WAIRARAPA DISTRICT HEALTH BOARD

PUBLIC MEETING

REAP House, Rangtumau Room
340 Queen Street, Masterton

Tuesday, 4 June 2013 at 9:00 am

	Item	Action	Presenter	Min	Time	Pg
PROCEDURAL				10	9:00 am	
1.1	Karakia					
1.2	Apologies	RECORD				
1.3	Conflicts of Interest	RECORD				
1.4	Confirmation of Minutes	APPROVE				
1.5	Matters Arising	NOTE				
DISCUSSION PAPERS						
2	Chief Executive Report	NOTE	Graham Dyer	20	9:10 am	
DECISION PAPERS						
3	CPHAC DSAC Membership Fees	APPROVE	Graham Dyer	5	9:30 am	
4	Inequalities in cancer control	APPROVE	Maureen Beukers	10	9:35 am	
INFORMATION						
5	CHPAC DSAC Arrangements	NOTE	Bob Francis	5	9:45 am	
6	**COMMITTEE REPORT BACKS**					
6.1	CPHAC	NOTE	Ashley Bloomfield	5	9:50 am	
6.2	HAC	NOTE	Pete Chandler	5	9:55 am	
OTHER						
7	Elections Update	NOTE	Nadine Mackintosh			
8	General Business			5	10:00 am	
9	Resolution to Exclude the Public	APPROVE	Bob Francis			
Close					10:00 am	
REGIONAL PUBLIC HEALTH PRESENTATION At the end of the public excluded session					**12:25 pm**	

Wairarapa District Health Board

REGISTER OF BOARD MEMBERSHIP INTERESTS
New Zealand Public Health and Disability Act 2000

Board Member	Disclosure Date	Value and /or Nature of Transaction or Interest	Statutory Committee
Bob Francis (Board Chairman)	14/04/08	• Chairman - Pukaha Mount Bruce • Chariman - Wairarapa Healthy Homes • Trustee – Wairarapa Community Transport Trust • Chairman – Aratoi Foundation • Board Member Capital and Coast DHB	Audit and Risk Committee Hospital Advisory Committee Community & Public Health Advisory Committee (Chair) Disability Support Advisory Committee (Chair)
Leanne Southey (Deputy Chair)	06/12/10 27/09/11 12/06/12	• Director, Southey Sayer Limited • Chartered Accountant to Health Professionals including Selina Sutherland Hospital and Selina Sutherland Trust • Trustee, Wairararpa Community Health Trust • Sister-in-Law is employed by WDHB • Member of Trustlands Trust • Director and part owner of Mangan Graphics Ltd	Audit and Risk Committee (Chair) Community & Public Health Advisory Committee Disability Support Advisory Committee
Liz Falkner	14/04/10 18/12/07	• Salaried General Practitioner with Masterton Medical Limited • General Medical Practice in which Doctor Falkner works is a member of the Wairarapa Community PHO. • Medical Advisor – Post Polio Support Society NZ Inc	
Rob Irwin	06/12/10	• Trustee Wairarapa Community Health Trust	Hospital Advisory Committee Audit and Risk Committee
Charles Grant	07/05/12	• Nil	Te Iwi Kainga

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Board Member	Disclosure Date	Value and /or Nature of Transaction or Interest	Statutory Committee Membership
Helen Kjestrup	18/12/07 30/08/11	• Clinical Services Manager Masterton Medical Ltd • Shareholder, Property Investment Company – Kjestrup Properties • Assessor for Royal College of GPs for Cornerstones Programme • Member of Compass Quality Board	Hospital Advisory Committee
Rick Long	06/12/10 03/10/11 05/03/13	• Chairman of Wairarapa Community Transport Services Inc • Chairman of Tolley Educational Trust • Trustee for Sport and Vintage Aviation Society • Biomedical Services New Zealand Limited	Audit and Risk Committee Community & Public Health Advisory Committee Disability Support Advisory Committee Clinical Board
Vivien Napier	18/12/07 24/02/09	• RNZ Plunket Society Member • South Wairarapa District Council Deputy Mayor • Director Katson Developments (importing of farm machinery) • Vice President of the Wairarapa Branch Plunket Society	Hospital Advisory Committee (Chair) Audit and Risk Committee
Fiona Samuel	01/10/12	• Nurse Manager at Metlifecare	Hospital Advisory Committee
Janine Vollebregt	14/04/08	• DHB Nurse Educator for the UCOL Undergraduate Maori Students. This 0.4 FTE position is effective from 30 April 2008 to 30 June 2010.	Community & Public Health Advisory Committee Disability Support Advisory Committee (Chair)

WAIRARAPA & HUTT VALLEY DHB EXECUTIVE LEADERSHIP TEAM

Interest Register

APRIL 2013

Name	Interest
Graham Dyer *Chief Executive*	• Trustee, Bossley Dyer Family Trust • Wife is a Director of i-Management which does consulting and audit work in the Health Sector • Trustee, Hutt Hospital Foundation Trust • Member, Crisp Interim Governance Board • Member, Health Workforce New Zealand
Ashley Bloomfield *Director Service Integration and Development*	• Trustee, AR and EL Bloomfield Trusts • Fellow, NZ College of Public Health Medicine • Sister is a nurse at Hutt DHB • Wife was employed at Hutt Family Planning Association clinic during 2009-10
Pete Chandler *Chief Operating Officer*	• No interests declared.
Carolyn Cooper	• No interests declared.
Helen Pocknall *Executive Director Nursing and Midwifery*	• Board Member, Health Workforce New Zealand
Kuini Puketapu *Maori Health Advisor*	• Chair of Board of Trustees, Pukeatua Te Kohanga Reo • Board Member, Te Runanganui o Taranaki Whanui ki te Upoko o te Ika a Maui who has contracts with Hutt Valley DHB to provide health services in the Hutt Valley area and is an approved Whanau Ora provider • Member, Wainuiomata Community Governance Group • Chair, Waiwhetu Medical Group which is a limited liability company affiliated to Te Awakairangi Health PHO • Member, Whanau Ora Regional Leadership Group Whanganui a Tara
Richard Schmidt *Strategic Development Manager*	• No interests declared.
Russell Simpson *Executive Director Allied Health, Scientific and Technical*	• Director, Allied Health Wairarapa DHB • Chair, Central Region Directors of Allied Health • Member, Regional Leadership Committee
Iwona Stolarek *Chief Medical Officer*	• Member, ASMS JCC • Member, MCNZ Education Committee • National Clinical Director Cancer Programme – Ministry of Health • Husband Andrew Simpson: - Executive Director for Medicine Cancer & Community CCDHB - Executive Member of the Cancer Society Wellington Division
Cate Tryer *General Manager Quality and Risk*	• Shareholder and Director of Framework For Compliance Ltd (FFC) • Husband is an employee of Hutt Valley DHB
Stephanie Turner *Director Maori Health*	• Represent Rangitane Iwi on the Wairarapa Cultural Trust (Aratoi) • Establishing member of Pasifika Wairarapa Trust • Director Waingawa Ltd • Director Aroha Ki Te Whanau Trust • Member Cameron Community House Governance Group

Minutes of the Board Meeting of the Wairarapa District Health Board
Held in the Ruamahanga Boardroom, Corporate Office,
Wairarapa District Health Board
9 Russell Street, Masterton
Tuesday 2 April 2013

Present: Bob Francis (Chair), Liz Falkner, Charlie Grant, Rob Irwin, Helen Kjestrup, Rick Long, Viv Napier, Fiona Samuel, Leanne Southey and Janine Vollebregt.

In attendance: Graham Dyer (Chief Executive), Helen Pocknall (Director of Nursing and Midwifery), Stephanie Turner (Director Maori Health), Andrew Bos (General Manager Clinical Services), Ashley Bloomfield (Director Service Integration and Development Unit), Pete Chandler (Chief Operating Officer), Carolyn Cooper (Director People and Culture), Eric Sinclair (General Manager Finance and Information) and Tracy O'Neale (Board Secretary).

Graham Dyer, Chief Executive (CEO), introduced members of the new 2DHB Executive Leadership Team (ELT) to the Board. The ELT were welcomed by Bob Francis, Chairman, and members of the Board.

1. Apologies

Apologies were received from Tai Gemmell and Alan Shirley.

2. Conflicts of Interest

There were no conflicts of interest noted in relation to the agenda.

3. Minutes from the last meeting of the Board

Resolved:

THAT THE MINUTES FROM THE LAST BOARD MEETING HELD ON 5 MARCH 2013 BE CONFIRMED AS A TRUE AND ACCURATE RECORD WITH MINOR AMENDMENT.

Matters Arising

The Board are pleased the Health and Disability Commissioner (HDC) is able to attend the 3DHB combined Hospital Advisory Committee (HAC) meeting on 24 May 2013 but are still keen for him to visit Wairarapa to speak to the Clinical Society on 6 August 2013. The Board Secretary will follow up with HDC.

4. Report back from the Community Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC) Meeting

The Board received a report outlining the key items discussed at the CPHAC/DSAC meeting held on 15 March 2013.

The Committee endorsed a proposed approach to engage disability stakeholders in the work of the Committee. It is intended to hold two sub-regional forums, the first in June 2013, and a local forum

once per year. Members of the Board preferred that the local forum be held at least twice per year prior to the sub-regional forums to enable input from the disability community. This will be considered at the forum in June 2013.

Resolved:

THAT THE BOARD NOTES THE CONTENTS OF THE REPORT FROM THE COMMUNITY PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 15 MARCH 2013.

5. Chief Executive's Report

Mr Dyer, spoke to his report highlighting the key points:

- The Ministry of Health (MOH) have provided positive feedback on Wairarapa DHB's performance on the 2012/13 quarter two Health Target results. More focus is required on the primary care target for better help for smokers to quit noting that Wairarapa is currently sitting top of the target which is largely due to the work that has been undertaken under Tihei Wairarapa.
- Mr Dyer gave a brief update on the 2DHB Executive Leadership Team (ELT) process. Mr Dyer advised that the position of General Manager Population Health will not be permanently appointed to and that the Director Service Integration and Development Unit (SIDU) will act in the role to determine the approach required for the future. Ashley Bloomfield, Director SIDU, advised there are good synergies as SIDU moves to a more operational role in service development and integration.
- Mr Bloomfield advised the Board that the sub-regional and Regional Public Health request for proposal (RFP) for services to improve maternal and child nutrition and physical activity was ranked third out of 45 proposals received by the MOH. A feature of the proposal was the integration across primary and secondary health. The Board requested information on how the proposal will work across the three DHBs. This will be provided to the June 2013 Board meeting.
- The DHB posted an adverse financial result for February 2013 ($2,312k). A plan is being developed to bring the DHB back on track to achieve the $3.1m planned deficit for 2012/13.
- The Board are keen to highlight the ground breaking work that is being undertaken in relation to the 3DHB Hospital Services Development Plan (HSD) with staff, the MOH and the community.
- Mr Dyer advised that Wairarapa DHB was compliant for Elective Services Performance Indictor (ESPI) 2 and ESPI 5 for March 2013. Daily reporting and monitoring has achieved this excellent result and the Board would like to thank the Elective Services Team and Booking Team for their efforts in achieving compliance. The Chairman will write an acknowledgement from the Board. Discussions continue with Hutt Valley and Capital and Coast DHBs regarding a plan to achieve the five month wait time target by the end of June 2013.
- The Social Sector Trials will be expanded from 1 July 2013 to include Masterton and South Wairarapa. Experience has shown that the trails can be successful where there is a person appointed with the ability to co-ordinate recourses across the agencies involved. The new trial will have close links to Whanau Ora. The Board require the trial adds value to the work already underway in Wairarapa. The Board requested a report for the May Board meeting.

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- This year's flu campaign has been launched. Management are working with the unions on a joint communication to encourage more staff to get vaccinated. It was noted that the uptake of the vaccine in primary care has been very good.

Balanced Scorecard

Mr Dyer took the Board through the measures in the Balanced Scorecard (BSC) that had been updated since the last Board meeting.

Resolved:

THAT THE BOARD RECEIVES THE CHIEF EXECUTIVE'S REPORT NUMBERED D1698.

6. Financial Report

Eric Sinclair, General Manager Finance and Information, spoke to the Financial Report highlighting key points.

- The DHB posted a deficit of ($2,312k) for the eight months ending 31 January 2013 which was $291k adverse to the planned result.
- The adverse result was largely due to a full year to date wash up for Pharmaceutical Cancer Treatment which has been recognised for the first time.
- High workforce costs also impacted the result. The challenge of the five month wait time in terms of workforce costs will be critical for the provider arm in achieving its planned end of year result.
- The costs for the long stay patient at Starship Hospital have been less than anticipated.
- The report recommended to the Board that the $6m debt tranche due for a reset of interest rate in April 2013 be separated into two debt tranches of $3m each, one maturing in 2018 and the other in 2019 which will result in a sizeable saving in current costs.
- The Board discussed the increase in patient transport costs and asked management to be mindful in the budget of future transport costs due to patients travelling for services.

Resolved:

THAT THE BOARD

1. RECEIVES THE FINANCIAL REPORT FOR THE YEAR ENDED 28 FEBRUARY 2013
2. APPROVES THAT THE DEBT TRANCHE DUE FOR INTEREST RATE RESET ON 15 April 2013 BE:
    a. SEPARATED INTO TWO DEBT TRANCHES OF $3M
    b. ONE TRANCHE TO HAVE A MATURITY DATE OF 15 DECEMBER 2018
    c. ONE TRANCHE TO HAVE A MATURITY DATE OF 15 DECEMBER 2019.

7. Terms of Reference (TOR) for the Community and Public Health Advisory Committee and Disability Support Advisory Committee

The Board received the revised TOR for the CPHAC and DSAC following feedback from the CPHAC meeting held on 15 March 2013.

It was noted that each Board are required to approve the TOR and to agree their seconded sub-regional members. A recommendation will come back to the Board for approval in May 2013.

Mr Bloomfield explained that the two Committees will provide advice to the Boards, that advice may differ between Boards.

Members of the Board stressed the importance of local meetings to give the community the opportunity to provide input into the sub-regional Committee meetings. A single key contact for the Committees would be useful and should be communicated to the Community. It was noted that Capital and Coast DHB have a dedicated disability role which will now cover Wairarapa and Hutt Valley DHBs. The CPHAC and DSAC work programme will be circulated to the Board.

It was noted that the HAC TOR were supported by the HAC and will be approved at the next Committee meeting.

Resolved:

THAT THE BOARD:

1. APPROVE THE TERMS OF REFERENCE FOR THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
2. APPROVE THE TERMS OF REFERENCE FOR THE DISABILITY SUPPORT ADVISORY COMMITTEE
3. APPROVE THE MEMBERSHIPS OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE AS DIRECTED BY THE BOARD INCLUDING THE ABILITY TO CO-OPT EXPERT ADVISORS AS REQUIRED.

8. Correspondence

The Board noted the letter received from Hon Tariana Turia regarding progress of Whanau Ora in the Central Region.

Move into confidential business at 9.28am.

Resolved:

THAT THE PUBLIC BE EXCLUDED FROM CONFIDENTIAL BUSINESS ITEMS LISTED WITHIN THE BOARD MEETING AGENDA PURSUANT TO THE FOLLOWING:

1. TO ENABLE THE BOARD TO DELIBERATE IN PRIVATE ON ITS RECOMMENDATIONS
2. WITHHOLDING OF INFORMATION IS NECESSARY TO MAINTAIN THE EFFECTIVE CONDUCT OF PUBLIC AFFAIRS THROUGH THE FREE AND FRANK EXPRESSION OF OPINIONS BY OR BETWEEN OR TO MEMBERS OR OFFICERS OR EMPLOYEES OF ANY LOCAL AUTHORITY.

Move into open business at 12noon:

Lynnette Field and Andrea Rutene joined the meeting at 12noon.

9. Child Oral Health

Mr Francis welcomed Ms Field and Ms Rutene to the meeting. Ms Field gave an informative presentation on Child Oral Health in Wairarapa, children at risk, statistics on dental disease, agencies involved in working with children and their families to reduce the risk of disease and what other DHBs are doing in this area.

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Mr Francis thanked Ms Field for her presentation.

The meeting closed at 12.30pm.

Resolved:

THAT THE PUBLIC BE EXCLUDED FROM CONFIDENTIAL BUSINESS ITEMS LISTED WITHIN THE BOARD MEETING AGENDA PURSUANT TO THE FOLLOWING:

1. TO ENABLE THE BOARD TO DELIBERATE IN PRIVATE ON ITS RECOMMENDATIONS
2. WITHHOLDING OF INFORMATION IS NECESSARY TO MAINTAIN THE EFFECTIVE CONDUCT OF PUBLIC AFFAIRS THROUGH THE FREE AND FRANK EXPRESSION OF OPINIONS BY OR BETWEEN OR TO MEMBERS OR OFFICERS OR EMPLOYEES OF ANY LOCAL AUTHORITY.

Bob Francis, Chairperson

Date

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DRAFT **PUBLIC**

WAIRARAPA DISTRICT HEALTH BOARD

PUBLIC MEETING

DRAFT Board Minutes of 10 May2013, held at the The Dowse Art Museum, 45 Laings Road, Lower Hutt
Commencing at 3.40pm

PRESENT

Bob Francis	Chair
Leanne Southey	Deputy Chair
Viv Napier	Member
Fiona Samuel	Member
Helen Kjestrup	Member
Rick Long	Member

IN ATTENDANCE

Graham Dyer	Chief Executive, Wairarapa and Hutt Valley DHB
Tania Harris	Acting General Manager, Corporate Services, Wairarapa and Hutt Valley DHBs
Nadine Mackintosh	Board Secretary, Wairarapa and Hutt Valley DHB

APOLOGIES

Janine Vollebregt	Member
Rob Irwin	Member
Charles Grant	Member
Tai Gemmell	Member

1. **PROCEDURAL**
Nil

1.1 CONFLICTS OF INTEREST

CONFIRMED: The Board confirmed that it was not aware of any matters (including matters reported to and decisions made, by the Board at this meeting) which would require disclosure.

MOVED Viv Napier **SECONDED** Helen Kjestrup **CARRIED**

2. **FINANCIAL REPORT FOR MARCH 2013**

The report was taken as received. It was reported to the Board that the agreement that was reached with the three DHBs on the establishment of SIDU was that no DHB would be disadvantaged. If Wairarapa or Hutt Valley costs were based on PBF then costs would have increased to both Wairarapa and Hutt Valley DHBs.

AP. Management to provide details on the costs back to the Board

NOTED: Carried

DRAFT **PUBLIC**

3. FINANCIAL REPORT FOR APRIL 2013

The Board resolved to **DISCUSS** the April 2013 financials in public.

MOVED: Viv Napier **SECONDED:** Helen

A draft version of the April result was provided to the meeting with management requesting that a final report be circulated to the Board and discussed at the June Board meeting. It was noted that there was a 46K favourable position for the budget deficit for the month, acknowledging the year to date position is a deficit of $3,079mil which is $205k adverse to budget.

4. GENERAL BUSINESS

Nil

5. RESOLUTION TO EXCLUDE THE PUBLIC

RESOLVED: The Board resolved to agree that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

Agenda Item	NZ Public Health & Disability Act
2013/14 Budget	Section 9(2)(f) (iv) Subject to Ministerial Approval

MOVED: Viv Napier **SECONDED:** Leanne Southey **CARRIED**

The Public Session of the Board meeting closed at 4.00pm

DATE OF THE NEXT MEETING

The next meeting will be Tuesday 4 June 2013

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting.

DATED this day of 2013

BOB FRANCIS
WAIRARAPA DHB CHAIR

WAIRARAPA DISTRICT HEALTH BOARD

PUBLIC MEETING

DRAFT Board Minutes of 10 May2013,
held at the The Dowse Art Museum,
45 Laings Road, Lower Hutt

Commencing at 9:00am

PRESENT

Bob Francis	Chair
Leanne Southey	Deputy Chair
Viv Napier	Member
Fiona Samuel	Member
Helen Kjestrup	Member
Rick Long	Member

IN ATTENDANCE

Virginia Hope	Chair of the Meeting
Debbie Chin	Crown Monitor for Hutt Valley and Capital & Coast
Graham Dyer	Chief Executive, Wairarapa and Hutt Valley DHB
Ashley Bloomfield	Director SIDU
Pete Chandler	COO, Wairarapa and Hutt Valley DHBs
Iwona Stolarek	CMO, Wairarapa and Hutt Valley DHBs
Tania Harris	Acting General Manager, Corporate Services, Wairarapa and Hutt Valley DHBs
Carolyn Cooper	Director, People and Culture
Ashley Bloomfield	Director SIDU
Shayne Nahu	Group Manager, Child, Youth & Older People, SIDU
Wayne Skipage	Group Manager, Strategy, Planning & Intelligence, SIDU
Cary Virtue	Executive Director Operations, Capital & Coast DHB
Kelvin Watson	Executive Director, Clinical & Corporate Support Services, Capital & Coast DHB
Nadine Mackintosh	Board Secretary, Wairarapa and Hutt Valley DHB
Jennifer Ashman	Board Secretary, Capital & Coast DHB

Members of Hutt Valley Board
Member of Capital & Coast Board
Members of the Public

APOLOGIES

Janine Vollebregt	Member
Liz Faulkner	Member
Rob Irwin	Member
Charles Grant	Member
Tai Gemmell	Member
Mary Bonner	CEO, Capital & Coast DHB
Keith Hindle	Hutt Valley DHB Board Member and Capital & Coast DHB Board Member;
Ken Laban	Hutt Valley DHB Board Member

1. PROCEDURAL BUSINESS

The meeting was opened with a Karakia by Peter Douglas, acknowledging the passing of the Capital & Coast Chief Executive's mother and providing the Board(s) sincere thoughts to her and her family at this time.

The meeting of three District Health Boards is convening contemporaneously. The Resolutions will be moved and seconded by the Chairs and Deputy Chairs and carried members of their respective Boards.

Members of the Boards and staff of the DHBs introduced themselves to the public.

1.2 APOLOGIES

Apologies were reported and recorded as above.

MOVED: Bob Francis **SECONDED**: Leanne Southey **CARRIED**

1.3 INTEREST REGISTER

No updates to the interest register were received.

1.4 CONFLICTS OF INTEREST

No potential conflicts were received, there would be an opportunity at the beginning of each item for members to declare conflicts of interest.

2. CHIEF EXECUTIVE REPORT

The Chief Executive of Wairarapa and Hutt Valley DHB led the Board through the contents of the paper noting that the work across the three DHBs will be provided as updates from staff throughout the process of the day. The report was taken as read and the Board:

- Noted that Kia Ora Hauora is a Māori workforce development programme aimed at strengthening Māori workforce

- Noted the benefits outlined with respect to the Radiology picture archive system for the 3DHBs and the use of an after hours shared registrar by Hutt Valley and Capital & Coast DHBs
- Noted that the Capital & Coast DHB cardiovascular initiative is supported by the 2DHB (Wairarapa and Hutt Valley DHBs) Chief Executive
- Noted the 2DHB (Wairarapa and Hutt Valley DHB) finalised executive leadership team structure and noted the steps being taken to minimise the loss of institutional knowledge
- Noted the 2DHB health passport initiative
- Noted the positive breast screening update was not supported by the figures in the accompanying graphs
- Noted that the child health action plan update referenced Capital & Coast DHB only
- Noted that the SIDU Board is comprised of senior management staff across the spectrum including Māori, Pacific and disability representatives. It is responsible for reviewing business cases to ensure they align with the Board(s) requirements and are aligned to the annual plan(s); carry out Value for Money reviews and procurement investigations, as well as being responsible for all 3 DHB funding that is received and contracted out to PHOs. It was clarified that this is now one funding group, instead of three and that its reporting mechanism is via CPHAC to the Board(s)
- Noted that a discussion paper is going to the May CPHAC meeting regarding the direction of the PHO agreement to outline the scope and content of proposed alliances between PHOs and DHBs. Several committees within and across the 3 DHBs already include primary health as members, connecting continuity of care across the regions
- Noted the Hutt Valley DHB Chief Executives advice that key issues facing the DHBs are being provided to the Boards in both the Public and Public Excluded agendas

The following actions were requested:

Actions:

1. Management were requested to provide a report to the Capital & Coast DHB Board on the Kapiti breast screening figures
2. Management were requested to report to the respective Board(s) on the health passport initiative and where the 2 DHBs sit relative to national uptake figures
3. Management were requested to provide a Hutt Valley child health update to the Hutt Valley DHB
4. Boards to have discussions on feasibility of amalgamation of Boards.

NOTED The Board **noted** the contents of the report.

MOVED: Bob Francis **SECONDED**: Leanne Southey **CARRIED**

3. SINGLE SERVICE PROFILE SHOWCASE

The Chief Medical Officer of the Wairarapa and Hutt Valley DHB provided a presentation on ENT noting this was chosen as it was a vulnerable service with limited training opportunities.

The presentation provided the background to the development of the sub regional ENT services which began from the inception of the sub regional clinical leadership group, developed in 2010 in response to Ministerial expectations of collaboration. The ENT service was one of four clinical services discussed as a priority area. Some shared processes have been developed, such as IT, HR, Concerto eTree and computerised theatre notes. As the development of a new business model across the 3 DHBs progresses, future initiatives include developing a single point of entry for referrals and booking, a common waiting list of patients, shared surgical targets etc. Currently the project is also working on outcome measures based on the triple aim criteria.

The presenter noted that the project has assisted with relationship building across the 3 DHBs; that the thinking is now more sub regional with clinicians involved and looking in this direction. Other sub-specialities are also starting to think in this way, utilising the learnings from other services.

The Chair noted that it was important to emphasise that this development is being clinically led and the Wairarapa and Hutt Valley DHB Chief Medical Officer was thanked, both for the interesting presentation as well as her clinical input into the project.

NOTED The Board **noted** the contents of the presentation.

MOVED: Bob Francis **SECONDED**: Leanne Southey **CARRIED**

4. REGIONAL ORAL HEALTH UPDATE

The Chief Operating Officer of Wairarapa and Hutt Valley led to the discussion advising the progress in this area was moving in a positive direction. The paper was taken as read with the following noted:

- The action plan outlines re-engineering work within the dental service plus the overall strategy and approach within the community
- Service developments include expediting the programme of new hubs being built although identification of land for Wellington remains an issue.
- The general management of the service has been working successfully with Capital & Coast and the team is working with SIDU on monitoring and reporting of the service with an example of month reporting being included for information.
- This overall reporting of this programme of work is reported through the CPHAC Committee and has been noted as an equity indicator. The movement of this service to SIDU will benefit from a portfolio review.

The following actions were requested:

Actions:

1. An issue is the monitoring of pre-school rates, targets are improving, pre-school enrolment for Maori and Pacific is low but it is an area that will be managed.
2. Further reporting on uptake of on-line enrolments.

NOTED The Board **noted** the contents of the paper

MOVED: Bob Francis **SECONDED**: Leanne Southey **CARRIED**

5. ANNUAL PLAN 2012-13 6 MONTH REPORT AND PERFORMANCE REPORTING

The paper was presented by the Director of SIDU and the Group Manager, Strategy Planning and Intelligence Group and was taken as read.

The paper provided a six month report on the 3 DHBs 2012/13 annual plans, the government health targets and other key performance measures for the period. The relevance of this retrospective report to other more recently published information on progress was discussed. It was reported that management would have opportunity to view all information in order to provide a considered report.

In the June CPHAC Primary Care is the focus of information and an interpretation of rates of access for all DHBs can be provided to that CPHAC and reported to the Boards.

The following actions were requested:

Actions:

1 Management to provided analysis and consider preparing an action plan detailing solutions for improvement over the next 12 months to three years.
2. Management to provide updates on new specialist appointments to future HAC meetings, particularly when we have information across the three DHBs
3. Management to review opportunity to amend X and Y axis in order to provide consistency.

The Board **RESOLVED** to:

a. **NOTE** the six month report against the Annual Plans for Wairarapa, Hutt Valley and Capital & Coast DHBs.
b. **NOTE** the most recent results against government health targets and other key performance measures for 2012/13
c. **NOTE** the actions being taken to improve performance across the sub region on the two primary care targets – cardiovascular risk assessments and smoking cessation
d. **NOTE** the quarter 3 performance results provided in Appendix 1 for the three DHBs

6. GENERAL

Review of Equity Paper

The Chair of the meeting reiterated that the action relating to the recent publication of the paper is in progress via discussions with management on the most appropriate way to present and discuss the information contained in the report to the Boards. The Director SIDU advised that equity indicators are being developed in conjunction with CPHAC which is the sub regional committee reporting through to the Boards. Quarterly reports to the Boards will include indicators specific to the relevant Board, plus reporting on 2-3 headline (3 DHB) targets.

7. RESOLUTION TO EXCLUDE

The resolution to exclude the public was tabled and brief discussion took place about the items identified for exclusion.

The Board **RESOLVED** to**:**

AGREE that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

Agenda Item	NZ Public Health & Disability Act
2013/14 Annual Plan	Section 9(2)(f) (iv) Subject to Ministerial Approval
Regional Services Plan	
3DHB Internal Audit Plans	Section 9(2)(i) Enable a Minister of the Crown or any department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities
3DHB Health & Services Development Plan	
Health of Older People Workshop	
CRISP Presentation	
Health Benefits Limited Presentation	
MSD Social Sector Trial Presentation (Wairarapa and Porirua)	

MOVED: Bob Francis **SECONDED**: Leanne Southey **CARRIED**

8. NEXT MEETING

The date of the next meeting will be Tuesday 4 June 2013.

Meeting adjourned at 10.30am
The meeting reconvened at 3.20pm

9. MSD SOCIAL SECTOR TRIAL (PORIRUA AND WAIRARAPA)

The Board resolved to move the discussion on this paper into the public session of the meeting.

MOVED: Bob Francis **SECONDED:** Leanne Southey **CARRIED**

The presentation outlined the overarching principles and model of the trials which are being run in six areas throughout New Zealand including the Porirua and Wairarapa districts aimed at improving the health of youth aged 12-18. Health incentives were developed in partnership between MSD, primary and secondary health and specific to the needs of the youth within the areas. Evaluation of the results to date has seen the life of the trials extended past the current end dates with plans to increase the trial numbers.

The reasons for poor youth health in Porirua were outlined, and are well known and examples of specific initiatives planned for this region were given. The presenters were thanked for updating the Board on this important initiative.

The next trials will be due to start 1 July 2013.

The following actions were requested:

Actions:
1. Results of the trials to be provided to the Wairarapa Board in June 2013.

The meeting closed at 3.40pm

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting.

DATED this day of 2013

BOB FRANCIS
WAIRARAPA BOARD CHAIR

Follow up Actions and Matters Arising from Wairarapa DHB Board Meetings

Issue	Response
Invite the Health and Disability Commissioner (HDC) to provide a briefing to the Board and the Clinical Society on the HDC process. Provide bullet point list of issues to Viv Napier and Pete Chandler.	The HDC Commissioner has confirmed that he can join the Hospital Advisory Committee Meeting on 24 May and will attend the Board and Clinical Society meetings on 6 August. Completed.
Artwork Proposal	Final recommendations and budget will come to the Board.
Presentations to the Board	Peter Gush has been invited to speak to the Board regarding Regional Public Health's role in the region in June and has accepted. The Wairarapa Whanau Ora Collective has been invited to speak to the Board regarding their progress in July. Te Hauora, Pathways and CareNZ have been invited to meet with the Board to discuss joint initiatives in August.
Performance statistics for Wairarapa regarding Maori Cancer Treatment, locally and regionally.	A report will be provided to the Board at its May 2013 meeting.
Set of principles developed by Whanganui DHB to guide decisions on the Regional Governance Group to be shared with the Board.	Contact has been made with Whanganui DHB to source the set of principles and has been followed up.

1

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**INFORMATION PAPER** **Date:** 20 May 2013
Author	Graham Dyer, Chief Executive
Subject	**Chief Executive's Report**
RECOMMENDATION It is recommended that the Board **note** the contents of this report.	

1 GOVERNMENT PRIORITIES AND HEALTH TARGETS

The Quarter Three Health Targets for 2012/13 have not been published by the Ministry of Health and are attached as Appendix Two.

