AGENDA

Whanganui District Health Board

Meeting date	**Friday 6 April 2018**	
Timetable	9.15am	Board-only time
	9.45am	Patient story
	10.00am	Board meeting starts
	12.45pm	Board meeting completed
	1.00pm	Lunch with MidCentral board
	1.30pm	centralAlliance meeting
	3.00pm	End of meeting
Venue	Board Room Ward and Administration Building Whanganui Hospital 100 Heads Road Whanganui	

Embargoed until Saturday 7 April 2018

Contact
Phone 06 348 3393
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Also available on website
www.wdhb.org.nz

Distribution

Board members *(full copy bound)*

- Mrs D McKinnon, Board Chair
- Mr G Adams
- Mr C Anderson
- Mrs P Baker-Hogan
- Ms J Duncan
- Mr D Hull
- Mr S Hylton, Deputy Chair
- Mrs J MacDonald
- Ms A Main
- Dame T Turia

- Mr Peter Brown, Board Secretary

Executive Management Team and Ministry of Health *(full copy bound)*

- Mr Russell Simpson, Chief Executive Officer
- Mr Brian Walden, General Manager Corporate
- Mrs S Blake, Director of Nursing, Patient Safety and Quality
- Mrs S Campion, Communications Manager
- Mr H Cilliers, General Manager, People and Performance
- Ms K Fry, Director Allied Health
- Mrs R Kui, Director Maori Health
- Dr F Rawlinson, Chief Medical Officer
- Ms T Schiebli, General Manager, Service and Business Planning

- Mrs Nicola Holden, Relationship Manager, Ministry of Health

Managers *(full copy unbound)*

- Mrs Eileen O'Leary, Project Manager Planning and Funding
- Mr Matthew Power, Funding Manager Planning and Funding
- Mr Peter Wood-Bodley, Business Manager Surgical
- Mr Gordon Lehany, Medical Director Mental Health

Public *(public section only unbound)*

- Whanganui District Health Board Business Managers
- Mrs M Bennett, Hauora A Iwi Board Chair
- Mrs K Anderson, Chief Executive Officer, Hospice Wanganui
- Whanganui Chronicle
- Dr B Douglas, Jabulani Medical Practice
- Ms Caryl Blomkvist
- Whanganui Public Library

Agendas are available online one week prior to the meeting.

Whanganui District Health Board: How we will do our business

The board will be guided by its beliefs and principles. In taking policy and expenditure decisions the board will seek clear evidence that proposals will satisfy our beliefs and as many of these guidelines as possible.

The Whanganui District Health Board will favour proposals that will:

We believe in: Integrity ⁂ Fairness ⁂ Looking Forward ⁂ Innovation

	Our Guidelines:	What We Mean:
1	Increase **access** to improved health outcomes for people in the district.	Whether we come to you or you come to us, we're going to make sure you get the care you need.
2	**Reduce disparities** of health outcomes in our population.	If life is tough your health probably isn't good either. Improving your health will be at the top of our list.
3	Improve the quality of **diagnosis** and **treatment** provided by the WDHB.	Our people will be supported to get good gear and know-how to get it right. And we will get it right.
4	Promote an environment that encourages continuous **improvement** in service quality and effectiveness.	Each day, the DHB team who work here will figure out what they can do better – and then do it.
5	Promote **integration** and **partnership** with other services, agencies and community providers, from primary to tertiary care levels.	Sick people don't need to know whether they're in primary, secondary care or whatever. Sick people just want to be looked after. This is our problem, not theirs.
6	Develop and maintain a **skilled and motivated team** which is supported to grow professionally and deliver an excellent service.	Those people on our team who work hard and smart for our patients and for their workmates are the key to our success. We will treat them like the special people they are.
7	Deliver **greater health gains** from what resources we have.	Money is tight, so we'll be smarter.
8	Demonstrate financial sustainability, clinical sustainability, and best practice asset management for the **long term**.	We're here for the long haul. We will spend our money wisely and when we buy gear, we'll take care of it. We won't start things that can't last.
9	Demonstrate effective, **honest** and respectful engagement and **communication** with the community and ensure advancement of the community's interests.	No bull. We can't always share everything, but we'll be upfront, we'll tell you the truth and most of all we'll really listen.

Agenda
Public session

Meeting of the Whanganui District Health Board

to be held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
Friday 6 April 2018, commencing at 10.00am

Board members

Mrs Dot McKinnon (QSM) Board Chair
Mr Graham Adams
Mr Charlie Anderson (QSM)
Mrs Philippa Baker-Hogan (MBE)
Ms Jenny Duncan
Mr Darren Hull
Mr Stuart Hylton
Mrs Judith MacDonald
Ms Annette Main (NZOM)
Dame Tariana Turia (DNZM)

Karakia/reflection - Annette Main

1 Apologies -

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

3 Late items

4 Delegations

Nil

5 Patient story

Mr Trevor Gibson will relate to the meeting his experiences recovering in hospital under the auspices of the falls prevention team.

6 Minutes of board meetings

6.1 Whanganui District Health Board meeting held 2 February 2018.

Recommendation

That the minutes of the public session of a meeting of the Whanganui District Health Board held on 2 February 2018 be approved as a true and correct record.

6.2 Matters arising

7 Minutes of meetings received *(for information only)*

7.1 Combined Statutory Advisory Committee meeting held 16 March 2018.

Recommendation
That the minutes of the public session of a meeting of the Combined Statutory Advisory Committee held 16 March 2018 be received.

8 Board and committee chairs' reports – page

8.1 Board
8.2 Combined Statutory Advisory Committee
8.3 Risk and Audit Committee

9 Chief Executive's report – page

10 Decision items

10.1 Communication Policy review

11 Discussion/noting items – page

11.1 Health and Safety report
11.2 Communications report

12 Information section

13 Date of next meeting 18 May 2018

14 Exclusion of public

Recommendation

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

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 2 February and 23 February 2018 public excluded section	For reasons set out in the board's agenda of 2 February and 23 February 2018	As per the board agendas of 23 February 2018
Chief Executive's report	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)
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 To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Adverse events	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest.	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations	Section 9(2)(i) and 9(2)(j)

Persons permitted to remain during the public excluded session

That the following person(s) may be permitted to remain after the public has been excluded because the 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 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 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

WHANGANUI DISTRICT HEALTH BOARD

REGISTER OF CURRENT CONFLICTS AND DECLARATIONS OF INTEREST

Up to and including 16 March 2018

BOARD MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Graham Adams	16 December 2016	Advised that he is: ▪ A member of the executive of Grey Power Wanganui Inc. ▪ A board member of Age Concern Wanganui Inc. ▪ Treasurer of NZCE (NZ Council of Elders) ▪ A trustee of Akoranga Education Trust, which has associations with UCOL.
Charlie Anderson	16 December 2016 3 November 2017	Advised that he is an elected councillor on Whanganui District Council. Advised that he is now a board member of Summerville Disability Support Services.
Philippa Baker-Hogan	10 March 2006 8 June 2007 24 April 2008 25 September 2009 29 November 2013 7 November 2014 3 March 2017	Advised that she is an elected member of the Whanganui District Council. Partner in Hogan Osteo Plus Partnership. Advised that her husband is an osteopath who works with some surgeons in the hospital on a non paid basis but some of those patients sometimes come to his private practice Hogan Osteo Plus and that she is a partner in that business. Appointed to Whanganui Community Foundation from 1 October 2009 Advised that she is Chair of the Future Champions Trust, which supports promising young athletes. Philippa Baker-Hogan declared her interest as: ▪ A member of the Whanganui District Council District Licensing Committee; and ▪ Chairman of The New Zealand Masters Games Limited Philippa Baker-Hogan declared her interest as a trustee of Four Regions Trust.
Jenny Duncan	18 October 2013 1 August 2014	Advised that she: ▪ Is a member of the Whanganui Community Foundation ▪ Is an elected member of the Whanganui District Council Advised that she is an appointed member of the Castlecliff Community Charitable Trust
Darren Hull	28 March 2014 27 May 2014 20 June 2014 23 May 2016	Advised that he acts for clients who may be consumers of services from WDHB. Advised that he: ▪ is a director & shareholder of Venter & Hull Chartered Accountants Ltd which has clients who have contracts with WDHB ▪ acts for some medical practitioners who are members of the Primary Health Organisation ▪ acts for some clients who own and operate a pharmacy ▪ is a director of Gonville Medical Ltd Advised he is on the Whanganui Regional Health Network Risk & Audit Committee. Advised he is no longer on the Whanganui Regional Health Network Risk & Audit Committee.
Stuart Hylton	4 July 2014 13 November 2015 15 March 2017	Advised that he is: ▪ Executive member of the Wanganui Rangitikei Waimarino Centre of the Cancer Society Of New Zealand. ▪ Appointed Whanganui District Licensing Commissioner, which is a judicial role and in that role he receives reports from the Medical Officer of Health and others. Advised that he is an executive member of the Central Districts Cancer Society. Advised that he is appointed as Rangitikei District Licensing Commissioner.

Judith MacDonald	22 September 2006	Advised that she is: ▪ Chief Executive Officer, Whanganui Regional Primary Health Organisation ▪ Director, Whanganui Accident and Medical
	11 April 2008	Advised that she is a director of Gonville Health Centre
	4 February 2011	Declared her interest as director of Taihape Health Limited, a wholly owned subsidiary of Whanganui Regional Primary Health Organisation, delivering health services in Taihape.
	27 May 2016	Advised that she has been appointed Chair of the Children's Action Team
Annette Main		No current declared interests.
Dot McKinnon	3 December 2013	Advised that she is: ▪ An associate of Moore Law, Lawyers, Whanganui ▪ Chair, Powerco Wanganui Trust ▪ Wife of the Chair of the Wanganui Eye & Medical Care Trust
	4 December 2013	Advised that she is Cousin of Brian Walden
	23 May 2014	Advised that she is a member of the Health Sector Relationship Agreement Committee.
	31 July 2015 and 10 August 2015	Advised that she is appointed to the NZ Health Practitioners Disciplinary Tribunal
	2 March 2016	Advised that she is a member of the Institute of Directors
	16 December 2016	Advised that she is Chair of MidCentral District Health Board
	3 February 2017	Advised that she is on the national executive of health board chairs
Tariana Turia	16 December 2016	Declared her interests as: ▪ Pou to Te Pou Matakana (North Island) ▪ Member of independent assessment panel for South Island Commissioning Agency ▪ Life member CCS Disability Action ▪ National Hauora Coalition Trustee Chair ▪ Cultural adviser to ACC CEO ▪ Te Amokura of Te Korowai Aroha Trust (National)
	15 November 2017	Recorded that she has been appointed Te Pou Tupua o te Awa.

BOARD ADVISORS

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

COMBINED STATUTORY ADVISORY COMMITTEE MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Maraea Bellamy	7 September 2017	Advised that she is: ▪ Te Runanga O Ngai Te Ohuake (TRONTO) Delegate of Nga Iwi O Mokai Patea Services Trust. ▪ Secretary of Te Runanga O Ngai Te Ohuake. ▪ Hauora A Iwi - Iwi Delegate for Mokai Patea.
Frank Bristol	8 June 2017	Advised that he is: ▪ Member of the WDHB Mental Health and Addiction (MH&A) Strategic Planning Group co-leading the adult workstream. ▪ An executive member of the National Early Intervention for Psychosis society. ▪ In a management role with the NGO Balance Aotearoa which holds Whanganui DHB contracts for Mental health & addiction peer support, advocacy and consumer consultancy service provision. ▪ Working as the MH & A Consumer Advisor to the Whanganui DHB through the Balance Aotearoa as holder of a consumer consultancy service provision contract. ▪ Working as Consumer Advisor to MidCentral DHB MHA Services. Member of MidCentral DHB MHA Executive Management team. ▪ Member of Sponsors and Reference groups of National MH KPI project.

		▪ Member of Health Quality and Safety Commission's MH Quality Improvement Stakeholders Group. ▪ Member of Te Pou/Ministry of Health Information and Data reference group ▪ Member of Ministry of Health 'He Tangata" (MH Outcomes Framework) Informatics workstream ▪ Member of Whanganui DHB/WRHN Strategic IT group ▪ Has various roles in Whanganui DHB MHA WD, Quality Improvement programmes and Strategic planning ▪ Member of Whanganui DHB CCDM Council ▪ Steering group partner via Balance Aotearoa with Ministry of Health on Disability Action Plan Action 9d).This is legal and improvement work associated with MH Act, Bill of Rights and UN Convention on Rights of Disabled people. ▪ Balance Aotearoa is a Disabled Persons Organisation (DPO) and a member of the DPO Collective doing work with the Disability Action Plan representing the mental health consumers. ▪ Life member of CCS Disability Action
	14 July 2017	Advised that he is doing consultancy work for Capital and Coast District Health Board
	1 September 2017	Advised that he has been appointed to the HQSC Board's Consumer Advisory Group
Andrew Brown	13 July 2017	Advised that: ▪ he is an independent general practitioner and clinical director of Jabulani Medical Centre; ▪ he is a member of Whanganui Hospice clinical governance committee; and ▪ most of his patients would be accessing the services of Whanganui District Health Board.
Leslie Gilsenan	11 September 2017	Advised that he is the Service Manager, CCS Disability Action Whanganui (formerly Whanganui Disability Resources Centre).
Matt Rayner	11 October 2012	Advised that: ▪ He is an employee of Whanganui Regional PHO – 2006 to present ▪ His fiancée, Karli Kaea-Norman, is an Employee of Gonville Health Limited
	26 October 2012	Advised that he is a member on the Diabetes Governance Group
	31 July 2015	Advised that he is: ▪ employed by the Whanganui Regional Health Network (WRHN) ▪ a trustee of the group "Life to the Max"
	27 May 2016	Advised that he is a member of the Health Solutions Trust
	1 September 2017	Advised that he is now a trustee of Whanganui Hospice
Ailsa Stewart		No current declared interests.
Grace Taiaroa	1 September 2017	Advised that she is: ▪ Hauora A Iwi (Ngā Wairiki Ngāti Apa) representative ▪ General Manager Operations – Te Runanga o Ngā Wairiki Ngati Apa (Te Kotuku Hauora, Marton) ▪ Member of the WDHB Mental Health and Addictions Strategic Planning Group ▪ Member of the Maori Health Outcomes Advisory Group.
	16 March 2018	Advised that she is deputy chair of the Children's Action Team

RISK AND AUDIT COMMITTEE MEMBERS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS

NAME	DATE NOTIFIED	CONFLICT/DECLARATIONS
Anne Kolbe	26 August 2010	▪ Medical Council of NZ – Vocational medical registration – Pays registration fee ▪ Royal Australasian College of Surgeons – Fellow by Examination – Pays subscription fee

	▪ Private Paediatric Surgical Practice (Kolbe Medical Services Limited) – Director – Joint owner ▪ Communio, NZ – Senior Consultant - Contractor ▪ Siggins Miller, Australia – Senior Consultant - Contractor ▪ Hospital Advisory Committee ADHB – Member – Receives fee for service ▪ Risk and Audit Committee Whanganui DHB – Member – Receives fee for service ▪ South Island Neurosurgical Services Expert Panel on behalf of the DGH – Chair – Receives fee for service
18 April 2012	Advised that she is an employee of Auckland University but no longer draws a salary.
20 June 2012	Advised that she holds an adjunct appointment at Associate Professor level to the University of Auckland and is paid a small retainer (not salary).
17 April 2013	Advised that her husband John Kolbe is: ▪ Professor of Medicine, FMHS, University of Auckland ▪ Chair, Health Research Council of New Zealand, Clinical Trials Advisory Committee (advisory to the council) ▪ Member Australian Medical Council (AMC) Medical School Advisory Committee (advisory to the board of AMC) ▪ Lead, Australian Medical Council, Medical Specialties Advisory Committee Accreditation Team, Royal Australian College of General Practitioners ▪ Member, Executive Committee, International Society for Internal Medicine ▪ Chair, RACP (Royal Australasian College of Physicians) Re-validation Working Party ▪ Member, RACP (Royal Australasian College of Physicians) Governance Working Party
12 February 2014	Advised that she is a Member of the Australian Institute of Directors – pays membership fee
18 February 2016	Joined the inaugural board of EXCITE International, an international joint venture sponsored by the Canadian Government, to consider how to pull useful new technology into the marketplace. No fee for service, although costs would be met by EXCITE International.
13 April 2016	Advised that she: ▪ is an observer to the Medicare Benefits Schedule Review Taskforce (Australia).
10 August 2016	Advised that: ▪ Transition of the National Health Committee business functions into the NZ Ministry of Health was completed on 9 May 2016. The Director-General has since disbanded the NHC executive team. ▪ Emma Kolbe, her daughter, has taken up a position at ESR (Institute of Environmental Science and Research), Auckland as a forensic scientist working in the national drugs chemistry team. ▪ She is chair, Advisory Council, EXCITE International. ▪ She is member of MidCentral District Health Board's Finance, Risk and Audit Committee.

