mental health and addiction services to our community.

Synopsis
The report below highlights:

Acute Inpatient Services
- reached 12.5% occupancy in August 2018
- occupancy remains high but strategies are in place to use all the community's resources to manage demand
- rates of seclusion and restraint have increased in line with high occupancy. We have initiatives in place to minimise this.
- There has been a gradual increase of clients/tangata whaiora placed under compulsory treatment.

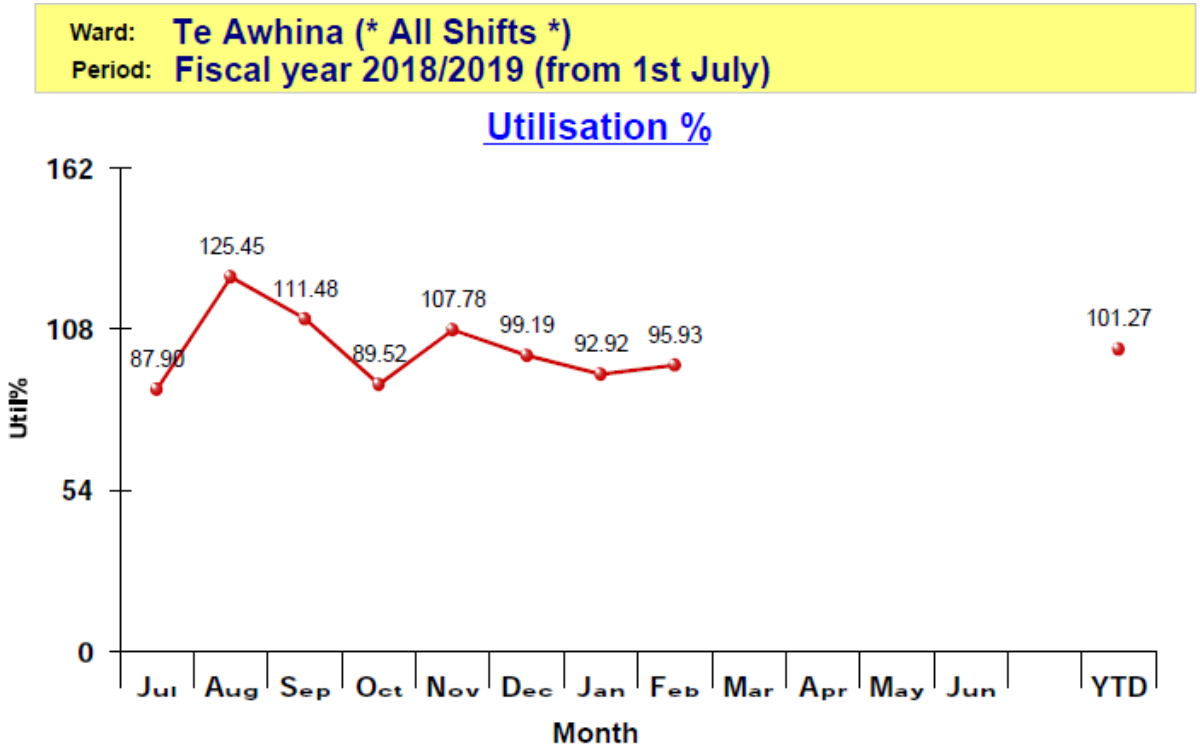
Community Mental Health and Addictions Services
- Steady increase over the last 2 years
- Quality and appropriateness of referrals improving
- Network Model of Care (Community Hubs) bedding in well.

Infant, Child, Adolescent Mental Health and Addictions Services (ICAMHAS)
- 14% increase in total referrals over 2 years
- Complex presentations
- Resource-intensive responses.

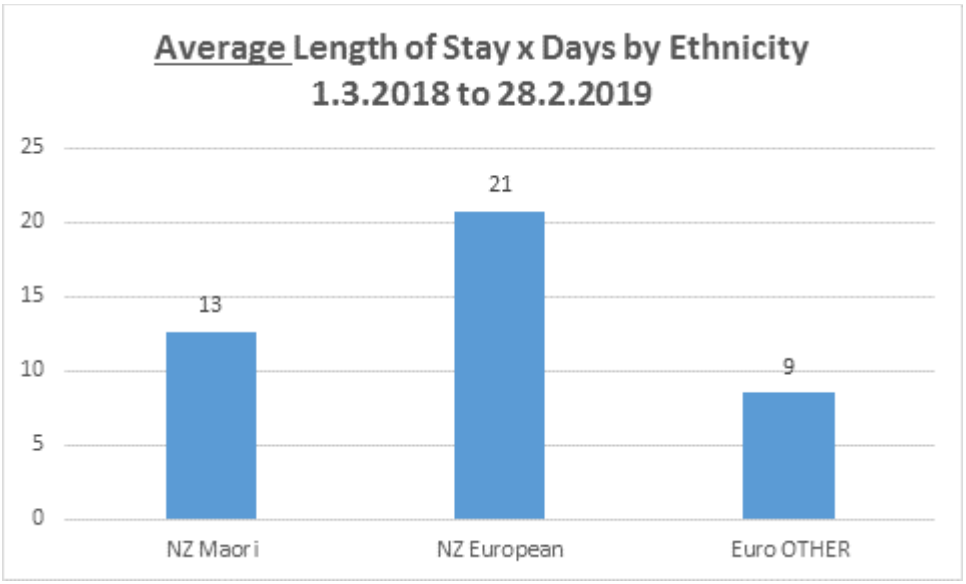
Te Awhina – Acute Inpatient Service

In 2018, Te Awhina experienced an increased demand on inpatients services. Te Awhina is a 12-bed inpatient ward and in August/September 2018 reached 24 inpatients. An Emergency Operations Centre (EOC) was established and we are now in the recovery phase. The recovery has prioritised issues and activities to assist with the acute demand.

- Te Awhina has 4380 bed nights available per annum: from 1.3.18 to 28.2.19 3958 bed nights used



- Average length of stay for all admissions is 17 days



Immediate response to acute demand

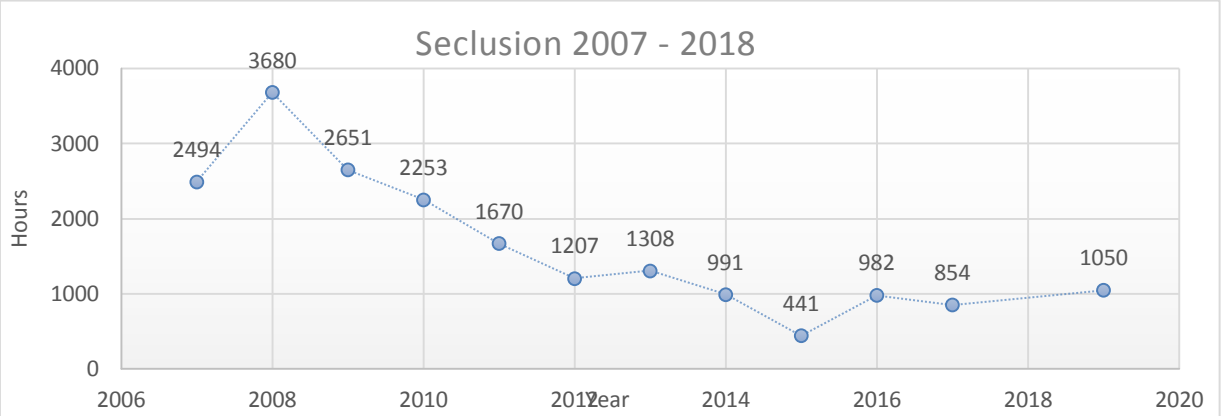
- EOC established
- Huddles with NGO and Iwi partners
- Admin support (0.5 FTE) for medical director and management team
- Review of workforce and recruit male Māori staff
- Flexibility and goodwill of staff.

Medium term response (current)

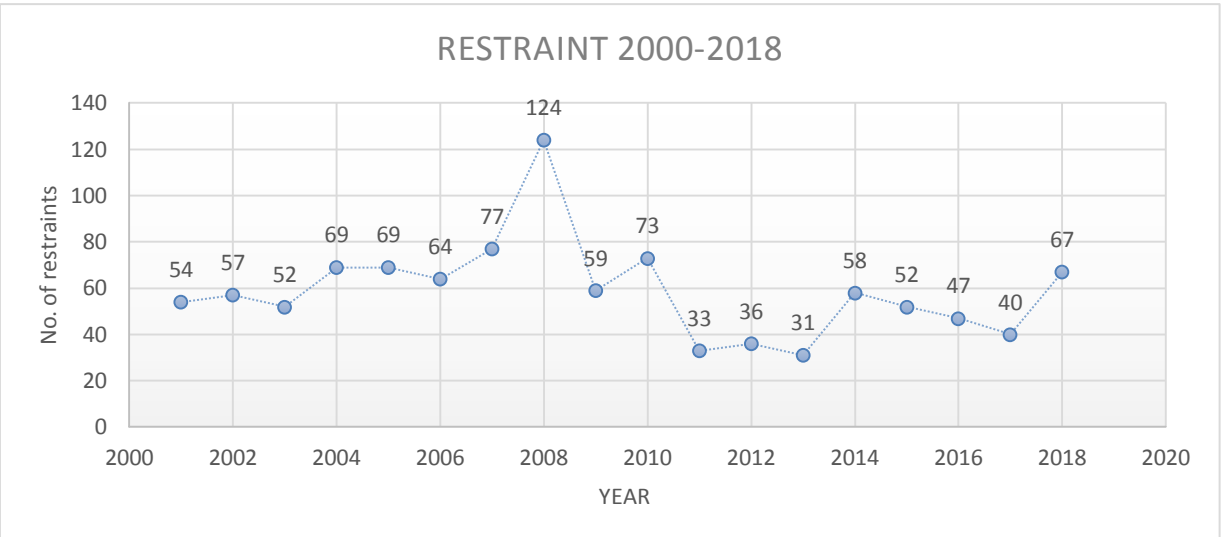
- Clinical staff and annual training plan for inpatient mental health staff
- Huddle room set up, morning ward rounds re-established
- Focus on relationship building with NGO and community partners
- Haumoana Navigator appointed to Te Awhina.

Seclusion and Restraint

- The increased demand correlates with an increase of seclusion and restraint incidents.
- This is despite the socialisation and acceptance of 'Zero Seclusion' concept by staff and the implementation of the Safe Practice and Effective Communication (SPEC) programme that has an emphasis on de-escalation and least restrictive alternatives.



- The inpatient unit has made significant gain in reducing seclusion in recent years. The figures for 2018 were the highest since 2013.
- In 2013, the community had problems with widespread use of synthetic cannabis.
- Methamphetamine intoxication has been associated with seclusion rates in 2018.
- Males made up 80% of seclusion episodes (Māori males 70% of these).



- Females made up 80% of restraint incidents.
- Restraint incidents are generally associated with mental illnesses opposed to intoxication related deterioration in mental state.
- Increase of restraint and seclusion impacted on both inpatient units.
- Over-crowding of Te Awhina has required Stanford staff to assist and provide support to TA staff on a constant basis over the last 12 months.

Community Mental Health and Addictions Services

There has been a steady increase in referrals received over the last two years. The appropriateness and quality of referrals received has increased since the introduction of the Network Model of Care. NGOs and Iwi providers are identified members of each HUB and are attending the weekly HUB multi-disciplinary team meetings.

Current response

- Zoom hardware has been installed in all Mental Health and Addictions Services sites to facilitate communication, virtual consults, rural attendance at MDT meetings
- Currently considering e-texting as a communication tool
- Training scheduled for clinicians in improved use of electronic diaries
- Trialling speech recognition software and will move to Microsoft 365 to enable speech recognition for all clinicians
- Establishing the Single Point of Entry (SPOE) project group
- Using secondments and casual staff to fill vacancies and considering swing shifts.

