WHANGANUI
DISTRICT HEALTH BOARD
*Te Poari Hauora o Whanganui*

# AGENDA

## Combined Statutory Advisory Committee

| | |
|---|---|
| Meeting date | **Friday 14 June 2019** |
| Start time | **9.30am** |
| Venue | Board Room<br>Fourth Floor<br>Ward and Administration Building<br>Whanganui Hospital<br>100 Heads Road<br>Whanganui |

**Embargoed until Saturday 15 June 2019**

**Contact**
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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
- Ms L Adams, 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
- Mr M Bothma, Acting Funding and Contracts Manager
- Ms K Fraser-Chapple, Business Manager, Medical, Community and Allied Health
- Mrs L Torr, Business Manager, Medical Management Unit
- Mr P Wood-Bodley, Business Manager, Surgical Services
- Mrs A Bunn, Portfolio Manager, Health of Older People
- Ms C Sixtus, Portfolio Manager, Primary Care
- Mrs L Allsopp, Manager Patient Safety and Quality
- Mrs J Haitana, Associate Director of Nursing
- 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 QSO, Archivist
- Wanganui Public Library
- Wanganui Chronicle
- Ms Mary Bennett, Hauora A Iwi Chair

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WHANGANUI
DISTRICT HEALTH BOARD
*Te Poari Hauora o Whanganui*

# 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

# 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 14 June 2019, commencing at 9.30am**

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**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 3 May 2019 be approved as a true and correct record.

## 5 Matters arising — Page 23

## 6 Committee Chair's report — Page 23
A verbal report may be given at the meeting

## 7 Whanganui DHB Annual Work Programme — Page 24

7.1 Whanganui Alliance Leadership Team (WALT) — Page 24

7.2 Pro Equity update — Page 25

7.3 The first 1000 days of life — Page 29

7.3 Workforce and organisational development — Page 34

7.4 Financial performance — Page 36


## 8 Reference and Information Section


| Attachment | Description | Page |
|---|---|---|
| 1 | New Zealand's Maternity and Child Health Services – preconception to 6 years | **48** |
| 2 | Economics of early intervention | **49** |
| 3 | Whanganui SUDI prevention discussion 18 October 2017 – services for wāhine, hapū and whānau in Whanganui | **55** |
| 4 | NZ Child and Youth Epidemiology Service 2017 - Whanganui DHB vs New Zealand | **56** |
| **Reference attachments – combined committee interest** | | |
| 5 | Glossary | **57** |
| 6 | Combined Statutory Advisory Committee - Terms of Reference | **61** |


## 9 Date of next meeting
Friday 26 July 2019


## 10 Glossary and Terms of References *(for reference only)* — Page 57

## 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 3 May 2019 (public-excluded session) | For the reasons set out in the committee's agenda of 3 May 2019 | As per the committee's agenda of 3 May 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 17 May 2019

### BOARD MEMBERS

| NAME | DATE NOTIFIED | CONFLICT/DECLARATIONS |
|---|---|---|
| **Graham Adams** | 16 December 2016 | Advised that he is:<br>▪ A member of the executive of Grey Power Wanganui Inc.<br>▪ A board member of Age Concern Wanganui Inc.<br>▪ Treasurer of NZCE (NZ Council of Elders)<br>▪ A trustee of Akoranga Education Trust, which has associations with UCOL. |
| **Charlie Anderson** | 16 December 2016 | Advised that he is an elected councillor on Whanganui District Council. |
| | 3 November 2017 | Advised that he is now a board member of Summerville Disability Support Services. |
| **Philippa Baker-Hogan** | 10 March 2006 | Advised that she is an elected member of the Whanganui District Council. |
| | 8 June 2007 | Partner in Hogan Osteo Plus Partnership. |
| | 24 April 2008 | Advised that her husband is an osteopath who works with some surgeons in the hospital on a non paid basis but some of those patients sometimes come to his private practice Hogan Osteo Plus and that she is a partner in that business. |
| | 29 November 2013 | Advised that she is Chair of the Future Champions Trust, which supports promising young athletes. |
| | 7 November 2014 | Philippa Baker-Hogan declared her interest as:<br>▪ A member of the Whanganui District Council District Licensing Committee; and<br>▪ Chairman of The New Zealand Masters Games Limited |
| | 3 March 2017 | Philippa Baker-Hogan declared her interest as a trustee of Four Regions Trust. |
| **Maraea Bellamy** | 7 September 2017 | Advised that she is:<br>▪ Te Runanga O Ngai Te Ohuake (TRONTO) Delegate of Nga Iwi O Mokai Patea Services Trust.<br>▪ Secretary of Te Runanga O Ngai Te Ohuake.<br>▪ Hauora A Iwi - Iwi Delegate for Mokai Patea. |
| | 4 May 2018 | Advised that she is:<br>▪ a director of Taihape Health Limited.<br>▪ a member of the Institute of Directors. |
| | 1 February 2019 | Trustee of Mokai Patea Waitangi Claims Trust |
| **Jenny Duncan** | 18 October 2013 | Advised that she is an elected member of the Whanganui District Council |
| | 1 August 2014 | Advised that she is an appointed member of the Castlecliff Community Charitable Trust |
| | 5 April 2019 | Member of the Chartered Institute of Directors<br>Trustee of Four Regions Trust |
| **Darren Hull** | 28 March 2014 | Advised that he acts for clients who may be consumers of services from WDHB. |
| | 27 May 2014 | Advised that he:<br>▪ is a director & shareholder of Venter & Hull Chartered Accountants Ltd which has clients who have contracts with WDHB<br>▪ acts for some medical practitioners who are members of the Primary Health Organisation<br>▪ acts for some clients who own and operate a pharmacy<br>▪ is a director of Gonville Medical Ltd |
| **Stuart Hylton** | 4 July 2014 | Advised that he is:<br>▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society Of New Zealand. |

| Member | Date | Interest |
|---|---|---|
| | | ▪ 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:<br>▪ Chairman of Whanganui Education Trust<br>▪ 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:<br>▪ Chief Executive Officer, Whanganui Regional Primary Health Organisation<br>▪ 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:<br>▪ An associate of Moore Law, Lawyers, Whanganui<br>▪ 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:<br>▪ a Director of Chardonnay Properties Limited (a property owning company)<br>▪ Chair of the DHB Regional Governance Group<br>▪ an advisory member on the Employment Relationship Strategy Group (ERSG) |
| **Tariana Turia** | 16 December 2016 | Declared her interests as:<br>▪ Pou to Te Pou Matakana (North Island)<br>▪ Member of independent assessment panel for South Island Commissioning Agency<br>▪ Life member CCS Disability Action<br>▪ National Hauora Coalition Trustee Chair<br>▪ Cultural adviser to ACC CEO<br>▪ Te Amokura of Te Korowai Aroha Trust (National) |
| | 15 November 2017 | Recorded that she has been appointed Te Pou Tupua o te Awa. |

## COMBINED STATUTORY ADVISORY COMMITTEE MEMBERS

| NAME | DATE NOTIFIED | CONFLICT/DECLARATIONS |
|---|---|---|
| **Frank Bristol** | 8 June 2017 | Advised that he is:<br>▪ Member of the WDHB Mental Health and Addiction (MH&A) Strategic Planning Group co-leading the adult workstream.<br>▪ 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.<br>▪ Working as the MH & A Consumer Advisor to the Whanganui DHB through the Balance Aotearoa as holder of a consumer consultancy service provision contract.<br>▪ Member of Sponsors and Reference groups of National MH KPI project.<br>▪ Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders Group.<br>▪ Has various roles in Whanganui DHB MHA WD, Quality Improvement programmes and Strategic planning<br>▪ Member of Whanganui DHB CCDM Council<br>▪ 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.<br>▪ 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.<br>▪ 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 | Appointed to Te Pou Clinical Reference group. |
| **Andrew Brown** | 13 July 2017 | Advised that:<br>▪ he is an independent general practitioner and clinical director of Jabulani Medical Centre;<br>▪ he is a member of Whanganui Hospice clinical governance committee; and<br>▪ most of his patients would be accessing the services of Whanganui District Health Board. |
| **Heather Gifford** | 20 November 2018 | Advised that she is:<br>▪ Ngāti Hauiti representative on Hauora a Iwi;<br>▪ Senior Advisor and founding member of Whakauae Research for Māori Health and Development (currently engaged in research with WDHB);<br>▪ Member of Te Tira Takimano partnership Board of Nga Pae o Te Maramatanga (Centre for Māori research excellence, Auckland University); and<br>▪ 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:<br>▪ He is an employee of Whanganui Regional PHO – 2006 to present<br>▪ 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:<br>▪ employed by the Whanganui Regional Health Network (WRHN)<br>▪ 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<br>▪ General Manager Operations – Te Runanga o Ngā Wairiki Ngati Apa (Te Kotuku Hauora, Marton)<br>▪ Member of the WDHB Mental Health and Addictions Strategic Planning Group<br>▪ 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:<br>▪ He is Board member, Fire and Emergency New Zealand.<br>▪ He is Director/Shareholder, Inglis and Broughton Ltd. |
| | 10 April 2019 | ▪ His niece, Nadine Mackintosh, is employed by Whanganui DHB as Board Secretary and EA to the chief executive. |

| NAME | DATE NOTIFIED | CONFLICT/DECLARATIONS |
|---|---|---|
| **Anne Kolbe** | 26 August 2010 | ▪ Medical Council of NZ – Vocational medical registration – Pays registration fee<br>▪ Royal Australasian College of Surgeons – Fellow by Examination – Pays subscription fee<br>▪ Private Paediatric Surgical Practice (Kolbe Medical Services Limited) – Director – Joint owner<br>▪ Communio, NZ – Senior Consultant - Contractor<br>▪ Siggins Miller, Australia – Senior Consultant - Contractor<br>▪ Hospital Advisory Committee ADHB – Member – Receives fee for service<br>▪ Risk and Audit Committee Whanganui DHB – Member – Receives fee for service<br>▪ 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:<br>▪ Professor of Medicine, FMHS, University of Auckland<br>▪ Chair, Health Research Council of New Zealand, Clinical Trials Advisory Committee (advisory to the council)<br>▪ Member Australian Medical Council (AMC) Medical School Advisory Committee (advisory to the board of AMC)<br>▪ Lead, Australian Medical Council, Medical Specialties Advisory Committee Accreditation Team, Royal Australian College of General Practitioners<br>▪ Member, Executive Committee, International Society for Internal Medicine<br>▪ Chair, RACP (Royal Australasian College of Physicians) Re-validation Working Party<br>▪ 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:<br>▪ is an observer to the Medicare Benefits Schedule Review Taskforce (Australia). |
| | 10 August 2016 | Advised that:<br>▪ 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.<br>▪ She is chair, Advisory Council, EXCITE International.<br>▪ She is member of MidCentral District Health Board's Finance, Risk and Audit Committee. |
| 12 September 2018 | Advised that she:<br>▪ 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.<br>▪ 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 3 May 2019, commencing at 9.30am**

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**Combined Statutory Advisory Committee members in attendance**
Mr Stuart Hylton, Combined Statutory Advisory Committee chair
Mr Graham Adams
Mrs Philippa Baker-Hogan MBE
Mrs Jenny Duncan
Mr Darren Hull
Mrs Judith MacDonald
Ms Annette Main NZOM
Ms Maraea Bellamy
Mr Leslie Gilsenan
Mr Matt Rayner
Ms Grace Taiaroa
Ms Heather Gifford

**In attendance for Whanganui District Health Board (WDHB)**
Mr Paul Malan, General Manager Service & Business Planning
Mrs Rowena Kui, Director Māori Health
Ms Kim Fry, Director Allied Health
Mr Mark Dawson, Communications Manager
Ms Katherine Fraser-Chapple, Business Manager, Medical, Community and Allied Health
Mr Mike Bothma, Acting 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 Ben McMenamin, Bowel Screening Project Manager, Service & Business Planning
Mr Ned Tapa, Haumoana – Whānau Navigator
Ms Rihi Karena, Kaitakitaki – Clinical Services Manager, Māori Health Services
Ms Jacqui Broughton, Kaitakitaki, Māori Health Services
Ms Maree Langford, Acting Executive Assistant, Service and Business Planning *(minutes)*

**In attendance at this meeting**
Wheturangi Walsh-Tapiata, Chief Executive Officer, Te Oranganui
Bonnie Sue, Manager, Ngati Rangi Community Health Centre Inc
Ngawini Martin, Best Practice/Operations, Mokai Patea Services
Teresa MacLean, Whānau Ora Team Leader, Mokai Patea Services
Gemma Kennedy, Clinical Services Manager, Taihape Health Limited
Shayna Te Riaki, Ruapehu Whānau Transformation, Administrator/Tech Tutor Te Pae Tata

Unconfirmed

**Media**
There was no media in attendance at this meeting

**Public**
Ms Ailsa Stewart QSO, WDHB Archivist and Board Member of Whanganui Alzheimer's Society

**Karakia/reflection**
Ned Tapa opened the meeting with a karakia/reflection

## 1 Welcome and apologies

The chair welcomed everyone and whaka whanaungatanga (introductions) were made.

Apologies were received and accepted from: Dame Tariana Turia, Mr Frank Bristol, Andrew Brown, Dot McKinnon, Charlie Anderson and Mr Russell Simpson.

## 2 Conflict and register of interests update

### 2.1 Updates to the register of interests
Nil.

### 2.2 Declaration of conflicts in relation to business at this meeting
Nil.

## 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 22 March 2019 be **approved** as a true and correct record.

## 5 Matters arising

There were no matters arising from the previous meeting.

## 6 Committee Chair's report

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

- The chair acknowledged the passing of Dame Tariana Turia's husband George Turia.
- The chair expressed his excitement that Whānau Ora was to be highlighted at today's hui.
- The chair acknowledged Dame Tariana's involvement in and pioneering of Whānau Ora policy.
- The chair acknowledged the presence of MHOAG members, guest speakers from Mokai Patea Services, Taihape Health Limited, Te Oranganui, Ruapehu Whānau Transformation, and others visitors who travelled to be part of the discussion.
- The Chair issued a challenge: do we know what Whānau Ora means? Do we know what it looks like? Do we know what it means for it to be delivered across all services in a seamless way?

Unconfirmed

# 7 Whanganui DHB Annual Plan Work Programme

## 7.1 Whanganui Alliance Leadership Team (WALT)

*Lead: Paul Malan, GM Service and Business Planning on behalf of Russell Simpson, Chief Executive*

A verbal update was provided by Paul Malan on behalf of the chief executive, with items of note being:

- At the last meeting WALT noted the Pro Equity report and fully endorsed Whānau centred care
- The work on acute demand continues
- WALT discussed taking part in a HRT special interest group on integrated care. It would give us benchmarking data from across the New Zealand
- Data sharing framework was discussed and some progress was made
- Discussion was held about system level measures (SLM). The SLM plan will be closely related to the acute demand work and also fall within the overarching SLM which are set centrally.

## 7.2 Whānau Ora

### 7.2.1 Introduction

*Lead: Rowena Kui, Director Māori Health*

Rowena thanked the chair and Paul Malan for putting Whānau Ora on the agenda. The discussion is timely as there is some positive progress, but there is more work to be done and some system barriers to address. A video featuring Sir Mason Durie was played. His kōrero describes the Whānau Ora approach to healthcare, its challenges, its aspirations and how Māori knowledge can impact Māori health. He describes a defining moment in his career, when as a young house surgeon he met a Māori girl (his patient) and her Koro (grandfather) and what he learned became part of his journey in Health. The He Korowai Oranga framework aims for Pae Ora which is underpinned by three aspirations:

1. Mauri Ora – strong flourishing mauri. Mauri is often referred to as 'life force'. The challenge is to shift the mauri that is languishing to a mauri that flourishes. It is about lifestyle change - fostering healthy lifestyles, increasing health literacy, strengthening identity, encouraging self-management and restoring dignity.
2. Whānau Ora – strong, healthy, independent empowered Whānau. Whānau have the potential to positively or negatively impact on health. Both the individual and their Whānau need the attention of healthcare professionals. Whānau Ora requires inter-sectoral collaboration as the health sector cannot bring about the necessary changes by itself.
3. Wai Ora – an environment that is compatible with good health and strong Mauri. You cannot separate the environment from health. Natural and man-made environments are determinants of good health and a flourishing Mauri.

Video link: https://www.youtube.com/watch?v=ypKwMUWSUt4

### 7.2.2 Kaupapa Māori Services

#### 7.2.2.1 Mokai Patea Services Taihape

*Leads: Ngawini Martin, Best Practice/Operations, Mokai Patea Services*
*Teresa MacLean, Whānau Ora Team Leader, Mokai Patea Services*
*Gemma Kennedy, Clinical Services Manager, Taihape Health Limited*

Ngawini acknowledged Tracey Hiroa, General Manager of Mokai Patea Services, who was unable to attend today. She explained how Mokai Patea Services was formed, the structure

Unconfirmed

of the organisation, their mission and vision and values. The past and present governance members present at the hui were acknowledged.

Mokai Patea Services' organisational model of Whānau Ora was shared. Mahi Tahi - working together as one, is central to the concept, with supporting values including staff involvement, staff wellbeing, professional development, and unique approaches to recruitment.

**Model of care**

The model of care was explained. Referrals enter the service via self-referral, whānau referral, or an organisational referral. The Team Leader does a needs assessment and a care plan is created with agreed goals to work towards, which are evaluated every three months by the Winor. Once goals are achieved the person exits the programme, however some choose to re-enter the service and work on a new goal. In the case of non-engagement a review is undertaken and the individual is discharged if, after encouragement, there is no demonstrated commitment to achieving the goals set.

**Scope/Delivery**

Kimihia (seek) → Whakatupu (build) → Toha (share) → Tuhono (connect).

The programme is actively inclusive of tamariki, rangatahi, kaumatua and whānau – they work with the whole whānau, not just the individual. In the application of their work whānau is not just whakapapa (blood relatives) but anyone that the individual connects to; the individual identifies who is whānau to them. The aim is to inspire courage, truth, self-esteem, knowledge, learnings, skills and facilitate connections with whānau and the community.

**External Linkages**

The vast external linkages were noted. Ngawini acknowledged the people at the meeting who are a part of their external network.

*Taihape Health Limited*

The link between Mokai Patea Services and Taihape Health Limited was highlighted. The relationship is strong and has many points of connection from governance level to grass-roots. The teams share some professional development and supervision. An interdisciplinary team approach is taken and creates an environment that breaks down barriers, champions equity and provides wrap-around care for whānau. The two organisations share population health information, care plans and Mokai Patea Services are actively involved in whānau engagement with screening and immunisation, diabetes work and facilitate access to acute care, among other things.

