WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

AGENDA

Combined Statutory Advisory Committee

Meeting date	**Friday 3 May 2019**
Start time	**9.30am**
Venue	Board Room Fourth Floor Ward and Administration Building Whanganui Hospital 100 Heads Road Whanganui

Embargoed until Saturday 4 May 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 M Dawson, 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
- 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 3 May 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 25

Nil

6 Committee Chair's report

A verbal report may be given at the meeting

7 Whanganui DHB Annual Work Programme — Page 26

8 Reference and Information Section

9 Date of next meeting

Friday 14 June 2019

10 Glossary and Terms of References *(for reference only)* — Page 54

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 22 March 2019 (public-excluded session)	For the reasons set out in the committee's agenda of 22 March 2019	As per the committee's agenda of 22 March 2019
Annual Planning 2019/20	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 22 March 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 3 November 2017	Advised that he is an elected councillor on Whanganui District Council. Advised that he is now a board member of Summerville Disability Support Services.
Philippa Baker-Hogan	10 March 2006 8 June 2007 24 April 2008 29 November 2013 7 November 2014 3 March 2017	Advised that she is an elected member of the Whanganui District Council. Partner in Hogan Osteo Plus Partnership. 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. Advised that she is Chair of the Future Champions Trust, which supports promising young athletes. 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 Philippa Baker-Hogan declared her interest as a trustee of Four Regions Trust.
Maraea Bellamy	7 September 2017 4 May 2018 1 February 2019	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. Advised that she is: ▪ a director of Taihape Health Limited. ▪ a member of the Institute of Directors. Advised that she is a trustee of Mokai Patea Waitangi Claims Trust.
Jenny Duncan	18 October 2013 1 August 2014 22 March 2019	Advised that she is an elected member of the Whanganui District Council Advised that she is an appointed member of the Castlecliff Community Charitable Trust Advised that she is a member of the Four Regions Trust
Darren Hull	28 March 2014 27 May 2014 20 June 2014 23 May 2016	Advised that he acts for clients who may be consumers of services from WDHB. 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 Advised he is on the Whanganui Regional Health Network Risk & Audit Committee. 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 ▪ 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. ▪ 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. ▪ Member of Sponsors and Reference groups of National MH KPI project. ▪ Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders 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
	22 March 2019	Advised that he has been appointed to Te Pou Clinical Reference 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.
	22 March 2019	Advised that his niece, Nadine Mackintosh, works at the WDHB.

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 22 March 2019, commencing at 9.30am**

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

In attendance for Whanganui District Health Board (WDHB)
Mr Russell Simpson, Chief Executive
Mr Paul Malan, General Manager Service & Business Planning
Mr Brian Walden, General Manager Corporate Services
Mrs Rowena Kui, Director Māori Health
Mr Hentie Cilliers, General Manager People and Performance
Ms Kim Fry, Director Allied Health
Mr Declan Rogers, Nurse Manager Surgical Services/Acting Director of Nursing
Mr Jeff Hammond, Associate Director of Nursing, Mental Health Services
Mrs Judie Smith, CNM/Acting Nurse Manager, Mental Health Services
Mr Matt Power, Funding and Contracts Manager
Ms Andrea Bunn, Portfolio Manager, Mental Health and Health of Older People
Ms Candace Sixtus, Portfolio Manager, Service and Business Planning
Ms Barbara Charuk, Portfolio Manager, Service and Business Planning
Ms Eileen O'Leary, Portfolio Manager, Service & Business Planning
Mr Kilian O'Gorman, Business Manager, Service and Business Planning
Mrs Nadine Macintosh, Executive Assistant to the Chief Executive, Board Secretariat
Ms Harriet McKenzie, Project Co-ordinator
Ms Maree Langford, Acting Executive Assistant, Service and Business Planning *(minutes)*

In attendance at this meeting
Mr Phil Murphy, Health Informatics Manager, WDHB and WHRN
Mr Brad van Bakel, Health Informatics Analyst, WHRN
Ms Rebecca Casey, Nurse Practitioner – Health of the Older Adult, WRHN

Nicole Jordan, Occupational Therapist - Falls Prevention
Tina Van Bussel, Role, Fracture Liaison Nurse, WHRN
Sandy Taylor, Long Term Conditions Clinical Navigator
Lillian Chamberlain, Social Worker

Media
There was no media in attendance at this meeting

Public
Ms Ailsa Stewart, Board Member, Whanganui Alzheimer's Society

Karakia/reflection
Matthew Rayner opened the meeting with a karakia/reflection.

The chair acknowledged the passing of Maurice Ball, husband of past Board member Barbara Ball.

The chair also acknowledged the passing of former Board member Ray Stevens, and his contributions to our DHB and the wider community.

A minutes silence was held in acknowledgement of the victims of the terrorist attack in Christchurch last Friday, 15 March.

1 Welcome and apologies

Apologies were received and accepted from: Mr Graham Adams, Mr Leslie Gilsenan, Mrs Judith MacDonald.

Moved: Jenny Duncan Seconded: Charlie Anderson CARRIED

2 Conflict and register of interests update

2.1 Updates to the register of interests

Frank Bristol has a change to his register of interests.
Action: Frank Bristol to email through the changes.

Dot McKinnon is no longer a member of the Four Regions Trust.

Jenny Duncan is now a member of the Four Regions Trust

Dame Tariana Turia has some amendments to her register of interests.
Action: Dame Tariana Turia to confirm changes.

2.2 Declaration of conflicts in relation to business at this meeting

Frank Bristol declared that he is involved in the mental health service and would like the opportunity to speak to this item in the agenda.

3 Late items

No late items were advised.

4 Minutes of the previous meeting

The committee resolved 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.

Moved: Jenny Duncan **Seconded**: Dot McKinnon CARRIED

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:

The chair reflected on the tragedy that occurred seven days ago in Christchurch and acknowledged those that are grieving following the attack. It was noted how one person's viewpoints can have such a tragic impact on other people. The chair challenged us to learn from these experiences, both individually and as a Board, and to consider how we interact with people whose beliefs are different to our own.

We can also reflect on and learn from Christchurch hospital's emergency response, which was excellent. How are we placed to handle something of a similar magnitude?

The chair acknowledged the theme of the agenda for today's meeting – Acute Demand.

Representatives from the WHRN (WRHN) will present in relation to acute demand information and work programme, and while Judith MacDonald is not here to lead the discussion, her contribution to this is noted and evident in the paper provided for the agenda.

7 Whanganui DHB Annual Plan Work Programme

7.1 Whanganui Alliance Leadership Team (WALT)

Presenter: Russell Simpson, Chief Executive

A verbal update was provided by the chief executive.

The chief executive noted that the majority of today's agenda focuses the Acute Demand work stream which is driven by the Whanganui Alliance Leadership Team (WALT). This is a positive example of key organisations working closely together to understand our population data, needs and requirements for acute emergency care.

The Committee

a. **Noted** WALT have agreed to join the Central Region Lower North Islands Health Pathways platform with MidCentral DHB.
b. **Noted** that WALT are working on a business case for pathways for sharing information, which will replace Map of Medicine (no longer supported by the vendor)
c. **Noted** that a memorandum of understanding for a data sharing agreement has been drafted
d. **Noted** other work streams: Service Level Agreements (SLAs) for Child Health, Mental Health and Older People.

Over the last 14 months there has been notable positive change in WALT. Relationships within WALT have strengthened, there are solid work plans in place, and traction being made on these work plans.

Maraea Bellamy and Grace Taiaroa joined the meeting at 9.42am

7.2 Service Improvement Initiatives – Acute demand information and work programme

Leads: Judith MacDonald, Chief Executive, WHRN, Sub-Alliance Acute Demand Working Group
Harriet McKenzie, Project Co-ordinator
Brad van Bakel, Health Informatics Analyst, WHRN
Phil Murphy, Health Informatics Manager, WDHB and WHRN

Apologies were given for Judith MacDonald

The Committee

a. **Noted** the research undertaken to date in phase one
b. **Noted** the proposed work streams for phase two

The chief executive introduced Harriet, Brad and Phil and informed the Committee and attendees that the Sub-Alliance Acute Demand Working Group is a sub-group that has originated out of WALT. It demonstrates WDHB and partners working closely together to produce an overview of acute demand data for the region and is the first time we have seen data on a large scale.

Harriet extended Judith's apologies, acknowledging Judith's leadership of the project. She advised their presentation would cover the following:

- Acute Demand project
- Data sources
- Presentation of data: key learnings from phase 1
- Work streams for phase 2.

Acute Demand Project
There has been a significant increase in unplanned care presentations through the front door – both Whanganui Accident and Medical (WAM) and the Emergency Department (ED). The working group is tasked with providing an understanding of patient flow and acute care presentations, and co-construct a system-wide response to reduce avoidable presentations. A priority is to eliminate inequity for Māori.

A phased approach was taken:
Phase 1: Data collection / understanding patient flow – for discussion today
Phase 2: Undertake a work programme to address avoidable presentations – to commence shortly
Phase 3: Undertake a process of quality improvement and review.

Data Sources
- System data from ED, Inpatients, WAM and WRHN General Practice members. Data currently excludes National Hauora Coalition (NHC) due to a data timing issue.
- Health Roundtable, NZ Whole of System Report 2017
- St Johns Ambulance 2018 system data (transported and non-transported)
- ED discharge summary audit
- ED full note reviews triage 3,4,5
- WAM full note reviews triage 3,4,5
- WAM/ED patient survey
- Discussions with leaders in aged care
- Indications from a primary care initiative following up ED/WAM visits.

7.1.1. Presentation of data: key learnings from phase 1

Emergency Department
- All services show a general increase in demand 2015-2018
- This is particularly evident in the older age groups
- The leading age group for ED volumes is 65-84 years of age which continues to rise.
- There is a peak in presentations at ED as WAM closes.

Whanganui Accident and Medical
- WAM have experienced overall growth of 7% from 2015 to 2018
- Increase in presentations the 0-14 age group
- Presentations of the 55+ age group to WAM have increased 20.7% from 2015 to 2018
- The majority of WAM's volumes come from paediatric attendances, which vary seasonally
- Some people appear to use WAM as their GP
- Presentations peak in winter.

WAM & ED Combined
- The older you are, the more likely you are to receive care in ED rather than WAM
- There is a peak in volume of Māori presentations post WAM closing – data to be further explored.

St John Ambulance
In 2018 St John Ambulance transported 6,049 patients, of which:
- 55% were 65+ years old
- 92% went to ED (only 157 went to WAM)
- 85% were St Johns Ambulance status 3 and 4.

A further 3,186 incidents were attended by St John Ambulance and not transported and 51% of these were 65+ years of age. Further work will be done with St John Ambulance in the coming project phases.