To date in quarter four, Wairarapa is on track to meet the four hospital health targets:

- ED 6 hour wait target
- Elective Health target
- Smoking cessation advice target
- Cancer waiting times target

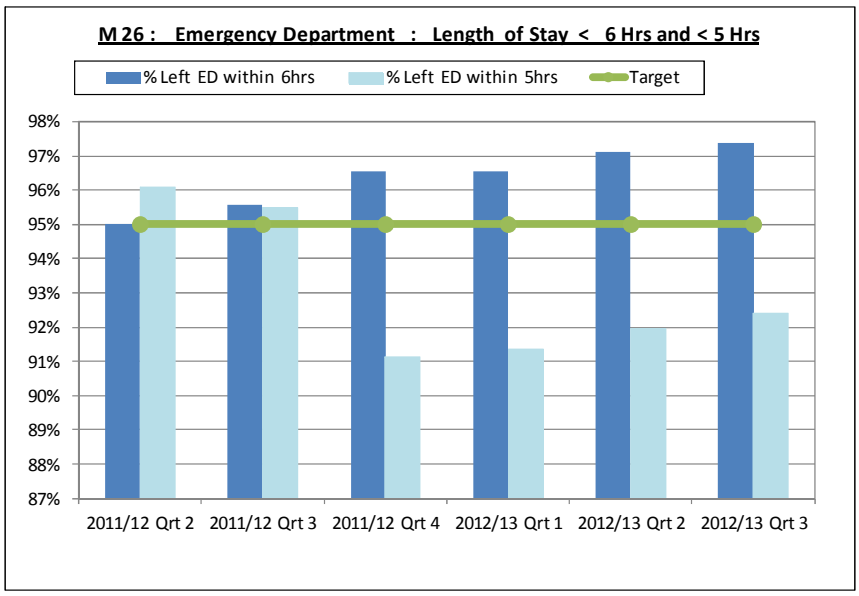
Health Target: Emergency Department 6 hour wait

95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

	Q1	Q2	Q3	Current Q: Month 1	Current Q: Month 2	Current Q: Month 3	Current Quarter to date
Hutt %	86%	92%	95.1%	98%			98%
Attend/day	122	117	119	121			
Wairarapa %	97%	97%	97.4%	98%			98%

Wairarapa is currently exceeding the 95% target in Quarter four to date.

Wairarapa DHB ED 6 Hour Wait Trend



Wairarapa was the first DHB within the sub-region to deliver the ED 6 hour wait target. The above trend graph shows ongoing improvement over the last year.

Health Target: Elective Surgery and other Elective Services Performance Indicators (ESPI's)

Improved access to Elective Surgery

TARGET:

Wairarapa DHB: **1,841 elective surgical patients will be treated and discharged during 2012/13**

Hutt Valley DHB: **4,946 elective surgical patients will be treated and discharged during 2012/13**

	Q1	Q2	Q3	Current Q: Month 1	Current Q: Month 2	Current Q: Month 3	Current Quarter to date	Year to date % against plan
Hutt %	105%	94%	111%	117%			117%	104%
Volume	1323	1200	1206	493			493	4,222
Wairarapa %	111%	104%	99%	106%			106%	99.7%
Volume	487	432	411	161				

2

Wairarapa remains on track to meet the Elective Health Target by 30 June 2013.

Achieving the five month wait position is a significant challenge for the DHB and will require ongoing micro-management by the Surgical, Women's and Children's Directorate Leadership Team. Achieving the 5 month wait for surgery at Wairarapa will require:

- Additional sessions in ophthalmology
- Additional sessions at Hutt for complex general surgery patients
- Potential outsourcing of 7-10 orthopaedic patients.

Arrangements are currently being progressed to ensure that our waiting time obligations are met but as economically as possible.

Health Target: Smoking cessation advice

TARGET:
95% of hospitalised smokers will be provided with advice and help to quit by July 2013

	Q1	Q2	Q3	Current Q: Month 1	Current Q: Month 2	Current Q: Month 3	Current Quarter to date
Hutt %	97%	97%	95%	95%			95%

Wairarapa is meeting the smoking cessation advice target.

1.2 Balanced Scorecard

The updated measures of the Balanced Scorecard (BSC) are reported in Appendix Three.

2 IMPROVING PROCESSES AND CULTURE

2.1 People and Culture

Over three days the two Chairs, two CEs, CMO and Director of SIDU held 3DHB 'Roadshow' presentations at the three DHBs describing progress against the 3DHB Programme announced last October. The presentation is attached as Appendix Four.

2.2 Training in disability responsiveness for funded providers

The report to the May Boards' meeting noted the commitment by one home support provider to train its staff across all sites. This request for support has been positively received by SIDU and the Senior Disability Advisor has organised with Enliven for this first round of training.

All services that wish to engage in training of front line staff will receive advice from SIDU on the range of trainers available and a database is being developed of trainers who can deliver initial training. While there are many trainers available for basic disability responsiveness training, there are fewer available to deliver more in-depth training that includes clinical issues linked to significant impairments.

A number of measures are being taken to increase the capacity of services and health professionals to improve their ability to respond as follows:

- Whitireia Polytechnic is now inviting experienced disability professional staff to train student nurses
- The development of specialised resources to support clinicians to work appropriately with people with significant impairments (to be completed by July 2013), which will be shared with staff and services across the three DHBs
- Disability responsiveness is steadily being built into hospital services as part of the five year joint New Zealand Disability Strategy Implementation Plan Hutt Valley and CCDHB (2012-16)
- The performance of providers in relation to contractual obligations around disability responsiveness will include monitoring and support with advice and where appropriate training.

2.3 Expansion of the use of the health passport

As noted at the May Boards' meeting, at least 12,000 passports have been taken up across Hutt Valley and Capital and Coast DHBs. The passport has been commended by professionals and consumers alike and feedback is emerging about its value, particularly for patients who have head injury, early dementia and for those with complex health needs and intellectual impairment.

The national rollout has been slow, but seven DHBs have taken up the health passport while several others have taken steps to initiate a launch. There is increased pressure to do so from community members and clinicians as the value has become clear.

Capital and Coast and Hutt Valley DHBs have the highest uptake nationally, in part because they were first to pilot the passport. However, in all DHBs it has been difficult to measure utilisation as there is no electronic data collection related to the use of the passport. Coded passports have been handed out by HDC to improve monitoring and this will yield better data once analysis is completed.

Rollout to Wairarapa DHB is considered to be a priority action for 2013/14. The first 500 passports are free to DHBs and the commitment and awareness of community providers will support the rollout considerably. A project scope will be developed once consultation on the need for the passport has been completed across all interested stakeholders at Wairarapa DHB.

3 FINANCIAL SUSTAINABILITY

3.1 Financial Result April 2013

The DHB has posted a deficit of ($3,079k) for the ten months ended 30 April 2013 which is $205k adverse to the planned result.

The adverse result is largely due to workforce costs, clinical supplies and IDF's. More details are contained in the Finance Report.

4 WORKING WITH OUR NEIGHBOURS

4.1 Annual Planning

The final draft of Wairarapa DHB's Annual Plan is due to the Ministry on 24 May. Further refinement of the document has been undertaken to ensure:

(a) it meets the expectations of the Minister and is consistent with the performance requirements of the National Health Board;

(b) it is aligned within a sub regional context to ensure it represents a cohesive approach to service sustainability and population health improvement across the three Boards;

(c) it reflects the partnership between primary care and the DHB within the well-established alliance between our organisations;

(d) it reflects the connections between our local activity and the collective activity of the regional services plan

(e) it provides clarity around the approach SIDU will take in respect to service change in the coming year.

Feedback from the National Health Board has been positive with few amendments required.

The near final drafts of all three annual plans were reviewed by the Wairarapa, Hutt and Capital and Coast Boards at their combined meeting on 10 May 2013 and approved in principle, subject to final sign-off on the budgets from the FRACs.

Wairarapa DHB is required to submit balanced forecasts for 2013/2014.

There is currently work underway (and this will continue on through the first half of 2013/2014)to confirm how the savings by the Funder will be achieved.

4.2 Allied Health Restructure

A review of the Allied Health leadership structure across Wairarapa (WDHB) and Hutt Valley DHBs (HVDHB) is now complete. The review included an extensive engagement and consultation process with staff and the PSA. This process commenced with an Intentions Paper released on the 12 March 2013, which set out the parameters of a review of the Allied Health Scientific and Technical (AHST) leadership structure. From 12 March to the 9 April 2013, a total of 57 individuals and groups were interviewed in predominantly AHST leadership roles. The feedback provided in these interviews was collated and used to develop the Consultation Document, released on 10 April 2013. The Consultation Document provided staff with a proposed AHST leadership structure that could be implemented in and across both DHBs for consultation.

It was encouraging that, although, we had a high level of staff engagement prior to the release of the consultation document, a healthy number of submissions were still received. Much of the feedback was positive, and many individuals felt their views had been acknowledged and addressed in the engagement process. It was also encouraging to receive feedback from those who work alongside AHST leaders and staff on a daily basis.

The decision on the new model of leadership for all AHST disciplines (in scope) working in and across WDHB and HVDHB in the new 2DHB leadership landscape includes:

- Three Director of AHST (DAHST) roles supporting the Executive Director AHST across all directorates
- The DAHST roles will work across both DHBs (professionally and operationally)
- The Professional Leaders will continue to have operational and professional responsibilities at HVDHB, and professional responsibilities at WDHB
- The WDHB Team Leader roles will report operationally to the DAHST (Medical and Surgical), with a change in title to WDHB Physiotherapy, Occupational Therapy or Social Work Leader, depending on the discipline
- The HVDHB Team Leader roles will continue to report operationally and professionally to the relevant Professional Leaders.

The new structure commences on 17 June once the formal Expression of Interest process, interviews and appointments have been made.

4.3 Hand Therapy Service for Wairarapa DHB

Patients who need hand therapy have had surgery or suffered an injury leaving them with wounds, scars, burns, injured tendons or nerves, fractures, and sometimes amputation(s) of the fingers, hands, or arms. Others include patients who suffer from the effects of conditions such as carpal tunnel syndrome or tennis elbow, as well as chronic problems as arthritis or a neurologic condition (i.e. stroke).

Historically, hand therapy has been provided for those patients living in the Wairarapa, by Hand Therapists at Hutt Valley DHB at the Hutt Hospital site. This has meant all patients requiring hand therapy have had to travel to Hutt Hospital for follow up. Appointments could be several times a week which means there is a large commitment of time and resources by the patient.

In February 2012, a patient residing in the Wairarapa contacted both DHBs to ask why a Hand Therapy service was not provided at Wairarapa DHB. It has taken a year of planning but from 4 April 2013 the service came to fruition. A hand therapist from Hutt Valley DHB is now travelling to the Wairarapa weekly to run a satellite clinic for acute hand therapy on the Masterton site. This will mean that patients requiring acute hand therapy can be treated locally.

4.4 Sub Regional Disability Forum June 2013

The first sub regional community Disability forum is being held on 25 June 2013 at Orongomai Marae, Railway Road, Upper Hutt.

SIDU and National DPA (Disabled Person's Assembly) are distributing joint formal invitations to all interested stakeholders before the end of May, noting that the date has already been circulated to the sector. Several Board members, key staff including clinicians and senior Ministry of Health officials have indicated their intention to attend. An agenda and information will be sent out once all participants are confirmed. Closing date for confirmation is 11 June 2013.

4.5 Update on 3DHB Family Carers submission to Ministry of Health

As outlined in the 2013 Budget, the decision has been made to allow payment of family carers for those supporting people with the highest and most complex support needs. Needs assessment services will make decisions on who will be eligible but the grounds for eligibility are still to be clarified. It is expected that around 1600 people nationwide will be eligible and that family members will be paid up to 40 hours per week.

The Ministry of Health stated that consideration would be given later in the year to possibly widen the scope to include people with chronic illness supported by family members.

The decision to stage implementation starting with those who have the highest needs is in keeping with recommendations made to the Ministry of Health in the sub-regional DHB submission to the Ministry in November 2012. It is expected that significant further consultation with DHBs will take place before eligibility is extended to other groups.

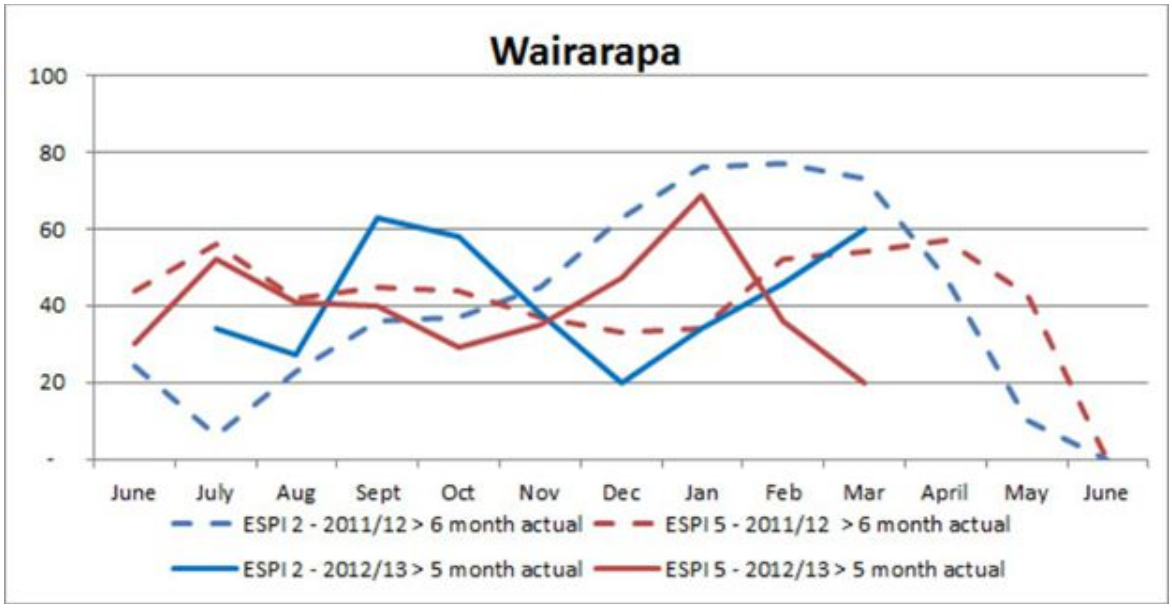
5 OTHER MATTERS OF INTEREST TO THE BOARD

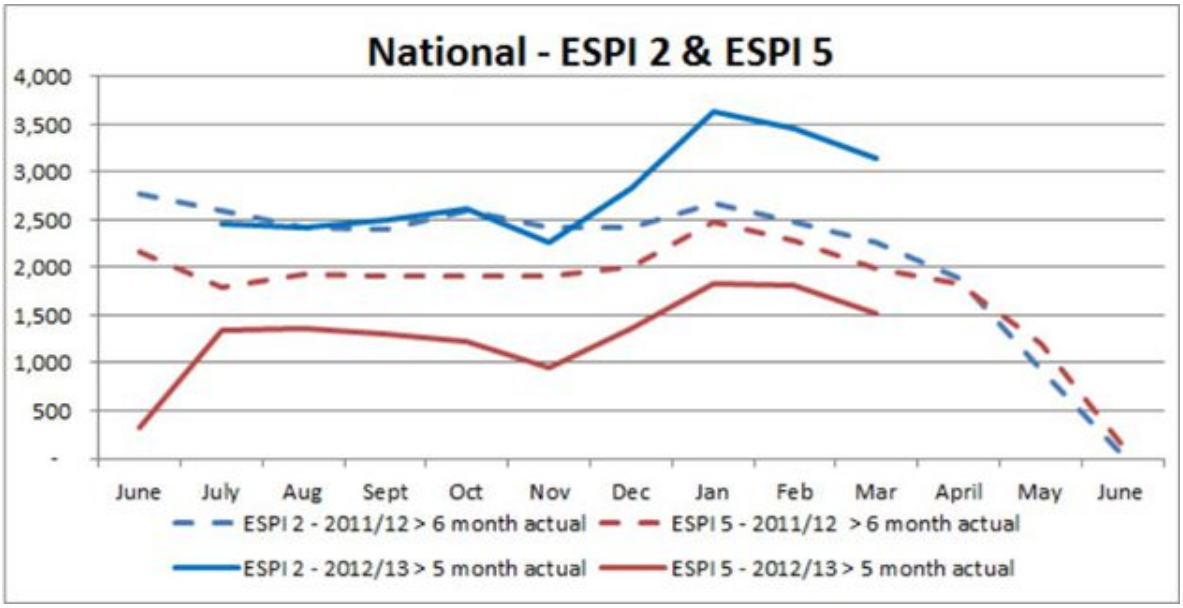
5.1 Elective Services Performance Indicators

There is now less than five weeks remaining to reach the June 2013 goal of no one waiting longer than five months for first specialist assessment or elective treatment. Management have placed a high priority

on delivering against our plans to ensure the required reductions are achieved. Weekly updates are being provided to the National Health Board confirming the weekly total still requiring FSA or treatment by the end of June.

The following graphs show last year's improvement against the six month target and current progress towards five months at a national level and Wairarapa DHB. (Note: Canterbury DHB is excluded from the national graph for the year).





6.2 Significant Emergent issues – H7N9

RPH is closely monitoring the emergence of H7N9 in China. This influenza virus has considerable pandemic potential as humans have no pre-existing immunity and it has a high mortality rate. Currently the virus has not demonstrated sustained person to person spread. RPH are reviewing our response preparedness and have sent an advisory to primary and secondary care.

6.3 Breastscreen Central Services

Improving and increasing access is a priority area of work that the Breastscreen Central Service is aware of and continually reviewing. All possible options need to be considered within the requirements set by the National Policy and Quality Standards overseen by the National Screening Unit within the National Health Board. For example one of the considerations is the two year re-screening cycle for eligible women. The Mobile Unit is locked into a rotational roster to meet this timeframe across the Greater Wellington area. Currently the Mobile is at Paraparaumu until 16 August 2013 and then it moves to Te Whaea Services in Newtown Wellington until the 13 December 2013. These sorts of logistics have to be worked through in order to meet the needs of the population.

6.4 Communications Update

I have included as Appendix One the projects and initiatives the DHB's Communications Team have been working on since the last Board meeting.

6.4 Official Information Act Requests

Bob Francis and I meet with the Editor of the Dominion Post, Bernadette Courtney, and the Editor of the Times Age, Andrew Bonallack, to discuss relationships and the number of Official Information Act requests received from the media. Both meetings were positive with all parties willing to work together to improvement relationships.

Attached as Appendix Five are details of requests for information the DHB has received under the Official Information Act since the last Board meeting and our responses.

Appendix One – Communications Update

1 External communications / Media

Health Highlights

Monthly column in Wairarapa News: This month focussed Advance Care Planning, International Nurses and Midwives days, and Hospice donation of an Oxygen Concentrator. Content 2/3 duplicated in Hutt Valley DHBs 'Health Highlights' column.

Access Radio

Discussion with the two Wairarapa advisors from NZ Autism. Also Immunisation Week.

Media releases/responses

- Wairarapa Hospice donates O2 concentrator
- Smokefree initiatives
- April Falls campaign
- Patient condition updates
- Assault of nurse in ambulance
- Role of Suicide Prevention Coordinator at Wairarapa DHB
- K2 in Wairarapa

2 Tihei Wairarapa

Weekly advertising of after-hours arrangements continues, to support ED wait time target.

3 Working with our neighbours

Sub-Regional

- 3DHB 'Roadshow' presentation with 2 Chairs, 2 CEs, CMO and Director of SIDU in process this week, describing progress against the 3DHB Programme announced last October.
- 3DHB Radiology – staff engagement progressing, communications plan being revised.
- Clinical pathways – SIDU has picked up project management of this for the SRCLG, vendor presentations underway.

2DHB

- 2DHB staff forums held with CE on both sites were well received.
- Organisational chart and ELT contact lists produced and made available to stakeholders.

Regional

- Working with Sue Walbran on website and communications around the Regional Training Hub

4 Internal communications

Intranet stories

3DHB 'view from the top'

New national patient safety campaign launched

Mastered it – 5 nurses graduate with masters degrees

International nurses and midwives days

Clinical Board update

Healthline answers 3 millionth call

3DHB email changes

Bowel screening pilot

Keeping it CRISP

Welcome to new Acting Hospital Manager

Protecting Privacy

Admin angels

OT falls prevention initiative

Update on avian influenza

Welcome to new nursing director

Working together – rapid cycle improvement

Allied Health consultation document

New CNS, Cancer Coordination

Single ICT function across 3 DHBs

690,000 kiwis immunised against influenza

Further 2DHB appointments

April Falls campaign

New community psychiatric nurses appointed

Book donation to dental mobiles

Library resources now available online

5 Newsletters

- **Insite –** Issue 199 circulated, focused on staff developments and changes
- **Exsite –** A special edition of the Quality newsletter produced with focus on privacy issues. Part of the national Privacy Week campaign.

6 Communications projects

- Considerable work on 2DHB – staff forums, organisation charts, contact lists.
- 3DHB 'roadshow'

- SharePoint intranet workspace developed for ELT, members and EAs being trained. Terms of reference for shared intranet project developed.
- Wairarapa Maternity website in development, cloned from the Hutt Maternity site.
- Website and intranet regularly updated
- Forms and resources produced or updated for clinical staff
- April Falls campaign an excellent way of highlighting quality improvement initiatives.
- Cancer Coordination Nurse story picked up by and used in a Ministerial media release
- Booklet outlining role of Clinical Nurse Specialists updated and sent to all General Practices.
- Privacy Week campaign – newsletter produced as placemats on café tables, quiz about privacy issues promoted, posters up, stories on intranet.
- A new series of stories on mental illness and recovery prepared for fortnightly publication in the Wairarapa News. Focus on personal stories from people who have experienced mental illness and support available in the community.
- Promotion of Smokefree survey of DHB staff who smoke. An initiative to set up Quit Group for staff in recognition of World Smokefree Day.
- April Falls campaign – a month long campaign .

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Wairarapa District Health Board

FINANCIAL REPORT

APRIL 2013

Report Number D0000

1. ORIGIN OF THE REPORT

This report is a regular report and standing agenda item providing an update on the latest financial result and other relevant financial matters to the Board of Wairarapa District Health Board (WDHB).

2. RECOMMENDATIONS

That the Board:

1. **RECEIVES** the financial report for the 10-months ended 30 April 2013.

3. COMMENTARY

3.1 Overview

The summary statement of financial performance is shown on page 6. This shows that the DHB has posted a deficit of ($3,079k) for the ten months ended 30 April 2013 which is $205k adverse to the planned result.

3.2 Financial Commentary

3.2.1 Revenue

Revenue is favourable to plan by $1,936k for the ten months ended 30 April 2013. There are four main reasons for this variance:

- Additional CFA revenue received from the Ministry of Health through the Funder arm which is offset by additional costs.
- ACC revenue is ahead of plan by $282k. This reflects additional volumes in the AT&R ward and the continued focus on ACC revenue collection.
- Biomed dividend of $150k was approved by the Biomed board and received on 2 November.
- The $525k 'gain on sale' from the sale of the old Hospital was booked in January.

3.2.2 Workforce expenses

Workforce expenses are adverse by ($800k) for the ten months. The two main areas impacting the workforce costs are medical and nursing.

- Medical workforce costs are adverse by ($550k) across employed and contracted medical staff. This reflects the costs of locums engaged to provide the necessary cover for two long term SMO sickness absences from mid July through to mid-September for one and onto November

for the other. Neither of these sickness related absences were expected at the time the budgets were set. One of the positions impacted is anaesthetics where cover is required to maintain elective surgery production and lessen any negative impact on ESPI compliance. Also, In November we had 2 RMO'S who were unable to work nights so had to backfill their positions due to limitations on their APC**.** Because some clinical staff will not work without a Registrar, we need to backfill their roles whereas in the past we were able to "get by" without doing so**.** In January additional costs were incurred due to a number of additional locums being required to ensure rosters were able to be filled. The gaps in the roster were due to leave, staff resignation or retirement & 1 SMO who was under supervision. Extra locums were also required to reduce ESPI compliance for pain and orthopaedics. At the last ASMS meeting held in November, the CE agreed to a 1:2 payment for SMO's acknowledging a 1:2 roster is untenable. It was also agreed at the November ASMS meeting that Computers/iPads etc were able to be purchased from CME expense entitlements. Unbudgeted costs for this financial year are expected to total $30k. Finally, unexpected prior year CME expenses totalling approximately $30k have been booked in the last two months.

- Nursing costs are adverse to budget by ($489k) for the ten months to the end of April. Contributing factors include:
  - FTE's are 5.3 adverse YTD.
  - Additional HCA costs incurred March/April for the care of the ex Star ship Hospital patient.
  - Higher than planned YTD Staff RN costs in AAU and HDU due to AAU demand and the requirement to triple staff HDU at times for ventilated patients. AAU staffing is currently not budgeted.
  - High acute workload in Periop in the first half of the year which resulted in higher than planned after hours and weekend work. In addition sick leave has been higher than budgeted due to three people having long term conditions.
  - Nursing staff in Periop needing to respond to a number of 'call-backs' in February & March where they were required to work after hours.

- As flagged in February, the Paediatrics ward is currently incurring higher than planned expenses as a result of the ex Star ship Hospital being admitted to Wairarapa Hospital. Unbudgeted Nursing and clinical supplies costs through to June are estimated to be up to $90k.

3.2.3 Outsourced services

Outsourced services are $216k favourable to plan for the ten months. This is primarily due to the September accruals correction for mental health inpatient beds. This is partially offset by increased radiology costs caused by the additional volumes being experienced within the hospital services.

3.2.4 Clinical supplies

Clinical supplies are ($592k) adverse to plan YTD.

Key areas contributing to the adverse variance are:

- Higher utilisation of the intragam blood product occurred earlier in the first half of the year. Generally, usage has now settled close to budgeted levels and this is expected to continue. Blood products have contributed ($61k) to the adverse result.
- Patient transport and accommodation is ($87k) adverse to budget. These costs reflect the subsidised travel for patients and a family member where services are provided, generally out of the Wairarapa. This is demand driven and is paid under the National Travel & Assistance Policy issued by the MOH.
- Disposable Instruments are ($95k) adverse to budget. The higher than planned costs are partly attributed to one surgeon doing more complex surgery than was done in the past. Also, the repatriation of some elective surgery has meant an increase in clinical supplies costs.

3.2.5 Non-clinical supplies

Non-clinical supply costs are favourable to plan by $643k for the ten months with this variance spread across a number of cost lines with no significant variances at the individual cost line level.

3.2.6 Funder payments

The YTD adverse variance in payments to external providers is ($103k). Pharmaceuticals are ($573k) adverse YTD but this is offset by favourable DSS costs.

IDF expenses are ($645k) adverse to plan YTD. $637k of the adverse variance relates to 'wash-up' accruals. PCT's (Pharmaceutical Cancer Treatment) and Outpatient figures are based on actuals to the end of February extrapolated out to the end of April. The PCT's 'wash-up' expense accrual to the end of April is $388k.

Regarding the over spend in pharmaceuticals; data to complete the analysis is not available from Sector Services until 3 months following the end of the month. As expected this variance reflects the change with the new national contract where customers, previously under close control but well managed, are now provided with 1 or 3 months of pharmaceuticals.

The following graph shows the trend for total community pharmaceutical spend over the last 15 months and this clearly shows the high level of expenditure for July and August to account for the transition payment and the initial increase in drugs dispensed as patients are moved off close control (the high cost in June reflects the final Pharmac rebate wash-up position as previously advised to the Board). The graph also shows the significant decrease in expenditure in September which indicates the initial hypothesis for the expenditure levels was correct.

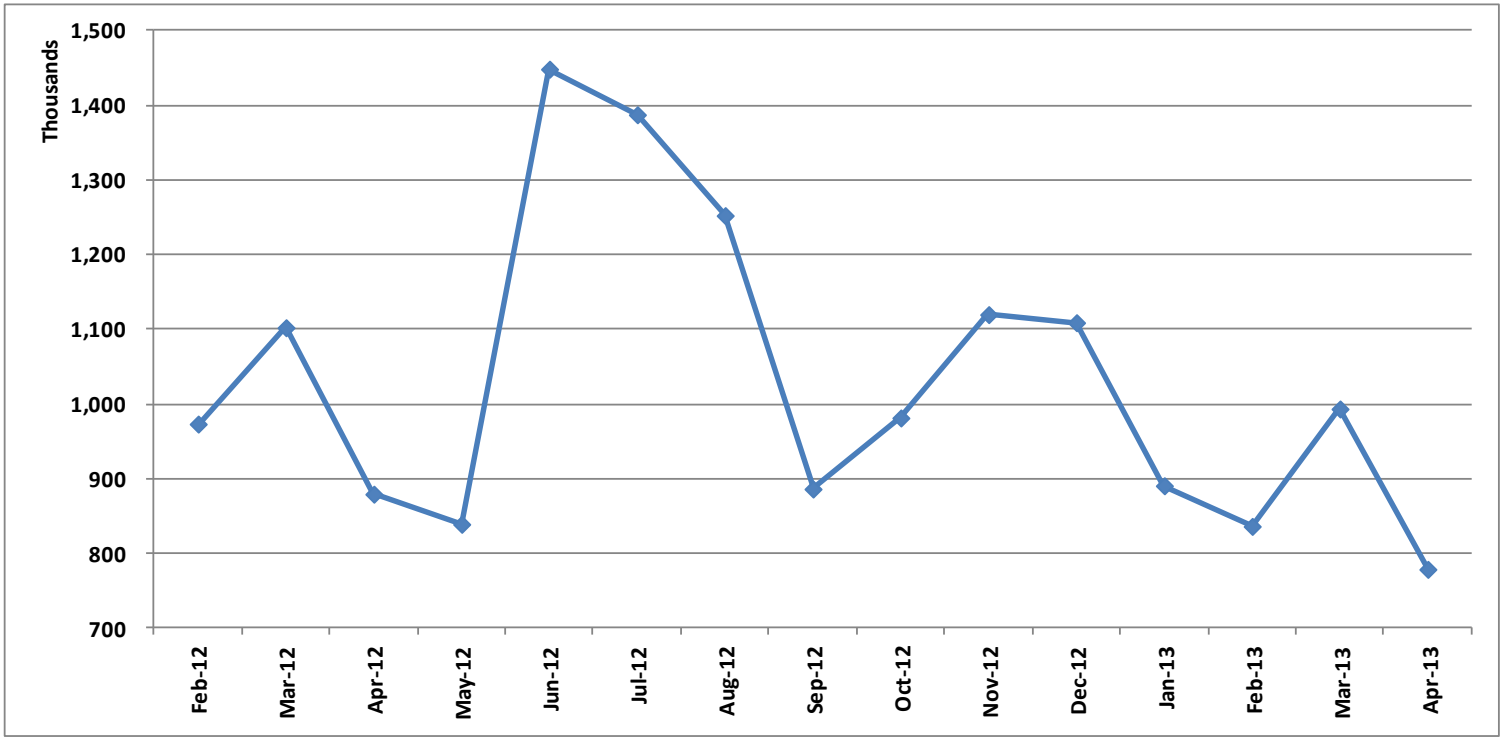


Figure1: Total Community Pharmaceutical Expenditure February 2012 to April 2013

3.3 Ministerial Cap on Management & Administration Staff

WDHB remains within the cap set by the Minister for management and administration staff. The cap reduced by 3% on 1 July to 131 FTEs. A further reduction in the number will occur with the transfer of 1.0FTE to the CRISP programme. The payroll transfer to CCDHB of the Strategic Development team (now part of SIDU) took effect 1 April and this is reflected in the reduced actual FTE numbers reported below.

It is noted that the definition applied to an FTE with the cap differs to that applied to normal FTE reporting and also includes any subsidiaries of a DHB. The definition applied is that one employed FTE is based on one person who works a 40 hour week, a person working more than 40 hours a week is counted as one FTE.

The following table shows the current levels:

Management/Administration Cap

Full Time Equivalent (FTE) Staff Numbers

for the period ended April 2013

	Year to Date		
	Actual	**Budget**	**Variance**
Employed FTE	101.3	124.0	22.7
Vacant FTE	6.0	0.0	(6.0)
Contractor FTE	4.0	3.0	(1.0)
Subsidiary FTE	4.0	4.0	0.0
Total FTEs	**115.3**	**131.0**	**15.7**

4. FINANCIAL STATEMENTS

The detailed financial statements are included on the following pages.