*Māori Health Outcomes Advisory Group (MHOAG)*

Mokai Patea Services is one of the five iwi providers that make up MHOAG. Grace praised the interaction and strength of relationships between the organisations – the information sharing, peer support and the ability to challenge each and inspire best practice. Members each represent priority areas and update the wider group on those areas. Shared project interactions with the WDHB have been highly successful – 'our DHB's DNA' and Bowel Screening Programme are two examples.

**Outcomes achieved and measuring tools**

- Gemma shared the notable improvement in statistics for the Taihape Māori population seen at Taihape Health Limited – in some cases lagging total population by a percentage point or two, but in other cases surpassing total population – a significant achievement.

Outcome timeframes:

- Short term - dependency - needs identification, prioritization, meeting immediate needs.
- Medium term - reduced dependency - characterised by attitude and behavioural change. Knowledge base is increased and relationships are forming

Unconfirmed

- Long term - Independence - characterised by empowered/self-managing Whānau, self-seeking knowledge and relationships maintained and strengthened.

Measuring tools:
Aside from the three monthly evaluation of care plans, a number of other measuring tools are used, both internal and external, from whānau feedback and evaluation, social media engagement, Iwi/rūnanga feedback to feedback from external organisations.

Discussion arose as per below:
- It was queried what areas Mokai Patea Services receive support from. Ngawini advised they hold a Whānau Ora contract with WDHB and have a contract with the Ministry of Social Development to provide community support for whānau. They also run the Rangitahi to Rangitahi programme, Youth Justice programme and Building Financial Capability programme.
- The number of people enrolled in the Whānau Ora programme is approximately 50 whānau, up to 150 individuals.
- For around 80% of people who come through the door what they come in for is not what they are actually want help for.
- One of the greatest issues to resolve is disconnection within whānau.
- A board member commented that they would like to see more services available to those with regional contracts.
- A key challenge for whānau is accessing services from out of town.

Maraea added a kōrero, emphasising the importance of the organisations structural change and how this empowered whānau and enabled delivery of services in a different way. It was also noted that provision of services is more than what they are funded for.

The chair thanked Ngawini, Teresa and Gemma for the insight in their services and how Whānau Ora is a cornerstone for what they are doing.

*Mike Bothma left at 11.09am*

#### 7.2.2.2 Te Oranganui

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

Wheturangi acknowledged the work or Sir Mason Durie and also Dame Tariana Turia – a key instigator and still a key driver of Whānau Ora and ensuring it is an applied concept. She views WDHB as a leader in Whānau Ora and noted that the application of Whānau Ora is critical to address the negative health statistics for our Māori population.

Whānau Ora in Te Oranganui:
- Even before Whānau Ora became a policy, Te Oranganui had a vision for it through Dame Tariana Turia – their first CE. Consequently a way of practice was developed that was different to all the other health and social service providers
- Their whole approach is about whānau
- Specific contracts for Whānau Ora are held with WDHC the Whānau Ora commissioning agency
- Wheturangi explained the Whānau Ora funding models and how they apply to Te Oranganui. She recommended looking at the Commissioning Agency models, as there are different ways of doing things, and some good ideas that could be applied
- Te Oranganui is not a collective but conversations are being held with other providers about working together in delivering Whānau Ora
- Te Oranganui are seeing champions arise out of whānau through their work.

The DHB boundaries can be contentious as they do not match the boundaries of the three iwi that govern Te Oranganui.

Unconfirmed

**Outcomes**

Whānau Ora outcomes framework:

- 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.

Wheturangi gave a context for the whānau story video shown. The video featured ex-gang member Tāne Puru and illustrated the positive impact and long reaching influence of the services provided to Tāne and his whānau by Te Oranganui. His kōrero spoke of empowerment, no longer being afraid to ask for help, feeling loved and being able to love in return. Due to their work with Tāne one of his family members with a long term condition has become a registered member of their clinic; Tāne's involvement opened up pathways for a whole whānau to receive support. Tāne has gone on to represent our region in the Justice Review and has been invited to national and international forums to talk about what Whānau Ora can achieve as a model and a tool for change.

Wheturangi encouraged the Committee to take on Sir Mason Durie's assertion that health cannot be done on its own; WDHB has the opportunity lead the way! She endorsed the Pro Equity work being done by WDHB, and our commitment to learning more about Whānau Ora.

The chair acknowledged Wheturangi's kōrero and the clarity it provided the group about funding models and some of the challenges they face.

*The order of the meeting was changed, and 7.2.4 was brought forward in the agenda ahead of 7.4.3.*

### 7.2.4 Community Development Programme

**Ruapehu Whānau Transformation**

*Lead: Shayna Te Riaki, Ruapehu Whānau Transformation, Administrator/Tech Tutor Te Pae Tata*

Shayna acknowledged Erena Makaere, the project manager, who was unable to attend the hui today.

In 2013, Ngati Rangi Iwi led initiative, working alongside whānau and the Waimarino community (Raetihi, Ohākune, Waiouru), set out to achieve Whānau centered solutions five key areas of focus: education, employment, housing, health and social, 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. There were 23 solutions in the initial plan and 20 have been completed. The new plan has 40 new solutions. This plan was developed for the community, by the community, with over 4,000 people having input into it.

The Ruapehu Whānau Transformation methodology is based on evidence building through information (statistics), contextualised with local experiences and aspirations (stories) which then allowed the collective community to develop whānau centred solutions. The goal is to create sustainable platforms for change. The Ruapehu Whānau Transformation framework was shared and explained.

**Outcomes**

*Education*
Impressive achievements in education results were shared:

Unconfirmed

| | 2012 | 2016 |
|---|---|---|
| NCEA Level 1 | 45% | 71% |
| NCEA Level 2 | 50% | 93% |
| NCEA Level 3 | 18% | 57% |

*Te Whare Āhuru ki Ruapehu*
One of the solutions focusses on healthy homes. It includes help with heating, repairs and maintenance and home ownership.

*Other*
This initiative has increased employment and brought money into the community. It has empowered the community and built relationships within the community, creating a culture where people lean on and support one another.

The Chair thanked Shayna for her presentation and congratulated Ruapheu Whānau Transformation on their achievements.

Discussion arose as per below:

- Philippa Baker-Hogan queried whether the funding came from current resources or through new contracts or other sources. Shayna confirmed there was some funding to roll-out the initial plan and community groups who led parts of the roll-out contributed time and funds. While funding was important, Wheturangi Walsh-Tapiata noted that key people from the iwi who had funding knowledge came home to be part of the kaupapa, but the collaborative nature of the project facilitated its implementation in ways other than funding. Maraea Bellamy agreed and added that the ideas came and were committed to - the limited funding didn't stop the foundation for this initiative being built. Grace Taiaroa advised that this kaupapa started from humble beginnings with minimal funding and with many people doing the mahi (work) voluntarily. Grace challenged the Board to shift our thinking - what would our wish-list be if we didn't have to consider costs?
- Judith acknowledged Ruapehu Whānau Transformation – as custodians of some of the health services offered in their region WRHN support their vision and feel privileged to be involvement in the work they are doing.

*A break was taken by the Committee at 11.49am*

*Wheturangi Walsh-Tapiata, Gemma Kennedy, and Andrea Bunn left, Mike Bothma returned.*

*The meeting reconvened at 12.04pm*

### 7.2.3 DHB Māori Health Services

**Te Hau Ranga Ora Service**

*Lead: Rihi Karena, Kaitakitaki – Clinical Services Manager*

Rihi acknowledged:

- Kuia Kaumatua, Uncle John, Auntie Jo and Auntie Dardi, Auntie Puki who paved the way for the mahi the team does.
- Dame Tariana Turia a key driving force of Whānau Ora policy in our nation
- Past WDHB CE Julie Patterson for her support of the Whānau Ora approach and mandating and facilitating its implementation into the WDHB
- Current WDHB CE, Russell Simpson who has also champions Whānau Ora in our DHB
- Māori health providers and speakers today for and their innovation, passion and drive and resilience to make things happen for our people
- All the services that came before Haumoana and paved the way for the mahi that is done now.

Unconfirmed

The history of WDHB's journey towards Whānau Ora was shared. At the outset of implementation 50 recommendations were made. A number have been put in place and some are ongoing. These included:

- Development of Te Hau Ranga Ora (Haumoana) service in March 2014
- Hāpai te Hoe – WDHB's staff induction programme – September 2016. New staff are introduced to WDHB's whānau centred care approach. The Treaty of Waitangi is discussed and historical events of this area which impact on Māori people and their engagement with health services.
- Visiting policy – a change to visiting hours (8am-8pm) facilitating a collaborative approach with whānau around the care of their loved one. This policy also involves designating a lead support person within the whānau to liaise with.
- WDHB has conducted a Pro Equity review and a plan is in place achieve equitable outcomes.

The adoption of the Tohu imagery was explained. The Tohu depicts the Whānau Ora concept of Whānau: mama, papa and tamariki and the extended whānau – kaupapa whānau (DHB whānau), whakapapa whānau (family/whānau).

*Katherine Fraser-Chapple left at 12.19pm*

Workforce Development is a key initiative, focussing on attracting, retaining and supporting Māori staff. Employing more Māori staff makes our service more accessible for Māori and their whānau. Career assistance is provided for those pursing a specific career in health. WDHB links into the National Partnership Programme – Kia Ora Hauora. Other local and national programmes were discussed. We have increased numbers of Māori staff working at WDHB but have not yet achieved our goal percentage.

*Eileen O'Leary left at 12.25pm*

Te Hau Ranga Ora (THRO team)

- Rihi explained the role of the THRO team (haumoana): to support patients, their whānau, and also our staff. Haumoana walk in both worlds - Māori and non-Māori. They offer 24/7 on-call support.
- Building relationships is a key part of the role – with patients, whānau, staff and external services and networks. The wide range of networks and referral centres haumoana work with was noted.
- A video was shown about the THRO service and the focus on patient centred care.

*Katherine Fraser-Chapple returned at 12.33pm*

Rowena acknowledged all staff in the Māori Health service, particularly the haumoana and the leadership team in implementing the change. The challenges and barriers to the implementation of Whānau Ora, which required substantial culture change, were considerable. The increase in understanding and cultural acceptance seen has taken time but there is more work to do. The Pro Equity work is another significant step in our journey. Rowena also acknowledged who came before us – Te Oranganui, and the continued support of the WDHB in implementing Whānau Ora policy.

Discussion arose as per below:

- Heather Gifford commented on the Collective Whānau Ora model in other centres mentioned by Wheturangi that are funded by the commissioning agency and encouraged us all to work together if there are conversations happening in our iwi provider space to share information, and find answers to any barriers. Can the Whānau Ora Collective embrace all of our Whānau Ora providers, including iwi providers and our WDHB service?

### 7.2.5 **Whānau Ora Commissioning**

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

Paul Malan gave an overview of the commissioning review of the second (commissioning) phase of Whānau Ora. The review emphasised some successes and challenges of the approach. One challenge

Unconfirmed

highlighted was health leadership at a local level; the current commission approach can feel remote to us and it is difficult to understand its application unless a local entity is selected by a commissioning agency for full support.

At the Whānau Development Summit in March 2019, 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 stated that Whānau Ora is *the* framework for intersectoral collaboration, particularly across social sector agencies. With the clear Ministerial support for and positioning of Whānau Ora we have a huge opportunity to take this concept forward. Whānau Ora will be written into the Annual Plan. The work following on from the Pro Equity report is fundamental in setting down our policy and framework for Whānau Ora. The presentations seen today have shown that we have a great foundation to work from.

### 7.2.6 Challenges

*Lead: Rowena Kui, Director Māori Health*

Rowena directed the committee to the challenges noted in the agenda and encouraged the committee to reflect on them.

Whānau Ora is about contributing to the health and wellbeing of our wider community. Listening to stories, understanding the realities and hearing the kōrero 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 cross-sectoral funding streams all make a difference to improving the health outcomes for whānau. Rowena noted the synergy in this room on this subject, thanked everyone for their participation, and thanked the Committee for their support to raise and discuss this topic.

Discussion about the Whānau Ora section of the agenda arose as per below:

- It was queried whether the links and presentations today could be accessed. They will be made available on request.
- Matthew Rayner acknowledged the revolution from past to present seen in both the WDHB haumoana service and Taihape Health Limited/Mokai Patea Services collaborations and looks forward to what can be achieved in the future.
- Judith MacDonald shared some thoughts, noting that our history has not always been easy. In her current project work on Acute Demand which involves working across the system she has discovered we can underestimate how difficult it can be for people to understand the journey of change we are on.
- Philippa Baker-Hogan felt that the haumoana video was a powerful representation of Whānau Ora within our DHB and would like to see this distributed more widely.
- Darren Hull encouraged us not to lose site of the fact that Whānau Ora applies to all of our patients and our whole community. There need to be systems and processes in place that ensure support is offered to all.

The Chair acknowledged we are on a journey and there is more work to do. He thanked the speakers and guests, noting that today we have been presented with a snapshot of where were have been, were we are now and some excellent initiatives taking place in the wider community.

*Kim Fry left at 1.02pm*

Unconfirmed

Four recommendations were moved by the chair, that the committee:

1. **Note** the Whānau Ora Presentation and information
2. **Thank** the presenters and acknowledge their excellent work and results
3. **Acknowledges** the importance of Whānau Ora as the cornerstone of WDHB's planning work, services and work streams
4. **Recommends** that WDHB takes all opportunities to socialise Whānau Ora.

The motion was seconded and carried. Grace Taiaroa expressed reservations with the recommendations at this time.

*A break was taken by the Committee at 1.10pm*
*Philippa Baker-Hogan left at 1.11pm*
*The meeting reconvened at 1.13pm*

## 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*

The report was taken as read.

Discussion arose as per below:
- The underspend in urology was queried. It was **noted** that the Board requested an update on urology services.

*Katherine Fraser-Chapple, Candace Sixtus and Mike Bothma left at 1.16pm*

## 8 Reference and Information Section

The information papers noted below were taken as read.

1. Whānau Ora – background information
2. Executive Summary extracted from Whānau Ora review 2018, Tipu Matoro ki te Ao, Final Report to the Minister for Whānau Ora 2018.

## 9 Date of next meeting

Friday, 14 June 2019.

## 10 Glossary and terms of reference

For information only.

Unconfirmed

## 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 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 22 March 2019 |

**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 |

The public session of the meeting ended at **1.16pm**

Unconfirmed

## 5 Matters arising from previous meetings Page

## 6 Committee Chair's report Page

A verbal report may be provided at the meeting.

# 7. Whanganui DHB Annual Plan work programme

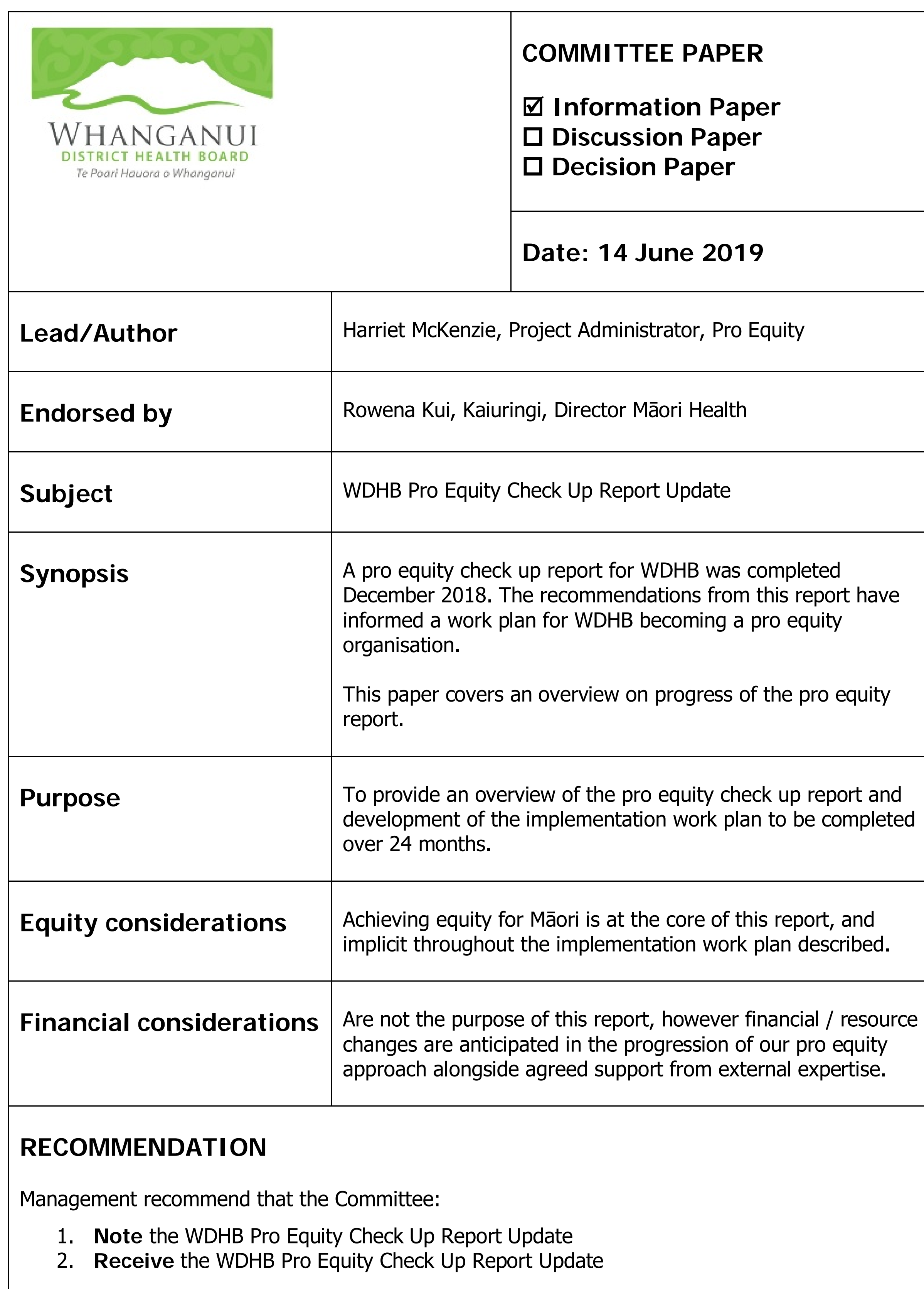
## 7.1 Whanganui Alliance Leadership Team

*Lead: 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 Pro Equity Update



| | |
|---|---|
| WHANGANUI<br>DISTRICT HEALTH BOARD<br>*Te Poari Hauora o Whanganui* | **COMMITTEE PAPER**<br><br>☑ **Information Paper**<br>☐ **Discussion Paper**<br>☐ **Decision Paper**<br><br>**Date: 14 June 2019** |
| **Lead/Author** | Harriet McKenzie, Project Administrator, Pro Equity |
| **Endorsed by** | Rowena Kui, Kaiuringi, Director Māori Health |
| **Subject** | WDHB Pro Equity Check Up Report Update |
| **Synopsis** | A pro equity check up report for WDHB was completed December 2018. The recommendations from this report have informed a work plan for WDHB becoming a pro equity organisation.<br><br>This paper covers an overview on progress of the pro equity report. |
| **Purpose** | To provide an overview of the pro equity check up report and development of the implementation work plan to be completed over 24 months. |
| **Equity considerations** | Achieving equity for Māori is at the core of this report, and implicit throughout the implementation work plan described. |
| **Financial considerations** | Are not the purpose of this report, however financial / resource changes are anticipated in the progression of our pro equity approach alongside agreed support from external expertise. |

**RECOMMENDATION**

Management recommend that the Committee:

1. **Note** the WDHB Pro Equity Check Up Report Update
2. **Receive** the WDHB Pro Equity Check Up Report Update

### 7.2.1 Introduction

Baker Jones completed the WDHB Pro Equity Check Up Report in December 2018. The recommendations from the report are endorsed by the WDHB Board (Board) and Hauora A Iwi (HAI). The implementation work plan to be completed over 24 months was presented to the joint Board and HAI hui 30 April 2019.

