# AGENDA

# Whanganui District Health Board

Meeting date **Friday 21 February 2020**

Start 9.30 am Public session
Public excluded session

Venue Board Room
Level 4, Ward and Admin Building
100 Heads Road
Whanganui

## Embargoed until Saturday 22 February 2020

**Contact**
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Also available on website
www.wdhb.org.nz

## Distribution

### Board members

- Mr K Whelan, Board Chair
- Ms A Main, Deputy Chair
- Mr G Adams
- Mr C Anderson
- Ms T Anderson-Town
- Mrs P Baker-Hogan
- Mr Josh Chandulal-Mackay
- Ms M Ma
- Mrs J MacDonald
- Ms S Peke-Mason
- Mrs N Mackintosh, Board Secretary

### Executive Management Team

- Mr R Simpson, Chief Executive
- Ms L Adams, Director of Nursing/Chief Operating Officer
- Ms L Allsopp, General Manager Patient Safety, Quality and Innovation
- Mrs A Forsyth, Director Allied Health Scientific and Technical
- Mrs R Kui, Director Equity Māori Health
- Mr A McKinnon, General Manager Corporate
- Mr P, General Manager, Service and Business Planning

### Ministry of Health

Ms Nicola Holden

**Agendas are available online one week prior to the meeting.**

# WHANGANUI DISTRICT HEALTH BOARD
# TE POARI HAUORA O WHANGANUI

*Kaua e rangiruatia te hāpai o te hoe, e kore to tātou waka e ū ki uta.*
*Do not lift the paddle out of unison or our canoe will never reach the shore.*

**We foster an environment that places the patient and their family at the centre of everything we do - an environment which values:**

- learning and improvement
- courage
- partnering with others
- building resilience.

**We are:**

- open and honest
- respectful and empathetic
- caring and considerate
- committed to fostering meaningful relationships
- family-centred.

**He wāhi whakamana tangata whaiora, whakamana whānau! Ko te whai anō hoki i ngā waiaro:**

- ka whai matauranga
- ka whai mana
- ka toro atu te ringa
- ka whai rangatiratanga.

**Koi anei tātou:**

- ka ū ki te pono
- ka aroha ki te tangata
- ka manaaki tangata
- ko te mea nui he tangata, he tangata me ōna āhuatanga katoa
- ko te whānau te pūtake.

**Nothing about me without me, and my whānau/family**
***Ko au ko toku whānau, to toku whānau ko au***

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

# AGENDA

Held on Friday, 21 February 2020
Board Room, Level 4, Ward and Admin Building
100 Heads Road, Whanganui Hospital, Whanganui

**Commencing at 9.30am**

## BOARD PUBLIC SESSION

| | ITEM | PRESENTER | Time | Page |
|---|---|---|---|---|
| **1** | **Procedural** | | | |
| 1.1 | Karakia/reflection | | 9.30 | |
| 1.2 | Apologies | K Whelan | 9.35 | |
| 1.3 | Continuous disclosure<br>1.3.1 amendments to the register of interests<br>1.3.2 declaration of conflicts in relation items on agenda | K Whelan | 9.38 | 7 |
| 1.4 | Confirmation of minutes<br>1 November 2019 | K Whelan | 9.40 | 9 |
| 1.5 | Chairs report | K Whelan | 9.45 | |
| 1.6 | CSAC Draft Minutes – For information only | | | 17 |
| **2** | **Chief Executive report** | **R Simpson** | **9.55** | **25** |
| **3** | **Decision papers** | | | |
| 3.1 | 2020 Board and Committee Meeting Dates | R Simpson | 10.05 | 31 |
| 3.2 | Standing Orders Policy | R Simpson | 10.15 | 33 |
| 3.3 | Finance Risk & Audit Terms of Reference | A McKinnon | 10.25 | 35 |
| 3.4 | Combined Statutory Advisory Committee Terms of Reference | P Malan | 10.35 | 37 |
| **5** | **Information papers** | | | |
| 5.1 | Detailed financial report – January 2020 | A McKinnon | 10.45 | 39 |
| 5.2 | Health and safety report | L Allsopp | 10.50 | 53 |
| 5.3 | HDC Advocacy – For information only | L Allsopp | | 61 |
| **6** | **Date of next meeting** | | | |
| **7** | **Reasons to exclude the public** | **Board Chair** | **10.55** | **31** |
| **GLOSSARY** | | | | |

| **8** | **APPENDIX** | |
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| 5.2.1 | HDC Advocacy Services Report 2019 | 85 |

# Interest Register

12 February 2020

| Name | Date | Interest |
|---|---|---|
| Ken Whelan<br>*Chair* | 13 December 2019 | Crown monitor for Waikato DHB<br>Crown monitor for Counties DHB<br>Board member RDNZ (NZ)<br>Chair Eastern Bay of Plenty PHO<br>Contractor General Electric Healthcare Australasia |
| Annette Main<br>*Deputy Chair*<br>*Chair CSAC* | 18 May 2019 | A council member of UCOL |
| Talia Anderson-Town<br>*Chair FRAC* | Nil | |
| **Adams** Graham | 16 December 2016 | ▪ A member of the executive of Grey Power Wanganui Inc.<br>▪ A board member of Age Concern Wanganui Inc.<br>▪ The treasurer of NZ Council of Elders (NZCE)<br>▪ A trustee of Akoranga Education Trust, which has associations with UCOL. |
| **Anderson** Charlie | 16 December 2016 | An elected councillor on Whanganui District Council. |
| | 3 November 2017 | A board member of Summerville Disability Support Services. |
| **Baker-Hogan** Philippa | 10 March 2006 | An elected councillor on Whanganui District Council. |
| | 8 June 2007 | A partner in Hogan Osteo Plus Partnership. |
| | 24 April 2008 | Her husband is an osteopath who works with some of the hospital surgeons, on a non paid basis, on occasions hospital patients can attend the private practice, Hogan Osteo Plus, which she is a Partner at. |
| | 29 November 2013 | Chair of the Future Champions Trust, supporting promising young athletes. |
| | 7 November 2014 | A member of the Whanganui District Council District Licensing Committee. |
| | 3 March 2017<br>20 September 2019 | A trustee of Four Regions Trust.<br>A director of The New Zealand Masters Games Limited. |
| **Hylton** Stuart | 4 July 2014 | ▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society of New Zealand.<br>▪ The Whanganui District Licensing Commissioner, which is a judicial role and in that role he receives reports from the Medical Officer of Health and others. |
| | 13 November 2015 | An executive member of the Central Districts Cancer Society. |
| | 15 March 2017 | The Rangitikei District Licensing Commissioner. |
| | 2 May 2018 | ▪ The chairman of Whanganui Education Trust<br>▪ A trustee of George Bolten Trust |
| | 2 November 2018 | The District Licensing Commissioner for the Whanganui, Rangitikei and Ruapehu districts. |
| **Chandulal-Mackay** Josh | 10 December 2020 | An elected councillor on Whanganui District Council |
| **Ma** Materoa | 16 December 2020 | Board member of Emerge Aoteoroa<br>Member Matanga Mauri Ora, Committee MoH, MH&AOD<br>Board member of Science Challenge Z tipu Tea, Auckland Uni<br>CEO Te Tihi O Ruahine Whānau Ora Alliance |
| **MacDonald** Judith | 22 September 2006 | ▪ The chief executive of Whanganui Regional Primary Health Organisation<br>▪ A director, Whanganui Accident and Medical |
| | 11 April 2008 | A director of Gonville Health Centre |
| | 4 February 2011 | A director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape |
| | 27 May 2016 | The chair of the Children's Action Team |
| | 21 September 2018 | A director of Ruapehu Health Ltd |
| **Peke-Mason** Soraya | Nil | |

| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **DRAFT MINUTES**<br>Held on Friday, 1 November 2019<br>Boardroom, Level 4, Ward & Admin Block,<br>Whanganui Hospital 100 Heads Road, Whanganui |
|---|---|
| **Public Board Meeting** | **Commencing at 10.00 am** |

**Present**
Mrs Dot McKinnon, Board Chair
Mr Stuart Hylton, Deputy Chair
Mr Graham Adams, Member
Mr Charlie Anderson, Member
Mrs Philippa Baker-Hogan, Member
Mr Darren Hull, Member
Ms Jenny Duncan, Member
Mrs Judith MacDonald, Member
Ms Annette Main, Member
Dame Tariana Turia, Member

**Apologies**
Ms Maraea Bellamy, Member
Mr Russell Simpson, Chief Executive

**In attendance**
Ms Lucy Adams, Acting Chief Executive/Director of Nursingc
Mrs Nadine Mackintosh, Board Secretary
Mr Hentie Cilliers, People and Culture Manager
Mrs Rowena Kui, Director Maori Health
Mr Paul Malan, GM Business and Service Planning
Mr Andrew McKinnon, GM Corporate

**Guests**
One member of the public was present at the meeting. Other members in attendance were the staff responsible for presentation of papers to the Board.

## 1. Procedural

The Board Chair welcomed all members to the meeting, advising that no advice had been received on appointed board members at this stage and for some it may be their last meeting. J Duncan was congratulated on her appointment to deputy mayor of Whanganui District Council.

A McKinnon was welcomed to his first board meeting as GM Corporate.

### 1.1 Karakia/reflection

J MacDonald opened the meeting with a reflection on the Health Forum, outlining a key message to develop one health system not 20 systems. We need to continue to operate as a cohesive and confident board and work towards addressing the inequalities as one system in the upcoming term.

*P Baker-Hogan arrived at 10.03am*

The chair requested a moment of silence to acknowledge the recent passing of A Anderson who was a past board member.

### 1.2 Apologies

The Board resolved to **accept** an apologies from M Bellamy and R Simpson.

The board chair thanked L Adams for all the work as acting chief executive and acknowledged that the departure of B Walden, GM Corporate, noting he requested to not hold a farewell.

### 1.3 Continuous Disclosure

1.3.1 Amendments to the Interest Register

Nil

1.3.2 Declaration of conflicts in relation to business at this meeting

Nil

### 1.4 Confirmation of minutes

1.4.1 9 August 2019

The minutes of the meeting held on 9 August 2019 were accepted as a true and accurate record.

**CARRIED**

1.4.2 20 September 2019

The minutes of the meeting held on 20 September 2019 were accepted as a true and accurate record.

**CARRIED**

### 1.5 Matters Arising

The Board received the matters arising.

### 1.6 Board and Committee Chair Reports

1.6.1 Board Chair verbal report

The board chair provided a verbal update on her attendance at the 2019 Health Forum. The forum had a number of informative speakers and the sessions were well attended and well received.

Some of the key points were:

- Equity
- Wellbeing
- Person directed support
- Workforce
- Future directions

1.6.2 Combined Statutory Advisory Committee verbal report

Nil

### 1.7 Combined Statutory Advisory Committee

The board **received** the CSAC minutes for information only.

## 2. Fit for Surgery Patient Presentation

*Presenters: Rosalie Drummond, Programme Participant and Christine Taylor, Sports Whanganui*

The board chair welcomed R Drummond, a programme participant since April 2019, to the board meeting for the purpose of providing a consumer perspective briefing of the service.

R Drummond advised the board that the referral process was not well understood and further education was required to avoid disappointment. The major contributing factor for Rosalie was she did not meet the BMI threshold for surgery and was referred to the fit for surgery programme. Rosalie and Christine have worked as a team with Rosalie having achieved good weight loss, and improved mobility with an ability to walk over 1km. Rosalie has had a follow-up appointment with Orthopaedics and is awaiting confirmation of her surgical procedure.

Overall the programme outcome for patients is increased mobility and reduction of pain medication with an improved lifestyle change as they participate in a fit for life programme. The programme continues for 12 months following a procedure with formal reviews at 6 and 12 months. It was noted one of the key benefits is mobility as joint surgery does not fix the mobility.

One of the findings from the programme is that it the progress with mobility affects their ability to receive physio assistance.

The DHB made a shift two years ago to promote the wellness and welfare of the patient so that the patient will have the lifestyle and mobility functions following a joint replacement. This programme is a joint initiative and has been recognised both nationally and internationally.

GP learning and development on the programme has commenced and will be ongoing and this will assist with the understanding of patient criteria and referral process.

The board thanked Rosalie and Christine for their attendance and wished Rosalie all the best with the programme outcomes and surgery.

## 3. Chief Executive Report

The chief executive report was taken as read.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the paper entitled 'Chief Executive Report'.

b. **Note** the progress on the development of the Ministry of Health Māori Health Framework.

c. **Note** the collaborative approach being undertaken to address SH4 road closure.

d. **Note** that Whanganui DHB went live on the national bowel screening programme on 22 October 2019.

**Moved** D McKinnon **Seconded** S Hylton **CARRIED**

**Action**: Management to liaise with MidCentral in relation to the gorge closure and possible subsidy.

## 4. Decisions Papers

### 4.1 Trauma operating table replacement

The trauma operating table replacement paper was taken as read.

The key improvement factor for the new table is to provide correct traction, with the ability to hold a higher weight load than the current table.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the report 'Trauma operating table replacement'.

b. **Note** that the current trauma operating table is over 20 years old and is now out of date with current technology and needs to be replaced.

c. **Note** that $140,000 has been budgeted in the 2019/20 financial year, and $10k will be reallocated from the theatre capital budget.

d. **Note** that surgeons and nursing staff have been involved in trialling trauma operating tables and have supported this proposal.

e. **Approve** in accordance with the delegation policy, the purchase of a trauma operating table at a price of $150,464, which includes a maintenance agreement up to year 10.

**Moved** S Hylton **Seconded** J MacDonald **CARRIED**

## 5. Discussion Papers

### 5.1 DHB Elections 2019 Update

The DHB Elections 2019 Update was take as read.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the report 'DHB elections 2019 final update'.

b. **Note** that the final election result, including special votes, was received on 17 October 2019.

c. **Note** that Josh Chandulal-Mackay has been elected as a new member of the board.

d. **Note** that Ministerial appointments have not yet been advised.

e. **Note** that the new board will take office on Monday 9 December 2019.

**Moved** A Main **Seconded** J Duncan **CARRIED**

## 6. Information Papers

### 6.1 centralAlliance Update 2019

The board chair noted that we have not had the board to board attendance with MidCental DHB although there has been plenty of work continuing on across the DHBs'.

This paper provides an update on the programme of work for the 2019/20 work plan. The laboratory changes require a board endorsement and a paper will go to RAC for endorsement prior to board approval.

Board discussion ensued on the following areas:
- Prioritising governance discussions,
- Laboratory services
- A chemotherapy service based in Whanganui DHB, particularly low complexity chemo supported by a nurse practitioner.

- The chemotherapy service proposal has advanced toward an outreach clinic with telemedicine follow up appointments.
- The urology service as a single service is reliant on the WebPAS roll out.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the paper entitled centralAlliance Update – 2019/20

b. **Endorse** that the boards receive two joint governance meetings in 2020.

**Moved** D Hull **Seconded** S Hylton **CARRIED**

### 6.2 Health and Safety Update

The Health and Safety Update was taken as read.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the health and safety update.

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

c. **Note** that the overall trend for the top five injury/incident categories indicate no change over the period.

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

- Aggression injuries/incidents increased over the three year period.
- Manual handling injuries/incidents decreased slightly over the three year period.
- Infection Control injuries/incidents decreased over the three year period.
- Slip, Trip, Falls injuries/incidents increased slightly over the three year period.
- Struck by, bumped injuries/incidents decreased over the three year period.

### 6.3 Communications Unit Update

The communications unit update was taken as read.

The Board of Whanganui District Health Board

a. **Received** the paper entitled 'Communications Unit Update: April 2019 – September 2019'.

b. **Noted** the cross sectoral commitment to address and reduce the impacts of the SH4 road closure.

### 6.4 Smokefree 2025

The smokefree 2025 paper was taken as read.

The board had an in-depth discussion on vaping with concerns on the detrimental impacts for both non-smokers and smokers wanting quit.

The chair will have a discussion with chair of the tobacco steering group to develop a DHB position statement on vaping. It was suggested that Mr H McRobbie of MoH be invited to a future meeting to provide expert advice on vaping.

The Ministry is working on legislative policy and regulations for vaping and the DHB will want to ensure their views are captured as part of this process.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the paper entitled 'Smokefree 2025'.

b. **Endorsed** that the board write to the Minister and Ministry of Health that our board is against vaping and the harm that it does to our community.

c. **Note** that Whanganui DHB continues to support the Ministry of Health position on vaping.

**CARRIED**

**Action:** Draft a position statement for vaping to send to the Minister with a letter advising that our board is against vaping and harm that it has on our community.
Provide details of our funding contributions for quit smoking programmes.
Source influential youth prepared to be ambassadors for stop smoking campaigns.

### 6.5 Six month report on inter-district flows (IDFs)

We are responsible for monitoring and funding for our populations' care and IDFs report on procedures both within and outside our district.

We are beginning to look at planning for IDFs for 2020/21 in particular those areas that we have significant volumes of IDFs and what services or service components we can consider to be undertaken at our DHB.

IDFs inform a production plan and we should have a lens on it, acknowledging that as a small DHB we need to consider the viability of services for a local and regional health system.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the report 'Six-monthly report on inter-district flows'.

b. **Note** that the inter-district flows outflows and inflows for the year ending 30 June 2019 were $2,277k and $386k unfavourable to budget respectively.

c. **Note** that inter-district flows outflows continue to be higher than budget, and inflows lower than budget and combined present a risk to the forecast.

d. **Note** that mitigation strategies have been implemented to better manage the IDF volumes.

**Moved** D McKinnon **Seconded** A Main **CARRIED**

**Action**: The financial report is to separate the IDF reporting from the financial.

### 6.6 2019 WDHB Board welcome and induction amended programme

The paper was taken as read.

The Board of Whanganui District Health Board resolved to:

a. **Receive** the 2019 WDHB Board welcome and induction amended programme

b. **Note** schedule of meeting opportunities for new WDHB board members.

**Moved** P Baker-Hogan **Seconded** D McKinnon **CARRIED**

## 7. Date of next meeting

The next meetings of the Whanganui DHB Board were confirmed for:

- Combined Statutory Advisory Committee held on 22 November 2019 in the Boardroom
- Board meeting held on 13 December 2019 in the Boardroom.

## 8. Reasons to exclude the public

Whanganui District Health Board resolved to:

**Agree** that the public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table;

**Note** that the grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act, believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists for withholding under the Official Information Act 1982 (OIA), as referenced in the following table.

| Agenda item | Reason | OIA reference |
|---|---|---|
| Whanganui District Health Board minutes of meeting held on 1 November 2019 | For reasons set out in the board's agenda of 1 November 2019 | As per the board agenda of 1 November 2019 |
| Chief executive's report<br><br>Board & committee chair reports | To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations)<br><br>To protect the privacy of natural persons, including that of deceased natural persons<br><br>To avoid prejudice to measures protecting the health or safety of members of the public<br><br>To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest. | Section 9(2)(i) and 9(2)(j)<br><br>Section 9(2)(a)<br><br>Section 9(2)(c)<br><br>Section 9(2)(ba) |
| Pharmacy Moratorium<br>Insurance renewal for 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) |
| Allied Laundry AGM<br>TAS AGM | To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty | Section 9 (2) (g) (i) |

**Persons permitted to remain during the public excluded session**

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

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

**Moved** D McKinnon **Seconded** J MacDonald **CARRIED**

**The public section of the meeting concluded at 12.20pm**

# Minutes
## Public session

## Meeting of the Combined Statutory Advisory Committee

**held in the Board Room, Fourth Floor, Ward/Administration Building**
**Whanganui Hospital, 100 Heads Road, Whanganui**
**on Friday 22 November 2019, commencing at 9:35am**

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**Combined Statutory Advisory Committee members in attendance**
Mr Stuart Hylton, Committee Chair
Mr Graham Adams
Mr Charlie Anderson (QSM)
Ms Maraea Bellamy
Dr Andrew Brown
Mr Frank Bristol
Ms Jenny Duncan
Mr Darren Hull
Mrs Judith MacDonald
Mr Matthew Rayner
Ms Te Aroha McDonnell
Hon Dame Tariana Turia (DNZM)
Dr Heather Gifford

**In attendance for Whanganui District Health Board (WDHB)**
Mr Russell Simpson, Chief Executive
Mr Paul Malan, General Manager Service and Business Planning
Ms Deanne Holden, Executive Assistant to GM Service and Business Planning, (Secretariat)

**In attendance**
Ms C Hefferman, AccessAbility
Mr P Millar, Ministry of Health
Ms C Sixtus, Portfolio Manager, Service & Business Planning
Mr K O'Gorman, Business Support, Service & Business Planning
Mr A McKinnon, General Manager, Corporate,
Mr R Masaisai, Clinical Manager Therapies, Allied Health
Ms B Charuk, Portfolio Manager, Service & Business Planning
Ms E O'Leary, Project Manager, Service & Business Planning
Mr S Carey, Funding and Contracts Manager, Service & Business Planning

**Karakia/reflection**

P Malan opened the meeting with a karakia/reflection.

The Chair welcomed the following to the meeting and thanked them for their attendance:
Mr Paul Millar, Ministry of Health and Ms C Hauffman, AccessAbility

## 1 Apologies

It was resolved that apologies be accepted and sustained from the following:
L Gilsenan, D McKinnon, A Main, P Baker-Hogan.

Apologies for lateness were noted from: Dame T Turia, M Rayner, T A McDonnelle

The chair acknowledged the recent passing of committee member Annette Mains' father, Bill Main, and passed condolences on behalf the committee to the Main Whanau.

**Moved**: G Anderson **Seconded**: C Anderson

## 2 Conflict and register of interests update

2.1 Amendments to the register of interests

2.2 Declaration of conflicts in relation to business at this meeting

In reference to item 7.3 "Disability overview and update" Mr F Bristol declared that he works for the disability organisation "Balance Whanganui".

## 3 Late items

Nil

## 4 Minutes of the previous committee meeting

That the minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 18 October 2019 be **accepted** as a true and correct record with the following amendments.

Attendees: amend "Mr John Chandulal-Mackay" to "Mr Josh Chandulal-Mackay"
Item 7.3: amend "Moved: C Anderson" to read "Moved: G Adams"

**Moved**: J Duncan **Seconded**: G Adams

## 5 Matters Arising

The matters arising were accepted as complete.

A request to add the word "reference" to subject heading was noted by the secretariat.

## 6 Committee Chair's Report

The Chair acknowledged the mahi of Ms Alisa Stewart who works tirelessly behind the scenes on behalf of the WDHB. Ms Stewart recently arranged replacement of the ceremonially gavel in the Board Room.

The art committee was thanked for the work undertaken in commissioning photography as part of a DHB led community competition. The recent unveiling of winning photographs in the Whanganui Accident & Emergency and radiology corridors' was a success with an excellent attendance by the community and staff.

The Chair thanked committee members for their support over the past 12 months and noted this would be the last meeting for 2019 and of the current committee. It was noted that health issues remain an obstacle to wellbeing for many with Māori, elderly and children all continuing to have a high representation. There were however also many positives to take forward to the New Year including:

- at Government level there are a number of positive actions to come out of the Heather Simpson report
- at DHB level, the committee is continuing to challenge itself in becoming more community focused in its governance work
- our CEO is continuing to lead transformation at an operational level

**Moved**: S Hylton **Seconded**: G Adams

# 7 Whanganui DHB Annual Work Programme

## 7.1 Whanganui Alliance Leadership Team (WALT)
**Russell Simpson, Chief Executive Officer**

A verbal report was provided by R Simpson with summary of the key points from WALT below:

- The next meeting is scheduled for 2 December 2019
- Presentation to the Positive Ageing Forum was recently held at Council Chambers. Workshops are planned for next year to provide a platform for the community to advise the key challenges and barriers being experienced
- Health pathways and bowel screening are operational with initial feedback for both being positive
- Work continues on addressing after hour issues
- Mr Simpson advised he felt the past two years have been transformational and he is heartened as to where the WDHB is headed.

*T McDonnelle arrived 9.50 am – apologies for lateness*

R Simpson then updated committee on the following recent events:

- An overwhelming response had been received to the recent photography competition with over 300 submissions. The recent unveiling saw approximately 100 attendees from the community alongside WDHB staff. Mr Simpson added to the Chairs, his personal thanks to the art team.

- The recent 50th anniversary of the Porritt lecture series culminated in a lecture by Dr Jan Bone, Head Emergency physician in Christchurch at the time of the 2010-2011 earthquakes. Thanks passed to Ms L Torr and the medical management team for organising the event.

- The three yearly certification audit was recently completed. Initial feedback is excellent with auditors making specific mention that the WDHB is doing very well. Areas of note around pharmaceutical management and credentialing in particular portrayed WDHB as a standout DHB. Thanks were passed to all staff involved, with particular thanks to L Allsopp and the patient safety quality and risk team.

- The full report will be made public in due course once received and ratified by MOH.

### 7.2 Non Financial Performance Reporting
**P Malan, GM Service & Business Planning**

A paper entitled "Non financial performance reporting" was tabled by P Malan.

P Malan acknowledged the work undertaken by K O'Gorman in preparation of the report for committee.