Network Model of Care

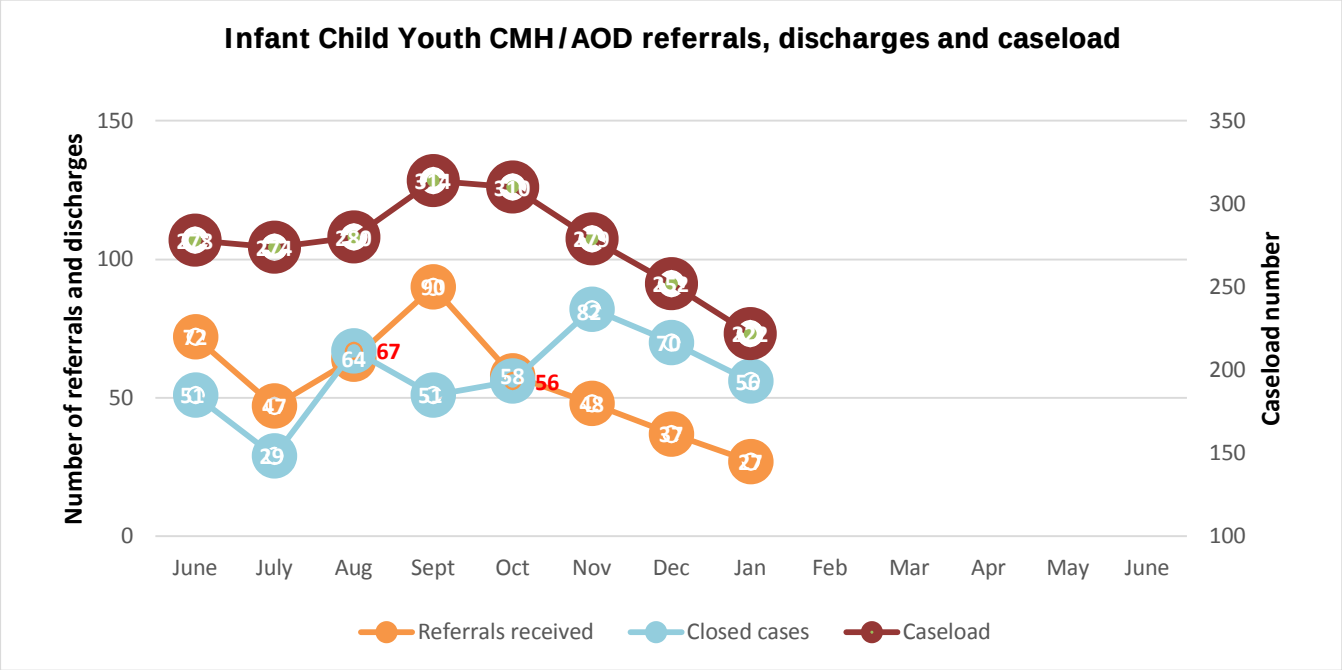
- Visit by Health Quality Safety Commission team who viewed the model
- Counties Manukau District Health Board to schedule a visit to view model mid-2019
- Hawkes Bay District Health Board to schedule visit to view model
- Planning meetings with PHO
- Development of Community Mental Health and Addictions Services descriptor and point of contact document for general practitioner practices, including information to support appropriate referrals (Map of Medicine presentation levels – e.g. mild to moderate presentation and best practice interventions).

Mental Health Act

The last two years has seen a gradual increase of those who have come under a Compulsory Treatment Order.

	Sec 29 (community)	Sec 30 (inpatient)	Total
31 Dec 2015	59	24	83
30 June 2016	57	29	86
31 Dec 2016	57	27	84
30 June 2017	53	26	79
31 Dec 2017	67	20	87
30 June 2018	67	26	93
31 Dec 2018	69	25	94
March 2019	68	26	94

Infant, Child Adolescent Mental Health and Addictions Services (ICAMHAS)



- December-January referrals drop due to school holidays.
- Total referrals for ICAMHAS /SUPP in the last two years 2017/2018 have increased from 680 to 778 (14%) with no increase in FTE resource.
- Referrals are for more complex mental health presentations often including care and protection issues as well as suicidal presentations and at risk youth.
- As the caseload often requires working alongside other agencies and is inclusive of family involvement the therapy/treatment can be intensive and resource demanding.
- Staffing: 8.5 FTE ICAMHAS and 3.3 FTE SUPP.

Health Quality Safety Commission (HQSC)

The five HQSC Mental Health & Addictions projects are:

1. Zero Seclusion – towards eliminating seclusion by 2020: current project since April-May 2018
2. Connecting Care – improving service transitions: commenced and in initial phase
3. Learning from Serious Adverse Events: introduction March 2019
4. Maximising physical health: start date to be advised
5. Improving medication management and prescribing: start date to be advised.

PRIMHD compliance

Whanganui District Health Board (WDHB) Mental Health and Addictions Services (MH&AS) was one of the first of the central regional district health boards to adopt webPAS. The information and communication technology change was challenging and the service has had to compromise workflows for the most of the year. Although all the issues are still being worked though, the MH&AS has been awarded full PRIMHD (the national collection for Mental Health and Addictions data) compliance by the Ministry of Health with a rating of 99.03%.

7.6 Service Improvement Initiatives – Workforce and Organisational Development

Leads: Hentie Cillers, General Manager People and Performance

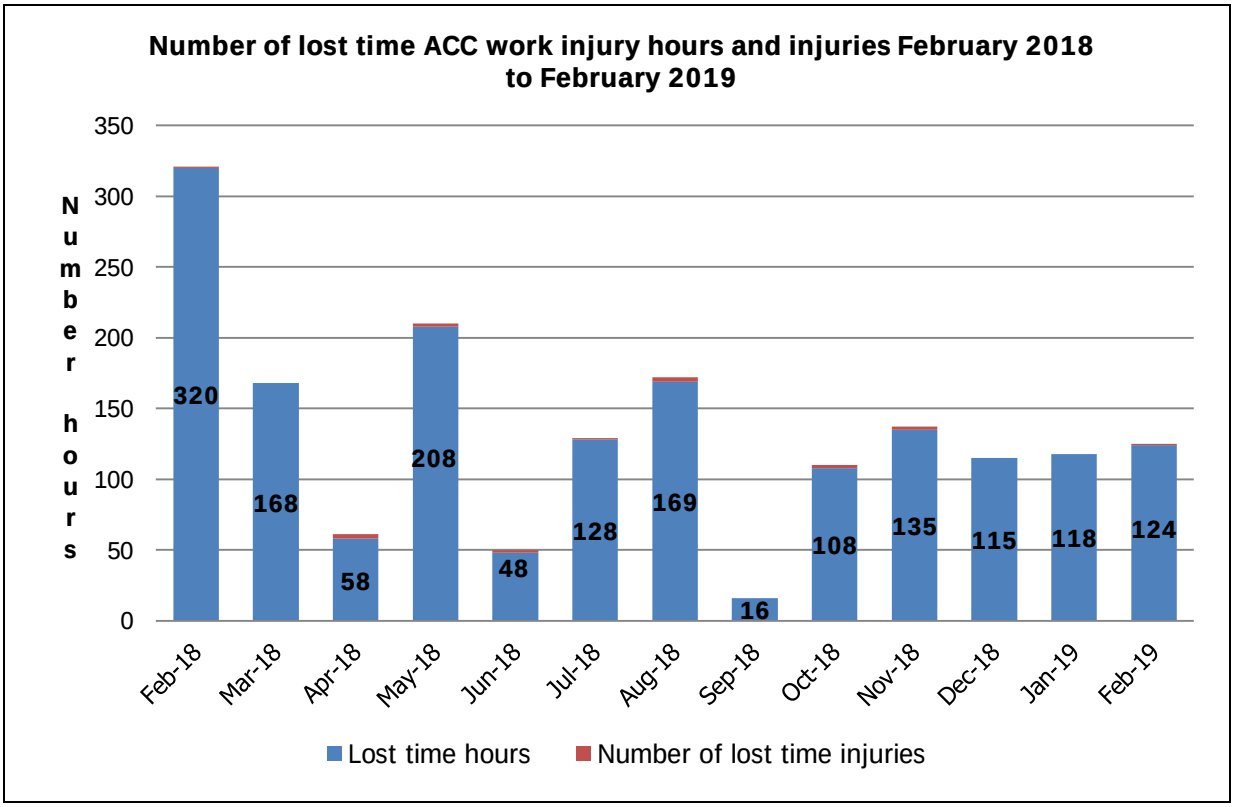
Purpose
The purpose of this report is to update the Combined Statutory Advisory Committee.

Health and Safety March 2019

Staff injuries
Forty six injuries were reported in November to February, twelve of which are an ACC claim. There were three lost time injuries recorded from November to February.

Return to work plans
From November to February, one employee with a work related injury, eight employees with a non-work related injury and four with a medical condition were on return work plans.

Notifiable injuries or events
There were no notifiable injuries or events notified to WorkSafe New Zealand in from November to February.



The graph above details lost time ACC work injury hours from February 2018 to February 2019. The numbers above the columns represent the number of lost time injuries. There were three ACC lost time injuries registered through payroll from November 2018 to February 2019.

1. Employee hit on side of head when observation machine fell
2. Employee tripped and twisted knee when stepping off a step at a client's home
3. Employee injured ribs after tripping over a box.

7.7 Financial Performance

Leads: Matt Power, Funding and Contracts Manager
Kath Fraser-Chapple, Business Manager Medical, Community & Allied Health
Peter Wood-Bodley, Business Manager Surgical Services and Procurement
Mike Bothma, Business Manager Mental Health and Addictions

Purpose

The purpose of this report is to update the committee on the Funder arm and Provider arm financial performance for the period ending 28 February 2019.

7.7.1 Whanganui DHB Summary

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2019 ($000s)
CONSOLIDATED

	Month				Year to Date				Annual	
	Actual	Budget	Var		Actual	Budget	Var		Budget 2018-19	Actual 2017-18
Provider Division	(523)	(588)	65	F	(7,022)	(6,555)	(467)	U	(8,442)	(5,504) U
Corporate	(9)	(43)	34	F	(100)	(315)	215	F	27	1,189 F
Provider & Corporate	**(532)**	**(631)**	**99**	**F**	**(7,122)**	**(6,870)**	**(252)**	**U**	**(8,415)**	**(4,315) U**
Funder Division	768	764	4	F	792	520	272	F	526	(366) U
Governance	36	18	18	F	130	2	128	F	3	502 U
Funder divison & Governance	**804**	**782**	**22**	**F**	**922**	**522**	**400**	**F**	**529**	**136 U**
Net Surplus / (Deficit)	**272**	**151**	**121**	**F**	**(6,200)**	**(6,348)**	**148**	**F**	**(7,886)**	**(4,179) U**

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

The financial results for the first 8 months of 2018/19 show a $148k favourable variance to budget.

7.7.2 Whanganui DHB Funder

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2019 ($000s)
FUNDER DIVISION

	Month				Year to Date				Annual	Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2018-19	Actual 2017-18
REVENUE										
Government and Crown agen	20,296	20,160	136	F	162,783	161,204	1,579	F	242,267	234,232
Inter-district Inflow	666	622	44	F	4,980	4,974	6	F	7,461	7,313
Other Income Revenue	39	29	10	F	205	279	(74)	U	406	502
Total Revenue	**21,001**	**20,811**	**190**	**F**	**167,968**	**166,457**	**1,511**	**F**	**250,134**	**242,047**
EXPENDITURE										
Personal Health	7,765	7,895	130	F	65,074	65,674	600	F	99,079	95,358
Disability Support	268	268	-	F	2,143	2,143	-	F	3,214	3,054
Mental Health	1,529	1,529	-	F	12,252	12,229	(23)	U	18,343	17,897
Public Health	14	6	(8)	U	111	49	(62)	U	73	245
Maori Services	9	9	-	F	73	73	-	F	110	108
Total own provider expenditur	**9,585**	**9,707**	**122**	**F**	**79,653**	**80,168**	**515**	**F**	**120,819**	**116,662**
Personal Health	3,563	3,440	(123)	U	29,783	29,271	(512)	U	44,049	42,352
Disability Support	2,263	2,275	12	F	19,569	19,415	(154)	U	29,154	28,575
Mental Health	734	641	(93)	U	5,241	5,125	(116)	U	7,688	7,380
Public Health	77	91	14	F	645	729	84	F	1,094	869
Maori Services	130	131	1	F	1,090	1,129	39	F	1,654	1,557
Inter-district Outflow	3,551	3,432	(119)	U	28,554	27,459	(1,095)	U	41,189	41,134
Total Other provider expenditu	**10,318**	**10,010**	**(308)**	**U**	**84,882**	**83,128**	**(1,754)**	**U**	**124,828**	**121,867**
Governance	330	330	-	F	2,641	2,641	-	F	3,961	3,884
Total Expenditure	**20,233**	**20,047**	**(186)**	**U**	**167,176**	**165,937**	**(1,239)**	**U**	**249,608**	**242,413**
Net Surplus / (Deficit)	**768**	**764**	**4**	**F**	**792**	**520**	**272**	**F**	**526**	**(366)**

Revenue

$1,511k favourable variance to budget for the Funder Division mainly due to:

- Anticipated pay equity revenue from the Ministry of Health ($383k) offset by additional expenditure. This funding is passed on in full to providers to meet their obligations under the pay equity settlement
- A one off wash-up on 2016/17 and 2017/18 in-between travel costs ($431k)
- Funding to extend access to primary care ($400k) offset be additional expenditure
- Funding for MECA increases ($231k) offset by own provider costs
- Electives wash-up of ($93k).