Minutes
Public session

Meeting of the Whanganui District Health Board

held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 2 February 2018, commencing at 9.45am

Present

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

In attendance

Mr Russell Simpson, Chief Executive
Mrs Sandy Blake, Director of Nursing, Patient Safety and Quality
Mrs Sue Campion, Communications Manager
Mr Hentie Cilliers, General Manager Human Resources and Organisational Development
Mrs Kim Fry, Director Allied Health
Mrs Rowena Kui, Director Māori Health
Dr Frank Rawlinson, Chief Medical Officer
Mr Brian Walden, General Manager Corporate
Mr Peter Brown, Board Secretary

Public

Members of the press, public and staff

Karakia/reflection

Judith MacDonald opened the meeting with a karakia/reflection.

1 Apologies

Nil.

2 Conflict and register of interests update

2.1 Amendments to the register of interests
Nil.

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

3 Late items

Nil.

4 Delegations

Nil.

5 Patient story

A patient recounted his experiences to the board regarding his discharge from Whanganui Hospital after the amputation of his leg. "I thought I was better than I was" and he was keen to go home, but in reality he was not ready to go home and the home environment into which he was going was not yet suitable and ready for him.

His experience was that while he was in hospital the systems ran well, but there were issues and problems in relation to his discharge. The reality was that he was discharged from a ward with full support to a home environment with issues in terms of access into the house, access into and out of bed and access to trained support.

The investigations and learnings from the case include the following:

- The patient was (and most patients would be) keen to go home, but there needs to be a balance between agreeing to discharge the patient to home and making sure that it is safe for the patient to return home.
- It was also recommended that a patient should have an option to be accompanied by a clinical staff member on request or in cases such as this, processes to make sure that the environment that they are being discharged to is suitable and safe for them.
- Generally a patient would be moved from an acute ward to rehab. The question of whether the patient should have been moved from AT&R to rehab was not raised in this case.
- The case also highlights the transition from secondary to primary care. In this case ACC knew that it was elective surgery, had visited the patient and provided a wheelchair etc. From the hospital's perspective, it was understood that the patient wished to be discharged home, that ACC had visited the home, that arrangements were in place for the patient to be discharged home and that he would have the necessary support.
- The case indicates that discharge planning needs to be reviewed.

Points made and comments noted included:

- Although it was understood that ACC had support arrangements in place, there should have been checks to ensure that ACC were involved and that the support was in place.
- The board is looking for assurances that the systems are in place.

- Forms alone are not the whole answer, the communication between hospital staff, ACC and others involved in the discharge needs to be functioning well. In this case hospital staff understood and were hearing that ACC were involved, had everything set up, knew the patient was coming because it was elective surgery etc, but in reality that was not the case.
- The ACC physiotherapist was able to get onto the ward and have access to the patient for treatment, there were no barriers to that, but there appear to be no policies and procedures in place between the DHB and ACC.
- The patient has received sincere apologies for the shortcoming experienced in this case.

Transition of care is the issue. The Health and Disability Commissioner is focusing on the transition of care in some of his recent findings and those discussions are also taking place within the medical fraternity
Our biggest vulnerability is in terms of ED and discharges back into the community. We see about 20,000 people a year and at least 14,000 of those will go straight back into the community with expectations around follow-up and so on. Transition of care is at the nub of tying the various components of the health care system together.

The question is, how do we ensure that these systems are talking to one another to enable and ensure that logic and the right outcomes happen?

All reported incidents such as this are reported to the Clinical Board.

6 Minutes of board meetings

6.1 Whanganui District Health Board meeting

It was resolved that:

The minutes of the public session of the meeting of the Whanganui District Health Board held on 15 December 2017 be approved as a true and correct record.

Matters arising

Nil.

7 Minutes of committee meetings

7.1 Combined Statutory Advisory Committee meeting

Nil.

8 Board and Committee Chairs' reports

Verbal reports may be given at the meeting

8.1 Board

Taken as read.

8.2 Combined Statutory Advisory Committee

Taken as read.

8.3 Risk and Audit Committee

- The committee chair advised that the committee is still looking to appoint another independent member. Two have been interviewed, one has withdrawn and the other is still being considered.
- The Risk Management Framework and controls for managing those risks are being reviewed.
- The framework will be reported back to the board later this year.
- The board chair proposed that the committee chair attend the MidCentral Risk and Audit Committee meeting and vice versa to compare how each committee works.

9 Chief Executive's report

9.1 Patient Safety and Service Quality

Taken as read.

9.2 Mental Health Services' Government Inquiry

Taken as read.

9.3 Elective Services

Points noted included:

It was noted that ESPI non-compliance is costly and that in the fourth month of non-compliance the Ministry imposes a financial penalty of $434,000. The fourth month would be April and the team is working hard to achieve compliance.

Ophthalmology is suffering from short staffing. The MidCentral and Taranaki District Health Boards are being supportive. Two new staff have been recruited and when they come on board, that department will be fully staffed. The board tries not to exceed expected timeframes and refers patients out when necessary. Once the service is fully staffed it is expected that referrals in to the service will increase.
The board is currently in dialogue with Waikato District Health Board to get patients referred to Whanganui, but we are running out of time to obtain the previously agreed outsourced work.

9.4 Māori Health

The agenda for Te Kaha will be circulated when available.

9.5 Regional Health Informatics Programme

Taken as read.

9.6 Summary financial report for December 2017

Taken as read.

9.7 Compliance with statutory requirements

Taken as read.

10 Decision items

Nil.

11 Discussion/noting items

11.1 Health & Safety Report

The chair suggested that a regular walk around by board members should be facilitated, checking on health and safety issues.

It was resolved that the Whanganui District Health Board

1. **Receives** the paper entitled 'Health and Safety report'.

11.2 People and Performance Department's six-monthly report

Points noted included:

Nationally, the high performance high engagement ("HPHE") framework has been endorsed by DHBs, the CTU affiliate unions and the Ministry. It is planned to implement HPHE at Whanganui District Health Board.

To date, six hundred and twenty staff have been trained in the "Speak Up for Safety" programme, which goes live in May.

I think this means that other boards are consulting with us regarding our implementation of the programme.
The CEO sees the programme as critical and is supportive of its implementation throughout the health system, not just in the hospital.

It was resolved that the Whanganui District Health Board

1. **Receives** the paper entitled 'People and Performance Department's six-monthly report'.

11.3 Clinical Board's six-monthly report

Points noted included:

Philippa Baker-Hogan suggested that the CEO review the Clinical Board (CB) structure and whether the reporting is appropriate.

The CEO will be looking at everything with fresh eyes, but observed that clinical governance and patient safety are sacrosanct.

Philippa Baker-Hogan noted that, in her view, the CB is too hospital-centric and would benefit from wider input

The chair of the CB noted that part of the work is around the organisation having an understanding of clinical governance and that clinical governance does not just sit with the CB . It is about all the different committees, groups, departments and teams doing clinical governance. All those teams are doing clinical governance, but may not understand what it means.

I think what is meant here is that the CB are ensuring appropriate risk management is taking place within the organisation and that each area is aware of what that entails and reports accordingly.

It was resolved that the Whanganui District Health Board

1. **Receives** the paper entitled 'Clinical Board's six-monthly report'.

12 Information papers

Points noted included:

Annette Main noted that the implementation of free WIFI being made available to our patients is of significant benefit and acknowledged the assistance of Inspire in enabling that service.

In relation to the board's detailed financial report for December 2017, there has been approximately a 4% a year growth in acute volumes. As a sector we are falling behind plan.

The chair noted that the budget is due in May and the letter of expectation will most probably be received just prior to that. She advised that although there will be some assistance from the census (from the district's population growth) the board is not expecting that there will be a significant increase in funding beyond what has already been announced.

13 Date of next meeting

23 February 2018 Annual Planning Workshop and Friday 6 April 2018 from 10.00am board meeting 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.

Agenda item	Reason	OIA reference
Whanganui District Health Board minutes of meeting held on 15 December 2017 public-excluded session	For the reasons set out in the board's agenda of 15 December 2017	As per the board's agenda of 15 December 2017
Chief Executive's report	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)
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 To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
Adverse events	To protect the privacy of natural persons, including that of deceased natural persons To avoid prejudice to measures protecting the health or safety of members of the public To protect information which is subject to an obligation of confidence or which any person has been or could be compelled to provide under the authority of any enactment, where the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied; or would be likely otherwise to damage the public interest	Section 9(2)(a) Section 9(2)(c) Section 9(2)(ba)
WRHN audit report	To enable the district health board to carry out, without prejudice or disadvantage, commercial activities or negotiations (including commercial and industrial negotiations)	Section 9(2)(i) and 9(2)(j)

Persons permitted to remain during the public excluded session

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 11.00am.

6.1 Matters arising

The following items arise from the meeting held 2 February 2018. The numbering relates to the number of the item in those minutes.

5 Patient story

The general manager allied health has provided an update regarding concerns from board members that systems are in place to ensure patients are being discharged into a safe home environment.

11.1 Health and Safety report

At the behest of the board chair, the general manager people and performance has suggested that a walk-around of the campus takes place following the board meetings of 18 May and 2 November. We will await advice from the board regarding their specific areas of interest.

11.3 Clinical Board's six-monthly report

Following a board member's query, the CEO will provide information regarding the structure and appropriate reporting systems of the Clinical Board through the CEO Friday Update.

Minutes
Strategic Focus Workshop

Meeting of the Whanganui District Health Board

held in the Board Room, Fourth Floor, Ward/Administration Building
Whanganui Hospital, 100 Heads Road, Whanganui
on Friday 2 February 2018, commencing at 9.45am

(The strategic focus workshop commenced at 11.15 am).

Present

Whanganui District Health Board
Mrs Dot McKinnon, Board Chair
Mr Graham Adams
Mr Charlie Anderson
Mrs Philippa Baker-Hogan
Mrs Jenny Duncan
Mr Darren Hull
Mr Stuart Hylton, Deputy Chair
Mrs Judith MacDonald
Ms Annette Main
Dame Tariana Turia
Peter Brown, Board Secretary

Hauora A Iwi
Mary Bennett, Chair
Grace Taiaroa, Deputy Chair

Whanganui Regional Health Network
Ken Young, Chair
Judith MacDonald, Chief Executive
Alaina Teki-Clarke, Board of Trustees
Michael Lamont, Board of Trustees
Michael Sewell, Board of Trustees

National Hauora Coalition
Simon Royal, Chief Executive
Rawiri Jansen, Clinical Director
Jonathan Murray, Group Manager Primary Health Services and Manager Mōhio Project

Allied Health
Kim Fry, Director Allied Health

WDHB Executive Management Team
Russell Simpson, Chief Executive
Sandy Blake, Director of Nursing, Patient Safety and Quality
Rowena Kui, Director Māori Health
Frank Rawlinson, Chief Medical Officer
Brian Walden, General Manager Corporate

Facilitator
Andrew Tripe

1 Apologies

An apology from John Maihi was recorded. An e-mail from Uncle John was conveyed to the meeting, advising that we need to:

- be working collaboratively but maintain independence;
- build better communication and connectedness;
- build sensitive, caring, professional staff; and
- have the right people, practising in the right way.

An apology was recorded from Tracey Schiebli, general manager service and business planning.

2 Presentations

The Whanganui District Health Board chair noted that the board is looking to identify a few (say three) key strategic issues to focus on and push over the next year and following years. The board wants to look further out than just the coming year and the annual plan.

Four presentations were provided, by Whanganui Regional Health Network, National Hauora Coalition, Hauora A Iwi and Wanganui District Health Board. The presentations were tabled (except for Hauora A Iwi) and are not repeated at length in these minutes.

2.1 Whanganui Regional Health Network

Whanganui's population is getting older and we are seeing increasing demand on all services, increasing complexity (often with co-existing conditions) and growing volumes.

We have an aging work force.

Studies have shown the general practice funding model is not fit for purpose and nationwide, general practices are under pressure.

The strategy being espoused is multi-disciplinary teams, but in practice that is often just a doctor and a nurse. In some places healthcare hubs are being used with multidisciplinary teams. Strategically we should be looking at the models being adopted in other areas and look at how they can be implemented in our area.

In practice, integration work is long and arduous. It needs to be done over an appropriate timeframe (often five years or more) and needs to have a coherent strategy.

We need a strategy that looks ahead and creates a flexible health system, because there will be changes in service provision over time. We need:

- to be thinking about utilisation of resources;
- a sub-regional collaborative plan;
- integrated information systems, interconnectedness across the sub region must be a priority, IT systems must talk to one another; and
- a coherent strategy, people want to be part of something that aligns with their attitudes, values, beliefs and improves people's health care.

If the system does not respond to people's needs early enough then that increases demand on secondary and tertiary care.

Ken Young described the model of "healthcare homes". For the model to work properly you need:

- the system to respond more as a team
- PHOs, general practices and DHBs to be more aligned
- referrals from general practice rather than necessarily from specialist services
- high trust and accountability
- clinical leaders changing the health system
- to be working more widely than just PHOs and DHBs, you need to include other NGOs and, to be effective, there needs to be wide collaboration; and
- to allow reasonable but not exorbitant profits.

The multiple issues in pharmacy prescriptions are illustrative of the problems from a lack of integration and centralisation of IT systems.

The WDHB chief executive observed that relationships are critical and even though systems will continue to not talk to one another, people can. The inter-sectorial cross-continuum of care is something that he is particularly keen to hear about and while there will be continuing work on ICT systems and integration, we can and must still talk among ourselves.

No one organisation and no one leader has everything in their kete to do what needs to be done. Cooperation and collaboration is needed, not just between hospital and primary care, but also with whanau.

We need to trust our patients and whanau to know what is best for them and be actively involved in decisions about their care.

Philippa Baker Hogan observed that the issues are cross-sectorial and not just issues within the health sector.

2.2 National Hauora Coalition

The coalition's philosophy, vision and values were summarised. In recent years their focus has been very much about shifting the focus of the healthcare system away from disease management and injury rehabilitation to a whanau centred - outcomes driven - evidence informed – systematic approach.

The coalition is Auckland based, across five different health boards, with an enrolled population of about 130,000, a majority of whom are high needs including Maori, Pacific and low income families.

The coalition thinks that Healthcare homes already exists within New Zealand within our Maori providers, as a Maori version of Healthcare homes.

We currently have a very siloed approach to addressing problems in society. The lack of integration of activities across the government sector is fundamentally a problem in addressing the social determinants of health. The coalition advocates a Whanau Ora approach.

The health system serves the broader population's intent.

They introduced and spoke about Mōhio, a clinical information platform for general practice and primary care organisations. It provides a suite of integrated tools to support clinical outcomes, information collection, decision support, reporting and more.

They provided examples of the gains achieved from the Mana Kids programme, reducing rheumatic fever; tracking skin infection and hospitalisations of 5 -12 year olds in the area they serve.

They spoke about how the Mana Kids programme operates. The coalition's job is to organise (usually involving about three staff) but working with other services. The kids are at the centre of the program. Every high needs school involved in the programme has a nurse and a whanau support worker. They have seven different providers (some of whom are with other PHOs) and whole lot of protocols to ensure that every child is checked each day as to whether they have a sore throat etc and if they have a problem those problems are dealt with in an organised way. The programme involves 88 schools, 34,000 kids and every child being dealt with by health worker all the way through the year. The result has been a 48% decrease in acute rheumatic fever rates despite rising shortages and problems with housing in the area. The fiscal cost avoided from the investment in that program must be substantial. Funding for the programme comes from a range of sources including MSD, DHB, HRC, social investment agencies, philanthropic funding etc. There have been reductions in public health nurse costs etc.

These programmes are often disruptive to existing practice. It involves people acting and behaving differently. Mana Kids is a rheumatic fever programme, it is the biggest in New Zealand, but it is making a huge impact on other conditions such as skin infections, children's attendance rate at schools, injury prevention etc.

The approach can be applied to oral health, it becomes a gateway to address and improve other issues. MSD has realised it can solve some of its issues and fiscal liabilities from investing in the health system.

Systems need to be organised differently with nurses practising at the top of their scope etc.

They issued a challenge to the board to get to equity in 20 years and to focus on children to achieve that.

Looking at other cohorts, what do we need to do now to be where we want to be in another 20 years' time?

The greatest marginal gains will be from focusing on Maori. If something is good for Maori it will be good for the rest of the community.

We should look for enablers such as Mana Kids to achieve what we are wanting to achieve.

2.3 Whanganui District Health Board

In addition to the presentation, points made and comments noted included:

There is a lot of very good collaborative work that is occurring, the outreach service, the children's work that is done together, the heads forum etc. Even though at a systems level some of the systems are not joined up, at a grassroots level a lot of good collaborative work is happening in practice.

In relation to health work force equity, at a DHB hospital level we are struggling to make headway, numbers have increased but the workforce has also increased and currently Maori comprise about 10% of the workforce.

We need integrated patient centric care.

We need to give careful thought to how we can communicate with all partners in a way that enables us to understand each other better, build trust and to work together better to co-design services and systems.

2.4 Hauora A Iwi

Hauora a Iwi's worldview is:

- wellness versus illness
- whanau versus individual
- holistic versus silo.

The Memorandum of understanding between WDHB and Hauora A Iwi is being signed. The aim is to partner to make sure that we are making an impact and getting the health gains that we want for our people. We want an effective partnership that goes beyond just "ticking the box" and satisfying the legislative obligations.

Hauora A Iwi's goals are:

- giving effect to Whanau Ora
- achieving health equity for Maori; and
- improving capacity, enhancing capability.