Wairarapa District Health Board

Statement of Financial Performance

For the Period to April 2013

	Month			Year To Date			Annual
	Actual $000	Budget $000	Budget Var $000	Actual $000	Budget $000	Budget Var $000	Budget $000
Revenue	**11,001**	**10,806**	**195**	**110,105**	**108,169**	**1,936**	**129,837**
Expenditure							
Medical	918	858	(60)	9,379	8,828	(550)	10,546
Nursing	1,438	1,294	(144)	13,346	12,857	(489)	15,486
Allied Health	417	426	8	4,052	4,283	230	5,130
Support	70	58	(13)	603	599	(4)	713
Management/Admin	621	595	(26)	5,900	5,913	13	7,082
Workforce Expenses	**3,465**	**3,231**	**(234)**	**33,280**	**32,480**	**(800)**	**38,957**
Outsourced Services	301	368	67	3,371	3,587	216	4,339
Clinical Supplies	653	628	(25)	6,881	6,290	(592)	7,568
Non-Clinical Supplies	631	722	92	6,451	7,094	643	8,580
Efficiency Line	0	(104)	(104)	0	(1,039)	(1,039)	(1,247)
Funder Provider Payments	4,056	4,162	106	38,229	38,126	(103)	45,334
IDF Expenses	2,196	2,134	(62)	21,981	21,336	(645)	25,604
Total Expenditure	**11,301**	**11,140**	**(160)**	**110,194**	**107,875**	**(2,319)**	**129,135**
EBIDCC	**(300)**	**(335)**	**35**	**(88)**	**294**	**(382)**	**702**
Interest, Depreciation & Capital Charge	305	317	12	2,991	3,168	177	3,802
Net Surplus / (Deficit)	**(605)**	**(651)**	**46**	**(3,079)**	**(2,874)**	**(205)**	**(3,100)**

Wairarapa District Health Board

Statement of Financial Performance by Arm

For the Period to April 2013

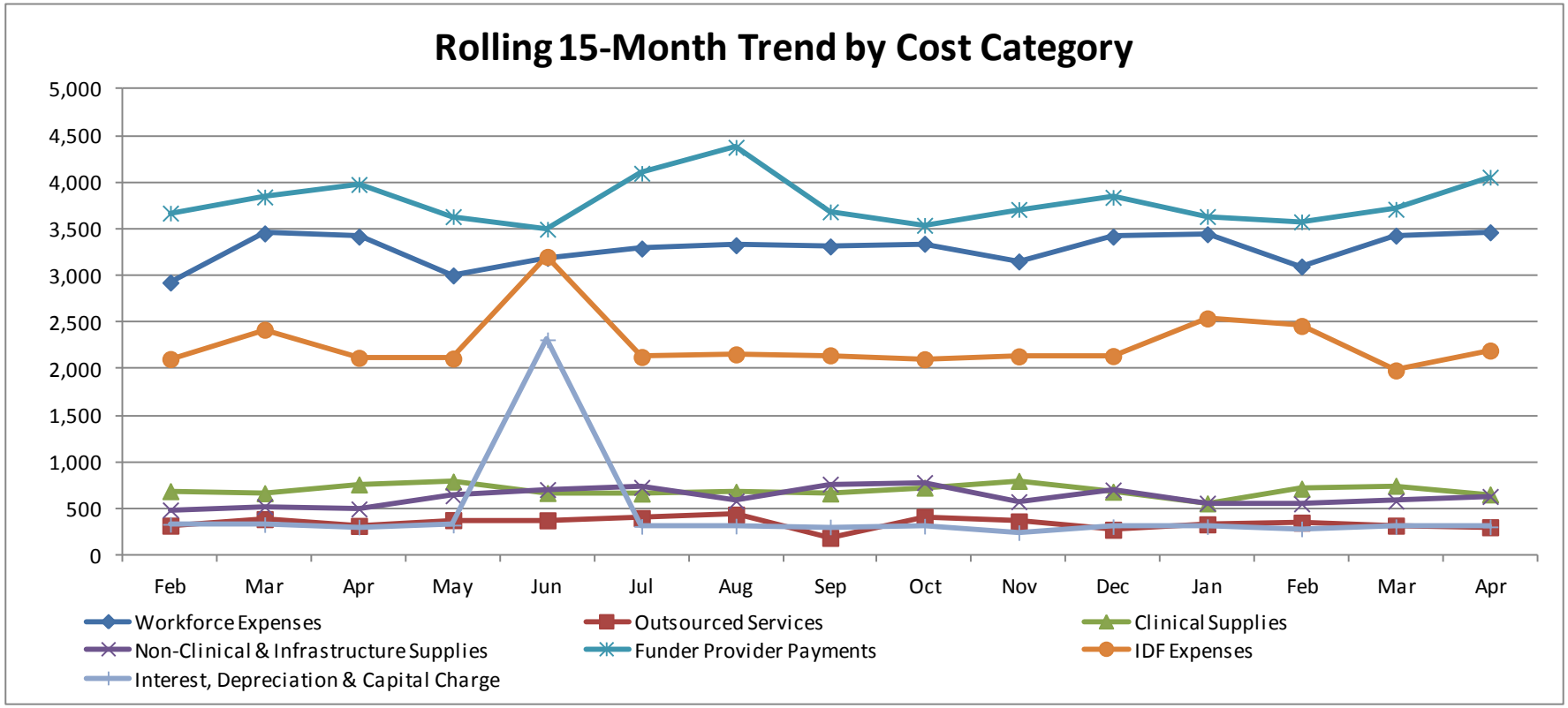
	Month			Year To Date			Annual
	Actual $000	Budget $000	Budget Var $000	Actual $000	Budget $000	Budget Var $000	Budget $000
Funder							
Revenue	10,403	10,366	37	104,290	103,656	634	124,388
Expenditure	10,816	10,839	23	105,707	104,895	(812)	125,457
Net Contribution	**(413)**	**(473)**	**60**	**(1,417)**	**(1,239)**	**(178)**	**(1,069)**
Provider							
Revenue	4,912	4,728	184	48,756	47,389	1,367	56,901
Expenditure	5,104	4,906	(199)	50,415	49,031	(1,384)	58,946
Net Contribution	**(192)**	**(178)**	**(14)**	**(1,659)**	**(1,642)**	**(17)**	**(2,045)**
Governance							
Revenue	252	256	(3)	2,578	2,556	22	3,067
Expenditure	252	256	4	2,581	2,550	(32)	3,053
Net Contribution	**0**	**()**	**0**	**(3)**	**6**	**(9)**	**14**
Net Surplus / (Deficit)	**(605)**	**(651)**	**46**	**(3,079)**	**(2,874)**	**(205)**	**(3,100)**

Wairarapa District Health Board

Revenue Analysis

For the Period to April 2013

	Month			Year To Date		
	Actual $000	Budget $000	Budget Var $000	Actual $000	Budget $000	Budget Var $000
Vote Health & PBF	9,646	9,632	13	96,674	96,322	352
Other MOH	539	518	20	5,444	5,214	229
Health Workforce New Zealand	81	29	52	430	348	82
Inter District Flows	284	284	0	2,844	2,844	0
Other DHBs	110	57	53	570	567	2
ACC	113	136	(23)	1,644	1,362	282
Patient/Consumer	7	11	(3)	96	109	(13)
Training Fees & Subsidies	0	0	0	0	0	0
Other	221	138	82	2,404	1,404	1,001
Internal Revenue	()	()	0	0	()	0
Total Revenue	**11,001**	**10,806**	**195**	**110,105**	**108,169**	**1,936**

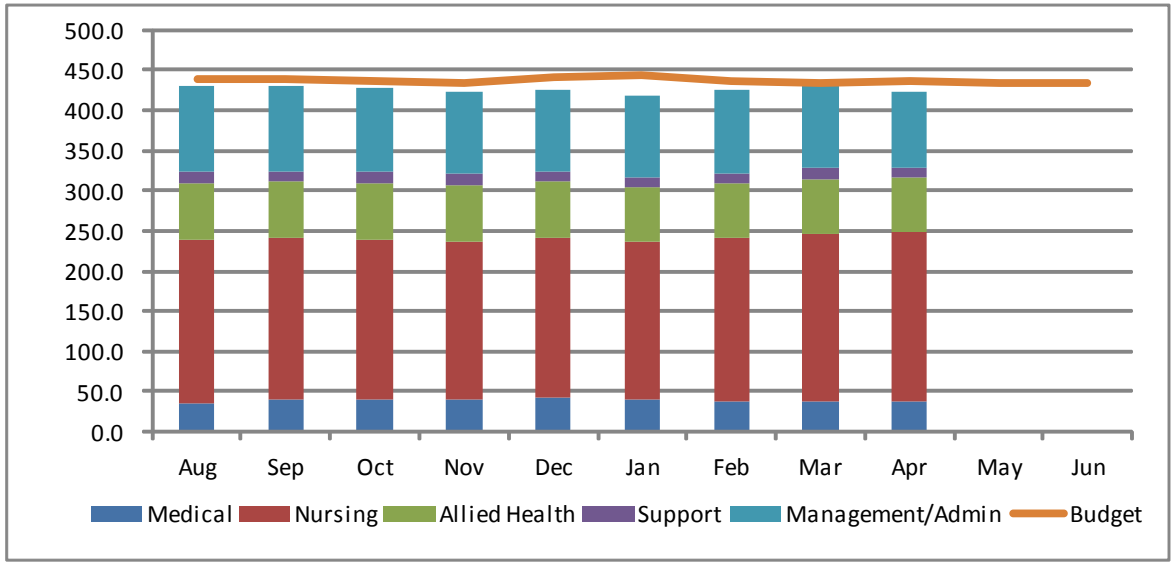

Rolling 15-Month Trend by Cost Category
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
Workforce Expenses
Outsourced Services
Clinical Supplies
Non-Clinical & Infrastructure Supplies
Funder Provider Payments
IDF Expenses
Interest, Depreciation & Capital Charge

Wairarapa District Health Board

Full Time Equivalent (FTE) Staff Numbers

for the period ended April 2013

	Month			Year to Date			Annual
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Medical	36.6	44.3	7.7	38.8	44.0	5.2	44.1
Nursing	210.8	197.4	(13.5)	202.6	197.3	(5.3)	197.2
Allied Health	68.2	74.5	6.3	69.0	75.0	6.0	74.9
Support	13.8	13.1	(0.7)	13.6	13.3	(0.3)	13.2
Management/Admin	94.4	107.6	13.2	102.8	107.8	5.0	107.6
Total FTEs	**423.9**	**436.8**	**12.9**	**426.8**	**437.4**	**10.6**	**437.0**



Wairarapa District Health Board

Statement of Financial Position

for the period ended April 2013

	Actual $000	Budget $000	Variance $000
Property, Plant & Equipment	41,414	42,626	-1,212
Investments	742	2,319	-1,577
Trust funds	315	200	115
Non-Current Assets	**42,471**	**45,145**	**-2,674**
Cash & HBL sweep	825	0	-825
Debtors & prepayments	4,432	5,110	-678
Inventories	834	725	109
Properties intended for sale	0	0	0
Curent Assets	**6,091**	**5,835**	**256**
TOTAL ASSETS	**48,562**	**50,980**	**-2,418**

	Actual $000	Budget $000	Variance $000
Crown equity	37,347	37,304	43
Revaluation reserve	2,155	2,155	0
Retained earnings	-33,488	-30,447	-3,041
Crown Equity	**6,014**	**9,012**	**-2,998**
Interest-bearing loans	15,772	25,227	9,455
Employee entitlements	697	620	-77
Trust funds	315	210	-105
Non-Current Liabilities	**16,784**	**26,057**	**-9,273**
Cash & HBL sweep overdraft	0	1,090	1,090
Creditors & accruals	9,160	8,513	-647
Employee entitlements	6,048	6,071	23
Interest-bearing loans	10,556	237	-10,319
Current Liabilities	**25,764**	**15,911**	**9,853**
TOTAL EQUITY & LIABILITIES	**48,562**	**50,980**	**-2,418**

5. TREASURY MANAGEMENT

5.1 Key Financial Ratios

The following table shows the four key financial ratios used to assess the financial performance by the Crown Health Financing Agency.

Wairarapa District Health Board

Key Financial Ratios

for the period ended April 2013

	Year to Date		
	Actual	**Budget**	**Variance**
Net Surplus ($000)	-3,079	-2,874	-205
Working Capital Ratio	0.24	0.31	-0.07
Interest Coverage	-0.46	-0.16	-0.30
Gearing	81%	83%	2%

5.2 Borrowing Schedule

The following table shows the borrowing facilities currently available to the DHB and the amounts drawn against each facility.

Wairarapa District Health Board

Borrowing Schedule

for the period ended April 2013

	Facility Limit $000	Maturity Date	Amount $000	Interest Rate
Working Capital				
HBL Sweep arrangement	5,000		0	3.97% Floating
Selina Sutherland	700	08-Dec-20	**578**	7.00% Fixed margin plus OCR
Term Borrowing (Crown Health Financing Agency)				
Core	25,750			
		15-Dec-18	3,000	3.08% Fixed
		15-Dec-19	3,000	3.20% Fixed
		15-Apr-14	4,500	2.59% Fixed
		15-Apr-15	4,500	6.67% Fixed
		15-Apr-16	5,000	5.18% Fixed
		15-Apr-17	1,250	2.93% Fixed
		15-Dec-17	4,500	4.85% Fixed
			25,750	
Total Borrowing	**32,050**		**26,328**	

How is My DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2012/13 QUARTER THREE (JANUARY–MARCH) RESULTS

www.health.govt.nz/healthtargets

Now that the hospital target has been achieved, we are ranking DHBs against the primary care target.

Shorter stays in Emergency Departments

		Quarter three performance (%)	95%	Change from previous quarter
1	West Coast	100		–
2	Waitemata	98		–
3	Wairarapa	97		▲
4	South Canterbury	97		–
5	Whanganui	97		–
6	Counties Manukau	97		–
7	Taranaki	96		▲
8	Nelson Marlborough	96		–
9	Hutt Valley	95		▲
10	Tairawhiti	95		–
11	Auckland	95		–
12	Canterbury	94		–
13	Lakes	94		▲
14	Northland	94		–
15	Hawke's Bay	93		▼
16	Southern	93		▲
17	Bay of Plenty	90		▼
18	MidCentral	90		▼
19	Waikato	89		▲
20	Capital & Coast	88		–
	All DHBs	94		–

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

Improved access to Elective Surgery

		Quarter three performance (%)	100%	Progress against plan (discharges)
1	Northland	121		▲
2	Lakes	117		▲
3	Waikato	116		▲
4	Taranaki	114		▲
5	Hawke's Bay	112		▲
6	Bay of Plenty	111		▲
7	Counties Manukau	110		▲
8	Canterbury	107		▲
9	MidCentral	106		▲
10	South Canterbury	106		▲
11	Hutt Valley	103		▲
12	Tairawhiti	102		▲
13	Waitemata	101		▲
14	Whanganui	100		▲
15	Nelson Marlborough	100		▲
16	Auckland	100		▼
17	Wairarapa	99		▼
18	Southern	99		▼
19	Capital & Coast	98		▼
20	West Coast	98		▼
	All DHBs	106		▲

Improved access to elective surgery

The target is an increase in the volume of elective surgery by at least 4000 discharges per year. DHBs planned to deliver 109,293 discharges for the year to date, and have delivered 6878 more.

Shorter waits for Cancer Treatment

		Quarter three performance (%)	100%	Change from previous quarter
1	Northland	100		–
1	Waitemata	100		–
1	Auckland	100		–
1	Counties Manukau	100		–
1	Lakes	100		–
1	Bay of Plenty	100		–
1	Tairawhiti	100		–
1	Hawke's Bay	100		–
1	Taranaki	100		–
1	MidCentral	100		–
1	Whanganui	100		–
1	Capital & Coast	100		–
1	Hutt Valley	100		–
1	Wairarapa	100		–
1	Nelson Marlborough	100		–
1	West Coast	100		–
1	Canterbury	100		–
1	South Canterbury	100		–
1	Southern	100		–
20	Waikato	99.7		–
	All DHBs	99.9*		–

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy. Six regional cancer centre DHBs provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin. Medical oncology services are provided by the majority of DHBs.

* One patient, who was ready-for-treatment, waited four weeks and two days for chemotherapy during quarter three.

Increased Immunisation

		Quarter three performance (%)	85%	Change from previous quarter
1	Wairarapa	96		▲
2	Hawke's Bay	94		▲
3	Hutt Valley	94		–
4	Southern	93		–
5	MidCentral	93		▼
6	Canterbury	93		▲
7	Whanganui	92		▲
8	South Canterbury	92		▼
9	Auckland	91		–
10	Capital & Coast	91		▼
11	Waitemata	90		▼
12	Taranaki	88		▲
13	Bay of Plenty	88		▲
14	Nelson Marlborough	87		▼
15	Counties Manukau	86		▲
16	Lakes	85		▼
17	Tairawhiti	85		▲
18	Northland	83		–
19	Waikato	81		–
20	West Coast	78		▼
	All DHBs	89		–

Increased immunisation

The national immunisation target is 85 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014. This quarterly progress result includes children who turned eight-months between January and March 2013 and who were fully immunised at that stage.

Better help for Smokers to Quit

	Change from previous quarter	95%	Hospitals
	–		99
	–		98
	▲		99
	▲		95
	▼		97
	–		92
	▼		93
	–		98
	–		96
	▼		93
	▲		91
	▲		91
	–		93
	▼		91
	–		96
	▲		95
	▲		96
	–		97
	–		97
	–		90
	–		95

		Quarter three performance (%)	90%	Primary care	Change from previous quarter
1	Hawke's Bay	91			▲
2	South Canterbury	82			▲
3	Bay of Plenty	82			▲
4	Taranaki	63			▲
5	Wairarapa	63			▲
6	Southern	61			▲
7	Nelson Marlborough	59			▲
8	Northland	55			▲
9	Capital & Coast	55			▼
10	Lakes	54			▼
11	MidCentral	53			▲
12	West Coast	53			▲
13	Waikato	51			▲
14	Tairawhiti	47			▲
15	Counties Manukau	45			▲
16	Whanganui	42			▲
17	Auckland	41			▲
18	Waitemata	39			–
19	Hutt Valley	34			▲
20	Canterbury	31			▲
	All DHBs	51			▲

Better help for smokers to quit

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.

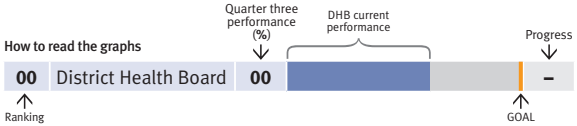
More Heart and Diabetes Checks

		Quarter three performance (%)	75%	Change from previous quarter
1	Taranaki	70		▲
2	Northland	69		▲
3	Wairarapa	69		▲
4	Bay of Plenty	68		▲
5	Hawke's Bay	67		▲
6	Waikato	67		▲
7	Waitemata	65		▼
8	Auckland	64		▲
9	Whanganui	63		▲
10	Tairawhiti	63		▲
11	Lakes	62		▲
12	Counties Manukau	61		▲
13	Capital & Coast	60		▲
14	Southern	59		▲
15	South Canterbury	59		▲
16	West Coast	58		–
17	Nelson Marlborough	56		▲
18	MidCentral	55		▲
19	Hutt Valley	42		▲
20	Canterbury	29		▲
	All DHBs	59		▲

More heart and diabetes checks

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved in stages by July 2014. The current stage is to achieve 75 percent by July 2013.

How to read the graphs



This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

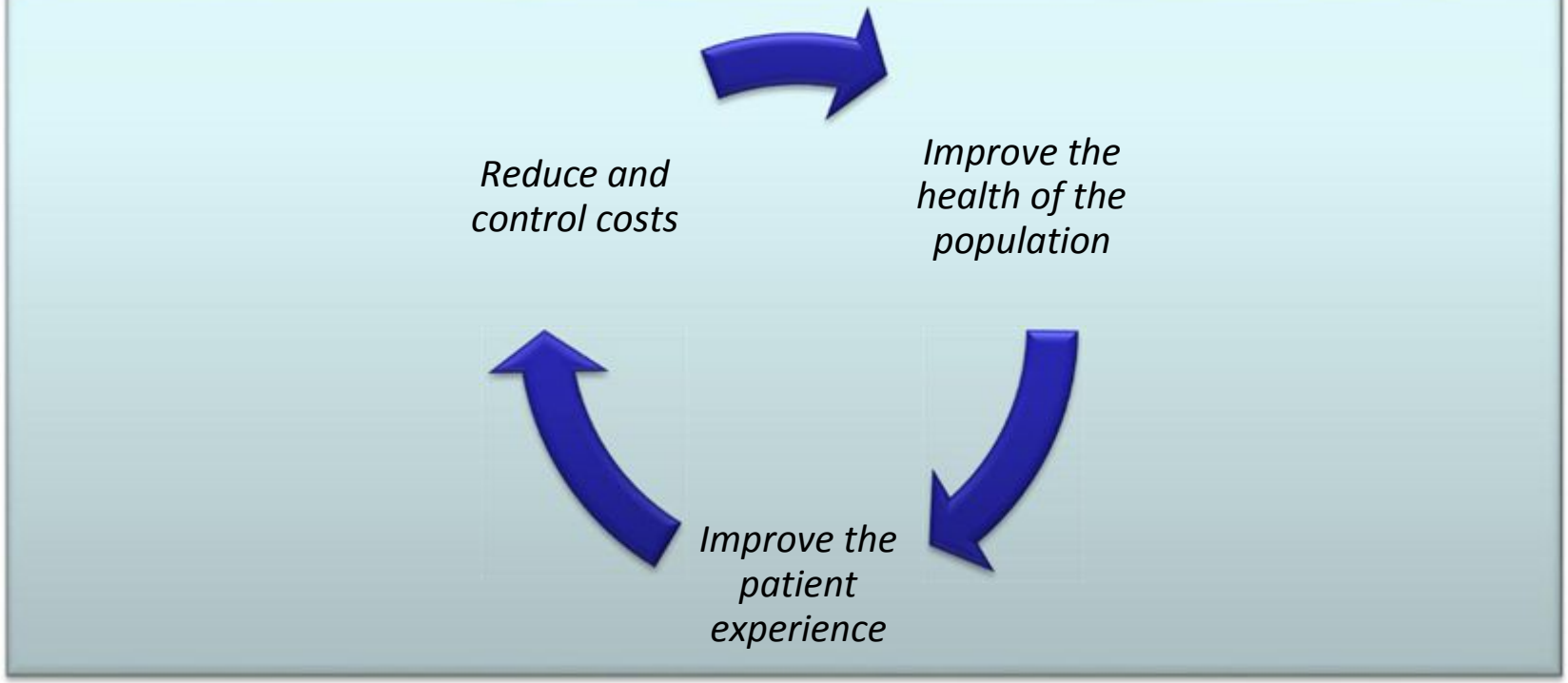
New Zealand Government

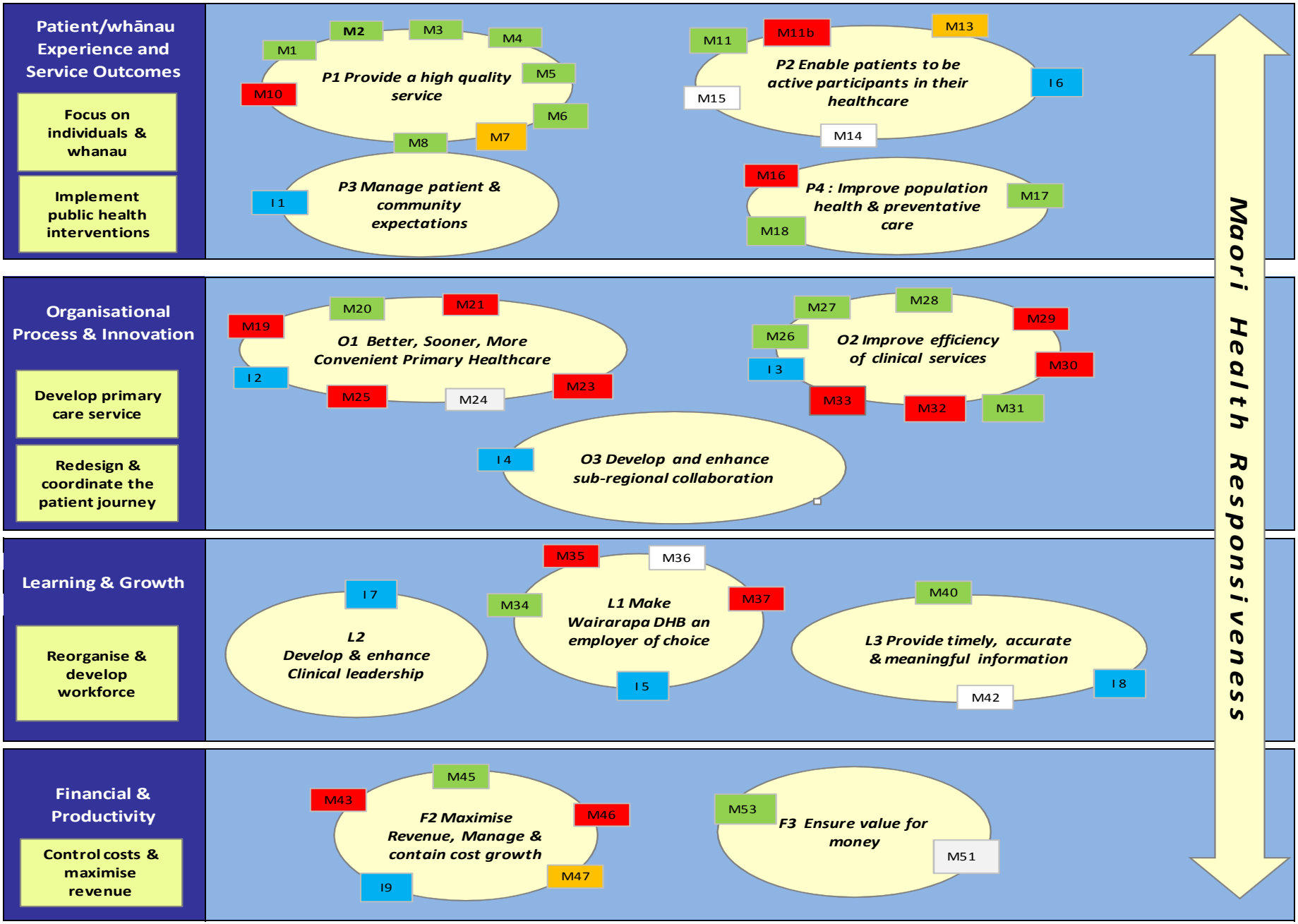
Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Balanced Scorecard April 2013
Board Report

Vision: "Well Wairarapa, Better health for all“

Mission: "To improve, promote and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices"




Patient/whānau Experience and Service Outcomes
Focus on individuals & whanau
Implement public health interventions
M1
M2
M3
M4
M5
M6
M7
M8
M10
P1 Provide a high quality service
I 1
P3 Manage patient & community expectations
M11
M11b
M13
P2 Enable patients to be active participants in their healthcare
I 6
M15
M14
M16
P4 : Improve population health & preventative care
M17
M18
Organisational Process & Innovation
Develop primary care service
Redesign & coordinate the patient journey
M19
M20
M21
O1 Better, Sooner, More Convenient Primary Healthcare
I 2
M25
M24
M23
M27
M28
M29
M26
O2 Improve efficiency of clinical services
I 3
M30
M33
M32
M31
I 4
O3 Develop and enhance sub-regional collaboration
Learning & Growth
Reorganise & develop workforce
I 7
L2 Develop & enhance Clinical leadership
M35
M36
M34
L1 Make Wairarapa DHB an employer of choice
M37
I 5
M40
L3 Provide timely, accurate & meaningful information
I 8
M42
Financial & Productivity
Control costs & maximise revenue
M45
M43
F2 Maximise Revenue, Manage & contain cost growth
M46
I9
M47
M53
F3 Ensure value for money
M51
Maori Health Responsiveness

Monthly Snapshot (April 2013)

Measures that are performing below expectations or trending down or borderline i.e. red or orange in the current month.

Measure Number	Measure Description	Calculation Formula	Measure Leader	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
M21	Ambulatory sensitive (avoidable) admissions	Reduce the number of ASH admissions by 15% over 09/10 levels over 3 years targeting cellulitis, asthma, gastroenteritis, and angina and chest pain and pneumonia	Hospital Manager	✖	✖	✖	✖	✖	✖	✖	✖	✓	✓	✖	
M23	Triage 4 & 5 ED Non-Admissions	Reduce triage 4 & 5 ED non-admitted self-presentations over 2009/10 levels, by 30% , over the next 3 years	Michele Halford / Russel Clark	✓	✓	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖
M25	Reduce Outpatient volumes	Reduce OPD volumes, for medical and paediatric clinics, to 2006 levels over the next 3 years.	Janice Byford-Jones	✖	✖	✖	✖	✖	✖	✖	✓	✖	✖	✖	✖
M33	Improved Access to Elective Services	Discharges for elective services at agreed level. A total of 1841 elective surgical discharges	Sarah Boyes/ Carolyn Braddock	✖	✓	✓	✓	✓	✓	✓	✓	✓	✖	✖	
M35	Staff turnover	Staff Turnover reported against Employee Group and Length of Service. Target 10 %	Gretchen Dean	✓	✓	✓	✓	✖	✖	✖	✖	✓	✓	✖	✖
M43	Budget performance - revenue & expenditure (bottom line)	Actual vs Budget net financial result (bottom line), financial results including ACC, Selena	Nick McGruddy	✖	✖	✖	✖	✖	✓	✖	✖	✓	✖	✖	✖
M46	Inter-District Flows	Total spend on IDF's / CWDs / avg CWD	Nigel Broom	✖	✖	✓	✓	✓	✓	✓	✓	✖	✖	✖	✖
M47	FTEs Actual vs. Planned	Positive or nil variance against both: - Actual vs. Planned FTE numbers - Performance against management/admin cap	Nick McGruddy	✖	✓	✓	⚑	⚑	⚑	⚑	✓	⚑	⚑	✓	⚑

Snapshot & Trends (1 of 2)

✓ Performing to expectations

Cause for concern, trending down or borderline

✗ Performing below expectations

Measure Number	Measure Description	Calculation Formula	Measure Leader	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
M1	National patient satisfaction survey	Placeholder, MoH measure currently being developed	Cate Tyrer	✓	✓				✓	✓	✓				
M2	Increased Immunisation	From the 1st July 2012 the Health Target has changed to 85% of eight months olds will have their primary course of immunisation on time by July 2013, 90% by July 2014 and 95 percent by December 2014.	Lisa Burch	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	
M3	Resolution of complaints	Number of complaints compliant with HDC requirements , and number of complaints received.	Cate Tyrer	✓	✓	✓	✓	✗	✓	✗	✗	✓	✓	✓	
M4	Blood Stream Infections (BSI)	Hospital Acquired BSI's < 3.5 per quarter per 1,000 bed days (approx. 14 per annum)	Lizzie Daniell	✗	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	
M5	Reportable events	Reportable events -inpatient falls < 115 and medication errors <50 (DAP measures)	Cate Tyrer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M6	Improving the health status of people with severe mental illness through improved access	The average number of people domiciled in the WDHB region, seen per year rolling every 3 months being reported. Targets Child & Youth (0-19) Maori, Other and Total 2.8. Adults (20-64) Maori 4.2, Other 3, Total 3. Older People (65+) Maori, Other and Total 0.59.	Simon Phillips	✓	✓										
M8	Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010	Glenda Foster	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
M11	Better help for smokers to quit	90 % of hospitalised smokers will be provided with advice and help to quit by July 2011 and 95% by July 2012 .	Linda Spence	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
M11b	Better help for smokers to quit	90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2012.	Lisa Burch	✗	✗	✗	✗	✗	✗	✗	✗				
M15	Reducing the frailty of over 85 population through Primary Care.	Number of FOCUS clients over 85 years that are living well in the community as a proportion of the total over 85 population. Tihei target to increase to 81% over 3 years.	Joanne Edwards	✗	✗	Measure on hold									
M17	Life expectancy at birth	Life expectancy is the average length of life of a group of people from a given age, in this case from birth, ethnicity split	Andrea Rutene												
M19	More Heart & Diabetes Checks	The target is that by July 2012, 60% of eligible population will have had their cardiovascular risk assessed in the last 5 years. Target will increase in stages to 90% by July 2014	Astuti Balram	✓	✓	✗	✗	✗	✗	✗	✗				
M21	Ambulatory sensitive (avoidable) admissions	Reduce the number of ASH admissions by 15% over 09/10 levels over 3 years targeting cellulitis, asthma, gastroenteritis, and angina and chest pain and pneumonia	Hospital Manager	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓	✗	
M23	Triage 4 & 5 ED Non-Admissions	Reduce triage 4 & 5 ED non-admitted self-presentations over 2009/10 levels, by 30% , over the next 3 years	Michele Halford / Russel Clark	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
M25	Reduce Outpatient volumes	Reduce OPD volumes, for medical and paediatric clinics, to 2006 levels over the next 3 years.	Janice Byford-Jones	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗

Snapshot & Trends (2 of 2)