Own provider - internal

- $515k favourable variance to budget with internal provider. Mainly due to $1,014k electives favourable wash up with own provider (offset by provider division unfavourable variance). This is partially offset by payments for MECA increases, higher than expected adolescent dental expenditure and pharmaceutical expenditure due to more pharmaceutical cancer treatment being delivered in Whanganui rather than by MidCentral DHB.

Other provider - external

- Payments to external providers and other DHBs are $1,754k unfavourable to budget. This is mainly due to a $1,095k unfavourable variance to budget for inter-district outflows based on a 12 monthly rolling average of demand, $556k unfavourable variance in community pharmaceutical expenditure.
- Primary care initiatives are $185k unfavourable to budget with less than expected costs keeping the unfavourable variance lower than additional revenue.
- Pay equity expenditure is $383k unfavourable to budget. There is additional revenue to offset this variance.
- There is $165k favourable variance in health of older people expenditure, with $356k favourable variance in aged residential care expenditure care offset by $191k unfavourable variance in homebased support and other expenditure.
- Travel assistance payments are favourable to budget by $139k with immunisation expenditure $63k unfavourable to budget.

Consolidated financial performance for Provider and Corporate February 2019

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2019 ($000s)
PROVIDER & CORPORATE

	Month				Year to Date				Annual	Actual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget	2017-18
REVENUE										
Government and Crown agency	712	672	40	F	6,557	6,940	(383)	U	11,608	10,508
Funder to Provider Revenue (internal)	9,584	9,707	(123)	U	79,654	80,167	(513)	U	120,819	116,987
Other income	102	94	8	F	1,013	881	132	F	1,529	1,382
Total Revenue	**10,398**	**10,473**	**(75)**	**U**	**87,224**	**87,988**	**(764)**	**U**	**133,956**	**128,877**
EXPENDITURE										
Personnel										
Medical	1,750	1,877	127	F	14,817	15,611	794	F	23,786	21,788
Nursing	3,079	3,096	17	F	26,311	26,230	(81)	U	39,471	34,978
Allied	899	959	60	F	7,714	8,293	579	F	12,471	10,861
Support	67	61	(6)	U	538	531	(7)	U	794	745
Management & Admin	863	859	(4)	U	7,316	7,503	187	F	11,234	10,332
Total Personnel(Exl other & outsourced)	**6,658**	**6,852**	**194**	**F**	**56,696**	**58,168**	**1,472**	**F**	**87,756**	**78,704**
Personnel Other	164	201	37	F	1,326	1,352	26	F	2,163	1,720
Outsourced Personnel	599	481	(118)	U	4,518	3,902	(616)	U	5,980	5,912
Total Personnel Expenditure	**7,421**	**7,534**	**113**	**F**	**62,540**	**63,422**	**882**	**F**	**95,899**	**86,336**
Outsourced Clinical Service	598	557	(41)	U	4,740	4,717	(23)	U	7,103	6,888
Clinical Supplies	1,150	1,211	61	F	11,081	10,766	(315)	U	15,961	15,102
Infrastructure & Non Clinical Supplies Costs	991	1,006	15	F	9,677	9,549	(128)	U	13,754	13,286
Capital Charge	281	284	3	F	2,400	2,407	7	F	3,543	3,262
Depreciation & Interest	445	463	18	F	3,514	3,593	79	F	5,517	5,206
Internal Allocation	44	49	5	F	394	404	10	F	594	696
Total Other Expenditure	**3,509**	**3,570**	**61**	**F**	**31,806**	**31,436**	**(370)**	**U**	**46,472**	**44,440**
Total Expenditure	**10,930**	**11,104**	**174**	**F**	**94,346**	**94,858**	**512**	**F**	**142,371**	**130,776**
Net Surplus / (Deficit)	**(532)**	**(631)**	**99**	**F**	**(7,122)**	**(6,870)**	**(252)**	**U**	**(8,415)**	**(1,899)**
FTEs										
Medical	107.3	116.5	9.2	F	103.0	111.2	8.2	F	112.3	101.2
Nursing	481.2	461.0	(20.2)	U	459.8	455.3	(4.6)	U	455.0	424.2
Allied	149.9	159.9	10.0	F	149.1	160.8	11.7	F	160.7	147.5
Support	14.6	15.9	1.3	F	14.9	16.0	1.1	F	16.0	14.8
Management & Admin	176.3	170.5	(5.8)	U	169.3	171.4	2.1	F	171.4	166.1
Total FTEs	**929.3**	**923.8**	**(5.5)**	**U**	**896.2**	**914.7**	**18.5**	**F**	**915.4**	**853.9**

STATEMENT OF FINANCIAL PERFORMANCE by Cluster ($000s) for the period ended 28 February 2019

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
Surgical Cluster	**313**	**424**	**(111)**	**U**	**2,860**	**3,206**	**(346)**	**U**	**4,977**
Medical Cluster	**266**	**317**	**(51)**	**U**	**2,714**	**3,343**	**(629)**	**U**	**4,962**
Allied Health Cluster	**(566)**	**(571)**	**5**	**F**	**(5,585)**	**(5,595)**	**10**	**F**	**(7,966)**
Mental Health Cluster	**(41)**	**(24)**	**(17)**	**U**	**(1,186)**	**(1,184)**	**(2)**	**U**	**(1,679)**
Public Health& Community Cluster	**(104)**	**(140)**	**36**	**F**	**(512)**	**(1,040)**	**528**	**F**	**(1,619)**
Corporate & Other Service	**(400)**	**(637)**	**237**	**F**	**(5,413)**	**(5,600)**	**187**	**F**	**(7,090)**
Net Surplus / (Deficit)	**(532)**	**(631)**	**99**	**F**	**(7,122)**	**(6,870)**	**(252)**	**U**	**(8,415)**

Month result

The favourable variance for the month of $99k was mainly due to personnel costs.

Overall volumes were 87% of budget, with acute at 94% and elective at 76%. Electives reflect a planned drop in orthopaedic volumes; general surgery was also lower due to leave. Both dental and gynaecology electives are over budget for the month.

The reduction in elective volumes has resulted in a $353k reduction in revenue from the funder as elective volumes are paid on a fee for service basis. This was offset by additional $235k Ministry of Health funding for the PSA nurses and allied health MECA settlements, the costs of which we have

absorbed. Other revenue was favourable to budget mainly due to increased ACC revenue. A large portion of this relates to Belverdale Hospital, and are offset by associated costs.

Personnel and outsourced medical costs are favourable to budget, mainly due to vacancies in allied health and medical job groups. Nursing costs were also favourable to budget, but not FTE. This was due to the staff mix, with less senior nurses being used. A portion of the favourable variances in medical is offset by outsourced cost with obstetrics and gynaecology and mental health reflecting the largest usage of locums for the month to cover vacancies.

Outsourced service costs are unfavourable to budget due to rest home convalescence which was under-accrued in previous months. The year-to-date figure is equal to budget. Pacific Radiology costs were slightly over budget due to volumes.

Clinical supply costs are favourable to budget as expected with the lower elective and acute volumes. Pharmaceutical costs are over budget as we continue to see a rise in Cytotoxic drug costs which is a cancer drug. Some expired antidote drugs added $12k to the variance. This is a hospital-only drug that must be held in case of urgent need. Most years, the drug is turned over adequately through usage.

All other clinical supply costs are favourable to budget. We have another two high needs patients who had a combined usage of $24k of bloods for the month. This could impact negatively in coming months.

Infrastructure/non-clinical costs are favourable to budget mainly driven by IT costs.

Year-to-date result

The year-to-date result is $252k unfavourable, a further decrease this month. Revenue and clinical supply costs are the main drivers of the overall unfavourable variance, slightly offset by personnel costs that are reflecting a favourable variance.

Revenue is unfavourable to budget due to the continued planned reduction in electives which are currently at 91% of target. ACC cases have also reduced and this has resulted in reduced revenue with offsetting reduced costs in clinical supply costs.

Personnel costs are favourable to budget in all job groups except nursing. Numerous vacancies, especially in medical RMOs, are the main reason for the favourable variances. Nursing costs are under pressure as volumes and acuity continue to remain very high. Wards are under pressure with volumes in excess of 90% combined with high acuity.

Clinical supply costs are unfavourable to budget due to increased pharmacy costs which are volume-driven and have some offsetting revenue. Blood costs are also over budget due to a few long-term patients with very high blood needs. These costs are being monitored and everything is being done to reduce costs. Mobility aid costs are unfavourable to budget as additional clinics are run with a view of reducing the amount of elective surgery by the use of orthotics.

Patient meals and additional orderly costs are unfavourable to budget as a direct result of higher volumes throughout the hospital.

Outlook and mitigations

High volumes over the first five months of the year has declined in the last three months where patient volumes have been under budget. The volume trend for the balance of the year remains uncertain although a volume increase is likely as we move into winter months.

MECA settlements have been running at between 4.5 and 5% and remain a risk until the Government agrees to fund the unbudgeted cost impact. Overall, personnel costs are expected to remain close to budget.

Variable costs such as clinical supplies have moderated with the reduction in volumes. Growth in pharmaceutical costs is evident, partly driven by local provision of chemotherapy services.

Appendix One – Cluster reporting

1. Surgical Services Cluster Financial Results and Commentary for February 2019

Lead: Barbara Walker Management Accountant

STATEMENT OF FINANCIAL PERFORMANCE ($000s)
SURGICAL CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	333	312	21	F	2,448	2,810	(362)	U	4,429
Funder to Provider Revenue (internal)	3,477	3,846	(369)	U	30,753	31,961	(1,208)	U	48,074
Other income	11	9	2	F	152	88	64	F	131
Total Revenue	**3,821**	**4,167**	**(346)**	**U**	**33,353**	**34,859**	**(1,506)**	**U**	**52,634**
EXPENDITURE									
Personnel	1,687	1,859	172	F	14,844	15,641	797	F	23,612
Personnel Other	43	55	12	F	321	349	28	F	556
Outsourced Personnel	427	377	(50)	U	3,193	3,095	(98)	U	4,763
Total Personnel Expenditure	**2,157**	**2,291**	**134**	**F**	**18,358**	**19,085**	**727**	**F**	**28,931**
Outsourced Clinical Service	184	148	(36)	U	1,263	1,369	106	F	2,082
Clinical Supplies	502	625	123	F	5,020	5,314	294	F	7,996
Infrastructure & Non Clinical Supplies Costs	178	185	7	F	1,519	1,536	17	F	2,300
Depreciation, Interest & Internal Allocation	487	494	7	F	4,333	4,349	16	F	6,348
Total Other Expenditure	**1,351**	**1,452**	**101**	**F**	**12,135**	**12,568**	**433**	**F**	**18,726**
Total Expenditure	**3,508**	**3,743**	**235**	**F**	**30,493**	**31,653**	**1,160**	**F**	**47,657**
Net Surplus / (Deficit)	**313**	**424**	**(111)**	**U**	**2,860**	**3,206**	**(346)**	**U**	**4,977**
FTEs									
Medical	29.9	30.9	1.0	F	29.0	30.6	1.7	F	30.54
Nursing	147.7	151.3	3.6	F	144.5	149.0	4.5	F	149.08
Allied	1.2	2.7	1.5	F	2.2	2.7	0.5	F	2.73
Support	7.0	8.4	1.4	F	7.6	8.4	0.8	F	8.40
Management & Admin	22.5	28.7	6.1	F	26.3	28.8	2.5	F	28.81
Total FTEs	**208.3**	**222.0**	**13.6**	**F**	**209.5**	**219.6**	**10.1**	**F**	**219.6**

Month

A surplus of $313k is reflected for the month, that is, an unfavourable variance to budget of $111k for February. This primarily due to lower revenue due to delivery of elective CWD below budget. FTE is also favourable to budget by 13.6 FTE. Revenue is above budget for ACC surgery and assessments $23k, however elective volumes delivered below contract (general surgery 17.9 CWD, ophthalmology 4.8 CWD, orthopaedics 55.4, and urology 4.7 CWD) this being reduced by over-delivery in the other specialities to a net of 70.2CWD has impacted February's result by $369k under budget. Personnel costs are favourable to budget by $134k (in medical costs training $22k and overtime $42k, nursing ordinary time $106k under), this is however offset by outsourced personnel $50k unfavourable, mainly due to the long term locum costs of the O & G SMO $35k over. Both elective and acute volumes were delivered below the contracted volumes (acute 87% delivery and electives 73% delivery). In line with the lower service delivery other expenses were $101k below budget. Rest home convalescence, Belverdale implant costs and pharmaceuticals all over budget being offset by under spends in other areas primarily implants and prostheses $63k and treatment disposables $53k.