We need an appropriate workforce.

We need:

- a strategy for wellness (with people at the centre of everything)
- partnership (that is mana-enhancing)
- prevention rather than intervention or cure (Pae ora)
- rangatiratanga (we need to acknowledge that we are all unique, that our needs are unique and that the system needs to respond accordingly.)

We need new approaches and to focus on:

- How do we become more community centric with the dollars that we spend rather than hospital centric. That involves everyone in the room being on the same page on. The question is whether everyone is willing to do that?
- Alternative services appropriate for the individual, not just traditional specialist medical services.
- Technology enhanced services.

All of this, in addition to business as usual.

3 Identification of strategic drivers and strategic enablers

Andrew Tripe asked everyone present to identify:

- three things that will drive better health outcomes for this district's "strategic focus"; and
- three things ("enablers") to achieve those outcomes.

Time was then given for members to provide three strategic drivers and three strategic enablers and the responses provided were gathered together for subsequent collation and consideration.

4 Questions and comments

- Little or nothing heard in the strategic planning session that hasn't been heard before;
- we need to identify what we need to do differently;
- we need action orientation;
- it must be people-centred;
- we need strategic focus and strategic drivers to deliver outcomes;
- the execution challenge sits with management to advance the identified areas of strategic focus;
- we need good data (and cohort identification) to be available to enable better decision-making;
- we need to acknowledge the things that are working well; and
- we need to identify how to incentivise performance.

5 Way forward

The responses from the workshop will be collated and presented back to the board and partners present for consideration and feedback and then to management for implementation.

Closure

Adopted this day of 2018

.....
Chair

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

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 16 March 2018, commencing at 9.30am

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

In attendance
Mrs Rowena Kui, Director Māori Health
Dr Frank Rawlinson, Chief Medical Officer
Ms Andrea Bunn, Portfolio Manager, Mental Health and Health of Older People
Ms Sue Campion, Communications Manager
Dr Gordon Lehany, Medical Director, Mental Health
Mrs Sandy Blake, Director of Nursing and General Manager Patient Safety
Ms Candace Sixtus, Portfolio Manager, Primary Care
Mr Hentie Cilliers, General Manager, People and Performance
Mr Peter Wood-Bodley, Business Manager, Surgical Services
Ms Louise Torr, Manager Medical Management Unit
Mr Matthew Power, Funding and Contracts Manager
Mrs Anne Kauika,
Mrs Kath Fraser-Chapple, Business Manager, Business Management and Support

Mr Peter Wood-Bodley, Business Manager, Surgical and MH
Mr Jon Buchan, Portfolio Manager, Service and Business Planning
Mr Ben McMenamin, Bowel Screening Project Manager
Mrs Kath Butters, Nurse Manager MH
Mr Jeff Hammond, Associate Director of Nursing MH
Mrs Eileen O'Leary, Project Manager
Mrs Tricia Wells, Executive Assistant to the WDHB and Medical Directorate

Media
No media representative attended the meeting.

Public
There were two members of the public present, representatives of Grey Power
Ms Ailsa Stewart, historical project co-ordinator

Karakia / reflection
Mr Matt Rayner offered a Karakia.

1 Welcome and apologies

Apologies were received and accepted from Dot McKinnon.

2 Conflict and register of interests update

2.1 Updates to the register of interests

New update:

Grace Taiaroa advised she is now the deputy chair of the Children's Action Team.

Amendments to the register of interest:

There were no amendments to the register.

2.2 Declaration of conflicts in relation to business at this meeting

There were no declarations of conflict in relation to this meeting.

3 Late items

No late items were advised.

4 Minutes of the previous meeting

It was resolved that:

The minutes of the public session of the meeting of the Combined Statutory Advisory Committee held on 1 December 2017 be approved as a true and correct record.

5 Matters arising

There were no matters arising from the previous meeting.

6 Committee Chair's report

The chair welcomed the CEO to the first committee meeting of the year and acknowledged Russell's activity in the community over recent weeks, making himself known to and listening to concerns of various organisations.

7 Whanganui DHB Annual Plan Work Programme

7.1 Whanganui Alliance Leadership Team (WALT)

Lead: Russell Simpson, Chief Executive

The chief executive advised that the observations outlined in this report are his own and not necessarily opinions of others.

- There is an absence of an agreed work plan.
- The TOR has been agreed and is currently in the process of being reshaped.
- WALT in turn needs to be re-set, in terms of the question "so what?" What we are not doing is impacting on our community.
- Include inter-sectorial partners to set direction.
- The key is that we need to stop meeting in our own circles to enable us to come up with other outcomes.

Discussion points included:

- Consideration being given to the WDHB sitting at the table as the Whanganui District Council develop their economic plan as some areas could well interact.
- No existing community plans are focussed at this level. We need to challenge ourselves as a community and welcome feedback regarding stakeholder representatives.
- Health should not be the "owner" rather having the right people around the table, i.e. representing the large Pacifica community.

The CEO advised that everyone spoken to in the community shares the same concern regarding the lack of a plan for the community. An initial community forum should be established for groups to express what the imperatives are for our own community and then we look at alignment to develop the composition and develop a programme of work.

There is a wealth of knowledge in the community whose voices are stifled at this level. Matt Rayner suggested mentoring is a way to encourage the future participation from the wealth of knowledge held by young people in our community.

7.2 Relationships to support advancing Maori health

Lead: Rowena Kui, Director Māori Health

Manatu Whakaaetanga Memorandum of Understanding (MoU) 2017-2020

No further discussion.

Te Whiti ki te Uru central region Iwi relationship board forum

No further discussion.

Building relationships with Iwi, Māori communities and provider organisations

No further discussion.

7.3 Regional clinical information systems

Lead: Dr Frank Rawlinson, Chief Medical Officer

The report to the committee was corrected, in that the transition was 16/17 February 2018.

The lead up to webPAS going live necessitated a significant increase in staff numbers and overtime during that period. The CMO stated that as a DHB we owe a great deal of thanks to the nursing and administration staff, in particular, for their commitment and hard work overcoming the challenges of working with a new system.

The committee chair offered a vote of thanks to all staff involved in the transition, on behalf of the committee.

7.4 Workforce and organisational development

Lead: Hentie Cilliers, General Manager People and Performance

Taken as read, with the following points noted:

Performance reviews and support

- Completed performance review status for senior medical staff has dropped to 30%.
- There are questions being asked nationwide regarding annual reviews and changing more to a regular managerial "check-in".
- We need to critically look at what we subject our staff to, especially those managers who have large staff numbers, i.e. webPAS culture change programmes and the general busyness of the hospital. It does not mean the conversations are not being had, rather that they are not being formalised.
- 41% completed performance appraisals in the nursing community in both primary and secondary, which is the best position we have been in.

Health and Safety

- The media sensationalism surrounding the increase in injuries from aggression was unfortunate. Many of the incidents do not involve injuries and behavioural incidents in mental health (MH) are always a challenge.
- MH has been working at capacity and incidents are currently tracking down. Every incident involves a review, from which we are trying to learn.
- There is an increasing rate of cognitive impairment in our community, which is increasing the incidents through related admissions to hospital.

Follow-up request
The incidence of aggression in comparably sized DHBs will be ascertained and reported to the next board meeting.

7.5 Service Improvement Initiatives - Mental Health and Addictions

Lead: Jeff Hammond, Associate Director of Nursing

Taken as read, with the following points noted:

7.5.1 Substance Addiction (Compulsory Assessment and Treatment) (SACAT) Act 2017

- Those directed under the Act to have compulsory treatment will be assessed over an eight week period at Nova Trust, which will potentially have nine beds. To date there is no-one in treatment under the Act.
- There is a huge amount of work going on to get people ready for Nova and then they may not meet the requirements.
- There is support within the system for the parents and children of the patients.
- There is a small SACAT team in place in this district and there are no resourcing issues which have arisen for us so far. Jeff Hammond is the area manager for Manawatu, Whanganui and Hawke's Bay.

Annette Main would like to see this community lead the way in engaging with other agencies to address the district's huge problem of addiction.

Judith MacDonald advised she has had some early meetings with the police regarding an alcohol strategy for our district and sees this as an important piece of work going forward.

7.5.2 Whanganui DHB Supporting Parents Healthy Children (COPMIA) briefing report: November 2017 - February 2018

The report was taken as read, with the nurse manager advising that we are national leads in this space and can feel rightly proud of that work.

7.5.3 Suicide prevention

Advice has been received by the associate director of nursing following the Ministry meeting with suicide prevention co-ordinators early in March which included:

- An interim plan from each DHB is required. Some community contracts will continue, but the initial advice is that the planning and co-ordination of those contracts sits with DHBs.
- We need to be aware of who those contract holders are and ask the question "are they competent".
- We need a significant plan to benefit our community and show leadership.
- Our district plan is being driven by the CMO and HOD mental health, which is yet to be presented to the board.

The associate director of nursing acknowledged all the people who work in this space, which is very hard work with unmeasured successes.

Follow-up request
Inform the board through the CEO's Friday Update on the current status of the interim plan for our DHB.

7.5.4 Restraint and seclusion 2017

- Incidents have steadily reduced over the years, however, there are peaks, i.e. the use of synthetic cannabis, and an aging workforce which needs to be utilised in a way to keep them safe.

- Zero seclusion by 2020 is a national target, set as a goal for reducing harm of disturbed and unwell people. All treatments have potential harm, we must balance the harm and the benefits.
- Restraint is used where there is imminent harm to others, so we must protect our staff as well.
- The highest rate of seclusion is of Maori men and the highest for restraint is of European women.
- The measurement of prescribing rates of antipsychotics for restraint and physical restraint is difficult, as the medication use is more complicated than the use for a "restraint". Where seclusion facilities do not exist, chemical restraint is employed, so we must be aware of best possible care.
- We must be careful how we collate data so that it tells the correct story, especially in the public arena.

7.5.5 Quality improvement and service development update

The nurse manager spoke to this section of the report and noted:

- Our unit has achieved the highest compliance in the country for treatment care.
- Te Oranganui, provider arm specialist services and WRHN is providing the only kaupapa Maori AOD service in Corrections in the country.
- Child and Adolescent Mental Health wait time has improved over five years from the bottom of the table to the top, i.e. up to the age of 18.

These outstanding results were commended by the chief executive and the Communication Department will look into publication of a good news story.

7.6 Service Improvement Initiatives – surgical services

Lead: Peter Wood-Bodley, Business Manager Surgical Services and Procurement

Elective Services and ESPIs

The report was taken as read.

7.7 Cancer prevention

Implementation of the National Bowel Screen Project

Ben McMenamin, the project lead spoke to a presentation regarding the plans leading up to the role-out of the national project.

Discussion points noted:

- The age group chosen was based on the outcome of a pilot carried out at Waitemata DHB and the data lines up well with the bowel cancer statistics locally.
- As a DHB we can request the Ministry to put priority populations first.
- Ministry will allocate money to set up the screening and ongoing costs will be funded.
- The challenge to get people to participate is in providing the information in an efficient manner, which will not be achieved if there is simply a mail delivery.
- Very clear plans need to be in place regarding how we engage with Maori and Pacifica and those within the target category can be identified through the PHOs. This will be much more efficient than depending on a national co-ordination centre.
- Local champions will be put in place to work smarter and driving the participation together to be ready by "go live" May 2019.

The presentation is available from the executive assistant to the general manager service and business planning.

Ben was congratulated for his drive and expertise as the project manager.

7.8 Service Improvement Initiatives – Community initiatives

Lead: Candace Sixtus, Portfolio Manager Primary Care, Service and Business Planning

Paper taken as read and points noted:

Fit for surgery pathway

- For those that cannot reduce the weight, are we offering other alternatives, i.e. Bariatric surgery or other programmes. Will the lack of options create more inequalities?
- There are clinical areas to delve into regarding equity and next steps on this pathway and accordingly Marco Meijer will be asked to address the committee.
- Why wait until people are obese before we do something about it – we should be educating from the kohanga through.
- During the CE's meetings with community providers they discussed ways to reduce the burden of cost to people and believes there is a commitment to providing access to transportation and entry to facilities.

Follow-up request
A report containing how many people are being told a month they are not fit for surgery, the reasons why and what happens to those people will be provided for the next committee agenda.

7.9 Service Improvement Initiatives – Maternal, Child and Youth Health

Lead: Jon Buchan Portfolio Manager: Maternal Child and Youth, Service and Business Planning

Raising Healthy Kids Target

Paper taken as read and points noted:

- The equity curve is going in the right direction and there is confidence the data collected is correct, it is an excellent result.
- The Before School programme has been going for around 10 years and is a proven measure.
- There is a lot of work being done in the healthy families' space, with kohanga children leaner than in the past.

7.10 Financial performance

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

Financial Performance (Funder Division)

Paper taken as read and points noted:

- The deterioration in the February financial performance will be updated in the Friday CE Update.
- Key components still lie around IDFs not being realised from Waikato.
- There are accruals and unsettled MECAS affecting the February outcome, together with the additional resource required for the initiation of webPAs.
- There is comfort in that we are not a lot different from other DHBs at this time.

- We are moving into an environment where we are up-staffing in accordance with the RDA settlement last year, which is affecting the medical staff budget.
- Collaborative discussions will take place both regionally and with MidCentral over the next six to eight weeks.

Financial Performance (Provider Division)

There was particular interest from members regarding the possible effect the lack of a medical director for the Emergency Department has had on results and the CMO made the following comments:

- Despite consistently advertising the role, there has been no permanent medical director in ED since 2015, with the CMO continuing to fulfil that role. There is also a requirement for the HOD to hold a FACEM, which further restricts applicants. Hutt Valley, although in a much better situation than us, has also struggled to fill ED positions, including that of HOD.
- We have a very good interaction within the community regarding ED and compliments are historically much higher, so it is not apparent that there are any adverse effects to service delivery.
- Traditionally graduates prefer to work where they trained, however, there is beginning to be a move South as positions in Auckland fill.
- The current quarter has been particularly difficult with the webPAS implementation and the complexity and high numbers of people accessing the department. The high number of admittances to ED reflect whole of system issues, i.e. accessing ultrasound services afterhours.

7.11 Whanganui DHB Dashboard of Measures – results for Quarter Two 2017/18

Paper taken as read, with the following explanation noted:

For a number of measures we only report for particular quarters, therefore 69% are not in red, because other factors supplied are taken into account by the Ministry.

8 Date of next meeting

Friday, 4 May 2018.

9 Glossary and terms of reference

Report was taken as read.

10 Exclusion of public

It was resolved that:

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

Agenda item	Reason	OIA reference
Minutes of meeting held on 1 December 2017 (public excluded session)	For the reasons set out in the committee's agenda of 1 December 2017	As per the committee's agenda of 1

Persons permitted to remain during the public excluded session

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

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

The public session of the meeting ended at 12.22pm.

8 Board and committee chairs' reports

8.1 Board

A warm and safe home, meaningful work (whether it be earning, learning, helping or volunteering), positive engagement with others, education, health and wellness – we all need these and we all deserve them. As board members, we are just part of the social service sector which is tasked to deliver some of these needs.

I recently attended a business breakfast meeting where the Prime Minister and Minister of Finance presented a global view of their work. The audience included secondary students, diplomats, business people and politicians – our Prime Minister inspired many by her frankness, her honesty, her feminising of the political scene and her wide knowledge and skill. She has a strong social conscience, as does Dr David Clark, our Minister of Health and they are both very aware of the pressures the health industry is experiencing.

Our strategic priorities sit well beside the four key priorities of Minister Clark. He is focusing on inequalities, accessibility of primary care, mental health and a strong public health service. His plans are futuristic and look past the three year election cycle but measurable change every year is a necessity. As board members, he has made it plain that we are accountable for improving the health of our populations and working within our budgets. Our strategic focus is just that.

Mental health and addiction are a growing concern for us all. I applaud the Mental Health Inquiry led by Ron Paterson, formerly of the HDC who, with his panel, is visiting us soon. His panel wishes:

- to hear community voices,
- report on how we are preventing mental health and addiction,
- how we are responding to people's needs (gaps and opportunities),
- and recommend specific changes to improve, particularly with regard to equity of access, community confidence and better outcomes.

Another seminar I attended was hosted by the Health Quality and Safety Commission – the focus was on our communities and health. Key topics included the value of consumer engagement and the power of the patient experiences and how we are (or are not) meeting our community's needs. Inspiring speakers included Janine Shepherd, Jake Bailey and Dr Lance O'Sullivan. Google them to hear their stories.

Well done Frank Bristol, as a member of the consumer advisory group, for facilitating a patient-focused session.

Kohiri te manu	The bird sings
Takiri mai I tea ta	The morning has dawned
Ka ao ka ao ka Awatea	The day has broken
Tihei mauri ora	Behold there is life

Every day is another day to work on making a difference to our population's health and wellbeing.

8.2 Combined Statutory Advisory Committee

A verbal report will be given.

8.3 Risk and Audit Committee

Highlights from the last meeting held on 14 February 2018 are:

- Work continues to identify an independent replacement on the committee following Kate Joblin's resignation.
- A new format of risk reporting to the committee is being trialled and developed. It is within the context of a review of the risk framework within which the WDHB operates.