GP Volumes
- There is year-on-year growth in GP (General Practice) presentations
- GP volumes are driven largely by the 45-84 year age group, where demand is high and increasing substantially

- 13% of Māori aged 45-64 years are not seen in general practice compared to only 4% of 65-84 year old non-Māori.
- Seasonal demand is particularly visible in children and the elderly
- Multiple visits to general practice tends to equate with multiple admissions (i.e. they are high users of all services).

Triage

- The majority of ED events are triage 3 patients. Triage is recorded on a scale of 1 to 5 with 1 being critical (requiring immediate care) and 5 being low urgency
- Triage 3 has been growing; 50% of all presentations to the front door in 2015, to 63% in 2018
- WDHB is an outlier for triage 3 presentations with the highest proportion of triage 3's at ED in the country. This merits further investigation. Having a combined ED/WAM set up could be a contributor to this because some lower urgency presentations go directly to WAM.
- ED is a specialist service, so patients on the lower end of the triage scale are taking up a specialist spot but may not need this level of care.

GP appropriate presentations

ED full note review of randomly selected patients:

- 60% of triage 3 could have potentially been treated by a GP
- 72% of the triage 4 and 5 group.

WAM full note review of randomly selected patients:

- 40% of the non-ACC triage 3 patients who presented during GP open hours were potentially GP appropriate.

ED/WAM patient survey:

- 38% contacted their GP in the 1-2 days before coming to ED/WAM. Of these, 81% came to ED or WAM for the same reason they had tried to contact the GP.

The data highlights:

- GP access difficulties
- Perception that GP's are busy – anticipate inability to access GP
- Perception that ED/WAM is an appropriate place to go for care, including referral by entities such as Healthline
- Convenience of ED/WAM – not needing to book an appointment, and the ability to come at a time that is convenient.

Inpatient volumes

- The majority of acute inpatient admissions are generated by ED
- 19.2% increase in acute admission volumes from 2015-2018
- Inpatient service demand is much higher for the elderly population
- WDHB admitted 48% of ED presentations compared to the peer group average of 36%, the second highest percentage in the country.

Readmissions

- The readmission rate for frail patients is 22%
- The hospital-wide, condition non-specific acute readmission rates at 7 and 28 days were shared
- Discharges from the Medical Ward present higher rates of readmission compared to many other areas
- Further investigation is warranted to see what may be driving readmissions.

Length of stay

- The older the patient, the longer they tend to stay in hospital
- 45-64 year olds create the most volume and 85+ year olds create disproportionate demand considering the small volume of population
- The average length of stay has been trending slightly downwards for older patients
- There is an overall increase in acute demand, but patients are being discharged faster

- ED is an outlier in length of stay – more research to be done in this area
- Measuring time in care – in the past data collection was more subjective in nature, our current technology enables us to timestamp more exactly (so while there may appear to be a jump in figures, it is not directly comparative).

Community Care Conditions (CCC)

- The Health Roundtable (HRT) has an algorithm that identifies CCC in a patient's diagnosis list
- The criteria for our internal reporting is that the primary reason for admission is CCC. The proportion of CCC events in all acute admissions is still approaching 30%
- Proportion of acute IP discharges from medical ward which fit the HRT CCC criteria
- Although ED and Acute Assessment Unit (AAU) pick up a lot of the CCC activity, the medical ward appears to be loaded with acute CCC activity, where over half of the acute volume is CCC related.

7.2.2 Work stream proposal to progress to phase 2

The key work streams for phase two are:

- Fragmented health system
- Older persons
- WAM/ED – reducing acute flow and evaluating triage
- General Practice
- Māori leadership group.

There is no defined timeframes for the completion phase 2 currently.

The following points were noted in general discussion:

- The data needs to be informed by patient stories as social factors are complex may not be clearly represented in the data. Patients were interviewed and a patient survey was done, but more work to understand patient stories will occur in phase 2. Patient stories alongside data will be used to look for patterns in different areas, including Rural and Māori populations
- Outcome measures from the patient perspective are important to include in the project work.
- The significant challenges of equity for Māori was noted
- The triaging model will be reviewed with the aim to better direct patients to either ED or WAM
- The cost of WAM may be a factor in the high number of presentations to ED
- One third of people come to WAM when the GP is open. There was discussion about GP availability, both real and perceived
- The co-location of ED and WAM can be confusing to the patient
- The location of the ambulance bay at the back of ED may reinforce a patient's perception that they need to go to ED
- We need to consider that the public may like the WAM system, and the public's requirements and preferences around health care are changing. Having a WAM and ED side by side can pose challenges, but it also brings opportunities to do things differently
- The social issues and influencers around ambulance calls were discussed
- Readmissions are staying relatively static despite reduced shorter length of stays
- Engaging general practice in this project is key. A working group involving GPs was suggested
- Funding options to be considered
- Other areas that will be reviewed by the project team include Mental Health, Outpatients and co-morbidities.

Committee members thanked Harriet, Phil and Brad for their presentation. The chair congratulated project team on the completion of phase 1 and hopes that the comments provided and offers of help from committee members assists the team with phase 2 of the project. The committee were encouraged to make contact with the project team with any ideas or feedback.

Harriet McKenzie, Phil Murphy and Brad van Bakel left the meeting at 10.49am
Candace Sixtus left the meeting at 10.49am

7.3 Health of Older Persons – Falls Prevention

Lead: Andrea Bunn, Senior Portfolio Manager Health of Older People

Andrea introduced Nicole Jordon (Occupational Therapist - Falls Prevention) who has significant input into in-home and community strength and balance and Tina van Bussel, Fracture Liaison Nurse (WRHN) who works with people who have had fragility fractures.

Andrea noted that we are in partnership with ACC and the HQSC around falls prevention and following up those with fragility fractures is a population health initiative for our older population. It is not an issue that can be resolved immediately, but we are trending in the right direction and in the long term this should positivity impact acute demand. She also advised that fragility fractures are important, as evidence shows that if you suffer a fragility fracture you are more likely to require hip replacements in the future.

Brian Walden arrived at 10.57am

Tina spends 20 hours a week dedicated to fractures. Her data sources include WAM notes, inpatient notes, ACC and ED and she noted the following:

- There are a lot of patients coming into ED after suffering a fall
- Whanganui patients are fortunate to have access to free DEXA scans
- We have a geriatrician who is interested in orthopaedics, who is working with the fracture service – this is rare for a small DHB
- One medication type, IV Aclasta, is not fully funded.

Nicole spoke about In-Home Strength and Balance and Community Strength and Balance, noting:

- Team includes a physiotherapist and registered nurse as well as Nicole (occupational therapist).
- The team receives referrals from GPs, district nurses, allied health, St John Ambulance and from the community. Referrals are triaged and interventions are planned.

In-Home Strength and Balance

- Based on the Otago exercise programme and holistic in-home assessment includes referral for medication reviews, home safety assessments. Following the assessment the team refer on to other agencies or services in the hospital as required.
- Demand for the In-Home service is high, and wait lists are a challenge. Mitigation methods are in place.

Community Strength and Balance

- There are nine providers on board the 'Live Stronger for Longer' movement
- There are some established classes and some providers wanting to establish classes
- Nicole assesses providers who want to establish classes on the nine 'Live Stronger for Longer' evidence based criteria. Once they meet the criteria, they are advertised on the DHB website and the ACC database and they keep data on attendance numbers
- There are nine providers offering approximately 35 classes, including rural and within Marae, covering a range of activity types
- A challenge is getting new people through the service
- There is a good ethnic mix of participants, and they are looking to re-establish a class at Ratana.

Action: Andrea Bunn to give Nicole Jordon Grace Taiaroa's contact details

Andrea finished the presentation by noting that the Live Stronger for Longer is a very important initiative, and from an age-friendly perspective we should all be promoting this.

The following points were noted in general discussion:

- There was discussion around collaborative work with orthopaedics

- Prevention of falls is key
- Nationally we are doing well – results can be viewed on HQSC website. Andrea highlighted that this is a legacy of former Director of Nursing Sandy Blake, who was a falls expert and established a systematic perspective within our DHB
- Osteoporotic fractures are common – for women aged 50+ there is a 1 in 3 chance of an osteoporotic fracture, and for men aged 50+ a 1 in five 5 chance
- Māori population aged over 65 is projected to increase significantly 2016-2026. Are we doing enough to prepare for this?

The chair thanked them for their presentation and noted that the targets are age and risk appropriate and we are achieving well.

Nicole Jordon and Tina van Bussel left at 11.08am

7.4 Services Improvement Initiatives – Advance Care Planning

Lead: Rebecca Casey, Nurse Practitioner – Health of the Older Adult, WHRN

Rebecca Casey introduced herself, Lillian Chamberlain - social worker and WDHB lead for advanced care planning, and Sandy Taylor - long term conditions nurse, and Advanced Care Planning trainer.

Rebecca presented to the Committee about to Advance Care Planning (ACP) in relation to acute demand, noting the following:

- WDHB provide an ACP service in conjunction with Alzheimer's Whanganui Inc
- Rebecca highlighted the benefit of an advanced care plan and accessibility to these
- ACP is important for people with a life limiting illness or condition. It is a living document

Rowena Kui, Hentie Cilliers arrived at 11.10am

- ACP was described of as a way for people to have a plan in place for when they are unable to communicate for themselves. It also allows medical professionals and whānau to understand what care and treatments the person does and does not want, and under what conditions – it provides a context around advanced directives. This can reduce the stress on both medical staff and whānau making decisions in difficult circumstances
- ACP is needed because we are living longer and long-term conditions are the leading cause of death – generally we know what we will die from
- There is a key distinction between prolonging life and prolonging death
- The HQSC have put out a five year ACP strategy – advising what they will do, and what they want DHBs to do
- There are four DHB work streams that HQSC are involved with that link to ACP and a meeting with HQSC will occur soon to talk about the best way to streamline these and how to incorporate into our health system
- For stories from people who have done advanced care planning and other resources, visit: www.advancecareplanning.org.nz
- A Northland Iwi has produced a te reo version - is being localised and it will be available soon
- ACP is good for the individual, their whānau and our health care system.

Rebecca acknowledged the early adoption of ACP by Whanganui and noted the work of Julie Nitschke (WHRN) and Jennie Fowler (WDHB), and praised the collaborative approach being used to promote ACP to the community. Education has been done in a number of areas, including departments in the hospital, local lawyers and Wanganui Prison. We are ahead of the game, but there is more we can do, including:

- Signposting – promoting ACP in the hospital, and in general practice and developing a system to incorporate this into the health system holistically
- Information technology improvements are required

- Some general practices and DHBs have recently started using Medtech to share ACPs.

The chief executive reported that he has circulated over 100 brochures in the last fortnight at presentations to Aged Concern and Grey Power. He advised that there is no age limit on preparing an ACP. He also noted added pressure on staff when families argue over what to do for their loved one.

Rebecca Casey, Lillian Chamberlain and Sandy Taylor left at 11.30am

7.5 Services 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

The chair noted a correction to the paper in the agenda on page 28 under Synopsis for Acute Inpatient services occupancy should read 125% (not 12.5%).