A verbal summary of the key points were provided by S Carey, Funding & Contracts manager as below:

- Committee was asked to note that the paper tabled provides a synopsis of preliminary quarter 1 results as the quarter was not finalised when papers went to print
- A change to requirements for quarterly reporting has resulted in increased narrative which has the benefit of providing an overview to committee of ongoing conversations being held with the MOH
- The report is formatted to a "traffic light" system of green (achieved), orange (partial), red (not achieved) however the colour should not be read in isolation, instead it should be read in line with the narrative provided.
- Although progress on immunisations is classed as satisfactory it was agreed there is still a need for urgent action and prioritisation.
- It was noted that item B SS11, Faster Cancer Treatment (62 days) is not achieved. The committee would like to be kept informed of any change to this performance measure with an agreed action point below.
- It was further noted that item SS15 "Improving waiting times for colonoscopies 19/20 was reported as partially achieved. This measure to be closely monitored for likely improvement following the bowel screening programme implementation.
- ACTION: Management to provide to committee further detail relating to performance measure B SS11 Faster Cancer Treatment (62 days) 19/20 to include a report detailing scale and ethnicity breakdown.

*It was resolved that the committee:*

**Receive** the paper entitled "Non-Financial Performance Reporting"

**Note** new reporting requirements against Annual Plan and Q1 feedback

**Moved**: S Hylton **Seconded**: G Adams

### 7.3 Disability overview and update
**E O'Leary, Portfolio Lead Community Responsiveness**

A paper entitled "Disability overview and update" was tabled by E O'Leary with a verbal summary of the key points provided and shown below:

E O'Leary thanked committee for the opportunity to focus on disability and introduced P Millar, Principal Advisor for Systems Transformation with the MOH.

Ms O'Leary acknowledged committee member, L Gilsenen who prior to the meeting had provided her with the New Zealand Disability Support Network (NZDSN) 20/20 report. The report was tabled with the following action noted.

Action: secretariat to distribute to committee via email.

A definition of disability was clarified for committee as something a sector "does" not something individuals "have". Ms O'Leary explained that individuals have impairments, disability is how we as a sector can disable them due to their impairment.

Within the community there is an increasing visibility of people with impairments. The sector is being redefined with a focus on individual and whānau needs, as opposed to services being offered on the basis of cost and ease of delivery.

Whanganui regional data shows a higher than national average incidence of impairment in the local population.

Ms O'Leary introduced P Millar who addressed committee, with a summary of key points shown below:

Mr Millar provided committee with an informative overview of the areas in which the health sector is changing focus to ensure those living with impairments are not disadvantaged.

Challenges faced by those individuals and whānau living with impairment are diverse and complicated. Only 5% of the population living with impairment are supported by their own income therefore timely and relevant access to support is imperative. Those living with impairments are four times more likely to experience depression and emergency department presentations.

*Dame T Turia joined the meeting 10.15am*

Mr Millar outlined the importance of lived experience in decision making. Lived experience differs from knowledge or understanding with the benefit of listening to those with lived experience only just being realised.

The sector is being challenged to move from a focus of budget based policy design to supporting lived experience conversations. This allows officials in the sector to be challenged to alter traditional ways of thinking. It has been found when lived experience shapes a conversation the engagement and outcome for the individual and whānau better supports individual life goals being reached.

Further a change in focus to lived experience modelling will ensure those eligible for support do not become disengaged due to the system not meeting their individual need. Person directed care allows for tailored support which can provide short term intervention and stop the need for long term expensive care. Person directed support is cost efficient long term.

J McDonald commended Mr Millar on his excellent articulation of the issues and concerns.

Further discussion ensued with agreement the sector must ensure it is not shaped by resource and protocol, and that individual lead care and support is paramount.

The Chair thanked the speakers for their time and for bringing the challenges to the table for discussion.

Action: Letter of thanks for attendance and insightful presentation to be sent to Mr Millar.

*It was resolved that the Combined Statutory Advisory Committee*

**Receive** the paper entitled "Disability overview and update"

**Note** the Ministry of Health's six actions for health sector leadership

**Note** the Accessibility Charter

**Endorse** further work to develop an Accessibility Charter Action Plan, in preparation for HAI endorsement towards WDHB signing the charter

**Moved**: S Hylton **Seconded**: F Bristol

### 7.4 People and Performance Update
**Hentie Cilliers, GM People and Performance**

A paper entitled "People and Performance Update" was tabled with a verbal summary of the key points summarised below:

Following a request from committee on 18 October 2019 it was noted the report includes further detail on status of hard to fill vacancies.

A letter of offer is due to be sent in relation to the ophthalmology position with work continuing on securing an emergency consultant and other key roles.

In relation to disability awareness, the people and performance team encourage staff to declare any impairment to ensure appropriate supports are provided to staff.

G Adams noted it was encouraging to see a drop in staff turnover.

A question was raised regarding the availability of nurses for specialised areas such as Te Awhina. A response was provided that although there is a national nursing shortage, there is no such concern for the WDHB at present.

Further, it was advised that most if not all nurses studying locally will usually be offered a position at intake. A review is currently being undertaken regarding the feasibility of increasing yearly intakes from 1 to 2 per year. It is hoped that the increased intake will be in place for 2020.

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

**Receive** the paper entitled "People and performance update, November 2019"

**Note** WDHB has a low staff turnover percentage compared with other DHBs

**Note** from an employment perspective the WDHB is an equal employment opportunity employer and does not discriminate against anyone with a disability

**Note** there were no notifiable injuries or events notified to WorkSafe New Zealand in October

**Moved**: M Bellany **Seconded**: H Gifford

## 8 Reference and Information

1 New Zealand Disability Support Network (NZDSN) 20/20 report

## 9 Date of next meeting

Friday 21 February 2020 from 9:30am in the Board Room, Whanganui District Health Board, 100 Heads Road, Whanganui.

## 14 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.

**Moved**: S Hylton **Seconded**: G Adams

| Agenda item | Reason | OIA reference |
|---|---|---|
| Combined Statutory Advisory Committee minutes of the meeting held on 22 November 2019 (public-excluded session) | For the reasons set out in the board's agenda of 22 November 2019 | As per the board's agenda of 22 November 2019 |
| Emerging issues and alerts | To protect the privacy of natural persons, including that of deceased natural persons<br><br>To avoid prejudice to measures protecting the health or safety of members of the public<br><br>To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest | Section 9(2)(a)<br><br>Section 9(2)(c)<br><br>Section 9(2)(ba) |
| Multi-employer collective agreement or negotiations | 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) |
| Staff matters | To protect the privacy of natural persons, including that of deceased natural persons<br><br>To avoid prejudice to measures protecting the health or safety of members of the public<br><br>To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest | Section 9(2)(a)<br><br>Section 9(2)(c)<br><br>Section 9(2)(ba) |
| Adverse events | To protect the privacy of natural persons, including that of deceased natural persons<br><br>To avoid prejudice to measures protecting the health or safety of members of the public<br><br>To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest | Section 9(2)(a)<br><br>Section 9(2)(c)<br><br>Section 9(2)(ba) |

**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 and senior managers and clinicians present | Management and operational information about Whanganui District Health Board | Management and operational reporting and advice to the board |
| Board secretary | Minute taking, procedural and legal advice and information | Recording minutes of board meetings, advice and information as requested by the board |

The public session of the meeting ended at 11.20am

**Adopted this** day of 2020

.....
Chair

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

**Recommendations**

Management recommend that the Board:

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

b. **Notes** the capital investments for both Waimarino health services and a new chemotherapy infusion unit.

c. **Notes** the recent certification audit undertaken by the Designated Audit Agency (DAA)

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

## 1. Capital Investment

### 1.1 Waimarino Health Services

Waimarino's health services will get a $2 million boost as part of the Government's $300 million capital investment in district health boards, announced by Minister of Health David Clark.

The money is for a collaborative project involving Whanganui DHB, Healthy Families and Ruapehu Whanau Transformational Programme to support community wellness initiatives. Whanganui District Health Board was delighted to have this project approved as it would provide great benefit to the community and were in keeping with the DHB's vision of 'Thriving Communities - He Hapori Ora".

A community wellness centre, where all social and health services could be co-located for easy access and more effective services was a dream identified through engaging with families across southern Ruapehu. To have one connected service with all the staff working as one will really improve efficiency but, more importantly, the quality of service the community will receive.

This is a testament to the efforts of the local community in realising the aspirations of the Ruapehu Whanau Transformation plan.

This shows the value of co-designing with the community in creating solutions for the future wellbeing of people. It is also an important step in improving rural health services. Ruapehu mayor Don Cameron welcomed the investment.

The most pivotal part of the research included community workshops with local Ruapehu people aged nine years up to 75-plus years, inviting conversation on what was working now with our health system, what wasn't working for them and what would they want to see in a wellness centre. 'Alternative wellbeing practices' and 'co-location' were the strongest messages received. Lego visualisation was used to visualise their dreams of what a wellness centre could look like. Interestingly, all the groups included alternative services - rongoa Maori, alternative health/wellbeing practices. The community want easier access to both western medical science and other science and knowledge systems and practices to lead their own wellbeing.

### 1.2 New chemotherapy and infusion unit

The announcement of a new chemotherapy and infusion unit for Whanganui Hospital will mean no more trips to Palmerston North for some cancer patients. Health minister David Clark included $800,000 funding for the unit when he revealed $300 million of capital investment in New Zealand's district health boards.

Just how many Whanganui cancer patients will benefit is yet to be decided as the new unit is still in the concept stage.

In making the announcement last week, Mr Clark said regional services and improving access had been identified as priority areas for the government with the aim being "a more equitable health system which delivers for all New Zealanders".

Currently, Whanganui patients have about 780 chemotherapy treatments a year undertaken by MidCentral DHB at Palmerston North Hospital. The proposal was closely aligned with the theme "care closer to home" as it would reduce travel for patients, their whānau and DHB staff.

Chemotherapy closer to home will reduce time spent away from home and family, and increase independence for patients. However, for clinical reasons, not all Whanganui patients will be suitable for treatment at the new unit.

As the project develops, one decision will be whether to have a purpose-built unit or to revamp an existing building. Initially, MidCentral staff will be used at the unit as Whanganui staff get trained up.

Both projects will provide great benefit to the community and are in keeping with the DHB's vision of 'Thriving Communities -- *He Hāpori Ora'* and reflect the DHB's commitment to achieving equity in health outcomes for Māori.

## 2. Summary financial results to 31 January 2020

The January 2020 monthly financial result is favourable to budget by $154k; and the year-to-date result is unfavourable to budget by $683k.

The detailed financial report for January 2020 is included as an *Information item*.

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 Jan 2020 ($000s)**
**CONSOLIDATED**

| | Month | | | | Year to Date | | | | Annual | Annual |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Var | | Actual | Budget | Var | | Budget 2019-20 | Actual 2018-19 |
| Provider division | (1,588) | (1,931) | 343 | F | (5,872) | (6,352) | 480 | F | (9,348) | (9,430) |
| Corporate | (16) | (22) | 6 | F | (334) | (511) | 177 | F | (622) | 970 |
| **Provider & Corporate** | **(1,604)** | **(1,953)** | **349** | **F** | **(6,206)** | **(6,863)** | **657** | **F** | **(9,970)** | **(8,460)** |
| Governance | (59) | (72) | 13 | F | (518) | (570) | 52 | F | (946) | (703) |
| **Governance** | **(59)** | **(72)** | **13** | **F** | **(518)** | **(570)** | **52** | **F** | **(946)** | **(703)** |
| DHB Funder division (exl IDF net flow) | 3,308 | 3,356 | (48) | U | 19,807 | 19,550 | 257 | F | 33,681 | 36,959 |
| **Funder division (exl IDF net flow)** | **3,308** | **3,356** | **(48)** | **U** | **19,807** | **19,550** | **257** | **F** | **33,681** | **36,959** |
| **Net Surplus/ (Deficit) before IDF net flow** | **1,645** | **1,331** | **314** | **F** | **13,083** | **12,117** | **966** | **F** | **22,765** | **27,796** |
| Inter-district net flow | (3,107) | (2,947) | (160) | U | (22,277) | (20,628) | (1,649) | U | (35,362) | (36,794) |
| **Inter-district net flow** | **(3,107)** | **(2,947)** | **(160)** | **U** | **(22,277)** | **(20,628)** | **(1,649)** | **U** | **(35,362)** | **(36,794)** |
| **Net Surplus/ (Deficit) after IDF net Flow** | **(1,462)** | **(1,616)** | **154** | **F** | **(9,194)** | **(8,511)** | **(683)** | **U** | **(12,597)** | **(8,998)** |
| NoS Impairment | - | - | - | | - | - | - | | - | (1,048) |
| Holiday pay provision | - | - | - | | - | - | - | | - | (3,608) |
| **One-off** | **-** | **-** | **-** | | **-** | **-** | **-** | | **-** | **(4,656)** |
| **Net Surplus / (Deficit)** | **(1,462)** | **(1,616)** | **154** | **F** | **(9,194)** | **(8,511)** | **(683)** | **U** | **(12,597)** | **(13,654)** |

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

## 2.1 Explanation of key variances contributing to the $154k positive impact for January 2020

**Provider is $343k favourable to budget** due to favourable personnel costs, lower clinical supplies expenditure and lower theatre output. Overall planned orthopaedic volumes are 78.1% of target and unplanned volumes 96.9% to target. There was also an increase in pharmaceutical revenue (internally offset by unfavourable funder cost) and a lower depreciation cost. These were partially offset by increased medical locum costs and outsourced clinical service expenditure.

**Corporate is $6k favourable to budget** due to lower personnel costs (due to vacancies not filled) and lower depreciation and interest. These costs were partly offset by higher building maintenance costs.

**Governance $13k favourable to budget** due to lower personnel costs and other operating expenses.

**Funder result (excluding IDFs) was $48k unfavourable to budget** before IDF net flow – mainly due to an increase in pharmaceutical and health of older people costs. These were partly offset by lower costs in mental health and public health services.

**Inter-district flows were $160k unfavourable to budget** mainly due to Capital and Coast DHB and MidCentral DHB inpatient services.

### 2.2 Year-to-date result compared to budget

The January 2020 year-to-date result is unfavourable to budget by $683k. This was mainly due to higher than expected inter-district outflows.

**Provider $480k favourable to budget** due to lower clinical supplies expenditure related to lower theatre output (orthopaedics overall volume is 196 CWD lower than planned, with planned volumes at 72.9% of target and unplanned volumes $103.7% of target). There has been an increase in pharmaceutical revenue (internally offset by unfavourable funder cost). These were partially offset by higher nursing personnel costs and medical personnel costs (net of locum costs), as well as an increase in outsourced clinical service costs related to ophthalmology and radiology services.

**Corporate $177k favourable to budget** due to lower personnel costs (vacancies not filled), increases in other income and a reduction in building insurance costs. These are partially offset by higher building maintenance costs.

**Governance $52k favourable to budget** due to lower personnel costs and other operating expenses.

**Funder (excluding IDFs) $257k favourable to budget** due to health of older people service (increased revenue from prior year wash up and lower costs) and prior pay equity funding.

**Inter-district flows $1,649k unfavourable to budget** mainly due to Capital and Coast DHB variance of $1,245k (239 CWD higher than budget). This increased volume relates to high acute demand for cardiothoracic, vascular surgery and respiratory inpatient service (240 CWD relates to 11 patients who have greater than 15 CWD). MidCentral DHB variance of $223k relates to increased acute demand for haematology, maternity inpatients and elective demand for the urology inpatient service. Service changes and reduction in inter-district outflows $126k and inter-district inflows for various DHBs $55k.

## 3. Novel coronavirus (COVID-19)

In January 2020, Chinese authorities confirmed a new type of coronavirus, known as COVID-19 (formerly known as 2019-nCoV). The Ministry of Health is closely monitoring the situation and following guidance from the World Health Organization. The likelihood of an imported case in New Zealand is high, however the likelihood of a widespread outbreak remains low.

There are no confirmed cases of COVID-19 in New Zealand to date but the likelihood of importing a case is high. The risk of an ongoing outbreak in New Zealand remains low, but the Ministry of Health is monitoring the situation closely. If any public health measures are needed for this virus, advice will be released.

## 4. Certification Audit

The Designated Audit Agency or DAA Group visited Whanganui District Health Board (WDHB) 19-21 November 2019.The agency acts on behalf of the New Zealand Ministry of Health. The auditors are fully trained and qualified healthcare assessors. This certification process ensure safe, appropriate care is occurring in each healthcare facility as well as adherence to the New Zealand healthcare standards.

The Ministry of Health audit begins with each healthcare standard being documented, by the facility, on how this standard is met. The standards are NZS 8134:2008 Health and Disability Services Standards including NZS 8134.1.2008 Health and Disability Services (Core) Standards, NZS 8134.2.2008 Health and Disability Services (Restraint Minimization and Safe Practice) Standards, NZS 8134.3.2008 Health and Disability Standard Services (Infection Prevention and Control) Standards.

Documented evidence on how we meet the standards is supplied to the DAA Group prior to their visit. The auditors then follow system tracers to ensure that the standards are being followed throughout the organisation. Staff, patients, families and consumers are interviewed in the process.

At the end of each systems tracer a brief overview is given to DHB management. On the final day of the audit a draft report is presented to the organisation. The final report will be available in approximately three months, once peer reviewed and the Ministry of Health approval is gained.

This year the organization received 14 corrective actions in the draft report. Ten of these corrective actions were deemed low level and 4 were deemed moderate level. These corrective actions allow for ongoing quality improvement at WDHB.

Areas of excellence acknowledged included, Stanford house, medical credentialing and medicine management.

This is an excellent result, and highlights the ongoing quality of work that is achieved at WDHB.

## 5. National Bowel Screening Programme

Whanganui DHB commenced with the National Bowel Screening Programme on Tuesday 22nd October. Following commencement of the programme, the National Coordination Centre for bowel screening has started the process of sending invitations and test kits to eligible people aged 60-74 years. The invitation strategy is based on birthdays, with people born on an even date (i.e. 2nd, 4th, 6th etc. of the month) being invited in the first year of the programme and people born on an odd date (i.e. 1st 3rd 5th etc. of a month) being invited in the second year. People aged 60-74 years who are in the priority population group for screening (i.e. Māori or Pacific Island ethnicity/people who reside in a high deprivation area) are eligible to be invited to participate at any time, regardless of when their birthday is.

Data from the Bowel Screening Register shows that in the six weeks since commencement, a total of 952 people have been sent test kits. Of those who have been sent kits:

- 15 people have had a positive test result, meaning they will be referred to Whanganui DHB for bowel screening colonoscopy
- 181 people have had a negative result, meaning no further investigation is required at this time and they will be invited to participate again in two years' time if still eligible
- 9 people have had a spoilt kit, meaning their kit could not be tested by the laboratory. This is usually because they have not labelled their sample correctly, have not completed the consent form or their test was not received by the laboratory within seven days, as required. Replacement kits are sent to all people who have spoilt kits, with follow-up phone-calls being made to priority population groups, via the National Coordination Centre, to clarify the reason the previous kit was spoilt, to reduce the chance of this occurring again
- 747 have not yet completed their kits

A breakdown of screening status by ethnicity is shown below:

| Screening Status | Māori | Pacific | Asian | Other | Total |
|---|---|---|---|---|---|
| Abnormal | 2 | | | 13 | 15 |
| Normal | 32 | 1 | 2 | 146 | 181 |
| Spoilt | 1 | | | 8 | 9 |
| Not Completed | 182 | 10 | 19 | 536 | 747 |
| **Grand Total** | **217** | **11** | **21** | **703** | **952** |

The achievement of equity for people of Māori and Pacific Island ethnicity is a priority for bowel screening at Whanganui DHB. The following local initiatives have been implemented to support equity for these populations:

- Whanganui DHB is seeking approval from the Ministry of Health to extend the bowel screening age range for Māori to include ages 50-59 years.
- A bowel screening equity working group, consisting of kaimahi from all five kaupapa Māori health services, Whanganui Regional Health Network, Whanganui Cancer Society and WDHB health promotion team has been established. The group meets regularly to discuss operational strategy for promoting bowel screening and engaging Māori and Pacific Island populations in the programme.
- Lists of Māori participants who have been sent test kits but have not completed them have been distributed to five kaupapa Māori Health Services, for early follow-up, to confirm receipt of the test, answer any questions and encourage participation.
- Māori and Pacific Island participants, who have not completed their kits following the active outreach services provided by the National Coordination Centre, will be referred to kaupapa Māori Health Services and the Whanganui Regional Health Network Manaaki Te Whānau team for further local outreach.
- We are encouraging General Practice teams to submit requests for bowel screening kits for all Māori and Pacific Island patients, when they present for appointments. Requests for test kits can be submitted electronically via the practice's "Patient Dashboard" system in their Patient Management System. Since commencement of the programme, 125 requests have been submitted from General Practice Teams. 28 patients have completed their test kits since receiving them, 25 of which were of Māori ethnicity.
- The project team are working with data analysts to develop a bowel screening equity report that shows participation rates by ethnicity, and monitors volumes of kits requested by General Practice teams, along with request outcomes and follow-up activity. Reports will be made available to General Practice teams, so that they are aware of equity status within their own practice, and can take action if required.
- The project team are working with primary care representatives to implement a process whereby all Māori and Pacific Island patients are sent letters advising them about the bowel screening programme and inviting them to contact their practice to arrange for a test kit to be sent, if they would like to do so.

| | |
|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Decision paper** |
| | **Item 3.1** |
| **Author** | Nadine Mackintosh, Board Secretary |
| **Endorsed by** | Russell Simpson, Chief Executive |
| **Subject** | **2020 Board and Committee Meeting Dates** |

**Recommendations**

It is recommend that the board

a. **Receive** the paper '2020 Board meeting dates'
b. **Note** the proposed meeting dates have been aligned to the timelines for approving financial statements and production of key ministerial reporting.
c. **Approve** the 2020 board and committee meeting dates

## 1 Purpose

This report seeks the board's support of the 2020 meeting schedule for Board and it's Committees.

## 2 Summary

The Board's meeting schedule is set annually and is done on a calendar year basis. Management has reviewed the meeting calendar and proposed dates that align with timelines for approving financial statements and production of key ministerial reporting.

Members affirmed Friday's as being the preferred day for Whanganui DHB meetings, and supported the dates circulated via email, which some minor adjustments which are addressed in this paper.

It is recognised that often reports seeking a Board decision need to first receive committee endorsement. So that this can occur within the meeting cycle, it is proposed that the same report would be submitted to the committee and the Board, and that the committee chair would provide a verbal report to the Board outlining the committee findings.

Key approval dates associated with the annual planning process can be accommodated within the meeting calendar.

A copy of the proposed meeting calendar is set out overleaf.

## 3 Proposed Meeting Schedule

| 2020 MEETING SCHEDULE FOR WDHB BOARD & COMMITTEES | | | | | |
|---|---|---|---|---|---|
| **Meeting**<br><br>**Time** | **CSAC**<br><br>**9am-1pm** | **FRAC**<br><br>**1pm-4pm** | **Board**<br><br>**9am-1pm** | **Joint Boards WDHB / HAI**<br><br>**1pm – 3pm** | |
| **Date of meeting** | | | **21 February** | **21 February** | |
| Deadline for reports | | | 7 February | 7 February | |
| Reporting period | | | Dec 19/Jan 20 | Dec 19/Jan 20 | |
| **Date of meeting** | **13 March** | | **20 March** | | |
| Deadline for reports | 28 February | | 6 March | | |
| Reporting period | 31 Dec Qtr | | Board Planning | | |
| **Date of meeting** | | **17 April** | | **24 April** | |
| Deadline for reports | | 8 April | | 10 April | |
| Reporting period | | Feb/Mar 20 | | MoU review | |
| **Date of meeting** | **15 May** | | | | |
| Deadline for reports | 1 May | | | | |
| Reporting period | 31 March Qtr | | | | |
| **Date of meeting** | | **19 June** | **5 June** | | |
| Deadline for reports | | 5 June | 22 May | | |
| Reporting period | | May financials | April financials | | |
| **Date of meeting** | | | **24 July** | **24 July** | |
| Deadline for reports | | | 10 July | 10 July | |
| Reporting period | | | Budget/YE | Budget/YE | |
| **Date of meeting** | **14 August** | **14 August** | | | |
| Deadline for reports | 31 July | 31 July | | | |
| Reporting period | 30 June Qtr | 19/20 YE/Jul 20 | | | |
| **Date of meeting** | | **18 September** | **18 September** | | |
| Deadline for reports | | 4 September | 4 September | | |
| Reporting period | | August 20 | Annual Report | | |
| **Date of meeting** | **9 October** | | | | |
| | Annual Plan Workshop Day | | | | |
| **Date of meeting** | **13 November** | **13 November** | **27 November** | | |
| Deadline for reports | 30 October | 30 October | 13 November | | |
| Reporting period | 30 Sept Qtr | September | October | | |

Whanganui DHB have received advice from MidCentral that the next central alliance meeting (for services with MidCentral DHB) has been proposed for March/April.

| | |
|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Decision Paper** |
| | **Item No. 3.2** |
| **Author** | Nadine Mackintosh, Board Secretary |
| **Endorsed by** | Russell Simpson, Chief Executive |
| **Subject** | **Standing Orders Policy** |

**Recommendations**

That the Whanganui District Health Board:

a. **Receive** the paper titled Standing Orders
b. **Adopts** the standing orders policy as reviewed
c. **Agrees** the standing orders policy will be next reviewed at the commencement of each board term.