✓ Performing to expectations

Cause for concern, trending down or borderline

✖ Performing below expectations

Measure Number	Measure Description	Calculation Formula	Measure Leader	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13
M26	Shorter stays in ED	95% of patients will be admitted, discharged or transferred from ED within 6 hours	Michele Halford / Russel Clark	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
M33	Improved Access to Elective Services	Discharges for elective services at agreed level. A total of 1841 elective surgical discharges	Sarah Boyes/ Carolyn Braddock	✖	✓	✓	✓	✓	✓	✓	✓	✓	✖	✖	
M34	Employee headcount by ethnicity	Number of employees who have identified their ethnic origin split into Total, Maori and other.	Gretchen Dean	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M35	Staff turnover	Staff Turnover reported against Employee Group and Length of Service. Target 10 %	Gretchen Dean	✓	✓	✓	✓	✖	✖	✖	✖	✓	✓	✖	✖
M43	Budget performance - revenue & expenditure (bottom line)	Actual vs Budget net financial result (bottom line), financial results including ACC, Selena	Nick McGruddy	✖	✖	✖	✖	✖	✓	✖	✖	✓	✖	✖	✖
M45	Reduce Pharmacy Spend	Reduce the community pharmacy spend by $750,000 in total over 3 years, through implementation of a structured pharmacy programme	Nigel Broom	✓	✓	✓	✖	✖	✖	✖	✖	✓	✓	✓	✓
M46	Inter-District Flows	Total spend on IDF's / CWDs / avg CWD	Nigel Broom	✖	✖	✓	✓	✓	✓	✓	✓	✖	✖	✖	✖
M47	FTEs Actual vs. Planned	Positive or nil variance against both: - Actual vs. Planned FTE numbers - Performance against management/admin cap	Nick McGruddy	✖	✓	✓					✓			✓	
M51	Capital Expenditure to Plan	Capital Expenditure should be delivered in line with plan	Nick McGruddy	Measure Under Review											
I1	Manage patient & community expectations	Report on engagement of community via CEO's Report	Tracey Adamson												
I4	Sub regional developments	3 DHB Health Service Programme	Programme Lead												
I4	Sub regional developments	Other Sub Regional Initiatives - Joint appointments, service collaboration.	Robyn Brady												
I5	Te Arawhata Totika	Progress report on the milestones on Te Arawhata Totika, implementation plan	Stephanie Turner												
I7	Clinical leadership	Annual report on self assessment of the work undertaken to improve clinical leadership	Helen Pocknall												
I8	Delivery against CRISP	Progress report on Central Region Information Systems Plan (CRISP)	Gary Ireland												
I9	Performance Initiative Actions	Light green and dark green dollar savings	Robyn Brady												

Measure & Definitions (1 of 2)

Objective Number	Objective	Measure Number	Measure Description	Active	Calculation Formula	SLT Sponsor	Measure Leader	MoH Code
P1	Provide a high quality service	M1	National patient satisfaction survey	Y	Placeholder, MoH measure currently being developed	Cate Tyrer	Cate Tyrer	OS-12
P1	Provide a high quality service	M2	Increased Immunisation	Y	From the 1st July 2012 the Health Target has changed to 85% of eight months olds will have their primary course of immunisation on time by July 2013, 90% by July 2014 and 95 percent by December 2014.	Simon Everitt	Lisa Burch	HT4
P1	Provide a high quality service	M3	Resolution of complaints	Y	Number of complaints compliant with HDC requirements , and number of complaints received.	Cate Tyrer	Cate Tyrer	WRDHB
P1	Provide a high quality service	M4	Blood Stream Infections (BSI)	Y	Hospital Acquired BSI's < 3.5 per quarter per 1,000 bed days (approx. 14 per annum)	Cate Tyrer	Lizzie Daniell	WRDHB
P1	Provide a high quality service	M5	Reportable events	Y	Reportable events -inpatient falls < 115 and medication errors <50 (DAP measures)	Cate Tyrer	Cate Tyrer	WRDHB
P1	Provide a high quality service	M6	Improving the health status of people with severe mental illness through improved access	Y	The average number of people domiciled in the WDHB region, seen per year rolling every 3 months being reported. Targets Child & Youth (0-19) Maori, Other and Total 2.8. Adults (20-64) Maori 4.2, Other 3, Total 3. Older People (65+) Maori, Other and Total 0.59.	Alliance Leadership Team	Simon Phillips	Tihei
P1	Provide a high quality service	M8	Shorter waits for cancer treatment	Y	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010	Simon Everitt	Glenda Foster	HT3
P2	Enable patients to be active participants in their healthcare	M11	Better help for smokers to quit	Y	90 % of hospitalised smokers will be provided with advice and help to quit by July 2011; and 95% by July 2012.	Andrew Bos	Linda Spence	HT5
P2	Enable patients to be active participants in their healthcare	M11b	Better help for smokers to quit	Y	90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2012.	Simon Everitt	Lisa Burch	HT5
P2	Enable patients to be active participants in their healthcare	M15	Reducing the frailty of over 85 population through Primary Care.	N	Number of FOCUS clients over 85 years that are living well in the community as a proportion of the total over 85 population. The measure is the inverse of the percent of people over 85 years who have been assessed as having high/very high support needs. Tihei target to increase to 81% over 3 years.	Alliance Leadership Team / Robyn Brady	Joanne Edwards	Tihei
P4	Improve Population health & preventative care	M17	Life expectancy at birth	Y	Life expectancy is the average length of life of a group of people from a given age, in this case from birth, ethnicity split	Simon Everitt	Andrea Rutene	WRDHB
O1	Better, Sooner, More Convenient Primary Healthcare	M19	More Heart and Diabetes Checks	Y	The target is that by July 2012, 60% of eligible population will have had their cardiovascular risk assessed in the last 5 years. Target will increase in stages to 90% by July 2014	Simon Everitt	Astuti Balram	HT6
O1	Better, Sooner, More Convenient Primary Healthcare	M21	Ambulatory sensitive (avoidable) admissions	Y	Reduce the number of ASH admissions by 15% over 09/10 levels over 3 years targeting cellulitis, asthma, gastroenteritis, and angina and chest pain and pneumonia	Alliance Leadership Team	Hospital Manager	Tihei
O1	Better, Sooner, More Convenient Primary Healthcare	M23	Triage 4 & 5 ED Non-Admissions	Y	Reduce triage 4 & 5 ED non-admitted self-presentations over 2009/10 levels, by 30% , over the next 3 years	Alliance Leadership Team	Michele Halford / Russel Clark	Tihei
O1	Better, Sooner, More Convenient Primary Healthcare	M25	Reduce Outpatient volumes	Y	Reduce OPD volumes, for medical and paediatric clinics, to 2006 level (2,910 patients), over the next 3 years	Alliance Leadership Team	Hospital Manager	Tihei

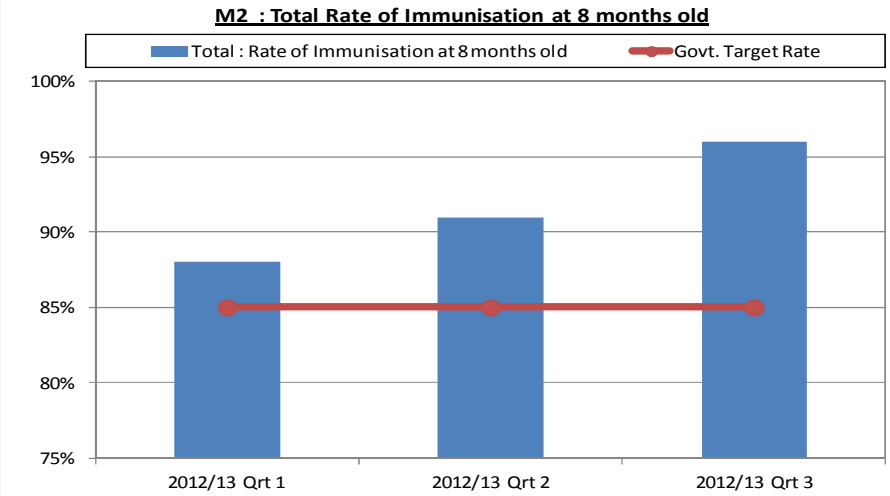
Measure & Definitions (2 of 2)

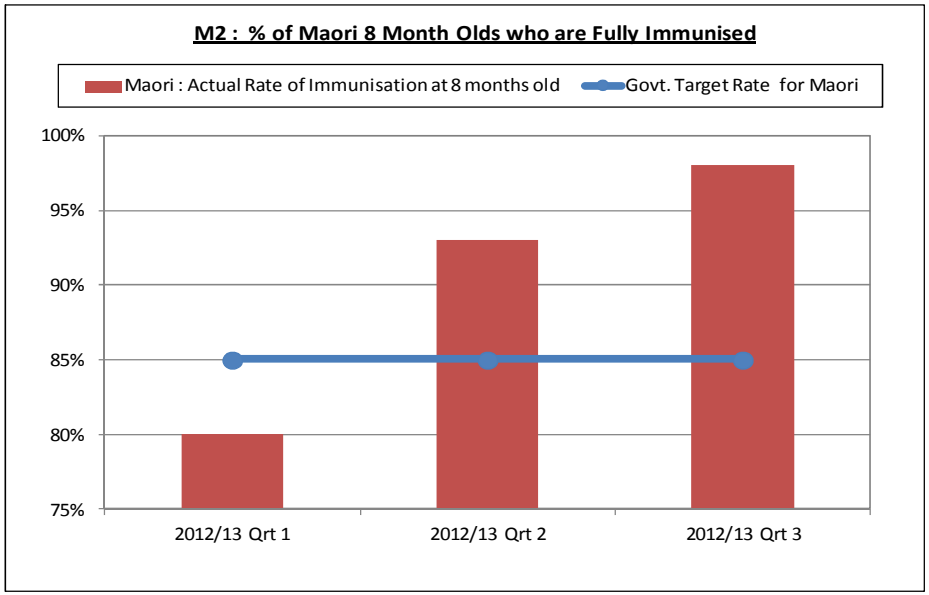
Objective Number	Objective	Measure Number	Measure Description	Active	Calculation Formula	SLT Sponsor	Measure Leader	MoH Code
O2	Improve efficiency of clinical services	M26	Shorter stays in ED	Y	95% of patients will be admitted, discharged or transferred from ED within 6 hours	Pete Chandler	Michele Halford / Russel Clark	HT1
O2	Improve efficiency of clinical services	M33	Improved Access to Elective Services	Y	Discharges for elective services at agreed level. The target is a total of 1841 elective surgical discharges per annum.	Pete Chandler	Sarah Boyes / Carolyn Braddock	HT2
L1	Make Wairarapa DHB an employer of choice	M34	Employee headcount by ethnicity	Y	Number of employees (headcount) who have identified their ethnic as Maori as a proportion of total employees (headcount).	Gretchen Dean	Gretchen Dean	WRDHB
L1	Make Wairarapa DHB an employer of choice	M35	Staff turnover	Y	Staff Turnover reported against Employee Group (target 10 %)	Gretchen Dean	Gretchen Dean	OS-01
F1	Maximise Revenue, Manage & contain cost growth	M43	Budget performance - revenue & expenditure (bottom line)	Y	Actual vs Budget net financial result (bottom line), financial results including ACC, Selena	Tania Harris	Eric Sinclair	WRDHB
F2	Maximise Revenue, Manage & contain cost growth	M45	Reduce Pharmacy Spend	Y	Reduce the community pharmacy spend by $750,000 in total over 3 years, through implementation of a structured pharmacy programme	Simon Everitt	Nigel Broom	Tihei
F2	Maximise Revenue, Manage & contain cost growth	M46	Inter-District Flows	Y	Total spend on IDF's / CWDs / avg CWD	Simon Everitt	Nigel Broom	WRDHB
F2	Maximise Revenue, Manage & contain cost growth	M47	FTEs Actual vs. Planned	Y	Positive or nil variance against both - Actual vs. Planned FTE numbers - Performance against management/admin cap	Tania Harris	Eric Sinclair	WRDHB
F3	Ensure value for money	M51	Capital Expenditure to Plan	N	Capital Expenditure should be delivered in line with plan	Tania Harris	Nick McGruddy	OS-2
P3	Manage patient & community expectations	I 1	Manage patient & community expectations		Report on engagement of community via CEO's Report	Tracey Adamson	Tracey Adamson	SI-4
O3	Develop & enhance Sub-Regional collaboration	I 4	Sub regional developments		3 DHB Health Service Programme	Tracey Adamson	Programme Lead	WRDHB
O3	Develop & enhance Sub-Regional collaboration	I 4	Sub regional developments		Other Sub Regional Initiatives - Joint appointments, service collaboration.	Robyn Brady	Robyn Brady	WRDHB
L1	Make Wairarapa DHB an employer of choice	I 5	Te Arawhata Totika		Progress report on the milestones on Te Arawhata Totika, implementation plan	Stephanie Turner	Stephanie Turner	Maori HP
L2	Develop & enhance Clinical Leadership	I7	Clinical leadership		Annual report on self assessment of the work undertaken to improve clinical leadership	Alan Shirley	Helen Pocknall	PP-1
L3	Provide timely, accurate & meaningful information	I8	Delivery against CRISP		Progress report on Central Region Information Systems Plan (CRISP)	Eric Sinclair	Gary Ireland	WRDHB
F2	Manage and contain cost growth	I9	Performance Initiative Actions		Light green and dark green dollar savings	Eric Sinclair	Robyn Brady	WRDHB

M2 Increased immunisation

8 month olds < 85% red, >=85% green

BSC Objective: P1 Provide a high quality service
Objective Owner: Simon Everitt
Measure Leader: Lisa Burch





Description:

From the 1st July 2012 the National Health Target has changed to 85% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90% by July 2014 and 95 percent by December 2014.

We will also continue to measure the rate of two year olds who are fully immunised at 2 years of age against a target of 95%.

Issues:

The measure is of children turning eight months within the quarter. Relatively small numbers (around 130 per quarter) can result in some fluctuation in results, but the result in quarter 3 was very pleasing.

Implications :

On-going efforts to coordinate public health, primary care and outreach immunisation services has been effective in producing excellent results in the last twelve months and these need to be maintained.

Comment / Actions:

For the three months ending 31 March:

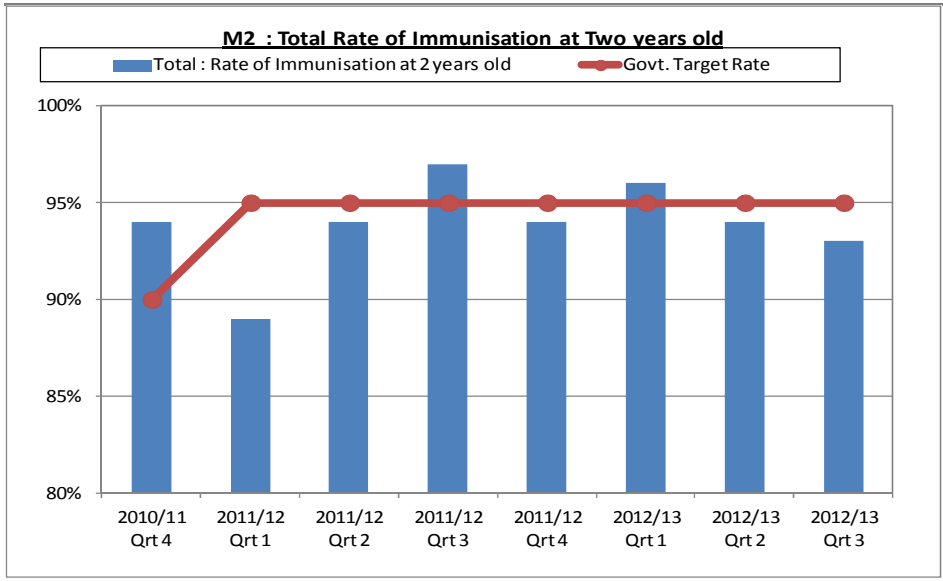
137 babies eligible , 132 (96%) fully immunised. Health Target of 85% Achieved. 56 0f 57 Maori 8 month babies were fully immunised (98%). 4 of the remaining five babies were not immunised as their parents declined all or part of their vaccination. 1 baby was opted off the NIR

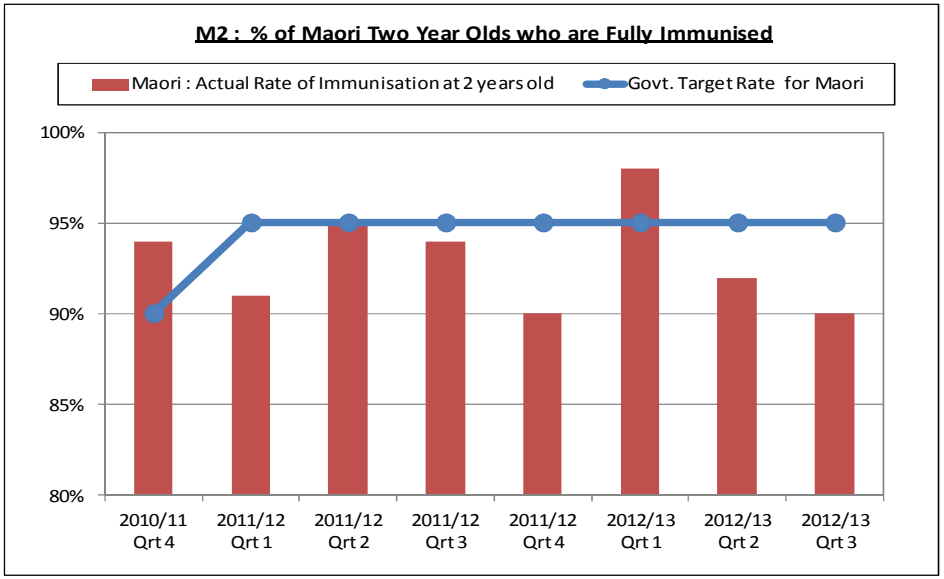
Continued over page.

M2 Increased immunisation

8 month olds < 85% red, >=85% green

BSC Objective: P1 Provide a high quality service
Objective Owner: Simon Everitt
Measure Leader: Lisa Burch





The NIR coordinator runs an overdue report for each practice on a fortnightly basis to ensure that all children are being followed up. These reports are also monitored and children whom have not commenced their immunisations by 12 weeks, and who have not completed their immunisations by 6 and 20 months, are referred directly to outreach for immediate follow-up.

The NIR coordinator also runs reports from each practice of all immunisations given in a certain time frame, and then checks each one off on the NIR to ensure that they have messaged through accurately, so that we have the most up to date information.

The majority of babies not fully immunised at 8 months have declined the pneumococcal vaccination. Education sessions are being planned to ensure that vaccinators are able to provide parents with appropriate advice. The process for referral to outreach has also been reviewed to ensure that all babies receive their first vaccinations in a timely manner.

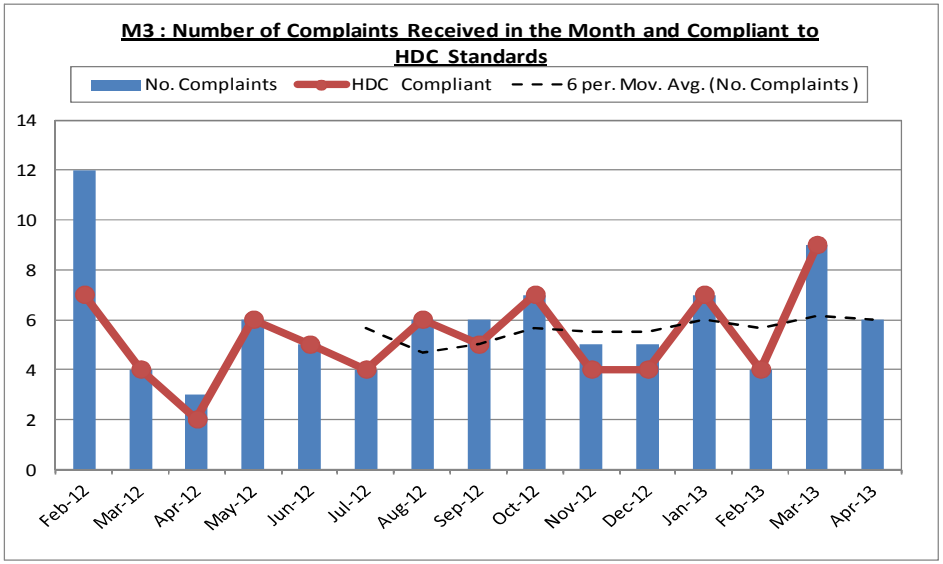
These two graphs measure the rate of two year olds who are fully immunised at 2 years of age against a target of 95%.

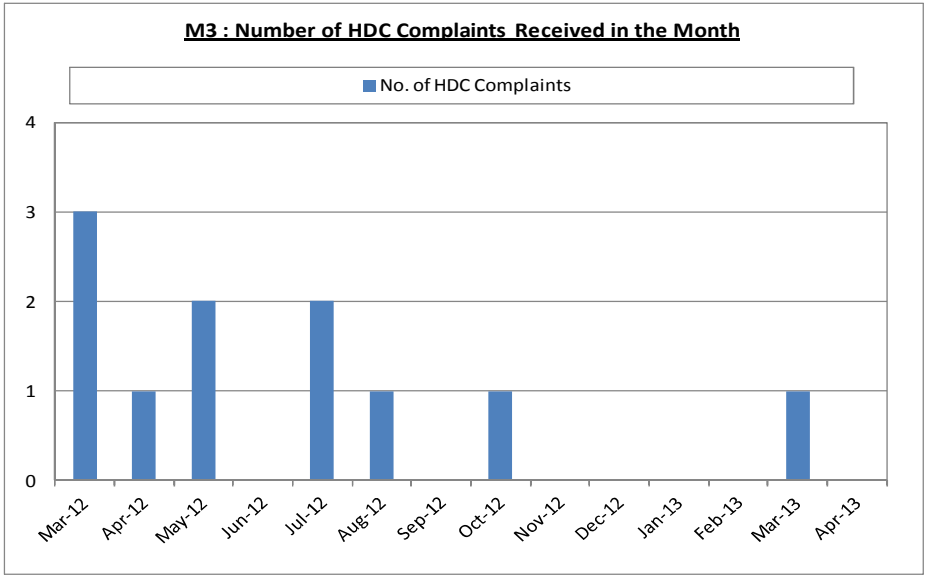
128 of 142 eligible 2 year olds were fully vaccinated. 10 of the remaining children had parents who declined one or more vaccines and 2 opted off the NIR.

M3 Resolution of complaints

100% HDC Compliance green, < 100% red

BSC Objective: P1 Provide a high quality service
Objective Owner: Cate Tyrer
Measure Leader: Cate Tyrer





Description:

Number of complaints which have been received in the month, along with how many are compliant with HDC timeframe requirements.

6 complaints were received by the Quality Department in April.

- 1 related process issues.
- 2 related to treatment provided.
- 1 related to communication issues.
- 2 related to staff attitude

No HDC complaints were received in April.

Issues :

There are some issues starting to emerge with the timeliness of complaint response. It is hoped this will be resolved once the new managers settle into their new roles.

Implications :

The HDC recommends that all complaints are either responded to or kept informed of delays within 20 days of receipt.

Comment / Actions:

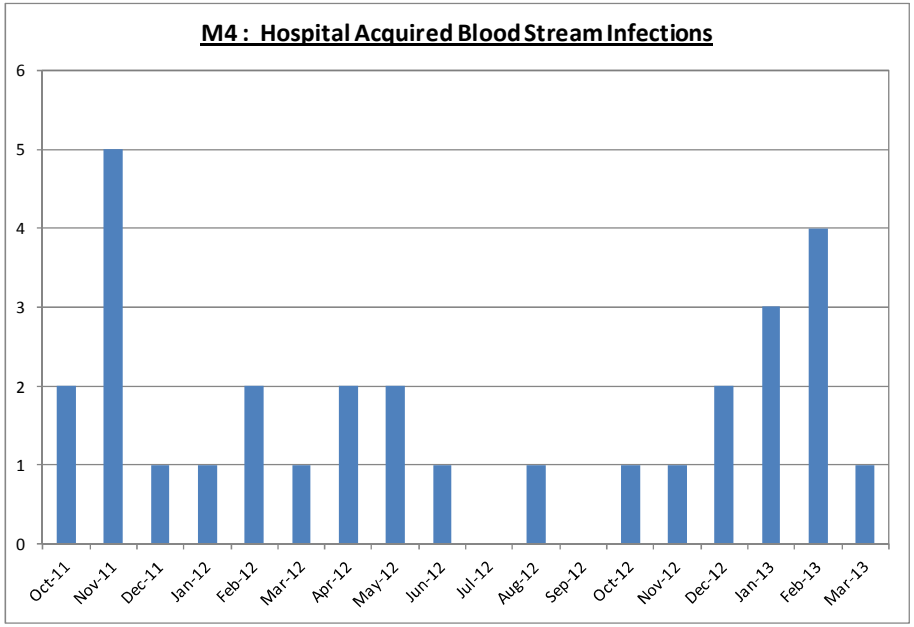
Compliance data will be one month behind reporting month , as an additional month is required to determine if compliance has been met.

All complaints received in March were compliant with the HDC timeframe requirements.

M4 Blood stream infections (BSI)

<=1 per month green, >1 red

BSC Objective: P1 Provide a high quality service
Objective Owner: Cate Tyrer
Measure Leader: Lizzie Daniell



Description:

Hospital acquired blood stream infections. The target is for this to be less than 14 per annum.

Plan:

Roll out regular education to staff in clinical setting regarding transmission based precautions, infection prevention and control and hand hygiene training/ audits. Carry out regular infection control audits of environment and practice, etc.

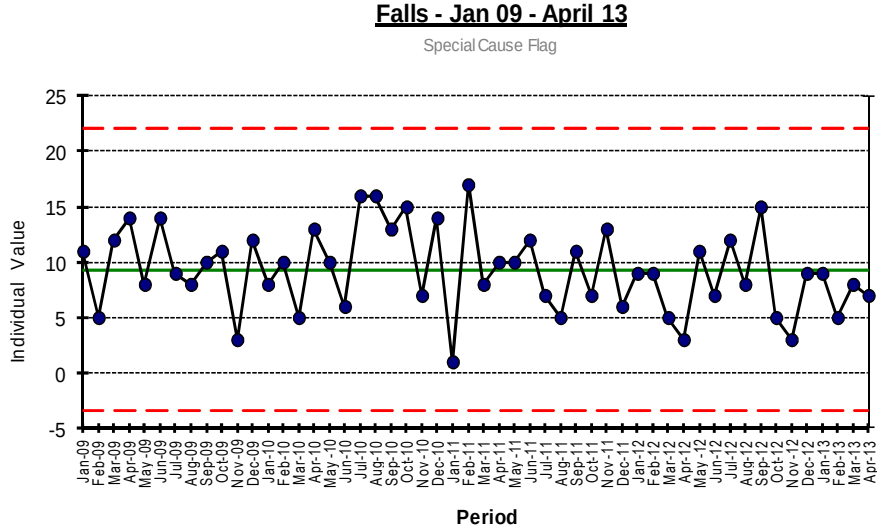
Comment / Actions:

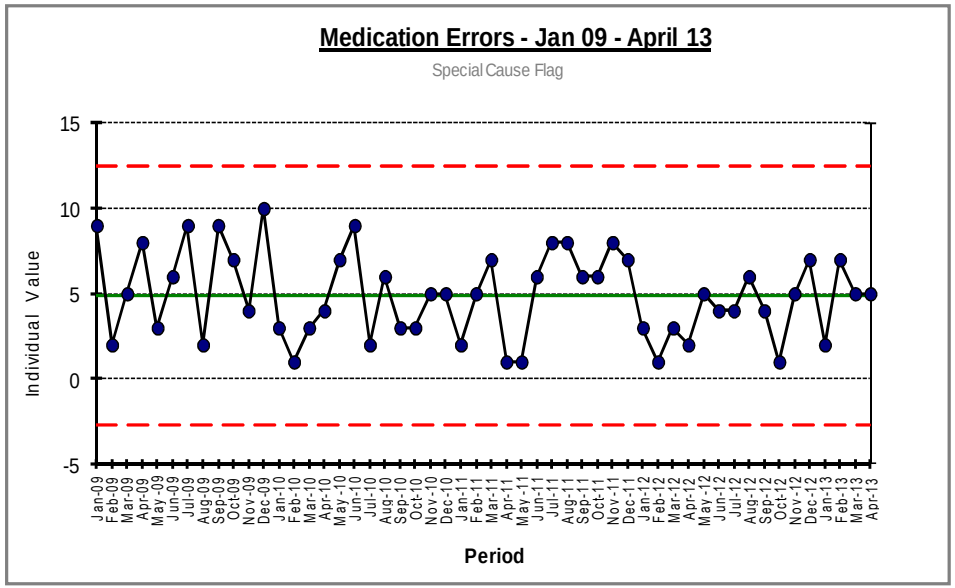
YTD to March 2013 = 13 (annual target 14). Continue to manage within accepted parameters and review episodes of higher than expected BSIs to reduce a potential trend in increase.
Of the 3 incidences in January, only one originated in Wairarapa, the other two patients received pacemakers at Wellington and returned with the infection so skew our data.

M5 Reportable events

> Median per 1,000 bed days red, <= median per 1,000 bed days green

BSC Objective: P1 Provide a high quality service
Objective Owner: Cate Tyrer
Measure Leader: Cate Tyrer





Description:

Inpatient falls to be < 115 per year (10 per month).

Medication errors to be < 50 per year (4 per month).

Now measured per 1,000 bed days to more accurately reflect the trends by taking into account acuity.

Comment / Actions:

YTD Total Falls = 81

YTD SAC 1,2 & 3 Falls = 19 (1 SAC2, 18 SAC3)

YTD Total Med Errors = 46

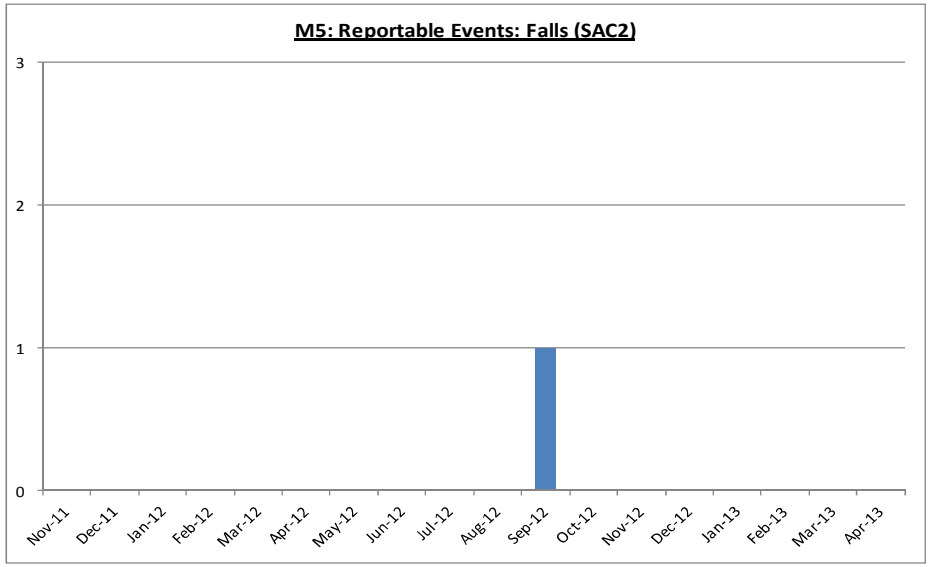
Medication.

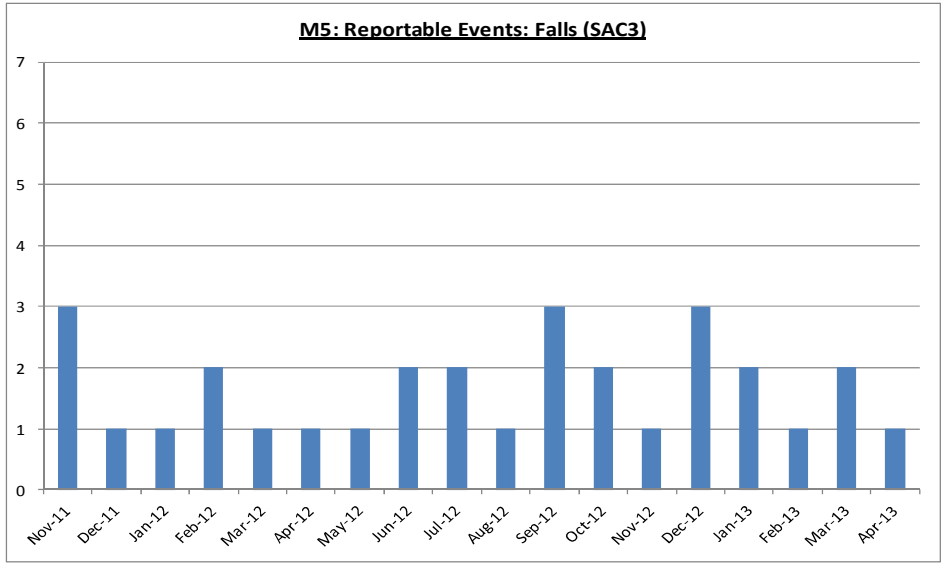
All the medication errors bar one were SAC 4 which means they were either near misses or no harm resulted for the patient. The other was a SAC 3 which meant that the error was administered to the patient but no harm occurred.