Acute Inpatient Services
- Occupancy reached its peak in August 2018 and remains high
- There are strategies in place to manage this demand
- Our partners in the community have been very helpful - opening their beds for our utilisation, taking respite patients, etc. Relationships with NGOs and community partners have been enhanced.
- Heavy utilisation increases seclusion rates (may be higher than graphs provided).

Te Awhina
- First graph on page 29 – the data does not account for patient leave, so is not fully reflective of utilisation rates
- EOC centre opened last year due to demand / issues for staff
- Increase in violent incidents on wards. Staffing has been reviewed and more training given
- Intoxication and methamphetamine use significantly impact seclusion rates and use staff resources
- It was noted that the effect of one or two individuals can have a high impact on our seclusion rates due to the size of our service.

Community Mental Health and Addictions Services
- We are looking at a number of information technology initiatives to improve services
- Network Model of Care (the Hub model) is being embedded
- Mental Health Act table on page 31 – noted that this should be viewed as a 'snapshot in time'. It doesn't reflect the continual flow of people coming on and off the Mental Health Act. Some patients can be under the Act for the rest of their lives which will have implications for the service in the future.

Infant, Child, Adolescent Mental Health and Addictions Services (ICAMHAS)
- Referrals increased by 14% in the last two years
- Significant work has gone into increasing the accessibility of this service.

The chair thanked Jeff for his report.

The following points were noted in general discussion:
- HQSC initiatives are being embraced
- PRIMHD compliance – used to lead the way, and now we are back there after overcoming the challenges of transitioning to a new IT system

- The number of Māori under the Mental Health Act was queried in relation to the table on page 46, as it appears to be increasing. It was noted that the graph refers to rates, not a number of people. The number of Māori on the Mental Health Act is acknowledged as high nationally
- Ongoing/anticipated demand at Te Awhina and long term strategy was discussed. The Hub Model is still being embedded, and there is a strong believe it will positively impact admission rates to Te Awhina. The Hub model was explained
- It was queried how well we work with the community at large to keep people stable. Our Mental Health team give advice about services that can be accessed, which helps situation to be managed at the earlier level. We are becoming more outward focussed.

Jenny Duncan left at 11.45am
Charlie Anderson left at 11.45am

- The CE noted that we have a couple of particularly challenging patients in the service at present
- Staff safety is always a concern
- Planning guidance from the Government following the Mental Health Inquiry is expected by the end of April 2019
- The suicide Prevention Plan and the repeal and review of the Mental Health Act will likely be the first two initiatives to be worked on
- It was suggested that Mental Health Service be a theme of a future Combined Statutory Advisory Committee agenda.

Jeff Hammond, Eileen O'Leary and Andrea Bunn left at 11.55am
Kilian O'Gorman arrived at 11.55am

7.6 Service Improvement Initiatives – Workforce and Organisational Development

Lead: Hentie Cilliers, General Manager People and Performance

The paper was taken as read

It was noted in addition to the paper:
1. Interviewing for the Director of Nursing role next week
2. Will be appointing to Medical Director ED role.

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

Apologies were given for Kath Fraser-Chapple

The chair noted that this is Matt Power's last Combined Statutory Advisory Committee meeting as he leaves to go to another role, and thanked him for his sound advice over the years.

The report was taken as read with one query on increased nursing FTE whilst acuity and demand were reduced. The general manager corporate services reported the variances were in medical, ED and Mental Health.

The chief executive reported that financially the DHB is tracking well against budget, with the current position positive to budget noting that nationally many DHB financial positions are reporting a deterioration.

CE reported on the national picture advising that WDHB was only one of four to meet our year-to-date financial position. This was acknowledged by the Committee.

Ailsa Stewart left 12.00pm

7.8 Non Financial Quarterly Reporting

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

The paper was taken as read

The following points were noted in general discussion:

- Immunisation and the challenges related to of non-vaccination were highlighted. The recent measles outbreak was noted.

8 Reference and Information Section

The information papers noted below were taken as read.

St John Ambulance service data for WDHB region 2018
1. patients seen and not transported to ED
2. patients seen and transported to ED.

9 Date of next meeting

Friday, 3 May 2019.

10 Glossary and terms of reference

For information only.

11 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 **12.02pm**

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 Whānau Ora

WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui	**COMMITTEE DISCUSSION PAPER**
	Date: 3 May 2019
Author	Candace Sixtus, Portfolio Manager Service & Business Planning
Endorsed by	Rowena Kui, Director Māori Health Paul Malan, General Manager Service and Business Planning
Subject	Whānau Ora: understanding the approach, delivery and potential to improve the health and wellbeing of whānau and our community.

RECOMMENDATION

Management recommend that the Committee:

1. Note the Whānau Ora information paper
2. Receive the presentations
3. Discuss the application of Whānau Ora across the district.

Purpose
To increase our collective understanding of the Whānau Ora philosophy, approach and delivery of Whānau Ora services. And understand what positive impact this approach can have on the health and wellbeing of whānau and our community.

Whānau Ora is a culturally – grounded, holistic approach to improving the wellbeing as a group, and addressing individual needs within the context of whānau, hapu, Iwi and the wider community.

Further background reading and information is included in section 8 - information papers:
8.1 – Whanau Ora - background information.

> *"Whānau Ora is about empowering whānau to take control of their future. What we want for our whānau is to be self-determining, to be living health lifestyles, to be participating fully in society and to be economically secure."*
> *(Dame Tariana Turia, October 2010).*

7.2.1 Introduction

Lead: Rowena Kui, Director Māori Health

Today's committee meeting will feature presentations and video clips from services and community development programmes in our region. These programmes deliver Whānau Ora through varied approaches and across different settings.

This will be an interactive session where members are encouraged to ask questions of those presenting and of the Māori Health Outcomes Advisory Group who will also be attending and participating.

Sir Mason Durie (video)
The launch of He Korowai Oranga 2014. Sir Mason's korero describes the Whānau Ora approach to health care, challenges and aspirations and is a great way of introducing our session today.

7.2.2 Kaupapa Māori Services

7.2.2.1 Mokai Patea Services Taihape

Leads: Ngawini Martin, Mokai Patea Services
Gemma Kennedy, Taihape Health Limited

This service delivery model encompasses an integrated model with primary care and other key stakeholders within the Taihape community including health, social sector, justice and education. The DHB established an approach between Mokai Patea and Taihape Health Limited which ensured a working relationship that supports the provision of services that are responsive to Māori and enhances community knowledge and linkages.

7.2.2.2 Te Oranganui

Lead: Wheturangi Walsh-Tapiata, Chief Executive Officer Te Oranganui

Our Whānau Ora program empowers whānau to realise and achieve their full potential with kaimahi working alongside to identify needs and support achievement of aspirations. Through a holistic approach to wellbeing taking into account the overall wellbeing of the whānau in the following areas:

- Oranga – health
- Matauranga – education/knowledge
- Whānaungatanga – socialisation
- Mahi – employment
- Wairuatanga – beliefs
- Te Ao Māori – cultural

The presentation will include a video clip of a whānau story.

7.2.3 DHB Māori Health Services

Te Hau Ranga Ora Service

Leads: Rihi Karena, Kaitakitaki, Haumoana staff

As the Whanganui DHB Māori Health Service, Te Hau Ranga Ora encapsulates the DHBs commitment to Māori health including service delivery to patients and their whānau, Māori cultural guidance, education and support and workforce development. The Haumoana team provide the connection

between the DHB and external providers and services, working with our patients and their whānau to support improved outcomes.

A video of the service will be included to demonstrate the way the service works with whānau when they are in hospital or accessing DHB services.

7.2.4 Community Development Programme

Ruapehu Whānau Transformation

Leads: Erena Mikaere, Head of Special Projects, Strategy & Innovation, Ruapehu Whānau Transformation
Shayna Te Riaki, Ruapehu Whānau Transformation

In 2013, a Ngati Rangi Iwi led initiative, working alongside whānau and the Waimarino community, set out to achieve how collectively the community can achieve solutions where whānau are empowered to lead their own transformation through a collective impact approach. Now into the second phase, the launch of the Ruapehu Whānau Transformation Plan 2020 builds on the success of the first plan and focuses on areas including education, health and housing.

7.2.5 Whānau Ora Commissioning

Lead: Paul Malan, General Manager Service and Business Planning

In April 2018, the government commissioned a review of the second phase of Whānau Ora. The first phase (2010 – 2014), was focused on building the approach and developing provider capability through government contracting via district health boards. The second phase replaced the first during 2014 with two significant changes of emphasis: firstly, a shift towards building whānau capability (rather than provider capability) and, secondly, a new delivery approach focusing on whānau outcomes being delivered through a new commissioning model.

The new commissioning model set up three sub-national commissioning agencies with oversight from Te Puni Kokiri: Te Pou Matakana (covering the North Island); Te Pūtahitanga o Te Waipounamu (covering the South Island and Chatham Islands); and Pasifika Futures, (covering the whole country and focusing on Pasifika families).

The Executive Summary of the review, delivered in February 2019 is included as an Information Paper in section 8. Please refer to Information Paper 8.2 – Executive Summary extracted from **Whānau Ora review 2018, Tipu Matoro ki te Ao, Final Report to the Minister for Whānau Ora, 2018**. The full report can be accessed at: https://www.tpk.govt.nz/docs/tpk-wo-review-2019.pdf.

At the recent Whānau Development Summit, key considerations from the review were highlighted by the Minister for Māori Development, Hon Nanaia Mahuta and the Minister for Whānau Ora, Hon Peeni Henare.

- The approach has a positive impact and the barriers to scalability need attention;
- The model is accountable and transparent and bureaucracy could be reduced;
- There is potential for whānau-centred approaches to be applied more widely across government

Minister Henare posited that Whānau Ora is the framework for integration across agencies, particularly across social sector agencies.

7.2.6 Challenges

Lead: Rowena Kui, Director Māori Health

Listening to stories, understanding the realities and hearing the korero of whānau, encapsulates the essence of Whānau Ora. How services are provided to engage whānau; strong relationships between services and agencies; systems without barriers and access to across sector funding streams makes a difference to improving the health outcomes for whānau. Contributing to the health and wellbeing of the wider community.

Some ongoing challenges to this work that we need to find solutions for are:

- Is what we are purchasing meeting the needs of Māori whānau?
- Māori whānau who access kaupapa Māori services have whānau plans (health and social plans with whānau goals and priorities). How do we ensure these plans are able to inform primary, secondary health and other services?
- How do we break down the system barriers and silo funding?
- Not all services are culturally aware and able to work with Māori whānau to improve their wellbeing. Why not?
- Why are we not working across sector more effectively?
- Social governance and resourcing models can be effective as long as all parties are authentic in their relationships.