A copy of the report is available on the WDHB website.

WDHB has committed to become a pro equity organisation. The health of Māori is our most enduring and challenging inequity.

Implementation of the work plan relies on commitment from the WDHB executive team to assume responsibility for various components of the plan, supported by the director Māori health and led by the chief executive. The work plan is one of our key priorities, with an important component being to empower our leaders to drive and embed our DHB pro equity approach across the organisation.

### 7.2.2 Resources

The following resources are available to the support the implementation of the work plan:

- Baker Contracting (Gabrielle Baker) – external expertise
- Harriet McKenzie – project administrator
- Jacqui Broughton – Kaitakitaki, 1.0 FTE secondment (6 months) to Te Hau Ranga Ora
- Executive sponsorship – Brian Walden general manager corporate and Rowena Kui, director Māori health.

### 7.2.3 Workforce Development

Pro Equity workforce development sessions have commenced, led by Gabriel Baker. The learning outcomes from the sessions are:

- Understand the drivers of health inequities and their impacts on health outcomes for Māori and our communities
- Understand our collective responsibility to be pro equity
- Become a thoughtful leader, assessing actions for their impact on equity
- Reaffirm and build on existing strengths and knowledge
- Be confident using the tools to enable pro equity actions
- Understand the link to our goals, values, whānau/family-centred care and cultural awareness and confidence.

The aim is to create sustainable change to become a pro equity organisation. This requires supporting our staff to increase their knowledge so that they 'think' pro equity and apply the most appropriate tools, apply critical thinking analysis and identify the best solutions to enable the action needed to achieve our goals. This is rather than just 'doing equity' by applying prescribed tools in an ad hoc fashion.

The agreement with Baker contracting includes mentorship for executive team members to support leadership, role modelling and advice to specific initiatives, service improvements and application of tools. Harriet can book a zoom session with Gabrielle on request.

### 7.2.4 Te Hau Ranga Ora Leadership Support

It is important to ensure that the implementation of the work plan and achieving equity for Māori is not viewed as the sole responsibility of Te Hau Ranga Ora.

As we move into our revised structure a Te Hau Ranga Ora leader will be a member of each 'hub' management team, providing cultural and Te Ao Māori advice and support to the team and hub.

The leaders are Mal Rerekura, Ned Tapa, Rihi Karena and Jacqui Broughton. The equity training sessions that this team is receiving is aimed at how they can support colleagues to understand equity, the most effective use of the tools, quality assurance techniques, addressing challenges to the process and championing achieving equity for Māori. Along with providing advice through a Māori lens to the actions, initiatives and service changes that will be required. This approach builds on what the team is already doing, particularly Rihi, working with her nursing leadership and service and business planning team colleagues.

The professional development for the haumoana team will be focussed on understanding equity, our goals and the process we are undertaking as an organisation. Enabling them to answer questions from their colleagues on the floor and clarifying that this is not just another 'Māori thing' that is being done.

### 7.2.5 Māori Reference Group

A Māori reference advisory group will be formed to support the implementation of the work plan. The development of the terms of reference is in progress. The group will comprise Māori health professionals and community members from across the DHB region. The purpose of the group is to provide a Te Ao Māori lens and advice to outputs of the work plan such as communication messages, recruitment policy and process etc.

An example of the positive way this type of group can be utilised across wider projects and initiatives can be seen in the group involved in providing advice to the acute demand work Judith MacDonald is leading for WALT.

The group may meet twice a year with the rest of their interaction done via an email group. It is proposed that the sponsors for the group would be Rowena Kui director Māori and Ned Tapa Haumoana cultural advisor and educator.

### 7.2.6 Spreading the Word and Consistent Messaging

Kōrero is already out in our organisation about equity including misunderstandings that this is something that we will just do as a one-off or that the Māori health team will do.

It is essential that leaders 'walk the talk' with consistent messaging and a planned stepped approach to informing our staff, our partner organisations, our community and our DHB colleagues. Our communications team will play an important role in providing guidance on this approach and key messages.

### 7.2.7 Links to Values and Whānau Ora

Working as a values-based organisation, acknowledging whānau centred care as an enabler of best practice, using a strength based approach when working with patients and whānau to build resilience in whānau and communities are all key components to support a successful pro equity approach.

### 7.2.8 Including Community Partners

Community partners will be encouraged to participate and are key to achieving equity in health outcomes for Māori across the system. Professional development workshops will be arranged in July and August and Jacqui will be available to work alongside community partners as they introduce pro equity into their work practices.

### 7.2.9 Implementation Work Plan

The implementation work plan is framed using the recommendations identified in the Pro Equity Check Up Report:

1. *Strengthen leadership and accountability for equity* - for sustained success, Whanganui DHB's EMT must be the champions of a pro equity approach and take on an organisational leadership role to this effect.

2. *Build Māori workforce and Māori health and equity capability* - Whanganui DHB needs the right skills to drive Māori health equity, and a workforce that is fit for purpose to meet the needs of the population that they serve. This includes more Māori staff (particularly in senior roles), and contemporary Māori health and equity expertise across the Whanganui health workforce (not limited to DHB staff).

3. *Improve transparency in data and decision-making* - improving transparency in decision-making will support the DHB to demonstrate a pro equity approach and be held accountable (by the Board, Hauora A Iwi and the wider community) in its pursuit of equitable health outcomes.

4. *Support more authentic partnership with Māori* - there is a strong potential to work with iwi, hapu and whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. This needs to be turned into action to avoid appearing to be rhetoric, which could undermine the promise provided by the new Hauora A Iwi MoU.

Responsibility has been assigned to members of the executive management team and key actions and timeframes are described under each recommendation. Te Hau Ranga Ora leaders will be available to support the team working with the executive lead.

Reporting will be the responsibility of the executive lead in line with the reporting framework as agreed with the Boards, included in the implementation plan.

### 7.2.10 Key Performance Indicators

Key performance indicators related to pro equity will be developed for the executive team and leaders in each hub.

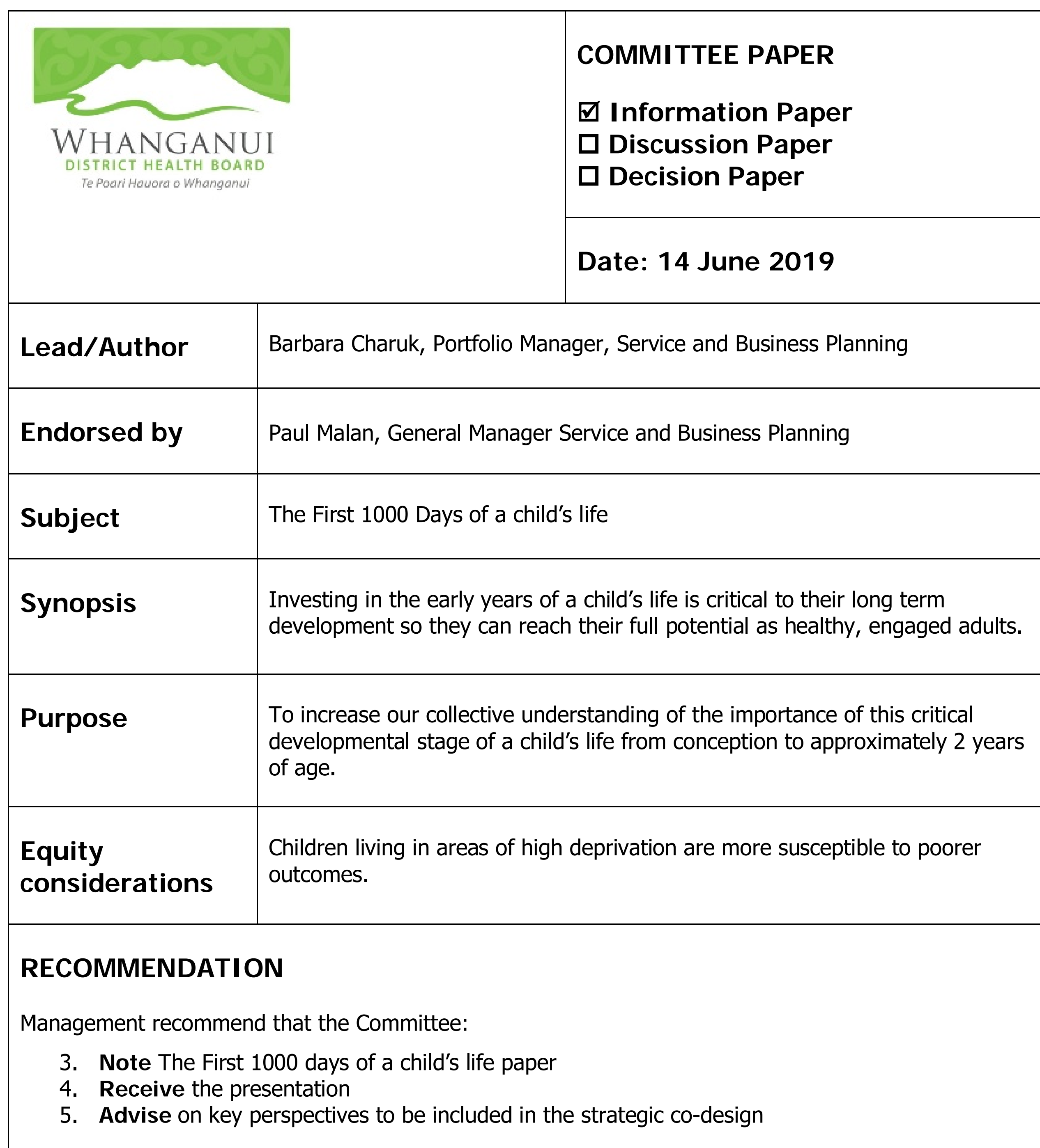
### 7.2.11 Challenges

The key challenges for us as a team are:

- To maintain the momentum throughout the implementation period (24 months) alongside other competing priorities
- Enable a sustainable approach past the implementation period
- Sticking to our kaupapa – equity is a buzzword in the sector at present; we need to ensure we don't get distracted by this
- Be brave enough to take action
- Be pro equity within current budget.

***"Kaua e rangiruatia te hapai o te hoe, e kore to tatou waka e u ki uta"***
***"Do not lift you paddle out of unison or our canoe will never reach the shore"***

## 7.3 The First 1000 days of life



| WHANGANUI DISTRICT HEALTH BOARD<br>Te Poari Hauora o Whanganui | **COMMITTEE PAPER**<br><br>☑ **Information Paper**<br>☐ **Discussion Paper**<br>☐ **Decision Paper** |
|---|---|
| | **Date: 14 June 2019** |
| **Lead/Author** | Barbara Charuk, Portfolio Manager, Service and Business Planning |
| **Endorsed by** | Paul Malan, General Manager Service and Business Planning |
| **Subject** | The First 1000 Days of a child's life |
| **Synopsis** | Investing in the early years of a child's life is critical to their long term development so they can reach their full potential as healthy, engaged adults. |
| **Purpose** | To increase our collective understanding of the importance of this critical developmental stage of a child's life from conception to approximately 2 years of age. |
| **Equity considerations** | Children living in areas of high deprivation are more susceptible to poorer outcomes. |

**RECOMMENDATION**

Management recommend that the Committee:

3. **Note** The First 1000 days of a child's life paper
4. **Receive** the presentation
5. **Advise** on key perspectives to be included in the strategic co-design

### 7.3.1 Introduction

Every year the New Zealand government invests significantly in early childhood by way of pre-natal and post-natal care, Well Child and immunisation programmes, other health services, parenting programmes, early childhood care and education services and welfare.

The Ministry of Health publicly funds core universal, targeted and referred maternity and child health services delivered by a variety of providers (refer Information Paper 8.1 – New Zealand's Maternity and Child Health Services – preconception to 6 years).

While the majority of children are well supported by their families, whānau, communities and government services, there is also a significant subset of children who miss out on this support. A number of risk factors for adult diseases and some mental health conditions develop from childhood. Child health and wellbeing also has a wider impact on educational achievement, violence, crime and unemployment.

Support for children and their families in the early years of life represents a cost effective investment as it addresses issues before they become serious problems.

Professor Richie Poulton of the Dunedin Longitudinal study states "the best scientific research in the world now tells us the greatest social good will be achieved by investing a child's earliest years".

## Government priorities

In 2018 the Child Poverty Reduction Bill and the Children's Amendment Act were passed into law, with the aim of reducing child poverty and improving child wellbeing.

The creation of the first Child and Youth Wellbeing Strategy is set for release later this year and proposes an outcomes framework to guide and monitor progress across sectors.

The Minister of Health, in his letter of expectations for DHBs 2019/20, highlights the need for improved outcomes for the first 1000 days of life, and support for the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

These priorities are recognised in the recently released Wellbeing Budget 2019.

## The importance of the first 1000 days of life

The quality of experiences during the first 1000 days of life forms either a strong or fragile foundation for everything that follows. The most rapid period of brain growth is in the last trimester of pregnancy and the first two years of life when 80% of brain development occurs.

Scientific research and technological advancements provide an understanding on how exposure to adverse childhood experiences (ACEs[1]), trauma or toxic stress can impact on brain development and thus on physical and emotional health, and quality of life across a person's lifetime (refer Information Paper 8.2 – Economics of early intervention). While ACEs are found across the population, there is more risk of experiencing them in areas of higher deprivation. Children who have abusive or otherwise stress-filled childhoods are more likely to develop heart disease, diabetes, cancer and other health and social problems throughout their adult life. They may struggle to remain engaged in education or to gain employment, they may develop mental health and addiction problems, or engage in criminal activity and violence.

The National Council on the Developing Child estimated the economic impact of child abuse and neglect in New Zealand to be about $2 billion a year (2012).

It is estimated that "at least one in five New Zealand children experience significant deprivation that compromises their health, their education, and their future."[2]

[1] ACEs include: exposure to family violence, parental abandonment, being the victim of child abuse and neglect, exposure to family violence, caregivers with mental health and/or addictions problems, or a member of the household being in prison.

[2] Dr C Dale, Brainwave Trust, September 2011.

The cost of treating adult health and social problems resulting from childhood trauma far outweighs the current expenditure on the early years. Instead, our focus should be on investing more in the first 1000 days of life for a greater return on investment and prevention of adult ill health and thus reducing expenditure later on in life (Figure 1).

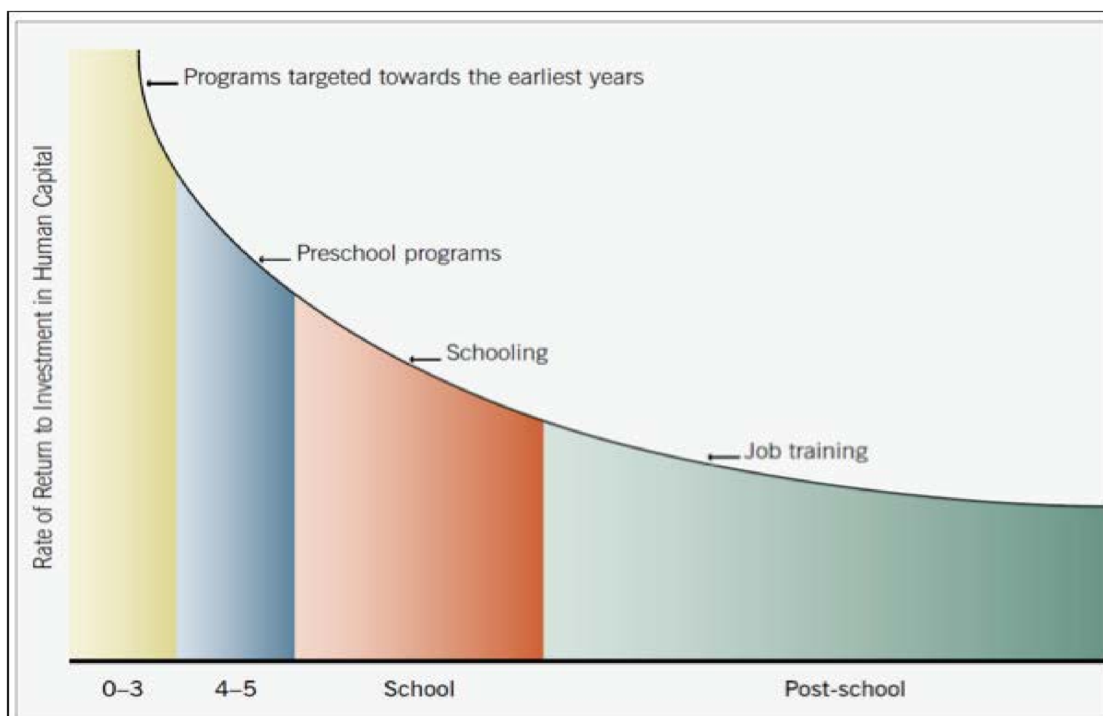



*Figure 1 - Brainwave Trust, 2012*

**System level transformation**

Health alone cannot create the changes required to ensure better outcomes for children and their families. It will require greater collaboration across sectors and government ministries. The government's Child and Youth Wellbeing Strategy will provide an outcomes framework from which to work from. At WDHB, system level change is being promoted and progressed by the Chief Executive and Board.

## 7.3.2 Current Situation

This section describes a sample of existing processes, inter-agency collaborations and specific interventions that identify and provide support for the first 1000 days of life in the Whanganui District. Information Paper 8.3 – Whanganui SUDI prevention discussion 18 October 2017 - provides a more detailed list of available services.