M5 Reportable events

> Median per 1,000 bed days red, <= median per 1,000 bed days green

BSC Objective: P1 Provide a high quality service
Objective Owner: Cate Tyrer
Measure Leader: Cate Tyrer





SAC 2 Description:

A SAC 2 clinical event is one which is where serious harm occurs and requires either transfer to a higher level of care or extra interventions e.g. surgery and was not the intended outcome of the patients journey.

SAC 3 Description

A SAC 3 event is where injury occurred but did not impact on the stay in hospital and did not require any invasive treatment e.g. skin tears, haematomas.

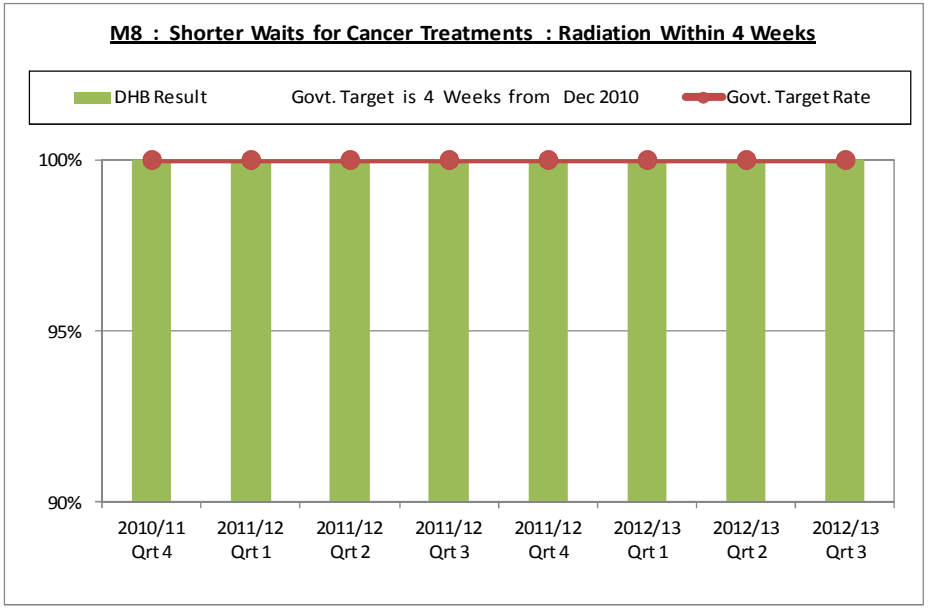
Comment / Actions:

The SAC 3 injuries was a minor skin tear.

M8 Shorter waits for cancer treatment

< 100% red, >=100% green

BSC Objective:	**P1 Provide a high quality service**
Objective Owner:	**Simon Everitt**
Measure Leader:	**Glenda Foster**



Description:

Specialist cancer treatment and symptom control is essential to reducing the impact of cancer. This measure was previously the health target Shorter waits for cancer treatment – radiotherapy. it now includes chemotherapy. This is a MoH Health Target and is set at "All patients, ready-for-treatment, (for radiotherapy or chemotherapy) will wait less than four weeks."

Issues:

We have reviewed the monthly wait time templates produced by Mid Central and Capital & Coast Cancer Centres for the quarter and for radiotherapy, this target was met, with no patients waiting longer than 4 weeks because of capacity constraints for either their FSA or time from decision to treat to start of radiation treatment. This is the result reported on by the Ministry of Health.

For chemotherapy, two people waited longer than 4 weeks (4 - 6 weeks) for their first specialist appointment (FSA) because of capacity constraints, both at Capital & Coast.

Implications:

Comment Actions:

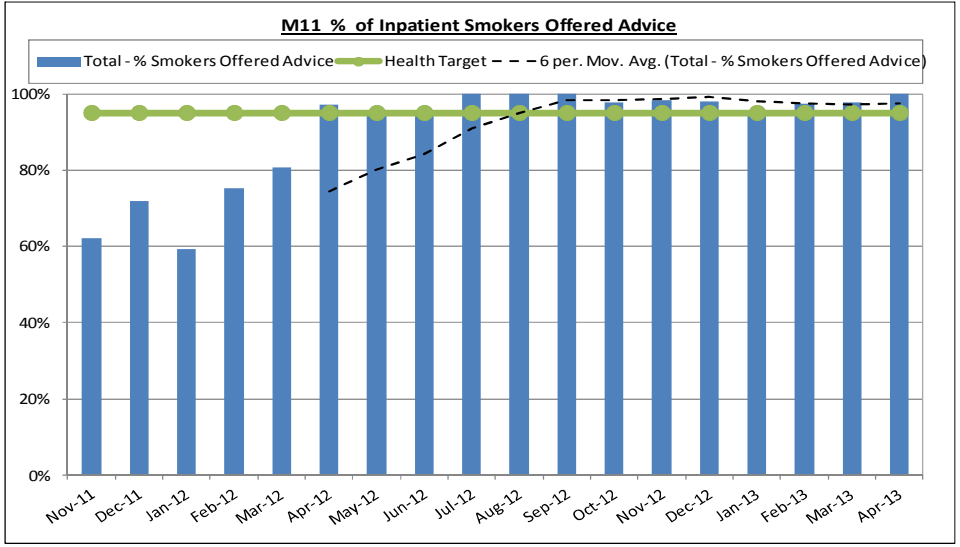
•Monitor waiting times for radiotherapy in both Mid-Central and Capital & Coast Treatment Centres through current quarterly reporting processes.

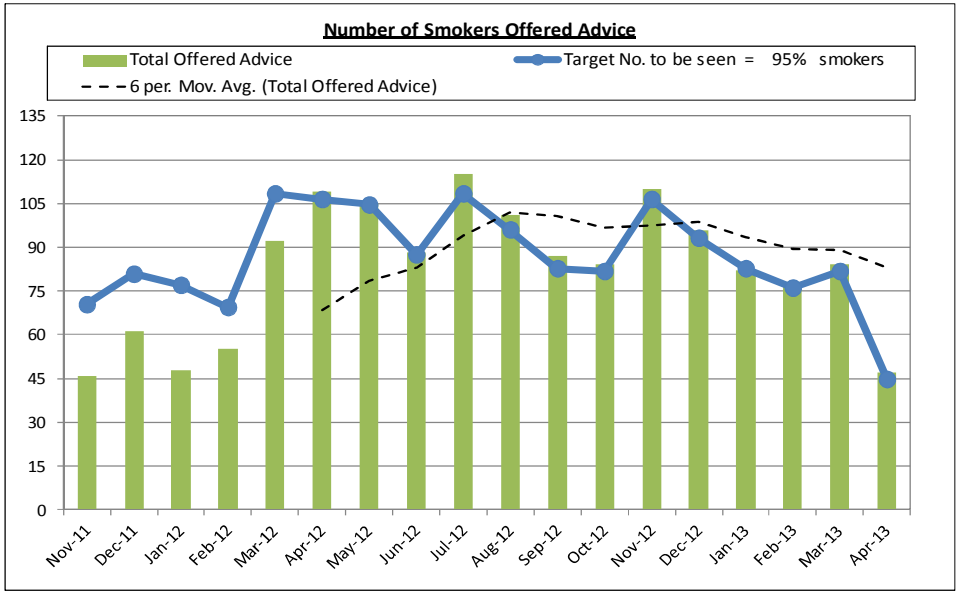
•Participate in CRRN project for implementing the Faster Cancer Treatment indicators.

M11 Better help for smokers to quit

< 95% red, >=95% green

BSC Objective: P2 Patients as active participants
Objective Owner: To be advised
Measure Leader: Linda Spence





Description:

Better help for smokers to Quit – 90 percent of hospitalised smokers will be provided with advice and help to quit by July 2011 and 95 percent by July 2012. This is a MoH Health Target (HT5) and is based on 15+ year olds admitted with specific ICD10 codes.

This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers.

Potentially not all smokers admitted to the hospital are screened. The screened number of patients may not be reflective of smoking prevalence in the region.

Comment Actions:

SFC assisting WDHB Maternity Manager in gathering information for MOH Maternity Health Target.

Survey for staff who smoke has been developed with help from IT and WDHB communications. It is hoped that enough staff will be interested to form a WDHB Quit Group.

April 9 attended a presentation by ASPIRE Researchers on E Cigarettes as a smoking cessation aid and the effects of smoking in movies

Presented at the Joint Replacement Education session

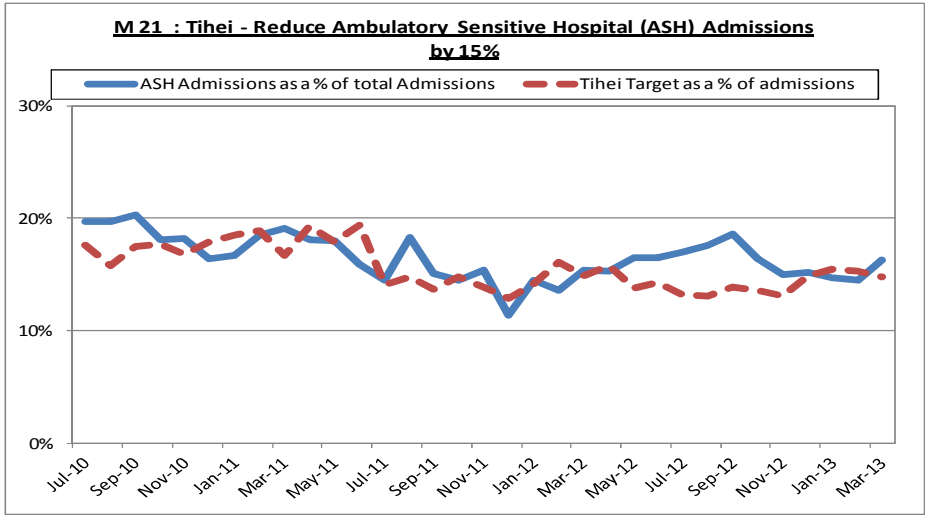
Continue work in hospital supporting cessation in wards and on discharge.

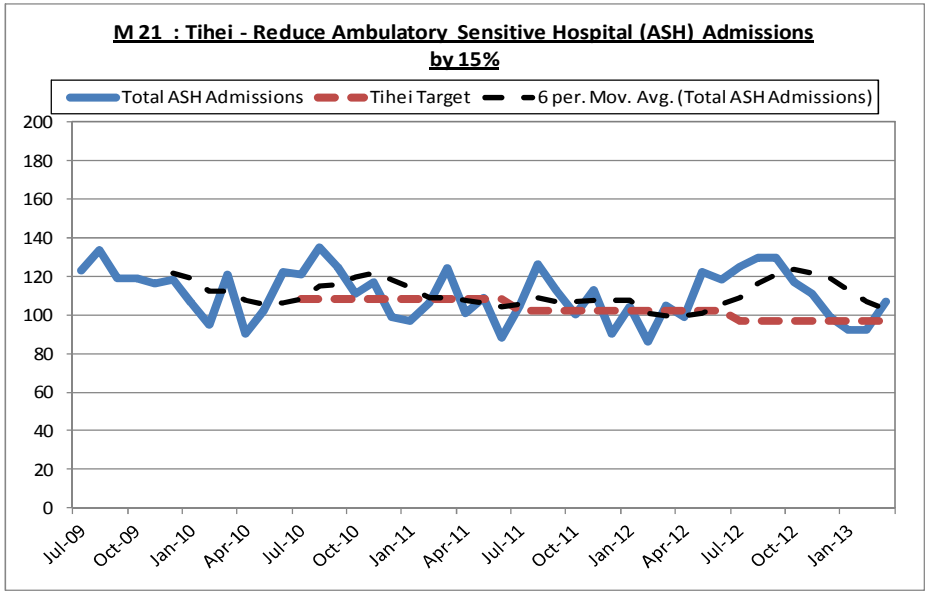
Collective planning for World Smokefree Day May 31 underway.

M21 Ambulatory sensitive (avoidable) admissions

< = target green,, > 10% of target red

BSC Objective:	**O1 Better, sooner, more convenient PHC**
Objective Owner:	**Alliance Leadership Team**
Measure Leader:	**Hospital Manager**





Description:

Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services , delivered in community settings , including through primary health care. They provide an indication of access to , and the effectiveness of , primary health care, as well as the management of the interface between the primary and secondary health sectors. They may also be indicative of the high number of elderly patients with complex chronic health needs currently residing in the community. 3 hour ED patients are being admitted again from 2011/12 which will inflate the numbers recorded as previously these patients had not been classified as admissions . For the purpose of comparisons across the years these have been removed.

Comment Actions:

Discussion underway about how reducing ASH admissions may be better managed as year 3 deliverables under Tihei. No further progress at this point in year.

Continued work programmes in place to address ASH admissions are EDHUG (ED High User Group), introduction of the guided care model, the cellulitis project and increased focus for CNS group where applicable.

Continues to be a decreasing trend across all measures and all age ranges.

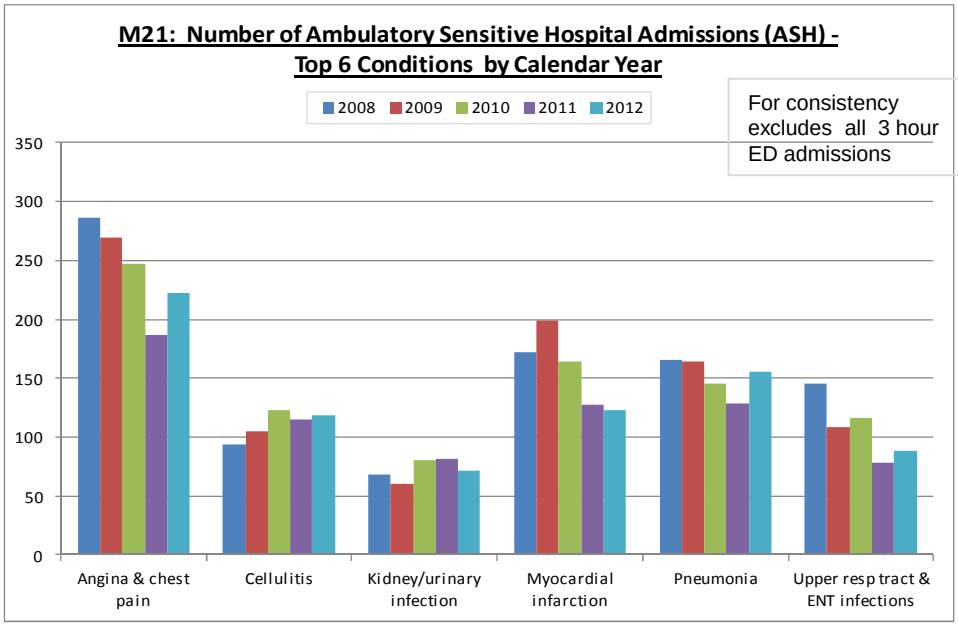
M21 **Ambulatory sensitive (avoidable) admissions**

< = target green, > target but within 10% orange, > 10% of target red

BSC Objective: O1 Better, sooner, more convenient PHC
Objective Owner: Alliance Leadership Team
Measure Leader: Hospital Manager

FiscalYear	ASH Admissions	Annual Reduction
09/10	1,365	
10/11	1,333	-2.3%
11/12	1,282	-3.8%
Since 09/10	- 83	-6.1%

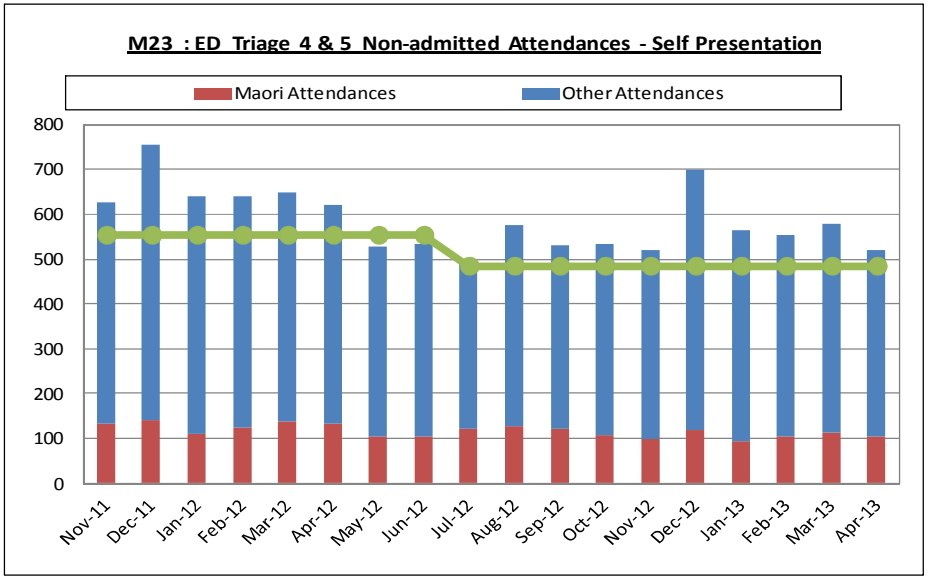
* excludes all 3 hour ED admissions

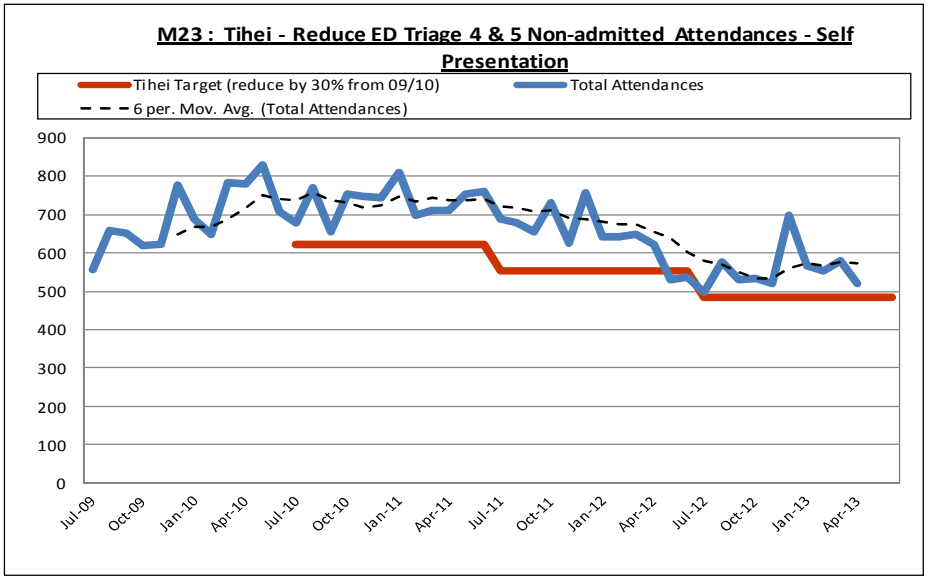


M23 Triage 4 & 5 non-admissions

< = Tihei target green, >Tihei target red

BSC Objective: O1 Better, sooner, more convenient PHC
Objective Owner: Alliance Leadership Team
Measure Leader: Michele Halford / Russel Clark





Description:

The number of non-admitted, triage 4 & 5 ,ED self presentation is growing. The target is to reduce these , from the total of 8,304 FY2009/10 by 30% , over the next 3 years. The Tihei targets are:

- FY2010/11 – 7,474 – actual result 8,775
- FY2011/12 – 6,644 – actual result 7,741
- FY2012/13 – 5,814- actual result YTD (April 13) 5,573

Issues:

Ease of access, efficient turn around in the Emergency Department and free public service are disincentives in encouraging patients with minor or less urgent health needs to access their GP. Information leaflets/ posters within the Department and in local newspapers provide a constant reminder for people accessing health services to utilise the most appropriate resource.

Comment Actions:

Through the implementation of clinical guidelines which include the disposition of patients to the most appropriate follow up has seen increased number of referrals to GPs for ongoing care.

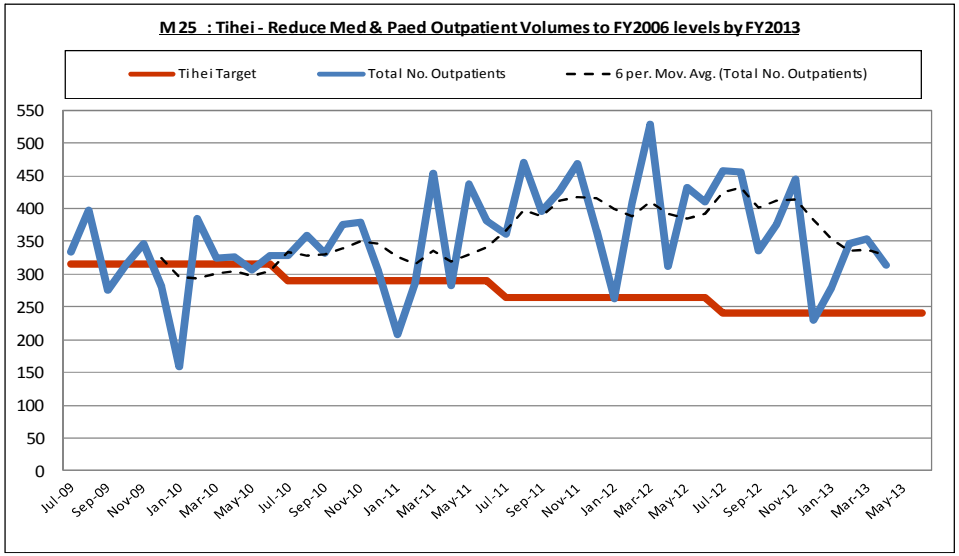
This includes: Orthopedic treatment guidelines, DVT treatment guidelines and IV antibiotic therapy for cellulitis (identified and resourced through Tihei)

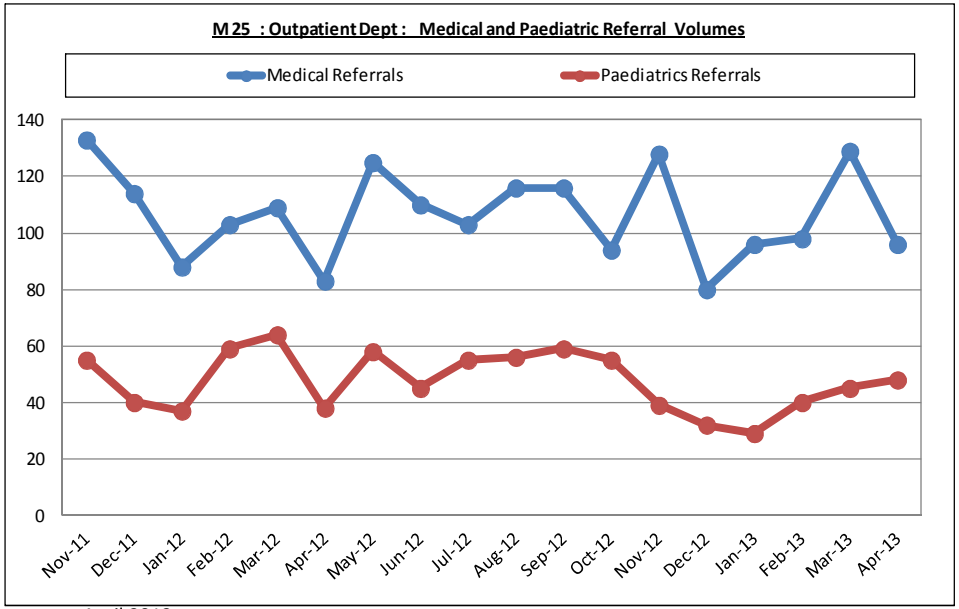
Significant social events for the Wairarapa, particularly during the Christmas/ New Year period, have had less of an impact due to their increased first-aid resources at the events.

M25 Reduce medical and paediatric outpatient volumes

< = Tihei target green, >Tihei target red

BSC Objective:	**O1**	**Better, sooner, more convenient PHC**
Objective Owner:		**Alliance Leadership Team**
Measure Leader:		**Hospital Manager**





Description:

Reduce Outpatient Department volumes, for medical and paediatric clinics to 2006 level over the next 3 years.

This will mean a reduction from 3,953 patients in 2009 back down to 2,913 by 2013.

The top graph includes first and follow-up appointments however the bottom graph only includes referrals in for a first appointment.

Comment Actions:

Referral data is being analysed by Long Term Conditions workgroup in Tihei .

There are no specific initiatives currently in place to address paediatric outpatient volumes.

Apart from the introduction of the guided care model there are no current initiatives in place to address medical outpatient volumes.

M33 Improved access to elective services

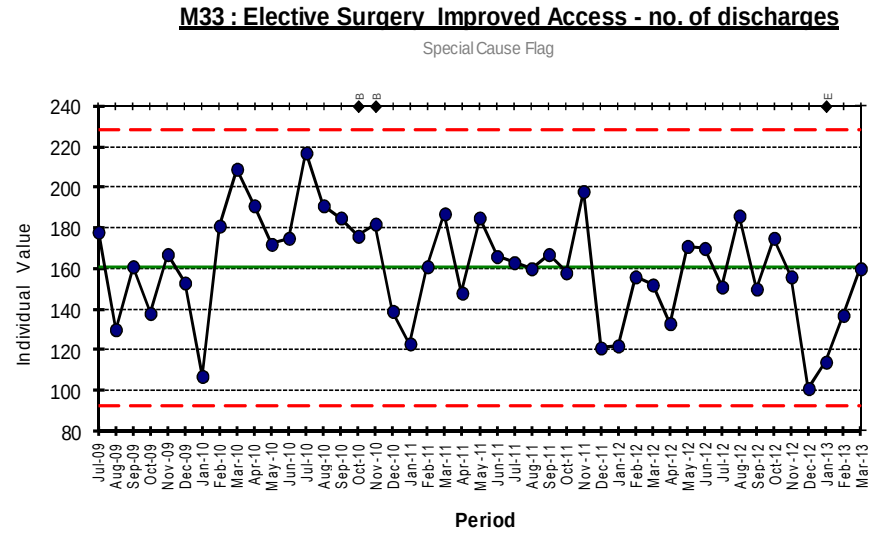
> = YTD target green, < YTD target red

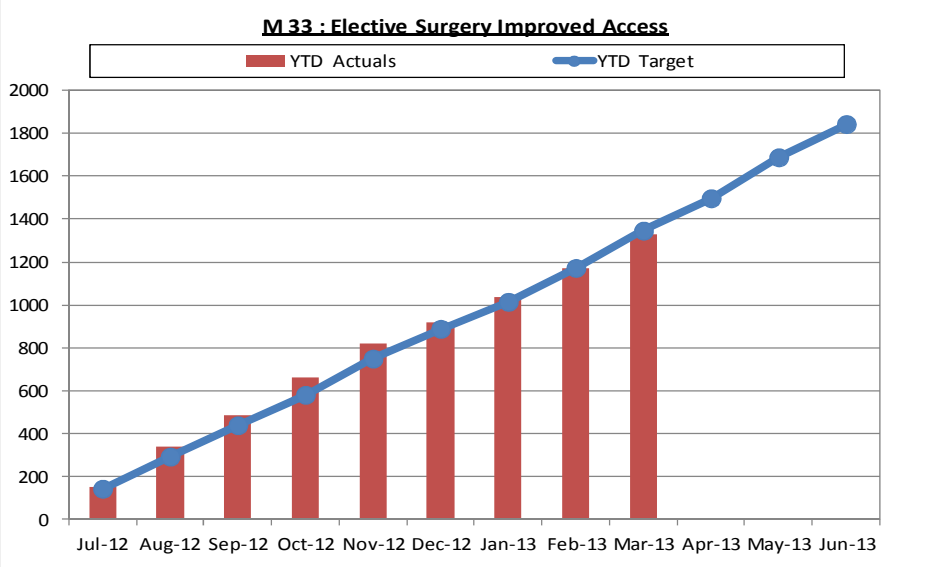
E. 2 of 3 Beyond 2 Sigma

BSC Objective: O2 Improve efficiency of clinical services

Objective Owner: Pete Chandler

Measure Leader: Sarah Boyes / Carolyn Braddock





Description:

Over the last 7 years the number of publicly funded elective surgical discharges rose by an average of 1,432 discharges per annum. This growth did not keep up with the population growth over the period.

The MoH has an expectation that the annual increase in elective surgical discharges will improve and the WRDHB's target is 1,841 discharges. This is a MoH Health Target (HT6).

Issues :

The MoH data is not refreshed until approximately 6 weeks after the end of the month.

Comment Actions:

Health Target unchanged for 2012/13 at 1,841 discharges.

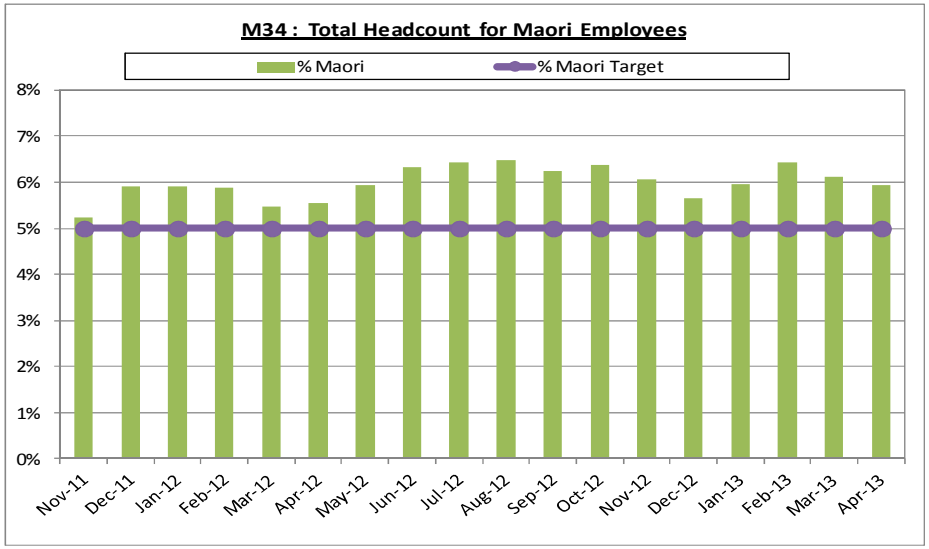
Results to March-13 Health Target is showing 1,330 discharges against a plan of 1,344, 14 surgical discharges behind plan year to date.

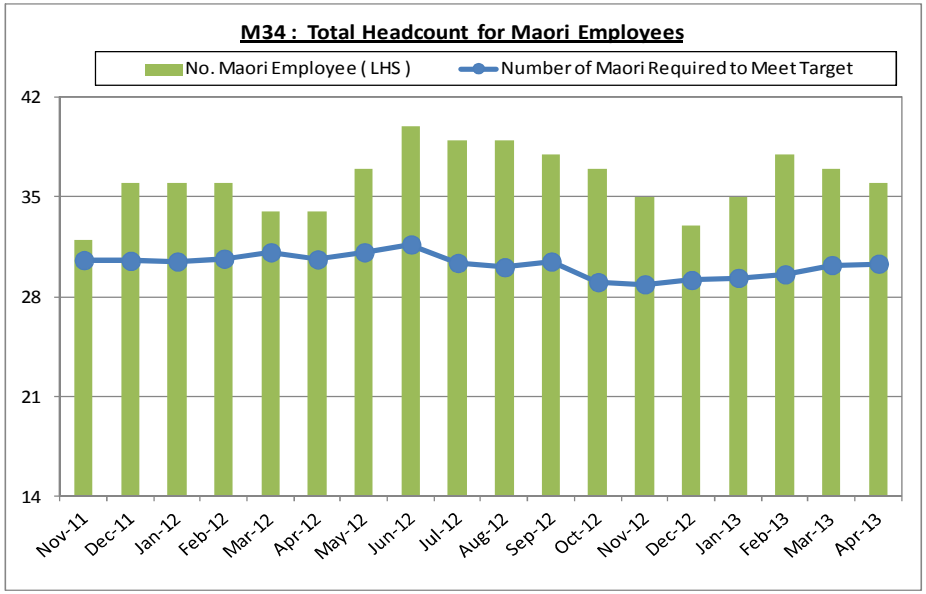
The health target was not achieved for quarter three – 14 discharges short at 99% partially achieved, but expectation of achieving the Health Target in quarter 4

M34 Employee headcount by ethnicity

> = target 5% green, < target red

BSC Objective: L I WDHB an employer of choice
Objective Owner: Gretchen Dean
Measure Leader: Gretchen Dean





Description:

The Maori Health Plan aims to increase the headcount for Maori to ensure Maori employed by the DHB meets or exceeds 5% during 2013.