Year to date

Year to date the Surgical Cluster reflects a result of a surplus of $2,860k being a total of $346k unfavourable to budget and 10.1 FTE favourable. Elective volumes under delivered to budget by 238CWD or $1,206k and ACC income $363k unfavourable to budget. For the cluster overall CWD are below contracted volumes by 502 CWD or 10% (acute 90.7% and electives 88.4% delivery). In line with lower delivery volumes YTD expenditure is also less than budget by $1,160k. Personnel expenses under budget comprising, medical $330k and 1.7 FTE, nursing $391k and 4.5 FTE, Administration $89k and 2.5FTE, (administration impacted by the transfer of expenses from 1 January). Outsourced personnel the only area overspent $98k, (long term Gynaecology locum to cover a vacancy $191k over, Anaesthetic SMO locum cover for sabbatical leave during July and August $53k over, these being offset by underspends in Urology $121k due to reduced sessions provided by MCDHB until a 5th Urologist is appointed). Pharmaceuticals and facilities being the only areas over budget YTD.

Outlook and mitigations

Key focuses for the Surgical Cluster are to manage PVS and maintain both the nursing and clinical supplies costs within the budget. Changes to the Orthopaedic surgery rosters have been implemented that appear to have impacted on volumes. Timely and correct ACC claiming is also a priority and claiming for last year's ACC is now underway. YTD overall acute volumes are under delivered, however,

General Surgery continues to be over delivered. It is important that acute volumes are not exceeded as excess acutes delivery will drive unfunded costs for the cluster, to date acutes delivery is well controlled.

N.B. Ward administration was transferred to Hospital Admin cluster as from 1 January 2019. The FTE and budget comparative relating to the Administration function will continue to show in the Surgical Cluster until financial year end.

2. Medical Services Cluster Financial Results and Commentary for February 2019

Lead: Barbara Walker Management Accountant

STATEMENT OF FINANCIAL PERFORMANCE ($000s)
MEDICAL CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	101	95	6	F	1,054	1,098	(44)	U	1,764
Funder to Provider Revenue (internal)	2,515	2,515	-	F	21,371	21,371	-	F	32,090
Other income	8	7	1	F	66	53	13	F	80
Total Revenue	**2,624**	**2,617**	**7**	**F**	**22,491**	**22,522**	**(31)**	**U**	**33,934**
EXPENDITURE									
Personnel	1,641	1,636	(5)	U	13,663	13,486	(177)	U	20,552
Personnel Other	66	64	(2)	U	522	473	(49)	U	694
Outsourced Personnel	26	17	(9)	U	375	122	(253)	U	193
Total Personnel Expenditure	**1,733**	**1,717**	**(16)**	**U**	**14,560**	**14,081**	**(479)**	**U**	**21,439**
Outsourced Clinical Service	1	1	-	F	11	11	-	F	17
Clinical Supplies	197	158	(39)	U	1,470	1,356	(114)	U	2,073
Infrastructure & Non Clinical Supplies Costs	163	160	(3)	U	1,337	1,329	(8)	U	1,986
Depreciation, Interest & Internal Allocation	264	264	-	F	2,399	2,402	3	F	3,457
Total Other Expenditure	**625**	**583**	**(42)**	**U**	**5,217**	**5,098**	**(119)**	**U**	**7,533**
Total Expenditure	**2,358**	**2,300**	**(58)**	**U**	**19,777**	**19,179**	**(598)**	**U**	**28,972**
Net Surplus / (Deficit)	**266**	**317**	**(51)**	**U**	**2,714**	**3,343**	**(629)**	**U**	**4,962**
FTEs									
Medical	61.1	66.8	5.7	F	57.0	61.9	4.9	F	63.1
Nursing	142.9	127.9	(15.0)	U	134.6	124.2	(10.4)	U	124.3
Allied	-	-	-	F	-	-	-	F	-
Support	-	-	-	F	-	-	-	F	-
Management & Admin	0.8	3.0	2.2	F	2.4	3.1	0.6	F	3.1
Total FTEs	**204.9**	**197.7**	**(7.1)**	**U**	**194.0**	**189.1**	**(5.0)**	**U**	**190.4**

Month

A result of $266 surplus being $51k unfavourable to budget is reflected for the Medical Cluster for February. This is due to small overruns in medical and nursing staffing costs and outsourced contractors, with clinical supplies the largest area of over spend at $39k. This comprises pharmaceuticals $8k over (antidotes, infections, nutrition), patient appliances $4k (hover matts) and treatment disposables $31k (blood intragam $24k due to a high use patient requiring transfusions for a fortnight in medical ward, blood test $2k, IV supplies $9k over). Revenue was over budget $7k, due to favourable ACC revenue for AT&R Ward non-acute inpatient rehabilitation. Acute volumes were 2.5 CWD (99.3% delivery) under target volumes for the month. EDs' bed utilisation ran at 139%, CCU at 89% and the Medical Ward at 84%. The FTE is unfavourable to budget by 7.1 FTE and personnel costs $16k over budget. This was due to medical personnel of $4k over budget (although 5.7 FTE below budget, 4 strike days by the RMO's during February would contribute to this result), overspends in nursing personnel of $10k (15 FTE above budget). Part of this anomaly appears to be due to budget phasing of the FTE. Trendcare supports the nursing resource drawn to the cluster was in-line with clinical requirements.

Year to date

Year to date result for the Medical Cluster shows a surplus of $2,714k, this being unfavourable to budget $629k and 5 FTE. Total revenue is under budget by $31k due in main to ACC income being under budget by $36k, and outpatient clinics $16k. YTD CWD are over delivered to contract (77 CWD overall due to an excess delivery of 179 CWD in General Medicine, offset by delivery below contract in Emergency Medicine of 102 CWD). Expenditure is driven by this over delivery. This is reflected in personnel costs over budget by $479k (medical and admin personnel $132k under budget offset by nursing $358k over and outsourced locums $252k over budget). Other expense areas are $119k over budget, instruments and equipment $8k, other clinical $7k, pharmaceuticals $27k and treatment disposables $59k (mainly blood intragam $40k, for the high needs high use patient in the medical

ward for 4 months of this year and IV supplies $48k). Also in line with levels of service delivery support expenses are $31k over budget (patient meals $10k, additional orderlies $12k and laundry $14k).

Outlook and mitigations

Acute volumes have maintained the trend of over delivery of CWD to contract that was evident last year (YTD 153.2 CWD delivered above 2017 YTD volumes). High volumes will continue to drive unfunded costs, reduction of the volumes is needed to realign with budget as reduced volumes should match to a corresponding reduction in Personnel and Clinical costs. Locum RMO's to cover the roster is driving outsourcing costs. Although several RMO's commenced employment the impact of Schedule 10 resourcing means more recruitment will need to be undertaken, until that time expenditure on Locums will continue. ED nursing FTE was not increased in the 18/19 budget however actual FTE in 17/18 ran over budget and is currently 4.9 FTE average over budget. This is therefore a risk area for the 18/19 budget.

N.B. Ward administration was transferred to Hospital Admin cluster and 3 RCs previously reported in the Medical cluster were transferred to Patient Safety and Nurse Directorate as from 1 January 2019. The FTE and budget comparative relating to the Administration function will continue to show in the Medical Cluster until financial year end.

3. Allied Health Cluster Financial Results and Commentary for February 2019

Lead: Mike Bothma Management Accountant

STATEMENT OF FINANCIAL PERFORMANCE ($000s) for the period ended 28 February 2019
ALLIED HEALTH CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	190	173	17	F	1,462	1,440	22	F	2,243
Funder to Provider Revenue (internal)	1,023	1,016	7	F	8,564	8,188	376	F	12,264
Other income	14	23	(9)	U	271	267	4	F	492
Total Revenue	**1,227**	**1,212**	**15**	**F**	**10,297**	**9,895**	**402**	**F**	**14,999**
EXPENDITURE									
Personnel	833	853	20	F	7,179	7,369	190	F	11,084
Personnel Other	29	33	4	F	165	121	(44)	U	221
Outsourced Personnel	77	73	(4)	U	600	569	(31)	U	849
Total Personnel Expenditure	**939**	**959**	**20**	**F**	**7,944**	**8,059**	**115**	**F**	**12,154**
Outsourced Clinical Service	397	387	(10)	U	3,330	3,161	(169)	U	4,734
Clinical Supplies	170	146	(24)	U	1,988	1,651	(337)	U	2,219
Infrastructure & Non Clinical Supplies Costs	63	62	(1)	U	597	580	(17)	U	878
Depreciation, Interest & Internal Allocation	224	229	5	F	2,023	2,039	16	F	2,980
Total Other Expenditure	**854**	**824**	**(30)**	**U**	**7,938**	**7,431**	**(507)**	**U**	**10,811**
Total Expenditure	**1,793**	**1,783**	**(10)**	**U**	**15,882**	**15,490**	**(392)**	**U**	**22,965**
Net Surplus / (Deficit)	**(566)**	**(571)**	**5**	**F**	**(5,585)**	**(5,595)**	**10**	**F**	**(7,966)**
FTEs									
Medical	2.0	2.6	0.6	F	2.2	2.6	0.3	F	2.6
Nursing	9.4	7.0	(2.4)	U	8.8	7.1	(1.8)	U	7.1
Allied	103.6	106.5	2.9	F	101.7	106.9	5.2	F	106.8
Support	0.2	0.2	(0.0)	U	0.2	0.2	(0.0)	U	0.2
Management & Admin	12.1	15.4	3.3	F	15.5	15.5	0.0	F	15.5
Total FTEs	**127.3**	**131.6**	**4.4**	**F**	**128.4**	**132.2**	**3.8**	**F**	**132.1**

Month result

Allied Cluster is reflecting a small favourable variance for the month. Personnel costs and revenue reflect favourable variances which is partially offset by outsourced services and clinical supply costs.

Revenue is $15k favourable for the month with dental electives at 103% accounting for part of the favourable variance. Internal pharmaceutical revenue is also favourable to budget but this does have offsetting costs. Both high tech and MRI services ACC revenue reflects a favourable variance as the submission of claims are caught up with. Dental co-payments are slightly under budget but this is an invoicing issue as we only invoice patients on receipt of the Rapid Dental invoice for their dentures.

Personnel and outsourced personnel cost are favourable to budget due largely various vacancies. Nursing personnel costs is unfavourable to budget as we have a staff member returning to work after a long illness that cannot perform the full duty and this has resulted in additional staff being contracted. Outsourced cost are unfavourable to budget due higher than normal therapist outsourcing as well as medical locums for dentistry and the increased electives. Outsourced services cost is unfavourable to budget as the Pacific Radiology cost continues to exceed budget due to volumes.

Clinical supply cost is unfavourable to budget due mainly to pharmaceutical costs which are higher than budget. Cytotoxic drug costs continue to exceed budget, but there is offsetting revenue. The new Eye drug which is about $10k per month and not budgeted for, further increased the unfavourable variance as did the antidote drug cost which was high due to our current stock being replaced as it has expired. Blood costs was also higher than normal for the month. Clinical equipment minor purchases is also unfavourable to budget due various items purchased for the OT area.

Infrastructure cost are slightly over budget due to rental for the dental caravans which included a portion from January as well.

Year to date

The year to date variance is now reflecting an increased favourable variance due to this months increased revenue. Most of this increased revenue does however come with additional costs attached and we can see clinical supply costs unfavourable to budget due to the additional volumes. Personnel and outsourced cost are favourable to budget YTD due to the ongoing vacancies in Allied personnel. Outsourced service costs are unfavourable to budget due to the ever increasing radiology outsourced costs.

Outlook and mitigations

Personnel cost will increase as and when vacancies are filled mainly in the Allied job group. Pharmaceutical cost are going to be under pressure due to the $10k per month budget shortfall, as well as the cost of the new eye drug being used that was not budgeted. For most of these increased cost however, we should see increased revenue in the form of pharmaceutical internal revenue as well as internal PCT revenue. The radiology outsourced costs are also increasing and contribute to reducing the favourable variance.