**Multi-agency responses**

- **Te Rerenga Tahi** - WDHB led
  A multi-agency team involved in maternity or child care whose aim is to help pregnant women and their families who may need extra support. It is a consented partnership approach. Group members include: midwives, WDHB clinicians, NGOs, government agencies, Kaupapa Māori services, PHOs etc).

- **Family Violence Integrated Services (FVIS) -** Police, Ministry of Social Development led
  FVIS aims to ensure that whānau and families experiencing serious family violence are effectively engaged with and can readily access the best possible support in order to build

safety. It is a collaborative, co-ordinated interagency responses from Police call outs. Representatives from: Police, Oranga Tamariki, NGOs, Kaupapa Māori services, Health (WDHB, WRHN), Corrections.

A WDHB social worker attends the regular case management meetings and receives referrals for follow up for all pregnant women.

- **Health, Education and Disability Support Services Forum (HEaDSS) - WDHB led**
  Interagency group with a focus on getting the right support for children with disabilities, high needs, behavioural or developmental issues. Attended by WDHB clinicians, Ministry of Education, NGOs, Kaupapa Māori services, NGOs, Oranga Tamariki, Disability support services.

There are also other inter-agency groups who have a focus on the early years such as: teen parent group, WIN1000, Violence Intervention Network.

### WDHB based initiatives

The WDHB have the following initiatives in place to address family violence and child abuse and neglect which can contribute significantly to adverse childhood events.

- **Violence Intervention Programme (VIP)**
  VIP seeks to reduce and prevent the health impacts of family violence (partner and child abuse and neglect) through early identification, assessment and referral of victims presenting to health services. Frontline staff are trained to recognise and give appropriate support to victims. The VIP team also involved in multi-agency networking and information sharing across primary care and the community.

- **Child Protection Alert System (CPAS)**
  A national alert system that allows health professionals to see child protection alerts lodged in any DHB. Alerts draw the attention of healthcare professionals to serious child protection concerns already known within the health system, so they can decide its relevance to the latest presentation.

- **Memorandum of Understanding between WDHB, Police and Oranga Tamariki Ministry for Children**
  This MOU provides the basis for how the parties will work together and offer advice to each other in the management and safety of children and young people with suspected or confirmed abuse or neglect. As part of this MOU, Oranga Tamariki provides a hospital liaison social worker who works directly with health professionals.

### Interventions with families/whānau

Examples of a few interventions that aim to support children and whānau will be presented as follows:

- **Te Rerenga Tahi/Family Violence Integrated Services**, as above.
  *Sarah Grigson, Midwife/TRT coordinator*
  *Kim Ostern and Tania Baker, Social Workers, WDHB*

- **Wait, Watch, Wonder**
  *Zona Julian, Infant Child and Adolescent Mental Health and Addiction Services (ICAMHAS), WDHB*

  Effective as a short term intervention for attachment and behavioural problems in infants and young children.

- **Well Child/Tamariki Ora service-Te Oranganui Trust**
  *Maria Potaka, Registered Nurse, WDHB*

  Home-based health checks, education, support and follow up services to all tamariki from birth to age 3 and their whānau. Links to Te Oranganui Whānau Ora and Family Start services.

- **Jigsaw Whanganui**
  *Vanya Teki, Social Worker*

  Provide intensive home-based social work support for families under stress, young parent support, parenting programmes, therapeutic programme for mothers experiencing past pain.

### 7.3.3 Conclusion and next steps

The evidence is compelling that early intervention in the early years of a child's life is essential and health has an important role to play.

WDHB is committed to providing services that meet the needs of children and their families and ensure the very best outcomes for them.

To achieve this, we must work in partnership with families, others sectors, NGOs, and iwi to provide responses that are integrated and equitable. This will involve system level changes as well responsive health services. We collect data that demonstrates how we are doing in relation to many child health targets that will be used as a baseline to measure our progress and how to target future service developments (refer Information Paper 8.4 – NZ Child and Youth Epidemiology Service 2017 - Whanganui DHB vs New Zealand).

Whanganui DHB will develop a 3-5 year strategic plan that focuses on the First 1000 days of life. The plan will be progressed using co-design processes and ensure that equity is at the forefront of our developments.

## 7.4 Workforce and organisational development

*Lead: Hentie Cilliers, General Manager People and Performance*

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

**Staffing status**
The April year to date 2018/19 annual turnover is 6.99%. Although higher than the turnover for the same period 2017/18 of 5.47%, turnover is still relatively low.

The April year to date sick leave (paid and unpaid) for 2018/19 as a percentage of total hours paid is 3.08%. This is lower than the year to date sick leave for 2017/18 (3.31%) and 2016/17 (3.22%). Sick leave taken trends are similar to previous years.

The April year to date 2018/19 excessive annual leave balance as a percentage of all leave balances is 3.79%. This is higher than the 2017/18 balance of 2.90%.

**Recruitment / resignation issues**
Current medical vacancies include a consultant psychiatrist, gastroenterologist, general surgeon, emergency consultant and senior house officers.

Other clinical vacancies include a clinical pharmacist, occupational therapist and physiotherapist.

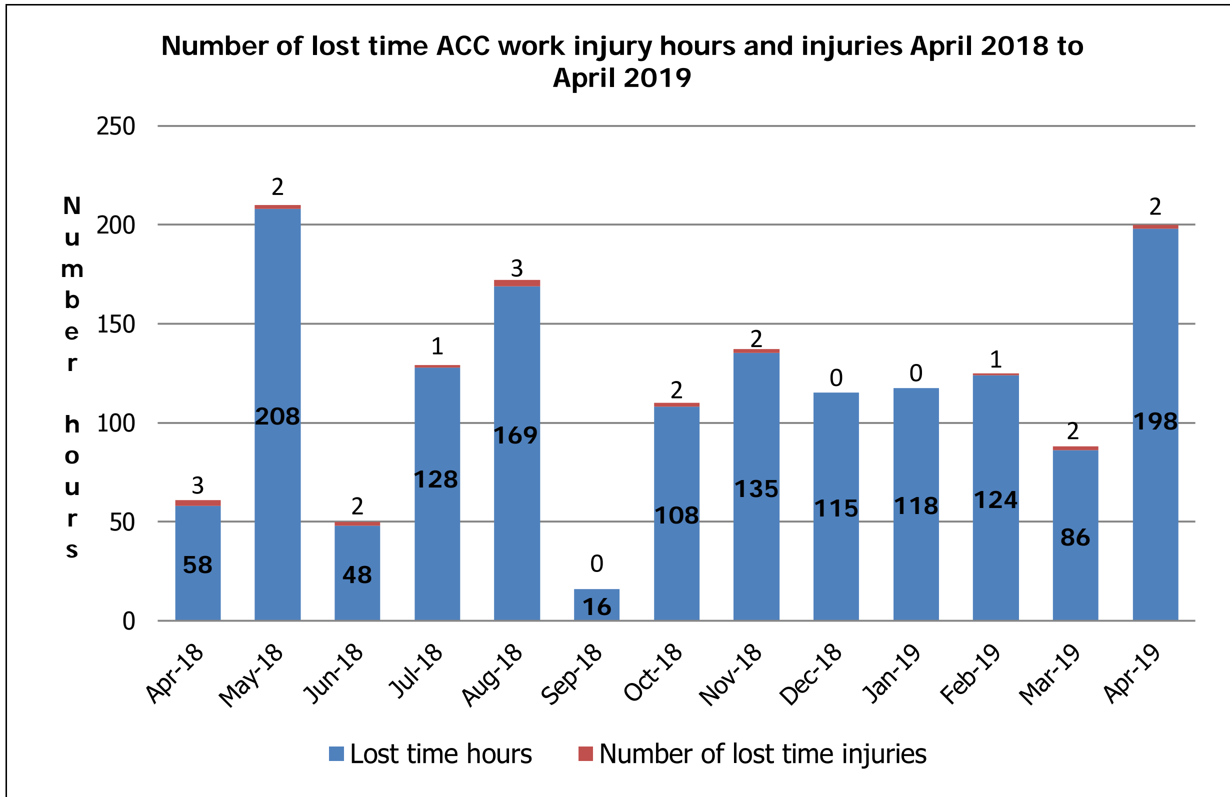
**Performance reviews and support**
Thirty six percent (36%) of staff have current performance agreements/reviews in place. The planned review of the WDHB approach to performance agreements/reviews has not yet commenced.

**Employee Relations**
Bargaining continues for the NZRDA and Medical Radiation Technologist MECAs.

**Health and Safety**
Thirty three injuries were reported in March and April, thirteen of which are an ACC claim. There were four lost time injuries recorded in March and April.

From March and April, three employees with a work related injury, ten employees with a non-work related injury and one with a medical condition were on return work plans. There were no notifiable injuries or events notified to WorkSafe New Zealand in March and April.

The graph below details lost time ACC work injury hours from April 2018 to April 2019. The numbers above the columns represent the number of lost time injuries. There were four ACC lost time injuries registered through payroll in March and April 2019.


Number of lost time ACC work injury hours and injuries April 2018 to April 2019
Number hours
250
200
150
100
50
0
3
58
2
208
2
48
1
128
3
169
0
16
2
108
2
135
0
115
0
118
1
124
2
86
2
198
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
Lost time hours
Number of lost time injuries

## 7.5 Financial Performance

*Leads: Mike Bothma, Acting Funding and Contracts Manager, Business Manager and Management Accountant Mental Health and Addictions*
*Katherine Fraser-Chapple, Business Manager Medical, Community & Allied Health*
*Barbara Walker, Management Accountant*
*Raju Gulab, Financial and Business Support Manager*

**Purpose**
The purpose of this report is to update the committee on the Funder and Provider financial performance for the period ending 30 April 2019.

### 7.5.1 Whanganui DHB summary

*Lead: Mike Bothma, Acting Funding and Contracts Manager*

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 30 April 2019 ($000s)**
**CONSOLIDATED**

| | Month | | | | Year to Date | | | | Annual | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Var | | Actual | Budget | Var | | Budget 2018-19 | Actual 2017-18 | |
| Provider Division | (1,347) | (1,303) | (44) | U | (8,660) | (8,027) | (633) | U | (8,442) | (5,504) | U |
| Corporate | 187 | 108 | 79 | F | 114 | (243) | 357 | F | 27 | 1,189 | F |
| **Provider & Corporate** | **(1,160)** | **(1,195)** | **35** | **F** | **(8,546)** | **(8,270)** | **(276)** | **U** | **(8,415)** | **(4,315)** | **U** |
| Funder Division | 490 | 574 | (84) | U | 629 | 748 | (119) | U | 526 | (366) | F |
| Governance | 59 | 1 | 58 | F | 276 | 14 | 262 | F | 3 | 502 | U |
| **Funder divison & Governance** | **549** | **575** | **(26)** | **U** | **905** | **762** | **143** | **F** | **529** | **136** | **F** |
| **Net Surplus / (Deficit)** | **(611)** | **(620)** | **9** | **F** | **(7,641)** | **(7,508)** | **(133)** | **U** | **(7,886)** | **(4,179)** | **U** |

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

The financial results for the first 10 months of the 2018/19 financial year show a $133k unfavourable variance to budget year-to-date.

### 7.5.2 Whanganui DHB Funder

*Lead: Mike Bothma, Acting Funding and Contracts Manager*

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 30 April 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 agei | 20,761 | 20,301 | 460 | F | 203,996 | 201,665 | 2,331 | F | 242,267 | 234,232 |
| Inter-district Inflow | 813 | 622 | 191 | F | 6,331 | 6,218 | 113 | F | 7,461 | 7,313 |
| Other Income Revenue | 26 | 31 | (5) | U | 254 | 342 | (88) | U | 406 | 502 |
| **Total Revenue** | **21,600** | **20,954** | **646** | **F** | **210,581** | **208,225** | **2,356** | **F** | **250,134** | **242,047** |
| **EXPENDITURE** | | | | | | | | | | |
| Personal Health | 8,164 | 7,993 | (171) | U | 81,747 | 82,083 | 336 | F | 99,079 | 95,358 |
| Disability Support | 268 | 268 | - | F | 2,679 | 2,679 | - | F | 3,214 | 3,054 |
| Mental Health | 1,529 | 1,529 | - | F | 15,309 | 15,286 | (23) | U | 18,343 | 17,897 |
| Public Health | 14 | 6 | (8) | U | 138 | 61 | (77) | U | 73 | 245 |
| Maori Services | 9 | 9 | - | F | 91 | 91 | - | F | 110 | 108 |
| **Total own provider expenditur** | **9,984** | **9,805** | **(179)** | **U** | **99,964** | **100,200** | **236** | **F** | **120,819** | **116,662** |
| Personal Health | 3,789 | 3,547 | (242) | U | 37,500 | 36,657 | (843) | U | 44,049 | 42,352 |
| Disability Support | 2,295 | 2,403 | 108 | F | 24,267 | 24,285 | 18 | F | 29,154 | 28,575 |
| Mental Health | 652 | 641 | (11) | U | 6,673 | 6,406 | (267) | U | 7,688 | 7,380 |
| Public Health | (15) | 91 | 106 | F | 712 | 912 | 200 | F | 1,094 | 869 |
| Maori Services | 122 | 131 | 9 | F | 1,339 | 1,392 | 53 | F | 1,654 | 1,557 |
| Inter-district Outflow | 3,953 | 3,432 | (521) | U | 36,196 | 34,324 | (1,872) | U | 41,189 | 41,134 |
| **Total Other provider expendit** | **10,796** | **10,245** | **(551)** | **U** | **106,687** | **103,976** | **(2,711)** | **U** | **124,828** | **121,867** |
| Governance | 330 | 330 | - | F | 3,301 | 3,301 | - | F | 3,961 | 3,884 |
| **Total Expenditure** | **21,110** | **20,380** | **(730)** | **U** | **209,952** | **207,477** | **(2,475)** | **U** | **249,608** | **242,413** |
| **Net Surplus / (Deficit)** | **490** | **574** | **(84)** | **U** | **629** | **748** | **(119)** | **U** | **526** | **(366)** |

**Revenue**
$2,356k favourable variance to budget for the Funder mainly due to:

- $368k PSA Nurses and Allied Health MECA settlement (offset by own provider personnel costs).
- $256k anticipated pay equity revenue from the Ministry of Health offset by additional expenditure. This funding is passed on in full to providers to meet their obligations under the pay equity settlement.
- $764k in-between travel wash up funding for prior year and current year.
- $651k funding to extend access to primary care ($529k) offset by additional expenditure
- $131k electives wash up.
- $84k school-based health (offset by costs).
- $50k ACC injury prevention; and various other $52k.

**Expenditure own provider - internal**

- $236k favourable variance to budget with internal provider (own provider); mainly due to $1,037k electives favourable wash up with own provider (offset by provider unfavourable variance). This is partly offset by payments for MECA increases $368k, smoke free $78k, higher than expected adolescent dental expenditure and pharmaceutical expenditure due to more pharmaceutical cancer treatments being delivered in Whanganui rather than by MidCentral DHB $247k, school-based health $84k and alcohol and other drugs $24k.

**Expenditure other provider - external**

- Payments to external providers and other DHBs are $2,713k (including IDFs) unfavourable to budget mainly due to a $1,872k unfavourable variance to budget for inter-district outflows mainly cardiology, cardiothoracic, neurosurgery, specialist neonates and general surgery (based on a 12 month rolling average) and $759k unfavourable variance in community pharmaceutical expenditure.
- Primary care initiatives are $278k unfavourable to budget with less than expected costs keeping the unfavourable variance lower than additional revenue.
- Travel assistance payments are favourable to budget by $150k, with immunisation expenditure $56k unfavourable to budget.

- Pay equity expenditure is $235k unfavourable to budget. This is offset by additional revenue.
- Health of older people expenditure is $18k favourable to budget; residential care $105k, respite care $159k and various day programme and carer support $49k. This is partly offset by pay equity $235k (offset by revenue) and home-based support $96k.
- Mental health is $267k unfavourable to budget - mainly advocacy peer support family and Whānau budgeted under personnel health community-based allied health.