Issues:

The % of Maori by headcount is currently exceeding the 5% target set in the Maori Health Plan. It is noted that a increase of 1 or 2 FTE does have a significant impact on the %.

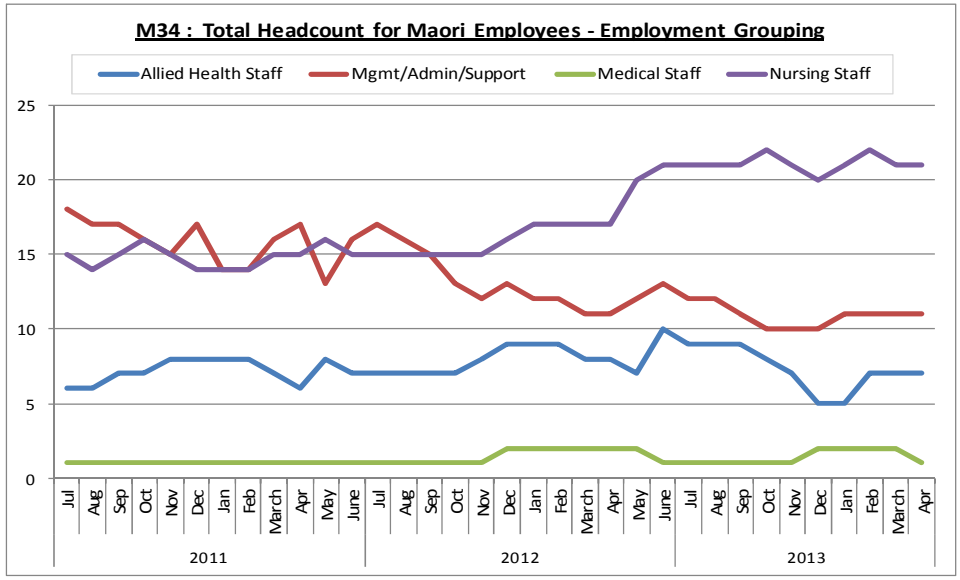
Implications:

Ensuring we have a workforce representative of our community enables us to provide more culturally appropriate health care. The trend in nursing is representative of the pro active models and effort placed on recruitment and retention of Maori via the Nursing Directorate and Maori Health Directorate.

M34 **Employee headcount by ethnicity**

> = target 5% green, < target red

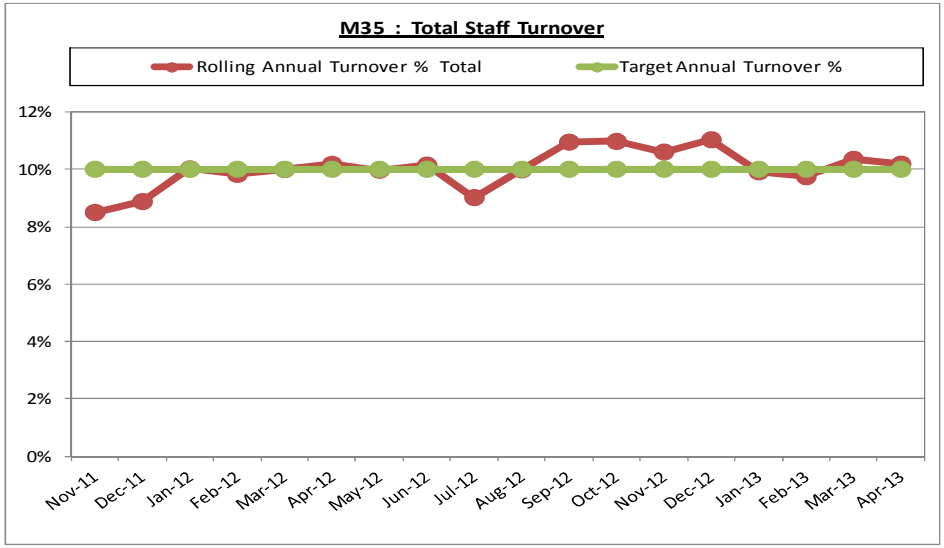
BSC Objective: L I WDHB an employer of choice
Objective Owner: Gretchen Dean
Measure Leader: Gretchen Dean

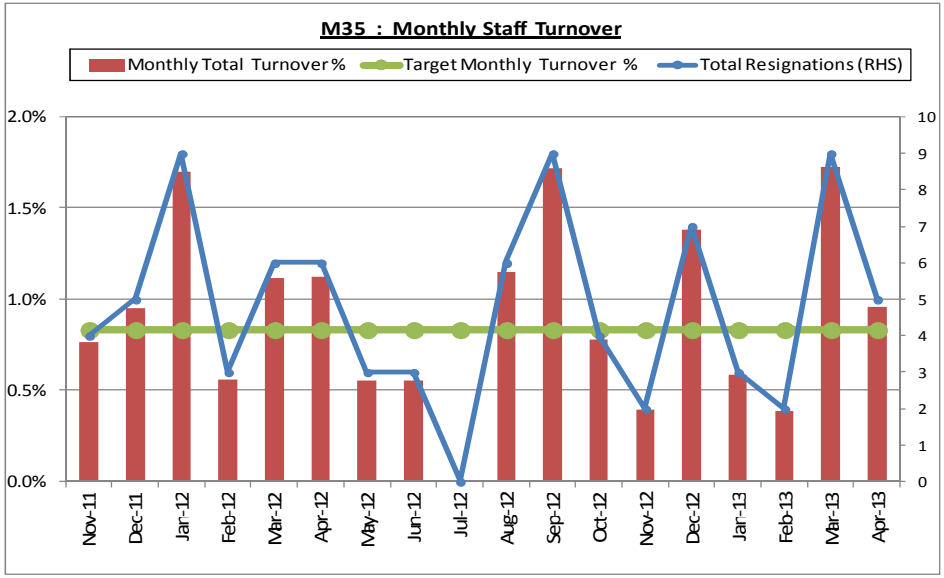


M35 Staff turnover

> = target 10% red, < target green

BSC Objective: L1 WDHB an employer of choice
Objective Owner: Gretchen Dean
Measure Leader: Gretchen Dean





Description:

Based on a rolling annual turnover for 12 months for voluntary resignations.

Addressing clinical workforce shortages, and developing clinical leadership, have been identified by the government as two key actions that will assist the sector to deliver improved health care delivery. This is a MoH ownership dimension measure (OS-01) and is reported quarterly.

Comment Actions:

It is expected that over a time of significant change, such as that involved in the integration of HVDHB and WaiDHB that turnover will increase. We will be monitoring turnover during this period.

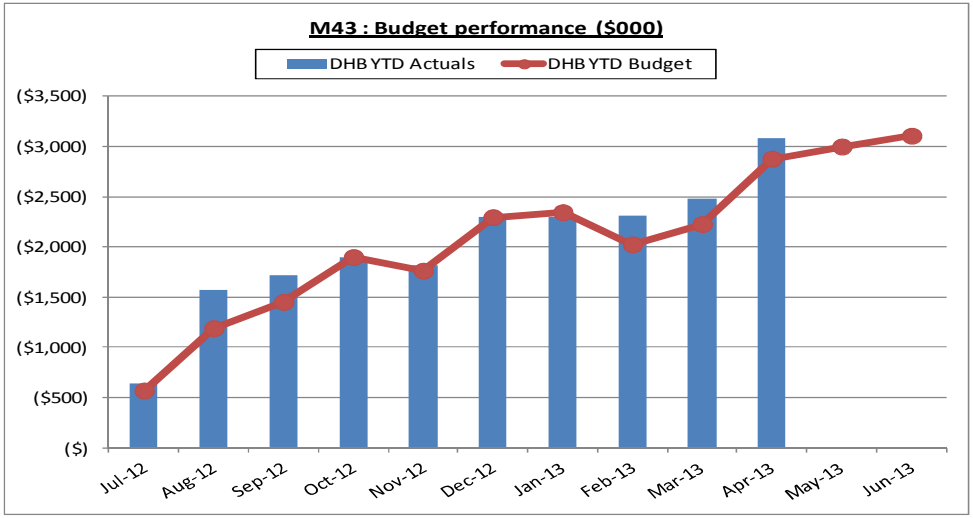
M43 Budget performance

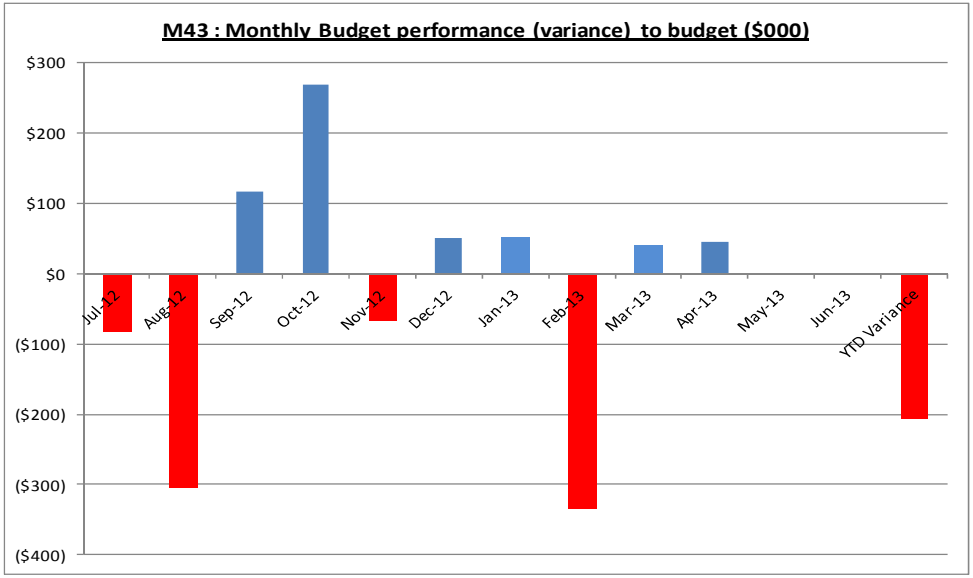
YTD Actuals < = budget green, > budget red

BSC Objective: F2 Maximise Revenue, Manage & contain cost growth

Objective Owner: Tania Harris

Measure Leader: Nick McGruddy





Description:

The DHB financial result YTD.

Comment Actions:

For the month of April Total DHB revenue is $195k favourable to budget, bringing the total YTD revenue to $1.936M favourable to budget. Total DHB expenditure is $149k adverse to budget, bringing the total YTD expenditure to $2.141M adverse to budget.

YTD net result is $205k adverse to budget.

Pease refer to the Board Financial Report for more detail.

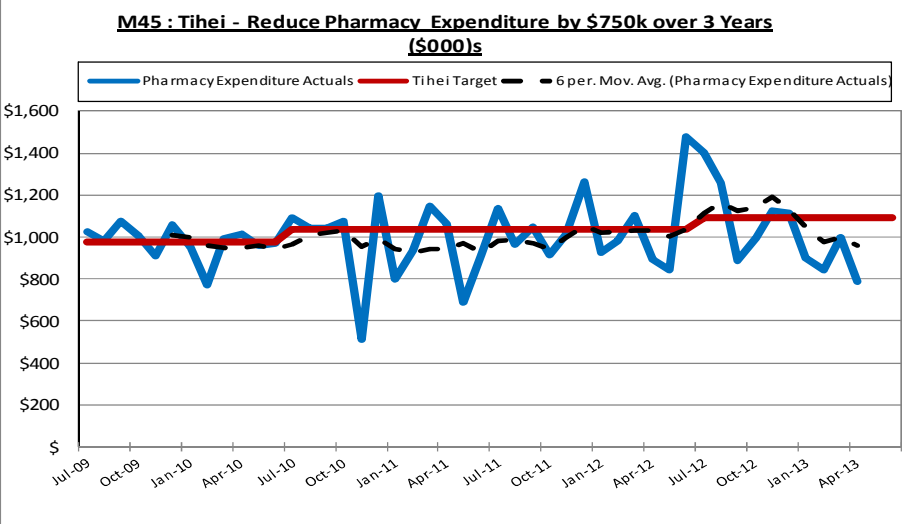
M45 Reduce Pharmacy spend

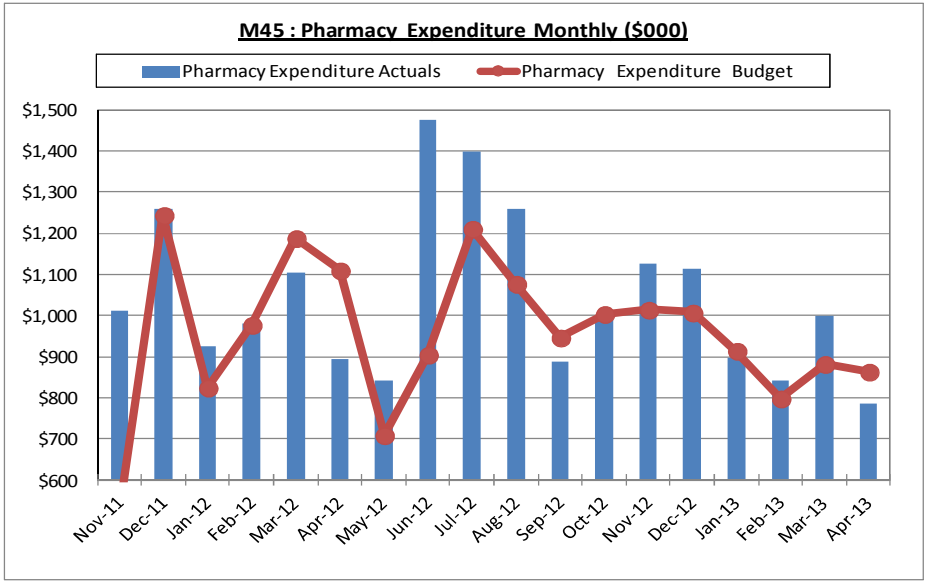
6 month mov. average < = Tihei target green, > Tihei target red

BSC Objective: F2 Maximise Revenue, Manage & contain cost growth

Objective Owner: Simon Everitt

Measure Leader: Nigel Broom





Description:

Contain current levels of growth in pharmacy expenditure.

Issues:

Pharmacy growth has been running at between 6% and 10% pa for the past 4 years.

Implications:

Pharmacy cost growth has been at a level that is significantly higher than annual revenue increases and was unsustainable into the future.

The new national pharmacy agreement has taken effect from 1 July 2012. It not only provides a more patient focused service model but also limits cost growth as it is funded within a fixed national funding envelope of $370.5m for 12/13.

The Optimed programme can also reduce pharmaceuticals costs if it results in either reduced waste or simply less drugs being prescribed per patient.

Monthly Comment :

The pharmacy spend was favourable to budget by $78k in April reducing the YTD unfavourable variance to $573k.

The YTD variance is partly due to vaccine costs for which we have received additional revenue of $382k for the year or $318k YTD. Much of the balance is as a result of the budgeted pharmacy efficiency target of $400k pa not being achieved (approx $333k YTD). Savings are expected to chrystallise as the new pharmacy contract is implemented and the proportion of fees paid via the transition payment mechanism decreases.

The rolling 6 month average remains below the Tihei target and is thus rated green indicating that the rate of expenditure growth in pharmaceuticals has declined compared to recent years.

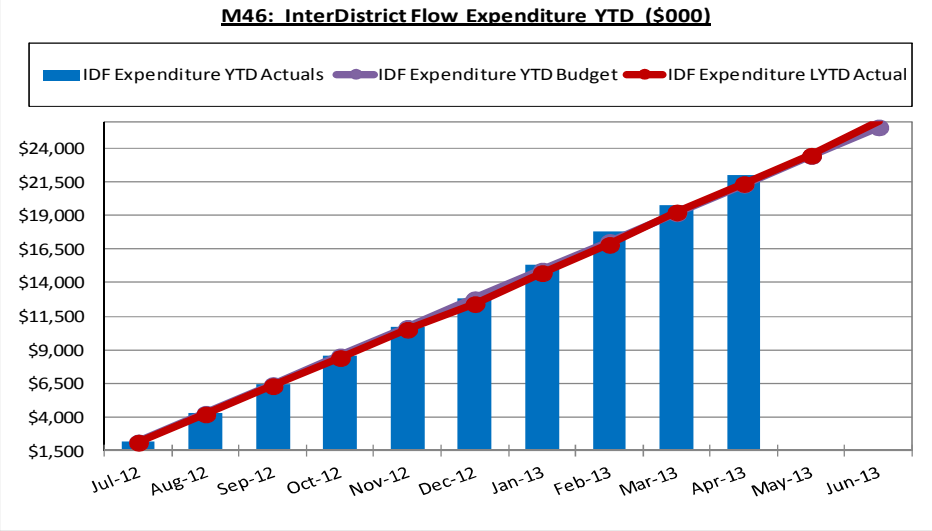
M46 Inter-district flows

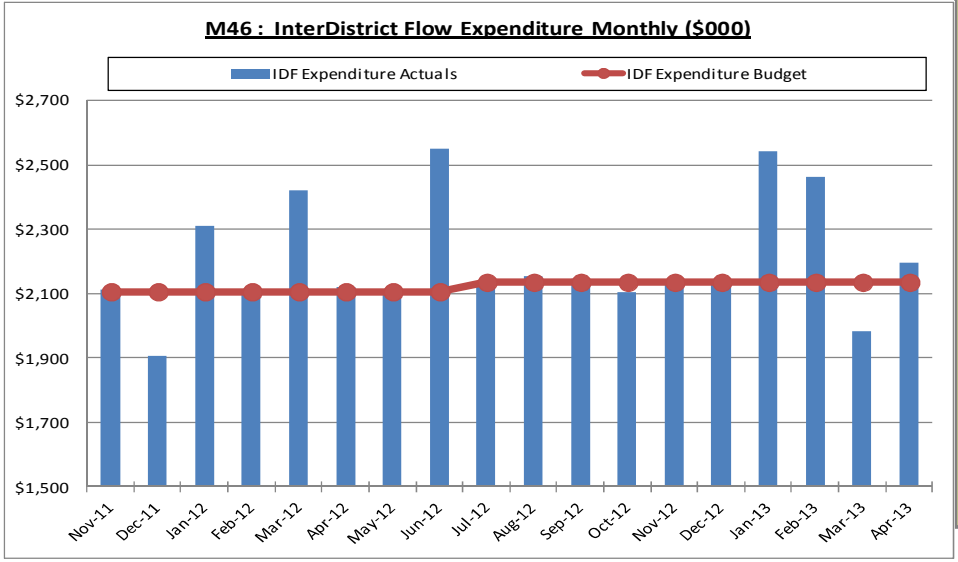
YTD Actuals < = budget green, > budget red

BSC Objective: F2 Maximise Revenue, Manage & contain cost growth

Objective Owner: Simon Everitt

Measure Leader: Nigel Broom





Description:

Contain IDF expenditure to within budgeted levels in 11/12.

Issues:

In recent years, IDF costs have been well in excess of budget (09/10 washup was $2.6m over budget)

Implications:

IDFs have posed a major financial risk to the DHB.

Actions:

We are actively engaging in regional and sub-regional service planning in an effort to deliver services in the most efficient way possible.

We have also undertaken General Surgery elective cases from Hutt DHB with patients travelling to Masterton for their procedures, thus increasing IDF inflows.

Comment :

IDFs are showing as $62k adverse for the month and now $647k adverse YTD. Our current washup provision is sitting at $637k and is made up of $388k for PCTs offset by a net positive washup accrual of $201k for inpatients ($198k fav) and outpatients ($3k). There is also a provision of $450k as contingency for movement in IDFs over the remaining two months of the year. As a result of this provision, the indicator remains red as we are over budget. It should also be noted that the budget included a savings target of $300k for repatriated IDFs which is currently being achieved.

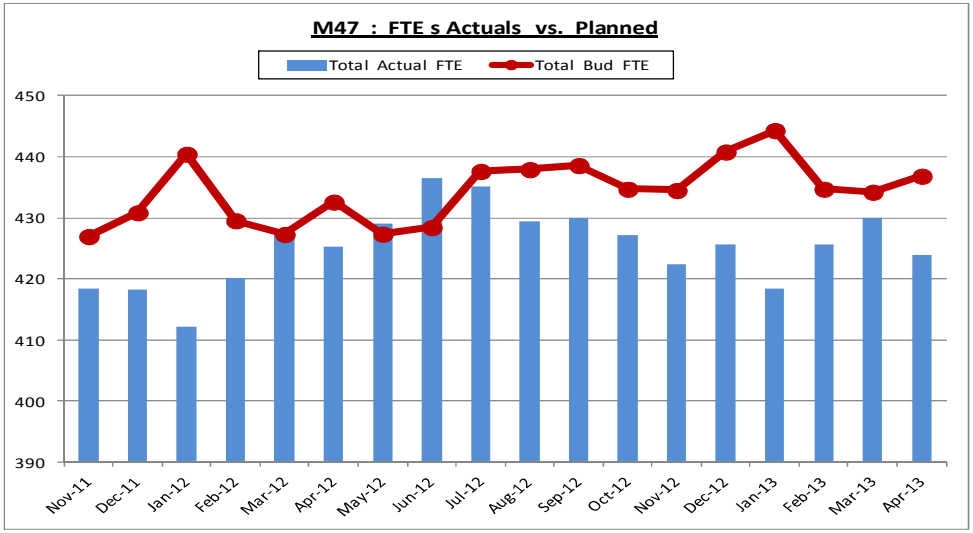
M47 FTEs Actual vs. planned

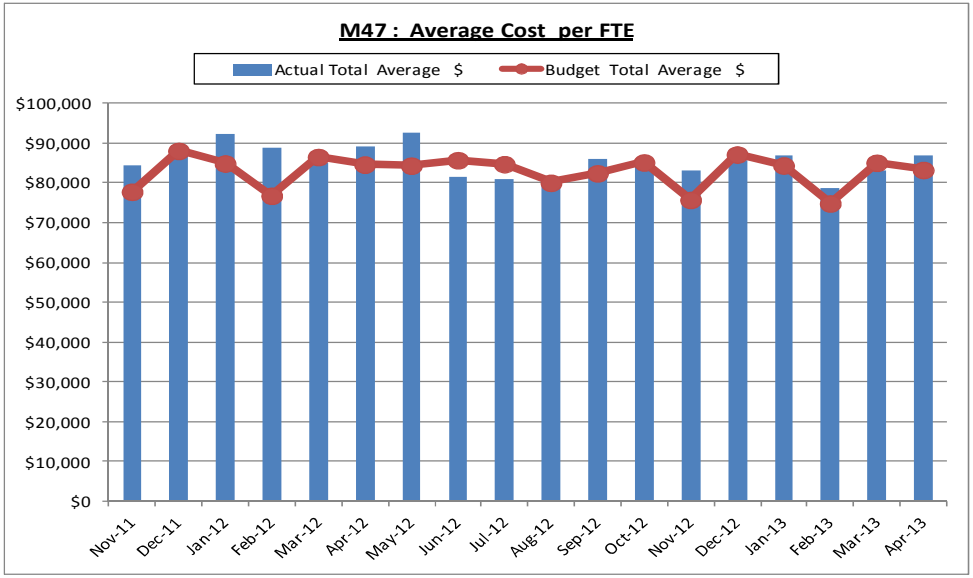
FTE & Average < budget green, either > budget orange, both > budget red

BSC Objective: F2 Maximise Revenue, Manage & contain cost growth

Objective Owner: Tania Harris

Measure Leader: Nick McGruddy





Description:

The actual number of fulltime equivalent employees against the budgeted numbers. (excludes Ambulance)

Comment Actions:

The budgeted FTE is 436.9 however the result for the month shows an actual of 423.9 a variance of 13.0FTE favourable.

The monthly actual cost per FTE at $86,819 is higher than the budgeted $83,351.

3DHB HSD
Health Services Development

Staff Forums
May 2013

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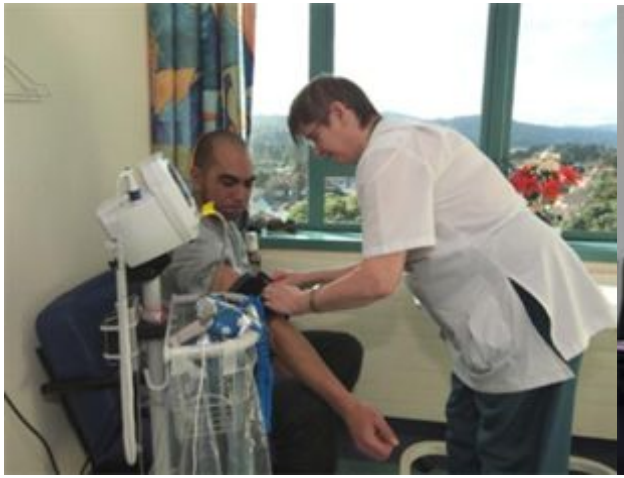

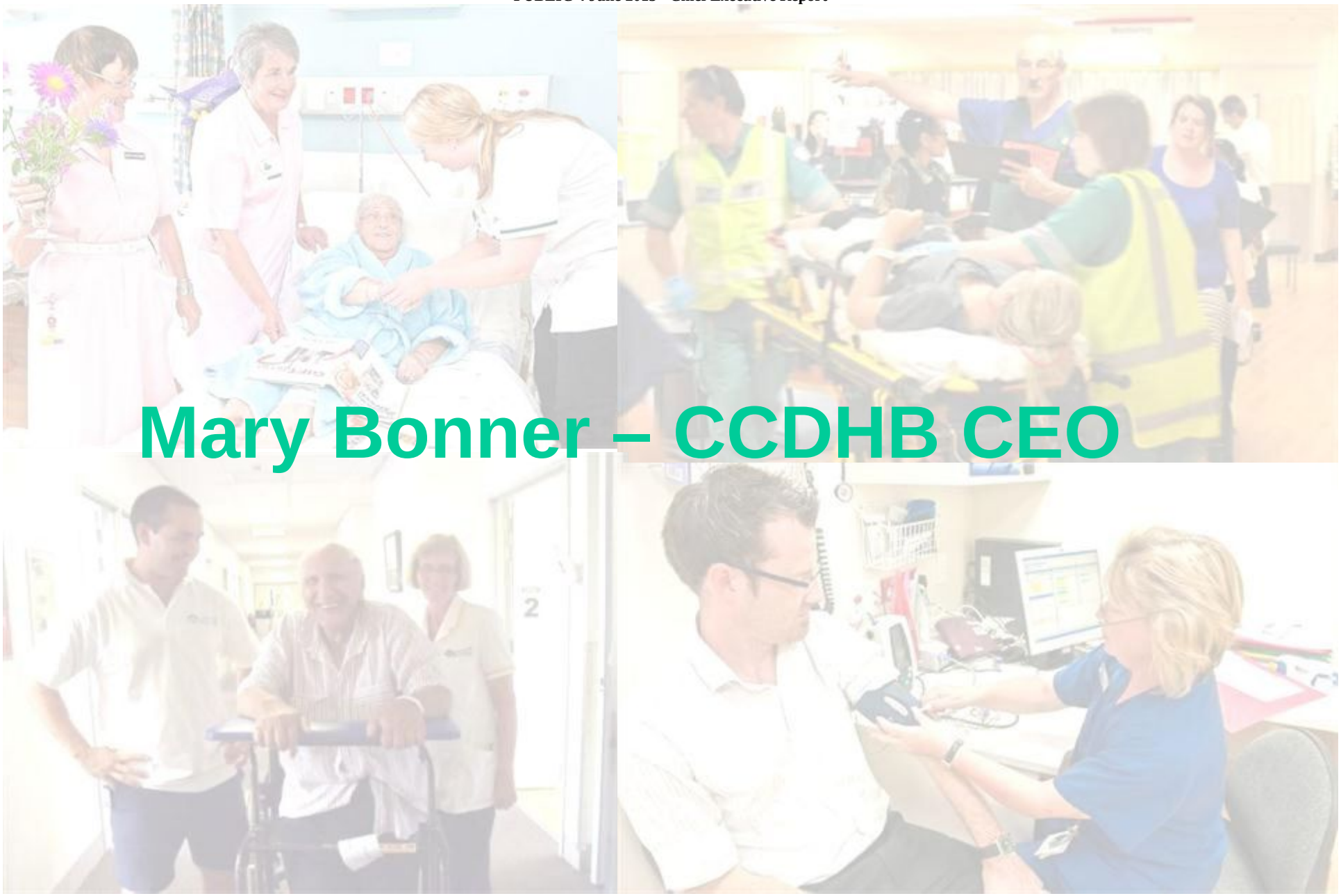

Mary Bonner – CCDHB CEO

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Vision

Improved health for our communities

through

integrated services across a single population

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Two Workstreams

Enabler

Examples include: SIDU, HR, ICT, Communications, Radiology, optimal facility use

Clinical

Examples include: ENT, Gastroentology, Orthopaedics and Child health

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Optimal Facility Use

All facilities required to meet projected future demand.

Royal Australasian College of Surgeons report recommended looking at elective/acute services.

Modelling work to look at possible options for:

- Tertiary services configuration
- Elective/acute split
- Strengthening role and sustainability of services at Wairarapa and Kenepuru

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Graham Dyer – CEO WDHB / HVDHB

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3DHB Partnership

Health and financial gains can be captured simultaneously through a joined-up approach to service delivery

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Working across the 2DHBs

- ELT amalgamation completed
- Rapid cycle improvement teams
- Management workforce partnership
- New ways of working with staff and unions

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2DHB Executive Leadership Team

CLINICAL

- **Iwona Stolarek ,** Chief Medical Officer
- **Russell Simpson**, Executive Director Allied Health Scientific and Technical
- **Helen Pocknall** Executive Director of Nursing and Midwifery

INTEGRATION

- **Ashley Bloomfield**, Director, SIDU, General Manager Pop Health (Acting)
- **Carolyn Cooper**, Executive Director, People and Culture
- Primary care, Maori and Pacific, ICT Communications

COPPORATE

- **Graham Dyer** Chief Executive
- **Pete Chandler** Chief Operating Officer
- **Tania Harris**, General Manager, Corporate Services (Acting)
- **Cate Tyrer** General Manager, Quality and Risk
- **Richard Schmidt** Executive Officer

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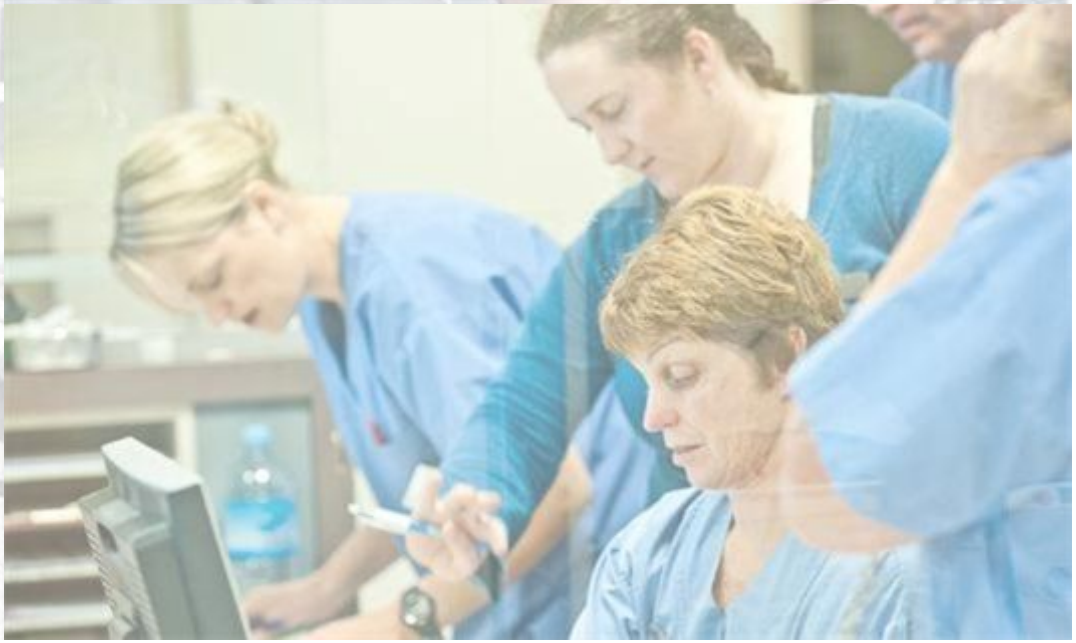
Where to next?