4. Mental health and Addictions services Cluster Financial Results and Commentary for February 2019

Lead: Mike Bothma Management Accountant

STATEMENT OF FINANCIAL PERFORMANCE ($000s)" for the period ended 28 February 2019
MENTAL HEALTH CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	2	4	(2)	U	64	57	7	F	103
Funder to Provider Revenue (internal)	1,529	1,529	-	F	12,252	12,229	23	F	18,343
Other income	-	15	(15)	U	97	117	(20)	U	175
Total Revenue	**1,531**	**1,548**	**(17)**	**U**	**12,413**	**12,403**	**10**	**F**	**18,621**
EXPENDITURE									
Personnel	1,107	1,151	44	F	9,719	9,921	202	F	14,899
Personnel Other	12	16	4	F	86	129	43	F	221
Outsourced Personnel	46	-	(46)	U	216	-	(216)	U	-
Total Personnel Expenditure	**1,165**	**1,167**	**2**	**F**	**10,021**	**10,050**	**29**	**F**	**15,120**
Outsourced Clinical Service	-	1	1	F	2	4	2	F	7
Clinical Supplies	18	19	1	F	179	164	(15)	U	245
Infrastructure & Non Clinical Supplies Costs	111	107	(4)	U	912	890	(22)	U	1,331
Depreciation, Interest & Internal Allocation	278	278	-	F	2,485	2,479	(6)	U	3,597
Total Other Expenditure	**407**	**405**	**(2)**	**U**	**3,578**	**3,537**	**(41)**	**U**	**5,180**
Total Expenditure	**1,572**	**1,572**	**-**	**F**	**13,599**	**13,587**	**(12)**	**U**	**20,300**
Net Surplus / (Deficit)	**(41)**	**(24)**	**(17)**	**U**	**(1,186)**	**(1,184)**	**(2)**	**U**	**(1,679)**
FTEs									
Medical	11.9	13.5	1.6	F	12.5	13.4	0.9	F	13.36
Nursing	106.1	101.2	(4.9)	U	101.9	101.7	(0.2)	U	101.16
Allied	28.9	30.1	1.2	F	29.2	30.4	1.2	F	30.37
Support	-	-	-	F	-	-	-	F	-
Management & Admin	16.4	17.3	0.9	F	15.6	17.4	1.7	F	17.37
Total FTEs	**163.3**	**162.0**	**(1.3)**	**U**	**159.1**	**162.8**	**3.7**	**F**	**162.3**

Month result

The past few mon the high volumes in the service continues and that is seeing cost pressures across all areas which has resulted in an unfavourable variance to budget for the month.

Revenue is unfavourable to budget as we no longer have anyone seconded to the prison and the budget is set until year end as per the original contract.

Personnel and outsourced personnel cost are favourable to budget due mainly to vacancies held in the medical job group. Nursing costs have continued to escalate as the volumes remain very high. Nursing overtime is again very high. Volumes in Te Awhina has remained high and is currently at an average of 96% for the month. The favourable variance in personnel costs have been offset by large unfavourable variances for locums that are covering leave and vacancies in the medical job group.

Clinical supply cost are favourable to budget. The favourable variance is due mainly in patient related costs which has reduced over the past few months. Pharmaceutical costs offsets this favourable variance and has shown an increase in line with the volumes we are seeing.

The increased volumes is also reflected in patient meals which are unfavourable to budget for the month.

Year to date

The year to date figure is still reflecting a favourable variance. This is due to fairly large favourable variances for the other job groups apart from nursing. Clinical supply cost is favourable to budget with the reduced home base support cost, offsetting the higher than budgeted pharmaceutical costs. These higher costs as mentioned are purely volume driven. The infrastructure costs is also unfavourable to budget due to the higher than anticipated volumes.

Outlook and mitigations

The current high patient volumes are not expected to reduce as this seems to be a country wide problem. This will see continued pressure on staffing levels as well as clinical supplies. The situation is being monitored.

5. Public Health and Community Cluster Financial Results and Commentary for February 2019

Lead: Kylie Gibson Management Accountant

STATEMENT OF FINANCIAL PERFORMANCE ($000s) for the period ended February 2019
PUBLIC HEALTH & COMMUNITY CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	56	67	(11)	U	1,063	1,183	(120)	U	1,667
Funder to Provider Revenue (internal)	535	527	8	F	4,280	4,218	62	F	6,327
Other income	1	1	-	F	8	6	2	F	10
Total Revenue	**592**	**595**	**(3)**	**U**	**5,351**	**5,407**	**(56)**	**U**	**8,004**
EXPENDITURE									
Personnel	422	478	56	F	3,519	4,150	631	F	6,218
Personnel Other	6	4	(2)	U	50	39	(11)	U	61
Outsourced Personnel	-	-	-	F	-	-	-	F	-
Total Personnel Expenditure	**428**	**482**	**54**	**F**	**3,569**	**4,189**	**620**	**F**	**6,279**
Outsourced Clinical Service	-	-	-	F	-	-	-	F	-
Clinical Supplies	132	124	(8)	U	1,091	1,071	(20)	U	1,608
Infrastructure & Non Clinical Supplies Costs	36	30	(6)	U	270	266	(4)	U	398
Depreciation, Interest & Internal Allocation	100	99	(1)	U	933	921	(12)	U	1,338
Total Other Expenditure	**268**	**253**	**(15)**	**U**	**2,294**	**2,258**	**(36)**	**U**	**3,344**
Total Expenditure	**696**	**735**	**39**	**F**	**5,863**	**6,447**	**584**	**F**	**9,623**
Net Surplus / (Deficit)	**(104)**	**(140)**	**36**	**F**	**(512)**	**(1,040)**	**528**	**F**	**(1,619)**
FTEs									
Medical	0.2	0.3	0.1	F	0.2	0.3	0.1	F	0.29
Nursing	50.0	51.2	1.2	F	45.7	51.0	5.3	F	51.05
Allied	8.3	12.2	3.9	F	8.7	12.3	3.5	F	12.27
Support	1.2	1.0	(0.2)	U	1.2	1.0	(0.2)	U	1.02
Management & Admin	0.8	9.7	9.0	F	6.3	9.8	3.5	F	9.80
Total FTEs	**60.5**	**74.4**	**13.9**	**F**	**62.2**	**74.4**	**12.2**	**F**	**74.4**

Month result

For the month of February 2019 the public health and community cluster showed a favourable variance of $36k. This is due to favourable personnel costs within the cluster. There are vacancies in public health and community nurse specialities services which are currently being recruited to. Clinical supplies were over budget due to bandages and dressing costs as well as IV supplies, this is due to patient acuity. All public health costs remain within budget. Smoke free revenue is not budgeted so will show a favourable variance throughout the year of $7k per month. All administration stuff for the cluster have now been moved to a new RC which will show the cluster as favourable for the remainder of the financial year, current month is $22K. ACC revenue was unfavourable to budget for the month due to declined and held claims by ACC.

Year to date

For the YTD to December 2018 the public health and community cluster showed a favourable variance of $528k. $75k of this is due to the moving of admin staff. The remaining $453k is due to favourable personnel costs within the service. In the month of February many vacancies were filled so it is expected that this favourable variance will start to diminish. District nursing is now managing within their FTE budget but the cost of patient supplies continues to remain over budget, it is expected that this trend will continue due to patient acuity and type of product used. ACC is unfavourable to budget YTD, it is not expected that this will meet budget by year end.

Outlook and mitigations

All clinical vacancies in the service are actively being recruited to currently so it is expected that the favourable clinical personnel costs will start to diminish. Clinical supply costs were expected to trend slightly downward due to purchase of NPWT equipment, but the service continues to have a large number of patients requiring high costs dressings so the impact of this purchase has not been noticed. The service is now capturing data on all high cost consumables, this will enable review of dressing use to ensure right product for right patient. This data capture will also potentially increase ACC revenue claiming as well as lessen the number of products purchased for ACC clients by the WDHB. The public health service has a new contract for school based health services. Staff recruitment occurred during February. The funding will be received in March and will be backdated to cover the new staff. The new contract should have a slightly favourable result for the service.

7.8 Non Financial Quarterly Reporting

Leads: Paul Malan, General Manager Service and Business Planning,
Kilian O'Gorman, Business Manager Service and Business Planning

Purpose

The purpose of this item is to provide the committee with the results of our quarter two Ministry of Health reporting. Brief explanations are also provided for those items that were not achieved.

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Non Financial Quarterly Reporting
Quarter 2 2018-19
FINAL RATINGS

Achieved
Partially Achieved
Not Achieved
Not Applicable

Measures *(Notes follow at base of report)*	Detail	WDHB 2018/19 Performance target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Focus Area 1 (a) Improving equity for priority populations - pregnancy, early years, and and adolescence						
HT4: Increased Immunisation *see note 1	Indicator: 95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	≥95% Total	90%	86.2%		
HT7: Raising healthy kids	Indicator: by December 2017, 95% of children identified in B4SC will be offered a referral to a health professional	≥95% Total	88%	91%		
PP10: Oral Health- mean DMFT score at year 8	Ratio year 1 (Jan to Dec 2017) of Drilled, Missing or Filled Teeth : to healthy teeth Ratio year 2 (Jan to Dec 2018)	≤0.83 ≤0.83				
PP11: Children caries-free at five years of age	Ratio year 1 (Jan to Dec 2017) of children who are caries free as a % of all children Ratio year 2 (Jan to Dec 2018)	≥56% >56%				
PP12: Utilisation of DHB-funded dental services by adolescents (school year 9 up to and including age 17 years)	% utilisation of services year 1 (Jan to Dec 2017) % utilisation of services year 2 (Jan to Dec 2018)	≥85% ≥85%				
PP13: Improving the number of children enrolled in DHB funded dental services	Measure 1 : Pre-school children enrolled in DHB funded oral health services 0-4 years % year 1 (Jan to Jun) Measure 1 : Pre-school children enrolled in DHB funded oral health services 0-4 years % year 2 (Jul to Dec) Measure 2 : Enrolled pre-school and primary children overdue for their examinations 0-12 years % year 1 (Jan to Jun) Measure 2 : Enrolled pre-school and primary children overdue for their examinations 0-12 years % year 2 (Jul to Dec)	≥95.0% ≥95.0% ≤10.0% ≤10.0%				
PP21: Immunisation coverage (previous health target) *see note 2	Indicator 1: 95 per cent of two year olds are fully immunised Indicator 2: 95 per cent of four year olds are fully immunised Indicator 3: least 75% of girls 2004 birth cohort are fully immunised for HPV Indicator 4: at least 75% of those aged 65 years and over received an influenza vaccine Report on activities in the Annual Plan	≥95% ≥95% ≥75% ≥75% Narrative	86% 90% 71%	91% 86% n/a n/a		
PP25: Prime Minister's youth mental health project	Indicator: Progress local alliance Service Level Agreement plan to implement named initiatives/actions to improve primary care responsiveness to youth	Narrative report				
PP27: Supporting vulnerable children	Indicator: Progress actions and milestones identified in DHB Annual Plans / support the implementation of the Children's Action Plan and the Vulnerable Children Act 2014.	Narrative report				
PP37: Child Health Breastfeeding	70% of infants are exclusively or fully breastfed at three-months	≥70%				
PP39: Supporting health in schools	Report on activities within the Annual Plan	Narrative report				
PP44: Maternal Mental Health	B PP38 Delivering annual plan for each Government planning priority:BPS related components 17/23	Narrative report				
SI2: Delivery of regional service plans	A single progress report on behalf of the region agreed by all DHBs within that region	Narrative report				
SI13: Smoke free babies				n/a		
SI5: Delivery of Whānau Ora	Meet performance expectations across the five priority areas of Mental health, asthma, Oral health, Obesity, and Tobacco	Narrative report				
SI18: Newborn enrolment with General Practice *see note 3	55% of newborns enrolled by six-weeks of age 85% of newborns enrolled by three-months of age Report on activities in the Annual Plan	≥55% ≥85% Narrative report	n/a 86.00% n/a	n/a 67.00% n/a		

WHANGANUI DISTRICT HEALTH BOARD
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Non Financial Quarterly Reporting
Quarter 2 2018-19
FINAL RATINGS