**Appendix 3.2.1 –** Standing Orders Policy

## 1 Purpose

The purpose of this item is to obtain the Board's approval of the Standing Orders

## 2 Summary

This policy is reviewed at the commencement of each board term, so was last reviewed by the board in December 2017.

The Standing Orders Policy outlines how the district health board's governing bodies will conduct the business of the board.

## 3 Key Changes

### 3.1 Resolutions

The policy has been reviewed and only one minor change was suggested, to receive a mover and seconder for decisions by the board.

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|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Decision paper** |
| | **Item 3.3** |
| **Author** | Margaret Bell, FRAC Secretariat |
| **Endorsed by** | Andrew McKinnon, General Manager Corporate |
| **Subject** | **Review of Finance, Risk and Audit Committee's Terms of Reference** |

**Recommendations**

That the board:

a. **Receive** the paper entitled 'Review of Risk and Audit Committee's Terms of Reference'.

b. **Note** that the terms of reference are due to be reviewed and approved by the board following triennial elections.

c. **Approve** the revised terms of reference (Appendix one).

**Appendix 3.3.1** Committee's Terms of Reference (WDHB-8001 v7) – showing tracked changes

## 1 Purpose

To seek approval of the revised Risk and Audit Committee's (Finance, Risk and Audit Committee) terms of reference.

## 2 Background

The Committee's terms of reference are reviewed every three years, following the board elections.

At its meeting on 3 February 2017, the board agreed to review the Risk and Audit Committee's terms of reference in January/February 2020.

## 3 Amendments to existing document

A copy of the current terms of reference for the Committee, including tracked changes for amendments, is included as **Appendix one.** A summary of the proposed amendments follows.

| Proposed amendment | Reason |
|---|---|
| Change the name of the committee to Finance, Risk and Audit Committee | The current terms of reference already state that the committee's purpose, objectives and specific activities include financial risk.<br>The committee does already review financial risks, so this is simply adding the word 'Finance' into the committee's name throughout the document to clarify its role. |
| Item 2 – Membership<br>Two sentences have been removed from the first paragraph and the subheading 'Term of office' brought forward in the document. | This section talks about the period of membership for board members terminating no later than four months after the end of the term of the board that appointed them. It has often caused confusion, and the 'Term of office' section was added in 2017 to clarify the process. However, at |

| Proposed amendment | Reason |
|---|---|
| Reference to remuneration changed to the Cabinet Fees Framework | that time, we forgot to remove the earlier references.<br><br>By referring to the Cabinet Fees Framework, it will be possible to review the fees at any time – without also needing the board to approve a revised version of the committee's terms of reference or to approve a revision of the Board Manual. |
| Item 5 – Attendance at meetings<br>Added that all meetings of the committee are public excluded. | This has been understood, but not actually stated in the terms of reference. The standard wording used by other DHBs has been added. |
| Item 7 – Functions<br>Streamlined based on a recent update of the terms of reference for MidCentral DHB's Finance, Risk and Audit Committee | This captures the work and functions of the committee, but does not include specific detail of the committee's activities and objectives. It makes it easier to read and understand. |

| | |
|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Decision Paper** |
| | **Item No. 3.4** |
| **Author** | Paul Malan, GM Strategy, Commissioning & Population Health |
| **Subject** | **Combined Statutory Advisory Committee, Terms of Reference** |

**Equity consideration**

In accordance with the principle of active participation, the partnership with Hauora a Iwi is being strengthened in the membership appointment process.

**Recommendations**

Management recommend that the Whanganui District Health Board:

a. **Receive** the paper titled Combined Statutory Advisory Committee, Terms of Reference
b. **Note** the membership make-up and appointment process has been changed to reflect our commitment to partnership
c. **Note** the change to the anticipated number of CSAC meetings in a year
d. **Endorse** the updated Terms of Reference

**Appendix 3.4.1 -** Draft TOR – Combined Statutory Committee February 2020 v2.0

## 1 Purpose

The purpose of this item is to obtain the Board's endorsement of the updated Terms of Reference for the Combined Statutory Advisory Committee.

## 2 Summary

The New Zealand Public Health and Disability Act (2000) requires each District Health Board to establish three advisory committees to the board. These are: A community and public health advisory committee; a disability support advisory committee; and a hospital advisory committee. In 2017 all the advisory committees were amalgamated into the Combined Statutory Advisory Committee (CSAC).

A Terms of Reference was approved on 3 February 2017, following board elections, with a scheduled review in February 2020.

The draft updated Terms of Reference is attached for endorsement by the Board.

## 3 Key Changes

### 3.1 Membership make up and process for appointment

Changes have been made in accordance with our pro-equity agenda, aiming to ensure a strengthened partnership approach with Hauora a Iwi in the composition and process for appointments. See section 4. membership and procedure.

### 3.2 Frequency of meetings

Changes have been made to the frequency of meetings anticipated and confirms that members are expected to take part in any annual plan workshops. The frequency of "at least four" aligns with the quarterly reporting process so that monitoring of quarterly progress against plan is deliberated by the committee with recommendations to the board. The board or the committee chair can elect to have more frequent meetings.

| | |
|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Information paper** |
| | **Item 4.1** |

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

### Recommendations

That the Whanganui District Health Board:

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

2 **Note** the January 2020 monthly result of a $1,492k deficit is favourable to budget by $154k.

3 **Note** the year-to-date result of a $9,194k deficit is unfavourable to budget by $683k.

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 Jan 2020 ($000s)**
**CONSOLIDATED**

| | Month | | | | Year to Date | | | | Annual | Annual |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Var | | Actual | Budget | Var | | Budget 2019-20 | Actual 2018-19 |
| Provider division | (1,588) | (1,931) | 343 | F | (5,872) | (6,352) | 480 | F | (9,348) | (9,430) |
| Corporate | (16) | (22) | 6 | F | (334) | (511) | 177 | F | (622) | 970 |
| **Provider & Corporate** | **(1,604)** | **(1,953)** | **349** | **F** | **(6,206)** | **(6,863)** | **657** | **F** | **(9,970)** | **(8,460)** |
| Governance | (59) | (72) | 13 | F | (518) | (570) | 52 | F | (946) | (703) |
| **Governance** | **(59)** | **(72)** | **13** | **F** | **(518)** | **(570)** | **52** | **F** | **(946)** | **(703)** |
| DHB Funder division (exl IDF net flow) | 3,308 | 3,356 | (48) | U | 19,807 | 19,550 | 257 | F | 33,681 | 36,959 |
| **Funder division (exl IDF net flow)** | **3,308** | **3,356** | **(48)** | **U** | **19,807** | **19,550** | **257** | **F** | **33,681** | **36,959** |
| **Net Surplus/ (Deficit) before IDF net flow** | **1,645** | **1,331** | **314** | **F** | **13,083** | **12,117** | **966** | **F** | **22,765** | **27,796** |
| Inter-district net flow | (3,107) | (2,947) | (160) | U | (22,277) | (20,628) | (1,649) | U | (35,362) | (36,794) |
| **Inter-district net flow** | **(3,107)** | **(2,947)** | **(160)** | **U** | **(22,277)** | **(20,628)** | **(1,649)** | **U** | **(35,362)** | **(36,794)** |
| **Net Surplus/ (Deficit) after IDF net Flow** | **(1,462)** | **(1,616)** | **154** | **F** | **(9,194)** | **(8,511)** | **(683)** | **U** | **(12,597)** | **(8,998)** |
| NoSImpairment | - | - | - | | - | - | - | | - | (1,048) |
| Holiday pay provision | - | - | - | | - | - | - | | - | (3,608) |
| **One-off** | **-** | **-** | **-** | | **-** | **-** | **-** | | **-** | **(4,656)** |
| **Net Surplus / (Deficit)** | **(1,462)** | **(1,616)** | **154** | **F** | **(9,194)** | **(8,511)** | **(683)** | **U** | **(12,597)** | **(13,654)** |

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

### Overview

**Result for the month of January 2020 was favourable to budget by $154k**

This was mainly due to provider, corporate and governance; offset by unfavourable inter-district outflows.

- Provider $343k favourable to budget due to favourable personnel costs, lower clinical supplies expenditure, lower theatre output (planned orthopaedics volumes 78.1% and unplanned volumes 96.9% to target), increased pharmaceutical revenue (internal offset by unfavourable funder cost) and depreciation costs. These were partially offset by medical locums and outsourced clinical services.
- Corporate $6k favourable to budget due to lower personnel costs (vacancies), depreciation and interest; partly offset by higher building maintenance costs.
- Governance $13k favourable to budget due to lower personnel costs and other operating expenses.

- Funder result (excluding IDFs) $48k unfavourable before IDF net flow, mainly due to pharmaceuticals and health of older people costs. These were partly offset by mental health and public health services.
- Inter-district flows $160k unfavourable to budget mainly due to Capital and Coast DHB and MidCentral DHB inpatient services.

**Year-to-date January 2020 result was unfavourable to budget by $683k**

This was mainly due to higher than expected inter-district outflows.

- Provider $480k favourable to budget due to lower clinical supplies expenditure related to lower theatre output (orthopaedics overall volume 196 CWD lower than planned; planned volumes 72.9% and unplanned volumes $103.7% to target) and increased pharmaceutical revenue (internal offset by unfavourable funder cost). These were partially offset by higher nursing personnel costs and medical personnel costs (net of locum costs) and outsourced clinical service costs related to the ophthalmology and radiology services.
- Corporate $177k favourable to budget due to lower personnel costs (vacancies), increases in other income and a reduction in building insurance costs; partially offset by higher building maintenance costs.
- Governance $52k favourable to budget due to lower personnel costs and other operating expenses.
- Funder (excluding IDFs) $257k favourable to budget due to health of older people service and prior pay equity funding.
- Inter-district flows $1,649k unfavourable to budget mainly due to Capital and Coast DHB variance of $1,245k (239 CWD higher than budget) related to high acute demand for cardiothoracic, vascular surgery and respiratory inpatient services (240 CWD relates to 11 patients who have greater than 15 CWD). MidCentral DHB variance of $223k related to acute demand for haematology, maternity inpatients and elective demand for the urology inpatient service; service changes and reduction in inter-district outflows $126k and inter-district inflows for various DHBs $55k.

## Funder division financial performance

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 Jan 2020 ($000s)**
**FUNDER DIVISION**

| | Month | | | | Year to Date | | | | Annual | Annual |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | Budget 2019-20 | Actual 2018-19 |
| Personal Health | 2,994 | 3,026 | (32) | U | 16,609 | 17,247 | (638) | U | 29,525 | 31,809 |
| Disability Support | (10) | 95 | (105) | U | 1,562 | 794 | 768 | F | 1,599 | 2,450 |
| Public Health | 47 | - | 47 | F | 18 | - | 18 | F | - | 134 |
| Maori Services | 7 | 7 | - | F | (33) | (34) | 1 | F | - | 59 |
| Other | 9 | 2 | 7 | F | 83 | 53 | 30 | F | 53 | 315 |
| Mental Health | 119 | 116 | 3 | F | 796 | 784 | 12 | F | 1,290 | 874 |
| Funding Admin | 142 | 110 | 32 | F | 772 | 706 | 66 | F | 1,214 | 1,318 |
| **Net Surplus / (Deficit) before IDF net flow** | **3,308** | **3,356** | **(48)** | **U** | **19,807** | **19,550** | **257** | **F** | **33,681** | **36,959** |
| **Inter-district net flow** | (3,107) | (2,947) | (160) | U | (22,277) | (20,628) | (1,649) | U | (35,362) | (36,794) |
| **Net Surplus / (Deficit) after IDF net flow** | **201** | **409** | **(208)** | **U** | **(2,470)** | **(1,078)** | **(1,392)** | **U** | **(1,681)** | **165** |

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 Jan 2020 ($000s)**
**FUNDER DIVISION**

| | Month | | | | Year to Date | | | | Annual | Annual |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | Budget 2019-20 | Actual 2018-19 |
| **REVENUE** | | | | | | | | | | |
| Government and Crown agency | 21,461 | 21,318 | 143 | F | 149,597 | 149,322 | 275 | F | 255,914 | 245,537 |
| Other Income Revenue | 9 | 2 | 7 | F | 83 | 53 | 30 | F | 53 | 315 |
| **Total Revenue** | **21,470** | **21,320** | **150** | **F** | **149,680** | **149,375** | **305** | **F** | **255,967** | **245,852** |
| **EXPENDITURE** | | | | | | | | | | |
| Personal Health | 8,691 | 8,519 | (172) | U | 63,227 | 62,558 | (669) | U | 107,033 | 98,923 |
| Disability Support | 162 | 162 | - | F | 1,135 | 1,135 | - | F | 1,945 | 3,214 |
| Mental Health | 1,567 | 1,567 | - | F | 10,970 | 10,970 | - | F | 18,805 | 18,367 |
| Public Health | 11 | 51 | 40 | F | 78 | 236 | 158 | F | 489 | 166 |
| Maori Services | 9 | 9 | - | F | 66 | 66 | - | F | 113 | 110 |
| **Total own provider expenditure** | **10,440** | **10,308** | **(132)** | **U** | **75,476** | **74,965** | **(511)** | **U** | **128,385** | **120,780** |
| Personal Health | 3,862 | 3,837 | (25) | U | 28,224 | 28,132 | (92) | U | 48,363 | 45,020 |
| Disability Support | 2,739 | 2,623 | (116) | U | 17,656 | 18,229 | 573 | F | 31,013 | 29,118 |
| Mental Health | 748 | 750 | 2 | F | 5,327 | 5,227 | (100) | U | 8,978 | 8,882 |
| Public Health | 41 | 82 | 41 | F | 560 | 575 | 15 | F | 986 | 855 |
| Maori Services | 134 | 134 | - | F | 1,022 | 1,023 | 1 | F | 1,695 | 1,595 |
| **Total Other provider expenditure** | **7,524** | **7,426** | **(98)** | **U** | **52,789** | **53,186** | **397** | **F** | **91,035** | **85,470** |
| Governance | 198 | 230 | 32 | F | 1,608 | 1,674 | 66 | F | 2,866 | 2,643 |
| **Total Expenditure** | **18,162** | **17,964** | **(198)** | **U** | **129,873** | **129,825** | **(48)** | **U** | **222,286** | **208,893** |
| **Net Surplus / (Deficit) before IDF net flow** | **3,308** | **3,356** | **(48)** | **U** | **19,807** | **19,550** | **257** | **F** | **33,681** | **36,959** |
| Inter-district Inflow | 709 | 661 | 48 | F | 4,569 | 4,625 | (56) | U | 7,928 | 6,984 |
| Inter-district Outflow | (3,816) | (3,608) | (208) | U | (26,846) | (25,253) | (1,593) | U | (43,290) | (43,778) |
| **IDF new flow** | **(3,107)** | **(2,947)** | **(160)** | **U** | **(22,277)** | **(20,628)** | **(1,649)** | **U** | **(35,362)** | **(36,794)** |
| **Net Surplus / (Deficit) after IDF net flow** | **201** | **409** | **(208)** | **U** | **(2,470)** | **(1,078)** | **(1,392)** | **U** | **(1,681)** | **165** |

| **Comments on results** | **Negative** |
|---|---|

**Month comments**

Funder result was $48k unfavourable before IDF net flow mainly due to pharmaceuticals and health of older people costs. Including IDF result was $208k unfavourable to budget.

**Year-to-date comments**

Funder result was $257k favourable before IDF net flow, mainly due to laboratory, prior year pay equity funding wash up, health of older people and interest income. Including IDFs, the result was $1,392 unfavourable to budget due to higher than expected inter-district outflows for Capital and Coast DHB (cardiothoracic, vascular surgery and respiratory inpatient service) and MidCentral DHB (haematology, maternity inpatients and urology inpatient service).

| | Variance $000 | Impact on forecast |
|---|---|---|
| **Revenue (excluding IDF inflow)** | **$305 F** | |
| **Crown revenue** | **$275 F** | |
| ▪ Personal health side contract – prior year elective wash up | $6 F | |
| ▪ Personal health side contract – MECA funding | $21 F | Offset by costs |
| ▪ Personal health side contract – clinical priority consultation | $15 F | Offset by costs |
| ▪ Personal health side contract – Gateway assessment | $28 F | Offset by costs |
| ▪ Personal health side contract – Well Child Tamariki | $13 F | Offset by costs |
| ▪ Personal health side contract – primary care and other | ($9) U | Offset by costs |
| ▪ Personal health side contract – school-based health | $22 F | Offset by costs |
| ▪ Health of older people – in-between travel | $69 F | Offset by costs |
| ▪ Health of older people – prior year, one-off | $126 F | |
| ▪ Mental health – AOD and sleepover | $54 F | Offset by costs |
| ▪ Mental health – pay equity | $59 F | Offset by costs |
| ▪ Public health – bowel screening programme | ($157) U | Offset by costs |

| | | |
|---|---|---|
| ▪ ACC SAATS | $5 F | |
| ▪ ACC Fit for Surgery | $10 F | |
| ▪ ACC injury prevention | $13 F | |

| | | |
|---|---|---|
| **Other income** – mainly interest | $30 F | |

| | | |
|---|---|---|
| **Expenditure (excluding IDF)** | **($48) U** | |
| | | |
| **Payment to own provider** | **($669) U** | |
| ▪ Personal health – dental adolescent and child | $48 F | |
| ▪ Personal health – pharmaceutical | ($696) U | |
| ▪ Personal health – bowel screening | $157 F | Offset by costs |
| ▪ Personal health – MECA funding | ($20) U | Offset by revenue |
| | | |
| **Payment to external provider** | **$495 F** | |
| **Personal health** | **($68) U** | |
| ▪ Laboratory | $66 F | Price increase applicable from Nov 19 onwards, expected saving of $41k |
| ▪ Dental | ($59) U | Demand-driven, partly offset by internal $16k |
| ▪ Pharmaceutical – demand-driven | $272 F | Partly offset by $512k internal |
| ▪ Primary health care and general medical subsidy | ($93) U | Timing |
| ▪ Immunisation | ($45) U | Timing |
| ▪ Domiciliary and district nursing | ($280) U | Demand-driven, partly offset by HOP |
| ▪ Travel and accommodation | ($90) U | High month claiming |
| ▪ Rural support | $27 F | |
| ▪ Palliative care | $25 F | |
| ▪ Community-based allied health | $21 F | |
| ▪ Price adjuster | $44 F | Saving |
| ▪ Various other | $20 F | |
| | | |
| **Health of Older People** | **$689 F** | |
| ▪ Personal care household management | $35 F | Demand-driven |
| ▪ Age-related residential care – demand-driven | ($3) U | Demand-driven |
| ▪ Residential care hospitals | $373 F | Demand-driven |
| ▪ Respite care | $148 F | Demand-driven |
| ▪ Other | $20 F | |
| | | |
| **Mental health** | **($100) U** | |
| ▪ Mental health services – home-based support and various other service | ($100) U | Demand-driven service |
| **Inter-district inflows** | | |
| Expected inflow from other DHBs | **($56) U** | |
| **Inter-district outflows** | **($1,593) U** | |
| ▪ Capital and Coast DHB related to cardiothoracic, vascular surgery and respiratory inpatient service (239 CWD) | ($1,245) U | Longer term trend uncertain, volume varies month to month |
| ▪ MidCentral DHB related to haematology, maternity inpatients and urology inpatient service | ($223) U | |
| ▪ Reduction in inter-district outflows and service change net impact | ($165) U | |
| ▪ Mental health – Capital and Coast DHB | $40 F | |

| |
|---|
| **Governance** |
| **Month comments** |

| |
|---|
| The result was $13k better than budget due to personnel costs from vacancies and other operating expenses. |

| **Year-to-date comments** | | |
|---|---|---|
| The result was $52k better than budget due to personnel costs, operating expenses; partly offset by outsourced management personnel. | | |
| | **Variance $000** | **Impact on forecast** |
| ▪ Personnel costs (vacancies and leave) | $32 F | |
| ▪ Corporate training, printing and forms and stationery, advertising, board expenses, consultancy and other | $20 F | |

## Inter-district flows (IDFs)

**Inter-district flow**

| | Year to Date | | | | Year to Date | | | Annual | Annual | Annual | Annual |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual $000 | Budget $000 | Variance $000 | | Actual CWD | Budget CWD | Variance CWD | Budget 2019-20 $000 | Budget 2019-20 CWD | Actual 2018-19 $000 | 2018-19 CWD |
| **REVENUE** | | | | | | | | | | | |
| Outflow inpatient | $14,729 | $13,096 | ($ 1,633) | U | 2,824 | 2,511 | (313) | $22,450 | 4,304 | $22,624 | 4,464 |
| Inflow inpatient | ($ 2,019) | ($ 2,187) | ($ 168) | U | (387) | (419) | (32) | ($ 3,749) | (719) | ($ 2,926) | (577) |
| **Inpatient IDF net flow** | **$12,710** | **$10,909** | **($ 1,801)** | **U** | **2,437** | **2,091** | **(345)** | **$18,701** | **3,585** | **$19,698** | **3,887** |
| Outflow other | $12,117 | $12,157 | $40 | F | - | - | - | $20,840 | | $21,154 | |
| Inflow other | ($ 2,550) | ($ 2,438) | $112 | F | - | - | - | ($ 4,179) | | ($ 4,058) | |
| **Other IDF net flow** | **$9,567** | **$9,719** | **$152** | **F** | **-** | **-** | **-** | **$16,661** | | **$17,096** | |
| **Total IDF net flow** | **$22,277** | **$20,628** | **($ 1,649)** | **U** | **-** | **-** | **-** | **$35,362** | | **$36,794** | |

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

The overall inter-district net flow is $1,649k unfavourable to budget.

### IDF outflows

Inpatient outflows are $1,633k unfavourable mainly due to:

- Capital and Coast DHB unfavourable variance of $1,245k (239 CWD higher than budget). This is related to acute demand for cardiothoracic, vascular surgery and respiratory inpatient services (242 CWD relates to 11 patients).
- MidCentral DHB unfavourable variance of $223k relates to acute demand for haematology, maternity inpatients and elective demand for urology inpatient services.
- Reduction in inter-district outflows $165k.

The main risks in relation to the 2019/20 IDF budget is the acute inpatient outflow related to national services.

### IDF inflows

IDF inpatient inflows of $168k unfavourable to budget relates to the seven-month impact of additional IDF budgeted of $287k (55 CWD) for the full year. Work has commenced for the MidCentral DHB gynaecology electives. However, overall IDF inflow volumes are close to budget.

### IDF other flows

- $152k favourable other IDF net flows variance is due to a service change to the outpatient service with Auckland DHB, MidCentral DHB and Capital and Coast DHB.

## Provider and Corporate financial performance

**STATEMENT OF FINANCIAL PERFORMANCE for the period ended 31 Jan 2020 ($000s)**
**PROVIDER & CORPORATE**

| | Month | | | | Year to Date | | | | Annual Budget 2019-20 | Annual Actual 2018-19 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| **REVENUE** | | | | | | | | | | |
| Government and Crown agency | 789 | 725 | 64 | F | 6,411 | 6,215 | 196 | F | 10,756 | 11,301 |
| Funder to Provider Revenue (internal) | 10,440 | 10,308 | 132 | F | 75,476 | 74,965 | 511 | F | 128,385 | 120,780 |
| Other income | 96 | 85 | 11 | F | 869 | 629 | 240 | F | 1,100 | 1,742 |
| **Total Revenue** | **11,325** | **11,118** | **207** | **F** | **82,756** | **81,809** | **947** | **F** | **140,241** | **133,823** |
| **EXPENDITURE** | | | | | | | | | | |
| Personnel | | | | | | | | | | |
| Medical | 2,239 | 2,354 | 115 | F | 13,094 | 14,481 | 1,387 | F | 24,994 | 22,362 |
| Nursing | 4,129 | 4,139 | 10 | F | 25,048 | 24,681 | (367) | U | 41,956 | 39,994 |
| Allied | 1,097 | 1,128 | 31 | F | 7,259 | 7,398 | 139 | F | 12,601 | 11,727 |
| Support | 80 | 84 | 4 | F | 542 | 567 | 25 | F | 965 | 852 |
| Management & Admin | 1,034 | 1,102 | 68 | F | 7,186 | 7,385 | 199 | F | 12,480 | 11,525 |
| **Total Personnel(Exl other & outsourced)** | **8,579** | **8,807** | **228** | **F** | **53,129** | **54,512** | **1,383** | **F** | **92,996** | **86,460** |
| Personnel Other | 149 | 169 | 20 | F | 1,590 | 1,523 | (67) | U | 2,560 | 2,319 |
| Outsourced Personnel | 612 | 456 | (156) | U | 5,203 | 3,511 | (1,692) | U | 6,145 | 7,105 |
| **Total Personnel Expenditure** | **9,340** | **9,432** | **92** | **F** | **59,922** | **59,546** | **(376)** | **U** | **101,701** | **95,884** |
| Outsourced Clinical Service | 572 | 533 | (39) | U | 4,683 | 4,373 | (310) | U | 7,615 | 7,447 |
| Clinical Supplies | 1,200 | 1,311 | 111 | F | 10,059 | 10,326 | 267 | F | 17,356 | 16,573 |
| Infrastructure & Non Clinical Supplies Costs | 1,119 | 1,054 | (65) | U | 9,301 | 9,271 | (30) | U | 14,630 | 13,099 |
| Capital Charge | 217 | 217 | - | F | 1,662 | 1,663 | 1 | F | 2,749 | 3,521 |
| Depreciation & Interest | 449 | 494 | 45 | F | 3,119 | 3,282 | 163 | F | 5,882 | 5,428 |
| Internal Allocation | 32 | 30 | (2) | U | 216 | 211 | (5) | U | 278 | 331 |
| **Total Other Expenditure** | **3,589** | **3,639** | **50** | **F** | **29,040** | **29,126** | **86** | **F** | **48,510** | **46,399** |
| **Total Expenditure** | **12,929** | **13,071** | **142** | **F** | **88,962** | **88,672** | **(290)** | **U** | **150,211** | **142,283** |
| NoSImpairment | - | - | - | | - | - | - | | - | 1,048 |
| Holiday pay provision | - | - | - | | - | - | - | | - | 3,608 |
| **Total one-off** | **-** | **-** | **-** | | **-** | **-** | **-** | | **-** | **4,656** |
| **Net Surplus / (Deficit) after one-off** | **(1,604)** | **(1,953)** | **349** | **F** | **(6,206)** | **(6,863)** | **657** | **F** | **(9,970)** | **(13,116)** |
| **FTEs** | | | | | | | | | | |
| Medical | 105.9 | 116.9 | 10.9 | F | 100.1 | 112.6 | 12.5 | F | 112.5 | 112.3 |
| Nursing | 489.7 | 495.8 | 6.1 | F | 472.8 | 463.9 | (8.9) | U | 462.2 | 455.0 |
| Allied | 140.2 | 154.3 | 14.1 | F | 151.7 | 153.6 | 2.0 | F | 153.4 | 160.7 |
| Support | 15.9 | 16.9 | 1.0 | F | 15.8 | 16.8 | 1.0 | F | 16.8 | 16.0 |
| Management & Admin | 154.6 | 178.6 | 24.1 | F | 173.9 | 178.1 | 4.2 | F | 177.9 | 175.9 |
| **Total FTEs** | **906.3** | **962.5** | **56.1** | **F** | **914.2** | **925.0** | **10.8** | **F** | **922.9** | **919.9** |

**Comments on result** **Positive**

**Month comments**

Inpatient volumes were 109.5% to target in January 2020 with unplanned (acute) being 103% and planned (elective and arranged) being 136.3% of budget for the month (mainly dental, ENT, general surgery and gynaecology).