- Triple Aim
- More joined up services
- Maintain separate boards
- IS/ICT
- Radiology
- HBL

Iwona Stolarek – SRCLG



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SRCLG history

- Started 2010 by the CMOs to look at educational training and other opportunities
- Mid 2010 four clinical services were discussed as priority areas
- Ministerial expectations of collaboration
- Focus on quality of care and sustainable services
- MOU signed by Board Chairs 2012

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Sub Regional Clinical Leadership Group

SRCLG reports monthly through CPHAC and to the 3 Boards

The group is lead by CMO Iwona Stolarek and includes:

- CEOs - Graham Dyer and Mary Bonner
- COOS - Pete Chandler and Chris Lowry
- Directors of Allied Health, Nursing and Midwifery, CMOs
- Clinical Leaders and SMOs
- SIDU project leaders

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Projects underway

- ENT
- Gastroenterology
- Child Health
- Palliative Care
- Radiology

Case study - ENT

- Chosen as a vulnerable service because of workforce issues
- With the same model of care and
    - increasing referrals
    - inequitable access we needed more SMOs
- Needed to address issue of Registrar training

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ENT

Clinically led project to look at:

- best models of service provision
- best delivered services to joint populations
- best use of resources
- optimising our facility usage

Focus was on 7 parameters of quality

Some of the people at the table ...

- SMOs
- Allied health Audiology, Speech language
- RPH- ear van
- Primary care
- Maori and Pacific
- Nursing
- Management
- Planning and Funding
- GP liaison
- Project lead and project manager
- Nursing

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Outcomes and Learnings

- Complex tertiary level and the majority of acute work continues at Wellington Hospital
- Increased secondary level elective surgery for tonsils and grommets to help with unmet needs
- Increased day surgery rates
- Better involvement of Allied Health - voice clinic

Learnings

- IT, HR, funding are key enablers
- Concerto eTree was developed to look up notes in all 3 DHBs
- Computerised theatre notes introduced
- SMOs still have 3 emails, logins, swipes etc
- HR processes to support workforce moving around the sub region – working with Unions
- One stop shop for annual leave etc

Ashley Bloomfield - SIDU

Service Integration and Development Unit

- Single service across the 3DHB region
- Focus on service integration at local and sub-regional approach
- Work strongly driven by triple aim approach

Goals

PATIENT

Patient/Whanau centered care

Reduced risk of harm

POPULATION

Improve health outcome

Reduced health disparities

SYSTEM

Whole of health system approach

Best use of collective resources

Empowered workforce for joined up service

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ICC Work Programme

- Increase information flow between Primary/Secondary
- Clinical pathways
- Diabetes care improvement Plan
- Acute Demand and Afterhours
- Older Persons Initiatives
- Te Kahui
- Workforce initiatives
- Child Health

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Tihei Wairarapa Work Programme

- BSMC Business Case in place past three years
- Acute Demand, Long Term Conditions, Frail Elderly and Mental Health
- Shared Care Record used across hospital
- Two specialist mental health nurses working in primary care practices
- Reduction in Triage 4 & 5 presentations to ED
- Guided Care Model for the management of LTC

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PSSG Work Programme

- Increase information flow between primary/secondary
- Avoidable Hospitalisations (cellulitis, gastroenteritis, respiratory conditions)
- Diagnostics – Community Radiology
- Medications Management
- Better management of acute demand
- Primary Care sustainability
- Surgical Pathways

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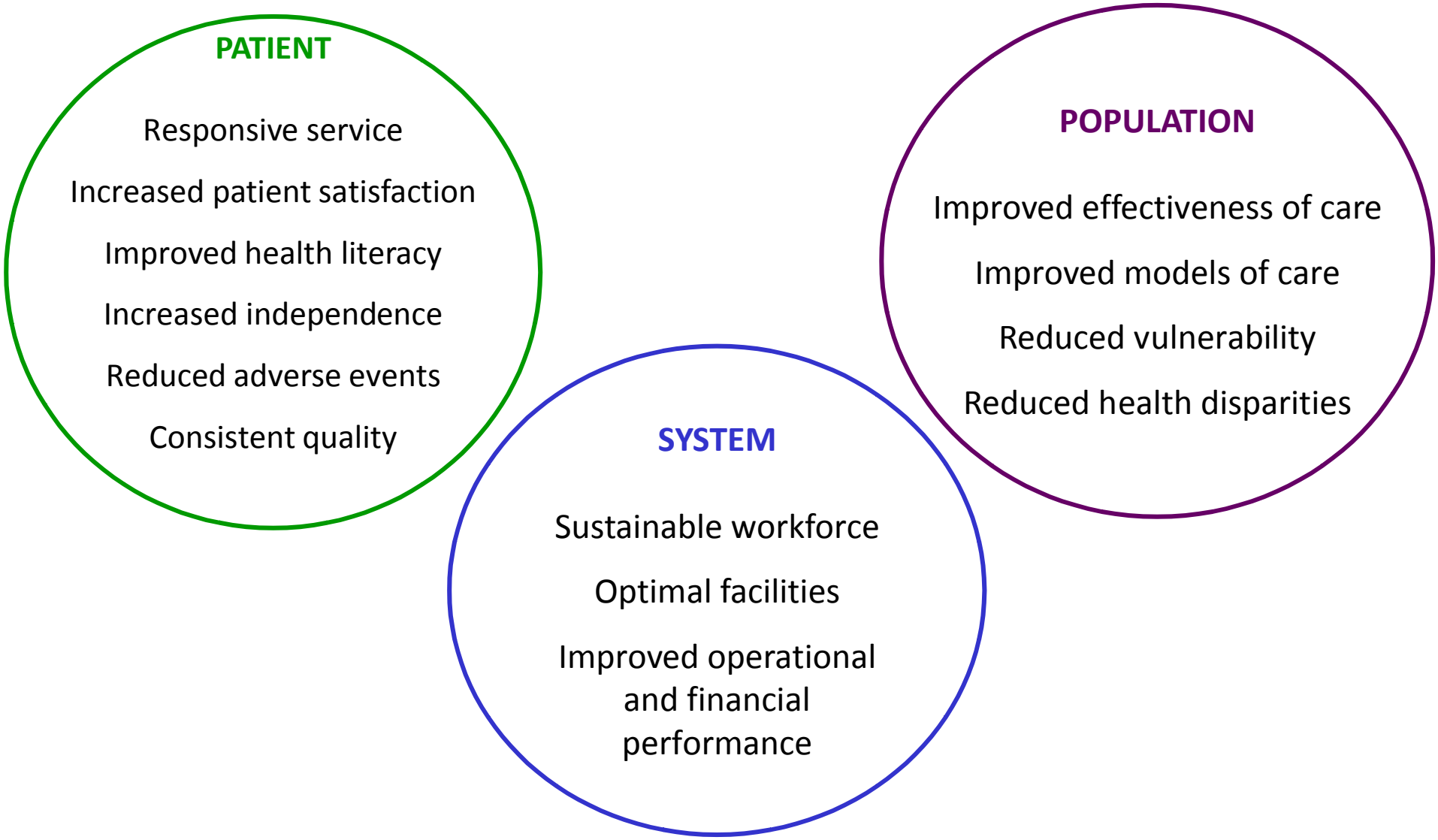
What will success look like?



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Appendix Two – Official Information Act Requests

<table>
<tr><th>OIA</th><th>Requestor</th><th>Date</th><th>Request/Response</th><th>Status</th></tr>
<tr><td>OIA 626</td><td>Alyson Kana
NZACA</td><td>07/03/13</td><td>Under the Official Information Act I request information regarding the people who have been assessed and are therefore eligible to receive aged residential care under the Aged Related Residential Care Services Agreement in your DHB. To be specific, I request the number of assessments and therefore the number of people aged over 65 who have become eligible and have entered into each individual aged residential care facility in your DHB by month for the 2012 calendar year.
Response:
Following discussion with Alyson Kana at NZACA and further clarification, we wish to resubmit our data for NZACA OIA request 626:
<table>
<tr><th colspan="13">Aged Residential Care Admissions 2012</th></tr>
<tr><th>Provider</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
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<tr><td>Kandahar</td><td>0</td><td>0</td><td>1</td><td>4</td><td>2</td><td>1</td><td>5</td><td>1</td><td>1</td><td>1</td><td>2</td><td>1</td></tr>
<tr><td>Arbor House</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>1</td><td>2</td><td>0</td><td>1</td><td>2</td><td>0</td><td>0</td></tr>
<tr><td>Greytown Lifecare</td><td>2</td><td>3</td><td>0</td><td>2</td><td>1</td><td>3</td><td>0</td><td>0</td><td>2</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Lansdowne Lifecare</td><td>1</td><td>2</td><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>1</td><td>0</td><td>1</td><td>0</td><td>1</td></tr>
<tr><td>Metlifecare</td><td>0</td><td>1</td><td>0</td><td>1</td><td>1</td><td>1</td><td>0</td><td>5</td><td>0</td><td>3</td><td>1</td><td>0</td></tr>
<tr><td>Roseneath</td><td>0</td><td>1</td><td>0</td><td>1</td><td>1</td><td>1</td><td>2</td><td>3</td><td>0</td><td>1</td><td>0</td><td>3</td></tr>
<tr><td>Glenwood</td><td>2</td><td>1</td><td>2</td><td>3</td><td>0</td><td>1</td><td>1</td><td>1</td><td>2</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td>Carter Court</td><td>3</td><td>0</td><td>0</td><td>2</td><td>0</td><td>0</td><td>2</td><td>3</td><td>1</td><td>1</td><td>1</td><td>0</td></tr>
<tr><td>Wharekaka</td><td>1</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td>1</td><td>1</td><td>0</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td>Aversham</td><td>1</td><td>1</td><td>1</td><td>0</td><td>1</td><td>0</td><td>2</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Lyndale</td><td>4</td><td>1</td><td>0</td><td>1</td><td>0</td><td>0</td><td>3</td><td>1</td><td>0</td><td>1</td><td>1</td><td>0</td></tr>
</table>
</td><td>Completed 15/03/2013</td></tr>
</table>

Appendix Two – Official Information Act Requests

<table>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Cornwall</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>3</td><td>1</td><td>0</td><td>2</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td>Lyndale Manor</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>2</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Lansdowne Park</td><td colspan="9">Opened October 2012</td><td>4</td><td>4</td><td>1</td></tr>
<tr><td>TOTAL</td><td>14</td><td>13</td><td>5</td><td>15</td><td>6</td><td>15</td><td>25</td><td>17</td><td>11</td><td>13</td><td>7</td><td>5</td></tr>
</table>
Note:
Data includes people entering care for the first time during 2012 and includes those who were assessed as eligible prior to 2012. It does not include changes in levels of care or transfers in from other areas.
</td><td></td></tr>
<tr><td>OIA 629</td><td>Lyndon Keene
ASMS Researcher</td><td>11/03/13</td><td>For work that I am undertaking for the Association of Salaried Medical Specialists, this is a request for the following data, please, under the Official Information Act:
The number of permanent full-time equivalent (FTE) surgeons employed by your DHB, by specialty, for each of the last five years.
The permanent head-counts of surgeons employed by your DHB, by specialty, for each of the last five years.
Response
In accordance with Section 18(d) of the OIA, we are refusing your request on the basis that the information requested will soon be publicly available. The information will be available by 30 April 2013 on the media page of the DHB Shared Services website (www.dhbsharedservices.health.nz).
If you have any further questions about this request please contact Mick Prior, Manager - Strategic Employment Relations, DHB Shared Services (mick.prior@dhbsharedservices.health.nz).</td><td>Completed 10/04/2013</td></tr>
<tr><td>OIA 630</td><td>Annette King
MP</td><td>19/03/13</td><td>1. What cuts or increases to funding have been made to home care and personal care services for the elderly in the 2011/12 and 2012/13 financial years, including the amount and aspect affected?
<table>
<tr><th></th><th>Change between 2011/12</th><th>Change between 2012/13</th></tr>
<tr><td>Home Care</td><td>-$45,733</td><td>-$103,000</td></tr>
</table>
</td><td>Completed 16/04/2013</td></tr>
</table>

Appendix Two – Official Information Act Requests

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>
<table>
<tr><td>Personal Care</td><td>+$436,032</td><td>+$13,000</td></tr>
<tr><td>Total</td><td>+$390,299 (Increase)</td><td>-$90,000 (Decrease)</td></tr>
</table>
2. What was the total amount of funding allocated for home care and personal care services for the elderly in the 2011/12 and 2012/13 financial years?
<table>
<tr><th>Financial Year</th><th>Budget</th><th>Forecast/Actuals</th></tr>
<tr><td>2011/12</td><td>$2,400,000</td><td>$2,221,554 (Actuals)</td></tr>
<tr><td>2012/13</td><td>$2,310,000</td><td>$2,232,313 (Forecast)</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>OIA 631</td>
<td>Debra Williams
CASPER</td>
<td>19/03/13</td>
<td>This is an OIA request for the purpose of gathering national Suicide information to analyze.
Can I please have a copy of your current protocol for all types of attempted Suicide?
Also your emergency response protocol to all types of attempted Suicides?
This includes methods of care, treatments, interventions and medical procedures.
Response:
Please find attached our protocol ‘People Presenting at Wairarapa DHB Emergency Department with Self Harm or Attempted Suicide’.</td>
<td>Completed 16/04/2013</td>
</tr>
</table>

Appendix Two – Official Information Act Requests

People Presenting at WDHB Emergency Department with Self Harm or Attempted Suicide 2011

Process

Patient and family, whanau, friends presents to ED
Privacy considered

⬇

ED Triage determines ISH/AS status and medical treatment requirements
Privacy is maintained

⬇

ED Administration – File & Galen checked for MH contact status.
Contact phones/address is gained from the patient and support people.

⬇

Maori Health Unit /other support people are contacted where indicated

⬇

ED contact **MH Duty Clinician** to inform of admission and plan MH assessment (with 1 hour target)

⬇

Standards

Access:

- People presenting at ED require privacy in order to talk about what has happened
- Family, whanau, friends will be included as part of the patient's support system
- Patient and family, whanau, friends will be informed of all ED/MH processes.
- Maori have access to appropriate support people - ED contact Maori Health Unit/ AH contact for cultural support.

Assessment

- ED staff will check to ensure that current patient/family/friend contact phone numbers and addresses are recorded in the clinical file.
- All people presenting with ISH/AS will have a MH assessment before discharge from ED. This will occur within 1 hour of triage determining ISH/AS (or as soon as patient is responsive – able to communicate with ED/MH clinicians).

Appendix Two – Official Information Act Requests

			Private room/area is used –for assessment. MH assessment findings and treatment plan are recorded in the ED file (MH Stickie on page) ⬇ ED and MH clearance for discharge from ED occurs ⬇ The "What Happens Next" brochure / Support Plan is developed and given to patient and support people by MH Clinician Copied to ED/MH files by MH clinician ⬇ ED send electronic discharge letter to GP within 24hrs ⬇ MH clinician follows up on planned contact ⬇ MH clinician informs GP of outcome of any planned contact	• Patient and family, whanau, friends are involved and informed of the assessment findings and treatment plan • Family, whanau, friends are provided an opportunity to gain an understanding of ISH/AS prevention support strategies **Discharge** • Where admission to inpatient medical ward occurs referral to MHS will be made if required • All patients being discharged from ED will have a What Happens Next Support Plan in place for the next 48 hrs and will be followed up by MH clinician • The patient and family, whanau, friends will know what is happening following discharge. (Copy of What Happens Next Plan) • GP is informed of their patient's discharge/event within 24 hrs (includes follow up process). Copy in ED notes **Follow-up** • All people discharged with a follow-up plan will be contacted by a MHS clinician. (Client can record appt time on What Happens Next brochure) • GP is informed (letter) of outcome of planned contact with patient • GP follow-up	
OIA 632	Annette King MP	03/04/13	How many patients on surgical waiting lists does the DHB currently have under Active Review, and how does this compare to the numbers in 2008,2009,2010,2011 and 2012. Response: Wairarapa District Health Board does not currently have any surgical patients under Active Review, and there have been no surgical patients under Active Review for the past five years.	Completed 30/04/2013

Appendix Two – Official Information Act Requests

OIA 633	Kena Duignan	11/04/13	1. Please provide the results of your last reported patient catering satisfaction surveys. If there is commercially sensitive information in them feel free to remove but still provide the survey results. *In the January 2013 survey, 65% of patients had their expectations met and 28% had their expectations exceeded in response to overall satisfaction with food and food service.* 2. Do you collect food waste data from patient catering? If so, please provide that data. *No* 3. Is your DHB intending to take part in the joint catering contract that will result from Health Benefits Limited's current review? *HBL process continues and no decision has been made at this point.* 4. What is your current catering system? i.e. is it cook-chill, cook-freeze, or prepared fresh? *Prepared fresh.* 5. What is the annual dollar value of your patient catering contract? *Commercially sensitive.* 6 Do you have any sustainability clauses in the contract? Including but not limited to: waste, transport, local sourcing, ethical purchasing, and animal welfare. If so please provide copies of them. *No* 7. Do you have any nutrition and/or quality clauses in your patient catering contract? If so please provide copies of them *We would note that HBL, as part of the work it is doing, is working very closely with DHB dieticians and has agreed with the sector a set of national diet codes that will be part of any options evaluation. This is the first time such national standards have been agreed.*	Completed 01/05/2013
OIA 634	Annette King MP	15/04/13	1. What is the DHBs current waiting time for MRI Scans? *Urgent MRI scans are scanned and reported between two – twenty four hours from the request being received.* *Routine MRI scans between 75% and 80% of scans are scanned and reported within six weeks of the*	Completed 01/05/2013

Appendix Two – Official Information Act Requests

			request being received. 2. What is the DHBs current waiting time for Ultra Sounds? *Acute and emergency scans are scanned and reported within two – twenty four hours.* *Urgent Ultra Sound scans are scanned and reported between two – seven days from the request being received.* *All routine Ultra Sound scans are scanned and reported within eight - twelve weeks of the request being received.*	
OIA 635	Annette King MP	15/04/13	What are the estimated saving the DHB expects to make in the 2013/2014 and 2014/2015 financial years as a result of the HBL proposal to centralise patients meal provisions? This request was transferred to Health Benefits Limited.	Transferred to HBL 16/04/2013
OIA 636	Bronwyn Torrie Dominion Post	15/04/13	There has only been one case of an incident of social media. - When the incident occurred*: 2011* - What the incident was: *The incident involved inappropriate discussion and photos of a medical nature being placed on a personal face book page.* - Who was involved in the incident: *We are unable to provide neither the profession nor the position of the staff member as it will identify the individual.* - What action was taken against the staff member? *The individual was provided with a warning.* - Whether an apology or payment was made to any patients involved? *No.* Wairarapa DHB does not have any specific guidelines in relation to social media however we set our expectations of employ conduct in our Code of Conduct and we also have a robust Privacy policy which refers to appropriate use of medical and personal information. We do discuss social media and the appropriate use of social media sites in our employee orientation.	Completed 01/05/2013

Appendix Two – Official Information Act Requests

<table>
<tr>
<td>OIA 637</td>
<td>Sue Moroney
Labour MP</td>
<td>18/04/2013</td>
<td>1. What clinical trials are taking place currently in your DHB for cancer patients?
2. What is the process for inviting patients tp participate in those clinical trials?
3. Does your DHB assess patients suitability for these clinical trials prior to gaining the patients informed consent, prior to enrolling them in a clinical trial?
4. What is your DHBs protocol for enrolling patients in clinical trials?
Response:
Wairarapa DHB does not conduct clinical trials for cancer patients.</td>
<td>Completed 22/04/2013</td>
</tr>
<tr>
<td>OIA 638</td>
<td>Alyson Kana
NZ Age Care</td>
<td>22/04/2013</td>
<td>Under the Official Information Act (OIA) I request by month for each of the months of January 2012, February 2012, March 2012, January 2013, February 2013 and March 2013 the total number of people aged over 65 in your DHB who:
1. were referred for a NASC assessment,
2. assessed as at risk of requiring long-term residential care, and
3. entered into aged residential care.
Wairarapa District Health Board
<table>
<tr><th></th><th>Jan-12</th><th>Feb-12</th><th>Mar-12</th><th>Jan-13</th><th>Feb-13</th><th>Mar-13</th></tr>
<tr><td>Referred for NASC assessment</td><td>31</td><td>46</td><td>38</td><td>31</td><td>34</td><td>30</td></tr>
<tr><td>Assed as at risk of requiring long-term residential care**</td><td>24</td><td>33</td><td>22</td><td>16</td><td>17</td><td>18</td></tr>
<tr><td>Entered into aged residential care***</td><td>14</td><td>13</td><td>5</td><td>15</td><td>16</td><td>11</td></tr>
</table>
</td>
<td>Completed 09/05/2013</td>
</tr>
</table>

Appendix Two – Official Information Act Requests

OIA 639	Clint Smith	23/04/13	This is an OIA request for the following information: • A list of instances where your organisation has commissioned public opinion research or market research since November 2008, including but not limited to polls and focus groups. This list should include the dates during which the research was carried out, the type of research, its cost to your organisation, and the name of the organisation commissioned to carry it out in each instance. • The results of piece of research in the list above. • Your organisation's total expenditure on public opinion research and market research for each financial year beginning with 2008/09 to the present. Most of Wairarapa District Health Board feedback is done by way of satisfaction surveys, targeted service evaluation and consumer engagement into the service development or projects. There is no centralised repository for such information in a small DHB such as ours, it is very ad hoc and needs driven. Response: We have in the past had consumer focus groups for Maori engagement and service delivery, and also for Maternity services. To pull the data together would be a huge challenge, very time consuming, therefore very costly, hence I am declining your request under Section 18(f) of the Official Information Act 1982. Under Section 28(3) of the Official Information Act you have the right to contact an Ombudsman to review this decision.	Completed 17/05/2013
OIA 640	Chloe Johnson Herald on Sunday	30/04/13	1. Please provide the amounts of prescription-only pharmaceuticals which have been unaccountably taken from the District Health Board's stocks from January 2008 to present, i.e. it has gone missing. Please break down into name of medication, volume and year. 2. Also, please provide the number of missing medical supplies, including but not limited to devices, across all of the District Health Board from January 2008 to present. Please break down into name of device, volume and year. The information sought in this request is to be used as part of a report by the Herald on Sunday into the use of prescription pharmaceuticals in New Zealand. As the information will be used to ensure a greater understanding and appreciation of the District Health Board, I ask that any fee is waived.	In Progress

Appendix Two – Official Information Act Requests

OIA 641	Nicole Mathewson The Press	30/04/13	1. How many people are currently on the waiting list for each surgery speciality? (i.e. neurosurgery list, orthopaedic surgery list) 2. How many people have had to wait: a) longer than six months for elective surgery during the last two years? b) longer than five months for elective surgery during the last two years? c) longer than four months for elective surgery during the last two years? 3. How many people have been referred by a GP in the last two years to their DHB for a first specialist assessment and have not been allowed to have one? 4. how many people have been seen at a specialist assessment and recommended for surgery and then did not get onto a waiting list or were added to a waiting list and subsequently removed from it before their surgery was done? 5. Would the DHB support a community-based survey being carried out to find out how many people in the community have had a need for, and could have benefited from, elective surgery, but who might not have been seen by a GP or other relevant health professional? And why or why not? 6. What is the DHB's view on the maximum waiting time for elective surgeries being reduced to five months in June and how is this expected to affect the general public?	In Progress
OIA 642	Kris Faafoi MP	03/05/13	What cuts or increases to funding have been made to home care and personal care services for the elderly in the 2009/10, 2010/2011 financial years? What was the total amount of funding allocated for home care and personal care services for the elderly in the 2009/2010, 22010/2011 years?	In Progress
OIA 643	Hazel Armstrong Law, Barristers & Solicitors	17/05/13	What Audiological services does your DHB provide for adults and paediatrics? How many audiological tests were provided/funded in the last financial year? In the last financial year what was the expenditure on Audiological tests, and The source of funding for Audiological tests i.e. MoH, ACC, DHB? In the last financial year, how many patients were seen for Audiological services? Please place into	In progress

Appendix Two – Official Information Act Requests

			categories: adult/children, diagnostic/rehab, ENT. In the last financial year, what was the waiting time by category for adult and paediatric services? In the last financial year, did the DHB part charge for any devices or services (i.e. mark up on hearing aids or a fitting fee)? If so, please describe by category for adults/paediatric? If so, what was the total revenue obtained? In the last financial year, did the DHB provide Audiological services by full members of the NZAS ie audiologists? If not, what are the qualifications of those persons providing Audiological services within the DHB? Are MoH funding and subsidies accessed by full members of the NZAS? Does your DHB contract out (full or part service) to a private clinic? If so, what services do they provide? Does the private clinic employ full members of the NZAS to provide services on behalf of DHB patients? Does your DHB provide audiological services for UNHSEIP?	

PUBLIC EXCLUDED

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**FRAC INFORMATION PAPER** **Date:** 17 May 2013
Author	Richard Schmidt, Executive Officer
Subject	**CPHAC and DSAC: Fees for Committee Members**

RECOMMENDATION

That the Board:

a. **AGREE** to pay for the combined meetings on an equitable basis as the members are spending a little more time and focusing on matters relating to both CPHAC and DSAC. If this principle is applied to members, they will be remunerated at the rate of $350 per meeting to a maximum of $3,500 per annum. If this principle is applied to the Chair's remuneration this will amount to $437.50 per meeting to a maximum of $4,375 per annum.
b. **AGREE** that the sum of $350 be shared by the three DHBs if they meet at the same time.
c. RECOMMEND the Board Secretaries finalise the practicalities of implementing the payment schedules
d. AGREE that none of this paper will be released into the public forum as it contains legal advice
e. NOTE that final advice from State Services Commission regarding this approach is yet to be received, and that if changes to the proposed approach are required, the matter will be returned to FRAC.

1 PURPOSE

To finalise how committee members should be paid in light of the fact that there are no longer separate DSAC meetings and separate CPHAC meetings and that they are now held at the same time.

2 BACKGROUND

The law relating to payments should be guided by the provisions in the Board manual and the Cabinet Fees Framework Circular (CO) (12)6.

Clause 91 of the Fees Framework states that Committee members receive $2,500 a year on the basis that they have 10 meetings. If they have less than 10 meetings then it is paid on a pro rata basis. In effect this means that a committee member of DSAC and CPHAC would be paid $250 for each meeting.

Last year DSAC sat four times in the year and CPHAC sat ten times in the year. CPHAC committee meetings went from 9 am to 12 noon, 10 times a year and DSAC committee meeting went from 1-3pm 4 times a year. Currently with the joint meetings they go on from 9am to 1pm.

As the fees framework envisages the committees operating separately, there is no clear guidance on what fee should be paid when the committees of more than one DHB sits together.

Under the previous system each DHB would have paid each member $250 x10 ($2,500) for CPHAC meetings and $250 x 4 ($1,000) for DSAC meetings. Therefore a person who was on both DSAC and CPHAC would been paid $3,500 if they attended all meetings of DSAC and CPHAC. This is on a pro rata basis $350 for each sitting.

PUBLIC EXCLUDED

Three payment options are suggested:

(a) Pay only one fee which is $250.
The risk here is that members could argue that they are actually dealing with matters relating to different statutory committees and that they are spending approximately an additional hour each time, as a result of the joint committees.

(b) Pay two fees which is $500.
This would however undermine a key purpose of the committees sitting together which is to get optimal benefits through regional collaboration.

(c) To pay $350 for the combined meetings on an equitable basis.
This would support that the members are spending a little more time and focusing on matters relating to both CPHAC and DSAC. This option would mean a payment consistent with previous amounts for members of both DSAC (convened 4 times per year) and CPHAC (convened 10 times per year).

If the Board agrees to option c and the same principle is applied to the Chair, then the Chair should get $437.50 for each meeting.

The 3 DHBs should meet costs equally (where the meetings are together). Therefore, if option c is adopted, the cost of $350 should be shared equally between the three DHBs and be paid to members only once. This means each member will get a total payment of $350 for each sitting.

Final advice from State Services Commission regarding this approach is yet to be received, and that if changes to the proposed approach are required, the matter will be returned to FRAC.

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**BOARD DECISION PAPER** **Date:** 4 June 2013

Author	Maureen Breukers, Business Support Manager
Endorsed by	Stephanie Turner, Director of Maori Health
Subject	Inequalities in cancer control- how well are we doing and how we can improve

RECOMMENDATION

Management recommend that the Board

a. **NOTE** this report and

b. **APPROVE** the recommendations as follows:

I. Set up a project to establish a pilot navigation programme to support Maori patients with cancer – Sponsored by Director of Maori Health

II. To be funded from existing resources within Maori Directorate

III. Following evaluation of the pilot programme consider extending to Hutt Valley DHB.

1 PURPOSE

The purpose of this paper is to respond to a Board request for information and statistics on the performance of Wairarapa DHB and the region regarding cancer screening and treatment for Maori.

2 INEQUALITIES IN CANCER CONTROL – HOW WELL ARE WE DOING AND HOW WE CAN IMPROVE

2.1 Introduction

The New Zealand Cancer Control Strategy: Action Plan 2005 - 2010 recognises cancer as a leading cause of morbidity and mortality among Maori. It also acknowledges the disparities between Maori and non-Maori in relation to incidence of cancer, mortality rates and utilisation of cancer services. Total cancer incidence is around 20% higher in Maori compared with non-Maori New Zealanders while mortality is almost twice as high. Cancer is the second leading cause of mortality among Wairarapa Maori, accounting for 30% of deaths.

2.2 Inequalities in cancer treatment and outcomes

Wairarapa DHB is part of the Central Cancer Network (one of four regional networks that promote a collaborative approach to service planning and delivery). CCN published a Health Needs Assessment Report, January 2009 that contains information on a range of cancer control data at a district and regional level. The report identified the following:

- Ethnic inequalities exist within the CCN Region for cancer screening, cancer incidence, and cancer outcomes.
- Maori and Pacific women have lower rates of screening coverage than other ethnicities for both cervical and breast cancer screening.

- When examining the top six cancer types for the years 2001-2005 (latest available), Maori had a significantly higher incidence rate than Other for lung and stomach cancers.
- The age standardisation rate (ASR) for cancer mortality for Maori was 1.7 times higher than that for Other.
- In the CCN region, Maori had a significantly higher mortality ASR than Other ethnicity for lung, breast and stomach cancers.
- Maori in the CCN Region had significantly lower on and five year relative survival rates (RSRs) than those of Other ethnicity for colorectal cancer and a significantly lower five year rate for breast cancer.
- Risk factors, particularly smoking and obesity are more prevalent amongst Maori.
- Maori have a lower life expectancy than Other ethnicities. For Other ethnicities in the Wairarapa life expectancy is 79 compared to 72 for Maori (note the latest available data 2004). Capital and Coast has the highest life expectancy for Other at 81 years and 72 for Maori.

Maori patients are more likely to be diagnosed with late-stage disease for cancers of the lung, breast, prostate, colorectum and cervix, and for melanoma. Differences in co-morbidity may also contribute to poorer cancer outcomes in Maori patients; they have higher prevalence o diabetes, cardiovascular and respiratory disease.

Evidence suggests that Maori experience particular barriers to accessing diagnostic cancer services and are more likely to experience unmet need for primary health care[1]. It has been reported that Maori may experience shorter consultation times and are less likely to be referred for specialist review compared with other ethnic groups.[2] Difficulties in access to and through the health system are likely to contribute to delayed cancer diagnosis in Maori patients. Once diagnosed there are also many factors that contribute to inequalities in treatment and outcomes such as unconscious stereotyping, communication difficulties, service location and cost.[3]

2.3 Health targets and indicators

Health targets and indicators enable us to measure in a consistent way how well we are doing as a DHB against national targets and benchmark against other DHBs. For some time we have been measuring screening rates (balanced score care measure) and waiting time once ready for treatment (health target and balanced score card measure). However it has been difficult to measure how long it takes for patients to see a specialist from the time their doctor suspects they have cancer and refers them to a specialist, to the start of their cancer treatment. The recent implementation of the Faster Cancer Treatment programme includes reporting on faster cancer treatment indicators, thus improving the timeliness of services.

Specialist cancer treatment and symptom control is essential to reducing the impact of cancer. One of the MoH Health Targets is that “All patients, ready for treatment will wait less than four weeks”. All DHBs are currently meeting the target at 100%.

The tables in the attached appendix show the latest data compiled for breast screening and cervical screening for Maori and the total population. For the period shown Wairarapa DHB has the best breast screening rate (75% against a target of 70%) for Maori women for the CCN area and the best cervical screening rate (76% against a target of 76%) for Maori women nationally.

[1] Simmonds S. Robinson B, Independent Maori Monitoring Report 2004-2006.
[2] Cringle s, Lay-Yee L, Davis P, Pearson J. A comparison of Maori and non Maori patient visits to Doctors. 2004.
[3] Taylor R, Arnett K, Begg s. Independent Maori Monitoring Report. 2007.