Achieved
Partially Achieved
Not Achieved
Not Applicable

Measures *(Notes follow at base of report)*	**Detail**	**WDHB 2018/19 Performance target**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Focus Area 1 (b) Improving equity for priority populations -	**Adulthood and healthy ageing**					
HT3: Faster cancer treatment	Indicator: patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	90%	88%	86%		
HT5: Better help for smokers to quit	Primary - 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking	≥90%	85.7%	91%		
	Maternity -90 percent of pregnant women who identify as smokers, being offered advice and support to quit smoking		91.2%	97%		
PP6: Improving the health status of people with severe mental illness through improved access	Percentage of people domiciled in the DHB region, seen per year : Age 0-19	≥4.0% Maori		5.3%		
		≥4.0% Other		5.1%		
		≥4.0% Total		5.2%		
	Percentage of people domiciled in the DHB region, seen per year : Age 20-64	≥5.36% Maori		10.1%		
		≥5.36% Other		6.1%		
		≥5.36% Total		7.1%		
	Percentage of people domiciled in the DHB region, seen per year : Age 65+	≥1.8% Total		2.3%		
PP7: Improving mental health services using transition planning	The percentage of Child & Youth clients discharged from the community mental health and addiction services with a transition plan (95% of clients discharged will have a quality transition or wellness plan)	≥95%	98%	97%		
	95% of audited files meet accepted good practice	≥95%	93%	93%		
PP8: Shorter waits for non-urgent mental health and addiction services	80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year.					
	1) 0-19 yrs mental health provider arm <= 3 weeks 2) < = 8 weeks	1) ≥80%	83%	75.3%		
	3) 0-19 yrs addictions (provider arm & AOD NGO) <= 3 weeks 4) <= 8 weeks	2) ≥95%	99%	96.9%		
		3) ≥80%	88%	79.5%		
		4) ≥95%	96%	91.6%		
PP20: Improved management for long term conditions (CVD, diabetes and stroke)	**Focus area 1** Long term conditions - Report on delivery of the actions and milestones identified in the Annual Plan.	Reported via teleconference Qrtrs 1 & 3				
	Focus area 2: Diabetes Management (HbA1c) Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control <65mmol		87.80%	61.0%		
	>65<80mmol	>65<80mmol		17.0%		
	>81<100mmol	>81<100mmol		9.0%		
	>100mmol	>100mmol		4.00%		
	Focus area 3: Cardiovascular (CVD) health 90% of eligible population have had their CVD risk assessed in the last five years	≥90.0%	88.5%	89.7%		
	Percentage of Maori men aged 35-44 years who have had their CVD risk assesses in the last five years		61.6%	60.7%		
	Focus area 4: Acute heart service 70 percent of high-risk patients will receive an angiogram within 3 days of admission.	≥70.0%	63.0%	60.0%		
	Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZAC QI ACS and Cath/PCI registry **data collection within 30 days.**	≥95.0%	100.0%	100%		
	Over 99% of patients presenting with ACS who undergo coronary angiography have completion of ANZAC QI ACS and Cath/PCI registry **data collection within three months**	≥99.0%				
	Focus area 5: Stroke Services 10 percent of potentially eligible stroke patients thrombolysed	≥10%	23.0%	11.0%		
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥80.0%	94.0%	100.0%		
	80 percent of stroke patients transferred to ATR are transferred within 7 days of acute admission	≥80.0%	100.0%	78.0%		
PP21: Immunisation FA 3 Influenza 65+	Indicator 4: at least 75% of those aged 65 years and over received an influenza vaccine	≥75%	70%			
PP23: Improving wrap around services – health of older people	Indicator: Progress on delivery of the actions and milestones to improve wrap around services for older people identified in DHB Annual Plans	Narrative report				
PP26: Rising to the Challenge	Focus area 1: Primary mental health integration initiatives	Narrative report				
The Mental Health & Addiction Service Development Plan	Focus area 2: Draft suicide prevention and postvention plans	Narrative report				
	Focus area 3: Improving crisis response services	Narrative report				
	Focus area 4: Improve outcomes for children	Narrative report				
	Focus area 5: Improving employment and physical health of persons with low prevalence conditions	Narrative report				
PP30: Faster cancer treatment	Part A 31 day indicator : patients to receive their first cancer treatment (or other management) within 31 days of the decision to treat	≥ 85%	94%	93%		
PP31: Better help for smokers to quit in public hospitals *(Previous Health Target)* *see note 4	Secondary - 95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	≥95%	85%	81.6%		
PP36 Maori under the Mental Health Act	DHBs will reduce the number of Maori under s29 MHA by the end of the year	≤173 per 100,000	179	274		
PP43: Population Mental Health	Report on activities in the Annual Plan	Narrative report				
Output 1: Mental health output delivery against plan Volume delivery for specialist Mental health and addiction services is within:	a) five percent variance (+/-) of planned volumes for services measured by FTE	100%	106%	106%		
	b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day	85%	96%	96%		
	c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	n/a				
OS3: Inpatient length of stay	Elective LOS	≤1.45 (days)	1.47	1.43		
	Acute LOS	≤2.30 (days)	2.25	2.22		
OS08:Reducing Acute readmissions to hospital	Less than 11.8% of discharges will be readmitted acutely within 28 days	<11.8%		14.70		
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 45-64 (Maori)	5,565 per 100,000		12110		
	Age 45-64 (Total)			6538		
SI10: Cervical Screening	Improving cervical screening coverage to over 80% of all ethnicities	80%		79.9%		
SI11: Breast Screening	Improving breast screening coverage to over 70% of all ethnicities	70%		79.1%		
SI14: Disability Support Services	Report on activities in the Annual Plan	Narrative report				
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan	Narrative report				
SI17: Improving Quality	Report on activities in the Annual Plan	Narrative report				

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Non Financial Quarterly Reporting
Quarter 2 2018-19
FINAL RATINGS

Achieved
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Measures *(Notes follow at base of report)*	**Detail**	**WDHB 2018/19 Performance target**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
PP23: Improving wrap around services – health of older people	Indicator: Progress on delivery of the actions and milestones to improve wrap around services for older people identified in DHB Annual Plans	Narrative report				
PP26: Rising to the Challenge The Mental Health & Addiction Service Development Plan	Focus area 1: Primary mental health integration initiatives	Narrative report				
	Focus area 2: Draft suicide prevention and postvention plans	Narrative report				
	Focus area 3: Improving crisis response services	Narrative report				
	Focus area 4: Improve outcomes for children	Narrative report				
	Focus area 5: Improving employment and physical health of persons with low prevalence conditions	Narrative report				
PP30: Faster cancer treatment	Part A 31 day indicator : patients to receive their first cancer treatment (or other management) within 31 days of the decision to treat	≥ 85%	94%	93%		
PP31: Better help for smokers to quit in public hospitals *(Previous Health Target)* *see note 4	Secondary - 95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	≥95%	85%	81.6%		
PP36 Maori under the Mental Health Act	DHBs will reduce the number of Maori under s29 MHA by the end of the year	≤173 per 100,000	179	274		
PP43: Population Mental Health	Report on activities in the Annual Plan	Narrative report				
Output 1: Mental health output delivery against plan Volume delivery for specialist Mental health and addiction services is within:	a) five percent variance (+/-) of planned volumes for services measured by FTE	100%	106%	106%		
	b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day	85%	96%	96%		
	c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	n/a				
OS3: Inpatient length of stay	Elective LOS	≤1.45 (days)	1.47	1.43		
	Acute LOS	≤2.30 (days)	2.25	2.22		
OS08:Reducing Acute readmissions to hospital	Less than 11.8% of discharges will be readmitted acutely within 28 days	<11.8%		14.70		
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 45-64 (Maori)	5,565 per 100,000		12110		
	Age 45-64 (Total)			6538		
SI10: Cervical Screening	Improving cervical screening coverage to over 80% of all ethnicities	80%		79.9%		
SI11: Breast Screening	Improving breast screening coverage to over 70% of all ethnicities	70%		79.1%		
SI14: Disability Support Services	Report on activities in the Annual Plan	Narrative report				
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan	Narrative report				
SI17: Improving Quality	Report on activities in the Annual Plan	Narrative report				
Focus Area 3: ENABLERS of BETTER HEALTH & INDEPENDENCE						
HS: Supporting delivery of the New Zealand Health Strategy	Each DHB provides one highlight per strategy per quarter	Achievement report				
PP22: Improving system integration and SLMs	Indicator: Progress on delivery of the actions and milestones to improve integration identified in DHB Annual Plans	Narrative report				
PP32 Ethnicity Data in PHO and NHI registers	Combination data and narrative report on Progress with EDAT Ethnicity Data Audit Toolkit	Report				
PP33 Maori Enrollment in PHOs	Combination data and narrative report on Improving Maori enrollment to 90%	90%				
PP40: Responding to climate change	Report on activities in the Annual Plan	Narrative				
PP41 : Waste disposal	Report on activities in the Annual Plan	Narrative				
SI3: Ensuring delivery of service coverage	Report progress during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan	Narrative report				
SI16: Strengthening Public Delivery of Health Services	Meeting service coverage requirements and supporting sector inter-connectedness	Narrative report				
SI17: Improving Quality	Report on activities in the Annual Plan	Narrative report				
OS10: Improving the quality of data submitted to national collections	Focus area 1 - Improving the quality of identity data within the national health index	Various ratings against national collections				
	Focus area 2 - Improving the quality of identity data in the national health index and data provided to the national collection systems (NCS)					
	Focus area 3 – Improving the quality of PRIMHD					
Focus Area 3: ENABLERS of BETTER HEALTH & INDEPENDENCE						
HS: Supporting delivery of the New Zealand Health Strategy	Each DHB provides one highlight per strategy per quarter	Achievement report				
PP22: Improving system integration and SLMs	Indicator: Progress on delivery of the actions and milestones to improve integration identified in DHB Annual Plans	Narrative report				
PP32 Ethnicity Data in PHO and NHI registers	Combination data and narrative report on Progress with EDAT Ethnicity Data Audit Toolkit	Report				
PP33 Maori Enrollment in PHOs	Combination data and narrative report on Improving Maori enrollment to 90%	90%				
PP40: Responding to climate change	Report on activities in the Annual Plan	Narrative				
PP41 : Waste disposal	Report on activities in the Annual Plan	Narrative				
SI3: Ensuring delivery of service coverage	Report progress during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan	Narrative report				
SI16: Strengthening Public Delivery of Health Services	Meeting service coverage requirements and supporting sector inter-connectedness	Narrative report				
SI17: Improving Quality	Report on activities in the Annual Plan	Narrative report				
OS10: Improving the quality of data submitted to national collections	Focus area 1 - Improving the quality of identity data within the national health index	Various ratings against national collections				
	Focus area 2 - Improving the quality of identity data in the national health index and data provided to the national collection systems (NCS)					
	Focus area 3 – Improving the quality of PRIMHD					

System level measure results are included for information only - there are no quarterly ratings assigned by the Ministry.

Notes on Quarter Two 2018-19 for measures 'Not Achieved'

Note 1: HT Increased Immunisation
About 9% of this cohort (n=195) either 'opted off' or declined immunisation, with a further 5.1% being missed

Note 2: PP21 Immunisation coverage
About 6% - 8% these cohorts (n=440) either 'opt off' or decline immunisation, with just 2% of 24 month olds being missed by the programme, and 7% of 5 year olds. Data on influenza vaccinations is not available, as is off-season.

Note 3: New-born enrolment with general practice
Ministry of Health Note 2/2/19: as expected national enrolment coverage has decreased during Q2 to 66 percent mainly due to the early submission of registers prior to the Christmas break. Based on previous year trends we anticipate that Q3 will have significantly higher coverage.

Note 4: PP31 Better help for smokers to quit in public hospitals
We are currently working with IT to investigate if the recent decline in performance is system driven i.e., is 'advice given' not being picked up in the numerator appropriately, and if so, to what extent is this influencing results. There is little to suggest at this point, that any change in practice is underway, or failure by clinicians to follow best practice in Smoking Cessation protocols. We continue to be diligent in reiterating the appropriate messaging to those at the patient-clinician interface

Note 5: HT1 Shorter stays in emergency departments
This is an ongoing work programme to determine what steps need to be put in place to meet the target, including an assessment of ED staffing, the impact of transfer of patient care from ED and where delays are occurring in the process. Benchmarking is underway with TAS looking at data from other DHB's around levels of presentation per capita, staffing ratios etc.