**The overall result for the month of January was $349k favourable to budget**

- **Revenue $207k favourable to budget** – mainly due to:
  - Government revenue $64k favourable related to ACC contract $56k (offset by costs), training fees $12k revenue. This was partly offset by various ACC revenue and other of $4k.
  - Internal revenue $132 favourable due to outpatient pharmaceuticals (unbudgeted).
  - Other income $11k favourable due to increased pharmaceutical co-payment.
- **Total personnel costs $92k favourable** to budget mainly due to:
  - Medical personnel net unfavourable variance of $47k – locum costs $162k, partly offset by favourable payroll costs of $115k. Locum costs were made up of ophthalmology $15k, ED to cover vacancies $33k, anaesthetics to cover vacancies $42k, RMOs to cover vacancies $11k, mental health to cover vacancy $34k,

gynaecology to cover maternity leave $38k, ACC contract $7k, and general medicine $5k. This was partly offset by savings in the urology service $23k.
  - Nursing personnel costs were $10k favourable due to ward nursing costs; partly offset by community mental health.
  - Allied personnel costs were $31k favourable due to physiotherapy, audiology and dental.
  - Support personnel costs were $4k favourable to budget.
  - Management personnel net favourable variance of $74k – favourable payroll costs of $68k and outsourced personnel costs $6k. Outsourced favourable relates to IT outsourced costs (offset by IT vacancies) $6k and payroll costs relate to closure of management and admin services over the holiday period.
  - Personnel other costs $20k favourable to budget.
- **Outsourced clinical and other services $39k unfavourable** to budget due to ACC contract $36k (offset by revenue) and ophthalmology $3k.
- **Clinical supplies $111k favourable** to budget due to:
  - Theatre consumables $36k favourable mainly related to orthopaedics.
  - District nursing consumables $8k favourable.
  - Ward costs $26k favourable – mainly related to treatments and disposables and pharmaceuticals.
  - Pharmaceuticals $16k favourable – mainly eye, respiratory, immunisation and cytotoxic drugs.
  - Dental costs $12k favourable mainly related to dental consumables.
  - Blood costs $13k favourable – demand-driven.
- **Infrastructure and non-clinical supplies $65k unfavourable** due to expected stock write-off of pandemic supplies, building maintenance and accreditation costs.
- **Depreciation and interest favourable to budget by $45k** – mainly depreciation related to IT and buildings.

**Year-to-date comments**

Inpatient volumes were 101.3% to target in January 2020 with unplanned (acute) 101.6% and planned (elective and arranged) 100.3% of budget year-to-date.

**The overall year-to-date result was $657k favourable to budget.**

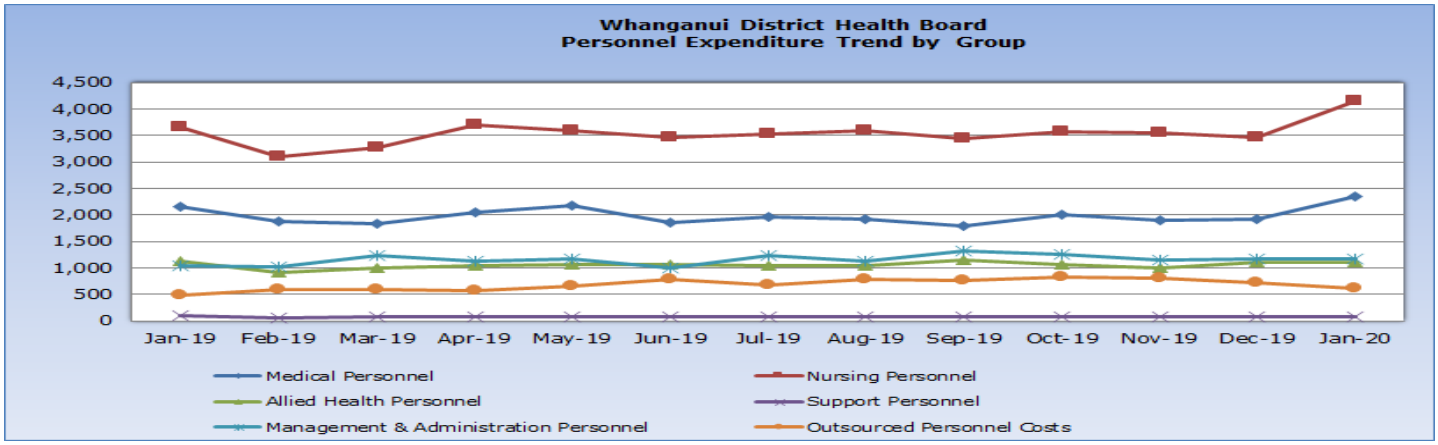
- **Revenue $947k favourable to budget** – mainly due to:
  - Government revenue $196k favourable due to ACC contract $104k, ACC revenue $106k (ACC home-based nursing $50k, ACC non-acute inpatient $23k, ACC implant $35k, various other $15k, offset by ACC radiology $17k), national travel assistance $15k, outpatient clinics $9k, Hutt Valley DHB outpatient clinics for plastic surgery $21k, training fees $27k, cervical screening $4k and various other $5k. This was partly offset by Health Workforce NZ clinical training $95k (medical personnel clinical training revenue and other $22k, Hauora Māori $73k – volume-driven).
  - Internal revenue $511k favourable related to outpatient pharmaceuticals.
  - Other income $240k favourable mainly related to ophthalmology cost recovery from MidCentral DHB $54k, flight nurses cost recovery $33k, air ambulance wash up $8k, dental co-payment $27k, pharmaceutical co-payment $17k, non-resident patient revenue $25k, training fees $12k, donation $5k, Quality Awards $10k (offset by costs) and various other $49k.
- **Total personnel costs $376k unfavourable to budget** – mainly due to:
  - Medical personnel net unfavourable variance of $230k – unfavourable locum costs $1,621k; partly offset by favourable payroll costs of $1,391k. Locum costs made up of ophthalmology to cover vacancies $106k, orthopaedics $16k, RMOs to cover vacancies $218k, ED to cover vacancies $416k, anaesthetics to cover vacancies $331k, mental health to cover vacancy $308k, gynaecology to cover maternity leave $344k, dental $25k, ENT $5k and other $11k. This was partly offset by ACC contact $38k and urology $121k.
  - Nursing personnel $367k unfavourable due to high nursing costs in the Surgical Ward, Medical Ward, CCU, ED, Maternity Ward, ATR community service and patient safety unit.
  - Allied personnel costs $82k favourable – favourable payroll costs of $139k, partly offset by outsourced costs of $57k.
  - Support personnel $25k favourable.
  - Management personnel net favourable variance of $185k – payroll costs of $199k, partly offset by ICT outsourced costs of $4k and shared cost of mental health regional director $10k.
  - Personnel other costs $67k unfavourable to budget – mainly RMO recruitment costs, parental leave and gratuities.

- **Outsourced clinical and other services $310k unfavourable** to budget due to ACC contract $116k (offset by revenue), radiology services $42k, ophthalmology $27k, surgical terminations $57k, dental patient treatment $46k, laboratory $19k (offset by funder savings) and various other $3k.
- **Clinical supplies $267k favourable** to budget due to:
  - Theatre consumables $189k favourable mainly related to orthopaedics (overall volume 196 CWD lower than planned, planned volumes 72.9% and unplanned volumes $103.7% to target).
  - District nursing consumables $95k favourable– mainly related to treatment and disposables (mainly dressings).
  - Ward consumables $68k favourable mainly related to lower pharmaceutical costs.
  - Dental costs $15k favourable mainly related to dental consumables.
  - Blood costs $95k favourable (demand-driven).
  - Various other $8k favourable.

  Partly offset by:
  - Radiology $42k unfavourable mainly related to clinical equipment repairs and maintenance, minor purchases, IV supplies and repairs and maintenance.
  - Patient travel $108k unfavourable (demand-driven).
  - Orthotics and surgical footwear $53k unfavourable.
- **Infrastructure and non-clinical supplies $30k unfavourable** due to books and journals $49k, catering for Quality Awards $12k (offset by other revenue), laundry $12k and facility maintenance $79k, pandemic stock write-off $32k. These were partly offset by health workforce training costs $72k (timing, offset by revenue), building insurance costs due to a change in the premium allocation method $78k. (Premium would have been $275k if the old allocation method was used, compared to the current premium of $235k) and various other $4k.
- **Depreciation and interest** favourable to budget by $163k, deprecation $152k (mainly related to IT, buildings and clinical equipment, capital spend not occurring as quickly as budgeted), interest $11k.

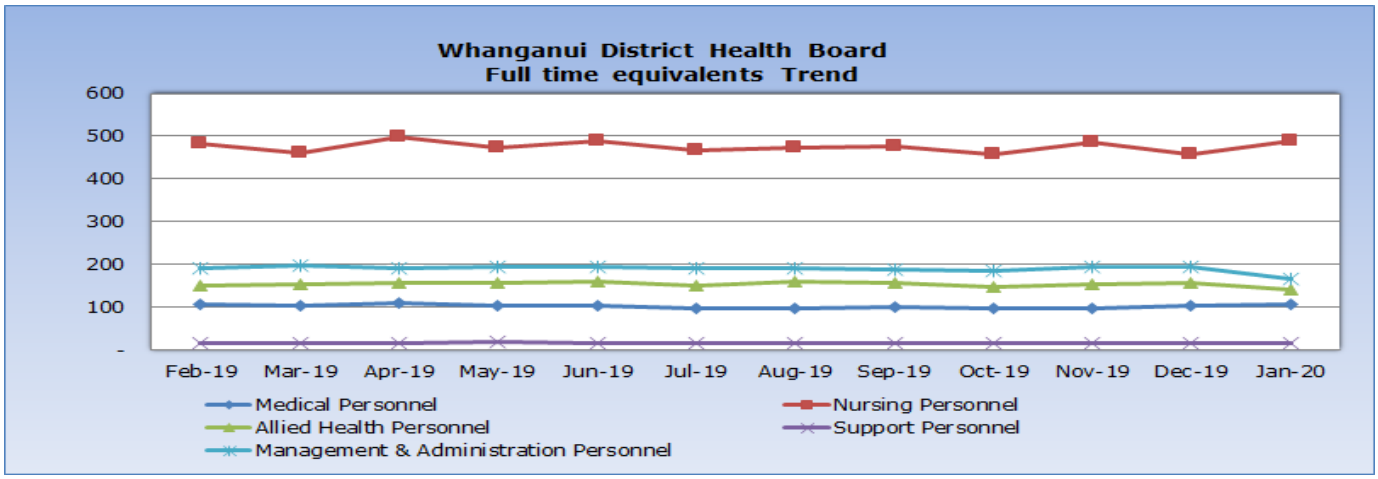
## Supplementary information on costs

*Personnel cost trends*



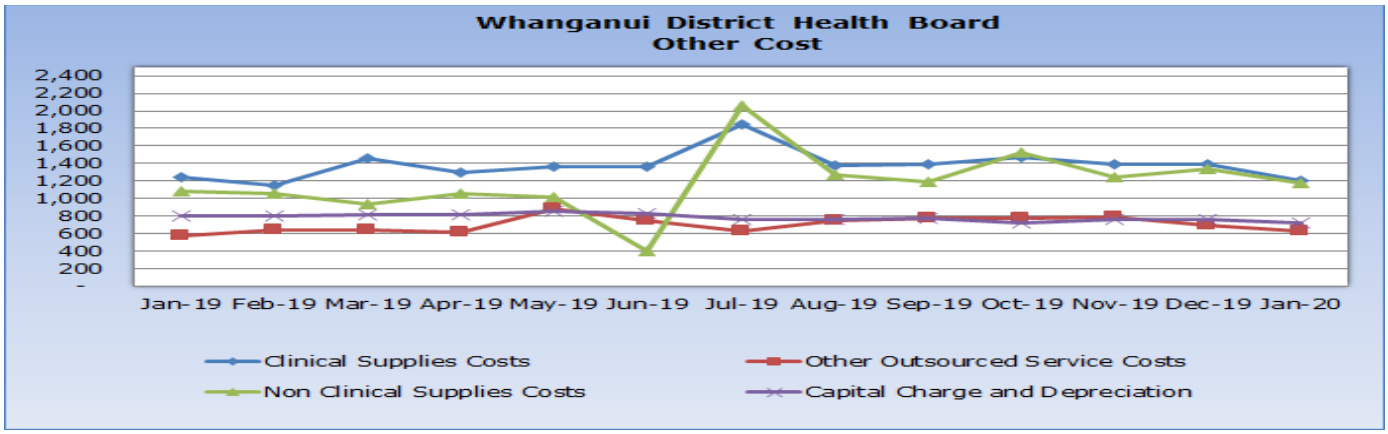

- Overall personnel cost upward trend shows the impact of the statutory days in January.
- Outsourced personnel costs downward trend in January compared to the prior month due is to ACC contract.

*FTE trends*




The FTE trend largely reflects the impact of statutory holidays and timing of leave; otherwise the trend is comparable to the prior period.

*Other operating costs*




- Clinical supplies downward trend in January compared to the prior month is due to theatre consumables and pharmaceuticals.
- Non-clinical supplies downward trend in January compared to the prior month is due to telecommunications and facility maintenance costs.
- Other outsourced service downward trend in January is comparable to the prior month and is due to ACC contract and dental costs.
- Capital charge and depreciation trend for January is comparable to the prior month.

**Rolling trend of financial performance**

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

| | Jan-19 | Jan-20 | 1 month Average | Last 12 Month Rolling Total | Budget 2019-20 | 12mth rolling total Vs Budget 2019-20 | | Actual 2018-19 | Actual 2017-18 |
|---|---|---|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | | | | |
| MoH - Government And Crown Agency | 22,061 | 22,959 | 22,646 | 271,752 | 274,598 | (2,846) | U | 263,822 | 251,767 |
| Other Income Revenue | 108 | 105 | 162 | 1,942 | 1,168 | 774 | F | 2,072 | 2,439 |
| **Total Revenue** | **22,169** | **23,064** | **22,808** | **273,694** | **275,766** | **(2,072)** | **U** | **265,894** | **254,206** |
| **EXPENDITURE** | | | | | | | | | |
| Medical Personnel | 2,161 | 2,352 | 1,975 | 23,697 | 26,334 | (2,637) | U | 23,598 | 22,100 |
| Nursing Personnel | 3,662 | 4,148 | 3,539 | 42,470 | 42,497 | (27) | U | 40,633 | 37,029 |
| Allied Health Personnel | 1,122 | 1,110 | 1,052 | 12,621 | 12,953 | (332) | U | 12,040 | 11,072 |
| Support Personnel | 95 | 81 | 78 | 930 | 969 | (39) | U | 855 | 726 |
| Management & Administration Personnel | 1,043 | 1,166 | 1,169 | 14,027 | 14,656 | (629) | U | 13,357 | 12,529 |
| Outsourced Personnel Costs | 492 | 612 | 702 | 8,425 | 6,145 | 2,280 | F | 7,123 | 7,115 |
| **Total Personnel Expenditure** | **8,575** | **9,469** | **8,514** | **102,170** | **103,554** | **(1,384)** | **U** | **97,606** | **90,571** |
| | | | | - | | | | | |
| Other Outsourced Service Costs | 575 | 622 | 714 | 8,568 | 8,215 | 353 | F | 7,999 | 7,282 |
| Clinical Supplies Costs | 1,243 | 1,200 | 1,392 | 16,707 | 17,362 | (655) | U | 16,579 | 15,935 |
| Infrastructure & Non Clinical Supplies Costs | 1,088 | 1,172 | 1,189 | 14,263 | 15,483 | (1,220) | U | 13,628 | 13,636 |
| Other Provider Payments | 6,891 | 7,525 | 7,392 | 88,698 | 91,034 | (2,336) | U | 85,469 | 80,733 |
| Inter-district-outflow | 3,935 | 3,816 | 3,802 | 45,621 | 43,290 | 2,331 | F | 43,778 | 41,134 |
| **Total Other Expenditure** | **13,732** | **14,335** | **14,488** | **173,857** | **175,384** | **(1,527)** | **U** | **167,453** | **158,720** |
| **Net Surplus / (Deficit) before Int, Depr & C** | **(138)** | **(740)** | **(194)** | **(2,333)** | **(3,172)** | **(4,983)** | **U** | **835** | **4,915** |
| Capital Charges | 353 | 273 | 325 | 3,905 | 3,535 | 370 | F | 4,401 | 4,357 |
| Depreciation | 446 | 449 | 457 | 5,482 | 5,858 | (376) | U | 5,432 | 4,737 |
| Interest Costs | - | - | - | - | 32 | (32) | U | - | - |
| **Total Interest Depreciation and Capital E** | **799** | **722** | **782** | **9,387** | **9,425** | **(38)** | **U** | **9,833** | **9,094** |
| **Total Expenditure** | **23,106** | **24,526** | **23,785** | **285,414** | **288,363** | **(2,949)** | **U** | **274,892** | **258,385** |
| **Net Surplus/ (Deficit)** | **(937)** | **(1,462)** | **(977)** | **(11,720)** | **(12,597)** | **877** | **F** | **(8,998)** | **(4,179)** |
| NOSimpairment | - | - | - | - | - | - | F | 1,048 | - |
| Holiday pay provision | - | - | - | - | - | - | F | 3,608 | - |
| **Total One-off** | **-** | **-** | **-** | **-** | **-** | **-** | **F** | **4,656** | **-** |
| **Net Surplus/ (Deficit)** | **(937)** | **(1,462)** | **(977)** | **(11,720)** | **(12,597)** | **877** | **F** | **(13,654)** | **(4,179)** |

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

| | Jan-19 | Jan-20 | 1 month Average | Last 12 Month Rolling Total | Budget 2019-20 | 12mth rolling total Vs Budget 2019-20 | | Actual 2018-19 | Actual 2017-18 |
|---|---|---|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | | | | |
| Provider division & Corporate | (1,358) | (1,588) | (734) | (8,804) | (9,349) | 545 | F | (9,430) | (5,504) |
| Corporate | (28) | (16) | 70 | 843 | 1,050 | (207) | U | 970 | 1,041 |
| **Provider & Corporate** | **(1,386)** | **(1,604)** | **(663)** | **(7,961)** | **(8,299)** | **338** | **F** | **(8,460)** | **(4,463)** |
| Governance | (63) | (59) | (62) | (748) | (946) | 198 | F | (703) | (290) |
| DHB Funding | 512 | 201 | (251) | (3,011) | (1,681) | (1,330) | U | 165 | 574 |
| **DHB Funding & Governance** | **449** | **142** | **(313)** | **(3,759)** | **(2,627)** | **(1,132)** | **#** | **(538)** | **284** |
| NoSImpairment | - | - | - | - | - | - | | (1,048) | - |
| Holiday pay provision | - | - | - | - | - | - | | (3,608) | - |
| One-off | - | - | - | - | - | - | F | (4,656) | - |
| **Net Surplus/ (Deficit)** | **(937)** | **(1,462)** | **(977)** | **(11,720)** | **(10,926)** | **(794)** | **U** | **(13,654)** | **(4,179)** |

The 12-month rolling average of $11.7 million looks significantly better than when compared to the 2019/20 annual of $12.6 million. The rolling average does not reflect price increases and significant MECA increases during the year, or increased demand expenditure and inter-district outflows.