## 7.5.3 Whanganui DHB Provider and Corporate

*Lead: Raju Gulab, Financial and Business Support Manager*

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 30 April 2019 ($000s)**
**PROVIDER & CORPORATE**

| | Month | | | | Year to Date | | | | Annual | Actual |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | Budget | 2017-18 |
| **REVENUE** | | | | | | | | | | |
| Government and Crown agency | 904 | 1,070 | (166) | U | 8,377 | 9,047 | (670) | U | 11,608 | 10,508 |
| Funder to Provider Revenue (internal) | 9,984 | 9,805 | 179 | F | 99,964 | 100,200 | (236) | U | 120,819 | 116,987 |
| Other income | 77 | 101 | (24) | U | 1,214 | 1,110 | 104 | F | 1,529 | 1,382 |
| **Total Revenue** | **10,965** | **10,976** | **(11)** | **U** | **109,555** | **110,357** | **(802)** | **U** | **133,956** | **128,877** |
| **EXPENDITURE** | | | | | | | | | | |
| Personnel | | | | | | | | | | |
| Medical | 1,966 | 2,095 | 129 | F | 18,488 | 19,670 | 1,182 | F | 23,786 | 21,788 |
| Nursing | 3,666 | 3,449 | (217) | U | 33,143 | 32,916 | (227) | U | 39,471 | 34,978 |
| Allied | 1,015 | 1,057 | 42 | F | 9,663 | 10,377 | 714 | F | 12,471 | 10,861 |
| Support | 85 | 65 | (20) | U | 698 | 661 | (37) | U | 794 | 745 |
| Management & Admin | 968 | 946 | (22) | U | 9,333 | 9,361 | 28 | F | 11,234 | 10,332 |
| **Total Personnel(Exl other & outsourced)** | **7,700** | **7,612** | **(88)** | **U** | **71,325** | **72,985** | **1,660** | **F** | **87,756** | **78,704** |
| Personnel Other | 194 | 229 | 35 | F | 1,846 | 1,779 | (67) | U | 2,163 | 1,720 |
| Outsourced Personnel | 563 | 500 | (63) | U | 5,668 | 4,916 | (752) | U | 5,980 | 5,912 |
| **Total Personnel Expenditure** | **8,457** | **8,341** | **(116)** | **U** | **78,839** | **79,680** | **841** | **F** | **95,899** | **86,336** |
| Outsourced Clinical Service | 575 | 607 | 32 | F | 5,913 | 5,902 | (11) | U | 7,103 | 6,888 |
| Clinical Supplies | 1,302 | 1,241 | (61) | U | 13,847 | 13,318 | (529) | U | 15,961 | 15,102 |
| Infrastructure & Non Clinical Supplies Costs | 994 | 1,162 | 168 | F | 11,602 | 11,702 | 100 | F | 13,754 | 13,286 |
| Capital Charge | 281 | 284 | 3 | F | 2,961 | 2,975 | 14 | F | 3,543 | 3,262 |
| Depreciation & Interest | 463 | 484 | 21 | F | 4,442 | 4,545 | 103 | F | 5,517 | 5,206 |
| Internal Allocation | 53 | 52 | (1) | U | 497 | 505 | 8 | F | 594 | 696 |
| **Total Other Expenditure** | **3,668** | **3,830** | **162** | **F** | **39,262** | **38,947** | **(315)** | **U** | **46,472** | **44,440** |
| **Total Expenditure** | **12,125** | **12,171** | **46** | **F** | **118,101** | **118,627** | **526** | **F** | **142,371** | **130,776** |
| **Net Surplus / (Deficit)** | **(1,160)** | **(1,195)** | **35** | **F** | **(8,546)** | **(8,270)** | **(276)** | **U** | **(8,415)** | **(1,899)** |
| **FTEs** | | | | | | | | | | |
| Medical | 109.5 | 114.1 | 4.6 | F | 103.9 | 111.8 | 8.0 | F | 112.3 | 101.2 |
| Nursing | 498.8 | 470.5 | (28.4) | U | 463.7 | 455.9 | (7.8) | U | 455.0 | 424.2 |
| Allied | 156.7 | 160.1 | 3.4 | F | 150.4 | 160.7 | 10.4 | F | 160.7 | 147.5 |
| Support | 17.0 | 15.9 | (1.2) | U | 15.3 | 16.0 | 0.7 | F | 16.0 | 14.8 |
| Management & Admin | 175.8 | 171.6 | (4.2) | U | 170.9 | 171.4 | 0.5 | F | 171.4 | 166.1 |
| **Total FTEs** | **957.9** | **932.2** | **(25.7)** | **U** | **904.1** | **915.8** | **11.7** | **F** | **915.4** | **853.9** |

**STATEMENT OF FINANCIAL PERFORMANCE by Cluster ($000s)**

| | Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | Budget |
| **Surgical Cluster** | **167** | **78** | **89** | **F** | **3,661** | **3,917** | **(256)** | **U** | **4,977** |
| **Medical Cluster** | **157** | **205** | **(48)** | **U** | **3,412** | **4,136** | **(724)** | **U** | **4,962** |
| **Allied Health Cluster** | **(653)** | **(661)** | **8** | **F** | **(6,905)** | **(6,855)** | **(50)** | **U** | **(7,966)** |
| **Mental Health Cluster** | **(314)** | **(181)** | **(133)** | **U** | **(1,587)** | **(1,434)** | **(153)** | **U** | **(1,679)** |
| **Public Health& Community Cluster** | **66** | **5** | **61** | **F** | **(526)** | **(1,218)** | **692** | **F** | **(1,619)** |
| **Corporate & Other Service** | **(583)** | **(641)** | **58** | **F** | **(6,601)** | **(6,816)** | **215** | **F** | **(7,090)** |
| **Net Surplus / (Deficit)** | **(1,160)** | **(1,195)** | **35** | **F** | **(8,546)** | **(8,270)** | **(276)** | **U** | **(8,415)** |

**Month**
The result for the month is $35k favourable to budget. Inpatient volumes are 95.2% to target in April 2019, with acute being 92.5% and elective being 104.2% of budget for the month.

Revenue is $11k unfavourable to budget – mainly due to:

- Internal revenue $179k favourable related to elective volume $62k, pharmaceutical and dental $43k (internal, offset by funder cost), school-based health service $21k, Smoke-free $8k, additional PSA Nurses and Allied Health MECA settlement funding $45k.
- Government revenue $166k unfavourable due to health workforce Hauora Māori $88k (offset by costs), ACC contract $122k (offset by costs), ACC home-based nursing $16k, ACC theatre implants $12k, ACC MRI $24k. This is partly offset by other DHB revenue $72k, ACC non-acute inpatient $15k, national travel assistance $7k and various other $2k.
- Other income $24k unfavourable mainly relates to mental health prison contract support withdrawal $14k, triage nurses support to WRPHO (contract expired) $24k. This is partly offset by flight nurse cost recovery $10k and various other $4k.

Total personnel costs are $116k favourable to budget mainly due to high nursing costs in the Medical Ward, ED, AT & R Ward, CCU, AT & R community service, district nursing, mental health service and Paediatric Ward; support and management personnel accrued based on current MECA offer. This is partly offset by medical and allied health and MECA settlement funding.

Outsourced clinical and other services is $32k favourable to budget, mainly due to ACC contract $35k, CCDHB infectious disease (SMO support) $5k. This is partly offset by Echo service and various other $8k.

Clinical supplies is $61k unfavourable to budget due to patient travel $24k (demand driven), pharmaceuticals $40k. This is partly offset by various other $3k.

Infrastructure and non-clinical supplies are $168k favourable due to accreditation $58k (will resume in November 2019), corporate training $38k, utilities $7k, Hauora Māori $88k (offset by revenue). This is partly offset by patient meals $17k and laundry $8k.

Depreciation is better than budget by $21k.

**Year-to-date result $276k unfavourable to budget**
Inpatient volumes were 92.5% to target in April 2019, with acute being 95.4% and elective being 92.5% of budget.

Revenue is $802k unfavourable to budget due to:

- Internal revenue $236k unfavourable mainly due to under-delivery of elective volumes, resulting in an unfavourable wash up of $1,037k (offset by funder). This is partly offset by pharmaceuticals $234k, dental $13k and Smoke-free $78k, mental health, alcohol and other drugs $24k, school-based health service $84k and PSA Nurses and Allied Health MECA settlement funding $368k.
- Government revenue $670k unfavourable mainly due to ACC contract $444k (offset by costs), ACC home-based support $149k, ACC non-acute inpatient rehabilitation $15k, ACC patient with high blood use reimbursement $61k (patient discharged), ACC implant and other ACC $43k, Health Quality and Safety Commission (HQSC) falls prevention contract $18k, health workforce medical personnel training $83k, cervical screening $15k). This is partly offset by ACC radiology $26k, training fees $65k, one-off HQSC $10k, national travel assistance $20k, colonoscopy revenue $10k and outpatient clinics $27k
- Other income $104k favourable due to one-off Capital and Coast DHB secondment revenue $41k, ACC contract patient consumables revenue $14k, non-resident and other $43k, dental $13k and donation from Countdown $36k, Auckland DHB air ambulance wash-up $10k, flight nurses cost recovery $31k. This is partly offset by prison contract $57k, triage nurses support to WRPHO (contract expired) $24k and various other $3k.

Personnel costs is $841k favourable to budget mainly due to medical personnel and allied health management vacancies. This is partly offset by medical personnel locum costs, high nursing personnel costs in ED, Medical Ward, AT & R Ward, CCU, AT & R community service, mental health service and Paediatric Ward.

Outsourced clinical services is $11k unfavourable to budget due to radiology service $168k, laboratory $6k, ophthalmology $10k, audiology $5k, dental $11k, and Echo service $15k, NZHP food service negotiated settlement costs (FSA) $23k, outpatient $5k). This is partly offset by ACC contract $138k (offset by revenue), infectious disease SMO support from Capital and Coast DHB $49k and rest home convalescence $45k.

Clinical supplies is $529k unfavourable to budget due to:

- Wards consumables $201k – treatment and disposable consumables $45k ($85k IV supplies for new IV pump, and is under review) , pharmaceutical $153k (Medical Ward $62k mainly fungal infection control drug, mental health inpatient service $48k and CCU $24k, ED $10k and Paediatric $9k); and HoverMatt for CCU and medical wards $24k, this is partly offset by various orthotic $8k other client related cost and various other $13k.
- Pharmaceutical $217k (partly offset by $234k pharmaceutical internal revenue).
- Orthotics – mobility aids and wheelchairs $76k (demand-driven).
- Patient travel $181k (demand-driven).
- Radiology $18k (contrast media, syringes and repairs and maintenance).
- District nursing $15k (bandages, dressing, ostomy, this is partly offset by pharmaceutical cost).
- Dental supplies $7k.
- Various other $8k.
- This is partly offset by theatre consumables $194k (lower than budgeted output).

Infrastructure and non-clinical supplies is $100k unfavourable to budget due to accreditation $58k (will resume in November 2019), travel and accommodation $21k, stationery, printing and forms $79k, advertising $18k, other equipment minor purchases $15k, corporate training $41k, utility costs $19k, and IT $66k. This is partly offset by orderlies service additional $11k, facilities additional costs $67k, laundry service $18k, patient meals $52k, professional fees $21k (mainly pro equity audit), postage and courier $21k, telecommunications $27k.

Depreciation is $103k favourable due to the timing of the purchase of clinical and IT equipment.

**Outlook and mitigations**

Operating risks - mainly IDF outflows, MECA settlements above 2.43% not funded by the Ministry of Health, and community pharmacy expenditure. IDF risk is around $600k.

Operating risk – Ministry of Health have funded all significant MECA settlements above 2.43% to date except SECA settlement which particularly impacts Spotless staff. Spotless have claimed $200k for the 2018/19 financial year.

Provision was made in the 2017/18 annual accounts of $550k but the cost is likely to be more. The Risk and Audit Committee will review this issue in more detail at their 12 June meeting.

One-off impairment of the National Oracle Solution (NOS) asset $1,048k held as shares in NZHP is a risk depending on sector-wide agreed treatment.

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

## Appendix one: cluster reporting

### 1. Surgical Services

*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 | 256 | 384 | (128) | U | 3,057 | 3,584 | (527) | U | 4,429 |
| Funder to Provider Revenue (internal) | 3,737 | 3,691 | 46 | F | 38,558 | 39,812 | (1,254) | U | 48,074 |
| Other income | 13 | 7 | 6 | F | 170 | 111 | 59 | F | 131 |
| **Total Revenue** | 4,006 | 4,082 | (76) | U | 41,785 | 43,507 | (1,722) | U | 52,634 |
| **EXPENDITURE** | | | | | | | | | |
| Personnel | 1,990 | 2,056 | 66 | F | 18,630 | 19,626 | 996 | F | 23,612 |
| Personnel Other | 32 | 46 | 14 | F | 424 | 455 | 31 | F | 556 |
| Outsourced Personnel | 384 | 406 | 22 | F | 3,989 | 3,909 | (80) | U | 4,763 |
| **Total Personnel Expenditure** | 2,406 | 2,508 | 102 | F | 23,043 | 23,990 | 947 | F | 28,931 |
| Outsourced Clinical Service | 145 | 182 | 37 | F | 1,549 | 1,720 | 171 | F | 2,082 |
| Clinical Supplies | 569 | 608 | 39 | F | 6,290 | 6,612 | 322 | F | 7,996 |
| Infrastructure & Non Clinical Supplies Costs | 197 | 184 | (13) | U | 1,892 | 1,916 | 24 | F | 2,300 |
| Depreciation, Interest & Internal Allocation | 522 | 522 | - | F | 5,350 | 5,352 | 2 | F | 6,348 |
| **Total Other Expenditure** | 1,433 | 1,496 | 63 | F | 15,081 | 15,600 | 519 | F | 18,726 |
| **Total Expenditure** | 3,839 | 4,004 | 165 | F | 38,124 | 39,590 | 1,466 | F | 47,657 |
| **Net Surplus / (Deficit)** | 167 | 78 | 89 | F | 3,661 | 3,917 | (256) | U | 4,977 |
| **FTEs** | | | | | | | | | |
| Medical | 30.6 | 28.9 | (1.7) | U | 28.9 | 30.5 | 1.5 | F | 30.54 |
| Nursing | 155.1 | 153.7 | (1.4) | U | 145.5 | 149.3 | 3.8 | F | 149.08 |
| Allied | 1.4 | 2.7 | 1.4 | F | 2.0 | 2.7 | 0.7 | F | 2.73 |
| Support | 9.3 | 8.3 | (1.0) | U | 7.9 | 8.4 | 0.5 | F | 8.40 |
| Management & Admin | 20.6 | 28.8 | 8.2 | F | 25.3 | 28.8 | 3.6 | F | 28.81 |
| **Total FTEs** | 217.0 | 222.5 | 5.5 | F | 209.6 | 219.7 | 10.1 | F | 219.6 |

#### Month

Surgical cluster reflects a surplus of $167k, which is $89k favourable to budget for April. This is due to delivery of acute CWD below budget (no unfunded expenses incurred) and elective volumes above contracted volumes by $46k (acute 79% delivery and electives 103% delivery). Elective CWD exceeded delivery by 5.6 CWD due to ENT and general surgery. As ACC revenue is $122k unfavourable for the month this offset against the positive electives result for a net result for revenue of $76k below budgeted levels. FTE is favourable to budget by 5.5 FTE, the impact of this being personnel costs favourable to budget by $102k, (support staff over budget by $16k offset against underspends in all other groups). Other expenditure is $64k below budget. In line with reduced ACC income Belverdale expenses are $35k below budget, clinical supplies $38k favourable (under-spends in implants and prosthesis $5k, instruments and equipment $10k, pharmaceuticals $23k, other clinical $3k, offset by over expenditure in diagnostic supplies other clinical expenses). In spite of lower volumes, infrastructure expenses result is overspent for the month by $12k (due to laundry, patient meals, orderlies and security).

#### Year-to-date

Year-to-date the surgical cluster is unfavourable to budget by $256k but 10.1 FTE favourable. CWD are below contracted volumes by 10% overall (acutes 367.7 CWD below or 89.6% delivery, electives 247.4 CWD below contract or 90.3% delivery). In line with lower delivery volumes, year-to-date expenditure is also less than budget by $1,466k. Personnel expenses under budget comprising, medical $445k and 1.5 FTE, nursing $435k and 3.8 FTE, administration $135k and 3.6 FTE (administration impacted by the transfer of expenses from 1 January). Outsourced personnel was the only area overspent $79k, (long-term gynaecology locum to cover a vacancy $263k over, anaesthetic SMO locum cover for sabbatical leave during July and August $53k over. These were offset by underspends in urology $149k due to reduced sessions provided by MidCentral DHB until a fifth urologist is appointed). In line with lower service delivery and ACC income, other expenses are under budget by $519k, primarily due to Belverdale ACC expenses $148k, rest home convalescence $45k, implants and prosthesis $92k, treatment disposables $207k. Pharmaceuticals was the only area overspent to budget (mainly gastrointestinal $55k, musculoskeletal $42k).

#### Outlook and mitigations

Key focuses for the surgical cluster are to manage the impact of the lower CWD and maintain a corresponding reduction in expenditure within the budget. The changes made to the orthopaedic

surgery rosters have been implemented and these appear to have impacted on volumes. Timely and correct ACC claiming is also a priority and claiming for last year's ACC is making slow progress. Year-to-date overall acute volumes are under-delivered and mainly well controlled, however, general surgery is still over-delivered. Based on this under-delivery of acutes, unfunded costs have not been incurred. To maintain control of expenditure it is important that lower acute volumes delivery continues.

## 2. Medical Services

*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 | 108 | 95 | 13 | F | 1,314 | 1,431 | (117) | U | 1,764 |
| Funder to Provider Revenue (internal) | 2,647 | 2,647 | - | F | 26,730 | 26,730 | - | F | 32,090 |
| Other income | (18) | 7 | (25) | U | 58 | 67 | (9) | U | 80 |
| **Total Revenue** | **2,737** | **2,749** | **(12)** | **U** | **28,102** | **28,228** | **(126)** | **U** | **33,934** |
| **EXPENDITURE** | | | | | | | | | |
| Personnel | 1,849 | 1,847 | (2) | U | 17,083 | 17,048 | (35) | U | 20,552 |
| Personnel Other | 68 | 56 | (12) | U | 673 | 581 | (92) | U | 694 |
| Outsourced Personnel | 43 | 17 | (26) | U | 467 | 156 | (311) | U | 193 |
| **Total Personnel Expenditure** | **1,960** | **1,920** | **(40)** | **U** | **18,223** | **17,785** | **(438)** | **U** | **21,439** |
| Outsourced Clinical Service | 1 | 1 | - | F | 14 | 14 | - | F | 17 |
| Clinical Supplies | 174 | 181 | 7 | F | 1,864 | 1,699 | (165) | U | 2,073 |
| Infrastructure & Non Clinical Supplies Costs | 168 | 165 | (3) | U | 1,654 | 1,657 | 3 | F | 1,986 |
| Depreciation, Interest & Internal Allocation | 277 | 277 | - | F | 2,935 | 2,937 | 2 | F | 3,457 |
| **Total Other Expenditure** | **620** | **624** | **4** | **F** | **6,467** | **6,307** | **(160)** | **U** | **7,533** |
| **Total Expenditure** | **2,580** | **2,544** | **(36)** | **U** | **24,690** | **24,092** | **(598)** | **U** | **28,972** |
| **Net Surplus / (Deficit)** | **157** | **205** | **(48)** | **U** | **3,412** | **4,136** | **(724)** | **U** | **4,962** |
| **FTEs** | | | | | | | | | |
| Medical | 61.3 | 67.1 | 5.8 | F | 57.9 | 62.7 | 4.8 | F | 63.1 |
| Nursing | 146.8 | 132.1 | (14.7) | U | 135.5 | 124.6 | (10.9) | U | 124.3 |
| Allied | - | - | - | F | - | - | - | F | - |
| Support | - | - | - | F | - | - | - | F | - |
| Management & Admin | 0.3 | 3.1 | 2.8 | F | 2.0 | 3.1 | 1.0 | F | 3.1 |
| **Total FTEs** | **208.4** | **202.3** | **(6.1)** | **U** | **195.4** | **190.4** | **(5.1)** | **U** | **190.4** |

### Month

For April, a negative variance to budget of $48k and 6.1 FTE, is reflected for the medical cluster. Revenue fell short of budget expectations due to the reversal of an unneeded accrual for staff support at Whanganui Accident and Medical, $24k under budget for the month this being offset by ACC income over budget $14k. Acute volumes for April continued to exceed the PVS target volumes (17.8 CWD higher or 104% delivery) attributable to general medical. Overruns in staff and contractor costs - primarily nursing, especially the Medical Ward 4.5 FTE and $40k (high one-to-one hours), ED 5.8 FTE and $58k (acuity and volume of patients), also CCU 1FTE and AT & R 2 FTE over. They were operating at a FTE level in excess of budget but in line with clinical requirements indicated by TrendCare. Medical outsourced overrun by $26k is primarily due to locum cover for maternity leave, and this offsets against the medical staff costs of $79k and 5.8 FTE under budget. Other expenses comprise unders and overs to net off to $4k under budget.