2.4 Faster Cancer Treatment Programme

The Faster Cancer Treatment programme implemented nationally aims to improve services by standardising care pathways and timeliness of services for cancer patients throughout New Zealand.

The programme goal is that over time all patients will have access to the same quality care within the same timeframes, no matter where they live. Since the appointment of the CNS Cancer Care Coordinator at Wairarapa DHB a month ago a lot has been achieved in establishing systems to identify and track patients including ethnicity and report on the agreed indicators which measure timely appointment, tests and treatments. Although the system is partly manual eventually this will be automated.

Although this is a programme for all ethnicities the Wairarapa DHB CNS Cancer Care is aware that Maori have some of the worst cancer health outcomes and of the issues such as lower than average presentation for appointments and uptake of treatment. She was involved with a reducing inequalities project funded by the Central Cancer Network which resulted in an education programme for health professionals (through a partnership between the Maori Directorate, Cancer Society and Whaiora) trained in the Cancer Society "Kia Ora E Te Iwi".

2.5 Proposal to establish a pilot navigation programme (Maori)

Small changes to improve access at each of the many steps patients need to take on their health care pathway e.g., tailored communications, culturally appropriate education, support in navigatng the pathway and respectful engagement may add up to a large overall improvement in Maori access to healthcare (Hill, Sarfati, Robson, & Blakely, 2013).

In 2011 the Wairarapa Cancer Society was awarded a small grant by the Central Cancer Network for a reducing inequalities initiative. The Wairarapa Cancer Society used this grant to research the cancer experience for Maori in the Wairarapa. Project research goals included better understanding the Wairarapa cancer patient's journey and barriers to service engagement. It was also thought that the research process itself would increase Cancer Society engagement with local Maori community and build Maori community knowledge about available cancer support services.

Two of the three project recommendations have been successfully implemented. These included provider collaboration to increase Maori access to cancer support services and the development and implementation of support groups, educational programmes and postreatment recovery support for the Wairarapa Maori cancer community.

The development of a patient navigator role to improve the cancer journey for local patients was the third recommendation. This has yet to be actioned. Following completion of the project the WDHB Whanau Ora Facilitator has trained and been co-facilitatiing with Cancer Society staff 'Living with Cancer' and 'Kia ora te Iwi' programmes for Wairarapa Maori cancer patients. With the appointment of the CNS Cancer Care Coordinator we have the combined skills and onsite expertise to implement a patient navigation service.

Navigating the cancer system can be a long and confusing process for Maori. It is proposed that a project be established to develop a pilot patient navigator programme including (but not limited to) the development of roles and responsibilities around cancer support within the DHB systems, linking in with the community such as Cancer Society using resources and tools currently available within the cancer community. If successful the programme could be considered for roll out to Hutt Valley DHB.

It is envisaged that a navigator be available at the point of diagnosis (usually outpatients clinics) and be a person who is trained in understanding the likely cancer pathway, who can offer current information and support and with whom the patient feels comfortable (culturally acceptable). There are exisitng staff who have the skills and knowledge to provide this service; CNS Cancer Care

Coordinator, Whanau Ora Facilitator and Oncology Social Workers. The aim of this project will be to improve the patient journey for Maori, and thus improve outcomes.

3 SUMMARY

There are ethnic inequalities within the Wairarapa DHB area and the CCN region for cancer incidence, and cancer outcomes. Generally speaking, Maori tend to present later with symptoms, affecting the success of treating this disease.

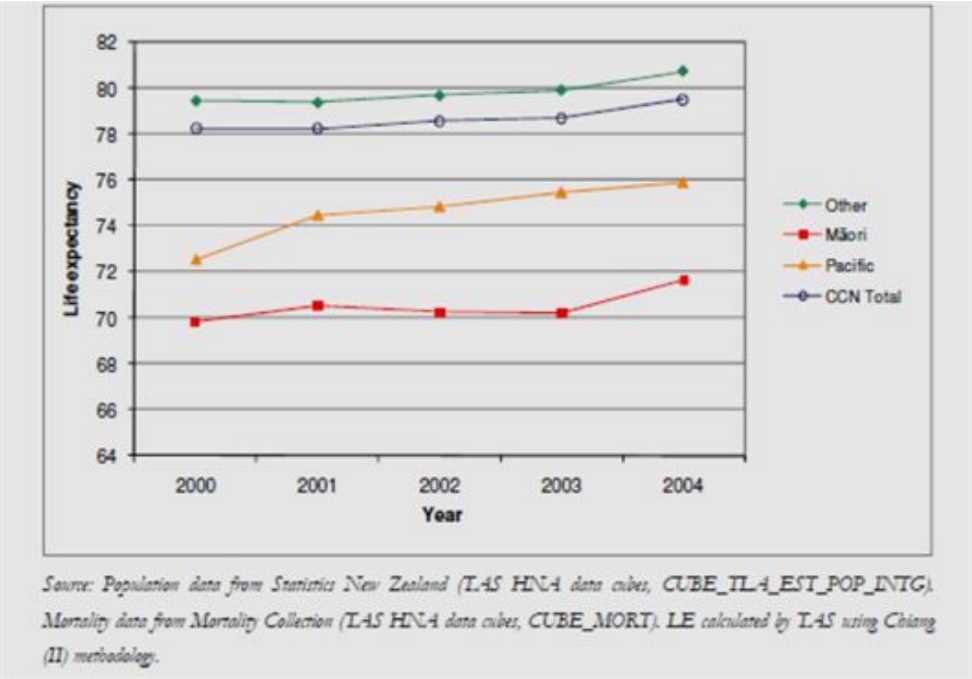
A lot of work has been done nationally and in the Wairarapa to reduce inequalities and develop culturally appropriate services. To date there has been a focus on educating health professionals and developing interagency collaboration to introduce Maori to cancer support services. Wairarapa DHB achieves well above the target for screening rates for both Maori and total population. The implementation of the Faster Cancer Treatment programme will enable us to identify patterns and trends, inequalities and barriers to service engagement with the aim of improving the diagnosis, treatment and care of patients with cancer.

Now is the time to take the next step and set up a project to establish a pilot navigation programme that will streamline the model of practice, improve coordination of care and add a layer of support that will improve the cancer journey for Maori patients. After evaluating the success of the project it could be considered for implementation at Hutt Valley DHB.

APPENDIX

Life Expectancy by Ethnicity for CCN Region (2004)

- taken from the CCN Health Needs Assessment report



Source: Population data from Statistics New Zealand (TAS HNA data cubes, CUBE_TLA_EST_POP_INTG). Mortality data from Mortality Collection (TAS HNA data cubes, CUBE_MORT). LE calculated by TAS using Chiang (II) methodology.

There are significant differences in mortality rates between CCN DHBs as shown in the table on the next page. Maori have a higher mortality rate than Other ethnicities for all eight DHBs in the CCN ranging from a difference of 22% higher (Capital and Coast) to approximately 60% higher (Tairawhiti, Hawkes Bay and Wairarapa).

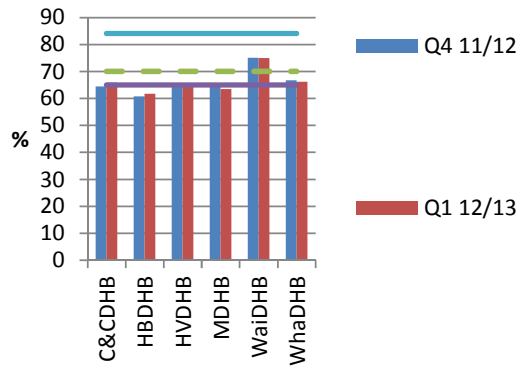
Maori patients are more likely to be diagnosed with late-stage disease for cancers of the lung, breast, prostate, colorectal and cervix, and for melanoma. Differences in co-morbidity may also contribute to poorer cancer outcomes in Maori patients; they have higher prevalence o diabetes, cardiovascular and respiratory disease.

Cancer – Breast Screening Rates

Definition of Indicator	Percentage coverage for women aged 50-69
Reporting period	Quarter 1 2012/13, 1 July 2012 – 30 September 2012
Numerator	Number of women aged 50-69 years screened in the last 2 years
Denominator	Total BSA population
Data period	24 months, 1 October 2010 – 30 September 2012
Data source	Ministry of Health

National Target = 70%	**Māori Raw Data**		**Māori**	**Trend since last Quarter**	**Total Population**	**Trend since last Quarter**
	Numerator	**Denominator**				
C&CDHB	1404	2131	66%	↑2%	71%	↑1%
HBDHB	1849	2998	62%	↑1%	74%	↑1%
HVDHB	1106	1701	65%	↑1%	75%	↑1%
MDHB	1284	2024	63%	↓1%	74%	↑1%
WaiDHB	359	479	75%	-	74%	-
WhaDHB	854	1291	66%	↓1%	74%	↑1%
Central Region	6856	10624	65%	↑1%	73%	↑1%
National Best DHB	213	254	West Coast 84%		Nelson Marlborough 83%	

Figure 13: Breast Screening Coverage for Māori Women aged 50-69 years (24 months data to 30/09/2012)

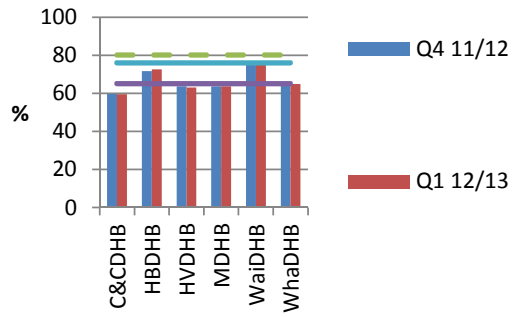


Cancer – Cervical Screening Rates

Definition of Indicator	Percent cervical screening coverage for women aged 25-69 years in the last three years
Reporting period	Quarter 1 2012/13, 1 July 2012 – 30 September 2012
Numerator	Number of women screened in the last three years
Denominator	Total hysterectomy adjusted population
Data period	36 months, 1 October 2009 – 30 September 2012
Data source	Ministry of Health

National Target = 80%	**Māori Raw Data**		**Māori**	**Trend since last Quarter**	**Total Population**	**Trend since last Quarter**
	Numerator	**Denominator**				
C&CDHB	4602	7723	60%	-	81%	-
HBDHB	6073	8360	73%	↑1%	81%	↑1%
HVDHB	3425	5431	63%	↓1%	80%	-
MDHB	4140	6511	64%	-	75%	↓1%
WaiDHB	950	1251	76%	↓1%	81%	↓1%
WhaDHB	2256	3480	65%	-	77%	↓1%
Central Region	21446	32756	65%	-	80%	-
National Best DHB	950	1251	Wairarapa 76%		Taranaki 85%	

Figure 14: Cervical Screening Coverage for Māori Women aged 25-69 years (36 months data to 30/09/2012)



PUBLIC

	MATTERS ARISING UPDATE
	Date: May 2013
Author	Bob Francis
Subject	CPHAC / DSAC Arrangements

RECOMMENDATION

It is recommended that the Boards **NOTE** that management will continue with the monthly meeting schedule and reporting with a review at the November 2013 CPHAC meeting.

1 PURPOSE

At the December 2012 Board meeting there was a resolution to review the arrangements for CPHAC by June 2013 and that SIDU and Disability Advisors provide advice on an improved mechanism for obtaining the input of people with disabilities into the work of DSAC.

2 OUTCOME

As Chair of the Committee I would like to report to the Boards that the membership of the committee is working well, noting there remains a need to resolve a Maori membership appointment. In the interim attendance by the Maori Partnership Chairs of each DHB will remain in place.

At the meeting it was also agreed that SIDU and Disability Advisor be requested to provide advice on an improve mechanism for obtaining the input of people with disabilities into the work of DSAC.

A sub regional forum to consider DHB engagement on disability issues with our community is being held at Orongomai Marae in Upper Hutt. We are working alongside National DPA. We are asking people who have leadership responsibility within our three DHB areas to be part of a process of sharing issues, good practice and to take a step to a shared planning process to move forward over future years.

Community groups are being invited to send representation from across the spectrum of experiences from the sub region. Local engagement is happening currently to get the right people there.

In conclusion I would like to advise there has been a considerable amount of work undertaken in the first half of this year to guide development of the Annual Plans, RSP and to some extent the MHPs ensuring we include the sub regional collaboration context in the reporting. The SIOU team have also developed a 3DHB Health Services Development work programme reporting which will continue to be reported on throughout the year.

The second half of the year will see the committee focusing on a move into more regular reporting, but I recommend we continue with the monthly meeting schedule with a review at the November 2013 CPHAC meeting.

PUBLIC

	BOARD INFORMATION PAPER
	Date: May 2013
Author	Dr Ashley Bloomfield, Director of Service, Integration & Development
Subject	CPHAC / DSAC May Report Back

RECOMMENDATION

It is recommended that the Boards **NOTE** the contents of the report

1 PURPOSE

The purpose of this paper is to highlight the key points from the combined CPHAC & DSAC meeting held on 20 May 2013 at Capital and Coast District Health Board.

2 SUMMARY OF PAPERS

2.1 Open Agenda

- ***Subregional Disability Stakeholder Forum - 25 June 2013***

  The Committees were updated on the forthcoming sub-regional stakeholder forum. The disability community is involved in planning the agenda and format for the day.

- ***Equity Monitoring Framework & Indicators***

  An updated report (appended) included three proposed headline indicators and targets for 2013/14: Pre-school school dental service enrolments; cardiac and diabetes checks (national target); and hospital outpatient 'did not attend' (DNA) rates. Consistent national targets already exist for the former two, and DNA targets will be developed for each DHB.

  The Committees approved these headline indicators and targets to help focus action to improve equity for Maori, Pacific and high deprivation groups in these three areas.

  An updated paper confirming the targets and related actions will be presented at the July CPHAC-DSAC meeting.

- ***Refugee Health***

  Refugee Services presented on the results of a survey and pilot being undertaken in the Manawatu and Wellington regions, focused on providing the following:

  - Language support
  - Dedicated refugee health workers to support access to health services, especially primary care
  - Promotion of key activities among refugees – immunisation, smoking cessation and screening.

  Subsequent discussion covered the following areas highlighted in the background paper:

  - Ensuring there is information available in refugees' own language regarding health care services and how to access them
  - Ensure all refugees are registered with a PHO

- Should providers be responsible for ensuring their services are accessible to these populations?
- Ensure connections between Refugee Services and the DHB
- Communications *e.g.* texting services in own language; important as a group of vulnerable people
- Disability is highlighted in the report and is a significant issue for Refugee Services group.

Action Point: Report back to CPHAC-DSAC in six months on actions taken to address the issues identified and the outcomes / recommendations of the Refugee Services pilot.

- ***3DHB Programme***

  The Committees received a full update on 3DHB activities, of which an updated summary has been provided to Boards.

- ***Establishment of Alliance Leadership Teams (ALTs) as Part of the New PHO Agreement***

  A background paper updated the Committees on changes associated with the new national PHO Agreement, the move to Alliancing and the establishment of ALTs at CCDHB and HVDHB. The Committees requested an updated paper for June Boards' meetings outlining the implications of the new Alliancing arrangements for Boards, including an update on the PHO agreement and the reporting that will go with it to ensure visibility to the Boards.

- ***Annual planning update and proposed service change process during 2013/14***

  Final draft annual plans were due at the Ministry of Health on 24 May 2013. All three DHBs have considerable savings to make in 2013/14 that will require new models of care and service change. The SIDU GM, Strategy, Planning & Intelligence presented on the proposed service change process, highlighting:

  - The ongoing SIDU Value-for-Money Programme, which has a $7M target across the 3DHBs
  - Decisions or recommendations arising from Primary Care Alliances or 3DHB work-streams
  - Change that is Ministry driven.

  Question and answer session took place.

  The Committees requested that the presentation and process should be reported back to all three June Public Board meetings.

COMMUNITY PUBLIC HEALTH & DISABILITY SERVICES ADVISORY COMMITTEES

Issues Paper

To	Community & Public Health and Disability Services Advisory Committees
From	Dr Ashley Bloomfield – **Director, Service Integration & Development Unit**
Date	10 May 2013
Subject	**Proposed headline equity indicators as part of overall equity monitoring**
Status	Decision ☑ Information ☐
Prepared by	Rebecca Rippon – **Senior Service Analyst**

1 RECOMMENDATIONS

It is recommended that the Committee:

1. **Agree** the proposed headline equity indicators
2. **Note** the Annual Plan targets already associated with these headline indicators
3. **Note** that a report will be provided to the July 2013 CPHAC-DSAC meeting outlining the proposed activities and associated investment for the headline equity indicators and proposing DNA targets for the three DHBs
4. **Note** a full report against all measures, including activity towards improving equity, will be provided in November 2013.

2 PURPOSE

The purpose of this paper is to confirm headline equity indicators, to provide existing targets and provide baseline measures and activity.

3 BACKGROUND

A request was made by the Boards for the development of a small set of core indicators that the Boards could monitor to assess the impact of the DHBs' planning, funding and service delivery on equity within its population.

An initial set of indicators was proposed and first considered by the Committee in February 2013. They were selected based on the following criteria:

- Priority area – for both the Government and Boards
- Coverage across the life-course
- Ready availability of data
- Measures of both the process of health care delivery and health outcomes

- Consistency with the existing Maori Health indicators set.

Wider feedback was sought on the draft indicators, including from PHOs serving high needs populations, the Sub-Regional Pacific Strategic Health Group and Maori Health groups.

The proposed full equity monitoring covers the following 'domains' and includes the indicators below:

Domain	Indicator(s)	Comment
Determinants of health	• Rheumatic fever	• 'Better Public Services' goal • Measure to be determined – but likely to monitor achievement of milestones in sub-regional rheumatic fever action plan • Also part of child health
Child and youth health • Oral health • Youth mental health	• Pre-school enrolment in school dental services • School dental examination arrears rate • Mean number of decayed, missing or filled teeth (DMFT) at 12 years • Youth mental health (measure to be determined in line with national advice) • Ambulatory sensitive hospitalisations (ASH)	• **Proposed headline indicator** • Also relevant to determinants of health
Access to primary healthcare	• Proportion of population enrolled in a PHO • Average number of PHO visits per enrolled person per year	• Considering ways to measure and monitor access to primary care for non-enrolled people
Adult health / non-communicable disease prevention and control	• Cardiovascular risk assessments in primary care • Proportion of diabetics checked with an HbA1c ≤64mmol/mol • Ambulatory sensitive hospitalisations (ASH)	• National target and **proposed headline indicator** • Also relevant to determinants of health
Process of care / accessibility of specialist services	• Non-attendance at hospital outpatient appointments (DNAs)	• **Proposed headline indicator** • First Specialist Assessments have been chosen as disparities are significant and they are the first access to the hospital system for elective interventions

These indicators will be reported for Maori, Pacific and high deprivation groups where possible.

At the March 2013 CPHAC meeting it was proposed that a small number of "headline indicators" be selected, for which aspirational targets could be set to drive improvement in equity in these key areas. SIDU has considered the suggested headline indicators and further detail on these measures is provided below, including proposed targets.

4 PROPOSED HEADLINE INDICATORS AND TARGETS

The measures proposed to be "headline indicators" are:

1. Pre-school enrolment in dental services
2. Cardiovascular disease (CVD) risk assessment in primary care
3. Did Not Attend (DNA) rates for hospital outpatient appointments

The headline indicator areas represent some of the major contributors to avoidable morbidity in both children and adults. They have been chosen because there are documented disparities relating to either the indicator itself or downstream outcomes (*e.g.* with respect to CVD inequities in cardiac surgical interventions and mortality rates). They are key measures of effective access to community-based primary and secondary healthcare services and are amenable to intervention by DHBs and PHOs.

Each headline measure is described below along with existing targets from the 2013/14 Annual Plan (**AP**). It should be noted that in line with Government policy the proposed targets are the same for all population groups. There are nationally set targets for the first two indicators but more work is required to identify DNA targets for the three DHBs.

Narrative reporting describing DHBs' activity and investment to support improvement towards the targets for these headline indicators will be provided at the July 2013 meeting, as well as proposed DNA targets. High level information is included at present – this will be expanded on for the July report. Progress with implementing these actions will be provided as part of the first Equity Indicators Report in November 2013.

Charts displaying baseline information for each DHB are included with status indicators and narrative around action to improve results.

= Targets (on track to be) achieved

= Behind track to achieve one or more targets

= Not on track to achieve targets

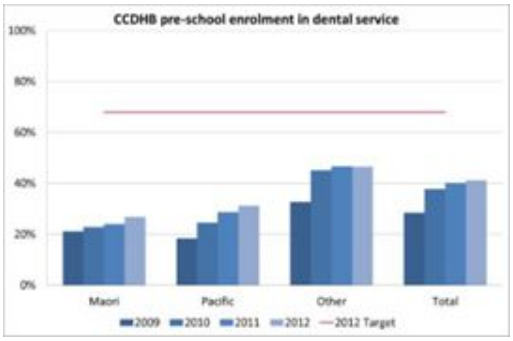
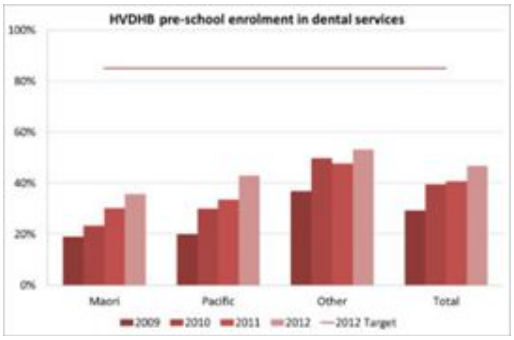
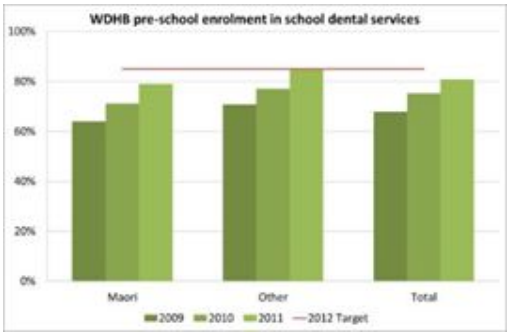
= Improvement from last result

= Worsening from last result

Headline Indicator: Proportion of pre-schoolers enrolled in a school dental service

Pre-school enrolment is a measure of access to dental services for young children. Enrolment rates are low for all pre-schoolers across the sub-region but lowest for Maori and Pacific children. By the time children reach primary school, there are significant disparities in oral health status that are potentially modifiable through improved access to early dental health care.

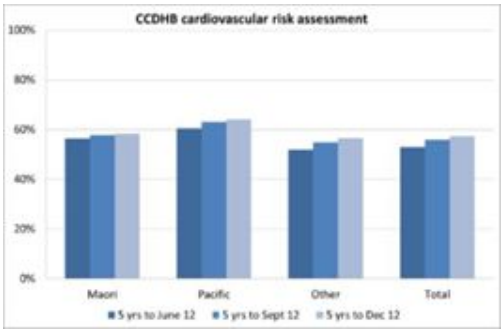
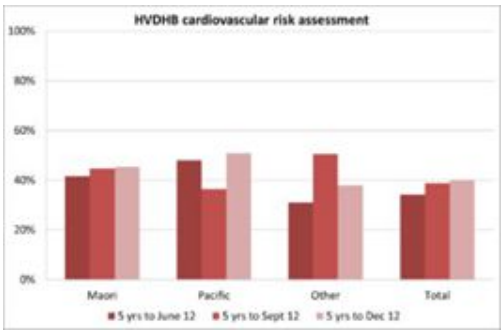
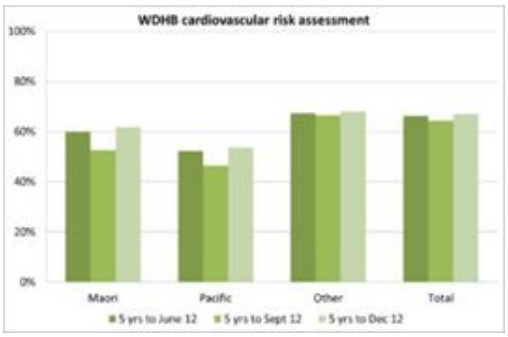
2013/14 Annual Plan Targets				Equity Monitoring Targets			
	Maori	Pacific	Other		Maori	Pacific	Other
CCDHB	65%	65%	65%				
HVDHB	65%	65%	65%	3DHB	85%	85%	85%
WDHB	85%	85%	85%				

Measure	Status	Commentary
		The Bee Healthy Dental Service provides oral health services for children in the Hutt Valley and Capital & Coast districts. An enrolment strategy has been developed which includes: enrolment at birth working with DHB birth data, increased enrolments via online web system – this is now in use and increasing in popularity with the public, strategic targeted enrolment initiatives which show improved rates for our high need populations already. These strategies will be supported and expanded to create improvement over the 2013 calendar year.
		
		Wairarapa results for 2012 are not included currently as ethnicity reporting inaccuracies require a manual re-count. 2011 results suggest that Wairarapa is on track to achieve the 85% target for Maori children.

Headline Indicator: Proportion of eligible enrolled people with cardiovascular risk assessment in the last five years

Increasing the number of heart and diabetes checks is one of the Government's health targets. There are large population health gains to be made by systematically implementing cardiovascular risk assessment and management. It is important to avoid inequity in implementation.

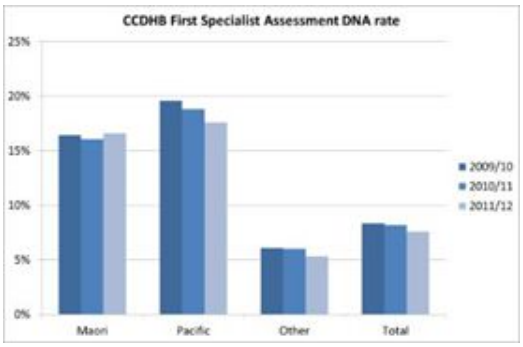
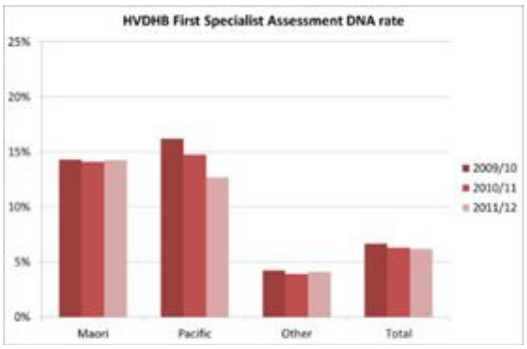
2013/14 Annual Plan Targets				Equity Monitoring Targets			
	Maori	Pacific	Other		Maori	Pacific	Other
CCDHB	90%	90%	90%				
HVDHB	90%	90%	90%	3DHB	90%	90%	90%
WDHB	90%	90%	90%				

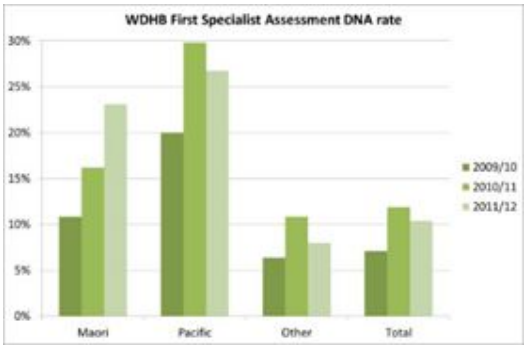
Measure	Status	Commentary
		Compass Health has contacted practices and provided information and advice, along with information on how many patients need CVD Risk Assessments and offering to provide nursing support to complete the assessments if needed. Ora Toa PHO continues to target high needs patients at community events, which has resulted in good Maori and Pacific rates. Compass Health has developed an assessment tool to help its practices identify patients and undertake CVD risk assessments. They also have 25 nurses across Capital & Coast and Wairarapa undertaking Heart Foundation training for CVD risk assessment in early 2013.
		Te Awakairangi Health Network has developed a strategic plan *"Cardiovascular Disease (CVD) Programme Plan 2012-2014*". The plan will guide a range of activities aimed at positioning the practices to improve their performance for CVD risk assessments and ensure a focussed approach to achieving the 90% health target by 30 June 2015 as agreed through the Primary-Secondary Strategy Group (**PSSG**).
		While the current target is not being achieved Wairarapa is the leading DHB for this measure, at 67%. Wairarapa PHO is continuing work with practices to improve performance for this measure.

Headline Indicator: Proportion of first specialist outpatient appointments where patient did not attend (DNAs)

Not attending hospital outpatient appointments may result in individuals not accessing secondary healthcare services that they need. Rates vary between services and Maori and Pacific have higher rates than others. Specific initiatives have been put in place to try and address non-attendance.

2013/14 Annual Plan Targets				Equity Monitoring Targets			
	Maori	Pacific	Other		Maori	Pacific	Other
CCDHB	Targets have not yet been set for first specialist assessment DNAs			3DHB	TBC	TBC	TBC
HVDHB							
WDHB							

Measure	Status	Commentary
		Capital and Coast Maori Health Development Group and Pacific Directorate have participated in the development of a project to improve the non-attendance (**DNA**) rates in outpatient clinics within CCDHB hospitals. Sampling of patients identified some common reasons for non-attendance: transport, health literacy, administrations issues such as not receiving letters and re-scheduling of appointments as well as the need for flexible booking opportunities. The project will include working between primary care and hospital services (including the hospital Pacific Health Unit and Whanau Care Service) to overcome barriers to attendance. This might involve revision of appointment letters, specific initiatives in practices with high patient DNA rates and investigation of new booking systems (learning from the success of Hutt Valley DHB).
		Hutt Hospital has improved surgical DNA rates by introducing a web-based booking system where patients select their own appointment time.

		Wairarapa Hospital has higher DNA rates than the other two DHBs. While the numbers for Pacific are relatively small, the number of Maori not attending appointments has increased substantially. This measure has not been routinely reported for Wairarapa and an update around proposed activity will be provided in July.

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**SECRETARIAT UPDATE** **Date:** 26 May 2013

Author	Nadine Mackintosh
Subject	2013 District Health Board Elections

RECOMMENDATION

It is recommended that the Board

a. **NOTE** the keys dates for the 2013 elections are based on current legislation and regulations.

b. **NOTE** that if the Local Electoral Amendment Bill (No.2) is enacted the nomination period will shift back one week to 19 July and run to 16 August.

c. **NOTE** voting on elections this year will use the Single Transferable Voting system

d. **NOTE** that the Ministry will run a communications programme to encourage public participation in the DHB elections and work with DHB communications staff on this.

e. **NOTE** that provisions have been made in our 2013/14 budgets for the elections costs.

The Board has already passed three resolutions:

1. The appointment of the electoral officer, Milan Hautler
2. Random order of candidate names
3. Early processing of votes

The following table highlights key dates for the 2013 elections, as they currently stand. These dates are based on current legislation and regulations. If the Local Electoral Amendment Bill (No 2) currently before Parliament is enacted as introduced, the nomination period will shift backwards one week to 19 July and run through until 16 August.

Date	Action
Monday 8 July	Enrolment update packs sent to all registered electors for them to check/update details.
Friday 26 July	Candidate nominations open.
Friday 23 August	Candidate nominations close (**12 NOON**)**.**
Friday 20 September	Delivery of voting documents starts – start of voting period, special votes are issued and early processing of votes begins.
Saturday 12 October	Election day – end of voting period (**12 NOON**) and announcement of preliminary results (as soon as practicable after the close of voting).
From Saturday 12 October	Special votes counted and official results declared (as soon as practicable after all valid votes have been counted).
Monday 9 December	Newly elected DHB Board members take office.

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**DECISION PAPER**
	Date: 28 May 2013

Author	Bob Francis
Subject	**Resolution to Exclude the Public**

RECOMMENDATION

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

The grounds for the resolution is the Committee, relying on Clause 32(a) of Schedule 3 of the Act believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists under the Official Information Act 1982 (OIA), in particular:

Agenda Item	NZ Public Health & Disability Act
Chairman's Report	Section 9 (2)(j) to enable a Minister of the Crown or any department or organisation holding the information to carry out, without prejudice or disadvantage, negotiations
Complaints Letter to the Chief Executive	
3DHB ICT Update	
Chief Executive Report	9(2)(a), 9(2)(i) Protect the privacy of natural persons and to enable a Minister of the Crown or any department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities
National Delegated Financial Authority Policy	Section 9(2)(f) (iv) Subject to Ministerial Approval
State Sector and Public Finance Reform Bill	
IDF Wash-ups	
Maori Health Plan	
Options for relocation of CAMHS	Section 9(2)(i) to enable a Minister of the Crown or any department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities
PHO Services and Alliances Agreement	
Community Lab Paper	
CRISP	