## Statement of financial position

## Summary Statement of Financial Position as at 31 Jan 2020 ($000)

| | Actual 2018-19 | Actual YTD 2019-20 | Budget YTD 2019-20 | Variance | Annual Budget 2019-20 |
|---|---|---|---|---|---|
| **ASSETS** | | | | | |
| Current Assets (exl trade other receivable | 4,632 | 1,665 | 1,626 | 39 | 1,626 |
| Trade and Other Receivables | 6,290 | **7,279** | **5,869** | 1,410 | 6,914 |
| Fixed Assets | 81,579 | 80,083 | 88,755 | (8,672) | 88,504 |
| Work in Progress (WIP) | 5,428 | 5,477 | - | 5,477 | - |
| Long Term Investments | 1,146 | 1,146 | 1,146 | - | 1,171 |
| **Total Assets** | **99,075** | **95,650** | **97,396** | **(1,746)** | **98,215** |
| **LIABILITIES** | | | | | |
| Bank Overdraft | - | - | - | - | - |
| Bank Overdraft - HBL | - | (4,439) | (7,381) | 2,942 | (6,918) |
| Employee Related - Current Liabilities | (16,713) | (19,291) | (18,243) | (1,048) | (18,181) |
| Trade and Other Payables | (18,234) | (17,092) | (16,266) | (826) | (15,904) |
| Crown Loan - Current | (135) | (135) | (135) | - | (101) |
| Finance Leased - Current | (95) | (97) | (97) | - | (97) |
| Crown Loan - Non-Current | (101) | (34) | (34) | - | - |
| Non - Current Liabilities | (873) | (885) | (885) | - | (942) |
| Finance Leased - Non- Current | (583) | (526) | (525) | (1) | (486) |
| **Total Liabilities** | **(36,734)** | **(42,499)** | **(43,566)** | **1,067** | **(42,629)** |
| **EQUITY** | | | | | |
| Equity | (62,341) | (53,151) | (53,830) | 679 | (55,586) |
| **Total Equity** | **(62,341)** | **(53,151)** | **(53,830)** | **679** | **(55,586)** |
| **Total Equity and Liabilities** | **(99,075)** | **(95,650)** | **(97,396)** | **1,746** | **(98,215)** |

| **Comments on result** | |
|---|---|
| There are no material concerns on the financial position. | **Positive** |
| Current assets reflect the better cash position (see cash flow explanation for detail).<br>Refer to working capital analysis and consolidated summary of cash flows for further variance explanations. | |

## Working capital

## Working Capital as at 31 Jan 2020 ($000s)

| | Actual 2017-18 | Actual 2018-19 | Actual YTD 2019-20 | Budget YTD 2019-20 | Variance | Annual Budget 2019-20 |
|---|---|---|---|---|---|---|
| **CURRENT ASSETS** | | | | | | |
| Cash and cash equivalents | 1,284 | 3,020 | 26 | 5 | 21 | 5 |
| Trust / special funds | 145 | 185 | 184 | 184 | - | 184 |
| Trade and other receivables | 8,750 | 6,290 | 7,279 | 5,869 | 1,410 | 6,914 |
| Investment | 3,000 | - | - | - | - | - |
| Inventory / Stock | 1,412 | 1,427 | 1,455 | 1,437 | 18 | 1,437 |
| **Total Current Assets** | **14,591** | **10,922** | **8,944** | **7,495** | **1,449** | **8,540** |
| **CURRENT LIABILITIES** | | | | | | |
| Bank Overdraft | - | - | - | - | - | - |
| Bank Overdraft - HBL | - | - | (4,439) | (7,381) | 2,942 | (6,918) |
| Trade and other payables | (13,476) | (17,971) | (16,285) | (15,914) | (371) | (15,904) |
| Income Received in Advance | (446) | (263) | (534) | (75) | (459) | - |
| Capital Charge Payable | - | - | (273) | (277) | 4 | - |
| Term Loans – Private (current portion) | (92) | (95) | (97) | (97) | - | (97) |
| Crown Loan - Current | (135) | (135) | (135) | (135) | - | (101) |
| Payroll Accruals & Clearing Account | (3,810) | (6,350) | (9,054) | (8,223) | (831) | (7,005) |
| Employee Related - Current Liabilities | (9,064) | (10,363) | (10,237) | (10,020) | (217) | (11,176) |
| ***Total Current Liabilities*** | **(27,023)** | **(35,177)** | **(41,054)** | **(42,122)** | **1,068** | **(41,201)** |
| **Working Capital** | **(12,432)** | **(24,255)** | **(32,110)** | **(34,627)** | **2,517** | **(32,661)** |
| **Working Capital ratio** | **54.0%** | **31.0%** | **21.8%** | **17.8%** | | **20.7%** |

| **Comments on result** | |
|---|---|
| | **Positive** |

| **Working capital variances** | **Variance $000** | **Impact on forecast** |
|---|---|---|
| Working capital better than budget due to: | **$2,517 F** | |
| **Current assets** | $1,449 F | |
| ▪ Trade and other receivables difference mainly due to the Pharmac rebate, pay-equity, in-between travel (IBT) and various other. | $1,410 F | Mainly timing |

| **Current liabilities** | **$1,068 F** | |
|---|---|---|
| | | |
| ▪ Referred to in cash flow below, mainly due to movement in working capital and capital, which is a timing variance and will be spent in due course. | $2,942 F | |
| ▪ Trade and other payables actual increased due to accrual provision funder demand-driven expenditure. | ($371) U | Mainly timing |
| ▪ Income in advance mainly related to 30 June 2019 carry forward balance for youth alcohol, Well Child, school-based health service, smokefree and sexual abuse assessment and treatment service (SAATS). | ($459) U | |
| ▪ Payroll related to expiry MECA provision. | ($1,048) U | |

**Cash flows**

**Consolidated Summary Statement of Cash Flows for the period ended 31 Jan 2020 ($000)**

| | Actual 2017-18 | Actual 2018-19 | Actual YTD 2019-20 | Budget YTD 2019-20 | Variance | |
|---|---|---|---|---|---|---|
| **Net surplus / (deficit) for year** | (4,179) | (13,654) | (9,194) | (8,511) | (683) | U |
| **Add back non-cash items** | | | | | | |
| Depreciation and assets written off on PPE | 4,720 | **5,417** | 3,121 | 3,274 | (153) | U |
| Revaluation losses on PPE | - | - | - | - | - | F |
| **Total non cash movements** | **4,720** | **5,417** | **3,121** | **3,274** | **(153)** | **U** |
| **Add back items classified as investment Activity** | | | | | | |
| (loss) / gAmn on sale of PPE | 16 | 15 | - | - | - | F |
| Profit from associates | (129) | (95) | - | - | - | F |
| GAmn on sale of investments | | | | - | - | F |
| Write-down on initial recognition of financial asset | 83 | 1,048 | - | | | |
| Movements in accounts payable attributes to Ca | 64 | 268 | 85 | 144 | (59) | U |
| **Total Items classified as investment Activity** | **34** | **1,236** | **85** | **144** | **(59)** | **U** |
| **Movements in working capital** | | | | | | |
| Increase / (decrease) in trade and other payables | **(873)** | **4,312** | **(1,142)** | (1,968) | 826 | F |
| Increase / (decrease) employee entitlements | **2,112** | **3,907** | **2,590** | 1,542 | 1,048 | F |
| | | | | - | - | F |
| (Increase) / decrease in trade and other receivable | (1,091) | 2,555 | (989) | 421 | (1,410) | U |
| (Increase) / decrease in inventories | (85) | (15) | (28) | (10) | (18) | U |
| Increase / (decrease) in provision | - | - | - | - | - | F |
| **Net movement in working capital** | **63** | **10,759** | **431** | **(15)** | **446** | **F** |
| **Net cash inflow / (outflow) form operating activ** | **638** | **3,758** | **(5,557)** | **(5,108)** | **(449)** | **U** |
| | - | - | - | - | | |
| Net cash flow from Investing (capex) | (6,402) | (4,572) | (1,759) | (5,166) | 3,407 | F |
| Net cash flow from Investing (Other) | (7) | (65) | 5 | 1 | 4 | F |
| Net cash flow from Financing | (351) | (385) | (122) | (123) | 1 | F |
| Net cash flow from deficit support | - | - | - | - | | |
| Net cash flow | (6,122) | (1,264) | (7,433) | (10,396) | 2,963 | F |
| Net cash (Opening) | 10,406 | 4,284 | 3,020 | 3,020 | - | F |
| **Cash (Closing)** | **4,284** | **3,020** | (4,413) | **(7,376)** | **2,963** | **F** |

| **Opinion on result:** | **Neutral** |
|---|---|

| **Cash flow variance** | **Variance $000** | **Impact on forecast** |
|---|---|---|
| **Closing cash is better than budget, made up of the following:** | **$3,136 F** | |
| **Net cash flow from operations** | **$163 F** | |
| ▪ Trade and other payables difference mainly related to accrual provision for funder demand-driven and IDF. | $826 F | Timing |
| ▪ Employee entitlement mainly relates to expiry MECA provision and timing accruals. | $1,048 F | |
| ▪ Trade and other receivable difference mainly due to Pharmac rebate and IBT and various other. | ($1,410) U | |
| **Net cash outflow from investing** | | |
| ▪ Capital expenditure programme running behind schedule, mainly clinical equipment, facility and IT-related projects (timing). | $3,407 F | Behind budget |

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

| | |
|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Information paper** |
| | **Item 4.2** |
| **Author** | Glenys Fitzpatrick, Health and Safety Advisor, Patient Safety, Quality and Innovation |
| **Endorsed by** | Louise Allsopp, General Manager, Patient Safety, Quality and Innovation |
| **Subject** | **Health and safety update** |

## Recommendations

Management recommend that the board:

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

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

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

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

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

## 1 Purpose

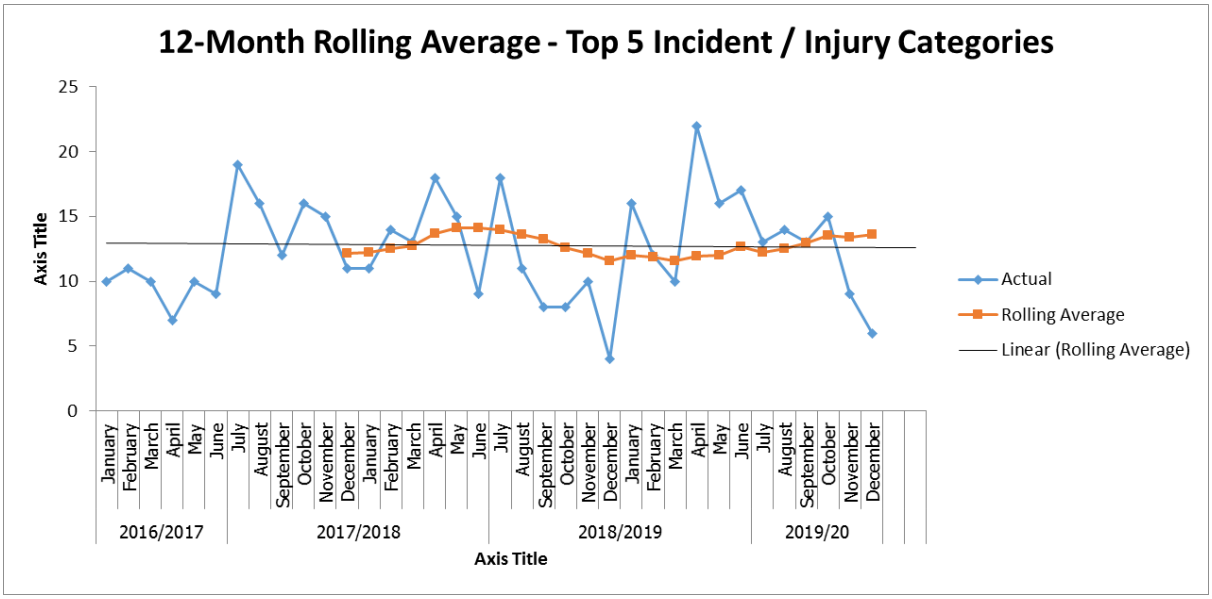
To enable the board to exercise due diligence on health and safety matters. This report on key health and safety system risks covers:

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

## 2 Incident/injury trends

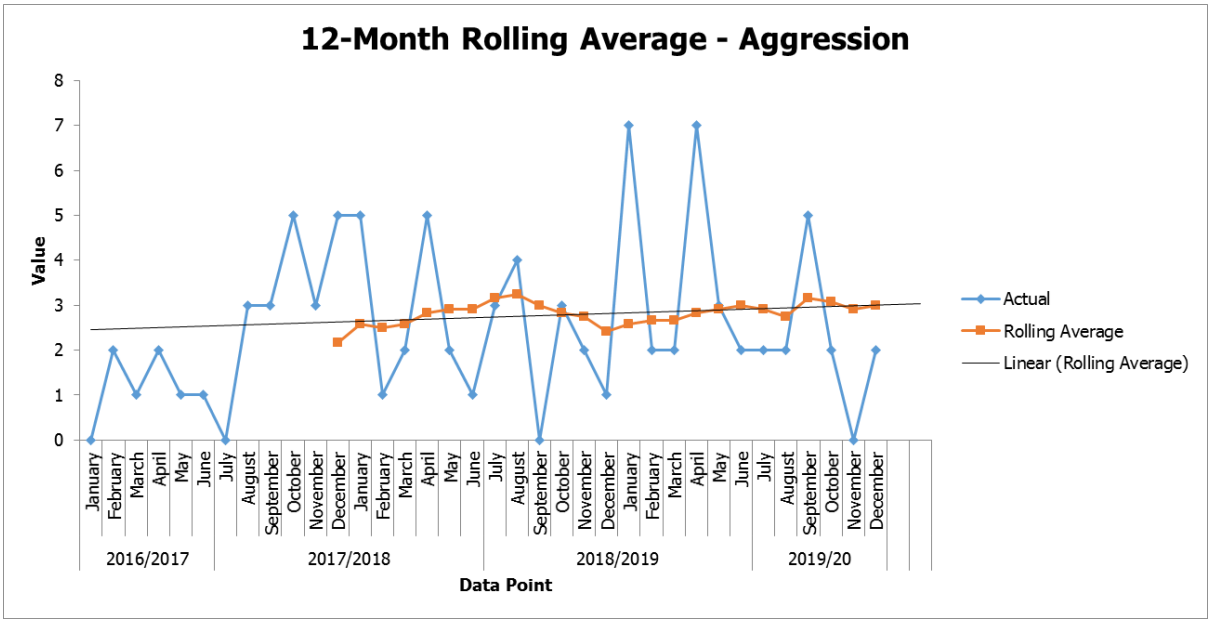
The graph below provides a rolling average, actual summary and trend line of the last three years' top five injury/incident trends.

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




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

## 2.1 Aggression



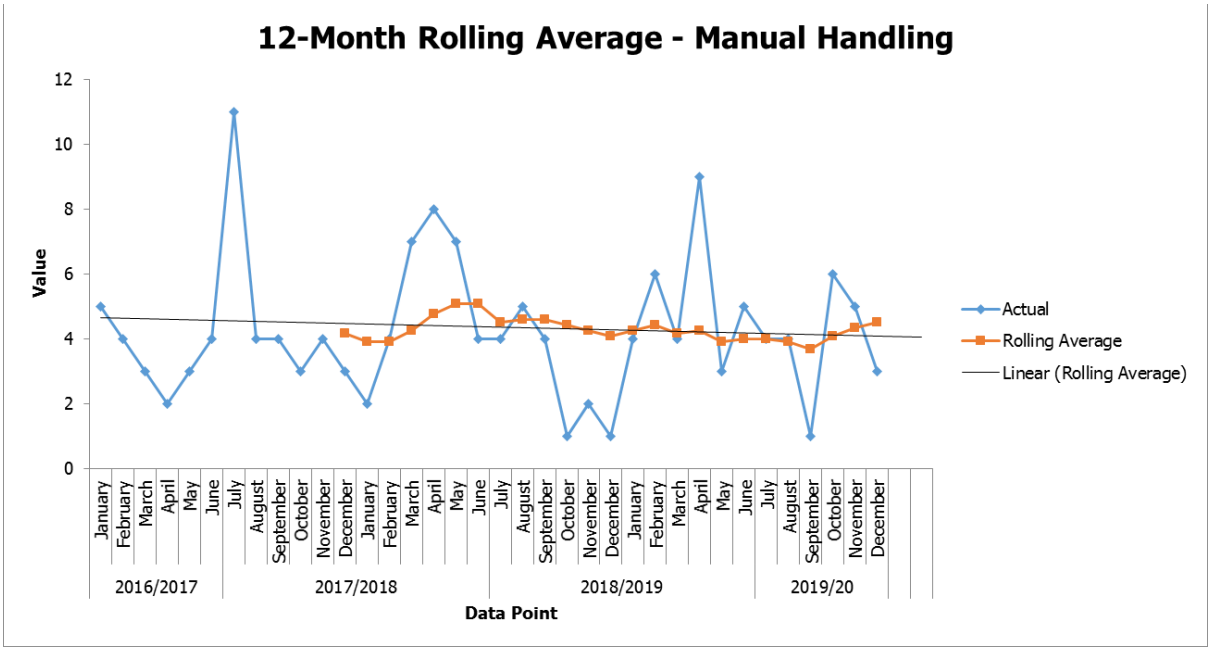

The trend line (based on the rolling average) shows an increase in the number of incidents/injuries over the three year period. Te Awhina, emergency department and the medical ward are areas with the highest number of reported injuries/incidents.

During November and December 2019 there were two physical aggression incidents at Te Awhina and in the medical ward, involving a confused patient and/or medical condition.

The medical ward incident involved a staff member being kicked in the stomach by a confused patient and the Te Awhina incident resulted in a staff member being scratched during the restraint of a client.

No issues were identified from these incidents.

## 2.2 Manual handling




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

During November and December 2019, there were eight manual handling injuries. Three were patient-related (AT&R, medical ward and theatre); three equipment/object (loans, medical ward and Taihape); one occupational overuse syndrome (OOS) in AT&R; and one whilst assisting an elderly visitor who was about to faint.

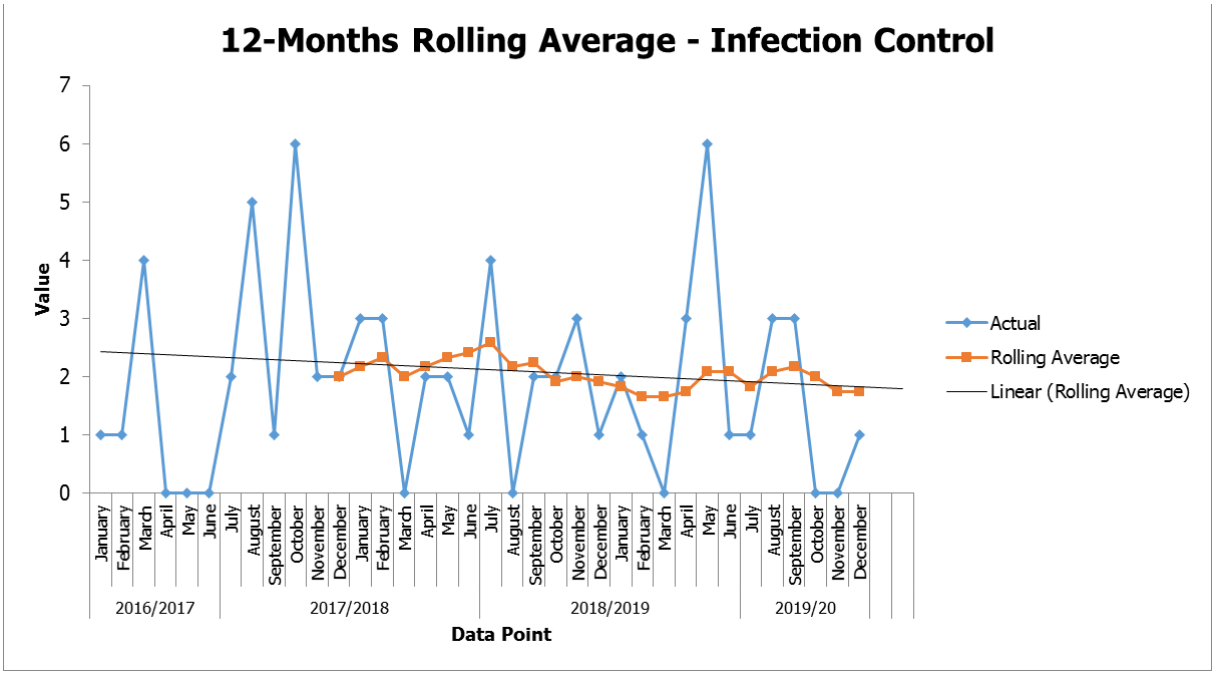
Issues identified:

- Staff member/s not using correct body mechanics and safe working height of equipment.
- Appropriate equipment not being identified and used by staff members (although training on correct use of equipment is provided).

Improved risk mitigations include:

- Manual handling training coordinator will provide extra education/training to the injured employee.
- Strengthening the ward champion programme – manual handling coordinator has given a presentation to the clinical nurse managers' meeting.
- Refresher manual handling sessions to be conducted by the ward champions.
- Feasibility study on installing a ceiling hoist in the Surgical Ward.
- Liaising with manual handling training coordinator to identify equipment for lifting heavy limbs.
- Shared feedback at staff meetings to increase the visibility and to raise awareness of staff injuries and manual handling.
- Workstation evaluations completed by an occupational therapist.

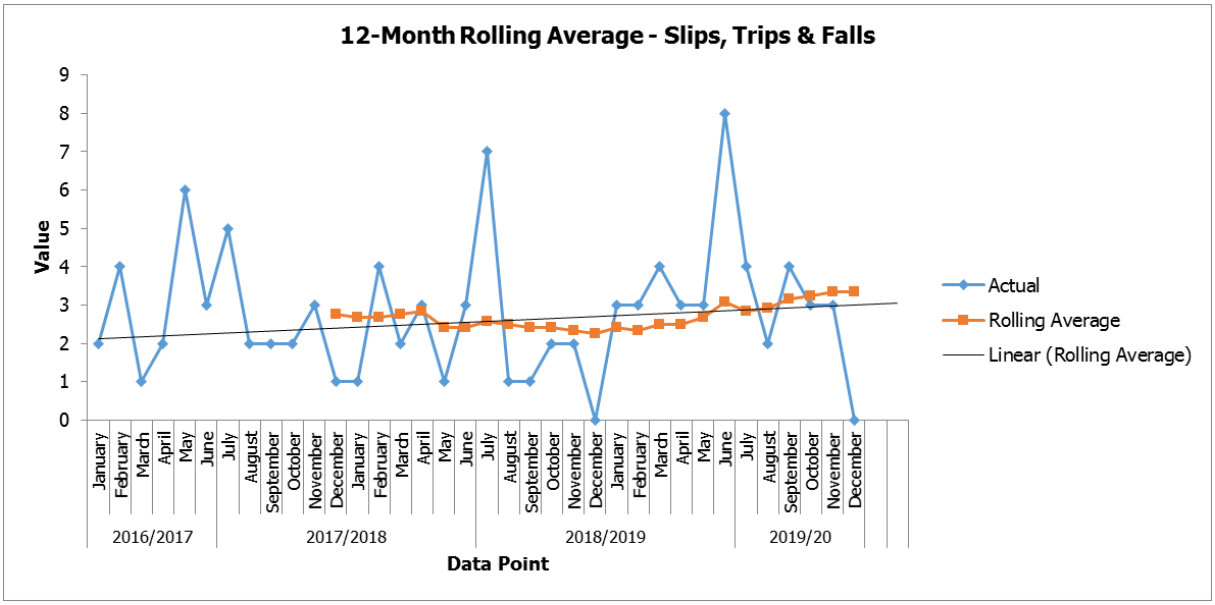
## 2.3 Infection prevention




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

During November and December 2019 there was one infection control (needle-stick) incident.

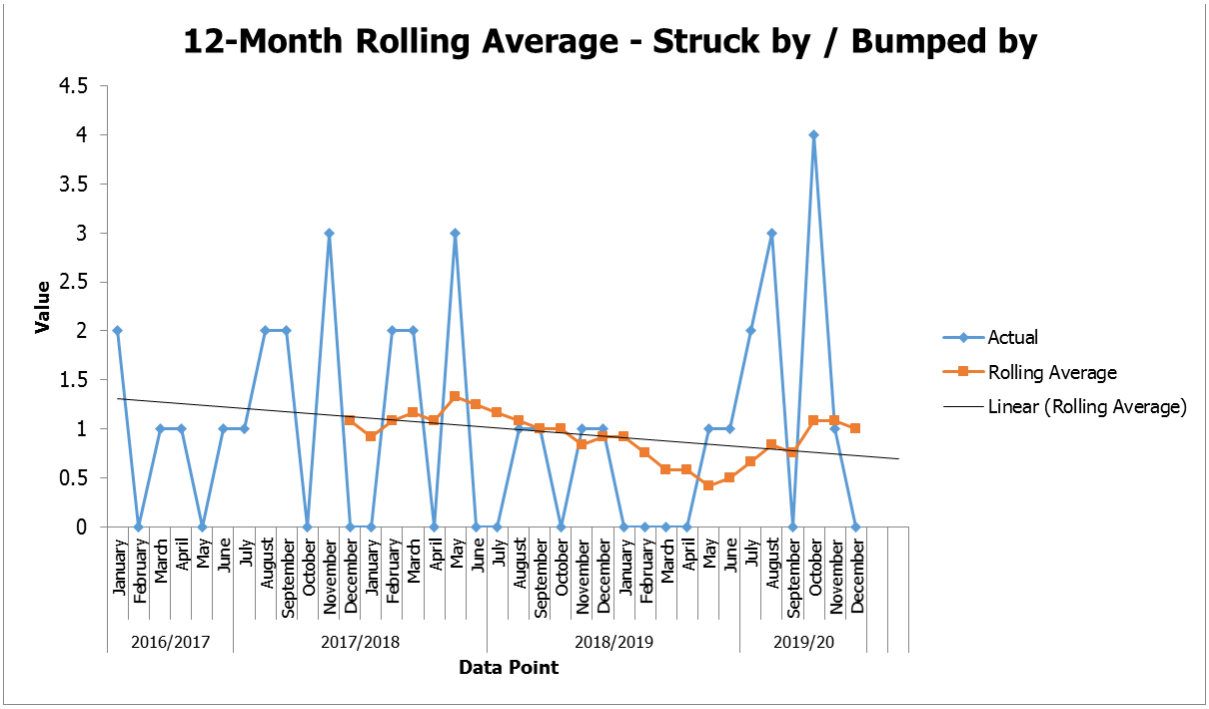
## 2.4 Slips, trips and falls




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

During November and December 2019, three slips, trips and falls incidents/injuries were reported. Injuries/incidents included: Tripped and fell (unknown cause); fell whilst carry an unconscious child; and fell off a chair when the chair slid out whilst sitting on it.

### 2.5 Struck by or bumped by



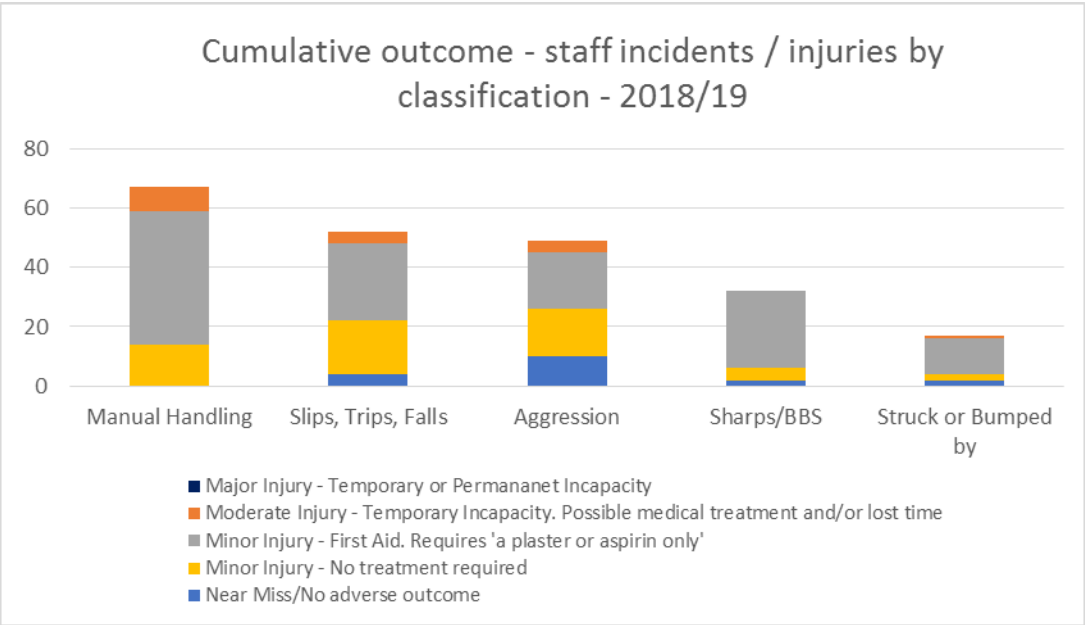

The trend line (based on the rolling average) shows a steep decline in the number of struck by or bumped by incidents/injuries over the three year period.