### Year-to-date

The year-to-date unfavourable variance for the medical cluster shows a surplus of $3,412k, this being unfavourable to budget $724k and 5.1 FTE. Total revenue is falling short of budget by $126k due to Health Workforce funding being under budget (lower PGY1s and PGY2s) by $83k and ACC income being under budget by $17k. Outpatient clinic revenue and revenue from cost recovery comprise another $35k of the unfavourable result. Acute volumes for the year-to-date are over-delivered to contract even with the contracted volume increase from the previous year (19 CWD overall and 55 higher year-to-date than April last year). The high levels of delivery and acuity of patients is reflected in personnel costs over budget by $438k (medical and admin personnel $251k under budget offset by nursing $474k and 10.9FTE over, outsourced locums $311k over budget). Other expense areas are $160k over budget, the most significant overruns being patient appliances $21k (primarily HoverMatts), pharmaceutical $87k (antidotes $10k, antifungal $14k, cardiovascular $28k, infections $33k, nutrition $15k), treatment disposables $42k (IV supplies $68k). Also support expenses are $34k over budget (patient meals $7k, additional orderlies $11k and laundry $20k).

**Outlook and mitigations**

Although over-delivering to contract due to an increase in contracted volumes acute, volumes has reversed the trend of large over delivery of CWD. High volumes drive unfunded costs, reduction of the volumes is needed to realign with budget as reduced volumes should match to a corresponding reduction in personnel and clinical costs. Locum RMOs to cover the roster is driving outsourcing costs, partly due to the strike days. Although several RMOs commenced employment, the impact of Schedule 10 resourcing means more recruitment will need to be undertaken and until that time expenditure on locums will continue. Ongoing overruns in nursing personnel in response to occupancy and acuity demands are also expected to continue, with no signs of demand easing. ED 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. This is therefore a risk area for the 2018/19 budget.

## 3. Mental Health and Addiction Services

*Lead: Mike Bothma, Business Manager & Management Accountant Mental Health and Addictions*

**STATEMENT OF FINANCIAL PERFORMANCE ($000s)for the period ended 30 April 2019**
**MENTAL HEALTH CLUSTER**

| | Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | Budget |
| **REVENUE** | | | | | | | | | |
| Government and Crown agency | 3 | 4 | (1) | U | 82 | 80 | 2 | F | 103 |
| Funder to Provider Revenue (internal) | 1,529 | 1,529 | - | F | 15,309 | 15,286 | 23 | F | 18,343 |
| Other income | - | 15 | (15) | U | 98 | 146 | (48) | U | 175 |
| **Total Revenue** | **1,532** | **1,548** | **(16)** | **U** | **15,489** | **15,512** | **(23)** | **U** | **18,621** |
| **EXPENDITURE** | | | | | | | | | |
| Personnel | 1,340 | 1,284 | (56) | U | 12,224 | 12,419 | 195 | F | 14,899 |
| Personnel Other | 20 | 23 | 3 | F | 132 | 170 | 38 | F | 221 |
| Outsourced Personnel | 51 | - | (51) | U | 305 | - | (305) | U | - |
| **Total Personnel Expenditure** | **1,411** | **1,307** | **(104)** | **U** | **12,661** | **12,589** | **(72)** | **U** | **15,120** |
| Outsourced Clinical Service | - | 1 | 1 | F | 2 | 5 | 3 | F | 7 |
| Clinical Supplies | 25 | 20 | (5) | U | 221 | 205 | (16) | U | 245 |
| Infrastructure & Non Clinical Supplies Costs | 118 | 110 | (8) | U | 1,143 | 1,106 | (37) | U | 1,331 |
| Depreciation, Interest & Internal Allocation | 292 | 291 | (1) | U | 3,049 | 3,041 | (8) | U | 3,597 |
| **Total Other Expenditure** | **435** | **422** | **(13)** | **U** | **4,415** | **4,357** | **(58)** | **U** | **5,180** |
| **Total Expenditure** | **1,846** | **1,729** | **(117)** | **U** | **17,076** | **16,946** | **(130)** | **U** | **20,300** |
| **Net Surplus / (Deficit)** | **(314)** | **(181)** | **(133)** | **U** | **(1,587)** | **(1,434)** | **(153)** | **U** | **(1,679)** |
| **FTEs** | | | | | | | | | |
| Medical | 12.9 | 12.9 | 0.0 | F | 12.4 | 13.3 | 0.9 | F | 13.36 |
| Nursing | 107.3 | 103.1 | (4.2) | U | 102.4 | 101.5 | (0.9) | U | 101.16 |
| Allied | 32.0 | 30.4 | (1.5) | U | 29.5 | 30.4 | 0.8 | F | 30.37 |
| Support | - | - | - | F | - | - | - | F | - |
| Management & Admin | 16.2 | 17.5 | 1.2 | F | 15.8 | 17.4 | 1.5 | F | 17.37 |
| **Total FTEs** | **168.4** | **163.9** | **(4.4)** | **U** | **160.2** | **162.6** | **2.4** | **F** | **162.3** |

**Month result**

Mental health services continues 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 now seen the service move into an unfavourable variance overall.

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 unfavourable to budget due the volumes in Te Awhina as well as the community teams remaining very high. Nursing overtime is again very high as is the sick leave. Volumes in Te Awhina has remained high and is currently at an average of 105% for the month.

Clinical supply costs are unfavourable to budget. The unfavourable variance is due mainly in patient related costs which has increased and reflects the current high volumes across the service. Pharmaceutical costs are also reflecting an unfavourable variance and has shown an increase in line with the volumes we are seeing.

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

**Year-to-date**

The year-to-date figure is now reflecting an unfavourable variance. This is due mainly to reduced revenue for the prison contract which is budgeted for until year end but we are not seconding anyone to the position. Personnel costs are unfavourable to budget due to high volumes and increased sick leave. Higher than budgeted pharmaceutical costs are purely volume driven. Patient meal costs continue to be higher than budget due to the high volumes.

**Outlook and mitigations**

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

## 4. Community, Rural and Public Health services

*Lead: Mike Bothma, Management Accountant Mental Health and Addictions*

| STATEMENT OF FINANCIAL PERFORMANCE ($000s) PUBLIC HEALTH & COMMUNITY CLUSTER | Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| April 2019 | Actual | Budget | Variance | | Actual | Budget | Variance | | Budget |
| **REVENUE** | | | | | | | | | |
| Government and Crown agency | 267 | 283 | (16) | U | 1,385 | 1,533 | (148) | U | 1,667 |
| Funder to Provider Revenue (internal) | 556 | 527 | 29 | F | 5,434 | 5,273 | 161 | F | 6,327 |
| Other income | 1 | 1 | - | F | 10 | 8 | 2 | F | 10 |
| **Total Revenue** | **824** | **811** | **13** | **F** | **6,829** | **6,814** | **15** | **F** | **8,004** |
| **EXPENDITURE** | | | | | | | | | |
| Personnel | 475 | 531 | 56 | F | 4,442 | 5,186 | 744 | F | 6,218 |
| Personnel Other | 15 | 4 | (11) | U | 72 | 48 | (24) | U | 61 |
| Outsourced Personnel | - | - | - | F | - | - | - | F | - |
| **Total Personnel Expenditure** | **490** | **535** | **45** | **F** | **4,514** | **5,234** | **720** | **F** | **6,279** |
| Outsourced Clinical Service | - | - | - | F | 1 | - | (1) | U | - |
| Clinical Supplies | 129 | 133 | 4 | F | 1,363 | 1,340 | (23) | U | 1,608 |
| Infrastructure & Non Clinical Supplies Costs | 31 | 31 | - | F | 330 | 329 | (1) | U | 398 |
| Depreciation, Interest & Internal Allocation | 108 | 107 | (1) | U | 1,147 | 1,129 | (18) | U | 1,338 |
| **Total Other Expenditure** | **268** | **271** | **3** | **F** | **2,841** | **2,798** | **(43)** | **U** | **3,344** |
| **Total Expenditure** | **758** | **806** | **48** | **F** | **7,355** | **8,032** | **677** | **F** | **9,623** |
| **Net Surplus / (Deficit)** | **66** | **5** | **61** | **F** | **(526)** | **(1,218)** | **692** | **F** | **(1,619)** |
| **FTEs** | | | | | | | | | |
| Medical | 0.3 | 0.3 | - | F | 0.2 | 0.3 | 0.1 | F | 0.29 |
| Nursing | 54.2 | 51.8 | (2.3) | U | 47.2 | 51.1 | 3.9 | F | 51.05 |
| Allied | 8.0 | 12.3 | 4.3 | F | 8.7 | 12.3 | 3.6 | F | 12.27 |
| Support | 1.3 | 1.0 | (0.2) | U | 1.2 | 1.0 | (0.2) | U | 1.02 |
| Management & Admin | 0.5 | 9.8 | 9.4 | F | 5.2 | 9.8 | 4.6 | F | 9.80 |
| **Total FTEs** | **64.2** | **75.3** | **11.1** | **F** | **62.5** | **74.5** | **12.0** | **F** | **74.4** |

**Month**

Public health and community cluster reflects a favourable variance of $61k for April. This is due to both revenue in excess of budget (Smoke-free and school-based health services) and favourable personnel costs within the cluster. Clinical supplies were over budget due to bandages and dressing costs which is due to patient acuity. All public health costs remain within budget. Personnel cost variance is due to the moving of administration staff (8.8 FTEs) into different reporting lines as well as vacant positions in clinical areas.

### Year-to-date

For the year-to-date to April 2019 the public health and community cluster showed a favourable variance of $692k. Of this, $167k of this is due to the moving of administration staff into different reporting lines. The remaining $525k is due to favourable personnel costs within the service and for unbudgeted revenue for smoke-free ($77k) and school-based health services (SBHS $83k). Staff have been recruited for the SBHS contract but they have remained within the current budget so limited offset against the revenue. District nursing is now managing within their FTE budget but the cost of patient supplies continues to remain over budget. It is expected that this trend will continue due to patient acuity and type of product used. Internal charges will remain over budget for the remainder of year due to the district nursing service providing more community runs and cars were not included in budget changes. ACC revenue remains unfavourable to budget year-to-date ($149k). It is not expected that this will meet budget by year-end.

### Outlook and mitigations

All clinical vacancies in the service are actively being recruited to, so it is expected that the favourable clinical personnel costs will start to diminish. Clinical supply costs continue to remain over budget with dressings being the main cause of this. The community nursing service continues to have a large number of patients requiring high-cost dressings. The service is now capturing data on all high-cost consumables. This will enable a review of dressing use to ensure the right product is being used for the right patient and also ensure that ACC is being charged for products used on ACC patients. The public health service has received additional contract funding, and the costs will fully offset the revenue.

## 5. Allied Health Services

*Lead: Mike Bothma, Business Manager*

**STATEMENT OF FINANCIAL PERFORMANCE ($000s)for the period ended 30 April 2019**
**ALLIED HEALTH CLUSTER**

| | Month | | | | Year to Date | | | | Annual |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | Budget |
| **REVENUE** | | | | | | | | | |
| Government and Crown agency | 251 | 194 | 57 | F | 1,955 | 1,851 | 104 | F | 2,243 |
| Funder to Provider Revenue (internal) | 1,055 | 996 | 59 | F | 10,672 | 10,208 | 464 | F | 12,264 |
| Other income | 32 | 24 | 8 | F | 321 | 314 | 7 | F | 492 |
| **Total Revenue** | **1,338** | **1,214** | **124** | **F** | **12,948** | **12,373** | **575** | **F** | **14,999** |
| **EXPENDITURE** | | | | | | | | | |
| Personnel | 927 | 933 | 6 | F | 8,984 | 9,215 | 231 | F | 11,084 |
| Personnel Other | 28 | 19 | (9) | U | 271 | 179 | (92) | U | 221 |
| Outsourced Personnel | 82 | 62 | (20) | U | 781 | 704 | (77) | U | 849 |
| **Total Personnel Expenditure** | **1,037** | **1,014** | **(23)** | **U** | **10,036** | **10,098** | **62** | **F** | **12,154** |
| Outsourced Clinical Service | 406 | 403 | (3) | U | 4,151 | 3,951 | (200) | U | 4,734 |
| Clinical Supplies | 229 | 150 | (79) | U | 2,424 | 1,948 | (476) | U | 2,219 |
| Infrastructure & Non Clinical Supplies Costs | 82 | 64 | (18) | U | 760 | 722 | (38) | U | 878 |
| Depreciation, Interest & Internal Allocation | 237 | 244 | 7 | F | 2,482 | 2,509 | 27 | F | 2,980 |
| **Total Other Expenditure** | **954** | **861** | **(93)** | **U** | **9,817** | **9,130** | **(687)** | **U** | **10,811** |
| **Total Expenditure** | **1,991** | **1,875** | **(116)** | **U** | **19,853** | **19,228** | **(625)** | **U** | **22,965** |
| **Net Surplus / (Deficit)** | **(653)** | **(661)** | **8** | **F** | **(6,905)** | **(6,855)** | **(50)** | **U** | **(7,966)** |
| **FTEs** | | | | | | | | | |
| Medical | 2.2 | 2.4 | 0.2 | F | 2.3 | 2.5 | 0.3 | F | 2.6 |
| Nursing | 8.8 | 7.1 | (1.7) | U | 8.8 | 7.1 | (1.8) | U | 7.1 |
| Allied | 107.8 | 106.1 | (1.7) | U | 102.7 | 106.8 | 4.1 | F | 106.8 |
| Support | 0.2 | 0.2 | (0.0) | U | 0.2 | 0.2 | (0.0) | U | 0.2 |
| Management & Admin | 12.9 | 15.5 | 2.6 | F | 14.9 | 15.5 | 0.7 | F | 15.5 |
| **Total FTEs** | **131.9** | **131.3** | **(0.6)** | **U** | **128.9** | **132.1** | **3.2** | **F** | **132.1** |

### Month

Allied cluster is reflecting a favourable variance for the month. Increased revenue is the main cause of the favourable revenue, but was offset by some additional costs due to volumes.

Revenue is $123k 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 MidCentral DHB is also favourable to budget due to the current clean-up process in invoicing.

Personnel and outsourced personnel costs are unfavourable to budget due largely to increased volumes for the Community Assessment Rehabilitation (CART) as well as falls prevention, resulting in higher than budgeted FTE. Outsourced costs are unfavourable to budget due to higher than budgeted orthotic outsourcing as well as medical locums for dentistry and the increased electives.

Outsourced services costs are unfavourable to budget as the Pacific radiology cost continues to exceed budget due to volumes.

Clinical supply cost is unfavourable to budget due mainly to pharmaceutical costs which continue to exceed budget. The new eye drug and cancer drugs are the main cause and this is due to ever-increasing volumes. The cancer drugs have offsetting revenue.

Infrastructure and non-clinical supply costs are unfavourable to budget due largely to the maintenance on the dental caravan as well as some unbudgeted staff accommodation for a fixed term position in radiology.

**Year-to-date**
The year-to-date variance is unfavourable to budget. Revenue continues to be the main favourable variance but there are offsetting costs associated with the increased revenue. Personnel costs as well as outsourced contractor costs continue to be unfavourable to budget. A mix of volumes resulting in higher than budgeted FTE as well as lump sum MECA payments are the reasons for the unfavourable variance. Pharmaceutical costs are the main reason for the clinical supply costs being unfavourable to budget. This is due to some unbudgeted costs as well as increased volumes for certain drugs. There is offsetting revenue for these costs.

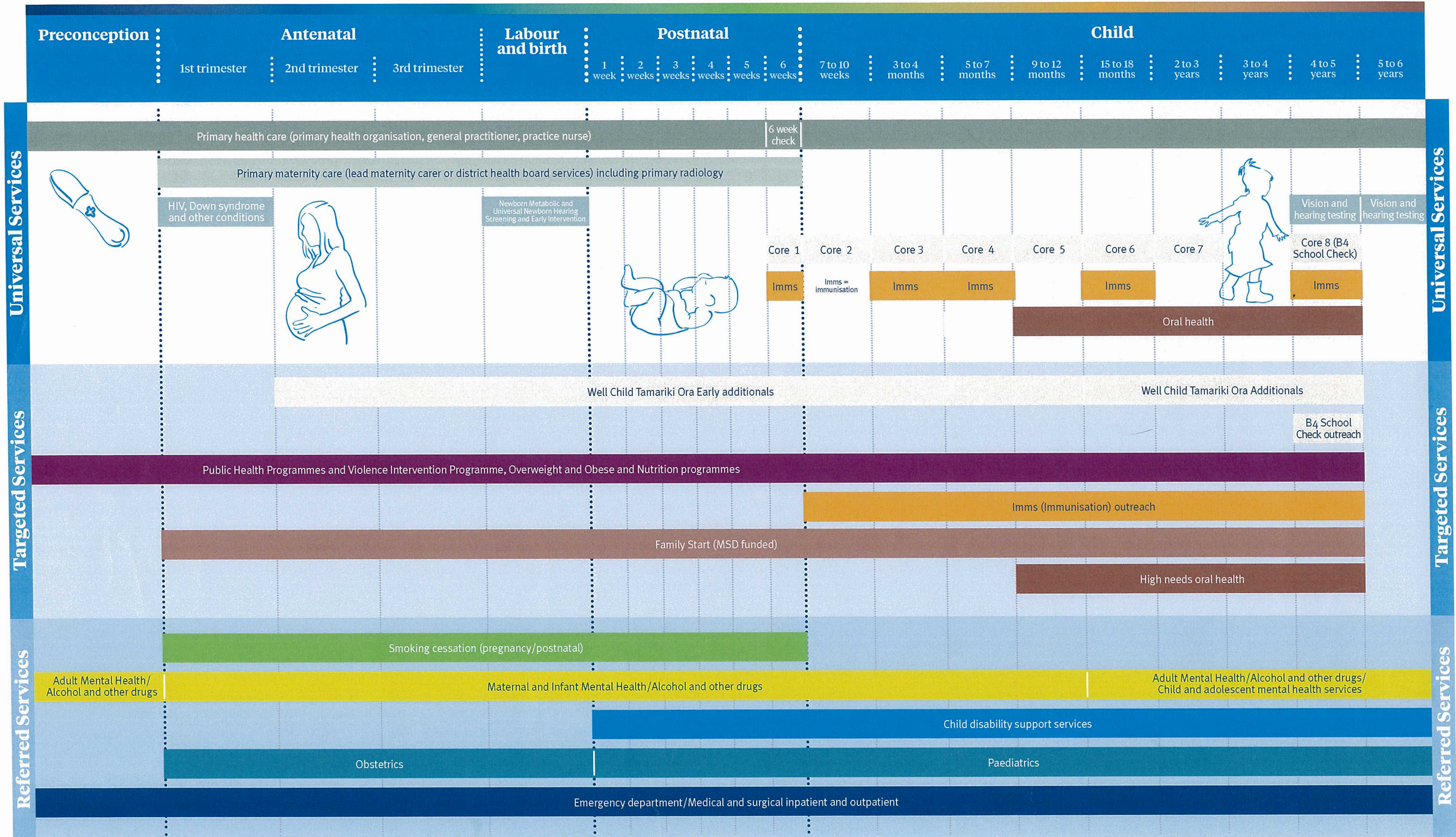
**Outlook and mitigations**
Personnel costs will increase as and when vacancies are filled, mainly in the allied health job group. Pharmaceutical costs are going to be under pressure due to the $10k per month budget shortfall, as well as the cost of the new eye drug being used that was not budgeted. For most of these increased 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.