7.3 Financial Performance

Leads: Mike Bothma, Acting Funding and Contracts Manager
Kath Fraser-Chapple, Business Manager Medical, Community & Allied Health
Peter Wood-Bodley, Business Manager Surgical Services and Procurement
Barbara Walker, Management Accountant
Mike Bothma, Business Manager Mental Health and Addictions
Raju Gulab, Financial and Business Support Manager

Purpose
The purpose of this report is to update the committee on the Funder Arm and Provider Arm financial performance for the period ending 31 March 2019.

7.3.1 Whanganui DHB Summary

Lead: Mike Bothma, Acting Funding and Contracts Manager

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 March 2019 ($000s)
CONSOLIDATED

	Month				Year to Date				Annual	
	Actual	Budget	Var		Actual	Budget	Var		Budget 2018-19	Actual 2017-18
Provider Division	(291)	(170)	(121)	U	(7,313)	(6,725)	(588)	U	(8,442)	(5,504) U
Corporate	27	(36)	63	F	(73)	(351)	278	F	27	1,189 F
Provider & Corporate	**(264)**	**(206)**	**(58)**	**U**	**(7,386)**	**(7,076)**	**(310)**	**U**	**(8,415)**	**(4,315) U**
Funder Division	(652)	(345)	(307)	U	140	175	(35)	U	526	(366) F
Governance	87	10	77	F	217	12	205	F	3	502 U
Funder divison & Governance	**(565)**	**(335)**	**(230)**	**U**	**357**	**187**	**170**	**F**	**529**	**136 F**
Net Surplus / (Deficit)	**(829)**	**(541)**	**(288)**	**U**	**(7,029)**	**(6,889)**	**(140)**	**U**	**(7,886)**	**(4,179) U**

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

The financial results for the first nine months of 2018/19 show a $140k unfavourable variance to budget.

7.3.2 Whanganui DHB Funder

Lead: Mike Bothma, Acting Funding and Contracts Manager

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 March 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 ager	20,452	20,160	292	F	183,235	181,364	1,871	F	242,267	234,232
Inter-district Inflow	538	622	(84)	U	5,518	5,596	(78)	U	7,461	7,313
Other Income Revenue	24	32	(8)	U	228	311	(83)	U	406	502
Total Revenue	**21,014**	**20,814**	**200**	**F**	**188,981**	**187,271**	**1,710**	**F**	**250,134**	**242,047**
EXPENDITURE										
Personal Health	8,508	8,417	(91)	U	73,582	74,090	508	F	99,079	95,358
Disability Support	268	268	–	F	2,411	2,411	–	F	3,214	3,054
Mental Health	1,529	1,529	–	F	13,781	13,757	(24)	U	18,343	17,897
Public Health	14	6	(8)	U	125	55	(70)	U	73	245
Maori Services	9	9	–	F	82	82	–	F	110	108
Total own provider expenditur	**10,328**	**10,229**	**(99)**	**U**	**89,981**	**90,395**	**414**	**F**	**120,819**	**116,662**
Personal Health	3,930	3,838	(92)	U	33,711	33,108	(603)	U	44,049	42,352
Disability Support	2,402	2,467	65	F	21,971	21,882	(89)	U	29,154	28,575
Mental Health	780	641	(139)	U	6,021	5,766	(255)	U	7,688	7,380
Public Health	81	91	10	F	727	821	94	F	1,094	869
Maori Services	127	131	4	F	1,217	1,261	44	F	1,654	1,557
Inter-district Outflow	3,688	3,432	(256)	U	32,242	30,892	(1,350)	U	41,189	41,134
Total Other provider expenditu	**11,008**	**10,600**	**(408)**	**U**	**95,889**	**93,730**	**(2,159)**	**U**	**124,828**	**121,867**
Governance	330	330	–	F	2,971	2,971	–	F	3,961	3,884
Total Expenditure	**21,666**	**21,159**	**(507)**	**U**	**188,841**	**187,096**	**(1,745)**	**U**	**249,608**	**242,413**
Net Surplus / (Deficit)	**(652)**	**(345)**	**(307)**	**U**	**140**	**175**	**(35)**	**U**	**526**	**(366)**

Revenue

$1,710k favourable variance to budget for the Funder Division mainly due to:

- Anticipated pay equity revenue from the Ministry of Health ($387k) 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 relating to in-between Travel costs ($431k)
- Funding to extend access to primary care ($529k) offset by additional expenditure
- Funding for MECA increases ($323k) offset by own provider costs
- Electives wash up of ($112k).

Own provider - internal

- $414k favourable variance to budget with internal provider (Provider Arm). Mainly due to $1,100k 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 $2,159k unfavourable to budget. This is mainly due to a $1,350k unfavourable variance to budget for inter-district outflows based on a 12 monthly rolling average of demand, and $617k unfavourable variance in community pharmaceutical expenditure.
- Primary care initiatives are $133k unfavourable to budget with less than expected costs keeping the unfavourable variance lower than additional revenue.
- Pay equity expenditure is $387k unfavourable to budget. There is additional revenue to offset this variance.

- There is $89k unfavourable variance in health of older people expenditure, with pay equity $387k (offset by revenue), $72k Homebase support and $119k aged residential care unfavourable expenditure, offset favourable variance in $245k residential hospital care, $145k respite care and various other $99k favourable variance.
- Travel assistance payments are favourable to budget by $157k with immunisation expenditure $56k unfavourable to budget.

7.3.3 Whanganui DHB Provider and Corporate

Lead: Raju Gulab, Financial and Business Support Manager

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 March 2019 ($000s)
PROVIDER & CORPORATE

	Month				Year to Date				Annual	Actual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget	2017-18
REVENUE										
Government and Crown agency	916	1,037	(121)	U	7,473	7,977	(504)	U	11,608	10,508
Funder to Provider Revenue (internal)	10,328	10,228	100	F	89,979	90,395	(416)	U	120,819	116,987
Other income	124	128	(4)	U	1,137	1,009	128	F	1,529	1,382
Total Revenue	**11,368**	**11,393**	**(25)**	**U**	**98,589**	**99,381**	**(792)**	**U**	**133,956**	**128,877**
EXPENDITURE										
Personnel										
Medical	1,705	1,964	259	F	16,522	17,575	1,053	F	23,786	21,788
Nursing	3,167	3,237	70	F	29,478	29,467	(11)	U	39,471	34,978
Allied	934	1,027	93	F	8,648	9,320	672	F	12,471	10,861
Support	76	65	(11)	U	613	596	(17)	U	794	745
Management & Admin	1,049	912	(137)	U	8,365	8,415	50	F	11,234	10,332
Total Personnel(Exl other & outsourced)	**6,931**	**7,205**	**274**	**F**	**63,626**	**65,373**	**1,747**	**F**	**87,756**	**78,704**
Personnel Other	326	198	(128)	U	1,652	1,550	(102)	U	2,163	1,720
Outsourced Personnel	587	514	(73)	U	5,104	4,416	(688)	U	5,980	5,912
Total Personnel Expenditure	**7,844**	**7,917**	**73**	**F**	**70,382**	**71,339**	**957**	**F**	**95,899**	**86,336**
Outsourced Clinical Service	597	579	(18)	U	5,337	5,296	(41)	U	7,103	6,888
Clinical Supplies	1,464	1,310	(154)	U	12,545	12,076	(469)	U	15,961	15,102
Infrastructure & Non Clinical Supplies Costs	930	992	62	F	10,608	10,541	(67)	U	13,754	13,286
Capital Charge	281	284	3	F	2,680	2,691	11	F	3,543	3,262
Depreciation & Interest	466	468	2	F	3,979	4,061	82	F	5,517	5,206
Internal Allocation	50	49	(1)	U	444	453	9	F	594	696
Total Other Expenditure	**3,788**	**3,682**	**(106)**	**U**	**35,593**	**35,118**	**(475)**	**U**	**46,472**	**44,440**
Total Expenditure	**11,632**	**11,599**	**(33)**	**U**	**105,975**	**106,457**	**482**	**F**	**142,371**	**130,776**
Net Surplus / (Deficit)	**(264)**	**(206)**	**(58)**	**U**	**(7,386)**	**(7,076)**	**(310)**	**U**	**(8,415)**	**(1,899)**
FTEs										
Medical	104.7	114.1	9.4	F	103.2	111.6	8.3	F	112.3	101.2
Nursing	459.8	446.5	(13.2)	U	459.8	454.3	(5.5)	U	455.0	424.2
Allied	153.9	160.6	6.7	F	149.7	160.8	11.1	F	160.7	147.5
Support	16.6	16.0	(0.7)	U	15.1	16.0	0.9	F	16.0	14.8
Management & Admin	178.8	171.1	(7.7)	U	170.4	171.4	1.0	F	171.4	166.1
Total FTEs	**913.7**	**908.3**	**(5.4)**	**U**	**898.2**	**914.0**	**15.8**	**F**	**915.4**	**853.9**

STATEMENT OF FINANCIAL PERFORMANCE by Cluster ($000s)for the period ended 31 March 2019 ($000's)

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
Surgical Cluster	**634**	**633**	**1**	**F**	**3,494**	**3,840**	**(346)**	**U**	**4,977**
Medical Cluster	**540**	**588**	**(48)**	**U**	**3,255**	**3,931**	**(676)**	**U**	**4,962**
Allied Health Cluster	**(666)**	**(599)**	**(67)**	**U**	**(6,251)**	**(6,195)**	**(56)**	**U**	**(7,966)**
Mental Health Cluster	**(87)**	**(70)**	**(17)**	**U**	**(1,273)**	**(1,254)**	**(19)**	**U**	**(1,679)**
Public Health& Community Cluster	**(80)**	**(184)**	**104**	**F**	**(593)**	**(1,223)**	**630**	**F**	**(1,619)**
Corporate & Other Service	**(605)**	**(574)**	**(31)**	**U**	**(6,018)**	**(6,175)**	**157**	**F**	**(7,090)**
Net Surplus / (Deficit)	**(264)**	**(206)**	**(58)**	**U**	**(7,386)**	**(7,076)**	**(310)**	**U**	**(8,415)**

Month
Clinical supply cost was the main contributor of the $58k unfavourable variance reflected this month.

Overall volumes are 92% of budget with acute at 90% and elective at 96%. Electives reflect a planned drop in orthopaedic volumes and 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 $85k reduced revenue from the funder as elective volumes are paid on a 'fee for service' basis. This was offset by additional $92k Ministry of Health for the PSA nurses and Allied MECA settlement (offset by personnel costs), $62k well child revenue, $8k smoke free revenue and $22k pharmaceutical and dental revenue (partly offset by increased pharmaceutical cost).

Personnel and outsourced medical costs are favourable to budget due mainly to various vacancies in Allied and medical job groups. Management and administration costs are unfavourable to budget due largely to an accrual to provide for the pending MECA settlement lump sum payments which not budgeted for. 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 for vacancies.

Outsourced service costs are unfavourable to budget due mainly to Radiology service cost related to volumes. Unbudgeted payment of $23k to NZHP for food service negotiated settlement has further increased this unfavourable variance.