Once the committee has finalised this work with management, feedback will be given to the board as well as a discussion of the board's risk appetite.

Management is preparing a draft revision for the April meeting, based on feedback given.

- Main risk areas discussed were :
  - Urology – referrals to the service continue to be closely monitored. Progress on staffing
  - Mental Health Services – challenges around bed occupancy and longer terms challenges including staff burn out

- Updates received and discussed on :
  - Radiology Service Accreditation Assessment Report
    - Clinical Governance & Patient Safety report
    - IDF analysis and update
    - IT Project implementations
    - Dec 17 financial results
    - Health & Safety Report

- The draft internal audit report was received on Clinical Coding Review, no major issues and management implementing recommendations.

- Draft scopes were reviewed for Staffing Levels for Patient Acuity & WDHB's Response to Inequities for Maori.

- The committee's annual Self Review was approved, after feedback had been received from the board and the internal & external auditors. A minor change to clarify Deloitte's tax advice received.

- External Audit Engagement Letter and fees for 2017/18 were received and approved.

9 Chief Executive's report

9.1 Patient Safety and Service Quality

'Speaking up for Safety' campaign

As of yesterday (22/3/18), we have now trained 933 staff on how to 'Speak up for Safety'. This represents over 70 percent of the combined employee and contractor workforce. Board members are encouraged to attend the training; if you are interested, please contact clare.raisin@wdhb.org.nz for dates and times. On 13, 15 and 16 March we trained 10 peer messengers and over 50 managers on the accountability aspects of the framework. This included how to give staff feedback when undesirable behaviours are notified. The notification tool is under development, with a first draft in testing phase. We are on track to implement the full framework by our target date of mid to end of May 2018.

Surveillance audit

The DAA Group will be undertaking a surveillance audit at WDHB between 2 and 6 July 2018. Surveillance audits are undertaken part way through a certification period to assure the Ministry of Health (the Ministry) that we continue to meet all relevant standards. The focus of the audit is on service delivery and review of criteria not fully attained at the previous audit. Note that as of December 2017, the Ministry has accepted all WDHB's corrective activities implemented since the 2016 Certification Audit. Currently a group of senior staff and workforce leaders are working through self-assessment and other preparations for the site visit and the board will be provided further updates as this progresses.

9.2 Mental Health Department

The Director General of Mental Health and Addiction's visit to our DHB has been confirmed as 5 April. A timetable for the day is currently being worked on.

9.3 Māori Health

Combined board meeting dates

The dates for the combined Hauora A Iwi and WDHB meetings for 2018 have been confirmed as:

8 May
11 September
4 December

Health Workforce New Zealand (HWNZ) Hauora Māori Training Funding 2018

HWNZ confirmed an allocation to district health boards of $2.5 million for the 2018 Hauora Māori Training Fund. Whanganui District Health Board's allocation is $72,775.00 exclusive of GST. Made up of $63,678 to cover course fees, travel and accommodation for successful applicants and $9,097 contribution to Whanganui District Health Board's programme coordination.

HWNZ propose that once DHBs have made their initial 2018 allocations, the remaining funds will be held in a ring fence, contestable pool. DHBs will be able to apply for funding on a case-by-case basis, as long as the full amount of their 2018 allocation is assigned and invoiced. This will enable DHBs who are performing well, an opportunity to access additional funds to grow and support Māori workforce.

Whanganui District Health Board's 2017 funding of $61,316.35 supported 24 trainees, an increase on 2016. All of whom successfully completed their courses:

- 16 - NCEA level three
- Six - NCEA level four
- One each in NCEA level five and six

The course types include Hauora Māori, health promotion and small business, with 19 of the 24 trainees from Māori community based organisations.

In addition, all applicants received Māori support funding to a total of $11,200 exclusive of GST. The purpose of the Māori support fund is to enhance the likelihood of the Māori workforce successfully completing HWNZ funded training programmes. It provides access to mentoring, cultural supervision, and cultural development activities that enable the personal, cultural and professional growth of the applicant. The funding is to a maximum of $1,200 exclusive of GST per applicant, approved on a case-by-case basis by HWNZ, on recommendation from the Whanganui District Health Board.

9.4 Elective Services

Elective service delivery for February appears under reported at 95% of contract. The perceived under reporting appears to be caused by the change-over in booking system mid-month and coding not being complete at time of reporting for February. Ward activity and clinical supply costs suggest greater activity than what is currently being reported. This is an administrative, rather than a patient scheduling issue.

ESPI compliance remains a challenge with internal hospital data indicating compliance in February, however reporting of activity since webPAS go live in February has made the tracking of patients difficult. The scheduling team have worked diligently to identify the issues and work with Information Technology Department to correct these reports.

ESPI compliance for March is tight. Extra dental, ENT and orthopaedic sessions have improved the prospect of achieving compliance however at time of reporting acute demand and non-attendance may influence the result.

9.5 Summary financial report for February 2018

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2018($000s)
CONSOLIDATED

	Month				Year to Date				Annual		
	Actual	Budget	Var		Actual	Budget	Var		Budget 2017-18	Forecast	Var
Provider Division	73	313	(240)	U	(1,906)	(1,205)	(701)	U	(1,921)	(3,122)	(1,201)
Corporate	95	1	94	F	332	19	313	F	22	522	500
Provider & Corporate	**168**	**314**	**(146)**	**U**	**(1,574)**	**(1,186)**	**(388)**	**U**	**(1,899)**	**(2,600)**	**(701)**
Funder Division	444	571	(127)	U	(54)	329	(383)	U	-	(800)	(800)
Governance	36	16	20	F	249	(2)	251	F	-	217	217
Funder divison & Governance	**480**	**587**	**(107)**	**U**	**195**	**327**	**(132)**	**U**	**-**	**(583)**	**(583)**
Net Surplus / (Deficit)	**648**	**901**	**(253)**	**U**	**(1,379)**	**(859)**	**(520)**	**U**	**(1,899)**	**(3,183)**	**(1,284)**

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

February 2018 – major variances

Provider and Corporate – $146k unfavourable

Driven by high inpatient volumes which in turn has driven nursing costs and clinical supplies. An allowance of $72k has been included for the increased cost of the nurses' multi-employer collective agreement settlement. ACC revenue was $56k less than budget due to MRI and the correction of invoicing to ACC for Assessment, Treatment and Rehabilitation-related patients (one-off).

Corporate costs are $94k favourable to budget, which mitigated some of the provider impacts.

Comparison of volumes

The occupancy in February 2018 was 12% higher than in February 2017, and very similar to the high levels experienced in January. At the same time, nursing one-on-one specialling hours has increased by 26% compared with February 2017. Both of these have impacted on nursing costs, which are $126k higher than budget. The year-to-date specialling hours related to various patient requirements are 37% higher than the 2016/17 year. If this level continues, an additional 8.5 FTE (health care assistants) will be required, costing $466k per annum.

Funder – $107k unfavourable

Driven by inter-district flows of $100k (including Waikato DHB electives that have not eventuated). Pharmaceutical costs are $160k unfavourable to budget, reflecting a rising trend over the last four months. Home-based support is also over budget by $90k, due to a miscoding of costs in prior months to 'Pay parity' costs, which triggered an offsetting revenue accrual. These impacts have been offset by lower aged care occupancy of $90k and mental health $121k.

Forecast to 30 June 2018

When establishing the budget for 2017/18 with the board, inter-district flow outflows were based on current trends for 2016/17, less a 3% volume adjustment of around $654k. The budget also included 75 case weights (CWD) for inter-district flow elective inflows, based on 50 CWD being secured through a contract from Waikato District Health Board and the balance from other district health boards. The key drivers of the variance to budget for the year-to-date and forecast are these two assumptions, nursing costs due to patient acuity, and higher multi-employer collective agreement settlements.

The forecast deficit projected to 30 June 2018 is $3,183k, compared to the budgeted deficit of $1899k. This is a variance of $1284k, which is an increase of $484k.

The main issues that have impacted include additional costs for the nursing multi-employer collective agreement, with the lump sum increasing from the latest offer. Inter-district flow inflows now exclude any Waikato DHB electives from the forecast for the rest of the financial year.

Risks in this forecast lie with the nurses' multi-employer collective agreement. Inter-district flows have been forecast at what management consider a realistic level, but this is lower than the high level of outflows experienced from May to October 2017, which then dropped back to more typical levels in November and December 2017. The multi-employer collective agreements relating to other unions (PSA, RMOs and midwives) are expected to settle after June 2018. Potential lump sum settlements have been accrued for expired contracts, but the amounts may not be enough.

The detailed February 2018 financial report, including a year-end forecast, is included as ***Information item one.***

9.6 Compliance with statutory requirements

To the best of my knowledge, I am not aware, nor have I been advised, of non-compliance with statutory requirement and the notice of delegation.

10 Decision item one

10.1 Review of Communications Policy

Purpose

This paper seeks board discussion on, and agreement to, renewing the Communications Policy for a further one year.

Background

In 2015, the WDHB Executive Management Team reviewed the Communications Policy and included expectations around the use of social media.

Policy review

The existing policy has been reviewed and extensively re-written, a copy of which is attached to this paper as ***Appendix one.***

Management comment

Management suggests the policy be renewed for a period of one year.

Recommendation

It is recommended that the Whanganui District Health Board:

1. **Receives** the paper entitled 'Review of Communications Policy'.

2. **Endorse**s the policy renewal for a further one year.

APPENDIX ONE

Policy

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

1. Purpose

The purpose of this policy is to state the Whanganui District Health Board's (WDHB) approach to communications – oral and written, internal and external.

2. Policy statement

Whanganui WDHB is committed to being open, honest and inclusive when communicating with internal and external audiences and to sharing information in a timely, consistent, appropriate, accurate and professional manner. WDHB is also committed to ensuring its communications reflect its values.

3. Scope

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

4. Prerequisites

In the application of this policy, the WDHB recognises:

- WDHB Privacy Policy
- WDHB Patient Condition Guidelines for Media
- WDHB Code of Conduct
- NZ legislation that guides communication
- The Ministry of Health's A Framework for Health Literacy
- NZ Health Literacy Guidelines – three steps to health literacy
- Te Reo Maori – te Whanganui mita

5. Definitions

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

6. Roles and responsibilities

Roles	Responsibilities
Board members	Endorse the policy Adhere to the policy
Chief executive	Adhere to the policy Approve delegations within the policy as required
WDHB kaumatua and kuia	Provide advice to enable implementation of the policy
Executive management team	Adhere to the policy Enable implementation of the policy
Board, committees and staff with delegated authority	Adhere to the policy Enable implementation of the policy
Operational management team	Adhere to the policy Ensure all staff are informed and apply the policy effectively
Communications manager	Leads operation of the policy Monitors use of the policy
Communications team	Enable operation of the policy
Staff	Understand their responsibilities and adhere to the policy and associated procedures.

7. Measurement criteria

- Media monitoring through Isentia
- Social media and website analytics (e.g. number of visits)
- Board reporting
- Feedback from patients and their whanau, communities, WDHB board and committees, staff Hauora A Iwi, community provides and Ministry of Health
- Evaluation

8. Related Whanganui District Health Board documents

Publications

- Communications Procedure
- WDHB Writing Style Guide and Writing Style Companion Guide
- Delegations Policy
- Information Communications and Technology Security Policy
- Code of Conduct Policy

9. Key words

Communication, media, publications, social media, submissions

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9. Key words

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Discussion item one

11.1 Health and safety report

Purpose

This paper enables the board to exercise due diligence on health and safety matters. This report covers:

- Incident trends and injuries in the workplace.
- Lost time and cost comparison.
- Employee participation.
- Transition training on the changes to the Health and Safety at Work Act 2015.
- Contractor management.
- Key health and safety systems risks.
- Health and safety work plan.

Injury reporting

WDHB staff are actively encouraged to formally record all accidents, incidents and near misses on RiskMan. The responsible manager review all incidents and investigates incidents resulting in time off work. A team undertakes a critical systems analysis (CSA) for all incidents resulting in major or potentially serious injuries. The clinical nurse specialist, infection prevention and control investigates all reported infection control incidents.

An average of 14 incidents have been reported per month for the 2017/18 financial year.

Fourteen percent of recoded incidents are near misses or do not result in any adverse outcomes. Almost eighty percent of reported incidents require no treatment or first aid only.

Notifiable events
No notifiable events were reported to WorkSafe New Zealand in the 2017/18 financial year.

Incident/injury report January and February
There were 22 injuries recorded by staff on RiskMan between January and February.

The following table shows a breakdown of the recorded incidents/injuries by incident class and outcome.

	Staff incidents/injuries January and February 2018						
Incident class	**Details**	**Outcome**					
		Near miss; no adverse outcome	**Minor injury; no treatment required**	**Minor injury; first aid only**	**Moderate injury; temporary incapacity**	**Major injury; temporary incapacity**	**Possibly potentially serious**
Manual handling	Lifted an oxygen cylinder and felt sharp twinge in lower back			✓			
	Strained lower back after cleaning up water off floor due to flooding			✓			
	Shoulder discomfort from moving computer and UPS			✓			
	Back injury whilst assisting a patient who grabbed and pulled downwards on employee			✓			

Slips/ Trips/ Falls	Tripped over whiteboard - dislocated finger			✓			
	Tripped over uneven driveway at clients home – grazed knee		✓				
	Slipped off loose toilet seat – injured lower back				✓		
	Tripped and fell on stairs – fractured hand				✓		
Aggression	Injured elbow during a client restraint		✓				
	Patient grabbed upper arm digging in fingernails		✓				
	Assaulted by a patient – bruise and graze to side of head		✓				
	Assaulted by a patient – bruise to top of head and back				✓		
	Assault by a patient resulting in a client restraint – sprains to upper arm and shoulder				✓		
	Hit by a confused patient	✓					
Infection Control	Needle stick injury (5)	✓	✓✓	✓✓			
	Scratch with used pair of scissors			✓			
Struck / Bumped by	Bruised fingers between two doors			✓			
	Hit head on theatre power boom			✓			
Totals		**2**	**6**	**10**	**4**	**0**	**0**

Definitions used in the above table:

- Near miss, no adverse outcome.
- Minor injury, no treatment – the employee has a minor injury but didn't feel the need to seek medical treatment.
- Minor injury, first aid only – would only require 'a plaster or aspirin'.
- Moderate injury, temporary incapacity – the employee may have sought medical treatment (from either ED or a GP) and there may have been lost time as a result of the injury.
- Major injury/temporary or permanent incapacity.

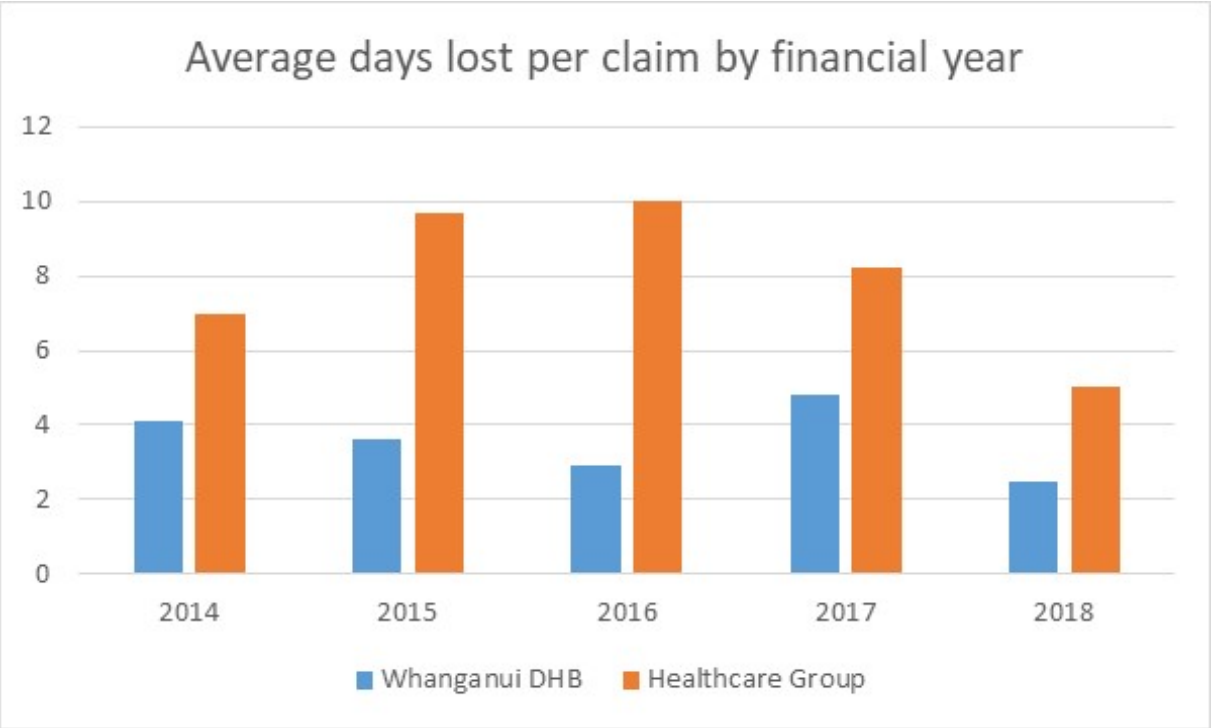
Manual handling trend

The manual handling incident trend report from 1 July 2014 to 28 February 2018 is included as ***Appendix one*** for information. ATR (14), CCU (16), ED (13), Medical (20), Surgical (30), Theatre (16) and Radiology (10) had the most incidents/injuries over this period, with most of these being patient-related.