# 8 Information papers

| Attachment | Description | Page |
| --- | --- | --- |
| 1 | New Zealand's Maternity and Child Health Services – preconception to 6 years | |
| 2 | Economics of early intervention | |
| 3 | Whanganui SUDI prevention discussion 18 October 2017 – services for wāhine, hapū and whānau in Whanganui | |
| 4 | NZ Child and Youth Epidemiology Service 2017 - Whanganui DHB vs New Zealand | |
| **Reference attachments – combined committee interest** | | |
| 5 | Glossary | |
| 6 | Combined Statutory Advisory Committee - Terms of Reference | |

# 8.1 New Zealand's Maternity and Child Health Services | Preconception to 6 years

MINISTRY OF HEALTH
MANATŪ HAUORA




- Primary health care
- Maternity
- Screening programmes
- Well Child/Tamariki Ora (Incl Plunket)
- Immunisation
- Oral health
- Family Start (MSD)
- Mental health
- Public health
- Disability support services
- Specialist medical
- Hospital – secondary and tertiary
- Smoking cessation

New Zealand Government

July 2012 HP 5528

Brainwave™

build a lifetime in the early years

*Brainwave Trust is a not-for-profit organisation that delivers easy to understand presentations to parents, professionals and the wider community using the latest scientific research on brain development.*

# The Economics of EARLY INTERVENTION

*"The saddest aspect of life right now is that science gathers knowledge faster than society gathers wisdom."*
Isaac Asimov

Brainwave Trust Aotearoa made a submission to the Health Select Committee's Inquiry into preventing child abuse and improving children's health outcomes in May 2012 in response to the first term of reference for the enquiry "to update knowledge of what factors influence best childhood outcomes from before conception to 3 years, and what are significant barriers regarding the impact of early experience on a child's brain development". We have been asked to provide further information on the economic argument for early intervention. This paper will demonstrate that intervening in the early years is not only effective but also economically efficient.

## NTRODUCTION

The case for intervention often rests on arguments of social justice and social good, such as removing inequality or reducing crime, however there are also economic ones. In this context, interventions are assumed to be ones that have been proven to work and produce the desired outcomes.

The economic argument for interventions is based on the cost of the interventions and a financial value attributable to the results, usually over a lifetime.

The economic argument for early intervention is based on the principle that given available resources are limited, investments in interventions should happen where they have the best chance of long term success and the best return for every dollar spent.

The social justice arguments for intervening in children's lives are readily apparent. However there are now powerful economic arguments for the same, thanks in large part to the pioneering work of Nobel laureate, Professor James Heckman and his colleagues. His work has married an understanding of developmental neuroscience (which has highlighted unique developmental opportunities and vulnerabilities in infancy and early childhood and their long term consequences) with detailed economic analysis. Whilst his work is primarily about the accumulation of human capital the spin offs are in many domains including better mental and physical health, lower imprisonment rates, lower unemployment, better school achievement etc. Some of the answer in improving productivity as a nation will, maybe surprisingly, be in how we treat our young children.

In Heckman's (2000) words:

> "The real question is how to use the available funds wisely. The best evidence supports the policy prescription: invest in the very young and improve basic learning and socialisation skills"

We note that by using scarce resources for targeted interventions to those most in need rather than universal interventions, the goal is equality of outcomes rather than equality of inputs or delivery.

## RISK AND PROTECTIVE FACTORS – an aid to targeting

Much of the scientific literature identifies risk factors which increase the likelihood of poor outcomes. Most children have some risk factors but, in terms of outcomes, these can be balanced by the protective factors which children also experience.

Risk factors can be considered like a pile of children's wooden blocks. It is the piling up of them, one after the other, without the support of foundations or cross braces (the protective factors) which cause the problem. The "final block" which made the tower fall over is often seen as the cause of a particular behaviour or outcome rather than the combination of the risk and protective factors. It is tempting to treat the "final block" instead of see the pattern of the blocks before them. Further it is the number of risk and protective factors which are important, not the existence of any one of these. In the same way, if just one block (risk factor) is removed or one more scaffold (protective factor) is introduced the tower can be more robust.

We know that most children from poor families thrive. However, for many families in poverty there are also other risk factors including drug and alcohol addictions, poor housing and housing mobility, moving schools regularly, chaotic households and unpredictable care, family violence. In the absence of strong family relationships the risks of poor outcomes are dramatically increased. By removing just one risk or adding one protective factor, benefits can be achieved.

We note that two children with ostensibly the same set of risk factors may nonetheless have significantly diverse outcomes – thanks to the complex interplay of their genes and in-utero experience with their postnatal environment and experiences.

## EARLY INTERVENTION – the Economic Argument

All governments operate in a constrained fiscal environment. The principal funding mechanism is through tax and voters typically have limited appetite for ongoing increases in tax. Benefit-cost analysis allows governments to spend their scarce resources where results can be shown it is worth it. Cost-effectiveness alone will dictate the decision among competing program models, but it cannot show that the total effect was worth the cost of the program (Weinrott, Jones & Howard, 1982, p179, cited in Welsh & Farrington, 2011)

There are a number of programmes that have been shown through careful experimental

design to be effective in changing behavioural outcomes, for example i.e. they do actually work. For most programmes it is reasonably straightforward to identify the costs.

Cost effectiveness is also relatively easy to count and can be used to choose between programmes with similar outcomes. If we can achieve x with each of these programmes, then which one uses the least cost and will be therefore most cost effective?

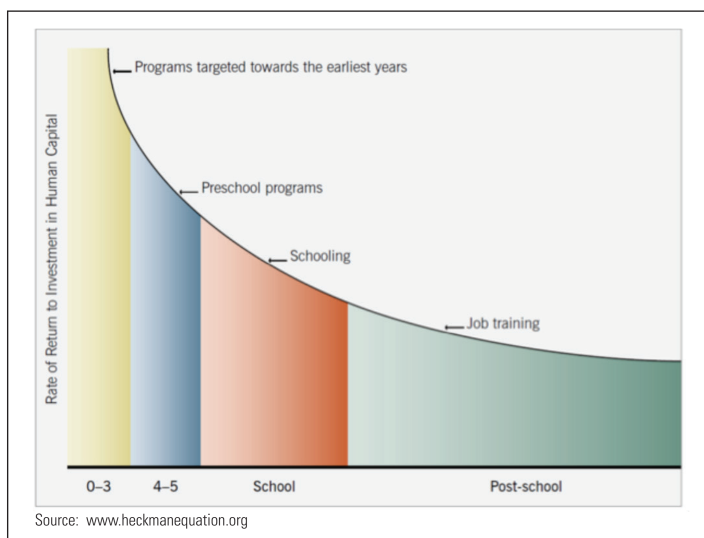
It is, however, highly complex to calculate the cost-benefit and understand the long term financial benefits of these interventions. The much discussed Perry Preschool project is one of the few that have been subject to long term follow up between a control and the subjects.

Recent research by James Heckman, Nobel Laureate in Economic Sciences and others has introduced a new level of analysis into the importance of family with respect to the cognitive and socio-emotional skills development of children. He emphasises the ability of non-cognitive skills like motivation and self confidence to moderate the impact of genetic disadvantages on socioeconomic success in later life. Poor non-cognitive skills are powerfully influential in terms of a child's subsequent involvement in crime, teenage pregnancy and education (Heckman et al, 2006). His work has for the first time intertwined economic analysis with an understanding of brain development in the early years.

After decades of rigorous research a great deal is known about the early causes of delinquency and later offending, for example. There is a growing body of scientific research that shows that early prevention is an effective and worthwhile investment of public resources when comparing the economic benefits and costs of early prevention compared with imprisonment, for example (Welsh & Farrington, 2011).

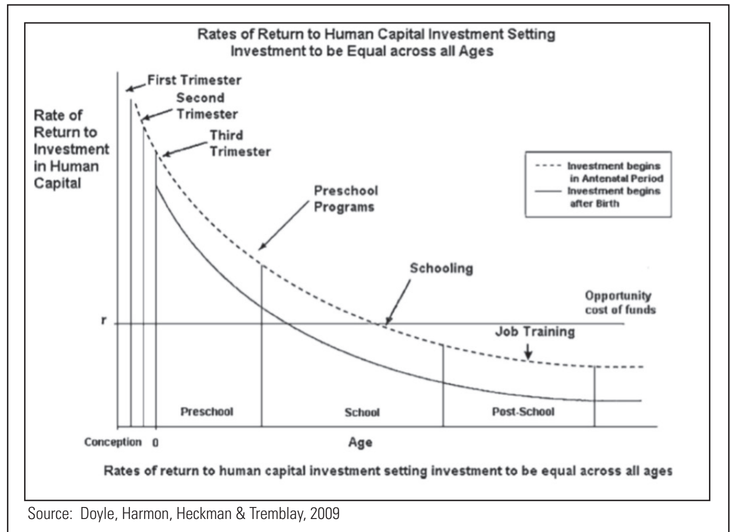
Heckman posits that early interventions promote schooling, reduce crime, foster workforce productivity and reduce teenage pregnancy and are estimated to have high benefit-cost ratios and rates of return. The longer society waits to intervene in the life cycle of a disadvantaged child, the more costly it is to remediate disadvantage. We need to capitalise on knowledge about the importance of the early years in creating equality and in producing skills for the workforce. (Heckman, Big Ideas).

The following graph neatly summarises the impact of early intervention. The graph shows the rate of return to human capital across different age ranges when investment is set to be equal at each age. It powerfully illustrates the relative effectiveness of early intervention especially when typically the rate of spending is the exact reverse of this – low in the early years and much higher in the later years. Early investments generate returns over a longer time horizon and also raise the productivity of later investments: learning begets learning, and skills acquired early facilitate later learning.



Source: www.heckmanequation.org

Doyle et al have hypothesised further that the earlier the intervention – even into early pregnancy - the higher the return, however they suggest that an explicit study testing this hypothesis is required. This is demonstrated in the following graph.



Source: Doyle, Harmon, Heckman & Tremblay, 2009

While the work of Heckman and others does not specifically contemplate health outcomes, we know they also are highly related with early adversity, particularly early mental health issues.

Longitudinal research from the 'High Scope Perry Preschool Study' has provided much discussion and analysis regarding the long term effectiveness of appropriate early interventions. The study is a scientific experiment begun in the 1960s that has identified both the short- and long-term effects of a high-quality preschool education programme for young children living in poverty. The experimental design included randomly assigned control groups and has now been evaluated over 40 years. The intervention was just 2 and half hours per day, 5 days a week of high quality preschool with highly trained (all degree educated) staff for 3 and 4 year old children, as well as home visits by teachers at least once every 2 weeks.

An estimated rate of return (the return per dollar of cost) to the Perry Preschool Program is in excess of 14 percent (Heckman, Moon, Pinto, and Yavitz, 2008). This high rate of return is higher than standard returns on stock market equity and suggests that society at large can benefit substantially from such interventions. These are underestimates of the rate of return because they ignore the economic returns to health and mental health and intergenerational benefits.

Cunha and Heckman(2007b, in Heckman Big Idea) and Heckman and Masterov (2007, in Big Idea) say that early interventions promote economic efficiency and reduce lifetime inequality rather than suffering a trade-off between the two. Heckman maintains that the optimal policy is to invest relatively more in the early years. But early investment must be followed up to be effective. The returns to early childhood programmes are the highest for disadvantaged children who do not receive substantial amounts of parental investment in the early years, although this does not necessarily reflect family poverty or parental education – quality of parenting is the scarce resource in economic terms. He summarises that about 50% of the variance in inequality in lifetime earnings is determined by age 18. In shaping adult outcomes, the family plays a powerful role that is not fully appreciated in current policies around the world.

Current social policy directed toward children focuses on improving cognition. Yet more than intelligence is required for success in life. Gaps in both cognitive and noncognitive skills between the advantaged and the disadvantaged emerge early and can be traced in part to adverse early environments. A greater percentage of children in the United States and many other countries is being born into adverse environments.

Longitudinal studies find that the personal benefits (cognitive development, behaviour and social competence, educational attainment, and earnings), social benefits (reduced delinquency and crime) and government savings (higher tax revenues, reduced social welfare spending), associated with intervening early in a child's life clearly outweigh the costs (Karoly et al, 2005).

We note that the excellent returns to early education that Heckman

uses are mostly based on a limited number of expensive experiments in the 1960s and 1970s that provided rich early education and care for a few hours a week to to limited numbers of disadvantaged 3 and 4 year old children. As such they cannot be extrapolated to suggest that universal preschool provides all the answers.

Heckman cautions against cherry picking selected aspects of a proven programme and expecting it to produce the same results. He also stresses the importance of high quality in preschool arrangements otherwise good outcomes cannot be expected.

The OECD recently reported that "country spending profiles examined are not consistent with the theory and evidence on child well-being. In contrast there is little or no obvious rationale for why so many Governments place the weight of their spending on late childhood".

## THE COSTS OF MALTREATMENT

There is a considerable cost burden to the country as the result of child maltreatment, which includes abuse and neglect in all its forms. Some of the areas where these costs accumulate are shown, as are the results of studies which have attempted to quantify the long term costs of maltreatment.

- Infometrics reported in August 2008 in "The nature of economic costs from child abuse and neglect in New Zealand" that, "based on overseas estimates, the annual cost of child abuse and neglect generates a bill every single year of around $NZ2 billion (or over 1% of GDP)". The value today of spending $NZ2 billion every year for the next 50 years is between NZ$19 billion and NZ$30 billion (depending on the discount rate - Infometrics used 10% to 6%). So, in economic terms, it would be cheaper for the country to spend up to, say NZ$19 billion now than having to spend the $2 billion we currently spend for each of the next 50 years.
- In a more recent report for Every Child Counts, on the effectiveness of public investment in New Zealand children, Infometrics reported in August 2011 that the economic cost to the New Zealand economy of poor child outcomes is of the order of 3% of GDP (approximately NZ$6 billion).
- In March 2009, the top 300 children and young persons in CYF care cost NZ$23 million per year – over $75,000 per child on average. Most of these mainly 14 to 17 year old boys were already know to CYF as preschoolers.
- Vote Corrections for 2012-13 was NZ$1.185 billion.
- Vote Social Development was over $21 billion, around half of which is dedicated for payment and services other than for seniors.
- There are numerous demands on the health budget apart from the immediate care of damaged children which include much later mental and physical health issues. However, a significant portion of the health budget can be attributable to the results of an adverse start in life.

*"The health and social consequences of child maltreatment are more wide-ranging than death and injury alone and include major harm to the physical and mental health and development of victims."*

- The recently released Innocenti Report 11 (Unicef, 2013) highlights where New Zealand stands relative to other developed countries on a number of measures. We highlight a few of those statistics for which adverse early environments are known to be a risk factor. For example:
  - Our child poverty rates of around 12% are comparable with Australia, somewhat higher than the UK and significantly lower than the US.
  - We have the 5th highest teen fertility rate of 26 births per 1000 girls aged 15-19, compared with 15 in Australia and 5 in the Netherlands but better than the UK(30), US(36), Romania(31) and Bulgaria(40).
  - NZ is one of only three countries, with Spain and Bulgaria, where more than 12% of young people aged 15 to 19 are not participating in either education, employment or training. This contrasts starkly with our overall 3rd best PISA scores of reading, maths and science literacy.

## EARLY INTERVENTION

Inequalities in health, cognitive development, and socio-emotional functioning emerge early in life. Many subsequent social issues, such as crime, teenage pregnancy, low education and unemployment can be traced to an adverse early years' environment. Targeted, early intervention programmes aimed at disadvantaged children and their families are an effective means of reducing these inequalities in that they can partially compensate for risk factors that compromise children's most critical stages of early development (Doyle, 2009).

Early intervention treats problems at source rather than waiting for an opportunity to treat the symptoms (Allen, 2011). We currently fund the treatment of "the symptoms" through the Health, Corrections, Education, Social Welfare and Justice budgets, among others.

The health and social consequences of child maltreatment are more wide-ranging than death and injury alone and include major harm to the physical and mental health and development of victims. And therefore contributes to a broad range of adverse physical and mental health outcomes that are costly, both to the child and society, over the course of a victim's life (WHO/IPSCAN, 2006).

Young children have less control over their environments than individuals at almost any other stage of development. As individuals age, they gain the independence and ability to shape their environments, rendering intervention efforts more complicated and costly (Duncan and Magnuson, 2004).

"The length of human life and the portion of it spent with parents provide abundant opportunities for individual and parent-focused interventions designed to enhance human potential." (Duncan and Magnuson p24, 2004)

Early childhood programmes have wide appeal across a large spectrum of constituencies as they help society's most vulnerable members. Their explicit aims include improvement in children's immediate learning and social and emotional competencies, and the improvement of children's success over the life-course. Also, they are implemented at a time when children are most impressionable and receptive to interventions. To the extent that "skill begets skill", interventions earlier in life taken on added importance since they can help ensure that children attain competencies needed to profit from opportunities later in life (Duncan & Magnuson, 2004).

## COSTLY OUTCOMES

This section identifies research which links adverse early experiences to a variety of poor outcomes to demonstrate these links in a number of domains. The list is not exhaustive but representative of the wide and rapidly accumulating body of knowledge.

There are a number of international longitudinal studies, particularly in the UK and NZ, that are useful in that they help to identify causes of problems rather than just the risks of poor outcomes. The scientific literature continues to mine these data sets and hundreds of papers are produced every year. Three highly regarded New Zealand studies form an important part of this body of research. The Dunedin Multidisciplinary Health and Development Study (1972/73) and the Christchurch Health and Development Study (1977) are two such studies which have provided rich data and have been most helpful in understanding risks and cause and effect. Growing Up in New Zealand is a new longitudinal study which recruited 7000+ babies born in 2008 and represents

the changes in the New Zealand population some 35-40 years later. Thousands of papers have been published in peer reviewed journals from longitudinal studies which have established connections between treatment of children in the early years and long term outcomes.

Although much of the research identifies risks and causes of bad outcomes but often the exact mechanism is not yet understood. Much current research is striving to understand the exact mechanism. An example is the epigenetic changes which can occur as the result of the early environment which can then be passed on to the next generation. This research is still evolving in content and clarity.