Clinical supply costs are unfavourable to budget due to pharmaceutical costs which have been adversely affected by a few issues. The STEMI kits (cardiology kits) for St John Ambulance were set up at an additional cost of $18k, a patient was treated in medical ward for fungal infection for two weeks ($35k), a new eye drug further increased the drug costs for the month. Flights have also seen an increase for the month, which also increased the unfavourable variance. For the month the disposable instrument cost for the dental caravans was also unfavourable to budget, but this is a bulk purchase and the year-to-date figure is within budget.

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

Year-to-date
The year-to-date unfavourable variance has increased again this month to $310k unfavourable. 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 $792k unfavourable to budget, mainly due to the planned reduced electives volume which are currently at 91.3% of target $1,100k. ACC reduced revenue relates to home base support and ACC contract (offset by cost saving).

Personnel costs are $957k favourable and 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 high. Wards are under pressure with volumes in excess of 90% combined with high acuity.

Clinical supply costs are $469k unfavourable to budget due to increased wards consumables. This includes IV supplies related to the new IV pumps, pharmacy costs which are volume and patient complexity driven and have some offsetting revenue, patient travel and orthotics. We are running additional orthotics clinics in order to reduce the amount of elective surgery. Ward clinical supplies costs were partly offset by lower theatre consumables, related to reduced theatre output.

Infrastructure/non-clinical costs are $67k unfavourable to budget mainly due to Hauora Māori health workforce training cost (offset by revenue), facility costs and patient meals, partly offset by stationery, printing and advertising.

Outlook and mitigations

High volumes over the first five months of the year have declined in the last four 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 the winter months.

MECA settlements have been running at 4.5% - 5% and remain a risk until the government makes a final decision on whether or not to fund the unbudgeted cost impact. Overall personnel cost are expected to remain close to budget.

Variable cost such as clinical supplies have moderated with the reduction in volumes. However, 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 March 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	353	389	(36)	U	2,801	3,199	(398)	U	4,429
Funder to Provider Revenue (internal)	4,068	4,160	(92)	U	34,821	36,121	(1,300)	U	48,074
Other income	5	16	(11)	U	157	104	53	F	131
Total Revenue	**4,426**	**4,565**	**(139)**	**U**	**37,779**	**39,424**	**(1,645)**	**U**	**52,634**
EXPENDITURE									
Personnel	1,795	1,930	135	F	16,639	17,570	931	F	23,612
Personnel Other	72	61	(11)	U	393	409	16	F	556
Outsourced Personnel	412	409	(3)	U	3,605	3,503	(102)	U	4,763
Total Personnel Expenditure	**2,279**	**2,400**	**121**	**F**	**20,637**	**21,482**	**845**	**F**	**28,931**
Outsourced Clinical Service	141	169	28	F	1,404	1,538	134	F	2,082
Clinical Supplies	700	690	(10)	U	5,720	6,004	284	F	7,996
Infrastructure & Non Clinical Supplies Costs	177	193	16	F	1,696	1,731	35	F	2,300
Depreciation, Interest & Internal Allocation	495	480	(15)	U	4,828	4,829	1	F	6,348
Total Other Expenditure	**1,513**	**1,532**	**19**	**F**	**13,648**	**14,102**	**454**	**F**	**18,726**
Total Expenditure	**3,792**	**3,932**	**140**	**F**	**34,285**	**35,584**	**1,299**	**F**	**47,657**
Net Surplus / (Deficit)	**634**	**633**	**1**	**F**	**3,494**	**3,840**	**(346)**	**U**	**4,977**
FTEs									
Medical	27.0	30.8	3.8	F	28.7	30.7	1.9	F	30.54
Nursing	144.3	147.0	2.7	F	144.4	148.8	4.3	F	149.08
Allied	1.1	2.7	1.6	F	2.1	2.7	0.6	F	2.73
Support	9.0	8.4	(0.6)	U	7.7	8.4	0.7	F	8.40
Management & Admin	21.8	28.8	7.0	F	25.8	28.8	3.0	F	28.81
Total FTEs	**203.2**	**217.8**	**14.6**	**F**	**208.8**	**219.4**	**10.6**	**F**	**219.6**

Month

The surgical cluster reflects a surplus of $634k and is $1k favourable to budget for March 2019.

This is due to both elective and acute volumes delivering just below the contracted volumes (acute 96% and electives 95%). FTE is also favourable to budget by 14.6 FTE. Revenue is under budget by $139k due to a wash up on elective CWD and ACC surgery and assessments $32k. Workplace insurance added $10k to this unfavourable result. Elective volumes delivered below contract (ENT 5.4 CWD, ophthalmology 8.1 CWD, orthopaedics 7.1 CWD and urology 0.7 CWD) were reduced by over-delivery in other specialties to a net of 15.3 CWD below contract. This has impacted the March result by $92k - under budget.

Personnel costs are $121k favourable to budget (medical costs training $21k and overtime $32k; nursing ordinary time $53k under budget was offset by over-payments in training $13k, membership $7k and parental grants $11k). This was offset by outsourced personnel costs being $3k unfavourable, mainly due to the long-term locum costs $42k over budget, under-payments in urology and $35k ACC.

In line with CWD being delivered close to contract, the lower service delivery other expenses were $18k below budget. Disposable instruments, clinical equipment minor purchases, implants and prostheses and pharmaceuticals were all over budget, but were offset by under-spends in other areas, particularly treatment disposables $12k.

Year-to-date

The year-to-date result shows a surplus of $3,494k, which is $346k unfavourable to budget and 10.6 FTE favourable.

For the year-to-date, elective volumes have been under-delivered to budget by 256 CWD or $1,300k. ACC income is $395k unfavourable to budget. For the cluster overall, CWD are 547 CWD below contracted volumes (acute 90.9% and electives 89% delivery). In line with the lower delivery volumes, year-to-date expenditure is also $1,300k less than budget. Personnel expenses are under budget – medical $419k and 1.9 FTE; nursing $422k and 4.3 FTE; administration $89k and 3 FTE. Administration was impacted by the transfer of expenses from 1 January. Outsourced personnel costs are over-spent by $102k due to long-term locum to cover a vacancy ($226k over) and locum cover for sabbatical leave during July and August 2018 ($53k over). These were offset by a $136k under-spend in urology due to

reduced sessions being provided by MidCentral DHB until a fifth urologist is appointed. Clinical repairs and maintenance, disposable instruments, pharmaceuticals and facilities are over budget for the year-to-date.

Outlook and mitigations
The key focus for the surgical cluster is to manage the impact of lower CWDs and maintain a corresponding reduction in expenditure within the budget. Changes to the orthopaedic surgery roster have been implemented and seem to have had an impact on volumes. Timely and correct ACC claiming is also a priority and progress is being made on claiming for last year's ACC work.

Overall acute volumes for the year-to-date are under-delivered, however general surgery continues to be over-delivered. It is important that acute volumes are maintained at delivery just under budget, as excess acute delivery drives unfunded costs for the cluster. Delivery of acutes has been well controlled.

2. Medical services cluster financial results and commentary for March 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	151	238	(87)	U	1,206	1,336	(130)	U	1,764
Funder to Provider Revenue (internal)	2,713	2,713	-	F	24,084	24,084	-	F	32,090
Other income	9	7	2	F	76	60	16	F	80
Total Revenue	**2,873**	**2,958**	**(85)**	**U**	**25,366**	**25,480**	**(114)**	**U**	**33,934**
EXPENDITURE									
Personnel	1,571	1,715	144	F	15,234	15,201	(33)	U	20,552
Personnel Other	83	51	(32)	U	605	525	(80)	U	694
Outsourced Personnel	49	17	(32)	U	424	140	(284)	U	193
Total Personnel Expenditure	**1,703**	**1,783**	**80**	**F**	**16,263**	**15,866**	**(397)**	**U**	**21,439**
Outsourced Clinical Service	1	1	-	F	13	13	-	F	17
Clinical Supplies	220	162	(58)	U	1,690	1,518	(172)	U	2,073
Infrastructure & Non Clinical Supplies Costs	151	167	16	F	1,488	1,493	5	F	1,986
Depreciation, Interest & Internal Allocation	258	257	(1)	U	2,657	2,659	2	F	3,457
Total Other Expenditure	**630**	**587**	**(43)**	**U**	**5,848**	**5,683**	**(165)**	**U**	**7,533**
Total Expenditure	**2,333**	**2,370**	**37**	**F**	**22,111**	**21,549**	**(562)**	**U**	**28,972**
Net Surplus / (Deficit)	**540**	**588**	**(48)**	**U**	**3,255**	**3,931**	**(676)**	**U**	**4,962**
FTEs									
Medical	61.3	64.6	3.3	F	57.5	62.2	4.7	F	63.1
Nursing	131.9	121.0	(11.0)	U	134.3	123.8	(10.5)	U	124.3
Allied	-	-	-	F	-	-	-	F	-
Support	-	-	-	F	-	-	-	F	-
Management & Admin	0.5	3.1	2.6	F	2.2	3.1	0.8	F	3.1
Total FTEs	**193.7**	**188.6**	**(5.1)**	**U**	**194.0**	**189.0**	**(5.0)**	**U**	**190.4**

Month
The medical cluster reflects a surplus of $540k and is $48k unfavourable to budget for March 2019.

This is due to revenue below budget of $92k for Health Workforce NZ; over-runs in outsourced contractors $32k; and clinical supplies over-spend of $58k. This comprises pharmaceuticals $61k over budget (cardiovascular $22k due to the set up of 12 STEMI pathway Fibrinolytic kits; infections $37k due to a patient requiring two weeks' treatment with medications costing up to $1800 per day); patient appliances $4k (HoverMatts). Treatment disposables were $5k favourable to budget net of over-spends in IV supplies of $12k, mainly due to under-spend on blood products of $14k. Acute volumes were 58 CWD less than target volumes for the month (85.6% delivery).

The bed utilisation rate in the Emergency Department was 127%; 95% in CCU and 94% in the Medical Ward. The FTE is unfavourable to budget by 5.1 FTE and personnel costs were $80k under budget. This was due to medical personnel $109k under budget, 3.3 FTE below budget. Over-spends in nursing personnel of $12k (11 FTE above budget) included 6.4 FTE in ED, 2.8 FTE in AT&R, and 1.8 FTE on the Medical Ward. Although this FTE level was in excess of the budget, it was aligned with clinical requirements indicated by TrendCare.

Year-to-date
The year-to-date result shows a surplus of $3,255k, which is $676k unfavourable to budget and 5 FTE. Total revenue is under budget by $114k due mainly to Health Workforce NZ funding being under budget by $83k (lower PGY 1s and PGY 2s); and ACC income being under budget by $52k.