WDHB days lost time and costs compared with the broader healthcare sector group

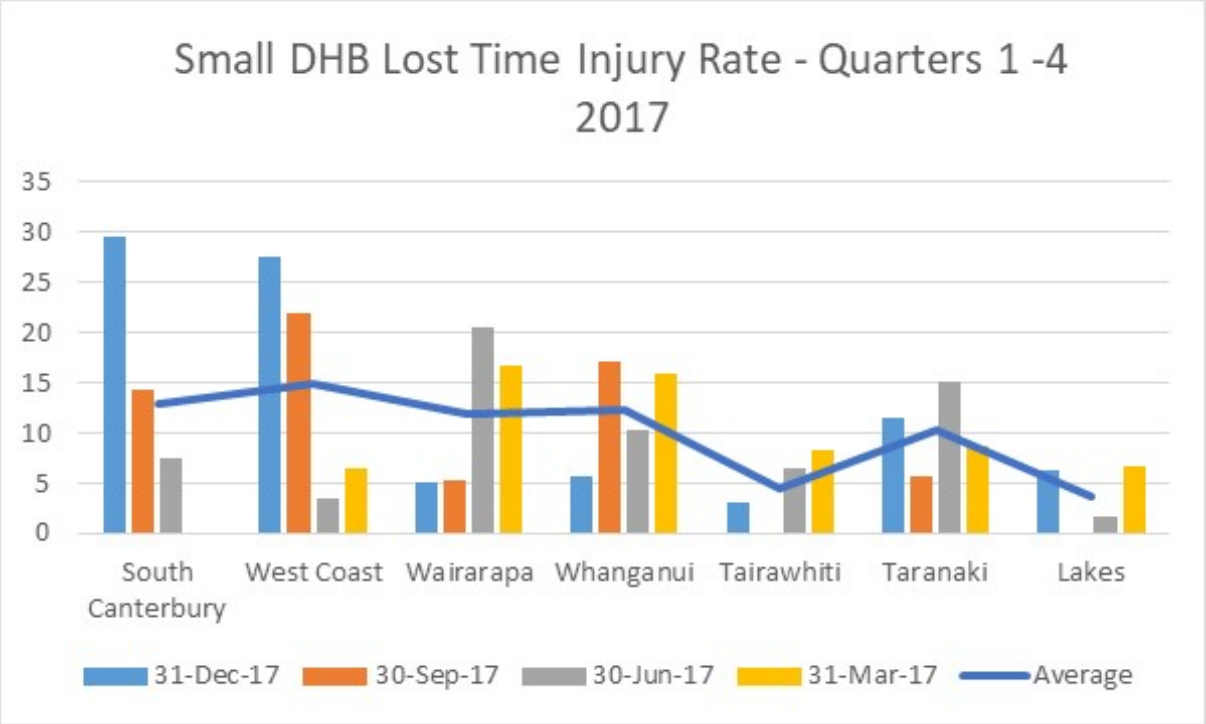
The graph below compares Whanganui DHB with the broader Healthcare group based on average days lost per claim.

The healthcare group (health organisations who uses Wellnz as third party provider) consists of eight DHBs (Hutt Valley, Capital and Coast, Hawkes Bay, the 3 Auckland DHBs and Canterbury DHB). It further includes Healthcare New Zealand, parts of BUPA and part of the aged care providers.



The average claim costs for WDHB for the last 5 years were $1,015. The average claim costs for the health sector group were $1,961. For the 2017 full year, the WDHB costs were 23% below the health sector group.

The graph below provides a snapshot of the lost time injury rate in the seven small DHBs as measured by in the 2017 quarterly snapshots.



Employee participation

The Unit Health and Safety Committee and the WDHB Health and Safety Committee met once in January and February. Fifteen of the 32 representatives attended the Unit Health and Safety Committee meeting.

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

- WorkWell Wellness Programme
- Health and safety training for mangers and health and safety representatives
- Hazardous substances
- Emergency alarm survey
- Lockdown exercise
- WebPAS update
- Health and safety objectives plan
- Health and safety committee terms of reference

Health and safety transition training

Training for the health and safety representatives is scheduled for 28 - 29 March and 5 – 6 June and an extra session for managers 19 April 2018.

Contractor management

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

Spotless H&S	Feb -17	Mar -17	Apr -17	May -17	Jun -17	Jul-17	Aug -17	Sep -17	Oct -17	Nov -17	Dec -17	Jan -18	Feb -18
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	1	0	1	0	0	0	0	0	1	0	0
Category E: Injury with no treatment	1	1	1	0	2	2	2	0	1	0	2	2	1
Category G: Non-work	0	0	0	0	0	0	0	0	0	0	0	0	0
Spotless H&S	**Feb -17**	**Mar -17**	**Apr -17**	**May -17**	**Jun -17**	**Jul-17**	**Aug -17**	**Sep -17**	**Oct -17**	**Nov -17**	**Dec -17**	**Jan -18**	**Feb -18**
Hazard	11	8	10	11	10	11	12	9	9	12	11	11	9
Safety Observations	17	18	17	16	16	17	16	18	18	17	18	14	15
Sub-Contracted to Spotless	**Feb -17**	**Mar -17**	**Apr -17**	**May -17**	**Jun -17**	**Jul-17**	**Aug -17**	**Sep -17**	**Oct -17**	**Nov -17**	**Dec -17**	**Jan -18**	**Feb -18**
Contractor Safety Interactions	5	4	4	5	4	5	5	5	5	6	4	5	5
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

Key health and safety risks

The recent internal audit by TAS highlighted the need to report key risks to the board at each meeting. The following table notes any progress made since the report to the board's September 2017 meeting.

Key risk	Management/actions – update
Community staff home visits – lone staff members general safety monitoring systems not fully functioning	▪ Draft policy completed following initial consultation. The Director of Maori Health is currently awaiting feedback before finalising the policy and procedures. ▪ The options available and costs of technology locators and duress alarm systems as part of the solution are being assessed.
Injury from manual handling of patients and objects is the highest injury category	▪ A service audit of thirteen hoists was completed. Two aged hoists (13 and 14 years old) failed the service. Working with managers to purchase new hoists. ▪ Feasibility study for all clinical areas to have a room specifically set up for a bariatric patient including ceiling hoist, correct toilet and access to the bathroom is being completed
Contractors' health and safety systems outside of Spotless Services are not being monitored and may be a risk	▪ A schedule of external contractors by department has been developed. ▪ Contractors will be risk rated according to the type of work performed on site. ▪ We will work with a sample of six contractors to evaluate their health and safety systems against compliance with the Act. ▪ Team leaders will be trained on how to evaluate risks associated with each contractor's visit so there is ongoing health and safety monitoring. ▪ Currently working with new contractors on safety plans

Health and safety work plan

The health and safety work plan through to February 2018, is included as *Appendix two.*

Recommendation

It is recommended that the Whanganui District Health Board:

1. **Receives** the paper entitled 'Health and Safety report'.

Manual handling trends **Appendix one**

Manual Handling Injuries by sub category by year from 1 July 2014 to 28 February 2018																	
	Patient/Client Related				Equipment or Object Related				OOS				Total				
Area	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018 Feb 18	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018 Feb 18	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018 Feb 18	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018 Feb 18	3 + yrs Feb 2018	
AAU													-	-	-	-	-	
Acute Stroke Unit	1												1	-	-	-	1	
ATR	5	1	1	2	1	3	1						6	4	2	2	14	ATR
CAF						1							-	1	-	-	1	
CCU	3	3	4	1	1	3		1					4	6	4	2	16	CCU
Chaplaincy					1								1	-	-	-	1	
Community Services			1			2	2					1	-	2	3	1	6	
Emergency	5	1	2	2	1	2							6	3	2	2	13	ED
Health Records							1		1				1	-	1	-	2	
Human Resources							2								2	-	2	
IT						1		1			1			1	1	1	3	
Loans			1												1	-	1	
Maori Health							1			1			-	1	1	-	2	
Maternity		1		1	3	1		1				1	3	2	-	3	8	
Medical	4	6	3	3	1	1	2						5	7	5	3	20	Medical
Nursing Resource Unit													-	-	-	-	-	
Outpatients						1				1			-	2	-	-	2	
Paediatric						1								1	-	-	1	
Patient Safety & Quality							1				1				2	-	2	
Patient Scheduling						1							-	1	-	-	1	
Pharmacy													-	-	-	-	-	
Public Health							2						-	-	2	-	2	
Radiology	3	1			1	1	2	1		1			4	3	2	1	10	Radiology
SMO Group										1			-	1	-	-	1	
Stanford					3								3	-	-	-	3	
Supply					1			2					1	-	-	2	3	
Surgical	6	6	7	8	1	2							7	8	7	8	30	Surgical
Surgical Day Unit	1				1								2	-	-	-	2	
Te Awhina	3	1	1	1									3	1	1	1	6	Te Awhina
Theatre	1	1	1	1	2	6	2	2					3	7	3	3	16	Theatre
Therapies			1					1					-	-	1	1	2	
Totals	**32**	**21**	**22**	**19**	**17**	**26**	**16**	**9**	**1**	**4**	**2**	**2**	**50**	**51**	**40**	**30**	**171**	

Health and safety work plan to 28 February 2018

Appendix two

Objective	Specific work areas	Actions	Responsibility	Timeframe	Status 28 February 2018
Complete recommendations from TAS audit May 2016	Capture and reporting of health and safety risks	Health and safety risks captured in RiskMan and reported to board	GM Corporate	30 June 2016	Reporting in place
	Overall ownership of hazardous substances	Facilities coordinator to have overall responsibility for monitoring compliance	Facilities Coordinator	31 October 2016	In progress
	Contractor management	Medlab to attend Health and Safety Committee meetings. Specialist equipment contractors monitored by department once pre-qualification checks completed. As significant contractors on the hospital site, Medlab and Spotless have been asked for their hazardous substance register. A review of hazards and health and safety system is to be undertaken.	GM Corporate	31 October 2016 Extended to 31 March 2017	WDHB departments asked to identify contractors working in their area – confusion over whether employed through Spotless or by DHB. Contractor template being trialled with radiology and ICT contractor. Met with SafeWise to discuss pre-qualification of contractors. A risk assessment will be completed on all contractors outside of Spotless to identify the contractors that need to go through the pre-qualification process. Stocktake of external contractors by department largely completed. Risk rating of contractors and assessment of health and safety systems of an initial group of six to be undertaken. Currently working with new contractors on safety plans
	Align health and safety framework to legislation	Develop a work plan to update policy and procedures	H&S Advisor	31 March 2017	In progress
	Organisation-wide training on health and safety	Train all team leaders, managers and health and safety representatives	H&S Advisor	By July 2017	Business Central training for managers, EMT and board scheduled completed – 22% of managers have not yet completed training. Health and safety representative training is scheduled 28 – 29 March and 5 – 6 June

Objective	Specific work areas	Actions	Responsibility	Timeframe	Status 28 February 2018
					and extra session for mangers 19 April 2018
	Documentation of toolbox meetings	Formalise capture of health and safety risks not captured elsewhere	Facilities Coordinator	30 June 2016	Requirement in place
	Engaging Medlab into health and safety processes	Medlab requested to attend monthly health and safety meetings. Review of Medlab hazards and health and safety system.	GM Corporate	30 September 2016	Medlab attended the June 2017 meeting and have provided their safety plan.
	Health and safety advice provided to Product Evaluation Committee	Health and safety coordinator to attend Product Evaluation Committee meetings	H&S Advisor	From August 2016	In place
Maintain ACC Accredited Employers Programme at tertiary level – implement recommendations from August 2016 & 2017 ACC audit	Ensure there is a robust process in place to evaluate individual management performance against health and safety responsibilities	Develop KPIs from the health and safety plan in staff objectives for subsequent evaluation in performance appraisals	GM HR GM Corporate	August 2016 to March 2017	In progress
	Strengthen organisational recognition of health and safety performance	Health and safety committees to proactively report H&S progress and successes	H&S committee members		Quality awards
	Consider having a statement of commitment to the provision of information and training for managers that is relevant to their roles contained in the WDHB's Health and Safety Policy	Update policy	H&S Advisor	30 September 2016	Completed August 2016
	Spotless Services to develop guidelines to direct the use of contractor safety assessments to monitor (sub)contractor health and safety performance	Spotless Services to develop formal monitoring system to record performance for subsequent assessment and review	GM Corporate	31 December 2017	In progress – see comments below
	Spotless Services to implement a formal process to gather sub(contractor) monitoring feedback for considering when reviewing approved suppliers	Spotless Services to close the loop on contractor performance monitoring so that 'ongoing approval' status can be substantiated	GM Corporate	31 December 2017	Spotless advised TAS auditor they have monitoring systems in place but were unable to show evidence at the ACC Accredited Programme audit. An audit will be undertaken prior to the next full ACC Employer Programme audit.

Objective	Specific work areas	Actions	Responsibility	Timeframe	Status 28 February 2018
	prequalification and ongoing 'approved' status				
	Evidence to be available to demonstrate that a selection of cover decisions on claims are reviewed at least annually for accuracy and compliance against legislation	Meet and agree process with Wellnz Complete accuracy and compliance checks of cover decisions against legislation each quarter with Wellnz	HS Advisor/Wellnz	October 2017 then quarterly	Completed Oct 2017 Met with Wellnz and agreed to meet quarterly to complete a quality check to ensure accuracy and compliance on claim files. Evidence (spreadsheet will be available at audit time)
	Evidence to be available to demonstrate that assessed entitlements have been confirmed for accuracy at least annually	Meet and agree process with Wellnz Complete accuracy checks that entitlements have been assessed correctly each quarter with Wellnz	HS Advisor/Wellnz	October 2017 then quarterly	Completed Oct 2017 As above
	Staff responsible for calculating and paying weekly compensation to have participated in training on the assessment and payment of weekly compensation two yearly	Payroll staff to complete training on assessment and payment of weekly compensation	Payroll staff	December 2017 then 2 yearly	Payroll staff have enrolled in ACC training module in April 2018
	All claim information is amalgamated upon closure of a claim into a master file	Meet and agree a process with Wellnz	HS Advisor/Wellnz	October 2017 then ongoing	Completed Oct 2017. Met with Wellnz. Agreed to send WDHB files to Wellnz case manager who will collate the information into one file.
	Checks are undertaken on claim files to ensure that only individual claim related information is held	Wellnz and WDHB to check claim files they hold to ensure only individual claim information related information is held	HS Advisor/Wellnz	October 2017 then ongoing	Met with Wellnz in October. Wellnz Case Manager and HS Advisor discuss claims by phone. Appointment times scheduled in diaries for last Monday of each month
	Return to work is assessed for potential hazards to prevent injury aggravation	Write process for identifying and assessing potential hazards and include on activity sheet Identify and assess hazards each time a staff member is returning to work from an injury	HS Advisor	October 2017 Ongoing	Process completed Return to work templates have a table to identify and assess potential hazards. Hazards will be identified and assessed at the first return to work planning meeting, then reviewed and updated at subsequent meetings.
	Employers have documented rehabilitation and return to work objectives and to meet tertiary requirements	Discuss and agree return to work objectives and have signed off by executive management team	HS Committee members	December 2017	Initially discussed at the Sept HS Committee meeting. Objectives tabled at March 2018 HS committee meeting. Discussion continuing.

Objective	Specific work areas	Actions	Responsibility	Timeframe	Status 28 February 2018
	evidence must be available to confirm that these objectives have been reviewed in consultation with relevant parties				
Ensure the health and safety framework remains operationally effective and meets the requirements of the Health and Safety at Work Act 2015 Key elements of the framework are as listed	Hazard identification and risk assessment	Review standing hazards and test that controls are in place and operating effectively	Health and Safety Committee	July 2016 and ongoing	This work is continuing
	Incident management and reporting – monitor the level of incident reporting, quality analysis, root cause	Incident report analysed by the Health and Safety Committee, with any issues elevated to executive management team and the board	Health and Safety Committee	Monthly report to the committee and board	In place
		Trend reporting completed every six months and evaluated by the H&S Committee, with any issues elevated	H&S Advisor and H&S Committee	January and July 2016 and January 2017 -ongoing every six months	In place. Trend report to 31 December 2017 included in February Board report.
	Employee participation – ensure effective and engaged participation in health and safety	Review number of health and safety representatives and identify areas that require a representative	H&S Chairs	October 2015	In place
		Monitor attendance at Unit Health and Safety Committee meetings	H&S Chairs	Monthly/ six-weekly	Work is continuing – H&S representative role is currently being developed for consultation.
		Ensure issues identified at Unit H&S Committee meetings are raised to the WDHB H&S Committee and actioned or reasons provided why they can't be actioned	Unit H&S Chairs	Monthly	In place
	PCBU (Person conducting a business or undertaking)/Contractor management of health and safety	Key contractor PCBUs included in health and safety meetings to coordinate activities	H&S Advisor Facilities Coordinator Spotless Services Medlab	July 2016 to March 2017	In place – Spotless and Medlab invited.