During November and December 2019 one bumped by incident/injury was reported when equipment fell off the shelf onto foot while positioning equipment on a shelf.

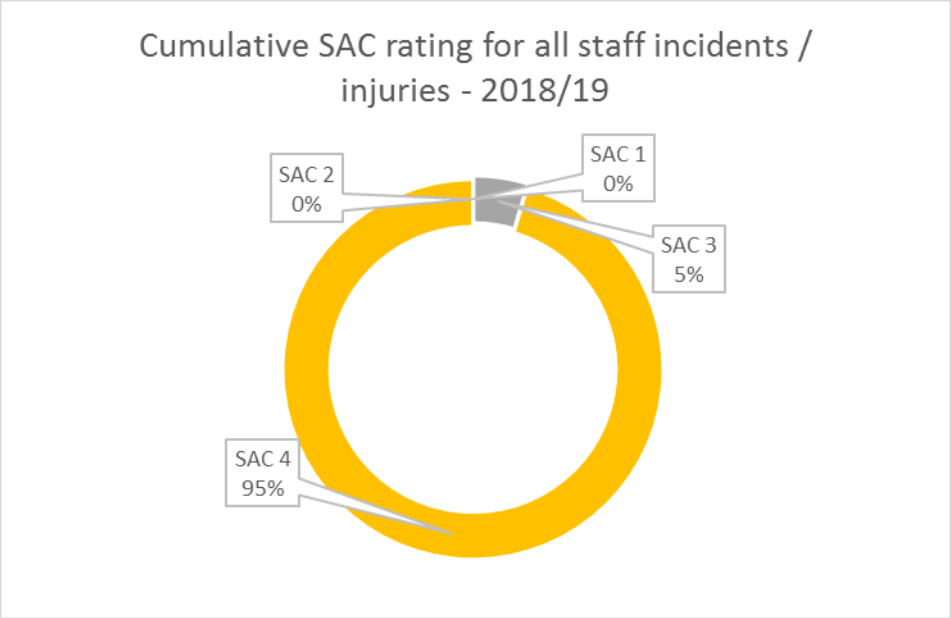
## 3 Incident/injury details

There were 15 staff incidents (injuries/potential injuries) recorded by staff on RiskMan in November and December 2019.

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



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




**Definitions used in the graph:**
SAC 4 Minor/minimal – no injury
SAC 3 Moderate – permanent moderate or temporary loss of function
SAC 2 Major – permanent major or temporary severe loss of function
SAC 1 Severe – death or permanent severe loss of function.

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

## 4 Employee participation

The WDHB Health and Safety Committee met in December.

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

- WorkWell wellness programme
- Review of monthly incident trends
- Rolling average trends and graphs for board report
- Monitor and update of health and safety objectives for 2019/2020
- Aggression workgroup
- Excellence and innovation in health and safety
- Communication plan
- Security reports
- Staff education and implementation of the lockdown procedure
- Manual handling
- The new organisational structure – health and safety advisor and reporting moved from People and Culture to Patient Safety, Quality and Innovation.

## 5 Contractor management

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

| Spotless H&S | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Category A: Fatality / Disabling | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Category B: Lost Time Injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Category C: Medical Treatment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Category D: First Aid / Allied Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Category E: Injury with no treatment | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Category G: Non-work | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Near Miss | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| **Spotless H&S** | **Nov-18** | **Dec-18** | **Jan-19** | **Feb-19** | **Mar-19** | **Apr-19** | **May-19** | **Jun-19** | **Jul-19** | **Aug-19** | **Sep-19** | **Oct-19** | **Nov-19** |
| Hazard | 9 | 15 | 8 | 10 | 10 | 10 | 9 | 8 | 10 | 12 | 11 | 9 | 10 |
| Safety Observations | 14 | 18 | 17 | 17 | 18 | 17 | 11 | 15 | 17 | 17 | 14 | 15 | 15 |
| **Sub-Contracted to Spotless** | **Nov-18** | **Dec-18** | **Jan-19** | **Feb-19** | **Mar-19** | **Apr-19** | **May-19** | **Jun-19** | **Jul-19** | **Aug-19** | **Sep-19** | **Oct-19** | **Nov-19** |
| Contractor Safety Interactions | 10 | 7 | 12 | 11 | 8 | 9 | 12 | 8 | 6 | 4 | 5 | 3 | 0 |
| Contractor Hazard | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Contractor Injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Contractor Near Miss | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | |
|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Information Paper** |
| | **Item. 4.2** |
| **Author** | Louise Allsopp and Jacqueline Pennefather |
| **Endorsed by** | Louise Allsopp, General Manager Patient Safety, Quality and Innovation |
| **Subject** | **HDC Complaints to District Health Boards** |

**Recommendations**

It is recommended that the Board

a. **Receives** the paper entitled HDC complaints to the Nationwide Health and Disability Advocacy Service

**Appendix 4.2.1 –** Complaints Received by the Nationwide HDC

## 1 Purpose

During the last quarter, HDC released a report "Complaints to the Nationwide Health and Disability Advocacy Service" (The Advocacy Report) this report summarises complaints where the complainant has utilised advocacy services linked to HDC.

## 2 Background

The Advocacy Report details trends seen in complaints received by the Advocacy service about DHB's in 2018/19. The data is aggregated and not individualised for each DHB.

The cover letter from the Director of Advocacy is specific to Whanganui District Health Board (WDHB) complaints. This information is confidential to WDHB.

For the 12 month period ending 30 June 2019, the local advocacy service supported Whanganui district patients and families with 135 complaints per 100,000 discharges. This is extremely positive as we actively offer advocacy details to patients and families through the complaints process.

The top four services complained about through advocacy were surgical services, medicine, mental health and emergency. The primary issues identified were care/treatment, communication and consent/information issues.

The majority of complaints were either resolved by advocacy (69.7%) or withdrawn (16%).

The full report is attached as an *Appendix.*

# Whanganui District Health Board

# Appendices
# public session

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

# POLICY

| Whanganui District Health Board Standing Orders Policy | |
|---|---|
| **Applicable To:** Whanganui District Health Board | **Authorised By:** Board |
| | **Contact Person:** Board Chair |

## 1 Role of the board

1.1 The board shall comply with the requirements of the NZ Public Health and Disability 2000 Act (the Act).

In accordance with Section 26 of the Act, the role of the board is to ensure:

a) All decisions relating to the operation of Whanganui District Health Board are to be made by or under authority of the board.

b) The board has all powers necessary for governance and management of the organisation.

c) The board delegates to the chief executive officer of the organisation the power to make decisions on management matters relating to the organisation, pursuant to clause 39 of Schedule 3 of the Act, such delegation to be made on such terms and conditions as the board thinks fit, notwithstanding clause 44 of Schedule 3 of the Act.

d) These Standing Orders shall apply to the board and all committees of the board.

## 2 Resolutions

2.1 Every endeavour shall be made to achieve consensus in decision-making.

2.2 Discussion on any proposal shall be broad and informal and constrained as to time by the guidance of the chairperson (the chair) rather than through procedural motions.

2.3 A resolution will provide identification or recording of a mover and seconder.

2.4 Silence when a motion is put shall be deemed to constitute an intention to support the motion.

2.5 Votes for and against particular motions shall not be recorded, unless requested by a board member.

2.6 Any resolution may be rescinded by a subsequent resolution at a subsequent meeting without recourse to procedural motions.

2.7 In accordance with Clause 29 (2) of the Third Schedule to the Act, the chair has no casting vote and if a vote is tied, the motion/question is deemed to be lost.

2.8 Board members shall attempt to contribute once only to discussion with a maximum speaking time of five minutes (except with the consent of the meeting) on a particular item, although the chair shall be entitled to summarise and guide debate.

2.9 No member shall speak on any motion after it has been put by the chair, or during a vote.

## 3 Public comment

3.1 No comment shall be permitted during a meeting from any member(s) of the public present, unless an invitation to this effect is extended by the chairperson. Where such requests are received, the chair shall be guided by the guidelines set out in Appendix 1 to this Policy.

3.2 The board shall from time to time hold open forums either as part of its meeting or separately from its meetings to provide opportunity for members of the public to express their views.

Where such forums are held, the chair shall be guided by the guidelines set out in Appendix 2 to this policy.

3.3 In the event that unauthorised comment is made, by any member of the public present during a meeting, no response shall be made by members, other than through the chair.

3.4 Deputations shall only be permitted to address the board with the prior consent of the chair. With the consent of the chair, board members may ask questions of speakers during the period reserved for public comment provided that such questions are to be confined to obtaining information or clarification on matters raised by the speaker.

Where a request for a deputation is received, the chair shall be guided by the guidelines set out in Appendix 3 to this Policy.

With the consent of the chair a deputation may be made in a language other than English but the deputation must, however, provide a translation in English on the substantive matter of the deputation and this translation will be what the board relies upon.

3.5 No discussion shall occur during a meeting as to whether any member(s) of the public may constitute a deputation for the purposes of these guidelines.

3.6 In the event that the behaviour of the public is deemed likely to prejudice, or to continue to prejudice, the orderly conduct of the meeting, the person(s) concerned shall be asked to leave. In the event that this request is refused, or the person(s) concerned attempt to re-enter the meeting, the meeting will be adjourned whilst management takes the appropriate actions as per clause 35, Schedule 3 of the Act.

3.7 With the permission of the chair, board members may ask questions of speakers, provided that such questions are to be confined to obtaining information or clarification on matters raised by the speakers.

3.8 In the event that any question is asked by a member of the public in relation to a matter that is known or in respect of which a decision has been previously made by the board the chair may ask the chief executive to provide an answer to that question.

## 4 Attendance at committee meetings

4.1 Board members may attend, as an observer, meetings of committees of which they are not a member, including both public and public excluded discussions. Such board members shall, at the request of the chair, with the committee's consent, be entitled to make comments in respect of matters under discussion by the relevant committee.

4.2 Other than board members, external appointed committee members' attendance at meetings of committees of which they are not a member shall be as a member of the public.

## 5 Teleconferences

5.1 The board may hold teleconferences in accordance with clause 14, Schedule 3 of the Act.

## 6 Minutes

6.1 The board or committee secretary shall prepare minutes in conjunction with the chair on the basis that the minutes are not a verbatim record of proceedings.

6.2 Minutes shall have no status, and be able to be amended at any time, up until they are confirmed.

6.3 The minutes shall note those decisions that require consideration by the board.

6.4 Minutes shall be kept in two sections reflecting the public and public excluded sessions of a meeting.

## 7 Agendas

7.1 Agendas shall be prepared based on an indicative work programme.

7.2 In the event that a member wishes to add an item to the agenda but is unable to do this through the work programme process, they shall raise with the board/committee chair as appropriate, who will progress the item in conjunction with management.

7.3 The chief executive shall have the authority to make formal recommendations on all matters appearing on an agenda except those pertaining to the chief executive's own employment and performance management.

7.4 In accordance with clause 28, Schedule 3 of the Act, if an item is not on the agenda, it may be dealt with at the meeting as a 'late item' if the board by resolution so decides, and it is explained at the meeting, at the time when it is open to the public, the reason why the item is not included on the agenda, and why discussion of the item cannot be delayed until a later meeting. Such late items can only be discussed if they are a minor matter relating to general business of the board/committee, and no resolution, decision or recommendation can be taken other than to refer the item to a later meeting for further discussion.

## 8 Excluding the public

8.1 That portion of the minutes pertaining to a part of the meeting when the public is excluded shall be publicly available once the draft minutes have been agreed by the chair and the board secretary unless a resolution to the contrary effect has been passed.

8.2 The public may be excluded from the meeting only for one of the reasons set out in section 32 of the Third Schedule to the Act and in accordance with the requirements of section 33 of the

Third Schedule to the New Zealand Public Health & Disability Act 2000.

## 9 Committees

9.1 In addition to those committees to be formed pursuant to Sections 34 to 36 of the of the Act , the board may appoint such committees as it shall think fit, to deal with any separate subject or subjects. Members of such committees shall be appointed by the board as the board sees fit.

9.2 Terms of Reference for such committees shall be set by the board as the board sees fit.

## 10 Quorum

No authority, power, or discretion of a Board, or its committees can be exercised, and no business transacted, unless a quorum of members is present. A quorum is determined as per clause 25, Schedule 3 of the Act:

- "If the total number of members of a district health board, or its committees, is an even number, then half that number is a quorum".
- "If the total number of members of a district health board, or its committees, is an odd number, then a majority of members shall be a quorum".

## 11 Meeting start times

11.1 All meetings which are open to the public shall start no earlier than the advertised time. They must commence within 10 minutes of the advertised start time.

11.2 The start time for other meetings can be amended in consultation with the chair.

## 12 Conduct at meetings

12.1 All persons present at the meeting shall act with courtesy, and shall not be disrespectful. They shall address each other by name or designation.

## 13 Disclosure and management of members' and management's interests

13.1 Where a member has a new interest, they shall advise this at the board/committee meeting under the 'register of interest' agenda item. This notice shall be recorded in the minutes, and the secretary shall update the Register of Interest accordingly.

In accordance with clause 36, Schedule 3 of the Act, a member of the board who is interested in a transaction of the organisation must, as soon as practicable after the relevant facts have come to the members knowledge, disclose the nature of the interest to the board.

13.2 A disclosure must be recorded in the minutes of the meeting at which the disclosure is made.

13.3 A member of the board who makes a disclosure may take part in any deliberation (but not any decision) of the board relating to the transaction concerned if a majority of the other members of the board permits the member to do so.

They shall reiterate the conflict/potential conflict at the time the specific item in question is to be discussed. At that time they shall outline the nature of the conflict and the board/committee shall agree what action shall be taken in respect of the conflict. Such action may include, but not be limited to, the member abstaining from the discussion and/or the

decision, or the member leaving the meeting while the matter is discussed. The conflict, its nature, and the board/committee's decision regarding its management shall be recorded in the minutes.

13.4 Where a member has declared a conflict of interest, or potential conflict of interest, and has been granted permission by the board/committee to speak on the item concerned, the member's comments shall be recorded in the minutes. (Refer section 4.0).

13.5 Where a member or officer has disclosed an interest in a transaction of the DHB in accordance with Appendix 3, Section 36(1) of the Act they shall not take part in any deliberation or decision of the Board relating to the transaction. Nor shall they be included in the meeting quorum requirements.

13.6 In addition to the above steps taken to manage conflicts of interest at the meeting, members shall take all other reasonable action necessary to uphold their legislative responsibilities regarding conflicts of interest as outlined in the Crown Entities Act 2004 and the NZ Public Health and Disability Act 2000

## 14 Confidentiality

14.1 No member of the board shall discuss confidential business of the district health board, with any person, unless authorised in writing to do so by the chair.

14.2 No member of the board or a committee shall release any confidential information to any person or make any statement to the media unless approved in writing by the chair.

## 15 Collective responsibility

15.1 Board members shall ensure that they will abide by the general principle of collective responsibility in respect of all decisions made by the board and once a decision is made board members shall all abide by that decision, notwithstanding that they may have voted against it, and will not publicly criticise any decision.

## 16 Definition

16.1 For the purpose of these Standing Orders, the term 'the chair' shall include deputy chairperson when this person is acting in the role of the chair.

16.2 The board means the members of the board of the Whanganui District Health Board acting together as a board in relation to a publicly owned health and disability organisation in accordance with Section 6(1) of the New Zealand Public Health and Disability Act 2000 (the Act).

16.3 For the purpose of these Standing Orders the term 'organisation' refers to Whanganui District Health Board.

16.4 For the purpose of these Standing Orders the term 'board members' shall, in respect of meetings of committees of the board, be deemed to include committee members who are not board members.

16.5 Within the context of this document the term 'information' means any information about or relating to Whanganui District Health Board or any of its employees or patients.

## 17 Application

17.1 These Standing Orders shall apply to the board and all committees of the board.

## Guidelines for receiving public comment on board/committee agenda items

1 Wherever possible, all requests for public comment on agenda items should be accommodated. The only constraining factors are content and time.

2 Public comment must relate to an item on the agenda for the meeting (or a component of an agenda item). *

Where the item is not on the agenda, there are two options:

a. Check the work programme to determine whether the topic is due for discussion at a future meeting. The person then has the option to return on that day and have their say.
b. The person can put their views in writing and send their letter to the chief executive.

If the item is subject to a formal consultation process, the comment should not be received. Instead, the person should be referred to the formal consultation process so that all public opinion on the item can be captured.

* Board/committee meetings are an inappropriate forum for discussion regarding the treatment and care to specific individuals, firstly, because of privacy issues, and secondly, it is more appropriate that the health professionals providing that care comment.

They are also an inappropriate forum for discussion regarding contracts, including employment contracts relating to Whanganui District Health Board staff and contractor's/provider's staff.

3 As a rule of thumb, 15 minutes in total should be allowed for public comment. The recommended time per person is two to three minutes. This enables five to eight speakers per meeting.

4 If a large contingent is received, the number of speakers needs to be clarified, taking into account other individuals who have requested permission to comment, and the overall time available. Generally, it is recommended that one, or perhaps two, people speak on behalf of the group.

5 The environment for public comment should be as friendly (non-intimidating) as possible. People must be aware of the process (refer 6 below) before the meeting starts. They must also be aware (before the meeting starts) of the time provision they have been given, e.g. two or three minutes, and at what stage of the meeting public comment will be held.

6 There are two options for when 'public comment' can be received:

- ☐ at the beginning of the meeting, after 'late items', or,
- ☐ when the agenda item is to be discussed.

If there are a number of members of the public wishing to speak, it is recommended that they all be heard at the beginning of the meeting.

7 The order of speakers should reflect the agenda order. That is, all speakers on agenda item 1 to speak first, following by those on agenda item 2, etc.

8 The meeting needs to be aware when public comment is to be received. It is recommended that this be outlined by the chair at the beginning of the meeting – before apologies. To

enable this to happen, the board/committee secretary should list the speakers, in order, and the agenda item(s) concerned.

9 When the board/committee is ready to take public comment, the chair should call the person's name, state the agenda item on which they are to comment, and confirm the time provision.

The person should then stand, so that they are clearly visible and speak. Alternatively, if there is sufficient room, place a chair close to the board/committee table and invite them to speak from there.

10 Debate on the viewpoint proffered should not take place with the individual concerned.

Members' questions of clarification may be taken through the board/committee chair.

11 Any debate or discussion on the viewpoint proffered should be addressed as part of the board/committee's discussion of that agenda item. If it raises issues that have not been fully canvassed by management, the management team should be asked to seek further information and report back. It is inappropriate to seek this information direct from the person concerned at the time of the meeting.

12 In some instances, a special meeting between management and the group/individual concerned, (outside of the board/committee meeting), may be appropriate as a consequence of the issues raised.

13 Recording of 'public comment' shall be in line with the Standing Orders for minuting meetings. That is, a summary of key points shall be recorded, not a verbatim transcription.

**APPENDIX 2**

## Guidelines for open forums

1 The open forum should be specifically mentioned in the statutory public advice of board meetings (newspaper advertisement).

A media release relating to the forum should also be issued in advance so as to raise public awareness of it.

2 The forum should be the second order of business at the meeting, with apologies the first so that members of the public can plan their attendance.

3 One hour should be set aside in the forum, and this should be clearly stated on the order paper.

At the beginning of the forum, this time provision should be clearly stated.

4 The forum should open with a karakia.

5 So that everyone has the opportunity to have their say, a time allowance should be agreed for each person to put their questions and views. This time allowance will be dependent upon the number of persons present, but as a general rule of thumb it should be not less than two minutes, or more than five.

Board members and officers responding to questions must also be aware of time restrictions.

6 The forum should be facilitated by the chair, or their nominated person. They should outline the ground rules/procedures at the outset.

7 Members of the public who wish to speak more than once should be allowed to do so, though preference should be given to ensuring all present have the opportunity to speak at least once.

8 All questions and views should be directed to the chair (or other nominated facilitator) in the first instance, who will ensure that the most appropriate person responds.

9 Everyone present should be reminded on the need to speak clearly so that they can be heard, and to respect all speakers by not talking during the expression of their views.

10 Every endeavour should be made to answer any questions raised at the forum.

If the relevant information is unavailable at the time, the person should be asked to leave their name with a nominated board officer. The question should be noted, and the response provided to the person in due course.

11 Questions regarding the treatment and care to specific individuals should not be answered in the forum, firstly, because of privacy issues, and secondly, it is more appropriate that the health professionals providing that care comment.

12 Should the board wish to consider a particular matter(s) raised, it may do so in accordance with Standing Order 5.4.

13 At the conclusion of the forum, if it is apparent that there are more questions, ask people to put these in writing and leave them, together with contact details, with a nominated board Officer. A response can then be provided in due course.

14 Recording of 'public forums' shall be in line with the Standing Orders for minuting meetings. That is, a summary of key points shall be recorded, not a verbatim transcription.

## Guidelines for deputations

1 Applications to make a deputation must be lodged in writing with the Principal Administration Officer at least 10 clear working days before the date of the meeting concerned. Applications must set out the substance of the deputation. Preferably, the application should provide a concise statement of what the deputation is seeking from the board.

2 All applications to make a deputation shall be referred to the chair for a determination. If, in the opinion of the chair, the matter which is the subject of a deputation is one of urgency, or major public interest, the chair may determine that the deputation be received by the board. The chair shall be entitled to refuse any request for a deputation which is considered by the chair to be repetitious, offensive or inappropriate.

3 The chair may direct the deputation to another committee or the full board meeting, which is dealing with the matter.

4 Where a deputation has been approved, it shall be included in the agenda for the meeting in question.

5 The deputation is to receive a copy of the agenda prior to the meeting.

6 Deputations shall be granted a set time to address the meeting. As a rule of thumb, 5-10 minutes should be allowed. This timeframe is for the total deputation, and remains regardless of the number of speakers the deputation elects to address the meeting. That is, the time limit is for the deputation, not per speaker.

7 When the board/committee is ready to receive the deputation, the chair should call the person/group's name and confirm the time provision.

The person(s) should then stand, so that they are clearly visible and speak. Alternatively, if there is sufficient room, place a chair close to the board/committee table and invite them to speak from there.

8 No discussions or questioning shall occur until the deputation has completed making its address.

9 Debate on the viewpoint proffered should not take place with the individuals concerned.

Members' questions of clarification may be taken through the chair.

10 If the deputation raises issues that have not been fully canvassed by management, the management team should be asked to seek further information and report back. It is inappropriate to seek this information direct from the deputation at the time of the meeting.

11 In some instances, a special meeting between management and the group/individual concerned, (outside of the board/committee meeting), may be appropriate as a consequence of the issues raised.

12 To enable full consideration and review of the matters raised via deputations, the committee/board may refer it to a subsequent meeting for determination. It may also refer it to another committee or the board as considered appropriate.

13 The chair may terminate a deputation in progress which is disrespectful or offensive, or where the chair has reason to believe that statements have been made with malice.

14 The environment for deputations should be as friendly (non-intimidating) as possible. People must be aware of the process before the meeting starts. They must also be aware (before

the meeting starts) of the time provision they have been given and at what stage of the meeting their time appears.

15. Recording of 'deputations' shall be in line with the Standing Orders for minuting meetings. That is, a summary of key points shall be recorded, not a verbatim transcription.

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

# Terms of Reference

| Finance, Risk and Audit Committee | | |
|---|---|---|
| **Applicable to** | **Authorised by** | Board Chair |
| Whanganui District Health Board | **Contact person** | Risk and Audit Committee |

## 1 Purpose

The ~~Whanganui District Health Board (WDHB) has an independent~~ Finance, Risk and Audit Committee~~'s ,~~ ~~appointed by and reporting to the board. The~~ role ~~of this committee~~ is to advise and assist the board to meet governance responsibilities relating to finance, risk, quality and safety management, audit and compliance. ~~on the organisation's effectiveness in identifying and managing its clinical and service provision risk, business risk, and financial risk. Risk and Audit Committee members are subject to the WDHB's Code of Conduct Policy.~~

The committee is established under clause 38, schedule 3 of the New Zealand Public Health and Disability Act 2001.~~[1] which enable the board to set up committee/s (further to the statutory committees) for a set purpose.~~

## 2 Membership

Members are appointed (or reappointed) by the board following the triennial board elections.
The committee shall comprise of:

- a minimum of three and a maximum of four members of the board, plus the board chair as an ex-officio member.
- two independent non-board members, including one member with a background in financial reporting, accounting or auditing and one member with a background in health service provision and auditing.
- the chair shall be appointed by the board, but the chair should have an appreciation and experience of the audit function.

To ensure the committee has an appropriate skill base and independence:

- members from the board itself should have the appropriate skills that are compatible with the committee's responsibilities.
- independent members will be appointed based on the knowledge and skills they would bring to the committee, being mindful of any skill/independence gaps identified.