For the year-to-date, CWD have been over-delivered to contract (15 CWD overall due to an excess delivery of 137 CWD in general medicine that was offset by delivery below contract in emergency medicine of 122 CWD). Expenditure is driven by this over-delivery. This is also reflected in personnel costs which are over budget by $397k. Medical and admin personnel costs are $251k under budget, but offset by nursing $364k and 10.5 FTE over budget, and outsourced locums $284k over budget. Locums included RMOs $159k over budget to cover vacancies, and SMOs $125k over budget to cover rosters and leave.

Other expense areas are $165k over budget; instruments and equipment $6k; other clinical $7k; pharmaceuticals $88k; and treatment disposables $54k (IV supplies $60k). In line with the levels of service delivery, support expenses are $25k over budget – including patient meals $5k, additional orderlies $12k and laundry $17k.

Outlook and mitigations
Acute volumes have largely reversed the trend of over-delivery of CWD to contract that was evident last year (year-to-date 54 CWD delivered above the 2017/18 year-to-date volumes). High volumes drive unfunded costs and a reduction in volumes is needed to realign with the budget, as reduced volumes should provide a corresponding reduction in personnel and clinical costs.

Locum RMOs to cover the roster drives outsourcing costs. Although several RMOs commenced employment, the impact of Schedule 10 rostering means more recruitment will need to be undertaken. Until that time, expenditure on locums will continue.

Ongoing over-runs in nursing personnel in response to occupancy and acuity demands are also expected to continue and there is no sign of demand easing. Emergency Department nursing FTE was not increased in the 2018/19 budget. However actual FTE in 2017/18 ran over budget and is currently 4.9 FTE average over budget. Therefore this is a risk area for the 2018/19 budget.

3. Mental Health Services cluster financial results and commentary for March 2019

Lead: Mike Bothma, Business Manager Mental Health and Addictions

STATEMENT OF FINANCIAL PERFORMANCE ($000s) for the period ended 31 March 2019
MENTAL HEALTH CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	15	19	(4)	U	80	76	4	F	103
Funder to Provider Revenue (internal)	1,529	1,529	-	F	13,781	13,757	24	F	18,343
Other income	1	15	(14)	U	98	131	(33)	U	175
Total Revenue	**1,545**	**1,563**	**(18)**	**U**	**13,959**	**13,964**	**(5)**	**U**	**18,621**
EXPENDITURE									
Personnel	1,165	1,214	49	F	10,884	11,135	251	F	14,899
Personnel Other	26	17	(9)	U	112	147	35	F	221
Outsourced Personnel	39	-	(39)	U	255	-	(255)	U	-
Total Personnel Expenditure	**1,230**	**1,231**	**1**	**F**	**11,251**	**11,282**	**31**	**F**	**15,120**
Outsourced Clinical Service	-	1	1	F	2	5	3	F	7
Clinical Supplies	17	20	3	F	196	185	(11)	U	245
Infrastructure & Non Clinical Supplies Costs	112	110	(2)	U	1,026	997	(29)	U	1,331
Depreciation, Interest & Internal Allocation	273	271	(2)	U	2,757	2,749	(8)	U	3,597
Total Other Expenditure	**402**	**402**	**-**	**F**	**3,981**	**3,936**	**(45)**	**U**	**5,180**
Total Expenditure	**1,632**	**1,633**	**1**	**F**	**15,232**	**15,218**	**(14)**	**U**	**20,300**
Net Surplus / (Deficit)	**(87)**	**(70)**	**(17)**	**U**	**(1,273)**	**(1,254)**	**(19)**	**U**	**(1,679)**
FTEs									
Medical	11.5	13.4	1.9	F	12.4	13.4	1.0	F	13.36
Nursing	101.9	98.6	(3.3)	U	101.9	101.3	(0.5)	U	101.16
Allied	30.1	30.3	0.3	F	29.3	30.4	1.1	F	30.37
Support	-	-	-	F	-	-	-	F	-
Management & Admin	17.2	17.3	0.1	F	15.8	17.4	1.6	F	17.37
Total FTEs	**160.7**	**159.7**	**(1.0)**	**U**	**159.3**	**162.5**	**3.2**	**F**	**162.3**

Month

Mental Health services continue to see high volumes both in the inpatient wards as well as other services. This has resulted in cost pressures across the entire service which has seen the small overall favourable variance become unfavourable.

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 costs are favourable to budget due mainly to vacancies held in the medical job group. The favourable variances for medical are however partially offset by outsourced costs needed to fill vacancies. Nursing costs have continued to escalate as the volumes remain very high. Nursing overtime is also high, as is sick leave. Volumes in Te Awhina has remained high and is currently at an average of 104% for the month.

Clinical supply costs are favourable to budget. The favourable variance is primarily due to patient related costs which have reduced over the past few months. Pharmaceutical costs offset this favourable variance and has shown an increase in line with the higher volumes being experienced.

Increased volumes are also reflected in patient meals which are unfavourable to budget for the month.

Year-to-date

The year-to-date figure is now reflecting an unfavourable variance mainly due to reduced revenue from the Prisons contract (budgeted for the year, with no one seconded to the position). Personnel costs are still favourable to budget due to numerous vacancies, mostly in the medical job group, however there are some offsetting outsourced costs to cover these vacancies. Higher than budgeted pharmaceutical costs are purely volume driven. The patient meal cost continues to be higher than budget due to high volumes.

Outlook and mitigations
The current high patient volumes are not expected to reduce; it appears to be a nationwide problem. This will see continued pressure on staffing levels as well as clinical supplies. The situation is being monitored.

4. Allied Health Services cluster financial results and commentary for March 2019

Lead: Mike Bothma, Management Accountant

STATEMENT OF FINANCIAL PERFORMANCE ($000s)for the period ended 31 March 2019
ALLIED HEALTH CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	242	217	25	F	1,704	1,657	47	F	2,243
Funder to Provider Revenue (internal)	1,053	1,024	29	F	9,617	9,212	405	F	12,264
Other income	19	23	(4)	U	290	290	-	F	492
Total Revenue	**1,314**	**1,264**	**50**	**F**	**11,611**	**11,159**	**452**	**F**	**14,999**
EXPENDITURE									
Personnel	878	913	35	F	8,057	8,282	225	F	11,084
Personnel Other	78	39	(39)	U	243	159	(84)	U	221
Outsourced Personnel	98	73	(25)	U	699	642	(57)	U	849
Total Personnel Expenditure	**1,054**	**1,025**	**(29)**	**U**	**8,999**	**9,083**	**84**	**F**	**12,154**
Outsourced Clinical Service	415	387	(28)	U	3,745	3,548	(197)	U	4,734
Clinical Supplies	207	147	(60)	U	2,195	1,798	(397)	U	2,219
Infrastructure & Non Clinical Supplies Costs	81	77	(4)	U	677	659	(18)	U	878
Depreciation, Interest & Internal Allocation	223	227	4	F	2,246	2,266	20	F	2,980
Total Other Expenditure	**926**	**838**	**(88)**	**U**	**8,863**	**8,271**	**(592)**	**U**	**10,811**
Total Expenditure	**1,980**	**1,863**	**(117)**	**U**	**17,862**	**17,354**	**(508)**	**U**	**22,965**
Net Surplus / (Deficit)	**(666)**	**(599)**	**(67)**	**U**	**(6,251)**	**(6,195)**	**(56)**	**U**	**(7,966)**
FTEs									
Medical	2.6	2.6	0.0	F	2.3	2.6	0.3	F	2.6
Nursing	8.9	7.1	(1.8)	U	8.8	7.1	(1.8)	U	7.1
Allied	106.0	106.8	0.8	F	102.2	106.9	4.7	F	106.8
Support	0.2	0.2	(0.0)	U	0.2	0.2	(0.0)	U	0.2
Management & Admin	11.8	15.5	3.7	F	15.1	15.5	0.4	F	15.5
Total FTEs	**129.4**	**132.1**	**2.7**	**F**	**128.5**	**132.2**	**3.7**	**F**	**132.1**

Month
Allied Cluster is reflecting an unfavourable variance for the month. Most cost groups are reflecting negative variances with the exception being personnel costs and depreciation. Increased revenue also partially offsets the unfavourable variance for the month.

Revenue is $49k favourable for the month with pharmaceutical revenue making up a large portion of the favourable variance. This does however have offsetting costs. The outpatient clinic revenue for Capital and Coast DHB is also favourable to budget due to the current clean-up process in invoicing.

Personnel and outsourced personnel cost are unfavourable to budget due largely to unbudgeted parental leave as well as a bulk payment for professional membership fees. Outsourced cost are unfavourable to budget due to 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. We have also seen an increased number of Orthotic clinics which has further increased the unfavourable variance for the month.

Clinical supply costs are unfavourable to budget due mainly to disposable instruments as well as dental supply costs. This is for the dental caravans which will be stocked up during the school holidays. Both these costs are within budget for the year-to-date. Mobility aids also show an increase in cost due to the higher than normal clinics undertaken.

Year-to-date

The year-to-date variance has fallen to an unfavourable position following this month's performance. Revenue continues to be the main favourable variance but there are offsetting costs associated with the increased revenue. Outsourced costs as well as clinical supply costs remain unfavourable to budget.

Outlook and mitigations

Personnel costs will increase as and when vacancies are filled mainly in the Allied job group. Pharmaceutical costs will be under pressure due to the $10k per month budget shortfall, as well as the cost of a new eye drug that was unbudgeted. For most of these increased costs 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.

5. Community, Rural and Public Health Services cluster financial results and commentary for March 2019

Lead: Mike Bothma, Management Accountant

STATEMENT OF FINANCIAL PERFORMANCE ($000s)
PUBLIC HEALTH & COMMUNITY CLUSTER

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	55	67	(12)	U	1,118	1,250	(132)	U	1,667
Funder to Provider Revenue (internal)	598	527	71	F	4,878	4,745	133	F	6,327
Other income	1	1	-	F	9	7	2	F	10
Total Revenue	**654**	**595**	**59**	**F**	**6,005**	**6,002**	**3**	**F**	**8,004**
EXPENDITURE									
Personnel	448	506	58	F	3,967	4,656	689	F	6,218
Personnel Other	7	5	(2)	U	57	44	(13)	U	61
Outsourced Personnel	-	-	-	F	-	-	-	F	-
Total Personnel Expenditure	**455**	**511**	**56**	**F**	**4,024**	**4,700**	**676**	**F**	**6,279**
Outsourced Clinical Service	1	-	(1)	U	1	-	(1)	U	-
Clinical Supplies	143	136	(7)	U	1,234	1,207	(27)	U	1,608
Infrastructure & Non Clinical Supplies Costs	29	31	2	F	300	296	(4)	U	398
Depreciation, Interest & Internal Allocation	106	101	(5)	U	1,039	1,022	(17)	U	1,338
Total Other Expenditure	**279**	**268**	**(11)**	**U**	**2,574**	**2,525**	**(49)**	**U**	**3,344**
Total Expenditure	**734**	**779**	**45**	**F**	**6,598**	**7,225**	**627**	**F**	**9,623**
Net Surplus / (Deficit)	**(80)**	**(184)**	**104**	**F**	**(593)**	**(1,223)**	**630**	**F**	**(1,619)**
FTEs									
Medical	0.1	0.3	0.2	F	0.2	0.3	0.1	F	0.29
Nursing	51.9	50.7	(1.2)	U	46.4	51.0	4.6	F	51.05
Allied	8.9	12.2	3.4	F	8.8	12.3	3.5	F	12.27
Support	1.3	1.0	(0.3)	U	1.2	1.0	(0.2)	U	1.02
Management & Admin	1.2	9.8	8.6	F	5.7	9.8	4.1	F	9.80
Total FTEs	**63.4**	**74.1**	**10.7**	**F**	**62.3**	**74.4**	**12.1**	**F**	**74.4**

Month

Public health and community cluster reflects a favourable variance of $104k for March. This is due to both revenue in excess of budget and favourable personnel costs within the cluster. Smoke free revenue is not budgeted so will show a favourable variance throughout the year of $7k per month, additional income for March of $63k is from back-dated school based health services. Clinical supplies were over budget due to bandages and dressing costs. This is due to patient acuity, as well as continence and ostomy supplies. All public health costs remain within budget. All administration staff for the cluster have now been moved to a new RC and cluster. This will reflect a favourable variance as costs the have moved but the budget remains. ACC revenue was $12k unfavourable to budget for the month due to declined and held claims by ACC.