Objective	Specific work areas	Actions	Responsibility	Timeframe	Status 28 February 2018
	Health and safety policies and procedures meet requirements of the Health and Safety at Work Act 2015 (HSWA)	Ensure policies and procedures are updated to reflect the changes to the HSWA 2015	H&S Advisor H&S Committee	July 2016 to March 2017	Health and Safety Policy updated July 2016. Due for review July 2018
Strengthen systems of management for hazardous substances	Implement recommendations from the test certifier's report – this will be ongoing work with projects when managing hazardous substances regulations have been written by WorkSafe New Zealand	Create action plan from the report's recommendations and implement	H&S Advisor Facilities Coordinator Spotless Services Team leaders	31 December 2016 Extended to 28 February 2018 due to faulty component for bulk oxygen	Majority of work completed – areas have been asked to update their hazardous substances register The backup oxygen has been relocated to a compliant area and is being prepared for cutover. Spotless have advised this work will be completed soon. Formalin exposure has been tested in theatre and found to be below the Workplace Exposure Standards (WES).
Reduce manual handling injuries	Manual handling training and outcomes	Continue to support manual handling trainer to implement programme to front line staff	H&S Advisor	July 2016 to August 2017	Training programme implemented. Bariatric equipment Development of policy and procedures completed. Bariatric pool equipment identified and purchased. Laminated cards indicating, location and how to procure equipment (includes rental options) will be available in all clinical areas shortly. Three staff attended interdisciplinary bariatric education seminar to gain a more in depth appreciation of the care of the bariatric patient and the need for education in WDHB. A bariatric training day was completed in November with more days scheduled for 2018. A gap in the equipment necessary to perform transfers for bariatric patients safely has been identified. Have obtained quotes for ceiling hoist in a single patient room on surgical ward - to be discussed at EMT. Secured low profiling bed and

Objective	Specific work areas	Actions	Responsibility	Timeframe	Status 28 February 2018
					motorised reclining chair for bariatric patients. Feasibility study for all clinical areas to have a room specifically set up for a bariatric patient including ceiling hoist, correct toilet and access to the bathroom is being completed
		Monitor manual handling trends to recognise achievements and follow up on any adverse trends	H&S Advisor	July 2016 to August 2017	In place. Manual handling training programme was implemented in January 2016.
Strengthen ability of frontline staff to manage aggression	Management of escalating situations expose staff to possible aggression	Form a working group for managing escalating situations and update procedures	Nurse Manager – Medical	Completed	Completed
		Present the Managing Escalating Situations Procedure to all frontline staff	Working group	Completed	Completed. Has been embedded into the organisation and is working well. The risk assessment form has been reviewed and amended to suit the needs of the clinical areas. Looking at ways to continue communication 'Let's Stop and Think' with each department. Now business as usual.
		De-escalation training to improve staff skills	Team leaders EMT	Ongoing	Mandatory requirement for mental health staff. General clinic staff now undertaking training. EMT to consider including de-escalation training as mandatory.
Strengthen health and safety monitoring of isolated staff working in the community	Community staff home visits – lone staff members general safety monitoring systems not fully functioning	Ensure line managers are taking responsibility for monitoring the whereabouts of staff working in the community – H&S reps to undertake spot audits on reports provided.	Team leaders to report quarterly to relevant GM. H&S reps to conduct spot audits.	Quarterly: 31 Dec, 31 Mar, 30 June, 30 Sept	In progress
		Improve systems and procedures to strengthen monitoring and reduce risk. Includes emergency response devices and keeping pace with national developments in this area.	Working group	31 March 2017	In progress

Discussion item two

11.2 Communication Department's report

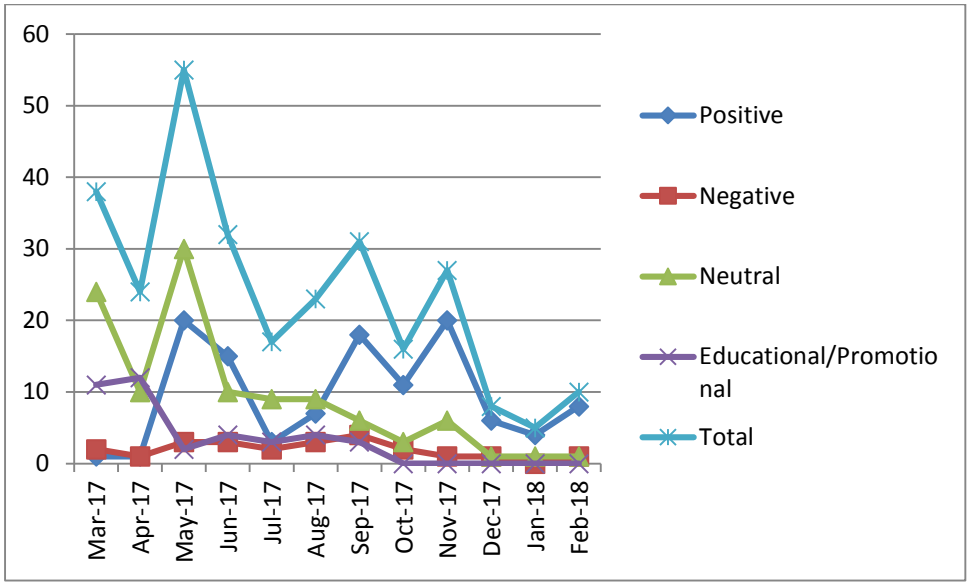
Purpose

This paper provides the board with a three-monthly overview of the Communication Department's

Media results

As expected, media interest in the WDHB has been both low and largely positive over the summer quarter.

Type	**December**
Positive	6
Negative	1
Educational/Promotional	0
Neutral	1
Type	**January**
Positive	4
Negative	0
Educational/Promotional	0
Neutral	1
Type	**February**
Positive	8
Negative	1
Educational/Promotional	0
Neutral	1



Social media

While we continue to share content promoting key health messages and campaigns, our current vacancies, Whanganui DHB news and events, our social media audiences also continue to grow (Facebook – 570 (1 March 2017 - 380 likes); Twitter – 846 followers (May 2017 - 697) with our posts reaching more people and receiving slightly increased engagement.
We are also sharing messages to our Instagram account (search Whanganuidhb) which currently has 88 followers.

Since our last report, social media posts have included promotion of:

- Vacancies
- Census 2018
- Aotearoa Bike Challenge/Bike Wise Whanganui
- Media releases
- Well Child Week
- Women's Wellness Month
- Alcohol Awareness
- SunSmart
- Water Only / Ditch the Fizz: Fizz free whanau challenge
- Back to School road safety
- Sexual Health Clinics

Website
www.wdhb.org.nz

Our website trends continue to be similar to those reported previously with a slight increase in:

- the number of unique users and visits to the WDHB website (11 Dec 2017 - 11 Mar 2017: 24,598 sessions / 72,683 page views) when compared to the same period in 2016/17
- the length of time users are typically spending on the website
- the number of pages they view per visit
- the proportion of users who return to the website more frequently.

Most users are aged 25-54 (72 percent of visitors) with 25-34 year olds accounting for the largest cohort. Females continue to account for most users, although the proportion who are male has increased from 20 to 26 percent over the past 12 months.

New staff member

The communications team is pleased to have appointed a new staff member into the .5 role *Communications Support - Health Promotion* role which works across both the communications and health promotion teams. The successful applicant's focus is to coordinate and build the DHB's social media presence to help us reach a wider audience.

Speaking Up For Safety (SUFS)

The communication team has been responsible for writing and distributing the Speaking Up For Safety (SUFS) messaging to staff and stakeholders, developing the SUFS reporting tool and designing posters to put the spotlight on the programme.

We were pleased to play a part in hosting a group from Wairarapa DHB with whom we have shared our messaging and posters. MidCentral, Wairarapa, Capital & Coast, South Canterbury, Southern and Lakes DHBs have also approached us regarding how we've implemented the SUFS programme. The poster developed in conjunction with the Cognitive Institute promoting the programme is attached to this paper as ***Appendix one.***

Recommendation

It is recommended that the Whanganui District Health Board:

1. **Receives** the paper entitled 'Communication Department's report to board'.

12 Information papers

Item number	Description
One	Detailed financial report for February 2018

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2018($000s)
CONSOLIDATED

	Month				Year to Date				Annual		
	Actual	Budget	Var		Actual	Budget	Var		Budget 2017-18	Forecast	Var
Provider Division	73	313	(240)	U	(1,906)	(1,205)	(701)	U	(1,921)	(3,122)	(1,201)
Corporate	95	1	94	F	332	19	313	F	22	522	500
Provider & Corporate	**168**	**314**	**(146)**	**U**	**(1,574)**	**(1,186)**	**(388)**	**U**	**(1,899)**	**(2,600)**	**(701)**
Funder Division	444	571	(127)	U	(54)	329	(383)	U	–	(800)	(800)
Governance	36	16	20	F	249	(2)	251	F	–	217	217
Funder divison & Governance	**480**	**587**	**(107)**	**U**	**195**	**327**	**(132)**	**U**	–	**(583)**	**(583)**
Net Surplus / (Deficit)	**648**	**901**	**(253)**	**U**	**(1,379)**	**(859)**	**(520)**	**U**	**(1,899)**	**(3,183)**	**(1,284)**

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

Overview

Result for the month of February 2018 is unfavourable to budget by $253k

- Provider division $240k unfavourable to budget is mainly due to nursing personnel costs – including allowance for likely increased cost of nurses' MECA settlement, rest home convalescence, high demand of blood products, treatment disposal costs related to district nursing non-acute and MRIs ACC revenue. Unfavourable elective wash up revenue (internal); partly offset by lower patient travel costs and pharmaceuticals.
- Corporate $94k favourable to budget is mainly due to depreciation, JADE software licence one-off saving, corporate training, personnel costs and national IT infrastructure (NIP) running late.
- Governance and funding admin $20k favourable to budget due to personnel costs and other operating costs.
- Funder division $127k unfavourable to budget, mainly due to higher than expected pharmaceutical expenditure ($161k), long-term home-based support expenditure ($96k) and hospital level aged residential care expenditure ($81k), along with inter-district inflows and outflows ($102k). This is offset by less than expected expenditure on specialist nursing ($109k) and rest home/dementia level aged residential care ($81k). Anticipated Ministry of Health mental health initiatives not yet materialising ($122k).

Year-to-date January 2018 result is unfavourable to budget by $520k, mainly driven by inter-district flows.

- Provider division $701k unfavourable to budget is mainly due to unfavorable $502k elective surgery wash up (internal) mainly due to no Waikato DHB electives that had been budgeted; high acute demand 108.8% to target, adding pressure to clinical staff; locum medical personnel to cover leave and vacancies in ophthalmology, orthopaedic and the obstetrics and gynaecology service; high demand for blood products; district nurse consumables, and patient transfer costs. This is partly offset by dental revenue; positive outpatient wash up with funder (internal); training revenue; and cost recovery for seconded mental health medical personnel. Depreciation relates to the timing of the capex purchase.
- Corporate $313k favourable to budget is due to insurance costs, personnel costs, RHIP business as usual cost (BAU), one-off gain for JADE licence, corporate training, national IT infrastructure (NIP) programme not eventuating and depreciation; partly offset by the timing of facility costs.
- Governance $251k favourable to budget is related to outsourced, Health Roundtable subscription (paid by provider), personnel costs, other operating costs and the reversal of accrued prior year IT costs (paid by funder).
- Funder division $383k unfavourable to budget is mainly due to anticipated other DHB surgical patient inflows not eventuating; pharmaceutical costs; inter-district outflows and outpatient wash up with own provider. This is partly offset by elective wash up with own provider (internal) and lower than anticipated health of older people and mental health costs.

Forecast 2017/18	Pressure on forecast
Forecast is $1.3 million unfavourable to budget. The main contributor is IDF outflows, due to a small number of acute high case weight events. Key assumptions in this forecast are: **Provider and Corporate** ▪ MECA increase of 2% + 2% for senior nurses from November 2017 plus $360k lump sum. However, the latest NZNO MECA will have domino effect when other MECAs are negotiated in the second half of 2018, impacting on the 2018/19 financial year. ▪ Nursing FTE pressure on wards. District nursing remains the same as plan from March to June (no further FTE increase). ▪ Senior medical personnel (SMO) outsourced personnel cost increase is forecasted, however this is expected to be offset by personnel costs. ▪ Elective volume delivery from March 2018 onwards to year-end remains as planned (December year-to-date $502k under-delivery). ▪ Depreciation adjusted due to timing of spend. ▪ $162k one-off funding for national patient flow capex project. **Funder** *IDFs* ▪ IDF inflows, excluding elective inflows from Waikato DHB – based on current 12-month rolling average. ▪ Elective IDF inflows from Waikato DHB – none of the budgeted 75 cases will be completed by the end of June 2018. ▪ IDF inpatient outflows – continue based on the 12-month rolling average, excluding outliers. ▪ IDF outpatient outflows unfavourable variance is extrapolated to full year. *Other personal health expenditure* ▪ Lower than expected demand for national travel assistance continues through the remainder of the year. ▪ Pharmaceutical expenditure trends will continue. ▪ Growing PHO enrolments will remain consistent over the remaining period. *Health of Older People* ▪ Current demand trends for home-based support services and aged residential care services are relatively stable and likely to continue. ▪ Age-related residential care average bed day cost the DHB is required to fund is also slightly lower than budgeted, helping contribute to favourable variances. ▪ Forecasts for the end of the year are based on current demand levels and bed day costs continuing for the remainder of the year. ▪ Pay equity will be cost neutral. ▪ In-between travel will be cost neutral. ▪ Lower than expected mental health expenditure. **Provider key impacts** Provider forecast is $1.2 million unfavorable to budget, due to under-delivery of elective volumes $502k; other personnel costs related to courses, conferences and recruitment; membership fees; outpatient clinic revenue. Nursing relates to high volumes and acuity; $875k includes nurses' MECA lump sum; laboratory contract price increase; high use of clinical supplies in theatre (orthopaedic); district nursing; ED; orthotics footwear and blood products (demand driven). Infrastructure and non-clinical supplies related to books and journals; postage; HWNZ training costs (offset by revenue). This is partly offset by outpatient wash up (internal); theatre consumables due to lower elective orthopaedic volumes; patient focused booking initiative revenue; ophthalmology service improvement initiatives revenue; clinical equipment depreciation and ACC contract favourable variance. **Corporate key impacts** Corporate forecast is $500k favourable to budget, mainly due to IT depreciation, reversal of RHIP regional desk support, one-off insurance savings, personnel costs related to leave and vacancies, national patient flow project funding (prior income in advance), and Allied Laundry prior year share of profits. This is partly offset by server maintenance and facility costs.	

Funder key impacts
Funder forecast is $800k unfavourable to budget, due to the continued impact of high case weight acute IDF outflow events and a tight IDF budget; pharmaceutical expenditure based on current demand trends. Partially offset by a static demand for home-based support services and aged residential care services.

Changes from prior forecast

Provider key impacts
$677k unfavorable variance compared to the prior forecast is mainly due to a $306k increase in nursing costs to accommodate the current lump sum payment offer; $73k related to staff training, CME training and professional memberships; $45k blood costs; $217k unfavourable elective wash up; $71k ACC MRI and AT&R non acute revenue. This is partly offset by depreciation and patient travel costs.

Corporate key impacts
$418k improvement in the corporate result compared to the prior forecast mainly relates to $162k one-off revenue for national patient flow project (prior income advance); $125k reversal of RHIP regional service delivery help desk; $46k RHIP opex and business as usual (BAU) costs; Oracle and JADE support $39k; $7k IT deprecation; $30k facility contract cost.

Governance and Funding Admin key impacts
$66k improvement in the governance result is mainly due to democracy – relating to advisory fees and having one board member vacancy, board and corporate training and personnel costs.

Funder key impacts
$390k unfavourable variance compared to the prior forecast is mainly due to $440k higher than expected IDF outflows in January which impacts on the averages used for forecasting; $311k reduction in IDF inflows due to no additional volumes expected from other DHBs (particularly Waikato DHB); $253k pharmaceutical expenditure based on current demand trends; re-estimation of home-based support expenditure $363k. This is partially offset by the anticipated timing of expenditure on specialist nursing $229k; anticipated Ministry of Health mental health initiatives not materialising $254k; further reduction in aged residential care demand $120k; timing of national patient flow implementation $162k; timing of fit for surgery implementation $96k .