Four members of the committee shall form a quorum.

The cost of meetings shall be met from the budget of the board.
Remuneration of committee members is as per the Cabinet Fees Framework and is paid on attendance only. Other board members shall have the right of attendance, and shall contribute to meetings at the invitation of the chair.

~~Members are appointed by the board following the triennial board elections and will be appointed for any period that terminates no later than four months after the end of the term of the board that appointed them (noting the full term of a board is three years). Members may be reappointed by the~~

~~'new' board. The appointment of a board member to the Risk and Audit Committee terminates if the member ceases to be a member of the board.~~

Finance, Risk and Audit Committee members are subject to the WDHB's Code of Conduct Policy.

## 3 Term of office

- Appointments of board members and independent (external) members are effective immediately from the date the board confirms the committee membership (usually in January/February following the board elections).
- A board member's term of office ends when they cease to be a board member or, if re-elected, when the board confirms membership of the new committee.
- An external member's term of office ends the last day of February in the year following the board elections. An external member is eligible for reappointment to the committee.

~~To ensure the committee has an appropriate skill base and independence:~~

- ~~members from the board itself should have the appropriate skills that are compatible with the committee's responsibilities.~~
- ~~independent members will be appointed based on the knowledge and skills they would bring to the committee, being mindful of any skill/independence gaps identified.~~

~~Four members of the committee shall form a quorum.~~

## ~~4~~3 Meetings

The Finance, Risk and Audit Committee will meet four times a year and hold such additional meetings as the committee chair ~~of the Risk and Audit Committee~~ shall decide ~~in order to fulfill its duties~~. In addition, the chair is required to call a meeting if requested to do so by any board or board committee member, the chief executive, the board's internal auditor, or the external auditors responsible for the financial audit of Whanganui District Health Board.

The timing of meetings should align with timing of:
- the planning stage of the external audit
- drafting of the annual accounts (September/October)
- drafting of the Statement of Intent
- appropriate oversight of service and clinical risks.

The agenda shall be drawn up by the general manager corporate in conjunction with the chair and shall be circulated at least seven days prior to each meeting of the committee.

~~The cost of meetings shall be met from the budget of the board.~~

## ~~5~~4 Attendance at meetings

All meetings of the Finance, Risk and Audit Committee are held with public excluded.

~~The chief executive will be responsible for ensuring that the committee is supported both at meetings and in the conduct of its business outside meetings by the appropriate senior staff members.~~

Each year, t~~T~~he internal auditor is required to attend at least two meetings~~, per year~~ and the external ~~financial~~ auditors will attend at least once ~~a year~~ and on an 'as required' basis. At least once a year, the committee shall meet separately with the internal auditor and the external auditors without executives present.

~~Other board members shall also have the right of attendance, and shall contribute to meetings at the invitation of the chair.~~

~~Remuneration of committee members is as per the board manual for board members, and by negotiation for non-board members.~~

## 65 Authority

The committee is authorised by the board to:

a. require the chief executive and delegated staff to attend its meetings, provide advice, provide information and prepare reports on request.
b. investigate any activity in the course of meeting the committee's objectives, including obtaining outside legal or other independent professional advice.
c. seek any information it requires from any employee, and all employees are required to cooperate with any request made by the committee.
d. have unlimited access to, and authority to seek information from internal and external auditors.
e. determine a planned internal audit programme in conjunction with senior management and to appoint internal auditors on a regular or one-off basis.
f. endorse mitigations proposed by management to address areas where performance is not in line with agreed plans.
g. endorse management action required to address external or internal audit findings.
h. interact with any other committee(s) that may be formed from time to time.

~~The committee is authorised by the board to investigate any activity in the course of meeting committee objectives. It is authorised to obtain outside legal, or other independent professional advice, and to secure the attendance of external parties with relevant experience and expertise if it considers this necessary. The committee is authorised to seek any information it requires from any employee and all employees are required to cooperate with any request made by the committee.~~

~~The committee shall have unlimited access to, and authority to seek information from, both the internal and external auditors, to fulfill its objectives, duties and responsibilities.~~

~~The committee is authorised to determine a planned internal audit programme in conjunction with senior management and to appoint internal auditors on a regular or one-off basis. The internal audit is to cover all elements of risk faced by the board ie, clinical and service provision, business and financial risk.~~

~~The committee shall have no executive powers with regard to its findings and recommendations.~~

## ~~6 Objectives~~

~~The committee will provide oversight and governance and regularly report to the board on:~~

~~6.1 the ability of the organisation to identify its clinical, service provision, business, and financial risks~~

~~6.2 the effectiveness of the strategies the organisation has in place to mitigate the clinical, service provision, business, and financial risks~~

~~6.3 the appropriateness of the control framework, monitoring and reporting mechanisms relating to clinical, service provision, business, and financial risks~~

~~6.4 the quality and reliability of the information used by the board to monitor, make decisions, and report externally relating to the safety and effectiveness of clinical practice, service provision~~

~~6.5 the quality and reliability of the information used by the board to monitor, make decisions, and report externally on the commercial and financial activities of the organisation.~~

## ~~7 Specific activities~~

~~The committee is responsible for meeting the objectives as set out in these terms of reference. The following are specific activities of the committee although not an exhaustive list:~~

~~7.1 Reviewing the board's clinical, service provision, business and financial risk management and internal control programmes through receipt of appropriate reports, including:~~

~~(i) Compliance with statutory, regulatory and policy requirements~~
~~(ii) Assessment of risks and related control systems~~
~~(iii) Current status and performance of those control systems.~~

~~7.2 Monitoring the adequacy of the patient safety and service quality strategies, structures, systems, and processes, including information technology systems.~~
~~7.3 Commissioning clinical, service provision, business and financial routine and special investigations and internal audits, and making recommendations to the board on any such reports and investigations.~~
~~7.4 Receiving all externally conducted reports on clinical and service provision and other patient related activity and making recommendations to the board on any such reports and investigations.~~
~~7.5 Receiving non-DHB provider audits and other reviews of non-DHB providers commissioned by the DHB, including audit and compliance reports.~~
~~7.6 Monitoring the financial separation of the Planning and Funding and the Provider Divisions of the WDHB.~~
~~7.7 Reviewing the independence and performance of the internal auditor and approving the ongoing internal audit programme, achieving an appropriate balance between clinical, service provision, business and the financial aspects of the organisation's activities, and ensuring the programme is adequately resourced.~~
~~7.8 Commissioning and receiving post event audit reports of major board decisions which relate to the clinical, service provision, business or the financial aspects of the organisation's activities.~~
~~7.9 Reviewing the Whanganui District Health Board's emergency preparedness, including the ability to manage emergencies relating to the need for extra-ordinary service provision or threats to business continuity.~~
~~7.10 Reviewing the annual financial statements before submission to the board, focusing particularly on changes in accounting policies, major judgements, and adjustments as a result of the audit and compliance with statutory and legal requirements.~~
~~7.11 Receiving and reviewing audit reports and all major investigation findings relating to the business and financial aspects of the organisation's activity, including the annual financial statements and making recommendations to the board on any such reports and investigations.~~
~~7.12 Reviewing the independence and performance of external auditors and making recommendations regarding the appointment of external auditors and discussing with the external financial auditor, the annual audit including the nature and scope of the audit, and ensuring coordination where more than one firm is involved.~~
~~7.13 Reviewing past or proposed transactions with members of management where such transactions may constitute a conflict of interest.~~
~~7.14 Reviewing the adequacy of insurance cover and exclusions from insured risks.~~
~~7.15 Receive and investigate disclosures under the board's Protected Information Disclosures Policy, where it is not appropriate for these to be received and investigated by the chief executive or other persons named in the Protected Information Disclosures Policy and Procedure.~~
~~7.16 Formally reviewing its own performance on an annual basis.~~
~~7.17 Consideration of other activities.~~

## 7 Functions

### 7.1 Finance

Ensure appropriate reporting processes are in place to enable the board and sub-committees to monitor and make decisions on the financial and commercial affairs of the WDHB.
Monitor the overall financial performance of WDHB, including the performance of provider functions.
Monitor the capital expenditure and overall financial position of WDHB.

### 7.2 Risk, quality and safety management

Ensure appropriate patient safety and service quality measures and reporting are in place to ensure that quality improvement at a system level can be monitored.
Ensure there are integrated governance systems to actively manage patient safety and the quality of service delivery.
Monitor and review the identification, assessment and prioritisation of enterprise risk, including eliminating or mitigation of risk.

### 7.3 Audit

Provide assurance that all audit processes required by statute and the board are completed.
Ensure that effective control environment and assurance programmes are in place.
Ensure all issues identified by audits are appropriately remedied and contribute to ongoing business improvement.

### 7.4 Compliance

Ensure WDHB is compliant with all relevant statutory, regulation and policy obligations and requirements.

### 7.5 Planning

Review and provide advice to the board on aspects of the budget and strategic framework related to finance, risk, safety and quality.

## ~~8~~ Reporting procedures

The committee will formally report to the board through the committee chair and by providing minutes of committee meetings to the board.

~~[1] Although the Risk and Audit Committee is not a committee required by Statute, clause 38 of schedule 3 applies to any board.~~

WHANGANUI
DISTRICT HEALTH BOARD
*Te Poari Hauora o Whanganui*

# Terms of Reference

| **Combined Statutory Advisory Committee** | |
|---|---|
| **Applicable To:**<br>Whanganui District Health Board | **Authorised By:**<br>Whanganui District Health Board |
| | **Contact Person:** Board Secretary |

## 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 achieving 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 hospital (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 chairs (Whanganui DHB and Hauora A Iwi) 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:

- Board appointments
  - The deputy chair of the board, who will be appointed to chair the committee
  - Up to four board members
- External (non-board member) appointments:
  - Up to two members of Hauora A Iwi board nominated by Hauora a Iwi board
  - At least three other members, nominated in consultation with Hauora a Iwi, and 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 at least four meetings will be held annually, and that members will also attend any annual planning workshops.

**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'.

Nationwide Health & Disability Advocacy Service
Ngā Kaitautoko

# Complaints to the Nationwide Health and Disability Advocacy Service involving District Health Boards

## Report and Analysis for the period 1 July 2018 to 30 June 2019

# CONTENTS

# DIRECTOR OF ADVOCACY'S FOREWORD

I am pleased to present the Nationwide Health and Disability Advocacy Service's analysis of complaints received in the 2018/19 year about District Health Boards (DHBs).

This report relates only to complaints made to the Advocacy Service. The Health and Disability Commissioner's DHB Complaint Report for January to June 2019 was published on 4 November 2019.

Under the Health and Disability Commissioner Act 1994, advocates are tasked with assisting consumers to resolve their complaints by agreement between the parties. Consumers are always at the centre of the Advocacy Service's complaints resolution process, with advocates guiding and supporting complainants to clarify their concerns and the outcomes they seek. This clarity enables the provider to write or speak effectively and directly to the complainant. Both sides being able to hear each other's stories is an essential part of the advocacy process. Often the advocacy process can support people to rebuild relationships, which is particularly important when the relationship will be ongoing.

The advocacy process is timely and effective. Eighty-three percent of complaints are closed within three months, and nearly 100% are closed within six months. Eighty-eight percent of all complaints to the Advocacy Service were either resolved successfully or withdrawn by the complainant. In the first instance, advocates always talk through the various options for dealing with any concerns, and in some cases just having the opportunity to talk through the options and the events or to draft a complaint letter with an advocate enables someone to achieve a degree of personal reconciliation, and they no longer need to make a formal complaint.

Most importantly, satisfaction surveys show that the advocacy process was a positive one for both consumers and providers, with 91% of consumers and 93% of providers surveyed saying they were satisfied or very satisfied with the advocacy process.

The high resolution and satisfaction rates achieved by the Advocacy Service reflects its consumer-focused approach and the commitment of providers to achieving early and effective resolution.

I hope the information contained in this report assists DHBs in understanding their complaint patterns and how these compare nationally.

Jessica Mills
**Director of Advocacy**
**Office of the Health and Disability Commissioner**

# EXECUTIVE SUMMARY

In the 2018/19 year, the Nationwide Health and Disability Advocacy Service (the Advocacy Service) received 1,148 complaints about services provided by DHBs. This was an 11% decrease on the average number of 1,287 complaints received over the previous four years, but was very similar to the 1,132 complaints received in 2017/18.

The 1,148 complaints received in 2018/19 equated to a rate of 117 complaints per 100,000 discharges. This is consistent with the rate of complaints received in the previous two years.

Complaints were received about a wide variety of DHB service types. Broadly similar to what was seen last year, the most commonly complained about service types in 2018/19 were surgical (30.6%), medicine (19.7%), and mental health (18.1%) services.

The majority of complaints about DHBs were about care/treatment (54%) and communication (29%) issues. The most common specific primary issues were a failure to communicate effectively with the consumer (17%) and inadequate coordination of care/treatment (11%). This is similar to what has been seen in previous years

Of the 1,094 complaints closed by the Advocacy Service in 2018/19, only 123 complaints were closed unresolved, with just 22 of those being referred on to HDC.


The new Advocacy Service information leaflet, available from www.advocacy.org.nz

# BACKGROUND

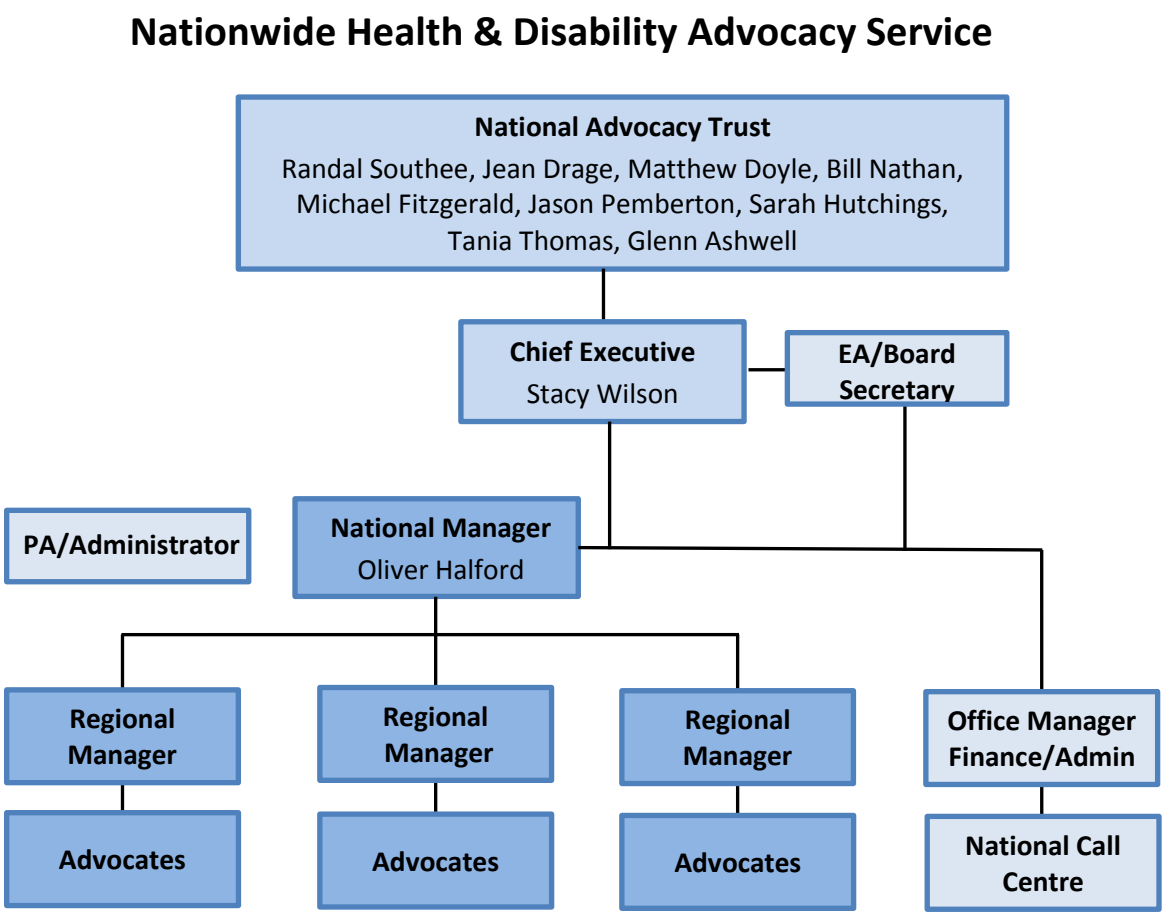
## 1. The Nationwide Health and Disability Advocacy Service

The Health and Disability Commissioner Act 1994 (the HDC Act) provides for the independent Advocacy Service and sets out the legislative functions of advocates. The HDC Act requires HDC and the Advocacy Service to operate independently of each other. Since 2008, the Director of Advocacy at HDC has contracted with a charitable trust, the National Advocacy Trust, to provide the Advocacy Service.

The service has recently refreshed its website and branding. The new leaflets and posters can be obtained from the Advocacy Service Website — www.advocacy.org.nz.

Nationwide Health & Disability Advocacy Service
Ngā Kaitautoko

**Figure 1.** The Nationwide Health and Disability Advocacy Service Organisation



## 1.1 Services

The Advocacy Service has community-based offices throughout New Zealand. Each year the Advocacy Service expects to receive and close approximately 2,700 complaints, deliver over 1,500 education sessions to consumer and provider groups on the Code of Health and Disability Services Consumers' Rights (the Code), make more than 3,500 network contacts, and respond to an estimated 12,000 enquiries. Advocates work within their local community to support and guide consumers to achieve prompt and successful resolution of their concerns through an alternative dispute resolution process that is flexible and time-effective.

**Figure 2.** The Nationwide Health and Disability Advocacy Service offices

## 1.2 The advocacy process

Any consumer in New Zealand can make a complaint to the Advocacy Service about a health or disability service that has been provided to them. When considering complaints, the Advocacy Service has the same jurisdiction as HDC — there must have been the provision of a health or disability service to a consumer by a provider, and a possible infringement of the consumer's rights under the Code.

Advocates use defined complaint resolution processes and aim to achieve positive outcomes for consumers, and develop professional and respectful working relationships with providers and consumers of all backgrounds. Consumers are always at the centre of the Advocacy Service's complaints resolution process, with advocates guiding and supporting complainants to clarify those concerns and the outcomes they are seeking to assist the consumer to approach complaint resolution with a realistic direction and clarity. This clarity and process enables the provider to write or speak effectively and directly to the complainant. Both sides being able to hear each other's stories is an essential part of the advocacy process.


The new Advocacy Service poster (A2, A3 & A4), available from www.advocacy.org.nz

## 1.3 Resolution

In the 2018/19 year, 88% of complaints to the Advocacy Service were either resolved successfully between the parties or withdrawn by the complainant. In the first instance, advocates always talk through the various options for dealing with any concerns. In some cases, just having the opportunity to talk through the options and the events or to draft a

complaint letter with an advocate enables someone to achieve a degree of personal reconciliation, and they no longer need to make a formal complaint.
Resolution is usually through written communication. In some instances, a face-to-face meeting between the parties is the best way to resolve a complaint. Often the advocacy process can support people to rebuild relationships, which is particularly important when the relationship will be ongoing, as with many DHB services. Frequently consumers want to ensure that what happened to them will not happen to someone else, and it can be very helpful for providers to hear this and be able to respond, face to face.

Ninety-three percent of providers and 91% of consumers surveyed in the 2018/19 year said that they were either satisfied or very satisfied with the advocacy process.

"The complaint … was very thorough, it laid out the questions the client had, the information that was required, the view of the client and also the expectations the client had for the complaint to be fully resolved." — A provider

"Having someone listen and let you 'rave' about your feelings and situation made a huge difference and I was then able to focus on the issue" — A complainant

The high rate of resolution, and high levels of consumer and provider satisfaction, reflect the strong consumer-centred approach of the Advocacy Service and significant provider commitment to the process.

## 2. This Report

This report describes the complaints the Advocacy Service received and/or closed about DHBs during the 2018/19 financial year.

The complaints are described both in terms of overall numbers and characteristics. In terms of complaints received, the issues included in the analysis are as articulated by the complainant to the Advocacy Service. Although the issues raised in complaints may not always be able to be substantiated by the advocacy process, those issues can provide valuable insight into the consumer's experience of the services provided and the issues consumers care about most.

This report provides a comparison with the trends reported for the 2017/18 year. We expect that, over time, as we continue to analyse the data to the degree of specificity demonstrated in this report, additional time series analysis will become possible, which we anticipate will be significantly useful.

In addition, it may be useful for DHBs to triangulate trends in the complaints received by the Advocacy Service with the trends in complaints received by HDC,[1] and with the complaints received directly by the DHB.

[1] In the 2018/19 year, the Advocacy Service referred 57 complaints about DHB services to HDC, and received 137 complaints about DHB services by way of referral from HDC. This means that 194 complaints in the HDC DHB report and this report are duplicated.

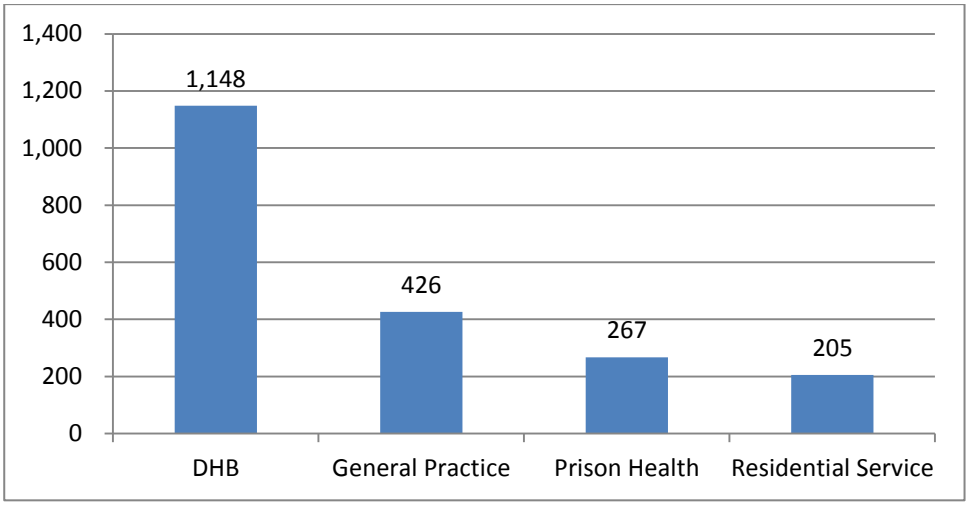
# COMPLAINTS RECEIVED BY THE ADVOCACY SERVICE

## 3. How many complaints were received?

### 3.1 Complaints received by the Advocacy Service by provider type

Figure 3 below details the commonly complained about group providers in complaints received by the Advocacy Service in 2018/19. The Advocacy Service received 1,148 complaints about DHB services in 2018/19, making DHBs the most commonly complained about group provider. This makes sense given the amount and type of care provided by DHBs in New Zealand.

**Figure 3.** The most common group providers complained about in complaints received by the Advocacy Service in 2018/19

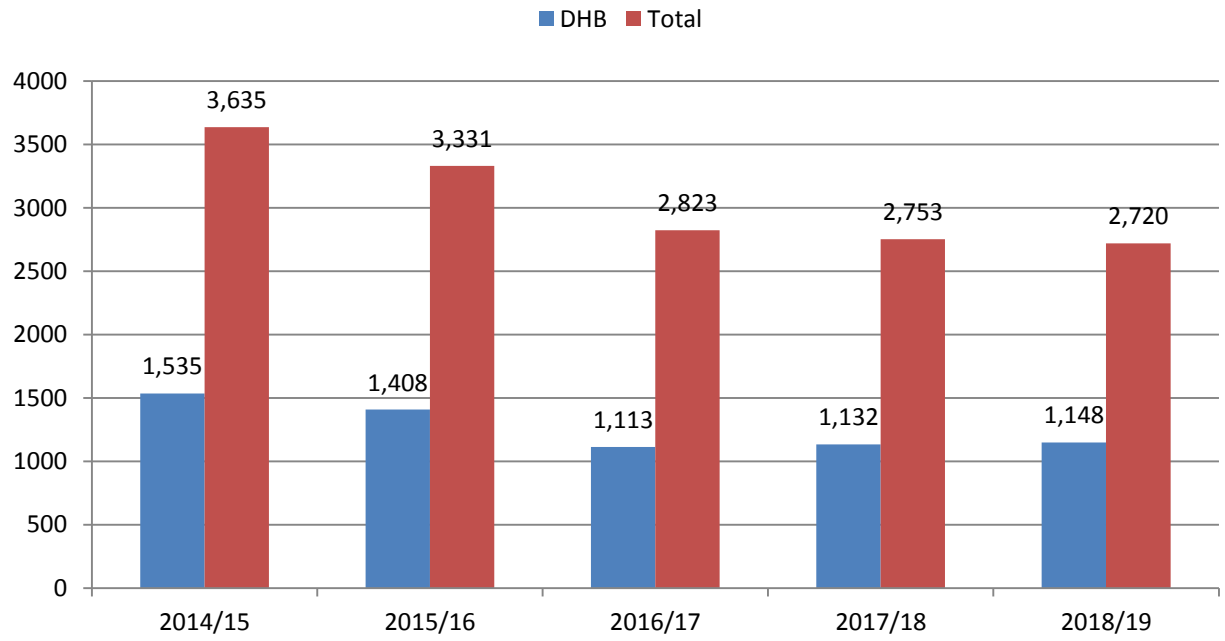



### 3.2 Number of complaints received about DHBs over last five years

Figure 4 below details the number of complaints received about DHBs as compared to the total number of complaints received by the Advocacy Service over the last five years. Complaints about DHBs tend to make up around 42% of all complaints received by the Advocacy Service each year.