8 Information papers

Attachment	Description	Page
1	St John Ambulance service data for WDHB region 2018 1. patients seen and not transported to ED 2. patients seen and transported to ED	
Reference attachments – combined committee interest		
2	Glossary	
3	Combined Statutory Advisory Committee - Terms of Reference	

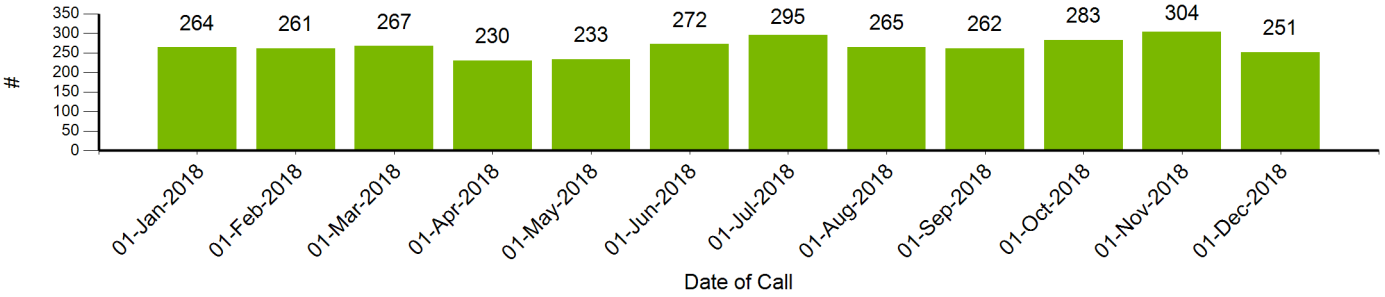
4 230 Summary - Patient Profile (Overall Sizing) By Incident ID

01-Jan-2018 to 31-Dec-2018

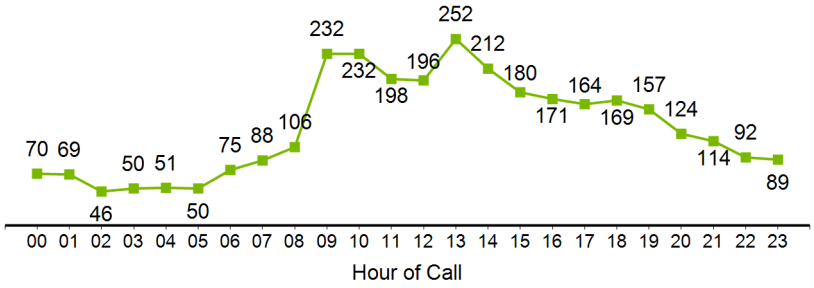
Patient Profile (Non-Transport) for Hawkes Bay, Horowhenua, Manawatu, Ruapehu, Whanganui Territory(s)

3,186	44%	38%	2%	17%	51%
# of incidents	% incidence at home	% patient with Status 4	% mental health crisis	% triggered by medical alarm	% equal or above 65 years old

Date of Call

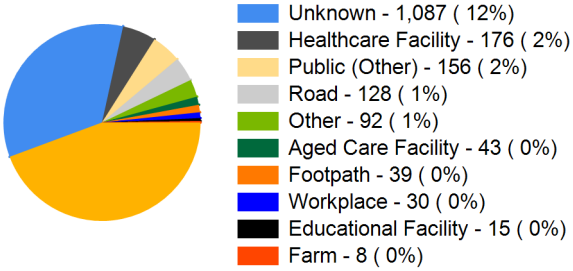


Hour of Day

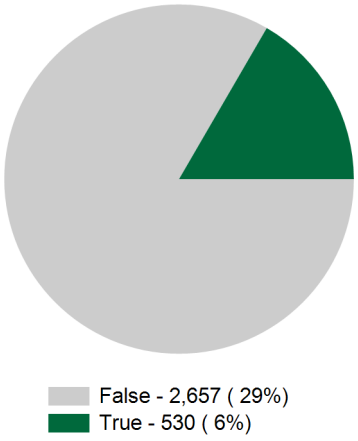


Day of Week

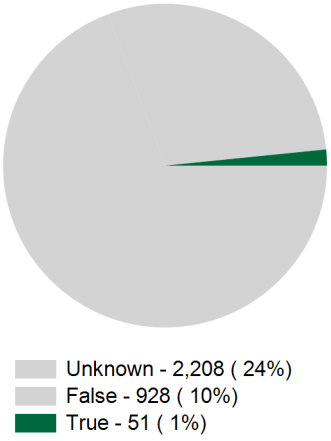
Incident Location



Medical Alarm Triggered



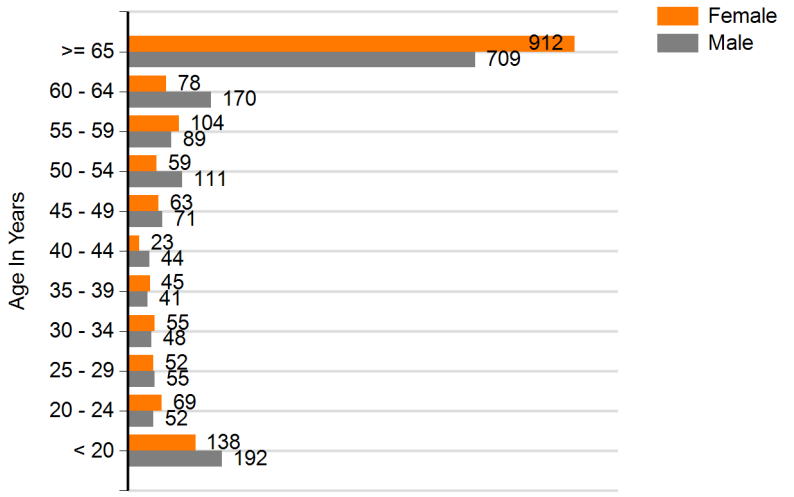
Mental Health Crisis



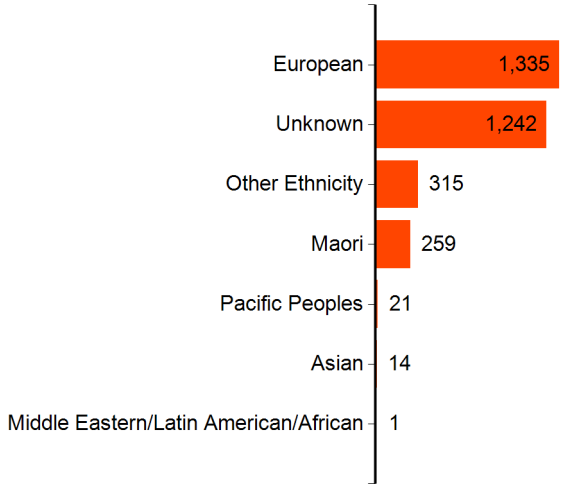
4 230 Summary - Patient Profile (Overall Sizing) By Incident ID

01-Jan-2018 to 31-Dec-2018

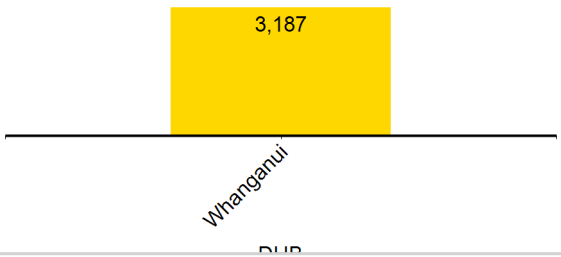
Age and Gender



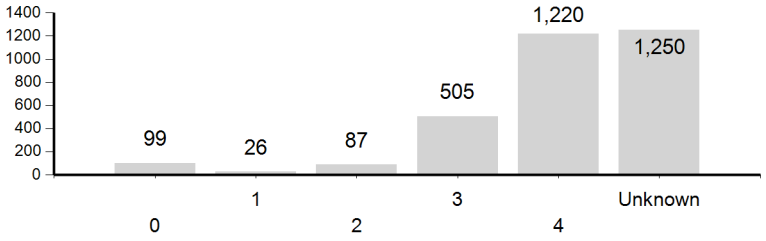
Ethnicity



DHB



Clinical Status Final

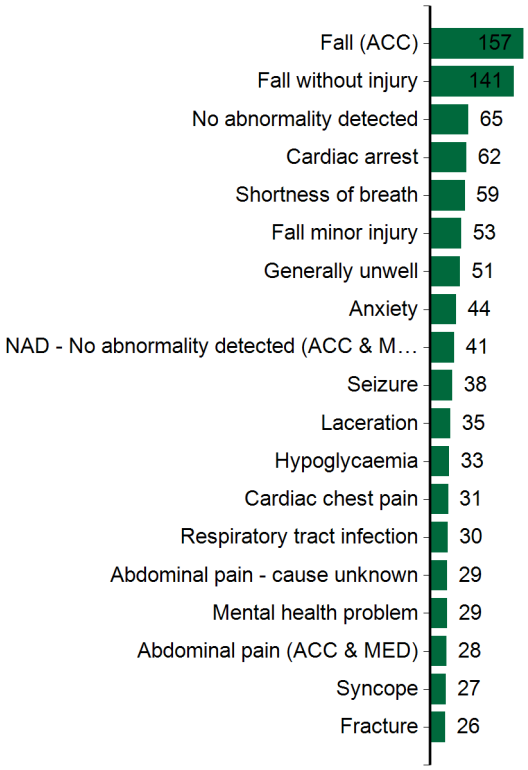


Outcome

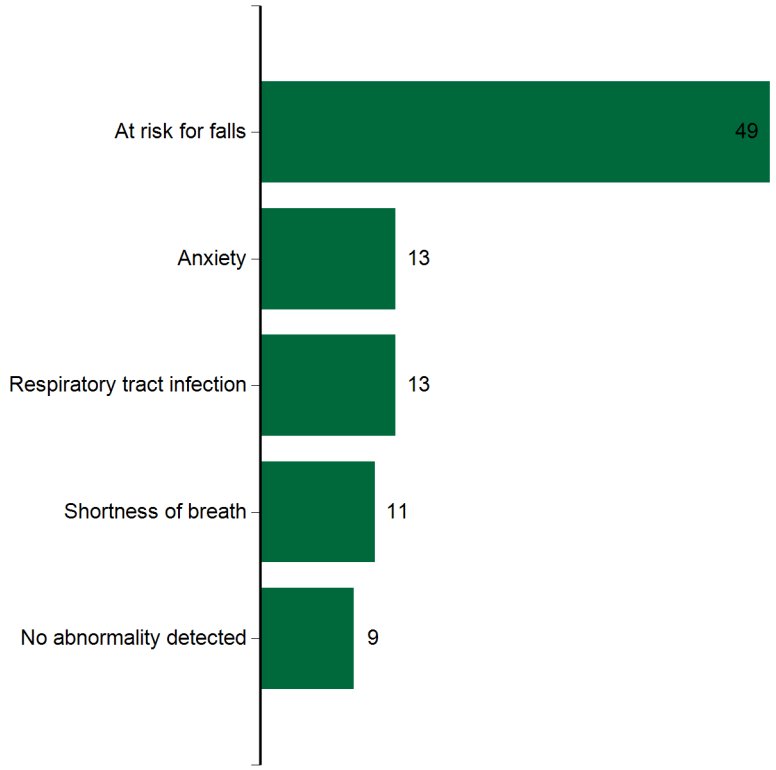
4 230 Summary - Patient Profile (Overall Sizing) By Incident ID

01-Jan-2018 to 31-Dec-2018

Primary Clinical Impression (Top 20)



Secondary Clinical Impression (Top 5)



Report parameter(s)

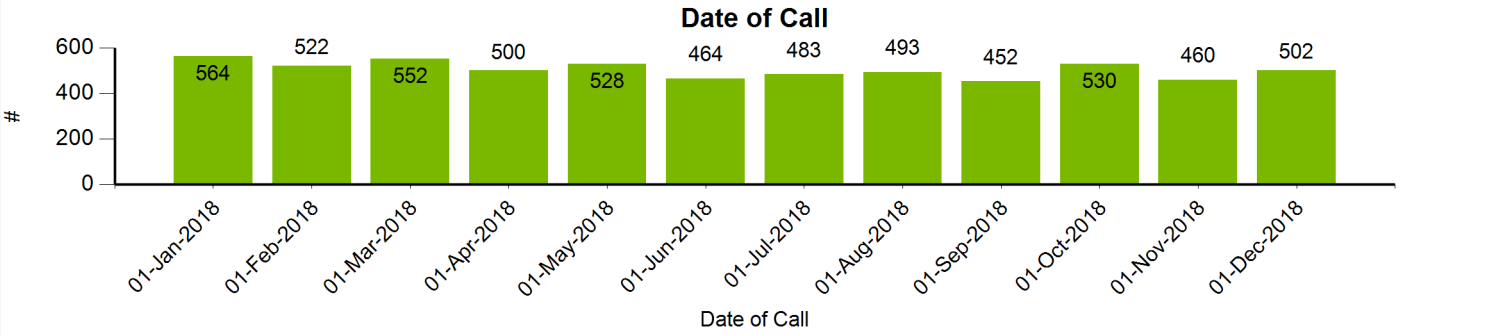
Clinical Hub Outcome: Attendance not treated, Cancelled, Other, See & Treat, Transport to non-ED, Unknown
Clinical Status Final: 0, 1, 2, 3, 4, Unknown

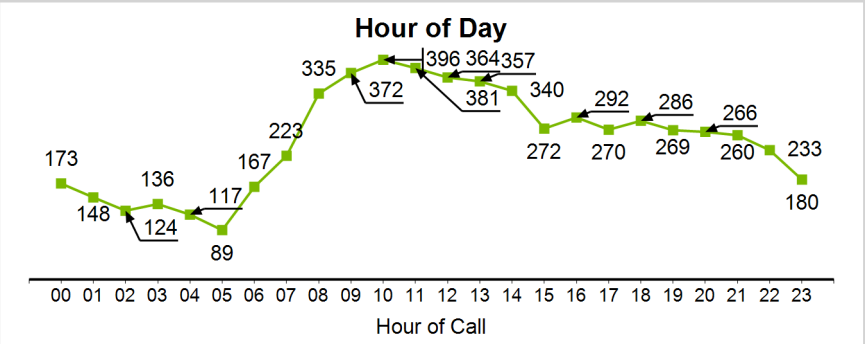
4 230 Summary - Patient Profile (Overall Sizing) By Incident ID