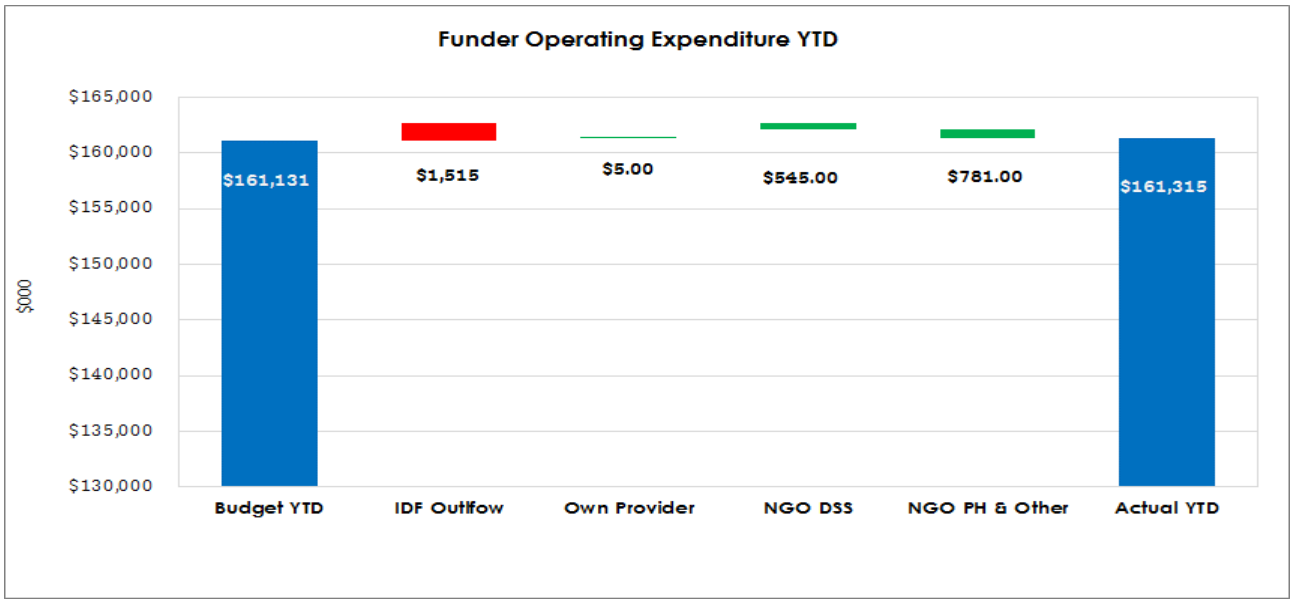
1. Funder division financial performance

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2018($000s)
FUNDER DIVISION

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2017-18
Personal Health	210	348	(138)	U	(1,765)	(95)	(1,670)	U	(600)
Disability Support	62	167	(105)	U	870	62	808	F	–
Public Health	14	3	11	F	52	(10)	62	F	–
Maori Services	(6)	7	(13)	U	6	(27)	33	F	–
Other	38	46	(8)	U	346	399	(53)	U	600
Mental Health	126	–	126	F	437	–	437	F	–
Net Surplus / (Deficit)	**444**	**571**	**(127)**	**U**	**(54)**	**329**	**(383)**	**U**	**–**

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2018($000s)
FUNDER DIVISION

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget 2017-18
REVENUE									
Government and Crown agency	19,242	19,412	(170)	U	155,765	155,126	639	F	232,774
Inter-district Inflow	694	742	(48)	U	5,150	5,935	(785)	U	8,902
Other Income Revenue	38	46	(8)	U	346	399	(53)	U	600
Total Revenue	**19,974**	**20,200**	**(226)**	**U**	**161,261**	**161,460**	**(199)**	**U**	**242,276**
EXPENDITURE									
Personal Health	7,900	7,932	32	F	63,531	63,598	67	F	95,781
Disability Support	254	254	–	F	2,033	2,033	–	F	3,049
Mental Health	1,491	1,491	–	F	11,931	11,931	–	F	17,897
Public Health	20	13	(7)	U	163	101	(62)	U	152
Maori Services	9	9	–	F	72	72	–	F	108
Total own provider expenditure	**9,674**	**9,699**	**25**	**F**	**77,730**	**77,735**	**5**	**F**	**116,987**
Personal Health	3,260	3,202	(58)	U	27,995	28,204	209	F	42,526
Disability Support	2,203	2,237	34	F	18,605	19,150	545	F	28,753
Mental Health	544	685	141	F	5,052	5,482	430	F	8,224
Public Health	62	85	23	F	603	713	110	F	1,055
Maori Services	143	131	(12)	U	1,094	1,126	32	F	1,649
Inter-district Outflow	3,320	3,266	(54)	U	27,647	26,132	(1,515)	U	39,198
Total Other provider expenditure	**9,532**	**9,606**	**74**	**F**	**80,996**	**80,807**	**(189)**	**U**	**121,405**
Governance	324	324	–	F	2,589	2,589	–	F	3,884
Total Expenditure	**19,530**	**19,629**	**99**	**F**	**161,315**	**161,131**	**(184)**	**U**	**242,276**
Net Surplus / (Deficit)	**444**	**571**	**(127)**	**U**	**(54)**	**329**	**(383)**	**U**	**–**



Comments on results	
	Negative

Month comments
Funder division $127k unfavourable to budget, mainly due to higher than expected pharmaceutical expenditure, long-term home-based support expenditure and hospital level aged residential care expenditure, along with inter-district flows. This is offset by less than expected expenditure on specialist nursing and rest home/dementia level aged residential care, along with anticipated Ministry of Health mental health initiatives not yet materialising.

Year-to-date comments
Funder division $383k unfavourable to budget, mainly due to inter-district flows and outpatient wash up; partly offset by less than expected expenditure on specialist nursing and health of older people, along with anticipated Ministry of Health mental health initiatives not yet materialising.

	Variance $000	**Impact on forecast**
Revenue YTD	($199) U	

Crown revenue	**639 F**	
▪ Personal health side contract – elective initiatives	$176 F	One-off
▪ Personal health side contract – primary care top-up	$55 F	Offset by costs
▪ Personal health side contract – PHO performance	$13 F	Offset by costs
▪ Personal health side contract – practice sustainably	$8 F	Offset by costs
▪ Personal health – Participation in child team	$98 F	Offset by costs
▪ Personal health – ACC sexual abuse assessment	$50 F	Timing
▪ Personal health – ACC falls prevention	0 F	Timing
▪ Health of older people – in-between travel (IBT)	$146 F	One-off $175k
▪ Health of older people – pay equity	$91 F	Offset by costs
▪ Mental Health – sleepover	($13) U	Offset by costs
▪ Public health side contract – cervical screening	($5) U	Offset by costs
▪ Public health side contract – Smoke-free	$20 F	Offset by costs

Inter-district inflows – expected inflows from another DHB did not eventuate	**($785) U**	Waikato DHB patients

Other income – mainly interest	**($53) U**	

Expenditure YTD	**$5 F**	
Payment to own provider		
▪ Personal health – elective wash up	$502 F	
▪ Personal health – outpatient wash up	($185) U	
▪ Personal health – cancer nurse coordinator	($80) U	

▪ Personal health – adolescent dental demand driven (partly offset by $70k of favourable external provider costs)	($119) U	No overall impact – offset by provider internal revenue
▪ Personal health – pharmaceuticals	($51) U	
▪ Public health – tobacco control	($62) U	

	Variance $000	Impact on forecast
Payment to external provider (excluded IDF)	**$1,326 F**	
Personal health	**$209 F**	
▪ Pharmaceutical – demand driven	($238) U	
▪ General medical subsidy	($102) U	Part offset by primary health care
▪ Primary health care	($51) U	
▪ Palliative care	$39 F	
▪ Domiciliary and district nursing	$151 F	
▪ Community based allied health	($57) U	
▪ Travel and accommodation	$107 F	
▪ Medical outpatient	$250 F	
▪ Surgical outpatient	$89 F	
▪ Other	$21 F	
Health of older people	**$545 F**	
▪ Pay equity	($91) U	Offset by revenue
▪ Personal care household management	($153) U	
▪ Age-related residential care – demand driven	$634 F	
▪ Residential care hospitals	$172 F	
▪ Ageing in place	($25) U	
▪ Other	$8 F	
Mental health	**$430 F**	
▪ Sub-acute and long-term inpatient	$90 F	
▪ Home-based support	$29 F	
▪ Community residential beds service	$6 F	
▪ MOH mental health initiatives	$272 F	
▪ Mental Health community service	$20 F	
▪ Other	$13 F	
Public health side contracts	**$110 F**	
▪ Nutrition and physical activity	$67 F	
▪ Tobacco control and other	$43 F	Offset by own provider cost
Māori Health service	**$32 F**	
Inter-district outflows	**($1,515 U**	
▪ Tight budget – IDF outflows and small number of high acute case weight events	($1,515) U	Longer term trend uncertain, volume varies month to month

1. Governance and funding administration financial performance

Month comments

The result was $20k favourable to budget due to personnel vacancies and timing of leave and other operating costs.

Year-to-date comments	
The result was $251k better than budget due to personnel costs, reversal of prior year IT accruals (paid by funder), Health Roundtable membership fee (paid by provider) and other operating costs.	**Positive**

	Variance $000	Impact on forecast
▪ Personnel costs	$136 F	
▪ IT, outsourced and other operating expenses and other	$115 F	

2. Provider and corporate financial performance

STATEMENT OF FINANCIAL PERFORMANCE for the period ended 28 February 2018($000s)
PROVIDER & CORPORATE

	Month				Year to Date				Annual
	Actual	Budget	Variance		Actual	Budget	Variance		Budget
REVENUE									
Government and Crown agency	606	724	(118)	U	6,853	6,903	(50)	U	10,508
Funder to Provider Revenue (internal)	9,675	9,699	(24)	U	77,730	77,735	(5)	U	116,987
Other income	117	111	6	F	1,115	874	241	F	1,382
Total Revenue	**10,398**	**10,534**	**(136)**	**U**	**85,698**	**85,512**	**186**	**F**	**128,877**
EXPENDITURE									
Personnel									
Medical	1,584	1,702	118	F	13,273	14,339	1,066	F	21,788
Nursing	2,867	2,741	(126)	U	23,725	23,240	(485)	U	34,978
Allied	831	836	5	F	7,085	7,201	116	F	10,861
Support	54	55	1	F	476	505	29	F	745
Management & Admin	782	790	8	F	6,842	6,858	16	F	10,332
Total Personnel(Exl other & outsourced)	**6,118**	**6,124**	**6**	**F**	**51,401**	**52,143**	**742**	**F**	**78,704**
Personnel Other	180	158	(22)	U	1,145	1,026	(119)	U	1,720
Outsourced Personnel	579	518	(61)	U	4,835	3,895	(940)	U	5,912
Total Personnel Expenditure	**6,877**	**6,800**	**(77)**	**U**	**57,381**	**57,064**	**(317)**	**U**	**86,336**
Outsourced Clinical Service	564	565	1	F	4,593	4,585	(8)	U	6,888
Clinical Supplies	1,162	1,171	9	F	10,269	9,932	(337)	U	15,102
Infrastructure & Non Clinical Supplies Costs	912	934	22	F	9,347	9,198	(149)	U	13,286
Capital Charge	271	270	(1)	U	2,191	2,183	(8)	U	3,262
Depreciation & Interest	389	428	39	F	3,013	3,277	264	F	5,206
Internal Allocation	55	52	(3)	U	478	459	(19)	U	696
Total Other Expenditure	**3,353**	**3,420**	**67**	**F**	**29,891**	**29,634**	**(257)**	**U**	**44,440**
Total Expenditure	**10,230**	**10,220**	**(10)**	**U**	**87,272**	**86,698**	**(574)**	**U**	**130,776**
Net Surplus / (Deficit)	**168**	**314**	**(146)**	**U**	**(1,574)**	**(1,186)**	**(388)**	**U**	**(1,899)**
FTEs									
Medical	100.5	102.3	1.8	F	96.0	101.3	5.3	F	101.2
Nursing	471.8	431.8	(40.0)	U	441.0	424.0	(17.0)	U	424.2
Allied	147.0	146.8	(0.2)	U	143.5	147.5	4.0	F	147.5
Support	13.7	14.0	0.3	F	15.0	15.2	0.2	F	14.8
Management & Admin	172.2	165.7	(6.5)	U	166.2	166.1	(0.1)	U	166.1
Total FTEs	**905.2**	**860.6**	**(44.5)**	**U**	**861.7**	**854.1**	**(7.6)**	**U**	**853.9**

Comments on result — **Positive**

Month comments

Inpatient volumes are 104.5% to target in February 2018, with acute being 111.1% and electives 86.7% of budget (estimated due to delays in webPAS reporting). The overall result for the month was $146k favourable to budget.

- Revenue is $136k unfavourable to budget, mainly due to unfavourable elective wash up $85k (internal), ACC contract revenue (offset by cost), ACC non acute revenue. This is partly offset by bowel screening establishment funding (offset by cost), pharmacy and dental revenue (internal).
- Personnel costs are $77k unfavourable to budget due to nursing personnel in medical wards, district nursing, adult mental health (Te Awhina), ED and theatre due to meeting the demand. This was partly offset by lower medical personnel costs. Includes additional accrual for likely increased cost of settlement of the nursing MECA.
- Outsourced clinical services are in line with budget, however the laboratory service and rest home convalescence were unfavourable to budget. This was partly offset by $22k orthopaedic surgery costs budgeted for Waikato DHB patients that did not eventuate and ACC contract (offset by revenue).
- Clinical supplies $9k favorable to budget, mainly due to patient travel and health promotion costs, and pharmaceuticals. This was partly offset by blood costs and district nursing consumables.
- Infrastructure and non-clinical supplies $22k were favourable due to telecommunication and corporate training. This was partly offset by laundry costs, additional security required for the Medical Ward and ED (Spotless), Health Roundtable affiliation fee, laundry costs and facility maintenance costs.
- The favourable variation for depreciation was due to timing of the purchase of clinical and IT equipment.

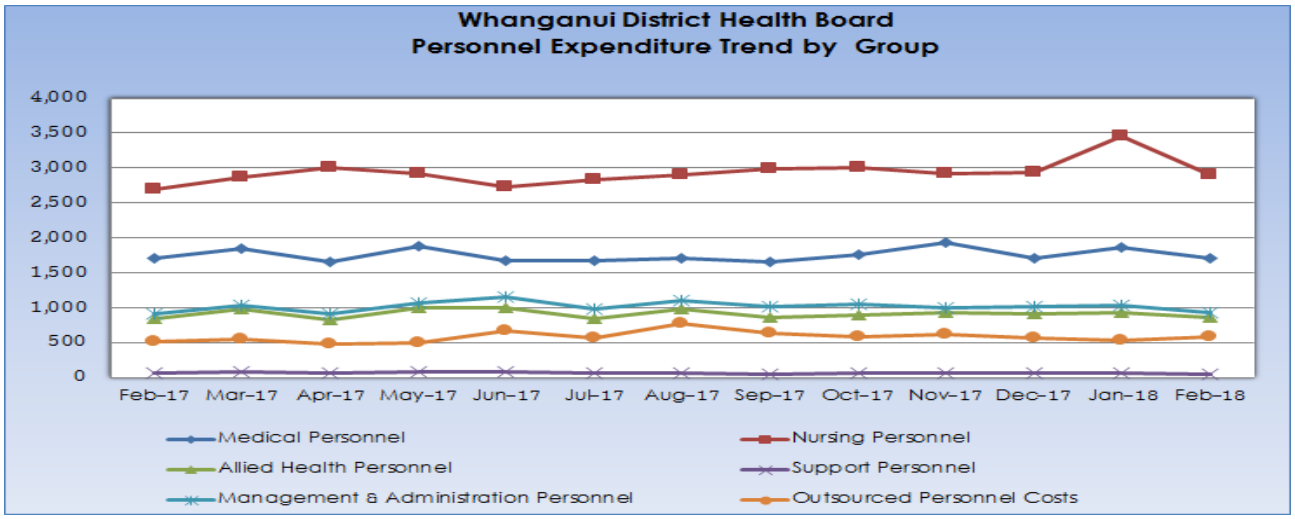
Year-to-date comments

Inpatient volumes were 105.5% to target in February 2018, with acute being 108.8% and elective being 97.7% of budget (estimated due to delays in webPAS reporting). The overall result is $388k unfavourable to budget.

- Revenue is $186k favourable to budget – mainly due to outpatient wash up with funder (internal), Smoke-free and cancer nurse coordinator (internal), elective booking scheduling, ophthalmology initiative funding, Pharmac hospital rebate, ACC contract revenue (offset by costs), government training fees, cost recovery for seconded medical personnel (offset by costs) and dental revenue (offset by funder). This was partly offset by under-delivery of elective volumes resulting in an unfavourable wash up of $502k, health workforce revenue (volume driven now, not paid as per contract) and outpatient clinic revenue.
- Personnel costs are $317k unfavourable to budget mainly due to nursing personnel costs due to high patient acuity, high medical personnel locum costs to cover leave and vacancies (offset by medical personnel), allied health outsourced related to physiotherapy, typing service for health records and radiology. This was partly offset by allied health personnel costs related to vacancies and support staff.
- Outsourced clinical services is $8k unfavourable to budget, mainly due to radiology service, laboratory service, dental service, rest home convalescence costs, audiology and tele-stroke hub service and ACC contract (offset by revenue). This was partly offset by orthopaedic surgery costs budgeted for Waikato DHB patients that did not eventuate and lithotripsy costs.
- Clinical supplies is $337k unfavourable to budget due to the impact of high patient acuity which added pressure on clinical supplies costs. $108k cost relates to district nursing for continence and hygienic supplies, ostomy, bandages and dressings; $145k high demand of blood products; $68k orthotic footwear related cost in outpatient and orthotics area and pharmaceuticals. This was partly offset by radiology clinical equipment leased costs and other operating costs.
- Infrastructure and non-clinical supplies $149k unfavourable to budget due to facility costs (timing), health workforce training programme (partly offset by additional revenue), patient meals and laundry costs related to high acuity, telecommunication costs related to wireless internet upgrade and relocation of the data cabling. This was partly offset by savings in regional health informatics project (RHIP) costs, insurance costs, staff travel and accommodation and accreditation costs.
- Depreciation better than budget variance is due to timing of purchasing of clinical and IT equipment.