The 1,148 complaints received about DHBs in 2018/19 was an 11% decrease on the average number of 1,287 complaints received over the previous four years, but was very similar to the 1,132 complaints received in 2017/18.

**Figure 4.** Complaints received by the Advocacy Service over last five years




The number of complaints received about individual DHBs in 2018/19 ranged from three complaints to 141 complaints. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and the number of services delivered by different DHBs.

## 3.3 Rate of complaints received

Expressing complaints to the Advocacy Service as a rate per 100,000 discharges will, over time, enable any trends to be observed better. Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as of the date of extraction (6 September 2019) and is likely incomplete. It should also be noted that discharge data provides a limited picture of DHB activity. Discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics. Furthermore, this data does not take into account the particular characteristics of the population each DHB serves.

In July 2018 to June 2019, according to Ministry of Health data there were 984,703 discharges nationally. This equates to an overall rate of 117 complaints to the Advocacy Service per 100,000 discharges during 2018/19. This is consistent with the rate of complaints received in the previous two years (115 and 116 complaints per 100,000 discharges).

For individual DHBs, the rate of complaints received by the Advocacy Service ranged from 53 complaints per 100,000 discharges to 372 per 100,000 discharges.

In relation to Advocacy Service complaints, an individual DHB's number and rate of complaints can be affected by a number of factors, for example, a high number of complaints may reflect a proactive approach at the DHB to complaints management. Therefore, it is recommended that each DHB assess its individual complaint rate against the number of complaints received directly by the DHB and the number and rate of complaints received by HDC for that DHB, in order to ascertain any trends that may be worthy of further attention.

# 4. Which DHB services were complained about?

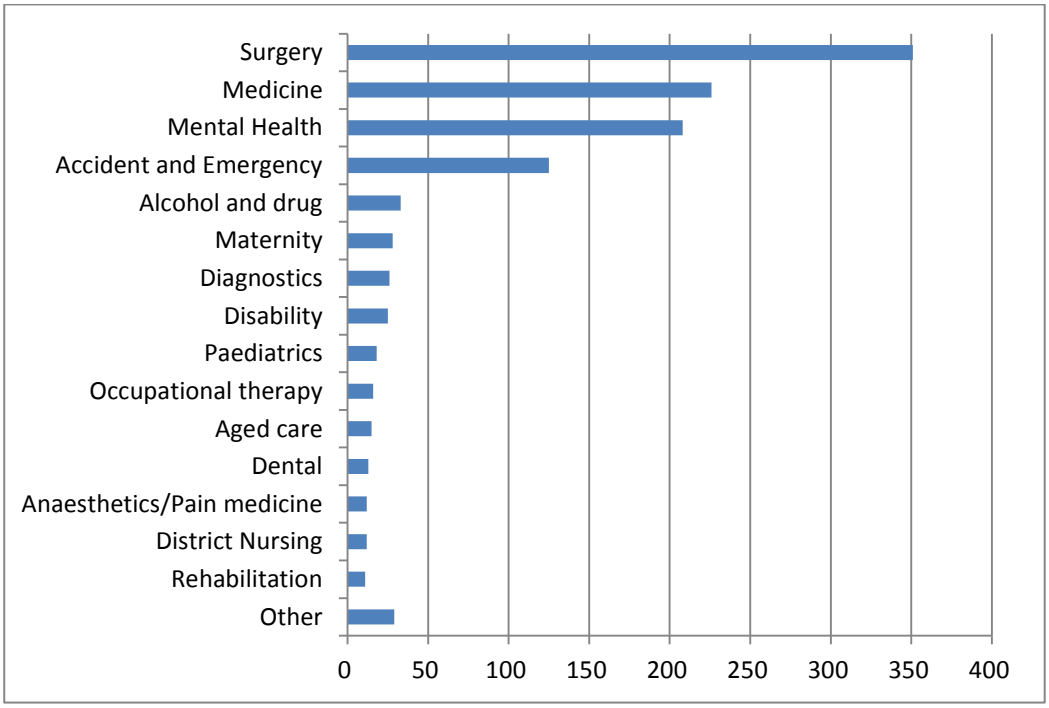
## 4.1 DHB service types complained about

Figure 5 below details the service types complained about in 2018/19. Service types responsible for less than 1% of complaints have been grouped together and classified as "other".

The most commonly complained about service type in 2018/19 was surgical services (30.6%). The most commonly complained about surgical specialties were orthopaedics (8.9%) and general surgery (8.4%).

Other commonly complained about service types were medicine (19.7%), mental health (18.1%), and emergency department services (10.9%). This is broadly consistent with the commonly complained about service types in HDC's DHB complaint reports, and with what was seen for complaints to the Advocacy Service in previous years

**Figure 5.** DHB service types complained about




A more nuanced picture of service types complained about, including individual surgical and medicine service categories, is provided below in Table 1.

**Table 1.** DHB service types complained about

| Service type | Number of complaints (%) | |
|---|---|---|
| **Aged Care** | **15** | **(1.3)** |
| **Alcohol and Drug** | **33** | **(2.9)** |
| **Anaesthetics/Pain Management** | **12** | **(1)** |
| **Dental** | **13** | **(1.1)** |
| **Diagnostics** | **26** | **(2.3)** |
| **Disability Services** | **25** | **(2.2)** |
| **District Nursing** | **12** | **(1)** |
| **Emergency Department** | **125** | **(10.9)** |
| **Medicine** | **226** | **(19.7)** |
| **Cardiology** | 19 | (1.7) |
| **Dermatology** | 2 | (<1) |
| **Endocrinology** | 7 | (<1) |
| **Gastroenterology** | 34 | (3) |
| **Geriatric Medicine** | 7 | (<1) |
| **Haematology** | 4 | (<1) |
| **Infectious Diseases** | 4 | (<1) |
| **Neurology** | 21 | (1.8) |
| **Oncology** | 34 | (3) |
| **Palliative Care** | 12 | (1) |
| **Renal/Nephrology** | 16 | (1.4) |
| **Respiratory** | 9 | (<1) |
| **Rheumatology** | 3 | (<1) |
| **Other** | 54 | (4.7) |
| **Intensive Care/Critical Care** | **4** | **(<1)** |
| **Maternity** | **28** | **(2.4)** |
| **Mental Health** | **208** | **(18.1)** |
| **Nutrition/Dietetics** | **2** | **(<1)** |
| **Occupational Therapy** | **16** | **(1.4)** |
| **Paediatrics** | **18** | **(1.6)** |
| **Physiotherapy** | **3** | **(<1)** |
| **Rehabilitation Services** | **11** | **(1)** |
| **Sexual Health** | **4** | **(<1)** |
| **Surgery** | **357** | **(30.6)** |
| **Cardiothoracic** | 9 | (<1) |
| **General** | 96 | (8.4) |
| **Gynaecology** | 42 | (3.7) |
| **Neurosurgery** | 15 | (1.3) |
| **Ophthalmology** | 19 | (1.1) |
| **Oral/Maxillofacial** | 5 | (<1) |
| **Orthopaedics** | 102 | (8.9) |
| **Otolaryngology** | 6 | (<1) |
| **Paediatric** | 13 | (1.1) |

| | | |
|---|---|---|
| **Plastic and Reconstructive** | 16 | (1.4) |
| **Urology** | 15 | (1.3) |
| **Vascular** | 5 | (<1) |
| **Unknown/Other** | 14 | (1.2) |
| **Other** | **10** | **(<1)** |
| **TOTAL** | **1,148** | |

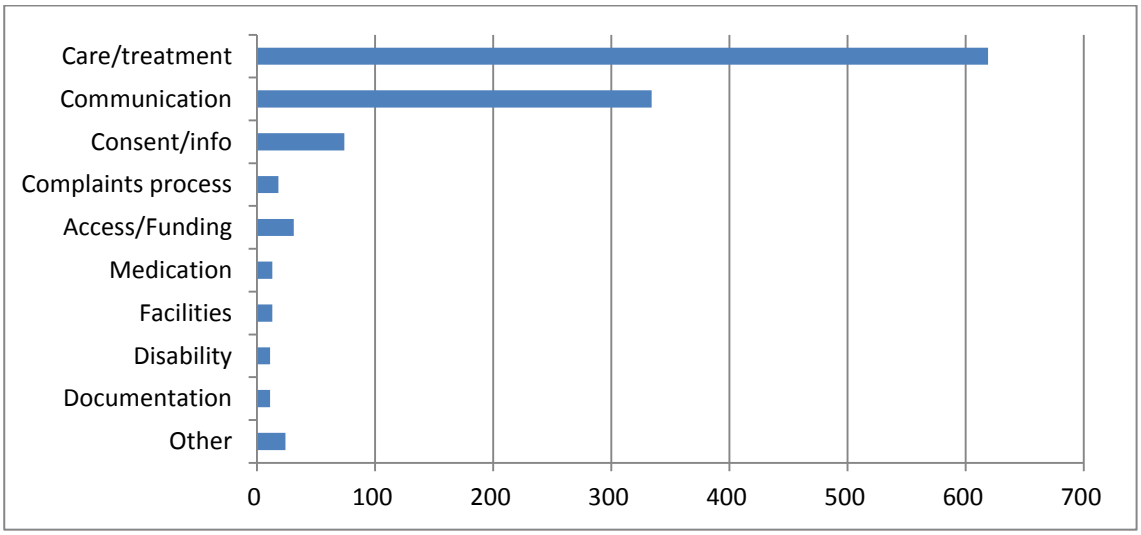
# 5. What did people complain about?

## 5.1 Primary issues identified in complaints

For each complaint received by the Advocacy Service, one primary complaint issue is identified. The primary issue is defined as the issue considered to be of most importance to the complainant. Table 2, below, shows the primary complaint issues complained about in complaints received by the Advocacy Service about DHBs in 2018/19.

Primary complaint issues were grouped into several over-arching categories. Among these categories, issues relating to care/treatment (54%) and communication (29%) were the most prevalent. This is similar to what was seen in 2017/18. The Advocacy Service receives a higher proportion of complaints primarily about communication, and a lower proportion of complaints about care/treatment issues, than is seen for complaints to HDC. The most commonly complained about primary issue categories are shown in Figure 6 below.

**Figure 6:** Most commonly complained about primary issues by category




When the specific primary complaint issues under each over-arching category are considered, failure to communicate openly/honestly/effectively with the consumer (17%), inadequate coordination of care/treatment (11%), inadequate/inappropriate treatment/procedure (7%), delay in treatment (6%), and inadequate/inappropriate examination/assessment (5%) emerge as the most common primary complaint issues (Table 2 below).

**Table 2.** Primary issues complained about

| Primary issue | Number of complaints (%) |
|---|---|
| **Access/funding** | **31 (2.7)** |
| Lack of access to services | 12 (1) |
| Waiting list/prioritisation issue | 16 (1.4) |
| Other access/funding issue | 3 |
| **Boundary violation** | **8 (0.69)** |
| Inappropriate communication (non-sexual) | 2 (<1) |
| Other boundary violation issue | 6 (<1) |
| **Care/treatment** | **619 (54)** |
| Delay in treatment | 73 (6.4) |
| Delayed/inadequate/inappropriate referral | 18 (1.6) |
| Inadequate coordination of care or treatment | 126 (11) |
| Inadequate/inappropriate care (non-clinical) | 15 (1.3) |
| Inadequate/inappropriate examination/assessment | 54 (4.7) |
| Inadequate/inappropriate follow-up | 36 (3.1) |
| Inadequate/inappropriate monitoring | 12 (1) |
| Inadequate/inappropriate testing | 8 (<1) |
| Inadequate/inappropriate treatment/procedure (clinical) | 81 (7) |
| Inappropriate admission or failure to admit | 5 (<1) |
| Inappropriate withdrawal of treatment | 10 (<1) |
| Inappropriate/delayed discharge/transfer | 20 (1.7) |
| Missed/incorrect/delayed diagnosis | 50 (4.4) |
| Personal privacy not respected | 4 (<1) |
| Refusal to assist/attend | 4 (<1) |
| Refusal to treat | 9 (<1) |
| Rough/painful care or treatment | 17 (1.5) |
| Unexpected treatment outcome | 37 (3.2) |
| Unnecessary treatment/over servicing | 5 (<1) |
| Other care/treatment issue | 35 (3) |
| **Communication** | **334 (29)** |
| Disrespectful manner/attitude | 76 (6.6) |
| Failure to accommodate cultural/language needs | 9 (<1) |
| Failure to communicate openly/honestly/effectively with consumer | 195 (17) |
| Failure to communicate openly/honestly/effectively with family | 38 (3.3) |
| Insensitive/inappropriate comments (not sexual) | 8 (<1) |
| Other communication issue | 8 (<1) |
| **Complaints process** | **18 (1.6)** |
| Inadequate information re complaints process | 2 (<1) |
| Inadequate response to complaint | 14 (1.2) |
| Other complaints process issues | 2 (<1) |
| **Consent/information** | **74 (6)** |
| Consent not obtained/adequate | 8 (<1) |
| Failure to assess capacity to consent | 2 (<1) |
| Inadequate information provided re adverse event | 5 (<1) |

| | |
|---|---|
| Inadequate information provided re condition | 8 (<1) |
| Inadequate information provided re fees/costs | 2 (<1) |
| Inadequate information provided re options | 15 (1.3) |
| Inadequate information provided re provider | 1 (<1) |
| Inadequate information provided re results | 4 (<1) |
| Inadequate information provided re treatment | 19 (1.7) |
| Incorrect/misleading information provided | 1 (<1) |
| Issues regarding consent when consumer not competent | 1 (<1) |
| Issues with involuntary admission/treatment | 4 (<1) |
| Other consent/information issue | 4 (<1) |
| **Disability-specific issues** | **17 (1.5)** |
| Inadequate physical access | 1 (<1) |
| Inadequate/inappropriate equipment provided | 6 (<1) |
| Inadequate/inappropriate support provided | 6 (<1) |
| Other disability-specific issue | 1 (<1) |
| Special needs not accommodated | 3 (<1) |
| **Documentation** | **11 (0.95)** |
| Delay/failure to disclose documentation | 1 (<1) |
| Delay/failure to transfer documentation | 2 (<1) |
| Inadequate/inaccurate documentation | 8 (<1) |
| **Medication** | **13 (1.1)** |
| Inappropriate/unlawful administration | 1 (<1) |
| Other medication issue | 5 (<1) |
| Prescribing error | 3 (<1) |
| Refusal to prescribe/dispense/supply | 4 (<1) |
| **Professional conduct** | **10 (0.87)** |
| Disrespectful behaviour | 4 (<1) |
| Inappropriate collection/use/disclosure of information | 3 (<1) |
| Threatening/bullying/harassing behaviour | 2 (<1) |
| Other professional conduct issue | 1 (<1) |
| **Other** | **13 (1.1)** |
| **TOTAL** | **1,148** |

## 5.2 Primary complaint issues by service type

Table 3 below displays the most common primary complaint issues complained about for commonly complained about service types.

Communication and coordination of care issues feature for almost all services. Emergency Department services saw a higher proportion of complaints around inadequate examinations/assessments than was seen for other service types.

These issues are broadly similar to what was seen in the previous year, although communication issues increased for surgical and general medicine services.

**Table 3.** Three most common primary issues in complaints by service type

| Surgery n = 351 | | Mental Health n = 208 | | Medicine n = 226 | | Emergency Department n = 125 | |
|---|---|---|---|---|---|---|---|
| Failure to communicate openly/ honestly/ effectively with consumer | 21% | Failure to communicate openly/ honestly/ effectively with consumer | 18% | Failure to communicate openly/ honestly/ effectively with consumer | 16% | Inadequate/ inappropriate examination/ assessment | 14% |
| Inadequate coordination of care/ treatment | 11% | Inadequate coordination of care or treatment | 8% | Inadequate coordination of care or treatment | 13% | Disrespectful manner/attitude | 14% |
| Inadequate/ inappropriate treatment or procedure (clinical) | 9% | Disrespectful manner/attitude | 8% | Delay in treatment | 8% | Inadequate coordination of care or treatment | 10% |

# COMPLAINTS CLOSED

## 6. How many complaints were closed?

The Advocacy Service closed 1,094 complaints about DHBs during 2018/19. It should be noted that complaints may be received in one financial year and closed in the following year. This means that the number of complaints received will not correlate with the number of complaints closed.

## 7. What were the outcomes of the complaints closed?

### 7.1 Available resolution options

The Advocacy Service options for closing complaints were:

- Resolved — which could be with active advocacy support or by self-advocacy with mentoring by an advocate;
- Loss of contact or withdrawal — as a result of the Advocacy Service losing contact with the consumer or the consumer electing to withdraw the complaint, sometimes following discussion of concerns with the advocate and finding personal resolution; or
- Unresolved at advocacy with or without referral to HDC.

Complaints may be referred to HDC, either directly at the consumer's request, or following an advocacy process if the advocate advises the consumer that the complaint is serious and requires HDC review or if the provider does not engage effectively in the advocacy process.

Of the 1,094 complaints closed by the Advocacy Service in 2018/19, only 123 complaints were closed unresolved, with just 22 of those unresolved complaints being referred on to HDC. In addition, there were 35 direct referrals by Advocacy to HDC.

When a complaint that has not been resolved by the Advocacy Service is referred to HDC, actions taken by the DHB to resolve the complaint with advocacy support are taken into account by HDC when assessing the complaint. Where a complaint has been referred to the Advocacy Service by HDC, the advocate is required to report back to HDC formally on the resolution process and outcome.

### 7.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in 2018/19 is shown in Table 4 below. Complaints assessed as being outside the jurisdiction of the Advocacy Service are not shown.

**Table 4.** Outcome of complaints about DHBs closed by the Advocacy Service in 2017/18

| Outcome for DHB | Number of complaints |
|---|---|
| **Direct referral to HDC** | 35 |
| **Not resolved — no further action** | 101 |
| **Not resolved — referred to HDC** | 22 |
| **Resolved** | 646 |
| **Withdrawn** | 290 |
| **TOTAL** | **1,094** |

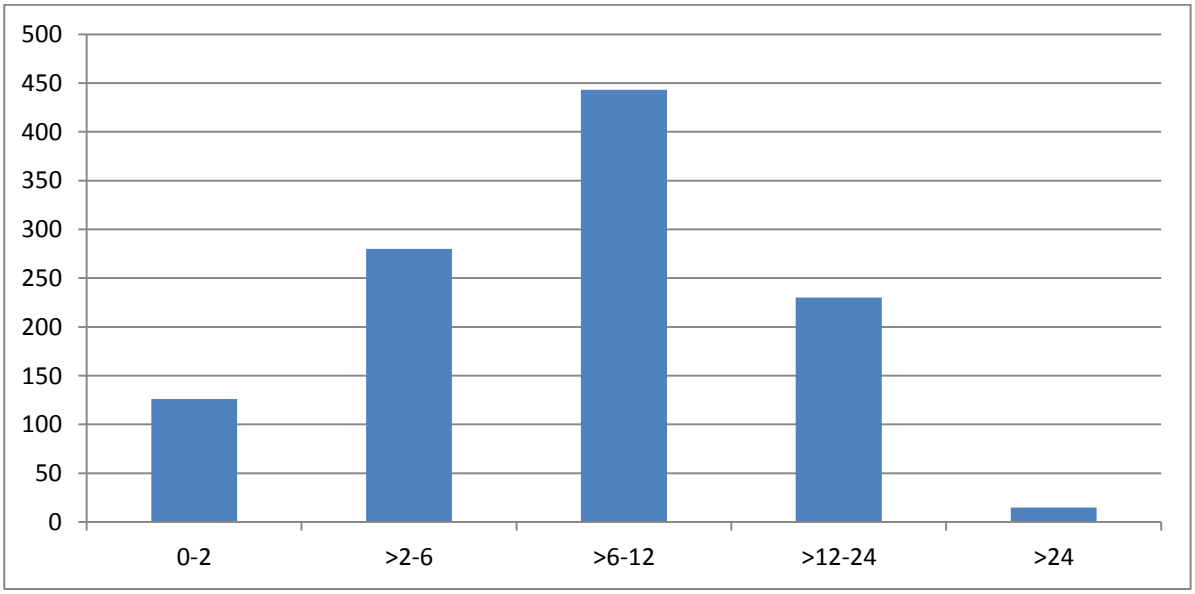
## 7.3 Timeliness of complaint closure

As shown in Figure 7 below, the Advocacy Service closed 78% of complaints about DHBs within 12 weeks, and 99% of complaints about DHBs within 24 weeks.

In comparison, when all complaints closed by the Advocacy Service in 2018/19 are considered, the Advocacy Service closed 83% of all complaints within 12 weeks, and 99% of all complaints within 24 weeks. The timeliness of complaint closures is often dependent on timely provider responses.

There were 197 complaints about DHBs open as at 30 June 2019.

**Figure 7.** Number of weeks taken to close complaints about DHBs




Example of new poster, available in A2, A3 & A4 sizes from www.advocay.org.nz

| | |
|---|---|
| WHANGANUI DISTRICT HEALTH BOARD Te Poari Hauora o Whanganui | **Decision paper** |
| | **Item. 5** |

| | |
|---|---|
| **Author** | Nadine Mackintosh, Board Secretary |
| **Endorsed by** | Russell Simpson, Chief Executive |
| **Subject** | **Resolution to exclude the public** |

## Recommendations

Management recommend that the Whanganui District Health Board:

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

| Agenda item | Reason | OIA reference |
|---|---|---|
| Whanganui District Health Board minutes of meeting held on 1 November 2019 | For reasons set out in the board's agenda of 1 November 2019 | As per the board agenda of 1 November 2019 |
| Chief executive's report<br><br>Board & committee chair reports<br><br>HDC Complaints | To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations)<br><br>To protect the privacy of natural persons, including that of deceased natural persons<br><br>To avoid prejudice to measures protecting the health or safety of members of the public<br><br>To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest. | Section 9(2)(i) and 9(2)(j)<br><br>Section 9(2)(a)<br><br>Section 9(2)(c)<br><br>Section 9(2)(ba) |
| Integrated Facilities Contract Extension<br><br>Dental Digital Image Capture Unit Procurement | To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations | Section 9(2)(i) and 9(2)(j) |
| Board Committee Membership<br><br>Delegations Policy | To maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation or officers and employees of any department or organisation in the course of their duty | Section 9 (2) (g) (i) |

### Persons permitted to remain during the public excluded session

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

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

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

| | |
|---|---|
| ACE | Advanced Choice of Employment |
| AH | Allied Health |
| AOD | Alcohol and Other Drugs |
| AoG | All of Government |
| APEX | Association of Professional and Executive employees |
| APC | Annual Practising Certificate |
| ASD | Autism Spectrum Disorder |
| ASMS | Association of Salaried Medical Specialists |
| AT&R | Assessment, Treatment & Rehabilitation |
| Capex | Capital expenditure |
| CAR | Corrective Action Request |
| CCU | Critical Care Unit |
| CMO | Chief Medical Officer |
| CPHAC/DSAC | Community Public Health/Disability Support Advisory Committee |
| CSA | Critical Systems Analysis |
| CSAC | Combined Statutory Advisory Committee |
| 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 |
| FMSS | Facilities Management and Support Services |
| FTE | Full Time Equivalent |
| GP | General Practitioner |
| HAC | Hospital Advisory Committee |
| HAI | Hauora a Iwi |
| HDC | Health and Disability Commission(er) |
| HPPPD | Hours Per Patient Per Day |
| HQPP | Hospital Quality and Productivity Programme |
| HQSC | Health Quality and Safety Commission |
| HWNZ | Health Workforce New Zealand |
| IANZ | International Accreditation New Zealand |
| InterRAI | International Resident Assessment Instrument |
| LMC | Lead Maternity Carer |
| MBIE | Ministry of Business, Innovation and Employment |
| MERAS | Midwifery Employee Representation and Advisory Services |
| MERT | Medication Error Review Team |
| MHAHT | Mental Health Assessment Home Treatment |
| 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) |
| PPEAR | Post Project Event Audit Report |
| PRIMHD | Project for the Integration of Mental Health Data |
| RAC | Risk and Audit Committee |
| RCA | Root Cause Analysis |
| RIS | Radiology Information System |
| RFI | Request for Interest |
| RFP | Request for Proposal |
| RHIP | Regional Health Informatics Programme *(formerly CRISP)* |
| RIS | Radiology Information System |
| RMO | Resident Medical Officer |
| RN | Registered Nurse |
| RSP | Regional Service Plan |
| SAB | Staphylococcus aureus bacteraemia |
| SAR | Severity Assessment Rating |
| SCBU | Special Care Baby Unit |
| SLT | Speech Language Therapist |
| SWIS | Social Workers In Schools |
| TAS | Technical Advisory Services |
| TOIHA | 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 |