Year-to-date

For the year-to-date to March 2019 the public health and community cluster showed a favourable variance of $630k. $95k of this variance is due to moving administration staff costs. The remaining $535k is due to favourable personnel costs within the service and for unbudgeted revenue for smoke free and school based health services. Even though during the month of February many vacancies were filled the favourable FTE variance has remained the same. District nursing is now managing within their FTE budget but the cost of patient supplies continues to remain over budget and it is expected that this trend will continue due to patient acuity and the type of product used. ACC revenue unfavourable to budget continues to increase, now $133k under budget year-to-date. The ACC budget is not expected to be met by year end.

Outlook and mitigations

All clinical vacancies in the service are actively being recruited to, 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 Negative Pressure Wound Therapy (NPWT) equipment, but the service continues to have a large number of patients requiring high cost dressings so the anticipated impact of this purchase is not visible. The service is now capturing data on all high cost consumables which will enable a review of dressing use to ensure the right product is used on the patient. This data capture will also potentially increase ACC revenue claims and 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 April and will be back-dated to cover the new staff. The new contract should have a slightly favourable result for the service.

8 Information papers

8.1 Whānau Ora - background information

Outlined below is background information describing the WDHB commitment to Whānau Ora and in partnership with Hauora A Iwi the three goals of the 2017 memorandum of understanding. Along with national strategies and frameworks that guide our work and decision-making.

Whanganui District Health Board Commitment to Whānau Ora

In 2013, following an independent review by Dr Mihi Ratima, the Whanganui District Health Board (WDHB) endorsed Whānau Ora – whānau/family centered care as a core approach to improve and enhance Māori health across our region. Beginning this journey required embedding this philosophy within the DHB then across the local sector. The four action responses identified in the review were:

- Adoption of whānau/family-centered approach as the foundation for all that we do – governance, management, service planning, development and delivery for all patients and their families
- Strong leadership - leading and championing the change - top down and bottom up
- Workforce development - increase workforce development and provide more support for staff to increase their knowledge/understanding of Māori tikanga traditions and values to be more confident when caring for Māori whānau
- Culturally responsive services - Māori whānau/families with high health needs require culturally responsive services, guidance and navigation through the health system so they can self-determine their journey confidently.

Hauora A Iwi and WDHB Board Partnership Agreement

The Memorandum of Understanding 2017 between Whanganui DHB and Hauora A Iwi describes a joint commitment to the following goals:

One: Giving effect to Whānau Ora – the right service, at the right time, in the right place, in the right way.
Two: Achieving health equity for Māori - monitoring performance through reporting.
Three: Improving capacity and enhancing capability – systems, delivery options and workforce.

These goals guide our actions and the work that we do alongside national strategies such He Korowai Oranga.

He Korowai Oranga NZ Māori Health Strategy 2014

The overall aim of the strategy is **Pae ora** - healthy futures, which incorporates three interconnected elements:

- **Whānau ora** – healthy families - whānau wellbeing and support, participation in Māori culture and Te Reo.
- **Wai ora** – healthy environments - education, work, income, housing and deprivation.
- **Mauri ora** – healthy individuals - life stage from pepi/tamariki to rangatahi then pakeke and a section that includes individuals of all ages.

Incorporating four pathways of action that are not mutually exclusive are intended to work as an integrated whole:

Te Ara Tuatahi: Development of whānau, hapū, iwi and Māori communities.
Te Ara Tuarua: Māori participation in the health and disability sector.
Te Ara Tuatoru: Effective health and disability services.
Te Ara Tuawhā: Working across sectors.

Kaupapa Māori Services

A kaupapa Māori service is based on Māori values and beliefs, delivered through a Māori model of care.

Ensuring that Māori Whānau/families have the choice to access a range of kaupapa Māori services is important. WDHB have made a commitment to the procurement and funding of Kaupapa Māori Health Services across the region.

It is important to acknowledge that the health demographic and needs of each geographical area where kaupapa Māori services are delivered are different. Therefore, the service delivery model for each provider is not prescribed and it is accepted that the approach to the way services are delivered and some of the service elements will differ from provider to provider.
The DHB and kaupapa Māori service providers have worked together to develop a contract arrangement that embraces the Whānau ora approach to wellbeing and care delivery. Measured by a mix of quantitative outputs and qualitative outcomes (Whānau stories).

There are five Māori health provider organisations in the WDHB health district, Te Oranganui, Mokai Patea, Te Puke Karanga Hauora, Ngati Rangi Community Health and Te Kotuku Hauora.

The DHB purchases kaupapa Māori services using the Whānau Ora Outcomes Framework – *Empowering Whānau into the Future* (approved by Iwi Leaders through the Whānau Ora Partnership Group 2015) as a guide and providers deliver services based on the outcomes described in the framework.

Whānau Ora Outcomes Framework

The Whānau Ora Outcomes Framework – *Empowering Whānau into the Future* (approved by Iwi Leaders through the Whānau Ora Partnership Group 2015) articulates seven whānau ora outcomes as follows:

- Whānau are self- managing and empowered leaders
- Whānau are leading healthy lifestyles
- Whānau are participating fully in society
- Whānau and families are confidently participating in Te Ao Māori (the Māori World)
- Whānau and families are economically secure and successfully involved in wealth creation
- Whānau are cohesive, resilient and nurturing
- Whānau and families are responsible stewards of their living and natural environments

Included below is a link to the Whānau Ora Outcomes Framework – *Empowering Whānau into the Future:* https://www.tpk.govt.nz/docs/tpk-wo-outcomesframework-aug2016.pdf

Māori Health Outcomes Advisory Group

The impetus for the development of this advisory group was that the Whanganui District Health Board acknowledges that iwi health organisations are expert in reaching and working with Māori whānau and communities. Therefore, the Whanganui District Health Board wished to work with iwi health providers collectively at an operational level to receive advice to enable improved health planning and health service provision to Māori communities. The group includes leaders from the five Māori health service providers in the district. Members also sit on different health planning and service improvement groups providing advice and support.

The terms of reference 2017 describes the intent of the group as follows:

Intent
The intent of the group is to work together to identify health strategies and service solutions that will reduce inequalities and improve the health for Iwi communities and Māori living in the Whanganui

District Health Board region by:

1. Providing strong and effective advice and support to the Whanganui District Health Board planning and decision-making processes.
2. Collectively to increase the capacity and capability of Iwi health providers to be responsive to the needs of Māori.

3. Jointly identifying the needs of the population to contribute to the WDHB Mahere Tau Annual Plan and health plans of each iwi health provider.

The partnership approach to this group will ensure that iwi health providers are enabled to:

1. Provide a strong collective voice to influence Whanganui District Health Board decision making related to planning and implementation of Māori health initiatives and solutions.
2. Have a greater ability to influence the structure and approach to addressing Māori health issues and achieving Māori health outcomes in the region.
3. Work with the Whanganui District Health Board service and business planning to develop the WDHB Mahere Tau Annual Plan and participate in other key planning processes.
4. Champion key priorities (to be identified): Champion to provide advice on matters related to Māori health on key Whanganui District Health Board steering/governance groups as the duly authorised iwi health providers' spokesperson.
5. Work with the Director Māori Health to contribute to the development of the WDHB Mahere Tau Annual Plan.

The WDHB is enabled to:

1. Receive strong and effective advice and support for planning and decision making processes related to Māori health outcomes and communities.
2. Improve its understanding of Māori communities.
3. Improve its understanding of how mainstream organisations and services can meet the needs of Māori.

To work collectively as iwi health providers to:

1. Improve practice across provider organisations.
2. Achieve greater co-ordination of resources and effort to maximize health outcomes.
3. Increase awareness and opportunities for each provider.
4. Identify opportunities to invest in infrastructure and kaimahi in order to continue to meet the needs/expectations of our whānau.
5. Increase capacity to inform Hauora A Iwi about the issues affecting Māori health in the region through various avenues available via each provider.

He Korowai Oranga New Zealand Māori Health Strategy will be used as an overarching reference/directive in the discussions and decision-making processes of the group. Other key reference documents will include the iwi health plans, Whanganui District Health Board Mahere Tau Annual Plan, Whānau Ora strategy and directions, primary health organisation annual plans and the Ministry of Health strategies and directions.

The sponsor for the advisory group is the director, Māori health, WDHB in collaboration with the general manager, service and business planning WDHB.

Executive Summary

Whānau Ora is a culturally anchored approach, shaped by Māori worldviews, cultural norms, traditions and heritage. Its foundational premise is that by empowering whānau to be self-determining, and providing support, encouragement, and inspirational ideas and opportunities, whānau can be the architects and drivers of a positive future. It is aspirational and strengths-based. Whānau Ora puts whānau in charge of decision-making, empowering them to identify their aspirations to improve their lives and build their capacity to achieve their goals[1].

It is currently in its second phase. The first phase was focused on building a whānau-centred approach, and provider capability to design and deliver whānau-centred services. Phase 1 was gradually wound down in tandem with the second phase being ushered in during 2014. The second phase fundamentally changed the emphasis towards building whānau capability and the delivery approach from government contracting with providers to outcomes being delivered through a new commissioning model.

In April 2018, the government agreed to conduct a review of this second phase, the Whānau Ora commissioning approach. This report is the outcome of that review. It provides a brief background to Whānau Ora, describes the current commissioning approach and addresses the core matters posed in the review Terms of Reference. Those matters were:

i. The ability of the Whānau Ora Commissioning Approach to effect sustainable change in the wellbeing and development potential of whānau;

ii. The extent to which the Whānau Ora service delivery model and commissioning approach is accountable and transparent in the achievement of outcomes for whānau; and

iii. The applicability of a whānau-centred approach as a useful exemplar for improving outcomes for whānau across Government with an emphasis on the social sector.