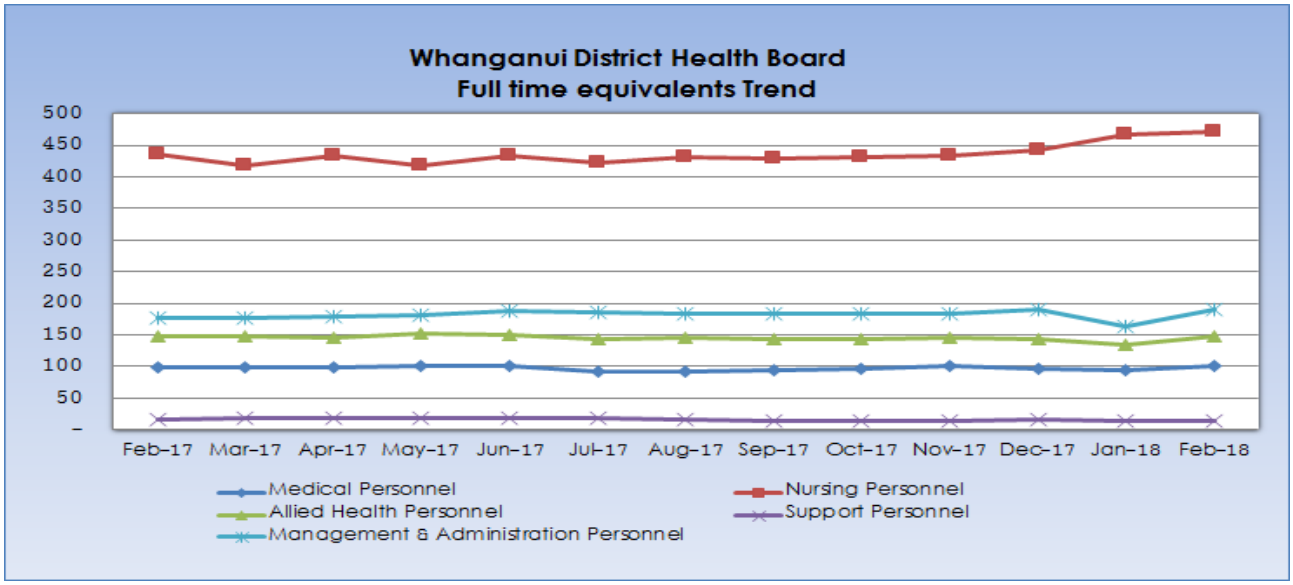
3. Supplementary information on costs

Personnel cost trends



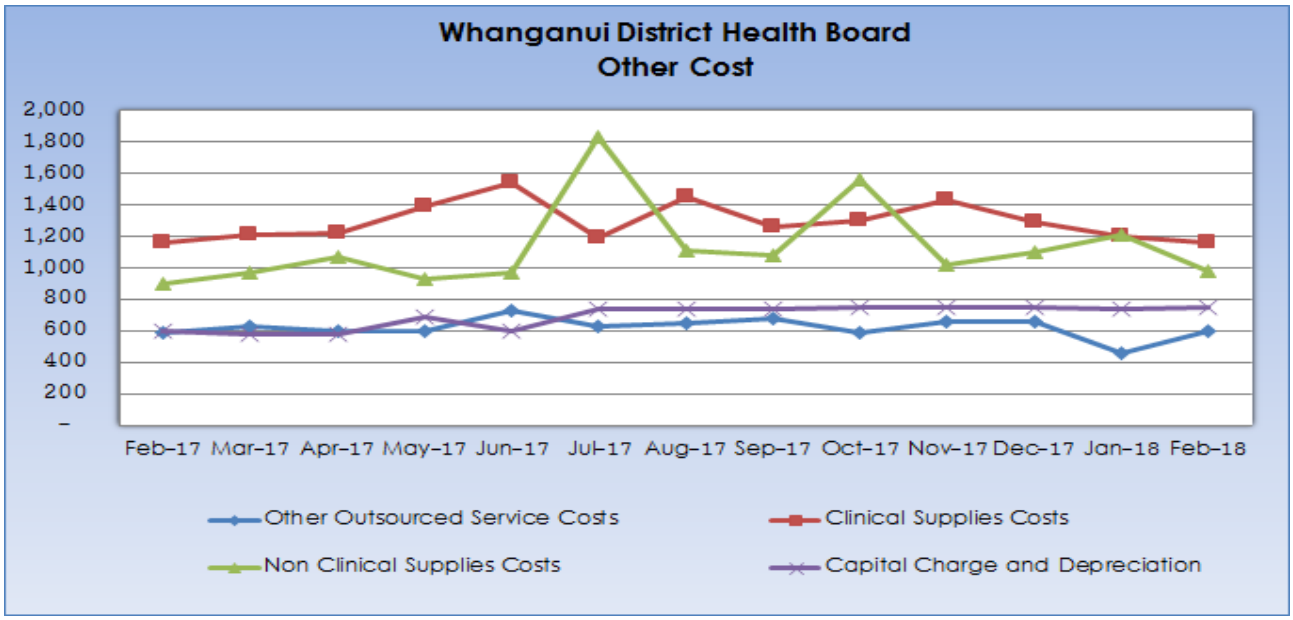
- All personnel downward trends in February 2018 compared to the prior month were due to having three less working day in the month. January captures the additional cost of December/January statutory days.

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. Increased nursing reflects high occupancy as well as additional cost of specialling patients in ATR, Medical and Surgical Wards.

Other operating costs



- Non-clinical supplies downward trend in February 2018 compared to the prior month is due to timing of the software maintenance fees, RHIP costs and professional fees related to valuation.
- Clinical supplies downward trend in February 2018 compared to the prior month is mainly to due pharmaceutical, blood and patient travel costs.
- Other outsourced upward trend in February 2018 compared to the prior month is due to ACC contract, laboratory and rest home convalescence costs.
- Capital charge and depreciation trend in January 2018 is comparable to the prior month.

4. Rolling trend of financial performance

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

	Feb-17	Feb-18	Last 12 Month Rolling Total	Budget 2017-18	Diff Rolling Total Vs Budget		Actual 2016-17	Actual 2015-16
REVENUE								
MoH - Government And Crown Agency	19,875	20,542	247,445	252,184	(4,739)	U	240,264	234,546
Other Income Revenue	115	156	2,089	1,998	91	F	1,966	2,430
Total Revenue	**19,990**	**20,698**	**249,534**	**254,182**	**(4,648)**	**U**	**242,230**	**236,976**
EXPENDITURE								
Medical Personnel	1,708	1,703	21,066	22,930	1,864	F	21,064	20,999
Nursing Personnel	2,695	2,904	35,468	35,288	(180)	U	33,855	31,754
Allied Health Personnel	838	852	10,991	11,072	81	F	10,720	10,119
Support Personnel	64	54	774	749	(25)	U	865	833
Management & Administration Personnel	906	931	12,291	12,465	174	F	11,775	11,273
Outsourced Personnel Costs	506	580	7,037	5,912	(1,125)	U	6,117	6,891
Total Personnel Expenditure	**6,717**	**7,024**	**87,627**	**88,416**	**789**	**F**	**84,396**	**81,869**
Other Outsourced Service Costs	584	602	7,457	7,368	(89)	U	7,474	6,970
Clinical Supplies Costs	1,163	1,163	15,646	15,106	(540)	U	14,569	13,702
Infrastructure & Non Clinical Supplies Costs	902	982	13,815	14,205	390	F	13,334	12,954
Other Provider Payments	5,995	6,210	79,062	82,208	3,146	F	76,829	75,027
Inter-district-outflow	3,154	3,320	39,719	39,198	(521)	U	38,253	37,907
Total Other Expenditure	**11,798**	**12,277**	**155,699**	**158,085**	**2,386**	**F**	**150,459**	**146,560**
Net Surplus / (Deficit) before Int, Depr & Ca	**1,475**	**1,397**	**6,208**	**7,681**	**(1,473)**	**U**	**7,375**	**8,547**
Capital Charges	154	359	3,658	4,360	702	F	2,422	3,028
Depreciation	389	390	4,731	5,220	489	F	4,695	4,540
Interest Costs	59	-	3	-	(3)	U	970	1,547
Total Interest Depreciation and Capital Exp	**602**	**749**	**8,392**	**9,580**	**1,188**	**F**	**8,087**	**9,115**
Total Expenditure	**19,117**	**20,050**	**251,718**	**256,081**	**4,363**	**F**	**242,942**	**237,544**
Net Surplus/ (Deficit)	**873**	**648**	**(2,184)**	**(1,899)**	**(285)**	**U**	**(712)**	**(568)**

- 12-month rolling average is $285k unfavourable to the annual budget of $1,899k.
- The 12-month rolling average has been impacted by high IDF outflows and anticipated Waikato DHB elective volumes not eventuating yet.

5. Statement of financial position

Summary Statement of Financial Position as at 28 February 2018 ($000)

	Actual 2016-17	Actual YTD 2017-18	Budget YTD 2017-18	Variance	Annual Budget 2017-18
ASSETS					
Current Assets (exl trade other receivable	11,871	12,691	6,230	6,461	6,790
Trade and Other Receivables	7,525	7,279	5,710	1,569	6,707
Fixed Assets	72,688	73,595	79,433	(5,838)	81,931
Work in Progress (WIP)	7,145	6,425	7,640	(1,215)	7,891
Long Term Investments	1,126	1,126	1,138	(12)	1,184
Total Assets	**100,355**	**101,116**	**100,151**	**965**	**104,503**
LIABILITIES					
Bank Overdraft	0	0	0	0	0
Bank Overdraft - HBL	0	0	0	0	0
Employee Related - Current Liabilities	(11,793)	(13,210)	(11,967)	(1,243)	(12,358)
Trade and Other Payables	(13,697)	(13,761)	(14,538)	777	(15,001)
Crown Loan - Current	(135)	(135)	(135)	0	(135)
Finance Leased - Current	(20)	(105)	(4)	(101)	0
Crown Loan - Non-Current	(371)	(270)	(270)	0	(236)
Non - Current Liabilities	(872)	(840)	(845)	5	(814)
Finance Leased - Non- Current	0	(708)	0	(708)	0
Total Liabilities	**(26,888)**	**(29,029)**	**(27,759)**	**(1,270)**	**(28,544)**
EQUITY					
Equity	(73,467)	(72,087)	(72,392)	305	(75,959)
Total Equity	**(73,467)**	**(72,087)**	**(72,392)**	**305**	**(75,959)**
Total Equity and Liabilities	**(100,355)**	**(101,116)**	**(100,151)**	**(965)**	**(104,503)**

Comments on result	
There are no material concern on the financial position.	**Positive**

- Current assets reflect the better cash position (see cash flow explanation for detail).
- Fixed asset actual is less than budget forecast expenditure as at 30 June 2017, and this has reflected on positive cash balance.
- Refer to working capital analysis and consolidated summary of cash flows for further variance explanations.

6.1 Working capital

Working Capital as at 28 February 2018 ($000s)

	Actual 2016-17	Actual YTD 2017-18	Budget YTD 2017-18	Variance	Annual Budget 2017-18
CURRENT ASSETS					
Cash and cash equivalents	7,406	8,071	1,741	6,330	2,301
Trust / special funds	138	138	139	(1)	139
Trade and other receivables	7,525	7,279	5,710	1,569	6,707
Investment	3,000	3,000	3,000	0	3,000
Inventory / Stock	1,327	1,482	1,350	132	1,350
Total Current Assets	**19,396**	**19,970**	**11,940**	**8,030**	**13,497**
CURRENT LIABILITIES					
Bank Overdraft	0	0	0	0	0
Bank Overdraft - HBL	0	0	0	0	0
Trade and other payables	(13,171)	(12,735)	(13,786)	1,051	(15,186)
Income Received in Advance	(1,624)	(1,391)	(1,067)	(324)	0
Capital Charge Payable	0	(719)	(714)	(5)	0
Term Loans – Private (current portion)	(20)	(105)	(4)	(101)	0
Crown Loan - Current	(135)	(135)	(135)	0	(135)
Payroll Accruals & Clearing Account	(2,330)	(3,796)	(2,715)	(1,081)	(2,580)
Employee Related - Current Liabilities	(8,365)	(8,330)	(8,223)	(107)	(8,913)
Total Current Liabilities	**(25,645)**	**(27,211)**	**(26,644)**	**(567)**	**(26,814)**
Working Capital	**(6,249)**	**(7,241)**	**(14,704)**	**7,463**	**(13,317)**
Working Capital ratio	**75.6%**	**73.4%**	**44.8%**		**50.3%**

Comments on result	
No concerns for cash position so long as deficit remains low.	**Positive**

Working capital variances	**Variance $000**	**Impact on forecast**
Working capital better than budget due to:	$7,763 F	
Current assets	$8,030 F	
▪ Higher in funds cash position than budget is due to capital projects being behind schedule – mainly clinical equipment and RHIP investment which is a timing variance that will be spent in due course.	$6,330 F	**Mainly timing**
▪ Trade and other receivables increased due to budgeted projection (which was based on historical information) are more than actual. Major contributors are the pay equity prepayment and in-between travel accrual provision.	$1,569 F	

Current liabilities	($567) U	
▪ Trade and other payables decreased due to budgeted projection (which was based on historical information) are less than actual.	$1,051 F	**Mainly timing**
▪ Income in advance mainly related 30 June 2017 carry forward balance for youth alcohol, Smoke-free, national patient flow, health sector participation in child health, and pay equity.	($324) U	
▪ Payroll accruals relates to expiry MECA provision.	(1,081) U	

1. Cash flows

Consolidated Summary Statement of Cash Flows for the period ended 28 February 2018 ($000)

	Actual 2016-17	Actual YTD 2017-18	Budget YTD 2017-18	Variance	
Net surplus / (deficit) for year	(712)	(1,379)	(859)	(520)	U
Add back non-cash items					
Depreciation and assets written off on PPE	4,687	3,020	3,286	(266)	U
Revaluation losses on PPE	–	–	–	–	F
Total non cash movements	**4,687**	**3,020**	**3,286**	**(266)**	**U**
Add back items classified as investment Activity					
(loss) / gain on sale of PPE	8	7	–	7	F
Profit from associates	(60)	–	–	–	F
Gain on sale of investments			–	–	F
Movements in accounts payable attributes to Capital purchase	(476)	476	–	476	F
Total Items classified as investment Activity	**(528)**	**483**	**–**	**483**	**F**
Movements in working capital					
Increase / (decrease) in trade and other payables	(1,094)	50	725	(675)	U
Increase / (decrease) employee entitlements	681	1,399	216	1,183	F
			–	–	F
(Increase) / decrease in trade and other receivables	(897)	246	1,864	(1,618)	U
(Increase) / decrease in inventories	34	(155)	(23)	(132)	U
Increase / (decrease) in provision	–	–	–	–	F
Net movement in working capital	**(1,276)**	**1,540**	**2,782**	**(1,242)**	**U**
Net cash inflow / (outflow) form operating activities	**2,171**	**3,664**	**5,209**	**(1,545)**	**U**
	–	–	–		
Net cash flow from Investing (capex)	(5,371)	(3,690)	(7,651)	3,961	F
Net cash flow from Investing (Other)	26	(1)	–	(1)	U
Net cash flow from Financing	(327)	692	(117)	809	F
Net cash flow	(3,501)	665	(2,559)	3,224	F
Net cash (Opening)	13,907	7,406	4,300	3,106	F
Cash (Closing)	**10,406**	**8,071**	**1,741**	**6,330**	**F**

Opinion on result:	**Neutral**

Cash flow variance	**Variance $000**	**Impact on forecast**
Closing cash is better than budget, made up of the following:	**$6,330 F**	
Net cash flow from operations	($1,545) U	
▪ Trade and other payables difference between the forecasted opening budget 1 July 2017 and 30 June 2017 actual, mainly related to funder division accrual provision for demand-driven expenditure.	($675)U	**Timing**
▪ Employee entailment relates to mainly provision for expiry MECA and increased in timing accruals (positive impact on cash)	$1,183 F	
▪ Trade and other receivables difference between the forecasted opening budget 1 July 2017 and 30 June 2017 actual and also increased provision for prepayment for pay equity and in-between travel (IBT) provision.	($1,618)U	

Net cash outflow from investing ▪ Capital expenditure programme running behind schedule, mainly IT related projects (timing).	$3,961 F	**Behind budget**

Net cash flow from operations	**$809 F**	
▪ Includes $675k EECA interest free loan for energy saving project (five years to pay back). ▪ $807k CT scanner finance leased with Whanganui Eye and Medical Care Trust (monthly instalment of $9,465.75 for 95 months, commenced February 2018).	$9 F $800 F	

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

Brian Walden

General Manager Corporate
23 March 2018