## PHYSICAL AND MENTAL HEALTH

There are now numerous studies which link early maltreatment of children with ongoing physical and mental health problems. One of the mechanisms at play is the role of stress in children's lives. Stress is a part of every life to varying degrees, but individuals differ in their stress vulnerability. Frequent neurobiological stress responses increase the risk of physical and mental health problems, perhaps particularly when experienced during periods of rapid brain development (Gunnar & Quevedo, 2007).

Our understanding of the long term effect of maltreatment (abuse and neglect, for example) and household dysfunction (e.g. marital discord, parent with alcohol and drug dependence) during childhood (known as "adverse childhood experiences" or ACEs) and adult health issues has been deepened by longitudinal research from the United States known as the ACE studies. Dozens of papers have been published based on the original data (www.cdc.gov/ace). These studies are among the first to study the impact of more than one type of abuse and counted one type of experience as 1 point e.g. examples of ongoing physical abuse count only once regardless of how often they occur. The findings indicate strong links between adverse experiences during childhood and adolescence, and chronic diseases, mental health issues and unhealthy behaviours such as substance abuse that occur many years later.

Those with many ACEs were more likely to have many health risk factors later in life (Felitti et al, 1998), however these consequences of early adversity may not be seen for many years (Anda, Butchart, Felitti, & Brown, 2010). For example, compared to those who grew up with no domestic violence, the adjusted odds ratio for any individual ACE was approximately two to six times higher if Intimate Partner Violence (IPV) occurred. There was also a powerful graded increase in the prevalence of every category of ACE as the frequency of witnessing IPV increased. In addition, the total number of ACEs was increased dramatically for those who had witnessed IPV during childhood. There was a positive graded risk for self-reported alcoholism, illicit drug use, iv drug use and depressed affect as the frequency of witnessing IPV increased (Dube et al, 2002). This highlights the perhaps unseen risks for children and the need to consider interventions for these children when this type of violence is exposed.

An adult with an ACE score of 4 or more was 2-4 times more likely to smoke, have poor health, have 50 or more sexual partners, and have had sexually transmitted disease compared to those with an ACE score of zero. An ACE score of 4 or more was also associated with a 4-12 fold increased likelihood of alcoholism, drug abuse, depression, and suicide attempt (Felitti et al, 1998).

The risk of developing Ischaemic Heart Disease (IHD) was significantly increased among those exposed to even one ACE (with the exception of marital discord) and those with an ACE Score of 7 or more were more than 3 times more likely to have IHD than those with none (Dong et al, 2004).

Childhood traumatic stress increased the likelihood of hospitalisation with an auto-immune disease such as coeliac disease, rheumatoid arthritis, multiple sclerosis, insulin-dependent diabetes, and irritable bowel syndrome. For women aged between 19 and 64, every increase in ACE Score increased the likelihood of an auto-immune disease related hospitalisation by 20%. These conditions may occur decades into adulthood and, it was suggested, may be as a result of the effect of the stress on the developing nervous system and immune function (Dube et al, 2009).

Risk behaviours such as smoking, over eating and physical inactivity may occur as responses by individuals to cope with the stresses they have experienced (Dong et al, 2004) and may explain why public health and prevention messages may not work for people who have suffered adverse childhood experiences.



The ACE research has also considered the potential protective effects of family strengths against early initiation of sexual activity, adolescent pregnancy and their long-term psychosocial consequences. Each category of family strength reported as being present (for women) was associated with a 30-40% decreased risk of adolescent pregnancy, and as the number of family strengths increased, the risk further decreased. These family strengths were found to be especially protective against early initiation of sexual activity for women who had experienced abuse or family dysfunction (Hillis et al, 2010).

Intervening in the zero-to-three period, when children are at their most receptive stage of development, has the potential to permanently alter their development trajectories and protect them against risk factors present in their early environment. Both biological and environmental conditions play a role. Children from low socioeconomic backgrounds typically have poorer health in terms of the prevalence of illness, the severity of illness, the likelihood of mortality, and the incidence of disease (Chen et al, 2002 in Doyle et al, 2009). Possible explanations for this include genetic influences, environmental exposures to toxins, quality of medical care, and behavioural factors (Anderson & Armstead, 1995 in Doyle et al, 2009).

## MENTAL HEALTH

The most common childhood mental health difficulties are conduct problems. Many studies look at this range of behavioural problems known as conduct problems, the most serious end of which is Conduct Disorder, a psychiatric diagnosis. A high proportion of those with conduct problems will go on to become involved in criminal activity (see later). These problems have many causes but early family relationships and parenting styles are particularly significant (Sainsbury, 2009). This section identifies the link between early behavioural problems and later ones and that many of these problems can be identified early.

A study of childhood mental health and life chances based on national birth cohort surveys (Richards and Abbott, 2009) showed that early mental health problems can lead to a wide range of adverse outcomes in later life, including continuing mental health difficulties, poor educational performance, unemployment, low earnings, teenage parenthood, marital problems and criminal activity. It also found that the scale of these negative outcomes was generally much greater among those whose early mental health problems took the form of conduct problems rather than emotional difficulties. A particularly strong association was found between conduct problems in early life and the subsequent likelihood of involvement in criminal activity.

Genetic risk for conduct disorder predicts early-emerging conduct problems, particularly in conjunction with maltreatment (Jaffee et al, 2005). The knowledge of a family history of antisocial behaviour may therefore be used to help prioritise interventions. An absence of any family history of antisocial behaviour may be one indicator that a maltreated child is at relatively low risk for conduct problems, although it is possible that these children would be at high risk for other adverse outcomes like anxiety or depression.

Compared with children of mothers with depression only, the children of depressed and antisocial mothers had significantly higher levels of antisocial behaviour and rates of conduct disorder. They were at an elevated risk of experiencing multiple caregiving abuses, including physical maltreatment, high levels of maternal hostility, and exposure to domestic violence. Children of depressed and antisocial mothers constitute a group at extremely high risk for early-onset psychopathology (Kim-Cohen et al, 2006).

Mental health problems often begin early in life and cause disability when those affected would normally be the most productive, unlike most physical illnesses ( Friedli and Parsonage, 2007). The scope for securing benefits by means of treatment, rather than prevention, appears to be distinctly limited. They go on to suggest that preventing conduct disorders in those children who are most disturbed would save around £150,000 (NZ$275,000) per case in lifetime costs.

The economic burden of child maltreatment in the US has been estimated as the average lifetime cost per victim of nonfatal child maltreatment of US$210,012 in 2010 dollars, and conclude that compared with other health problems the burden of child maltreatment is substantial, indicating the importance of prevention efforts (Fang et al, 2012). If we extrapolate this per child estimate just to the 27,000 substantiated cases of child maltreatment in New Zealand in 2010/11 (MSD, 2012) the total lifetime cost would be approximately NZ$6.7 billion.

# LAW AND ORDER

## Antisocial behaviour and criminality

Internationally there has been a lot of emphasis on reducing criminality and imprisonment. One effective strategy for crime prevention is not creating criminals. Numerous studies identify some of the precursors of criminal behaviour evident in the early years and the features of their lives which either cause these outcomes or indicate a significantly raised likelihood of these outcomes.

Data from the Dunedin study (White et al, 1990) found that having preschool behaviour problems (identified in a number of ways) was the best predictor of antisocial outcome at ages 11 and 15. This research highlights the opportunities for early identification and intervention.

An English review (Sainsbury, 2009) found that around 80% of all criminal activity in the UK is attributable to people who had conduct problems in childhood and adolescence, including about 30% with Conduct Disorder. UK estimates suggest that the lifetime cost of crime committed by a single prolific offender is around £1.5 million (NZ$2.75 million). They suggest that in the UK just 1% of the law and order budget would be sufficient to fund a comprehensive programme of pre-school support for 30% of all children born each year.

Childhood maltreatment is a universal risk factor for antisocial behaviour increasing later criminality by about 50% (Caspi et al, 2002). The earlier children experience harsh treatment, the more likely it is they will become aggressive. We note, however, the majority of maltreated males do not become delinquents or criminals.

Cohen & Piquero (2009) estimate the present value of saving a 14-year-old high risk juvenile from a life of crime to range from US$2.6 to $5.3 million (NZ$3 – 6.2 million). Similarly, saving a high risk youth at birth would save society between US$2.6 and $4.4 million (NZ$3 – 5.2 million).

Data from the Christchurch Health and Development Study has been used to identify trajectories to offending Children are not condemned to this trajectory if circumstances change but they are at high risk. Each one of the risk factors below increases the probability of antisocial behaviour as a young adult by between four times and ten times. Together they increase risk by hundreds of times.

The key maternal risk factors are these, the mother:

- is young
- has little education
- is from a disadvantaged family of origin where she received little care and affection
- is, or has been, substance dependent
- is socially isolated and without family connections
- has a number of male partners in a serial fashion. (Fergusson et al 2000, in About Time).

Whilst people will always need health care thanks to accidents, infectious diseases etc regardless of early adversity, this is not so of the Corrections budget. If we are able to eliminate early adversity (including pre-natal exposure to alcohol, for example) we would expect to eliminate a significant proportion of the need for imprisonment, for example. Just 5% of our current spend in Vote Corrections – would provide around $12,000 of services to wrap around each of the 5,000 most at risk families in New Zealand and their vulnerable children.

# EDUCATION

The extent to which unhelpful outcomes are interrelated was shown by Williams & McGee (1994) when they identified that reading disability at 9 years old predicated conduct disorder at age 15 in boys, findings that were independent of social disadvantage.

At the time of school entry, children who participate in early-education programmes are better prepared for school (West et al, 2000 in Duncan and Magnuson, 2004)

Heckman says "Early learning begets later learning and early success breeds later success, just as early failure breeds later failure". He goes on to add that a narrow focus on cognition ignores the full array of socially and economically valuable non-cognitive skills and motivation produced by schools, families and other institutions.

There is a large body of evidence regarding early adversity and lack of school success, however this is not the focus here.

# POVERTY

Apart from the obvious demands from the social welfare system, poverty is implicated in many poor outcomes. Again, many poor families bring up successful children, but many suffer compounding risk factors.

A recent US study, Fourth National Incidence Study of Child Abuse and Neglect (Sedlak et al, 2010) found that children in low socioeconomic status households (lowest 10%) experienced some type of maltreatment at more than 5 times the rate of other children; they were more than 3 times as likely to be abused and about 7 times as likely to be neglected.

Food security (or insecurity) is an issue of poverty. Zaslow et al (2008) found that food insecurity i.e. limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire food in socially acceptable ways worked indirectly through depression and parenting practices to influence security of attachment and mental proficiency in toddlerhood.

# LABOUR MARKET OUTCOMES

Caspi et al (1998) identified childhood and adolescent predictors of youth unemployment based on the Dunedin study as follows:

- human capital - lack of high-school qualifications, poor reading skills, low IQ scores, and limited parental resources significantly increased the risk of unemployment;
- social capital - growing up in a single-parent family, family conflict, and lack of attachment to school also increased the risk of unemployment;
- personal capital - children involved in antisocial behaviour had an increased risk of unemployment.

They observed that these predictors of unemployment reached back to early childhood suggesting that they began to shape outcomes years before these youths entered the work force.

Infometrics' David Grimmond presented the following graph in a speech for Every Child Counts entitled "Children and the Recession" in 2009. It amply illustrates that regardless of whether the economy is in recession or is buoyant, history shows that the unemployment rate is highest among those who have not completed schooling. The costs of unemployment are both personal and to society (by way of benefit payments and loss of productivity). We know that adverse early years experiences contribute to the likelihood of lack of completed schooling.

# KEY RESULT AREAS

We note that of the Government's 10 key result areas for 2013-15 the first eight are likely or very likely to be improved by appropriate interventions in the lives of disadvantaged children, although admittedly over a longer time frame.

**Reducing long-term welfare dependency**

1. Reduce the number of people who have been on a working age benefit for more than 12 months.

**Supporting vulnerable children**

2. Increase participation in early childhood education.
3. Increase infant immunisation rates and reduce the incidence of rheumatic fever.
4. Reduce the number of assaults on children.

**Boosting skills and employment**

5. Increase the proportion of 18 year olds with NCEA level 2 or equivalent qualification.
6. Increase the proportion of 25-34 year olds with advanced trade qualifications, diplomas and degrees (at level 4 or above).

**Reducing crime**

7. Reduce the rates of total crime, violent crime and youth crime.
8. Reduce reoffending.

*(Source: www.beehive.govt.nz/release/budget-focuses-better-public-service-results)*

## CONCLUSION

As a country we spend billions of dollars addressing the results of early childhood adversity. The research now provides compelling evidence regarding the long term ramifications of the construction of brain architecture in infants and children in the first few years. The early plasticity of the brain becomes its vulnerability. It also demonstrates the far reaching outcomes when those early years have been less than adequate in terms of the individual and society.

We know that the programmes that are in place to ameliorate those problems (prisoner rehabilitation, drug and alcohol programmes, remedial support in school etc) are an expensive impost on the taxpayer yet we still provide them. A dollar invested in the early years however provides a very much higher return than a dollar invested later.

Interventions which reduce ongoing expenses to the health system will also have benefits in education, corrections, etc which accrue both to society and the individual.

Of course, intervention in the early years is not the only possible point of intervention, but it does provide the best return.

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## 8.3 Whanganui SUDI prevention discussion Oct 18 2017 – Services for Wahine Hapu and Whanau in Whanganui

### Conception to Birth

**Lead Maternity Carers**
**GP Teams (EPAT)**

Family Planning
EPAT Early Pregnancy Assessment TOOL (GPT)
Antenatal Clinic/ Early Pregnancy Clinic in Hospital
Antenatal Education / Pregnancy and Parenting
Maternal Mental Health
Maori Mental Health
Public Health / Health Promotion
Specialist Care Nurses
Youth Services Trust
Pepi pod / wahakura distributor
Healthy Homes
Jigsaw
Tupho iwi Social Services
Te Kotuku Hauora
Ngati Rangi Services

*Services in Development:*
*Maternal Care Wellbeing and Child Protection Multi-Agency Group*

### Birth to 6 Weeks

**Lead Maternity Carers**

**DHB Hospital Maternity Services**

- Delivery suite
- Postnatal ward
- Hip checks
- Hearing screening
- Lactation Consultant
- Social Worker

DHB Paediatric Services

- Neonatal Unit / SCBU
- Paediatricians
- Home Care Nurses

GP Enrolments Service
Pepi pod / wahakura distributor
WCTO Services
NIR
Maternal mental health
Maori mental health
IRD Smart Start
MVCOT
Children's' Team
Travel Support
Healthy Homes
Jigsaw
Tupho iwi Social Services
Te Kotuku Hauora
Ngati Rangi Services

*Non Clinical / Non Professional Services*
*Mother Led Breastfeeding Support*

### 6 Weeks to 2 Years

**GP Teams**
**WCTO Services**
**Early Childhood Education**
**Kohanga Reo**
Receptionists at Services
Teen Parent Unit – City College
Immunisation outreach – Manaaki te Whānau.
Birthright
Barnardos
WINZ
Healthy Homes
Salvation Army
Whanau Ora Service
**Women's Centre**
IRD Smart Start
MVCOT
Children's' Team
Developmental Therapist
WRHN – Social work service
NGO's
Maternal Mental Health
Maori Mental Health
Pepi Pod / Wahakura Distributor
Developmental Therapist
Jigsaw
Tupho iwi Social Services
Te Kotuku Hauora
Ngati Rangi Services

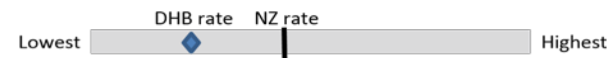
*Non Clinical / Non Professional Services*
*Mother Led Breastfeeding Support*

## 8.4 - NZ Child and Youth Epidemiology Service 2017

### Summary indicator graph, Whanganui DHB vs New Zealand

| Indicator | Period | Whanganui number | Whanganui rate | NZ rate | Lowest DHB rate | Indicator range | Highest DHB rate |
|---|---|---|---|---|---|---|---|
| Women not registered for antenatal care | 2015 | 44 | 5.40 | 4.45 | 0.43 | | 16.09 |
| Maternal smoker registered for antenatal care | 2015 | 211 | 27.37 | 15.52 | 5.40 | | 32.33 |
| Maternal BMI: obese (≥30.0 kg/$m^2$) | 2015 | 231 | 29.96 | 23.92 | 18.46 | | 34.19 |
| Preterm births (under 37 weeks gestation) | 2015 | 59 | 7.19 | 7.32 | 5.89 | | 9.21 |
| Low birthweight liveborn babies | 2015 | 53 | 6.46 | 5.72 | 3.27 | | 7.13 |
| Fetal death rate | 2010–2014 | 30 | 7.01 | 6.87 | 5.15 | | 8.44 |
| Infant mortality | 2010–2014 | 30 | 7.06 | 5.23 | 3.18 | | 7.63 |
| Child mortality rate (aged 1–4 years) | 2010–2014 | 5 | 28.24 | 23.82 | 11.45 | | 50.36 |
| Infants exclusively or fully breastfed at 6 weeks | 2015 | 451 | 70.58 | 68.67 | 61.37 | | 76.05 |
| Infants exclusively or fully breastfed at 3 months | 2015 | 407 | 55.98 | 57.61 | 48.99 | | 64.95 |
| Infants receiving breastmilk at 6 months | 2015 | 488 | 62.09 | 68.33 | 59.80 | | 76.21 |
| Immunisation coverage at milestone age: 8 months | Apr–Jun 2017 | 186 | 87.32 | 91.92 | 80.00 | | 95.09 |
| Immunisation coverage at milestone age: 24 months | Apr–Jun 2017 | 200 | 91.74 | 93.40 | 87.02 | | 95.32 |
| Children (4–5 years) measured as Obese at B4 School Check | 2016 | 105 | 12.79 | 8.06 | 3.95 | | 12.79 |
| Hospitalisations of 0–4 year olds for ambulatory care-sensitive conditions* | 2012–2016 | 1628 | 73.19 | 64.47 | 38.51 | | 82.57 |
| Proportion of five year old children free from dental decay | 2015 | 558 | 56.25 | 59.47 | 42.71 | | 70.02 |
| Mean number of decayed, missing or filled teeth at age 5 years | 2015 | - | 2.22 | 1.81 | 1.18 | | 3.38 |
| Hospitalisations of 1–4 year olds for dental caries | 2011–2015 | 299 | 16.72 | 10.45 | 5.51 | | 20.85 |

* includes ED cases



## 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.

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

# Terms of Reference

| Combined Statutory Committee | |
|---|---|
| **Applicable To:**<br>Whanganui District Health Board | **Authorised By:**<br>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'.