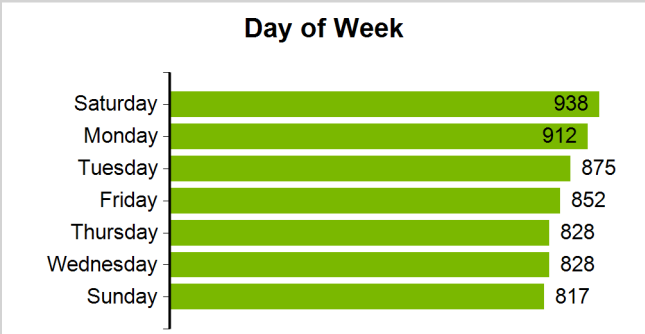
01-Jan-2018 to 31-Dec-2018

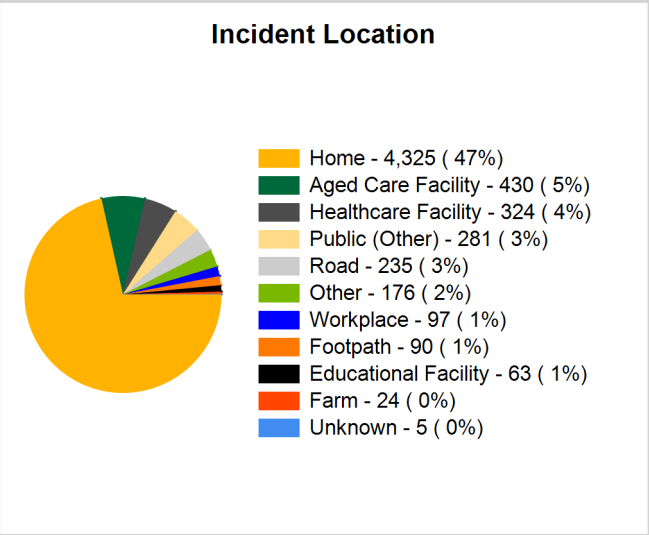
Patient Profile (Transport to ED) for Hawkes Bay, Horowhenua, Manawatu, Ruapehu, Whanganui Territory(s)

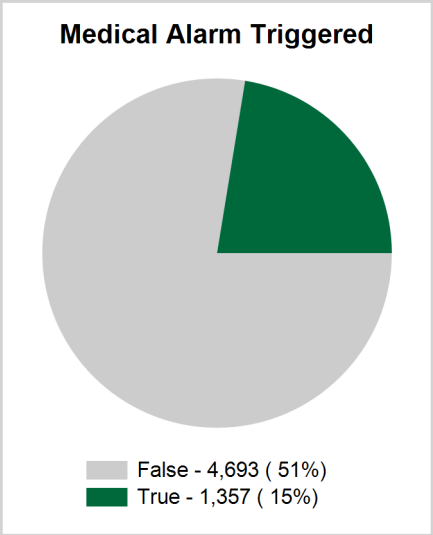
6,049	71%	13%	2%	22%	55%
# of incidents	% incidence at home	% patient with Status 4	% mental health crisis	% triggered by medical alarm	% equal or above 65 years old

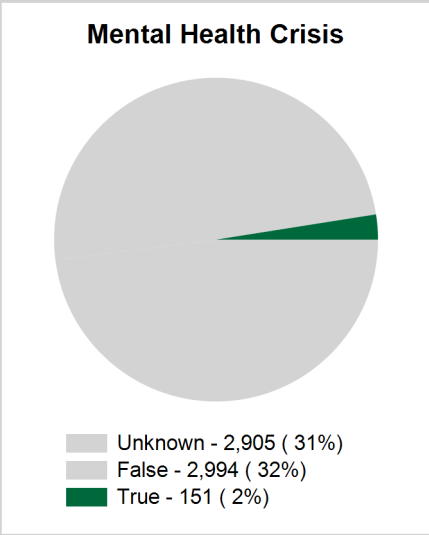








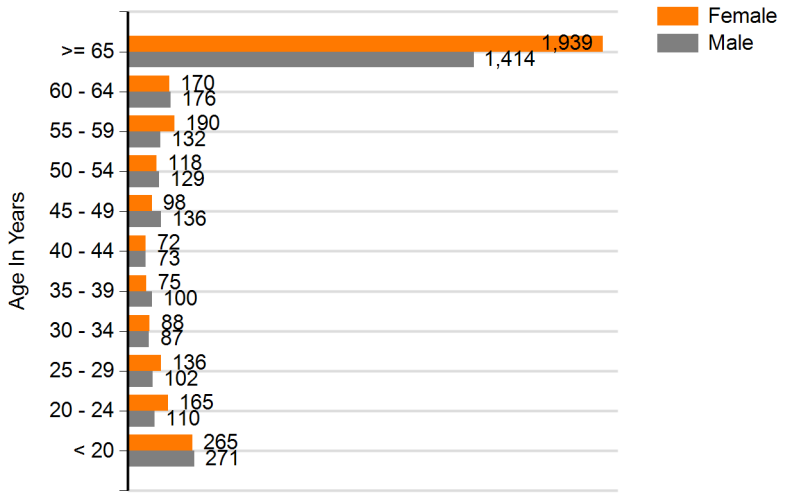




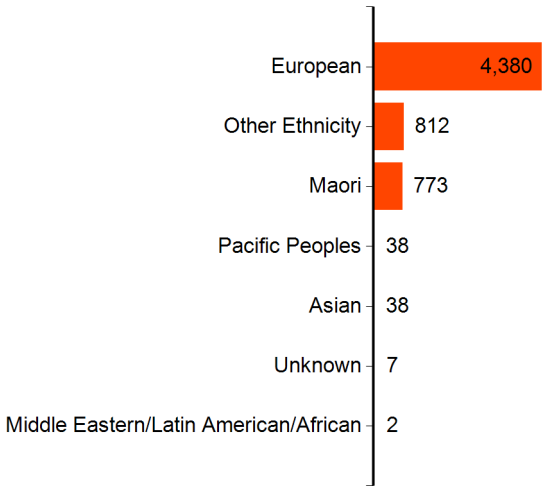
4 230 Summary - Patient Profile (Overall Sizing) By Incident ID

01-Jan-2018 to 31-Dec-2018

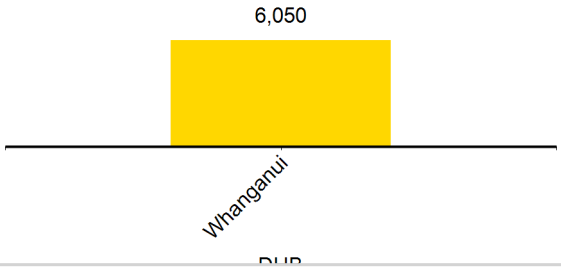
Age and Gender



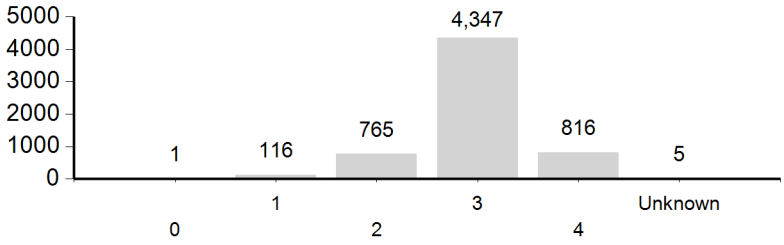
Ethnicity



DHB

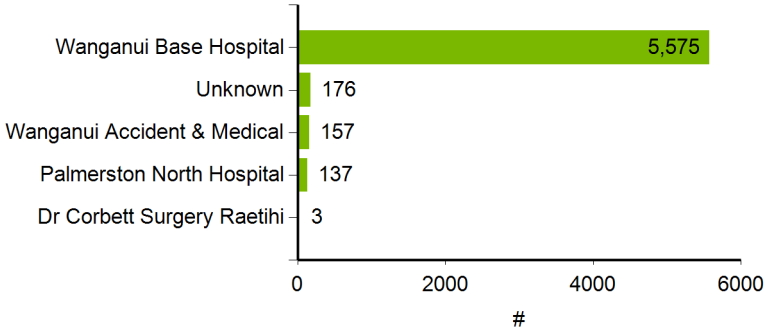


Clinical Status Final



Outcome

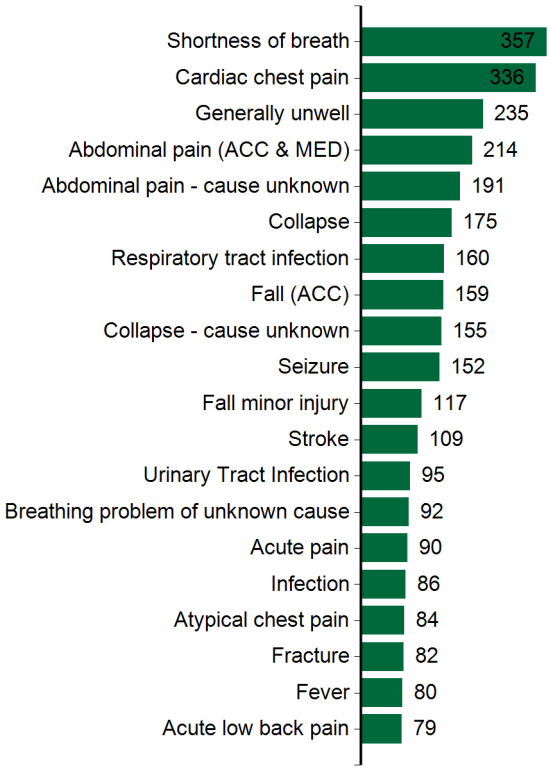
Destination of Transport (Top 5)



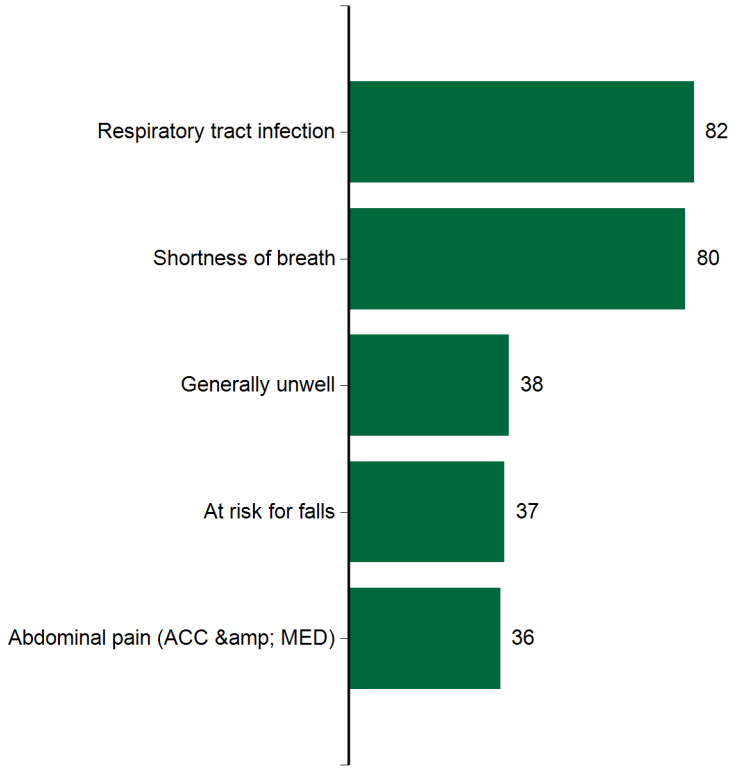
4 230 Summary - Patient Profile (Overall Sizing) By Incident ID

01-Jan-2018 to 31-Dec-2018

Primary Clinical Impression (Top 20)



Secondary Clinical Impression (Top 5)



Report parameter(s)

Clinical Hub Outcome: Transport to ED
Clinical Status Final: 0, 1, 2, 3, 4, Unknown

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

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

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

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

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

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

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

Terms of Reference

Combined Statutory Committee	
Applicable To: Whanganui District Health Board	**Authorised By:** Whanganui District Health Board
	Contact Person: Chief Executive

1. Committee of the board

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

2. Functions of the committee

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

3. Delegated authority

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

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

4. Membership and procedure

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

Membership will consist of:

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

5. Meetings

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

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

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