The Current Commissioning Approach

In 2014, following government's earlier decision to revisit the arrangements for Whānau Ora, a tender process resulted in agreement to three community-initiated proposals to establish Commissioning Agencies. Those agencies are:

i. Te Pou Matakana, supporting whānau and families in the North Island;

ii. Te Pūtahitanga o Te Waipounamu, representing a grouping of nine South Island iwi, supporting whānau and families in the South Island (including the Chatham Islands); and

[1] Formative Evaluation of the Whānau Ora Commissioning Agency Model, Te Puni Kōkiri, 2016.

iii. Pasifika Futures, supporting Pasifika families across New Zealand.

The commissioning approach involves a number of core parties, each with distinct roles and responsibilities for Whānau Ora. They include:

i. The Minister for Whānau Ora, with portfolio responsibility and parliamentary accountability;

ii. The Whānau Ora Partnership Group, a Crown-Iwi relationship mechanism charged with strategic leadership of Whānau Ora and oversight of progress of the commissioning approach;

iii. Te Puni Kōkiri, as the administering agency for the Whānau Ora appropriations;

iv. The Commissioning Agencies, responsible for establishing outcome priorities for their constituent communities, and commissioning outcomes in pursuit of those priorities; and

v. Whānau Ora partners, providers and whānau entities, engaged by Commissioning Agencies and working with whānau to achieve those outcomes.

One of the features of the Commissioning Approach is that it is permissive and flexible, designed to bring decision-making closer to communities, and ensure locally appropriate intervention. The intent is that Commissioning Agencies can develop their own outcome priorities (consistent with the broader Whānau Ora Outcomes Framework), and define the commissioning activities that will be delivered through them by Whānau Ora partners, providers and whānau entities, or in some cases directly by them.

Te Pou Matakana and Pasifika Futures commissioning activities include a mix of navigation and whānau planning, direct support to whānau, and focused projects often involving multiple partners. Te Pūtahitanga o Te Waipounamu has taken a social enterprise approach to its commissioning by investing in whānau-developed and local-level initiatives. It is also growing a Whānau Ora navigation approach to respond to the immediate and longer-term needs of whānau.

Has the Whānau Ora Commissioning Approach resulted in sustainable change for whānau?

The Whānau Ora commissioning approach creates positive change for whānau. In all areas we visited, and across all monitoring reports we reviewed, we have seen whānau progress towards achieving their self-identified priorities. However, the approach is relatively new, and we believe it is too early to form a view as to whether or not that positive change will be enduring. We believe that the intentions of Whānau Ora, aiming to build resilience and capability within

whānau to be self-managing and to be the architects of their own solutions, create the conditions to achieve sustainable change.

In addition to change for participating whānau, there are a range of other impacts, most of which have the potential to benefit whānau in the future.

We identified a number of features of the model that contribute to its success, including:

i. That it is culturally anchored, whānau-centred and strengths-based;

ii. That it is flexible, allowing Commissioning Agencies, partners, providers and whānau entities to progress issues of most importance to whānau;

iii. That there is a high level of support provided by Commissioning Agencies to partners, providers and whānau entities; and

iv. That it is supported by a committed and passionate workforce, who are able to connect with the whānau they work with and are invested in the success of their communities.

We also identified a number of challenges, both within the commissioning model and within the wider environment in which it operates.

In terms of challenges within the commissioning model:

i. The extent of the geographic area that each Commissioning Agency serves impacts on their ability to remain closely connected to their constituent whānau and communities. We consider that there is scope to explore more localised commissioning options in the North Island;

ii. Each Commissioning Agency invests in bespoke administrative arrangements to support the delivery and accountability of Whānau Ora. We consider that there is an opportunity for Commissioning Agencies to co-invest in administrative arrangements for which they have common requirements;

iii. Demand for Whānau Ora outstrips the funding and resources available to partners, providers and whānau entities to provide support. In some areas, the level of demand was overwhelming, and fundamentally impacted on the approach taken by partners and providers, from being aspiration focused to providing short-term crisis-based interventions. This raised concerns that in some cases navigators were required to address situations that should be the domain of clinicians or qualified social workers, and that this mode of operation diverts valuable Whānau Ora resources from the intended approach of building resilience and capacity to be self-managing towards crisis intervention that should be the

responsibility of central government agencies and/or the NGOs they contract to provide this level of intervention;

iv. There are a number of issues with and for partners, providers and whānau entities that are contracted by Commissioning Agencies. These are predominantly around funding concerns; and

v. There are issues with reach, particularly reach into rural areas and to deprived populations.

There were also a number of challenges in the wider environment in which Whānau Ora operates, including:

i. There have been difficulties in building understanding among government agencies (in Wellington) about the Whānau Ora 'story' – what it is, how it works, and how government agencies can work with Whānau Ora, leaving some of them hesitant and questioning as to its validity and robustness as an agreed government approach;

ii. We believe that this has impacted on the extent of 'buy-in' and uptake of Whānau Ora among government agencies; and,

iii. We were most concerned that central government agencies are opting out of their own responsibilities. We were told of numerous occasions where not only were Whānau Ora partners meeting the service delivery responsibilities of other agencies, they were also expected to do so.

Because we have found that the Whānau Ora Commissioning Approach has resulted in positive change for whānau, and we believe that the conditions are in place for this change to be sustainable, we have made a number of recommendations relevant to this aspect of the Terms of Reference. They include recommendations to:

i. Continue and grow the investment in the Whānau Ora Commissioning Approach;

ii. Ensure that government agencies meet their own service delivery responsibilities, and commit to engaging with Whānau Ora;

iii. Extend the effort of Te Puni Kōkiri to provide a greater sense of leadership of Whānau Ora within government, and to better support other agencies to engage in Whānau Ora;

iv. Encourage Commissioning Agencies to co-invest where they have mutual interests, and invest in getting closer to their communities; and

v. Focus Whānau Ora partners and providers on its stated intent.

Is the Commissioning Model Accountable and Transparent?

We were asked to consider the extent to which the Whānau Ora service delivery model and commissioning approach is accountable and transparent in the achievement of outcomes for whānau.

There is a significant and formal accountability regime attached to the Whānau Ora Commissioning Approach. As is expected with public funding, that chain of accountability is formalised through all parts of the Whānau Ora system, and we consider that it is well adhered to by the parties to that system. However, given that the Commissioning Approach is outcomes focused, we would have expected an accountability regime that was principally focused on the achievement of outcomes: we found a significant focus on process.

We agree with Commissioning Agencies, and other parts of the Whānau Ora system, that there is a disproportionate level of external scrutiny applied to Whānau Ora. In its relatively short lifespan, it has been the subject of a number of external reviews, including reviews by the Office of the Auditor-General, the Productivity Commission, an independent evaluation and now this ministerial review. While Commissioning Agencies do not resile from being held accountable, they are frustrated that this level of scrutiny does not seem to be applied even-handedly to other government-funded initiatives.

Part of the accountability arrangements for Whānau Ora include a Whānau Ora Partnership Group, comprised of Ministers of the Crown and representatives of the Iwi Leaders Group. Concern has been raised in the Pasifika Whānau Ora community that there is no Pasifika voice in this mechanism, or parallel mechanism for Pasifika involvement at a strategic level. We chose not to make recommendations on the composition of the Partnership Group: it is a Crown–iwi relationship mechanism, and only the parties to it should consider its scope and membership. We do, however, consider that there is merit in establishing a reference group, to provide the Minister with independent views that can represent the whānau voice.

One aspect of the Whānau Ora accountability system that generated significant comment was the reporting tools that partners and providers are required to use to report to Commissioning Agencies. These were generally considered to be unnecessarily time-consuming, and not fit-for-purpose, as they did not properly capture the extent of effort, or the extent of change experienced by whānau.

We also found that there were checks and balances in place to support decision-making. However, there were concerns raised that there is no 'downward transparency' – that is, that the criteria, rationale and processes for decision making are not visible to partners, providers and whānau themselves.

We have made a number of recommendations in relation to accountability and transparency. They include recommendations to:

i. Consider the strategic leadership arrangements for Whānau Ora;

ii. Promote Whānau Ora and whānau-centred approaches across government; and

iii. Examine and strengthen processes for downward transparency to partners, providers and whānau.

Is a Whānau-Centred Approach More Widely Applicable Across Government?

The Terms of Reference required us to scope the applicability of a whānau-centred approach as a useful exemplar for improving outcomes for whānau across government, with an emphasis on the social sector. While we were asked to consider the question of whether a whānau-centred approach is a useful *exemplar,* we have erred on the side of caution, favouring the term *example.* Exemplar could be interpreted as the best approach. As we have not assessed alternative approaches to social service delivery we do not believe that we can consider whether it is an exemplar.

We have already noted our findings:

i. That the Whānau Ora Commissioning Approach results in positive change for whānau;

ii. That it creates the conditions for that change to be sustainable;

iii. That it operates within, and meets the requirements of, a structured accountability system; and

iv. That it operates in a transparent manner.

In order to address the question of whether whānau-centred approaches could be more widely applicable across government, we have reviewed a number of recent reports on good social investment. We consider that Whānau Ora and whānau-centred approaches demonstrate a number of features that align closely with the success factors identified in these reports.

We therefore are of the view that there is the potential for whānau-centred approaches to be applied more widely across government. We were asked to scope how that might occur, and we have identified two key approaches to achieving this. The first is to embed reference to, and requirements about, whānau-centred approaches through levers available in the machinery of government, including:

i. Influencing the Living Standards Framework, including Treasury's Budget instructions and guidance for the 2019 Wellbeing Budget;

ii. Embedding requirements for the social sector to progress whānau-centred approaches through strategies and legislation that are currently being developed to support the wellbeing of New Zealanders;

iii. Completing a whānau-centred policy framework for use across government;

iv. Embedding whānau-centred approaches within the wider NGO sector; and

v. Improving the quality and availability of data about whānau.

We also believe that there is a culture shift needed within government, and to that end we have recommended that Te Puni Kōkiri work with other agencies to capitalise on opportunities, and address the perceived barriers that inhibit the uptake of Whānau Ora, and whānau-centred approaches.

We consider that this review report is the beginning, not the end, of the process to address the issues canvassed in the Terms of Reference for the review. We have noted that this is not a policy report, and we are not policy or machinery-of-government experts. We leave the policy work in the hands of those experts, and trust they will develop proposals to give effect to the intent of our recommendations.

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

AAU	Acute Assessment Unit
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
HRT	Health Round Table
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

Kupu Māori	English
Koroheke	Elder (male)
Kotahitanga	Unity, cohesion, sharing vision, working together, trust, relationships
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

Kupu Māori	English
	behaviour and within a health context indicates the way resources, guardianship, responsibilities, obligations and future generations will be protected
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'.